THE FIRST NATIONS

Health Transformation Agenda

ASSEMBLY of FIRST NATIONS • ASSEMBLÉE des PREMIÈRES NATIONS

February 2017

Acknowledgements: The Assembly of First Nations (AFN) would like to thank the many dedicated front-line workers, technicians, policy staff, Elders and First Nations leaders that work tirelessly for First Nations people and provided incalculable direction to us over the past number of years and, particularly, in this submission.

The AFN also acknowledges the wisdom of our Elders who had the foresight to fight for the health of our peoples and maintain the sacred knowledge that will help to build and sustain healthy communities for generations to come.

NOTE: NOTHING IN THIS SUBMISSION ABROGATES OR DEROGATES FROM ANY INHERENT ABORIGINAL AND TREATY RIGHT. NOTHING IN THIS DOCUMENT AND PROPOSED PROCESSES SHALL SUPERSEDE OR HINDER BILATERAL TREATY AND SELF-GOVERNMENT TABLES.

TABLE OF CONTENTS

ELDERS AND KNOWLEDGE KEEPERS' STATEMENT ON THE HEALTH ACCORD

A group of Elders, convened by the Assembly of First Nations, met on November 24-25, 2016 to discuss First Nations health and the new Canada Health Accord. As a result of the gathering, they issued the following statement:

"The Elders Gathering on Health supports efforts to ensure First Nations people have access to the best health programs and services available. However, we must remain mindful that mainstream health systems in Canada are broken, and they were not created to reflect First Nations and our ways of life.

The Elders have a vision for First Nations health that reflects a wholistic understanding of health that includes physical, emotional, mental and spiritual wellness. This vision is grounded in our nationhood and guided by the sacred principles gifted to us by our ancestors and the Creator.

The Elders support the AFN to call on federal, provincial and territorial governments to honour their moral, legal and Treaty obligations towards First Nation health, as well as to support efforts to reinvigorate First Nations sacred systems of wellness as part of rebuilding our nationhood, our young people, our families and our communities, as led by Elders."

EXECUTIVE SUMMARY

"First Nations hold the right to self-determination over healthcare for our people, and federal and provincial governments hold a responsibility to work with First Nations on healthcare,"

- National Chief Perry Bellegarde

While the story of First Nations health is often framed as shocking and tragic, the reality is that many First Nations people and communities right across Canada have developed and are developing innovative and successful health and wellness programs and services up against profound challenges including jurisdictional disputes, uncertainty, underfunding, and geography, amongst others. First Nations communities, despite having some of the poorest health outcomes in Canada and with extremely inadequate resources to address them, are charting a path forward in transforming their systems of health and wellness to better meet their respective communities' needs based on wholistic and culturally-based worldviews. The renegotiation of the Health Accord, provides an opportunity for provinces, territories and the federal government to advance First Nations health with First Nations as full partners., We provide this submission that we have entitled the *First Nations Health Transformation Agenda* (FNHTA) to encourage relationship building, outline a menu of policy options and highlight innovative practices with the potential to continue to transform health systems for First Nations for the better.

The relationships between First Nations governments, the federal government, and provincial and territorial governments must reflect the new era of reconciliation; federal, provincial and territorial governments must respect First Nations inherent rights, Aboriginal and Treaty rights that are protected under section 35 of the *Constitution Act, 1982*[1], as well as the *United Nations Declaration on the Rights of Indigenous Peoples* (the *Declaration*[2]). F/P/T governments must also honour and adhere to the Truth and Reconciliation Commission's (TRC) Calls to Action. Finally, in order to be participants in the reconciliation era, F/P/T governments must respect First Nations right to self-determination which includes the right and responsibility to determine, establish and administer their own health and wellness programming.

This FNHTA submission does not replace, but rather encourages dialogue with First Nations regarding a new Health Accord and health for First Nations in general. In order to implement each recommendation in this document Canada and the provinces/territories must embrace and engage First Nations as full partners. Failure to do so would be nothing less than an extension of the kinds of paternalism that has contributed to the overall poor health outcomes of First Nations seen today.

The key to progress is getting the relationships right! As such, any new investments from Canada to the provinces and territories as part of the Health Accord that have a potential impact on First Nations include

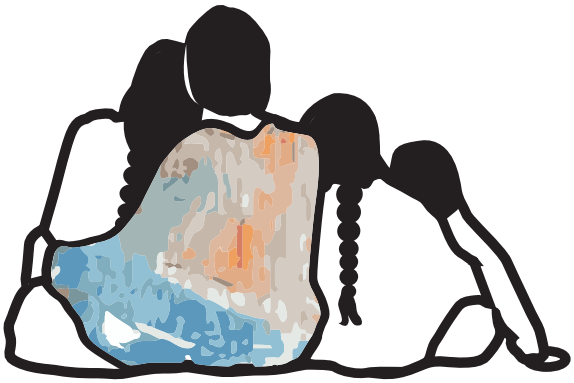
[1] *Canadian Charter of Rights and Freedoms*, s 2, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[2] The United Nations General Assembly. 2007. *Declaration on the Rights of Indigenous People*.

an obligation to work in full partnership with First Nations in developing and implementing policies and programs within the respective provincial or territorial jurisdictions.

Ultimately, First Nations want to move beyond the narratives that amplify the deficits and move towards narratives that highlight First Nations' strengths in the area of health and wellness**.** To this end specific recommendations were developed for Canada, the provinces and the territories that identify key investment areas to close the gap between health outcomes for First Nations and the rest of Canada. The structure of the investments should be accountable to First Nations and must move away from siloed and short-term funding and towards sustainable and long-term funding that is responsive to and that is based on First Nations needs and priorities. In addition, these investments must be directed towards building and sustaining capacity within First Nations as a means to uphold First Nations' right to self-determination. First Nations are seeking the necessary tools, such as enabling policy, funding, and technology to implement our own solutions and build on the many strengths that we already possess.

Within the FNHTA specific recommendations have been developed in the areas of: Closing the Jurisdictional Gaps, including Jordan's Principle; Support for Traditional Healing; Ensuring Cultural Safety/Humility; Supporting First Nations Human Resources for Wellness; Investing in Adequate Health Facilities and Capital Supports; Ensuring Flexible and Adequate Primary Care Investments; Supporting First Nations Initiatives on Chronic and Communicable Diseases; Expanding Access to eHealth; Ensuring Access to Child and Family Programming; Supporting First Nations Mental Wellness and Addictions Programming; Ensuring Access to Home and Community Care, including Palliative Care; and Supporting First Nations Health Data Initiatives.



GETTING THE RELATIONSHIPS RIGHT

Including First Nations priorities into the Health Accord negotiations represents, perhaps, the greatest opportunity for F/P/T governments to take meaningful steps to address the health crisis faced by First Nations in the last ten years. Including First Nations as partners in the Health Accord is an opportunity to generate shared priorities on key issues and close the troubling gap between health funding disparity and outcomes between First Nations and non-First Nations people in Canada as a step towards reconciliation.

To develop this submission, the drafters drew on several government-commissioned reports regarding First Nations health that were developed over the last few decades including, the Royal Commission on Aboriginal Peoples (RCAP), the Romanow Commission, and the Kelowna Accord, among others. These documents remain relevant because their recommendations were largely unheeded and, in the case of the Kelowna Accord, the commitments left unfulfilled.

The "business as usual" approach when it comes to First Nations must be retired in favour of a new reconciliation era approach that compels new relationships between First Nations peoples, on-First Nations people, the provinces, territories and Canada. It is incumbent on all levels of governments to work with First Nations to transform the relationship into one that reflects First Nations inherent, Aboriginal and Treaty rights under section 35 of the Constitution Act, 1982, the *Declaration*, and the TRC Calls to Action. These relationships must also reflect the innovation and energy of the current generation of First Nations young people who value their culture, are confident in their rights and responsibilities and are no longer satisfied with the status quo.

The primary objective of this submission is to compel all F/P/T governments to work with First Nations in their respective jurisdictions to get the relationships right. Therefore, the FNHTA Calls to Action for F/P/T governments are less prescriptive and less specific than the above-noted reports. This new relationship begins with:

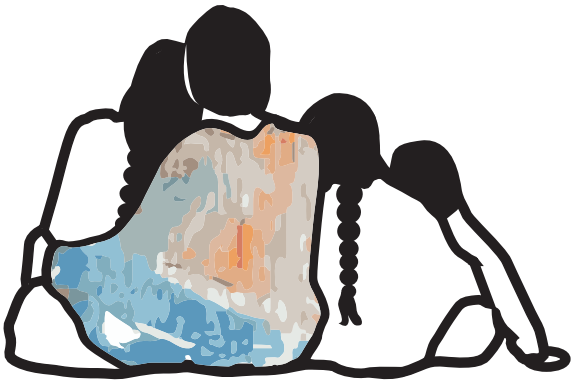
1. Welcoming First Nations health into the Health Accord;

2. Clarifying areas of federal, provincial/territorial, and First Nation jurisdictions, and

3. Creating empowered mechanisms to address existing and emerging areas of jurisdictional confusion.

Transforming the relationship is no longer a question of "if"; it is a question of "when" and "how". These questions must be answered by F/P/T governments and First Nations together.

First Nations have the right and responsibility to determine their own programming on health and wellness. Self-determination is a key theme that will play out throughout this submission. The AFN has an explicit mandate to support and promote First Nations control of First Nations health. As such, this submission includes a number of Calls to Action for the Heath Canada's First Nations and Inuit Health Branch (FNIHB) to strengthen, improve, and transform their approach to programming. FNIHB is currently responsible for most health programs that are delivered on-reserve. First Nations experience with FNHIB programs is that they are often siloed, informed by Eurocentric ideologies and urban-centric evidence, chronically underfunded and often not meeting community needs. To resolve these issues and ensure effective programs with improved outcomes, if and when First Nations take over control of health programming, they must acquire strong and adequately funded programs that are designed by and with First Nations. First Nations must be empowered to negotiate for adequate and appropriately funded programs that are informed and based on First Nations' perspectives on effective health care.



VISION STATEMENT OF THIS SUBMISSION

The First Nations Health Transformation Agenda's goal is **equitable health and wellness outcomes for First Nations**, not just equal investment. Indeed, this was one of the principles identified in RCAP nearly twenty years ago. Achieving equitable outcomes requires full access to high quality, responsive, comprehensive, wholistic, culturally-relevant and coordinated health services and service provision for First Nations within federal, provincial, territorial and First Nations systems. In addition, focussed attention must be paid to the determinants of health including the environment, education, gender, economic opportunities, community safety, meaningful access to culture and land, access to justice, and individual and community self-determination, among others. While there are certainly tasks within this submission that relate just to the federal government, and some just for the provinces and territories, the vision is presented wholistically as a first step in imagining a continuum of wellness programs and services for and with First Nations individuals and communities.

Achieve equitable health outcomes requires:

- Resolving jurisdictional barriers in order to ensure First Nations enjoy the same level of health care as other people in Canada;
- F/P/T governments must ensure that First Nations receive health services free of racism and feel culturally safe within health care settings within their respective jurisdictions;
- That First Nations and First Nations-mandated organizations be at the decision-making table at all jurisdictional levels when decisions are made related to First Nations health and health systems broadly;
- F/P/T governments to demonstrate a commitment to meaningfully work with First Nations in a trilateral fashion to determine a service delivery and governance model that best serves First Nations health care needs; and
- Finally, that F/P/T governments must be held accountable for the commitments they make through this Health Accord process.

Achieving equitable outcomes requires full access to high quality, responsive, comprehensive, wholistic, culturally-relevant and coordinated health services and service provision for First Nations within federal, provincial, territorial and First Nations systems.

PRINCIPLES

1. **Health as Wholistic Wellness:** There is not a single definition of wellness within diverse First Nations cultures. Nonetheless, First Nations worldviews share a common understanding of the interconnectedness between the physical, mental, emotional and spiritual realms. Achieving wellness also obliges attention to the determinants of health. It also recognizes and respects traditional medicines as a key aspect of healing and wellness for First Nations people.

2. **Distinctions-Based:** Moving towards a Health Accord that is inclusive of Indigenous peoples compels recognition of the diversity within Indigenous peoples, specifically First Nations peoples, including cultural, historical and political diversity, as well as differences in the legislative, political and legal relationship between First Nations, Inuit and Métis to the F/P/T governments. As such, the Health Accord should be distinctions-based.

3. **Respect for First Nations Authority and Expertise:** The First Nations health crisis is the result of government policies that develop programs and services *for* First Nations health without their direct and meaningful involvement, from beginning to end. Many F/P/T governments have increasingly recognized that First Nations themselves are the most qualified to articulate and plan for First Nations health needs. In addition, it is the inherent right and responsibility of First Nations to lead First Nations health systems.

4. **Supporting First Nations Capacity First:** Ensuring the long-term sustainability of First Nations-led health systems requires ensuring capacity is supported at the First Nations-level. Any new investments must **start** by ensuring First Nations have adequate capacity, rather than building up infrastructure and capacity within federal, provincial and territorial health systems first.

5. **Recognize Diversity:** To improve the health and well-being of First Nations, geopolitical and cultural diversity must be reflected in all approaches used. As noted in the report from the *Commission on the Future of Health Care in Canada* (the Romanow Commission), “it may be best to emphasize regional or local solutions than can focus on communities or community needs rather than searching for broad solutions that are unlikely to address the unique needs of different communities across the country.”[3] In terms of the Health Accord, provinces, territories and the federal government must work with local and regional First Nations to determine the appropriate path forward on the priorities identified here, and other priorities as identified by regional First Nations themselves.

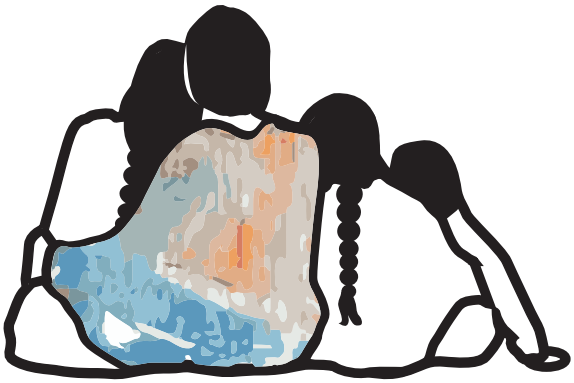
[3] Roy J. Romanow, Q.C, Building Values: The Future of Health Care in Canada, report (2002), 222.

6. **Partnerships:** Ensuring equitable access to healthcare demands the removal of jurisdictional barriers while also recognizing that these partnerships do not abrogate or derogate from Aboriginal or Treaty rights of First Nations protected under section 35 of the Constitution Act, 1982, nor does it release the Crown from their fiduciary duty to or duty to consult with First Nations on matters that could potentially affect their rights.

   To be effective partners F/P/T governments must consider First Nations needs in providing health programs and services in all jurisdictions and communities, regardless of their relationship to the *Indian Act* and regardless of their place of residence (urban, rural, remote, on-reserve or off-reserve). It also requires attention to the unique wellness needs of First Nations women, Elders, youth, children and Two Spirit people[4], among others.

   The principle of partnerships also recognizes that First Nations have the right to fully participate in all discussions that may affect their lives and wellbeing and that First Nations themselves are best positioned to articulate First Nations needs and develop programs and services to meet those needs.

[4] In general, the term *Two Spirit* is used to describe sexual and gender diversity including LGBTQ, but also in gender identities that do not fit within the male/female gender binary.



BACKGROUND AND CONTEXT

This information is provided so that readers are aware of the current situation and state of First Nations health, the context of the determinants of health, the AFN organizational background and about how this submission was developed.

THE FIRST NATIONS HEALTH CRISIS

The health and wellness of many First Nations peoples and communities in Canada is in profound crisis. The headlines in the news exemplify many tragic stories from across the country including well-documented suicide clusters, children dying from treatable conditions, and preventable deaths caused, in part, by racism and discrimination within mainstream systems. Outside of the headlines, First Nations are all too familiar with the many more persistent and silent crises occurring across the country.

The significant data deficiency adds additional challenges to addressing First Nations health outcomes. The data that does exist paints a shameful picture that should induce urgent action from all governments and government departments. In comparison to the general Canadian population, First Nations peoples: Face higher rates of chronic and communicable diseases; Are exposed to greater health risks because of poor housing and contaminated water; Have more limited access to healthy foods and employment opportunities; Experience 5-7 year lower life expectancy; Have an infant mortality rate that is about 1.5 times higher; and 5-6 higher rate of suicides.

The data available on health outcome indicators demonstrate that, in general, First Nations experience lower levels of health in all measurable areas. There is an urgent need for immediate action from all governments, in all jurisdictions, to close the health outcomes gaps for First Nations.

High rates of HIV incidence in the Aboriginal population are also cause for great concern. In 2011, Aboriginal peoples represented less than 4% of the Canadian population, yet represent "8.9% of all prevalent HIV infections…an increase of 17.3% from the 2008 estimate."[5] In addition, Aboriginal people represent

[5] Public Health Agency of Canada. Centre for Communicable Diseases and Infection Control. *HIV/AIDS EPI Updates: Chapter 1- National HIV Prevalence and Incidence Estimates for 2011*. (Ottawa, October, 2014), 5.

"about 12.5% of new HIV and AIDS cases diagnosed in Canada in 2008."[6] Recent reports suggest that the rates of new HIV infections in some First Nations and regions are some of the highest in the world.[7]

First Nations chronic disease rates are concerning especially considering the longer-term consequences for late detection and the systemic challenges in terms of disease management. For example, First Nations women have been shown to die from cancer at a higher rate than non-Aboriginal Canadian women of the same age.[8] Further, survival rates among First Nations are lower than average because cancers do not tend to be diagnosed until more advanced stages.[9] Diabetes rates within First Nations communities are extremely high. Findings from the most recent First Nations Regional Health Survey (2008/10) (RHS), which surveys on-reserve First Nations, indicate that the age-standardized prevalence of diabetes for First Nations adults age 25 years or older is 20.7%. Further, this rate has effectively remained stagnant from the RHS 2002/03 rate of 20.1%. In addition, statistics on diabetes and First Nations youth paint a grave portrait of the future. The World Diabetes Foundation reports that, "while First Nation people represent 2.5% of the Canadian population, they represent 45% of the youth with new onset type 2 diabetes" [… and] in Manitoba, 92% of cases of type 2 diabetes are of self-declared First Nation heritage which is a gross overrepresentation as only 10% of the Manitoba population are of indigenous origin."[10] These rates of chronic disease are even more troubling when you consider these conditions tend to have deeper impacts on First Nations. For example, amputation rates for First Nations living with diabetes are high, to the extent that Thunder Bay, a hub of health services for many First Nations in Northwestern Ontario, is now called the amputation capital of Canada.[11] Likewise, a study on First Nations health care use in Manitoba documented a rate of amputation for First Nations living with diabetes that is 16 times the provincial average.[12]

Regarding mental health and wellness, First Nations experience mental health challenges such as depression and anxiety at a greater rate than the general Canadian population. The RHS found that 22% of First Nations adults reported thoughts of suicide at some point in their lifetime which is double the percentage than the 9.1% of adults in the general Canadian population.[13] Health Canada reports that suicide and self-inflicted injuries are the leading causes of death for First Nations youth and adults up to 44 years of age.[14] Closely linked to mental health and wellness is the issue of substance misuse. Some First Nations have reported rates of opioid addiction from 43% to as high as 85% in their communities' population.

