ATHABASCA UNIVERSITY

SEEKING TO IMPROVE COLLABORATIVE CAPACITY TO ENHANCE MULTILATERAL HEALTH CARE COLLABORATION BETWEEN FIRST NATIONS, FEDERAL AND PROVINCIAL GOVERNMENTS IN ALBERTA

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NATHALIE LACHANCE

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Abstract

Over the years, a number of efforts have been underway to enhance health care collaboration between First Nations, federal and provincial governments. One of those more recent initiatives is the subject of this research – the Joint Action Plan to Improve the Health of First Nations in Alberta. The Joint Action Health Plan was developed in 2014 to enhance collaboration between First Nations of Treaty No. 6, Treaty No. 7 and Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch – Alberta Region (Health Canada) to achieve quality of health services. This participatory action research was conducted by interviewing 25 mid-to senior level individuals involved in the development and implementation of the Joint Action Health Plan. The theoretical foundation used to ground this research is collaboration theory. More specifically, this research is anchored by Wood and Gray's definition of collaboration and the three-phase process of collaboration (preconditions, processes and outcomes). This is supplemented by the work of Foster-Fishman and her colleagues on the four elements of collaborative capacity (member capacity, relational capacity, organizational capacity and programmatic capacity). This research seeks to inform practice by providing 11 recommendations and identifying three key elements to enhance health care collaboration. First, the need for civil servants in First Nations, federal and provincial governments to take into account the impact of colonization on collaboration. Second, the need for reconciliation to enhance relationships between First Nations and governments as well as more broadly between First Nations Peoples and Settler society in Canada. And, thirdly the need to address the knowledge gap of federal and provincial civil servants, especially non-Indigenous employees, as we seek to

develop meaningful collaboration between First Nations, federal and provincial governments. This research also contributes to research by: using collaboration theory within the context of health care collaboration between First Nations, federal and provincial governments; highlighting the cyclical rather than linear nature of collaboration; adding values to the definition of collaboration; and, demonstrating the interconnectedness of the four elements of collaborative capacity.

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List of Symbols, Nomenclature, or Abbreviations

AANDC	Aboriginal Affairs and Northern Development Canada
AFNIGC	The Alberta First Nations Information Governance Centre
AHS	Alberta Health Services
AoTC	Assembly of Treaty Chiefs
CIHR	Canadian Institute of Health Research
FNIHB	First Nations and Inuit Health Branch of Health Canada (2000 to present)
FNIHB-AB	First Nations and Inuit Health Branch – Alberta Region
HCoM	Health Co-Management
INAC	Since 2015, INAC is the acronym for Indigenous and Northern Affairs Canada, earlier this acronym was also used for Indian and Northern Affairs Canada.
JAHP	Joint Action Health Plan; acronym also used for its full title Joint Action Plan to Improve the Health of First Nations in Alberta
MSB	Medical Services Branch of Health Canada (1962 to 2000)
MNC	Métis National Council
NAHO	National Aboriginal Health Organization
NDP	New Democratic Party
NIHB	Non-Insured Health Benefits
OCAP	Ownership, Control, Access and Possession
PAR	Participatory Action Research
RCAP	Royal Commission on Aboriginal Peoples
TRC	Truth and Reconciliation Commission
TSAG	First Nations (Alberta) Technical Services Advisory Group
UN	United Nations
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

Chapter 1 – INTRODUCTION

With this research project, I sought to better understand and improve collaborative capacity in order to enhance health care collaboration between First Nations, federal and provincial governments. More specifically, I sought to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta which was jointly developed by First Nations organizations and governments in Alberta, Alberta Health, Alberta Health Services and the First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB) of Health Canada. While I could describe the focus of this research as interorganizational collaboration within a cross-cultural context, this wording fails to fully acknowledge the nature of this work and the complexities of collaboration between First Nations, federal and provincial governments. Further, my focus is on the work of civil servants in these governments which led to a focus on the social, political and cultural aspects of collaboration. I understand that legal and jurisdictional matters also impact collaboration between First Nations, federal and provincial governments but are not the focus of this research as these are perceived as being out of the control of the participants.

To ensure that honourable and respectful conduct as I engaged with participants, I sought guidance from a number of Indigenous researchers (Baker, 2016; Battiste, 2008; Hampton, 1995; Kovach, 2012; Simpson, 2001; Wilson, 2008) who stressed the importance of identifying connections to the research. I approached this research as a practitioner, as someone who has worked in the field of Indigenous health for more than 20 years. For most of my career, in Indigenous organizations and at FNIHB-AB, I have aimed to work collaboratively and the Joint Action Health Plan is simply one of the more

recent collaborative endeavours in which I have been involved. Over the years, I have been involved in a number of collaborative endeavours between First Nations organizations and governments, FNIHB-AB and in some cases Alberta Health and/or Alberta Health Services. These collaborative endeavours have both yielded results and encountered a number of challenges. As I began to read for this dissertation, I related to the three phases of collaboration, preconditions, processes and outcomes, which are identified in academic and management literature. As a practitioner, I could relate to the simplicity of this theory as I understood preconditions as the starting point, processes as the steps that allow us to move from development to implementation and finally the outcome. Considering that I often interact with the same people on a number of initiatives, I understood this process as cyclical, believing that today's preconditions were based on yesterday's outcomes. As I began this journey, I was particularly interested in the processes' phase of collaboration and the concept of collaborative capacity which refers to "the conditions needed … to promote effective collaboration and build sustainable community change" (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001, p. 242). However, as I gathered more information from interviews and Indigenous literature, I began to wonder if I had underestimated the importance of preconditions and more specifically the broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society.

On this journey, I often reflected on an advice given to me by an Elder I interviewed who told me "if you don't know, ask" (FN07). This dissertation highlights both what I did not know and what I asked. Over the course of this research, I uncovered

a number of instances where I found out that what I thought I knew was incorrect or only part of a more fulsome story leading me to begin to see and hear differently. So, I may still not fully know what I do not know and when I failed to ask a question that would have enlightened me but this research has profoundly changed me and I am hoping that not only will I use what I have learned to be a better – meaning more collaborative and supportive – partner but that by sharing this story I will also give individuals working in a similar context tools to be a better partner.

Statement of the Issue

In a country where the 1986 Ottawa Charter for Health Promotion (World Health Organization, 1986) was developed, health policy makers and practitioners seek to better understand the impact of health determinants on health outcomes. Numerous reports (Alberta Health and The Alberta First Nations Information Governance Centre, 2016a, 2016b, 2016c, 2016d; British Columbia Office of the Provincial Health Officer, 2009; Health Canada, 2005, 2008, 2013; Lachance, Hossack, Yacoub, Wijayansinghe, & Toope, 2010; United Nations Human Rights Council, 2014) indicated significant gaps in health outcomes between First Nations and non-First Nations peoples in Canada. In seeking to assess overall health of a population, life expectancy and infant mortality rate are often used as key indicators. In 2015, the life expectancy at birth for First Nations peoples was 11.9 years shorter than for other Albertans and the gap in life expectancy was widening as it was 7.3 years in 1999 (Alberta Health and The Alberta First Nations Information Governance Centre, 2016d). While 74 per cent of Canadians who died in 2004 were over the age of 65, only 34 per cent of First Nations peoples in Alberta who died in 2003 were in that age group (Lachance et al., 2010). In the last three decades,

significant gains have been made in terms of infant mortality rates for First Nations peoples, yet it is still much higher at 9.6 deaths per 1,000 live births, than for other Albertans, which is at 4.3 per 1,000 live births (Alberta Health and The Alberta First Nations Information Governance Centre, 2016a). Those significant gaps in health outcomes lead to increasing interest in health inequities (CIHR Institute for Population and Public Health, 2009; National Collaborating Centre for Determinants of Health, 2011, 2013).

Gains in health outcomes are often sought through improvements to socio-economic determinants of health (e.g., high school graduation rates or employment opportunities) or by increasing quality of health services. The first approach would encourage a more holistic approach with a broader group of stakeholders and is believed to have the potential of yielding greater results in terms of health outcomes. The second approach would seek to use "medical and public health-based interventions… to significantly improve health at the community level" (Alexander et al., 2003, p. 131S) and is the focus of this research. More specifically, I sought to address one of the issues raised in the most recent report of the United Nations Special Rapporteur on the Rights of Indigenous Peoples which indicates that "federal, provincial and aboriginal governments [need to] improve upon their coordination in the delivery of [health] services" (United Nations Human Rights Council, 2014, p. 23). I also understood that "almost all federal, provincial and territorial governments in the past have been criticized for their inability to partner with Indigenous communities to create mutually beneficial public policies" (Alcantara & Spicer, 2015, p. 95).

In seeking to address this issue, it is important to clarify the terminology used in this document. First, while section 35 of the *Constitution Act, 1982* identifies as Aboriginal Peoples of Canada – Indian, Inuit, and Métis Peoples of Canada (Government of Canada, 1982), I used the more specific tribal affiliation (e.g. Cree, Blackfoot) when known such as in referring to Indigenous scholars. While I knew the tribal affiliation of most participants, I sought to protect their confidentiality by using the more generic term First Nations. In more national and/or international contexts, I opted for Indigenous (Vowel, 2016). Over the years, a number of terms have been used to describe First Nations and Indigenous peoples, I respected the wording and capitalization used in the source document. Second, as I drafted this dissertation, I debated the many options available to describe the relationships between First Nations Peoples and non-First Nations and/or non-Indigenous peoples in Canada. I weighed the input of Métis writer Chelsea Vowel (2016) who offered caution about using the negative form to describe a group. As I sought to refer more broadly to the non-Indigenous population in Canadian society, I opted for the wording used by Mohawk scholar Taiaiake Alfred, who refers to Settler society (Alfred, 2009). Third, there is a growing body of academic and management literature on the concept of "working together". For this research I preferred to use the word "collaboration" and the definition outlined by Wood and Gray (1991), which is provided in chapter 3, however in a few instances as illustrated above with the reference from the UN Special Rapporteur on the Rights of Indigenous Peoples, I included references using other words such as partnership, coordination and integration when the concepts outlined are similar to my understanding of collaboration. Third, following the lead of a number of authors, I understand collaboration as including three

phases – preconditions, processes and outcomes (Butterfield, Reed, & Lemak, 2004; B. Gray & Wood, 1991). Fourth, collaboration literature often refers to problem or problem domain. I understand the word problem within this context as simply a joint issue that we seek to address. For the Joint Action Plan to Improve the Health of First Nations in Alberta, partners indicated their desire to enhance collaboration and governments as we seek to improve quality of health services. Fifth, considering my interest in the processes stage, I sought to better understand collaborative capacity which has been defined as "the conditions needed … to promote effective collaboration and build sustainable community change" (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001, p. 242). This focus on collaborative capacity is also linked to my interest in the social, political and cultural aspects of collaboration rather than its legal and jurisdictional components.

Overview of Health Care in Canada

The foundation of health care in Canada dates back to the *Constitution Act, 1867* where section 92 (7) grants to the provinces exclusive jurisdiction over "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the Province, other than marine hospitals" (Government of Canada, 1867). The introduction of a publically-funded health care system in Canada began after the Second World War, as both federal and provincial governments sought to expand the social safety net of Canadians. Provinces led the development of Canada's public health care system resulting in "a national program … composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage" (Health Canada, 2010a). To ensure consistency across provinces, the federal government uses "its constitutional

'spending powers' which enables it to make a financial contribution to certain programs under provincial jurisdiction, generally subject to provincial compliance with certain requirements" (Madore, 2005, p. 4). In 1984, the federal government articulated the national requirements for a publicly-funded health care system through the *Canada Health Act.* The purpose of the Act is "to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made" (Government of Canada, 1984, p. 5). The Act identifies five criteria for federal funding: public administration, comprehensiveness, universality, portability and accessibility (Government of Canada, 1984). When the Canada Health Act was enacted health expenditures accounted for 20.3 percent of the provincial budget in Alberta (Government of Alberta, n.d.-a, n.d.-b); in 2017-2018, they are expected to represent 39 percent of the Alberta government operational spending (Government of Alberta, 2017). The federal funding accounted for 23.5 percent of that funding (Government of Alberta, n.d.-a), in 2017-2018 it is expected to represent 20.4 percent (Government of Alberta, 2017). Therefore, the Government of Alberta is allocating an increasingly larger proportion of its budget to health care and while the federal government's contribution is increasing, its proportion of the provincial health care budget is decreasing. The large sums involved in health care often lead to discussions around aggregation of services and economies of scale as well as to the appropriate level of growth for the federal funding. In Alberta, there are discussions in regards to optimum models for service delivery especially for primary care as exemplified by discussions on the Primary Care Networks as well as the Family Care Clinics model that was proposed a few years ago.

Overview of Health Care for First Nations Peoples in Canada

First Nations lived on this continent for thousands of years and have healing practices that predate the arrival of settlers. First Nations healing practices include but are not limited to medicinal plants, healing circles, sweat lodge ceremonies, midwifery, nature retreats, and spiritual ceremonies (Lux, 2001; Mashford-Pringle, 2011; Shroff, 2011). I limited the focus of this research to government-funded health care and began this overview in the 19th century. While section 92 (7) identifies provision of health services as a provincial jurisdiction, section 91 (24) of the *Constitution Act, 1867* identifies "Indians, and Lands reserved for the Indians" (Government of Canada, 1867, p. 4) as a federal jurisdiction. In parallel and also late in the 19th century, the Crown signed treaties with First Nations peoples; of particular interest for this research are Treaty No. 6 (1876), Treaty No. 7 (1877) and Treaty No. 8 (1899). Treaty No. 6 includes the "Medicine Chest Clause" which states "that a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent" (Government of Canada, 1964).

Delivery of health services to First Nations peoples began in 1904, when the Department of Indian Affairs appointed a general medical superintendent (Health Canada, 2007). Management of health services for First Nations and Inuit peoples was transferred to the Department of Health and Welfare upon its creation in 1945. Medical Services Branch (MSB) was established in 1962 (Health Canada, 2007) and renamed First Nations and Inuit Health Branch (FNIHB) in 2000. With the creation of Medical Services Branch, the federal government increased its involvement in health care adding 46,000 new hospital beds between 1948 and 1953 (Lux, 2016). These segregated

hospitals were expected to "operate at half the costs of provincial hospitals" (Lux, 2016). In 1967, the Hawthorn report provided "a study of the social, educational and economic situation of the Indians of Canada" (Hawthorn, 1967, pp. v). The Hawthorn study outlined that "the Indian should [not] be required to assimilate… in order to receive what he now needs nor at any future time" (Hawthorn, 1967, p. 6) rather it advocated for the "right of Indians to be citizens plus" (Hawthorn, 1967, p. 6) which would ensure that "both [federal and provincial] levels of government applied their respective legislative and fiscal resources in a cooperative fashion" (Hawthorn, 1967, p. 210). In its 1969 White Paper, the federal government proposed "that services come through the same channels and from the same government agencies for all Canadians" (Government of Canada, 1969, p. 7). First Nations peoples responded to the White Paper by declaring the proposed policy "a thinly disguised programme of extermination by assimilation" (Cardinal, 1999, p. 1) and a way for the federal government "to wash its hands of Indians entirely, passing the buck to the provincial governments" (Cardinal, 1999, p. 1). The federal government withdrew the White Paper but "its underlying philosophy seemed to animate federal policy for years to come" (Royal Commission on Aboriginal Peoples, 1996, p. 203). Further, Margaret Lux indicated that establishment of "national and health insurance finally provided the federal government with a golden opportunity to jettison its legal responsibilities for Aboriginal people's health" (Lux, 2016, p. 191). In the 1974 Policy of the Federal Government concerning Indian Health Services, the federal Minister of Health "reiterated that no statutory or treaty obligations exist to provide health services to Indians" (Health Canada, 2007). A few years later, the federal government outlined the basis for its involvement in the delivery of health services for

First Nations and Inuit peoples with the 1979 Indian Health Policy (Health Canada, 1979) which included three pillars for action:

- Community development which highlights the importance of involving First Nations peoples in addressing health issues while acknowledging the need for support by the larger Canadian community.
- Traditional relationship between First Nations peoples and the federal government which outlines the need for an ongoing role for the federal government as both an advocate and promoter as well as seeks to encourage better communications and greater involvement of First Nations peoples in the development and implementation of health care.
- Interrelated Canadian health system where the federal government commits to maintain its involvement, encouraged the provinces to play their role in filling the gaps in the "diagnostic and treatment of acute and chronic diseases and in the rehabilitation of the sick" (Health Canada, 1979, np) and encouraged greater involvement of First Nations peoples in the decision-making process.

Building on the community development pillar of the Indian Health Policy, the federal government released the 1989 Transfer Policy which provides an opportunity for increased control of health services by First Nations peoples (Health Canada, 1999). In 2012, FNIHB released its strategic plan (Health Canada, 2012c) including four priorities: high quality health services; collaborative planning and relationships; effective and efficient performance; and, a supportive environment in which employees excel.

In a model that is duplicated across most provinces, health care for First Nations peoples in Alberta is provided and/or funded by First Nations organizations, Alberta

Health Services, Alberta Health and FNIHB-AB. First Nations peoples have access to the provincial health system including hospital care and specialized services through Alberta Health Services and physician care funded by Alberta Health. However, there are a number of barriers in accessing these health services including issues of cultural safety and appropriateness, limited responsiveness to the needs of First Nations peoples, as well as discrimination and racism in the health care system (Allan & Smylie, 2015; Currie, 2014b; Currie et al., 2013; Lavoie, Boulton, & Gervais, 2012). First Nations peoples can access federally-funded health programs and services including Non-Insured Health Benefits (NIHB) which covers prescribed medication, medical supplies and equipment, dental care, vision care, short-term crisis counselling and medical transportation (Health Canada, 2010b); the range and scope of these services can be similar to private insurance plans as well as some provincially-funded insurance plans. There are some differences between NIHB and provincially-funded plans. For example, some of those plans such as Alberta Aids to Daily Living may exclude NIHB clients (Alberta Government, 2013) even when some of the benefits are not covered by NIHB resulting in poorer access for some benefits for First Nations peoples than for other Albertans. Most First Nations communities are funded by FNIHB-AB to deliver health programs and services including health promotion and disease prevention activities, public health, and limited treatment, essentially home and community care (Health Canada, 2012b). The comparability of federally- and provincially-funded health programs and services is impacted by funding, aggregation of services and economies of scale. To supplement the existing FNIHB-funded basket of services, a number of communities have established partnerships with Alberta Health Services and/or local

Primary Care Networks to offer access to a broader range of health professionals such as nurse practitioners, midwives and physicians, as well as other programs and services including diagnostic and screening services (Health Canada, 2012b). In Alberta, four of the 47 First Nations communities are defined as remote and isolated giving them access to FNIHB funding to offer primary care. Finally, FNIHB-AB staff is providing direct health services in a number of First Nations communities, in most cases, it is linked to the provision of nursing services (Health Canada, 2012b) but it also includes environmental health services as well as some preventative dental services. In summary, the range of services and the level of care vary between communities; some programs and services are available on-reserve while others are only accessible off-reserve; and, while some benefits are available to all First Nations peoples regardless of residence, others are limited by residency requirements (Health Canada, 2010b, 2012b). Those differences in service levels between communities impact continuity of care for First Nations peoples and the level of care available often fails to compare with services to residents of communities of similar sizes and remoteness.

Over the years, a number of health care collaborations have been developed and implemented at the community, Tribal Council, Treaty and provincial levels. In 1996, most First Nations Chiefs in Alberta signed a Co-Management Agreement with the federal Minister of Health that support the co-management, co-assessment and co-analysis of the FNIHB-AB funding (Co-Management, 1996). Today, a number of Co-Management sub-committees exist to support the joint work of First Nations communities and FNIHB-AB. In 2014, First Nations organizations and governments, Alberta Health Services, Alberta Health and FNIHB-AB drafted the Joint Action Plan to

Improve the Health of First Nations whose goal is "to enhance collaboration between First Nations [organizations and governments], Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations [peoples] that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014, p. 1).

Significance of the Research

The previous sections provided a quick overview of the development of health care for Canadians and First Nations peoples. The involvement of so many jurisdictions has been described as "a complex array of federal, provincial, and aboriginal services, and concerns have been raised about the adequacy of coordination among these" (United Nations Human Rights Council, 2014, p. 10). In Alberta, I have been involved and/or I am aware of a number of existing collaborations stemming from the work of individuals seeking to address a range of health issues. While this could be perceived as adaptive to the needs of First Nations communities, it often leads to opportunities for collaboration that often wane once the crisis has been addressed or with staff turnover; limiting the ability to build a more systemic approach to address issues collaboratively. As I sought to enhance collaboration, academic and management literature reminds us that collaboration is not a panacea (Kreuter, Lezin, & Young, 2000; Mayo, 1997; McGuire, 2006; New Zealand Ministry of Social Development, 2003), rather it is grounded in the "belief that in spite of the difficulties in forming enduring partnerships that are based in mutuality, the end result is worth the effort and within partnerships there is the hope of bringing people together in a common purpose" (Calabrese, 2006, p. 169).

Therefore with this research, I sought a more systematic approach to collaboration, one which would have the ability to impact how health care is delivered throughout the province. To do so, I sought to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. As a preliminary step towards multilateral health care collaboration, the Joint Action Health Plan does not define collaboration nor its desired outcome; however, it identifies activities to enhance collaboration including activities that can lead to further engagement of First Nations peoples as decision-makers in the health system. Recognizing that this greater engagement of First Nations peoples requires changes in service delivery models as well as relationships between partners, I sought to better understand and improve collaborative capacity of partners. Collaborative capacity includes four elements: member capacity which includes the skills, knowledge and attitudes of members; relational capacity which refers to the relationships between participants and partnering organizations; organizational capacity which refers to the structure and accountability mechanisms to facilitate collaboration; and, finally, programmatic capacity which outlines the ability of the collective to deliver. To do so, my research question is: How can improved collaborative capacity enhance health care collaboration between First Nations organizations, Alberta Health, Alberta Health Services and FNIHB-AB? This question anchored this research on the more social, cultural and political aspects of collaboration rather than tackling its more legal and jurisdictional aspects.

In Chapter 2, I provide the broader context of Indigenous research and my lenses as a participant and researcher. In Chapter 3, I provide a literature review on

collaboration and collaborative capacity as well as lay the foundation for the preconditions by outlining the broader context of relationships between First Nations, federal and provincial governments as well as take into account the relationships between First Nations Peoples and Settler society. In Chapter 4, I outline how this research was undertaken using a five-step participatory action research. In Chapter 5, I link key elements of my literature review with what I heard as I interviewed participants and what I experienced as a participant. In Chapter 6, I share my understanding of what I read, heard, and experienced to inform research prior to sharing possible recommendations for the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta in Chapter 7.

Chapter 2 – WEAVING INDIGENOUS AND WESTERN WAYS OF KNOWING

With this research, I sought to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments in Alberta focusing on the more social, cultural and political aspects of collaboration. This research project was developed as a doctoral dissertation as I sought to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. The Joint Action Health Plan was jointly developed between First Nations of Treaty No. 6, Treaty No. 7, Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch – Alberta Region (Health Canada). Within a Western way of knowing, this research is about inter-organizational collaboration, collaborative capacity and public administration and management. A literature review on these concepts as well as the broader context of relationships between First Nations and governments is provided in Chapter 3.

To define this research solely within a Western way of knowing however would fail to acknowledge the importance of Indigenous ways of knowing also underpinning this research. Therefore, in this chapter I outline a number of elements I took into account as I anchored my research. As the intent of the Joint Action Health Plan is to improve First Nations health outcomes and as Indigenous peoples and organizations are involved in this research, I took into consideration the broader context of Indigenous research. Some of the participants were non-Indigenous (including myself) and while some of the organizations involved have a clear mandate to serve First Nations (e.g., First Nations organizations and governments as well as Health Canada's First Nations and

Inuit Health Branch), other partnering organizations (e.g., Alberta Health and Alberta Health Services) have a broader mandate. Therefore, this research is also cross-cultural (Smith, 1999). As a cross-cultural research project, jagged worldviews (Little Bear, 2000) were often my reality. In this chapter I outline how I sought to ensure congruence between epistemology, ontology, axiology and methodology (Wilson, 2008). Considering my focus on collaboration, this congruence cannot be obtained solely within one way of knowing and required that I weave Indigenous and Western ways of knowing. As I undertook what I found to be a fairly challenging weaving process, I was buoyed by the words of an Elder I interviewed who reminded me that what is important is not being the best but rather being the best you can be with the gifts you have (FN07).

Indigenous Research

I am a non-Indigenous researcher yet I frame this research within the broader context of Indigenous research. I do so based on the following definition by Mohawk scholar Marlene Brant Castellano:

> Aboriginal research means research that touches the life and well-being of Aboriginal Peoples. It may involve Aboriginal Peoples and their communities directly. It may assemble data that describes or claims to describe Aboriginal Peoples and their heritage. Or, it may affect the human and natural environment in which Aboriginal Peoples live. (Brant-Castellano, 2004, p. 99)

I believe my research meets all four criteria outlined in this definition. First, as I sought to enhance health care collaboration between First Nations, federal and provincial governments, it qualifies as "touch[ing] the life and well-being of Aboriginal Peoples" (Brant Castellano, 2004, p. 99). For my research, I further narrow this understanding to

one of Canada's constitutionally-defined groups, First Nations Peoples, though the Constitution refers to "Indians" (Government of Canada, 1982). Considering my focus on health care is also constitutionally-defined as a provincial jurisdiction, I further limit it to Alberta. Well over two thirds of the participants in my research are Indigenous people whether they work in First Nations, federal or provincial governments. Therefore, it also meets the second criteria which indicates that "it may involve Aboriginal Peoples and their communities directly" (Brant Castellano, 2004, p. 99). As a participatory action research project, I worked with First Nations individuals and organizations as I developed the research project and as it unfolded. Research on collaboration between First Nations, federal and provincial governments cannot be undertaken without acknowledging and describing the broader context of relationships between First Nations and governments, therefore meeting the third criteria "it may assemble data that describes or claims to describe Aboriginal Peoples and their heritage" (Brant Castellano, 2004, p. 99). Finally, collaboration is about relationships and is part of the human environment outlined in the fourth criteria (Brant Castellano, 2004).

As I approached this research within the broader context of Indigenous research, I was cognizant that Indigenous peoples "continue to regard research, particularly research originating outside their communities, with a certain apprehension or mistrust" (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council and Social Sciences and Humanities Research Council of Canada, 2014, p. 109). This relationship to research is articulated even more clearly by Maori researcher Linda Tuhiwai Smith who stated that "from the vantage point of the colonized… the term 'research' is inextricably linked to European imperialism and colonialism… The word

itself, 'research' is probably one of the dirtiest words in the Indigenous world's vocabulary" (L. T. Smith, 1999, p. 1).

In outlining an Indigenous research agenda, Smith identified a typology of research projects. Reviewing her list, I believe this research can be categorized as an "intervening" project since it "takes action research to mean literally the process of being proactive and becoming involved as an interested worker of change" (Smith, 1999, p. 147). With this research, I sought to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. While the Joint Action Health Plan builds on a number of existing collaborations (more information to be provided in Chapter 3), this initiative can be defined by a focus on change whether we consider: the participants' expressed desire for change; the change in relationships between participants and more broadly the participating organizations; as well as, some of the desired outcomes including improving First Nations health outcomes.

In advocating for the need for Indigenous research, Smith emphasized the need for decolonization which she defined as "centring our concerns and world views and then coming to know and understand theory and research from our own perspective and for our own purposes" (Smith, 1999, p. 39). Mohawk scholar Taiaiake Alfred outlined this need for decolonization by stating:

> Decolonization… is a process of discovering the truth in a world created out of lies. It is thinking through what we think we *know* to what is actually true but is obscured by knowledge derived from our experiences as colonized peoples…. In a colonized reality, our struggle is with all existing forms of political power, and

> to this fight, we bring our only real weapon: the power of truth. (Alfred, 2009, p. 280)

Cree-Saulteaux scholar Margaret Kovach further wrote that "the purpose of decolonization is to create space in everyday life, research, academia, and society for an Indigenous perspective without it being neglected, shunted aside, mocked or dismissed" (Kovach, 2012, p. 85). As a non-Indigenous researcher, I am acutely aware – though more now than at the beginning of my research – of the dangers that I can further contribute to the colonization of First Nations peoples and communities. This brings to the forefront the role of the non-Indigenous researcher in Indigenous research. Michi Saagiig Nishnaabeg scholar Leanne Simpson wrote:

> Outside researchers who are useful to Aboriginal peoples do not have their own research agendas, or they are at least able to put them aside. They are willing to spend time looking inside themselves, uncovering their own biases, and privileges and they are willing to learn *from* our people – not *about* Aboriginal peoples, but about themselves and their place in the cosmos. They are willing to be transformed, in a sense, they are willing to be developed. (Simpson, 2001, pp. 144-145)

As I conducted this research, I aimed to live up to those expectations. In conducting this research, I learned from Indigenous peoples whether they were the participants I interviewed, the supervisory committee members who guided me or the authors I read. Further, I aimed to better understand how I can be a more supportive and collaborative partner taking into account a quote from Malcom X that was reiterated by Mohawk scholar Taiaiake Alfred: "Whites who are sincere should organize among

themselves and figure out some strategy to break down the prejudice that exists in white communities. That is where they can function more intelligently and more effectively" (as cited in Alfred, 2009, p. 236). Mi'kmaw scholar Marie Battiste defined non-Indigenous researchers as outsiders and stated that "they may be useful in helping Indigenous peoples articulate their concerns, but to speak for them is to deny them the self-determination so essential to human justice and progress" (Battiste, 2008, p. 504). I understand the importance of delineating between articulating Indigenous concerns and speaking for Indigenous peoples and I aim to safely remain on the right side of this delineation. Battiste also stressed the importance of linguistic competence stating that "researchers cannot rely on colonial languages to define Indigenous reality" (Battiste, 2008, p. 504), unfortunately, I did just that as I conducted all my work in English, though English is just as much a second language for me as it is for a number of participants.

Linked to decolonization is the work of Mohawk scholar Patricia Monture who reminded us of the need "to understand the cost to other individuals that they silence, wilfully or not. Just as important, it offers the opportunity to consider the cost to themselves of silencing others" (Monture, 1991, p. 14). This resonates for me as I seek to acknowledge my power as a participant and as a researcher. While I acknowledge my position as a government employee, as a member of the regional management team at FNIHB-AB, I often fail to see myself as powerful. Incidentally, that is not very different from what many of the participants in this research have said about themselves even though they were all middle and senior leaders in their respective organizations. Even as I recognize my challenges in fully acknowledging my own power, I recognize that I have a voice and I wield power both as a researcher and as a participant. As a participant in

the Joint Action Health Plan Working Group, I wield power in sharing information and in representing the interests of the federal government based on my understanding of existing policies, programs and services. I sincerely hope that our discussions can lead to enhanced service delivery and better First Nations health outcomes, but cannot ignore the power I wield.

As a researcher, I wielded power as I made most decisions whether it is by creating the participants' list, identifying the questions to be asked, or deciding literature and what elements of the participants' input to be included. This same power is the source of my deepest fear… which is no matter how hard I worked, no matter how hard I tried to ask questions that gave participants an opportunity to express their worldviews, no matter how much I read, no matter how often I listened and read the transcripts to ensure that I was truthful to the participants' voice, no matter how much I immersed myself in Indigenous academic, fiction and non-fiction literature, and no matter how careful I was as I sought to limit the imposition of my own worldviews that I may not have done enough to honour the contributions of the many participants, especially the First Nations participants, in this research project.

In trying to address this issue, I constantly sought to mitigate my power and ensured that the voices of my colleagues were heard by doing the following:

- providing copies of the questionnaire and consent form to the participants prior to the interviews;
- opting to conduct semi-formal interviews as an approach to rein in my participation and give myself a better chance to truly hear my colleagues;
- providing participants an opportunity to review their transcripts;

- sharing a short summary of early findings in June 2016 and giving the participants an opportunity to provide input;
- providing some participants and colleagues an opportunity to review and discuss the information I gathered at a focus group in January 2017; and,
- benefiting from the support and guidance provided by my supervisory committee which included individuals with tremendous experience in working collaboratively with Indigenous people, organizations and governments. While the composition of my committee changed during the course of my studies, most members were Indigenous individuals.

Connecting Ontology, Epistemology, Methodology and Axiology

As I conducted this research, I was often confronted by a number of elements – my status as non-Indigenous researcher conducting Indigenous research, my status as a participant and as a researcher, my focus on inter-organizational collaboration within a cross-cultural setting, the Indigenous and Western ways of knowing and the tensions created by the requirements of a Western knowledge system stemming from conducting this work as a doctoral dissertation (Kovach, 2012; Roy, 2014). As I weaved these sometimes disparate threads, I relied on the following: "We must stop and consider the preliminary assumptions underlying our beliefs and ideas. These assumptions shape the content of our thinking. This revaluation is necessary before we blindly make our way forward assuming we all think, learn, and understand alike" (Monture, 1991, p. 13).

As I sought to ensure alignment between ontology, epistemology, methodology and axiology (Kovach, 2012; Wilson, 2008), which is described by Wilson as relational, I also sought to acknowledge Indigenous and Western ways of knowing. Some of the

pieces were easier to weave together, as my choice of participatory action research as a methodology is supported in both Indigenous and Western knowledge systems. In other cases, there were marked differences, especially in regards to ontology and epistemology. In the next section, I outline my understanding of both Indigenous and Western ways of knowing as I sought alignment between ontology, epistemology, methodology and axiology. In doing this work, I relied heavily on the work of Cree scholar Shawn Wilson who wrote that "the ontology and epistemology are based upon a process of relationships that form a mutual reality… [while] the axiology and methodology are based upon maintaining accountability to those relationships" (Wilson, 2008, pp. 70-71).

Ontology

Considering the cross-cultural nature of my work, I used the work of researchers conducting Indigenous research to frame this concept as they have a wealth of knowledge within the cross-cultural context I sought to operate within and have experienced the tensions between Indigenous and Western ways of knowing. Ontology is described as "the form and nature of reality" (Roy, 2014, p. 117) while Aboriginal ontology:

> emphasizes the concept of relatedness, which refers to the links of humans to each other as well as to the natural environment and to the spiritual world. According to this ontology, reality is defined in a relational manner; entities (people, land, nature, spirits, ancestors, ideas, etc.) are defined by the relationships they hold. (Roy, 2014, p. 118)

To anchor ontology, I use the descriptions of Aboriginal philosophy and Eurocentric values provided by Blackfoot scholar Leroy Little Bear who wrote:

> In Aboriginal philosophy, existence consists of energy. All things are animate, imbued with spirit, and in constant motion. In this realm of energy and spirit, interrelationships between all entities are of paramount importance, space is a more referent than time. (Little Bear, 2000, p. 77)

He also further described "Aboriginal philosophy as being holistic and cyclical or repetitive, generalist, process-oriented, and firmly grounded in a particular place" (Little Bear, 2000, p. 78). He stated that "one can summarize the value systems of Western Europeans as being linear and singular, static, and objective" (Little Bear, 2000, p. 82) and that these assumptions "make it hard for a person to appreciate an alternative way of thinking and behaving" (Little Bear, 2000, p. 83). Chickasaw scholar Eber Hampton further wrote:

> Emotionless, passionless, abstract, intellectual, academic research is a goddamn lie, it does not exist. It is a lie to ourselves and a lie to other people. Humans – feeling, living, breathing, thinking humans – do research. When we try to cut ourselves off at the neck and pretend an objectivity that does not exist in the human world, we become dangerous, to ourselves first, and then to the people around us. (Hampton, 1995, p. 52)

Therefore, I must also acknowledge that I am neither neutral nor objective. I have a vested interest. I deeply care about my research, our work on the Joint Action Health Plan and I feel strongly connected with Indigenous Peoples. Before I outline my worldviews, I would like to, once again, quote Little Bear who wrote that "no one has a pure worldview that is 100 percent Indigenous or Eurocentric; rather everyone has an

integrated mind, a fluxing and ambidextrous consciousness, a precolonized consciousness that flows into a colonized consciousness and back again" (Little Bear, 2000, p. 85).

I define myself as a francophone. My worldviews have been shaped by growing up speaking French in a Montréal suburb and with deep roots in the rolling fields of the Eastern Townships where my grandparents lived. I grew up in a part of Québec where French language and Catholicism went hand in hand – though the latter declined significantly in the face of Québec's rapidly growing laicism of the 1960s and 1970s. Even though the suburb next door and the Eastern Townships had important Anglophone population, I did not become fluent in English until I attended one of Montréal's English universities. Life in the suburb also gave me few opportunities to engage with Indigenous peoples and communities. Even though I grew up a mere 15 kilometres from Kanesatake, my interactions with Indigenous peoples were very limited until my mid-20s. As a francophone, my identity has also been shaped by my life outside Québec – as a francophone studying in a francophone university in Moncton (New Brunswick) who then moved to Ottawa prior to relocating to Edmonton (Alberta) in 1999. Being francophone and living in a minority setting further shapes who I am while bringing some points of convergence with Indigenous peoples as I also understand the need to function in a second language, the importance to protect and promote my language and culture as well as advocating for the recognition of our collective rights.

While I identify as a francophone, my research builds on a personal journey reflecting my increasing commitment to this work – enhancing health care collaboration between First Nations, federal and provincial governments. And more importantly, it is about relationships and how I feel connected with Indigenous, and more specifically First

Nations and Métis Peoples in Alberta. When I embarked upon this journey – seeking to obtain a Doctorate of Business Administration (DBA) – I had a job I loved as a policy analyst for FNIHB-AB and a desire to do it better. I managed my workload by compartmentalizing, trying as much as possible to separate the different elements in my life. I fully understand that no one is ever only a student or a researcher and neither am I. Yet, I often referred to juggling my "work", "school work", "family" and "school board" lives, commitments and/or responsibilities. This division made it easier to juggle and assess priorities as well as to ensure that I respected guidelines in regards to ethics and conflict of interest. However, it failed to acknowledge that I am also a multidimensional human being and the multiple connections between each of those four elements.

The first of these connections is between my personal and professional lives as I met my husband through work more than 20 years ago. From this initial connection comes a number of roles as wife, mother, step-mother, grandmother, aunt, daughter-in-law and sister-in-law which connect me to the Indigenous community as I am part of a large, blended, multi-generational Métis and First Nations family. My husband, my son, my step-children and our eight grandchildren are Métis and First Nations individuals who are actively involved in promoting the traditional dances of the Métis. Being a member of a family that has been performing and showcasing traditional Métis dances for more than four generations, I have the opportunity to spend countless hours with traditional Indigenous performers as they share their unique First Nations, Métis or Inuit cultures. Many members of our family have also been actively involved in a number of Indigenous organizations in Edmonton for decades. Through that personal involvement, I maintain

strong personal connections with First Nations and Métis people in and around Edmonton and, to a more limited extent, the rest of the province.

My personal and professional lives have also been intertwined as I have now been working in the field of Indigenous – First Nations and Métis – health for more than 20 years. I began working in this field in 1996 when I joined the Métis National Council (MNC) as Project Coordinator, Health and Literacy. Being part of the MNC was a wonderful opportunity as I benefited from learning first hand of the political events of the day – the mid- to late 1990s – but also the oral stories and the perspectives of Métis leaders and Elders of key events including the Charlottetown Accord negotiations, the Constitution talks of the early 1980s and the inclusion of Métis under section 35 of the *Constitution Act, 1982* or many of the experiences of the Métis through the 19th and 20th centuries. In 2001, I became the first Director of the Métis Centre at the National Aboriginal Health Organization (NAHO). Joining NAHO in its early days was also a unique opportunity, and in many ways it felt like coming home… as I had been part of the early discussions leading to the creation of NAHO while working at the MNC. At NAHO, I re-established relationships with many of the Métis leaders and Elders I had met while working at the MNC and it allowed me to work more closely with First Nations and Inuit peoples. We were involved in a number of discussions between policy makers and academics on a wide range of health topics as we held forums across the country related to Indigenous health and health service delivery, spearheaded the development of a national public opinion poll on Indigenous health and colleagues at the First Nations Centre wrote the first few articles on the principles of First Nations Ownership, Control, Access and Possession (OCAP) in regards to health information as

well as launched the 2002-2003 Regional Health Survey. In 2003, I joined First Nations and Inuit Health Branch – Alberta Region. Since joining FNIHB, I have led the Mental Health and Addictions Team (2003-2006), been involved in the development of the Blueprint on Aboriginal Health which was part of the Kelowna Accord (2005), and been responsible for the development and implementation of collaborative initiatives including the Aboriginal Health Transition Fund (2006-2010) and the Health Services Integration Fund (2010 to present). Since 2012, I am the Director, Policy, Planning and Partnership Facilitation at FNIHB-AB (Health Canada) and one of my responsibilities stems from the second strategic goal of the FNIHB Strategic Plan, "collaborative planning and relationships" (Health Canada, 2012c). As part of my work, I was involved in the development of the Joint Action Plan to Improve the Health of First Nations in Alberta.

Considering the increased focus on collaboration within my work and my personal interest in more collaborative approaches, I began to examine options to ground my doctoral dissertation that would connect my work and school lives. I identified a number of potential options within the health field in Alberta and in other parts of the country. In narrowing down the options with my supervisory committee I decided to choose a project that would provide me an opportunity for meaningful work that would be of value within the context of my work and have the potential to impact health service delivery in Alberta. As a mid-level civil servant, I sought to develop a research project that could help other mid- and sometimes more senior level civil servants in addressing the social, cultural and political aspects of collaboration. More concretely, I opted to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. Considering my status as a

FNIHB-AB employee, a participant in the process that led to the development of the Joint Action Plan to Improve the Health of First Nations in Alberta, and my role as a researcher, I had to tread carefully as I juggled the ethical requirements from my employer (FNIHB), Athabasca University, some of the partnering organizations (AH and AHS), while ensuring respectful and meaningful engagement with Indigenous peoples.

As I weave the many threads of my life, I believe that I share some of the responsibilities outlined by Linda Tuhiwai Smith, a Maori scholar, who outlined a number of criteria as she defined the insider-outsider concept integral to Indigenous research. She identified five criteria: the need for self-reflexivity; the need to think critically about our research, our relationships and the data collection and analysis; the need for support; the need for clear research goals and an acknowledgement that an insider would "have to live with consequences of their processes on a day-to-day basis for ever more, and so do their families and communities" (L. T. Smith, 1999, p. 137). Even though I am non-Indigenous, I believe these criteria apply to me. At the same time, I am also well aware that I do not have the lived experience of Indigenous researchers. Allison Jones, a non-Indigenous New Zealander, who has undertaken Indigenous research, explained the importance of Indigeneity and the limitations of non-Indigenous researchers:

> Even progressive settler educators who seek collaboration with indigenous others necessarily remain only partially able to hear and see. What determines this ability is not merely indigeneity. It is not *simply* that Kuni is Maori that gives her the privileged ability to see what I cannot as we work together; it is an issue of *access to knowledge*. One's experience, knowledge, and recognition by one's

> own people provide an indigenous person with the authority and insight to contribute *as Maori* to research on Maori things. With enough immersion in Maori language and culture, it may be logically *possible* for me as a Pakeha/settler to interpret past and current events "from a Maori point of view". But in practical terms, outside such complete immersion, it is unlikely as a Pakeha that I will see, hear, and feel from that viewpoint or get emphatically inside, say, the story of Ruatara (Jones & Jenkins, 2008, p. 479).

I have worked and lived with Indigenous peoples for more than 20 years and I share her feelings in terms of limitations to my knowledge and experience. I continue to seek to broaden that knowledge but it is important to acknowledge that "to acquire Indigenous knowledge, one cannot merely read printed material, such as books or literature, or do field visits to local sites. Rather, one comes to know through extended conversations and experiences with elders, peoples, and places of Canada" (Battiste, 2008, p. 502). So, while I have learned a lot through this research by reading more Indigenous authors, from the participants who graciously shared their knowledge and experience during the interviews and the focus group, and as a participant in the Joint Action Health Plan Working Group, I still have much more to learn in terms of Indigenous knowledge.

Epistemology

As with ontology, I outline epistemology based on information provided in Indigenous research. Wilson described epistemology as "the study of the nature of thinking or knowing. It involves the theory of how we come to have knowledge, or how

we know that we know something" (Wilson, 2008, p. 33). Battiste further defined it by stating:

> Indigenous people's epistemology is derived from the immediate ecology; from people's experiences, perceptions, thoughts and memory, including experiences shared with others; and from the spiritual world discovered in dreams, visions, inspirations, and signs interpreted with the guidance of healers and elders. Most Indigenous peoples hold various forms of literacies in holistic ideographic systems, which act as partial knowledge meant to interact with the oral traditions. They are interactive, invoking the memory, creativity, and logic of the people (Battiste, 2008, p. 499).

Jones shared the challenges of non-Indigenous researchers conducting Indigenous research by writing:

> The limits to understanding between indigene and colonizer are not only rooted in our different histories, experiences, and cultures -- and therefore what we can hear and what we are told. Limited understanding can also be seen as epistemologically inevitable. (Jones & Jenkins, 2008, p. 479)

In outlining theory, Michi Saagiig Nishnaabeg scholar Leanne Simpson referred to the deeply personal nature of theory and stated that "in its most basic form [it] is simply an explanation for why we do the things we do" (Simpson, 2011, p. 39). In terms of theoretical framework, there is a reluctance by Indigenous researchers to limit Indigenous research to a single paradigm though both positivist and post-positivist research paradigms have been identified as not suitable (Bishop, 1998; Denzin & Lincoln, 2008; Roy, 2014) as the Western ways of knowing fail to acknowledge the existence of

Indigenous ways of knowing (Smith, 2000). Smith further wrote that "from an Indigenous perspective Western research… brings to bear, on any study of Indigenous peoples, a cultural orientation, a set of values, a different conceptualization of such things as time, space and subjectivity, different and competing theories of knowledge, highly specialized forms of language, and structures of power" (Smith, 1999, p. 42).

In choosing a theory to ground my research, I opted for a theoretical framework that is not based in an Indigenous way of knowing however I feel this theoretical framework can be readily understood within both Indigenous and Western ways of knowing. This framework is based on the work of Wood and Gray on collaboration (B. Gray, 1985; B. Gray & Wood, 1991; Wood & Gray, 1991). Essentially, I use the definition of collaboration provided by Wood and Gray (1991) as well as their work in describing the three phases of collaboration – preconditions, processes and outcomes. I believe the simplicity of this three-phase model reflects the experience of practitioners and.

Methodology

Methodology "refers to the theory of how knowledge is gained, or in other words the science of finding things out" (Wilson, 2008, p. 34). Further, Mi'kmaw scholar Marie Battiste recommended that "any research conducted among Indigenous peoples should be framed within the basic principle of collaborative participatory research, a research process that seeks as a final outcome the empowerment of these communities through their own knowledge"(Battiste, 2008, p. 508). Roy also stated that "methodologically speaking, relational knowledge translates into relational obligation for the researcher which links to Aboriginal axiology" (Roy, 2014, p. 118). To conduct this

research, I used a methodology that fits within both Indigenous and Western ways of knowing by opting for participatory action research (PAR). In making this decision, I was guided by the favourable opinions of a number of sources (Brant Castellano, 2004; Roy, 2014; Wilson, 2008). More information on Participatory Action Research is provided in Chapter 4.

Axiology

Cree scholar Shawn Wilson defined axiology as "the ethics or morals that guide the search for knowledge and judge which information is worthy of searching for" (Wilson, 2008, p. 34). In outlining axiology, Wilson referred to the concept of relational accountability. He outlined this concept by stating: "we are accountable to ourselves, the community, our environment or cosmos as a whole, and also to the idea or topics that we are researching. We have all of these relationships that we need to uphold" (Wilson, 2008, p. 106). He further wrote:

> What is more important and meaningful is fulfilling a role and obligations in the research relationship – that is being accountable to your relations. The researcher is therefore a part of his or her research and inseparable from the subject of that research. The knowledge that the researcher interprets must be respectful of and help to build the relationships that have been established through the process of finding out information. Furthermore, the Indigenous researcher has a vested interest in the integrity of the methodology (respectful) and the usefulness of the results if they are to be of any use in the Indigenous community (reciprocity). (Wilson, 2008, p. 77)

Simpson outlined a fairly similar concept as she stated "by inserting ourselves into these stories, we assume responsibilities – responsibilities that are not necessarily bestowed upon us by the collective, but that we take on according to our own gifts, abilities and affiliations" (Simpson, 2011, p. 41). I believe this concept of responsibility reflects how I frame my accountability. My accountability is multi-layered as it encompasses personal accountability, a more organizational accountability referring to my responsibilities as a participant and researcher, accountability to the collaborative and my colleagues on the Joint Action Health Plan Working Group as well as accountability to the people we serve – the First Nations peoples.

Earlier, I identified how my work and school lives were connected with this research project but it is also connecting with my personal life. Choosing to connect my school and work lives also means that participants in my research are colleagues, individuals with whom I have existing personal and professional relationships. While I met some more recently, I have known others for years. In some ways, it made the identification of participants easier and it had the potential to improve access. At the same time, it increased the stakes both in terms of requirements for ethical and respectful research protocols as well as potentially exposing both the participants and myself more than we normally do within the context of our work; and, even more so for colleagues in First Nations organizations and governments, as I am not only a researcher but also a federal government employee.

Cree scholar Shawn Wilson stated that "if research doesn't change you, then you haven't done it right" (Wilson, 2008, p. 135). This research has changed me as to whether or not I have done it right; I will let others judge me. In 2012, I might still have

been joking about the fact that I was working for the "dark side" which is how employees in Indigenous organizations and governments often refer to FNIHB and other departments working directly with Indigenous peoples. While I had an understanding of the relationships between First Nations and the federal government from stories shared by my family members, friends and colleagues, I realise now that my understanding was not as broad based as it should have been. And while I still have so much more to learn, the interviews, the discussions with families, friends and colleagues along this journey as well as the readings of the last few years have increased my understanding of colonization and its impact (Alfred, 2009; Borrows, 2002; Daschuk, 2013; King, 2012; Little Bear, 2000; Little Bear, Boldt, & Long, 1992; Simpson, 2001, 2011; Smith, 1999).

With this research project, I combined many of my roles and added a few more as I built on existing relationships as a colleague, employee, student, researcher and friend. I hope that the outcomes will benefit First Nations communities in Alberta and elsewhere in Canada. As I worked on this project I hoped that it would lead us to improve the collaborative capacity required to enhance health care collaboration between First Nations, federal and provincial governments focusing on the more social, cultural and political aspects of collaboration. I believe I did everything I could to conduct myself honourably and I hope that I have honoured my relationships with my family, friends and colleagues in collecting, analysing and sharing this information.

Chapter 3 – REVIEW OF THE LITERATURE

In Chapter 2, I outlined my roles and my lenses as both a researcher and a participant while also identifying my connections to Indigenous communities. As I sought to improve collaborative capacity to enhance health care collaboration between First Nations, federal and provincial governments in Alberta, I identified this research as being focused on inter-organizational collaboration while acknowledging its cross-cultural nature. In drafting this literature review, I also felt the need to document my journey. Chickasaw scholar Eber Hampton said "memory comes before knowledge" (Hampton, 1995, p. 53). He articulated this concept by referring to the need to unwrap experiences. I felt the same way as I wrote this chapter. I could have outlined my understanding of the concepts covered such as collaboration, collaborative capacity as well as the broader context of relationships between First Nations, federal and provincial governments and between First Nations Peoples and Settler society as it stands today. However, I chose to document my literature review more chronologically outlining not only what I learned by the end of this journey but also the process of learning. Considering my need to navigate Indigenous and Western ways of knowing, I felt this approach allowed me to share how my lenses started to change and how I began to see and hear differently as I read on collaboration, collaborative capacity and the broader context of relationships between First Nations, federal and provincial governments.

My doctoral journey began in 2012 when I enrolled in the Doctorate of Business Administration at Athabasca University. I spent the first two years grounding myself in academic and management literature and I initially framed this project within existing literature on inter-organizational collaboration and more specifically as it relates to the

health care field. The first sections of this chapter are based on this literature review and cover both collaboration and collaborative capacity. Much of this information resonated with me as it reflected my experiences as a practitioner. I could recognize some of our successes, and some of our challenges, as we worked together through the Co-Management structure, or through a number of projects funded by the Aboriginal Health Transition Fund and the Health Services Integration Fund as well as the Joint Action Plan to Improve the Health of First Nations in Alberta. At the same time, some of the information provided did not always fit neatly, for example repeated interactions are seen as contributing positively to collaboration (Bowen, Newenham-Kahindi, & Herremans, 2010), yet, this did not always pan out for us. One could argue that there have been repeated interactions between participants for many years and between some of the organizations for extended periods of time and while these may have been beneficial, sometimes it was quite the opposite. Considering these repeated interactions, I thought it would be important to examine the broader context of relationships between First Nations, federal and provincial governments and between First Nations Peoples and Settler society in Canada. Reflecting on my lenses as a non-Indigenous researcher, a federal government employee and my educational background in public administration, it may not be surprising that my initial literature review was mostly based on federal government publications and their references to renewed relationships between First Nations Peoples and the federal government. I had included some information from Indigenous scholars (Cardinal, 1999; Cardinal & Hildebrandt, 2000; Mashford-Pringle, 2011) but this was fairly limited. After defending my proposal and as I prepared for the interviews and their analysis, I began to immerse myself more thoroughly in Indigenous

literature – academic, non-fiction and fiction. Considering the alignment between this literature review and some of the participants' interviews, I frame this section as preconditions to collaboration. I conclude this chapter by providing information on more recent political changes in Canada and Alberta.

Collaboration

As I sought to learn more about inter-organizational collaboration I began a literature review by using keywords such as collaboration, partnership, coalition, alliance, network, integration, collaborative capacity, collaborative partnership, community development and community engagement. In reviewing many existing definitions (Gajda, 2004; A. Gray, 2002; B. Gray, 1985; Hardy, Phillips, & Frost, 1998; Kanter, 1994), I anchored my work based on the definition of collaboration developed by Wood and Gray which states that "collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (Wood & Gray, 1991, p. 146). The definition includes a number of key elements. First, it acknowledges that the stakeholders may have common or different *interests* in addressing a particular problem domain. Second, *autonomous* refers to the fact that the "stakeholders retain their independent decision-making powers" (Wood & Gray, 1991, p. 146). Third, the *interactive process* highlights the need for "a change-oriented relationship" (Wood & Gray, 1991, p. 148). Fourth, the reference to *shared rules, forms and structures* acknowledges that these may or may not exist at the beginning of the collaboration. Fifth, by stressing the need for *action or decision*, Wood and Gray highlighted that the "participants must intend to act or decide" (Wood & Gray, 1991, p. 148). Finally, the

reference to a *domain* emphasizes the need for "the participants to orient their processes, decisions, and actions toward issues related to the problem domain that brought them together" (Wood & Gray, 1991, p. 148).

There are a number of articles written on collaboration and the delivery of health services. While some of those articles referred to partnership and collaboration as a relatively new concept (Alexander et al., 2003; McGuire, 2006; Miller & Ahmad, 2000), others are quick to point out that collaboration in health care existed for decades (Sigmond, 1995). In the last twenty years, the notion of "working together" and health services have been used extensively for health promotion and public health in many countries including United Kingdom (Miller & Ahmad, 2000), United States of America (Beatty, Wilson, Ciecior, & Stringer, 2015; Bogue, Antia, Harmata, & Hall, 1997; Bolland & Wilson, 1994; Butterfoss Dunn, Goodman, & Wandersman, 1996; Fawcett et al., 1995; Fawcett, Francisco, Paine-Andrews, & Schultz, 2000; Francisco, Paine, & Fawcett, 1993; Henize, Beck, Klein, Adams, & Kahn, 2015; Kreuter et al., 2000; Lasker, Weiss, & Miller, 2001; Logsdon, 1991; Roussos & Fawcett, 2000; Sigmond, 1995; Zuckerman & Kaluzny, 1991; Zuckerman, Kaluzny, & Ricketts, 1995) and New Zealand (A. Gray, 2002; New Zealand Ministry of Social Development, 2003; New Zealand Ministry of Social Policy, 2000).

Collaboration: A Three-Phase Process

Collaboration is described as a three-phase process (Butterfield et al., 2004; Wood & Gray, 1991). The first phase includes the *preconditions* to collaboration, which are described as the problem setting stage (B. Gray, 1985; Logsdon, 1991) where interests, legitimacy and interdependence of partnering organizations (Hardy, Phillips, & Frost,

1998; Logsdon, 1991; Weick, 2001) are recognized and where authority and representativeness of members (Fawcett et al., 1995; B. Gray, 1985; Huxham & Vangen, 2000; Page Hocevar, Jansen, & Fann Thomas, 2007; Westley & Vredenburg, 1991) are assessed.

Logsdon (1991) indicated that for a successful collaboration only two of these preconditions are essential: interests and interdependence. Logsdon associated with interest the desire to enhance "the legitimacy of the organization by acting in consonance with social norms or expectations of its stakeholders" (Logsdon, 1991, p. 25). Interest may also connect with the notion of discursive legitimacy which is described as "actors are understood to speak legitimately for issues and organizations affected by the domain" (Hardy, Phillips, & Frost, 1998, p. 219). Logsdon associated interdependence with the recognition that "mutually beneficial interests can be achieved" (Logsdon, 1991, p. 26).

Many authors (Fawcett et al., 1995; B. Gray, 1985; Page Hocevar et al., 2007) stressed the importance of identifying the key stakeholders, ensuring participation of individuals who have the authority to affect change, and reflecting an appropriate cross-section of stakeholders. However, some authors indicated that there could be challenges linked to the identification of stakeholders including: ill-defined membership list (Huxham & Vangen, 2000); ambiguity of members about their status as decision-maker or support to the collaborative effort (Huxham & Vangen, 2000); stakeholders' representativeness and the challenges of reporting back to thinly institutionalized organizations (Westley & Vredenburg, 1991).

The second phase of collaboration is the *process* stage which is described as "direction setting" (B. Gray, 1985) or more ambiguously as the "black box" of

collaboration (Fleisher, 1991). Some authors included in this phase elements identified as preconditions by other authors such as confirming membership and clarifying decision-making processes (Roberts & Bradley, 1991); coincidence of values (B. Gray, 1985); and, advocacy for formalization of processes. In advocating for formalization and/or institutionalization authors proposed options on both short-term (Roberts & Bradley, 1991) and more permanent basis (Westley & Vredenburg, 1991). The institutionalization process is perceived as confirming the commitment of the partners and as establishing the level of formality to be achieved by the collaborative process.

The third and final phase of collaboration is *outcomes*. The ability of collaboration to be "instrumental in achieving social development ends" (Huxham & Vangen, 1996, p. 5) especially as it relates to collaboration with a community (Bowen et al., 2010). In examining community collaboration, a number of outcomes are identified in terms of the levels of collaboration to be attained. It typically progresses from one-way communication, to two-way communications prior to demonstrating greater engagement of partners. In collaboration literature, I found two models of particular interest: the *continuum of community engagement* (Bowen, Newenham-Kahindi, & Herremans, 2008; Bowen et al., 2010) and the *engagement spectrum* (New Zealand Office for the Community and Voluntary Sector, 2011). The first model, the *continuum of community engagement*, has three strategies. The first strategy, *transactional engagement* refers to engagement that is defined by one-way communication, occasional interactions and limited trust. In *transitional engagement*, two-way communications are introduced and the partners are working more closely together allowing for trust to be developed. Finally, *transformational engagement* is described as "the most proactive

corporate engagement strategy… [it] is characterized by joint learning and sensemaking" (Bowen et al., 2010, p. 305).

The second model, the *engagement spectrum*, is a four-quadrant model that outlines different levels of communications, actions and decisions between partners. The model was designed to strengthen engagement between Indigenous populations and the New Zealand government (New Zealand Office for the Community and Voluntary Sector, 2011). I believe its four quadrants can be best summarized by the words – to, for, with and by. The first quadrant, *Inform*, is mostly characterized by one-way communication and minimal input into decision-making. This is when decisions are imposed upon a group, I refer to this as the *to* quadrant. With the second quadrant, *Consult*, external views are sought and are considered in the decision-making process but decisions tend to be made on behalf of the group – the *for* quadrant. The third quadrant, *Partner*, emphasizes shared decision-making and can be identified as the *with* quadrant. The fourth quadrant, *Empower*, is characterized by community-led decision-making and is described as the *by* quadrant as the group is making and implementing its own decisions based on its needs and priorities. The model is grounded by active relationships between partners. This emphasis on relationship building could be linked to Kanter's work on levels of integration where she emphasized the importance for partners to have shared activities at all levels within a given collaboration (Kanter, 1994). According to Kanter, a successful collaboration is about "creating new value together" (Kanter, 1994, p. 97) and would require to concurrently achieve five levels of integration. Strategic integration requires regular contacts amongst top leaders. Tactical integration includes joint development of projects by middle managers while operational integration

emphasizes day-to-day collaboration. The fourth level, interpersonal integration encourages interpersonal ties between staff. The fifth and final level reflects cultural integration where greater awareness of cultural differences and similarities are developed (Kanter, 1994).

Collaborative Capacity

Recognizing the significant challenges of collaboration at the inter-organizational level, a number of authors (Fann Thomas & Page Hocevar, 2006; Foster-Fishman et al., 2001; Roussos & Fawcett, 2000) examined the requirements for collaborative capacity which is defined as "the conditions needed … to promote effective collaboration and build sustainable community change" (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001, p. 242). Linked to the concept of collaborative capacity is the concept of internally-ready organizations within an externally enabled environment (Salsberg et al., 2007). This concept highlights the need of partnering organizations to contribute to the development of collaboration. It outlines the need for participants to ask themselves "how can they support the internal readiness of their organization?" and "how can they support other participants / organizations within the collaborative effort?" (Salsberg et al., 2007). Other authors identified the need for community engagement activities that seek to enhance experience and competence; group structure and capacity; environmental support and resources; as well as, remove social and environmental barriers (Fawcett et al., 1995; Roussos & Fawcett, 2000). Figure 1 shows the collaborative capacity model developed by Foster-Fishman and her colleagues (Foster-Fishman et al., 2001). It includes four elements of collaborative capacity; member, relational, organizational and

programmatic capacity. Please note that I created the visual depiction of the model as a way to support my ability to explain the four elements.

Figure 1. Critical Elements of Collaborative Capacity

Source: (Adapted from Foster-Fishman et al., 2001, pp. 244-245)

Member Capacity

Key elements of member capacity are "both the existing skills/knowledge and attitudes members bring to the table and efforts taken to build, support, and access this capacity" (Foster-Fishman et al., 2001, p. 243). Member capacity appears to be linked to some of the elements identified as preconditions to collaboration especially as they relate to attitudes of partners such as perception of legitimacy of others, commitment to collaborate, trust towards other partners and acceptance of other partners (B. Gray, 1985; Logsdon, 1991). While Logsdon (1991) stressed the importance of interests and interdependence of partners and Kanter (1994) referred to individual excellence for strong partners seeking positive outcomes, Foster-Fishman and her colleagues

highlighted the importance of having "a positive attitude towards collaboration… and other stakeholders" (Foster-Fishman et al., 2001, p. 244).

Relational Capacity

The notion of relational capacity is strongly connected to the relationships between participants and participating organizations. Foster-Fishman and her colleagues identified five key components: development of a positive working climate; development of a shared vision; power sharing; valuing of diversity; and, development of positive external relationships (Foster-Fishman et al., 2001). This is also quite similar to the work of other authors who outlined the need for a clear vision and mission, action planning, leadership, resources for community mobilizers, documentation and feedback on intermediate outcomes, technical assistance and the importance of making outcomes matter (Fawcett et al., 2000).

Relational capacity also includes what is described as the "glue" of collaboration: trust and commitment (Alexander et al., 2003; Bowen et al., 2010; Vangen & Huxham, 2003; Zuckerman & Kaluzny, 1991; Zuckerman et al., 1995). Some authors identified building trust as the short term focus of new partnerships indicating that "considerable efforts in the short term are focused on building trust and collaborative decision-making norms, rather than active movement towards the goals of the partnerships" (Alexander et al., 2003, p. 132S). While other authors stressed the ongoing nature of building and maintaining trust (Vangen & Huxham, 2003) and identified it as being "based on repeated interactions between the parties" (Bowen et al., 2010, p. 307). The second element of this "glue", commitment, is described as "[t]he underlying central philosophy of strategic alliances" (Zuckerman, Kaluzny, & Ricketts, 1995). It may well be that if

one partner fails to live up to his/her commitments that trust cannot exist, but the notion of commitment in terms of government and non-profit organizations collaboration is also particularly interesting as "[t]he move towards commitment, in contrast to control as the underlying managerial paradigm, represents a shift in our way of thinking about health service organizations" (Zuckerman & Kaluzny, 1991). Another key element of relational capacity is the concept of power (Hardy et al., 1998; Huxham & Vangen, 1996). Some authors advocated for sharing power (Foster-Fishman et al., 2001) and others went further issuing a word of caution that if "one partner is significantly more powerful than another and/or has greater access to information than the other, then the outcome of this mutual struggle may be only too predictable, as the community sector has all too often found its cost" (Mayo, 1997, p. 5).

Finally, the concept of relational capacity brings forward the need for a different role for public managers one where they "should focus on their responsibility to serve and empower citizens as they manage public organizations and implement public policy" (Denhardt & Vinzant Denhardt, 2000, p. 549). As a result, the "role of government is transformed from one of controlling to one of agenda setting, bringing the proper players to the table and facilitating, negotiating, or brokering solutions to public problems (often through coalitions of public, private, and non-profit agencies)" (Denhardt & Vinzant Denhardt, 2000, p. 553). Combining a number of these elements, the New Zealand government recommended to public servants "[t]o foster relationships based on trust, respect and mutual understanding" (New Zealand Office for the Community and Voluntary Sector, 2011, p. 4).

Organizational Capacity

Foster-Fishman and her colleagues defined organizational capacity as effective leadership and formalized procedures (Foster-Fishman et al., 2001). It includes two key elements: accountability and formalization of structure and/or processes. In this context accountability refers to how members are held accountable by the organizations that appointed them as well as to the collaborative effort underway (Kernaghan, 1993); this form of dual accountability may have convergent or divergent values and objectives. Others stressed the challenges of accountability when there is ambiguity regarding membership status; when some members represent more than one organization (Huxham & Vangen, 1996, 2000); or when the organization or collective of organizations represented by members is thinly institutionalized (Westley & Vredenburg, 1991).

For a number of authors, the concept of organizational capacity is linked to institutionalization (Fawcett et al., 1995; Kanter, 1994) which is defined as "the relationship is given a formal status, with clear responsibilities and decision processes" (Kanter, 1994, p. 100). Institutionalization can take a number of forms. First, it can lead to the establishment of a stand-alone organization to formalize the partnership. Second, it can lead to building capacity to collaborate within the respective organizations (Alexander et al., 2003). Third, boundary organizations, which are defined as "collections of actors who are drawn together from different ways of knowing or bases of expertise for the purpose of coproducing boundary actions", (Feldman, Khademian, Ingram, & Schneider, 2006, p. 95) can be developed. This would also connect to the need "to engage participants through listening and understanding, the creation of a shared organizational language so that engagement makes sense to members of the organization,

and a strong connection with moving beyond talk into action" (Bowen et al., 2010, p. 306).

