An evaluation of the FNHC prepared for Chiefs and leaders in BC
Date: November 3, 2023

Exploring the Journey of the First Nations Health Council (FNHC)

What We Heard Report

Photo by BirdImages via iStock of whales on the traditional territories of the Songhees and Esquimalt First Nations

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ACKNOWLEDGEMENTS

Giving Thanks

This report presents findings from an independent evaluation of the First Nations Health Council (FNHC). Ference & Company Consulting, a private consulting firm specializing in program evaluation, was hired to conduct the evaluation after an open and public bid process. The resulting report was prepared on unceded Coast Salish territories, specifically the Semiahmoo, sc̓əwaθən məsteyəxʷ (Tsawwassen), xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish), and səl̓ilw̓ətaʔɬ (Tsleil-Waututh) Nations.

The learnings from this evaluation are a result of feedback and wisdom provided by First Nation leaders and other representatives with various experiences with the FNHC. We would like to extend our sincerest thanks to everyone who provided their time and feedback for the evaluation. We also extend our gratitude to all Nations in BC who graciously accepted our presence at their Fall 2022 and Spring 2023 Regional Caucuses, as well as at the provincial Gathering Wisdom for a Shared Journey XII forum.

Ongoing Engagement Needs

Recognizing we were not able to engage all First Nations in BC due to time and budget limitations surrounding the evaluation, ongoing engagement with communities is needed before any conclusions or recommendations can be put forward regarding the future of the FNHC's structure, roles, and governance. The FNHC has designed a two-year engagement plan that will facilitate the collection of additional voices to ensure the FNHC remains Community-Driven, Nation-Based.

As part of the 2023-2025 FNHC Engagement Plan, the findings of this FNHC evaluation will help to inform discussions on the evolution of the First Nations health governance structure, including the structure, roles, and responsibilities of the FNHC over the next two years, leading to a consensus paper for decision at provincial Gathering Wisdom for a Shared Journey XIII forum.

EXECUTIVE SUMMARY

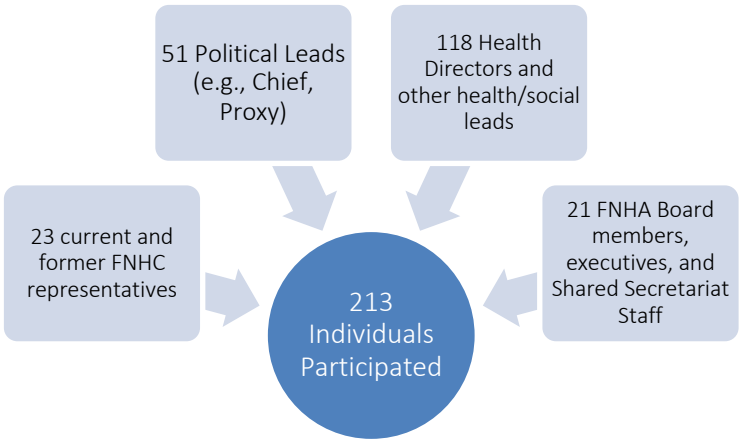
The First Nations Health Council (FNHC) provides political representation, leadership, and advocacy to support BC First Nations to identify and achieve their health priorities. There are 3 representatives in each of the 5 health regions for a total of 15 members. There is also an Elder Advisor who supports the work of the FNHC.

Evaluation Overview. At Gathering Wisdom for a Shared Journey X, the FNHC committed to a voluntary, external, and independent evaluation to support its direct accountability to First Nations in BC. After an open and public bid, Ference & Company Consulting Ltd. was selected to conduct the evaluation. Guidance and financial oversight for the contract were provided by the FNHC-FNHDA Shared Secretariat. A volunteer, regionally appointed Chiefs' Working Group informed the development of the Statement of Work for the evaluation.

Objectives of the Evaluation

- Support increased accountability and continuous learning
- Assist the FNHC in identifying current strengths
- Share stories of change over time
- Highlight opportunities to improve the Council's governance, role, and structure

Evaluation Participants



Limitations of the Evaluation and Next Steps for Engagement

Although engagement efforts were undertaken throughout the evaluation to increase the number of participants, the final numbers are not representative of all BC First Nations Chiefs and leaders. Further, there was a lack of consensus among evaluation participants about the best path forward. There is a need for ongoing and comprehensive engagement of Chiefs and leaders to reach consensus on next steps.

As a result, this evaluation focuses on highlighting the feedback provided by evaluation participants to date, including suggestions for moving forward, rather than providing concrete recommendations for changes to the FNHC. These findings will be used by the FNHC during their engagements over the next two years to inform discussions on the evolution of the First Nations Health Governance Structure, including the structure, roles, and governance of the FNHC. This will result in a Consensus Paper for decision at Gathering Wisdom for a Shared Journey XIII.

Key Takeaways. The following presents the key themes that were heard from evaluation participants across the areas of focus for the evaluation:

Structure. The 15-member structure of the FNHC allows for 3 representatives from each of the health regions to sit on the Council, engage in Regional Caucuses and Sub-Regional Assemblies, and build relationships with regional health authorities. However, the current structure lacks representativeness and does not reflect the unique size, structure, and needs of regions and communities.

Governance. Efforts have been made to separate business and political functions within the First Nations Health Governance Structure. However, the dual role held by FNHC representatives as members of the FNHA Society, particularly their role in appointing the FNHA Board, presents challenges with maintaining separation of business and politics (e.g., the FNHC is instructed to not get involved in the operational matters of the FNHA).

Roles and Responsibilities. The FNHC has undertaken community engagement and asked for feedback at Sub-Regional Assemblies, Regional Caucuses, and Gathering Wisdom for a Shared Journey province-wide forums. There is a need for the FNHC to go beyond reporting and engagement at these forums to ensure all communities are being heard. For example, in-person and one-on-one engagements were identified as wise practices.

Impact. The FNHC has had an impact on health system transformation through their work on the Social Determinants of Health, the provision of oversight during the transition of First Nations health programs and services from the federal government to the FNHA, engagement with Nations to help them achieve their Community-Driven, Nation-Based health objectives, and collaborations with the FNHA and FNHDA as well as federal and provincial government partners.

Opportunities for Moving Forward. Based on what was heard during the evaluation, the following opportunities should be explored in close collaboration with BC First Nations Chiefs and leaders to reach a consensus on next steps for the structure, governance, and roles of the FNHC within the Health Governance Structure moving forward:

- Change the Structure. Adopt a representative structure that supports regionalization and aligns with Directive #1: Community-Driven, Nation-Based and ensure Chiefs and leaders are engaged in this process.
- Update Mandate. Update the FNHC mandate to reflect regionalization as well as the 10-Year Strategy on the Social Determinants of Health and ensure Chiefs and leaders are engaged in this update.
- Update Processes. Strengthen internal processes and procedures, including how the FNHC separates business and politics, by documenting and clarifying processes for dispute resolution, examining the dual role of FNHC representatives as members of the FNHA Society, adopting criteria for representatives, and providing training opportunities for new and current representatives.

- Strengthen Community Connection. Strengthen communications and engagement with Nations and communities by increasing reporting and accountability to First Nations and providing more opportunities for community level feedback.
- Evaluate. Participate in regular evaluation review processes of the FNHC that focus on Community-Driven, Nation-Based measures of success, as well as progress on advancing system transformation.