Recent reports show that First Nations people in British Columbia and Manitoba are disproportionally hospitalized for conditions that would be treatable in community-based primary healthcare services[15]

---

[6] Canadian Aboriginal Aids Network. "Aboriginal HIV and AIDS Statistics." May 13, 2012. Accessed November 17, 2016. http://caan.ca/regional-fact-sheets/.

[7] Andre Picard, "Saskatchewan should declare HIV-AIDS public health emergency," *The Globe and Mail* (September 19, 2016).

[8] Michael Tjepkema et al., Mortality of Métis and Registered Indian Adults in Canada: An 11-Year Follow-up Study, (Ottawa: Statistics Canada, 2009).

[9] First Nations Information Governance Centre, "First Nations Regional Health Survey (RHS) 2008/10: National Report on Adults, Youth and Children living in First Nations Communities," (2012): pg. 179. Withrow et al. (2016). Cancer Survival Disparities Between First Nation and Non-Aboriginal Adults in Canada: Follow-up of the 1991 Census Mortality Cohort *Cancer Epidemiol Biomarkers Prev*.

[10] Expert Meeting on Indigenous Peoples, Diabetes and Development Report, (World Diabetes Foundation Secretariat, 2012), pg. 17.

[11] Grand Chief Alvin Fiddler, "Submission to the Standing Committee on Aboriginal Affairs and Northern Development for the Committee's Study on the Nishnawbe Aski Nation Declaration of a Health and Public Health Emergency" (April 12, 2016): pg. 7.

[12] Patricia Martens et al., *The Health And Health Care Use of Registered First Nations People Living In Manitoba: A Population-Based Study*, (Winnipeg: Manitoba Centre for Health Policy, 2002).

[13] FNIGC, RHS 2008/10, pg. 197.

[14] Centre for Suicide Prevention, "Aboriginal Suicide Prevention Resource Toolkit," (2013): pg. 2.

[15] Which includes primary care in nursing stations and in those communities that successfully negotiated access to physicians, and prevention services in all communities.

if such services were available, accessible and responsive.[16] In Manitoba, First Nations represent 15% of the provincial population, and yet utilized 28% of provincial healthcare expenditures. Disproportionate rates of hospitalizations due to potentially preventable ailments result in provincial authorities paying for the costs of delayed federal investments on-reserve.[17] These jurisdictional barriers cause inefficiencies across the federal-provincial/territorial and First Nations health care systems and are undermining the sustainability of the overall national healthcare systems, especially in provinces and regions where the proportion of First Nations is higher.

These statistics regarding the health crisis in First Nations represents a snapshot of the present-day health inequities experienced by First Nations peoples and communities. The data available on health outcome indicators demonstrate that, in general, First Nations experience lower levels of health in all measurable areas. They clearly demonstrate the urgent need for immediate action from all governments, in all jurisdictions, to close the health outcomes gaps for First Nations.

THE CONTEXT OF THE DETERMINANTS OF HEALTH

Rising costs and demand for Canadian health care poses an unprecedented challenge for health care policy makers at all levels of government. Despite strong evidence supporting greater effectiveness of an integrated population health versus an individual biomedical approach, Canada lags behind other nations in matching theory to practice. Adopting a Determinants of Health (DOH) lens for the Canadian health care system further exemplifies the gap between the well-being of First Nations and non-First Nations people in Canada. By examining the DOH, policy and law-makers at all levels of government can more readily identify root causes of health outcomes that fall outside the conventional health realm, leading to wholistic and sustainable approaches to wellness, and ultimately improving the health of First Nations in Canada. In addition, health care providers, governments and policy makers cannot view the current state of First Nations health without also considering the colonial context that has included dislocating Indigenous peoples from their homelands, imposing western patriarchy, banning of cultural and spiritual practices, and the undermining of Indigenous traditional forms of governance, legal orders, economic and social systems and structures.

Given the multiple and intersecting sources of health and wellness, closing the gap on First Nations health outcomes requires equally fulsome and wholistic investments in health systems, as described in our recommendations below. First Nations' health programs and services are extraordinarily underfunded in a manner that would never be acceptable within provincial/territorial systems.

F/P/T government departments with mandates related to the determinants of health must consider health impacts on First Nations when making policy decisions. The emerging "Health in All Policies" (HiAP) approach systematically works across sectors to address factors impacting health, creating shared goals and an integrated government response to wellness. HiAP improves accountability of decision makers by emphasizing the consequences of various policies on the determinants of health, the health system and overall population wellbeing.

[16] Lavoie et al. (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine* (Vol. 71), pg. 717-724.

[17] Lavoie. (2016). A Comparative Financial Analysis of the 2003-04 and 2009-10 Health Care Expenditures for First Nations in Manitoba: unpublished manuscript. Winnipeg, MB: MFN-Centre for Aboriginal Health Research.

ACTION

ON A "HEALTH IN ALL POLICIES" APPROACH

◊ **The AFN recommends federal, provincial and territorial governments adopt a cross-ministerial Health in All Policies approach with specific attention to the impact on First Nations health.**

ASSEMBLY OF FIRST NATIONS ORGANIZATIONAL BACKGROUND

The AFN is the national body representing First Nations governments and approximately 1.5 million people living on reserve and in urban and rural areas. The National Chief is elected every three years and receives direction from the Chiefs in Assembly. The AFN is dedicated to advancing the priorities and aspirations of First Nations through review, study, response and advocacy on a broad range of issues and policy matters.

There are 634 First Nations in Canada with established governance systems, each led by a Chief who is entitled to be a member of the Assembly. The AFN National Executive is made up of the National Chief, 10 Regional Chiefs and the chairs of the Elders, Women's and Youth councils. First Nations are part of more than 50 distinct nations with unique cultures and languages.

First Nations have a unique and special relationship with the Crown and the people of Canada as set out in the Royal Proclamation of 1763 and manifested in Treaties, the Constitution Acts of 1867 and 1982, Canadian common law and International law, and as outlined in the United Nations Declaration on the Rights of Indigenous Peoples.

AFN HEALTH ACCOUNTABILITY/GOVERNANCE STRUCTURE

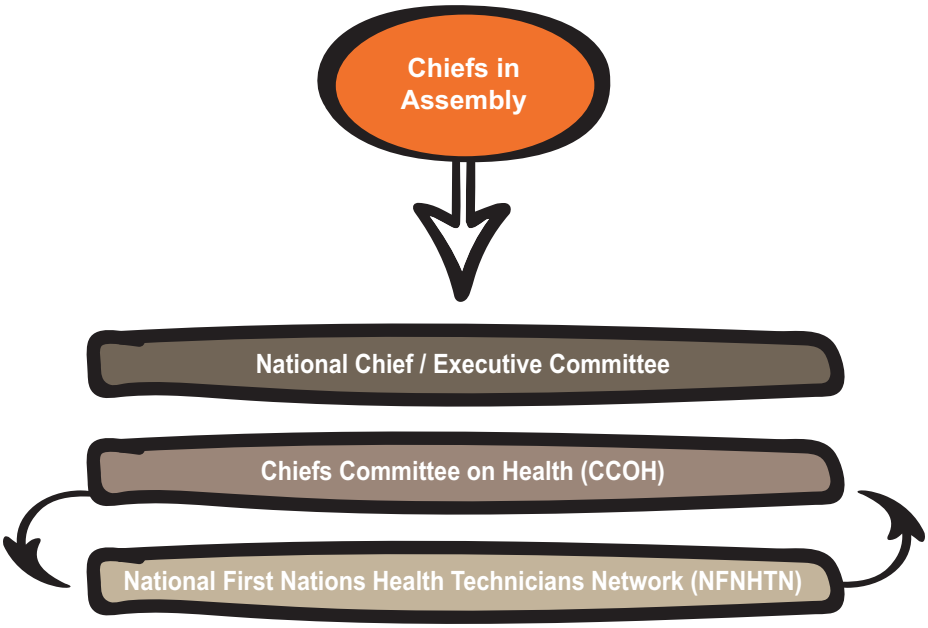
The AFN governance structure which guides the health staff was designed, despite the challenges of geography and regional variations, to ensure the highest degree of input from regions as well as accountability to leadership.

The National First Nations Health Technician Network (NFNHTN) is a group that advises on AFN health activities, communicating the vital regional perspectives. This group is comprised of health technicians from each region across the country who, in turn, takes their direction from First Nations communities themselves, guided by their own regional processes. The NFNHTN meets face-to-face at least 4 times per year, and maintains steady contact between these meetings and makes recommendations to the AFN. Regional health plans and regional resolutions also feed into AFN work.

Recommendations from the NFNHTN are then considered by the AFN Chiefs Committee on Health (CCOH). Similar in structure to the NFNHTN, the CCOH is comprised of a representative Chief from each of the ten regions across the country and is chaired by the AFN Executive member who holds the health portfolio. Decisions made by both the NFNHTN and CCOH direct the work of AFN health staff. CCOH subsequently reports back and is accountable to Chiefs in Assembly.

The AFN Health team, the NFNHTN and the CCOH also receive expert advice from numerous working groups which are NFNHTN subcommittees that are comprised primarily of issue experts and regional First Nations representatives. Issue areas include public health, home and community care and mental wellness, among others.

Ultimately, the Chiefs in Assembly are the highest level of accountability within the AFN structure. Chiefs meet at duly convened assemblies biannually (Annual General Assembly and a Special Chiefs Assembly).



APN HEALTH POLICY STAFF

Chiefs in Assembly provide the AFN with mandates on priority issues through resolutions. These resolutions provide AFN Teams (Core; Implementing Rights; Achieving Change; and Safe, Secure and Sustainable Communities) with direction and set the AFN national policy agenda.

DEVELOPMENT OF THE FNHTA

The FNHTA represents the health priorities identified by the AFN through years of work with guidance and direction from the AFN's respective governance processes including the National First Nations Health Technicians Network (NFNHTN), the Chiefs Committee on Health (CCOH) and Chiefs in Assembly.

Chiefs in Assembly passed a resolution at the July 2016 Annual General Assembly which mandated the AFN to develop this submission. Specifically, the resolution:

1. Call[s] on the Assembly of First Nations' (AFN) Chiefs Committee on Health to coordinate an expert task group and regional engagement to develop several priorities related to the four pillars identified by the Health Minister (home care, mental wellness, pharmaceuticals and innovation) as well as any other First Nation priorities outside of those pillars.

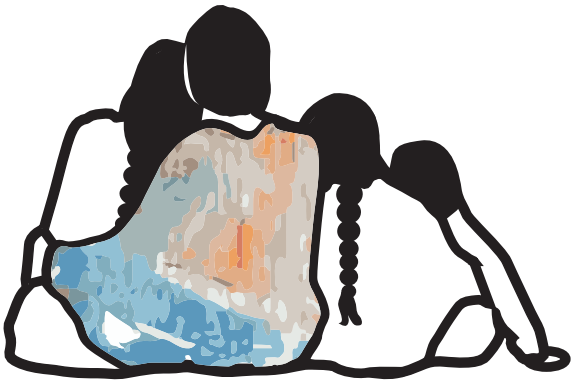
2. Direct[s] that any submission of the AFN be high-level in terms of subject area and national in scope, to allow for regional specificity and respect regional processes while also serving as direction for investments at the federal Cabinet table.

3. Endorse[s] that the primary objective of the AFN contribution is to influence the provinces and territories to work with First Nations in their respective jurisdictions to ensure provincial and territorial systems are responsive to First Nations' needs and to close the jurisdictional gaps between federal, provincial, territorial and First Nations health systems.

In addition to the long-standing priorities gathered through years of engagement through the AFN's regional and assembly processes, this submission also builds on the work that informed the Kelowna Accord over ten years ago. Further, the AFN received guidance from numerous content experts, largely through the development of an AFN Health Accord Task Team, as noted in the resolution, consisting of experts on specific health issues, health governance and health policy within the First Nations context.

In addition, AFN Regional Chief Isadore Day, the Executive portfolio holder for health, undertook several engagements sessions with policy staff, front-line staff, health managers, and a dedicated session for Elders, among others to validate the priorities presented here.

Finally, the FNHTA was reviewed by legal experts in Aboriginal law.



THE FIRST NATIONS RIGHT TO HEALTH

First Nations have the right to be meaningfully consulted on any proposed government activities that may adversely impact Aboriginal and Treaty rights under section 35 of the *Constitution Act*, 1982. In contemplating conduct that might adversely impact potential or established Aboriginal or Treaty rights, the Crown has a constitutional duty to consult, and if appropriate, accommodate.

All F/P/T governments have a fulsome obligation to ensure that First Nations are consulted and accommodated regarding conduct that affects First Nations rights, including (but not limited to) health policies and programs on-reserve.

Our Elders teach us that Treaties between First Nations peoples and the Crown are an articulation of the Creator's gifts and wisdom; they are sacred. In addition, the Treaties articulate relationships and ongoing legal obligations. In the case of health, Treaties reaffirmed First Nations jurisdiction over their own health care systems and established a positive obligation on the Crown to provide "medicines and protection."[18] Crown treaty obligations are found both in verbal commitments and in the text of the Treaties.

Promises of non-interference with First Nations' way of life were prominent in the negotiations of numbered Treaties 4, 6, 7 and 8:

> *"In 1871, Treaty Commissioner Archibald opened the negotiation of the numbered treaties by stating that the "Great Mother" Queen Victoria wished the Indian people to be "happy and content and live in comfort… to make them safer from famine and distress…to live and prosper … [with] no idea of compelling you to do so."*[19]

First Nations have a right to self-determination, including over health policies and systems, a principle that is supported by inherent Aboriginal and Treaty Rights, the United Nations Declaration on the Rights of Indigenous Peoples and the Truth and Reconciliation Commission of Canada's Calls to Action.

While the most commonly cited reference to the treaty right to health is found in Treaty 6, there is significant evidence demonstrating explicit promises of health provision in numerous treaty negotiations. Noted legal scholar and expert on Aboriginal health and the law, Dr. Yvonne Boyer

[18] Yvonne Boyer, *Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers*, (Saskatoon: Purich Publishing Limited, 2014): 141.
[19] Ibid., 142.

notes that in “Treaties 6, 8, 9 and 10 there is explicit reference to medicine in either wording of the treaties or in records of the oral negotiations surrounding treaties. Treaty 7 elders confirm the treaty right to medicines, medical care, and indeed health was negotiated.”[20]

Boyer also notes in her research that the Federal Court clarified the extent of the medicine chest clause in the 1935 *Dreaver* decision to include “all medicines, drugs, or medical supplies …to be supplied free of charge to Treaty Indians.”[21] Significantly, this judgement “has not been overruled.”[22] Also significant is that the Supreme Court articulated that Treaties should be interpreted flexibly and that “any ambiguities about the language in a treaty or the negotiations must be resolved in favour of the Indian signatories. Further, any treaty limitations that restrict the rights of Indian signatories must be narrowly interpreted.”[23]

Aboriginal rights are separate from Treaty rights because they apply whether or not a First Nation signed a Treaty. An “Aboriginal right” according to the Canadian common law means a practice or activity that was “integral to the distinctive culture” at the time of first contact with Europeans and still exists in some form today.[24] The Supreme Court has confirmed what First Nations have always held, that Indigenous peoples hold a set of unique rights based on their existence before contact with Europeans. Boyer notes:

> *“The Supreme Court has confirmed that it is the duty of a just government to protect these inherent rights. These inherent rights are not dependent upon Canadian law for their existence... Aboriginal rights and fundamental freedoms stem directly from recognition of the inherent and inalienable dignity of Aboriginal Peoples.*[25]

First Nations also have the right to enact their own laws. In addition to the inherent right to self-determination, the *Indian Act* provides that First Nation bands[26] may enact by-laws with respect to, among other things, the health of residents on-reserve.[27]

When it comes to health, these inherent rights are predicated on the fact that pre-contact First Nations had total control over complex and diverse health practices and wellness activities to ensure a healthy society. These inherent rights have never been extinguished or altered and therefore, First Nations continues to maintain the right of self-determination over their health practices and systems.

[20] Ibid., 143.
[21] Ibid., 147.
[22] Ibid., 147.
[23] Yvonne Boyer, “Aboriginal Health: A Constitutional Rights Analysis,” *NAHO Discussion Paper Series: Legal Issues*, (June 2003): 17.
[24] Olthuis, Kleer, Townshend LLP. *Aboriginal Law Handbook*, 4th ed (Toronto, ON: Thomson Reuters Canada Limited, 2012) at p 33.
[25] Boyer, “Aboriginal Health,”pg. 8
[26] *Indian* Act, RSC 1985, cI-5, s 2(1).
[27] *Indian* Act, RSC 1985, cI-5, s 81(1)(a).

INTERNATIONAL INDIGENOUS AND HUMAN RIGHTS TO HEALTH

UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES

Further bolstering the First Nations right to health and to self-determination in health are several international documents grounded in human and Indigenous rights. Perhaps most notable among these documents is the United Nations Declaration on the Rights of Indigenous Peoples (the *Declaration*) adopted by the United Nations (UN) General Assembly on September 13, 2007 At that time, Canada, along with the United States, Australia and New Zealand voted against the Declaration. Finally, on November 12, 2010, the Government of Canada issued a statement in support of the Declaration. In May of 2016, nearly a decade after it was adopted by the UN General Assembly, the Government of Canada formally dropped its objector status and adopted the *Declaration*, without reservation.

Within the UN system, a declaration is a document that states agreed-upon standards but are not legally enforceable. Declarations are not as strong as conventions which are legally binding agreements between UN Member states.[28] Nonetheless, the *Declaration* remains a strong advocacy instrument in demanding and protecting Indigenous rights, including the right to health and wellness. Further, domestic courts are free to rely on declarations in making their determinations. In addition, the *Declaration* is, in large part, built upon on principles found in legally enforceable conventions and international treaties including the International Covenant on Economic, Social and Cultural Rights.

The Declaration is comprised of 46 articles which describe specific rights held by Indigenous peoples and state obligations to protect those rights. Included are a number of articles with implications for First Nations health and health programming. Principal among them is Article 18 which states:

> *"Indigenous peoples have the right to take part in decision-making in all matters affecting them. This includes the right of indigenous peoples to select who represents them and to have indigenous decision-making processes respected."*[29]

In addition, Article 19 demands that governments:

> *"Seek indigenous peoples' views and opinions and work together with them through their chosen representatives in order to gain their free, prior and informed consent before laws are passed or policies or programs are put in place that will affect indigenous peoples."*

[28] Conventions such as the UN Convention on the Rights of the Child are legally binding under international law; however, declarations such as *the Declaration* are not directly legally-binding however, Indigenous and legal scholars argue that while it is true that a Declaration in and of itself does not create binding legal obligations but other assessments have found that some of the key provisions of *the Declaration* can reasonably be regarded as matching already established principles of general international law and therefore implying the existence of equivalent and parallel international obligation to which states are bound to comply with.

[29] Other countries are using *the Declaration*. In Bolivia, *the Declaration* is part of the Constitution: Bolivia's National Law 3760 of 7 November 2001 incorporates *the Declaration* without change. Numerous other Latin American countries have acknowledged their commitment to *the Declaration* in their Constitutions. The Philippines' Indigenous Peoples Act protects against resource extraction by Canadian and other corporations and others.