Programmatic Capacity

Programmatic capacity refers to clear and achievable goals and objectives, the ability to achieve quick wins as well as the unique and innovative character of the collaborative endeavour (Foster-Fishman et al., 2001). For programmatic capacity to be developed there must be a recognition that "integrative health management [needs] to reflect a more relational approach to program and policy development" (Edwards & Martin, 2012, p. 166). Grand Chief Edward John highlighted the need to be careful and avoid one size fits all model (Grand Chief John, 1994). A number of factors could guide the key elements of programmatic capacity including, but not limited to, community size, culture, remoteness and isolation.

Beyond Collaboration and Collaborative Capacity

My literature review on collaboration connected with my experience as a practitioner. Gray and Wood's definition summarised relatively well my involvement in collaborative work and I felt even more strongly about the three-phase process which I perceive as a clear and succinct way of describing collaboration. While the model is usually outlined in a linear fashion, I understood it as a much more cyclical process as I often thought that today's preconditions are based on yesterday's outcomes. As it is not uncommon for my colleagues and I to work with more or less the same individuals on different initiatives even though we may change positions within our respective organizations or move to different organizations. Therefore, I believed that as we move from project to project we built on previous relationships and previous successes as well

as tried to overcome previous challenges leading to my more cyclical understanding of the three phases of collaboration.

In this regard, the Joint Action Plan to Improve the Health of First Nations in Alberta is not an exception as it involves a number of individuals and partnering organizations who have worked together in the past as we seek to build upon previous collaborative initiatives (e.g. HSIF Exploring Partnerships, Co-Management). As a participant, I believe we experienced both successes and challenges. I understand the Joint Action Health Plan as seeking a higher level of collaboration between First Nations organizations and governments, Alberta Health, Alberta Health Services and FNIHB-AB. As we pursue this higher level of collaboration we tried to build on existing pieces such as the common goal and objectives identified in the Joint Action Health Plan and regularly scheduled meetings however this has not necessarily translated into a smooth transition from development to implementation. In terms of implementation, we made some gains such as the joint submission of an application to access the Indian Registry System and keen interest from many communities to identify community projects that could benefit from enhanced collaboration that resulted in funding over a dozen projects. However, we also faced challenges in confirming membership of both the Working Group and the Steering Committee, finalising our terms of reference as well as confirming the respective mandates of the Joint Action Health Plan Working Group and Steering Committee.

Some of these struggles led to my interest in what has been described as the "black box" of collaboration – processes. I thought that I could use my research to better understand the *how* – how can we better work together and enhance collaboration? This

interest in the *how* led me to the concept of collaborative capacity and its four elements – member capacity, relational capacity, organizational capacity and programmatic capacity (Foster-Fishman et al., 2001). As with collaboration, I can understand collaborative capacity and can relate it to my experience as a practitioner. These concepts do not feel purely theoretical but rather grounded in practice. Yet, neither collaboration nor collaborative capacity can fully explain what I experience as a practitioner supporting collaborative endeavours between First Nations, federal and provincial governments. Considering my focus on the work of civil servants in First Nations, federal and provincial civil servants, I was more interested in the social, cultural and political aspects of collaboration. Participants also identified legal and jurisdictional barriers to our collaboration but treated these as elements out of our control and I have done the same documenting those shared by participants without assessing their impact on collaboration. However, as I collected data through interviews and Indigenous literature I began to wonder if my interest in processes may not have been premature and began to shift some of my focus from processes to preconditions.

This interest in preconditions is not completely new as I considered the broader context of relationships between First Nations, federal and provincial governments as I drafted my proposal. Considering my interest in health care, I had referred to a number of documents dating back to the late nineteenth century, the *Constitution Act, 1867,* the *Indian Act, 1876* and three of the numbered treaties – Treaty No. 6 (1876), Treaty No. 7 (1877) and Treaty No. 8 (1899). For the *Constitution Act, 1867*, I identified two sections of interest: Section 91 (24) which states that the federal government assumes federal responsibility for "Indians, and Lands reserved for the Indians" (Government of Canada,

1867, p. 4) and section 92 (7) which grants to the provinces exclusive jurisdiction over "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the Province, other than marine hospitals" (Government of Canada, 1867).

In my proposal, I indicated that the *Indian Act, 1876* was drafted by the federal government to consolidate existing legislations. Records also show that the Indian Act "rests on the principle, that the aborigines are to be kept in a condition of tutelage and treated as wards or children of the State" (Department of the Interior as cited in the Royal Commission on Aboriginal Peoples, 1996, p. 349). I understood that First Nations leaders and scholars expressed strong criticisms towards the "legacy of legislated colonial regimes" (Doerr, 1997, p. 283) including the Indian Act. I also understood that many First Nations leaders have expressed the need to repeal the legislation while highlighting that this cannot be done without protection of First Nations sacred rights (Cardinal, 1999). Anishinabe scholar John Borrows wrote:

> The Indian Act is an affront to the rule of law throughout Canada. It stands as evidence of the arbitrary nature of Canada's political order relative to Aboriginal peoples. It must be repealed and replaced by a document that facilitates the recreation of normative order in Aboriginal communities. (Borrows, 2002, p. 133)

The Indian Act has also been described as "providing the legislative base for Canadian government control over Indians, represent[ing] a serious obstacle to Indian aspirations to self-government" (Little Bear, Boldt, & Long, 1992, p. xix). They further outlined both First Nations' desires and concerns in repealing or modifying the Indian Act by stating:

> While Indians resent the Indian Act and want to end their state of colonial dependence under it, they adamantly and vehemently resist all moves by the federal government to repeal or modify the Act without constitutional guarantees for their Treaty and aboriginal rights. They suspect that the Canadian government's interest in changing or eliminating the Act has more to do with its desire to extricate itself from costly treaty obligations than it has with the proclaimed concern to decolonize Indians (Little Bear, Boldt, & Long, 1992, p. xix).

These concerns highlight some of the challenges in the relationship between First Nations and the federal government. In drafting my proposal, I thought that I understood some of that context as I outlined that First Nations and the Crown have a long standing relationship and "there is a need to recognize and understand the past and its effects on Aboriginal health and health care" (Mashford-Pringle, 2011, p. 171). I was also aware of how the relationship between Indigenous and non-Indigenous in Canada was described by the Royal Commission on Aboriginal Peoples (RCAP). RCAP offered two perspectives. It described the first perspective as being linear having a past, present and future implying that while some aspects of this relationship may have been regrettable that "it is over and done with" (Royal Commission on Aboriginal Peoples, 1996, p. 34). The relationship can be improved and "we look to the future to establish a *new* relationship which will be more balanced and equitable" (Royal Commission on Aboriginal Peoples, 1996, p. 34). More recent writings by Anishinabe scholar John Borrows referred to this concept by stating ironically "What's past is past. We can only be just in our time. We must be just today" (Borrows, 2002, p. 79). The second

perspective described the relationship as cyclical which began with an *original relationship* dating to the early days of contact where "it often featured a rough-and-ready equality and involved a strong element of mutual respect" (Royal Commission on Aboriginal Peoples, 1996, p. 34). The *down cycle* shows where the relationships began a downturn to reach a *low point* "where adherence to the principles of equality and respect was almost negligible" (Royal Commission on Aboriginal Peoples, 1996, p. 35) and an *up cycle* as "efforts are made to *renew* the original relationship" (Royal Commission on Aboriginal Peoples, 1996, p. 35). The Royal Commission on Aboriginal Peoples further stated that while "it would be wrong to draw hard and fast distinctions in this area, we have found that many Aboriginal individuals tend to take a cyclic perspective, while the linear approach is more common in the larger Canadian society" (Royal Commission on Aboriginal Peoples, 1996, p. 35). As someone with strong connections with Indigenous communities I was relatively confident that I understood and related to the cyclical approach. Yet, as I drafted my proposal, I showed little of that understanding.

When I drafted my proposal I used government sources to outline the federal government's approaches for renewed relationships with First Nations over the last fifty years. In hindsight, this decision showed how my lenses were framed by my status as a non-Indigenous researcher and government employee as well as my educational background in public administration. Among those approaches outlined by the federal government, I had identified the following:

- The 1967 Hawthorn's study which stated that "the Indian should [not] be required to assimilate… in order to receive what he now needs nor at any future time" (Hawthorn, 1967, p. 6) as it advocated for the "right of Indians to be citizens plus"

(Hawthorn, 1967, p. 6) which would ensure that "both [federal and provincial] levels of government applied their respective legislative and fiscal resources in a cooperative fashion" (Hawthorn, 1967, p. 210).

- The 1969 White Paper proposed a "partnership" outlining significant changes including the elimination of the special status of First Nations peoples; equality with other Canadians; access to government services through the same channels as other Canadians; and, repealing of the Indian Act (Government of Canada, 1969).
- In the 1974 Policy of the Federal Government concerning Indian Health Services, the federal Minister of Health "reiterated that no statutory or treaty obligations exist to provide health services to Indians" (Health Canada, 2007).
- As part of the 1979 Indian Health Policy (Health Canada, 1979), the federal government stated that it "recognizes its legal and traditional responsibilities to Indians, and seeks to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian institutions" while outlining the need for "support from the larger Canadian community" and highlighting "[p]rovincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick".
- The *1989 Transfer Policy* (Health Canada, 1999) identified the need for increased "First Nation and Inuit control".
- In 1998, the federal government unveiled Gathering Strength – Canada's Aboriginal Action Plan where it "formally expresse[d] to all Aboriginal people in Canada our profound regret for past actions of the federal government which has contributed to these difficult pages in the history of our relationship together" (Stewart, 1998, np).

In this statement the Minister of Indian Affairs and Northern Development called for a renewed partnership and defined it by referring to relationships that would be "characterized by mutual respect and recognition, responsibility and sharing" (Stewart, 1998, np).

- In 2005, the Blueprint on Aboriginal Health which was part of the Kelowna Accord included an acknowledgment of the need for "comprehensive, wholistic and coordinated service provision" ("*Blueprint on Aboriginal health"*, 2005).
- In 2006, the Transformative Change Accord in British Columbia proposed "new approaches" between First Nations, federal and provincial governments in British Columbia (Government of British Columbia, Government of Canada, & The Leadership Council representing the First Nations of British Columbia, 2006);
- In 2008, the Prime Minister of Canada issued a Statement of Apology where he said "on behalf of the Government of Canada and all Canadians, I stand before you, in this Chamber so central to our life as a country, to apologize to Aboriginal peoples for Canada's role in the Indian Residential Schools system" (Harper, 2008, np).
- In 2012, FNIHB released its First Nations and Inuit Health Strategic Plan where it committed to "build on a positive and productive relationship" and to enhance "collaborative planning and relationships" (Health Canada, 2012c).

I understood that some of these proposals were poorly received. I had referred to the First Nations' response to the 1969 White Paper by quoting Cree scholar Harold Cardinal who described the proposed policy "a thinly disguised programme of extermination by assimilation" (Cardinal, 1999, p. 1). Other initiatives, such as the British Columbia Tripartite Framework Agreement on First Nation Health, were better

received by both First Nations and the government of British Columbia as it led to the creation of the First Nations Health Authority of British Columbia and First Nations control of FNIHB programs in British Columbia.

Chickasaw scholar Eber Hampton shared that "research is about learning and … is a way of finding out things" (Hampton, 1995, p. 48). This research has definitely been about learning and while I remain a non-Indigenous researcher and participant, someone who has lived and worked with Indigenous peoples for more than 20 years, a government employee working in a department that frames its delivery of health programs and services for First Nations on a policy basis rather than on a legislative or Treaty basis, with this research I began to see and hear differently. This next section demonstrates some of that learning and represents my attempts in addressing the significant gaps in my earlier literature review in regards to relationships between First Nations, federal and provincial governments and more broadly between First Nations Peoples and Settler society. To develop this section, I was guided by the participants who identified these as elements framing our collaboration however, it is not meant to be an extensive review of the legal and jurisdictional aspects of collaboration between First Nations, federal and provincial governments. To honour the input of my First Nations colleagues, I also sought to develop this section by delving more deeply into Indigenous literature and relying on First Nations voices to tell the story.

Preconditions… Colonization, Assimilation and Broken Trust

As cited earlier, "research is about learning" (Hampton, 1995, p. 48) and results in more than its fair share of humbling moments. One of those moments occurred when I reviewed my proposal and noticed that I had sparingly referred to a number of words that

are used by Indigenous scholars to describe the relationships between First Nations and the federal governments: colonization, colonialism, assimilation, cultural genocide, oppression and broken trust.

In regards to colonization and colonialism, Indigenous scholars have pointed to both our colonial past and the ongoing colonization of First Nations in Canada (Alfred, 2009; Corntassel, 2009, 2012; Coulthard, 2014; Fanelli, 2013; Little Bear et al., 1992; Simpson, 2001, 2011). In describing colonization, Anishinabe scholar John Borrows linked it with the concept of power, as he wrote:

> Colonization is not a pretty thing, when you look into it. In reconciling Crown assertions of sovereignty with ancient rights stemming from Aboriginal occupation, the court labels colonization as infringement (as if the interference with another nation's independent legal rights where a minor imposition at the fringes of the parties' relationship). Labelling colonization infringement is an understatement of immense proportions. While these infringements must be consistent with the special fiduciary relationship between the Crown and Aboriginal peoples, the effect of the court's treatment is to make Aboriginal land rights subject to the colonizer's objectives. The assertion of sovereignty places Aboriginal people in a dependent, feudal relationship, with the Crown. This dependent relationship, and the effects of sovereignty's assertion, are further illustrated by the Supreme Court's description of the content of Aboriginal title. It is, paradoxically, a right to the land itself held by the Crown for the use and benefit of the Aboriginal group. While Aboriginal peoples may use their title lands for a wide variety of purposes, the fact that this title is held by another

> places Aboriginal peoples in a position analogous to serfs, dependent on their lord to hold the land in their best interests (Borrows, 2002, pp. 98-99).

Colonization and colonialism are also linked to perceptions of Indigenous self-government which is as follows:

> Indian leaders lay claim to sovereignty and nationhood for their people… They hold that their right to self-government is an inherent right derived from the Creator, who gave that authority to all the Indian people. They point out that this is a right that pre-dates the Canadian government; thus, the Canadian government was never in a position to create or grant Indian self-government but merely to acknowledge it. They assert, furthermore, that their inherent and historical right to self-government was explicitly recognized by the Crown in the treaty agreements with Indians. Therefore, any power exercised by the Canadian government over Indians, unless it has been freely delegated by Indians, is illegal. The Canadian government's position is quite different. It holds that Indians possess and can exercise only those powers that are bestowed on them by Parliament. In the Canadian government's view, Indians are subject to the laws of Canada, and their right to self-government, if any, is a delegated and limited privilege. This position has been consistently upheld in judicial decisions by Canadian courts (Little Bear et al., 1992, p. xiv).

Anishinabe scholar John Borrows also outlined feelings of oppression experienced by First Nations by writing the following:

> Currently, Aboriginal peoples often feel oppressed. They struggle to fully identify themselves as citizens in Canada because they rarely see their primary

> perspectives and interests mirrored in the law, the expressed goals of the state, or the prevailing associations in society. Their failure to fully identify with Canada is not wholly a problem of legal status or degree of participation with others, although these are obviously contributing factors. Aboriginal exclusion from more holistic notions of citizenship runs even deeper. Current conceptions of citizenship are deficient both because they fail to give socio-cultural recognition to Aboriginal peoples' primary relationships and loyalties *and* because non-Aboriginal Canadians have not considered or made many of these allegiances, relationships, and obligations their own. Aboriginal control of Canadians' affairs would nourish Aboriginal peoples' own view of their place in the world and assist other Canadians in adjusting their views and activities to take into account Aboriginal peoples, institutions, and ideologies. (Borrows, 2002, p. 144)

Above, I have simply referred to broken trust. This topic was raised a number of times by participants in interviews as they talked about limited trust, lack of trust, mistrust and distrust, which will be documented in Chapter 5. Anishinabe scholar John Borrows outlined the relationship by referring to the oral traditions of First Nations:

> Memories of government deception, lies, theft, broken promises, unequal and inhumane treatment, suppression of language, repression of religious freedoms, restraint of trade and economic sanctions, denial of legal rights, suppression of political rights, forced physical relocation, and plunder and despoliation of traditional territories. (Borrows, 2002, p. 88)

In this section, I also aim to correct this important gap as I provide an overview of the relationships between First Nations, federal and provincial governments. This

literature review was conducted in a more organic fashion as I started with a few books identified as must-read by one of my committee members, Dr. Tracey Lindberg. Her suggested reading list included Indigenous academic, non-fiction and fiction literature. These readings became the starting point of my literature review as I branched off based on citations and references to other works. I understand that "to acquire Indigenous knowledge, one cannot merely read printed material, such as books or literature" (Battiste, 2008, p. 502), but I must acknowledge how important the readings were in enabling me to hear and see differently. Earlier, I shared that I feel strong personal and professional connections with Indigenous peoples and communities. I have benefited of the guidance and wisdom of many Elders, community members and as our family is actively involved in promoting traditional Métis dancing I have been able to learn more about Indigenous cultures and oral traditions. Yet, the readings brought in another layer of understanding. They allowed me to connect some of the pieces that I had failed to connect on my own and while the overview is mostly based on academic and non-fiction readings, my views were also shaped by the Indigenous fiction I read. The overview that follows is by no means exhaustive but provides information on the broader social, political and cultural context within which the Joint Action Plan to Improve the Health of First Nations in Alberta arises. As such, I identify five key components of this broader context. With the first component, I provide information about the numbered Treaties and how they are understood by First Nations. With the second component, I include information about the Treaty Right to Health. For the third component, I provide an overview of Indigenous writings on two of the most recent statements by the federal government, Gathering Strength – Canada's Aboriginal Action Plan (1998) and the

Statement of Apology to Former Students of Indian Residential Schools (2008). Fourth, I group together a number of events that occurred in 2015 as we were beginning the implementation the Joint Action Health Plan. Last but not least, I include background information as it relates to health care collaborative endeavours between First Nations, federal and provincial governments in Alberta.

The Numbered Treaties

First Nations Peoples and the Crown signed a number of treaties; of particular interest for my research are three of the numbered treaties. For most Canadians, and I was no exception, I was taught that treaties were land-sale agreements. This statement stems from the first clause in a number of treaties such as Treaty No. 6 which states:

> Indians inhabiting the district hereinafter described and defined, do hereby cede, release, surrender and yield up to the Government of the Dominion of Canada, for Her Majesty the Queen and Her successors forever, all their rights, titles and privileges, whatsoever, to the lands included within the following limits… (Government of Canada, 1964, np)

This view fails to acknowledge the First Nations' understanding of treaties and treaties negotiations. In this regard, Anishinabe scholar John Borrows outlined both the Treaty process and concerns of First Nations on its outcomes:

> The treaty process has been exposed as a deeply flawed means by which to acquire these interests. In almost every treaty negotiation one can detect dishonesty, trickery, deception, fraud, prevarication, and unconscionable behaviour on the part of the Crown. In most treaties, there was no consensus or 'meeting of the minds' on the question of the Crown receiving sovereignty or

> underlying title to the land from Aboriginal peoples. Moreover, in many parts of Canada the Crown has never negotiated with Aboriginal peoples to receive a transfer of any rights to land or governance. The Crown has merely asserted such rights, and acted as if their unilateral declarations have legal meaning. Most Aboriginal peoples regard the Crown's assertions and actions in this regard as the gravest injustice ever perpetrated upon them. They contend that they cannot be dispossessed of their land or governing powers unless they agree to surrender these rights with adequate knowledge and informed consent. (Borrows, 2002, pp. 113-114)

Grounding their work in international laws, a number of Indigenous scholars highlighted that the treaties were not land-sale agreements but rather agreements negotiated between sovereign nations (Alfred, 2009; Borrows, 2002; Cardinal & Hildebrandt, 2000; Little Bear et al., 1992; Turpel, 1991; Venne, 1998). Cree scholar Mary Ellen Turpel wrote:

> Treaties were not de facto instruments for the recognition of diverse Indigenous cultures. In reality, they were political agreements intended to make way for economic and military progress, as defined according to standards of the newcomers. It is clever how the Canadian law of treaties (Aboriginal-European) ascribes to treaties the status of contracts or domestic agreements: they are not seen as international agreements between sovereign peoples or nations. If you inquire as to why treaties are not viewed as agreements between two (or more) sovereign peoples, the argument is, either, that Aboriginal peoples (either at the time of treaty-making or now) were not sufficiently "civilized" and organized to

> qualify as "sovereign" peoples, or that they had already "lost" their sovereignty through some predestined and mysterious process such as the good providence of being "discovered". The conclusion to either argument is that treaties are akin to paternalistic contracts. (Turpel, 1991, p. 57)

In a study undertaken with Treaty Elders from Saskatchewan on the meaning of the treaties, Harold Cardinal and Walter Hildebrandt concluded "that treaties were not understood by First Nations narrowly as land surrenders, but were understood as land-sharing agreements that assured First Nations the right to earn a living through continuing traditional ways of earning a living or by adopting new ways" (Cardinal & Hildebrandt, 2000, p. 69). They further wrote that "in the focus sessions with the Elders, it became clear that their view and understanding of the Treaties differed significantly and substantively from the written text of the Treaties" (Cardinal & Hildebrandt, 2000, p. 25).

Indigenous scholars linked the understanding of the treaties to Canada's colonialism and the different worldviews of the signatories (Borrows, 2002; Cardinal & Hildebrandt, 2000; Venne, 1997). Cardinal and Hildebrandt wrote "the treaties cannot be understood in isolation. Non-Aboriginal understanding of treaties and the treaty process is shaped by its colonial history. The First Nations' perspective must be understood in the context of their world views" (Cardinal & Hildebrandt, 2000, p. 1). Linked to the treaties was the First Nations' understanding that "these relationships were, in part, to consist of mutual ongoing caring and sharing arrangements between the treaty parties, which included a sharing of the duties and responsibilities for land, shared for livelihood purposes with the newcomers" (Cardinal & Hildebrandt, 2000, p. 15). In defining this mutual relationship, Michi Saagiig Nishnaabeg scholar Leanne Simpson wrote "in

treaties, the relationship must be one of balance. One nation cannot be dominant over the other. One nation cannot control all of the land and all of the resources" (Simpson, 2011, p. 107). She further wrote:

> Nursing is ultimately about a relationship. Treaties are ultimately about a relationship. One is a relationship based on sharing between a mother and a child and the other based on sharing between two sovereign nations. Breastfeeding benefits both the mother and the child in terms of health and in terms of their relationship to each other. And the other must benefit both sovereign independent nations to be successful. (Simpson, 2011, pp. 106-107)

A number of Indigenous authors (Alfred, 2009; Borrows, 2002; King, 2012; Simpson, 2011; Venne, 1997, 1998, 2007) emphasized the absence of mutual benefits as well as Canadians perceptions of generosity towards First Nations. Anishinabe scholar John Borrows wrote:

> Canadians are quite happy to uphold the right for non-Native people to perpetually live on treaty lands but often blanche when Native people assert perpetual rights to housing, education, medical care, or federal transfers of money. The rule of law should not sanction such uneven and arbitrary applications of normative order. (Borrows, 2002, p. 134)

The Medicine Chest Clause and the 1979 Indian Health Policy

Another key element of the treaties relevant to this research and the relationships between First Nations, federal and provincial governments is the Medicine Chest Clause that is included in Treaty No. 6. The clause states that "a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of

such agent" (Government of Canada, 1964, np). Many First Nations peoples believe the delivery of health services by the federal government is based on this clause which is understood as the Treaty Right to Health. As part of the negotiations that led to Treaty No. 6, First Nations requested "a free supply of medicines" (Taylor, 1985, np) and the reference to a Medicine Chest Clause should be interpreted to mean "the full benefits of medicare" (Taylor, 1985, np). Cree scholar Sharon Venne wrote that the request was made for universal health care and that "the leaders did not give up their traditional health care and medicines to the non-Indigenous people in this process. This was a gift from the Creator which they were not prepared to share with non-Indigenous people" (Venne, 1997, p. 194). A Medicine Chest Clause was also requested as part of the negotiations leading to Treaty No. 8 (Government of Canada, 1966).

In its 1974 Policy of the Federal Government concerning Indian Health Services, the federal Minister of Health "reiterated that no statutory or treaty obligations exist to provide health services to Indians" (Health Canada, 2007) which paved the way for the 1979 Indian Health Policy which states that:

> The over-riding concern from which the policy stems is the intolerably low level of health of many Indian people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community (Health Canada, 1979, np).

One of the three pillars of the 1979 Indian Health Policy refers to the interrelated Canadian health system and the role of the provincial government in the delivery of

health services. On one side, "all provinces are uniformly reluctant to accept financial responsibility for services to Indians within their boundaries" (Little Bear, Boldt, & Long, 1992, p. xiii). While on the other side:

> Indians have been very reluctant to accept services and assistance from provincial governments. They see in the federal government's move to integrate Indian bands into the provincial-municipal structure much more than a simple extension of provincial services. They interpret it as part of the federal government's hidden agenda to abrogate its constitutional and treaty obligations to the Indian people. They view a transfer of dependency from the federal government to ten provincial governments as the death sentence for their historical claim to nationhood and self-government. Furthermore, they reject the assertion that a transfer of dependency will produce an improvement in their life-condition. (Little Bear et al., 1992, pp. xiii-xiv)

Federal Government Statements – Reconciliation (1998) and Apology (2008)

The Royal Commission on Aboriginal Peoples was established on August 26, 1991 to "investigate the evolution of the relationship among aboriginal peoples (Indian, Inuit and Métis), the Canadian government, and Canadian society as a whole" (as cited in Royal Commission on Aboriginal Peoples, 1996, p. 2) and to propose solutions regarding the relationship on a wide range of topics. The RCAP has been described as "an unparalleled means of renewing Canada's relationship with Aboriginal peoples" (Belanger & Newhouse, 2004, p. 165). The five-volume final report was tabled in 1996. On January 7, 1998, the federal Minister of Indian Affairs and Northern Development unveiled Gathering Strength – Canada's Aboriginal Action Plan. This statement was met

with mixed reviews from Indigenous scholars and leaders. For Onondaga scholar, David Newhouse, it is "the first statement by a government of the New World that acknowledges that it has been wrong in its treatment of the people that it encountered" (Newhouse, 2004, p. 140). Newhouse wrote that the statement "says explicitly that Aboriginal peoples have lived here for thousands of years, had their own forms of government, were organized into nations with distinct national cultures, and made contributions to the development of Canada" (Newhouse, 2004, p. 141). Newhouse also highlighted the participation of Aboriginal peoples from one of the national Aboriginal organizations in drafting the statement (Newhouse, 2004). In a review of the same statement, Jeff Corntassel and Cindy Holder assessed the statement against eight criteria established to assess similar apologies and concluded that it is a "quasi-apology" prior to adding:

> Nothing short of a full apology by the Prime Minister of Canada [would be] adequate. Additionally, the Statement of Reconciliation did not form part of Canada's official parliamentary or legal record – it was merely posted on the Indian and Northern Affairs website. (Corntassel & Holder, 2008, p. 473)

Yellowknives Dene scholar Glen Coulthard was also critical of Gathering Strength – Canada's Aboriginal Action Plan for the minimal monetary commitment but most importantly for its failure to acknowledge that the colonial past referred in the document is ongoing (Coulthard, 2014).

In 2008, Prime Minister Harper presented a Statement of Apology to former students of Indian Residential Schools in the House of Commons. Initially, the statement was described by some a "genuine and necessary first step in the long road to forgiveness

and reconciliation" (Coulthard, 2014, p. 105). However, the genuineness of the apology was questioned a few months later as Prime Minister Harper stated that Canada has "no history of colonialism" (Ljunggren, 2009, np) at a G20 summit. Coulthard further wrote that in the 2008 apology "there is no recognition of a colonial past or present, nor is there any mention of the much broader system of land dispossession, political domination, and cultural genocide of which the residential school system formed only a part" (Coulthard, 2014, p. 125). These statements were echoed by Jeff Corntassel who wrote that "contemporary colonialism continues to disrupt Indigenous relationships with their homelands, cultures and communities" (Corntassel, 2012, p. 88).

In 2013, the United Nations Special Rapporteur on the Rights of Indigenous Peoples, James Anaya, met with Indigenous, federal and provincial leaders to assess the situation of Indigenous peoples in Canada. In his report, he flagged the significant well-being gap between Indigenous and non-Indigenous peoples in Canada and identified a number of recommendations. He indicated that despite some positive work many "processes have contributed to the deterioration rather than the renewal of relationship" (United Nations Human Rights Council, 2014, p. 18). He also shared his "overarching concern… that the [federal] government appears to view the overall interests of Canadians as adverse to aboriginal interests rather than encompassing them" (United Nations Human Rights Council, 2014, p. 18).

Because it's 2015…

In 2015, a number of key events led to increased interest in the relationship between First Nations, federal and provincial governments. The first of these events was the release of the summary of the final report of the Truth and Reconciliation

Commission (TRC) on May 31, 2015. The complete final report was released a few months later on December 15, 2015. The Truth and Reconciliation Commission was established in 2008 as a result of the 2006 Indian Residential Schools Settlement Agreement. In its introductory paragraph, the Commission stated:

> For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and, through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct, legal, social, cultural, religious, and racial entities in Canada. The establishment and operation of residential schools were a central element of this policy, which can best be described as cultural genocide. (Truth and Reconciliation Commission of Canada, 2015b)

The Truth and Reconciliation Commission advocated for reconciliation which it defined as follows:

> Reconciliation is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in this country. In order for that to happen, there has to be awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes, and action to change behaviour. (Truth and Reconciliation Commission of Canada, 2015, p. 6)

The Truth and Reconciliation Commission identified 94 calls to action; seven of them are identified as related to the health field. The first of these seven calls to action (call to action number 18) is more overarching as it calls upon:

> Federal, provincial, territorial and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous

> Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law and constitutional law, and under the Treaties. (Truth and Reconciliation Commission of Canada, 2015b, p. 207)

The other health priority areas identified by the Truth and Reconciliation Commission included the need to: measure and close the gaps in health outcomes; address jurisdictional concerns as they relate to individuals not residing on-reserve, Métis and Inuit peoples; fund Aboriginal healing centres; recognize Aboriginal healing practices; increase the number of Aboriginal health-care providers; and, require cultural competency training for students in medical and nursing schools (Truth and Reconciliation Commission of Canada, 2015b).

The next two events are political events and the results of elections in Alberta and Canada. In May 2015, the provincial election resulted in the defeat of the Progressive Conservative Party that had ruled Alberta for more than four decades by the New Democratic Party. As part of its electoral platform the NDP promised "a renewed partnership with Indigenous Peoples" (Alberta NDP, 2015, p. 20) including commitments to "implement the 2007 United Nations Declaration on the Rights of Indigenous Peoples, and build it into provincial law" (Alberta NDP, 2015, p. 20) as well as to "work with Alberta Indigenous Peoples to build a relationship of trust and ensure respectful consultation" (Alberta NDP, 2015, p. 20). Upon election of the NDP government, Confederacy of Treaty Six First Nations issued a congratulatory letter to the new government (Grand Chief Martial, 2015, p. 1). In a similar note, Treaty 8 First Nations of Alberta stated "we are looking to meeting with her [Premier Notley] to discuss

new ways to repair and reinvigorate relations between our two governments" (Treaty 8 First Nations of Alberta, 2015, p. 1). In its inaugural Speech from the Throne, Alberta's NDP government stated that "we need to return to a respectful relationship with this land's Indigenous peoples" (Alberta Government, 2015, np). On June 22, 2015, the Alberta government stated that "as a first step in reconciliation, the government apologized for not taking a stand to stop children from being taken from their homes as part of the federal residential school system" (Alberta Government, 2015c, np). In a news release issued after this announcement, the Confederacy of Treaty Six First Nations states:

> Five Chiefs of Treaty Six joined the Premier in her announcement yesterday and are willing to work collectively with the provincial government. This partnership is long overdue and the Chiefs welcome actions that can be implemented provincially in order to protect their communities (Confederacy of Treaty Six First Nations, 2015, p. 1)

In early July 2015, the Alberta Government announced that it would "review its existing programs and policies in consultation with Indigenous peoples to identify ways to implement the objectives and principles of the United Nations Declaration on the Rights of Indigenous Peoples" (Alberta Government, 2015g). In response to this announcement, Confederacy of Treaty Six First Nations issued a letter to the Premier stating:

> With this in mind having a new Alberta Premier representing a new Alberta Government commit to implementing the articles contained in the UN Declaration brings a renewed sense of optimism in anticipation of what the announcement will

> offer Indigenous peoples in Alberta today. We would ask that as the new Premier you afford us the opportunity to participate in reviewing the respective Ministries portfolios and mandates as much as it may apply to or affect our First Nations. (Grand Chief Martial, 2015a, p. 1)

In the fall of 2015, the provincial government held separate meetings with the leadership of Treaty No. 6, Treaty No. 7 and Treaty No. 8 First Nations to discuss a renewed government-to-government relationship (Alberta Government, 2015a, 2015e, 2015f; Treaty 8 First Nations of Alberta, 2015b). On December 15, 2015, the provincial government welcomed the final report of the Truth and Reconciliation Commission stating that "we cannot erase the past, but we can walk hand-in-hand with Indigenous people to build a better future for all" (Alberta Government, 2015d). As part of that same press release, the Alberta government indicated that it was "implementing the principles of the UN Declaration in a way that is consistent with our Constitution and Alberta law" (Alberta Government, 2015d, np) which may be a narrower scope than initially outlined in their electoral platform and earlier press releases (Alberta Government, 2015g; Alberta NDP, 2015). In early 2016, Treaty 8 First Nations of Alberta and the province of Alberta signed a protocol agreement identifying the creation of tables to discuss a number of matters of mutual concerns including health (Treaty 8 First Nations of Alberta and the Province of Alberta, 2016). Similar protocol agreements are being negotiated in other parts of the province and the Blackfoot Confederacy signed its own protocol agreement on March 24, 2017.

The federal election of October 2015 also led to a change in government as the Liberal Party of Canada defeated the Conservative Party of Canada. As part of its

electoral platform, the Liberal Party of Canada promised to "re-engage in a renewed nation-to-nation process with Indigenous Peoples to make progress on the issues most important to First Nations, the Métis Nation, and Inuit communities – issues like housing, infrastructure, health and mental health care, community safety and policing, child welfare, and education" (Liberal Party of Canada, 2015, p. 46). Upon his swearing in, Prime Minister Trudeau issued an open letter to Canadians in which he stated "it is also time for a renewed, Nation-to-Nation relationship with Indigenous Peoples, one based on a recognition of rights, respect, co-operation, and partnership. Not only is this the right thing to do, but it is also a sure path to economic growth" (Trudeau, 2015, np). In the mandate letter issued by Prime Minister Trudeau to his Minister of Health, Minister Philpot, he stated "no relationship is more important to me and to Canada than the one with Indigenous Peoples. It is time for a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership" (Trudeau, 2015a, np). Shortly after, the National Chief of the Assembly of First Nations, Perry Bellegarde, stated:

> As we reflect on our progress over the past year, I want to begin by noting the important role First Nations electors played in helping to elect a government that is expressly committed to rebuilding the Crown's relationship with our peoples on a foundation of rights recognition. (Bellegarde, 2015, p. 1)

In its Speech from the Throne, the Liberal government stated that "because it is both the right thing to do and a certain path to economic growth, the Government will undertake to renew, nation-to-nation, the relationship between Canada and Indigenous peoples, one based on recognition of rights, respect, co-operation and partnership"

(Canada Governor General, 2015, p. 6). On December 8, 2015, Prime Minister Trudeau delivered a speech to the Assembly of First Nations Special Assembly where he stated:

> It is time for a renewed, nation-to-nation relationship with First Nations Peoples. One that understands that the constitutionally guaranteed rights of First Nations in Canada are not an inconvenience but rather a sacred obligation. One that is based on recognition of rights, respect, co-operation and partnership. One that is guided by the spirit and intent of the original treaty relationship; one that respects inherent rights, treaties and jurisdictions; and one that respects the decision of our courts. I know that renewing our relationship is an ambitious goal, but I am equally certain that it is one we can, and will, achieve if we work together. (Trudeau, 2015b, np)

In that same speech, Prime Minister Trudeau also stated "in partnership with Indigenous communities, the provinces, territories and vital partners, we will fully implement the calls to action of the Truth and Reconciliation Commission, starting with the implementation of the United Nations Declaration on the Rights of Indigenous Peoples" (Trudeau, 2015c, np). A few days later, in accepting the final report of the Truth and Reconciliation Commission, Prime Minister Trudeau said:

> We recognize that true reconciliation goes beyond the scope of the Commission's recommendations. I am therefore announcing that we will work with leaders of First Nations… to design a national engagement strategy for developing and implementing a national reconciliation framework informed by the Truth and Reconciliation Commission's recommendations. (Trudeau, 2015c, np)

In a summary of his government first 100 days, Prime Minister Trudeau stated that they had engaged "in a renewed nation-to-nation process with Indigenous Peoples based on the recognition of rights, respect, co-operation and partnerships" (Trudeau, 2016, np) identifying as key activities "ongoing, regular meetings between the Government of Canada and the National Aboriginal Organizations" (Trudeau, 2016, np) and the reception of "the Final Report of the Truth and Reconciliation Commission and… [commitment] to fully implement its Calls to Actions, starting with the implementation of the United Nations Declaration on the Rights of Indigenous Peoples" (Trudeau, 2016, np). In May 2016, at the United Nations in New York, the Honourable Carolyn Bennett, Minister of Indigenous and Northern Affairs Canada stated:

> Today's announcement that Canada is now a full supporter of the Declaration, without qualification, is an important step in the vital work of reconciliation. Adopting and implementing the Declaration means that we will be breathing life into Section 35 of Canada's Constitution, which provides a full box of rights for Indigenous peoples. (Government of Canada, 2016, np)

In July 2016, at the Annual General Assembly of the Assembly of First Nations, the Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada referred to the recent work of her government by stating that it "adopted without qualifications, the United Nations Declaration on the Rights of Indigenous Peoples" (Wilson-Raybould, 2016, p. 3). In that same speech, she also said:

> As much as I would tomorrow like to cast into the fire of history the Indian Act so that the Nations can be reborn in its ashes – this is not a practical option – which is why simplistic approaches, such as adopting the UNDRIP as being Canadian

> law are unworkable and, respectfully, a political distraction to undertaking the hard work required to actually implement it. (Wilson-Raybould, 2016, p. 9)

Another element of this broader context is the beginning of negotiations for the renewal of the national Health Accord which began shortly after the 2015 federal elections. The national Indigenous organizations (NIOs) were invited to meet with the federal, provincial and territorial health ministers as discussions began in January 2016 (Assembly of First Nations, 2016). As part of these discussions, federal and provincial health ministers met with national Indigenous leaders in October 2016 and committed "to participate in a two-day conference focused on Indigenous peoples' health next summer" (Cruickshank, 2016, np). As of August 2017, this 2-day conference has not been held. As federal and provincial Ministers of Health could not agree on a national Health Accord, the national discussion became a series of bilateral discussions between the federal and provincial governments on new funding arrangements (Solomon, 2016). On March 10, 2017, the governments of Alberta and Canada announced that they had reached agreement on a 10-year funding arrangement (Health Canada, 2017).

On December 15, 2016, Prime Minister Trudeau further committed to additional steps towards reconciliation including: creation of permanent bilateral mechanisms with the national Indigenous organizations; the creation of a National Council of Reconciliation; and, funding to the National Centre for Truth and Reconciliation (Trudeau, 2016b). In a series of town halls in January 2017 hosted by Prime Minister Trudeau, many Indigenous individuals voiced their "growing impatience and frustration" (Akin, 2017, np) with his government. On August 28 2017, Prime Minister Trudeau announced the dissolution of Indigenous and Northern Affairs Canada and appointed two

new Ministers: a Minister of Indigenous Services and a Minister of Crown-Indigenous Relations and Northern Affairs (Trudeau, 2017d). In three mandate letters issued on October 4, 2017, Prime Minister Trudeau indicated the anticipated transfer of First Nations and Inuit Health Branch from Health Canada to Indigenous Services (Trudeau, 2017a, 2017b, 2017c) which became effective on December 4, 2017.

Health Care Collaboration in Alberta

Collaboration is not a new concept for First Nations organizations and governments in Alberta. The previous pages highlighted a number of statements by First Nations leaders in Alberta stressing their desire to work together with both federal and provincial governments. One of the better known collaborative agreements is the Co-Management Agreement which was signed in 1996 by First Nations Chiefs and the federal Minister of Health, David Dingwall. The First Nations signatories were Chief Robert Breaker, Siksika Nation, on behalf of First Nations communities in Treaty No. 7, Chief Archie Cyprien, Athabasca Chipewyan First Nation, on behalf of First Nations communities in Treaty No. 8, and Chief Rod Alexis for Alexis Nakota Sioux Nation. In 1999, the other First Nations communities from the Yellowhead Tribal Council joined Alexis Nakota Sioux Nation to become part of the Co-Management Agreement. In 2010, the four bands of Maskwacis Cree Nations joined. Today, 39 of the 47 First Nations communities in Alberta are part of the Co-Management Agreement including all First Nations communities in Treaty No. 7 and Treaty No. 8 and nine of 17 First Nations communities in Treaty No. 6. The Co-Management Agreement allows First Nations organizations and governments and FNIHB-AB to co-manage the funding for FNIHB-AB (Co-Management, 1996). Since the inception of the Co-Management Agreement, its

purpose and structure were evaluated a number of times. The 2001-2002 evaluation concluded that:

> There are clear merits to remaining in this agreement. One of which is to continue to protect the amount of dollars the Alberta Region receives under envelope allocation. Without the Co-Management Agreement, resourcing to First Nations health would again be in the sole hands of FNIHB and consultation would occur nation to nation without a sense of direction from the goals of First Nations [peoples] in Alberta as a whole. There is also merit in the idea of co-management that is the mandated effort to co-analyze, co-assess and co-administer health resourcing and planning to First Nations communities. (Large, 2002, pp. 56-57)

The 2007-2008 review was essentially an administrative review of an administrative agreement seeking to strengthen the structure of Co-Management. It resulted in a streamlined committee structure, the establishment of co-chairs for all sub-committees and the creation of a secretariat (Co-Management Review Working Group, 2008; Kishk Anaquot Health Research, 2007). The 2010 evaluation assessed progress in implementing the recommendations of the 2007-2008 review. The most recent evaluation of Co-Management was undertaken in 2014-2015 and concluded that "it is a viable model for the administrative processes to co-manage the funding envelop and programs as stated in the original… Agreement" (Breaker & Wong, 2015, p. 4). The report includes recommendations to strengthen the operations of the Co-Management structure.

The Co-Management Agreement is not the sole health partnership in Alberta as there are a number of formal and informal collaborative endeavours including: bilateral memorandum of understanding that were jointly developed and resulted in First Nations tribal councils and communities signing two similar documents one with FNIHB-AB and one with Alberta Health Services; joint committees including representatives of First Nations organizations and governments, Alberta Health, Alberta Health Services and FNIHB-AB; and, a number of practical approaches that result in the delivery of provincial services on-reserve including midwifery, nurse practitioners and physician care in a number of First Nations communities (Health Canada, 2012b).

The most recent of these initiatives is the Joint Action Plan to Improve the Health of First Nations in Alberta which was developed in September 2014. The Joint Action Health Plan is a two-page document which outlines the foundation for a new multilateral health care collaboration that is to unfold over an 18-month period. The goal of the Joint Action Health Plan is "to enhance collaboration between First Nations organizations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations peoples that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014, p. 1). The Joint Action Health Plan includes the following objectives: strengthening relationships; increasing accessibility, coordination and quality of health services; and, increasing First Nations control of health services and programs (Co-Management, 2014). This latest collaborative endeavour is the subject of this research. A copy of the Joint Action Health Plan is included in Appendix B.

Chapter 4 – RESEARCH METHODOLOGY

With this section, I outline the key elements of the methodology used to conduct this research. In the first section, I provide the purpose of my study before outlining my research question and sub-questions in the second section. In the third section, I provide background information on my project. Fourth, I provide a quick overview of the partners to the Joint Action Plan to Improve the Health of First Nations in Alberta as all the participants in this research work for these organizations. In the fifth section, I provide information on the methodology used to conduct this research – Participatory Action Research. Finally, the sixth section outlines the approach used to conduct this research.

Purpose of the Study

In previous chapters, I outlined the broader context of relationships between First Nations, federal and provincial governments in Canada; provided an overview of academic and management literature on collaboration; and, clarified my lenses as I pursued this research. While I began this research project prior to the release of the final report of the Truth and Reconciliation Commission, its definition of reconciliation is relevant to my research:

> Reconciliation is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in this country. For that to happen, there has to be awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes, and action to change behaviour. (Truth and Reconciliation Commission of Canada, 2015a, p. 6)

I believe that one of those actions that can be used to change behaviour is enhanced collaboration between First Nations, federal and provincial governments. As part of my literature review on collaboration, I shared information about an engagement spectrum (New Zealand Office for the Community and Voluntary Sector, 2011) that could be used to support our work towards meaningful collaboration as we seek to move from the *to* and *for* quadrants into the *with* quadrant while understanding the need for greater First Nations control with the *by* quadrant. I believe a key area for enhanced collaboration is health care as First Nations, federal and provincial governments are all actively involved in its delivery and a number of collaborations are currently underway between First Nations, federal and provincial governments across the country.

In 2014, First Nations of Treaty No. 6, Treaty No. 7, Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch – Alberta Region (Health Canada) developed a Joint Action Plan to Improve the Health of First Nations in Alberta. Again, the purpose of this research is to document and support the further development and implementation of this action plan. The Joint Action Health Plan (JAHP) is a two-page document which outlines the foundation for a new multilateral health care collaboration that is to unfold over an 18-month period starting in the fall of 2014 and with key deadlines until March 31, 2016. The goal of the Joint Action Health Plan is "to enhance collaboration between First Nations [organizations and governments], Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations [peoples] that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014, p. 1). The Joint Action Health Plan includes three objectives. The first objective, "strengthening relationships" (Co-Management,

2014, p. 1), identifies activities to increase mutual awareness and understanding of the participating organizations. It also includes activities that could lead to more formal relationships including development of a joint document stating the need for a renewed relationship and a health information governance agreement. The second objective, "increasing accessibility, coordination and quality of health services" (Co-Management, 2014, p. 1), identifies a number of activities including: documenting and seeking opportunities to increase the scope and/or range of existing collaborative endeavours; enhancing the coordination of health benefits; and, developing a strategy to better serve the needs of northern First Nations residents. The third objective, "increasing First Nations control of health services and programs" (Co-Management, 2014, p. 2), encourages a higher level of control in the delivery of health services, particularly federally-funded health services, by First Nations peoples. It also articulates the need for broader engagement of First Nations Elders to guide enhanced collaboration as well as to ensure cultural competency.

Research Question

As a research project that sought to support enhanced health care collaboration between First Nations, federal and provincial governments, I weaved many threads together. Some of these threads were linked to my roles as participant, employee, colleague, student and researcher; others were linked to my need to navigate Western and Indigenous ways of knowing; and, my lenses as a non-Indigenous person living and working with First Nations individuals. I undertook this research as I sought to fulfill the requirements for a doctoral dissertation which brings another layer of Western-based requirements (e.g. ethical requirements from Athabasca University, conflict of interest

guidelines from Health Canada, and research agreement with Alberta Health Services). The development of the research question and sub-questions was an example of this weaving as in seeking to meet the doctoral requirements and building on two years of coursework and academic readings. I developed the following research question: How can improved collaborative capacity enhance health care collaboration between First Nations organizations, Alberta Health, Alberta Health Services and FNIHB-AB? In a Western way of knowing, the dependent variable is enhanced collaboration as assessed by individuals involved in the development and implementation of the Joint Action Health Plan while the independent variables are elements of collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity. In a Western way of knowing my question allows me to lay the ground work to document and support enhanced collaboration. However, a Western way of knowing was not sufficient for my research as I also felt the need to define my work within an Indigenous way of knowing. I believe an Indigenous way of knowing would not refer to independent and dependent variables but would rather acknowledge the importance of relationships. Onondaga scholar David Newhouse defined the epistemological foundations of Indigenous research by stating that:

> Its methods are focused not so much on quantitative data – upon measuring things – but understanding the relations that exist between things, not so much as attempting to understand linear cause and effect, but upon trying to understand the influences upon the whole system. (Newhouse, 2004, p. 152)

Considering my research's focus on collaboration and change, it is interesting to note that Blackfoot scholar Leroy Little Bear viewed a state of constant flux and motion as central to what he described as Native American paradigms:

> These paradigms consist of and include ideas that there is constant flux/motion, that all of creation consists of energy waves, that everything is animate, that everything is imbued with spirit, that all of creation is interrelated, that reality requires renewal, and that space is a major referent. (Little Bear, 2009, p. 9)

In drafting my sub-questions, I was also confronted by potentially conflicting Western and Indigenous worldviews. In the end, I opted to ground my questions in academic literature hoping that they would not contradict or limit the expression of Indigenous worldviews. I crafted the sub-questions to align with the three phases of collaboration (Butterfield et al., 2004; Wood & Gray, 1991) – preconditions, processes and outcomes. For the sub-questions on processes, I also took into consideration the work on collaborative capacity (Foster-Fishman et al., 2001) – member, relational, organizational and programmatic capacity. As a practitioner, I understood and connected with these concepts and I hoped that my colleagues in First Nations, federal and provincial governments would also be able to do the same. The sub-questions were as follows:

- Preconditions – What are the impacts of existing relationships between First Nations, federal and provincial governments to the collaborative capacity to enhance multilateral health care collaboration?
- Processes –What are the key elements of collaborative capacity required to enhance health care collaboration between First Nations, federal and provincial governments?

How can an increased knowledge of collaborative capacity be used to enhance collaboration between partnering organizations?

- Outcomes – How is improving collaborative capacity impacting collaboration?

Research Project

This section outlines the broader context in which the Joint Action Health Plan was further developed and implemented, while acknowledging that this research is not being conducted in a vacuum as First Nations, federal and provincial governments engage with each other on a regular basis at the bilateral level but also at the trilateral level in a number of social spheres. I am involved in many collaborations related to First Nations health in Alberta and so are many of the individuals I interviewed as part of this research project.

Background Information

In Chapter 3, I provided the broader context of relationships between First Nations, federal and provincial governments. In this section, I more specifically examine existing relationships between First Nations organizations and governments, Alberta Health, Alberta Health Services and FNIHB-AB. As part of this broader context, a position paper developed by the Confederacy of Treaty Six First Nations in 2014 outlines the poor health outcomes of First Nations as a result of colonization and dispossession:

> Canada must recognize that the crisis began with colonization and dispossession and became endemic when social and economic disadvantage became entrenched. The crisis will not end until these conditions are changed. If the health of Indigenous peoples in Canada is to be improved, all levels of Canadian government must resolve to provide health care, goods and services, through

> Indigenous controlled mechanisms and structures. (Confederacy of Treaty Six First Nations, 2014, p. 1)

In this same position paper, the Confederacy of Treaty Six First Nations stated that "the provision of health services is a Treaty Right" (Confederacy of Treaty Six First Nations, 2014, p. 5). It further stated "the Treaty Right to Health must be understood in as broad a manner as possible. The Treaty Right to Health goes far beyond a simple medical kit, access to health and the building of hospitals. It is also about what can help us lead a healthy life" (Confederacy of Treaty Six First Nations, 2014, p. 5). The report identified a number of emergent issues including the fact that "as First Nations, we are bounced back between the federal and provincial systems. It is evident that Canada and Alberta are in violation of the Canada Health Act where the provincial health system limits access to seamless health care" (Confederacy of Treaty Six First Nations, 2014, p. 7).

While the Joint Action Health Plan appeared to promise a new multilateral dialogue between the partners, there are a number of existing collaborations between the participating organizations. As briefly referred earlier, one of these existing endeavours is the Co-Management Agreement which was signed in 1996 by First Nations Chiefs and the federal Minister of Health. It was created to co-manage, co-assess and co-analyse the FNIHB-AB funding. The structure has dual accountability to the Assembly of Treaty Chiefs who mandated it and to FNIHB whose funds they are co-managing (Co-Management, 1996; Co-Management Review Working Group, 2008; HCoM Health Co-Management Secretariat, 2015; Kishk Anaquot Health Research, 2007; Large, 2002). In April 2014, Alberta Grand Chiefs, the Co-Management Committee and some health

portfolio Chiefs met with the federal Minister of Health who suggested the development of a joint work plan that would include the province. The concept of a joint work plan was not entirely new as First Nations, Alberta Health, Alberta Health Services and FNIHB-AB had been working together through the Health Services Integration Fund (HSIF). Between 2012 and 2016, four HSIF projects sought pragmatic approaches to enhance collaboration and improve coordination of health services for First Nations peoples. Of particular interest for the work to be undertaken with the Joint Action Health Plan is the HSIF Exploring Partnerships project which sought to establish "a process for exploring a formal partnership for seamless health service delivery between the Government of Alberta, Government of Canada, and the respective Governments of First Nations in Treaty 6, 7 and 8 territories in Alberta" (Maskwacis Health Services, 2012, p. 4). Formally, HSIF Exploring Partnerships reported to the Co-Management Committee through the Operations and Support Sub-Committee but some of its work also connected with another sub-committee within the Co-Management structure, the Non-Insured Health Benefits Sub-Committee, as it sought to address the need for enhanced coordination of federally- and provincially-funded health benefits. The structure of Co-Management is included in Appendix D. As the HSIF Exploring Partnerships Working Group reported to the Co-Management structure and included many of the individuals who would have been asked to draft this joint work plan, we took advantage of the existing structure to begin this work. During the spring and summer of 2014, the HSIF Exploring Partnerships Working Group spearheaded the development of the Joint Action Health Plan through discussions at its regular meetings; broad distribution of the draft document to colleagues in partnering organizations which led to further opportunities for

input; and, a meeting with the Co-Management Committee who provided direction upon review of an early draft. From these discussions, a two-page document was drafted, reviewed and approved by the Co-Management Committee in September 2014 before being forwarded to the federal Minister of Health a few days later (Chief Threefingers, Chief Weasel Head, Chief Cardinal, & Andrews, 2014). It was hand-delivered to the provincial Minister of Health in early December 2014 by one of the Co-Management Chiefs. Both federal and provincial Ministers of Health indicated their support for the Joint Action Plan to Improve the Health of First Nations in Alberta in February 2015 (Ambrose, 2015; Mandel, 2015). In summary, the Joint Action Health Plan was jointly developed by individuals working in First Nations governments, Alberta Health, Alberta Health Services and FNIHB-AB; approved through the Co-Management structure including First Nations and FNIHB-AB leadership; and, supported by federal and provincial Ministers of Health within a 10-month period.

A Quickly Changing Landscape

The Joint Action Health Plan was drafted relatively quickly but 2015 brought many changes at the programmatic and political levels which impacted the proposed timelines for the further development and implementation of the Joint Action Health Plan. At the program level, HSIF was a time-limited program that expired on March 31, 2015. The four HSIF projects had the ability to carry-forward unspent 2014-2015 funds into 2015-2016 which allowed for some work to continue partly through the 2015-2016 fiscal year. This was the case for the HSIF Exploring Partnerships Working Group which continued to play a lead role into the further development and implementation of the Joint Action Health Plan. In late July 2015, Health Canada announced the renewal of upstream

programs including HSIF stating that the program's mandate is "to integrate federal and provincial health services to improve access for First Nations and Inuit by funding First Nations and Inuit organizations, communities and other entities to deliver 'ready to implement' integrated service delivery arrangements" (Health Canada, 2015, np). Upon confirmation of renewal, the level of funding for 2015-2016 was set at $1.013 million for FNIHB-AB which represented half of the 2014-2015 allocation. The Operations and Support Sub-Committee of Co-Management was involved in reviewing and recommending the process for allocating these funds on behalf of the Co-Management Committee which approved it in September 2015. The process identified funding levels for each of the ten activities in the Joint Action Health Plan as well as a process to offer First Nations organizations and governments an opportunity to respond to a call for proposals that would allow them to receive and manage HSIF funds through their existing funding arrangements on behalf of First Nations in Alberta. In late September 2015, three First Nations organizations were confirmed to hold the funding arrangements. They worked with partnering organizations to develop a work plan for each of the activities and funds flowed in February 2016.

On the political front, there were also a number of changes. First, while the process for the Joint Action Health Plan had been vetted through Co-Management and presented to the Assembly of Treaty Chiefs (AoTC) in September 2014 as well as in February and May 2015, it had not been submitted for endorsement at the AoTC level. There are 46 First Nations governments in Alberta with electoral terms ranging from two to four years resulting in some turnover in the governance of a number of First Nations communities throughout the province. This turnover is reflected amongst the Chiefs who

attended the April 2014 meeting with the federal Minister of Health which led to the development of the Joint Action Health Plan. Second, the provincial election of May 2015 resulted in the defeat of the Progressive Conservative Party that ruled Alberta for more than four decades by the New Democratic Party. Third, the federal election of October 2015 also led to a change in government as the Liberal Party of Canada defeated the Conservative Party of Canada. Both the federal and provincial elections led to new public discourses in terms of relationships between Indigenous peoples and federal and provincial governments (Alberta Government, 2015b, 2015c; Alberta NDP, 2015; Canada Governor General, 2015; Liberal Party of Canada, 2015; Trudeau, 2015a, 2015b, 2015c). As previously mentioned both governments pledged to implement the United Nations Declaration on the Rights of Indigenous Peoples (Alberta Government, 2015g; Government of Canada, 2016; Trudeau, 2015c) and the calls to action of the Truth and Reconciliation Commission (Alberta Government, 2015d; Trudeau, 2015c, 2015d).

Invitations to participate in the Joint Action Plan Senior Steering Committee were sent by FNIHB Assistant Deputy Minister – Regional Operations in September 2015 to the participating organizations. Shortly thereafter, many of the partnering organizations and governments, though not all, confirmed their membership. Since then, many of the partners have had to replace participants as a result of staff turnover, elections or to reflect a decision to use a different approach to appoint members. Despite the ambiguity around membership, the first meeting of the Joint Action Plan Senior Steering Committee was held on February 1, 2016. Participants at the meeting included: Grand Chiefs from Treaty No. 7 and Treaty No. 8, a Chief from Treaty No. 7 and a Councillor with responsibility for the health portfolio for a group of communities within Treaty No. 6,

Assistant Deputy Ministers from Alberta Health and FNIHB, as well as a Vice-President from Alberta Health Services.

Participants

Participating in the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta are organizations of varying sizes and structures. Each of the partners is described in more detail below but essentially there are four broadly defined partners: First Nations organizations and governments, Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB), Health Canada.

First Nations of Treaty No. 6, Treaty No. 7, Treaty No. 8 (Alberta)

First Nations peoples in Alberta are not a monolithic group as there are significant cultural, socio-economic and geographic differences amongst First Nations communities. There is tremendous cultural diversity and the main spoken languages are Blackfoot, Cree, Stoney (Nakoda Sioux), Dene, Sarcee and Chipewyan (Aboriginal Affairs and Northern Development Canada, 2014). Politically, they are represented by a number of organizations at the local and regional levels (for more information, please refer to Appendix C). In Alberta, Indigenous and Northern Affairs Canada recognizes 45 First Nations communities located on 140 reserves (Aboriginal Affairs and Northern Development Canada, 2014). A number of First Nations communities are still seeking formal recognition by Indigenous and Northern Affairs Canada. While there are a number of independent bands, most nations are regrouped into one of eight tribal councils (Health Canada, 2012b) across the province. First Nations communities are associated with one of the three treaties signed in Alberta; Treaty No. 6 (1876), Treaty No. 7 (1877)

and Treaty No. 8 (1899). As I began this research each of the three Treaty areas was supported by a Treaty organization – Confederacy of Treaty 6, Treaty 7 Management Corporation and Treaty 8 First Nations of Alberta. In 2017, the Treaty 7 Management Corporation ceased to exist as a Treaty organization. The three Blackfoot communities joined together to form the Blackfoot Confederacy, while Tsuut'ina Nation and the Stoney Tribes established the Stoney Nakoda Tsuut'ina Tribal Council.

In terms of First Nations governance, Blackfoot scholar Leroy Little Bear stressed the importance of culture and defined it by stating that "prior to the arrival of Europeans on the North American continent, Native Americans were organized into nations with group life-ways that resulted in philosophies, customs, values, beliefs, and governance systems arising from Native American paradigms" (Little Bear, 2009, p. 9). Yet, considering the focus of this research – health care collaboration – and the role of the provincial government in its delivery (Government of Canada, 1867), I used provincial boundaries for what is present day Alberta. These boundaries are not aligned with First Nations governance as two of the three treaties (Treaty No. 6 and Treaty No. 8) cross to other provinces and territories. Strong relationships also exist between the Blackfoot Confederacy and the Blackfeet Nation in the United States of America. Further, while First Nations organizations and governments can work collaboratively at the provincial level through the Assembly of Treaty Chiefs (AoTC) and other mechanisms, few First Nations organizations operate at the provincial level in health. The Co-Management Committee is mandated by the Assembly of Treaty Chiefs to co-manage, co-assess and co-analyse the FNIHB-AB funding since 1996. Most First Nations communities in Alberta are participating within the Co-Management structure however a number of

communities within Treaty No. 6 never joined. More information is provided on the Co-Management Agreement and its structure later on in this chapter. The Alberta First Nations Information Governance Centre (AFNIGC) focuses on governance of First Nations information and was established in 2011. The First Nations (Alberta) Technical Services Advisory Group (TSAG) was established in 1996 and provides a wide range of services to First Nations communities in Alberta including technical services related to information technology and water monitoring. The Joint Action Plan to Improve the Health of First Nations in Alberta is not the only trilateral table in terms of social programming as First Nations, federal and provincial governments have signed a Memorandum of Understanding for First Nations Education in Alberta in 2010 and a Senior Officials Steering Committee for Child and Family Services has also been established. More recently, Treaty 8 First Nations of Alberta and the Blackfoot Confederacy negotiated protocol agreements to discuss matters of mutual concerns with the provincial government. (Government of Alberta and Blackfoot Confederacy, 2017; Treaty 8 First Nations of Alberta and the Province of Alberta, 2016)

Alberta Health

Alberta Health is the department responsible for setting strategic direction for the health system through the establishment of policy, legislation and standards; allocation of resources; and, administration of provincial programs such as the Alberta Health Care Insurance Plan and communicable disease control expertise (Alberta Health, 2016). In 2017-2018, Alberta's health budget is estimated at $21.406 billion (Government of Alberta, 2017). The federal government contribution through the Canada Health Transfer is estimated at $4.360 billion (Government of Alberta, 2017). Slightly under a fifth of its

funding, 19.1 percent or $4.185 billion, is dedicated to "Physician compensation and development"; the most important share of its funding, 68.5 percent, is allocated to Alberta Health Services (Government of Alberta, 2017).

Alberta Health Services

In May 2008, the government of Alberta announced the merging of nine regional health authorities, Alberta Alcohol and Drug Abuse Commission, Alberta Mental Health Board and Alberta Cancer Board to create a new single entity, Alberta Health Services which is responsible to deliver health services in Alberta (Alberta Health Services, 2016a). In 2017-2018, the organization had a budget of $14.654 billion (Government of Alberta, 2017). AHS has an extensive structure with more than 108,000 employees working in 650 facilities across the province (Alberta Health Services, 2016b). As part of the restructuring, AHS established an Indigenous Health Program which "partners with Indigenous peoples, communities and key stakeholders to provide accessible, culturally appropriate health services for First Nations, Métis and Inuit people in Alberta" (Alberta Health Services, 2016c). In 2016, Alberta Health Services created a Population, Public and Indigenous Health Strategic Clinical Network. AHS established a number of Strategic Clinical Networks "to find new and innovative ways of delivering care that will provide better quality, better outcomes and better value for every Albertan" (Alberta Health Services, 2016, np). Alberta Health Services is the largest organization involved in the further development and implementation of the Joint Action Health Plan. Participants in the Joint Action Health Plan Working Group and Steering Committee are employees working in or overseeing AHS Indigenous Health Program.

First Nations and Inuit Health Branch (FNIHB), Health Canada

First Nations and Inuit Health Branch (FNIHB) is a branch of Health Canada. Its mandate is to ensure the availability of or access to health services for First Nations and Inuit communities; assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and, build strong partnerships with First Nations and Inuit to improve the health system (Health Canada, 2012a, np). In 2012, Health Canada released its First Nations and Inuit Health Strategic Plan: A Shared Path to Improve Health which identified as its vision "healthy First Nations and Inuit individuals, families and communities" (Health Canada, 2012c). The strategic plan also identifies four strategic goals: high quality health services; collaborative planning and relationships; effective and efficient performance; and, a supportive environment in which employees excel" (Health Canada, 2012c).

FNIHB has a decentralized structure with a national office and regional offices. First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB) is one of ten regional offices and has an annual budget of slightly over $300 million and more than 300 full-time equivalent positions (HCoM Health Co-Management Secretariat, 2012). Almost half of the staff (mostly nurses) is directly providing health services to First Nations living on-reserve, while just over half of FNIHB's regional budget is allocated for the provision of non-insured health benefits (e.g. prescribed medication, dental care, vision care, etc.). FNIHB-AB is both a funder and a provider of health programs and services on-reserve.

Participatory Action Research

In choosing my research methodology, I wanted to ensure that there is as much alignment as possible between my research question, collaboration literature, existing relationships between First Nations, federal and provincial governments, my personal relationships with the participants in this research many of whom are colleagues who kindly accepted to share their knowledge, experience and wisdom with me, and more broadly my relationships with First Nations peoples in Alberta. As I sought to document and support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta, I opted for one of the more collaborative research methodologies, participatory action research (PAR).

In opting for PAR, I also considered four key elements of the broader context as it relates to community-based research, Indigenous research, my roles as a researcher and participant and the key characteristics of PAR. First, in terms of community-based research, Métis scholar Cindy Gaudet signalled the collaborative nature of community-based research by indicating that it engages many stakeholders and "focuses on community as opposed to individuals" (Gaudet, 2014). Further, Ernest A. Stringer described community-based research by stating:

> Its purpose is to build collaboratively constructed descriptions and interpretations of events that enable groups of people to formulate mutually acceptable solutions to their problems. Community-based research, however, recognizes that any research process has multiple outcomes and takes into account the need to enact ways of working that protect or enhance the dignity and identities of all people involved. It is oriented toward ways of organizing and enacting professional and

> community life that are democratic, equitable, liberating and life enhancing. (Stringer, 1999, p. 188)

Second, I am a non-Indigenous researcher. I aimed to take into account the broader context of Indigenous research as well as sought to be respectful and mindful of Indigenous ethics and the need for "reciprocal relationship and collective validation" (Brant-Castellano, 2004, p. 105). In assessing the many options in terms of methodology, I opted for participatory action research (PAR) as it is described as having "received a positive reception in Aboriginal communities and has gained acceptance in some quarters of the research community" (Brant-Castellano, 2004, p. 106). The Tri-Council Policy Statement's chapter for research involving Indigenous peoples, article 9.12, recommends "applying a collaborative and participatory approach to the nature of the research" (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council and Social Sciences and Humanities Research Council of Canada, 2014, p. 128) which I understood as encouragement for the use of PAR. Further, "any research conducted among Indigenous peoples should be framed within basic principle of collaborative participatory research, a research process that seeks as a final outcome the empowerment of these communities through their own knowledge" (Battiste, 2008, p. 508). PAR has also been described by its emphasis on the "ownership and control of the research by those involved in and affected by the research" (Ortiz, 2003, p. 2). Not all Indigenous scholars agree on the value of participatory action research. For example, Michi Saagiig Nishnaabeg scholar Leanne Simpson expressed reservations as she believes it operates within a western paradigm rather than an Indigenous paradigm (Simpson, 2001).