ACRONYMS AND ABBREVIATIONS

DRIPA	Declaration on the Rights of Indigenous Peoples Act
FNHA	First Nations Health Authority
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
MOU	Memorandum of Understanding
PM&E	Performance measurement and evaluation
TCA: FNHP	Transformative Change Accord: First Nations Health Plan
TCFNH	Tripartite Committee on First Nations Health
TFNHP	Tripartite First Nations Health Plan
ToR	Terms of Reference
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

1.0 INTRODUCTION

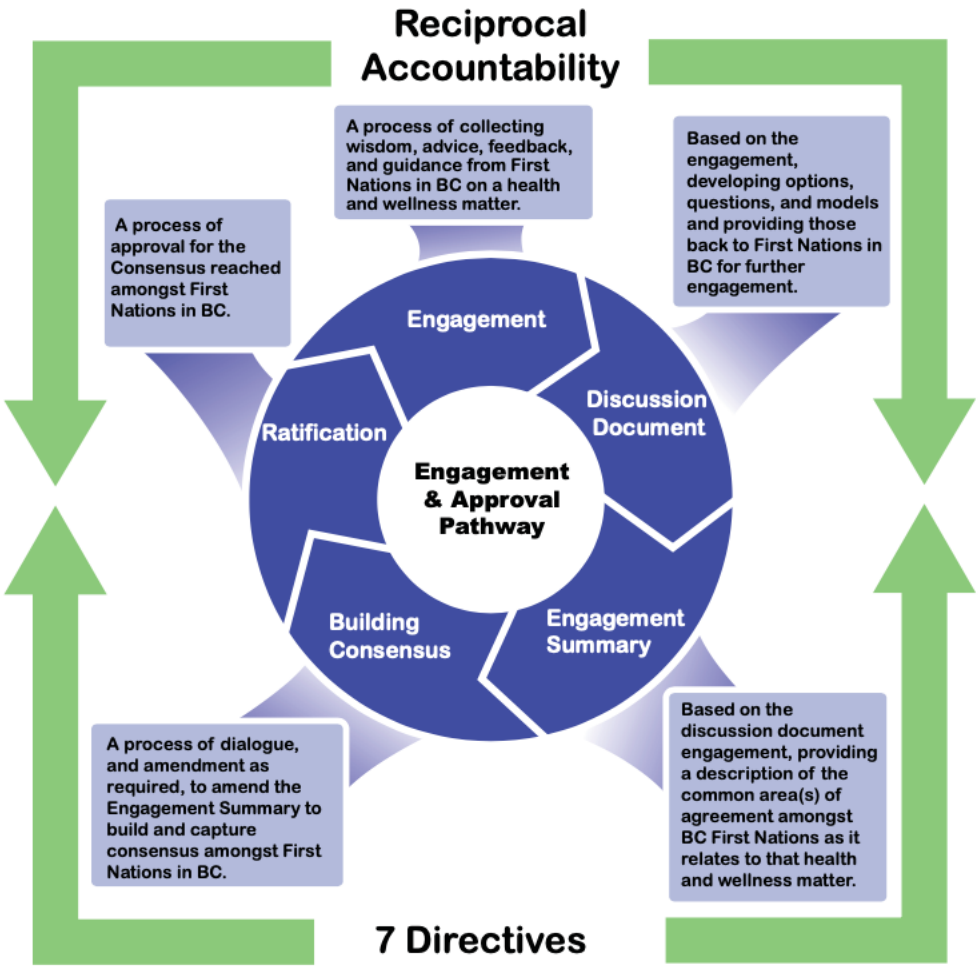
1.1 Background

Created as a result of the signing of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Tripartite Framework Agreement) in 2011, the First Nations Health Governance Structure is representative of and accountable to First Nations in British Columbia (BC) and has the following provincial-level First Nations components:

1. First Nations Health Council (FNHC). Political and advocacy body comprised of 15 regionally appointed representatives plus an Elder Advisor. The FNHC provides political leadership for the implementation of Tripartite commitments and supports the health priorities of BC First Nations.
2. First Nations Health Directors Association (FNHDA). Comprising of health directors and managers working in First Nations communities, the FNHA provides technical advice to the FNHC and FNHA on the implementation of health plans and supports the education and professional development of First Nations community Health Directors and Health Managers.
3. First Nations Health Authority (FNHA). Planning, management, health service delivery, and funding of health programs (including the services formerly delivered in BC by Health Canada's First Nations Inuit Health Branch Pacific Region).
4. Tripartite Committee on First Nations Health (TCFNH). Composed of representatives from BC First Nations leadership as well as federal and provincial governments, the TCFNH belongs to the Tripartite Framework Agreement and provides a forum for the Government of Canada, the Province of British Columbia, and First Nations in BC to make progress on and implement their tripartite health agreements by ensuring that First Nations in BC are fully involved in the provincial and federal governments' health program, service delivery, and decision-making regarding the health of First Nations in BC.

The FNHC, FNHDA, and FNHA receive direction from community leadership and Nations throughout the five regions of the province through community engagement sessions. As part of Resolution 2011-01, the FNHC was asked by First Nations to develop a process for strategic decision-making. In response, the FNHC designed the Engagement and Approvals Pathway which would act as a guide for gathering input to help make strategic decisions related to the First Nations Health Governance Structure (Figure 1). The Pathway guides the FNHC through an 18-month process for engagement regarding province-wide decisions related to governance and is consistent with the 7 Directives and the principle of reciprocal accountability.

Figure 1: Engagement and Approvals Pathway



Source: *Consensus Paper and Resolution 2012-01: Navigating the Currents of Change: Transitioning to a new First Nations Health Governance Structure*

These entities are mandated by documents such as the Tripartite First Nations Health Plan, Consensus Papers and Resolutions (2011, 2012), and the Tripartite Framework Agreement to work collaboratively and in partnership and are guided by a shared vision and values.

1.2 First Nations Health Council (FNHC)

The FNHC was established by First Nations in BC in 2007 to implement the *Transformative Change Accord: First Nations Health Plan* (TCA: FNHP). Their objective is to use their political leadership role to develop understanding of the new arrangement amongst First Nations, and more recently to bring focus to addressing social determinants of health; particularly, those that affirm, promote, and restore the mental health and wellness of First Nations in BC and that contribute to healing, reconciliation, and Nation rebuilding.

1.2.1 Mandate of the FNHC

The FNHC has a specific mandate, which is outlined in the *British Colombia First Nations Perspectives on a New Health Governance Arrangement: Consensus Paper* (2011) and Resolution #2011-01. The mandate provides the foundation for FNHC's work and includes:

Dedicated political leadership for the implementation of the Health Plans:

- Provide continued political leadership for implementation of the TCA: FNHP and *Tripartite First Nations Health Plan* (TFNHP).
- Reflect a philosophy and culture of trust, unity, honesty, humility, healthy living, traditional practices and teachings in operations, planning, and decision-making.

Support to First Nations in achieving their health priorities and objectives:

- Support Community-Driven and Nation-Based approaches.
- Promote individual health and wellness responsibilities, including self-care and health literacy.
- Promote the transfer of health services to local and regional levels wherever possible, practical, and feasible.