Perhaps most directly tied to health and wellness is Article 24 which states:

> *"Indigenous peoples have the right to use traditional medicines and health practices that they find suitable. They have the right to access healthcare and social services…without discrimination. Indigenous individuals have the same right to health as everyone else, and governments will take the necessary steps to realize this right."*

OTHER INTERNATIONAL MECHANISMS

In addition to *the Declaration*, First Nations maintain a human right to health, as do all Canadian citizens, based on Canada international commitments including the *Universal Declaration of Human Rights* (Article 25), the *International Covenant on Economic, Social and Cultural Rights* (Article 12), the *Convention on the Rights of the Child* (Article 24), the *Convention on the Elimination of All Forms of Racial Discrimination* (Article 5), the *Convention on the Elimination of All Forms of Discrimination against Women* (Articles 12 and 14), and the *Convention on the Rights of Persons with Disabilities* (Article 25), *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *Convention on Biological Diversity*, and the *International Covenant on Civil and Political Rights* ,

In 2000, the UN Committee on Economic, Social and Cultural Rights issued a General Comment, which is an interpretation of the provisions of a convention, on the Right to Health to clarify the obligations to health found within the International Covenant on Economic, Social and Cultural Rights (ICESCR). The General Comment articulates the four elements of the right to health: Availability, Accessibility, Acceptability, and Quality. In meeting these elements, the ICESCR:

"…imposes on State parties three types of obligations:

- *Respect: This means simply not to interfere with the enjoyment of the right to health ("do no harm").*
- *Protect: This means ensuring that third parties (non-state actors) do not infringe upon the enjoyment of the right to health (e.g. by regulating non-state actors).*
- *Fulfil: This means taking positive steps to realize the right to health (e.g. by adopting appropriate legislation, policies or budgetary measures)."*[30]

In addition, the General Comment advised on the minimum level of State obligations in the fulfillment of the Right to Health called the "Core Content". The Core Content includes essential primary health care, minimum essential and nutritious food, sanitation, safe and potable water, and essential drugs. In addition, it also obligates States to develop and implement a national public health strategy and plan of action.[31]

[30] World Health Organization, "The Right to Health: Factsheet," (November 2013) < http://www.who.int/mediacentre/factsheets/fs323/en/>.

[31] *Ibid*.

Canada endorsed the *Declaration of Joint Commitment in addressing the World Drug Problem* in 2016 at the UN General Assembly, Special Session on the World Drug Problem.[32] Under this Declaration the Canadian government committed to establishing a foundation of a drug control system protecting the health of people from the inappropriate use of narcotic drugs. Combined with the *Declaration*, a federal response to this obligation requires support for a First Nations-led culturally-relevant approach that moves away from criminalizing First Nations people for drug misuse rooted in poverty, intergenerational trauma and disconnection from their cultures and identities.

RECONCILIATION AND HEALTH

The Truth and Reconciliation Commission (TRC) of Canada concluded and issued its Final Report and Calls to Action in June 2015. Implementing the Calls to Action represent an incredible opportunity and responsibility for individuals, families, communities and governments in all jurisdictions to make reconciliation real. As the TRC notes:

> *Reconciliation must become a way of life. It will take many years to repair damaged trust and relationships in Aboriginal communities and between Aboriginal and non-Aboriginal peoples. Reconciliation not only requires apologies, reparations, the relearning of Canada's national history, and public commemoration, but also needs* ***real social, political, and economic change****.*[33]

TRC Calls to Action 18-24 are specifically related to health and call for a number of actions including: acknowledging the current state of health of Aboriginal peoples; encouraging consultation on measurable goals; addressing jurisdictional disputes; sustainable funding; recognizing Aboriginal healing practices; addressing cultural competency needs; need for Aboriginal health staff and educating nursing and medical students.

We highlight the following Calls to Action in particular:

Call to Action #18 calls upon:

> The 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.

Call to Action #22 calls on:

> Those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

---

[32] United Nations General Assembly, Our joint commitment to effectively addressing and countering the world drug problem, (S-30/1), Thirteenth special session, (April 19, 2016).

[33] The Truth and Reconciliation Commission of Canada, 2015. *Final Report of the Truth and Reconciliation Commission of Canada, Volume One: Summary: Honouring the Truth, Reconciling for the Future.* (Toronto: James Lorimer & Company): pg. 184.

Call to Action #23:

Call[s] upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.

ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii. Provide cultural competency training for all healthcare professionals.

Beyond the TRC Calls to Action 18-24, are many other Calls to Action which address the broader determinants of health. When viewed together, the TRC final report offers a foundation for working towards reconciliation as individuals and as collectivities, governments and non-governmental organizations, First Nations and non-First Nations people. The priority areas articulated in this document are tied directly to the Calls to Action; thus, action on our priorities also moves towards meeting the recommendations and expectations of the Truth and Reconciliation Commission of Canada.

PROVINCES, TERRITORIES AND FIRST NATIONS

> *Continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians*
> *- Canada Health Act, Preamble*

The purpose of the *Canada Health Act 1984*[34] *(CHA)* is to specify the conditions and criteria with which the provincial and territorial health insurance programs must conform in order to receive federal transfer payments under the Canada Health Transfer. The *CHA* is framed by the Canadian Health Care Policy, which stated primary objective is:

> *to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers*[35]*.*

The provincial/territorial health insurance plans (commonly called Medicare) are required to abide by 5 principles to be eligible to a full federal cash contribution: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility.

The insurance plan must cover insured health services which are defined as,

> *hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation.*[36]

[34] Canada Health Act (R.S.C., 1985, c. C-6)
[35] CHA, Section 3.
[36] Ibid. Section 2.

In order to satisfy the **universality** criterion outlined in the legislation, the health care insurance plan must:

> *entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions*[37].

This criterion applies to First Nations, Métis and Inuit, as well as all other provincial and territorial residents.

The *Canada Health Act* 1984 does not, however, apply on-on-reserve. When adopted, the legislation defined key parameters with the objective to nationally define a framework for the organization and management of provincial health systems. Provinces that opted to adopt and abide by these parameters received federal funding under the Canada Health Transfer.[38] In contrast, the Health Canada-FNIHB-funded healthcare system, that does operate on-reserve, in effect sits outside all health legislative frameworks.

While including the Health Canada-funded First Nations healthcare system under the Canada Health Act 1984 would yield few benefits, detailing federal, provincial/territorial and First Nations' jurisdiction is essential to resolve many jurisdictional barriers.

There are numerous mechanisms which confer responsibilities on the provinces and territories for First Nations health, including the TRC Calls to Action, *the Declaration* and Jordan's Principle. For example, the provinces and territories are explicitly mentioned in several of the Calls to Action related to health, which were noted above. The *Declaration* also places obligations on subnational governments (provincial/territorial) and the *Vienna Convention on the Law of Treaties*, a foundational document in international law and generally understood as part of customary law, which states, "A party may not invoke the provisions of its internal law as justification for its failure to perform" a treaty obligation (Article 17). This applies equally to a customary international law obligation. Perhaps in recognition of the necessity of sub-national governments respecting international obligations, both Alberta and Manitoba have recently committed to implementing the *Declaration*.

[37] Ibid. Section 10.

[38] Lavoie et al. (2013). Aboriginal Health Policies in Canada: The Policy Synthesis Project. Prince George, BC.

THE FIRST NATIONS

Priority Areas For Action

JORDAN'S PRINCIPLE

JORDAN'S PRINCIPLE DEFINITION

Where a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government, regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/ department of first contact must pay for the services without delay or disruption. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved.

- First Nations Child & Family Caring Society

Perhaps the most compelling motivation for provinces and territories to take up responsibility for First Nations health is Jordan's Principle (JP). JP is "a child-first principle intended to ensure that First Nations children do not experience service denials, delays, or disruptions because of jurisdictional disputes over the provision of or payment for services."[39] Jordan's Principle was developed in honour Jordan River Anderson, a First Nations child from the Norway House Cree Nation in Manitoba who was born with complex medical needs. Since Jordan was a First Nations child whose family lived on-reserve but was receiving medical care off-reserve, there was a dispute between the federal and provincial government about who would pay for services after Jordan's

"There will be shame on each and every one of us in this House who stood, supported and spoke in favour of this motion, and eventually will vote on this motion, if we do not actually put some substance behind the words we have spoken here."

-MP Jean Crowder, speaking on her Private Members Motion in support of Jordan's Principle

[39] The Jordan's Principle Working Group (2015) Without denial, delay, or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle. Ottawa, ON: Assembly of First Nations. Pg. 8.

doctors cleared him to return home. Had Jordan been a non-First Nations child living off-reserve, he would have been able to go home and have his in-home services covered. Instead, Jordan spent an additional two years in hospital while the province and the federal government fought over responsibility to support his in-home services. At the age of five, Jordan died without ever having spent a single night in a family home.

In 2007, the House of Commons unanimously passed a private members motion (M-296) stating:

> *That, in the opinion of the House, the government should immediately adopt a child first principle, based on Jordan's Principle, to resolve jurisdictional disputes involving the care of First Nations children.*

Several provincial and territorial jurisdictions have stated support for Jordan's Principle and have taken some action in terms of implementation. Other provinces tried and failed to pass legislation on JP. The very nature of Jordan's Principle requires action from all jurisdictions, and the issue of JP implementation remains a concern across the country. As such, TRC's Calls to Action #3"calls upon **all levels of government** to fully implement Jordan's Principle."

In addition, the recent decision of the Canadian Human Rights Tribunal (CHRT) on First Nations child welfare, ordered Indigenous and Northern Affairs Canada (INAC)

> *"to immediately consider Jordan's Principle as including all jurisdictional disputes (this includes disputes between federal government departments) and involving **all First Nations children** (not only those children with multiple disabilities)."*[40]

As part of the federal response to the CHRT ruling, Health Canada-FNIHB developed the Jordan's Principle- Child First Initiative (JP-CFI) that includes a funding commitment of up to $382 million over three years. While the injection of funding is notable, the parameters set on the funding are problematic and not in keeping with the CHRT decision. For example, the JP-CFI is limited only to "First Nations children with a disability or interim critical condition living **on-reserve** have access to needed health and social services within the normative standard of care in their province/territory of residence."[41] This is particularly egregious as JP is fundamentally about overcoming jurisdictional barriers, not reaffirming them. In addition, the JP-CFI excludes children in the Northwest Territories, despite clear direction from the CHRT that Jordan's Principle apply to all First Nations children, no matter where they reside. Health Canada-FNIHB has argued that there is no potential for JP cases in the NWT because the territorial government is supposed to provide services for First Nations as a result of the fiscal transfer agreement between Canada and the territory. However, First Nations in NWT are still eligible for Health Canada's Non-Insured Health Benefits (NIHB) program and are therefore still vulnerable to territorial/federal disagreements over responsibility for products and services in line with what NIHB provides. Thus, the JP-CFI fund remains an insufficient response to the CHRT.

[40] 2016 CHRT 10, Para. 33.

[41] Health Canada, "A New Approach: Jordan's Principle, A Child First Initiative," *Powerpoint* Presentation (September 7, 2016): slide 3.

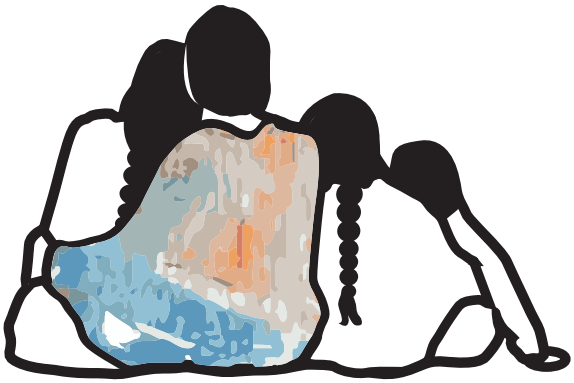
In addition, the Health Canada response limits eligible children to only those with “a disability or interim critical condition”, a limitation that is not part of the CHRT decision. Questions remain around how children’s conditions are deemed “critical” and who makes that determination. With this submission, the AFN reiterates the call of the TRC for provincial/territorial and all federal departments to immediately and meaningfully implement Jordan’s Principle, using the fulsome definition agreed to in the House of Commons in 2007 and reiterated in the CHRT ruling. This will require each jurisdiction to engage with First Nations to develop a clear process to ensure First Nations children, both on and off reserve, do not suffer delays in health care services.

ACTION

ON JORDAN’S PRINCIPLE

- **That all F/P/T governments and departments immediately and meaningfully implement Jordan’s Principle, as called for by the TRC, using the fulsome definition agreed to in the House of Commons in 2007.**

- **That the federal government meets the standard set out in the Canadian Human Rights Tribunal including the definition and scope of Jordan’s Principle, as well as in terms of collaboration with First Nations related to JP implementation.**



OVERCOMING THE JURISDICTIONAL CHASMS

As stated previously, ongoing uncertainty around jurisdictional responsibility in many areas, health, education and child welfare among them, deeply impacts the lives of First Nations people and communities across the country. The most obvious example of the life and death consequences of jurisdictional ambiguity and intergovernmental disagreements over responsibility as highlighted by the case of Jordan River Anderson and subsequent the development of Jordan's Principle. There are many more examples like Jordan, among children and adults, that illustrates the immediate and pressing need to meaningfully implement Jordan's Principle between and within all jurisdictions.

Section 91(24) of the *Constitution Act*, 1867, provides the federal government with exclusive authority to make laws with respect to "Indians, and Lands reserved for the Indians"[42] meaning First Nation affairs and reserve lands falls within the federal sphere of jurisdiction. However, most health and social services are within provincial jurisdiction and provided by provinces. First Nations often find themselves caught between or outside these areas of jurisdiction which leads to numerous issues regarding service provision and continuity of services.

Although JP is a child-first principle, the same jurisdictional chasms also profoundly impacts adults. There are many cases of First Nations adults who are denied services from provincial ministries and the First Nations and Inuit Health Branch (FNIHB), both claiming the other is responsible while the same service would be provided to a non-First Nation person without hesitation. Even if unintended, jurisdictional disputes result in discrimination based on race/nationality.

There are diverging views between First Nations on the appropriate role of the federal and provincial/territorial governments around health. For example, many First Nations see the Treaty relationship as one with the Crown, as represented by the federal government, and are therefore not interested in the notion of provincial involvement in health services for First Nations. They see that responsibility as the federal government's alone.

[42] *Constitution Act, 1867*, 91(24).

In contrast, some First Nations are seeking to partner with provinces/territories, alongside their work with the federal government. Based on this diversity, the AFN will not suggest a singular policy position related to clarifying jurisdictional challenges. Rather, the AFN is calling on the federal government to engage in a trilateral process with each province and territory, and with the First Nations within those respective jurisdictions to come to a clear and actionable shared position on jurisdictional responsibilities. In the interim, the AFN is calling for the federal government and provincial/territorial governments to commit to a principle, in line with Jordan's Principle, for all First Nations people, regardless of age.

ACTION

OVERCOMING JURISDICTIONAL CHASMS

- **That the federal government, where there is interest from First Nations, engage in a trilateral process with provincial/territorial governments, and with the First Nations within those respective jurisdictions, to come to a clear and actionable shared position on jurisdictional responsibilities.**

- **That the F/P/T governments immediately commit to a patient-first principle, in line with Jordan's Principle, for all First Nations people, regardless of age or residency.**

BUILDING FIRST NATIONS CAPACITY: GOVERNANCE AND ACCOUNTABILITY

First Nations possess a strong inherent, Treaty and human right under Indigenous, Canadian and international law to self-determination over all matters that affect their life, including health programs and services. Beyond the legal and moral arguments, social psychology demonstrates that First Nations with a higher degree of self-determination, both individually and collectively, enjoy better health outcomes. For example, a pivotal study out of British Columbia found evidence that cultural continuity- understood generally as individuals and communities maintaining, rebuilding and/or living out fundamental aspects of their culture- reduced suicide rates.[43] However, cultural continuity requires self-determination across the social determinants of health including in education, economies, languages, child welfare, land use, and most importantly, in health and wellness programming. Stated simply, self-determination is a vital social determinant of First Nations health.

Many First Nations, tribal councils, and provincial/territorial First Nations organizations are increasingly interested in taking over some level of administration and authority over health programming and services. A Manitoba study showed that First Nation communities who managed their own on-reserve health services had lower rates of hospitalizations for conditions that are treatable at the community level.[44] To support the objectives of these groups, we encourage policy makers at Health Canada-FNIHB and in provincial/territorial health ministries to work with First Nations in good faith to support First Nations self-determination in health in terms of developing appropriate governance and accountability models involving each jurisdiction. In addition, it requires all partners ensure that the programs and services to be transferred to First Nations authorities are fully funded. First Nations should not be expected to take over programs which are underfunded, putting the communities in an unenviable position of delivery sub-standard health programs and services to their own people.

We encourage policy makers at Health Canada-FNIHB and in provincial/territorial health ministries to work with First Nations in good faith to support First Nations self-determination in health.

[43] M. J. Chandler and C. Lalonde, "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations," Transcultural Psychiatry 35, no. 2 (June 1, 1998): 191-219.

[44] These conditions are known as Ambulatory Care Sensitive Conditions. Lavoie et al. (2010). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? Social Science & Medicine (Vol. 71, pp. 717-724).

GOVERNANCE MODELS

It is not the role of the AFN to advocate for a particular governance model for First Nations seeking authority over their own health systems. As noted above, there are models which are working towards respecting the First Nations right to self-determination and towards improving health outcomes.

FIRST NATIONS HEALTH AUTHORITY (BC)

Perhaps the clearest example of innovation when it comes to the delivery of health services to First Nations is the model in British Columbia (BC) with the First Nations Health Authority (FNHA). The FNHA is the result of ten years of internal work achieving consensus within British Columbia First Nations and negotiations with Canada and the province of British Columbia. Key to establishing the FNHA was the sustained support of leadership in all three parties over that ten-year period evidenced by the numerous key agreements articulating the relationship, governance and funding. The overall process was supported with funding to enable the change management required by the creation of this model of governance.

Key to the establishment of the FNHA was a commitment from the province of British Columbia and Canada for long term, sustainable funding. Through "the Tripartite Framework Agreement on First Nation Health Governance and the Canada Funding Agreement [the FNHA was] provided up to $4.7 billion in funding to the Authority over 10 years, from the 2013–14 fiscal year to the 2022–23 fiscal year." In addition, the agreements include an annual escalator of 5.5% for at least 5 years, along with a commitment within the agreement to negotiations on the escalator for the following 5 years.

In 2013, the FNHA took over full responsibility for programs and services for over 200 First Nations that were previously delivered by Health Canada-FNIHB's Pacific office including in the areas of:

> primary care, mental health and addictions programs, and the administration of non-insured health benefits. It also assumed responsibility for coordinating health programs and services with the province's existing regional health authorities and for funding and supporting the delivery of health services at the local level in First Nations communities. The Authority established some of its own goals to guide the transition, including minimizing disruption of services to First Nations communities.[45]

The agreements supporting the FNHA provide a certainty that is largely absent from the current system of funding from Health Canada-FNIHB where terms of agreements make long term and wholisitic planning difficult. This is compounded by the fact that funding often arrives in communities late in the fiscal year, making thoughtful and sustainable program delivery exceedingly difficult. In addition, FNIHB programs are subject to funding cuts without input from First Nations who rely on them, based on the political will of the government in power. For example, both the Health Services Integration Fund and the Aboriginal Health Human Resources Initiative were hit with devastating cuts in 2012 as part of the Harper government's Economic Action Plan.