Third, I was drawn to PAR as it is one of the methodologies where "there is no big difference between the researcher and the researched group / community / organization; they are not separate entities, even if they have clear differences" (Eriksson & Kovalainen, 2012, p. 194). In this regard, Métis scholar Cindy Gaudet identified the need for "self-inquiry or self-knowing within a participatory methodology" (Gaudet, 2014, p. 78). She further wrote:

> A participatory mode of research within Indigenous thought seeks a deeper inquiry to examine the process of situating relationship and our human relatedness as a central component. How do I see myself in relationship to the community? Who am I being in this research? Where do I come from? Why is this important? (Gaudet, 2014, p. 77)

Some may note many differences between the non-Indigenous Francophone from suburban Quebec conducting a doctoral research and the participants in this research involving First Nations, federal and provincial government officials in Alberta. However, I believe we have many similarities as like many of the participants I have been involved in the field of Indigenous health for many years. I am also a government employee as I have been working for First Nations and Inuit Health Branch – Alberta Region (Health Canada) for well over a decade sharing professional experiences with many of the participants. On a personal level, while being non-Indigenous, my husband, son, step-children and grand-children are First Nations and Métis individuals who are actively involved in the Indigenous community in Edmonton and Alberta. While I could identify a number of differences, I share the views of Cree scholar Shawn Wilson who outlined the responsibilities of researchers by stating that "we are accountable to

ourselves, the community, our environment or cosmos as a whole, and also to the idea or topics that we are researching. We have all those relationships that we need to uphold" (Wilson, 2008, p. 106).

Fourth, the key characteristics of PAR align well with my research. Participatory Action Research (PAR) is a part of the larger family of Action Research which was originally defined by Kurt Lewin in the 1940s but also evolved in parallel fashion in Great Britain through the work of what has become known as the Tavistock Institute of Human Relations (Susman & Evered, 1978). One of the more cited definitions of action research states that "action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework" (Rapoport, 1970, p. 499).

A number of key characteristics have been identified for action research. First and foremost, action research is "future-oriented" (Susman & Evered, 1978, p. 589). It seeks to build a better future by addressing practical concerns and has the ability to "build on the past, take place in the present with a view to shaping the future" (Shani, Coghlan, & Cirella, 2012, p. 48). Second, action research is collaborative (Greenwood, Foote Whyte, & Harkavy, 1993; Kemmis & Wilkinson, 1998; Susman & Evered, 1978), it acknowledges the interdependence of the researcher and the researched. Therefore, it "is most often described as being an *enquiry with people* rather than *research on people*" (Eriksson & Kovalainen, 2012, p. 196). Third, action research "implies system development" as its "process encourages the development of the capacity of a system to facilitate, maintain, and regulate the cyclical process of diagnosing, action planning, action taking, evaluating and specifying learning" (Susman & Evered, 1978, p. 589). It

has been described as an appropriate tool for research when "the research question is related to understanding the process of change" (Eriksson & Kovalainen, 2012, p. 194). Action research "generates theory grounded in action" (Susman & Evered, 1978, p. 589) and has been defined as "the marriage between theory and action [which] could produce informed, improved behaviour and encourage social change" (Dickens & Watkins, 1999, p. 128). This marriage is perceived as essential as "without collaboration, practitioners engaged in uninformed action; researchers developed theory without application; and neither group produced consistently successful results" (Dickens & Watkins, 1999, p.128). Fifth, action research has been described as "agnostic" (Susman & Evered, 1978, p. 590) recognizing that "theories and prescriptions for action are themselves the product of previously taken action and, therefore, are subject to re-examination and reformulation upon entering every new research situation" (Susman & Evered, 1978, p. 590). Action research has also been defined as an "emergent process" (Greenwood et al., 1993) which "recognizes that the objectives, the problem and the method of the research must be generated from the process itself, and that the consequences of selected actions cannot be fully known ahead of time" (Susman & Evered, 1978, p. 590). Finally, action research is situational (Susman & Evered, 1978), it is defined by its ability to "incorporate local knowledge" (Greenwood et al., 1993, p. 2) as well as by its "close collaboration with the research object and its practical problem solving" (Eriksson & Kovalainen, 2012, p. 193).

A number of terms have been applied to the fairly broad family of action research. For this research, I opted for participatory action research (PAR). As PAR "is most often related to shared ownership of research projects, commitment to social, political and economic development of community, and orientation towards action" (Eriksson &

Kovalainen, 2012, p. 195). PAR is also often used in "communities that are vulnerable to colonization by the dominant culture" (Reason, 1998, p. 270). As a member of the action research family, participatory action research shares the key characteristics outlined for action research. The key elements that differ in participatory action research are "the participatory intent of the research process and the degree of participation actually achieved" (Greenwood et al., 1993, p. 1) and its "emphasis on involving and researching with the participant of a community" (Sense, 2006, p. 5). To achieve this greater level of participation, the role of the PAR researcher has been described as "mov[ing] away from one of expert to enabler" (Cassell & Johnson, 2006, p. 799). PAR requires the researcher to "demonstrate a high level of aptitude and flexibility" (Sense, 2006, p. 4) as they may be called upon to carry out a number of activities as enabler to the process as they progressively shape "the emergent inquiry in unison with the changing needs/goals of the participants" (Sense, 2006, p. 4).

While participatory action research differentiates itself from action research by the greater level of engagement of the participants in the research project, PAR still unfolds as a cyclical and iterative process that is the trademark of action research. The number of steps in an action research cycle typically varies from three to six steps. At its most basic the Lewinian spiral involves three steps – look, think and act (Creswell, 2008). For this research, I opted for the five-step process outlined by Susman and Evered (1978). The first step, *Diagnosing*, seeks to identify or define the issue prior to *Action planning*, which allows participants to "consider alternate courses of action for solving a problem" (Susman & Evered, 1978, p. 588). The third step, *Action taking*, leads to the selection and implementation of a chosen course of action. *Evaluating* seeks to assess the

consequences of the action prior to the fifth and final step, *Specifying learning*, which identifies general findings (Susman & Evered, 1978, p. 588). A number of authors indicate that the iterative nature of qualitative research and participatory action research leads to often simultaneous activities and therefore the delineation between the PAR phases is not always clearly defined (Creswell, 2003, 2008; Kemmis & Wilkinson, 1998; Reason, 1998, 2006).

Research Approach

This section outlines the key activities for each of the five phases of this participatory action research, however, prior to delving into the five phases of PAR I am providing information on the work done prior to the beginning of my research project.

Planning for Research

As outlined in Chapter 2, I embarked upon the Doctorate of Business Administration (DBA) knowing that I loved my job and I wanted to do it better. As I progressed through the DBA, I gradually narrowed down my research interest to improving collaborative capacity to enhance health care collaboration between First Nations, federal and provincial governments. As part of the process that led from a research idea to a full-fledged research proposal and this dissertation, I regularly engaged with a number of colleagues in First Nations organizations and governments, at FNIHB-AB, at Alberta Health and Alberta Health Services. In the early days of my DBA, I would often share some of the articles and books that I found of interest (Bowen et al., 2008; Foster-Fishman et al., 2001; Kahane, 2010; New Zealand Office for the Community and Voluntary Sector, 2011). I also worked with my supervisory committee as I made the transition from a broad research interest to a more specific research project.

As I examined options, I acknowledged that while I could see many advantages to documenting the further development and implementation of the Joint Action Health Plan such as the concrete nature of the work, its potential to influence how First Nations, federal and provincial governments can work together and its potential for being meaningful work in terms of enhancing collaboration between First Nations, federal and provincial governments in Alberta. More selfishly, I thought that a project linked to my work could benefit both my work and school lives and that access to participants may be facilitated by the fact that I have worked in this field and lived in this province for 20 years. At the same time, some of those advantages raised a number of challenges in terms of ethical considerations particularly as they relate to my roles as a doctoral student/researcher and as a government employee. Therefore, early in the planning process, I sought to confirm whether or not it was possible to pursue this dissertation and if so how it could be done appropriately, respectfully and ethically. One of my first steps was to review chapter 9 of the Tri-Council Policy Statement 2 (2014) which outlines guidelines for research involving First Nations which were later incorporated into my ethics submission to the Review Ethics Board of Athabasca University. I also sought more information and solicited advice from a member of the Athabasca University's Faculty of Business Review Ethics Board to better understand what would be required to address ethical considerations. These early discussions, led to some of the early decisions for my dissertation, including my decision to pursue qualitative rather than quantitative research as well as my choice of participatory action research as a methodology. Prior to engaging more broadly, I also sought to confirm the requirements from my work as an employee of the federal government. I discussed the project with

my manager, outlined what I aimed to achieve as well as identified steps to mitigate any concerns. As a federal government employee, I needed to ensure that the proposed research project did not constitute a real or potential conflict of interest with my work at Health Canada and my responsibilities in regards to the Values and Ethics Code for the Public Sector. I submitted a confidential report about my proposed research in the summer of 2014 and received confirmation a few months later that my research activity did not constitute a real, apparent or potential conflict of interest. Commitments made as part of this report were also included in my ethics submission.

Considering the participatory and collaborative nature of PAR (Creswell, 2008; Kemmis & Wilkinson, 1998) and my interest in collaboration, I also sought to engage with First Nations leaders. I presented my research interest to the Health Co-Management Committee in September 2014. The purpose of the presentation was to begin the engagement process and assess potential interest for this research project with a key group of decision-makers. As this very initial feedback was positive, I pursued the development of a research proposal which I defended in the spring of 2015.

As I developed my ethics submission, I worked with the Alberta First Nations Information Governance Centre to ensure that the proposed research would be respectful of First Nations' processes and the Ownership, Control, Access and Possession (OCAP) principles for ethical research. I shared my draft proposal and ethics submission with the Alberta First Nations Information Governance Centre (AFNIGC). The feedback received from AFNIGC was also included as part of my ethics submission. My ethics submission was reviewed by my academic supervisor prior to being submitted to the Review Ethics Board of Athabasca University which approved it in June 2015 and renewed its approval

in June 2016 and June 2017. Participation of government employees in this research project was also subject to organizational processes. Colleagues from Alberta Health required access to the questionnaire ahead of the interview and approval by their supervisors. Colleagues from Alberta Health Services required the signature of an AHS research agreement which was signed in the summer of 2015. Colleagues at Health Canada were allowed to participate but could not do so during the federal election.

Using Participatory Action Research

As with many participatory action research projects, the five phases are not always clearly delineated but essentially:

- Phase 1 – Diagnosing Phase began in the summer of 2015 and ended with the first meeting of the Joint Action Health Plan Steering Committee of February 1, 2016. Informed by my western and Indigenous literature on qualitative research, participatory action research, collaboration as well as the broader context of relationships between First Nations, federal and provincial governments, I developed the interviewer guide and the questionnaire. During this phase, I also conducted 21 interviews.
- Phase 2 – Action Planning began in February 2016 as I delved into data analysis while pursuing review of existing literature on qualitative research methodology as well as Indigenous fiction, non-fiction and academic literature.
- Phase 3 – Action Taking began in June 2016 when I first shared a short summary of the findings to date with the participants and conducted an additional four interviews with new participants to the Joint Action Health Plan Working Group.

- Phase 4 – Evaluating occurred as I shared the information gathered through interviews with the Joint Action Health Plan Working Group in a focus group held on January 23, 2017.
- Phase 5 – Specifying Learning occurred with the completion of the dissertation and will continue to occur as findings are shared more broadly.

Phase 1 – Diagnosing phase. The focus of Phase 1 was data collection. I gathered information by pursuing my literature review of western and Indigenous literature focusing on interorganizational collaboration, qualitative research, participatory action research as well as the broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society. As a participant, I had access to a number of documents relating to the further development and implementation of the Joint Action Health Plan. For my research, I only used publicly available documents which were shared with all participants. The key element of data collection in this phase were the interviews with participants. While I understand that informal less structured conversations may have felt more natural, I opted for semi-structured interviews as a way to ensure that I was collecting the opinion of my colleagues as well as ensure consistency in my participation across all interviews. In order to strengthen data collection, I also requested the permission to record the interviews as a way to ensure that I was recording the views of the participants and not my understanding of their views. To support data collection through interviews as well as to ensure proper protocol in working with First Nations colleagues, I sought guidance from the Alberta First Nations Information Governance Centre (AFNIGC) in regards to research agreements and consent forms. My colleague suggested that I draft a consent

form based on a document developed by the Assembly of First Nations Quebec-Labrador (Assembly of First Nations Quebec-Labrador - AFNQL, 2014). The consent form adapted for this research project is included in Appendix E and included a request to record the interview.

During the summer of 2015, I finalised the interview questionnaire (Appendix F) and interviewer guide (Appendix G) that I initially drafted as part of my ethics submission. To finalise the documents, I solicited and incorporated input from my supervisory committee. The interview questionnaire included eighteen open-ended questions which were developed based on theoretical concepts of collaborative capacity and collaboration theory. I also sought to acknowledge different ways of knowing and tried to provide opportunities for the participants to articulate them. The interview questionnaire and interviewer guide were pilot-tested by conducting mock interviews with two colleagues; one of them is a First Nation individual. As a result of the mock interviews, the interviewer guide and interview questionnaire were modified. Small wording changes were made but most importantly the questionnaire was restructured into four broad categories. Within the first broad category, I included questions that sought to clarify the participants' understanding of some key concepts: health care, on-reserve / off-reserve and collaboration. I aligned the next three categories with the three phases of collaboration – preconditions, processes and outcomes. The section on processes relied on the literature on collaborative capacity and sought information on member, relational, organizational and programmatic capacity.

As I began this research, the structure for the Joint Action Health Plan was still being developed. I expected that membership of the working group and steering

committee to be finalised before I began conducting interviews, however this was not the case and it is still not fully the case as of September 2017. Therefore, I developed a list of potential participants based on the individuals who had been involved with previous HSIF projects, the Health Co-Management structure as well as my knowledge of the partnering organizations and participants. As I have been a FNIHB-AB employee for well over a decade, I knew all the participants prior to the interviews. I have worked alongside many of them. In some cases, we have personal and professional relationships that have existed for years while I engaged with others more recently through HSIF Exploring Partnerships or other work at FNIHB. As for interviewing FNIHB staff, I interviewed some of my superiors but did not interview any subordinates or peers.

The first round of interviews occurred as we were transitioning between the HSIF Exploring Partnerships project and the official launch of the Joint Action Health Plan structure. As the first official meeting of the Joint Action Health Plan Senior Steering Committee was held on February 1, 2016, this also became the cut-off date to wrap up interviews for Phase 1. I conducted one interview in October 2015, 12 interviews in November 2015, six interviews in December 2015 and two interviews in January 2016.

To minimise any perception that I was using my role at FNIHB as a way to secure interviews, I never requested interviews with individuals I met as part of my FNIHB role and responsibilities. I further avoided issuing requests to participants when I expected to meet them in the coming days, giving them a chance to accept or refuse the request without meeting me shortly thereafter this was especially true with participants from First Nations organizations an governments. While I readily shared information about my doctoral studies during the coursework phase, I became increasingly cautious in sharing

information during this phase and only discussed my research within a research context or when asked. Requests for interviews were done by phone using my personal phone or sent via email using my university email account. I requested 29 interviews; 24 participants accepted and 21 interviews were conducted, two requests were not answered and three of my requests were refused. For three of the accepted interviews, I was not successful at confirming a date and time despite multiple attempts at reaching participants. To acknowledge the high level of diversity between First Nations in the three Treaty areas, participation was requested and tracked by the respective Treaty areas. The length of the interviews ranged from 43 minutes to 91 minutes; the average length was just over an hour at 64 minutes and the median length was 63 minutes. Table 1 provides a more detailed response rate for each of the partnering organizations as well as information on the average length of interviews. Most interviews were conducted in public spaces though some were conducted in the participants' offices. Even though participants reside across the province, most interviews were conducted in Edmonton.

The consent form and interview questionnaire were sent to all participants prior to the interviews. Each participant was approached individually to protect their confidentiality, however, many participants knew of each other's participation in this research as they often disclosed or enquired about the research at public meetings outside the research context.

Table 1 – *Participants in Phase 1 Interviews*

Organization	**Interviews requested**	**Interviews completed**	**Indigenous participants**	**Gender of participants**	**Average length of interviews (minutes)**
Treaty 6 First Nations	8	4	4	1F 3M	61
Treaty 7 First Nations	5	3	3	1F 2M	78
Treaty 8 First Nations	6	4	2	1F 3M	66
Regional First Nations organization	1	1	1	1F	82
Alberta Health	3	3	0	3F	59
Alberta Health Services	3	3	1	1F 2M	66
First Nations and Inuit Health Branch	3	3	2	3F	47
Total	29	21	13	11F 10M	

In most cases, interviews were preceded by informal discussions with participants. These discussions included a range of personal and professional topics and provided an opportunity to discuss the interview process. The recording allowed me to more clearly delineate between my two roles as a researcher and as a FNIHB employee. The discussion would switch from a more conversational tone before I began to assume my interviewer/researcher role as I began recording. All participants except one agreed to be recorded; and, all interviews except the first one were transcribed by an external transcriber. For the interview that was not recorded, I took notes and shared them with the participant who reviewed and approved them. As I wanted to learn from each of the interviews and transcription, I listened to the audio file and took detailed notes prior to

transcription. Transcripts of interviews were shared with participants who were provided two weeks to review and correct their transcript. Some, though not all, participants confirmed reception of their transcript and indicated having read it. Only one participant requested a correction acknowledging that the transcript reflected what she had said but asked for a few words to be deleted which was done.

For most of the last ten years, I have been involved in discussions between First Nations, federal and provincial governments as we seek to enhance health care collaboration, yet in many of the interviews I learned new information. In some cases, I felt that I was able to see behind the positions to the actual interests of the participants and the participating organizations. In a demonstration of the lack of clear delineation between each of the five phases, a number of participants decided to share with the group in subsequent meetings information they had shared with me leading the way to some action taking.

Phase 2 – Action planning. The beginning of Phase 2 could be February 1, 2016 as this was identified as the end of Phase 1 but such a clear delineation fails to acknowledge the iterative nature of qualitative research and participatory action research. This research project was no different. In a clear demonstration of the challenges of clearly delineating between the five phases of PAR, the first planning activities occurred as I was collecting data during Phase 1. After each interview, I journaled my thoughts, impressions and feelings by jotting them down in my research journal, I also sent to my academic supervisor a summary of the key information gathered as well as my thoughts and feelings. Both journal entries tended to be similar but they were never identical, as the process of entering into conversation with my academic supervisor gave me an

opportunity to think about each of the interviews in a different way. To move from an active participant role as an interviewer to the more passive role of note-taker was helpful in getting me a better sense of the information I was collecting.

As I began data analysis, I also read and re-read literature on qualitative research (Creswell, 2003, 2008; Denzin & Lincoln, 2008; Saldana, 2015) and Indigenous research (Assembly of First Nations Quebec-Labrador - AFNQL, 2014; Baker, 2016; Battiste, 2005; Bishop, 1998; Brant Castellano, 2004; Bull, 2010; First Nations Centre, 2005, 2009; Gaudet, 2014; Loppie, 2007; Pidgeon & Hardy Cox, 2002; Simpkins, 2010; Simpson, 2001; University of Manitoba. Faculty of Health Sciences, 2013) as well as on participatory action research (Creswell, 2008; Eriksson & Kovalainen, 2012; Kemmis & Wilkinson, 1998; Reason, 2006; Stringer, 1999; Susman & Evered, 1978). The focus of this reading was to better understand the requirements for analysis. I also immersed myself in Indigenous literature both fiction and non-fiction. I had read some Indigenous authors and my family life allows me to be connected at a cultural level with First Nations Peoples, yet I feel this immersion in Indigenous literature gave me an additional layer of understanding as I enjoyed the works of Sherman Alexie (2001, 2005, 2008, 2009, 2013, 2016), Dawn Dumont (2011), Marilyn Dumont (2015), Thomas King (1993, 2012, 2014), Tracey Lindberg (2015), Lee Maracle (2002a, 2002b, 2014), Aaron Paquette (2014), Eden Robinson (1998, 2001, 2006), Ruth Scalp Lock (2014), Leanne Simpson (2011, 2013a, 2013b), Drew Hayden Taylor (2006, 2007, 2010, 2011), Richard Van Camp (1996, 2013), Katherena Vermette (2012), Richard Wagamese (2002, 2008a, 2008b, 2011, 2014, 2016) and many others.

Once all transcripts were reviewed, I began analysing the information using NVivo. I also worked extensively and even more so in the first few months on paper copies as I sought to immerse myself in the information I had collected. I read all transcripts and jotted down ideas, possible codes or groupings in the margins and identified some possible concepts or themes that were present in the more than 600 pages of transcripts. I had a good sense of the whole before I used the autocoding function to group the information based on the four sections identified in my semi-structured interview questionnaire. The first section was used to define key concepts while the other three sections aligned with the three phases of collaboration – preconditions, processes and outcomes. Second, I grouped similar questions and their responses allowing me to take the 18 questions of the interview and group them into 14 questions. In grouping the questions, I kept the first three questions which were used to define key concepts as independent questions. I also treated all the questions related to the preconditions as separate questions. For the processes, I grouped the questions to reflect the four elements of collaborative capacity. Therefore, question 8 was kept independent as the sole question referring to member capacity; while questions 9 through 13 were grouped under relational capacity. Questions 14 and 15 were grouped under organizational capacity while question 16 was kept independent as the sole question for programmatic capacity. Finally, the question on outcomes was kept as separate. I ended the interviews with an open ended question inviting my colleagues to identify any additional relevant information which was analysed and added to the relevant section. By grouping the information by sections and questions, it allowed me to review the

information in more manageable chunks. Based on this information, I began to draw concept maps outlining the participants' views.

This first round of analysis was followed by a deeper round of analysis that began in the summer of 2016 where I used the autocoded information to delve deeper into my data. For Section 1, I opted to study the information by questions as there was limited information overlap between the answers provided by the participants though additional concepts were defined by the participants such as health and the Treaty Right to Health. I then reviewed the information and began coding and regrouping the key concepts based on the outline of the summary drafted in June 2016. I used the broad categories identified by Wood and Gray (B. Gray & Wood, 1991; Wood & Gray, 1991) to provide the framework to conduct the analysis. Given the importance of the broader context of relationships between First Nations and governments, I extracted it from the legitimacy component and kept it on its own. For Section 3, I used the questions groupings to get a better sense of the information collected for each of the four elements of collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity. In my preliminary round of analysis, I used Foster-Fishman's article to anchor the organization of the data. For Section 4 particularly the outcomes, I simply grouped the participants' answers based on their similarities. Any additional information provided was simply grouped with the most relevant section.

Phase 3 – Action taking. By definition "Action planning" needs to lead to action. As I began this project, I hoped to conduct pre- and post-interviews with participants to assess how improved collaborative capacity could lead to enhanced collaboration. However, progress on the Joint Action Plan to Improve the Health of First

Nations in Alberta was much slower than expected. The first Steering Committee meeting on February 1, 2016 did not yield the results that participants expected and a follow-up phone call on April 29, 2016 to review and approve terms of reference for the Steering Committee did not have quorum. As a member of the Joint Action Health Plan Working Group, I am aware that a number of participants within both the Working Group and the Steering Committee described these meetings as difficult. The next meeting of the Joint Action Health Plan Steering Committee occurred on June 26, 2017 and was described much more positively.

The further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta was also impacted by a number of events beyond the federal and provincial elections of 2015 and the delayed renewal of the Health Services Integration Fund (HSIF). At the Annual General Assembly of the Confederacy of Treaty No. 6 in 2016, a resolution was passed for Treaty No. 6 to withdraw from the Health Co-Management Agreement. Considering the importance of the Co-Management Agreement to the collaborative work between First Nations and FNIHB-AB, this led to some uncertainties until both Treaty No. 6 signatories (Yellowhead Tribal Council and Maskwacis Cree Nations) to the Health Co-Management Agreement reconfirmed their participation in the Co-Management process. Communities within Treaty 7 Management Corporation withdrew from the organization and moved to create two Tribal Councils – Blackfoot Confederacy and Stoney Nakoda Tsuut'ina Tribal Council. In other words, while many participants continued to express a desire for collaboration, the climate for change was also evolving.

As for action taking within the context of this research, in late June 2016, I sent to all participants a summary of the information I gathered through the interviews. This summary is enclosed in Appendix H. I received limited feedback from participants on the summary which paved the way for follow-up activities as part of Phase 4 including additional interviews and a focus group.

Phase 4 – Evaluating. As indicated earlier, I planned to conduct a second round of interviews with the same participants during the fourth phase of this participatory action research. This design was to take into account the timelines established in the Joint Action Plan to Improve the Health of First Nations in Alberta where the last identified deadline was March 31, 2016. While we made progress on a number of activities, progress was slower than expected and no activities were completed by that date.

Considering the delays in developing and implementing the Joint Action Health Plan and changes in membership, I opted for an alternate approach whereby I solicited interviews from some of the newer participants. For this second round of interviews, I solicited six interviews. Five participants accepted and I was able to conduct four of these interviews however the last one could not be conducted and one request went unanswered. The interviews were held in November and December 2016. As there was limited new information to our collaboration, I used the same questionnaire (Appendix F) and interviewer guide (Appendix G) for these interviews. As with the first round of interviews, I listened to the interviews and took detailed notes prior to having them transcribed externally. I ensured accuracy of the transcripts by listening to the audio-recording as I reviewed the transcripts and by sending a copy of the transcripts to the

participants for their review – no changes were requested. Those interviews were then coded as per the previous interviews. Table 2 provides a summary of all participants whether they were interviewed in Phases 1 or 4.

Table 2 – *Interview Participants in Phases 1 and 4 Combined*

Organization	**Interviews requested**	**Interviews completed**	**Indigenous participants**	**Gender of participants**	**Average length of interviews (minutes)**
Treaty 6 First Nations	9	5	5	2F 3M	59
Treaty 7 First Nations	6	3	3	1F 2M	78
Treaty 8 First Nations	9	6	4	2F 4M	63
Regional First Nations organization	1	1	1	1F	82
Alberta Health	4	4	1	3F 1M	58
Alberta Health Services	3	3	1	1F 2M	66
First Nations and Inuit Health Branch	3	3	2	3F	47
Total	35	25	17	13F 12M	

As I finalised data gathering with participants, I continued data analysis using NVivo. I used the autocoding function of NVivo as well as spent time coding at a more micro level the data from interviews based on a number of articles from the emerging field of collaboration theory (Foster-Fishman et al., 2001; B. Gray, 1985; B. Gray & Wood, 1991; Wood & Gray, 1991). As I analysed data, I continued to add to my literature review from both Western and Indigenous literature to ensure I had the theoretical knowledge required for analysis. I also spent most of the fall of 2016, writing,

editing and revising the first four chapters of my dissertation. Leveraging the information stemming from data gathering and data analysis I also sought to ensure coherence between the many pieces of my research as I navigated between data gathering from interviews and literature review, data analysis including review of existing literature on methodology for qualitative research and writing of my dissertation. To validate the information gathered and analysed, I conducted a focus group with 15 members of the Joint Action Health Plan Working Group on January 23, 2017. Many of the participants in the focus group had been interviewed for this research but not all. Considering my dual status as a participant and as a researcher and the need to take into account ethical considerations, the request to hold a focus group with the Working Group had been sent by my academic supervisor to the Co-Chairs who reviewed and approved the request. The focus group provided me reassurances in terms of understanding the data collected as well as provided further insights that benefited the remaining data analysis as well as dissertation writing. The focus group was the official end of Phase 4.

Phase 5 – Specifying learning. In the fifth and final phase of this doctoral research, I sought to weave together what I heard from participants in the interviews, what I read through my ongoing Western and Indigenous literature reviews and what I experienced as a participant. As I made the transition from data analysis to dissertation writing, I learned that in getting up close and personal with the data, I preferred to get a sense of the whole and the broader answers rather than the more dissected coding I had spent so much time doing in NVivo. In documenting my findings, I also preferred to weave the information from all sources – interviews, literature review and experiences as a participant – rather than focus more narrowly on any of those pieces. I believe this

more macro level approach allowed me to make a better sense of the whole and the complexities of collaboration between First Nations, federal and provincial governments than a more targeted approach would have. I used collaboration literature to guide my analysis and writing identifying points of convergence and divergence between participants and between participants and the literature review. I understand that the field of collaboration theory at the inter-organizational level is emerging and I did not find previous academic or management literature showing its use within the context of Indigenous research. Therefore, as I undertook this research I often weave not only the data I gathered through interviews and as a participant but also the work of Indigenous scholars. This weaving was then connected to the work on the three phases of collaboration (preconditions, processes and outcomes), collaborative capacity, the New Zealand engagement spectrum, and Kanter's integration levels. In order to visually depict the complexity of collaboration between First Nations, federal and provincial governments, I worked with a graphic designer to show the different concepts underpinning such collaboration which is included in Chapter 7. Finally, as I was preparing the last complete draft of the dissertation, I reread the transcripts and my journal to ensure consistency and accuracy.

Chapter 5 – FINDINGS

As I undertook this research, I reflected on the understanding of ethics developed by Mohawk scholar Marlene Brant Castellano who wrote that "ethics, the rules of right behaviour, are intimately related to who you are, the deep values you subscribe to, and your understanding of your place in the spiritual order of reality" (Brant Castellano, 2004, p. 103). This was an important reminder as I endeavoured to weave together what I heard as I interviewed the participants, what I experienced over the last couple of years as a participant in the Joint Action Health Plan Working Group and what I read both in terms of Indigenous and western literature. As I wrote this chapter, I was acutely aware that I am not a neutral and objective observer. My lenses influence the information I gathered and how I understand it. I have a vested interest in the success of the Joint Action Health Plan – as a researcher who undertook this work as a doctoral student in the Doctorate of Business Administration at Athabasca University, as a participant who is a FNIHB-AB employee, and maybe more importantly at the personal level as a mother, step-mother, grand-mother, aunt, friend and colleague who hopes that greater collaboration can lead to better health care and health outcomes for First Nations individuals, families and communities.

With this chapter, I bring the participants' voices to the forefront. As indicated in Chapter 4, I interviewed 25 participants representing over 26 hours of audio-recording and 700 double-spaced pages of transcripts. I had existing personal and/or professional relationships with every participant prior to the interviews. Regardless of our organizational affiliation, I consider all the participants as my colleagues and some of them as my friends. While I met and began to work with some of them more recently,

many of the participants are individuals I have worked alongside for a number of years, some for well over a decade. In drafting this chapter, I opted to anchor the presentation of the information I gathered through interviews on existing Indigenous and management literature. In some areas, there is a high level of congruence between the existing literature and the participants' input but this is not always the case. Therefore, in presenting this information, I identified both areas of congruence and areas where the alignment is not as clear. Further, I took into consideration the input received from a focus group with the Joint Action Health Plan Working Group on January 23, 2017.

In presenting the participants' input, I sought to share their voices while ensuring their confidentiality and anonymity. While I could have identified the First Nations participants from First Nations organizations and governments based on their band and/or tribal affiliation or more broadly by their affiliation to a Treaty area, I was afraid that to do so may lead to disclosing their identity. Therefore, I opted to simply identify them as First Nations participants, all data from individuals working in First Nations organizations and governments are represented by an alphanumerical code starting with FN. A similar approach is used for provincial participants; employees from Alberta Health are identified with an alphanumerical code starting with AH while employees of Alberta Health Services have an alphanumerical code starting with AHS. Some of the FNIHB participants were regionally-based while one or more were based in Ottawa, in all cases FNIHB participants are identified by an alphanumerical code starting with HC.

As my data collection was anchored by my literature review on collaboration (Butterfield et al., 2004; Wood & Gray, 1991), I developed this chapter based on the three phases of collaboration – preconditions, processes and outcomes. As most of the

existing literature on collaboration provided limited information on the processes stage, I anchored the participants' input in regard to processes on the four elements of collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity – developed by Foster-Fishman and her colleagues (Foster-Fishman et al., 2001). Further, I supplemented literature on collaboration by Indigenous literature as I sought to better understand the broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society in Canada. As I had done with the interviews, prior to sharing the participants' views on collaboration and collaborative capacity, I begin by sharing their understanding of frequently used, though not usually defined, concepts within our collaborative work on the Joint Action Health Plan.

Defining Key Concepts

The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta is "to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014). The five elements of quality are based on the Quality Matrix for Health developed by the Health Quality Council of Alberta (Health Quality Council of Alberta, 2005). While the goal of the Joint Action Health Plan defines quality it does not define collaboration and health services nor does it specify whether we are referring to provision of health services for First Nations individuals residing on- and/or off-reserve. As I gathered information through interviews, I solicited my colleagues' understanding of these concepts.

Sharing our Understanding of Health Care

The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta refers to health services; however, as I drafted the questionnaire and interviewed participants I sought the participants' understanding of health care. It is an interesting slip and a number of participants shared that their understandings of health care is broader and inclusive of health services (AH01, AH02). For example, a provincial participant indicated "I think oftentimes health care is used synonymously with health services, but I see it much more broadly" (AH02).

As participants shared their understanding of health care, they also shared information about a number of related concepts. In this section, I am also including the information provided by the participants in regards to their understanding of health, the Treaty Right to Health and the Medicine Chest Clause. While quality is defined within the goal of the Joint Action Health Plan, a number of participants identified additional elements to define quality health care which are also provided.

Sharing our understanding of health. A number of First Nations participants began by outlining that First Nations people were healthy for thousands of years prior to the signing of the Treaties. In referring to this previous state of health and well-being, they talked of the need to live in harmony with the land, the use of traditional medicines, the importance of Indigenous knowledge as well as the individual's responsibility in maintaining his or her own health. More specifically, they shared the following:

> In the history of the Indigenous people of this island, they must have been healthy. There were millions of people on this island. If we are to believe in our own historical research, not what is written by someone else. Our original people

> knew how to live with each other and to live in harmony with nature and locations… They were nomadic in that way, they would go from one side to this side to pick up this herb, this medicine, and they shared and exchanged. (FN07)
>
> Our Elders tell us we were healthy people before the Treaty was signed. It was our responsibility to keep ourselves healthy. So that's our inherent right, they say. That shouldn't change with modern times. (FN11)

In Indigenous literature, there are references to thriving First Nations societies for thousands of years (Daschuk, 2013; Dickason & Newbigging, 2010; Lux, 2001). Many scholars documented the tremendously negative impact of Colombian contact on the health of First Nations population (Daschuk, 2013; Mashford-Pringle, 2011; Romaniuk, 2014). A First Nation Elder signalled the impact of new diseases on the previously healthy status of First Nations:

> With respect to health, one of the things that happened with the coming in [of settlers] was the introduction of new diseases: tuberculosis, smallpox, diphtheria, and all these other things. [To] the original people, those were new diseases. They didn't have them. They didn't have any medicines to combat [them] so a lot of them passed on. (FN07)

Indigenous literature also documented this understanding as Cree scholar Sharon Venne indicated "the Chiefs knew about the diseases of non-Indigenous people that were destroying their populations, and needed to have the non-Indigenous medicine to fight them" (Venne, 1997, p. 194).

In defining health, Western literature often refers to the 1948 definition from the World Health Organization which defined health as "a state of complete physical, mental

and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2003). Participants shared that broad understanding of health as they outlined a holistic approach to health referring to: a holistic perspective in terms of mind, body, spirit (HC02, FN09, FN15); the need for physical, emotional, mental and spiritual health (FN11, FN12, FN13); the need to live in harmony (FN07); holistically referring to individual, family and community (FN15); or, social determinants of health (AH01, AHS02, HC03, AH04). A federal participant referred to both a holistic approach and the need to address the social determinants of health:

> I think it's that holistic approach to health. When I always think about health, I think about not only the individual, but the environment which affects the individual's health, like housing, and a social determinants of health approach. Because we know health just isn't about Band-Aids and taking care of acute sickness. (HC03)

Finally, a First Nation participant defined what it is to be healthy by stating "that you're strong in mind, body, and spirit and you can take care of yourself and other people, that you can be relied upon" (FN15).

Seeking a shared understanding of health care. As participants were asked to share their understanding of health care, a participant suggested that someone's understanding would likely be linked to their education, professional and personal experiences (FN04). Considering the diversity amongst participants, it may not be surprising that there was more limited agreement in defining health care despite the fairly broad consensus around their understanding of health. This is exemplified by the

response provided by a provincial participant who began defining health care by sharing what he described as his "bias" as a population and public health practitioner:

> That's my bias, because I'm involved in the population and public health, and so you need to be thinking from the standpoint of what are the activities and actions that are going to improve the health status, whether it's Indigenous people or the population of Alberta or the whole population of the country. (AHS02)

Within the context of the Joint Action Health Plan, some participants advocated for defining health care within the common scope of all partnering organizations. A provincial participant summarized this view by saying "let's focus on the things that we have most in common. And from the health ministry, the areas that we influence more are those more typical core health care services" (AH03). A federal participant also identified a fairly similar starting point but linked it to the Canada Health Act and "the basket of services that's been introduced since that time" (HC01). While a First Nation participant defined health care by saying that it "starts from the beginning, preventative, all the way up to palliative and everything in between, emergency and maintenance and immunization, all the rest of that fun stuff" (FN06). Another federal participant described a three-system model as follows:

> The province has certain things that they offer as part of their contribution to the health system, and if you think about that continuum of care, they contribute to a lot of pieces on that journey or that continuum. Likewise, the federal system has some of the pieces to contribute, and then certainly First Nations. So it's trying to think through what that model would look like for health that is focused on an individual, on a family, and/or a community. (HC02)

Answers from some provincial participants suggested that health care would be grounded by health services but not necessarily limited by them as one described health care as "all those intervening supports and services that lead to health" (AHS03) and another said:

> I think the word "health" in health care is critically important, because for me health care has to start with the social determinants of health. It has to create a foundation where people have good health, and it has to respond in those circumstances where people's health fails them to greater or lesser degrees. (AH01)

Mostly though not exclusively First Nations participants sought to use the broader understanding of health as a foundation. Some described their understanding of health care as comprehensive by saying "How do you define health care? Comprehensive… And health care would also mean your whole environment around you to be safe and clean, including water, housing" (FN03). A second First Nation participant linked it to his understanding of health by saying "health care is holistic, holistic health, mental, emotional, spiritual, physical. I think that's what health care is. [It] is to maintain that balance" (FN12). A third First Nation participant said that health care "should be all-inclusive for our people, because that's the way they think" (FN05). A fourth First Nation participant shared his understanding of health care as including "everything from prevention to primary care, that we're ensuring that mind, body, and spirit, individual, family, and community are taken care of" (FN15). Another First Nation participant shared that she "would like it to mean seamless holistic incorporating physical and

biological extending to balanced wellness" (FN13). Two provincial participants, one of whom is Indigenous, shared that broad understanding as they said:

> To me health care is our ability to achieve and maintain good health and well-being, both mental and physical.... It includes health services but also prevention, public health, reducing inequalities, so there [are] elements outside of just health services. (AH02)

> So this concept of wellness, traditional wellness, has to come from you, the individual, and then the community... And that could include health care services, but it could also include traditional wellness approaches. So the concept of holistic wellness doesn't just include going to the doctor and getting medicine or a Band-Aid. It includes the ability to do stuff that makes you well. And even if it's traditional, like, dancing, jigging, music, that kind of stuff that keeps you well. (AHS01)

Some participants included the social determinants of health as part of their understanding of health care and identified the importance of healthy public policy.

> I think health care has to be defined using the social determinants of health, and it's so much broader than what we deliver in terms of immunization and family health. So to me it's really important that when we talk about the health care of the community, we talk about the whole mind, body, soul, price of food, everything. (FN09)

> Every piece that directly or indirectly impacts the health of individuals is my definition of health care. Whether it's policy, whether it's services, whether it's programs, whether it's personal growth, whether it is directed growth, whether

> it is public perception, or whether it is some of the less definables, such as the social determinants of health. (AH04)

Considering the varied perspectives on health care, we may want to follow the advice of one of the participants who highlighted the need for the Joint Action Health Plan Steering Committee "to have a conscientious debate" (AHS02) about whether we understand it as part of the "broad concept of health" including the First Nations concept of physical, emotional, mental and spiritual health, or the more Western-based social determinants of health or whether we want "to really focus on service delivery maybe beginning with primary care and ensuring that there's good access and coordination for secondary and referral care and long-term care" (AHS02).

Seeking to better define quality of care. In sharing their understanding of health care a number of First Nations participants identified parameters for quality of care. The most frequently identified parameter was the provision of health services on-reserve (FN01, FN11, FN02, FN08, FN10). Participants identified the need for enhanced primary care, enhanced opportunities through the Alternate Relationship Plan (ARP) for physicians, greater access to diagnostic tools and specialists while acknowledging that access may look differently based on community size.

Some participants outlined the need for care that is free of racism and discrimination (FN01, FN03). In a recent article, Richard Matthews described the Canadian health care system as being "founded on systemic racism through the violent unilateral imposition of Canadian social, economic, cultural and political dominance over Indigenous land and lives" (Matthews, 2017, p. E78). As a health professional, one of the First Nation participants linked racism to competence (FN01) and to the education

and training of health care providers saying that "we're taught to have those tones of paternalistic-type conversations with our clients" (FN01). There is an increasing body of Indigenous literature on the health impact of racism and discrimination within existing policies and legislations (Allan & Smylie, 2015; Bourassa, McKay-McNabb, & Hampton, 2004; Kubik, Bourassa, & Hampton, 2009; Truth and Reconciliation Commission of Canada, 2015b) and within the broader society (Currie, 2014a, 2014b; Currie et al., 2013; Currie, Wild, Schopflocher, & Laing, 2015). Further, participants identified the impact of racism and discrimination on our collaborative work; more information will be provided within the preconditions section.

The "role of the health care relationship in mitigating harm" (Jacklin et al., 2017, p. E110) is included in more recent literature which emphasized the importance of humility and interest in cultural Indigenous practices as a way forward. This was reiterated by another First Nation participant who outlined the need for cultural sensitivity, safety and appropriateness (FN11) and who indicated that it is much more present with health services accessed on-reserve. A number of participants emphasized the role of Elders in ensuring cultural sensitivity, safety and appropriateness as well as for their ability to share traditional knowledge and Indigenous healing and medicines (FN01, AHS01, FN07, FN11, FN12). Further, a First Nation participant also identified the need to approach First Nations patients by changing the focus from disease to wellness:

> We have to focus away from disease process thinking and we have to really focus on wellness, even when a person is diagnosed with a disease, or a chronic disease, I find First Nations don't like to focus so much on talking about the disease process, they like to really focus on what's well in their life. (FN01)

Sharing our Understanding of the Treaty Right to Health and the Medicine Chest Clause

Considering the foundational nature of the Treaty Right to Health and the Medicine Chest Clause, I include the participants' understanding in this section even though they are also an essential component of the preconditions and the broader context within which the Joint Action Health Plan operates. A First Nation participant outlined her understanding of the Treaty Right to Health and how it shapes her understanding of health care. She began by outlining her understanding of the sanctity of the Treaty Right to Health:

> The premise is the Treaty Right to Health and how there's a spiritual definition entrenched in that statement. That there was three parties involved when the Treaty was being negotiated, and it was sanctified by a ceremony that used a pipe between the First Nations, the government representative, the Queen's representative, and God. And all that's included in there does not have a time limit. It's supposed to evolve. And depending on what kind of sicknesses we have, back in those days there were smallpox and our grandfathers realized that they did not have the medicines to combat some of these diseases, just like we do today, and that we need that commitment that basically the Queen's representatives are going to ensure that those are provided. So that's my definition of "health care". (FN03)

The sacred nature of the Treaties is also found in Indigenous literature. Treaties were described as sacred texts by Robert A. Williams (Williams Jr., 1999) and sacred promises, ceremonies, use of the pipe and involvement of the Creator were also

referenced in research undertaken with Treaty Elders from Saskatchewan (Cardinal & Hildebrandt, 2000). In referring to the sacred nature of the Treaties, Cree scholar Sharon Venne wrote "it was more than a pipe ceremony: it was a solemn undertaking by both sides before the Creator that this agreement would last into the future" (Venne, 1997, p. 188). This participant's understanding of health care as comprehensive aligned with comments from another First Nation who provided contextual information in regards to the Medicine Chest Clause. He highlighted both the limited number of medicine chests that would have been in Canada when Treaties were signed and how their provision should guarantee the highest level of care:

> We're told that at the time of the Treaty… There were only nine Medicine Chests in Canada or Rupert's Land, and at that time, if there were only nine, who got it? The farmer who was baling hay looking after cows didn't get that Medicine Chest? The guy who was walking across the country didn't have access to the Medicine Chest. Only the highest guard, the highest level of authority in the country received it, if there were only nine. But if they want to include that in an agreement with First Nations people, that's a completely different set of values. So, again, we'll go back that if we're going to look at health services, we'll be treated like the Queen of England in our health services. (FN12)

These statements also aligned with existing Indigenous literature as Cree scholar Sharon Venne wrote "the Chiefs and Headmen successfully negotiated universal health care for all Indigenous peoples within Treaty 6" (Venne, 1997, p. 194). In that article, she also shared First Nations' concerns in regards to the provision of health care by the federal government which were also identified by some participants. A First Nation

participant referred to the federal government by saying "they're not willing to step up to their side of the Treaty and honour the Treaty Right to Health and deliver the services to First Nations the way they should" (FN06). A second First Nation participant referred to the federal-provincial jurisdiction in First Nations' health by saying "we know our primary health care providers are the province but no matter who our health care provider is, the federal government is responsible" (FN05). A third First Nation participant described having negotiated partnerships with the provincial government as a way "to provide better service for the people" (FN02). He explained those partnerships by stating that he perceived the provincial government as also being the Crown while pointing out that this view is not shared by all First Nations people. Concerns over provincial involvement are not new as they were documented in Indigenous literature more than 25 years ago by Blackfoot scholar Little Bear and his colleagues who wrote "Indians have been very reluctant to accept services and assistance from provincial governments... They interpret it as part of the federal government's hidden agenda to abrogate its constitutional and treaty obligations to the Indian people" (Little Bear, Boldt, & Long, 1992, p. xiii-xiv).

A number of government participants referred to the Treaty Right to Health but defined their involvement in health in much more operational terms as they outlined the roles of First Nations, federal and provincial governments in delivering health care (HC01, HC02, AHS02). Two provincial participants acknowledged the need for increased understanding of the Treaties and the Treaty Right to Health (AHS01, AHS02). One of them further said "Alberta Health Services had never heard of the Treaty Right to Health… so the understanding of what it really means and how it impacts services was

never there but it needs to be there" (AHS01). He also identified a number of more recent developments that could improve his organization's capacity in this regard including the Wisdom Council and the commitments to implementing the calls to action of the Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples. Two federal participants who were interviewed shortly after the 2015 federal elections made references to the Treaty Right to Health. The first participant highlighted the need to "believe in the spirit and intent of the Treaty relationship" (HC01). In a number of instances during the interview, she referred to the commitment of the new federal government and its potential for renewed relationships based on rights. For example, she shared "if we have a government who wants to introduce a renewed relationship based on Treaty rights and the implementation of Treaty rights then it could become a very positive platform for the Joint Action [Health] Plan" (HC01). Further, another federal participant shared her understanding of the First Nation perspective in regards to Treaty rights and relationships:

> I think from a First Nation perspective, the Treaty perspective could really impact the willingness and the openness to have some conversations around Treaty Right to Health and what that means. And some might hold very firm that they don't even want to have a conversation with the province, because they feel like the province compromises their Treaty Right to Health. They really feel that the federal government represents the Crown and that special relationship with the Crown through Treaty. So I think that might have an impact as we sort of navigate forward. (HC03)

In summary, participants in First Nations organizations and governments showed a deep understanding of the Treaty Right to Health and the Medicine Chest Clause that may not be mirrored by government participants, especially provincial participants. Further, some participants shared that there could be concerns in regards to the legitimacy of the provincial government as a partner considering existing Treaty rights. More information regarding legitimacy of partners will be provided within the preconditions section.

Sharing our Understanding of the On- and Off-Reserve Concepts

The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta indicates that it seeks "to achieve quality of health services for First Nations" (Co-Management, 2014) without defining whether this refers to health care provision and/or residency of First Nations on- or off-reserve. Health care for First Nations is provided by many jurisdictions as First Nations organizations and governments, Alberta Health, Alberta Health Services and FNIHB-AB are all involved. Some programs and services are available regardless of on- or off-reserve residency but not all. As I interviewed participants from First Nations organizations and governments of Treaty No. 6, Treaty No. 7 and Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch, I asked whether this silence regarding on- and off-reserve in the Joint Action Health Plan should be maintained. Participants from all partnering organizations agreed on the need to maintain that silence and not specify on- and off-reserve, however, the reasons outlined for this approach varied.

A First Nation participant indicated "we can't draw an imaginary line of on-reserve / off-reserve. I think genetically and inherently, we are who we are and we can't

change that" (FN01). A number of First Nations participants also linked it to what they described as the portability of the Treaty Right to Health:

> First Nations are First Nations. The Treaty Right to Health is portable no matter where you go. There's an expectation that it's going to follow you… I live here on-reserve. My children live off-reserve. My expectation and their expectation is that they're going to receive the same kind of care that I'm going to get or vice versa that they get. As far as I'm concerned there's no jurisdiction. (FN03)

> I think remain silent, because then it gets back to that Treaty agenda. If we make it specific to on-reserve/off-reserve, they'll say, No, no way; I'm a Treaty Indian. My Treaty rights travel with me no matter where I go. (FN05)

Some participants highlighted the transiency of First Nations individuals and families who frequently move between on- and off-reserve residences. A First Nation participant described this situation by saying "there's a lot of transiency going back and forth, back and forth" (FN15) while another said:

> Our populations are so transient that they can be on-reserve today, off-reserve tomorrow, and back on by Saturday. And I think that's very short-sighted for us if we think that we're going to take a look and solve real issues within the community if we have this artificial barrier of service. I think we have to take a look at the population as a whole as they exist and as they move and as they transfer around. (FN09)

A First Nation participant expressed concerns that specifying on-reserve / off-reserve residency would result in denial of services as he said "the only reason I don't think it needs to be, [is] because then it will be used by somebody to deny services. And

that's my worry" (FN06). Finally, two participants from First Nations organizations in two different Treaty areas linked it to jurisdictional concerns. A participant said "I think on- and off-reserve is a provincial/federal politics issue. It shouldn't play a part in what it is that we do" (FN09) and the second participant says that the identification of jurisdictions will result in "ways to say no service" (FN12).

A number of participants also flagged the need for equity in health care. Some provincial participants referred to equity of opportunity and the need to be broad and inclusive (AHS02 and AH03) while another linked it to her experience in population health as she said:

> If we're talking about addressing health disparities, if we're talking about improving health outcomes and supporting communities, the communities aren't necessarily defined by the communities as on-reserve or off-reserve. From a population perspective, the geographic location where somebody's living doesn't matter when you're talking about the health of a group of people. (AH02)

A First Nation participant linked this concept to equality of rights by saying "at the end of the day, provincially we're still counted in the cash. So not only are we First Nations, but we're also Albertans. We should have equal rights to services as everybody else" (FN14). References to equality, funding and financial contributions were present in a number of interviews and are outlined further in both the preconditions and processes sections of this chapter.

Provincial participants also expressed their preference for maintaining the silence between on- and off-reserve but anchored it differently referring to relationships between federal and provincial governments. As someone who has participated in many

discussions with provincial colleagues over the years, I was struck by the language used during the interviews as I had not always understood it as clearly as part of my intergovernmental work at FNIHB-AB. In some ways, my perception was not very different from what was articulated by a federal participant who said "there used to be a distinction between on- and off-reserve, and the province really perpetuated that for the most part because in their mind and their perspective, they used to maintain that anything on-reserve was not their jurisdiction" (HC03). She acknowledged more recent changes as she indicated that "the Health Accord is applicable to all Albertans, that sort of on/off-reserve boundary is getting a little bit more grey. It's not so black and white anymore" (HC03). Provincial participants also identified misunderstanding about the role of the provincial government in health as one said:

> From a legal perspective, [there is] a lot of misunderstanding about the role of the Province on reserve and their real strong sense that we're just not allowed on[-reserve]. Not that people don't want to go on to provide services, but just that we're not. I always say it's almost like they view the province like Swiss cheese, where the reserves are carved out and they're somehow associated with the federal government if you're talking government to government, but not with the Province. And, of course, from a legal perspective, that's not correct. (AH01)

In outlining this changing context, this provincial participant also expressed her desire to not be misunderstood and while acknowledging some of the challenges she stressed the importance of meeting the health care needs of First Nations individuals:

> There's this hesitation to go on reserve, and partly it's a funding barrier, that somehow the federal government should provide funding for anything we do

> there, which, again, I don't think from a legal perspective is necessarily correct. So my perspective is that when we approach health care that in some respects, and I don't want this to be misinterpreted, in some respects there's no boundaries. I mean, the Province needs to look at health care and the needs of the population in Alberta without regard to location, that everyone's health care needs are equally important, and there should not be a difference in that regard. (AH01)

These concerns are not new as they were documented in Indigenous literature by Blackfoot scholar Little Bear and his colleagues twenty-five years ago as they wrote:

> Although the Constitution permits the provincial governments to extend any services to Indians that the federal government allows (and the federal government has been extremely permissive in this regard), all provinces are uniformly reluctant to accept financial responsibility for services to Indians within their boundaries. In part this explains why Indian bands are still outside the bulk of provincial programs. (Little Bear et al., 1992, p. xiii)

Another provincial participant associated with Alberta Health Services rather than the ministry shared his support in developing an approach to care that meets the needs of the community:

> Who cares? Build it and make it happen is what you'd like to say. So it seemed like there was some ability to say, Okay, what's a model and approach to care that is going to be responsible at a community level and kind of has the right partners, very much what we're talking about in the bigger collaborative. (AHS02)

In outlining their understanding of the on-/off reserve concept, two of the federal participants referred to points of access. The first one outlined the need "to access the

right care at the right time by the right provider" (HC02) and identified the absence of on-/off-reserve references within the Joint Action Health Plan as opening up the possibilities (HC02). A second federal participant also referred to points of access but linked it to individuals' choices to reside on- or off-reserve acknowledging that in some cases this choice can be limited:

> So I think the way to define it is looking at it from a perspective of point of access and therefore under which jurisdiction do you fall because of that point of access. It is a form of individual choice, recognizing, of course, that there are some very important housing shortages in many, many communities. (HC01)

Participants indicated their preference for the silence of the Joint Action Health Plan regarding on-/off-reserve, however, they identified circumstances where it may be useful to be more specific. First, a First Nation participant indicated that if the Joint Action Health Plan is encompassing "the health care and well-being of people in general" (FN10) then it would not need to specify whether or not it refers to First Nations residing on- and/or off-reserve but that it may be needed if considerations need to be given to the unique health care needs as well as health issues and challenges of on- and/or off-reserve residents. Second, a First Nation participant shared that "the real reason why they can't or don't want to come is because we never asked them to come onto the reserve, nor did we give them permission to come on the reserve" (FN02). Third, a federal participant shared that clarification may be required for the on-/off-reserve concept if the Joint Action Health Plan is to be used to outline jurisdictional responsibility:

> If you're actually going to use the Joint Action [Health] Plan in a tripartite way to clarify areas where people are left without timely access to service because of

> jurisdictional disputes between federal/provincial points of government then you have to define what is the difference between the on-reserve versus the off-reserve understanding of jurisdictional responsibility. (HC01)

In summary, participants believed that except in some specific circumstances such as point of access discussions and clarification of jurisdictional responsibility the Joint Action Plan to Improve the Health of First Nations in Alberta should maintain its silence in regards to the on-/off-reserve concept.

Sharing our Understanding of Collaboration

The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta states that it seeks "to enhance collaboration" (Co-Management, 2014), however, the word "collaboration" is not defined. In outlining their understanding of collaboration, a number of participants began by expressing their views of the word. Some see "collaboration" as a strong word at the higher end of a spectrum that includes words such as consensus, compromise, coordination and cooperation. A provincial participant compared collaboration to synergy and identified it as strength as it "produces something stronger than the sum of the parts" (AHS02). While another provincial participant referred to a book she had read that outlines co-operation, coordination, and collaboration:

> And collaboration is a higher end and includes co-operation, and coordination, but it's a higher level of synergy where parties take the time to work through [issues of common interests] and it's like a partnership… it's embedded in collaboration that it's an ongoing engagement, and there is a level of accountability meaning both responsibility and authority to do the work collectively to create a better way

> forward… collaboration is really about honesty. It's about humility. It's about trust-building. It's about working together towards an innovation and a solution that then becomes the next step. (AHS03)

Others find collaboration weak believing that it refers to "an intent to work together. It doesn't actually have a commitment to do anything or to resolve anything" (HC01). While a provincial colleague preferred partnership stating:

> The use of the term "partner" rather than "collaborator", and one of the reasons why I think that that's a good word is that in some ways collaboration doesn't necessarily mean that there's an equal footing because you can collaborate with people who have different levels of power. But partnership, to me, feels like a more direct way of trying to be equal or on the same playing field. (AH02)

One of the most commonly used definitions of collaboration in academic and management literature is the definition provided by Wood and Gray who defined it as follows: "collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, forms, and structures, to act or decide on issues related to that domain" (Wood & Gray, 1991, p. 146). As indicated earlier, Wood and Gray identified six key elements to their definition: stakeholders of a problem domain; autonomy; interactive process; shared rules, norms and structures; action or decision; and, domain orientation (Wood & Gray, 1991). These elements are reflected in the answers provided by the participants. Further, as a number of participants outline values, I have decided to add them as a seventh element even though they could be underpinning the shared rules, norms and structures.

Stakeholders of a problem domain. For Wood and Gray this refers "to the groups or organizations with an interest in the problem domain and raises whether they have common or different interests" (Wood & Gray, 1991, p. 146). The participants more frequently made references to common interests rather than different interests. Common interest was phrased as an "understanding that we have a common goal" (FN06); "sharing a common interest" (AH03); "coming together around an issue" (AHS02); working towards "the same things" (FN01, FN04), a common goal (HC03, FN11, FN15) or a common objective (AH03); "work[ing] on solving common issues" (FN11) and "working in the spirit of partnership towards a vision or common goal" (HC02); "working together with a goal, a focus in mind"; achieving a "mutual goal" (FN02) or "the same kind of outcome" (FN03); and, addressing an issue that can't be addressed unless you work together" (AH01). While the Wood and Gray definition identifies common and different interests, only one First Nation participant framed his interest in collaboration by outlining the need "to meet our own benefit" (FN08) as he referred to the importance of never losing of the needs of his Nation in seeking partnership with the provincial government. While another First Nation shared her experience in negotiating with a local Primary Care Network highlighting the need for the partner to see a benefit to the collaborative endeavour (FN13).

Autonomy. A number of participants referred to the autonomy of the participating organizations. A First Nation participant described it as "we're not always going to agree on the same things, we're always going to have policies and protocols that interfere with our ability to come to a mutual understanding" (FN01). A First Nation participant shared his experience in working with the provincial government and in

"trying to take a proactive approach and really trying to define that relationship in our own terms" (FN08). In this regard, autonomy connected with a few other key elements such as accountability and authority which are further defined within organizational capacity. A second First Nation participant referred to the work of the three governments in health care and the need to understand each other and how each other work (FN11). Autonomy of participating organizations was also identified by a provincial participant who framed it as follows:

> If the Nations are in control here in terms of what happens then let's talk about who is making what decisions for who or what level. No Nation -- nobody can make a decision for another Nation, okay. Given. Check. Those are some of the key decision-making principles, things I think we need to have in place that everybody is autonomous and has the right to buy in or not buy in. (AHS03)

Interactive process. Many participants reflected on the interactive nature of collaboration and its focus on change-oriented relationships. A First Nation participant highlighted that "you see a real willingness and a commitment from all of us as individuals that something within us is really working towards those same things" (FN01). A provincial participant described it as bringing "their individual strengths and viewpoints forward in a way that creates something bigger and better than the individual parts" (AHS02). He also outlined the commitment and willingness required to move off position and take into account others' positions to create a new position together (AHS02). Another provincial participant signalled the need to create synergy, to work through issues, to maintain an ongoing engagement and to collectively create a better way forward (AHS03).

Shared rules, norms and structures. In their definition of collaboration Wood and Gray referred to shared rules, norms and structures. A First Nation participant identified a lack of understanding of First Nations protocols by government participants: "they knew when they violated them that they did something wrong but they didn't understand what it was because protocols are generally unwritten" (FN01). She referred to the support of Elders in outlining the need to respect each other and our respective worldviews:

> And it [working with Elders] really helped us to respect each other and understand that we didn't need to dominate one over the other we just needed to respect each other and accept our different worldviews and they were always going to be different and that we respected each other for our worldviews. (FN01)

Another First Nation participant referred to working relationship agreements where partners identify their goal and alternate resolution process (FN02). A First Nation participant outlined the need to have processes "put in place [that] have strict timelines, and stick to those timelines; otherwise, it's just another initiative. There's no commitment to it" (FN05).

Action or decision. Wood and Gray included within their definition of collaboration the need for action and/or decision. A provincial participant articulated this element by referring to it as "coming together to do something that won't happen unless we do come together" (AH01). A few participants referred to the decision-making process indicating the need for consensus (AH03) while another further described it as consensus that would be sought for the greater good (FN03).

Domain orientation. Finally, Wood and Gray defined domain as "the set of actors (individuals, groups, and/or organizations) that become joined by a common problem or interest" (Gray, 1985, p. 912). A First Nation participant described our domain by referring to "how we deliver health care and how people access health care, how people understand what health care is" (FN08). Another First Nation participant outlined it by stating that "there's an understanding for the clients' needs to be met, [and] minimal hiccups in terms of services being provided" (FN14).

Values. In their definition of collaboration, Wood and Gray indicated the need for shared rules, norms and structures however they did not specifically refer to the need for shared values. Wood and Gray (1991) did not include values within their definition, however Gray (1985) included coincidence of values within the second phase of collaboration – processes. I understand values may be perceived as underpinning the rules, norms and structures within a collaborative endeavour but as the participants highlighted a number of values without necessarily linking them to shared rules, norms and structures, I choose to do the same. A First Nation Elder referred to the seven teachings – courage, truth, respect, love, honesty, wisdom and humility (FN07). A number of participants indicated respect (FN01, AH01, FN03, FN12); one further defined it as "respecting each and every single person's input" (FN03). A First Nation participant linked together kindness and respect saying "because we're negotiating on difficult things does not mean that we have to be unkind about it, we can do it in a respectful way" (FN01). While another First Nation participant highlighted the need to "show respect to everyone in terms of what their skill is" (FN12) and he outlined the need to respect the knowledge of traditional knowledge-keepers. Participants also referred to the need for

equality as they identified "equal footing" and "level playing field" (AH02) as well as "the ability for each partner to have an equal say or at least an equitable say on what's being discussed" (AHS01). A First Nation participant linked honesty and equality by describing collaboration as working together "honestly and equally" (FN06). A First Nation participant also identified the need for flexibility (FN13). A provincial participant highlights the need for trust (AH01) and considering the many references to trust, or its lack thereof, as part of the interviews, further information is provided within the next two sections – preconditions and processes.

In conclusion, there was a fair amount of congruence between the participants' understanding of collaboration and the definition provided by Wood and Gray. All six elements are represented in the answers provided by the participants. I believe the inclusion of values complements the existing definition and provides an additional layer in terms of concretely developing a shared understanding.

The Three Phases of Collaboration

Collaboration is often described as having three phases – preconditions, processes and outcomes. These phases are used to organize the input of participants. However, the delineation between the three phases and particularly between preconditions and processes are not identical across collaboration literature. In other words, some authors will define as preconditions what others may see as processes. For example, Gray (1985) identified as preconditions convenor characteristics while others include it within the processes phase (Foster-Fishman et al., 2001). While I used the work of Gray and Wood (1985, 1991) to anchor most of this section, I supplemented the information they provided on the processes phase with the work of Foster-Fishman (2001) on collaborative

capacity. Further, I also used Indigenous literature to take into account the broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society.

Preconditions: The First Phase of Collaboration

Gray and Wood described the first phase as "the preconditions that make a collaboration possible and that motivate stakeholders to participate" (Gray & Wood, 1991, p. 13). In an earlier article, Gray identified the first phase of collaboration as problem-setting and is "concerned with [the] identification of the stakeholders within a domain and mutual acknowledgment of the issue which joins them" (Gray, 1985, p. 916). She identified as key elements of preconditions: identification of the stakeholders; stakeholders expectations about positive outcomes; degree of recognized interdependence; legitimacy of the stakeholders; convenor characteristics; as well as, shared access and power (B. Gray, 1985). I use these categories to group the information provided by the participants. Within legitimacy of stakeholders, Gray indicated that "perceptions of legitimacy will undoubtedly be colored by historical relationships among the stakeholders" (Gray, 1985, p. 922). As participants identified a number of elements inclusive of past and current relationships between partnering organizations, I wished to honour the participants' voices and rather than treat this information as a sub-category of legitimacy, I established a stand-alone category to outline the participants' input in regards to the relationships between First Nations, federal and provincial governments. Further, considering the importance given to this topic by the participants I begin this section with this category.

Relationships between First Nations, Federal and Provincial Governments

In Chapter 3, I provided a literature review on relationships between First Nations, federal and provincial governments and to a more limited extent between First Nations Peoples and Settler society. While I narrowed the focus of this broader context, the information provided was not limited to health and health care nor to Alberta. As I interviewed participants, I initially sought to better understand the impacts of relationships between First Nations, federal and provincial governments on the implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. Participants went much further as they outlined a much broader context taking into account: relationships between the participants and participating organizations involved in the Joint Action Health Plan; relationships between First Nations, federal and provincial governments; as well as, relationships between First Nations Peoples and Settler society. In a recent study on health care experiences of Indigenous people, the researchers referred to this broader understanding of First Nations participants by sharing that they are "influenced by personal and collective historical experiences" (Jacklin et al., 2017, p. E111). I believe this reference to collective historical experiences connects with statements by some participants who referred to the expertise of First Nations peoples in knowledge transfer (FN01, FN07, FN11).

The Treaties as a foundation to our relationship. Earlier in this chapter, I outlined the participants' understanding in regards to the Treaty Right to Health and the Medicine Chest Clause. In this section, I outline the impact of the Treaties on relationships between First Nations, federal and provincial governments as well as more broadly between First Nations Peoples and Settler society.