Health advocacy and relationships:

- Health advocacy, knowledge sharing, and collaboration with government partners and others at the highest levels (including internationally).
- Advocacy for service improvements for First Nations.
- Provide a BC First Nations leadership perspective to research, policy, and program planning processes related to First Nations health in BC.
- Develop relationships and alliances with other First Nations organizations, government Ministries and Departments, and others, to achieve progress on the social determinants of health.

Politically oversee the transition of Health Canada's First Nations and Inuit Health Branch Regional Office for British Columbia to a new First Nations Health Authority

Promote and ensure communication, transparency, cost-effectiveness, and accountability of the FNHC to First Nations:

- Operate to a good governance standard, including having an approved and transparent Terms of Reference (ToR); transparent processes; active, participatory members; cost-efficiency; professionalism; regular accountability and reporting; on-going evaluation of the role and benefit of the FNHC.
- Develop and implement a robust and sustainable communications strategy enabled by the Regional Tables.

Further, the FNHA Society's Constitution and Bylaws outlines that FNHC representatives will also serve as members of the FNHA Society, the business arm of the health governance structure. In this role, FNHC representatives appoint the FNHA Society's Board of Directors, its Officers and the FNHA Auditors, accept the Annual Report and Audited Financial Statements, and uphold the Constitution and Bylaws.

1.3 About the Evaluation

1.3.1 Objectives and Scope

To support its direct accountability to First Nations in BC, at the provincial Gathering Wisdom for a Shared Journey X forum, the FNHC committed to a voluntary, external, and independent evaluation. The objective of the evaluation was to support increased accountability and continuous learning, assist the FNHC in identifying current strengths, share stories of change over time, and highlight opportunities to improve the Council's governance, role, and structure.

The evaluation focused on the years 2011/12 – 2022/23 and solely on the FNHC.

After an open and public bid process, Ference & Company Consulting Ltd. was contracted by FNHA to conduct the evaluation. Guidance and financial oversight for the contract were provided by the FNHC-FNHDA Shared Secretariat. A volunteer, regionally-appointed Chiefs and leaders' Working Group informed the development of the Statement of Work for the public bid.

The FNHC did not participate on the Working Group, was not involved in reviewing the proposals received, and did not provide any direction to Ference & Co. about the evaluation.

The evaluation addressed the following questions, which were based on issues identified in the Statement of Work for the evaluation.

Table 1: Evaluation Issues and Questions

Evaluation Issue	Questions
Structure	To what extent is the structure of the FNHC effective and functional as a province-wide, 15-member council, with regional (3-of-3) and individual representatives (1-of-1)?
	To what extent is the overall structure of the FNHC relevant and representative of the First Nations in each region? Are there recommendations to make on the criteria the FNHC uses for Council representatives?
	To what extent are the structures of the Partnership Working Group and the Engagement and Transformation Working Group effective? Are there recommendations for the two working groups to be more effective?

Governance	To what extent does the FNHC, in partnership with the FNHA and FNHDA, separate business and politics within the health governance system?
	To what extent is the dual role that FNHC representatives hold as members of the FNHA Society effective?
	To what extent has the FNHC has served to maintain and strengthen the standards of good governance within the health governance system?
	Are the documented commitments and processes for the FNHC, FNHDA, and FNHA to collaborate, build relationships, and address issues and disputes effective?
	To what extent are the FNHC ToR) effective? Are there recommendations to make the ToR more effective?
Roles	To what extent has the FNHC, in partnership with the FNHA and FNHDA, carried out the work and fulfilled its roles and responsibilities pursuant to Resolution #2011-01 and Resolution #2012-01?
	To what extent is the role of the Chair and Deputy Chair effective? Are there recommendations the FNHC should consider that would make these roles more effective?
	To what extent are FNHC representatives effective in their roles as advocates for their constituents and in disseminating communications on FNHC business?
	How is the role of FNHC effective in regionalization?
Impacts	How has the FNHC contributed to the BC First Nations Health Governance Structure's shared vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities?
	What has been the overall impact of the FNHC since the transition of First Nations health programs and services from Canada to the First Nations Health Authority?
	Has the FNHC supported communities to achieve their health priorities and objectives?
	What influence has the FNHC had in moving toward system transformation?
Evaluation Needs	Is there a need for the FNHC to go through a mandatory evaluation review process?
	What are the lessons learned and best practices to capture how the FNHC has been working to date?
	What are useful indicators and measures of performance that would best capture how well the FNHC is working to date?
	Is there a need for the FNHC to go through a mandatory evaluation review process?

1.3.2 Evaluation Methodology

The evaluation used multiple lines of evidence to address the evaluation issues and questions, including gathering knowledge through a document review and engagement through interviews, group discussions, in-person engagements, and an online survey. The following paragraphs outline the methodologies utilized to collect information.

Gathering Knowledge through Documents

The document and file review addressed various evaluation issues and questions based on available documentation. Foundational documents were reviewed to gain context on the history of the FNHC and its relationships with First Nations communities in BC, as well as the other pillars at the health governance structure (FNHA, FNHDA). Regional documents, including Caucus summary reports, partnership accords and their evaluations, and health plans, were reviewed to provide context for each of the five regions and their work with the FNHC. Minutes and records of decisions from FNHC meetings were reviewed to track the work of the FNHC over time and gain an understanding of the roles undertaken by the Chair, Deputy Chair, and Working Groups.

Engagement through One-on-One Interviews, Group Discussions, and Surveys

The FNHC-FNHDA Shared Secretariat provided Ference & Company with contact lists of potential respondents, which included:

- Political Leads (including Chiefs, Proxies)
- FNHC Evaluation Chiefs' Working Group
- FNHDA
- Health Directors
- FNHC Representatives (current and former)[1]
- FNHA Board Members
- FNHA Executives
- FNHC-FNHDA Shared Secretariat Staff
- Federal partners (e.g., Indigenous Services Canada)
- Provincial partners (e.g., BC Ministry of Mental Health and Addictions, Ministry of Health)
- Regional health authorities (e.g., Board members)

Chiefs and leaders were invited to participate in the online survey via email and were also given the option to provide written feedback or participate in an interview if they preferred. FNHC representatives and FNHA Board members and staff were invited to participate in a virtual interview and were offered the opportunity to complete the online survey if they preferred.

If respondents opted for an interview, they were asked for their consent to record the interview for the purposes of notetaking at the start of the interview. After the interview, we utilized recordings to

[1] Current and former representatives are collectively referred to as "FNHC Representatives" throughout the report.

clean the notes from the interview, and then emailed the notes to respondents for validation. One group discussion with health leaders was also conducted virtually as part of the evaluation. These respondents are reflected in the total completed responses for Health Directors and other health/social leads.

All contributors were informed in advance about confidentiality and privacy measures and given an opportunity to ask questions. Respondents were also informed that they would be asked for consent before any quotes they shared would be included in evaluation outputs, such as this report, or any other products.

In total, 213 individuals participated in the evaluation. The table below provides an overview of respondents by group and the response rates.