[45] Auditor General of Canada, *Report 7: Establishing the First Nations Health Authority in British* Columbia (Fall 2015): Pg. 5.

INNOVATION

In Governance Models: First Nations Health Action Plan in Ontario

Emerging Model: Ontario First Nations

In May of 2016 the Province of Ontario announced investments of $222 million over three years aimed at closing service gaps in Northern Ontario in the areas of primary care, public health and health promotion, seniors care and hospital services, and life promotion and crisis support. The investments include $25 million over three years and $14 million ongoing in home and community care, $48 million over three years and $30 million ongoing in primary care, and $15.5 million over three years and $10.15 million ongoing in diabetes prevention and management. The Ontario First Nations Health Action Plan represents an achievement in overcoming the federal/provincial jurisdictional quagmire that has stymied progress within the First Nations health realm. A key test for this initiative will be how First Nations are involved at every stage in the development and administration of these new investments.

THE CREE BOARD OF HEALTH AND SOCIAL SERVICES OF JAMES BAY

The Cree Board of Health and Social Services of James Bay (CBHSSJB) was founded in 1978 following the signing of the James Bay and Northern Quebec Agreement (JBNQA). Under Section 14 of the JBNQA, the Cree of Eeyou Istchee negotiate with the province of Quebec every five years for a healthcare budget allocation.

CBHSSJB is responsible for the administration of health and social services for all persons residing either permanently or temporarily in the Cree territory of James Bay, including both the delivery of provincial services and in the management and delivery of a number of federal programs including home care and most community health programs.

The CBHSSJB model's flexibility has allowed the Board to overcome the strict program siloes and consolidate programs into three large areas:

1. The Nishiiyuu Miyupimaatisiiun department which operates a regional land-based healing program and works towards finding ways to integrate the Cree healing traditions.

2. The Miyupimaatisiiun department which includes health and social services, the regional hospital and the network of Community Miyupimaatisiiun Centres (health centres) within First Nations communities.

3. The Pimuhteheu department which focusses on public health, prevention, wellness and community planning.[46]

[46] First Nations of Quebec and Labrador Health and Social Services Commission, "First Nations in Quebec Health and Social Services Governance Project Review of Health and Social Services Provided to Quebec First Nations and Inuit," (2015): Pg. 24.

CBHSSJB offers an important example of First Nations taking ownership of their own health programs and services and administering them in a way which better reflects their needs and cultural teachings in spite of ongoing concerns about the inadequacy of funding provided for service delivery.

OFF-RESERVE SERVICES

In addition to First Nations health systems on-reserve, there is a growing need for First Nations-led health services in urban centres to meet the needs of First Nations relocating for short or long periods of time to access health, education and employment opportunities. First Nations peoples living in urban environments face several unique barriers in terms of accessing health services including: racism and a fear of racism and discrimination based on current or past experience or on the experience of loved ones within mainstream systems, as well as lack of access to cultural healing and support. A 2010 study found that "72% of Aboriginal residents of urban areas consider access to traditional healing practices to be important or more important than mainstream care, but only 30% have "very easy" access to it."[47] A number of important programs and institutions exist across the country to address access to culturally-relevant services for off-reserve First Nations and Aboriginal people, including the Aboriginal Health Access Centres in Ontario such as the Wabano Centre for Aboriginal Health in Ottawa, the Vancouver Native Health Society and Anishnawbe Health Toronto. These, and many other urban Aboriginal health organizations, are pillars in their communities and have earned the trust of their clients. Most are accountable to Indigenous communities via their respective Boards of Directors which consist of the people that they serve. While these urban health centres face many challenges- most related to unpredictable non-profit or charity funding- they have proven to be invaluable in terms of connecting urban Indigenous communities, integrating traditional and Western healing practices and providing a continuum of health services.

SHARED DECISION MAKING AND RECIPROCAL ACCOUNTABILITY

Provinces/territories and the federal government are responsible for working with First Nations in their respective jurisdictions to determine the appropriate model that reflects the principle of self-determination. While the AFN does not give an opinion on what appropriate health governance and accountability models look, provincial/territorial systems must ensure -at minimum- that First Nations be at the decision-making table on all matters related to First Nations health and wellness in a full-decision making capacity.

When it comes to provincial and territorial health systems, there are numerous opportunities for shared decision-making based on the principle of reciprocal accountability. The emerging principle of reciprocal accountability is broadly understood as "shared responsibility – amongst First Nations (at community, regional and provincial/[territorial] levels), the Federal Government, and the Provincial/[territorial] Government (including Health Authorities) – to achieve common goals."[48]

[47] UAPS in Jessica Place, "The Health of Aboriginal People Residing in Urban Areas," *National Collaborating Centre for Aboriginal Health,* (2012): pg. 20.

[48] First Nations Health Council, "Consensus Paper: British Columbia First Nations Perspectives on a New Health Governance Arrangements," (n.d.) pg. 16.

For example, only:

> *Ontario and Nova Scotia have policies that stipulate the make-up of the Board of Directors [for Regional Health Authorities (RHAs)] must reflect the population the RHAs it is set up to serve. Aboriginal peoples are not specifically mentioned. Ontario is the only province to have established a council composed of Aboriginal peoples to advise on regional priority setting in healthcare, which is provided through the Local Health Integration Networks.*[49]

The extent to which diversity on the Board of Directors leads to policy decisions that better serve the population remains unclear. Still, this model provides a straightforward first step towards meaningful First Nations engagement in the provincial and territorial health systems.

KEY DEFINITIONS	
Cultural Continuity	Individuals and communities maintaining, rebuilding and/or living out fundamental aspects of their culture including governance, health and wellness practices, land use, spirituality, language and familial structures, among many others. Rather than viewing culture as rooted only in the past, this perspective understands culture as constantly negotiating with forces of change.
Health Governance	Health governance sets out where responsibility rests within an organization, or set of organizations related to health systems, including the management and delivery of health programs and services. Stated another way, health governance is about who has the authority and responsibility to make decisions across the policy spectrum.
Reciprocal Accountability	A process through which all parties to a plan, action, agreement etc. take mutual responsibility for their conduct, one to another -(First Nations Health Blueprint for British Columbia, July 15, 2005)
Shared Decision-Making	Shared decision-making is an operationalization of the principle of reciprocal accountability. Rather than simply "informing" policy, this means First Nations must be empowered to participate in an equal decision-making capacity.

INTERNATIONAL EXPERIENCE OF SHARED DECISION-MAKING

Shared decision-making authority examples exist within the international sphere. New Zealand formally includes Māori within regional and local healthcare planning and decision-making structures.[50] Like Canada, New Zealand's healthcare system is comprised of regionalized systems, similar to the F/P/T systems and sub-p/t authorities such as health authorities. However, unlike Canada, in 2000 New Zealand enacted legislation that provides a formal voice for the Māori within healthcare planning and decision-making. Specifically, "legislated provisions require the District Health Boards (DHBs) to: negotiate formal agreements with Māori communities, have Māori representation on the board, and ensure all providers

[49] Josée G. Lavoie, Amohia Frances Boulton, and Laverna Gervais, "Regionalization as an Opportunity for Meaningful Indigenous Participation in Healthcare: Comparing Canada and New Zealand," The International Indigenous Policy Journal 3, no. 1 (March 2012) pg. 10.
[50] Ibid.

within the healthcare system demonstrate responsiveness to Māori clients."[51] Notably, the DHBs are required to report on progress in closing the health outcomes gap on an annual basis.

ACCOUNTABILITY AND GOVERNANCE IN THE YUKON AND THE NORTHWEST TERRITORIES

The experience of First Nations in the Yukon and the Northwest Territories (NWT) related to jurisdiction differs from that of First Nations south of the 60th parallel. Unlike in First Nations in the south, Health Canada does not provide any primary care programming in the territories; instead primary care is provided by the territorial governments. Further, in the NWT, Canada transfers funds for virtually all First Nations health programming to the Government of NWT who then provides services directly or through contribution agreement with First Nations communities. In the Yukon, 11 of the 14 First Nations have self-government agreements and operate health promotion and upstream programs that have been transferred to them under their respective agreements. There are also some project-based investments delivered by First Nations through contribution agreements from Health Canada-FNIHB. The eleven nations with self-government agreements have all acquired their community based programming through the agreements program and services transfer agreement. The four First Nations without agreements still have contribution agreements with Canada for their community based programs. The language within federal program guidelines is particularly relevant in the North because programs meant to serve "First Nations on-reserve" often exclude First Nations in the Yukon and NWT. As a result, there are some programs where First Nations have to compete with non-First Nations communities for funding from the Public Health Agency of Canada.

These unique arrangements in the North require a distinct set of considerations related to accountability. For example, both the federal and territorial governments are obligated to ensure that First Nations in the North play a key role in developing and administering programs and services for First Nations and that accountability goes back to First Nations themselves. Simply, relationships between governments and First Nations must include respect the right of First Nations self-determination, a principle which is as true in the North as it is anywhere else in Canada. In addition, despite federal transfers to First Nations or the territories, First Nations in the North maintain rights under Section 35 of the *Constitution* which exist without regard for geography or self-government arrangements. While there may be differences with regard to the manner in which the federal government interacts with the provinces versus the territories in the realm of health, the rights of First Nations people across Canada remain indivisible. Therefore, any new investments from the federal government on First Nations health must be extended to First Nations in the territories whether they are inside or outside existing self-government agreements.

[51] Ibid., 4.

INNOVATION

In Accountability: Indigenous Health Ombudspersons

Often, federal, provincial and territorial health services fail to meet the needs of First Nations people. First Nations advocates are fighting from outside the system and largely rely on perceived "good will" from those within the system to respond to First Nations' needs. This is a huge drain on the time and resources of First Nations advocates, and negatively affects the health consequences for the First Nations clients. There are times when First Nations are driven to pursue legal avenues to reach a just solution. This is certainly not an ideal situation for both First Nations and F/P/T governments. Certainly, the long-term solution is health systems run by and for First Nations themselves; however, in the short and medium term, patients are left feeling disempowered by fighting a system that can be a hostile one for First Nations people. A potential innovation to address this short and medium term need is the development of ombudspersons, at the F/P/T levels, on Indigenous health.

An Ombudsperson on Indigenous Health would be independent and impartial office, where those who feel that they have been treated unfairly by governments, other public bodies and trustees can go to seek recourse with the power to investigate, facilitate resolutions and recommend government responses. Complainants must be assured of confidentiality, fairness, respect and cultural safety. Key in the development of an office such as this is the full involvement of First Nations within the respective jurisdiction from the earliest stages. There very well may be First Nations who do not see the utility of such as office; other regions may take up this innovation. Both positions should be respected.

FIRST NATIONS' SELF-DETERMINATION IN CITIZENSHIP AND HEALTH FUNDING

Respecting First Nations self-determination means respecting how First Nations choose to define and determine citizenship within their nations. Many First Nations have designed their own citizenship and membership laws based on customary law and tradition. These laws often differ from "Indian Status" as determined under *the Indian Act*. To date, federal funding calculations for health services on-reserve only include those who are registered as an "Indian" under the *Indian Act*.[52] However, there exists a chasm between First Nations-determined citizenship and residency, and government-determined population figures derived from "Indian status". This can have serious consequences in terms of the adequacy and stability of health programs that are, in reality, servicing a larger population.

First Nations communities are unfairly burdened when government program funding formulas only count status "Indians" who are "ordinarily resident" on-reserve. First Nations have little choice, with little recourse, but to provide health and wellness programs and services to community members and First Nations citizens that have not been counted under a funding formula, but still require those services.

[52] This may change based on the recent Supreme Court of Canada *Daniels* decision; however, to date, eligibility for the Indian Registry remains unchanged.

This is particularly challenging in remote and isolated communities, where there are virtually no other options to access health services other than those within the First Nation. It is unethical and unfair to expect First Nations to turn away their own community members. The health program funding that First Nations receive from Canada is already stretched thin and undercounting significant portions of a community' population based on Indian status contributes to the hardships. Moving forward, a nation-to-nation relationship requires governments to recognize and respect First Nations right to determine their own citizenship and determine adequate funding to provide health services for their communities appropriately.

CAPACITY FOR FIRST NATIONS ORGANIZATIONS

A key component of supporting First Nations self-determination means supporting First Nations communities and organizations build and maintain the capacity to do the important work on First Nations health. The persistent assumption of mainstream organizations that are providing programs or services for First Nations is that First Nations do not have the capacity to do the work themselves. Not only is this logic paternalistic, it is entirely circular. Specifically, First Nations communities and organizations will continue to be subject to assumptions on lack of capacity and struggle to take on health priorities if the capacity dollars continue to go towards mainstream organizations with little accountability back to First Nations themselves. To address this, Chiefs in Assembly passed Resolution 07/2016 at the 2016 Annual General Assembly which:

1. *Request[s] that the Federal Government prioritize support for First Nations organizations over mainstream organizations doing work on behalf of First Nations, in order to build capacity within First Nation communities and organizations.*

2. *Direct[s] the Assembly of First Nations (AFN) to work more closely with First Nation organizations, when possible, to address the issues and priorities faced by First Nation communities in a culturally competent and relevant way.*

With respect to First Nations provincial and territorial representative organizations (PTOs), the recent shift towards working with First Nations on policy and programming is certainly a positive step forward in recognizing and responding to First Nations self-determination on health. However, many First Nations organizations operate under extensive budget restraints which limit the ability of these organizations to work on developing meaningful partnerships and positive relationships with all levels of government. For example, many PTOs are still operating under significant budget cuts from the last federal government. First Nations leadership and staff are at risk of burnout because they are still required to meet exponentially higher expectations for engagement without a matching increase in capacity support for First Nations organizations, including tribal councils, treaty and regional organizations.

PTO FUNDING CUTS BY YEAR[53]							
Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Ongoing
Reductions to non-service delivery organizations ($ 000)	$14,201	$14,778	$14,778	$14,778	$14,778	$14,778	$14,778

[53] Canada, Treasury Board of Canada, "Strategic and Operating Review," February 19, 2016, accessed November 28, 2016, https://www.tbs-sct.gc.ca/ip-pi/trans/sor-esf-eng.asp.

ACTION

ON SUPPORTING FIRST NATIONS CAPACITY: GOVERNANCE AND ACCOUNTABILITY

- That provincial/territorial governments work with First Nations in a shared-decision making capacity when any decisions are made that may affect First Nations generally, but specifically in health programming. First Nations themselves will determine the extent of their participation.

- That provincial/territorial governments and Health Canada-FNIHB engage with First Nations in their respective jurisdictions to jointly determine a model for working together on First Nations priorities for health services and closing programming gaps. This may include determining a model of authority and governance.

- That provincial/territorial governments support, both in policy and through stable adequate resourcing, First Nations in developing health centres for the urban Indigenous populations.

- That Health Canada-FNIHB restores the recent cuts to First Nations representative organizations, and allow flexibility to ensure that investments to First Nations and First Nations organizations for engagement and collaboration meet the demands on their time and resources.

- That Health Canada-FNIHB makes meaningful investments, in line with those provided in BC, to building First Nations health governance capacity.

- That Health Canada commit to working with First Nations and First Nations organizations in transitioning funding currently being provided to mainstream organizations that do work on behalf of First Nations, towards First Nations organizations that are mandated by First Nations themselves and that demonstrate the potential for and interest in taking on that work themselves.

- That F/P/T governments work with First Nations to explore the development of an Ombudsperson for Indigenous Health.

- That Health Canada-FNIHB work with First Nations to determine funding levels based, in part, on community membership and citizenship, rather than based on "Indian Status" alone.

- That the federal government extend any new investments on First Nations health to First Nations in the territories whether or not they have signed self-government agreements.

THE AFN – HEALTH CANADA – FNIHB ENGAGEMENT PROTOCOL

The federal government, through Health Canada's First Nations and Inuit Health Branch, must commit to working with First Nations in a way that respects and supports First Nations self-determination, governance and reciprocal accountability. There has been some improvement in this area over the last number of years, but work still needs to be done.

In 2014, the Assembly of First Nations and Health Canada-FNIHB, developed and signed the AFN-FNIHB Engagement Protocol, which seeks to achieve three main objectives. They are to:

1. Outline how the AFN and FNIHB will work together to ensure First Nations regions and communities and FNIHB regions are engaged in the advancement of the FNIHB Strategic Plan;

2. Recognize and map out how the First Nations and Inuit Health Strategic Plan and the First Nations Health Foundational Plan complement each other; and,

3. Respecting relevant processes and time required, map out a process for engagement that includes national, regional and community level collaboration, as well as engagement with other partners of mutual interest (such as health professional associations, provinces and territories, First Nations non-government organizations).

The Engagement Protocol represents an important innovation in the relationship between the AFN and Health Canada-FNIHB. It is essentially guiding a cultural shift within a federal department. Nevertheless, there remain challenges related to the consistent application of the Engagement Protocol across all program areas and regions. In order for the Engagement Protocol to be given the appropriate weight and attention, there must be accountability built into the process, rather than a system of immediate enforcement when the protocol is not respected.

ACTION

ON THE AFN-FNIHB ENGAGEMENT PROTOCOL NEXT STEPS

- ◊ **That Health Canada- FNIHB work with the AFN in developing Engagement Protocol accountability mechanisms. This could include requiring program areas to report on their engagement activities, as a deliverable, and to make that reporting available to First Nations and the AFN.**

- ◊ **That Health Canada-FNIHB work with the AFN to develop training, both for new hires and existing staff, on implementing the AFN-FNIHB Engagement Protocol.**

ECONOMIC DEVELOPMENT AND HEALTH

First Nations private sector involvement in providing healthcare products and offering health care industry services is a growing area of interest. Federal/provincial and territorial governments can play a key role in supporting First Nations in business ventures related to the healthcare products and services industries from pharmacy, medical supplies and equipment, medical transportation utilizing First Nations owned airlines and ground transportation, and even First Nations contractors for building and maintaining health facilities. Not only does this have the potential to increase access for First Nations clients to much needed products and services, it also potentially has a corresponding positive impact in terms of the relationship between economic development, income security and health outcomes. The AFN has long advocated for economic development based on partnership development, investment, strategic and pragmatic procurement and enhancing employment activities.

Federal/provincial and territorial governments can play a key role in supporting First Nations in business ventures related to the healthcare products and services industries

INNOVATION

In Social Enterprise Spirit Meter from the Tribal Councils Investment Group of Manitoba

Launched in 2016, the Spirit Meter from the Tribal Councils Investment Group of Manitoba presents a unique model of social enterprise. The Spirit Meter is a blood glucose meter for the monitoring and treatment of type 1 and 2 diabetes. 50% of the profits from the Spirit Meter will be reinvested into education programs focussed on First Nations diabetes.