During the interviews, many participants stressed the importance of the Treaty relationship between First Nations Peoples and the Crown. Considering my focus on health care, the Medicine Chest Clause within Treaty No. 6 is also identified as a foundational piece. As First Nations participants outlined their understanding of the Treaty relationship, there is congruence with existing Indigenous literature. For example, a First Nation participant outlined her views by identifying both the importance of the Treaty relationship for First Nations and how it reflected a relationship with the Crown rather than with the federal government:

> First Nations take a stance upholding the Treaty and not doing anything to delineate or move away from the Treaty relationship and always bringing that to the table that it supersedes the relationship that the federal government has with First Nations because their Treaty is not with… the federal government it's with the Crown… before this country was even created. (FN01)

Similar statements can be found in Indigenous literature as Cree scholar Sharon Venne wrote that Canada was not mentioned in Treaty No. 6: "even the written version of Treaty 6 acknowledges that the treaty was entered into with the Queen of England, Scotland, Ireland, and Wales – without mentioning the colony of Canada" (Venne, 1997, p. 189). She further indicated that without Canada being identified as party to the Treaty it "does not have the authority to change the treaty" (Venne, 1997, p. 189).

A number of First Nations participants shared their concerns about the federal government's position in regards to treaties. A participant said "the federal government does not want to live up to their side of the Treaty. They're willing to ignore it" (FN06) while another said:

> It's a battle of words, English words. That's what it boils down to. It's a battle of what the government actually puts in black and white, is where the battleground is and always has been, with the intent of, basically in our view trying to get out of the obligation of the Treaties. That's what it boils down to. And that in itself is the biggest issue. Until that, at some point in time, it comes to some kind of terms that we can agree with, then those issues are going to remain. It's not going to go anywhere. (FN03)

A First Nation participant also referred to the consistency of the First Nations position in regards to the Treaty Right to Health: "has any Chief come to you in the last twenty years and changed their position on the importance of the Treaty Right to Health? No. It's been very, very consistent and very much of be more inclusive" (FN06). A number of Indigenous and non-Indigenous scholars also criticised the federal government's approach to the Treaties as a foundation to our relationship (Alfred, 2009; Borrows, 2002; Cardinal, 1999; Dickason & Newbigging, 2010; Saul, 2014; Venne, 1997, 1998, 2007). For example, Cree scholar Sharon Venne wrote "the written text expresses only the government of Canada's view of the treaty relationship: it does not embody the negotiated agreement" (Venne, 1997, p. 173). A federal participant described current and past relationships between First Nations, federal and provincial governments as a negative legacy and outlined its impact on our discussions:

> There is a very significant negative legacy that comes into play with respect to the Crown and Treaty First Nations relationship, and so that underpins essentially the ability for those discussions to result in positive outcomes in some circumstances, because there are still a lot of limitations that are placed on how that relationship

> is defined and how it can be enacted positively for First Nations. So unless we can actually address some of those barriers in the context of the Joint Action [Health] Plan, it definitely will impede the overall effectiveness that we can have in the Joint Action [Health] Plan. (HC01)

Her reference to negative legacy connects with the work on relational legacy which refers to "the sedimentation of unresolved issues" (Baba & Raufflet, 2014, p. 15) and would impact the ability to work together between First Nations, federal and provincial governments.

In terms of knowledge and understanding of the Treaty Right to Health, a provincial participant (AHS01) shared both the limited awareness of these concepts within Alberta Health Services, and the opportunity provided by the provincial government's commitment to renewed relationships including implementation of the United Nations Declaration on the Rights of Indigenous Peoples and the calls to action from the Truth and Reconciliation Commission.

Therefore, First Nations participants have an in-depth knowledge of Treaty rights and Treaty relationships and see it as a foundation to our relationship. Government participants demonstrate some awareness but identify limitations in terms of their knowledge.

Assimilation, colonization and oppression. As I asked participants about the relationships between First Nations, federal and provincial governments, a number of participants talked of assimilation, colonization and oppression (FN01, AH02, FN06, FN07, FN11, FN15). A First Nation participant said "I'm not a big fan of that assimilation policy, and that's exactly what I see" (FN06) before adding "they want to

assimilate us" (FN06) where "they" referred to the federal government. He also indicated that "the underlying assumption that Canada is a colonizing state is not recognized" (FN06). He further compared the relationship between First Nations Peoples with federal and provincial governments as an abusive relationship:

> It's like a relationship. You cheat on me a couple times, even if I go back with you… I'm not entirely going to trust you. And that's where I'm seeing there's a lot of abuse between the federal government, provincial government, on First Nations. First Nations have no choice. We're still having to go back to this partner, these abusive partners. And we keep hoping. So with the new Liberal government now we get slapped instead of being punched. But the abuse will still continue. (FN06)

Other participants also outlined these concepts as a First Nation participant referred to an understatement in describing the treatment of First Nations Peoples since contact: "I think that's probably the greatest understatement of all time [to say] that we haven't been treated fairly but it does a lot to a people. That kind of relationship does a lot to a people in a very negative way" (FN15). This is also congruent with existing Indigenous literature and the work of Métis scholar Carrie Bourassa and her colleagues who wrote "at a fundamental level, we understand that the colonization processes that began many years ago and continue today have material and social consequences that diminish access to social determinants of health for both Aboriginal men and Aboriginal women" (Bourassa, McKay-McNabb, & Hampton, 2004, p. 27).

Two First Nations participants referred to control. The first one, a First Nation Elder, referred to the control that has been given by First Nations Peoples as he says:

> We have given the government too much control over us. We have given the justice department too much control over us. We have given the medical community too much control over us… it would be better overall if we go back to doing things for ourselves. (FN07)

The second First Nation participant referred to teachings received from Elders and highlighted the need for First Nations Peoples to take control of their own destiny:

> The Elders are telling us we have to take control of our own destiny, our own life. We have to get [for] lack of a better phrase, our house in order. We have to know who we are, and we have to take control of our lives, not feel that we're under the Indian Act, to put it bluntly, but that's not the end-all that governs us. We have to govern ourselves and get away from this mentality of paternalism. We're nobody's child. We're adults. We have to take control of our own lives. (FN11)

A First Nation participant also questioned the decision to maintain policies that are causing harm by saying "if the policy is causing harm why are we upholding a policy that we know is causing harm?" (FN01). This participant also indicated that "historical harms aren't from contact because historical harms continue as [of] yesterday" (FN01) as she further outlined the need for reconciliation. This ongoing colonization has been identified by a number of Indigenous authors and scholars (Alfred, 2009; Bourassa et al., 2004; Corntassel, 2009, 2012; Coulthard, 2014; Fanelli, 2013; Little Bear et al., 1992). Further, the health system is described as "not culturally safe owing to the ways that health law, health policy and health practice continue to erode Indigenous cultural identities" (Matthews, 2017, p. E78). The Truth and Reconciliation Commission also drew attention to this as call to action 18 calls upon governments to both acknowledge

the impact of government policies and legislations on the health status of Indigenous peoples and to implement the health care rights of Indigenous peoples (Truth and Reconciliation Commission of Canada, 2015).

Racism and discrimination. A number of participants shared concerns in regards to racism and discrimination. A First Nation participant identified the ongoing challenges by stating "there's so much historical discrimination" (FN13) while another one declared:

> And to be so bold to say that to a patient who is relying on you for care, and to turn around and make him feel so small and [suggest] that they don't deserve services? That's totally wrong. It's against human principles and it goes against the principles of the *Canada Health Act*. (FN03)

She also shared her concerns with racism and discrimination based on existing policies and legislation by stating the need "to ensure that we don't run into these situations where First Nations' health is being compromised based on the colour of their skin, based on the status of which they hold within the government as a status First Nation" (FN03). A second First Nation participant added to these concerns and the lack of sustainability for First Nations health care:

> I don't like to throw the race card out there but I really like to try and believe that we're treated like all Canadians and all Albertans but we're clearly not in service delivery because we are not being protected in the form of a Health Legislation Act like other Canadians and other Albertans are. We are being delivered a service which has no sustainability. (FN01)

The racism and discrimination are not only perceived within existing policies and legislations, in the unequal allocations of resources and to encounters with health care providers as a First Nation participant also identified concerns with racism within the context of our collaborative discussions. She outlined that racism limits our ability to work collaboratively:

> And just being [a] First Nation woman, myself, I have seen over time, and I've experienced individuals who are a bit racist. You can see it in their mannerisms, the way they look at you, the tone of their voice. And there have been individuals like that at the other end of the table, is what I [have] seen and I observed. But I didn't say anything. However, over time I notice that they drop off the table, because they don't have any interest in trying to address the issue of systemic racism within the system itself when they have representatives who are. It's very, very difficult. (FN03)

Finally, a First Nation participant indicated the need for reconciliation saying: "reconciliation needs to happen somewhere, we can't even begin reconciliation when there's not even acknowledgment that anything is wrong" (FN01). The importance of reconciliation is also central to the work of the Truth and Reconciliation Commission which stated that for it to occur "there has to be awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes, and actions to change behaviours" (Truth and Reconciliation Commission of Canada, 2015b, p. 6). These definitions and understanding of key elements required to achieve reconciliation raise the question as to whether collaboration can occur without first acknowledging the

challenges resulting from assimilation, colonization, oppression, racism and discrimination.

Limited trust, lack of trust, mistrust and distrust. As First Nations participants shared their understanding of relationships between First Nations, federal and provincial governments, they often referred to limited trust, lack of trust, mistrust and distrust. A First Nation participant shared that "the trust is not there, and, quite frankly, I don't think the federal and provincial governments are coming in all honesty with their full agendas available to First Nations people and organizations" (FN06). As First Nations organizations receive funding from federal and provincial governments and need to report on the funding received, he felt that First Nations information was readily available to federal and provincial governments creating an uneven playing field in discussions between First Nations, federal and provincial governments as a result of inequities in resources, capacity, power and access to information. This sentiment is shared by another First Nation participant who referred to underlying motives and the need to read between the lines:

> Until we reach that common ground… it is going to be us versus them, because we're always in a mindset that the government has ulterior motives, and it's hidden between the lines in their black and white, and what they write, with their pens and nowadays computers, but trying to read between the lines is always a trick. I've learned to use that trick over time… I do find there's underlying motives between the language that they use and the paper that's put in front of you. And that creates a trust factor, we'll say. (FN03)

In further describing the lack of trust between First Nations, federal and provincial governments she declared "the trust level was so low that we didn't want to be even seen in the same room" (FN03). These two participants referred to the lack of trust and provided examples to explain this lack of trust from First Nation people and organizations towards federal and provincial governments and its impact in our ability to build and maintain working relationships. However, as I conducted the interviews trust concerns were not limited to lack of trust but also included references to mistrust and distrust. Dictionary definitions often treat mistrust and distrust as synonymous but based on discussions with participants, I understand these concepts not as synonymous but rather as a gradient starting with lack of trust before moving to mistrust and distrust. This is supported by existing management literature that defines mistrust as "misplaced trust" referring to betrayed trust while distrust is described as "a measure of how much the truster … believes that the trustee will actively work against them in a given situation" (Marsh & Dibben, 2005, p. 20).

A number of participants shared their mistrust. A First Nation participant said "from our perspective, there's mistrust, and that goes back years and years and years" (FN02) and another First Nation participant shared that "there is so much historical mistrust" (FN13). A First Nation participant simply stated "there's immediate mistrust right now" (FN12) while a participant working in a First Nation organization described both skepticism and mistrust (FN04). A First Nation participant linked mistrust to the government's approach towards the Treaties by saying "there's so much mistrust already in place, and that's because of Treaty obligations" (FN05).

Distrust was brought forward by a First Nation participant who simply stated "I think there's a lot of distrust" (FN06) while a second First Nation participant linked it to barriers to collaboration as she identified "distrust, policy, [and] lack of capacity" (FN13). While acknowledging her perception that distrust is a strong word a First Nation participant linked it to the presence of agendas and motives of partners:

> I think distrust is a really strong word, but I'm not sure of another word to use. But just kind of questioning or wondering what the agenda or the motives or the actions are from either Alberta Health or from FNIHB themselves whether or not they're really working in the best interests of First Nations. (FN10)

In identifying lack of trust, mistrust and distrust, many First Nations participants emphasized the relationship between First Nations and federal governments but as with the last statement a number of First Nations participants also identified concerns regarding trust with the provincial government. A First Nation participant expressed some of these feelings as he linked mistrust and jurisdictional issues:

> There's still a lot of mistrust, a lot of mistrust between First Nations and the federal government, per se. And because of what they say, the jurisdictional question, they make the province a scapegoat as to why we shouldn't work with the province, because they weren't part of the Treaty. (FN05)

A First Nation participant also highlighted the relative new addition of the provincial government to the discussions on health highlighting that they have not traditionally been active in providing services on-reserve and the perception that the provincial involvement will result in offloading responsibilities from the federal to the

provincial government. He expressed concerns that ultimately it is a financial question rather than about closing the gap in health outcomes:

> There's a lot of mistrust even with… [the] federal government, there's a lot of mistrust there. A lot of mistrust with the provincial government, because we just don't know a lot yet, because historically [they have] never really been doing much on reserve and whatnot, and so it does have an impact. In fact, I've heard it said many times that it's all about offloading. They don't really want to help us. It's all about cost-saving. It's never really truly about getting us up to par. (FN15)

This lack of trust between First Nations and provincial government is also documented in Indigenous literature as Blackfoot scholar Leroy Little Bear and his colleagues wrote "historically, under the provisions of the BNA Act and the Indian Act, Indians have had a very strong relationship with the federal government and a very weak relationship with the provincial governments" (Little Bear et al., 1992, p. xiii) before outlining the reluctance of First Nations to work with provincial governments which is perceived as an abrogation of Treaty rights rather than an offer for enhanced services (Little Bear et al., 1992).

Participants working for federal and provincial governments also shared their perceptions regarding the lack of trust, mistrust and distrust between First Nations, federal and provincial governments. A federal participant acknowledged the limited trust as she shared that "it's not blind trust, certainly" (HC02). A provincial colleague identified a number of considerations that he identifies as "ghosts in the room" that impact our ability to interact and work together:

> I'm referring to a number of pre-existing conditions, whether it be history, whether it be residential schools, whether it be even significant past issues and concerns. I think that's come into play. They affect the ability to trust. They affect the ability to create relationships, and they are what I refer to as the ghosts in the room, those things that you or I may not necessarily have any part of or certainly don't buy in or prescribe to, but they affect our perspectives and the type of discussions that we can have. That's only on the First Nations side. But, I mean, each one of those components that exists for all parties at the table, whether it's the positions or perspectives that are developed by Cabinet, whether federal or provincial, whether it is the internal considerations about budget and priorities. (AH04)

Another provincial participant also acknowledged the lack of trust and fear from the communities, the Nations and the people, and states that "based on history, I think that's really quite reasonable" (AHS03). A federal participant also outlined the impact of past decisions on the trust level and how she perceived it as also having an impact on the further development and implementation of the Joint Action Health Plan:

> I think a lot of the history certainly impacts the trust of the partners at the table because of judgments of the day, and back in time or the political will or direction [of] a particular government… impacts where people are together around the Joint Action [Health] Plan table. (HC02)

These comments from participants on trust, lack of trust, mistrust and distrust also connected with existing literature on trust (Mayer, Davis, & Schoorman, 1995; Schoorman, Mayer, & Davis, 2007). In their integrative model of interorganizational

trust, Mayer, Davis and Schoorman (1995) outlined that for trust to exist the trustor must believe that the trustee has benevolence, integrity and ability and the trustor must be willing to take risks. Considering the information gathered through interviews with participants and through Indigenous literature, there are many examples demonstrating that First Nations individuals, organizations and governments doubt the benevolence, ability and integrity of federal and provincial governments which then impacts their willingness to take the risks required to trust.

Collaboration literature often refers to the importance of trust that needs to be present at the beginning of the collaborative relationship. Some have argued that it is a key ingredient and it needs to be there to develop collaboration (Alexander et al., 2003; Zuckerman, Kaluzny, & Ricketts, 1995) while some argue that trust can be built both when there is no existing relationship between the partners and when "previous relationships have not engendered mutual trust" (Vangen & Huxham, 2003, p. 15). First Nations participants shared their lack of trust, mistrust and distrust as well as its impact on their willingness to take risks. Many government participants acknowledge the limited trust and its impact on building and maintaining relationships. As part of the interviews, I also solicited the participants' views on building trust and respectful relationships, this information is provided in the second step of collaboration – processes.

Inequities in resource allocations. In Chapter 4, I provided a high level overview of the partnering organizations which demonstrated significant differences in terms of their budget, their number of employees, and their service delivery mandates. A number of First Nations participants highlighted the limited resources of First Nations organizations in comparison with the resources available to the other partners.

Participants working in First Nation organizations shared their concerns regarding the lack of capacity of First Nations organizations (FN03, FN04, FN13, FN06, FN15) while a First Nation participant simply said "we could do so much more, so much more if we are just provided the adequate capacity to do it" (FN03). A First Nation participant also referred to the funding allocations between regions:

> There's some real ugly historic issues as it relates to allocations in this country. And in the past, Alberta has always been known as a have province, so we didn't get as much as other regions. For example, and still today, BC still gets way more allocations than Alberta in relation to Indian health programming than Alberta gets… those historical things are in play and makes it a lot harder for us to get down to business. (FN05)

In identifying concerns regarding equitability of resource allocations, First Nations participants did not limit their comments to the resources for participating in the Joint Action Plan to Improve the Health of First Nations in Alberta nor to the funding related to health. Rather they approached this topic more broadly within the context of relationships between First Nations, federal and provincial governments and between First Nations Peoples and Settler society. A First Nation participant began by sharing: "we're being deliberately underfunded" prior to adding:

> If we would have had access to the resources that were taken out of Treaty 8 territory at a rate where we could fund our own health care, education, child welfare, a lot of these issues may have been addressed already, because our capacity would have been the same. However, all the money gets sucked out of Treaty 8, sent to the federal government, who then doles out a pittance to Treaty 8

> First Nations, and the rest of the money is spent to keep the rest of Canada going. (FN06)

A First Nation participant outlined how decisions of the past continue to impact current resource allocations and the livelihood of First Nations individuals, families and communities:

> If our forefathers knew what we know today, we'd be a lot richer. Or they may have said this to them, No, we don't care how much money you give us, we're not going to allow you to ruin our land. (FN02)

Finally, a number of First Nations participants across the three Treaty areas (FN02, FN03, FN06, FN07, FN12) referred to paying taxes and perceptions of Canadians in regards to First Nations and taxation. First Nations participants signalled that they also pay taxes and statements to the contrary are not accurate. A First Nation Elder said: "I think that the Indigenous people of this great land are the biggest taxpayers in the country by virtue of the wealth of this country" (FN07). A second First Nation participant shared that First Nations have significantly contributed to the development of Canada and referred to accusations of not paying taxes as a reason to deny services:

> Accusations and everything that we don't pay taxes, we don't deserve anything kind of attitude. But, in fact, we paid up front for all these services. We didn't even get 1 percent of the land in total of Canada, and look at the billions and trillions of dollars now that they're receiving. And we get peanuts. (FN03)

A third First Nation participant shared how First Nations are also tax-payers and should receive some of the benefits:

> We're paying the taxes just like Joe Blow Albertan, and sometimes Joe Blow Albertan is only paying $1,300, and he gets those tax dollars back in his education for his kids in school. What about us? See nobody thinks to look at those things. It's like we do pay taxes; we should get our benefit for paying those taxes. (FN02)

Within this broader context of relationships between First Nations, federal and provincial governments, concerns regarding inequities in terms of resource allocations are understood by First Nations participants at a macro level. It is not limited to capacity to undertake the collaborative work on the Joint Action Plan to Improve the Health of First Nations in Alberta but rather through intergovernmental lenses as well as within the broader context of relationships between First Nations Peoples and Settler society. More information regarding capacity to support the Joint Action Health Plan will be provided in the processes section within organizational capacity.

Current levels of community engagement. As part of the interviews, I asked the participants to assess the level of community engagement between the partners. This question was based on the New Zealand Community Engagement Model and its four quadrants – to, for, with and by (New Zealand Office for the Community and Voluntary Sector, 2011) which was described in Chapter 3. Assessments of the current level of community engagement varied between participants and the most significant variation was between participants working in First Nations organizations and governments and participants of federal and provincial governments. Overall, participants in First Nations governments assessed the level of engagement as lower usually referring to the *to* and *for* quadrants while participants from the federal and provincial governments tended to identify our level of engagement at the *for* and *with* levels.

A First Nation participant articulated the relationship as being one-way and clearly within the "to" quadrant. He acknowledged that some efforts have been made but that these efforts are being limited by policy and legislation and therefore not providing an opportunity for meaningful change:

> There are some efforts that are being made where you have a cultural health person in hospitals and where you have First Nation people, like Co-Management, [or] this joint committee. You make groups where they're offering some idea, but they always hit a wall when they say, that's not how it should be done, the policy and legislation says that's as far as you can go. And it ends there. So you are speaking to us, telling us what to do. (FN12)

A second First Nation participant identified the engagement level as low associating it with the "for" quadrant as he referred to the federal and provincial governments as having both the ability to dictate and knowing what is best for First Nations:

> If you're looking at it as a spectrum, we're on the lower end. Both levels of government think they have the authority to dictate. And the authority – and the knowledge – no, that's not even the right word, either, but they know what's best for Indians, and they're delivering a program with very low levels of engagement. (FN06)

In describing the level of community engagement, provincial participants referred to building relationships and trust without clearly identifying a quadrant. While a federal participant described a slightly higher level of engagement than what was described by

First Nations colleagues. She acknowledged that the level of engagement is not quite two-way but she highlighted progress and interest to do better:

> I would say we're not quite at the two-way model, but we've -- certainly made strides to get there. I believe that governments are very good at dumping information, and information being one way but [we] haven't been as good at being interactive and engaging, whatever the medium is. I think there is a recognition by First Nations that there is a genuine interest and intent to do better, but there's lots of room to improve. (HC02)

In conclusion, relationships between First Nations, federal and provincial governments are expected to have an impact on the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. This collaboration is being undertaken within a much broader context of relationships between First Nations, federal and provincial governments as well as relationships between First Nations and Settler society. Considering the wealth of information provided by participants, I believe current and past relationships between participants and participating organizations cannot simply be a component of legitimacy.

Identification of Stakeholders

Gray identified as a key element to collaboration the ability to identify the participants "whose expertise is essential to building a solution" (Gray, 1985, p. 918). Collaboration literature identifies a number of potential issues in regards to the identification of partners. These issues can be both at the organizational and individual levels as authors refer to an ill-defined membership list, ambiguity of members about their decision-making authority, representativeness of stakeholders as well as the

challenges of reporting back to thinly institutionalized organizations (Huxham & Vangen, 2000; Westley & Vredenburg, 1991).

As part of the interviews, participants readily identified the partnering organizations to the Joint Action Plan to Improve the Health of First Nations in Alberta as First Nations of Treaty No. 6, Treaty No. 7 and Treaty No. 8, Alberta Health, Alberta Health Services and FNIHB-AB. At the organizational level, three broad challenges can be identified. First, First Nations endorsement of the Joint Action Plan to Improve the Health of First Nations was provided by the Health Co-Management Committee. The Committee includes members from nine communities from Treaty No. 6 (Enoch Cree Nation, Maskwacis Cree Nations and Yellowhead Tribal Council), communities from Treaty No. 7 and Treaty No. 8. A number of First Nations communities in Treaty No. 6 are not members of the Health Co-Management and not all communities are represented at the Co-Management Committee as it includes up to six Chiefs from the three Treaty areas rather than the 36 Nations who are its members. The Joint Action Plan to Improve the Health of First Nations in Alberta has been endorsed by the Health Co-Management Committee but has not received broader First Nations political support through a resolution from the Assembly of Treaty Chiefs. A First Nation participant identified the letters of support provided by the previous federal and provincial governments as a demonstration of their commitments but indicated concerns regarding the current level of First Nations commitment:

> We didn't really get a signed commitment from those three Chiefs saying, we're going to strive to work to get an agreement. They never ever signed. And there will be less – I think that's going to be the strongest hurdle right there is they're

> going to say, I think I want to take this back to the rest of the Chiefs. And that's where it's going to get derailed. It will get derailed. (FN02)

Second, in discussing membership and involvement of First Nations organizations and governments some participants shared that they did not think that all First Nations organizations and governments would be ready for this work. A First Nation participant outlined choices that may need to be made by the partnering organizations:

> We look at this Joint Action [Health] Plan and what it could mean, how it could benefit First Nations. It's not going to benefit all First Nations, and I think you have to just accept that and recognize those limitations as far as that goes. I think you have some groups out there who are ready, and you have some groups who are not ready. And you have to decide, do we collectively have enough strength there and vision and support to move things forward? So that's a decision that each First Nation has to answer. (FN08)

Third, members of the Joint Action Health Plan Working Group mulled over the possibility of including additional partners such as Indigenous and Northern Affairs Canada and Alberta Indigenous Relations. The draft terms of reference for the Joint Action Health Plan Steering Committee identified them as a potential partner but as of August 2017 they have not been invited to participate in either Steering Committee or Working Group meetings. Expanding membership would likely raise questions regarding the scope of the Joint Action Health Plan. Within the current scope, enhancing collaboration for achieving quality health services, it is unclear what Indigenous and Northern Affairs Canada and Indigenous Relations could contribute to the discussions as neither of them is involved in health care. However, if the scope is broadened to include

social determinants of health those two departments would have the mandate to participate, and so many other federal and provincial departments. Two federal participants (HC02, HC03) brought forward the potential benefits of involving Indigenous and Northern Affairs. One of these participants outlined the following:

> We've established a pretty good relationship with INAC and if you look at it from that social determinants of health approach, they have a huge responsibility as well. And I'm looking forward to the day where they start being brought into the conversations around how their full suite of programs also play into health holistically and how they can step up and contribute to the conversation and the vision. (HC03)

In identifying potential partners, a First Nation individual referred to the need for engaging at a more local level as he outlined the need to enhanced partnerships with local hospitals and health care providers such as physicians (FN11). A number of First Nations participants also identified the importance of existing partnerships at the local level which allows them to offer enhanced health care (FN02, FN08). The ambiguity in membership identified by the participants is not unique to this process as management literature also identifies these concerns in terms of roles and membership status of participants (Huxham & Vangen, 2000; Vangen & Huxham, 2003).

At the individual level, a number of challenges are identified in terms of identification of partners. First, as a participant in this process I was aware that the membership for both the Joint Action Health Plan Working Group and Steering Committee remained fluid. By fluid, I mean that some of the partnering organizations have not formally appointed representatives; for other partners, staff turnover resulted in

changes in membership; and, some regular attendees at the Working Group meeting identified themselves as observers rather than participants. This ambiguity around membership is not limited to our process as it is also identified in existing collaboration literature (Huxham & Vangen, 2000). Second, a number of participants framed their limitations in terms of their ability to speak and make decisions on behalf of their organizations (AH02, AHS01) while others signalled the importance of members to report back to their organization and the communities they represent (FN05, FN10). These challenges in representativeness of members is also documented in existing collaboration literature which highlights that it is more prevalent in cases like ours when some of the organizations participating in the collaborative endeavour represent not only one organization but also a group of organizations such as Tribal Councils and Treaty organizations (Westley & Vredenburg, 1991). However, this challenge was also shared by a number of participants representing federal and provincial governments. Some of these challenges will be outlined further as I discuss accountability within organizational capacity in the processes section.

Stakeholders Expectations about Positive Outcomes

In defining stakeholders expectations about positive outcomes, Gray outlined that the participating organizations "must believe that collaboration will produce positive outcomes" (Gray, 1985, p. 920). The goal of the Joint Action Plan to Improve the Heath of First Nations is "to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014). Participants identified three key expectations in terms of outcomes:

improving First Nations health outcomes; engaging First Nations individuals, organizations and governments in health care delivery; and, improving First Nations health care. Additional expectations were also identified in terms of programmatic improvements, policy and legislative changes as well as more evidence-based approaches informed by health information. Some identified only one of these outcomes but a number of participants identified two or more.

Considering that our foundational document is entitled the Joint Action Plan to Improve the Health of First Nations in Alberta, it may not be surprising that a number of participants identified first and foremost the opportunity to improve First Nations health outcomes as an expected outcome (AH01, AH03, FN04, AHS03, HC03, FN11). A First Nation participant identified this outcome by stating "to improve the quality of life and the health of First Nations individuals" (FN10). A provincial participant also highlighted the need to improve health outcomes while emphasizing the need to work with Indigenous communities and be ready to learn:

> And the impetus to work with Indigenous communities so that we improve health outcomes in the right way -- not saying that we know how to do it, but to learn and to do it, to improve health outcomes, is really a driving force. (AH01)

This last statement brings us to the second expected outcome identified by many participants which is to engage First Nations individuals, organizations and governments (AH01, FN03, AHS01, AHS03, FN13, HC03). A federal participant highlighted the importance of relationships and relationship-building as well as what she described as "a responsibility to be able to start having the conversations, drawing the province in, drawing the First Nations into that conversation and coming at it (improving health

outcomes) from a holistic approach" (HC03). A First Nation participant framed this expected outcome by saying "we cannot expect the federal government and the federal representatives to continue to always speak on our behalf. We have a voice. We should be able to bring it to the table as well" (FN03) before adding:

> So the Joint Action [Health] Plan, and having the key partners at the table, I feel, is very, very important. This is where we bring the voice to the ears who can make some changes, whether it be to policy, whether it [be] within their systems, whether it be addressing communications, whether it be addressing education, cultural competency, safety, and not only just for First Nations but every culture that comes through their doors. But specific to this, specific to First Nations and how they are treated as basically equals in terms of accessing the same quality of health services that everybody else enjoys. (FN03)

A provincial participant identified this expected outcome by saying "the commitment of this government to change the relationship and to have a more productive, if I can use that word, relationship is really strong" (AH01). She also linked it to the need to change the current health care model to a more community-based model as she shared "I feel that we have Indigenous communities that actually need to lead the way and teach us, because they are wiser than us" (AH01). A number of participants linked it to a strengthened ability to respond to community needs (FN02, FN03, AH02, AHS01, AHS03, FN13). Finally, a First Nation participant highlighted that "the [First Nations] communities have to lead the process" (FN08). Other participants referred to: the establishment of working relationships between all parties (HC01, FN08), the

establishment of more collaborative approaches (HC03, AH04); and, a more formal partnership that would lead to a Memorandum of Understanding (FN14).

Third, some participants identified the need to improve First Nations health care (FN02, FN03, AH03, AHS01, AHS03, FN06, FN08, FN10, HC03, FN11). A First Nation participant identified this expected outcome as follows: "we are fighting and moving for future generations, and… the focus up to now is really about improving access, about improving health care for those future generations" (FN08). A provincial participant indicated his desire to positively impacts the health care teams in First Nations communities (AHS01). A First Nation participant shared his fear that "sooner or later the federal government is going to push a choice on us, and if we want to have health services, that's going to mean a weakening of the Treaty Right to Health" (FN06).

A number of participants identified additional expected outcomes including improvements to Non-Insured Health Benefits (FN02) as well as opportunity to change existing policies (FN13), to clarify policy framework (AHS02) and to develop legislation (FN12). Two other participants identify the need for evidence-based approaches that are informed by health information (FN01, AH02).

Finally, some participants linked together two or more of the expected outcomes identified above. A First Nation participant linked two of these outcomes, improvements of both First Nations health outcomes and health care: "I think overall the end goal [is] to improve health care and the health and well-being of First Nations" (FN10). A federal participant linked together all three expected outcomes and the need to strengthen relationships with the provincial government as she states:

> We want to improve access and quality of health services accessible to First Nations, and we want to overall improve the state of health, which means we also want to look at partnerships on the determinants of health as well. We want to have better working relationships with provinces so that there's a better continuum of care that's established and better recognition that we have one whole system that needs to serve First Nations regardless of jurisdictional responsibility. (HC01)

A provincial participant shared that the expected outcomes identified above were the initial raison d'être for Alberta Health's involvement, however, he identified what his organization further learned from this process:

> When the Joint Action Health Plan first started, if I had to say what the primary motivation was, I would have to say that it was a combination of the desire to be able to see growth and change in Indigenous health and Indigenous health outcomes and in the delivery of services. And also the ability to work on a collaborative basis with the federal government and with First Nations to find those solutions together… Today I think it's much more complex than it was then. Each one of those pieces is still there but I believe that through this process and through just overall time and investments in Indigenous health and Indigenous health services perspectives that we've made in the last couple of years since the Joint Action Health Plan has gone on, I think there's a deeper sense of empathy and understanding for what those concerns actually are. (AH04)

Degree of Recognized Interdependence

Gray (1985) wrote that "the recognition by stakeholder groups that their actions are inextricably linked to the actions of other stakeholders is a critical basis for collaboration" (Gray, 1985, p. 921). The Joint Action Plan to Improve the Health of First Nations in Alberta has been described by members of its Working Group as the only trilateral health table in Alberta but it is not the only collaborative endeavour between First Nations, federal and provincial governments in the province. Many of the participants in this research project are actively involved in other collaborative endeavours, for most of the participants these are also related to health, though not exclusively.

Prior to highlighting the benefits of collaboration a few participants began by sharing their experiences in building relationships. They acknowledged some of their challenges and how they believed that those experiences allowed them to access more services for their communities as well as provide models for First Nations, federal and provincial governments alike. A First Nation participant shared:

> We've had some experiences, both good and bad, that got us to this point, and it's those experiences that have contributed in a very positive and meaningful way for our people. And it has opened up other doors for First Nations, and it has opened up the eyes of the government at the same time. (FN08)

A second First Nation participant echoed this sentiment: "any experience that you gain helps when you come into something new. Because you can see what would work, what didn't work, and everybody has their suggestions and a way to approach [it]" (FN14).

Participants engaged in collaborations at the community level highlighted the gains made in terms of access to services "literally we have like 6, 7 different specialists that come out, and that's unheard of on First Nations" (FN08). Another First Nation participant referred to working relationships with a local hospital and the process used to address concerns: "they compile the stuff, and then we come up with a solution, and it's implemented" (FN02). However, not all collaborations are viewed positively as a more recent one was described by a participant in a First Nation organization as offering "lip service" (FN04). A First Nation participant recognised the work done by First Nations colleagues:

> I think [the] more people that become aware of what's happening out there in certain places will help. It does help. It does help. I think … the community that's utilizing a lot of provincial support…. recognize[s] the difference that it is making. (FN15)

A number of provincial participants highlighted the contribution of the Alberta Health Services' Wisdom Council. The first participants shared that "the Wisdom Council helps the cultural competency and awareness and all the equity things and [provides] opportunities of thinking differently about strength-based development in Indigenous populations" (AHS02) while the second participant highlighted "the level of engagement with the Wisdom Council as an apolitical body that is really pushing forward" (AHS03). She further highlighted the role of the Wisdom Council in educating and increasing awareness of her organization's senior leadership:

> And then with the opportunity to dialogue with the Wisdom Council, they've recognized just how far they have to come to make a difference with Indigenous

> people and how horrible we are. Really, how horrible we are in Canada. So I would say that AHS is really warming to moving forward. (AHS03)

A federal participant identified the management of a crisis, the 2013 floods in southern Alberta, as positively contributing to the relationships between partnering organizations:

> That's something that stands out for me. It's like after that, then, there was a different feeling, different vibe. It was the first time… the province put big money and actually crossed that imaginary line in the sand. (HC02)

Therefore, participants identified an increasing level of recognized interdependence and for some, this development is fairly recent. As we increasingly recognized our interdependence, a provincial participant highlighted the importance of what he described as the ability to change the narrative to achieve greater success:

> I think every positive example is a step in the right direction. From my standpoint, and I may be oversimplifying this, but I have roots on both sides of the equation. So from my standpoint, if I was to make a significant change, it would be in changing our narrative, changing our perspective on what the relationships should be, what they look like, the way they were, what is defining our relationship today and what variables are impacting our perception on that relationship. Any time we can take a positive move forward, it's another opportunity for us to start changing the narrative. (AH04)

Legitimacy of Stakeholders

In writing this section, I used Gray's definition of a legitimate stake which is "the perceived right and capacity to participate in the developmental process" (Gray, 1985, p.

921). Earlier I indicated that Gray identified historical relationships within legitimacy of stakeholders, however, considering the abundance of information gathered from participants on current and past relationships, I opted to include this as a separate stand-alone section. This information was provided at the beginning of the preconditions section. In this section, I delve deeper into the complex web of relationships between First Nations, federal and provincial governments taking into account what Gray referred as the "prevailing norms [to] support collaboration" (Gray, 1985, p. 921). Considering the complex web of relationships between partnering organizations. I opted to outline these relationships at the bilateral level and created three categories: relationships between First Nations and federal governments; relationships between First Nations and provincial governments; and, relationships between federal and provincial governments.

Relationships between First Nations and federal governments. In regards to health, a few documents frame the relationships between First Nations and federal governments. First, the *Constitution Act, 1867* grants federal responsibility of "Indians, and Lands reserved for the Indians" (Government of Canada, 1867, p. 4) under section 91(24). Second, Treaty No. 6 (1876) states "that a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent" (Government of Canada, 1964). A federal participant anchored our relationships in these two documents by saying "the federal government's jurisdictional role as a representative of the Crown with respect to being a Treaty partner" (HC01). Third, the 1979 Indian Health Policy identifies three pillars for action: community development; traditional relationship between First Nations peoples and the federal government; and, the interrelated Canadian health system (Health Canada, 1979).

Further, there are regular and ongoing interactions between First Nations individuals, organizations and governments with the federal government, through First Nations and Inuit Health Branch, the federal government is both a funder and direct provider of health services and programs. FNIHB-AB provides funding to First Nations organizations and governments for the provision of a range of health services including health promotion and disease prevention, mental health and addictions as well as home and community care. Many FNIHB-AB employees provide front-line services such as public health nursing in First Nations communities. Direct service delivery also includes the provision of Non-Insured Health Benefits (e.g. medications, vision care, dental care, mental health as well as medical supplies and equipment) to First Nations individuals. A First Nation participant shared her concerns that by using the 1979 Indian Health Policy rather than a more solid legislative basis to frame the current relationship between First Nations and federal governments, it limits the ability to support better health outcomes and health care for First Nations (FN01).

To support the provision of those programs and services, First Nations Chiefs and the federal Minister of Health signed the Health Co-Management Agreement in 1996 (further information on this agreement was provided in Chapter 3). A number of participants shared their perspectives on this agreement. A First Nation participant described the Co-Management Agreement as an administrative agreement to co-manage the FNIHB-AB funding by First Nations and the federal government (FN03). While management literature identifies that repeated interactions can pave the way to strengthen relationships between partners participants provided more mixed reviews of those repeated interactions. A First Nations participant identified concerns describing the

process as being a deterrent where "a division was created by previous individuals that is not creating a healthy working relationship" (FN03). A federal participant had a more positive view:

> I think Co-Management goes a long way to help facilitate a lot of those conversations, and I think we are decades ahead as far as having an established working relationship with communities. So we need to nurture that relationship and honour that relationship. (HC03)

The First Nation participant further outlined that when the Co-Management Agreement was signed there was an expectation that a bilateral process would be established to provide a forum for discussion on the Treaty Right to Health (FN03). The Co-Management Agreement refers to a two-tier process; the first tier being an administrative process where we co-manage, co-assess and co-analyse funding, while the second tier refers to a bilateral process between First Nations and the Crown for Treaty negotiations that is not part of the Co-Management Agreement. In describing the relationship between First Nations organizations and FNIHB-AB, a few First Nations participants outlined the frequent changes in terms of policy and organizational changes including staff turnover. These changes are perceived as negatively impacting the ability to build and maintain relationships (FN08, FN14).

The Joint Action Plan to Improve the Health of First Nations in Alberta was developed in 2014 prior to the federal and provincial elections of 2015. A number of participants acknowledged that the Joint Action Health Plan was achievable with the previous governments and a federal participant stated that "even if we have to work with the status quo, I think we're able to support those discussions" (HC01). After the

elections, a number of federal and provincial participants identified a changed, and more supportive, environment. This context of renewed relationship is also identified by a federal participant: "if we have a government who wants to introduce a renewed relationship on the basis of Treaty rights and the implementation of Treaty rights, then, it could become a very positive platform for the Joint Action [Health] Plan" (HC01). She further said "it's just going to be how effective can we be as a partner on the basis of how much flexibility the government can give us" (HC01).

Two First Nations participants clearly identified that the Joint Action Health Plan is not to define the Treaty Right to Health. A First Nation participant said "we're not talking Treaties right now. We're talking about health care" (FN12). While a second First Nation participant said:

> That's not the right table [to define the Treaty Right to Health]. I think all that has to happen between the governments that signed the Treaty and it has to be done between leaders and it shouldn't be discussed just frivolously. It shouldn't be brought up. We're talking about health care. Treaty right is a different thing. (FN11)

Therefore, using Gray's definition of legitimacy, it appears that the participants see First Nations and the federal government as legitimate partners having a stake in the Joint Action Plan to Improve the Health of First Nations in Alberta. As I interviewed participants, they often highlighted capacity and policy issues that impact our ability to address anything more than administrative matters. Amongst the issues that are not addressed but should be were: policy and legislative matters. There was more limited consensus in regards to discussions on the Treaty Right to Health.

Relationships between First Nations and provincial governments. While section 91 (24) of the Constitution grants federal jurisdiction for "Indians, and Lands reserved for the Indians" (Government of Canada, 1867, p. 4) it also grants provincial jurisdiction under section 92 (7) for "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the Province, other than marine hospitals" (Government of Canada, 1867). The federal government began providing health care to First Nations in 1904. In the 1960s, as the provinces implemented provincial health care systems the national Hawthorn Study advocated for the "right of Indians to be citizens plus" (Hawthorn, 1967, p. 6) which would ensure that "both [federal and provincial] levels of government applied their respective legislative and fiscal resources in a cooperative fashion" (Hawthorn, 1967, p. 210) including health. In its 1979 Indian Health Policy, the federal government highlighted the role of the provincial governments in health care and encouraged the provinces to provide "diagnostic and treatment of acute and chronic diseases and in the rehabilitation of the sick" (Health Canada, 1979, np) as well as encouraged greater involvement of First Nations peoples in the decision-making process. Indigenous literature shares the concerns of First Nations with this approach. For example, Blackfoot scholar Leroy Little Bear and his colleagues wrote:

> Indians have been very reluctant to accept services and assistance from provincial governments. They see in the federal government's move to integrate Indian bands into the provincial-municipal structure much more than a simple extension of provincial services. They interpret it as part of the federal government's hidden agenda to abrogate its constitutional and treaty obligations to the Indian

> people. They view a transfer of dependency from the federal government to ten provincial governments as the death sentence for their historical claim to nationhood and self-government. Furthermore, they reject the assertion that a transfer of dependency will produce an improvement in their life-condition. (Little Bear et al., 1992, p. xiii-xiv)

A First Nation participant echoed these comments as he shared his concerns in regard to both the federal government's failure to honour the Treaties and its assimilation policy:

> The federal government has decided that they're going to be moving some of these services and programs to the provincial government. They're not willing to step up to their side of the Treaty and honour the Treaty Right to Health and deliver the services to First Nations the way they should. And so to get out of that responsibility and liability they need to include the province. And the province is saying, yeah, we'll do it, because it increases their base and their authority. And as part of the assimilation policy, more and more Indians are just going to have to fall under the provincial authority. (FN06)

Other First Nations participants expressed their concerns or the concerns of others about the involvement of the provincial government and its potential impact on the Treaty Right to Health (FN03, FN08). A First Nation participant who sought to establish stronger relationships with the provincial government indicated having been told by First Nations colleagues that she was sleeping with the government as well as being accused of selling out their Treaty rights (FN03). Government participants were also aware of these

concerns. For example, a provincial participant acknowledged how it can be perceived as jeopardizing the responsibilities of the federal government:

> There has to be an acknowledgment of the development of the Treaties and what those Treaties mean for communities and how working with the province might, from their perspective, jeopardize the responsibilities of the federal government to those Treaties [and] to fulfill those Treaty rights. (AH02)

A federal participant also shared her understanding of these concerns:

> Some [First Nations] might hold very firm that they don't even want to have a conversation with the province, because they feel like the province compromises their Treaty Right to Health. They really feel that the federal government represents the Crown and that special relationship with the Crown through Treaty. (HC03)

Beyond the limited prevailing norms to collaboration with the provincial government, participants offered additional concerns. First, concerns were raised by a First Nation participant in regards to the poor track record of the provincial government as a partner (FN06, FN15). A First Nation participant involved in a number of initiatives with the provincial government shared that "the province doesn't have a good history of inclusion of First Nations people or First Nations organizations in their delivery model systems" (FN06). Second, some participants shared their frustration and skepticism as they questioned the commitment of the provincial government. For example, a First Nation participant said: "We're all Albertans at election time, but once the election is over, then all of a sudden we're referred back to being First Nations again, and the province doesn't want to come on reserve and help us out" (FN06). A second First

Nation participant shared a similar concern within the context of the Joint Action Health Plan, as he found the more senior provincial officials "kind of reluctant to enter into any agreement" (FN02). If some First Nations participants doubted the commitment of the provincial government, a provincial participant also shared concerns "that they (First Nations leaders and technicians) may not see the value of Alberta Health Services or even the province… in the discussion" (AHS01) referring to the observer status of AHS at the Health Co-Management Committee meetings.

Third, both through the interviews and as a participant in the process, I heard questions from participants in terms of financial contributions by the provincial government to the Joint Action Health Plan process. While both Alberta Health and Alberta Health Services provide in-kind support in terms of assigning staff to the Joint Action Health Plan Working Group as well as to some of the activities, no additional provincial resources have been identified as of August 2017. One First Nation participant referred to the request of one of the federal members of the Joint Action Health Plan Steering Committee for a financial contribution from the province by saying "it would be nice if Alberta Health and Alberta Health Services would commit some funds to this working group process… If you're going to be there, be part of it" (FN02). In terms of funding, provincial participants also shared a number of concerns. A provincial participant shared that "from an attitude perspective, there's genuine commitment, and we're ready. From a funding perspective, we're in very challenging economic times" (AH03). She further outlined that "if we put forward the right proposal that aligns with what we're trying to achieve and shows meaningful work to be done, I'm confident – I won't do the strongly confident – but I'm confident that we'd get support for it" (AH03).

Further, some participants from Alberta Health and Alberta Health Services shared that their funding is applicable to all Albertans and to provide more targeted funding could be challenging (AH03, AHS02). One of these participants identified that the ability to look at this from an equity lens may be useful:

> We look after all Albertans. If you kind of underpin that thinking with a principle of equity, you then are pulled in the direction of really focusing on how to address all the inequity that is in Indigenous communities without using, we look after all Albertans, as an excuse to not do that. (AHS02)

While participants identified numerous concerns in terms of the legitimacy of the provincial partners, a number of First Nations participants outlined the importance of their participation (FN03, FN08). A First Nation participant shared "we cannot address health without the province being at the table" (FN03). While acknowledging First Nations perceptions that working with the provincial system may result in ignoring or not acknowledging the Treaty rights, a First Nation participant said "I think for us it's the opposite. We make it very clear from the get-go that relationship, that understanding, it's in our MOUs" (FN08). Further, he said "even though we've engaged the province we're still respectful and mindful of the Treaty Right to Health. That still exists and that's still our position. But that doesn't mean we're not involved with the province" (FN08). He was not alone in sharing these views as another First Nation participant described these partnerships as Treaty implementation (FN03). In describing these relationships, he described his experience with the provincial government in regards to Treaty rights as being more positive than with the federal governments:

> So it's about respecting those Treaty rights, not about ignoring them. And I find with the province in particular, of course they're open to that relationship. As opposed to the federal government at times they ignored that Treaty right. They won't acknowledge it, that it exists. (FN08)

At a more operational level, a number of First Nations participants perceived increased willingness of Alberta Health Services to work with First Nations organizations and governments. A First Nation participant said "Alberta Health Services now is ready to engage with us" (FN13) while another referred to the excitement of AHS workers "to see things change" (FN14). Another First Nation participant, a long-serving First Nation health director, highlighted his increased work with the provincial government saying "it's strange, because when I first came in [as Health Director]; I did all of my work with MSB (Medical Services Branch predecessor to FNIHB) and Health Canada. And now maybe 10 percent of my work is with Health Canada and 90 percent is with the province" (FN08). Alberta Health Services participants agreed that they can play a part. A participant shared that "AHS has the service delivery mandate so we have to be there" (AHS02). Another AHS participant signalled the importance of AHS Indigenous Health Program to be "a strong voice that isn't afraid to be political and isn't afraid to bring issues to the forefront that say, hey, there's a responsibility here for a service provider to address and look at First Nations health issues" (AHS01). However, even amongst the First Nations participants supporting provincial involvement at least one questioned the role of AHS in the discussions considering their more programmatic role and their status as a service delivery agency rather than a "political body" (FN02). An Alberta Health Services participant believed that her organization should participate but said

"Alberta Health Services should only be at the table because they're mandated by Alberta Health to deliver, and if they're mandated they need to be given the money to make it happen" (AHS03).

Finally, provincial participants identified higher level of support for engaging with First Nations Peoples as a result of the 2015 election. One of the provincial participants highlighted the Premier's commitment to renewed relationships with Indigenous peoples and believed that the Joint Action Health Plan is an important element of this new approach (AH03). A second provincial participant highlighted the new government's platform and the potential to have more community-based approaches:

> The provincial government's objectives, because they have a platform that's very specific, and it's very community-based, and they want to do home care, and they want to do long-term care, and they want to do addictions, mental health as priorities, and… in the sense, if you look at it from a Truth and Reconciliation lens, we still have Indigenous communities that have to move their Elders out of the community to get care at a certain point as they age. Well, that's heartbreaking. And, and, so looking at the priorities of this provincial government and what may be some of the interests of those communities and trying to find ways that we can come together to address that could just be so exciting and so beneficial on both sides. (AH01)

Therefore, using Gray's understanding of legitimacy, there is no clear consensus amongst participants around the legitimacy of the provincial partners. Some participants believed that it was crucial to have both Alberta Health and Alberta Health Services involved but some questioned if either or both of them are required. Further, while some

saw their involvement in the context of implementation of the Treaty Right to Health others saw it as having the potential to jeopardize it. At a more operational level, there is an increased recognition of the provincial role in health care but without dedicated funding the provincial commitment is questioned even by some of its advocates. This limited legitimacy has an impact on both the preconditions and processes for collaboration.

Relationships between federal and provincial governments. The further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta must also take into account the context of relationships between federal and provincial governments. While health care is identified as a provincial jurisdiction, the federal government is also an active player in this field – through the Canada Health Act and its contribution through the Canada Health Transfer. Further, it is a funder and provider of health programs and services to First Nations individuals, organizations and governments through Health Canada`s First Nations and Inuit Health Branch.

A provincial participant acknowledged some of the barriers to collaboration by identifying the context of federal and provincial relationships and more specifically the issue of financial responsibility:

> On the provincial side, I think the barriers are, well, the federal government has to fund some of this. You have to work out funding relationships, because if the Province just goes in and funds, then the feds will just back out, and that [there] will be floodgates, and we won't be able to afford it – there are so many fears. We're so driven by fear and fear to make a commitment, and part of it's been a

> litigious environment. And you get lawyers at the table, and everyone is afraid to say anything or make that commitment, and so instead of having collaborative, trusting, respectful conversations, you actually have very guarded and very interest-driven discussions. (AH01)

Based on existing literature, the sentiment expressed by this provincial official is neither new nor limited to Alberta as Blackfoot scholar Leroy Little Bear and his colleagues wrote the following in 1992:

> Although the Constitution permits the provincial governments to extend any services to Indians that the federal government allows (and the federal government has been extremely permissive in this regard), all provinces are uniformly reluctant to accept financial responsibility for services to Indians within their boundaries. In part this explains why Indian bands are still outside the bulk of provincial programs. (Little Bear et al., 1992, p. xiii)

As part of the interview she noted that fear should not be the driving force but rather that we "should go out there and try to improve outcomes and do it on a collaborative basis, because we can't do it without working together" (AH01).

As mentioned previously, the Joint Action Health Plan was developed and endorsed by both federal and provincial governments in February 2015 prior to the federal and provincial elections. Federal and provincial participants signalled the 2015 elections and commitments made by current federal and provincial government for renewed relationships with Indigenous Peoples as well as implementation of the United Nations Declaration on the Rights of Indigenous Peoples and calls to action from the Truth and Reconciliation Commission as promising for furthering collaboration. A

federal participant highlighted similarities between the new federal and provincial governments:

> We're at a good time in Alberta in terms of provincially and federally. We both seemingly have some common vision, some common commitments, similar mandates in a lot of ways. Both recognize that we need to do better in terms of First Nation health outcomes, we've done poorly as a health system, and there's some efficiencies to be gained but also ways of delivering the service better. (HC02)

She tempered her optimism in terms of similar agendas by referring to the size of the respective partners:

> I believe the province is wanting to work with, but we're a small partner in the big scope of things. We're a small player in terms of health, and, you know, money, really. They won't be distracted by their mandate and what their deliverables and big commitments are, so they'll play, but we're not top and centre for them, but they'll play nice. (HC02)

A federal participant referred to the new governments and the need to better understand their relationships especially within the context of the Health Accord negotiations (HC01). Since the interviews were completed, the negotiations of a national Health Accord were replaced with negotiations of a series of provincial Health Accords. The government of Alberta agreed to its bilateral accord in March 2017 (Health Canada, 2017).

A provincial participant expressed confidence to support this work but highlighted government cycles and stressed the importance of timeliness and the need to accomplish

as much as possible within the next 12 to 18 months which would have been from winter 2016 to spring 2017 (AH03). This was echoed by a First Nation participant:

> But right now it's beautiful timing. New fed, Liberal government's out there. They're like, Get stuff done, and, Here's some money; it's not all of it, but here's some. And, you know, people seem to be in the right places at the right time. If we do not jump on this opportunity and time frame, our battle will be a lot longer. (FN14)

A federal participant highlighted the federal role as a funder with responsibility to encourage a dialogue between First Nations, federal and provincial governments signaling the need to draw in both the First Nations and provincial governments (HC03). Therefore, using Gray's (1985) definition of legitimacy both federal and provincial governments perceived each other's right and capacity to be at the table but do not necessarily agree on what they should each contribute and highlighted the need to take into account the broader context of federal and provincial relationships.

Convenor Characteristics

Amongst the key preconditions identified by Gray (1985) are the convenor characteristics which she defined as "who initiates collaborative problem solving has a critical impact on its success or failure" (Gray, 1985, p.923). While Gray stressed the importance of a skilled convenor, this is not apparent from the input received from participants. This may reflect that not one person has played this role. Using collaboration literature, the convenor may be perceived as the FNIHB Assistant Deputy Minister, Regional Operations who invited partners to participate in September 2015. Yet, as a participant I am aware that this letter was jointly drafted with the partners. Over

the years, our group has used a number of approaches. The last few meetings of the HSIF Exploring Partnerships Steering Committee that preceded the creation of the Joint Action Health Plan Steering Committee were facilitated by an external facilitator. Meetings of the Joint Action Health Plan Steering Committee and Working Group are coordinated by one of the First Nations partnering organizations who uses both internal and external resources to facilitate the discussions. The Joint Action Health Plan Working Group is co-chaired by a First Nation representative and a government representative who are supported by a coordinating team whose members have regularly acted as facilitators at meetings. Since 2015, Elders participate in our discussions and their key role in facilitating our discussions was identified by a number of participants (FN03, FN11, FN13). Finally, some First Nations participants highlighted the participation of First Nations individuals they perceive as influential (FN08, FN15) in the Joint Action Health Plan Working Group and how that contributes to the strength of the group. In other words, there is no consensus amongst participants on a convenor and his or her roles and responsibilities.

Shared Access and Power

Management literature on collaboration often refers to the importance of power and its distribution amongst partnering organizations (Foster-Fishman et al., 2001; B. Gray, 1985; Mayo, 1997). A provincial participant highlighted the need to acknowledge power imbalances and the danger of not doing so:

> I think that in trying to work together without acknowledging the history and acknowledging that those imbalances of power exist, there is the potential for us to not [be] walking in the same direction as we try to move forward. (AH02)

A number of First Nations participants outlined the existence of power relationships (FN01, FN11). A First Nation participant referred to parental approaches by the federal government towards both provincial and First Nations governments highlighting the need to level the playing field:

> And considering that the province is basically a child of the government, as a parent, there's a parental kind of approach towards First Nations as well, they do that with the province in terms of what they can and cannot do in order to receive funding. It's the same with First Nations. And the relationship and the partnership because of that historical kind of approach, top-down approach, is still alive and well today. Until we reach that common ground, it's going to remain that way. (FN03)

A second First Nation participant highlighted the importance of information and how it has been used to support power imbalances between First Nations Peoples and governments:

> We don't understand the significance of the power of information. And we don't understand that since time of contact and since before contact that Western thinkers have been driven, their data have driven policy, policy change and policy development. We haven't quite grasped that concept because data have not been available to us it's only been taken from us and what we have perceived as being used against us. (FN01)

Wood and Gray (1991) identified preconditions as the first of three phases to collaboration and they outlined that "the preconditions … make a collaboration possible and… motivate stakeholders to participate" (Gray & Wood, 1991). Using this definition

and the key elements identified by Gray within the preconditions phase, I documented a number of challenges as First Nations of Treaty No. 6, No. 7 and No. 8, Alberta Health, Alberta Health Services and FNIHB-AB are seeking to further develop and implement the Joint Action Plan to Improve the Health of First Nations in Alberta. The preconditions to collaboration also have an impact on the next stages of collaboration – processes and outcomes.

Processes: The Second Phase of Collaboration

As a practitioner and researcher, I believe in the importance of working together and I have hands-on experience in terms of collaboration between First Nations, federal and provincial governments. With this section, I seek to weave together existing literature and participants' input on the second phase of collaboration – processes. Earlier, I indicated that literature on collaboration often tends to define processes in fairly broad strokes. For example, one author referred to this phase as the black box of collaboration (Fleisher, 1991). Gray (1985) defined it a bit more as she identified two elements within processes: coincidence of values and dispersion of power amongst stakeholders. Wood and Gray (1991) added a few more elements including: institutionalization of roundtables; explicit and voluntary membership; joint decision-making; agreed-upon rules; and, interactive process including temporary structure. This information is certainly important however as I sought more information on the second phase of collaboration, I appreciated the concrete approach proposed by Foster-Fishman and her colleagues on collaborative capacity including their suggestions to enhance collaborative capacity. In writing this section, I opted to anchor the participants' input based on the more concrete work of Foster-Fishman and her colleagues using the four

elements of collaborative capacity: member capacity, relational capacity, organizational capacity and programmatic capacity.

Member Capacity

Foster-Fishman and her colleagues described participants in a collaborative process as its primary asset. They further defined member capacity as the skills, attitudes and knowledge required of the individual participants to support the collaborative process (Foster-Fishman et al., 2001). As part of the interviews, I asked participants to identify the skills, attitudes and knowledge that participants bring to the table. Before answering this question, two of the participants indicated that attitude is more important than skills and knowledge (FN04, HC02) and one participant said that attitude is key (FN03). Two participants outlined the importance for the membership to include individuals with diverse experience, skills, attitude and knowledge:

> So the more diverse we are -- and I'm not just talking about skills, knowledge, and experience. I'm also talking about in terms of perspective. The more rounded we are, the better off we are. (AH04)

> It's quite the table. Different backgrounds, different ethnicities. So in that regard, I think that variation plays a positive part. Each one has their own work experience and life skills, different knowledge bases, different attitudes as well. You're hitting issues from different angles a lot of times and I think that's a good thing. (FN15)

Core Skills and Knowledge. In their article on collaborative capacity, Foster-Fishman and her colleagues identified three broad categories of core skills and knowledge: "ability to work collaboratively with others; ability to create and build

effective programs; [and,] ability to build an effective coalition infrastructure" (Foster-Fishman et al., 2001, p. 244).

Ability to work collaboratively with others. Foster-Fishman and her colleagues identified four key elements in terms of ability to work collaboratively with others. They identified two skills: effective communications and conflict resolution. A number of participants highlighted the importance of communications skills. For example, a provincial participant said: "the main skill set to fulfill all of this that's necessary is communication, broadly, because I think that none of this could be fulfilled if there were major challenges in communication" (AH02). Another provincial participant indicated that stating the need for effective communications is not sufficient as she asked "Meaning what, right? So let's not only define that; let's actually unpack that behaviourally" (AHS03). Linked to communications, some participants highlighted the importance of listening skills. For example, a First Nation Elder shared that "we have that capability to listen" highlighting that we have two ears and one mouth and therefore should use our ears twice as much (FN07). Three provincial participants referred to the need to listen referring to the need to "listen, learn and then share" (AHS01); the importance "to be able to hear what each other is communicating and the messages that are there" (AH03) and "the ability to listen, the ability to respond thoughtfully and carefully and respectfully" (AH04). Further, participants identified the need to tailor communications to audiences (FN11, FN13). A First Nation participant reflected on communications at our joint meetings by saying "I think the language at the table has to be so that everybody understands clearly, that there are no ambiguities with the language" (FN11). While a First Nation participant highlighted her experience as a health director and the need to

know how to communicate with community members, with leadership and with health care professionals, she also highlighted the importance of soliciting advice from Elders and to use words that resonate with their experience and knowledge (FN13). In their model Foster-Fishman and her colleagues only included conflict resolution skills within this section, but participants identified both conflict resolution (FN02) and negotiating skills (FN05). Another First Nation participant shared how she used her negotiating skills to find common ground between health care providers and the funders to better meet the needs of her community (FN13).

Foster-Fishman and her colleagues identified two knowledge components: knowledge of the norms and perspectives of other members; and, broad understanding of the problem domain (Foster-Fishman et al., 2001). These two knowledge components represent elements of the collaboration definition written by Gray (1985). As I used this definition to anchor my research, I demonstrated earlier how participants understood these concepts as elements of collaboration. In this section, I build on the work of Foster-Fishman and her colleagues to share the participants understanding of the knowledge required.

In terms of knowledge, a number of participants highlighted the need for broad-based knowledge (HC02, FN05, AHS03). Participants further defined four key elements of knowledge required to work collaboratively including: cultural understanding; understanding of health from a First Nations perspective; context of relationships between First Nations, federal and provincial governments; and, health systems in Alberta. The first of these elements is the need for cultural understanding which includes respect from non-Indigenous participants towards First Nations cultures and worldviews

and First Nations participants who are culturally based. A First Nation participant described this need for cultural understanding as she outlined the need for cultural brokers, individuals that provide "your connection between community, leadership [and] government" (FN01) while another First Nation described it as follows:

> You need somebody that is culturally based as well. Although we talk about the fact that we want to work with you, but understand my culture first. You need that kind of people in the room. Not preaching it, but just respecting it. Also knows how to respect other people's culture. (FN05)

The second element is closely linked to cultural understanding as it is the need to understand health from a First Nation perspective (AHS01, FN12). A First Nation participant emphasized the need to involve Indigenous health care providers to support that greater understanding of health from a First Nation perspective as well to develop trust:

> You should have people who comprehend the languages and the traditional values. There should be a doctor like [identifies a First Nation physician practicing in Alberta], who studied medicine. You got to have them, because we're talking about trust. We don't trust the mainstream society doctor. We see it as a commerce, so we need to find a way to dissect it, to take it apart, to take apart the system. (FN12)

The third element is a broad understanding of First Nations health issues including health status of First Nations and priorities in regards to health care (FN02, HC02, AHS03, AH04) as well as the context of relationships between First Nations, federal and provincial governments and First Nations understanding of the Treaty Right

to Health (AH01, FN02, AHS01, AHS03, HC01). A First Nation participant shared that "they should have some sort of historical background of where health was and how it's evolved to where it is today. They should know that. And they should have an outlook of what the future looks like" (FN02). While a provincial participant outlined that only once we have a more common understanding can we move forward:

> Within a lot of communities and community tables, there's going to be very strong vocal attitudes towards the government that just need to be heard and listened to. Treaty Right to Health today is, look what your government did to us, and all that kind of stuff. And once that's all done, we can move forward and develop a good relationship and start working together. (AHS01).

The fourth element is the need to understand the health systems and the mandate of the partners in Alberta (FN03, HC02, AHS03, FN11). A First Nation participant said "they need to understand the health systems. They need to understand the governance systems, structures" (FN03). A First Nation participant identified the need "to be educated on the different health care programs that are available on-reserve and… all the health care system off the reserve" (FN11). This was also identified by a provincial participant:

> There needs to be a strong knowledge about what is AHS, what's its role, how does it work? I think with FNIHB, same kind of thing. What's your plans, and what is Alberta Health's role? And not just at a high level with the Chiefs… I think that [applies to] everybody through the project. There needs to be good role clarity. (AHS03)

Foster-Fishman and her colleagues identified as a second element of ability to work effectively with others, knowledge of the norms and perspectives of other members which connects with Gray's definition of collaboration (1985). Participants went further as they signalled the need to understand both the norms and perspectives of their respective organizations and of their partnering organizations. Referring to the first part, a provincial participant highlighted the need to know one's organization's perspective and, if not, having the ability to acquire that knowledge (AH03). As some First Nations participants do not solely reflect the views of one organization but rather the views of a number of organizations, some participants highlighted the need to constantly gather and share information (FN05, FN10). More will be provided on this within relational capacity as it referred to the sometimes thin institutionalization of some of the partnering organizations. Highlighting some of the trust concerns brought forward as part of the preconditions, a First Nation participant shared his concerns that the ultimate goals of the federal and provincial partners have not been shared:

> Knowledge would be nice. If we actually knew what the ultimate goals of both the federal and the provincial governments are. If they're serious about delivering health services. (FN06)

Participants also identified the need to better understand the decision-making process of the partnering organizations. In referring to FNIHB-AB and AHS, a First Nation participant shared "We don't know your guys' internal structure, but all we know is it changes a lot, right?" (FN14) and another First Nation highlighted the compartmentalization of AHS and how people they thought of as decision-makers were not (FN04).

In summary, participants shared their limited understanding of the decision-making process of the partnering organizations as well as challenges in ensuring that they reflected the norms and perspectives of their organizations. More information on these topics is provided in the organizational capacity section.

Ability to create and build effective programs. Within this category, Foster-Fishman and her colleagues included more targeted knowledge which they identified as: understanding targeted problem or intervention; and, understanding target community (Foster-Fishman et al., 2001). Considering the list of knowledge requirements identified above one may argue that some of this knowledge may be better identified as targeted, yet as a participant in this process I agree with my colleagues who referred to the need for broad-based knowledge (HC02, FN05, AHS03). As the initiative develops, more targeted knowledge may be identified but nothing beyond what I have already included was identified by participants within this category.

In terms of skills, Foster-Fishman and her colleagues included "policy, politics and community change [as well as] grant writing and program planning, design, implementation and evaluation" (Foster-Fishman et al., 2001, p. 244). For the first element, "policy, politics and community change", provincial participants identified a number of elements to be considered. The first provincial participant identified the need for having skilled technicians:

> We need to have people who are… good at process and of being able to engage the people who are at the table in generating the ideas, understanding the strategic directions to take, and then beginning to translate them into projects, activities, and so on that are going to support it. (AHS02).

Building on the previous comment, another provincial participant shared:

> You don't just need someone there because of their title. You need someone there because they have an understanding and they work in the area of Indigenous health and they're able to help the conversation progress. So they need to know government objectives. They need to know health system objectives. They need to know some of the how. If we don't have anyone at the table that has that expertise or ideas we might stall. (AH01)

Connecting with the requirements for "program planning, design, implementation and evaluation" skills (Foster-Fishman et al., 2001, p. 244) a provincial participant identified the need for "skills in project planning and project implementation" (AHS03).