Table 2: Evaluation Respondents and Response Rates

Participant Group	Total Responses (n)*	Total Response Rate (%)
Chiefs (including Proxies) and leaders	51	26%
Health Directors and other health/social leads	118	61%
FNHC Representatives	23	56%
FNHA Board Members, Executives, and Shared Secretariat Staff	21	96%
Total	213	47%

**Total includes partial and completed response rates. Responses are counted as partial if not all survey questions were answered.*

Analysis and Reporting

Throughout this report, findings shared by all participant groups are noted with statements using the word "respondents" to generally reflect all respondent groups. Findings specific to FNHA Board members and staff and FNHC representatives are noted as such.[2]

Most of the responses from federal, provincial, and health authority partners (n=11) indicated little knowledge about the FNHC and identified an opportunity for the FNHC to strengthen its engagement with other partners, such as the regional health authorities. Due to their lack of familiarity and experience with the FNHC, they are not included in the findings for most of the report.

1.4 Engagement Efforts and Ongoing Limitations

Due to FNHC's role in the health governance structure, it was recognized that a strong response rate from political leads, in addition to valuable input from Health Directors and other health/social leads,

[2] FNHA Executives and FNHC-FNHDA Shared Secretariat Staff are collectively referred to as "FNHA staff" throughout the report.

FNHC representatives, and FNHA staff and Board members, was critical in order to form recommendations surrounding the FNHC's structure, governances, and roles. Engagement for the evaluation took place from November 2022 to July 2023. While engagement efforts were successful in tripling the initial response rate, the final numbers are not representative of all BC First Nations Chiefs and political leaders or other key partners.

To mitigate this challenge, the current evaluation focuses on documenting the feedback provided by respondents to date, including suggestions for moving forward, rather than providing recommendations for changes to the FNHC. Ongoing engagement by the FNHC is being conducted to collect additional views and wisdom from communities before any changes are made. Specifically, as part of the 2023-2025 FNHC Engagement Plan, the findings of the FNHC evaluation will help to inform discussions on the evolution of the First Nations health governance structure, including the structure, roles, and governance of the FNHC, over the next two years, leading to a Consensus Paper for decision by Chiefs and political leaders at the provincial Gathering Wisdom for a Shared Journey XIII forum.

Ultimately, the evaluation budget and deadlines did not allow for face-to-face broad community engagement. Despite this, extensive efforts were made to engage with as many Chiefs and political leaders as possible under these constraints. Based on feedback provided at Regional Caucuses and by respondents during data collection, the evaluation contract was extended to allow for more time for engagement.

The following outlines the engagement efforts that took place over the last year by the evaluation team:

- Attended the Fall 2022 Regional Caucuses to gather feedback on the evaluation approach and create buy-in among Chiefs and leaders.
- Conducted five rounds of follow-up communications to encourage participation.
- Extended the timeline for engagement by 6 months to allow for more participation (from March to July 2023).
- Streamlined data collection tools, particularly the survey, to reduce burden.
- Offered written responses to the interview guide through Word or email.
- Provided a toll-free number for remote communities to connect with us.
- Offered incentives for Chiefs, leaders, Health Directors, and other health/social leads to participate (a chance to win 1 of 10 iPads).
- Attended the Spring 2023 Regional Caucuses to engage Chiefs and leaders in the evaluation, including having a booth onsite.
- Delivered a presentation at the provincial Gathering Wisdom for a Shared Journey XII forum and invited people to engage in the evaluation, including having a booth onsite.
- Leveraged the connections of leaders and FNHC representatives by asking them to reach out to their contacts to encourage participation.
- Created a visual one-pager that the Shared Secretariat could include in their communications with Chiefs and leaders.

The following findings should be reviewed with caution, recognizing this is a “what we heard” to date report, and that further engagement on these results will be conducted.

2.0 WHAT WE HEARD

2.1 Structure

What is the structure of the FNHC?

- In 2007, appointment to the FNHC consisted of three representatives from the First Nations Summit, three representatives from the Union of BC Indian Chiefs, and one representative from the BC Assembly of First Nations.
- To move towards stronger representation of First Nations in BC, in 2010, the FNHC transitioned to 15 representatives, three from each of the five BC health regions.
- The structure has remained the same since 2010 and the selection process and term length of the FNHC representatives is determined by First Nations in each region.

2.1.1 What have been the successes of the structure?

Feedback provided by respondents in the evaluation highlighted the following major successes of the FNHC's structure:

➔ 15 representatives. The 15-member structure that was established in 2010 allowed for three representatives from each of the regions to sit on the Council, as opposed to only having seven Council members. This increased the representativeness of the FNHC and supported regional engagements and relationship building.

➔ Connecting with Communities and Building the Foundation. Leveraging this region-based structure, FNHC representatives engaged in regional and sub-regional assemblies to hear from Chiefs and leaders about their health priorities and needs. This led to the creation of the foundational Consensus Papers and Resolutions (2011 and 2012), which provided the FNHC with their mandate, and outlined the eventual transition of First Nations' health programs and services to the FNHA.

➔ Relationship Building with the BC Health Care System. The region-based structure also supported the creation of the Partnership Accords between First Nations in each region and their respective Regional Health Authorities and increased First Nation collaboration with the health care system in BC.

2.1.2 What have been the challenges with the structure?

Several challenges were identified by respondents regarding the current 15-member structure of the FNHC, including:

- ➔ Lack of representativeness and reach. Many respondents reported that the structure is not representative and adhering to the regional health authority boundaries is not working for all regions. Some noted that not all communities are heard or represented at Council given that there are only three representatives for each region, which does not reflect each region's size and structure. Others noted that some of their communities may be located in another region, despite being a part of the same Nation, due to the provincial health authority boundaries. Overall, there is a need for a structure that reflects a Community-Driven, Nation-Based approach, which would align with the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) and the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA).

    - Fraser Salish. Due to the large geographic nature and spread of some communities, having only three representatives in the region may not be effective.

    - Interior. In the Interior, there are seven Nations which does not align with the three representatives from this region on the FNHC. This was recognized as part of the Interior Region Caucus 2022-02: *Recognition of the Governments of the Seven Nations in the Provincial Health Governance Structure*, the FNHC ToR was to be amended to include the Interior region's governance structure including each of the Governments of the Seven Nations' engagement and decision-making pathway.

    - Northern. Due to the North's size in terms of the number of Nations and communities and geographical spread (including mostly rural and remote locations), three FNHC representatives are not enough. Leaders from the Northern region reported that their communities are often underrepresented, and their needs can go unheard.

    - Vancouver Coastal. In Vancouver Coastal, the structure may be effective given that the region has three Nation territories. However, there still may be challenges with the structure due to the split of the Stl'atl'imx Nation within the region (e.g., Southern Nation communities being part of Vancouver Coastal, and Northern communities being part of Interior Health).

    - Vancouver Island. Although the current structure and representation may appear appropriate for Vancouver Island given that there are three cultural families, it is still not enough to represent all communities in the region, particularly for the many rural areas of the Island.

➔ Too many for a single council. There was conflicting feedback regarding the composition of the FNHC structure moving forward. Although many respondents identified a need for more representation in the regions to support reach, some FNHC representatives identified that having 15 members on the FNHC is too many and lends to ineffectiveness and unproductive meetings (e.g., long meetings without enough tasks getting done). This will need to be considered closely when exploring alternate structures that are both representative and also efficient and effective.

➔ Lack of clarity. The components and layers of the structure (e.g., 1-of-1, 3-of-3) were noted as confusing and difficult to understand by a few respondents.