The federal government, and some provinces and territories have developed specific strategies to support procurement of government contracts for Indigenous businesses. The federal *Procurement Strategy for Aboriginal Business (PSAB)*, for example, contributed to the increase in the federal contracting of First Nations/Inuit and Métis businesses from $36 million in 1996 to $580 million in 2010.[54] The majority of Provinces and Territories are engaged, in one form or other, in promoting procurement opportunities for First Nation and other Aboriginal and/or northern businesses, and some are taking advantage of the federal government's electronic MERX contract bidding system, prequalified Aboriginal business inventory, and national supplier standing offer lists.

While the success of procurement strategies is notable, First Nations have identified challenges that impede the potential growth of First Nations' businesses. These challenges include overly burdensome bidding process, inadequate information about opportunities, and the perception of favoritism within the process. Beyond what is currently offered within procurement strategies, there is a need for more robust supplier development activities involving face-to-face contact between potential suppliers and government contracting officers on specific contracting projects. This will build capacity within First Nations businesses to particulate in procurement activities more successfully.

ACTION

ON SUPPORTING FIRST NATIONS ECONOMIC DEVELOPMENT IN HEALTH

- **That provincial/territorial governments work with First Nations to identify opportunities to support First Nations businesses working in the health care sphere. This support can take the form of partnership development, investment, strategic and pragmatic procurement, and enhancing employment activities.**

- **That the federal government work to ensure their Procurement Strategy for Aboriginal Business meets the needs of First Nations businesses including expanding mentorship opportunities. Support should be aimed at capacity building and institutional support, rather than one-off projects.**

- **That Health Canada-FNIHB work with First Nations to identify how First Nations businesses can be supported within FNIHB's suite of programs.**

[54] Canada. Indigenous and Northern Affairs Canada, "Update on the Implementation of the Federal Framework for Aboriginal Economic Development," January 22, 2013, accessed January 17, 2017, https://www.aadnc-aandc.gc.ca/eng/1357225364409/1357226235936.

SUPPORT FOR TRADITIONAL HEALING AND WELLNESS WITHIN ALL HEALTH SYSTEMS

First Nations have been mentally, physically, spiritually and emotionally well-served by traditional systems of healing and wellness for thousands of years. Kevin Berube of the Sioux Lookout Meno Ya Win Health Centre describes traditional healing as:

> *Working with a person to help them heal, not just physically but mentally, emotionally and spiritually. Also known as holistic healing, it involves an integrative approach that seeks to balance the body, mind and spirit with the environment. Traditional healing makes use of the healing properties of many medicines found in and on the land and water to help people suffering from physical ailments, along with healing ceremonies to help people with their mental, emotional and spiritual ailments. It's this combination that promotes holistic wellness.*[55]

Unfortunately, destroying these vital traditional wellness practices was central to colonization in Canada which dislocated Indigenous peoples from their lands and ways of being. For example, an 1884 amendment to the *Indian Act* banned key ceremonies, which are the sites and activities of healing practices, such as the Sundance and the Potlatch. First Nations people caught practicing traditional healing were imprisoned.[56] One legacy of these colonial policies is that contemporary attitudes about Indigenous healing practices are often considered as historical novelties and are "relegated to a realm of magic,"[57] rather than the outcome of thousands of years of distilled experiential wisdom.

First Nations have been mentally, physically, spiritually and emotionally well-served by traditional systems of healing and wellness for thousands of years.

[55] Kevin Berube, "Why Traditional Healing Has a Place in Modern Health Care," The Globe and Mail, April 25, 2015, accessed September 10, 2016, http://www.theglobeandmail.com/life/health-and-fitness/health/why-traditional-healing-has-a-place-in-modern-health-care/article24126195.

[56] Julian A Robbins and Jonathan Dewar, The International Indigenous Policy Journal, 2011, accessed January 17, 2017, doi:10.18584/iipj.2011.2.4.2., http://dx.doi.org/10.18584/iipj.2011.2.4.2.

[57] Ibid., pg. 9.

However, academics and medical practitioners are shifting towards recognizing the importance of supporting traditional healing within all health systems and some mainstream health providers, including individual hospitals or healthcare institutions are making efforts to incorporate traditional healing. Policy and programming at the F/P/T systems level are farther behind in this shift. First Nations need support to (re)build knowledge systems around traditional healing and the dismantling of systemic barriers to the meaningful inclusion of traditional healing. 78.4% of First Nations youth said that knowing and learning about traditional teachings is very important or somewhat important to them[58] and 86.1% of First Nations adults reported that it is very or somewhat important to learn about traditional teachings.[59] All jurisdictions must also work with First Nations to determine how traditional healing can be supported within mainstream healthcare settings.

INNOVATION

In Traditional Healing: Whitehorse General Hospital

While many mainstream health systems are just coming around to understanding the necessity of traditional healing and culturally-relevant care for First Nations patients, the Whitehorse General Hospital has been operating the innovative First Nations Health Program (FNHP) since 1993. The Yukon Hospital Corporation Board of Trustees includes a subcommittee called the First Nations Health Committee to guide the development and direction of the FNHP.

The FNHP includes culturally-relevant support services including care coordination, mental health patient advocacy and discharge planning, access to traditional medicines and spiritual supports, access to traditional foods through the cafeteria, access to a designated healing room, and emergency accommodation for families. Further, the FNHP holds cultural learning opportunities for hospital staff.

RECOGNITION OF CULTURAL SKILLS

Given the importance of cultural knowledge within First Nations health and healing, cultural skills must be respected, both formally and informally, within all health systems. This is currently not the case in most instances. For example, First Nations may have access to funding for the consultation services of psychologists or social workers within the National Native Alcohol and Drug Abuse Program (NNADAP) or National Youth Solvent Abuse Program (NYSAP) treatment and community-based services. Yet, First Nations often struggle to secure support for cultural practitioners and Elders that they may want to contract for cultural interventions and clinical supervision in these same programs and services.

[58] First Nations Information Governance Centre, Our Data, Our Stories, Our Future: The National Report of the First Nations Regional Early Childhood, Education and Employment Survey, (Ottawa, 2016). Pg. 44.
[59] Ibid. pg. 58.

Culturally-based programs, particularly those in mental wellness and addictions, require staff with cultural knowledge and those consultants should be paid on par with other types of consultants that First Nations health programs may hire.

ACTION

ON SUPPORTING TRADITIONAL HEALING

- ◊ That F/P/T governments support First Nations within their respective jurisdictions in (re)building traditional knowledge systems around healing and wellness.

- ◊ That provincial/territorial governments work with First Nations to determine how best these knowledge systems can be included and supported within the provincial/territorial health systems.

- ◊ That the provincial/territorial governments support the establishment of First Nations advocates that can act as systems navigators and cultural translators within mainstream systems.

- ◊ That Health Canada-FNIHB support, through policy and funding, the formal inclusion of traditional healing within programming including within mental wellness programming (which includes Non-Insured Health Benefits) and the First Nations and Inuit Home and Community Care program. This process must be led by First Nations. As a first step, the AFN recommends that this include an annual investment of $27.9 million.

CULTURAL AWARENESS/HUMILITY/ SAFETY WITHIN ALL HEALTH SYSTEMS

Closely related to the need to support traditional healing within all health systems is the dire need for cultural awareness/humility/safety within all health systems. As noted above, the TRC made explicit and pointed recommendations related to cultural competence based on the recognition of the preventable harm that can come from a healthcare system and healthcare practitioners that are, knowingly or not, biased against First Nations people. Indeed, this is a matter of life or death, as it was with Brian Sinclair who was a First Nations man that died of a treatable bladder infection after waiting for 34 hours in a Winnipeg hospital emergency room. In addition, a recent report from the Wellesley Institute notes, "that racism against Indigenous peoples in the health care system is so pervasive that people strategize around anticipated racism before visiting the emergency department or, in some cases, avoid care altogether."[60]

The TRC made explicit and pointed recommendations related to cultural competence based on the recognition of the preventable harm that can come from a healthcare system and healthcare practitioners that are, knowingly or not, biased against First Nations people.

INNOVATION

In Cultural Humility in British Columbia

The First Nations Health Authority (FNHA) in BC undertook an approach to "hardwire" safety and humility into health services province-wide. Activities include:

- A Declaration of Commitment on Cultural Safety and Humility in Health Services signed in July 2015 by the CEOs of BC's health authorities and the Deputy Minister of Health

[60] B. Allan and J. Smilie, First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada, (Toronto: The Wellesley Institute, 2015). pg. 2.

- Ongoing development of a Framework for Action to operationalize the Declaration. This will include regulatory bodies, professional associations, academic institutions, health authorities and service providers
- Each health authority working collaboratively with First Nations in their respective area on implementation to build those key localized relationships
- Launching a public awareness campaign called #itstartswithme to educate and encourage health care providers to learn more about cultural humility and safety.

Cultural awareness is primarily focussed on the reality that there are differences between cultures, and that those differences matter within the healthcare context. Cultural competence requires people working in health care systems to learn about First Nations cultures and account for those cultural differences while recognizing the power imbalances within cultural differences. Certainly, understanding First Nations histories, contemporary challenges and cultures is important, but no single course or curricula can make anyone fully culturally competent. Like all skills, cultural competency requires constant improvement and continual learning. No one can know and understand the complex lived experience of First Nations people within a few short sessions. Recently however, there has been a shift beyond cultural awareness and competence to cultural humility and cultural safety. British Columbia's First Nations Health Authority describes cultural safety as, "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care."[61] Getting to cultural safety requires a process of cultural humility which is:

> *A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience.*[62]

Essentially, cultural humility and safety is about those people in positions of power becoming comfortable with not knowing, not being the expert, and maybe even never really understanding the culture and lived experience of First Nations people.

At the core of cultural humility and safety are meaningful and trusting relationships, both individually and organizationally, from healthcare clients and practitioners, to policy makers. In addition, it is important to remember that First Nations cultures are diverse and regionally and specific. Pan-Aboriginal or even pan-First Nations approaches do not lead to the relationship building that is required. Therefore, each jurisdiction and sub-jurisdiction must work with First Nations to build those necessary relationships as a first step towards building healthcare institutions that are safe for and responsive to First Nations people.

[61] First Nations Health Authority, Creating a Climate for Change: Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in British Columbia, (n.p., n.d.).
[62] Ibid.

ACTION

ON CULTURAL HUMILITY AND SAFETY

- That the provincial/territorial governments create financial incentives for universities and colleges to build, with First Nations, mandatory courses on cultural humility/safety for all faculties with a role in health care, including both direct service provision and public policy and administration programs.

- That healthcare accreditation bodies work with the First Nations and health authorities to establish health service standards of excellence for cultural humility and safety.

- That provincial/territorial government and their respective healthcare regulatory bodies work with First Nations to develop and administer workplans related to ensuring cultural humility in the healthcare field.

- That Health Canada work with the AFN to develop and administer cultural humility/safety training for headquarters staff.

- That Health Canada ensures all healthcare staff in their employ working with First Nations receives mandatory training in cultural humility and safety, particularly nurses.

HEALTH INFRASTRUCTURE AND SUPPORT

COMMUNITY WELLNESS PLANNING

In general, Health Canada's contributions to First Nations health programs fall into three broad categories:

- **Set Agreements:** Rigid agreements with increased reporting, shorter durations (up to 3 years), and hard restrictions of the movement of funds between budget areas and carrying over funds to subsequent fiscal years. Funding is structured as either Project Funding, where projects are undertaken based on a workplan approved by Health Canada-FNIHB, or Community-Based where programs must be delivered as per the Health Canada-FNIHB program.
- **Flexible Agreements:** Lasting from 2-5 years, these agreements provide some level of freedom (in sub-activity levels) in reallocating resources, requires less frequent reporting, and allows for carry-forward if articulated in a plan, and with approval for the Minister. Contribution agreements within the Flex model include Project funding, and Community-Based where the recipient delivers programs based on a multi-year workplan approved by Health Canada-FNIHB.
- **Block, Block/Flexible Agreements:** Lasting from 5-10 years, these agreements allow for reallocation across program areas, allow for the reinvestment of any budget surpluses, and structure programs and services based on a comprehensive Health Plan developed by the community (inclusive of Mandatory FNIHB programs).

Adequate Health Infrastructure and Support requires consideration across the wellness spectrum from adequate health human resources, eHealth, health facilities and capital, primary care, family health and home care, among many others.

REGION	BLOCK FUNDING		FLEXIBLE FUNDING		SET FUNDING	
	Number of Agreements	Number of Communities	Number of Agreements	Number of Communities	Number of Agreements	Number of Communities
Atlantic	16	16	13	13	6	12
Quebec	23	24	4	4	12	12
Ontario	22	37	55	58	33	34
Manitoba	26	27	27	29	8	8
Sask.	20	59	11	13	13	13
Alberta	5	10	30	37	9	11
Northern			3	3	10	11
TOTAL	**112**	**173**	**143**	**157**	**91**	**101**

-FNIHB, "First Nations and Inuit Health Branch Programs and Services Mapping (DRAFT)" September 2016, pg. 13.

Health Canada-FNIHB have demonstrated an increased willingness to pursue innovative approaches to supporting First Nations health programs and services, including the British Columbia First Nations Health Authority model as described above. In addition, there has been an increase in the number of First Nations in block and block/flexible agreements, which allow for greater degrees of First Nations control. Yet many communities remain in the more restrictive set and flexible funding models. There continue to be many challenges associated with the structure of agreements both the way in which they structure how programs and services can be delivered, and how they can hinder First Nations self-determination on health.

The project funding that is part of set and flexible agreements is problematic because Health Canada-FNIHB generally sets the priorities for project funding, the available amounts are often low, reporting requirements are generally high, and the agreements tend to only last one year. Clearly these facts are at odds with the development of comprehensive wellness systems. In addition, project funding tends to favour communities who already have the built-in capacity to develop project proposals, and thus exacerbates the divide between have and have-not communities.

Health Canada-FNIHB programming includes a structural barrier to communities seeking to move from set and flexible agreements to block agreements. Specifically, block agreement recipients are required to develop a comprehensive community health and wellness plan to demonstrate readiness and guide programs and services. However, only communities that are already in block agreements can receive funding for community planning. There is no support for those First Nations who are in set and flexible models to develop those plans and thus move into block agreements. This is a significant barrier. In addition, the resources available for community planning in block agreements are not sufficient to fully develop comprehensive community wellness plans that include data analysis, consider cultural needs, and enable programs and services that overcome the artificial and inherited Health Canada-FNIHB program siloes.

While significantly more flexible, even the Block funding model requires recipients to spend their funds within Health Canada-FNIHB authorities and requires Health Canada-FNIHB approval on the Community Health Plan, and thus gives them the ultimate authority and unnecessarily limits the expression of First Nations self-determination.

ACTION

TO SUPPORT FIRST NATIONS COMPREHENSIVE COMMUNITY WELLNESS PLANNING

◊ **That Health Canada- FNIHB work with First Nations to develop an appropriate funding formula for comprehensive community planning aimed at community wellness across program areas and departments, with support for data analysis and planning, and capacity building.**

FIRST NATIONS HUMAN RESOURCES FOR WELLNESS

> *No amount of intervention from outsiders, however well meant, will help Aboriginal people achieve well-being. What outside forces cannot bring about, Aboriginal people can do for themselves. They can make the best decisions about the kind of health and healing services that will restore them to whole health—and they can do the work of making healing centres and lodges a success.*
>
> *-Royal Commission on Aboriginal Peoples, "Volume 3: Gathering Strength" Pg. 269.*

The shortage of First Nations health care professionals in Canada constitutes a significant barrier to health care access for First Nations generally and in particular to culturally safe care. First Nations nurses, physicians and allied health professionals are instrumental in ensuring that community members receive culturally competent care. This in turn encourages First Nations to seek preventative and primary care services, when they are assured that they will have a positive and culturally safe experience. Furthermore, building capacity in First Nations health human resources supports local economic development and self-determination over health systems.

In developing mechanisms to support First Nations health human resources there is also a need to expand what roles we consider to be part of health and wellness systems. From a wholistic First Nations perspective, wellness is not generated by physicians, nurses and dentists; rather, the community environment itself is a powerful facilitator of wellness and within that environment, there must be recognition of Elders, Cultural Practitioners, Cultural Teachers or early-learning educator, for example, have as much to do with health and wellness. Therefore, **efforts to strengthen First Nations health human resources must be flexible enough to support learners and professionals that may fall outside of the traditional Western understanding of "health care professionals".** An expanded definition of what constitutes a healthcare/wellness worker requires engagement with other government departments who play a role including Indigenous and Northern Affairs Canada (INAC).

Determining the number of First Nations healthcare workers is a challenge; however, an analysis by Health Canada-FNIHB compared Census data from 1996, 2001 and 2006, and found that "the absolute number of Aboriginal health workers [rose] from 8,840 in 1996 to 21,805; furthermore, their proportion increased from 1.2 per cent of all health workers to 2.15 per cent." However, while "this 59 per cent increase in absolute numbers is a huge achievement, it is worth noting that the Canadian Aboriginal population itself increased

45 per cent over the same period."[63] [64] While improvements have been made in growing the number of First Nations/Inuit and Métis in the healthcare field, these groups continue to make up a disproportionately small portion of the workforce, compared to their proportion of the overall population.

In an effort to address the nursing shortage in First Nations, Health Canada- FNIHB has implemented a nursing recruitment and retention strategy; however, this strategy does not specifically focus on building a First Nations health workforce. While the recruitment of nurses from the mainstream is important, doing so does not guarantee sustainability of nursing services or the provision of culturally competent care and; therefore, should only represent one pillar of a multi-pronged approach. While the integration of cultural safety into nursing curricula is vital, it cannot produce the level of insight possessed by someone who is from a First Nations community themselves. Sharing common experiences, culture, history and sense of identity with the population one serves, provides a robust foundation for the establishment of strong, successful and long lasting therapeutic relationships between provider and community. In general, First Nations nurses are likely better equipped to understand how traditional ways of knowing, being and doing directly influence health and wellness, and how best to incorporate these traditional ways into patient care. Furthermore, First Nations nurses are in an optimal position to successfully broker relationships and optimize communication between First Nations patients and mainstream providers and facilitate strengths based approaches to primary care[65] by drawing together other community services providers for collaboration in addressing needs of the community as a team.

EDUCATIONAL CHALLENGES

Recruiting and retaining First Nations students in health careers continues to be marred by a multitude of complex cultural, geographical, financial and educational barriers. In fact, these barriers begin at the earliest stages of learning including in early childhood education and secondary school levels, before students are even ready to apply to post-secondary education. Since 1996, First Nations education budgets have been capped at a maximum increase of 2% per year. In contrast, provincial and territorial education budgets have increased at a steady rate of 4% per year, on average, and as high as 10% in some instances, over the same time period. The difference in budget increases between First Nations and provincial/territorial education systems generated a $355 million funding shortfall from 1996-2014. The First Nations secondary school graduation rate in 2004-2009 was approximately 36% compared to the 72% Canadian secondary school graduation.[66] Although Budget 2016 promised increases to First Nations education budgets, there have been few impacts on the ground thus far. These realities do not allow First Nations students to gain the strong foundation of education that is required to prepare them for post-secondary education (PSE). F/P/T governments would be wise to consider these factors when developing wholistic policy responses to First Nations health challenges.

First Nations students who graduate from secondary school meet the next challenge upon acceptance to a PSE program – funding for school. While 7 in 10 First Nations youth aspire to complete a PSE degree,

[63] Heather Exner-Pirot and Lorna Butler, *Healthy Foundations: Nursing's Role in Building Strong Aboriginal Communities*, (The Conference Board of Canada, 2015): pg. 8.