Ability to build an effective coalition infrastructure. Foster-Fishman and her colleagues identified within the ability to build an effective coalition infrastructure skills "in coalition/group development [and] knowledge about coalition member roles/responsibilities committee work" (Foster-Fishman et al., 2001, p. 244). Participants did not refer to coalition and group development but highlighted the importance of understanding the roles and responsibilities of members. A First Nation participant emphasized the importance of members being able to speak on behalf of the group as well as advocate for approval within their own organization which she summarized as the ability to "influence others when need be" (FN03). Some participants signalled the need for more technical skills including ability to provide presentations, reports and briefings (FN03), as well as literacy and computer skills (HC02).

Core Attitudes Motivation. In their article on collaborative capacity, Foster-Fishman and her colleagues (2001) identified within *core attitudes motivation*

commitment to target issue or program. They also identified three levels of positive attitudes: positive attitudes towards the collaborative endeavour; positive attitudes towards the other stakeholders; and, positive attitudes about self as a legitimate and capable partner (Foster-Fishman et al., 2001). Prior to using the categories provided by Foster-Fishman and her colleagues, I believe it is essential to include within core attitude motivation, a statement from a federal participant who stressed the importance to acknowledge the Treaty relationship:

> I think they have to obviously come from a place where they believe in the spirit and intent of the Treaty relationship, because if you don't respect that, then First Nations will never trust you, because they'll feel that there's that lack of respect or recognition. So you have to believe it. (HC01)

Commitment to target issue or program. Foster-Fishman and her colleagues included within core attitudes motivation a commitment to target issue or program. Participants outline commitment both at the personal level as well as the organizational level. A First Nation participant shared "We don't have an exit strategy, we're in this for life – we're always going to be committed to the betterment of our people" (FN01). A provincial participant summarised her commitment by saying "I feel all in" (AH02) while another more senior provincial participant shared "I know the staff that we have, I'm quite confident that they have a sensitivity and a commitment to improving health outcomes and to serving in a public service sense and that they really want positive outcomes, that they're very motivated that way" (AH01). In terms of organizational commitment, a provincial participant whom I interviewed as part of the second round of interviews outlined Alberta Health's commitment by saying the following:

> I know that Alberta Health is behind this. Can I say that they were always behind it? No, I think that there were questions even earlier this year about the process. Was it working? Was it the most effective way? It's a reality. I mean, you need to weigh out what value and what merit any opportunity brings to the table. Is this the most effective way for us to get involved? And I believe that was a question. But now, certainly I can, without a doubt, say that I know that the organization is behind us, is behind me, is supporting that what I'm saying isn't just representing me. It's representing the organization. (AH04)

Positive attitudes towards collaboration. A number of participants referred to what Foster-Fishman and her colleagues labelled as positive attitudes towards collaboration which includes: "commitment to collaboration as an idea; views current systems/efforts as inadequate; believes collaboration will be productive, worthwhile, [and will] achieve goals; believes collaboration will serve own interests; [and], believes benefits of collaboration will offset costs" (Foster-Fishman et al., 2001, p. 244). First, in terms of commitment to collaboration as an idea, a provincial participant used similar words as she referred to the need for a commitment to collaboration (AH03) while a federal participant identified "openness and a willingness to work together" (HC03). A federal participant also identified the importance "to come with an open mind, a willingness to be partners, a respect for diversity, a true wanting to advance and contribute" (HC02). Second, in terms of viewing the current systems and/or efforts as inadequate, many participants identified concerns regarding health outcomes of First Nations (AH01, AH02, AH03, AH04, AHS02, AHS03, FN01, FN02, HC01. HC02, HC03), as well as fair and equal access to health services (FN02). A provincial colleague

also referred to this as the need for self-reflection not only at the personal level but also at the organizational level as she shared "self-reflection, not just as an individual, but as a representative of an organization, acknowledging where mistakes have been made in the past and being open to addressing those so that they don't happen in the future" (AH02). Third, participants tended to be more ambivalent in terms of believing that the collaboration will be productive, worthwhile and will achieve goals. They acknowledged the potential for collaboration and this was shared earlier as I outlined the participants' expectations of positive outcomes including: greater engagement of First Nations, better health outcomes, better health care and others. However, participants also shared the challenges in meeting the preconditions to collaboration and how some of the prevailing norms would not be supportive of enhanced collaboration between First Nations, federal and provincial governments. Foster-Fishman and her colleagues offered that collaboration should outweigh costs and serve the interests of partners. A First Nation participant shared her experience at building partnerships by saying that both parties have to benefit and she flagged that partners "always had to see some benefit to themselves" (FN13).

Positive attitudes towards the other stakeholders. Foster-Fishman and her colleagues included within positive attitudes about other stakeholders: "views others as legitimate, capable, and experienced; respects different perspectives; appreciates interdependencies; [and], trusts other stakeholders" (Foster-Fishman et al., 2001, p. 244). In terms of the first element viewing others as legitimate, capable and experienced partners, some participants shared positive perceptions of the partners around the table. For example, a provincial participant indicated her warm feelings towards one of her First

Nation colleagues and her organization and how it encourages her to do her best to move forward the collaborative work:

> I feel privileged to be learning from her all the time, and in some ways I feel guilty about it, because I'm not sure that she's getting as much out of the relationship as I am. I feel like I'm constantly learning from her, and I feel so fortunate to be in that position. I have a lot of respect for her and respect for the organization and what they're hoping to achieve, and I want to do everything in my power to help them fulfill their goals. And I think perhaps because of that I feel that we've been open to building things that are very positive, and I feel very optimistic about how we might be able to work together in the future. (AH02).

The second element identified by Foster-Fishman is respect for different perspectives. Respect was mentioned by many participants and within a number of contexts. A First Nation participant identified the "need to bring a level of respect and acknowledgment to the wisdom and knowledge that each individual actually brings to the table" (FN03). Respect is further mentioned as a core value of Indigenous peoples by two participants (FN03, FN07). Participants identified a number of additional core values including: respect for diversity (HC02), patience (AH03), and sincerity (HC03). Linked to these two elements is the perception shared by a First Nation participant that racism and discrimination also occurred at our joint meetings (FN03). This would not contribute to the development of positive attitudes towards other stakeholders and would require efforts to eradicate racism and discrimination amongst partners.

A number of participants referred to the third element identified by Foster-Fishman and her colleagues, appreciating interdependencies, as participants flagged the need for

optimism and openness (AH03) which a federal participant further described as the need to come in "with an open mind and ready to learn and contribute" (HC02). Another federal participant identified the need for a "very, very open mindset of all of the art of the possible" (HC01) which led her to outline the need to think outside the box which is also signalled by a First Nation participant (FN02). Another participant identified the need for advocacy (FN03). A First Nation participant acknowledged the progress made in the last ten years in terms of establishing better relationships with provincial and federal agencies but also identified the need to do more: "I would be more willing to form partnerships that's what I consider the provincial and the federal governments, as partners, [rather] than… adversaries. There's a place for politics, and it's not in the planning of health care" (FN11).

Foster-Fishman and her colleagues identified a fourth element – the need to trust other stakeholders. Based on the information provided in the preconditions, there are serious concerns regarding trust and more information will be provided on this within relational capacity. At the member capacity level, participants identified the need to relate with each other at the personal level. A First Nation participant described it as the need to "check your guns at the door" and to come in ready to work together (FN05). While a federal participant said: "we need to leave everything at the door and come from a place of sincerity and come from a place of vision". Linking with the work of Foster-Fishman and her colleagues a number of participants shared the need to view others as legitimate, capable and experienced partners. A provincial participant described it as follows:

> If I had to name anything, it is the ability to look beyond. It is the ability to be able to see us, each one of us, as individuals that are invested and that each one of us values the overall process and what it can become and what can come out of it. (AH04)

A First Nation participant signalled the need for compassion recognizing that the participants may be dealing with a number of issues that affects their participation at the table:

> Compassion for the individual, because you don't know what that individual is going through that's sitting at that table, taking time out of whatever may be going on, and understanding that they are there as a committed player. So there has to be a level of compassion for that individual as well, because you don't know. You really don't know what's going on in their lives. Sometimes people forget to be human, and understanding individuals and where they come from and what they're going through. (FN03)

Positive attitudes about self as a legitimate partner. Foster-Fishman and her colleagues included within core attitudes motivation positive attitudes about self as a legitimate partner which they defined as follows: "views self as legitimate and capable member [and] recognizes innate experience and knowledge bases" (Foster-Fishman et al., 2001, p. 244). In terms of viewing self as a legitimate and capable partner, a First Nation participant said "we have a voice, and we want to speak on our own behalf" (FN03). Further, many participants identified the knowledge and expertise of participants (AH01, FN03, FN15) and its importance for our work. However, not all participants described

themselves as positively. A First Nation participant shared that he thought that not everyone approaches this work with a positive attitude:

> We've got real attitudes in our community. We have real attitudes in our organizations as well. And those are a culture that's been built, because you have to fight for everything you have and it's a culture built within our organizations. You've – we've had to fight and compete for every darn bit you want. (FN05)

And, some non-Indigenous government participants identified the need for continuous learning identifying as priorities: cultural awareness and sensitivity as well as understanding of the broader context of relationships between First Nations Peoples and Settler society in Canada (AH03, AHS03).

Relational Capacity

Relational capacity refers to how participants and organizations relate within the context of the collaborative process. Foster-Fishman and her colleagues identified five components to relational capacity including: developing a positive working climate; developing a shared vision; promoting power sharing; valuing diversity; and, developing positive external relationships (Foster-Fishman et al., 2001). Prior to using these categories to group the participants' input and its link with existing literature, I provide a higher level picture reflecting the work of the Elders' Advisory in supporting the development of an ethical space at the Joint Action Health Plan Working Group. At the Working Group level, this work has been spearheaded by Danika Littlechild and Reg Crowshoe who facilitated a number of working sessions and developed a presentation to support our work (Crowshoe & Littlechild, 2017). Cree scholar Willie Ermine defined ethical space as follows:

> The "ethical space" is formed when two societies, with disparate worldviews, are poised to engage each other. It is the thought about diverse societies and the space in between them that contributes to the development of a framework for dialogue between human communities. The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous peoples and Western society in the pursuit of a relevant discussion on Indigenous legal issues and particularly to the fragile intersection of Indigenous law and Canadian legal systems. (Ermine, 2007, p. 193)

Within an ethical space, participants are asked to recognize that "all knowledge systems are equal, with no one system having more weight or legitimacy than another" (Crowshoe & Littlechild, 2017, p. 5). Blackfoot Elder Reg Crowshoe and Cree lawyer Danika Littlechild identified as principles of ethical space: mutual respect; generosity and fairness; kindness; good faith; sharing; basic right to health; and, Treaty Right to Health (Crowshoe & Littlechild, 2017).

Developing a positive working climate. There is limited consensus amongst participants on the current working climate as impressions range from positive to negative. Foster-Fishman and her colleagues flagged the importance of both creating positive internal and external relationships, in assessing the working climate participants referred to both the context of the Joint Action Health Plan as well as the broader context of relationships between First Nations, federal and provincial governments.

In terms of relationships between participants and participating organizations, some participants (AHS03, FN15) described a positive working climate between participants said "I think we work well together. I think we have good working

relationships" (AHS03) while another said "I feel good about the energy that's around those tables" (FN15). A few provincial participants indicated that they have seen growth in the development of positive working relationships (AHS02, AH04). Some participants outlined a more mixed response as a First Nation participant said "the working climate can be good sometimes and very poor other times" (FN03). And a participant outlined a more negative working climate as she shared what she heard in terms of distrust and questioning of the agenda or ulterior motives of government partners (FN10). During the course of the interviews, some participants referred to behaviours they thought did not contribute to a positive working climate including: absence at meetings, positional approaches, limited information sharing, limited engagement in discussions, objecting and refusing to engage and limited congruence between technicians and political leaders. Further, a participant shared concerns regarding an engagement session between Alberta Health and First Nations participants held at the end of a Joint Action Health Plan Working Group meeting (AP22). The engagement session was scheduled to leverage the participation of a number of First Nations individuals at an already existing meeting; however, this juxtaposition was identified as problematic by a number of First Nations participants within the Joint Action Health Plan Working Group. A First Nation participant shared her experience:

> We weren't aware of what we were participating in, and so I think there you saw a lot of uncomfortableness on are we allowed to be talking like this? Are we allowed to be participating? Because if we participate, then does that mean that we agree? (FN13).

The working climate is not only impacted by the behaviours of participants within the context of the Joint Action Health Plan. As a First Nation participant also referred to concerns of trust related to past experiences:

> Everybody answers to somebody I think there is more commitment now than there was three years ago. The trust is very hesitant on the ups [referring to higher level leaders in our respective organizations]. When it comes to the Chiefs, I can understand why the trust is hesitant, because agencies have been burnt before. First Nations have been burned before. AHS and Health Canada have been cut by the throat from time to time, too. (FN14)

More broadly and taking into account the external relationships that Foster-Fishman and her colleagues identified, many participants referred to the newly elected federal and provincial governments and their commitment to renewed relationships with Indigenous Peoples including implementation of the United Nations Declaration on the Rights of Indigenous Peoples and calls to action from the Truth and Reconciliation Commission. Participants described this new context by saying that they are "hopeful but careful" (FN06) or "cautiously optimistic" (HC02). In describing himself as hopeful, a First Nation participant who was interviewed after the 2015 federal and provincial elections indicated:

> I think there's a lot of distrust. There's a lot of good intentions. However, we'll see. We'll call it hopeful… the answers based on the previous federal government are going to be a lot different from the answers with the current federal government and a lot more hopeful. However, I'm still not 100 percent sold on the whole idea of change. (FN06)

Some of the concerns expressed by the participants related to the existing funding relationships between First Nations and federal governments as a First Nation participant said:

> This idea that money can be held back all year long until March 1st, and then there's a big immediate rush to spend all this money in February and March when I could have used that money in September. So how does that help a trusting relationship when I know I'm getting denied from April to December I keep getting denied, denied, denied, when I know come February, March, money is going to flow, and you better spend it quick. (FN06)

Trust. Foster-Fishman and her colleagues described a positive working climate as being cohesive, cooperative, trusting, open and honest as well as being able to effectively handle conflict (Foster-Fishman et al., 2001, p. 244). Considering the importance of trust within the preconditions, it is not surprising that participants would speak of limited trust, lack of trust, distrust and mistrust. In describing the level of trust, participants referred to both trust at the personal and organizational levels. A provincial participant signalled the importance of both personal and systemic experiences in developing trust as she said:

> It doesn't just happen overnight… You start on an open mind and expect that others will follow through. But we're also working on things that have a long history of relationships and experiences between governments and First Nations, and so when I think about trust, I also think, again, this is one area that can't help but be influenced by either individual or systemic experiences. (AH03)

At a personal level, a First Nation participant described the level of trust as it "comes and goes… There is no continuity of players at the table. They change, so that

trust always has to be built" (FN03). One of the provincial participants who stepped in and out of the process also flagged how her earlier departure and return impacted her ability to establish and maintain relationships (AH03). A provincial participant emphasized the importance of having a personal level of trust as she outlined the need to believe in the goodness of the people and their intentions (AHS03) while another participant stressed that without personal trust organizational trust is meaningless (AH04). Another provincial participant spokes of the current level of trust and its fragile state:

> We have achieved a modicum of trust and commitment, and by "modicum" I mean that we are in the sphere of trust and commitment whereby what we're doing is impacting our ability to trust and our ability to commit, and in turn, as a return, our offering of trust and our commitment is impacting our overall ability to collaborate, and each one of those is growing. But the reason I use the word "modicum" is because I believe that under the wrong circumstances I believe that we're still at a fragile state where things could crumble fairly quickly. (AH04)

As a segue from personal to organizational levels of trust, a number of participants, mostly First Nations participants outlined a greater level of trust with individuals with whom they have existing relationships as opposed to what they described as the "higher-ups", the individuals to whom many of the participants, including myself, report to within our respective organizations. A First Nation participant described it by indicating "it's at the upper level, there's not that same level of engagement and collaboration. They don't work together at that same level, and so that

same relationship is not there" (FN06). Another First Nation participant outlined this as follows:

> There's the trust of what we do at the table, then we [need to] be mindful of the trust and commitment from the higher-ups that at the end of the day have the signatory power. Then trust that the government above all will enforce it. (FN14)

As the discussion transitions from personal to organizational trust, a participant in a First Nation organization signalled that she believed the level of trust increased and the pace of its increase is also more rapid than it used to be (FN04). A First Nation participant signalled that the limited trust at the organizational level is not limited to relationships between First Nations, federal and provincial governments but is also evident between First Nations organizations:

> Even amongst each other, First Nations, the level of trust is questioned. There's always accusations that we have ulterior motives, or we are being selfish, and we're not protecting the Treaty Rights to Health and all this other stuff. It's right within First Nations, too. (FN03)

At the broader level a First Nation participant linked trust and reconciliation stating that trust cannot exist until reconciliation occurs:

> Trust can never be really fully gained, or it can't be palpable at the table because reconciliation has not started and until we get there and we have a lot of work to gain trust. We can work towards the idea of a trusting relationship but it's going to take many generations to fully trust one another and mostly on the First Nations side. (FN01)

In management literature, scholars are divided about the importance of trust at the beginning of collaboration. Some see it as an essential element without which nothing can be achieved (Alexander et al., 2003; Zuckerman et al., 1995) while others believe that it can be developed and gains can be made without fully developed trust (Huxham & Vangen, 2005). These views are shared by the participants as a provincial participant shared that to her "building the relationships, building of trust is an absolutely number one integral component of being able to achieve the Joint Action Health Plan" (AH02). While a First Nation participant outlined his belief in action:

> We could talk about trust and commitment until the cows come home, but how is that going to result in action at the community level? How is that going to result in improved services? How is that going to result in issues of chronic condition improving? How is that going to result in meaningful change at the community level? That's how I would flip that around. Those are all nice and fancy words, but they don't mean anything unless it results in some action. (FN08)

Some participants highlighted the need to deliver on the government promises as a federal participant said "I think there's a lot of big words, and I think if the government doesn't come out with something strong and real, I think that there will be a lack of trust pretty quickly" (HC01). She also stated that "if you really wanted to establish trust, you would start out the discussions with a recognition that we're having a Treaty Right to Health conversation. Then the people would trust you" (HC01). A provincial participant identified concerns regarding the lack of trust and its impact on the discussions:

> You come to the table, and then nothing really happens because nobody is willing to trust enough to put anything on the table. And I don't necessarily blame

people, but somewhere down the line someone has to take a leadership position. (AHS03)

This last statement connects with existing literature on trust whereby some authors anchor it on the relationship between the trustor and the trustee (Mayer et al., 1995). In their integrative model of trust, Mayer and his colleagues outlined the willingness to take risks as key element of trust. Considering the broader context of relationships between Indigenous Peoples and Settler society as well as current and past relationships between First Nations, federal and provincial governments, participants were able to provide multiple examples of broken trust. As some scholars argued that without trust collaboration cannot occur (Alexander et al., 2003; Zuckerman et al., 1995), this raises a number of questions in terms of collaborative endeavours and their potential for success.

Developing a shared vision. In terms of developing a shared vision, many participants reiterated what they identified as expected outcomes. Many participants referred to improving First Nations health outcomes (AH01, AH03, AHS02, HC03, FN11, AH04) while others indicated the desire to improving First Nations health care (AHS02, AHS03, AH04). A First Nation participant outlined his vision that it will "build hope" (FN11) while another First Nation participant expressed that it would allow for the creation of a legislation by First Nations to "provide health services to these individuals or these state people, First Nations state people, Treaty people" (FN12). Some participants had a more modest vision as a federal participant hoped that the Joint Action Health Plan will be the "conduit" or a transition piece that could lead to a "more evolved transformation" towards enhanced health care (HC02). For a number of First Nations

participants, this transformation means that it would either result in First Nations-led initiatives (FN04, FN08, FN10) or a permanent table to address issues (FN03) while a number of participants referred to working with the communities that are ready and able (AH01, AHS03, FN08, FN09). A provincial participant summarized this perspective as she linked it to a more First Nations-led approach: "work[ing] with the willing because if we work with the willing, then they can tell us. They need to tell us what they're hoping to achieve rather than us telling the communities what we think they can achieve" (AHS03).

A number of participants expressed their hope that it would lead to a joint commitment to working together (FN03, HC02, FN14, FN08) that better reflects "the current language and direction of both governments" (FN08). A First Nation participant saw this document as having wonderful signatures that would demonstrate the work we have done and that would be visible in all offices (FN14) while another First Nation participant said "definitely ensuring that the province realizes that we're here, we're not going anywhere, we have a voice, and that we have that partnership established between the three parties" (FN03).

A number of participants identified priority areas where gains can be made such as health information (AH02), crisis intervention, mental health, maternal and child health, access and follow-up with chronic disease management (AHS01) and a house of health for First Nations something akin to a clearinghouse where information could be shared amongst First Nations organizations and governments (FN03). Some participants identified the need to develop "shorter-term visions" (AH03) or "minor step goals"

(AH02) as a way to improve trust and knowledge of each other while improving services (AH03).

Promoting power sharing. Power sharing was identified by both Gray (1985) and Foster-Fishman and her colleagues (2001). Gray referred to "dispersion of power among stakeholders" (B. Gray, 1985) as a key element of the second phase of collaboration while Foster-Fishman and her colleagues highlighted the need to promote power sharing (Foster-Fishman et al., 2001). In Chapter 2, I outlined my perception of power and my own challenges in acknowledging my power as a participant and as a researcher. Maybe because of these struggles, I was keenly interested in hearing what the participants would say about power and not only did they have a lot to say but they also held very different views of power. Participants in the January 2017 focus group asked me to assess whether First Nations views of power were different from non-First Nations views. During the focus group, participants suggested that First Nations would come from a place of humility rather than power. This may appear in some of the comments but the views expressed by participants do not appear to be explained by cultural differences. Considering the tremendous amount of information I received from the participants on power, I divided this section into six sub-sections: understanding of power; often diametric views of participants as they outline both positive and negative views of power; sources of power; participants' assessment of power for both participants and participating organizations; how power is either wielded or maintained by both participants and participating organizations; and, from power relationships to collaborative relationships.

First, many participants begin by outlining how they understood power. A First Nation participant said "I define power -- wow -- as pow, no, err" (FN15). Provincial participants provided two definitions: "having the resources to have some influence over another party" (AH03) and "how people perceive their own sense of control in their lives and their self-determination, what they can do for themselves and for the lives of their family and friends" (AH02).

Second, participants outlined fairly diametric views of power. The first of these spectrums covered the gamut from negative to positive while the second one reflected on whether we all have power or whether we have none. For the first spectrum, a number of participants outlined negative views of power: "I tend not to think of power as a positive thing at all" (AH02), "I think power is – I don't think it's a sexy word anymore" (HC03) and a First Nation participant outlined it as follows:

> Well, it's a dangerous thing, and I haven't used it because it can be a negative reference. It can be a negative connotation, and I think for me I take great humility in the job that I have. It's not a responsibility that I take lightly… And so I don't ever use that word whenever I'm talking to people or explaining how we got here. Because I don't think it has a role in what we're doing here. (FN08)

Along this spectrum, a First Nation participant shared a more neutral view: "power to me is the ability to change things that not necessarily people think can be changed. It can be negative or positive, though" (FN15). A number of participants had more positive views of power as a participant from a First Nation organization believed that power and passion are interchangeable (FN04). A First Nation participant said "for me power is the ability to get things done, to move things along" (FN06) while a

provincial participant says that power means "the ability to identify a priority, to identify solutions to the priority, and to identify a process that they think would work best" (AHS01).

Third, participants identified a number of sources of power. Two First Nations participants outlined that money is power (FN03, FN14) while a provincial participant showed more ambivalence:

> I mean, is there power in having deeper pockets, then the governments definitely have deeper pockets, and there is power in having that sort of financial resource, but I don't think governments feel very powerful always in that regard. I think they feel under tremendous fiscal pressure. (AH01)

A few participants also identified knowledge as a source of power (AHS01, FN05, FN14). Further, a provincial participant provided a more nuanced approach identifying two sources of power – the first one coming from the community and the other from the health authority and their knowledge of best practices (AHS01). Further, a First Nation participant referred to information as power and indicated that "the whole concept of OCAP [Ownership, Control, Access and Possession] is about respect and appreciating that the true owners [of community information] are First Nations themselves" (FN01).

Fourth, participants showed a wide range of views as they assessed the power of fellow participants and participating organizations. A number of participants outlined that we all have power: "everybody has power in their own way" (FN15), "everybody wields power" (HC01), "I think all the players have a certain type of power, say over things, or ability to influence" (AHS02). Not all participants believed they had power as a First Nation participant said: "nobody really has the power" (FN02) and a provincial

participant shared that "even the sense of powerlessness is a sense of power" (AH04). A number of participants outlined power imbalances between participants. For example, a provincial participant reflected on her awareness of power differentials indicating that she did not think that others may always be aware as "if they did realize they exist, I think that they would be more inclined not to or try to make efforts to eliminate those differentials of power" (AH02). In reflecting on positions of power she said:

> I thought about how people are in positions of power because they are coming from a place of privilege, so things are, perhaps, given to them in a way that they don't realize is based on their privilege, and they're in a position of power because of it. So the sense of control that they might have over themselves and their choices could be perceived by them as hard work or what have you, but, really, it might be the fact that they have historical privilege because they're white, they speak English, they are born and raised in Canada, these sorts of things. (AH02)

Further, she outlined the challenges of not acknowledging the history by stating that "in trying to work together without acknowledging the history and acknowledging that those imbalances of power exist, there is the potential for us to not [be] walking in the same direction as we try to move forward" (AH02).

A First Nation participant outlined the power differential at the organizational level as she identified differences in capacity between First Nations, federal and provincial governments:

> The federal government has their huge pool of technicians. So does the province. And then there's the First Nations, where you've just got a few technicians.

> It's imbalanced. If we were provided the same capacity, we would be just as powerful in that whole triangular, like the three teepee poles we talk within the teepee model. You need the three to create that foundation. If you just have the two, it will topple over all the time. You need that third one to make it stable, so it will establish that teepee and its elements. So the power in itself is in the hands of the province and the federal government with their legislations, with their regulations, with their policies. And here we are on this side, hanging on to the Treaty Rights to Health and trying to ensure that those obligations are being fulfilled. So there's a definite power struggle there. (FN03)

Building on the definition of power that refers to self-determination, a number of First Nations referred to this concept as they outlined "it's better to actually be out there at the table speaking on behalf of your own communities rather than having somebody else do it for you" (FN03) while another indicated "I think a lot of nations are feeling they can voice their concerns" (FN11). Many participants outlined the power that Chiefs, and by extension Chief and Council, exert at the community level (HC01, FN09, FN13).

> The Chiefs are very powerful. They're as powerful as the Ministers, but yet we're so familiar with them, we're so always around them and so we sort of maybe dilute their power. Because if they wanted to, they could demand for Justin Trudeau to come. They really could. (FN13)

> The Chiefs exert power, because they have money, and they have independence, in terms of their leadership. They don't report to you. They don't report to me. They don't report to the province. They don't report to the feds. They report to their population. They have independence as political leaders, and

> they exert power. They have control over land. They have control over resources. They have control over voices. They exert power. (HC01)

Another federal participant referred to the Chiefs who are "politically connected" at both the provincial and federal levels which she further described as "wield[ing] a lot of power, [being] seen as the big hitters at these tables" (HC02).

First Nations Peoples are perceived as powerful based on their Treaty interpretations and how they are perceived in society in terms of the larger context such as their connection with the environment (AHS02). A few participants outline the power of First Nations Peoples but also indicate that this power may not be used to its full extent (AH03, FN06). For example, a First Nation participant said "First Nations don't necessarily have the power, or they haven't been exercising the power that they do have properly" though he also reflected that "I don't think all three parties, actually, are using their full power" (FN06). Further, a federal participant identified the lack of consensus at a more collective level for First Nations:

> I think First Nations autonomy is strained at times in terms of their collective. We can't paint all our partners with the same brush. Some are more willing than others. Some have the right knowledge, skills, and abilities and are easier to work with, and others are just, frankly, more difficult. (HC02)

As for the power of governments, the views were also varied amongst participants. A First Nation participant believed that "the one who has the power to decide that future is the actual Ministers, the heads of those governments" (FN02). A provincial participant shared "there could be power in feeling that you represent a higher authority whether it's the federal government, the provincial government, knowing that

you have legislation standing behind you and you have policy and a Minister and a government" (AH04). A federal participant outlined the power of federal and provincial civil servants:

> At the officials level we exert power in the sense that we can administratively pull levers in certain directions, and so as a result of that, we can shift things positively or negatively in favour of what the leadership are seeking. We can advise political leadership at the government level in a positive or negative way towards something. So we do have power. We do have some influence, and that goes both federally and provincially. (HC01)

Participants from the federal and provincial governments identified power in terms of shared priorities between the federal and provincial governments and the ability to move forward on a shared agenda (AH03, HC02). Participants shared their perspectives on the power of the federal government. A federal participant acknowledged her power in terms of having "control over financial resources and allocations" (HC01). This power is acknowledged by at least one provincial participant who stated "Health Canada [has] the power associated with funding, influences how we do work and impacts the work that we do" (AH03).

As for the power of the provincial government, a provincial participant stated "I think we as the Province have the least power at the table" (AH03) describing it further by saying "I think we have less ability to influence or drive. And maybe somebody else would say that they have less. So I think that we don't have the relationships that Health Canada and First Nations have" (AH03). A federal participant outlined what she perceives as the power imbalances between FNIHB-AB and Alberta Health:

> I believe the province is wanting to work with, but we're a small partner in the big scope of things. We're a small player in terms of health, and money. They won't be distracted by their mandate and what their deliverables and big commitments are, so they'll play, but we're not top and centre for them, but they'll play nice. (HC02)

Fifth, participants also shared how power is either wielded or maintained by the participants and/or participating organizations. A provincial participant said "in each of the meetings it becomes very apparent that the community members wield a big stick" (AHS01). A First Nation participant shared that power can also be wielded by "not being able to arrive to a decision" (FN03) while a provincial participant referred to passive resistance by not showing up for meetings, not making it a priority (AHS03). A few provincial participants refer to the creation of anger, shame and fear around the table (AHS03, AH04) "pointing out all the things that have gone wrong in previous situations" (AHS03). In saying so, they both acknowledged that horrible things have been done to First Nations Peoples as they referred to Canada's ongoing colonialism towards First Nations Peoples (AHS03, AH04).

Sixth, a number of participants outlined the need to shift from power relationships to collaborative relationships. Within this context, a provincial participant began by outlining that "traditional notions of power are shifting" (AH01). In outlining the challenge in moving from power to collaborative relationships she indicated the following:

> I do worry that we're governed by fear. We're afraid of floodgates because of fiscal issues. We're afraid of litigation. We're afraid that if we agree to this that

> we all stymie economic development. There's so much fear at play that it's hard to build trust and a positive focus. (AH01)

A federal participant shared that perceptions of power have no place at the table (HC03), while a provincial participant highlighted the need for reciprocity as a way to address power differentials (AH02). A First Nation participant shared that all participants should be considered equal:

> If we can all understand that at that table or at the steering committee that we're all equal, regardless fed, First Nation, or provincial, we're all equal, then they're on equal footing ground. A title is a title. It does wield some power and has some flexibility, but it doesn't make the person who they are. (FN14)

A number of participants highlighted the need to support greater capacity throughout the province (AH02) and "to bridge the gap so they can be more equal partners at the table" (AHS03). Finally, a First Nation participant highlighted the need to make sure "that the power of decision-making resides within the right place and that's with the people" (FN01).

Valuing diversity. In their model Foster-Fishman and their colleagues highlighted the need for the collaboration to value diversity. Few comments were made in this regard by the participants beyond acknowledging the current level of diversity amongst members of the Joint Action Health Plan Working Group and the need to respect diversity (HC02) which was identified by a federal participant.

Developing positive external relationships. The members of the Joint Action Health Plan Working Group and Steering Committee represent organizations with very different organizational structures. These different structures often result in challenges in

communicating within and across partnering organizations, more information to be provided in the accountability section within organizational capacity. These reporting structures impact the development of positive external relationships for the collaborative as not all parties can easily reach within and across their partnering organizations in sharing information, reaching consensus and making decisions. A First Nation participant highlighted the importance for First Nations participants to be able to communicate their work not only within their organization but also within their partnering organizations as she described the need for communications in terms of "being able to have that ability to articulate the needs, to articulate the challenges and the issues that exist and to be able to bring back information to the table" (FN10) and "making sure that they're connected to the First Nations, making sure that there's a relationship with those Nations and that they're meeting, that they're consistently meeting" (FN10). Another First Nation participant shared the work she does in sharing information with her community members and especially with Elders as she solicits their guidance (FN13). For federal and provincial government participants, they signalled the positive messages of the newly-elected governments (AH01, AH03, HC01, HC02, HC03) but one also expressed the need to be careful as it is not clear how this will translate concretely (HC01).

Organizational Capacity

Foster-Fishman and her colleagues indicated that "ultimately, if a coalition is to survive, it must have the organizational capacity to engage members in needed work tasks to produce desired products" (Foster-Fishman et al., 2001, p. 253). Organizational capacity includes five categories: effective leadership; formalized procedures; effective

communications; sufficient resources; and, continuous improvement orientation. Participants provided information on the first four elements but no information was shared that could be linked to continuous improvement orientation.

Effective leadership. In defining effective leadership, Foster-Fishman and her colleagues referred to "a strong leadership base, with current and emerging coalition leaders who have the skills, relationships, and vision to transform individual interests into a dynamic collective force that achieves targeted outcomes" (Foster-Fishman et al., 2001, p. 253). A First Nation participant stressed the need for "a positive attitude that rubs off on people in the room that make you want to do this" (FN05), he also indicated the need for champions "from all three levels, First Nations, provincial [and] federal governments" (FN05). In further describing these champions, he said "those people have real positive attitudes. They feel a part of it. They feel they can build it. They're true carpenters" (FN05). A second First Nation participant links it to his understanding of collaboration: "true collaboration to me means where everybody has a heart into the work that they're doing" (FN15). While a third First Nation participant said "I think it's important that you have these trailblazers, these community champions out in front leading the way and then having that experience and building that capacity and knowledge and then sharing that with other communities" (FN08).

Formalized procedures. Foster-Fishman and her colleagues identified the need for "formalized processes and procedures that classify staff and member roles and responsibilities and provide clear guidelines for all of the processes involved in the collaborative work" (Foster-Fishman et al., 2001, p. 254). As the collaborative structure to support the further development and implementation of the Joint Action Plan to

Improve the Health of First Nations in Alberta is still being developed (i.e. terms of reference and membership for the Working Group and Steering Committee have yet to be finalized), participants framed formalized procedures within this evolving context. Within formalized procedures, Foster-Fishman and her colleagues identified four categories: "clear staff and member roles [and] responsibilities; well-developed internal operating procedures and guidelines; detailed, focused work plan; [and,] work group / committee structure" (Foster-Fishman et al., 2001, p. 245). In providing input, participants often framed the requirements for a more informal rather than formal approach to procedures. Further, they provided input on three of the four categories, excluding operating procedures and guidelines.

Clear staff and members roles and responsibilities. The governance of the Joint Action Health Plan is supported by a small coordinating team and was not the focus of the participants' responses. Therefore, while this section could look at the roles and responsibilities of both staff and members, the focus is limited to membership. Further, in seeking to better define the roles and responsibilities of members, participants outlined two key elements: their accountability and their authority in terms of decision-making including their ability to represent the views of the organization(s) that appointed them. While I anchored most of this section on the work of Foster-Fishman and her colleagues, many of the elements brought forward by participants also connect with the work of other scholars (Huxham & Vangen, 2000; Westley & Vredenburg, 1991) particularly as it relates to decision-making and authority of participants.

Accountability. Most participants described their accountability as being multilayered (FN01, AH01, FN02, FN03, AH02, FN04, HC01, HC02, FN05, FN06,

AH04, FN14) as they identify being accountable to: themselves; their supervisor and/or organization; the collective process; and, the First Nations peoples they represent and/or serve. First, a number of participants outlined that they are accountable to themselves (AH02, HC02, FN06, AH04). Most of them linked this personal accountability be to a broader accountability whether it be their organization, the collective process or First Nations Peoples. For example, a First Nation participant described his personal accountability by saying "at home I can look at myself in the mirror and know I haven't done anything to hurt me or my people" (FN06). Three provincial participants also described their personal accountability. The first one summarised it by saying "as an individual, I feel accountable to my conscience" (AH02), a second referred to her commitment to public service (AH01) while the third one outlined how his personal sense of accountability determines how he responds and interacts to do his very best to be supportive of the overall process (AH04). A federal participant described her personal accountability as follows:

> And I'm accountable to me. I got to live with my own decisions and sometimes those decisions are easy to make, and sometimes they're very difficult. And at the end of the day, you have to kind of subscribe to your own ethics and values and what you are willing to do or not do. (HC02)

Second, participants outlined an organizational level of accountability by identified being accountable to their supervisor and/or their organization. Some participants identify their accountability to their supervisor (FN03, FN04, HC02) describing it as taking direction from them and being responsible for the work performed. Within this more organizational context, a federal participant outlined her accountability

to the employees and her team (HC02). A number of participants outlined accountability to their organization (AH01, FN02, FN03, AH02, AH04). Some First Nations participants framed this accountability as reporting to elected First Nations leaders in some cases directly (FN01, FN04) and in other cases through their board of directors (FN02, FN03). A number of participants working within more political structures framed their organizational accountability accordingly. For example, a provincial participant described her accountability to a government platform saying that she is "accountable for bringing forward to Ministers options and ways of making that happen" (AH01). Participants shared that this accountability is usually met through recording and sharing of information as well as provision of briefings and options (AH01, FN03, AH02, AH03).

Third, many participants outlined their accountability to the collective process (AH02, HC01, AHS02, FN10). A provincial participant outlined this accountability by sharing that her role is not solely to speak and report to her organization but also to ensure that her organization is aware when internal changes are required from her organization to better meet the needs of First Nations. She summarised this accountability by saying that she needs to "bring the working group back to Alberta Health" (AH02). A federal participant described her accountability by saying that she is accountable to the partners and her accountability would be vested in the partnership between the federal government, the province and the Chiefs… for the outcomes of this process" (HC01). A provincial participant suggested that framing accountability "as a mutuality as much as accountability" may yield better results (AHS02).

Fourth, many participants framed their accountability more broadly to the First Nations Peoples they serve and/or represent. A federal participant described this accountability by saying "I'm accountable to the Nations that I am providing service and programs to" (HC02).

Even within the more narrowed concept of accountability to First Nations Peoples, participants working in First Nations organizations and governments outlined varied levels of accountability reflecting the mandate of the organization that appointed them. In some cases, First Nations participants outlined accountability at a local level. For example, a First Nation participant described it as follows: "We're accountable to the people of this community. I'm not accountable to the rest of Alberta, to the other Alberta First Nations, nor do I speak on their behalf. When I speak and want, it's for [this] community" (FN02). A second First Nation participant who represents a Treaty organization framed it as a more multilayered accountability to her home community, her Tribal Council and her Treaty area:

> I have to be mindful. Like, I can't just focus on [my tribal council], because some needs are similar, but then there's a lot of needs that are different within the Treaty area… So I answer to a lot of people. I answer to Treaty [area]. I answer to [my Tribal Council]. I answer to my First Nations. (FN14)

Finally, a First Nation participant from a regional organization framed this accountability by saying "I'm mandated by the Chiefs of Alberta. But I see it deeper, the accountability is to the people and that includes, the Elders, the youth, the mothers, the babies" (FN01). Considering the important variations in accountability a First Nation participant highlighted the importance of having knowledgeable people at the table but

emphasizing the importance of ensuring that they are "connected to the First Nations, making sure that there's a relationship with those Nations and that they're meeting, that they're consistently meeting" (FN10). This may also explain the more informal approaches advocated by many participants acknowledging that our varied accountability requires flexibility.

Authority. Participants also link accountability and authority as they referred to their ability to speak and make decisions on behalf of their respective organization. As identified earlier this may relate better to other work on collaboration rather than being limited to Foster-Fishman and her colleagues. Some of the challenges identified by the participants appear to connect well with the work on ambiguity in regards to decision-making (Huxham & Vangen, 2000) and representativeness of members to their organizations (Westley & Vredenburg, 1991). While a provincial participant highlighted the need to bring together "people who have if not full decision-making capacity, the capacity to get decisions made. And you need people that have the authority to speak on certain items and to explore them and to play with them" (AH01). Many participants expressed concerns about their ability and their partners' ability to do so.

As part of this research a number of participants shared their limited ability to speak and make decisions on behalf of their respective organizations. A provincial participant said: "I'm representing the Aboriginal Health Program voice only, not Alberta Health Services" (AHS01). While another provincial participant identified the challenges of working in a larger organization and having limited information on the organizational perspective:

> I think the challenge is that while I am part of Alberta Health, and while the team I'm with is part of Alberta Health, I don't know that we can necessarily say we represent all of what Alberta Health does or is interested in doing. (AH02)

A First Nation participant outlined that the participants may not be fully aware of the position of higher level decision-makers:

> People are ready. They want to, but they're always very mindful of the higher-ups above them. We would like to work together, but let's be mindful of what we have to do. That can both be a positive and a negative, because that kind of thinking sometimes can hesitate and limit what a person is willing to do. (FN14)

Participants outlined their understanding of their partners' ability to represent or make decisions on behalf of their organizations. For example, a First Nation participant referred to the ability of FNIHB-AB to partner by saying "you're only as good as your Regional Director will allow you to be" (FN05). A federal participant shared "the governance is not always clear from a First Nation perspective" (HC02) while a provincial participant wondered if it would be possible for First Nations to come together as one voice that would have the authority to direct the work and to support First Nations discussions (AHS03). A First Nation participant believed the skills, knowledge, and attitude of the participants at the Working Group and Steering Committee levels are fine but expressed concerns regarding higher level government employees:

> It's the next level up, or the level above that. There's a level where they're not being honest with us. They're not being honest with their own people, and I think sometimes their people at the table will get side-swiped, blindsided the same as we do, and they have to come defend it. And it's hard to defend that stuff. (FN06)

This last comment brings up concerns of trust between First Nations and governments. However, considering that a number of participants expressed concerns in terms of their ability to speak on behalf of their respective organizations, whether they are working for First Nations, federal and provincial governments, this also leads to questions in regards to the institutionalization of partnering organizations. Thinly institutionalized organizations are described as "lack[ing] a developed internal hierarchy and a central authority" (Westley & Vredenburg, 1991, p. 72). Limited institutionalization has many impacts. For example, a First Nation participant signalled that he brings forward the consensus of the Chiefs that he works while acknowledging "some of them may have different opinions, and they may work on something else in their own manner" (FN06). Adding to the complexity of institutionalization is the changing political landscape not only at the federal and provincial governments level with the election of new governments but also at the level of First Nations governments with the election of new leaders and the dissolution of a Treaty organization (Treaty 7 Management Corporation).

In conclusion, while a participant signalled the importance of "political leadership, political authority [and] political accountability" (AHS02) based on participants' input there are a number of challenges in ensuring that this occurs as we seek to further develop and implement the Joint Action Plan to Improve the Health of First Nations in Alberta. A federal participant outlined the need to better understand the decision-making process of the partnering organizations as she said "we have to respect it, and we have to nurture it and make sure that we don't compromise anything as we navigate forward" (HC03).

Detailed / focused work plan. Foster-Fishman and her colleagues identified within formalized procedures the need for a detailed and/or focused work plan. A provincial participant highlighted the need to project-manage the further development and implementation of the Joint Action Health Plan suggesting that we have "100,000-foot, 60,000, and 10,000-foot levels of work… [as] a way to follow it through so we can look at the advantages, look at the unintended consequences, really make sure it's going to work for the First Nations, and that it can be sustained" (AHS03). However, a few participants stressed the importance of flexibility as a federal participant said "I always see a work plan as a fluid document" (HC03) and a First Nation participant highlighted the need to maintain flexibility (FN08). However, a federal participant perceived a work plan differently, as a way to ensure that we are delivering on the timelines and milestones set as well as part of her accountability to the process (HC01).

Work group / committee structure. Within formalized procedures, Foster-Fishman and her colleagues included work group and committee structure. A few participants discussed the current governance structure and the need to have both a decision-making level (FN03, HC02) and a more technical level (FN03). However, as this structure was outlined, participants flagged concerns regarding the appropriate level of representation. They highlighted engagement protocols stating that Chiefs should only meet with Ministers, while the current structure of the Joint Action Health Plan Steering Committee is providing governmental counterparts at the bureaucratic level (Assistant/Associate Deputy Ministers) (FN03, HC02). Further, a First Nation participant signalled the importance of cohesiveness at the Working Group level: "if you don't have a cohesive working group, we're not going to get anywhere" (FN02). A

provincial participant highlighted the need for a fluid model (AH04) and another provincial participant emphasized the need for a flexible and agile model (AH01); neither ones of those models were described.

In outlining the need for capacity, participants were asked to weigh in on a few options: increasing the capacity of the partnering organizations to collaborate; supporting a bridging organization; or, a combination of both. Participants were divided on the preferred option and some stated that it was simply too early to discuss the structure to support the implementation of the Joint Action Health Plan. For example, a provincial participant said: "I think at some point in the future, somewhere down the road, that creating some new structure that reflects all of us would be ideal. But I think we're far from that at this stage" (AH03). Another provincial participant also argued for the need to delay the discussion on structure:

> Part of me thinks we shouldn't start with structure, that structure is holding us back, because it's not one size fits all because our starting points are varied and that we should just start doing... And I'm more of a building block kind of perspective, that we should work with the willing and the able and start to see what's possible to learn from that initiative, that partly we need to be doing and learning, and then we can scale and spread it. (AH01)

A participant in a First Nation organization also suggested taking more time to design a structure that would be established based on meeting pre-established criteria (FN09) which have not been defined. While a First Nation participant highlighted the need for a model that is "not trying to fit a round peg in a square hole, because that's

where we've been sitting all this time. It has to be something that will work for all three [Treaty areas], and respecting that it has to be culturally appropriate" (FN03).

The participants identified the need for enhanced capacity and resources in First Nations organizations. A First Nation participant said "I think the best model would be to actually let us do it" (FN06) while expressing concerns that a bridging organization would be "just another level of bureaucracy" that may at some point be reluctant to give back its authority (FN06). A federal participant shared some concerns regarding a bridging organization providing the Health Co-Management Secretariat as an example that can work for the coordination of logistics but that to have "real commitment by the parties that would be required for this to work, you actually have to resource each of the partners separately to make sure that they are directly involved and have buy-in" (HC01). Yet, a number of participants suggested the creation of a bridging organization (FN04) though some acknowledged that this should be accompanied by capacity in First Nations organizations (AH02, HC03). In describing this last option, a participant referred to more than a secretariat function as she envisioned the partners contributing an employee each "to really give this approach some impactful and meaningful traction, you need to have people on the ground constantly, constantly going" (HC03). One participant also referred to the "need to build a starfish organization" (AHS03) which was described as being interconnected and having a shared leadership approach.

Effective communications. Within organizational capacity, Foster-Fishman and her colleagues identified the need for effective communications which they further divided into: "effective internal communication system [and] timely and frequent information sharing, problem discussion, and resolution" (Foster-Fishman et al., 2001, p.

245). So, this section builds on the communications skills required by members identified within member capacity. A federal participant outlined the need for ongoing communications:

> You can't move things along without making sure that you have a parallel communication piece as part of it, because you're going to have to educate people along the way. You're going to have to appease concerns along the way. You're going to have to promote what it is that you're doing to get that collective buy-in through every step of the way (HC03).

A number of participants outlined key elements of the communications process. A First Nation participant described her responsibility in sharing information with her colleagues at various tables identifying opportunities where the work of the Joint Action Health Plan could assist or support other endeavours (FN14). She also stressed the importance of sharing information between participants in the Joint Action Health Plan Working Group as some of the lessons learned or successes of other First Nations organizations could be helpful to other First Nations organizations (FN03, FN14).

Participants identified a number of concrete steps to strengthen communications. A First Nation participant highlighted to limit use of emails and signalled that it would be beneficial if senders would touch base with their intended recipients to ensure that the emails were received and understood as well as providing an opportunity to answer questions and further dialogue (FN05). Another participant highlighted the complexity of the work and the challenges of explaining it in layman's terms while still taking into account the history of events (FN03). Another First Nation participant shared the communication process within his Treaty area and how it could be leveraged to share

information (FN11). In summary, participants believed in the importance of communications but appeared to have limited agreement on what is an effective approach.

Sufficient resources. Within sufficient resources, Foster-Fishman and her colleagues included both "financial resources to implement/sponsor new programs and operate the coalition [as well as] skilled staff/convenor" (Foster-Fishman et al., 2001, p. 245). Many participants outlined the need for resources to support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta.

Financial resources. A First Nation participant signalled the need for resources "if we want to go beyond 3 kilometres an hour and actually start going around 10 kilometres an hour, we need that extra [capacity]; otherwise, you will find meeting to meeting that it's just inching centimetres, if not going back" (FN15). A provincial participant acknowledged the unequal availability of resources: "we have capacity for the work. That is not always the same for our First Nations partners who may not have that same equity in capacity to participate in all of the work that we bring on the table" (AH03). A federal participant also signalled the need for resources for First Nations partners:

> It's also not realistic to expect their existing capacity to actually reach out and do significant community engagement. They just don't have the money for that. You have to give them also [the] ability to [engage] and resource potentially the Tribal Councils or to resource some of the communities to actually be involved and participate in the consultation process. (HC01)

Considering the First Nations concerns raised within preconditions in regards to inequity in resource allocation, a number of participants identified the need for additional resources beyond the Joint Action Health Plan to support increased First Nation involvement in health care delivery. Participants signalled the need: to build capacity in First Nations communities and the challenges for a number of communities, especially remote communities to develop that capacity (FN09); for equitable funding on- and off-reserve (FN06); and for the "capacity to get things done" (FN15). A First Nation participant summed the need for additional resources of First Nations organizations and governments by saying "give me my money" (FN06). A provincial participant wished "that Alberta Health bucks up the money to facilitate the work that needs to happen" (AHS03). A federal participant said:

> Ultimately the more we can build capacity in First Nation organizations to be the controlling decision-makers of their own services, the better. And whether they do that directly or they purchase the service or what have you, they're still in control of it. So building that capacity in a way that's, strategic, that's built on trust, built on evidence, built on willingness by all partners. (HC02)

In light of these requests for resources by First Nations partners and the acknowledgement of federal and provincial partners, a provincial participant said "if the Chiefs need money to be put on the table, then put money on the table" (AHS03).

Skilled staff / convenor. Foster-Fishman and her colleagues identified as a second component of sufficient resources, the need for skilled staff and convenor. This element is also identified within the preconditions by Gray who referred to the need for a "legitimate / skilled convenor" (Gray, 1985, p. 918). A First Nation participant signalled

the important contribution of Elders to the work of the Joint Action Health Plan Working Group. She described their contribution by highlighting their remarkable skills:

> They're really powerful. Their knowledge can go so far, and it's more than the words that come out. It's reading between the lines. They try to make you understand by telling you little stories, and if you miss that story, then you just totally miss what the individual is trying to send, the message that they're trying to send. And it's comforting to know that they can come there with their knowledge and power because I know they retain it spiritually, culturally being sound, and that they bring that and to me personally, there's a level of comfort knowing that they're there. Because in a sense it's a validation of them being representative of the knowledge that was held to prove that there is Treaty Rights to Health. (FN03)

Programmatic Capacity

Foster-Fishman and her colleagues defined programmatic capacity as being needed "to guide the design and implementation of programs that have real, meaningful impact within their communities" (Foster-Fishman et al., 2001, p. 256). They further identified four categories within programmatic capacity: "clear, focused, programmatic objectives; realistic goals; unique and innovative [program]; [and], ecologically valid" (Foster-Fishman et al., 2001, p. 245). The emphasis on goals also connects with Gray's work who included as part of the preconditions "positive beliefs about outcomes" (Gray, 1985, p. 918). Participants mostly provided input towards the second category, realistic goals.

Realistic goals. Foster-Fishman and her colleagues established two sub-categories within realistic goals: identifying intermediate goals and achieving quick wins (Foster-Fishman et al., 2001). In identifying goals, participants identified intermediate and longer-term goals. As they framed some of those longer-term goals some participants highlighted that more work may be needed to transform the vision into goals (AH03, AHS03). For example, a provincial participant said "I think it's really high-level. We can agree with all of it, because it's so high-level, and it doesn't really get into the details" (AHS03). While another provincial participant highlighted that more progress is needed but also summarised what participants identified as goals:

> I think that we're nearer to a shared consensus than we were… even a month ago and two months ago and three months ago. Are we at a near overlay of understanding? Not yet. No, I think we're moving there. My sense of what we are there to do is to work collaboratively to address health, Indigenous health, and health services, concerns, gaps, overlaps, considerations, impacts emerging, emerging issues, considerations, and areas that keep people up at night, wondering whether or not they can sleep, considerations that affect one family member's ability to find solace in the situation that's facing their son, daughter, mother, aunt, uncle, grandparent, or other relative. It's about finding the means to bring our overall ability and force to bear to solve and to find solutions. (AH04)

This citation segues well into the five goals identified by the participants: endorsing a joint document; supporting a more evidence-based approach; supporting a building-block approach; improving health care; and, improving health outcomes. While not all these goals are intermediate, some participants identify intermediate steps for

some of them. For the first goal, partners endorsing a joint document, this was also identified earlier within relational capacity as a way to demonstrate partners' commitment to this process. A First Nation participant described this document as a way to articulate our intent to work together as well as to define collaboration and how we plan "to sustain it and to ensure that it's ongoing" (FN03). She believed it would be demonstration of an investment by the partners not solely in monetary terms but also in terms of commitment and the "importance to establish and ensure that those goals and objectives are met" (FN03).

In terms of supporting a more evidence-based approach, a provincial participant referred to the joint work done by the Alberta First Nations Health Information Working Group to secure access to the Indian Registry System as a way to enhance health information by linking the registry to the Alberta Health databases. As part of this work a data governance agreement is being negotiated and a provincial participant identified the need for flexibility in terms of what would be included within the agreement and what other work may be required to support it such as a health surveillance framework (AH02).

In terms of supporting a building-block approach a number of participants outline that it may be better to begin working with the First Nations organizations and governments who are willing and able to move forward (AH01, AHS03, FN08, FN09). In advocating for this approach a First Nation participant shared that "you cannot move forward with all 44. It's never going to happen" (FN08). A provincial participant also paraphrased a discussion with a First Nation leader:

> He had full respect for where the other Chiefs were, but he didn't think that everyone had to move forward together or move together, that people could be respected for where they are and how they wanted to move, but he also said he didn't want to be held back waiting for others, that he was ready to go forward on some fronts. (AH01)

Another provincial participant perceived this approach as a way to ensure that First Nations are leading the process (AHS03) and a participant in a First Nation organization indicated that "whether it's a band win or a Tribal Council win or a Treaty win or a regional win, it's still a win" (FN09).

In terms of improving health care, participants framed their responses at different levels. At the highest level, it is described as "the common goal of a better health care system for the people" (FN11) or a way "to ensure that Aboriginal people have the same supports and level of health care services that other people in Alberta have… it's about health equity" (AHS03). At a more intermediate level, a number of participants identified steps to lead us to improved health care including: the need for First Nations peoples to speak on their behalf as they share their issues and concerns with provincial and federal government officials (FN03); the need "to create an opportunity or a platform to develop ways to address First Nations health issues as prioritized by the First Nations community" (AHS01); and, using a building block approach (AH01, FN03, AHS03, FN08, FN09) as a way to acknowledge that "to improve health care services for the First Nations community …it won't be one size fits all, but it will be a collaborative initiative that takes into account a very diverse landscape" (AH01). With a building block approach, priorities for health care would be determined and addressed at a more

local level addressing concerns at the community or tribal council levels. A building block approach is perceived as facilitating the establishment of timelines and milestones (FN03), supporting the elimination of jurisdictional barriers (FN15), and ensuring that community needs are the main drivers (AHS03).

Finally, participants identified the need to improve health outcomes (FN02, AHS03, FN10). It was described it as "the whole reason why we would even be involved is to improve the health outcomes of our people" (FN02). Further, it would allow us to reach beyond "simply providing medications and fixing ailments… it's about improving a quality of life but also changing a lifestyle" (FN10). Another First Nation participant identified it as helping "First Nations [peoples] become healthier and healthy people, family, communities" (FN15). He concluded by saying that "Healthy people, family, communities" (FN15) should be our slogan.

Quick wins. With quick wins, Foster-Fishman and her colleagues referred to initiatives that "achieve targeted outcomes and sustain community support because they use limited resources in an efficient manner, provide focus for coalition member work efforts, complement existing community programs, and coalition credibility" (Foster-Fishman et al., 2001, p. 256). Considering the previous section of realistic goals which included longer term goals, it may not be surprising that some of the quick wins also seemed longer term. A summary of the quick wins in provided in Table 3.

Table 3 – *Summary of Quick Wins Identified by Participants*

Quick Wins
Increasing involvement of Elders to ensure cultural safety and competency as well as enhanced communications and engagement of First Nations partners
Pursuing some of the activities currently identified within the Joint Action Health Plan such as submitting a joint application to the Indian Registry System and developing a Data Governance Agreement; holding the Alternative Service Delivery Forum; and, enhancing coordination of benefits between Non-Insured Health Benefits (NIHB) and Alberta Aids to Daily Living (AADL)
Strengthening the delivery of health services including enhanced primary care, crisis intervention, mental health and addictions, women's shelters on-reserve, and respect for Jordan's Principle in addressing the needs of First Nations children
Strengthening processes with the creation of a commitment document between parties
Addressing funding issues such as wage parity for staff on-reserve and the need for the federal government to provide the same level of funding on- and off-reserve

The first quick win identified relates to the involvement of Elders in the Joint Action Plan to Improve the Health of First Nations in Alberta. A First Nation participant flagged their important contribution to date, their ability to continue making a difference, their key role in ensuring communications and engagement:

> As soon as you have the Elders in there, you're going to have buy-in from the Nations. That would be your quickest win…They've already established a lot of the cultural safety, the cultural competency in there, and all that stuff. They're building the foundation. And ensuring that their involvement is included in whatever activity that is going to go on and that there's a communication back to them. There has to be a technical team that will work with those Elders to ensure

> that that information is flowing back and forth… The Elders are the advisors to the leadership. (FN03)

Some participants identified the commitment document between partners as a quick win. A federal participant identified it as she highlights that "getting the mandate from First Nations… would be a quick win" (HC02). A joint document has been discussed and attempts have been made to draft one in 2015 as well as in 2017. As of August 2017, this work is still ongoing.

A number of participants identified activities that are currently identified within the Joint Action Health Plan such as submitting a joint application to the Indian Registry System and developing a Data Governance Agreement (AH03, FN04, HC02); holding the Alternative Service Delivery Forum (AH03) which was held in February 2017; and, enhancing coordination of benefits between Non-Insured Health Benefits (NIHB) and Alberta Aids to Daily Living (AADL) (AH03, HC02, FN06, AH04). In regards to NIHB-AADL, while many participants expressed their hope for it to be a quick win, many also acknowledged the challenges it has faced (AH03, HC02, AH04). In maintaining its inclusion as a quick win, a provincial participant said "imagine if it was supposed to be a quick win before, where we're at right now, knowing that the recommendations have already been developed" (AH04).

A number of participants identified as quick wins priorities to strengthen health care delivery including: enhanced primary care (AHS01, AHS02, AHS03), crisis intervention, mental health and addictions (AHS01, FN06, AHS02, HC03, FN14), prenatal and maternal child health care (AHS01), and respect for Jordan's Principle in addressing the needs of First Nations children (FN06, FN14). For many of these

priorities, a number of key areas were flagged. For example, participants identified a number of possible areas for improvement within mental health and addictions as they referred to: a protocol to support crisis intervention and mental health (AHS01); the creation of a joint travelling team including AHS and community members (AHS01); funding for youth addictions treatment centre in northern Alberta (FN06), supporting the implementation of the provincial mental health strategy (Valuing Mental Health); and, collaboratively addressing issues such as fentanyl and more broadly opioids (HC03); as well as developing joint tools to address privacy concerns in mental health and addictions (FN14). Multiple areas for improvement are also identified within primary care including supporting a more integrated approach (AHS03) or the Alternative Relationship Plans (ARPs) currently funded by Alberta Health and operated by Alberta Health Services (AHS01). A provincial participant identified the need for greater collaboration from FNIHB in terms of its definition of a primary care centre on-reserve and support of front-line staff in First Nations communities for the ARPs (AHS01).

Finally, participants identified as quick wins the need to "break down jurisdictional barriers" (FN15) and address funding issues. In describing the funding issues, a First Nation participant raised a number of issues including wage parity for nurses and other health para-professionals and professional on-reserve; limited funding for women's shelter on- and off-reserve; as well as the need for the federal government to provide the same level of funding on- and off-reserve (FN06).

Unique and innovative. As a participant of the Joint Action Health Plan Working Group, I heard members describe our group as the sole health tripartite table in Alberta. In that regard, our work is both unique and innovative, however, a First Nation

participant highlighted that many communities are already implementing our work as they build upon existing partnerships between First Nations, federal and provincial governments. He reminded me to "keep in mind, this Joint Action [Health] Plan is already happening in communities" (FN08).

Outcomes: The Third Phase of Collaboration

In describing the third phase of collaboration, outcomes, Gray referred to the "conditions which facilitate structuring" (Gray, 1985, p. 928) including: high degree of ongoing interdependence; external mandates; redistribution of power; and, ability to influence the contextual environment (Gray, 1985). Officially, work on the Joint Action Plan to Improve the Health of First Nations in Alberta began in 2014, however, its further development and implementation were delayed by a number of political and programmatic changes in 2015 including: First Nations, federal and provincial elections as well as the renewal of the Health Services Integration Fund (HSIF).

Participants shared their assessments of the development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta. I used their assessments to identify possible points of convergence with existing literature on collaboration. In outlining her assessment, a First Nation participant linked our current work to a previous funding opportunity, the Aboriginal Health Transition Fund (AHTF), as well as the first round of the Health Services Integration Fund indicating that "it's building bridges towards the bigger picture and how we can influence that" (FN03).

First, in terms of high degree of ongoing interdependence, participants acknowledged the siloed approaches used by their respective organizations as a First Nation participant said "we can't work in isolation anymore. It just doesn't work"

(FN11). A number of participants shared that an increasing number of First Nations communities are being proactive and innovative at breaking down some of those barriers (e.g. increasing access to services on-reserve such as primary care, specialists, diagnostic services, addressing concerns in the health system such as racism and discrimination, quality of services) (FN02, FN04, FN08). Some also highlight the importance of the Joint Action Health Plan to create a forum for discussion on joint issues (AH01, FN02, FN03, AH03, AHS01, FN08) and a platform for which to improve health care and ultimately health outcomes. As a participant of the Joint Action Health Plan Working Group I can attest to some of the gains made since I conducted the first round of interviews (October 2015 – January 2016). For example, all parties signed a joint application to request access to membership data from the Indian Registry System that will be linked with Alberta Health databases and for which we are working on a Data Governance Agreement. As participants we have been guided by the Elders' Advisory Group and increased our understanding of ethical space (Crowshoe & Littlechild, 2017). As a result of a call for proposals for Health Services Integration Fund, we have increased the number of First Nations-led community projects where we jointly seek to enhance collaboration between First Nations, Alberta Health, Alberta Health Services and FNIHB-AB. This latter work is supporting our efforts in enhancing a First Nations-driven initiative as well as supporting a more building-block approach as advocated by some participants. A provincial participant linked the progress made in terms of interdependence to increased empathy and understanding:

> I believe that through this process and through just overall time and investments in the Indigenous health and Indigenous health services perspectives that we've

> made in the last couple of years since the Joint Action Health Plan has gone on, I think there's a deeper sense of empathy and understanding for what those concerns actually are. (AH04)

Though not all participants are as optimistic as a provincial participant summarised our status in October 2015 by saying "I don't know if we're any further ahead than that overall vision still, and maybe because we're at this particular moment in time" (AH03).

Second, in terms of external mandates, many participants identified being more hopeful or cautiously optimistic as a result of the newly-elected federal and provincial governments (AH01, HC01, HC02, FN06, FN08). Participants highlighted commitments to renewed relationships with Indigenous Peoples including implementation of the United Nations Declaration on the Rights of Indigenous Peoples and the calls to action from the Truth and Reconciliation Commission. For example, a First Nation participant perceived the Joint Action Health Plan as an opportunity to combine efforts and even more so as we have new federal and provincial governments who seek to make a difference:

> I look at this Joint Action [Health] Plan… as a real opportunity for all of us [community], Treaty 7, Treaty 6, and Treaty 8, to combine our efforts and our forces together... And I think collectively that voice, we'd be very strong. Especially right now. We have a new government. They're looking at making some major changes so we're aligning in a special way here. (FN08)

Further, this same participant shared that he saw the commitments of the new governments as an opportunity to modify the Joint Action Health Plan in order to reflect this new level of readiness:

> And so what does this Joint Action Plan mean now with these new governments? So I think some elements of the Joint Action Plan have to be updated, and I think some aspects have to be reflective of the new language and the new direction that's happening. Because if it's not changed, I think if you don't update it, if you don't change it, it will be difficult to move it forward. (FN08)

A few participants highlighted the limited window of opportunity that has been given with the 2015 elections (AH03, FN08) acknowledging that both governments have four-year mandates.

Third, in terms of redistribution of power, a number of participants identified that power relationships are changing, though it is less clear how power is being redistributed. Power was mentioned in many interviews as participants outlined the importance of engagement of First Nations organizations and governments. A provincial participant outlined the need to switch from power relationships to collaborative relationships. Limited trust, lack of trust, mistrust and distrust were also often mentioned in interviews. A provincial participant shared her thoughts on the current trust level:

> There have been some incremental successes, some building of relationships, some better information sharing and understanding of different perspectives that I think that that helps build [but] I'm not sure we're at the trust stage. (AH03)

Fourth, as for influencing the contextual environment, it is still early days. Though a number of participants framed progress in terms of what one participant described as changing the narrative. A federal participant identified the Joint Action Health Plan as an introductory step:

> I think the Joint Action [Health] Plan is a small step to get to a larger vision. It's administrative in nature in a lot of ways…It's almost a transition piece that needs to happen before that trust and relationship and vision will gel for something bigger. (HC02)

While a second federal participant shared her belief that changes have occurred:

> When I first started at FNIHB those conversations weren't even being had. It was black and white. On/off-reserve. Not our responsibility. That's your guys' jurisdiction. So to be able to start having the conversations now around health needs and health outcomes, and collaboration and partnership is incredible. (HC03)

In conclusion, participants identified opportunities for further collaboration as well as its many challenges. The further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta has not been an easy journey. It appears to be early days for this collaboration as while some gains have been made in terms of understanding between participants and participating organizations, much more work remains to confirm the scope of the work ahead.