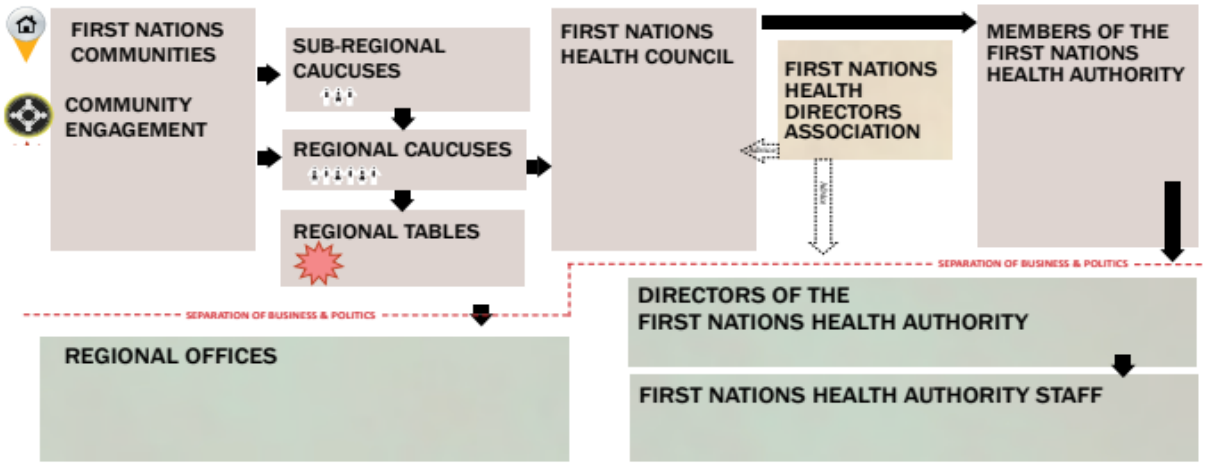
➔ Lack of youth representation. The lack of youth in the structure of the FNHC and the potential for this in the future was also noted by a few FNHC representatives.

2.2 Governance

What are the governance practices of the FNHC?

- As per the *BC First Nations Perspectives on a New Health Governance Arrangement: Consensus Paper* (2011), the FNHC has a mandate and resulting Terms of References that govern their work, which include standards of good governance for which they must strive.
- These standards of good governance, as outlined in the mandate of the FNHC, include having approved and transparent Terms of Reference; transparent processes; active, participatory members; cost-efficiency; professionalism; and regular reporting and accountability; and on-going evaluation of the role and benefit of the FNHC.
- An important element of the FNHC's mandate is to maintain a separation of business and politics in its work, meaning that, as the political arm of the health governance structure, the FNHC may not be involved in operational decisions, which are determined by the FNHA.

Figure 2: Separation of Business and Politics in the Health Governance Structure



Source: *Consensus Paper and Resolution 2012-01: Navigating the Currents of Change: Transitioning to a new First Nations Health Governance Structure*

2.2.1 What have been successes related to governance?

➔ Development of Terms of Reference. The FNHC developed ToR to govern their work in support of the mandate given to them by First Nations in BC. The ToR outline the structure, roles, and responsibilities of representatives at an individual, regional, and collective level, specific roles on the FNHC, the support from the FNHC-FNHDA Shared Secretariat, their process for addressing regional issues, and their accountability, engagement, and reporting duties. Some respondents reported that the ToR are effective and accurately describe members' roles, noting that they were pleased with the ToR and felt that they accurately described representatives' roles.

➔ Collaboration with other pillars of the First Nations Health Governance Structure. A few FNHA staff noted that it was the idea of the FNHC to create one shared vision statement among the FNHC, FNHA, and FNHDA, and that the FNHC further brought all three components together by encouraging their commitment through the *Relationship Agreement Amongst First Nations Health Authority, First Nations Health Council, First Nations Health Directors Association (May 2018).*

➔ Efforts to maintain separation of political and operational roles. Several crises have impacted communities, such as:

- The uncovering of the unmarked graves at former residential schools
- The toxic drug crisis
- The COVID-19 pandemic

- Environmental disasters (e.g., floods, wildfires)
- Systemic racism in the health care system, and beyond, in BC
- Colonialism

Maintaining the separation of business and politics can be challenging when these crises are impacting FNHC representatives' communities. However, FNHC representatives and FNHA staff mentioned that there is support provided to one another in the FNHC during these difficult crises. Notably, a few FNHC representatives and FNHA staff reported that the Chair of the FNHC does a good job of separating business and politics during meetings by reminding representatives of the need for this separation.

➔ Integration of healthy living, traditional practices, and teachings. Most respondents reported being satisfied with how the FNHC integrates healthy living and traditional practices into their work. Notably, some FNHC representatives and FNHA Board members and staff reported being satisfied with the integration of ceremony in events such as the provincial Gathering Wisdom for a Shared Journey forums Sub-regional Assemblies and Regional Caucuses, and meetings.

"I think that the 7 Directives, Community-Driven, Nation-Based, their engagement with the communities to build, this speaks to the fact that they have their ear to the community. Taking direction from community. To me, that's good governance."

– FNHA Staff and/or Board member

2.2.2 What have been the challenges related to governance?

Overall, the feedback provided identified a need for the FNHC to continue to work on and strengthen standards of good governance. This was evident through the following challenges that were described:

➔ Separating business and political functions. Some challenges identified by FNHC representatives and FNHA Board members and staff related to the separation of business and politics. Specifically, FNHC representatives hold dual roles as members of the FNHA Society. As part of this dual role, the FNHC appoints the FNHA Board, approves the annual report and audited financial statements, and abides by the Constitution and Bylaws, but is instructed to not get involved in the operational matters of the FNHA. Further, a few FNHA Board members and staff indicated that the process the FNHC follows for Board appointments is not always clear.

➔ Internal working processes. The FNHC has faced the challenge of bringing together multiple regional representatives from across the province who have differing perspectives and visions for their Nations and communities to try and work with one another. FNHC representatives

identified a **lack of a clear process for conflict resolution** within the FNHC, in addition to a process for removing members from their roles or position on the FNHC. The FNHC has faced internal **challenges with their working relationships** and leadership, most notably resulting in the removal of the Chair and Deputy Chair from their roles in 2019. Following this removal, the former Chair brought forward a lawsuit against the FNHA related to their removal.[3] This was highlighted by a few respondents in their feedback.

➔ **Communication with Nations regarding the ToR**. Although the ToR are publicly available online[4], some feedback provided by FNHC Representatives noted that the development of this document was **not transparent**, is outdated (last updated in 2019), and there is a lack of awareness among Chiefs and leaders about its existence and what is included in the ToR.

2.3 Roles and Responsibilities

What are the roles and responsibilities of the FNHC?

- The key responsibilities of the FNHC, as outlined in their mandate, broadly include political leadership for the implementation of Health Plans, support to First Nations in achieving their health priorities and objectives, health advocacy and relationships, and communication, transparency, and cost-effectiveness and accountability of the FNHC to First Nations.
- Representatives on the FNHC hold roles on the Council collectively (15-of-15), regionally (3-of-3), and individually (1-of-1).
- The FNHC includes a Chair and Deputy Chair who provide leadership for the direction of the FNHC, as well as an Elder Advisor who provides traditional knowledge and cultural support.
- For the Fraser Salish, Northern, Vancouver Coastal, and Vancouver Island Caucuses, FNHC representatives may serve as Chairs or co-Chairs of the Regional Caucus.