[64] It is worth noting that this data reflects self-reported Aboriginal identity and is not distinctions-based (First Nations/Inuit/Métis).

[65] Laurie Gottlieb, Bruce Gottlieb, and Judith Shamian, "Principles of Strengths-Based Nursing Leadership for Strengths-Based Nursing Care: A New Paradigm for Nursing and Healthcare for the 21st Century," Nursing Leadership 25, no. 2 (June 1, 2012): pg. 34-45.

[66] Assembly of First Nations, First Nation Elementary and Secondary Education: A Discussion Guide, (Ottawa, 2011), http://www.afn.ca/uploads/files/education/11-10-31_fn_education_-_a_discussion_guide_final.pdf, pg. 5.

1 in 4 cited the lack of funding for PSE as a barrier to access.[67] In 2008, it was estimated to cost an additional $724 million to support First Nations students in PSE.

Upon acceptance and confirmation of PSE funding, First Nations students then experience challenges with lack of cultural safety and supports within PSE institutions and programs. In addition, PSE institutions and programs often lack specific course content and curricula that reflect First Nations worldviews.[68] This is particularly relevant in nursing, midwifery and doula care, and health careers.[69]

External to program content, but related to the attendance at PSE institutions, First Nations students often experience various forms of discrimination, racism, and violence where they attend school which can be intensified if that student had to leave their community to attend the institution or program.

WORKFORCE RECRUITMENT AND RETENTION

Improving the recruitment and retention of healthcare professionals working in First Nations requires addressing the many challenges found within the workplace including achieving wage parity, ensuring the safety of workers and supporting training and mentorship of workers.

Certainly, a key aspect of ensuring health services for First Nations communities includes investments in First Nations health human resources. There is also a need to recruit healthcare professionals from the broader community. Retention of nurses who work for Health Canada within First Nations is abysmally low. For example, a 2010 report "identified Northern Ontario as having some of the lowest nurse retention rates in the country; one community, Sioux Lookout, hired 50 nurses in a three-year period and lost 45 of them, for a 10 per cent retention rate."[70]

In terms of financial support for First Nations health careers, Health Canada-FNIHB administers the Aboriginal Health Human Resources Initiative (AHHRI), which aims to increase the number of Aboriginal people entering into health careers and to ensure that community-based workers are trained and certified to improve the quality and consistency of healthcare services in First Nations and Inuit communities. This is achieved through the provision of scholarships and bursaries, currently administered by Indspire, and training/certification including for community-based workers health managers. AHHRI was funded at $100 million over five years from 2005-2010, $80 million from 2010-2015, and is now funded on an ongoing basis at $4.5 million/year. Within the scholarship/bursary stream, in 2014/15 Indspire awarded $2.5 million to First Nations, Inuit and Métis students pursuing health education. This represents only 16% of the total support requested by students in the healthcare field.[71] An additional annual investment of $15.5 million is required to restore AHHRI funding to 2005-2010 levels, comprising total annual funding of $20 million.

---

[67] Assembly of First Nations, "Fact Sheet: First Nations Post-Secondary Education," accessed November 5, 2016, http://www.afn.ca/uploads/files/pse-fact-sheet.pdf.

[68] While efforts are being made in many institutions to increase Indigenous content of courses, these may inadvertently perpetuate deficit-based understandings and stereotypes.

[69] Dawn Smith et al., "Aboriginal Recruitment and Retention in Nursing Education: A Review of the Literature," *International Journal of Nursing Education Scholarship* 8, no. 1 (January 2, 2011), doi:10.2202/1548-923x.2085.

[70] Exner-Pirot and Butler, *Healthy Foundations*, pg. 23.

[71] Health Canada- FNIHB, "Aboriginal Health Human Resources Initiative Presentation" for the Senior Management Committee (May 18, 2016): pg. 6.

There is also a significant role for on provinces/territories to support First Nations learners pursuing healthcare careers and indeed there are numerous jurisdictions which do provide some level of financial support; however, there is clearly a need for much greater level of investment from the federal government and provinces/territories.

PAY EQUITY

Health Canada-FNIHB has identified higher salary levels within provincial/territorial systems as negatively impacting the retention of clinical care staff when compared to what is offered for similar positions on-reserve. To fill the staffing needs, FNIHB utilizes nursing supply agencies that provide temporary nurses at higher rates. For example, using agency nurses costs an additional $106,000 of salary dollars per nurse.[72] While agency nurses play an important interim measure, their temporary nature makes building trust with patients and communities challenging. They also tend to be from urban centres and are unfamiliar with the cultural context and unique health needs of First Nations, particularly those in remote and isolated communities. Pay equity is also a challenge within other FNIHB programs including the National Native Alcohol and Drug Abuse Program (NNADAP). Despite efforts of NNADAP workers to increase their professional competency by meeting standards for Addictions Counsellor Certification, in addition to post-secondary education, the full-time salaries of some NNADAP workers do not meet or even approach provincial standard wages for qualified addictions workers with the same education, skills and hours of work. This results in a significant drain on the available workforce for First Nations.

MENTORSHIP/PEER NETWORKS FOR NURSES

As previously mentioned, First Nations constitute a population with complex needs when it comes to healthcare provision. Many health professionals, especially nurses, working in First Nations, particularly rural and remote ones, are often the sole provider of health services. As such, nurses in remote and rural communities are often faced with the dilemma of working beyond their legislated scope of practice, because they are often the only health professional in the community. This is combined with the fact that nurses may also be responsible for treating health conditions that are the result of social factors such as a lack of access to running water, inadequate and unsafe housing and the high cost of nutritious foods. This then becomes a question of liability should anything go wrong. Clearly, this is not an ideal situation for any health professional and contributes to the challenge of finding and keeping health professionals working in First Nations.

Establishing mentorship programs and peer networks will provide additional supports for nurses facing these challenging conditions. Studies have found that mentorship:

> *Improves retention of staff through the creation of a climate of support that in turn indicates an organizational culture of care. Other benefits include improved staff morale and levels of job satisfaction, and enhanced role transition, thereby assisting managers and clinical specialists with succession planning. Mentoring also promotes a cross-generational understanding of values and traits that can improve workplace relations.*[73]

[72] Ibid.

[73] Jane Mills, Donna Lennon, and Karen Francis, "Contributing to a Culture of Learning: A Mentor Development and Support Project for Australian Rural Nurses," International Journal of Nursing Practice 13, no. 6 (December 2007): pg. 395.

The AFN recommends that Health Canada-FNIHB focus on developing a mentorship program including a peer support network for nurses working in First Nations including providing access to an Advanced Practice nurse 24 hours per day.

CONTINUING EDUCATION/PROFESSIONAL DEVELOPMENT

Health Canada-FNIHB instituted five mandatory modules of additional training for nurses working in remote communities: Advanced Cardiac Life Support; International Trauma Life Support; Pediatric Advanced Life Support; Health Canada's Nursing Education Module on Controlled Substances in First Nations Health Facilities; and, Immunization Competencies Education Modules. Certainly, these modules are vitally important to prepare nurses for the situations that they may face. However, a 2015 study by the Auditor General found that only 1 out of the 45 nurses surveyed had completed all of the mandatory courses. FNIHB has noted that their inability to fully train their nurses is because of workforce retention. Not only do nurses leave before they complete the mandatory units, there are no nurses to fill-in for those leaving communities to attend training sessions. Improving the recruitment and retention of nurses using the recommendations noted above will address this challenge in the long-term. In the short term, Health Canada-FNIHB must increase resources to ensure an adequate supply of nurses via temporary backfilling.

ACTION

ON FIRST NATIONS HUMAN RESOURCES FOR WELLNESS

- That all governmental efforts to increase First Nations Human Resources for Wellness build in flexibility that respects First Nations wholistic understandings of health and wellness. This may include engaging departments/ministries beyond departments and ministries of health.
- That the federal government restore investments in the Aboriginal Health Human Resources Initiative (AHHRI) to 2005-2010 levels totalling $20 million annually, and work with First Nations to ensure the administration of AHHRI reflects First Nations priorities.
- That the federal government provide loan forgiveness on Canada Student Loans for health professionals (including midwives and doula care providers) working in First Nations communities, similar to what already exists for family doctors, residents in family medicine, nurse practitioners, and nurses who work in under-served rural or remote communities.
- That the provincial/territorial governments develop or expand targeted funds for university and college healthcare programs to increase First Nations participation and success with strategies that may include equity seats, preparatory and transition programs, and bridging programs from licensed practical nurse to registered nurse and licensed nurse practitioner, mentoring and peer support programs, and Elders-in-residence, among others.

- ◊ **That the provincial/territorial governments develop and/or expand scholarship and bursary funds for First Nations post-secondary students in healthcare fields.**

- ◊ **That Health Canada-FNIHB takes immediate steps to ensure parity with provincial/territorial standards in wages, pension and employee assistance programs for all front-line staff.**

- ◊ **That Health Canada-FNIHB, in partnership with First Nations, develops a mentorship program including peer support network for nurses working in First Nations communities including providing access to an Advanced Practice nurse 24 hours per day.**

- ◊ **As a short term measure, that Health Canada-FNIHB ensures an adequate supply of nurses to temporarily fill positions, allowing nurses to obtain mandatory course requirements.**

HEALTH FACILITIES AND CAPITAL

Health Canada- FNIHB's Health Facilities Capital Program supports health infrastructure on-reserve both in terms of capital for facilities and ongoing maintenance. The most recent program evaluation pegged the number of facilities supported through the Health Facilities Capital Program (HFCP) at:

> *989 buildings including 550 health facilities …in over 600 First Nation communities. This includes front-line medical services such as community health nursing and dental therapy, as well as maternal and child health, mental wellness and healthy living programs.*

In addition, as of July of 2015, Health Canada-FNIHB invests, "$30 million annually for repairs, renovation, and construction of health facilities, plus an additional $44 million for maintenance and operations."[74]

Numerous reports have found the HFCP to be inadequate to address the health infrastructure needs of First Nations communities. For example, the latest program evaluation found:

> *inadequacies related to O&M functions (clarity of roles and responsibilities, amount of money allocated and provision of on-going maintenance). There is [sic] not enough O&M activities being carried out in the communities to ensure sustainable operations, which may be accelerating the depreciation of facility components and increasing the need for major renovations and replacements over time. This is compounded by a lack of knowledge around O&M needs and processes both in programs and communities. These factors impact the degree to which communities have been able to effectively manage O&M.*[75]

The same evaluation found it difficult to assess how the program responds to infrastructure needs for a number of reasons including:

- inconsistent incorporation of community and health programming needs into capital planning processes;

[74] Sony Perron, Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health, Testimony at the Public Accounts Committee (Ottawa: June 1, 2015).

[75] Health Canada, "First Nations and Inuit Health Facilities and Capital Program- Cluster Evaluation" (March, 2012) <http://www.hc-sc.gc.ca/ahc-asc/performance/eval/hfcp-evaluation-pesi-eng.php#share>.

- differing capital project prioritization processes and interpretation of criteria across regions; and,
- the use of project selection partially based on the capacity of the First Nation/Inuit recipients to be able to manage the project.[76]

The final point is particularly notable here. While the need to ensure that First Nations recipients have the capacity to manage an infrastructure project, this can serve to further grow the divide between 'have' and 'have not' communities.

INNOVATION

In Jurisdictional Collaboration and First Nations Authority: All Nations' Healing Hospital

The All Nations' Healing Hospital (ANHH) in Fort Qu'Appelle, Saskatchewan opened in 2004 to serve 35 Treaty 4 First Nations. The hospital is owned by the File Hills Qu'Appelle Tribal Council and Touchwood Agency Tribal Council and governed by a Board of Governors made up of First Nations leadership. The hospital includes 14-beds for acute care, palliative care, 24-hour emergency services including 24-hour lab and x-ray services, and visiting specialist services. Within the hospital, the White Raven Healing Centre provides mental health and addictions services with a distinct spiritual/cultural program. In addition, there is an on-site women's health centre which provides maternal child health services and a low-risk birthing unit including a midwife. In 2016, the ANHH began development of a facility for dialysis and renal care.

In terms of community health, within the First Nations Health Services department, he ANHH's programs include home and community care, child development, nutrition, and health education. In addition, the hospital's White Raven Healing Centre provides mental health and addictions services which combine mainstream techniques with traditional healing practices.

The ANHH addresses wholistic health by incorporating many cultural elements including a ceremony room, facilities for sweat lodge ceremonies, access to traditional medicines, and a designated space for Elders.

In terms of funding, the government of Saskatchewan funds acute care costs and Canada provides funding for the community health programs, the White Raven Healing Centre and the hospital's traditional and cultural healing services. As a demonstration of the success of the ANHH, the hospital received an exemplary rating from Accreditation Canada.

[76] Ibid.

In 2015, a report from the Auditor General of Canada examining health access in Northern First Nations found critical weaknesses in the HFC program. Specifically, the Auditor General found:

> *numerous deficiencies in nursing stations related to health and safety requirements or building codes. For a sample of 30 deficiencies, the Department could not provide evidence that the deficiencies had been addressed. Furthermore, one of the residences at a nursing station that we visited had been unusable for more than two years because the septic system had not been repaired. Consequently, health specialists cancelled their visits to the community.*[77]

In response to this clear need, Budget 2016 committed $270 million in additional money for health facilities over five years. This funding will support the construction, renovation and repair of nursing stations, residences for health care workers, and health offices that provide health information on-reserve. While this is indeed a significant investment recently Health Minister Philpott noted that the recent investments on health infrastructure represent "a drop in the bucket" compared to actual need.[78] In fact, the increases announced in Budget 2016 do not even meet the estimated cost of the major projects within the Long-Term Capital Plan on the waiting list through Health Canada-FNIHB's Health Facilities and Capital Program, which has an estimated price tag of $350 million.

INNOVATION

In Jurisdictional Collaboration and First Nations Authority: Kateri Memorial Hospital Centre

Kateri Memorial Hospital Centre (KMHC) has been a part of the Kahnawà:ke community since 1905. When it first opened, the hospital was funded by the Jesuits, until 1955 when it came under Mohawk Council authority via a board of directors (although it is worth noting that much de facto authority remained in Ottawa as Indian Affairs set policies and had the authority to approve band council resolutions). With the advent of Medicare, uncertainty over jurisdictional responsibility for funding the KMHC continued. An agreement was reached in 1984 between the community and the province based on a 'nation-to-nation' principle in which Quebec would provide capital for a new facility and some operational costs. The hospital became a registered charity in 1991, allowing donations to advance health services in Kahnawà:ke.

KMHC is currently undergoing an expansion project, with roughly $23 million in funding from Quebec and $7.7 million from the community including a$2 million grant from Health Canada. The expansion will add 25 new long term and five short term beds.

The strategic direction of KMHC, and indeed health and social services for all of Kahnawà:ke, are guided by Onkwata'karitáhtshera (Kahnawake's One Health Authority) which demonstrates the community's wholistic focus through a composition of representatives from KMHC, the Community Services organization, fire and rescue, community representatives and the Mohawk Council.

[77] Auditor General, *Access to Health Services*, pg. 3.

[78] The Canadian Press, November 16, 2016, "First Nations infrastructure spending 'drop in the bucket,' says Philpott," <http://www.macleans.ca/politics/ottawa/first-nations-infrastructure-spending-drop-in-the-bucket-says-philpott>.

FACILITIES FOR WELLNESS

Healthy communities require structures that enable and support wellness. For First Nations communities, that means nursing stations and health centres that reflect a wholistic vision of health on both the individual and community level. Different communities will have distinct requirements in terms of infrastructure; however, the AFN heard a number of considerations to inform discussions between First Nations and Health Canada-FNIHB. These considerations include:

- Multipurpose buildings to support community wellness including meeting spaces and children's play spaces,
- Clinical rooms to meet the needs of inter-professional teams,
- Laundry facilities and locker rooms including showers , and
- Dedicated spaces for traditional healing and spirituality.

It has been widely reported that Attawapiskat is still without permanent mental wellness workers, in part, because of a lack of housing for the workers. Undoubtedly this is a situation familiar to many First Nations across Canada that endure the widespread housing crisis. Given the ongoing challenge in the recruitment and retention of health and wellness staff, it is a clear priority to ensure consideration for housing within facilities planning and investments.

ACTION

ON HEALTH FACILITIES AND CAPITAL

◊ **That Health Canada-FNIHB increase investments in the Health Facilities Capital Program (HFCP) to reflect demonstrated need, beginning with the existing waitlist but also forward-looking, and to ensure adequate resources for maintenance. Specifically, this will require an initial investment of at least $350 million to clear the existing waitlist, as well as a minimum of $20.9 million ongoing to avoid future waitlists.**

◊ **That Health Canada-FNIHB affirms that the focus of the HFCP program is to build spaces directed towards wholisitic individual and community wellness. This requires built-in flexibility to allow for First Nations themselves to determine their infrastructure needs, which may go beyond simply clinical applications.**

eHEALTH

Provincial, territorial and federal governments, as well as Canada Health Infoway, a federally-funded national coordinating body for digital health technologies, have made significant investments into eHealth infrastructure in Canada broadly. However, eHealth is at a critical point for First Nations in Canada. Over the past few years, eHealth has become recognized as a key enabler in the delivery of health services to First Nations and will ultimately contribute to better health outcomes for the First Nations people of Canada. Support for eHealth on-reserve is provided by Health Canada via FNIHB's First Nations and Inuit eHealth Infostructure Program (eHIP). Investments are directed towards broadband connectivity, public health surveillance systems, telehealth, electronic medical records (EMR) and electronic health records (EHR), IT technical support, maintenance and capacity development, and information management. The current eHealth budget for 2013/14-2017/18 is $99.8 million, $19 million of which was set aside for Electronic Medical Record (EMR)-specific applications meant to reach 100 communities. However, maintaining this existing support and reaching all First Nations would require an additional investment of at least $128 million for the EMR priority alone. Further investments would be needed to leverage the benefits of other eHealth initiatives, such as Telehealth, to other First Nations across the country.

INNOVATION

In Telemedicine

Keewaytinook Okimakanak (KO) Telemedicine utilizes videoconferencing and IT platforms to provide access to clinical, educational and administrative services to 26 remote First Nations in Northwestern Ontario. The program is the result of strong relationships between KO communities, the Ontario Telemedicine Network (OTN), the Ontario Ministry of Health and Long Term Care (MOHLTC) and Health Canada-FNIHB.

Last year, KOTM enabled more than 3,200 clinical encounters, an average of over 100 consultations per community, reaching out to almost one in every eight residents living in the region. Given remoteness with the average medical transportation trip costing $800, estimated savings to medical transportation budgets total $2.5 million annually. Simply, this innovation is demonstrating improved access for clients and costs avoided for both on-reserve and off-reserve health systems.

First Nations report that, while eHIP has been met with success where investments have been made, pilot projects tend to advantage communities who already have built-in capacity and risks widening the divide between have and have-not communities. In addition, a system made up of pilot projects risks producing many one-off projects rather than interoperable systems that are the very foundation of the potential of eHealth technologies. Another concern is that the eHealth priorities are determined largely by Health Canada-FNIHB rather than centering and supporting First Nations priorities. For example, the Health Canada-FNIHB National EMR Strategy did not fully engage with or champion First Nation priorities when it comes to EMR implementation and has resulted in many frustrations in implementing EMRs at the community level.