Chapter 6 – DISCUSSION OR IMPLICATIONS OF THE RESEARCH

In Chapter 5, I shared what I heard during the interviews and what I experienced as a participant in the Joint Action Health Plan Working Group while identifying points of convergence and divergence both amongst participants and with existing Indigenous and management literature. The focus of this chapter is to share my understanding of the key themes emerging from my research question and sub-questions.

I approached this research as a practitioner, someone who works alongside middle and sometimes more senior, leaders in First Nations, provincial and federal governments. As I have been involved in a number of collaborations, I began my research with a literature review exploring concepts of working together. In reviewing the different options, I was drawn by the simplicity of the three phases of collaboration and the potential to improve collaborative capacity. My research question and sub-questions were created based on that combined understanding and became the foundation of my research. My research question was as follows: How can improved collaborative capacity enhance health care collaboration between First Nations organizations, Alberta Health, Alberta Health Services and FNIHB-AB? My research sub-questions were based on the three phases of collaboration:

- Preconditions – What are the impacts of existing relationships between First Nations, federal and provincial governments to the collaborative capacity to enhance multilateral health care collaboration?
- Processes – What are the key elements of collaborative capacity required to enhance health care collaboration between First Nations, federal and provincial governments?

How can an increased knowledge of collaborative capacity be used to enhance collaboration between partnering organizations?

- Outcomes – How is improving collaborative capacity impacting collaboration?

With this research, I bring forward the voices of Indigenous and non-Indigenous participants working in First Nations, federal and provincial governments as we seek to enhance collaboration by further developing and implementing the Joint Action Plan to Improve the Health of First Nations in Alberta. Acknowledging that I am not a neutral and objective observer, I begin this chapter by documenting my lenses as a researcher and participant as well as share the participants' views in regards to my dual roles. I also summarise the participants' understanding of the key concepts identified in Chapter 5 prior to answering the three research sub-questions. Then I use the answers to my sub-questions to map the three phases of collaboration as we seek to enhance health care collaboration between First Nations, federal and provincial governments.

Researcher and Participant

In outlining my lenses as a researcher and as a participant, I also provide the input shared by participants about my roles. This information is grouped into three broad categories: member capacity; roles and responsibilities as a researcher and as a FNIHB-AB employee; and, evolving relationships at the personal and professional levels between the participants and I.

Member Capacity

Considering the importance of member capacity within collaborative capacity, I believe it is important to share the participants' views of my skills, attitudes and knowledge. In terms of skills and knowledge, a provincial participant referred to my

experience in government and more specifically my knowledge of the inner workings of government (AHS02). In terms of attitudes, a participant in a First Nation organization referred to my passion and my ability to make things happen (FN04). While a First Nation participant described the importance of patience as she flagged my need to learn to put a toe in the water to test its temperature before jumping in (FN03). In commenting on the building trust process a participant in a First Nation organization shared his perspective on our relationship by saying "your word's your word" (FN09).

Related but Separate Roles…

Earlier, I identified my connection to this research at personal and professional levels. In identifying myself as a participant, I often framed it within the context of my participation in the Joint Action Health Plan Working Group, while acknowledging that I do so representing First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB). As I have been working at FNIHB-AB and have been involved in a number of collaborative initiatives with First Nations and provincial governments for well over a decade, many participants perceived my status as a participant beyond my involvement with the 2014 Joint Action Plan to Improve the Health of First Nations in Alberta.

In Chapter 4, I shared that turning on the audio-recorder allowed our discussions to transition to this research. This does not mean, however, that participants ceased to see me as a colleague or counterpart as many shared their views on my dual roles. A provincial colleague summarised her perspective by describing my dual roles as "related but separate" (AH03). As she identified potential benefits stating that it gave me the opportunity to ask questions and look "at concepts that we may not be always discussing or thinking about that could inform our work" (AH03).

Roles and responsibilities. A number of participants shared their views on my roles and responsibilities by taking into account one or more of the following: my research; my work at FNIHB; and, my role with the Joint Action Plan to Improve the Health of First Nations in Alberta. Even with the benefit of hindsight, it is not clear what has been the impact of my dual roles on participants. I believe existing relationships with the participants were helpful in obtaining interviews and helped me get a solid participation rate (71 per cent). As I conducted the interviews, I felt that our existing relationships facilitated exchanges. Further, I frequently thought that I was receiving an additional layer of information which was not articulated in larger group meetings. The interviews felt very personal, privileged moments. Even though I used a semi-structured interview tool, I believe we disclosed more of each other than we normally would as my questions likely revealed as much about me as their answers did. While I am aware of the ethical requirements that I needed to respect as a researcher and as a federal employee conducting research, I have no information as to the impact of my status as a federal employee on the responses provided by the participants.

The transition from a working relationship to a research relationship began well before data collection as I approached the Co-Management Committee before finalising my research proposal. Engaging with participants in a research relationship began as I inquired about organizational ethical requirements and as I shared the consent form and interview questionnaire ahead of our meeting; setting the tone for a different type of discussion. As part of the interviews, some participants expressed their interest in hearing about commonalities and differences between responses (FN08). A request from a participant for a summary of findings (HC02) contributed to my decision to provide a

summary to all participants in June 2016 and to conduct a focus group in January 2017. Further, some participants (AHS01, FN03, FN05) provided suggestions for potential participants which were considered.

Even though interviews were different from our usual interactions, our existing relationships within the context of my work at FNIHB-AB still arose. Some participants commented at a more innocuous level as a First Nation participant referred to words or expressions I use to describe our work such as ambitious work plans or timelines (FN03). There were also exchanges on the level of support for the Joint Action Health Plan by First Nations partners (FN02, FN05, FN08). A participant in a First Nation organization shared his thoughts about a recent work-related meeting providing additional information explaining his statements (FN09). More serious concerns were also raised by some participants. For example, a First Nation participant referred to my role within FNIHB-AB saying "you know better than I do how much information is being withheld" (FN06) flagging inequities in access to information, trust concerns and power differentials between participating organizations as he believed this ability to withhold information is not possible for First Nations organizations and governments: "you get our reporting. You get everything we do" (FN06). At the same time, he seemed to also perceive me as separate from FNIHB-AB as when describing abusive relationships between First Nations, federal and provincial governments, he told me "and it's not on you… don't take that personally. I don't think that you're going to be slapping me around here" (FN06). Another First Nation participant also delineated his understanding of my roles as he referred to relationships between First Nations, federal and provincial governments. As he advocated for Alberta and Canada to cease these jurisdictional battles:

> You – sorry, not you – the researcher, and Alberta and Canada are supposed to carry on the responsibility of the land that they have taken over, which belonged to the British Crown. So when you took it over, you should have taken over the responsibilities of what the British Crown promised is how we understand it. That's how it should have happened. (FN12)

Participants also shared their views in terms of my roles and responsibilities as they relate more specifically to the Joint Action Plan to Improve the Health of First Nations in Alberta. Earlier, I shared my perception of the development of the Joint Action Health Plan indicating that I played a role in drafting it and believing that it was a collaborative process. Not all participants perceived it this way, as a First Nation participant described a more active involvement: "you would be the expert on the Joint Action [Health] Plan. I mean, you wrote it, for the most part" (FN08). He further outlined his perception of the work:

> I appreciate everything that's gone into making this Joint Action [Health] Plan happen, because it's not easy. You're up against so many things. You're up against policy. You're up against your own people. You're up against First Nations. It's not easy. And I think to your credit, you've still stuck with [it], this is a great opportunity for folks to move forward, and [it] speaks volumes, [it] gives me some confidence that this is something that can work for us. (FN08)

Evolving relationships. The interviews yielded input from First Nations participants in terms of evolving relationships at the personal, professional and organizational levels. A First Nation participant framed it at a much more personal level

reflecting on our evolving personal relationship while wondering whether this would have an impact at the organizational level:

> I know I'll be looking at yourself different, and you'll probably be looking at myself different, and we'll be talking about some of this other stuff. But at the end of the day, how much more of it can we actually do organizationally? I don't know. (FN06)

As a participant, I believe our relationships evolved as a result of the interviews and research interests. I feel privileged for having had the opportunity to meet and discuss collaboration with an amazing group of individuals. I learned from each and every one of the interviews and I was humbled by my colleagues' passion and wisdom. The frequent status updates requested by participants have also been strong motivators as well as opportunities to discuss and brainstorm some of the theoretical pieces I uncovered.

A second First Nation participant told me to "step back and start educating the non-Native people" (FN12). This need for increased awareness of non-Indigenous employees in federal and provincial governments was identified by the Truth and Reconciliation Commission as part of call to action 57. A few non-Indigenous scholars also flagged this need for settlers to better understand and educate non-Indigenous of our responsibilities (Penikett, 2006; Regan, 2010). One of those authors highlighted the importance of confronting this gap in knowledge as he wrote:

> Reminders of our colonial past are necessary because the settler approaches to land and government that coloured relations with Aboriginal people from the beginning prejudice negotiations even today. Unshackling ourselves from these

> prejudices is essential if respect and reconciliation are to be achieved at treaty tables. (Penikett, 2006, p. 4)

A third First Nation participant says: "your Joint Action [Health] Plan is already happening individually. There are some communities who have gone beyond your Joint Action [Health] Plan" (FN08). This highlights a perception of ownership of the Joint Action Health Plan as it relates to the provincial process while also highlighting the role of First Nations communities in implementing it at a community-level. This is also reinforced by one of our colleagues who said "whether it's a band win or a Tribal Council win or a Treaty win or a regional win, it's still a win" (FN09). These statements highlight the tremendous work done by many First Nations individuals, organizations and governments in establishing health partnerships that result in enhanced access and/or quality of health programs and services in First Nations communities. Further, a First Nation participant identified the need for the Joint Action Health Plan to be driven by First Nations and for government partners to step back:

> The communities have to lead the process. So at some point you have to give that up. It's kind of your baby, Nathalie. You put a lot of blood, sweat, and tears into this, but at some point you have to let that go. And it's a hard thing maybe to do, but for this to work for communities and government, that's what has to happen. It has to be the communities driving this process. It cannot be government. (FN08)

In response to the need for a First Nations-driven process, this participant played a key role in the establishment of a First Nations Caucus in May 2017 to support the further development and implementation of the Joint Action Plan to Improve the Health of First

Nations in Alberta. As for the second part of his statement, there is no doubt that the Joint Action Health Plan means a lot to me. Not only did I contribute to its development and been involved in its implementation but the work done for this research also makes it a significant part of my life. I both believe and understand that it needs to be First Nations-led. Yet, I think there are still many lessons for me to learn from his statement in terms of not only evolving relationships but also evolving roles and responsibilities. Based on this experience and considering the collaborative and iterative nature of our work, the lessons may not only be mine to learn as this brings us to collaboration – its three phases, the engagement spectrum and collaborative capacity.

Defining Key Concepts

In interviews, I sought the participants' understanding of the key concepts underpinning the Joint Action Plan to Improve the Health of First Nations in Alberta. In Chapter 5, I shared the participants' views and in this section I summarise this input as it provides elements that are helpful to answer each of the sub-questions. In Table 4, I provide a quick summary of that assessment.

Table 4 – *Assessment of Consensus on Key Concepts*

Key Concepts	Assessment	Comments
Understanding of health care		Broad consensus around the understanding of health whether the participants referred more broadly to the holistic concept of health articulated by First Nations Peoples or the more western-based social determinants of health Much more limited consensus in understanding of health care as some participants opted for an understanding of health care that aligns with the broader consensus of health while others preferred to focus on the common scope of partnering organizations Participants from First Nations organizations and governments identified a number of elements that should be included when considering quality health care; while participants from federal and provincial governments were much more silent
Understanding of the Treaty Right to Health and the Medicine Chest Clause		Participants from First Nations organizations and governments demonstrated a deep understanding of the Treaty Right to Health and the Medicine Chest Clause. Federal and provincial participants shared their more limited understanding and ability to speak on the Treaty Right to Health and the Medicine Chest Clause
Understanding of on- and off-reserve concepts		Broad consensus amongst all participants on the silence of the Joint Action Health Plan in terms of referring to on- and off-reserve whether it relates to residency of individuals or provision of services Some participants signalled that on- and off-reserve concepts could be discussed within the Joint Action Health Plan if it can lead to clarification on jurisdictional responsibilities or points of access
Understanding of collaboration		Participants' input was assessed based on the definition of collaboration developed by Wood and Gray. The elements identified in their definition broadly aligned with the input provided by participants Suggest adding values to the definition to reflect the importance given to them by participants,

Key: Broad consensus amongst participants
Some consensus amongst participants
Limited consensus amongst participants

Based on interviews with participants and my experience as a participant in the Joint Action Health Plan Working Group, I believe participants from First Nations, federal and provincial governments approach health care collaboration differently. It may be linked to the knowledge base of participants and/or the diverse mandates and health care delivery models of the First Nations, federal and provincial governments. Participants from First Nations organizations and governments approach health care collaboration on the basis of rights and more specifically the Treaty Right to Health while participants of the federal and provincial governments often approach it on the basis of needs – whether it is improving health outcomes, improving health care or engaging First Nations as a way to implement the United Nations Declaration on the Rights of Indigenous Peoples or the calls to action of the Truth and Reconciliation Commission. These different approaches have led to some difficult conversations with the Joint Action Health Plan Working Group and it may be useful to unpack these approaches, and seek to bridge the gap in knowledge as we continue to further develop and implement the Joint Action Plan to Improve the Health of First Nations in Alberta. This leads to the first recommendation. A complete listing of recommendations is provided in Appendix J.

Recommendation 1.

It is recommended that members of the Joint Action Health Plan Working Group and Steering Committee define their understanding of health care and use this definition as a foundation to clarify the purpose and scope of work of the Joint Action Plan to Improve the Health of First Nations in Alberta.

In terms of a shared understanding of the Treaty Right to Health and the Medicine Chest Clause, there were obvious discrepancies between the awareness and

understanding shared by the participants. Participants in First Nations organizations and governments shared their deep understanding while participants in federal and provincial governments shared their limitations in discussing the Treaty Right to Health and the Medicine Chest Clause. Further, provincial participants shared both their limited personal as well as organizational knowledge of Treaty discussions. Therefore, I assess this category as red. Within member capacity, additional training will be identified for participants of the Joint Action Health Plan Working Group and Steering Committee, a greater understanding of the Treaty Right to Health and the Medicine Chest Clause will be included.

In terms of a shared understanding of on- and off-reserve concepts, there were many commonalities between participants as they shared their preference for the ongoing silence in the Joint Action Plan to Improve the Health of First Nations in Alberta. The only exceptions were as they relate to our ability to address jurisdictional issues as well as discuss points of access. Considering the consensus amongst participants, I offer the following recommendation:

Recommendation 2.

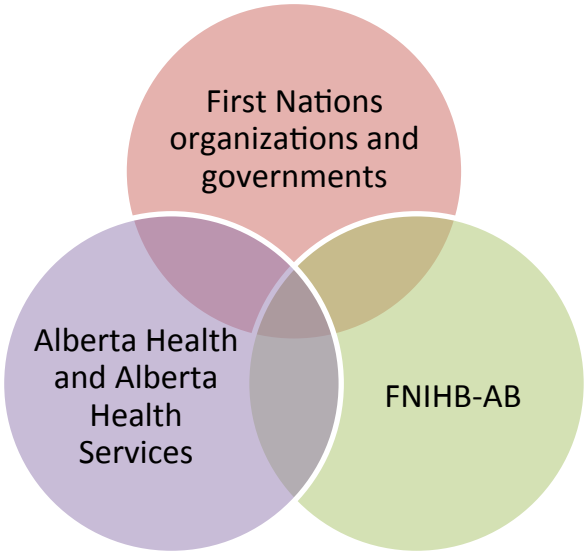
It is recommended that the Joint Action Plan to Improve the Health of First Nations Peoples in Alberta maintains its silence in regards to the on- and off-reserve residency of First Nations individuals and families. It is further recommended that members of the Joint Action Health Plan Working Group and Steering Committee use their discussions to address concerns related to jurisdictional issues and points of access to health care.

I also sought the participants' understanding of collaboration. Essentially, participants' input aligned with the definition of collaboration used to underpin this research (Wood & Gray, 1991). However, as many participants outlined the importance of values, I suggest adding this element to the definition, which is identified as a contribution to interorganizational collaboration research in Chapter 7. In summary, there is a fairly broad consensus amongst participants with three notable exceptions: understanding of health care, defining quality care and understanding of the Treaty Right to Health and the Medicine Chest Clause.

The Three Phases of Collaboration

As I embarked upon this research project, we had recently drafted and secured endorsement of the Joint Action Plan to Improve the Health of First Nations in Alberta by the Co-Management Committee. The goal of the Joint Action Plan to Improve the Health of First Nations is "to enhance collaboration between First Nations [organizations and governments], Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations [peoples] that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014, p. 1). To visually depict our work under the Joint Action Health Plan, we often used the graph in Figure 1 to show that our focus is on the triangle where all three circles meet indicating our common interests. We understand these circles as being an oversimplification of the context as First Nations organizations and governments represent many Nations, Tribal Councils and Treaty organizations. Further, while Alberta Health and Alberta Health Services have many points of convergence, they also have significant differences stemming from their different mandates and service delivery models.

Figure 2. Visual Depiction of the Joint Action Health Plan



I approached this research as a practitioner, I had been involved in a number of collaborations including the predecessor to the Joint Action Plan to Improve the Health of First Nations in Alberta, HSIF Exploring Partnerships. I thought I understood the challenges of collaborations at a provincial level as we sought to identify and act upon our common interests. I understood that we have high-level consensus in our common interests and this was demonstrated by the participants as they shared their expectations about positive outcomes –better First Nations health outcomes, better First Nations health care and greater engagement of First Nations. As a practitioner, I was aware of some of our challenges in moving from this high level consensus to more specific goals, objectives, activities, and outcomes. As a doctoral student I reviewed management literature and I saw potential in interorganizational collaboration as a way to anchor our work even though I did not find evidence of its use in the context of relationships between First Nations, federal and provincial governments. In reviewing literature on collaboration and being influenced by my lenses as a practitioner, I saw a number of

elements that I thought could help us. I appreciated the three phases of collaboration (Butterfield et al., 2004; B. Gray, 1985; B. Gray & Wood, 1991; Wood & Gray, 1991). I could relate to some of the challenges in regards to membership (Huxham & Vangen, 2000) and trust (Mayer et al., 1995; Vangen & Huxham, 2003), as well as saw potential in collaborative capacity (Foster-Fishman et al., 2001). Yet, while helpful these theoretical pieces did not seem to be able to fully explain the dynamics at play. In other words, we need more than an understanding of interorganizational collaboration to enhance health care collaboration between First Nations, federal and provincial governments. Based upon my interviews and my ongoing literature review, we must also take into account the broader context of relationships between First Nations, federal and provincial governments as well as the context of relationships between First Nations Peoples and Settler society in Canada (Alfred, 1999, 2009; Allan & Smylie, 2015; Borrows, 2002; Cardinal, 1999; Cardinal & Hildebrandt, 2000; Coulthard, 2014; Dickason & Newbigging, 2010; Little Bear et al., 1992; Simpson, 2011, 2001). In terms of this broader context, First Nations, federal and provincial governments are undertaking a number of initiatives to renew their relationships as First Nations, federal and provincial leaders signed a number of collaborative agreements including: the Protocol Agreements signed between First Nations of Treaty No. 8 and the Government of Alberta (Treaty 8 First Nations of Alberta and the Province of Alberta, 2016); the Protocol Agreement between the Blackfoot Confederacy and the provincial government (Government of Alberta and Blackfoot Confederacy, 2017); and, the Memorandum of Understanding on Joint Priorities between the Assembly of First Nations and Canada (Assembly of First Nations & Government of Canada, 2017).

Preconditions: The First Phase of Collaboration

Approaching this research as a practitioner, I understood that our context for collaboration could be challenging as we seek to enhance existing relationships between First Nations, federal and provincial governments. My understanding was intuitive building upon my experience as well as the shared experiences of colleagues, a keen interest in learning and a fair amount of gut-feeling. Through my practitioner lenses I was especially interested in the processes stage, what I thought was the "how" piece. I thought that enhancing our collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity – could enhance our ability to work together. My research sub-question on preconditions was informed by my experience as a practitioner, the literature review I had conducted up to that time as well as feedback from my supervisory committee. My research sub-question on preconditions is: What are the impacts of existing relationships between First Nations, federal and provincial governments to the collaborative capacity to enhance multilateral health care collaboration? Therefore, it focused on two elements: relationships and their impacts on enhancing collaborative capacity.

Chickasaw scholar Eber Hampton wrote "research is about learning and … is a way of finding out things" (Hampton, 1995, p. 48), I believe this is also the case with my research sub-question on preconditions. With the benefit of an ongoing literature review including Western and Indigenous literature, interviews with 25 participants, the focus group, and my participation in the Joint Action Health Plan Working Group, I now realise its limitations. First, by focusing on only one sub-element of the preconditions to collaboration I failed to acknowledge the importance of preconditions to collaboration,

this error has now been corrected as I documented and assessed both relationships and other preconditions to collaboration. Second, my sub-question referred to existing relationships between First Nations, federal and provincial governments but failed to identify the broader context of relationships between First Nations Peoples and Settler society. Further, by referring to existing relationships, I was not seeking to ignore past relationships though that was not clearly articulated. Third, my focus on processes was premature as it failed to fully acknowledge the importance of preconditions. To address some of these shortcomings, I will assess the preconditions to collaboration based on Gray's work (1985) prior to sharing my understanding of the additional input provided by participants.

In defining the three phases of collaboration, Gray and Wood identified "the preconditions that make a collaboration possible and that motivate stakeholders to participate" (Gray & Wood, 1991, p. 13). Gray identified six preconditions to collaboration including: identification of a requisite number of stakeholders; positive beliefs about expected outcomes; recognition of interdependence; perceptions of legitimacy amongst stakeholders; legitimate skilled convenor; and, shared access and power (B. Gray, 1985). Based on the input of participants and my experience as a participant, I developed an annotated assessment summarizing the participants input for each of these preconditions. The results are identified in Table 5.

Table 5 – *Assessment of Preconditions to Collaboration for the Joint Action Plan to Improve the Health of First Nations in Alberta*

Preconditions to Collaboration	Assessment	Comments
Identification of a requisite number of stakeholders		Broad consensus around the participation of First Nations of Treaty No. 6, Treaty No. 7 and Treaty No.8, Alberta Health and FNIHB Questions regarding AHS participation as an agency rather than a government partner but its role as the service delivery arm is also signalled Possible membership of Indigenous and Northern Affairs Canada and Indigenous Relations
Positive beliefs about expected outcomes		High level consensus on the expected outcomes but their breadth may impact ability for timely delivery and assessment of success
Recognition of interdependence		Increasing recognition of interdependence e.g. emergency response to 2013 floods, greater access to medical services on-reserve as a result of partnerships with AHS and PCNs, role of the Wisdom Council in providing guidance to AHS Participants shared the lack of consensus amongst First Nations leaders regarding the role of the provincial government as a Treaty partner
Perceptions of legitimacy amongst stakeholders		Based on Gray`s definition of legitimacy, partnering organizations have a legitimate stake meaning they have the right and capacity to participate, however: • Relationships between the partnering organizations limits perceptions of legitimacy • First Nations participants signalled concerns regarding capacity of First Nations organizations regarding access and sustainability of funding
Legitimate skilled convenor		No legitimate skilled convenor has been identified by participants though some individuals were identified for their contributions and credibility including Elders
Shared access and power		Participants outlined the presence of power relationships and power imbalances including: concerns regarding First Nations capacity and colonizing legislations and policies

Key: ▭ Participants did not provide sufficient information to assess
▭ Some elements within Gray's definitions of preconditions are met
▭ The elements within Gray's definition of preconditions are not met

In terms of identification of stakeholders, a consensus emerges amongst participants as they referred to First Nations of Treaty No. 6, Treaty No. 7 and Treaty No. 8, Alberta Health and First Nations and Inuit Health Branch. Even at this organizational level, the consensus does not mean unanimity as some participants questioned the need of having Alberta Health Services as a participant considering the involvement of Alberta Health and its impact on government-to-government relationships as AHS is a provincial agency rather than a provincial ministry. However, some participants also signalled the importance of having Alberta Health Services as the service delivery organization involved in the Joint Action Health Plan. Further, participants in this research and in the Joint Action Health Plan Working Group discussed the involvement of Indigenous and Northern Affairs Canada (INAC) and the provincial ministry of Indigenous Relations. Considering the broad consensus on partnering organizations, I opt to assess it as yellow, thereby indicating that it meets some of the elements within identification of stakeholders but not all (B. Gray, 1985). This ambiguity around membership is not unique to our collaboration as similar challenges have been identified in collaboration literature (Huxham & Vangen, 2000). Questions and comments regarding participants, their decision-making authority and their roles and responsibilities in light of the two-committee structure established are included within the processes stage.

Gray (1985) identified as the second precondition to collaboration – stakeholders' expectations about positive outcomes. Consensus emerged amongst participants in regards to their expectations about positive outcomes as they identified: improving First Nations health outcomes; engaging First Nations individuals, organizations and governments in health care delivery; and, improving First Nations health care. Some

participants shared that this consensus is relatively easy to achieve as these commitments are high-level (AH03, AHS03). However, in broadly defining expectations we may encounter other challenges as a few participants signalled the need to deliver quickly and that failure to do so leads to further lack of trust, mistrust and distrust (FN05, FN14). I assess this high level of consensus as yellow reflecting the consensus amongst participants but wanting to highlight the challenges of not having more clearly defined outcomes for the Joint Action Health Plan limits our congruence with Gray's definition of stakeholders' expectations about positive outcomes. If the expected outcomes remain at the vision level, it may be difficult to have timely results, to establish next steps and to assess our work.

Gray and Wood (1991) identified as the third precondition to collaboration the degree of recognized interdependence between participating organizations. Based on participants' input, the degree of recognized interdependence is increasing. However, some First Nations participants shared that a number of their First Nations colleagues are opposed to health care collaboration with the province reflecting prevailing norms that may not support collaboration at a provincial level. Therefore, I assess this precondition at yellow. Participants identified concrete examples demonstrating increased recognized interdependence including: the role of the Wisdom Council in guiding AHS approach in working with Indigenous Peoples; improved access to physician, diagnostic and specialist services in a number of First Nations communities through partnerships with Alberta Health Services and/or their local Primary Care Network; and, the emergency response to the 2013 floods in southern Alberta.

The fourth precondition to collaboration identified by Gray (1985) is perceived legitimacy between partners. She defined it by indicating that "a legitimate stake means the perceived right and capacity to participate in the developmental process" (Gray, 1985, p. 921). In Chapter 5, I shared the participants' input in terms of legitimacy in terms of right and capacity as well as dedicated a section to outline relationships between partners. In terms of right, First Nations participants outlined the lack of consensus amongst First Nations leadership in regards to the involvement of the provincial government in First Nations health (FN02, FN03, FN05, FN06, FN08, FN11, FN12, FN14). For some, the Treaty relationship can only be with the federal Crown as the Medicine Chest Clause is included in Treaty No. 6. For others, the provincial government also has responsibilities as a Crown. Some participants signalled advantages in working more collaboratively with the province including greater access to services (FN02, FN08) and possibility to establish respectful relationships acknowledging the Treaty relationship (FN08). However, others expressed concerns at the service delivery level including racism and discrimination, as well as the reluctance of provincial partners to fund programs and services. In terms of capacity, participants outlined the existing capacity of both federal and provincial governments. They acknowledge the importance of First Nations involvement while flagging concerns regarding the limited capacity provided to First Nations organizations and governments to be meaningfully engaged. Therefore, considering the significant concerns raised by participants in regards to legitimacy, the assessment can only be red reflecting that the elements of perceived legitimacy of partners as defined by Gray (1985) are not met.

Gray highlighted the importance of the convenor to collaboration but participants provided very little information on who is perceived as the convenor and what would be his/her roles and responsibilities. Participants preferred to highlight participation of key players including Elders and more senior First Nations participants without making references to the work of coordinators and Co-Chairs. This lack of information leads me to conclude that this precondition cannot be assessed. Further, the input provided by participants leads me to question whether this precondition is applicable or if the work of Foster-Fishman and her colleagues and its emphasis on member capacity and to a more limited extent organizational capacity (i.e., leadership; sufficient resources) is perhaps more applicable.

Finally, Gray identified the importance of shared access and power between partnering organizations. Participants identified the importance of power relationships and shared examples of power imbalances between First Nations, federal and provincial governments that are anchored in relationships between First Nations Peoples and Settler society in Canada. Considering the importance of the power imbalances identified by participants, I also assess shared access and power as red.

Therefore, a review of the preconditions to collaboration based on the criteria established by Gray and Wood highlights significant challenges in terms of enhancing collaboration between First Nations, federal and provincial governments. In her work, Gray singles out the impact of limited consensus of two of these preconditions as she writes “unless some consensus is reached about who has a legitimate stake in an issue and exactly what that joint issue is, further attempts to collaboration will be thwarted” (Gray, 1985, p. 917). I must acknowledge that these findings led me to much soul-

searching. Was the premise of my research faulty? Was I misguided with my limited awareness and understanding as a non-Indigenous individual? Is it that collaboration would not be a good foundation for relationships between First Nations, federal and provincial governments to work together? Or, is it that the preconditions to collaboration outlined by Gray and Wood are not appropriate to our preconditions to collaboration between First Nations, federal and provincial governments? Even in using the narrower definitions of health care provided by the participants, I believe that collaboration between First Nations, federal and provincial governments is essential to ensure a continuum of care for First Nations individuals, families and communities. Therefore, considering the wealth of information provided by some participants, I wish to honour their contribution and provide their perspectives on the preconditions to collaboration required to enhance multilateral health care collaboration between First Nations, federal and provincial governments as well as used their input to identify additional preconditions and formulate recommendations.

As we seek to enhance multilateral health care collaboration, three key elements needs to be considered. The first of these elements is the need to recognize both Indigenous and Western worldviews. For members of the Joint Action Health Plan Working Group and Steering Committee, this is done through ethical space. This leads to the third recommendation:

Recommendation 3.

It is recommended that participants engaged in interorganizational collaboration between First Nations, federal and provincial governments recognize both

Indigenous and Western worldviews and seek to work together within an ethical space that is respectful of both worldviews.

The second element refers to the relationships between the partnering organizations. Gray identified historical relationships as a subset of legitimacy, however, based on the participants' feedback, these relationships need to be identified as a separate stand-alone element. Participants described difficult relationships between First Nations, federal and provincial governments that are anchored by the relationships between First Nations Peoples and Settler society as they referred to assimilation, colonization, racism, discrimination, limited trust, lack of trust, mistrust and distrust.

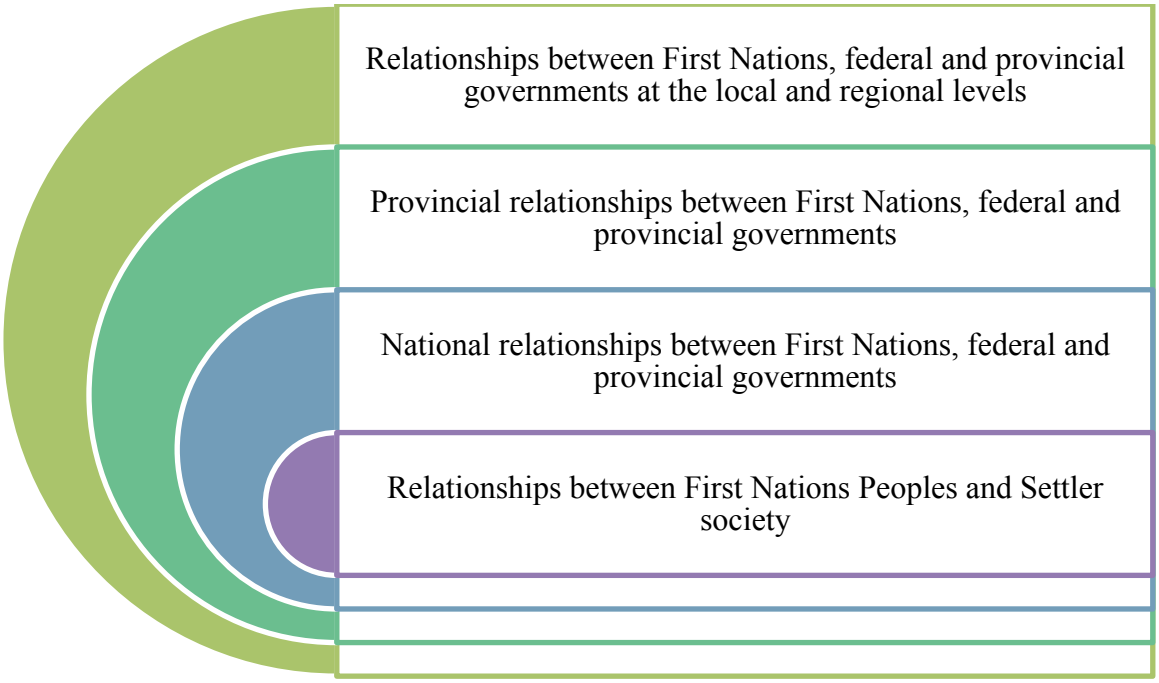
In considering trust, I believe elements identified by Mayer and his colleagues can be used to define the concerns identified by participants as they highlighted the need for the trustor to believe that the trustee demonstrates benevolence, integrity and ability and for the trustor to be willing to take risks in establishing a trusting relationship (Mayer et al., 1995). Through the interviews, First Nations participants highlighted the federal government's reluctance to live up to the Treaties (FN03, FN05, FN06, FN08) and concerns in regard to the adequacy and sustainability of funding for health programs and services delivered by First Nations organizations and governments (FN01, FN02, FN03, FN04, FN05, FN06, FN07, FN09, FN12, FN13, FN15). First Nations participants referred to the ongoing colonisation of First Nations, the harmful impact of current policies and legislations as well as the control of First Nations by federal and provincial governments (FN01, FN06, FN07, FN11). In terms of relationships between federal and provincial governments, jurisdictional concerns were raised as were the financial impacts of greater involvement by the provincial partners. In summary, using the work of Mayer

and his colleagues on trust, First Nations participants shared doubts in regards to the benevolence, integrity and ability of the federal and provincial governments as partners. Participants also reflected on the limited willingness to take the risks required for enhancing trust of First Nations participants (FN01, FN03, FN06, FN14) which was described as understandable by at least one government participant (AHS03) while two federal participants reflected on the negative legacy and impact of decisions by previous governments (HC01, HC02).

With my research sub-question, I inquired about the impact of existing relationships between First Nations, federal and provincial governments on collaborative capacity to enhance multilateral health care collaboration. Informed by my Indigenous literature review and interviews with participants, existing relationships are an important element of collaboration. However, relationships need to be further defined. By identifying the relationships as existing, I was not trying to limit us to the here and now but it is clear that both existing and past relationships are important and impact our collaboration. Based on the data gathered, it is also clear that there are layers to these relationships. At its core, the first layer refers to the impact of relationships between First Nations Peoples and Settler society in Canada. The second layer refers to relationships between First Nations, federal and provincial governments which could include agreements such as the recent Assembly of First Nations – Canada Memorandum of Understanding on Joint Priorities (Assembly of First Nations & Government of Canada, 2017). The third layer includes collaboration such as the Joint Action Plan to Improve the Health of First Nations in Alberta, the Memorandum of Understanding for First Nations Education in Alberta and the Health Co-Management Agreement. Finally, the

fourth layer includes collaboration between First Nations, federal and provincial governments at the community, Tribal Council and Treaty area levels.

Figure 3. Multilayered Relationships between First Nations, Federal and Provincial Governments



Based on the interviews and my experience as a participant, no collaboration is ever truly independent of each other but rather is part of a complex web of collaborations and relationships. For example, First Nations participants expressed concerns in regards to inequities in resource allocations. These concerns were not limited to funding for the Joint Action Health Plan or even health funding but rather more broadly highlighting the tremendous resources shared by First Nations Peoples as a result of Treaties. Further, all participants in the Joint Action Health Plan Working Group are involved in a number of collaborations at any given time, some may include the same partnering organizations but not necessarily. Therefore, this is a fluid environment whereby our work can influence the work of others as their work can influence ours.

Recommendation 4.

It is recommended that participants engaged in interorganizational collaboration between First Nations, federal and provincial governments recognize the interconnectedness of collaborations and understand the impact of their discussions on similar discussions between First Nations, federal and provincial governments.

The impact of the existing relationships and preconditions is felt as many First Nations participants expressed lack of trust, mistrust and distrust towards federal and provincial governments. In framing this limited level of trust, I shared that the level of trust appears to be lower at the organizational level between First Nations, federal and provincial governments than at the personal level between participants. As some participants articulated how they had more trust towards the government employees with whom they interact regularly (FN03, FN13) such as participants at our joint tables, however, this trust is also described as fragile (AH04). Existing relationships between First Nations, federal and provincial governments are only one component of the larger preconditions to multilateral health care collaboration between First Nations, federal and provincial governments. Considering the interconnected nature of collaboration and the different worldviews it would be useful to draw upon the advice of a participant in the focus group who reminded us of the importance of the circle as an infinity process – fixing things as we go (focus group, January 23, 2017) as well as seek to enhance not only our processes but also our preconditions.

Building on the context of relationships between First Nations Peoples and Settler society in Canada, participants highlighted the need for reconciliation (FN01, FN11,

FN12, AH01, AH02, AHS02, AHS03). As I conducted this research, the Truth and Reconciliation Commission released its final report and defined reconciliation as follows:

> Reconciliation is about establishing and maintaining a mutually respectful relationship between Aboriginal and non-Aboriginal peoples in this country. In order for that to happen, there has to be awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes and action to change behaviour. (Truth and Reconciliation Commission of Canada, 2015, p. 6)

By including within their definition of reconciliation awareness of the past, acknowledgment of the harm inflicted upon First Nations and atonement for its causes, the Truth and Reconciliation Commission reminded us that reconciliation does not begin with a clean slate but rather must acknowledge our shared past. In other words, we cannot say "What's past is past. We can only be just in our time. We must be just today" (Borrows, 2002, p. 79) as this would only lead to more injustice.

Over the last twenty years, the Royal Commission on Aboriginal Peoples, the Truth and Reconciliation Commission and Indigenous scholars have done tremendous work in terms of increasing awareness of the past and documenting the harm inflicted upon First Nations (Alfred, 1999, 2009; Allan & Smylie, 2015; Corntassel, 2009, 2012; Coulthard, 2014; Little Bear et al., 1992; Simpson, 2001, 2011). Yet, a number of Indigenous peoples continue to express concerns over the limited awareness of Canadians about our colonial past and present. This was especially evident as Canada celebrated its 150th anniversary as many Indigenous peoples expressed their frustration over a celebration that did not acknowledge the presence of Indigenous Peoples on this land for thousands of years nor the colonization of First Nations Peoples (Bascaramurty, 2017;

Puxley, 2017). In my interviews, Indigenous participants demonstrated a keen understanding of our colonial past and present as well as the broader context of relationships between First Nations Peoples and Settler society in Canada. However, a number of non-Indigenous government participants flagged their limited knowledge and the need for a greater understanding which leads to a recommendation in regards to the knowledge required of participants which is outlined in member capacity. This need for better informed federal, provincial and territorial civil servants was also identified by the Truth and Reconciliation Commission which flagged it in call to action number 57:

> We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal-Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. (Truth and Reconciliation Commission of Canada, 2015, p. 271)

Recommendation 4 has been drafted to take into consideration the input of participants on past and current relationships between First Nations, federal and provincial governments; the limited trust, lack of trust, mistrust and distrust expressed by participants in First Nations organizations towards the federal and provincial governments; and, the need for reconciliation.

Recommendation 5.

In light of the limited trust, lack of trust, mistrust and distrust expressed by participants in First Nations organizations and governments towards federal and

provincial governments, there is a need to focus on enhancing trust between partners. To do so, participants must seek to enhance relationships by enacting reconciliation as defined by the Truth and Reconciliation Commission as a foundational piece to enhancing trust.

In Figure 4, I summarise the key elements of preconditions as identified by participants: identification of partners; shared expectations of outcomes; degree of recognized interdependence' perceived legitimacy of partners; and, willingness to share access and power. Further, I added the preconditions identified by participants as they relate to health care collaboration between First Nations, federal and provincial governments including: the recognition of Indigenous and Western worldviews and the importance of ethical space; the need to acknowledge the impact of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society in Canada; and, the need for reconciliation as defined by the Truth and Reconciliation Commission.

Processes: The Second Phase of Collaboration

While I may not have fully acknowledged the importance of preconditions when I drafted my research sub-questions, I did demonstrate my keen interest in the processes phase as I identified two research sub-questions:

- What are the key elements of collaborative capacity required to enhance health care collaboration between First Nations, federal and provincial governments?
- How can an increased knowledge of collaborative capacity be used to enhance collaboration between partnering organizations?

To answer these two questions, I begin by providing an assessment of each of the collaborative capacity elements – member capacity, relational capacity, organizational capacity and programmatic capacity based on the input provided by the participants. As I did in Chapter 5, this section is organized based on the work of Foster-Fishman and her colleagues (2001).

Member Capacity

Foster-Fishman and her colleagues highlighted three elements within member capacity – skills, attitude and knowledge. In Table 6, I provide an assessment of member capacity as identified by the participants.

Participants expressed their appreciation for the skills and experience brought forward by their colleagues. More specifically, in terms of skills, participants shared that as middle and senior leaders in their respective organizations participants have a solid skills base and what they do not have can be learned. Participants identified a number of key skills including: communications skills, conflict resolution skills, negotiating skills as well as ability to advocate and influence. Within communications skills, participants flagged the need to improve our listening skills as well as our ability to tailor messages to the audience. They also identified more technical skills such as project management, presentation, literacy and computer skills. Based on the input of participants, I assess the current skills level as green.

Table 6 – *Assessment of Member Capacity*

Member Capacity	Assessment	Comments
Skills		Participants readily acknowledged their colleagues' skills Required skills include: communications (including listening skills and ability to tailor message to audiences), conflict resolution and negotiating skills.
Knowledge		Participants shared challenges in terms of understanding the norms and perspectives of their own organization as well as of partnering organizations The need for broad-based knowledge was identified and includes: cultural understanding; understanding of health from a First Nations perspective; relationships between First Nations, federal and provincial governments; and, health systems
Attitude		Importance of believing in the Treaty relationship between First Nations and the Crown High level commitment to improving First Nations health outcomes and health care Attitude towards health care collaboration between First Nations, federal and provincial governments is more ambivalent Attitude towards other stakeholders is ambivalent The broader context of relationships between First Nations, federal and provincial governments and between First Nations Peoples and Settler society in Canada impacts interactions between participants Participants shared a positive attitude about self as a partner

Key: Participants assess this element of member capacity as solid
Participants assess this element of member capacity as requiring improvements

In terms of knowledge, participants highlighted the benefits of broad-based knowledge identifying five key elements: cultural understanding; understanding of health from a First Nations' perspective; broader context of relationships between First Nations, federal and provincial governments; health systems; as well as norms and perspectives of own organization and partnering organization. First, participants identified the importance of having a cultural understanding – highlighting the need for First Nations participants to have a strong cultural foundation and for non-Indigenous participants to recognize and value that knowledge. This connects with the development of ethical space that is being spearheaded by Elders to support the work of the Joint Action Health Plan Working Group and Steering Committee. Second, participants highlighted the need to understand health from a First Nation perspective which includes the use of traditional medicines and so much more. It speaks to health and wellness inclusive of physical, mental, emotional and spiritual health as well as encompassing the health of individuals, families and communities. Third, participants highlighted the need to understand the context of relationships between First Nations, federal and provincial governments as well as the broader context of relationships between First Nations Peoples and Settler society in Canada. In this regard, it was evident from the interviews that non-Indigenous participants and especially those working for the federal and provincial governments do not have the in-depth knowledge of Indigenous colleagues for whom this has been a lived experience. This is especially key within the context of reconciliation as framed by the Truth and Reconciliation Commission (2015) which stressed the need to be aware of the past, acknowledge the harm inflicted and atone for its causes. Fourth, linked to an understanding of relationships between First Nations, federal and provincial governments

is an understanding of health systems including the different roles and responsibilities of each of the partnering organizations. Fifth, participants highlighted the need to better understand the norms and perspectives of the organization they represent as well as those of the partnering organizations.

In terms of training, some participants shared their appreciation for presentations offered in the last few years by the Elders and legal experts. As part of this foundational work, the Joint Action Health Plan Working Group has been guided by an Elders' Advisory that has provided teachings as we seek to build upon an ethical space reflecting both Indigenous and Western ways of knowing. More recently, one of the funded activities under the Joint Action Health Plan, the Alternative Service Delivery Forum, included a session by Elders on First Nations health and wellness as well as provided an opportunity to learn more about different service delivery models in First Nations communities across Canada. Considering the broad-based knowledge required of participants, participants' desire to increase their knowledge and the need for training identified, I assess knowledge as yellow indicating that improvements are required.

Finally, a number of participants identified attitude as the most important element of member capacity. They believed that attitude is essential to engage meaningfully and respectfully as we seek to enhance multilateral health care collaboration between First Nations, federal and provincial governments. First and foremost, participants shared the need to believe in the Treaty relationship between First Nations Peoples and the Crown – which connects with some of the preconditions identified above and speaks to its importance to our discussions. Second, whether they work for First Nations, federal or provincial governments and/or agencies, participants shared their deep commitment to

improving health outcomes of First Nations and improving health care. Participants expressed their desire to make a difference. Third, participants talked of the importance of a positive attitude towards health care collaboration. Some participants identified themselves as strong proponents of collaboration (FN02, FN08, FN09) but others shared their concerns and concerns of First Nations colleagues in engaging with the provincial government (FN03, FN06, FN15). Fourth, in terms of attitude towards other stakeholders, some participants shared their warm feelings and respect towards colleagues (AH02, FN01) while others shared having witnessed racism during our discussions (FN03). Concerns were also raised at the more organizational level, as participants reflected on the impact of relationships between First Nations, federal and provincial governments (AHS03, FN06, FN07, FN12). Fifth, in providing input participants demonstrated their positive attitudes towards their respective skills, knowledge and attitude as partners. Therefore, as participants identify both strengths and challenges in terms of attitude, I assess it as yellow.

Relational Capacity

In Chapter 5, I used the work of Foster-Fishman and her colleagues to anchor the participants' responses in regards to relational capacity. The elements of member capacity identified above also underpin relational capacity as without broad-based knowledge and a keen commitment to First Nations health, relational capacity is diminished. As I did with member capacity, I also provide an assessment of relational capacity based on the participants' input in Table 7.

Table 7 – *Assessment of Relational Capacity*

Relational Capacity	Assessment	Comments
Developing a positive working climate		Participants' assessments of the working climate range from negative to positive
Trust		Participants from First Nations organizations outlined their limited trust, lack of trust, mistrust and distrust of federal and provincial governments Participants expressed higher level of trust towards individuals with whom they interact regularly rather than higher level officials, they do not know or do not meet regularly
Developing a shared vision		Broad consensus around improving First Nations health outcomes, First Nations health care, and engaging First Nations individuals, organizations and governments in health care delivery
Promoting power sharing		Participants have mixed views on power ranging from positive to negative; and from believing that all participants have power to that no participant has any power Participants flagged concerns of power imbalances and of failing to leverage power
Valuing diversity		Respect for diversity was identified by only one participant
Developing positive external relationship		Participants commented on the need for positive external relationships but linked it to accountability (see organizational capacity)

Key: Participants did not provide sufficient information to assess
Participants assess this element of relational capacity as solid
Participants assess this element of relational capacity as requiring improvements
Participants assess this element of relational capacity as weak

Participants shared their mixed feelings about the working climate. While some participants describe it as being positive (AHS02, AHS03, FN15, AH04), others

identified fluctuations within the working climate describing it as being good sometimes but very poor at other times (FN03) while others identified it as being negative highlighting concerns regarding limited trust, lack of trust, mistrust and distrust (FN10). In terms of improving the working climate participants identified the need for a safe environment where "a strong sense of protection" would be provided (FN03) and where participants would have "the freedom to be able to express their views [and] their knowledge" (FN15) as well as have the ability to say "it like it is without having consequences and fear of reprisal" (HC02). Based on the participants' input and the mixed views on working climate, I assess this element of relational capacity as yellow highlighting that some improvements are required.

While Foster-Fishman and her colleagues included trust as a subset of working climate, based on the input of participants trust is much more than that within the context of collaboration between First Nations, federal and provincial governments. As participants abundantly talked of trust, building trust, limited trust, lack of trust, mistrust and distrust and recognizing the significant concerns expressed by participants, I assess trust at red. As participants outlined the importance of developing relationships to build trust at the personal level as well as emphasized that without personal trust organizational trust cannot exist (AH04),

A number of participants identified the importance of enhancing trust at the organizational level. Previous successful collaborative initiatives are perceived as engendering increased trust. However, some previous collaborations also demonstrated challenges in fulfilling commitments. Considering the input provided earlier regarding awareness of norms and perspectives of respective organizations as well as concerns that

will be identified within the next section on accountability and authority, this may reflect the participants limited knowledge and/or authority required.

From the interviews, it is clear that both trust and power are interconnected and neither are limited to the here and now emphasizing the need for a solid knowledge base for participants on existing First Nations, federal and provincial relationships as well as relationships between First Nations Peoples and Settler society in Canada. Participants echoed the messages of political leaders about the need for renewed relationships and the development of more collaborative relationships. While there is a significant knowledge gap between non-Indigenous and Indigenous participants, there is a willingness to learn and for more collaborative approaches. In another demonstration of the challenges of delineating clearly the four elements of collaborative capacity – power is generally understood as an element of relational capacity. However, participants flagged its impact on organizational capacity as participants describe power imbalances by referring to limited capacity and unfair resource allocations. These power imbalances are further linked to the broader context of relationships between First Nations Peoples and Settler society as discussions reached well beyond concerns over health funding. In light of these concerns, I also assess promoting power sharing as red. Many of the issues regarding power imbalances are systemic and require higher level decision-making than what can be provided by the participants I interviewed. However, greater awareness of these systemic issues is required by middle managers as they work towards interorganizational collaboration.

Participants demonstrated high level consensus on a shared vision as they shared on the need to improve First Nations health outcomes, First Nations health care and

greater engagement of First Nations individuals, organizations and governments in health care. I assess this broad level of consensus as green. However, to confirm the scope of the Joint Action Plan to Improve the Health of First Nations in Alberta it would be helpful to turn this high level consensus into a more concrete vision.

Within relational capacity, Foster-Fishman and her colleagues included the need to value diversity. Only one participant commented on the need to respect diversity. Though I understand there is significant diversity amongst First Nations communities and nations in Alberta, the limited input from participants leads me to conclude that there is simply not enough information to assess this element. However, a few participants highlighted the challenges of obtaining consensus amongst First Nations leaders at provincial and even Treaty levels (FN08, FN09). The last element of relational capacity is the development of positive external relationships. Participants provided minimal comments in regards to this last element but highlighted the need for greater communications and accountability which are highlighted within organizational capacity.

Organizational Capacity

Within collaboration literature, organizational capacity refers to the capacity of the collaboration as a collective. However, in interviews with participants, organizational capacity is not limited to our joint initiative as it is also linked to the capacity of the partnering organizations. Table 8 provides a summary of the assessment provided by participants on organizational capacity.

Table 8 – *Assessment of Organizational Capacity*

Organizational Capacity	Assessment	Comments
Effective leadership		Participants' provided limited input on effective leadership
Formalized procedures		Participants outlined multilayered accountability Many participants shared lacking clarity in regards to their authority to speak on behalf of their organization(s) and make decisions Participants expressed mixed feelings in regards to work plans Participants identified challenges with the current structure and no consensus on a way forward
Effective communications		Participants identified the importance of sharing information and identified challenges in ensuring effective communications
Sufficient resources		Participants shared concerns over the limited capacity of First Nations organizations and governments Participants highlighted the important role played by the Elders and the need to provide resources for their involvement

Key: Participants did not provide sufficient information to assess
Participants assess this element of organizational capacity as requiring improvements
Participants assess this element of organizational capacity as weak

Participants provided limited input on effective leadership beyond highlighting the need for a positive attitude which was further described as the need for champions, people who can imagine what it can look like and build it (FN05). Therefore, I do not have enough information to assess this element of organizational capacity. The second element of organizational capacity refers to formalized procedures, which includes:

accountability, authority, work plans and committee structure. Participants described a multilayered accountability where they identify being accountable to: themselves; their supervisor and/or organization; the collective process under the Joint Action Health Plan; and, the First Nations peoples we represent and/or serve. This description of our multilayered accountability highlights its commonalities but there are significant differences. Our very diverse organizational structures lead to different levels of accountability and to a number of participants who express concerns that they may not always know their authority as they engage in discussions and decision-making. In describing their accountability and authority, many participants signalled that they did not know the norms and perspectives of their organizations and of their partnering organizations. As these concerns regarding accountability and authority of the participants were shared by participants in First Nations, federal and provincial governments, it signals issues in terms of internal readiness.

In terms of formalized procedures, participants expressed mixed feelings towards the establishment of work plans. Some highlighted the need for flexibility with work plans (FN08, HC03) while others saw it as a way to ensure that deliverables are met and to ensure accountability to the collective (HC01). Further, two participants highlighted the need for implementation plans (FN08, AHS03).

The last element of formalized procedures refers to committee structure. There was no consensus by the participants in this regard. This may not be surprising as some of the foundational pieces such as terms of reference for the Joint Action Health Plan Working Group and Steering Committee have not been finalized as of August 2017. Further, in terms of supporting the collaboration participants did not agree on a preferred

model as they weigh the pros and cons of supporting capacity within partnering organizations, funding a bridging organization or an hybrid approach. Considering the lack of consensus on many of the elements of formalized procedures, I assess it as red.

In terms of effective communications, participants shared the need to enhance communications and recommended the development of a communications plan. The last element of organizational capacity refers to sufficient resources including both financial and human resources. Participants from First Nations, federal and provincial governments readily acknowledged the unequal organizational capacity of the partnering organizations. It is understood that First Nations organizations and governments do not have the capacity to participate to the same extent as federal and provincial governments. This leads to further power imbalances as well as trust concerns. Considering the participants concerns in regards to resources, I assess this as red. Within the context of the Joint Action Plan to Improve the Health of First Nations in Alberta, funding has been made available to support First Nations organizations and governments. For the last two fiscal years, funding was allocated to some of the collective work including the Joint Action Health Plan Working Group and Steering Committee, the Elders' Advisory and a forum on Alternative Service Delivery. Funding was also allocated to a number of First Nations organizations and governments to pursue targeted collaborative initiatives to enhance collaboration between First Nations, federal and provincial governments. This funding addresses only some of the concerns raised by the participants as much broader concerns are identified in terms of resource allocations between First Nations, federal and provincial governments. As with some of the more systemic issues raised above, there is

limited capacity by the members of the Joint Action Health Plan Working Group and/or Steering Committee to address insufficiency of financial resources.

Programmatic Capacity

With programmatic capacity, Foster-Fishman and her colleagues referred to the ability to deliver programs and services. The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta is to "to enhance collaboration between First Nations [organizations and governments], Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations [peoples] that is accessible, appropriate, acceptable, efficient, effective and safe" (Co-Management, 2014, p. 1). It also includes three objectives: strengthening relationships; increasing accessibility, coordination and quality of health services; and, increasing First Nations control of health services and programs (Co-Management, 2014). As I interviewed participants on the goals of the Joint Action Health Plan, they provided a broader, higher level list including: improving First Nations health outcomes; engaging First Nations individuals, organizations and governments in health care delivery; and, improving First Nations health care. Based on the interviews and my experience as a participant in the Joint Action Health Plan Working Group, I believe this higher-level list accurately reflects our discussions but also represents some of our challenges. First, while high level consensus can be achieved it is also challenging as it fails to provide goals for which performance indicators could be assessed such as targeting specific health outcomes to be achieved; areas of health care that could be enhanced; or, defining an understanding of greater engagement and types of decisions to be jointly made. Second, discussions around identification of priority areas (e.g., mental health and addictions,

primary care, continuing care, crisis intervention, recognition of traditional healing, cultural sensitive care) has also been challenging as many competing priorities make it difficult to identify a select few and agree to wait before tackling the others. Third, considering the current level of trust, collaboration literature would suggest that we need to start small, experience success and build upon it, however, the sheer scope of the work ahead and the need to do more than playing at the edge requires broad systemic changes. Foster-Fishman and her colleagues also included within realistic goals, quick wins. Some participants identified process-based quick wins, such as involvement of Elders, an Alternative Service Delivery Forum to share information, and development of a commitment document amongst partners. The first two have been enacted but the commitment document is still being drafted as of August 2017. Other more program-based quick wins were identified but progress has been minimal. Therefore, the programmatic capacity is being assessed as yellow as identified in Table 9.

Table 9 – *Assessment of Programmatic Capacity*

Programmatic Capacity	Assessment	Comments
Realistic goals		Participants have high level consensus on goals but these seem to reach far beyond the capacity of the Joint Action Plan to Improve the Health of First Nations in Alberta While participants identify a number of quick wins; many would not be quick to achieve

Key:

- Participants assess this element of programmatic capacity as requiring improvements

My first research sub-question on processes was: What are the key elements of collaborative capacity required to enhance health care collaboration between First Nations, federal and provincial governments? Based on the input provided by participants in interviews and the focus group, collaborative capacity would be helpful in enhancing multilateral health care collaboration. In reviewing the assessments provided above, a number of key elements could be strengthened. For member capacity, participants highlighted the need for broad-based knowledge and a positive attitude towards collaboration, other partners and self. In terms of relational capacity, participants outlined significant challenges in increasing trust and in sharing power. For organizational capacity, participants identified three key elements: accountability, authority and sufficiency of resources. As for programmatic capacity, participants identified a number of priorities which could make the selection of realistic goals and quick wins difficult. These elements are identified under the processes phase in Figure 4.

My second research sub-question was: How can an increased knowledge of collaborative capacity be used to enhance collaboration between partnering organizations? To answer this question, I opted to use the input provided by participants to improve collaborative capacity. Considering the broad knowledge required of participants in interorganizational collaboration between First Nations, federal and provincial governments, sixth recommendation focuses on knowledge.

Recommendation 6.

> In recognition of the broad-based knowledge required for members of the Joint Action Health Plan Working Group and Steering Committee, it is recommended that a learning plan be developed and that training, mentoring and coaching

> opportunities be provided. Training to be provided should include topics identified in call to action 57 of the Truth and Reconciliation Commission – "history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law and Aboriginal-Crown relations" (Truth and Reconciliation Commission of Canada, 2015, p. 271). Further, opportunities should be provided to learn more on the Treaty Right to Health and Medicine Chest Clause; health from a First Nations' perspective; broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society; health systems; norms and perspectives of own organization and partnering organizations.

Many of the elements within relational capacity relate to the broader context of relationships between First Nations, federal and provincial and limited organizational trust. Therefore, much of this work would be undertaken with recommendation 5 but recommendation 7 has been added to focus on the need to build personal relationships amongst participants. While recommendation number 8 is centered on power imbalances.

Recommendation 7.

> It is recommended that participants from First Nations, federal and provincial governments engaged in interorganizational collaboration acknowledge the importance of getting to know each other at a more personal level and dedicate time and resources for more informal engagement such as meet and greet and

offsite meetings. Further, participants are expected to demonstrate openness, honesty and humility in their engagement.

Recommendation 8.

It is recommended that civil servants in First Nations, federal and provincial governments increase their awareness of power imbalances and seek ways to mitigate them.

The focus of recommendations 9 and 10 is organizational capacity. The ninth recommendation seeks to address concerns of internal readiness of partnering organizations and their participants. The tenth recommendation is linked to the need for a communications plan to address concerns in regards to internal and external communications.

Recommendation 9.

Once the purpose and scope of the Joint Action Health Plan have been clarified, as per recommendation 1, it is recommended that partnering organizations review their membership and confirm the accountability expected and the delegated authority of their participants.

Recommendation 10.

It is recommended that a communications plan be developed to support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta.

Last but not least, recommendation 11 focuses on programmatic capacity and the need to develop an implementation plan.

Recommendation 11.

> It is recommended that members of the Joint Action Health Plan Working Group and/or Steering Committee develop an implementation plan for the Joint Action Plan to Improve the Health of First Nations in Alberta that scopes out the work to be performed including: vision, mission, goals, objectives, activities and timelines.

Outcomes: The Third Phase of Collaboration

Gray identified four elements to the outcomes phase: "high degree of ongoing interdependence; external mandates; redistribution of power; and, influencing the contextual environment" (B. Gray, 1985, p. 918). I use these elements to assess our outcomes to date with the Joint Action Plan to Improve the Health of First Nations in Alberta and to frame the answer to my research sub-question on outcomes.

Participants readily acknowledged an increased degree of recognized interdependence as a number of participants identified initiatives between some of the partnering organizations that lead to increased access and quality of health care (FN02, FN04, FN08, AHS01). Examples of increased interdependence include increased access to services on-reserve (e.g., primary care, specialists, diagnostic services), ability to engage to address concerns, and the role of the Wisdom Council in guiding Alberta Health Services. In recognition of the progress made in the last few years, I assess this as yellow.

In terms of external mandates, many participants highlighted the 2015 elections and the commitments of both federal and provincial governments to renewed relationships with Indigenous Peoples as well as to implement the calls to action from the

Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples. Participants also signalled the letters of support provided by the federal and provincial Ministers of Health in February 2015. However, a number of participants expressed concerns that political support from First Nations leaders has not been explicitly provided beyond two Co-Management motions (FN02, FN05, FN08). Considering some of the external mandates received but the need for more action, I also assess this as yellow.

Table 10 – *Assessment of Outcomes*

Outcomes	Assessment	Comments
High degree of ongoing interdependence		Participants outlined an increasing level of interdependence (e.g. increasing access to health care on-reserve, beginning to address concerns of racism and discrimination, joint application to access health information)
External mandates		Commitments of federal and provincial governments to renewed relationships with Indigenous Peoples as well as implementation of the calls to action from the Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples Letters of support for the Joint Action Plan to Improve the Health of First Nations in Alberta provided by federal and provincial Ministers of Health Political support from First Nations organizations and governments has not been clearly articulated
Redistribution of power		Interest in moving from power relationship to collaborative relationships but power and capacity have not been significantly altered
Influencing the contextual environment		Participants recognized the unique status of the Joint Action Health Plan Working Group and/or Steering Committee as a forum for multilateral health care collaboration

Key: Participants assess this element of outcomes as requiring improvements
Participants assess this element of outcomes as weak

Participants indicated a desire to move from power relationships to collaborative relationships. As indicated earlier within collaborative capacity, there are still significant power imbalances at the systemic level. Therefore, redistribution of power can only be

assessed as red. In terms of influencing the contextual environment, participants highlighted the gains made in terms of increasing understanding and empathy amongst partners. In recognition of some of the gains made, I assess this element as yellow.

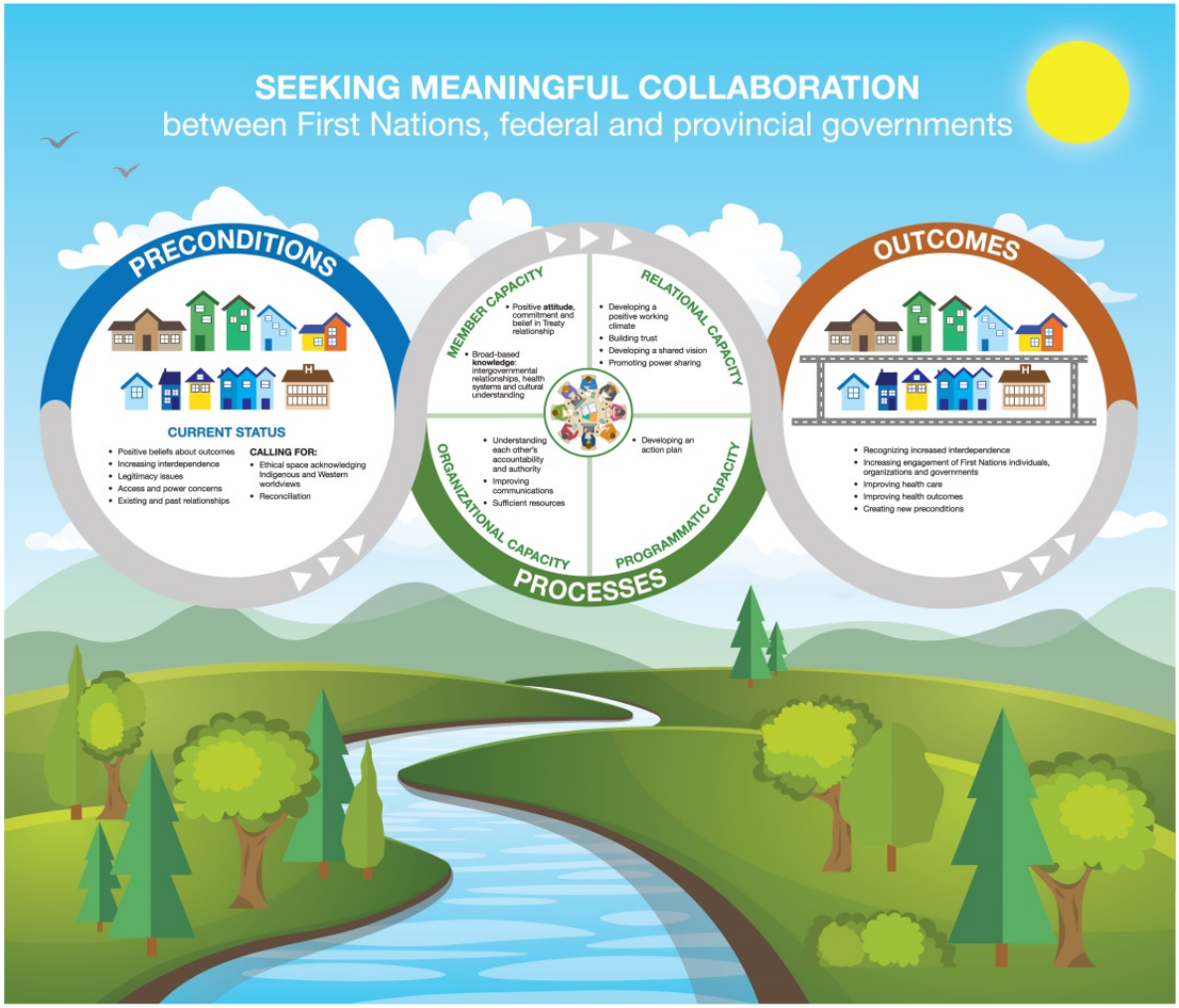
My research sub-question on outcomes was: How is improving collaborative capacity impacting collaboration? Considering my earlier comment on how I had underestimated the importance of preconditions, this question now seems overly ambitious. However, I believe the assessments of our preconditions, processes and collaborative capacity as well as outcomes can be useful in establishing next steps for the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta and more broadly for collaboration between First Nations, federal and provincial governments.