2.3.1 What have been successes related to the roles on the FNHC?

Through relationship-building, the FNHC has conducted the following while carrying out its mandate:

[3] A few months after the removal of the FNHC Chair, the CEO of the FNHA was dismissed from their position. In response to these events, FNHA members drafted a plan that included strategic next steps for FNHA Society Members moving forward (e.g., communicating their efforts to stabilize the FNHA to First Nations, implementing new practices with the Board, addressing the competency of the Board, and working with the FNHC to develop an 18-24 month strategy to undertake community engagement on the evaluations in order to consider renewed mandates and possibly renewed aspects of the governance structure.

[4] The Terms of Reference can be accessed at: https://www.fnha.ca/Documents/FNHC-TOR.pdf

- ➔ Working with Nations to achieve their health objectives. Efforts of the FNHC to bring forward voices from communities and advocate for them was mentioned by some respondents. This has occurred through the FNHC asking for feedback at Sub-regional Assemblies and Regional Caucuses, as well as provincial Gathering Wisdom for a Shared Journey forums. From these engagements, the FNHC produced engagement summary reports that describe the feedback provided from each region. An additional mechanism through which the FNHC has reported to First Nations is through virtual webinars and townhalls that were held during the COVID-19 pandemic to provide information and invite guests (e.g., Provincial Health Officer Dr. Bonnie Henry) to help answer public health questions. A few FNHC representatives also reported that FNHC representatives have engaged community members through emails, phone calls, and virtual and in-person meetings.

- ➔ Working with partners to lift Nations' voices through ongoing collaboration. Many FNHA staff and Board members and FNHC Representatives reported that processes for the FNHC, FNHDA, and FNHA to collaborate take place during their joint sessions for strategic planning, which take place twice per year. In addition to these sessions, the FNHC, FNHA, and FNHDA collaborate at provincial Gathering Wisdom for a Shared Journey forums held approximately every eighteen months, and at Regional Caucuses, which are also held twice per year. As noted in the Evaluation of the FNHA (2020), it was recommended that the FNHA engage with the FNHC as well as the FNHDA to review operations and functions and determine which organizational structures, functions and activities are best implemented regionally and which centrally. These ongoing collaborations could have the opportunity to impact the future structure of the FNHC and the First Nations Health Governance Structure.

"The current leadership are really strong in bringing people together and keeping people involved."

– FNHA Staff and/or Board member

2.3.2 What do FNHC Representatives and FNHA Board members and staff think of the specific roles of the FNHC?

FNHC Representatives and FNHA Board members and staff also provided feedback on the effectiveness of the specific roles on the Council:

Chair/Co-Chair

- Many FNHC representatives and FNHA Board members and staff reported that the roles of the Chair and Deputy Chair are **effective**, and the length of their term is appropriate.

- FNHC representatives and FNHA Board members and staff noted that the current Chair and Deputy Chair have **done well** at:
  - **Maintaining relationships** with various partners, in particular federal and provincial governments, which has helped in the negotiations of agreements.
  - **Chairing** meetings and governing the FNHC.

- The roles of the Chairs have **evolved** as different individuals have taken on the position. Since 2011, the FNHC has had three different Chairs and Deputy Chairs. Representatives noted how the individuals who have filled these roles over time have had varying leadership styles. Some described that the strong leadership style of a former Chair resulted in progress (e.g., Mental Health and Wellness MOU), while others noted that this leadership style resulted in members of the FNHC not feeling respected or heard and decisions being made without a proper process in place.

Elder Advisor

- The role of the Elder Advisor on the FNHC has been perceived as positive by both FNHC representatives and FNHA staff, with many reporting that the corporate history they hold is helpful. The Elder Advisor has been effective at **grounding** the FNHC in **culture** and re-focusing discussions during meetings.

- A few FNHC representatives indicated that since the role was established, **only one individual** has held the role and there was **no selection process** for this role.

- The documents demonstrate that the FNHC, FNHA, and FNHDA approved a shared Elder Advisor role description and regional selection process for the health governance structure in 2018. In 2019, the FNHC also approved an Elder Advisor Policy which included an amendment that the role should include both male and female representation, as well as staggered terms. During a review of the FNHC ToR in October 2022, the FNHC suggested that the sections in the ToR on Elder Advisors be updated with the additional selection processes that were approved in 2019.

- To date, these measures have not been implemented. With the onset of the pandemic and other merging priorities, the regions have not been able to establish a list of candidates for Elder Advisors.

"We have an Elder Advisor right now. He's very good at what he does. Logical and steeped in the historical, political, cultural aspects of his people. He brings that forward. I think that it's really important to formalize that."

– FNHC Representative

Partnerships Working Group and the Engagement and Transformation Working Group

- The two FNHC Working Groups (Partnerships Working Group and the Engagement and Transformation Working Group) are non-decision-making bodies that provide recommendations to the FNHC. FNHC representatives familiar with these bodies provided **examples of both Working Groups being effective in the past**, and these examples are noted in the table below.

- In present day, **not many people are familiar** with the Working Groups and a few people remarked that they have not been active since COVID-19. For those who were familiar, it was noted that in the past, appointment to the Working Groups did not have a clear process and that this was problematic.

- A few FNHC representatives questioned the relevance of having Working Groups going forward, especially since representatives may not have the capacity to take on the additional work that stems from these.

Table 3: Strengths of the FNHC Working Groups

Partnerships Working Group	Engagement and Transformation Working Group
Meeting with the Chair, Deputy Chair of the FNHC as well as representatives from the federal and provincial governments	Working on the Social Determinants of Health and the 10-Year Strategy
Provided recommendations that were used to inform the MOU on Mental Health and Wellness (2018)	Working on improving the communications to communities and regions
	Efforts to transform the health care system

2.3.3 What have been the challenges with roles and responsibilities?

Several challenges were noted regarding the current roles and responsibilities of the FNHC, including:

- Communication, accountability, and reporting. Many Chiefs and community health leaders identified a need for the FNHC to improve their engagement of communities as well as their reporting back on what was heard and how it will be addressed, beyond regional Caucuses and Gathering Wisdom. Current engagement efforts and communication channels are not reaching all communities. Some also reported only hearing from the FNHC at Regional Caucuses and provincial Gathering Wisdom for a Shared Journey forums. Current communication mediums may not be reaching Nations. This may be due to external reasons such as flooded email boxes or a lack of capacity to review all communications sent out by the FNHA, FNHC, and FNHDA.

> ***"They're listening and I can hear they're listening but no reply back. I stand up and speak and mention my concerns...Are they supposed to help me, or taking what I'm saying to present to federal/provincial government?"***
>
> **– Health Lead**

> ***"Information flow from regions down to community members is still lacking. It's not getting there."***
>
> **– FNHC Representative**

- Awareness and Role Differentiation. Feedback from Chiefs, leaders, Health Directors, and other health/social leads indicated that there may be a gap in understanding the difference between the role of the FNHC and the role of the FNHA among community members. Overall, a gap in knowledge about the FNHC and what they do, as well as who their representatives are was also noted by some Chiefs, leaders, Health Directors, and other health/social leads.