INNOVATION

In Electronic Health Records

The Cowichan Tribes on Vancouver Island have developed a client-centred electronic medical record and charting system called the Mustimuhw Community Electronic Health Record (cEMR). The platform is now part of the approved vendor list for British Columbia and is now being used in over 95 First Nations across the country including in Alberta, British Columbia, Saskatchewan, Manitoba, Atlantic and Ontario.

In addition, First Nations do not feel that there is adequate support for the sustainability of projects funded through eHIP. Even projects with a track record of success (KO Telemedicine, for example, which is highlighted below) must reapply for funding every year. Not only does this process take capacity away from service delivery, it stymies the ability of projects to plan in the long term. Another example of the impact of a lack of sustainability and reliability in funding is Kenora Chiefs Advisory (KCA) project. The initiative originated from a First Nation Client Registry (FNCR) led by the AFN in 2007. KCA built upon this project to develop and implement a First Nation Client Registry that enables communities to control their community demographic information and links them with provincial registries to provide health data to communities, in the form of cancer rates and cancer screening requirements. Despite their success, KCA has had to go from funder to funder every year to sustain the FNCR. While the project aligns with the Health Canada-FNIHB Strategic Plan, investments are directed by the Health Canada-FNIHB regions who have many other pressing and legitimate priorities. There is simply not enough funding to go around.

Another systemic mechanism which has disadvantaged First Nations in the area of eHealth is the fact that First Nations have largely been excluded from the Canada Health Infoway funding envelopes, and Infoway does not have dedicated funding for First Nations projects. As a result, First Nations projects are forced to compete with provincial/territorial projects who have vastly more capacity to begin with and other resources to draw from for global pots of funding. First Nations are explicitly excluded for competing for other funding envelopes including the $500 million earmark this year for EMR deployment in each province and territory. Despite these investments, integration of federal/provincial/territorial electronic health records will continue to be incomplete until integration First Nation eHealth applications are linked and interoperable with provincial/territorial systems.

The lack of meaningful consideration for First Nations eHealth needs within Canada Health Infoway is both a cause and a consequence of the lack of First Nations representation within the organization's structure and governance. For example, Infoway does not have an eHealth strategy for First Nations. Further, there is a lack of First Nations representation within governance bodies, specifically the Board of Directors and Corporate Members, which is comprised of the deputy ministers of health from the federal, provincial and territorial governments.

ACTION

ON eHEALTH

- ◊ **That Health Canada-FNIHB set aside dedicated funding to advancing eHealth initiatives in all First Nation communities based on community needs and priorities. At minimum, this requires additional investments of $65 million in 2017 ongoing.**

- ◊ **That F/P/T governments leverage their authority within Canada Health Infoway (CHI) governance structures to ensure First Nations needs are met, both in terms of representation in governance and levels of investment, within CHI.**

- ◊ **That provincial/territorial governments work with First Nations within their jurisdictions to develop solutions related to eHealth needs and priorities. This may include a joint strategy that compliments the provincial/territorial eHealth strategy.**

PRIMARY HEALTH CARE

Primary care is the first point of individual contact by First Nations with the health system at the community level. Health Canada- FNIHB describes its Primary Care program as:

> *Encompass[ing] health promotion and disease prevention programs to improve health outcomes and reduce health risks, public health protection, including surveillance, to prevent and/or mitigate human health risks associated with communicable diseases and exposure to environmental hazards, and primary care where individuals are provided diagnostic, curative, rehabilitative, supportive, palliative/end-of-life care and referral services. All of these services will be provided by qualified health providers who have the necessary competencies and meet the regulatory and legislative requirements of the provinces in which they practice.*[79]

However, the services described above are not universally available in First Nations, nor are they all funded through the program. Mandatory programs within Primary Care are: Communicable Disease Control and Management; Environmental Public Health within the Environmental Health; Clinical and Client Care; and Home and Community Care.

[79] Health Canada, *First Nations and Inuit Health Program Compendium 2011/12*, pg. 7.

INNOVATION

In Community Paramedicine

Given the challenges of primary care, particularly in rural and remote contexts, there is a growing move across Canada and internationally towards community paramedicine (CP) models. While they are certainly not a substitute for a robust interdisciplinary primary care team, they offer an opportunity to close some of the immediate gaps in service, particularly for rural and remote communities and reducing medical transportation costs, allowing patients to stay in their homes and communities, and increasing continuity of care. Community paramedicine is a relatively new innovation in Canada, but is currently being utilized in British Columbia, Ontario and Nova Scotia. Community paramedicine has been in use for over twenty years in Australia, New Zealand, the US and the UK.

Paramedics are often thought of as simply emergency responders, but their skills along with the technological advancements mean they are also well placed to provide a number of other services delivered in home or community settings. In particular, community paramedics can provide an important connection for community members, but in particular those living with chronic diseases such as diabetes congestive heart failure and chronic obstructive pulmonary disease by augmenting the services already-available in community through referral programs, clinics, home care, and community education. Clinics, for example, CP clinics can "typically provide general assessment, vital signs, and blood glucose monitoring and recording, medication and nutrition checks, immunizations, health education and referrals." These enhanced services are supported by technological advancements including cardiac monitoring, ultrasound, oximeters, and glucometers.

In 2015, British Columbia initiated a project that included community paramedicine projects in 9 communities, which informed the roll out of projects in 73 communities in 2016. Notably, the First Nations Health Authority (FNHA) is a key partner in these projects. While it is still early days, FNHA has identified a number of key strengths within the community paramedicine model including:

- reducing the financial and health costs to community members who previously had to travel long distances for care;
- expanded access to Naloxone, and training, which increase capacity for overdose care in areas not previously served; and,
- increased employment, particularly for First Nations, and as another avenue for First Nations involvement in health careers.

-with information from:
-Nolan, Hillier and D'Angelo, "Community Paramedicine in Canada," Emergency Medical Services Chiefs of Canada, (n.d.) and
-FNHA, personal email, September 30, 2016

According to Health Canada, in 2014/15, FNIHB provided primary care services on-reserve in 200 remote and isolated communities and 24hr urgent care in 80 remote/isolated communities. It operated nursing stations in 67 remote and semi-remote sites, 206 health centres in semi-isolated communities and 48 Health Stations. FNIHB views its role as providing Primary Care where provincial services are not readily available. The program is either directly provided by FNIHB or via contribution agreements.

This model is out of step with current research which demonstrates that communities with on-reserve access to primary care have better outcomes.[80]

There is a significant gap between First Nations access to health care compared to the general Canadian population. 80% of First Nations reported having a regular medical doctor, compared to 85% of the total population of Canada.[81] 14% of First Nations experienced a time when they felt they needed health care but did not receive it, compared with 11% of the total population.[82]

The state of primary care in many First Nations is catastrophic. Children have died from strep throat. A woman in an Ontario First Nation died after the nursing station in her community ran out of the oxygen. These preventable deaths are tragic and they should provoke outrage of all Canadians.

INNOVATION

In Primary Care Teams: Ts'ewulhtun / Coast Salish Primary Care Teamlet, Cowichan, BC

In early 2016, a partnership between the Cowichan Tribes, Island Health (provincial health authority) and the First Nations Health Authority developed a primary care teamlet that brings together a range of service providers to a single location. The teamlet includes a general practitioner, nurse practitioner, registered nurse/clinic manager, two registered nurses for health promotion/prevention and three licensed practical nurses acting as health coaches to act as client advocates/navigators. This model ensures access to consistent health provider, allowing for culturally safe and trusting relationships to be formed; it reduces reliance on medical transportation and emergency room visits and empowers clients to become engaged in their own health and wellness.

Currently, the distribution of primary care resources for First Nations in Canada is inconsistent and contributes to the growing divide between have and have-not communities. In order to ensure continuity of care, maximize resources, and avoid duplications, PHC services in First Nations must be innovative and tailored to community needs. What is required is a clear articulation of a minimum basket of essential services available to all First Nations communities. It must include a range of services from public health, health promotion and disease prevention to palliative services, balancing contemporary western medicine with traditional health supports. Other key elements include diagnosis and treatment, primary reproductive care, primary mental health care, primary palliative care, support for hospital, home and long term care facilities, service coordination and referral, patient education and preventative care, community-based opioid replacement therapy, and arrangements for 24/7 response.

[80] Lavoie et al., "Investments on Reserve".

[81] Christine Rotenburg, *Social Determinants of Health for the Off-Reserve First Nations Population, 15 Years of Age and Older, 2012*, (Ottawa: Statistics Canada, 2016) pg. 14.

[82] Ibid.

Comprehensive PHC services require adequate funding and must be delivered by strong and culturally safe primary care teams working with cohesive, functional, and supportive communication and referral processes which transcend jurisdictional and bureaucratic barriers. In addition, these PHC teams must be accountable to the population they serve. Simply, primary care for First Nations must be interdisciplinary, flexible, and reflective of community priorities. In addition, particularly for people with disabilities, adequate primary care also means access to massage, physio and occupational therapy.

ACTION

ON PRIMARY CARE

- **That Health Canada-FNIHB work with First Nations, however they choose to constitute themselves (individual community, tribal council, treaty area, region), to ensure First Nations have timely access to an adequately funded comprehensive primary care system that includes inter-professional teams, inclusive of cultural practitioners, and capacity to support community-based opioid treatment.**

- **That the F/P/T governments work with First Nations to develop systems- including reporting and accountability mechanisms- that ensure the seamless link between primary and specialized care, including assessment, care planning and discharge planning.**

CONTINUUM OF CARE

Most First Nations must utilize provincial and territorial health systems for many health concerns. Often there is no systemic case management that follows patients across jurisdictions and service providers. Communities must be provided with the resources to support capacity development in administering assessments, data management (such as Drug Use Screening Inventory, Native Wellness Assessment, the National Prescription Drug Survey), care planning, and then the development of discharge planning. This necessarily requires willingness on the part of provincial/territorial hospitals, regional health authorities, and other mental wellness services that are either brought into the community, brokered for access, or external to the community, to work in partnership with First Nations.

There is a urgent need for increased resources towards public health for First Nations both on and off reserve, including for prevention and treatment of both communicable and chronic diseases.

COMMUNICABLE DISEASE

The crisis of the spread of communicable diseases such as HIV/AIDS, tuberculosis and hepatitis C in First Nations communities is severe. Rates of sexually transmitted infections amongst First Nations youth are 5-10 times the national average.[83] Tuberculosis rates of First Nations living on-reserve are 26.6 per 100,000, while the rate for non-Aboriginal population is 0.9.[84]

Health Canada-FNIHB's Communicable Disease Control and Management (CDCM) Program supports prevention and health promotion activities, delivered either through Health Canada staff or via contribution agreements with First Nations with activities delivered by physicians, nurses and community healthcare workers. Activities can include surveillance, treatment of cases and outbreaks, immunizations and screenings, public education and the development of community pandemic planning. CDCM is a mandatory program and is meant to "meet legislated standards such as provincial and territorial public health legislation and health acts that ensures public health and safety."[85]

INNOVATION

In HIV/AIDS Programmiung: Big River First Nation's Know Your Status Program

Saskatchewan has the highest incidence of HIV in Canada and First Nations with the highest burden among First Nations people. Beginning in 2011, the Big River First Nation founded the Know Your Status program to address the limited access to testing and overcoming stigma. The program was developed by the community and funded by Health Canada-FNIHB and has since expanded to include treatment, harm reduction, food assistance and mental health counselling

Despite the clear need, these are the only two major programs for HIV/AIDS on reserve in Saskatchewan. Estimates put the needed number of programs on-reserve within Saskatchewan alone at 15. Fully implemented programs cost around $250,000 annually.

The primary challenge with the CDCM is that the allocations are insufficient to meet needs. The reason for the insufficient allocations is a lack of growth in some parts of the program and the expanded mandate to address Sexually Transmitted Blood Bourne Illnesses (STBBIs) in 2005 without any additional funds. Scientific advances in the emergence of anti-retroviral therapies for HIV, have dramatically increased life expectancies in individuals who have contracted the virus to the extent that HIV is now considered a chronic disease.

[83] Rachel Enni, "Health Disparities in Canada: A Focus on First Nations Children," in *Canadian Supplement to The State of the World's Children 2009*, by UNICEF (Toronto: Canadian UNICEF Committee, 2009) pg. 16.

[84] Health Canada, *Health Canada's Strategy Against Tuberculosis for First Nations On-Reserve*, (Ottawa, 2012) pg.4.

[85] Health Canada and the Public Health Agency of Canada, Office of Evaluation, *Evaluation of the First Nations and Inuit Health Branch Communicable Disease Control and Management Programs 2008-2009 to 2013-2014*, (March 2015): pg. iii.

Long-term funding is now required to support First Nations persons who are living with HIV. There is also a sound economic case for supporting HIV/AIDS prevention programming. The 2015 CDCM program evaluation cited:

> A 2011 national study [which] found the direct and indirect costs of people recently infected with HIV in Canada totaled $4.03 billion, or $1.3 million per person (lifetime cost), of which the direct medical costs accounted for 19%, labour productivity costs accounted for 52%, and loss in the quality of life accounted for 29%. Another study estimated that, for every dollar invested in community-based HIV prevention programs in Ontario, $51 in direct medical costs was avoided. An Australian study estimated that, for every $1 expended on HIV prevention programs, an estimated clinical care cost saving of $13 is achieved.[86]

Despite these advances, First Nations communities continue to struggle to address communicable disease with insufficient funding. On September 16-17, 2016, Canada committed $804 million (over 3 years) to the Global Fund to fight AIDS, Tuberculosis and Malaria. This contribution represents a 20% increase from previous commitments. Certainly, these new global investments are a positive step; however, further investments are needed at the domestic level as well because some First Nations have some of the highest rates of HIV/AIDS in the world. In addition, last year the federal government endorsed the 90-90-90 target recommended by UNAIDS. That is, a commitment by 2020 to see 90% of people with HIV get diagnosed, 90% of those diagnosed get treated, and 90% of those treated have low enough viral loads to prevent transmission. This endorsement has not seen any impact on investments for HIV/AIDS programming on-reserve in Canada.

The impact of various jurisdictional HIV/AIDS strategies for First Nations populations both on and off reserve is unclear. However, First Nations have shared concern with governments that, at least in some cases, buy-in from First Nations was low because of inadequate involvement of First Nations in the development, implementation and evaluation of HIV/AIDS strategies.

ACTION

ON COMMUNICABLE DISEASES

- **That Health Canada-FNIHB take steps to ensure alignment between the Communicable Disease Control and Management (CDCM) program with the mental wellness and addictions programming, including in the implementation of the Mental Wellness Continuum Framework.**
- **That the federal government ensure each First Nation has access to adequate resources to meet the 90-90-90 UNAIDS target. As a first step this requires increasing Health Canada-FNIHB's HIV/AIDS funding by a minimum of $16.8 M/year.**
- **That Health Canada-FNIHB support First Nations-created and directed communicable disease programs.**

[86] Ibid., pg. 40.

- ◊ That the provinces and territories adopt the 90-90-90 UNAID targets with specific investments to support First Nations, both on and off reserve, in achieving it.

- ◊ That provincial/territorial governments support First Nations-led initiatives on communicable diseases, and ensure meaningful First Nations involvement in all aspects of the development, implementation and evaluation of provincial/territorial communicable disease frameworks including on HIV/AIDS.

CHRONIC DISEASE

As mentioned previously, First Nations suffer disproportionately high rates of chronic disease, when compared to the non-First Nations population. Public Health interventions aimed at preventing chronic diseases, such as type 2 diabetes (referred to as diabetes henceforth), must first and foremost focus on building relationships across jurisdictions both within and outside of the health sector. Strong and effective relationships between First Nations and all levels of government are key to supporting First Nations as they drive health promotion and chronic disease prevention efforts. Effective cross-jurisdictional and cross-sectoral relationships are also necessary to address the complex interplay of the determinants of health (e.g. food security, mental health, housing and public infrastructure, and poverty) which contribute to the development of chronic disease. Importantly, governments must invest adequate resources to form and maintain these relationships in order to build the capacity and drive the system change that will be required to significantly improve chronic disease related morbidity and mortality rates among First Nations.

Since 1999, the cornerstone of federal First Nations diabetes policy has largely centered on the Aboriginal Diabetes Initiative (ADI) which supports community-based diabetes programming through contribution agreements. On June 30, 2015, the ADI was renewed and funding became ongoing (rather than requiring renewal) at 46.8 million annually.[87] Key areas of the ADI's current focus include diabetes in pre-pregnancy and pregnancy, community-led food security planning, and professional training to enhance clinical practice guidelines and the management of chronic disease.[88] However, Health Canada-FNIHB itself acknowledged that the current program funding is not sufficient to meet the target population, resulting in wait lists for programming.

The inadequacy of ADI as a response to the First Nations diabetes crisis is demonstrated in a 2009 study involving First Nations in Alberta which found "roughly 10% of participants had no regular health care providers, 46% had never seen diabetes nurses, and 18% had not visited diabetes care providers in the previous year".[89] Additionally, 38% of participants had never seen a dietician, 47% had not attended a formal diabetes education program, and only 24% of participants with renal damage were receiving treatment for the condition.[90]

In general, a lack of data on First Nations diabetes rates and on health-related outcomes associated with ADI-based interventions is another challenge within ADI. While yearly funding reports completed by communities offer details on the activities delivered, little is reported of any associated health

[87] Health Canada. "Renewal of Community-Based Aboriginal Health Promotion Programming". (July 21, 2015) Retrieved from http://news.gc.ca/web/article-en.do?nid=1012699.

[88] The Auditor General of Canada, "Chapter 5—Promoting Diabetes Prevention and Control," April 30, 2013 Accessed September 7, 2016. http://www.oag-bvg.gc.ca/internet/English/parl_oag_201304_05_e_38190.html.

[89] Oster, R., T., et al. (2009) Diabetes care and health status of First Nations individuals with type 2 diabetes in Alberta. Canadian Family Physician. 55:386-93. Pg. 389.

[90] Ibid.

impacts due to inadequate performance measures and an absence of well-defined indicators. The absence of national surveillance of First Nations diabetes rates to offer a basis for comparison further complicates matters. This current lack of available data also represents a significant obstacle when trying to understand current and future needs, thus potentially threatening long-term sustainability through chronic underfunding. Efforts to move forward on national surveillance of diabetes amongst First Nations continues to be undermined by a lack of coordination amongst national government entities and an absence of First Nations identifiers in provincial and territorial diabetes surveillance databases.[91] To ensure that diabetes amongst First Nations is appropriately addressed, the ADI program performance must be strengthened and surveillance and performance measurement, coupled with appropriate financial investments to support these efforts and current/future program demands must be put into place.

Another key challenge in addressing chronic diseases in communities is that Health Canada-FNIHB programs are largely focussed on diabetes, with little attention paid overall to other chronic diseases including cancer and chronic obstructive pulmonary disease. In response, Health Canada-FNIHB is developing a Chronic Disease Management Framework as part of the governmental response to a report from the Auditor General of Canada. The Chronic Disease Management Framework is meant to be an information resource for communities in implementing chronic disease management programs. However, the Framework will not come with funding and is therefore asking communities to do more, using already stretched program dollars. First Nations communities and health policy professionals view the develop frameworks with no increased investments or policy change as a waste of previous resources, a source of ongoing frustration, and does not contribute to positive and supportive working relationships between First Nations and Health Canada-FNIHB.