In conclusion, greater understanding and use of collaboration and collaborative capacity can help strengthen relationships between First Nations, federal and provincial governments. I have summarised the key elements of this understanding in Figure 4. First and foremost, collaboration between First Nations, federal and provincial government needs to have as its foundation the Treaty relationships between First Nations and the Crown. The background of Figure 4 reflects the importance of the Treaty relationships as the basis for collaboration between First Nation, federal and provincial government as well as its perennial nature, "as long as the sun shines, the grass grows and the rivers flow" (Treaty 8 First Nations of Alberta, 2017). Second, collaboration between First Nations, federal and provincial governments has a more cyclical rather than linear nature. Considering the impact of past and existing relationships between First Nations, federal and provincial governments as well as the

involvement of many participants in many concurrent collaborations, today's preconditions are impacted by yesterday's outcomes. Third, the preconditions to collaboration cannot be underestimated as they play a key role in our ability to better work together. Based on the participants' input, the key preconditions are: positive beliefs about outcomes; increasing interdependence; legitimacy issues; access and power concerns; current and past relationships. Within preconditions, we need to work together in ethical space acknowledging both Indigenous and Western worldviews as well as to seek reconciliation as defined by the Truth and Reconciliation Commission. Fourth, the four elements of collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity – provide a solid foundation to better support the processes phase of collaboration. Within member capacity, we need to acknowledge the importance of attitude as a key driver as well as the need for broad-based knowledge. Within relational capacity, four key sub-elements are particularly important: developing a positive working climate; building trust; developing a shared vision and promoting power sharing. Within organizational capacity, participants identified the need for capacity at the collective level but even more importantly for participating First Nations organizations and governments is the need to have the capacity in terms of financial and human resources to meaningfully participate. There is also a need for participants to better understand their own accountability and authority as well as those of their partners. Improving communications is also identified as key whether it is between participants, between participating organizations and more broadly with other stakeholders. Within programmatic capacity, participants identified many goals and possible quick wins highlighting the need for an action plan. Finally, in terms of

outcomes, participants identified gains made to date and the need for more progress in the following areas: interdependence between partners; involvement of First Nations individuals, organizations and governments in health care; and improvements to First Nations health care and health outcomes.

Figure 4. Seeking Meaningful Collaboration between First Nations, Federal and Provincial Governments



Chapter 7 – CONCLUSIONS

As I write the conclusion of my dissertation, I am once again drawn to the words of Cree scholar Shawn Wilson who wrote "if research doesn't change you as a person, then you haven't done it right" (Wilson, 2008, p. 135). I began this research journey in September 2012, just over five years ago. It has been an incredible journey, energizing, exhilarating and exhausting at the same time. I learned about collaboration as seen through the lenses of western management literature, about reconciliation through the lenses of Indigenous literature, about working together through the lenses of the 25 middle to senior level participants I interviewed and the participants in the focus group, as well as through my experience as a participant in the Joint Action Health Plan Working Group.

Within the context of this research, I interviewed an Elder who told me that if I did not know to just ask… I remember thinking but what if I do not know that I do not know. This may sound philosophical but it is not. As a non-Indigenous person conducting Indigenous research, I am often confronted by our different worldviews and a history written from a western perspective. This journey has been a deeply internal journey as I learned to see and hear differently, learning to take time and pause, to question what I had previously learned and to keep an open mind and heart in the face of learnings that challenge what I thought I knew and who I am. Within the context of my work on the Joint Action Health Plan Working Group this recognition of western and Indigenous learning is defined as ethical space (Crowshoe & Littlechild, 2017; Ermine, 2007) which also connects with the work on the two-eyed seeing approach (Bartlett,

Marshall, Marshall, & Iwama, 2015; Martin, 2012; Vukic, Gregory, & Martin-Misener, 2012).

As a demonstration of my learning, I would like to refer back to the notion of power. In Chapter 2, I shared my views outlining my understanding of power. As a federal government employee seeking to conduct Indigenous research, my supervisory committee reminded me of my own power and I believe that I failed to fully acknowledge its extent. I do not tend to see myself as someone who is powerful nor with much authority. Yet, as I conducted this research I began to acknowledge my own power, as well as my limited understanding of existing and past relationships between First Nations, federal and provincial governments, which was fairly similar to the knowledge of my non-Indigenous colleagues but a world away from the depth of knowledge of First Nations colleagues. Through this research, I increased my knowledge and challenged my worldviews by reading Indigenous authors and listening to First Nations colleagues who shared their experiences. At times, this has been quite difficult. I described some of those readings or discussions as more difficult and requiring me to step away – but I am now acutely aware that I have the luxury of stepping away. I can choose to continue, or not, to read a difficult book or I can choose to read it in more manageable chunks or I can put it aside for a few months before trying again, if ever. As for the more difficult conversations, I can be comforted by the more positive exchanges or the "you, but not you" comments. Today this is what I understand as "white privilege", the ability I have to shut it off, to downplay it or leave it aside while First Nations colleagues, friends and family members do not have this luxury. Along this

journey, I learned to limit my ability to choose the easy way and avoid the difficult conversations, books and learnings.

Without this learning, I would not fully grasp the impact of colonization on programs, policies and legislations nor would I be a supportive partner; one who will advocate and work towards change. Through the last few years, as I immersed myself in Indigenous literature and benefited from the wealth of knowledge and experience shared by the participants, I increasingly felt the need for practitioners, and especially for government employees, to better understand the broader context of First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society in Canada. In this chapter, I outline limitations to my research, answer my research question, outline what I believe are my contributions to interorganizational collaboration research as well as identify areas for future research.

Limitations

Before answering my research question, I believe it is important to identify some of the limitations of my research. The first limitation is based on what I bring and fail to bring to this research. I am a non-Indigenous person conducting Indigenous research. In conducting this research, I sought to be respectful of Western and Indigenous knowledge but I must acknowledge the challenges of navigating different ways of knowing.

Second, I approached this research as a practitioner with twenty years of experience in the field of Indigenous health in either advocacy or management capacity. While I began my career in Indigenous organizations, I worked as a mid-level federal civil servant for most of that time. With this research, I bring forward the views of Indigenous and non-Indigenous colleagues who are involved in collaborative work

between First Nations, federal and provincial governments in Alberta. Considering the much broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society in Canada, the focus on mid-to senior level management is a limitation. The participants I interviewed have the ability to influence and implement decisions but few if any of them have the authority to make the high-level decisions required for systemic changes. Therefore, the focus of this research is on the social, political and cultural aspects of collaboration rather than its more legal and jurisdictional aspects.

The third limitation is linked to my focus on collaboration. Using the New Zealand engagement spectrum (New Zealand Office for the Community and Voluntary Sector, 2011), I focused on the *with* quadrant where we, mid- to senior-level civil servants in First Nations, federal and provincial governments, seek to work together. I made this decision believing that to ensure a better continuum of care for patients, their families and communities would require enhanced collaboration between First Nations, federal and provincial health care systems. By doing so, I did not focus on the last quadrant, *by* where First Nations organizations and governments would be in control. I do not seek to diminish its importance but simply highlight this decision as a limitation to my research.

The fourth limitation is linked to my chosen methodology, participatory action research. Considering my dual roles as a researcher and participant, I hoped to be able to use a more participatory approach and to be able to engage more fully with my colleagues on this research. However, as I conducted this research and gathered more information through interviews and Indigenous literature, I became more cautious and

increasingly aware of my role as a federal civil servant. Using the words of the Truth and Reconciliation Commission to define reconciliation, I became increasingly aware of the past and as I acknowledged the harm inflicted, I sought to avoid repeating past behaviours. While I may not have perceived myself as powerful and may still struggle with understanding my own power, I became more cautious and stepped in only when invited or within clear parameters. For example, in one-on-one discussions with some participants, I would share interesting findings stemming from western and Indigenous literature, answer questions about my research or discuss what they shared during the interviews. When invited by the Co-Chairs, I facilitated some sessions of the Joint Action Health Plan Working Group. I also engaged more formally by sharing a summary of findings with interview participants in June 2016 and by holding a focus group with the Joint Action Health Plan Working Group in January 2017. A final summary of findings will be shared with participants upon completion of this dissertation.

Research Question

My research question was developed based on my experience as a practitioner, the literature review up to that time and discussions with some members of my supervisory committee. My research question is: How can improved collaborative capacity enhance health care collaboration between First Nations organizations, Alberta Health, Alberta Health Services and FNIHB-AB? My research question drove everything: the research sub-questions; the approach to my research; the methodology I chose to use; the drafting of my ethics applications; the tools I developed; and, much of the reading I did. Yet, stepping back and seeking to answer the question reminds me of the incredible journey the last three years have been.

Assumptions

Before answering my research question, I think it is important to identify the assumptions that underpinned it. First, it is clear that I believed in collaboration as my research question implied the desirability of health care collaboration between First Nations, federal and provincial governments. I still believe in collaboration, however, my understanding has evolved as a result of my research. I now truly understand collaboration as a process not a desired outcome. Collaboration is about working together and based on the interviews I conducted the outcomes of our collaboration could be: a joint document between partners; joint forum to address concerns; enhanced health care on-reserve; better coordination of services between health care providers; and, improved health outcomes.

Second, my research question gave me an opportunity to delve into the broader context of relationships between First Nations Peoples and Settler society but did not originally allude to its impact on collaboration between First Nations, federal and provincial governments. This was an important oversight. I believe I have now compensated for it as I documented the systemic issues flagged by participants including: ongoing colonization of First Nations peoples through legislations and policies; systemic racism and discrimination; and, concerns regarding adequacy and sustainability of funding for First Nations organizations and governments.

Third, my research question demonstrated my interest in the "how" with its focus on collaborative capacity. I understood collaborative capacity as a way to strengthen the process stage of collaboration. Based on the data I gathered over the last few years, I still think that collaborative capacity has a role to play to enhance health care collaboration

between First Nations, federal and provincial governments however I had underestimated the importance of preconditions.

In hindsight my research question was a useful starting point. It gave me an opportunity to better understand the many elements impacting health care collaboration between First Nations, federal and provincial governments. Yet, answering this question narrowly would not be helpful. Therefore, as I seek to honour the participants' input, I answer this question by taking into account this broader understanding.

In answering my research question, I identify three key elements: impacts of colonization on collaboration; reconciliation as a basis for collaboration; and, addressing the knowledge gap of federal and provincial civil servants, especially non-Indigenous civil servants.

Impacts of Colonization on Collaboration

Based on the data I collected through literature review, interviews and focus group, collaboration between First Nations organizations and governments, Alberta Health, Alberta Health Services and FNIHB-AB is more than interorganizational collaboration. It must be seen within the context of current and past relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler society in Canada.

First Nations scholars and participants in this research highlighted the health of First Nations individuals, families and communities pre-contact. In the early contact era there was a spirit of cooperation (Royal Commission on Aboriginal Peoples, 1996)but over time and with a rapidly increasing settler population, the relationships changed giving way to colonization, oppression, assimilation, racism and discrimination. Earlier,

I documented approaches of the federal government to renew relationships highlighting: the 1967 Hawthorn Report and its advocacy for Indians to be citizens plus; the partnership proposed in the 1969 Indian Act; the 1979 Indian Health Policy with its recognition of legal and traditional responsibilities; the 1989 Transfer Policy where it identified the need for increased First Nation and Inuit control; the 1998 response to RCAP with a call for renewed partnership; the 2008 Statement of Apology; and, more recently commitments to renewed relationships "based on a recognition of rights, respect, co-operation, and partnership" (Trudeau, 2015, np).

From my data collection, it is clear that the broader context of relationships between First Nations Peoples and Settler society in Canada influences relationships between First Nations, federal and provincial governments. In describing these latter relationships, participants highlighted jurisdictional issues, inequities in resource allocations, limited trust, lack of trust, mistrust and distrust. In regards to trust, the concerns raised by First Nations participants correlates with existing literature as they expressed doubts on the benevolence, integrity and ability (Mayer et al., 1995) of federal and provincial governments. We do not operate in a vacuum and the broader relationships between First Nations, federal and provincial government as well as between First Nations Peoples and Settler society in Canada have an impact on multilateral health care collaboration. Further, these broader relationships and the participants' understanding of them impact how participants come to the discussions. First Nations participants clearly articulated that they have a sound knowledge of the needs of First Nations individuals, families and communities but more importantly they come with an understanding of their Treaty and inherent rights and they see them as the

foundation for discussion. Federal and provincial participants approach the discussions differently often focusing on needs for: better health outcomes; better health care; and, greater engagement of First Nations individuals, organizations and governments. This latter engagement piece is based on commitments to implement the calls to action for the Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples.

Reconciliation as a Basis for Collaboration

There is an ongoing web of relationships between First Nations, federal and provincial governments though not all these relationships are collaborative. As we seek to further develop and implement the Joint Action Plan to Improve the Health of First Nations in Alberta, I asked participants to assess our relationships using the New Zealand engagement spectrum (New Zealand Office for the Community and Voluntary Sector, 2011). As indicated earlier, First Nations participants assessed our relationships within the *to* and *for* quadrants while participants from federal and provincial governments tended to score us within the *for* and *with* quadrants. This discrepancy in assessment is important as it impacts our ability to build our collaborative capacity. It reflects the needs of partners to pause and better understand each other's perspectives. Through the work we have done on ethical space, we understand the need to be mindful and respectful of both Indigenous and Western worldviews.

Therefore, as we embark upon collaboration, our work must be anchored by the reconciliation as defined by the Truth and Reconciliation Commission (2015) including awareness of the past, acknowledgement of the harm inflicted, atonement for its causes as we seek action to change behaviour. In other words, as we seek to enhance multilateral

collaboration between First Nations, federal and provincial governments, we must consider reconciliation as one of the preconditions to collaboration. However, the spirit of reconciliation cannot only be identified within the precondition it must also infuse the collaborative capacity that is the core of processes.

Addressing the Knowledge Gap of Federal and Provincial Civil Servants

This doctoral journey has been a deeply personal journey. Through this research I often referred to my dual role as a researcher and participant. As a researcher, I am a doctoral student enrolled in the Doctorate of Business Administration at Athabasca University. As a participant, I am a member of the Joint Action Health Plan Working Group as a FNIHB-AB representative. However, my connection to this research is much more than merely professional, as I am also driven at a personal level as a member of a large blended Métis and First Nations family. Yet, this research has been a learning journey as I realised how little I knew, how what I thought I knew was often incorrect or only part of a more fulsome story and how much more I still need to know. In that regard, my experience is not very different from what some non-Indigenous participants shared with me as they outlined their commitment, their passion, their desire to contribute but also their challenges and the need for humility as they outlined the knowledge gap between First Nations and non-Indigenous participants. Some of this knowledge gap stems from the different knowledge sources. Most First Nations participants have had access to oral stories for decades more than non-Indigenous participants who relied on written history until they learned more from Indigenous participants of Indigenous worldviews, and increased their understanding of health from a First Nation perspective as well as the broader context of relationships between First Nations, federal and

provincial governments. In seeking to address this knowledge gap, there is a need for ethical space (Crowshoe & Littlechild, 2017; Ermine, 2007) and two-eyed seeing (Bartlett et al., 2015; Martin, 2012; Vukic et al., 2012), the need to learn to question what we think we know to begin to hear and see differently. Without this knowledge and commitment, we cannot move beyond "What's past is past. We can only be just in our time. We must be just today" (Borrows, 2002, p. 79).

Contributions to Research

With this research, I believe I contribute to interorganizational collaboration research in four ways. First, I contribute by using collaboration theory in the context of health care collaboration between First Nations, federal and provincial governments. I believe a number of elements stemming from collaboration literature including its three phases of preconditions, processes and outcomes as well as collaborative capacity can be useful to enhancing collaboration between First Nations, federal and provincial governments. However, to support greater collaboration with First Nations organizations and governments, special attention must also be given to Indigenous worldviews, the impact of colonization and the need for reconciliation.

Second, the three phases of collaboration were used to anchor my interview guide and I feel a high level of congruence amongst participants whether they work in First Nations, federal and provincial governments. Participants in the focus group highlighted the need to acknowledge the importance of the circle as an infinity process – fixing things as we go (focus group, January 23, 2017). This leads us to our second contribution to research. In describing collaboration and its three phases – preconditions, processes and outcomes – there is usually a linearity with a beginning, a middle and an end (Butterfield

et al., 2004; B. Gray, 1985; B. Gray & Wood, 1991; Wood & Gray, 1991). While participants readily connected with the three phases, they did not understand it as a linear process but rather as a cyclical one where the outcomes of previous collaborations provide the basis for the next preconditions and collaborations. This cyclical view would also align with the Royal Commission on Aboriginal Peoples which framed First Nations understanding of relationships between First Nations and settlers as cyclical rather than linear. It also aligns more concretely with our work on the Joint Action Plan to Improve the Health of First Nations in Alberta, which was a deliverable of a previous collaborative initiative, HSIF Exploring Partnerships. Both initiatives were influenced by our work within the Co-Management structure as well as other collaborative efforts between First Nations, provincial and federal governments in Alberta. Further, the Joint Action Health Plan Working Group is interested in building on previous collaborations on continuing care and mental health and addictions; two areas that have been the subject of a number of collaborations including projects funded through the Health Services Integration Fund. Whether new collaborations result directly from a previous initiative such as the relationship between HSIF Exploring Partnerships and the Joint Action Plan to Improve the Health of First Nations in Alberta or whether it is building on similar initiatives in other social sectors, we regularly work together. We build on personal and professional relationships as the previous collaborations allow us to learn more about each other in terms of our strengths, weaknesses, interests, approaches and attitudes both at the personal and organizational levels. Many participants are regularly involved in collaboration. This is even more so for participants in First Nations organizations as they shared how other collaborations influenced positively or negatively the work on the Joint

Action Plan to Improve the Health of First Nations in Alberta. These multiple, often concurrent, collaborations colour the lenses of participants and contribute to our ability to build relationships between participants and partnering organizations. When collaboration functions well, it has the potential of engendering trust, however, when it does not, it leads to lack of trust, mistrust or distrust and contributes further to negative / relational legacy which may also cross over to other collaborations as we are often involved in a web of collaboration.

Our third contribution to research is linked to the definition of collaboration. To anchor this research, I used the definition of collaboration developed by Wood and Gray which states "collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain" (Wood & Gray, 1991, p. 146). Based on the input from participants there was a high level of congruence between elements identified in this definition and their understanding of collaboration. However, this high level of congruence does not mean that participants accepted the definition without contributing to it. As participants outlined their understanding of collaboration, they highlighted the importance of shared values. Arguably, shared values could underpin shared rules, norms and structures, however, considering the importance given to values, I believe it would warrant its addition. This may be linked to the cross-cultural context of our work, reflecting the importance of the seven sacred teachings to First Nations worldviews. Values identified as contributing to collaboration included respect, wisdom, love, humility, honesty, courage and truth. Therefore, I suggest amending the definition to read as follows: collaboration occurs when a group of autonomous

stakeholders of a problem domain engage in an interactive process, using shared *values*, rules, norms, and structures, to act or decide on issues related to that domain.

As I worked on this research, I often drew on the four elements of collaborative capacity – member capacity, relational capacity, organizational capacity and programmatic capacity as four quadrants of a circle. I understood them as being interconnected. As I gathered the data from the participants, the interconnectedness of the four elements of collaborative capacity became more evident and I believe this is our fourth contribution to research.

Future Research

As I worked on this research, I often felt that I raised more questions than I could possibly answer. I believe some of these questions could be areas for future research. First, my focus has been on collaboration between First Nations, federal and provincial governments as I sought to better understand how we move from the *to* and *for* quadrants of the New Zealand engagement spectrum (New Zealand Office for the Community and Voluntary Sector, 2011) to the *with* quadrant but much more work is needed to better support transition to the *by* quadrant. Second, I approached this research as a practitioner and more specifically as a federal civil servant with some work experience in Indigenous organizations, I believe I needed to do this work to better understand the perspectives of fellow middle to senior leaders in our organizations. However, I think much more work is needed to better understand the roles and responsibilities of civil servants as we embrace collaboration and reconciliation. Third, as I approached this research as a mid-level civil servant, I was interested in the social, political and cultural aspects of collaboration while I acknowledge the existence of legal and jurisdictional barriers to

collaboration these were not the focus of this research and could be an area of future research by other researchers. Fourth, I believe more research is needed to better understand how collaborative capacity of civil servants in federal and provincial governments can be enhanced. Part of this work would relate to the knowledge identified within call to action 57 of the Truth and Reconciliation Commission. However, the knowledge required needs to be broadened to recognize the impacts of colonization into our existing policies and legislations as well as provide opportunities to learn history from a First Nations perspective. Fifth, much more work is needed to increase understanding of health from First Nations perspectives and to develop a better understanding of our different worldviews whether it is building on the work on ethical space that underpins much of the Joint Action Plan to Improve the Health of First Nations in Alberta or whether it is enhancing our ability for two-eyed seeing. Sixth, I interviewed a number of Indigenous and non-Indigenous civil servants working for federal and provincial governments. However, I did not inquire on their perspectives in terms of the impact of their Indigeneity, or lack thereof, on how they approach collaboration with First Nations colleagues, organizations and governments. Finally, as I interviewed First Nations participants, I heard abundantly about limited trust, lack of trust, mistrust and distrust as it relates to collaboration between First Nations, federal and provincial governments. An area for future research would be to better understand the differences between limited trust, lack of trust, mistrust and distrust. Considering my interest in interorganizational collaboration, I think much more work is also required to better understand how we can build trust or how we can enhance collaboration taking into account the current trust level.

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APPENDIX A – Athabasca University Research Ethics Approval

June 19, 2017

Ms. Nathalie Lachance
Faculty of Business\Doctorate in Business Administration
Athabasca University

File No: 21832

Certification of Ethics Approval Date: June 30, 2015

New Renewal Date: June 18, 2018

Dear Nathalie Lachance,

Your Renewal Form has been received by the AU REB Office.

Athabasca University's Research Ethics Board (REB) has **approved** your request to renew the *certification of ethics approval* for a further year for your project entitled "Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments".

As you progress with the research, all requests for changes or modifications, ethics approval renewals and serious adverse event reports must be reported to the Athabasca University Research Ethics Board via the Research Portal.

To continue your proposed research beyond June 18, 2018, you must apply for renewal by completing and submitting an Ethics Renewal Request form before expiry. Failure to apply for **annual renewal** before the expiry date of the current certification of ethics approval may result in the discontinuation of the ethics approval and formal closure of the REB ethics file. Reactivation of the project will normally require a new Application for Ethical Approval and internal and external funding administrators in the Office of Research Services will be advised that ethical approval has expired and the REB file closed.

When your research is concluded, you must submit a Project Completion (Final) Report to close out REB approval monitoring efforts. Failure to submit the required final report may mean that a future application for ethical approval will not be reviewed by the Research Ethics Board until such time as the outstanding reporting has been submitted.

If you encounter any issue with the Research Portal's online submission process, please contact the system administrator via research_portal@athabascau.ca.

If you have any questions about the REB review & approval process, please contact the AUREB Office at (780) 675-6718 or rebsec@athabascau.ca.

Sincerely,

Office of Research Ethics

Athabasca University
RESEARCH CENTRE

June 20, 2016

Ms. Nathalie Lachance
Faculty of Business
Athabasca University

File No: 21832

Certification of Ethics Approval Date: June 30, 2015

New Renewal Date: June 19, 2017

Dear Nathalie Lachance,

Your Renewal Form has been received by the AU REB Office.

Athabasca University's Research Ethics Board (REB) has **approved** your request to renew the *certification of ethics approval* for a further year for your project entitled "Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments".

As you progress with the research, all requests for changes or modifications, ethics approval renewals and serious adverse event reports must be reported to the Athabasca University Research Ethics Board via the Research Portal.

To continue your proposed research beyond June 19, 2017, you must apply for renewal by completing and submitting an Ethics Renewal Request form before expiry. Failure to apply for **annual renewal** before the expiry date of the current certification of ethics approval may result in the discontinuation of the ethics approval and formal closure of the REB ethics file. Reactivation of the project will normally require a new Application for Ethical Approval and internal and external funding administrators in the Office of Research Services will be advised that ethical approval has expired and the REB file closed.

When your research is concluded, you must submit a Project Completion (Final) Report to close out REB approval monitoring efforts. Failure to submit the required final report may mean that a future application for ethical approval will not be reviewed by the Research Ethics Board until such time as the outstanding reporting has been submitted.

If you encounter any issue with the Research Portal's online submission process, please contact the system administrator via research_portal@athabascau.ca.

If you have any questions about the REB review & approval process, please contact the AUREB Office at (780) 675-6718 or rebsec@athabascau.ca.

Sincerely,

Office of Research Ethics

June 30, 2015

Ms. Nathalie Lachance
Faculty of Business
Athabasca University

File No: 21832

Ethics Expiry Date: June 29, 2016

Dear Ms. Nathalie Lachance,

Thank you for your recent resubmission to the Faculty of Business Departmental Ethics Review Committee, addressing the clarifications and revisions as requested for your research entitled, 'Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments'.

Your application has been **Approved** and this memorandum constitutes a ***Certification of Ethics Approval***. You may begin the research immediately.

This REB approval, dated June 30, 2015, is valid for one year less a day.

Throughout the duration of this REB approval, all requests for modifications, ethics approval renewals and serious adverse event reports must be submitted via the Research Portal.

To continue your proposed research beyond June 29, 2016, you must apply for renewal by completing and submitting an Ethics Renewal Request form. Failure to apply for **annual renewal** before the expiry date of the current certification of ethics approval may result in the discontinuation of the ethics approval and formal closure of the REB ethics file. Reactivation of the project will normally require a new Application for Ethical Approval and internal and external funding administrators in the Office of Research Services will be advised that ethical approval has expired and the REB file closed.

When your research is concluded, you must submit a Project Completion (Final) Report to close out REB approval monitoring efforts. Failure to submit the required final report may mean that a future application for ethical approval will not be reviewed by the Research Ethics Board until such time as the outstanding reporting has been submitted.

At any time, you can login to the Research Portal to monitor the workflow status of your application.

If you encounter any issues when working in the Research Portal, please contact the system administrator at research_portal@athabascau.ca.

Sincerely,

Fathi Elloumi
Chair, Faculty of Business Departmental Ethics Review Committee
Athabasca University Research Ethics Board

APPENDIX B – Joint Action Plan to Improve the Health of First Nations in Alberta

Goal: To enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe.

Activity	Level	Responsibility	Timeline	Deliverable
OBJECTIVE 1: Strengthening relationships				
Develop and sign a document outlining the needs for improved First Nations health outcomes and greater collaboration between Treaty 6, Treaty 7, Treaty 8 First Nations, provincial and federal governments	Provincial	Treaty 6, 7 and 8 FNIHB-AB Alberta Health	March 31, 2015	Document developed and signed
Establish principles to guide multilateral collaborative efforts	Provincial	Treaty 6, 7 and 8 FNIHB-AB Alberta Health Alberta Health Services	March 31, 2015	Principles established and adopted by all partners
Increase awareness of health systems by all partners	Provincial, Regional and Local	Treaty 6, 7 and 8 FNIHB-AB Alberta Health Alberta Health Services	Ongoing	Increased awareness of health systems
Develop and sign Alberta First Nations Health Information Sharing Agreement in accordance with AoTC resolution of June 12, 2013	Provincial	Treaty 6, 7 and 8 FNIHB-AB Alberta Health AFNIGC AANDC	December 31, 2015	Agreement to access and share AANDC Status Verification System to develop a First Nations identifier in Alberta developed and signed by all parties
OBJECTIVE 2: Increase accessibility, coordination and quality of health services				
Build on existing initiatives to	Multi-level	Treaty 6, 7 and 8	December	Document existing partnerships and

Activity	Level	Responsibility	Timeline	Deliverable
increase accessibility, coordination and quality of health services throughout the province, respectful of First Nations autonomy	based on initiatives	FNIHB-AB Alberta Health Alberta Health Services	31, 2014 March 31, 2015	integration successes including HSIF projects Explore opportunities to expand the scope of existing localized partnerships and integration successes throughout the province, respectful of First Nations autonomy, including consideration of: Alternative Relationship Plans for visiting physicians; Screening for cervical cancer, prostate cancer, breast cancer and diabetes; Mental health crisis response services; Ambulance services; Midwifery; Home and community care; Continuing care; Family Care Clinics; Nurse Practitioners; Mental health and addictions treatment programs and services and services / programs for First Nations with disabilities.
Seek to improve delivery of Non-Insured Health Benefits for First Nations in Alberta by engaging First Nations, Alberta Health, Alberta Health Services, FNIHB-AB and other key stakeholders such as professional associations and colleges, as well as Alberta Blue Cross	Provincial	Treaty 6, 7 and 8, FNIHB-AB Alberta Health, Alberta Health Services, Professional associations and colleges, Alberta Blue Cross	March 31, 2016	Work plan developed to improve coordination of Non-Insured Health Benefits and other programs and services offered to Albertans
Improve coordination of Alberta	Provincial	Treaty 6, 7 and 8	March 31,	Options paper developed and option

Activity	Level	Responsibility	Timeline	Deliverable
Aids to Daily Living and Non-Insured Health Benefits		FNIHB-AB Alberta Health	2015	chosen to improve coordination of Alberta Aids to Daily Living and Non-Insured Health Benefits
Identify opportunities to enhance health service delivery for First Nations residing in northern Alberta including medical transportation, mental health and addictions, primary care	Regional	Treaty 6, Treaty 8, Alberta Health, Alberta Health Services – North Zone, and FNIHB-AB	March 31, 2016	Issues identified and plan for pragmatic approaches to improve health services to northern residents developed.
OBJECTIVE 3: Increase First Nations control of health services and programs				
Explore opportunities for second-level and third-level transfer of federally-funded health services to First Nations	Multi-level based on initiatives	Treaty 6, 7 and 8 FNIHB-AB	March 31, 2016	Conceptual plan to establish a structure to facilitate second- and third-level transfer to First Nations developed
Develop a formal process for Elders' engagement that builds on the Elders knowledge and competence to support cultural practices and build relationships in health	Provincial	Treaty 6, 7 and 8	March 31, 2016	Process established and Elders engaged

APPENDIX C – First Nations Population in Alberta

Table C1 – *First Nations Communities in Alberta by Tribal Council and Treaty*

Treaty 6	Treaty 7	Treaty 8
Tribal Chiefs Ventures	Blackfoot Confederacy	Athabasca Tribal Council
Beaver Lake Cree Nation	Blood Tribe	Athabasca Chipewyan First Nation
Cold Lake First Nation	Piikani Nation	Chipewyan Prairie First Nation
Frog Lake First Nation	Siksika Nation	Fort McKay First Nation
Goodfish Lake First Nation		Fort McMurray First Nation
Heart Lake First Nation		Mikisew Cree Nation
Kehewin Cree Nation	Stoney Tribe (Bearspaw)	
	Stoney Tribe (Chiniki)	Kee Tas Kee Now Tribal Council
Yellowhead Tribal Council	Stoney Tribe (Wesley)	Loon River First Nation
Alexander First Nation	Tsuut'ina Nation	Lubicon Indian Nation
Alexis Nakota Sioux Nation		Peerless Trout First Nation
O'Chiese First Nation		Whitefish Lake First Nation
Sunchild First Nation		(Atikameg)
		Woodland Cree First Nation
Maskwacis		
Ermineskin Cree Nation		Lesser Slave Lake Indian Regional
Louis Bull Tribe		Council
Montana First Nation		Driftpile First Nation
Samson Cree Nation		Kapawe'no First Nation
		Sawridge Band
Independent Bands		Sucker Creek First Nation
Enoch Cree Nation		Swan River First Nation
Paul First Nation		
Saddle Lake First Nation		North Peace Tribal Council
		Beaver First Nation
		Dene Tha' First Nation
		Little Red River Cree Nation
		Tallcree First Nation
		Western Cree Tribal Council
		Duncan's First Nation
		Horse Lake First Nation
		Sturgeon Lake Cree Nation
		Independent Bands
		Bigstone
		Smith's Landing First Nation

Source: (Updated from Health Canada, 2012b)

APPENDIX D – Co-Management Structure

Source: (HCoM Health Co-Management Secretariat, 2015)

APPENDIX E – Consent Form[1]

Preamble:
The researcher, Nathalie Lachance, can be reached at 780.239.1600 or at nathalie_lachance@dba.athabascau.ca.

Research Project Title and Description:
Title:
Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments.

Description:
To document and support the forming of a collaborative process as articulated in the Joint Action Plan to Improve the Health of First Nations in Alberta.

Source of financing:
The research project is being undertaken by a doctoral candidate as part of her work to complete the dissertation requirements for a Doctorate of Business Administration at Athabasca University. No external sources of funding have been secured.

Duration of research project:
The research project is expected to unfold over a 24-month period from June 2015 to June 2017.

Certification obtained:
Ethics certification has been obtained by the Research Ethics Board of Athabasca University. Should you have any concerns about your treatment as a participant in this research project, please contact the Office of Research Ethics, Athabasca University, at 1.800.788.9041, ext. 6718 or by e-mail to rebsec@athabascau.ca.

Research goals and objectives:
The research project includes the following specific objectives:

- Take into account current and historical relationships between First Nations and governments as they seek to improve collaboration; and,
- To better understand and improve collaborative capacity as a way to enhance multilateral health care collaboration between First Nations of Treaty No. 6, Treaty No. 7, Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch – Alberta Region, Health Canada.

Methodology used:
The participant will be asked to take part in up to two interviews of an expected duration of 60 to 90 minutes. The interviews will be conducted using open-ended questions. The

[1] This template has been drafted based on the Assembly of First Nations Quebec-Labrador – AFNQL. (2014). *First Nations in Quebec and Labrador's Research Protocol.* Wendake.

planned sessions are to be held in two phases to allow a pre- and post- perspective on collaboration and will be held at the office of the participant.

Advantages / disadvantages:

- This Participatory Action Research will provide participants an opportunity to develop a greater understanding of the collaborative capacity required to enhance collaboration;
- An opportunity to contribute to the analysis and validation of results;
- An opportunity to identify and plan actions as well as assess the ability of these actions to improve collaborative capacity and enhance collaboration;
- Sharing lessons learned and increasing knowledge that can be used to strengthen the collaborative process.

Protection of personal data: Data gained through data collection will be strictly used for this research project. The name of the participants will not be shown in any report. In addition, the researcher must protect the confidentiality of answers; under no circumstances should the answers (raw data) be made public.

Duration of personal data conversation: As per university policy, the raw data gathered will be kept for up to five years after the end of the research prior to being destroyed. If you consent to audio-record the interview, the recording will be deleted once the transcript has been reviewed by the participants.

Language used: The interviews and focus groups will be conducted in English.

Compensation: A small gift in the form of a gift card will be provided to participants working in First Nations organizations and governments.

Commercialisation of results or conflicts of interests: No results will be commercialised.

Dissemination of results:

- Presentation to the Joint Action Plan Steering Committee and/or any other groups designated by the Steering Committee;
- Dissertation to be submitted to Athabasca University for granting of a Doctorate in Business Administration;
- Presentation to external audiences including management and academic conferences – opportunities to co-present will be provided; and,
- Publication of articles in management and academic journals – opportunities to co-author to be provided.

Liability clause: By accepting to participate to the research, participants do not waive any of their rights and do not release the researcher or any organization or institution involved of their legal and professional responsibilities.

Right of refusal and right to withdraw: Participation to the research project is voluntary and the participant can withdraw at any time, without providing justification or being prejudiced in any way. Upon withdrawal, all information provided by that participant will be removed from this research.

Any questions about the research project can be sent directly to the researcher:
Nathalie Lachance
8419 – 186 Street
Edmonton AB T5T 1H3
Tel.: 780.239.1600
E-mail: nathalie_lachance@dba.athabascau.ca

Or her supervisor:
Teresa Rose, MA, MBA, PhD, (CEC)
Faculty of Business
Athabasca University
Toll Free 1-855-859-3119
Direct: 587-352-3334
E-mail: teresa.rose@fb.athabascau.ca

Consent to participation:

- ☐ I, the undersigned, _____ (print name) **fully consent** to participating to the research project titled: "Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments".
- ☐ I, the undersigned, _____ (print name) **do not consent** in participating to the research project titled: "Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments".

Consent to audio-recording:

Considering the dual role of the researcher as a researcher and participant (as a FNIHB-AB employee) to the Joint Action Plan to Improve the Health of First Nations in Alberta, audio-recording of the interviews and/or focus groups would ensure that the views of the participants are recorded and not her understanding. Therefore, consent is also sought to audio-record the interviews. Participants can request for the audio-recording to be stopped at any time. Audio-recordings will not be shared publicly. A copy of the transcripts will be provided for your review. The audio-recording will be deleted once you have confirmed your review of the transcripts.

- ☐ I, the undersigned, _____ (print name) **fully consent** to have the interview / focus group discussion audio-recorded. I understand that I can request to stop the audio-recording at any time and that the recording will be deleted once I have reviewed the transcript. I also understand that the audio-recording will not be shared publicly.
- ☐ I, the undersigned, _____ (print name) **do not consent** in audio-recording of the interview / focus group.

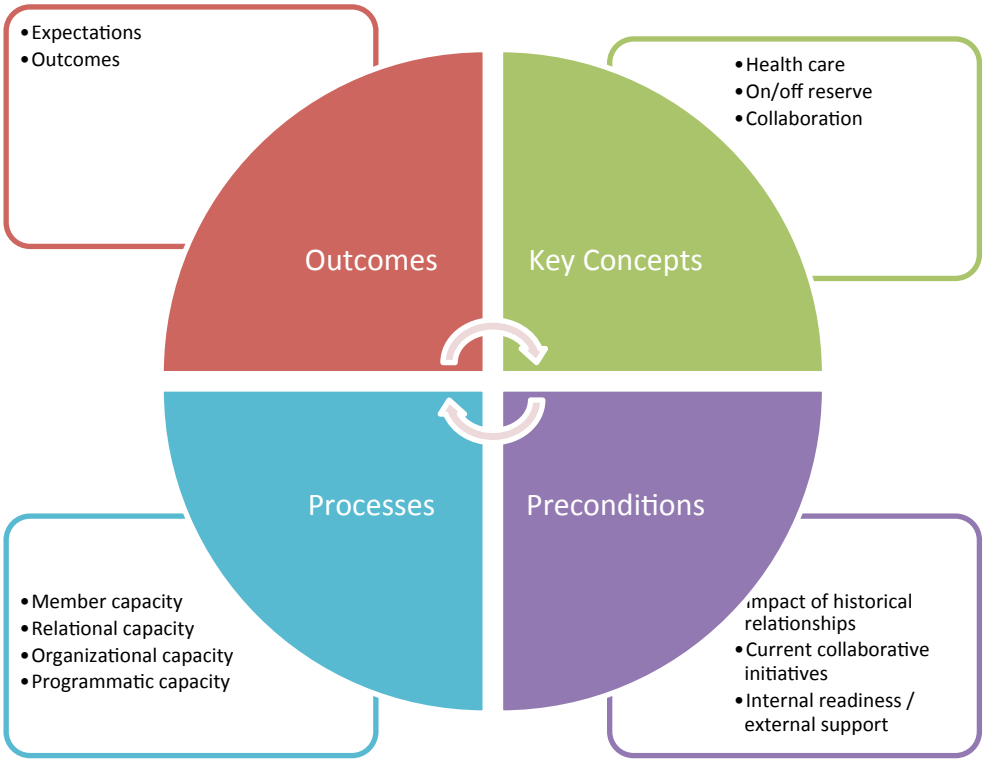
I am signing this form in two copies and am keeping one.

_____	_____	_____
Name of participant	Signature of participant	Date
_____	_____	_____
Name of researcher	Signature of researcher	Date

APPENDIX F – Interview Questions

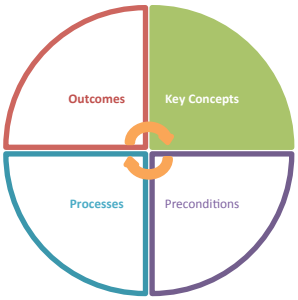
Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments

Interview Questions



September 2015

Defining Key Concepts – Questions 1 to 3



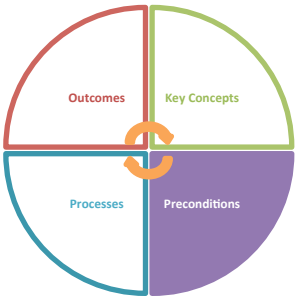
The goal of the Joint Action Health Plan to Improve the Health of First Nations in Alberta is "to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe". I would like to know more about some of the key concepts.

Question 1.
The goal of the Joint Action Health Plan defines "quality" of health services but it does not define health care. How would you like to define health care?

Question 2.
The Joint Action Health Plan does not specify whether it is considering the needs of First Nations residing on-reserve, off-reserve or both. Do you think it needs to be specified? If so, what do you think it should say?

Question 3. – For First Nations participants
From your understanding as an Indigenous person from your nation and culture, how do you define collaboration? What do you think is a useful term or understanding which might be used to describe working together?

Question 3. For non-First Nations participants
How would you define collaboration? What do you think is a useful term or understanding which might be used to describe working together?



Preconditions – Questions 4 to 8
For this next series of questions, I am moving away from seeking to clarify some of the concepts to seeking to better understand the context for collaboration as we begin to implement the Joint Action Health Plan.

Question 4.
In talking about context, I believe it is important to acknowledge that First Nations and governments have a long and fairly complex historical relationship. How do you think history impacts and influences the implementation of the Joint Action Health Plan?

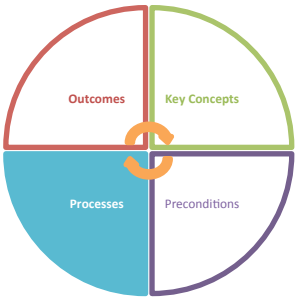
Question 5.
Collaboration between First Nations, Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch (FNIHB) is not new. There are a number of collaborative initiatives across the province. Based on your experience and knowledge, how do you think these more recent collaborative initiatives influence the implementation of the Joint Action Health Plan?

Question 6.
Linked to collaboration is the concept of community engagement which is typically defined by the level of communications and decision-making of partners. I understand that even amongst the same partners, the level of engagement may vary between initiatives. How would you assess the current level of engagement?

Question 7.
What are the key reasons explaining your organization's decision to participate, or not, in the Joint Action Health Plan?

Question 8.
Some of the work on collaboration refers to the need of the partnering organizations to be both ready internally (e.g., interests, time, resources) as well externally supported (e.g., external funding, support) to collaborate.

- How would you assess your organization's internal readiness to implement the Joint Action Health Plan (e.g. funding, staffing, attitudes, timing)?
- How would you assess the external support that you receive from your partners to implement the Joint Action Health Plan?



Processes – Questions 9 to 16

For this next series of questions, I am seeking your assessment of the existing collaborative capacity and identification of areas for improvement.

Question 9.
What do you think are the skills, knowledge and attitudes members bring to the table?

Question 10.
What is your vision for the Joint Action Health Plan?

Question 11.
How would you assess the current working climate between the partnering organizations involved in the Joint Action Health Plan?

Question 12.
The Joint Action Health Plan brings together many partners and organizations with widely different size, budget and capacity. For this question, I am looking for your perspective on power. I am not proposing a definition but rather seeking your understanding.

- How do you define power?
- How is power wielded?
- How are participants using or not using power?

Question 13.
Trust and commitment are often described as the glue required for collaboration.

- How would you assess the current level of trust / commitment between the partnering organizations as we begin implementation of the Joint Action Health Plan?
- What do you think are the elements required for a trusting relationship?

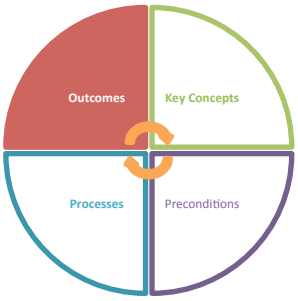
Question 14.
Supporting collaboration can be done by increasing the capacity of each of the partnering organizations to collaborate, by supporting a bridging organization or a combination of both – dedicating resources in all the organizations to collaborate and establish an organization that supports the collaborative process. What do you think would be the best model to implement the Joint Action Health Plan?

Question 15.
Another element of collaboration is accountability of the members. I am looking for information about your accountability to the organization(s) that appointed you to the Joint Action Health Plan as well as how you perceive your own accountability to the Joint Action Health Plan.

- As a participant in the Joint Action Health Plan, whose voice are you representing (i.e., personal, community, tribal council, Treaty area, other organization)? Who are you accountable to?
- How do you ensure that accountability? What does it mean in concrete terms?

Question 16.
I am also looking to see if a shared consensus is emerging around the goals and objectives of the Joint Action Plan and our ability to achieve them:

- What is your understanding of the goal(s) and objectives of the Joint Action Health Plan?
- How would you assess our ability to achieve them?
- What do you think could be some quick wins for the Joint Action Health Plan?



Outcomes – Questions 17 and 18

This last section is looking at the desired outcomes for the Joint Action Health Plan.

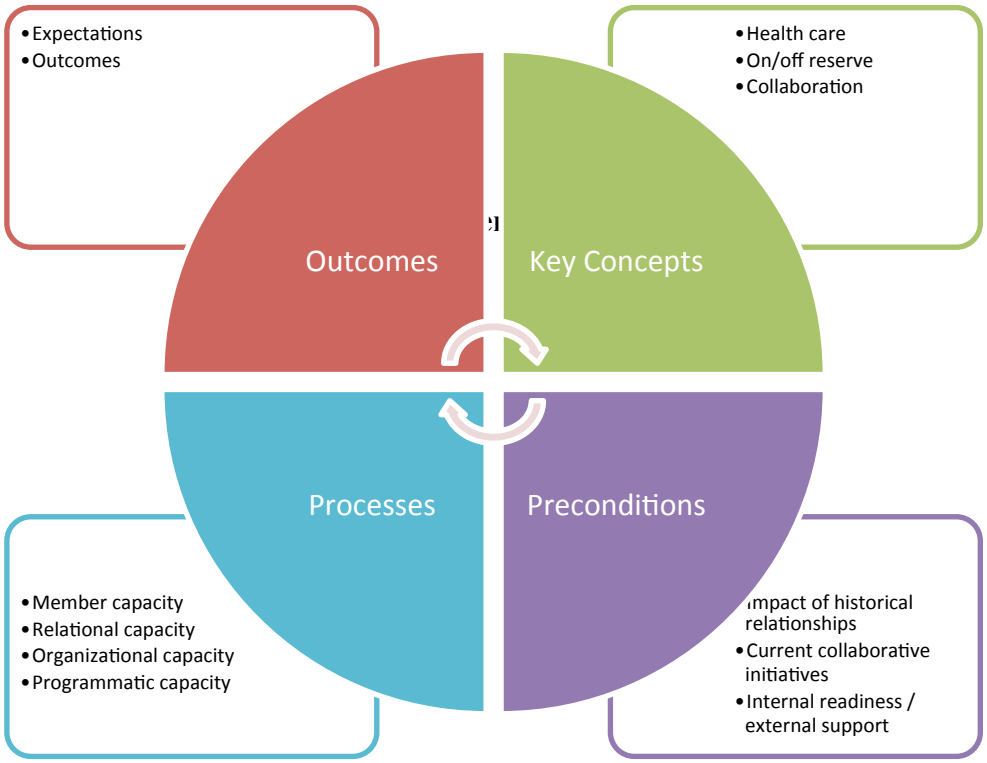
Question 17.
What do you expect to achieve with the implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta?

Question 18.
Do you have anything to add?

APPENDIX G – Interviewer Guide

Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments

Interviewer Guide



INTERVIEW GUIDE

Introduction

Thank you for giving me an opportunity to meet with you today.

If there is an existing relationship with the participant(s):

We have worked together for some time however I am not here in my usual capacity as an employee of First Nations and Inuit Health Branch – Alberta Region (FNIHB-AB). I am here as a university student seeking to document and support the forming of a collaborative process as articulated in the Joint Action Plan to Improve the Health of First Nations in Alberta.

OR

If there is no existing relationship with the participant(s):

As indicated in my request to meet with you, you have been identified as an individual contributing and/or influencing the development of the Joint Action Health Plan. You may know that I am an employee of First Nations and Inuit Health – Alberta Region (FNIHB-AB), however I am not here in this capacity. I am here as a university student seeking to document and support the forming of a collaborative process as articulated in the Joint Action Plan to Improve the Health of First Nations in Alberta.

Are the two roles related? Yes. Both as a FNIHB-AB employee and a university student, I seek to advance the work on the implementation of the Joint Action Health Plan. There are however important differences between both roles:

1. As a university student, I am required to abide by the ethical requirements as outlined in the ethics certification I have obtained from the Research Ethics Board of Athabasca University.
2. All information disclosed during this interview is confidential and will only be used for this research project.
3. In publicly sharing information about this research, no personal information will be disclosed and while statements from participants will be included; participants will not be identified.

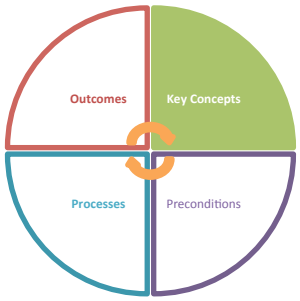
The title of my project is “Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments”. So, I am interested in better understanding how we can enhance the capacity to work together of First Nations organizations, Alberta Health, Alberta Health Services and FNIHB-AB.

Before beginning the interview, I would like to outline the following:

1. Your participation is voluntary. You do not have to answer any questions asked and you may skip any questions. You may also end your participation at any time.
2. The interview is likely to take one to one and half hours.

3. Before we can begin this interview, I need to ask you to review and sign the consent form.
4. A second element of consent is my request to record our discussion. By recording the discussion, I am simply trying to make sure that I record your words and not my understanding of your words.
5. A transcript of our discussions will be shared with you for your review, it will be your opportunity to ensure accuracy and add or remove any elements you wish. If you have agreed to record this discussion, I will delete the audiofile as soon as you approve the transcript.
6. Do you need further information?

Are you ready to begin?



Defining Key Concepts – Questions 1 to 3

The goal of the Joint Action Plan to Improve Health Outcomes for First Nations in Alberta is "to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe". I would like to know more about some of the key concepts. Some of the concepts have been identified but not defined – collaboration and health care while another one has not been identified but is likely to surface in coming weeks / months (First Nations on/off reserve).

NOTE: I understand there is great diversity amongst First Nations peoples in Alberta. By using the word, "Indigenous" I am not assuming that there would necessarily be a shared Indigenous understanding across cultures. Rather I am asking you to identify your understanding based on your _____ (e.g. Blackfoot, Cree, Stoney) culture.

Question 1.
The goal of the Joint Action Plan defines "quality" of health services but it does not define health care. How would you like to define health care?

Prompts:
- What understanding or philosophy of health do you think should be included in the Joint Action Plan?
- Who should be included as health care service providers? What programs or services would you like to see included?

Question 2.
The Joint Action Plan does not specify whether it is considering the needs of First Nations residing on-reserve, off-reserve or both.

- Do you think it needs to be specified?
- If so, what do you think it should say?

Prompts:

- What do you think are the opportunities of the proposed approach?
- What do you think are the challenges?
- What can be done to limit the impact of these challenges?

Question 3. – For First Nations participants
From your understanding as an Indigenous person from your nation and culture, how would you define collaboration?

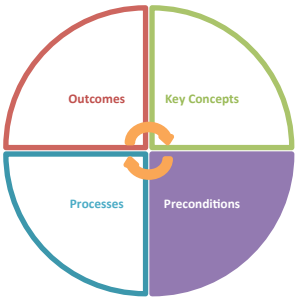
What do you think is a useful term or understanding which might be used to describe working together?

Prompts:

- You can outline your understanding by using the _____ language. What word(s) would you use? How do you spell it? What does it mean?
- How do you understand collaboration?
- If you don't like the word "collaboration" what word would you rather use?

Question 3. For non-First Nations participants
How would you define collaboration?

What do you think a useful term or understanding might be to describe working together?



Preconditions – Questions 4 to 8
For this next series of questions, I am moving away from seeking to clarify some of the concepts to seeking to better understand the context for collaboration as we begin to implement the Joint Action Health Plan.

Question 4.
In talking about context, I believe it is important to acknowledge that First Nations and governments have a long and fairly complex historical relationship. How do you think history impacts and influences the development and implementation of the Joint Action Plan?

Prompts:
- What actions, decisions or documents do you think are impacting and influencing the development of the Joint Action Plan?
- Are there understandings and philosophies that your nation/culture possesses that you would like to see reflected within this?
- Any other actions, decisions or documents you would like to add?

Question 5.
Collaboration between First Nations, Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch (FNIHB) is not new. There are a number of collaborative models across the province. Based on your experience and knowledge, how do you think these more recent collaborative initiatives influence the implementation of the Joint Action Plan?

Prompts:
- Are you currently involved in some collaborative activities between First Nations of Treaty 6, Treaty 7, Treaty 8, Alberta Health, Alberta Health Services and/or Health Canada (not including the Joint Action Plan)?
- Are there specific positive elements or challenges you might like to address?
- If so, what do you think we can learn from these activities?

OR if I know of some of the collaborative activities…

- I understand that you are involved in existing collaborative activities such as _____. What do you think we can learn from these activities?

Question 6.
Linked to collaboration is the concept of community engagement. Engagement is typically described as a spectrum with levels ranging from one-way communications to community-led initiatives. Each of the levels shows different levels of communications and decision-making. A New Zealand model has four levels which could be summarised with the words "to, for, with and by". In summary:

- "To" reflects the provision of services to a given community; communications is best described as one-way
- For First Nations is the beginning of two-way communication but there is little involvement by the community in the decision-making process
- "With" indicates joint decision-making
- "By" would lead to community-led initiative. Where would you identify the current level of engagement as we begin to implement the Joint Action Plan?

Prompts:

- I understand that even amongst the same partners, the level of engagement may vary between initiatives. So, if you prefer to answer this question by examining the level of engagement for different initiatives independently, please do so.

Question 7.
What are the key reasons explaining your organization's decision to participate, or not, in the Joint Action Health Plan?

Prompts:

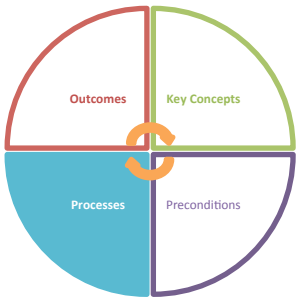
- You have been participating in a number of meetings, why did your organization decide to participate?
- Can you outline the reasons to participate at the organizational level or more broadly (i.e. representing a Treaty area)?

Question 8.
Some of the work on collaboration refers to the need of the partnering organizations to be both ready internally (e.g., interests, time, resources) as well externally supported (e.g., external funding, support) to collaborate.

- How would you assess your organization's internal readiness to implement the Joint Action Plan (e.g. funding, staffing, attitudes, timing)?
- How would you assess the external support that you receive from your partners to implement the Joint Action Plan?

Prompts:

- What do you think makes your organization ready to begin implementation of the Joint Action Plan?
- What do you think limits your organization's readiness to participate in the Joint Action Plan?
- What would you like your partners to do or say to show their support to the Joint Action Plan?
- Do you expect the same things from all partners? If not, please outline your expectations for the different partners to the Joint Action Plan.



Processes – Questions 9 to 16

For this next series of questions, I am seeking your opinion of the conditions needed to promote effective collaboration.

Question 9.
With the first question, I am looking at the capacity of members, people involved in each of the partnering organizations. What do you think are the skills, knowledge and attitudes members bring to the table?

Prompts:

- Would you answer differently if I were to ask you about the skills, knowledge and attitudes of individuals within your organization in comparison with individuals in partnering organizations?
- Is there anything that you would like you and your colleagues to bring more or less in terms of skills, knowledge or attitudes to the Joint Action Plan?

With the next few questions, I am seeking a better understanding of the relationships between the partnering organizations.

Question 10.
What is your vision for the Joint Action Health Plan?

Prompts:

- What do you expect to achieve with the Joint Action Health Plan?

Question 11.
How would you assess the current working relationships between the partnering organizations involved in the Joint Action Plan?

Prompts:
- What is working well in the working relationships between First Nations, Alberta Health, Alberta Health Services and FNIHB-AB?
- What do you think can be improved in terms of working relationships between the partnering organizations?
- Any ideas how the working climate can be improved?

Question 12.
The Joint Action Plan brings together many partners and organizations with widely different size, budget and capacity. For this next question, I am looking for your perspective on power. I am not proposing a definition but rather seeking your understanding.
- What do you think it means?
- How is power wielded?
- How are participants using of not using power?

Prompts:
- What can you tell me about power?
- How would you assess the power relationships?
- Who or what organization do you think is more powerful? How do you think they wield that power?
- Is a level playing field in terms of power desirable? If so, how do you think it can be done?

Question 13.
Trust and commitment are often described as the glue required for collaboration.
- How would you assess the current level of trust / commitment between the partnering organizations as we begin implementation of the Joint Action Plan?
- What are the elements of a trusting relationship that you think are necessary?

Prompts for trust:
- To what extent is there trust between the partnering organizations as we embark upon the Joint Action Plan?
- What is needed to enhance trust?

Prompts for commitment:
- What do you think is the level of commitment of your organization to the Joint Action Plan? Is your organization more committed to some parts rather than others?
- What do you think is the level of commitment of your partners to the Joint Action Plan?

With the next series of questions, I am seeking more information about the more appropriate structure to support the implementation of the Joint Action Plan.

Question 14.
Supporting collaboration can be done by increasing the capacity of each of the partnering organizations to collaborate, by supporting a bridging organization or a combination of both – dedicating resources in all the organizations to collaborate and establish an organization that supports the collaborative process. What do you think would be the best model to implement the Joint Action Plan?

Prompts:
- If advocating for capacity within each organization, how do you see us being able to develop shared capacity to work together?
- If advocating for a bridging organization, what do you think that organization could do to meet the needs of your organization?
- If advocating for a mixed approach, how can we strike the right balance?

Question 15.
Another element of collaboration is accountability of the members. The next few questions seek more information about your accountability to the organization(s) that appointed you to the Joint Action Plan as well as how you perceive your own accountability to the Joint Action Plan.
- As a participant in the Joint Action Plan, whose voice are you representing (i.e., personal, community, tribal council, Treaty area, other organization)?
- How do you ensure that accountability? What does it mean in concrete terms? Who are you accountable to?

Prompts:
- Are you bringing forward only one organizational voice or do you think you speak for a number of organizations?
- How do you ensure accountability to the organization(s) that appointed you?
- Are you satisfied with your ability to report back to the organization(s) that appointed you?
- If not, what would you need to be able to increase your accountability?

Question 16.
With the next few questions, I am looking to see if a shared consensus is emerging around the goals and objectives of the Joint Action Plan:

- What is your understanding of the goal(s) and objectives of the Joint Action Plan?
- How would you assess our ability to achieve them?
- What do you think could be some quick wins for the Joint Action Plan?

Prompts re. goal/objectives:

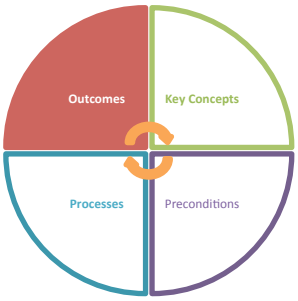
- Are you in agreement with the goal and objectives identified in the Joint Action Plan?
- Would you like to add, or delete, anything?

Prompts re. achievability:

- What do you think will be important for the goals and objectives to be achieved?
- What do you think it will take for the goal and objectives to be achieved?

Prompts re. quick wins:

- What are the activities that you think could be achieved more easily?
- More concretely, what does it mean for your organization?



Outcomes – Questions 17 and 18

This last section is looking at the desired outcomes for the Joint Action Health Plan.

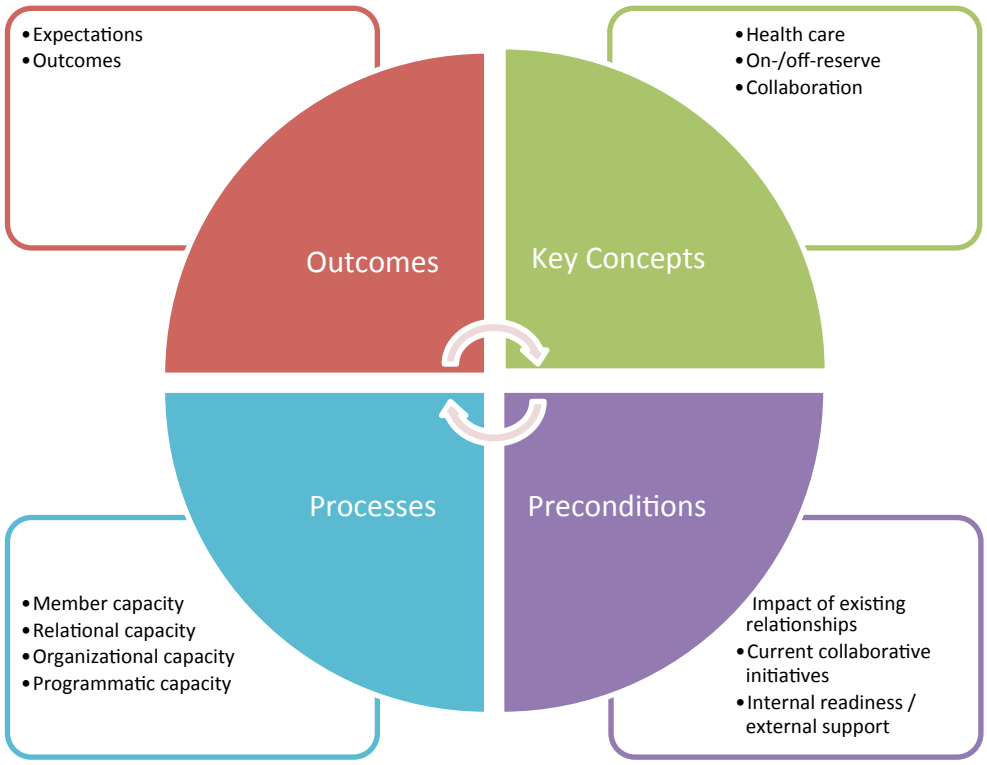
Question 17.
What do you expect to achieve with the implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta?

Question 18.
Do you have anything to add?

APPENDIX H – Summary Shared with Participants

Seeking to improve collaborative capacity to enhance multilateral health care collaboration between First Nations, federal and provincial governments

Short Summary



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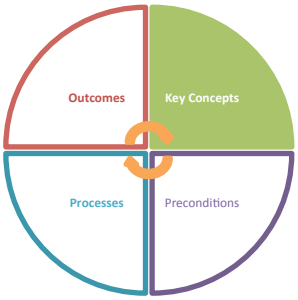


Understanding Key Concepts

The goal of the Joint Action Plan to Improve the Health of First Nations in Alberta is "to enhance collaboration between First Nations, Health Canada, Alberta Health and Alberta Health Services to achieve quality of health services for First Nations that is accessible, appropriate, acceptable, efficient, effective and safe". This section includes participants' understanding of concepts that were either:

- Identified as part of the interview questionnaire: health care, delineation between on- and off-reserve status of First Nations and collaboration.
- Brought forward by the participants: health, the Treaty Right to Health and the Medicine Chest Clause.

Health and health care

Participants were asked to define their understanding of health care but prior to defining this concept many participants began by outlining their understanding of health. Participants outlined a holistic approach to health that was defined as inclusive of mind, body and spirit; acknowledged physical, emotional, mental and spiritual elements of health and wellbeing; and, impacted by social determinants of health.

Some First Nations participants indicated that First Nations people were healthy for thousands of years prior to the signing of the Treaties. In referring to this previous state of health and well-being, participants talked about the need to live in harmony, the individual's responsibility in maintaining his/her own health, the use of traditional medicines as well as Indigenous knowledge of health and healing.

While participants shared a broad understanding of health, there was more limited agreement when they defined health care. Participants tended to define health care based on their education, professional and personal experiences. Within the context of the Joint Action Health Plan (JAHP), some participants advocated for defining health care within the common scope of all partnering organizations while others wanted to use the broader understanding of health as a foundation.

The goal of the Joint Action Health Plan defines quality of health care as being accessible, appropriate, acceptable, efficient, effective and safe. Participants further indicated that quality entails: provision of health services on-reserve or within close proximity, a range of culturally-based, culturally-safe or culturally-competent care as well as inclusion of traditional knowledge and medicines. Barriers to quality care were identified as: racism, discrimination, limited on-reserve access to diagnosis and treatment

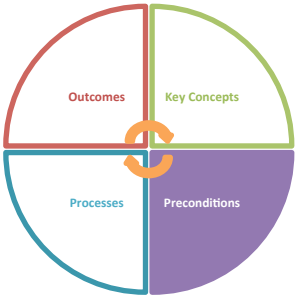
as well as limited ability to establish a community-based model of care that would encompass traditional and western models of care.

Delineating between First Nations residing on- and off-reserve
Participants from First Nations organizations and governments in Treaty No. 6, Treaty No. 7 and Treaty No. 8 (Alberta), Alberta Health, Alberta Health Services and First Nations and Inuit Health Branch were *unanimous* in stating that the work of the Joint Action Health Plan should not delineate between on- and off-reserve status of First Nations individuals.

Defining collaboration
Prior to defining collaboration, a number of participants expressed their views of the word. Some saw "collaboration" as a strong word at the higher end of a spectrum that would include words such as consensus, compromise, coordination and cooperation while others found it relatively weak and preferred the concept of partnership.

In defining collaboration participants outlined the need to work together as equal partners to achieve a common goal and/or address an issue that they cannot address by themselves. Trust, honesty, respect, kindness, two-way communications, equal partnership, interest-based problem-solving, and accountability were identified as contributing to collaboration.

Treaty Right to Health and Medicine Chest Clause
While there was no specific question referring to the Treaty Right to Health and the Medicine Chest Clause, many participants outlined their understanding as part of our conversations. Participants identified the spiritual nature of the Treaties as well as the promises made to First Nations by the Crown. Some participants understand the Crown as being the sole responsibility of the federal government while others identified responsibilities for both the federal and provincial governments. An understanding of the Treaty Right to Health was identified as key but most participants believe that its negotiation should not be part of the Joint Action Health Plan work. Many participants believe the Joint Action Health Plan can be used as a tool to answer the calls to action from the Truth and Reconciliation Commission and support the United Declaration on the Rights of Indigenous Peoples.



Preconditions

This section outlines the participants' perceptions of the context as the Joint Action Plan to Improve the Health of First Nations in Alberta is being further developed and implemented. The broader environment of relationships between First Nations, federal and provincial governments, more recent collaborative endeavours and capacity to support the collaborative work where considered as part of this section.

Relationships between First Nations, federal and provincial governments

For First Nations participants, colonialism is not something that happened in the past; it is something that has happened and continues to happen. In fact, many First Nations participants outlined the ongoing colonization, assimilation and integration of First Nations by the Crown which continues to fail to honour the Treaties and uses policies and legislation to further colonize First Nations. Many First Nations participants shared their frustrations in regards to the significant inequities in resource allocations despite the significant contributions of First Nations individuals and communities to the Canadian economy including payment of taxes and extraction of natural resources that were not ceded. Non-Indigenous participants often referred to the need to understand the history, to acknowledge Canada's negative legacy of colonialism and their hope that First Nations participants could guide them in building that greater understanding. Acknowledging their challenges in understanding this broader context, non-Indigenous participants highlighted the tremendous value of sessions or discussions that allowed them to enhance their understanding.