- Capacity challenges. Given the large geographic areas of many Nations and communities, having three representatives per health region may not be enough to support the needs of all First Nations in BC. With only three representatives per region, there may not be enough capacity among the three representatives to travel to all the communities in their region. Additionally, the FNHC-FNHDA Shared Secretariat, which supports the work of the FNHC, does not have additional capacity to further support the FNHC with outreach needs.

➔ Varying Skillsets. A few respondents mentioned how the effectiveness of representatives depends on who is in the role. A need was identified to strengthen training, orientation, and mentorship opportunities for incoming FNHC Representatives, as well as consider criteria for FNHC Representatives.

2.4 Impact

Since 2011, the FNHC has had many impacts on health programs and services. Impacts that were identified by respondents included:

➔ Overseeing the transition of First Nations health programs and services from the federal government to the FNHA. By doing this, the FNHC fulfilled one of the components of their mandate and helped ensure that communities had access to services.

➔ Engagement with First Nations to support their health objectives. Some FNHC representatives and FNHA staff reported that the FNHC has been working toward its shared vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities by working with and reporting to communities. A few Health Directors and other health/social leads noted that the FNHC helped to support regionalization and felt that the FNHC has listened to and advocated for communities. Positive feedback on the FNHC's role in helping communities was also provided by a few respondents, noting examples of the provision of funding to support health programs in communities.

During the Spring 2022 Regional Caucuses, the FNHC undertook engagements at all five Regional Caucuses on regionalization by asking the following questions:

1) A key theme of regionalization has been bringing resources, capacity, and services closer to home. What do you see as the largest gaps in capacity and what are the next steps in addressing them?
2) What is your long-term vision for regionalization?
3) How can regionalization support a Community-Driven, Nation-Based approach to engagement and service delivery?
4) As a final question, what is the most important next step?

The FNHC used the feedback provided to these questions to inform FNHA-FNHC-FNHDA joint planning as well as to inform the Ten-Year Strategy on the Social Determinants of Health, which First Nations Chiefs and political leaders in BC endorsed at the provincial Gathering Wisdom for a Shared Journey XII forum in March 2023.

➔ Collaboration with partners. The FNHC continues to have ongoing collaboration with the FNHA and FNHDA, as demonstrated through their joint planning sessions, as they work toward their shared vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities. There may be opportunities to improve these relationships going forward. Further, the relationships they have built with federal and provincial partners allowed them to negotiate with the federal government on federal health legislation that sought to improve the health of First Nations in BC. This includes the *Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* (2018), which helped to bring mental health services closer to home.

"I think the relationship could be strengthened and we could build more formal and informal processes. We do joint planning, it's the only time we see each other, but we need to have something other than that."

– FNHC Representative

"FNHC and FNHDA. They don't talk like they used to. FNHDA is a connection to community and services. FNHC doesn't know the issues we deal with daily. That working relationship has to improve. It used to be really good...They don't connect."

– Health Lead

➔ System transformation. The FNHC has most notably contributed to system transformation through their work on the Social Determinants of Health. This work began in 2016 with the MOU that was developed between the FNHC and the Province of British Columbia ("*A Regional Engagement Process and Partnership to Develop a Shared Ten-Year Social Determinants Strategy for First Nation Peoples in BC*"), and continued through engaging communities, resulting in the approval of the *10-Year Strategy on the Social Determinants of Health* at the provincial Gathering Wisdom for a Shared Journey XII forum. Additional ways the FNHC contributed to system transformation included:

- Some members' participation on the Task Team for the *In Plain Sight* report, which addresses Indigenous-specific racism and discrimination in the health care system in BC.
- Strong leadership of the FNHC during the COVID-19 pandemic, which they carried out by assisting with the response to crises (e.g., wildfires) during this time, and holding townhalls where community members could bring forward questions related to public health.

3.0 OPPORTUNITIES FOR MOVING FORWARD

Throughout the evaluation, respondents provided several suggestions to support improvements to the FNHC's structure, governance, and roles. The following provides key themes around opportunities for moving forward that can be used to inform future engagements.

Due to low response rates and lack of consensus among respondents about the best path forward, the following are not recommendations, as more engagement is needed with Chiefs and leaders directly before embarking on next steps.

Support Representativeness and Regionalization.

There are opportunities for the FNHC to increase their representativeness and support regionalization:

- ➔ **Adopting a more representative structure** would align with Directive #1 (Community-Driven, Nation-Based), the priority of regionalization, as well as DRIPA (i.e., Self-Determination and Inherent Right of Self-Government).
    - Although consensus was not reached about what a more representative structure should look like, respondents identified some initial ideas:

1. Provide additional support and capacity to the current FNHC representatives through more secretariat support and/or more involvement of Health Directors who have on the ground connections to communities. This would help to bolster the reach of the current representatives to communities in their regions.

2. Establish "Health Councils" in each of the five regions that have experienced Chairs and Deputy Chairs and are composed of either FNHC representatives and/or a variety of health leaders, as well as Knowledge Keepers/Elders. The composition and size of the councils may differ as it would be determined by the needs and structure of the Nations and communities. This would support reach to more communities and prioritization of health objectives at a more local, community level.
    - Further, to support ongoing broader level advocacy work and tripartite partnerships, have the Chair of each regional Health Council sit at a provincial table.

- ➔ Strengthening the representativeness of the role of the **Elder** Advisor by implementing the approved role description, selection processes, and Elder Advisor Policy, and by working with regions to establish a list of candidates for Elder Advisors.
- ➔ Exploring ways to include **youth** representation on the FNHC.

"With the move to regionalization, we need to shift the work to the regions and amend the structure of the FNHC to reflect this shift. I would suggest that we have one rep per region at the provincial table to help streamline the provincial work and develop a regional structure to reflect the need to focus on the work in our regions. Currently, even with our reps in the regions, there are still some communities being left behind and we need to ensure we are meeting the needs of all our communities."

– FNHC Representative

Strengthen Communication and Engagement with Nations.

There are opportunities for the FNHC to improve their communication and engagement with communities and Nations:

- ➔ Increase regular, consistent, face-to-face reporting and accountability to First Nations beyond Sub-regional Assemblies and Regional Caucuses, and Gathering Wisdom.
- ➔ Continue to support Community-Driven, Nation-Based approaches by asking communities for their solutions and how the Council can help support them to meet their own priorities.
- ➔ Provide enough time for Chiefs, leaders and community members to ask questions during engagement sessions and reporting.
- ➔ Clearly outline the role of the FNHC in reporting, along with who the representatives are for each region.
- ➔ Strengthen communications at regional tables.
- ➔ Increase capacity in reporting to be able to reach all communities and Nations.

A more representative and regionalized structure as suggested in the above section would further support these changes.

Update FNHC's Mandate.

At Gathering Wisdom for Shared Journey XII, the FNHC sought the approval of Chiefs in Assembly on a 10-Year Strategy on the Social Determinants of Health. Resolution #2023-01 received an 86% endorsement from the Chiefs and leaders who were present at Gathering Wisdom (146/170), while there were 24 votes against and three (3) abstentions.