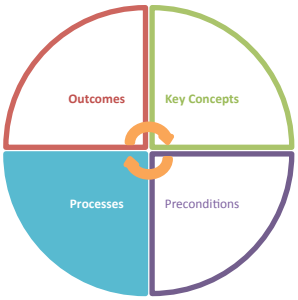
The concept of community engagement is typically defined by the level of communications and decision-making of partners. For most participants, the current level of engagement between partners was described at the lower-end of the spectrum where federal and provincial governments exercise authority by making decisions unilaterally ("to") or with limited engagement of First Nations peoples and communities ("for") rather than more collaboratively "with" First Nations individuals and communities or having those decisions made "by" First Nations individuals and communities.

More recent collaborative endeavours

A number of more recent collaborative endeavours were shared and described by the participants as being more respectful and positive. These more recent collaborative endeavours were perceived as allowing them to tear down barriers as well as being easier to establish with partners that were located near their community. They also identified their collaborative work as incremental resulting in progressive positive changes particularly in regards to addressing barriers to access quality health care.

Current capacity to support the collaborative work of the Joint Action Health Plan
A number of participants referred to the increasing commitment and readiness of First Nations, federal and provincial governments for collaborative work such as the Joint Action Health Plan. At the same time, a number of challenges were identified including:

- Lack of trust / distrust / mistrust between participants;
- Turnover in staff and leaders in organizations;
- Need for more data / evidence-based information;
- Need for reconciliation; and,
- Limited understanding of decision-making authority of participants and organizational decision-making processes.



Processes
This section summarizes the participants' views on the processes that would support the transition from preconditions to outcomes. The input was categorized based on existing literature on collaboration and includes the four elements of collaborative capacity: member capacity, relational capacity, organizational capacity and programmatic capacity.

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1. **Member capacity refers to the skills, attitudes and knowledge required of the individual participants to the collaborative process.**

Many participants indicated that attitude is more important than skills and knowledge. In defining attitude participants included: respect, openness, honesty, optimism, positive attitude, passion, humility, commitment, patience and trust. Many participants talked about the need to be willing to listen as well as the ability to learn and share. The belief in the spirit and intent of the Treaty relationship was also identified as key.

Participants identified a number of skills required for this collaborative work which can be grouped into two categories:

- Relationship-building skills including the ability to engage others, influence and advocate, negotiate, reflect and represent the communities' views. In some cases, these were simply referred as solid people skills; and,
- More technical skills including project planning and implementation, knowledge transfer as well as writing documents and preparing / delivering presentations.

In terms of knowledge, participants identified as important the following: understanding of health and health care from a First Nations' perspective; solid understanding of the

impact of colonialism on the health of First Nations; appreciation/respect of First Nations languages and traditional values; and, the need to understand health systems and how government works.

2. Relational capacity refers to how participants and organizations relate within the context of the collaborative process.

In assessing relational capacity participants were asked to discuss the following: vision, working climate, power sharing and trust as it relates to the further development and implementation of the Joint Action Health Plan. In terms of vision, participants appeared to share a relatively common vision as they referred to the need to improve First Nations health outcomes and health care.

Many participants spoke of an improved working climate and often referred to the recent federal and provincial elections qualifying themselves as cautiously optimistic. Some participants identified concerns with the current level of trust and the presence of personality-based conflicts.

While some participants viewed power more positively as the ability to identify priorities, solutions and options or more simply as the ability to get things done many participants viewed power negatively as a way to control decision-making and resources – some clearly stating that power was about information. In discussing power, a number of participants assessed the power of all partnering organizations believing that all organizations and participants had some power. While power imbalances were identified by almost all participants, none identified themselves as being powerful and few thought that their organization was powerful. In that regard, a participant outlined the danger of participants who fail to understand their own power.

Finally, a key component of relational capacity is trust. Most if not all First Nations participants stated that there is limited trust, lack of trust, distrust and mistrust within the context of relationships between First Nations and federal / provincial governments. This is perceived as impacting the further development and implementation of the Joint Action Health Plan as many indicated fears around hidden agendas and a federal dump and run.

3. Organizational capacity refers to the capacity to support the collaborative process in terms of structure or resources.

Supporting collaboration can be done by increasing the capacity of each of the partnering organizations to collaborate, by supporting a bridging organization or a combination of both. Participants were divided on the preferred option and many stated that it was simply too early to discuss the structure to support the implementation of the Joint Action Health Plan. Most participants identified the need for enhanced capacity and resources in First Nations organizations to ensure that the further development and implementation of the Joint Action Health Plan were First Nations-led. No consensus emerged as to what would best support the collaborative endeavour as participants identified pros and cons for the three options discussed to enhance capacity.

A second component of organizational capacity is accountability. For the participants, the concept of accountability appears to be broader than organizational capacity as participants outlined a multilayered understanding of accountability. The combined list includes accountability to: themselves; their governance structure; the First Nations they represent and/or serve; and, the collective process.

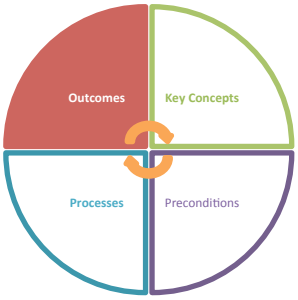
In terms of organizational capacity, the participants also outlined a number of key elements that relate directly to the further development and implementation of the Joint Action Health Plan including the need to strengthen understanding of the decision-making processes of respective partners and build on the successes of a number of communities that have used collaborative initiatives to enhance health care on-reserve.

4. Programmatic capacity refers to the capacity to deliver on the goals and objectives of the collaborative process.

Participants identified as goals for the Joint Action Health Plan: improved First Nations health outcomes and improved health care. These have also been identified as vision and outcomes. Some participants identified this lack of clarity between vision, goals and outcomes as a demonstration that the Joint Action Health Plan had not moved beyond the vision stage. Some also indicated that while the Joint Action Health Plan had high level support, it did not have an infrastructure to support its work though there was no consensus on what would constitute proper infrastructure.

Participants identified a number of possible "quick wins" for the Joint Action Health Plan. The combined list is as follows:

- Increasing involvement of Elders to ensure cultural safety and competency as well as enhanced communications and engagement of First Nations partners;
- Pursuing some of the activities currently identified within the Joint Action Health Plan such as submitting a joint application to the Indian Registry System and developing a Data Governance Agreement; holding the Alternative Service Delivery Forum; and, enhancing coordination of benefits between Non-Insured Health Benefits (NIHB) and Alberta Aids to Daily Living (AADL);
- Strengthening the delivery of health services including enhanced primary care, crisis intervention, mental health and addictions, women's shelters on-reserve, and respect for Jordan's Principle in addressing the needs of First Nations children;
- Strengthening processes with the creation of a commitment document between parties; and,
- Addressing funding issues such as wage parity for staff on-reserve and the need for the federal government to provide the same level of funding on- and off-reserve.



Outcomes
This last section provides an overview of the desired outcomes identified by the participants for the Joint Action Health Plan.

Outcomes

The work on the Joint Action Plan to Improve the Health of First Nations in Alberta began in 2014 but the political and programmatic changes of 2015 – First Nations, federal and provincial elections as well as the renewal of the Health Services Integration Fund (HSIF) – delayed its further development and implementation. Participants identified the following outcomes for the Joint Action Health Plan:

- Better relationships including mechanisms for collaboration at all levels, the need to act collaboratively quickly, an opportunity for trilateral / tripartite discussions on health and more senior level engagement on policy and operational issues;
- Improved health outcomes; and,
- Improved health care in a number of key areas including an ability to better respond to issues, home care, preventative measures, mental health, addictions and trauma, and palliative care.

APPENDIX I – Summary Tables of Findings

Table I1– *Defining Key Concepts: Sharing our Understanding of Health*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
First Nations people were healthy for thousands of years and impact of new diseases on the previously healthy status of First Nations (FN07) Living in harmony with the land, use of traditional medicines, Indigenous knowledge and individual's responsibility in maintaining his/her own health (FN11) A holistic perspective in terms of mind, body, spirit (FN09, FN15) Need for physical, emotional, mental and spiritual health (FN11, FN12, FN13) Need to live in harmony (FN07) Holistically referring to the health of individual, family and community (FN15) To be healthy means "that you're strong in mind, body, and spirit and that you can take care of yourself and other people, that you can be relied upon" (FN15)	Social determinants of health (AH01, AHS02, AH04)	A holistic perspective in terms of mind, body, spirit (HC02) Social determinants of health (HC03)

Table I2 – *Defining Key Concepts: Sharing our Understanding of Health Care*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Linked to the education, professional and personal experiences of individuals (FN04) Starts from preventative to palliative and everything in between, emergency and maintenance and immunization (FN06) Comprehensive… meaning your whole environment including safe and clean, including water, housing (FN03) Holistic mental, emotional, spiritual, physical health. Maintain that balance (FN12) All-inclusive for our people, because that's the way they think (FN05) Everything from prevention to primary care ensuring that mind, body, and spirit, individual, family, and community are taken care of (FN15) Seamless holistic incorporating physical and biological extending to balanced wellness (FN13)	Broader and inclusive of health services (AH01, AH02) Activities and actions that are going to improve the health status (AHS02) Core health care services (AH03) All those intervening supports and services that lead to health (AHS03) Starts with the social determinants of health. It has to create a foundation where people have good health, and it has to respond in those circumstances where people's health fails them to greater or lesser degrees (AH01) Ability to achieve and maintain good health and well-being, both mental and physical... It includes health services but also prevention, public health, reducing inequalities, elements outside of just health services (AH02) Health care services, but it could also include traditional wellness approaches	The basket of services that's been introduced since introduction of the Canada Health Act (HC01) Referring to a three-system model with contributions from the provincial, federal and First Nations health system (HC02)

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Using the social determinants of health, and broader than what we deliver in terms of immunization and family health. Talking about health care of the community, we talk about the whole mind, body, soul, price of food, everything. (FN09)	(AHS01) Every piece that directly or indirectly impacts the health of individuals is my definition of health care. Whether it's policy, whether it's services, whether it's programs, whether it's personal growth, whether it is directed growth, whether it is public perception, or whether it is some of the less definables, such as the social determinants of health (AH04)	

Table I3 – *Defining Key Concepts: Seeking to Better Define Quality of Care*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Provision of health services on-reserve (FN01, FN11, FN02, FN08, FN10) Greater access to diagnostic tools and specialists (FN02, FN08) Access may look differently based on community size (FN02) Free of racism and discrimination (FN01, FN03)	Need for enhanced primary care, enhanced opportunities through the Alternate Relationship Plan (ARP) for physicians (AHS01)	

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Training of health care providers encourage paternalistic-type conversations with our clients (FN01) Need for cultural sensitivity, safety and appropriateness (FN11) Ability to share traditional knowledge and Indigenous healing and medicines (FN01, AHS01, FN07, FN11, FN12) Need to focus on wellness (FN01)		

Table I4 – *Defining Key Concepts: Sharing our Understanding of the Treaties and the Medicine Chest Clause*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Sacred nature of the Treaties (FN03) Treaties have no time limit and are expected to evolve (FN03) Treaties as definition of health care (FN03) Understanding of Medicine Chests as the highest level of care (FN12) Reluctance of the federal government to	Need for increased understanding of the Treaties and the Treaty Right to Health (AHS01, AHS02) Alberta Health Services had never heard of the Treaty Right to Health… so the understanding of what it really means and how it impacts services was never there but it needs to be there (AHS01) Linked to work of the Wisdom Council	Need to believe in the spirit and intent of the Treaty relationship (HC01) Commitment of the new federal government and its potential for renewed relationships based on rights (HC01) If we have a government who wants to introduce a renewed relationship based on Treaty rights and the implementation of Treaty rights then it could become a very

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
step up to their side of the Treaty and honour the Treaty Right to Health and deliver the services to First Nations the way they should (FN06) We know our primary health care providers are the province but no matter who our health care provider is, the federal government is responsible (FN05) Working with the provincial government to provide better service for the people – perceiving provincial government as Crown but aware that not all First Nations would agree (FN02)	and the commitments to implementing the calls to action of the Truth and Reconciliation Commission and the United Nations Declaration on the Rights of Indigenous Peoples (AHS01) Concerns in regards to the legitimacy of the provincial government as a partner considering existing Treaty rights (AH02)	positive platform for the Joint Action [Health] Plan (HC01) From a First Nation perspective, the Treaty perspective could really impact the willingness and the openness to have some conversations around Treaty Right to Health and what that means (HC03)

Table I5 – *Defining Key Concepts: Sharing our Understanding of the On- and Off-Reserve Concept*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
We can't draw an imaginary line, genetically and inherently, we are who we are and we can't change that (FN01) Portability of the Treaty Right to Health (FN03)	Equity of opportunity and the need to be broad and inclusive (AHS02, AH03) From a population perspective, the geographic location doesn't matter when you're talking about the health of a group of people (AH02)	Perception that the province perpetuated on- and off-reserve delineation to maintain that anything on-reserve was not their jurisdiction (HC03) The Health Accord is applicable to all Albertans, so the on/off-reserve boundary

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Remain silent because it gets back to that Treaty agenda (FN05) Transiency of First Nations individuals and families (FN09, FN15) Worried it will be used to deny services (FN06, FN12) Jurisdictional concerns between federal and provincial governments (FN12) Have equal rights to services as everybody else (FN14) May be needed if considerations need to be given to the unique health care needs as well as health issues and challenges of on- and/or off-reserve residents (FN10) The real reason why [AHS] can't or don't want to come is because we never asked them to come onto the reserve, nor did we give them permission to come on the reserve (FN02)	From a legal perspective, [there is] a lot of misunderstanding about the role of the Province on-reserve and their real strong sense that we're just not allowed on. And, of course, from a legal perspective, that's not correct (AH01) There's this hesitation to go on reserve, and partly it's a funding barrier, that somehow the federal government should provide funding for anything we do there, which, again, I don't think from a legal perspective is necessarily correct. So my perspective is that when we approach health care that in some respects there's no boundaries. The Province needs to look at health care and the needs of the population in Alberta without regard to location, that everyone's health care needs are equally important, and there should not be a difference in that regard (AH01) Who cares? Build it and make it happen is what you'd like to say (AHS02)	is getting a little bit more grey. It's not so black and white anymore (HC03) Need to access the right care at the right time by the right provider (HC02) The absence of on-/off-reserve references within the Joint Action Health Plan as opening up the possibilities (HC02) Links it to individuals' choices to reside on- or off-reserve acknowledging that in some cases this choice can be limited and the on- and off-reserve discussion can be helpful to better understand points of access (HC01) Can be used to outline jurisdictional responsibility (HC01)

Table I6 – *Defining Key Concepts: Sharing our Understanding of Collaboration*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Sharing our Understanding of Collaboration			
		Collaboration as a strong word (AHS02, AHS03) Collaboration produces something stronger than the sum of the parts (AHS02) Collaboration as ongoing engagement, accountability, humility and trust-building working together towards an innovation that becomes the next step (AHS03) Preferring partner rather than collaborator; partnership feels more equal (AH02)	Collaboration as a weak word (HC01) Intent to work together but no commitment to resolve anything (HC01)
Stakeholders of a problem domain			
	Common interest is: • understanding of a common goal (FN06) • working towards the same things (FN01, FN04), a common goal (FN11,	Common interest is: • sharing a common interest (AH03) • coming together around an issue (AHS02) • working towards a common	Common interest is: • working towards a common goal (HC03) • working in the spirit of partnership towards a vision or common goal

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	FN15) • working on solving common issues (FN11) • working together with a goal, a focus in mind • achieving a mutual goal (FN02) or the same kind of outcome (FN03) Different interests are: • need to meet our own benefit never losing sight of the First Nations' needs (FN08) • need for the partner to see a benefit to the collaborative endeavour (FN13)	objective (AH03) • addressing an issue that can't be addressed unless you work together (AH01)	(HC02)
Autonomy	Recognition that we will have disagreements as well as policies and protocols that interfere with our ability to come to a mutual understanding (FN01) First Nations support for the Joint Action Health Plan (FN05, FN08)	Seeking clarity of key decision-making principles including autonomy of Nations (AHS03)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Interactive process	Using a proactive approach to define the relationship with the provincial government in our own terms (FN08) Need to understand the role of First Nations, federal and provincial governments in health care and how each other works (FN11) A real willingness and a commitment from all of us as individuals that something within us is really working towards those same things (FN01)	Bringing their individual strengths and viewpoints forward in a way that creates something bigger and better than the individual parts (AHS02) Commitment and willingness required to move off position and take into account others' positions to create a new position together (AHS02) Need to create synergy, to work through issues, to maintain an ongoing engagement and to collectively create a better way	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
		forward (AHS03)	
Shared rules, norms and structures			
	Lack of understanding of First Nations protocols by government participants (FN01)		
	Support of Elders in outlining the need to respect each other and our respective worldviews (FN01)		
	Working relationship agreements where partners identify their goal and alternate resolution process (FN02)		
	Need to have processes with strict timelines as without those there is no commitment (FN05)		
Action or Decision			
	Consensus that would be sought for the greater good (FN03)	Coming together to do something that won't happen unless we do come together (AH01)	
		Need for consensus (AH03)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Domain orientation	How we deliver health care and how people access health care, how people understand what health care is (FN08) Focus on meeting the clients' needs with minimal hiccups in terms of services being provided (FN14)		
Values	Seven sacred teachings (FN07) Respect (FN01, FN03, FN12), respecting each and every single person's input (FN03), show respect to everyone in terms of their skill (FN12), respect the knowledge of traditional knowledge-keepers (FN12) Kindness and respect (FN01) Honesty and equality (FN06) Flexibility (FN13).	Respect (AH01) Equality (AH02, AHS01) Trust (AH01)	

Table I7 – *Preconditions: Relationships between First Nations, Federal and Provincial Governments*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
The Treaties as a foundation to our relationship	Relationships with the Crown superseding the relationship with the federal government (FN01) Failure of the federal government to live up to their side of the Treaty (FN06) Battle of words, English words, to get out of the Treaties (FN03) Consistency of First Nations position in regards to the importance of Treaties (FN06)	Limited awareness of the Treaty Right to Health within AHS and opportunity to pursue through the provincial commitment to implement the United Nations Declaration on the Rights of Indigenous Peoples (AHS01)	Negative legacy that comes into play with respect to the Crown and Treaty First Nations relationship unless some of those barriers can be addressed it will impede effectiveness of the Joint Action Health Plan (HC01)
Assimilation, colonization and oppression	Not a big fan of that assimilation policy, and that's exactly what I see (FN06) The underlying assumption that Canada is a colonizing state is		

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Racism and discrimination	not recognized (FN06) Abusive relationship (FN06) Unfair treatment and its impact (FN15) Given the government too much control over us (FN07) Need to take control of our destiny (FN11) Upholding a policy that we know is causing harm (FN01) Historical discrimination (FN13) Racism by health care providers (FN03) First Nations' health is compromised based on skin colour and status (FN03) Not protected by health legislation like other Albertans and Canadians (FN01)		

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Lack of trust, mistrust and distrust	Racism and discrimination in collaborative work (FN03) Need for reconciliation (FN01) The trust is not there (FN06) Hidden agendas (FN06, FN10) Uneven playing field with First Nations reporting to federal and provincial governments without reciprocity (FN06) Ulterior motives and the need to read between the lines (FN03) Trust so low that we don't want to be in the same room (FN03) Historical mistrust (FN02, FN13) Immediate mistrust (FN12) Skepticism and mistrust (FN04)	Lack of trust which based on history is quite reasonable (AHS03) Ghosts in the room (AH04)	It's not blind trust, certainly (HC02) History impacts trust (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Inequities in resource allocations	Mistrust and cost-savings (FN15) Mistrust and Treaty obligations (FN05) Distrust (FN06, FN10, FN13) Concerns re. lack of capacity of First Nations organizations (FN03, FN04, FN13, FN06, FN15) Could do so much more if provided adequate capacity (FN03) Ugly historic issues as it relates to allocations in this country (FN05) We're being deliberately underfunded (FN06) Resources provided do not equate with resources extracted within a given Treaty area (FN06)		

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Current levels of community engagement	Resources and relationship to the land (FN02) First Nations as taxpayers (FN02, FN03, FN06, FN07, FN12) Accusations of not paying taxes as a reason to deny services (FN02, FN03, FN07, FN12) Paid up front and getting peanuts (FN03) To quadrant – efforts made but limited by policy and legislation and therefore not providing an opportunity for meaningful change; telling us what to do (FN12) For quadrant – governments know what's best for Indians, and they're delivering a program with very low levels of engagement (FN06)		For/with quadrants – not quite at the two-way model but making strides (HC02)

Table I8 – *Preconditions: Identification of Stakeholders*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Lack of signature from the Chiefs (FN02) Readiness of First Nations varies (FN08) Opportunities to engage at a more local level (FN11) Benefits of local level partnerships for enhanced care (FN02, FN08) Importance of reporting back to their organization and the communities they represent (FN05, FN10)	Limitations in terms of their inability to speak and make decisions on behalf of their organizations (AH02, AHS01)	Possible involvement of Indigenous and Northern Affairs Canada (HC02, HC03)

Table I9 – *Preconditions: Stakeholders Expectations about Positive Outcomes*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Improve First Nations health outcomes as an expected outcome (FN04, FN11) Improve the quality of life and the health of First Nations individuals (FN10) Engage with First Nations individuals, organizations and governments (FN03, FN13)	Improve First Nations health outcomes as an expected outcome (AH01, AH03, AHS03) Work with Indigenous communities so that we improve health outcomes in the right way (AH01) Engage with First Nations individuals,	Improve First Nations health outcomes as an expected outcome (HC03) Engage with First Nations individuals, organizations and governments (HC03) Start having the conversations, drawing the province in, drawing the First Nations into that conversation and improving health

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Speak on our behalf. We have a voice (FN03) Bringing our voice to the ears who can make some changes (FN03) Strengthened ability to respond to community needs (FN02, FN03, FN13). First Nations communities have to lead the process (FN08) Establishment of working relationships between all parties (FN08) Memorandum of Understanding (FN14) Improve First Nations health care (FN02, FN03, FN06, FN08, FN10, FN11) Improving health care for those future generations (FN08) Sooner or later the federal government is going to push a choice on us, and if we want to have health services, that's going to mean a weakening of the Treaty Right to Health (FN06)	organizations and governments (AH01, AHS01, AHS03) Commitment of the newly elected provincial government to change the relationship with First Nations peoples (AH01) Indigenous communities can lead the way – they are wiser than us (AH01) strengthened ability to respond to community needs (AH02, AHS01, AHS03) Establishment of more collaborative approaches (AH04) Improve First Nations health care (AH03, AHS01, AHS03) Positively impacts the health care teams in First Nations communities (AHS01) Clarify policy framework (AHS02) Evidence-based approaches informed by health information (AH02)	outcomes from a holistic approach (HC03) Establishment of working relationships between all parties (HC01) Establishment of more collaborative approaches (HC03) Improve First Nations health care (HC03) Improve access and quality of health services accessible to First Nations, and we want to overall improve the state of health, which means we also want to look at partnerships on the determinants of health as well. We want to have better working relationships with provinces so that there's a better continuum of care that's established and better recognition that we have one whole system that needs to serve First Nations regardless of jurisdictional responsibility (HC01)

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Programmatic level such as improvements to Non-Insured Health Benefits (FN02) Opportunity to change existing policies (FN13) Develop legislation (FN12) Evidence-based approaches informed by health information (AH02)	Looking for change in Indigenous health and Indigenous health outcomes and in the delivery of services as well as ability to work on a collaborative basis with the federal government and with First Nations to find those solutions together (AH04)	

Table I10 – *Preconditions: Degree of Recognized Interdependence*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Experiences have contributed in a very positive and meaningful way for our people and shown the way for other Nations (FN08) Any experience gained helps with new collaboration (FN14) Ability to secure more services i.e. 6-7 specialists (FN08) Solution-based approach with local	Wisdom Council helps enhance cultural competency and awareness and provides opportunities for strength-based development in Indigenous populations (AHS02) The role of the Wisdom Council as an apolitical body that is pushing forward (AHS03) Opportunity to dialogue with the Wisdom Council (AHS03)	Different feeling / vibe as a result of the management of the 2013 floods (HC02)

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
hospital (FN02) Collaboration as lip service (FN04) Provincial support helps (FN15)	Ability to change the narrative (AH04)	

Table I11 – *Preconditions: Legitimacy of Stakeholders*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Relationships between First Nations and federal governments	The 1979 Indian Health Policy limits the ability to support better health outcomes and health care for First Nations in comparison with a more solid legislative basis (FN01) The Co-Management Agreement is an administrative agreement to co-manage the FNIHB-AB funding by First Nations and the federal government (FN03) Creation of a division within		The federal government's jurisdictional role as a representative of the Crown with respect to being a Treaty partner (HC01) Co-Management as a tool to nurture and honour relationship with First Nations (HC03) Joint Action Health Plan was achievable with the previous governments and can be supported with the status quo (HC01)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	the Co-Management structure by previous individuals that is not creating a healthy working relationship (FN03) Expectation that a bilateral process would be established to provide a forum for discussion on the Treaty Right to Health within the Co-Management Agreement (FN03) Frequent changes in terms of policy and organizational changes including staff turnover at FNIHB-AB (FN08, FN14) We're not talking Treaties right now. We're talking about health care (FN11, FN12)		If we have a government who wants to introduce a renewed relationship on the basis of Treaty rights and the implementation of Treaty rights, then, it could become a very positive platform for the Joint Action Health Plan (HC01) Our effectiveness as a partner will be based upon the flexibility the government can give us (HC01)
Relationships between First Nations and provincial governments	The federal government has decided that they're going to be moving some of these services and programs to the provincial government. They're not	Need to acknowledge the Treaties and their meaning for First Nations communities and how working with the province might, from their perspective,	Some [First Nations] might hold very firm that they don't even want to have a conversation with the province, because they feel like the

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	willing to step up to their side of the Treaty and honour the Treaty Right to Health and deliver the services to First Nations the way they should. And so to get out of that responsibility and liability they need to include the province. And the province is saying, Yeah, we'll do it, because it increases their base and their authority. And as part of the assimilation policy, more and more Indians are just going to have to fall under the provincial authority (FN06) Expressing concerns about the involvement of the provincial government and its potential impact on the Treaty Right to Health (FN03, FN08) Accusations of sleeping with the government and selling out our Treaty rights (FN03) The province does not have a good history of inclusion of	jeopardize the responsibilities of the federal government to the Treaties (AH02) Considering the AHS observer status at the HCoM meetings, it seems that First Nations leaders and technicians may not see the value of Alberta Health Services or even the province in the discussion (AHS01) From an attitude perspective, there's genuine commitment, and we're ready. From a funding perspective, we're in very challenging economic times (AH03) If we put forward the right proposal that aligns with what we're trying to achieve and shows meaningful work to be done, I'm confident -- I won't do the strongly confident -- but I'm confident that we'd get support for it (AH03) Funding is applicable to all	province compromises their Treaty Right to Health. They really feel that the federal government represents the Crown and that special relationship with the Crown through Treaty (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	First Nations people or First Nations organizations in their delivery model systems (FN06) We're all Albertans at election time, but once the election is over, then all of a sudden we're referred back to being First Nations again, and the province doesn't want to come on reserve and help us out (FN06) Finds the more senior provincial officials reluctant to enter into any agreement (FN02) Seeking a financial contribution by Alberta Health / Alberta Health Services to the Joint Action Health Plan – if you're going to be there, be part of it (FN02) We cannot address health without the province being at the table (FN03, FN08) Acknowledging the Treaty	Albertans and to provide more targeted funding could be challenging (AH03, AHS02) Health equity lenses could be useful to support funding allocations (AHS02) AHS has the service delivery mandate so we have to be there (AHS02) AHS Indigenous Health Program is a strong voice that isn't afraid to be political and isn't afraid to bring issues to the forefront that say, hey, there's a responsibility here for a service provider to address and look at First Nations health issues (AHS01) Alberta Health Services should only be at the table because they're mandated by Alberta Health to deliver, and if they're mandated they need to be given the money to make it happen (AHS03)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	Right to Health in relationship with the province and in MOUs (FN08) Engaging with the province while being respectful and mindful of the Treaty Right to Health (FN08) It's about respecting those Treaty rights, not about ignoring them. And I find with the province in particular, of course they're open to that relationship. As opposed to the federal government at times they ignored that Treaty right. They won't acknowledge it, that it exists (FN08) Alberta Health Services is ready to engage with us (FN13) AHS workers are excited to see things change (FN14) When I first came in [as Health Director], I did all of my work with MSB and Health Canada.	Premier's commitment to renewed relationships with Indigenous peoples and the Joint Action Health Plan is perceived as an important element of this new approach (AH03) New government's platform and the potential to have more community-based approaches (AH01)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Relationships between federal and provincial governments	And now maybe 10 percent of my work is with Health Canada and 90 percent is with the province (FN08) Questioning the role of AHS as they are not the political body (FN02) Beautiful timing with new federal and provincial governments (FN14)	On the provincial side, I think the barriers are, well, the federal government has to fund some of this. You have to work out funding relationships, because if the Province just goes in and funds, then the feds will just back out, and that will be floodgates, and we won't be able to afford it -- there are so many fears. We're so driven by fear and fear to make a commitment, and part of it's been a litigious environment. And you get lawyers at the table, and everyone is afraid to say anything or make that commitment, and so instead of having collaborative, trusting,	We're at a good time in Alberta in terms of provincially and federally. We both seemingly have some common vision, some common commitments, similar mandates in a lot of ways. Both recognize that we need to do better in terms of First Nation health outcomes, we've done poorly as a health system, and there's some efficiencies to be gained but also ways of delivering the service better (HC02) I believe the province is wanting to work with us, but we're a small partner in the big scope of things. We're a small

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
		respectful conversations, you actually have very guarded and very interest-driven discussions (AH01) We should go out there and try to improve outcomes and do it on a collaborative basis, because we can't do it without working together (AH01) Confidence to support this work within the next 12 to 18 months (AH02)	player in terms of health, and, you know, money, really. They won't be distracted by their mandate and what their deliverables and big commitments are, so they'll play, but we're not top and centre for them, but they'll play nice (HC02) New governments and the need to better understand their relationships especially within the context of the Health Accord negotiations (HC01) Federal role as a funder with responsibility to encourage a dialogue between First Nations, federal and provincial governments signaling the need to draw in both the First Nations and provincial governments (HC03)

Table I12 – *Preconditions: Convenor Characteristics*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Key role of Elders in our discussions (FN03, FN11, FN13) Highlighting the participation of First Nations individuals they perceive as influential in the Joint Action Health Plan Working Group and how that contributes to the group (FN08, FN15)		

Table I13 – *Preconditions: Shared Access and Power*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Referring to parental approaches by the federal government towards both provincial and First Nations governments highlighting the need to level the playing field (FN03) Existence of power relationships (FN01, FN11) We don't understand the significance of the power of information. And we don't understand that since time of contact and since before contact that Western thinkers	I think that in trying to work together without acknowledging the history and acknowledging that those imbalances of power exist, there is the potential for us to not [be] walking in the same direction as we try to move forward (AH02)	

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
have been driven, their data have driven policy, policy change and policy development. We haven't quite grasp that concept because data have not been available to us it's only been taken from us and what we have perceived as being used against us (FN01)		

Table I14 – *Processes: Member Capacity*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Skills and Knowledge	Capability to listen – highlighting that we have two ears and one mouth and therefore should use our ears twice as much (FN07) Need to tailor communications to audiences (FN11, FN13) Conflict resolution (FN02) Negotiating skills (FN05) Using negotiating skills to find common ground between	Need to have everyone bring their own perspective and acknowledging different experiences, representing different groups and interests, as we work as collaboratively as possible (AH02) Communications skills (AH02) Need to unpack effective communications behaviourally (AHS03) Need to listen – listen, learn	Literacy and computer skills (HC02) Need for broad-based knowledge (HC02) Understanding context of relationships between First Nations, federal and provincial governments including health status of First Nations and priorities in regards to health care (HC02) as well as the context of relationships between First Nations, federal

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	health care providers and the funders to better meet the needs of her community (FN13) Ability to influence / advocate (FN03) Ability to provide presentations, reports and briefings (FN03) Need for broad-based knowledge (FN05) Cultural understanding: cultural brokers (FN01) and culturally-based (FN05) Understanding of health from a First Nations perspective (FN12) including First Nations health professionals (FN12) Understanding of context of relationships between First Nations, federal and provincial governments including health status of First Nations and priorities in regards to health	and then share, to be able to hear what each other is communicating and the messages that are there, the ability to listen, the ability to respond thoughtfully and carefully and respectfully (AHS01, AH03, AH04) People who are good at process and being able to engage, generating ideas, understanding strategic directions, and translating them into projects (AHS02) Understanding and experience in Indigenous health, able to help the conversation progress (AH01) Skills in project planning and project implementation (AHS03) Need for broad-based knowledge (AHS03) Understanding of health from a	and provincial governments and First Nations understanding of the Treaty Right to Health (HC01) Knowledge of health systems in Alberta and the mandate of the partners in Alberta (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	care (FN02) as well as the context of relationships between First Nations, federal and provincial governments and First Nations understanding of the Treaty Right to Health (FN02) Knowledge of health systems in Alberta and the mandate of the partners in Alberta (FN03, FN11) Understanding how to constantly gather and share information (FN05, FN10) Knowledge of the ultimate goals of both the federal and the provincial governments are and if they're serious about delivering health services (FN06) Understanding organizational structure of FNIHB (FN14) and AHS (FN04)	First Nations perspective (AHS01) Understanding context of relationships between First Nations, federal and provincial governments including health status of First Nations and priorities in regards to health care (AHS03, AH04) as well as the context of relationships between First Nations, federal and provincial governments and First Nations understanding of the Treaty Right to Health (AH01, AHS01, AHS03) Knowledge of health systems in Alberta and the mandate of the partners in Alberta (AH01, AHS03) Knowledge of one's organization's perspective and, if not, having the ability to acquire that knowledge (AH03)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Attitude			
	More important than skills and knowledge (FN04) Attitude is key (FN03) Importance of having different backgrounds, different ethnicities, different work experience and life skills, different knowledge bases, different attitudes as well. Hitting issues from different angles and that's a good thing (FN15) We don't have an exit strategy, we're in this for life – we're always going to be committed to the betterment of our people (FN01) Both parties have to benefit from the collaboration (FN13) Need to bring a level of respect and acknowledgment to the wisdom and knowledge that each individual brings to the	So the more diverse we are -- and I'm not just talking about skills, knowledge, and experience. I'm also talking about in terms of perspective. The more rounded we are, the better off we are (AH04) I feel all in (AH02) Sensitivity and a commitment of staff to improving health outcomes and to serving in a public service sense and that they really want positive outcomes, that they're very motivated that way (AH01) I can, without a doubt, say that I know that the organization is behind us, is behind me, is supporting that what I'm saying isn't just representing me. It's representing the organization (AH04) Commitment to collaboration (AH03)	More important than skills and knowledge (HC02) Openness and willingness to work together (HC03) Importance to come with an open mind, a willingness to be partners, a respect for diversity, a true wanting to advance and contribute (HC02) Respect for diversity (HC02) Sincerity (HC03) Open mind and ready to learn and contribute (HC02) Very, very open mindset of all of the art of the possible (HC01) Think outside the box (HC01) Need to leave everything at the door and come from a place of sincerity and come from a place

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	table (FN03) Respect as a core value of Indigenous peoples (FN03, FN07) Concerns of racism and discrimination at our joint meetings (FN03) Think outside the box (FN02) Need for advocacy (FN03 Willing to form partnerships with federal and provincial governments to achieve better health care (FN11) Check your guns at the door and come in ready to work together (FN05) Compassion (FN03) We have a voice, and we want to speak on our own behalf (FN03)	Need for self-reflection at both individual and organizational levels, acknowledging where mistakes have been made in the past and being open to addressing those so that they don't happen in the future (AH02) Warm feelings towards a First Nation colleague and tremendous respect for the organization – feeling optimistic about what can be accomplished together (AH02) Patience (AH03) Optimism and openness (AH03) Ability to look beyond and see each one of us, as individuals that are invested (AH04) Acknowledging the knowledge and expertise of participants (AH01)	of vision (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	We have real attitudes in our organizations as well. And those are a culture that's been built, because you have to fight for everything you have (FN05) Acknowledging the knowledge and expertise of participants (FN03, FN15)		

Table I15 – *Processes: Relational Capacity*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Developing a positive working climate			
	I feel good about the energy that's around those tables (FN15) The working climate can be good sometimes and very poor other times (FN03) Reporting distrust and questioning of the agenda or ulterior motives of government partners (FN10)	I think we work well together. I think we have good working relationships (AHS03) Seeing growth in the development of positive working relationships (AHS02, AH04) We're also working on things that have a long history of relationships and experiences	Cautiously optimistic (HC02) I think there's a lot of big words, and I think if the government doesn't come out with something strong and real, I think that there will be a lack of trust pretty quickly (HC01) If you really wanted to establish trust, you would start out the discussions with a

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	Discomfort over an engagement session (FN13) Increasing commitment but hesitancy regarding trust from higher level leaders as people have been burned before (FN14) Hopeful but careful (FN06) I think there's a lot of distrust. There's a lot of good intentions. The answers based on the previous federal government are going to be a lot different from the answers with the current federal government and a lot more hopeful (FN06) How does that help a trusting relationship when I know I'm getting denied from April to December I keep getting denied, denied, denied, when I know come February, March, money is going to flow, and	between governments and First Nations, and so when I think about trust it is influenced by individual and systemic experiences (AH03) Acknowledging the impact of leaving then returning to the discussions (AH03) Need to believe in the goodness of the people and their intentions (AHS03) Without personal trust organizational trust is meaningless (AH04) We have achieved a modicum of trust and commitment as I believe that we're still at a fragile state where things could crumble fairly quickly (AH04) You come to the table, and then nothing really happens because nobody is willing to trust enough to put anything on the table. And I don't necessarily	recognition that we're having a Treaty Right to Health conversation. Then the people would trust you (HC01)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	you better spend it quick (FN06) Trust comes and goes… There is no continuity of players at the table. They change, so that trust always has to be built (FN03) Greater level of trust with individuals with whom they have existing relationships as opposed to the "higher-ups", the individuals to whom we report to within our respective organizations (FN06) There's the trust of what we do at the table, then we [need to] be mindful of the trust and commitment from the higher-ups that at the end of the day have the signatory power. Then trust that the government above all will enforce it (FN14) The level of trust has increased and the pace of its increase is also more rapid than it used to	blame people, but somewhere down the line someone has to take a leadership position (AHS03)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	be (FN04) Even amongst each other, First Nations, the level of trust is questioned. There's always accusations of that we have ulterior motives, or we are being selfish, and we're not protecting the Treaty Rights to Health and all this other stuff. It's right within First Nations, too (FN03) Trust can never be really fully gained because reconciliation has not started and until we get there and we have a lot of work to gain trust. We can work towards the idea of a trusting relationship but it's going to take many generations to fully trust one another and mostly on the First Nations side (FN01) We could talk about trust and commitment until the cows come home, but how is that going to result in action at the community level? (FN08)		

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Developing a shared vision	Improving First Nations health outcomes (FN11) Build hope (FN11) Creation of a legislation by First Nations to First Nations state people, Treaty people (FN12) Will result in First Nations-led initiatives (FN04, FN08, FN10) Lead to a permanent table to address issues (FN03) Working with the communities that are ready and able (FN08, FN09) Lead to a joint commitment to working together (FN03, FN14, FN08) reflecting the current language and direction of both governments (FN08) Signed document outlining commitment (FN14)	Improving First Nations health outcomes (AH01, AH03, AH04, AHS02) Improving First Nations health care (AHS02, AHS03, AH04) Working with the communities that are ready and able (AH01, AHS03) Working with the willing because they can tell us. They need to tell us what they're hoping to achieve rather than us telling the communities what we think they can achieve (AHS03) Priority areas where gains can be made: health information (AH02); crisis intervention, mental health, maternal and child health, access and follow-up with chronic disease management (AHS01) Need to identify "shorter-term	Improving First Nations health outcomes (HC03) Hoping the Joint Action Health Plan will be a transition piece that could lead to a more evolved transformation towards enhanced health care (HC02) Lead to a joint commitment to working together (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
		visions" (AH03) or "minor step goals" (AH02) as a way to improve trust and knowledge of each other while improving services (AH03)	
	Ensuring that the province realizes that we're here, we're not going anywhere, we have a voice, and that we have that partnership established between the three parties (FN03)		
	Creation of a house of health for First Nations where information would be available to share amongst First Nations (FN03)		
Promoting power sharing	I define power -- wow -- as pow, no, err (FN15)	Having the resources to have some influence over another party (AH03)	I don't think it's a sexy word anymore (HC03)
	It's a dangerous thing. It can have a negative connotation. I don't think it has a role in what we're doing here (FN08)	How people perceive their own sense of control in their lives and their self-determination, what they can do for themselves and for the lives of their family and friends (AH02)	Everybody wields power (HC01)
	Power to me is the ability to change things that not necessarily people think can be changed. It can be negative or positive, though (FN15)	I tend not to think of power as a positive thing at all (AH02)	Power of Chiefs, and by extension Chief and Council, exert at the community level (HC01)
	Power and passion are	The ability to identify a	The Chiefs exert power, because they have money, and they have independence, in terms of their leadership. They

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	interchangeable (FN04) Power is the ability to get things done, to move things along (FN06) Money is power (FN03, FN14) Knowledge as a source of power (FN05, FN14) The whole concept of OCAP [Ownership, Control, Access and Possession] is about respect and appreciating that the true owners [of community information] are First Nations themselves (FN01) Everybody has power in their own way (FN15) Nobody really has the power (FN02) The federal government has their huge pool of technicians. So does the province. And then there's the First Nations, where	priority, to identify solutions to the priority, and to identify a process that they think would work best (AHS01) I mean, is there power in having deeper pockets, then the governments definitely have deeper pockets, and there is power in having that sort of financial resource, but I don't think governments feel very powerful always in that regard. I think they feel under tremendous fiscal pressure (AH01) Knowledge as a source of power (AHS01) The authority comes from the people that hold the knowledge of the best practices so the health authority, Alberta Health, and in FNIHB the governments, and their processes how to address priorities and deal with them (AHS01)	don't report to you. They don't report to me. They don't report to the province. They don't report to the feds. They report to their population. They have independence as political leaders, and they exert power. They have control over land. They have control over resources. They have control over voices. They exert power. (HC01) Politically connected Chiefs wield a lot of power, they are seen as the big hitters at these tables (HC02) I think First Nations autonomy is strained at times in terms of their collective. We can't paint all our partners with the same brush. Some are more willing than others. Some have the right knowledge, skills, and abilities and are easier to work with, and others are just, frankly, more difficult (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	you've just got a few technicians. It's imbalanced. If we were provided the same capacity, we would be just as powerful in that whole triangular, like the three teepee poles we talk within the teepee model. You need the three to create that foundation. If you just have the two, it will topple over all the time. You need that third one to make it stable, so it will establish that teepee and its elements. So the power in itself is in the hands of the province and the federal government with their legislations, with their regulations, with their policies. And here we are on this side, hanging on to the Treaty Rights to Health and trying to ensure that those obligations are being fulfilled. So there's a definite power struggle there (FN03) It's better to actually be out there at the table speaking on behalf of your own	I think all the players have a certain type of power, say over things, or ability to influence (AHS02) Even the sense of powerlessness is a sense of power (AH04) If people realize power imbalances exist, I think they would be more inclined to make efforts to eliminate those differentials of power (AH02) So the sense of control that they might have over themselves and their choices could be perceived by them as hard work or what have you, but, really, it might be the fact that they have historical privilege because they're white, they speak English, they are born and raised in Canada, these sorts of things (AH02) In trying to work together	At the officials level we exert power in the sense that we can administratively pull levers in certain directions, and so as a result of that, we can shift things positively or negatively in favour of what the leadership are seeking. We can advise political leadership at the government level in a positive or negative way towards something. So we do have power. We do have some influence, and that goes both federally and provincially (HC01) Power in terms of shared priorities between the federal and provincial governments and the ability to move forward on a shared agenda (HC02) Having control over financial resources and allocations (HC01) I believe the province wants to work with us, but we're a small

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	communities rather than having somebody else do it for you (FN03) I think a lot of Nations are feeling they can voice their concerns (FN11) Power of Chiefs, and by extension Chief and Council, exert at the community level (FN09, FN13) The Chiefs are very powerful. They're as powerful as the Ministers, but yet we're so familiar with them, we're so always around them and so we sort of maybe dilute their power. Because if they wanted to, they could demand for Justin Trudeau to come. They really could (FN13) First Nations Peoples have power but it may not be used to its full extent (FN06) Reflecting that all three parties	without acknowledging the history and acknowledging that those imbalances of power exist, there is the potential for us to not be walking in the same direction as we try to move forward (AH02) First Nations Peoples are also being perceived as powerful based on their Treaty interpretations and how they are perceived in society in terms of the larger context such as their connection with the environment (AHS02) First Nations Peoples have power but it may not be used to its full extent (AH03) There could be power in feeling that you represent a higher authority whether it's the federal government, the provincial government, knowing that you have legislation standing behind you and you have policy and a	partner in the big scope of things. We're a small player in terms of health, and money. They won't be distracted by their mandate and what their deliverables and big commitments are, so they'll play, but we're not top and centre for them, but they'll play nice (HC02) Perceptions of power have no place at the table (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	are not using their full power (FN06) The one who has the power to decide that future is the actual Ministers, the heads of those governments (FN02) Power can be wielded by not being able to arrive to a decision (FN03) If we can all understand that at that table or at the steering committee that we're all equal, regardless fed, First Nation, or provincial, we're all equal, then they're on equal footing ground (FN14) The power of decision-making resides within the right place and that's with the people (FN01)	Minister and a government (AH04) Power in terms of shared priorities between the federal and provincial governments and the ability to move forward on a shared agenda (AH03) Health Canada has the power associated with funding, influences how we do work and impacts the work that we do (AH03) I think we as the Province have the least power at the table (AH03) I think we have less ability to influence or drive. And maybe somebody else would say that they have less. So I think that we don't have the relationships that Health Canada and First Nations have (AH03) In each of the meetings it becomes very apparent that the	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
		community members wield a big stick (AHS01) Passive resistance by not showing up for meetings, not making it a priority (AHS03) Creation of anger, shame and fear around the table (AHS03, AH04) pointing out all the things that have gone wrong in previous situations (AHS03) while acknowledging that horrible things have been done to First Nations Peoples (AHS03, AH04) Traditional notions of power are shifting (AH01) I do worry that we're governed by fear. We're afraid of floodgates because of fiscal issues. We're afraid of litigation. We're afraid that if we agree to this that we all stymie economic development. There's so much fear at play that it's hard to build trust and a positive focus (AH01)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
		Need for reciprocity as a way to address power differentials (AH02) Need to support greater capacity throughout the province (AH02) Need to bridge the gap so they can be more equal partners at the table (AHS03)	
Valuing diversity			Need to respect diversity (HC02)
Developing positive external relationships			
	Being able to articulate the needs, the challenges and the issues and being able to bring back information to the table (FN10) Making sure that they're connected to the First Nations, making sure that there's a relationship with those Nations and that they're meeting, that they're consistently meeting	Positive messages of the newly-elected governments (AH01)	Positive messages of the newly-elected governments (HC01, HC02, HC03) but one also expresses the need to be careful as it is not clear how this will translate concretely (HC01)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	(FN10) Sharing information with community members and seeking guidance from Elders (FN13)		

Table I16 – *Processes: Organizational Capacity*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Effective leadership	A positive attitude that rubs off on people in the room that make you want to do this (FN05) Need for champions from all three levels, First Nations, provincial and federal governments – people who have real positive attitudes, they feel a part of it, they feel they can build it. They're true carpenters (FN05) Everybody has a heart into the work that they're doing (FN15)		

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	I think it's important that you have these trailblazers, these community champions leading the way and then having that experience and building that capacity and knowledge and then sharing that with other communities (FN08)		
Formalized procedures – Accountability	Multilayered accountability as they are accountable to: themselves; their supervisor and/or organization; the collective process; and, the First Nations peoples they represent and/or serve (FN01, FN02, FN03, FN04, FN05, FN06, FN14) At home I can look at myself in the mirror and know I haven't done anything to hurt me or my people (FN06) Accountability to their supervisor describing it as taking direction from them and	Multilayered accountability as they are accountable to: themselves; their supervisor and/or organization; the collective process; and, the First Nations peoples they represent and/or serve (AH01, AH02, AH04) As an individual, I feel accountable to my conscience (AH02) Commitment to public service (AH01) Personal sense of accountability that will	Multilayered accountability as they are accountable to: themselves; their supervisor and/or organization; the collective process; and, the First Nations peoples they represent and/or serve (HC01, HC02) And I'm accountable to me. I got to live with my own decisions and sometimes those decisions are easy to make, and sometimes they're very difficult. And at the end of the day, you have to kind of subscribe to your own ethics and values and what you are

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	being responsible for the work performed (FN03, FN04) Accountability to their organization reporting to elected First Nations leaders in some cases directly (FN01, FN04) and in other cases through their board of directors (FN02, FN03) Accountability is ensured through recording and sharing of information as well as provision of briefings and options (FN03) Accountability to the collective process (FN10) We're accountable to the people of this community. I'm not accountable to the rest of Alberta, to the other Alberta First Nations, nor do I speak on their behalf. When I speak and want, it's for this community (FN02)	determine how to respond and interact doing his very best to be supportive of the overall process (AH04) Accountability to their organization (AH01, AH02, AH04) Accountability to a government platform by bringing forward to Ministers options and ways of making that happen (AH01) Accountability is ensured through recording and sharing of information as well as provision of briefings and options (AH01, AH02, AH03) Accountability to the collective process (AH02, AHS02) I feel compelled to go to Alberta Health and do my best to make change internally as well. So I'm not just trying to bring Alberta Health to the working group. I think that in	willing to do or not do (HC02) Accountability to supervisor describing it as taking direction from them and being responsible for the work performed as well as accountability to the employees and her team (HC02) Accountability to the collective process (HC01) Accountable to the federal government, the province and the Chiefs for the outcomes of this process (HC01) Accountable to the Nations that I am providing service and programs to (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	I have to be mindful. I can't just focus on [my tribal council], because some needs are similar, but then there's a lot of needs that are different within the Treaty area. I answer to a lot of people. I answer to Treaty [area]. I answer to [my Tribal Council]. I answer to my First Nations (FN14) I'm mandated by the Chiefs of Alberta. But I see it deeper, the accountability is to the people and that includes, the Elders, the youth, the mothers, the babies (FN01) Need to be connected to the First Nations, making sure that there's a relationship with those Nations and that they're meeting, that they're consistently meeting (FN10)	some ways because of my accountability how I feel as a person, I need to make sure I also bring the working group back to Alberta Health. (AH02) Framing accountability as a mutuality (AHS02)	
Formalized procedures – Authority	People are ready. They want to, but they're always very	Need to bring together people who have if not full decision-	The governance is not always clear from a First Nation

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	mindful of the higher-ups above them. We would like to work together, but let's be mindful of what we have to do. That can both be a positive and a negative, because that kind of thinking sometimes can hesitate and limit what a person is willing to do (FN14) You're only as good as your Regional Director will allow you to be (FN05) It's the next level up, or the level above that. There's a level where they're not being honest with us. They're not being honest with their own people, and I think sometimes their people at the table will get side-swiped, blindsided the same as we do, and they have to come defend it. And it's hard to defend that stuff (FN06) Bringing forward the consensus of the Chiefs that he works while acknowledging some of	making capacity, the capacity to get decisions made. And you need people that have the authority to speak on certain items and to explore them and to play with them (AH01) I'm representing the Aboriginal Health Program voice only, not Alberta Health Services (AHS01) I think the challenge is that while I am part of Alberta Health, and while the team I'm with is part of Alberta Health, I don't know that we can necessarily say we represent all of what Alberta Health does or is interested in doing (AH02) Would it be possible for First Nations to come together as one voice that would have the authority to direct the work and to support First Nations discussions (AHS03)	perspective (HC02) Need to better understand the decision-making process of the partnering organizations as we have to respect it, and we have to nurture it and make sure that we don't compromise anything as we navigate forward (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	them may have different opinions, and they may work on something else in their own manner (FN06)	Importance of political leadership, political authority and political accountability (AHS02)	
Formalized procedures – Detailed / focused work plan			
	Need to maintain flexibility in developing work plans (FN08)	Need to look at our wok at 100,000-foot, 60,000, and 10,000-foot levels so we can look at the advantages, look at the unintended consequences, really make sure it's going to work for the First Nations, and that it can be sustained (AHS03)	I always see a work plan as a fluid document (HC03) A work plan is a way to ensure that we are delivering on the timelines and milestones set as well as part of her accountability to the process (HC01)
Formalized procedures – Work group / committee structure			
	Need to have both a decision-making level and a more technical level (FN03) Questioning if the level of representation or representation is appropriate with Chiefs and governmental counterparts at the bureaucratic level (FN03) If you don't have a cohesive	Need a fluid model (AH04) Need a flexible and agile model (AH01) I think at some point in the future that creating some new structure that reflects all of us would be ideal. But I think we're far from that at this stage (AH03)	Need to have a decision-making level committee (HC02) Questioning if the level of representation or representation is appropriate with Chiefs and governmental counterparts at the bureaucratic level (HC02) Real commitment by the parties

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	working group, we're not going to get anywhere (FN02) Taking time to design a structure that would be established based on meeting pre-established criteria (FN09) Need for a model that is not trying to fit a round peg in a square hole, because that's where we've been sitting all this time. It has to be something that will work for all three, and be culturally appropriate (FN03) I think the best model would be to actually let us do it (FN06) A bridging organization will be just another level of bureaucracy that may at some point be reluctant to give back its authority (FN06) Creation of a bridging organization (FN04)	We shouldn't start with structure because it's not one size fits all because our starting points are varied and that we should just start doing. So we should work with the willing and able. And I'm more of a building block kind of perspective, that we should work with the willing and able and start to see what's possible to learn from that initiative, that partly we need to be doing and learning, and then we can scale and spread it (AH01) Creation of a bridging organization accompanied by capacity in First Nations organizations (AH02) Need to build a starfish organization (AHS03)	is required, you have to resource each of the partners separately to make sure that they are directly involved and have buy-in (HC01) Creation of a bridging organization accompanied by capacity in First Nations organizations (HC03) A secretariat function where partners contribute an employee each to really give this approach some impactful and meaningful traction, you need to have people on the ground constantly, constantly going (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Effective communications			
	Responsibility to share information with her colleagues at various tables identifying opportunities where the work of the Joint Action Health Plan could assist or support other endeavours (FN14) Sharing lessons learned or successes of other First Nations organizations could be helpful to other First Nations organization (FN03, FN14) Limits of emails and benefits of senders to touch base with their intended recipients to ensure that the emails are received and understood as well as providing an opportunity to answer questions and further dialogue (FN05) Need to explain in layman's terms taking into account the history of events (FN03) Leveraging existing		You can't move things along without making sure that you have a parallel communication piece as part of it, because you're going to have to educate people along the way. You're going to have to appease concerns along the way. You're going to have to promote what it is that you're doing to get that collective buy-in through every step of the way (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	communication process within Treaty areas (FN11)		
Sufficient resources	Need for resources if we want to go beyond 3 kilometres an hour and actually start going around 10 kilometres an hour, we need that extra capacity; otherwise, you will find meeting to meeting that it's just inching centimetres, if not going back (FN15) Need to build capacity in First Nations communities and the challenges for a number of communities, especially remote communities to develop that capacity (FN09) Give me my money (FN06) If we want to get things done, we have to be able to provide that capacity to get things done (FN15) Importance of Elders in the process – They're really	We have capacity for the work, that is not always the same for our First Nations partners who may not have that same equity in capacity to participate in all of the work that we bring on the table (AH03) Wishes that Alberta Health bucks up the money to facilitate the work that needs to happen (AHS03) If the Chiefs need money to be put on the table, then put money on the table (AHS03)	It's not realistic to expect existing capacity in First Nations organizations to actually reach out and do significant community engagement. They just don't have the money for that. You have to give resources to be involved and participate in the consultation process (HC01) Ultimately the more we can build capacity in First Nation organizations to be the controlling decision-makers of their own services, the better. And whether they do that directly or they purchase the service or what have you, they're still in control of it. So building that capacity in a way that's, strategic, that's built on trust, built on evidence, built on willingness by all partners (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	powerful. Their knowledge can go so far, and it's more than the words that come out. It's reading between the lines. They try to make you understand by telling you little stories, and if you miss that story, then you just totally miss what the individual is trying to send, the message that they're trying to send. And it's comforting to know that they can come there with their knowledge and power because I know they retain it spiritually, culturally being sound, and that they bring that and to me personally, there's a level of comfort knowing that they're there. Because in a sense it's a validation of them being representative of the knowledge that was held to prove that there is a Treaty Rights to Health (FN03)		

Table I17 – *Processes: Programmatic Capacity*

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
Goals	A joint document to articulate our intent to work together as well as to define collaboration and how we plan to sustain it, and to ensure that it's ongoing (FN03) A joint document that is a demonstration of an investment by the partners not solely in monetary terms but also in terms of commitment and the importance to establish and ensure that those goals and objectives are met (FN03) Begin working with the First Nations organizations and governments who are willing and able to move forward (FN08, FN09) You cannot move forward with all 44. It's never going to happen (FN08)	More work may be needed to transform the vision into goals (AH03, AHS03) I think it's really high-level. We can agree with all of it, because it's so high-level, and it doesn't really get into the details (AHS03) I think that we're nearer to a shared consensus than we were even a month ago and two months ago and three months ago. Are we at a near overlay of understanding? Not yet. No, I think we're moving there. (AH04) Moving towards a more evidence-based approach e.g. work of the Alberta First Nations Health Information Working Group to secure access to the Indian Registry System (AH02)	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	Whether it's a band win or a Tribal Council win or a Treaty win or a regional win, it's still a win (FN09) The common goal is a better health care system for the people (FN11) Need for First Nations peoples to speak on their behalf as they share their issues and concerns with provincial and federal government officials (FN03) Advocating for a building block approach (FN03, FN08, FN09) A building block approach is perceived as facilitating the establishment of timelines and milestones (FN03) and could support the elimination of jurisdictional barriers (FN15) Need to improve health outcomes (FN02, FN10)	Begin working with the First Nations organizations and governments who are willing and able to move forward (AH01, AHS03) Building block approach as a way to ensure that First Nations are leading the process (AHS03) Reflecting on a discussion with a Chief indicating that he had full respect for where the other Chiefs were, but he didn't think that everyone had to move forward together or move together, that people could be respected for where they are and how they wanted to move, but he also said he didn't want to be held back waiting for others, that he was ready to go forward on some fronts (AH01) To ensure that Aboriginal people have the same supports and level of health care services	

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	Reaching beyond providing medications and fixing ailments to improving quality of life and changing lifestyle (FN10) First Nations [peoples] become healthier and healthy people, family, communities (FN15) Healthy people, family, communities should be our slogan (FN15)	that other people in Alberta have; it's about health equity (AHS03) Create an opportunity or a platform to develop ways to address First Nations health issues as prioritized by the First Nations community (AHS01) Advocating for a building block approach (AH01, AHS03) as a way to acknowledge that "to improve health care services for the First Nations community and that …it won't be one size fits all, but it will be a collaborative initiative that takes into account a very diverse landscape (AH01) Need to improve health outcomes (AHS03)	
Quick wins	Involvement of Elders in the Joint Action Health Plan committee structure will lead to	Joint application to the Indian Registry System and development of a Data	Getting the mandate from First Nations for a joint document (HC02)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	buy-in from the Nations, assurances of cultural safety, presence of cultural competency and ongoing communications with Elders who are the advisors to the leadership (FN03) Joint application to the Indian Registry System and development of a Data Governance Agreement (FN04) Enhancing coordination of benefits between Non-Insured Health Benefits and Alberta Aids to Daily Living (FN06) Enhancing crisis intervention, mental health and addictions (FN06, FN14) including funding for youth addictions treatment centre in northern Alberta (FN06) and developing joint tools to address privacy concerns in mental health and addictions (FN14) Respecting Jordan's Principle	Governance Agreement (AH03) Alternative Service Delivery Forum (AH03) Enhancing coordination of benefits between Non-Insured Health Benefits and Alberta Aids to Daily Living while acknowledging the challenges it faces (AH03, AH04) imagine if it was supposed to be a quick win before, where we're at right now, knowing that the recommendations have already been developed (AH04) Enhancing primary care (AHS01, AHS02, AHS03) including supporting a more integrated approach (AHS03) or greater collaboration with the Alternative Relationship Plans (ARPs) (AHS01) Enhancing crisis intervention, mental health and addictions (AHS01, AHS02) including	Joint application to the Indian Registry System and development of a Data Governance Agreement (HC02) Enhancing coordination of benefits between Non-Insured Health Benefits and Alberta Aids to Daily Living while acknowledging the challenges it faces (HC02) Enhancing crisis intervention, mental health and addictions (HC03) including supporting the implementation of the provincial mental health strategy (Valuing Mental Health) and collaboratively addressing issues such as fentanyl and more broadly opioids (HC03)

Elements	First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
	in addressing the needs of First Nations children (FN06, FN14) Need to break down jurisdictional barriers (FN15) Address funding issues including wage parity for nurses and other health para-professionals and professional on-reserve, limited funding for women's shelter on- and off-reserve, as well as the need for the federal government to provide the same level of funding on- and off-reserve (FN06)	establishment of a protocol to support crisis intervention and mental health and creation of a joint travelling team including AHS and community members (AHS01) Enhancing prenatal and maternal child health care (AHS01)	

Table I18 – *Outcomes*

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
It's building bridges towards the bigger picture and how we can influence that" (FN03) We can't work in isolation anymore. It just doesn't work (FN11)	The importance of the Joint Action Health Plan to create a forum for discussion on joint issues and a platform for which to improve health care and ultimately health outcomes (AH01, AH03, AHS01)	More hopeful or cautiously optimistic as a result of the newly-elected federal and provincial governments (HC01, HC02) I think the Joint Action Health Plan is a small step to get to a larger vision. It's

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
An increasing number of First Nations communities are being proactive and innovative at breaking down some of those barriers (e.g. increasing access to services on-reserve such as primary care, specialists, diagnostic services, addressing concerns in the health system such as racism and discrimination, quality of services) (FN02, FN04, FN08) The importance of the Joint Action Health Plan to create a forum for discussion on joint issues and a platform for which to improve health care and ultimately health outcomes (FN02, FN03, FN08) More hopeful or cautiously optimistic as a result of the newly-elected federal and provincial governments (FN06, FN08) I look at this Joint Action Health Plan as a real opportunity for all of us [community], Treaty 7, Treaty 6, and Treaty 8, to combine our efforts and our forces together. And I think collectively that voice, we'd be very strong. Especially right now. We have a new government. They're looking at making some major	I believe that through this process and through just overall time and investments in the Indigenous health and Indigenous health services perspectives that we've made in the last couple of years since the Joint Action Health Plan has gone on, I think there's a deeper sense of empathy and understanding for what those concerns actually are (AH04) I don't know if we're any further ahead than that overall vision still, and maybe because we're at this particular moment in time (AH03) More hopeful or cautiously optimistic as a result of the newly-elected federal and provincial governments (AH01) Limited window of opportunity that has been given with the 2015 elections (AH03) There have been some incremental successes, some building of relationships, some better information sharing and understanding of different perspectives that I think that that helps build but I'm not sure we're at the trust stage (AH03)	administrative in nature in a lot of way. It's almost a transition piece that needs to happen before that trust and relationship and vision will gel for something bigger (HC02) So hopefully the Joint Action Health Plan is going to start those conversations in this region, which to me, when I first started at FNIHB those conversations weren't even being had. It was black and white. On/off-reserve. Not our responsibility. That's your guys' jurisdiction. So to be able to start having the conversations now around health needs and health outcomes, and collaboration and partnership is incredible (HC03)

First Nations Organizations and Governments	Alberta Health and Alberta Health Services	First Nations and Inuit Health Branch
changes so we're aligning in a special way here (FN08) And so what does this Joint Action Plan mean now with these new governments? So I think some elements of the Joint Action Plan have to be updated, and I think some aspects have to be reflective of the new language and the new direction that's happening. Because if it's not changed, I think if you don't update it, if you don't change it, it will be difficult to move it forward (FN08) Limited window of opportunity that has been given with the 2015 elections (FN08)		

APPENDIX J – List of Recommendations

Recommendation 1.

It is recommended that members of the Joint Action Health Plan Working Group and Steering Committee define their understanding of health care and use this definition as a foundation to clarify the purpose and scope of work of the Joint Action Plan to Improve the Health of First Nations in Alberta.

Recommendation 2.

It is recommended that the Joint Action Plan to Improve the Health of First Nations Peoples in Alberta maintains its silence in regards to the on- and off-reserve residency of First Nations individuals and families. It is further recommended that members of the Joint Action Health Plan Working Group and Steering Committee use their discussions to address concerns related to jurisdictional issues and points of access to health care.

Recommendation 3.

It is recommended that participants engaged in interorganizational collaboration between First Nations, federal and provincial governments recognize both Indigenous and Western worldviews and seek to work together within an ethical space that is respectful of both worldviews.

Recommendation 4.

It is recommended that participants engaged in interorganizational collaboration between First Nations, federal and provincial governments recognize the interconnectedness of collaborations and understand the impact of their

discussions on similar discussions between First Nations, federal and provincial governments.

Recommendation 5.

In light of the limited trust, lack of trust, mistrust and distrust expressed by participants in First Nations organizations and governments towards federal and provincial governments, there is a need to focus on enhancing trust between partners. To do so, participants must seek to enhance relationships by enacting reconciliation as defined by the Truth and Reconciliation Commission as a foundational piece to enhancing trust.

Recommendation 6.

In recognition of the broad-based knowledge required for members of the Joint Action Health Plan Working Group and Steering Committee, it is recommended that a learning plan be developed and that training, mentoring and coaching opportunities be provided. Training to be provided should include topics identified in call to action 57 of the Truth and Reconciliation Commission – "history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law and Aboriginal-Crown relations" (Truth and Reconciliation Commission of Canada, 2015, p. 271). Further, opportunities should be provided to learn more on the Treaty Right to Health and Medicine Chest Clause; health from a First Nations' perspective; broader context of relationships between First Nations, federal and provincial governments as well as between First Nations Peoples and Settler

society; health systems; norms and perspectives of own organization and partnering organizations.

Recommendation 7.

It is recommended that participants from First Nations, federal and provincial governments engaged in interorganizational collaboration acknowledge the importance of getting to know each other at a more personal level and dedicate time and resources for more informal engagement such as meet and greet and offsite meetings. Further, participants are expected to demonstrate openness, honesty and humility in their engagement.

Recommendation 8.

Once the purpose and scope of the Joint Action Health Plan have been clarified, as per recommendation 1, it is recommended that partnering organizations review their membership and confirm the accountability expected and the delegated authority of their participants.

Recommendation 9.

It is recommended that civil servants in First Nations, federal and provincial governments increase their awareness of power imbalances and seek ways to mitigate them.

Recommendation 10.

It is recommended that a communications plan be developed to support the further development and implementation of the Joint Action Plan to Improve the Health of First Nations in Alberta.

Recommendation 11.

It is recommended that members of the Joint Action Health Plan Working Group and/or Steering Committee develop an implementation plan for the Joint Action Plan to Improve the Health of First Nations in Alberta that will scope out the work to be performed including: vision, mission, goals, objectives, activities and timelines.