Considering this new Resolution #2023-01 that brings forth a new 10-Year Strategy, the FNHC having met the part of their mandate that involved overseeing the transfer of federal First Nations programs and services to a new First Nations Health Authority, and the suggestions for a more representative structure, there is an opportunity to consider what a future mandate of the FNHC may include. Chiefs, leaders, Health Directors, and other health/social leads shared examples of elements that could be included in future mandates of the FNHC, including:

- ➔ Better engagement with communities and listening to what their needs are.
- ➔ Support Nation rebuilding and Community-Driven, Nation-Based decision-making.
- ➔ Advocate for community needs, including how those needs will be supported.
- ➔ Continuing their work on the Social Determinants of Health.

Update Internal Processes.

There are opportunities for the FNHC to improve and update internal processes, including:

- ➔ Developing a clear, documented process for internal **dispute resolution**
- ➔ Making the roles of the Chair and Deputy Chair more effective by:
  - Strengthening the transparency, governance, and selection process for the roles
  - Updating the ToR and ensuring it is reviewed by leadership
  - Establishing how the roles would be carried out if the FNHC shifted to a different, more representative structure
- ➔ Providing **training/professional development and mentorship** opportunities to new and current members to support their capacity and effectiveness.
- ➔ Adopting suggested **criteria for Council members,** such as having specific experience in health care governance, tripartite relations, and community engagement.
  - Considering having the FNHC consist of health and governance experts instead of political leads.
  - Asking Chiefs and Leaders to clearly outline advocacy instructions for the Council

Strengthen the Separation of Business and Politics.

There are opportunities for the FNHC to strengthen its practices of separating business and politics, including:

- ➔ Adopting and following **a formalized process** for maintaining separation in future structures of the FNHC (e.g., addressing the issue of their dual role as members of the FNHA Society).
- ➔ Providing **education** to leaders, community members, and the FNHA on the distinction between the roles of the FNHA and FNHC.
- ➔ Outlining a clear process for **selecting Board members.**

Participate in Regular Evaluation Processes.

Overall, the feedback received strongly supported the idea of the FNHC going through a mandatory evaluation review process. Most FNHA Board members and staff and FNHC representatives reported that this evaluation should be undertaken every 5 years, while most Chiefs, leaders, Health Directors, and other health/social leads reported that the evaluation should be undertaken every 2 or 3 years.

Future evaluations could also consider evaluating the FNHC, FNHA, FNHDA, and Tripartite Committee on First Nations Health collectively, and look at how each of these pillars of the Health Governance Structure is supporting regionalization.

Suggestions for potential indicators or measures of performance that could best capture how well the FNHC is working to date were provided by respondents, and included:

- ➔ Indicators measuring **advancement on system transformation** (i.e., advancements on the Social Determinants of Health, progress on the Mental Health and Wellness MOU, contributions toward the shared vision, etc.).
- ➔ **Community-driven and based** indicators (i.e., how well the FNHC is working with communities, reporting and accountability success, wellness of communities, successes and accomplishments at the community level, etc.).
- ➔ **Process based** indicators (e.g., type and number of meetings the FNHC is having).

"I think evaluation is always a good tool to have for them to hear our feedback and how they can improve. What are our recommendations for them as leaders? Do they want to have us voice concerns at every meeting? Are they willing to sit with me and talk about problem solving? I think an evaluation is always amazing and can help anyone, not just FNHC. Something that can be shared with leadership and communities. Always ways people can improve."

– Health Lead

4.0 PERFORMANCE MEASUREMENT AND EVALUATION

As there was strong agreement among respondents for a need to conduct more frequent reviews of the FNHC, there is an opportunity for an FNHC performance measurement and evaluation (PM&E) framework to be developed. PM&E frameworks lay out a plan for how to assess the progress of an organization/body and includes two parts: a performance measurement plan and an evaluation plan.

Important, while suggestions have been made regarding the frequency of evaluations as well as possible indicators of success to tack, the evaluation team recommends that engagements be undertaken with communities to formally co-develop a PM&E framework to ensure that it is Community-Driven and Nation-Based. The following provides an overview and examples of what is typically included in a framework, it is not a formalized plan for review of the FNHC.

Performance Measurement Plan. The performance measurement component collects output data on a more consistent basis (e.g., number of communities reached by the FNHC, number/nature of engagements held by the FNHC, number of communities who attended the engagements, number/nature of reporting documents created, frequency of reporting documents, etc.). Often this data is collated on a biannual or annual basis to track yearly statistics and identify trends.

It is important to note that this data does not necessarily speak to impact or whether outcomes are being met but does provide helpful metrics to tell the story of impact and outcomes (i.e., the context). Of course, this data is very Westernized and there will be more culturally appropriate/relevant data that is identified among communities during co-development of a performance measurement plan. The critical piece is that indicators of success (i.e., what tells us this is working) are identified in a formalized plan and collected on a regular basis to support greater accountability to Nations and communities regarding the operations of an organization/body.

Typically, performance measurement plans layout the data that should be collected, who will track it, when it will be collected, who is responsible for collating it and reporting it, and when reporting will occur. This involves creating forms or collection tools (e.g., surveys) as well as training people to know which data to collect, how, and when. For example, FNHC representatives would have to track their activities and report in a structured way based on the data that is identified to be collected. Another example could be having communities fill out an online satisfaction survey on an annual basis.

Evaluation Plan. The evaluation component is conducted less frequently and often includes more narrative and comprehensive exploration of key questions. For example, the current evaluation was provided with a number of issues that covered a variety of themes (i.e., structure, governance, roles, etc.) and then in-depth engagements were conducted to collect information on these areas of interest (e.g., individual and group discussions, review of documents). An evaluation also includes review of performance measurement data and weaves this into the story of how well an organization/body is working.

Regarding the frequency, there was conflicting suggestions from respondents of the current evaluation about how often future evaluations of the FNHC should take place. FNHC members and FNHA representatives reported that an evaluation should be undertaken every 5 years, while most Chiefs, leaders, and Health Directors reported that an evaluation should be undertaken every 2 or 3 years. From the experience of the current evaluation consultants, conducting an evaluation every 2-3 years allows for evaluations to focus on specific components given the frequency of the evaluation and often takes place in the non-profit sector, while 5-year cycles are typically more broad, covering the entirety of a organization/body and align with the frequency of federal government evaluations. It is worth noting that 2–3-year cycles can provide very rich, detailed information but do require more resources and can be more costly. Additional engagement of communities is needed to determine which frequency would be preferred and most valuable.

Typically, evaluation plans should lay out the "theory of change" which clearly identifies the activities of an organization as well as the expected outcomes (i.e., short term, medium term, and long-term goals that may be identified in a mandate or ToR) as well as how these activities are connected to the expected outcomes. Often people refer to this as a "logic model". Evaluation questions are then designed to examine these expected outcomes as well as other issues of interest. Based on the evaluation questions, data collection tools are created to be able to collect information on those questions to tell the story of the data including the successes and wise practices, challenges and lessons, as well as opportunities for moving forward and recommendations.

This is a very Westernized view of evaluation, so engagement of communities and co-development will be key in evaluation planning to ensure it is culturally appropriate/relevant, produces meaningful data for communities, and impacts change.

Next Steps. Decisions regarding the FNHC PM&E frameworks should be determined through additional engagements. Ongoing engagement by the FNHC is being conducted as part of the 2023-2025 FNHC Engagement Plan to collect additional views and wisdom from communities. These engagements should consider PM&E information and/or a contractor should be hired to conduct engagement and co-create the framework. This would support strong accountability to Nations and communities.