ACTION

ON CHRONIC DISEASES

- **That Health Canada-FNIHB increase investment to communities to develop and administer long-term, sustainable and community driven programs on chronic disease prevention and treatment.**
- **That Health Canada-FNIHB and related departments account for chronic disease in policy and program work related to food security.**
- **Related to data on chronic disease, that federal and provincial/territorial governments support First Nations data initiatives including, but not limited to, support for the First Nations Information Governance Centre(s).**
- **That provinces and territories work with First Nations within their jurisdictions to ensure provincial/territorial chronic disease promotion, prevention and treatment efforts meet the specific needs of First Nations.**
- **That all efforts to address chronic disease be focussed on building capacity within First Nations communities.**

[91] Auditor General.

CHILD AND FAMILY HEALTH AND MIDWIFERY

Infant mortality "is the single most comprehensive indicator of the level of health in a society, providing an important measure of the well-being of infants, children and their families."[92] When it comes to First Nations in Canada, the infant mortality rate paints a troubling picture. First Nations children die before the age of one at 2-4 times the Canadian average.[93] This is particularly troubling because the general Canadian rates are among the highest in the industrialized world (around 5 per 1000 births over the last decade).[94]

First Nations children under one year of age are hospitalized 50 times more frequently with streptococcal pneumonia and 80 times more frequently with chicken pox than non-Aboriginal children.[95] For on-reserve children, immunization rates are 20% lower than the general population.[96] Overall, 44% of First Nations children off-reserve has chronic health conditions.[97]

Pregnancy and childbirth were traditionally monumental moments in the lives of First Nations families and communities which were honoured and respected. Colonialism significantly shifted the cultural practices related to pregnancy and childbirth to a biomedical model which had the effect of isolating pregnant women and new mothers from their communities and support networks. This impact is especially amplified in remote regions where women are required to leave their home communities to give birth. All levels of government must support First Nations who are seeking to develop mechanisms that allow First Nations women to once again experience birthing closer to home. This may mean institutional support for midwifery programming, including support for traditional pregnancy and birthing practices. In addition, provincial and territorially-run hospitals should provide the space and resources required to ensure ceremonies and cultural practices around birthing are fully supported.

MATERNAL CHILD HEALTH

The benefits of maternal child health programming are well-documented. Home visits by nurses and family visitors is linked with improved parenting skills and quality of home environment, improved cognitive development of infants and young children, and the decreased incidence of unintentional injury. These visits have also improved detection and management of postpartum depression, improved rates of breast-feeding, and enhanced quality of social supports to mothers. [98]

The First Nations and Inuit Health Branch's (FNIHB) Maternal Child Health (MCH) program's purpose is to support pregnant First Nations women and families with infants and young children (ages 0-6), who live on-reserve, to reach their fullest developmental and lifetime potential. Specifically, this program includes home visiting by nurses and family visitors (experienced mothers in the community) as well as coordinating access to services for children with special needs. It is meant to support information and

[92] Janet Smylie et. al., "A Review of Aboriginal Infant Mortality Rates in Canada: Striking and Persistent Aboriginal/Non-Aboriginal Inequities," *Canadian Journal of Public Health*, (March/April 2010): 143.

[93] The Canadian Press, "Early Infant Mortality in Canada Called 2nd Worst in Developed World," May 8, 2013, Accessed July 18, 2016. http://www.cbc.ca/news/health/early-infant-mortality-in-canada-called-2nd-worst-in-developed-world-1.1314423.

[94] Ibid.

[95] Eni, pg. 13.

[96] Ibid.

[97] Ibid.

[98] Assembly of First Nations, (2010). *Maternal Child Health- Frequently Asked Questions*. Retrieved from http://64.26.129.156/article.asp?id=2270

linkages to other services for pregnant women and families with infants and young children allowing them to care for themselves. Currently, FNIHB reports that the MCH is delivered in 309 First Nations.

FATHERHOOD PROGRAMS

> *Fathers may well be the greatest untapped resource in the lives of Aboriginal children today. If we could understand and support them to get involved and stay connected with their children, that would be a big protective factor for these youngsters as they grow up.*
>
> *-Grand Chief Ed John, First Nations Summit, BC*

Historical, political, economic and social factors have contributed to First Nations men experiencing high rates of social exclusion, suicide, poverty and incarceration. Dr. Jessica Ball, of the Centre for Early Childhood Research and Policy at the University of Victoria notes that these realities create the "conditions that make it very difficult for fathers to be connected to their children and to sustain their connections…[and that] policy reforms and program supports must embrace multi-sectoral strategies to address the barriers and obstacles to sustained father involvement."[99]

Clearly, Dr. Ball and others have identified a lack of dedicated fatherhood programming for children and families. While some First Nations provide programming for fathers and families broadly, these are generally funded through already-underfunded maternal child health programs or the Family Violence Prevention program from Indigenous and Northern Affairs Canada. Dedicated funds for fatherhood program could support:

- Reinvigorating cultural teachings around fatherhood;
- Providing cross-generational connections; and,
- Creating a peer-network of fathers

In addition, these initiatives must provide flexibility to respond to community specificity and needs. In addition, given the diversity of community responses to this need, funding must not be governed by a strict funding formula.

EARLY CHILDHOOD PROGRAMS

In 1998, Health Canada-FNIHB founded the Aboriginal Head Start On-Reserve (AHSOR) program which aims to provide learning and developmental setting for children aged zero to six years, based on community priorities and needs. The six program components include: education; health promotion; culture and language; nutrition; social support; and parental/family involvement. Programming can be delivered in an outreach method, or via a central facility. FNIHB reports that AHSOR is currently delivered in 200 First Nations.

AHSOR is administered through contribution agreements with a degree of flexibility to allow communities to develop programming based on their own teachings, community assets and culture. AHSOR is a unique program whereby childhood health as wellness moves beyond narrowly defined "health" programming.

[99] National Collaborating Centre for Aboriginal Health, *…with Dad: Strengthening the Circle of Care*, (2011): Pg. 6.

AHSOR investments have likely played a positive role in Indigenous language regeneration. For example, according to the 2008/10 Regional Longitudinal Health Survey (RHS), "more First Nations children who had attended an Aboriginal Head Start program were able to speak or understand a First Nations language than those who had not attended."[100]

In purely economic terms, a number of studies on early childhood programs in the United States (for low-income families/not Indigenous specific) which demonstrate the impressive return on investment of such programs. For example, one study "estimated a return on investment between 7% and 11% and overall social benefits of between $8-$14 per dollar spent."[101] An evaluation of the Head Start program in the United States, that was the predecessor to the Canadian program, found that the return on investment for every spent dollar is between $7 and $9.[102] In terms of health care outcomes, children within the American program were "less obese, more likely to be immunized, and 19 to 25 percent less likely to smoke as an adult."[103] Despite these impressive outcomes, FNIHB reports that "even where the program is available, funding is often insufficient to reach the target population (waiting lists)."[104]

Overall, Aboriginal Head Start On-Reserve is considered a vital program, but the program is still not yet universally accessible. Currently, the federal government spends $59 million[105] annually on HSOR to provide 17% of children on-reserve with access. It is estimated that annual funding for HSOR must be $347 million to provide universal access.[106] It is expected that funding requirements for universal access can be achieved gradually over several years as capacity for HSOR increases. In addition, the need for childhood development programming does not end at six years old, particularly given the ongoing challenges of underfunding for on-reserve schools. Therefore, the program must expand to include children over six years.

CHILD DENTAL HEALTH

The AFN's 2010 oral health strategy, "Teeth for Life," articulates a multi-pillared approach to oral health that encompasses oral health promotion and disease prevention, as well as responsive dental health services. It notes that, compared to the general Canadian population, First Nations are less likely to access dental services. In addition, the national per capita Non-Insured Health Benefits[107] (NIHB) dental expenditure was only 55% of what the Canadian population spends per capita on dental services annually.[108] In addition, of 3-5 year old First Nations children, 85% had experienced dental decay.[109]

---

[100] First Nations and Information Governance Centre, *First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities* (Ottawa: 2012), pg. 354.

[101] Trefler in Health Canada and the Public Health Agency of Canada, Office of Evaluation, *Evaluation of the Healthy Living (2010-2011 to 2012-2013) and Healthy Child Development Clusters (2008-2009 to 2012-2013*), (Ottawa: November 2014) pg. 58.

[102] National Head Start Association, "Head Start's Return on Investment," <http://headstartva.org/wp-content/uploads/2014/08/Head_Start_Return_On_Investment_Brief_LAS-yv.pdf> (accessed August 23, 2016).

[103] Ibid.

[104] Health Canada, First Nations and Inuit Health Branch, *Draft Preliminary Assessment of Gaps in FNIHB Program Areas presentation*, (September, 2016): Pg. 10.

[105] Health Canada, First Nations and Inuit Health Branch, "Aboriginal Head Start on Reserve," (June 15, 2011), < http://www.hc-sc.gc.ca/fniah-spnia/famil/develop/ahsor-papa_intro-eng.php>.

[106] Calculated using an HSOR cost:coverage ratio of $57M:17%.

[107] Non-Insured Health Benefits is Health Canada's program which provides coverage to registered First Nations and recognized Inuit for a specified range of medically necessary items and services that are not covered by other plans and programs.

[108] Assembly of First Nations, *Teeth for Life: the First Nations Oral Health Strategy*, (2010): pg. iv.

[109] Kavita R. Mathu-Muju et al., "The Children's Oral Health Initiative: An intervention to address the challenges of dental caries in early childhood in Canada's First Nation and Inuit communities," *Can Journal of Public Health* 107, no. 2 (2016), e188-e193.

The average number of decayed, missing and filled primary teeth was 8.22, with 49% of decayed teeth untreated.[110] Among 6-11 year olds, 80% of First Nations children had experienced dental caries in their primary dentition compared with 48% of other Canadian children.[111]

In 2004 Health Canada-FNIHB introduced the Children's Oral Health Initiative (COHI) to supplement Primary Health Care and Public Health (PHCPH) dental providers in First Nations in providing early childhood (ages 0-7) tooth decay prevention. Activities include annual screenings, fluoride varnish, dental sealants and prevention education and are generally provided by dental hygienists and COHI Aides, community members hired to support the dental professionals, sometimes with support from dental therapists. Services are provided either directly to the communities through Health Canada-FNIHB staff or by the First Nations through a contribution agreement with Health Canada-FNIHB. COHI has increased children's access to dental hygiene and oral health promotion services, and raised the percentage of 0-4 year old children who have caries-free teeth. In a 2014 study comparing two Manitoba communities with COHI (with dental therapists) to four communities without these programs it was found that "Over one-third (39.8%) of the children in COHI and dental therapy communities had no decayed, missing or filled teeth (permanent teeth), compared to 13.1% of children in the non- COHI and dental therapy communities."[112]

While the COHI and dental therapy programs have demonstrated success and a high degree of support, there are a number of shortages that remain. Firstly, the poor access to dental services varies between communities and across regions. For example, while 98% of First Nations in Alberta have COHI programs, there is only 14% coverage in Northern region.[113] In addition, there is no COHI program in the Yukon. Access to dental therapists and dentists within communities is similarly inconsistent. As of 2013 the COHI program employed, either directly or through contribution agreement, approximately 115 dental therapists, 70 dental hygienists and 222 COHI aides.[114] The majority of federal dental therapists work in Saskatchewan and due to provincial regulatory restrictions, there are currently no dental therapists working in Ontario and Quebec. Demand for dental therapists far exceed supply and the situation is likely to get worse because in 2011 the National School of Dental Therapy in Prince Albert, Saskatchewan—the only source of dental therapy training in Canada—was closed after the federal government cut off financial support. This will have a disproportionate impact on First Nations as a relatively high percentage of dental therapists overall are Indigenous, improving the likelihood of culturally safe care. Related to access, current annual funding for COHI is $4.3 million which reaches about 55% of eligible children.[115] It is estimated that an additional $3.5 million will be required to increase COHI access to universal levels.[116]

Another deficiency in oral health promotion and prevention is the lack of programming for children over 8 years. For these children, dental care is primarily delivered by dentists, and often is more aimed at restorative or surgical interventions.[117] The success of COHI for children 8 and under should demonstrate the significant return on investment in these prevention activities.

[110] Ibid.

[111] Ibid.

[112] Health Canada and the Public Health Agency of Canada, *Cluster Evaluation*, pg. 53.

[113] Kavita R. Mathu-Muju et. al. pg. e190.

[114] Ibid., pg. e191.

[115] Email with First Nations and Inuit Health Branch, November 16, 2016.

[116] Calculated using a COHI cost:coverage ratio of $4.3M:55%.

[117] This dental care is provided for by FNIHB's Non-Insured Health Benefits Program and itself has significant limitations, most notably in orthodontics.

MIDWIFERY

The shocking infant mortality rates articulated above demonstrates the urgent need to rethink birthing practices for First Nations in Canada. The vast majority of First Nations women living in rural and remote communities must travel to urban centres, generally about four weeks in advance, to give birth, often alone. FNIHB's Non-Insured Health Benefits Program does not always cover travel for a spouse or other family members for support. A recent report of the National Aboriginal Council of Midwives notes that, "separation from these fundamental support systems, combined with a lack of maternal and newborn care that is culturally safe, has been linked to a range of concerns from low birth weight, to maternal and newborn complications, including prenatal and postnatal mood disorders."[118]

First Nations must have access to the highest level of pre-natal and post-natal care available to all Canadians. However, there is a role for midwifery and, specifically, First Nations midwifery. Support for First Nations midwifery is supported by TRC Call to Action #22 which "call[s] upon those who can effect change within the Canadian health-care system to recognize the value of aboriginal healing practices and use them in the treatment of aboriginal patients in collaboration with aboriginal healers and elders where requested by aboriginal patients."

INNOVATION

In Midwifery as Mental Wellness

Beyond the potential for midwifery in communities to improve the birthing experience for First Nations women, produce better health outcomes for mom and baby, and save dollars in medical transportation funding, babies being born in communities has the potential to positively impact community mental wellness. Carol Hopkins, Executive Director of the Thunderbird Partnership Foundation describes it this way:

"What does it mean when the only tears in First Nations communities come when people die? Most communities do not get to hear the cries of a baby being born. There is a life affirming message for the whole community in that."

Midwives have always played an important role in First Nations societies, as an integrated healthcare provider and cultural practitioner. While there is not a single accepted definition, Indigenous midwifery is generally thought of as:

> *A committed primary health care provider who has the skills to care for pregnant women, babies, and their families throughout pregnancy and for the first weeks in the postpartum. She is also a person who is knowledgeable in all aspects of women's medicine and she provides education that helps keep the family and the community healthy. Midwives promote*

[118] National Aboriginal Council of Midwives, *The Landscape of Midwifery Care for Aboriginal Communities in Canada*, (March 2016), pg. 3.

breastfeeding, nutrition, and parenting skills. A midwife is the keeper of ceremonies for young people like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation.[119]

Midwifery practice is regulated by the provinces and territories. British Columbia, Ontario and Quebec include exemptions within their regulations that allow for Aboriginal midwifery practice; however, Ontario is the only province where Aboriginal midwives are currently practicing within the exemption clause.[120] There are also First Nations, Inuit and Métis registered midwives practicing within provincial and territorial regulations. A review of legislation is required to assess whether these laws align with Section 35 of the Constitution. Some of the key initiatives from across Canada include the Kenhte:ke Midwives from Tyendinaga Mohawk Territory, Ontario, the Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Centre on Six Nations of the Grand River, Ontario, and the Seabird Island Band Midwifery Services in British Columbia.

The National Aboriginal Council of Midwives has developed several recommendations to support the expansion of Indigenous midwifery practice. The AFN supports these recommendations and reaffirms them in this submission.[121]

ACTION

ON CHILD AND FAMILY HEALTH AND MIDWIFERY

- **Related to cultural safety, that provincial/territorial governments work within their jurisdictions to ensure provincial and territorially-run hospitals provide the space and resources required to ensure ceremony and cultural practices around birthing are fully supported.**
- **That FNIHB's Maternal Child Health Program includes dedicated funding for fatherhood programs.**
- **That First Nations on reserve/in communities have universal access to FNIHB's Maternal Child Health program and expand the program to include children over age six years.**
- **That First Nations children on reserve/in communities have universal access to Head Start programming, requiring an additional annual investment of at least $347 million.**
- **That First Nations children on-reserve have universal access to COHI programming, requiring an additional annual investment of $3.5 million.**
- **That COHI eligibility be extended to include First Nations youth ages 8-18.**

[119] National Aboriginal Council of Midwives, "Aboriginal Midwifery in Canada," <http://www.aboriginalmidwives.ca/aboriginal-midwifery-in-canada> (accessed September 26, 2016).

[120] National Aboriginal Council of Midwives, *The Landscape*, pg. 4.

[121] For the full list of recommendations see National Aboriginal Council of Midwives, *Landscape,* page 23.

- ◊ **That the Treasury Board of Canada should develop an occupational classification for midwives. This will enable Health Canada-FNIHB to hire midwives to work in federal jurisdictions.**

- ◊ **That federal, provincial/territorial governments and educational institutions work with First Nations to support the development of Indigenous midwifery training programs.**

- ◊ **That the Health Canada-FNIHB support First Nations in developing and administering midwifery programs.**

HOME AND COMMUNITY CARE

The notion of *continuing care* aligns with First Nations wholistic views on health and wellness. Essentially, continuing care is a system of service delivery that encompasses a range of health and social services for all age groups, and addresses the wholistic health, social and personal care needs of individuals who do not have, or have lost, some capacity for self-care. These integrated services are designed to improve individual functioning, support family and community cohesion, and provide culturally appropriate care in the community where possible.

While the First Nations youth population is growing, the First Nations senior and elderly population is also growing. For example, the Indian Registry data at Indigenous and Northern Affairs Canada (INAC) demonstrates a 27% increase in registered First Nations aged 55+ between 2009 and 2014.[122] There are currently approximately 40,000 Indigenous (including First Nations, Métis and Inuit) peoples 65 or older and the number is expected to rise and by 2026, the percentage of Indigenous seniors will have tripled from current estimates. As the number of elderly First Nations citizens grows, so does the need for appropriate and adequate home and community care programs and services.

HEALTH CANADA'S FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM

Established as a mandatory program in 1999, the First Nations and Inuit Home and Community Care (FNIHCC) program uses a client needs assessment model and follows a case management process. FNIHB describes the program as:

> *Provid[ing] basic home and community care services that are comprehensive, culturally sensitive, accessible and responsive to the unique health and social needs of First Nations and Inuit. The program enables First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities. The program is primarily provided through contribution agreements with First Nation and Inuit communities and territorial governments and strives to be comparable to home and community care services offered to other Canadian residents in similar geographical areas.*[123]

[122] Fav Com, *PEOLC in First Nations and Inuit Communities*, (January 2016): pg. 1.

[123] Health Canada and the Public Health Agency of Canada, Office of Evaluation, *Evaluation of the First Nations and Inuit Home and Community Care Program 2008-2009 to 2011-2012* (Ottawa: September 2013), pg. ii.

In general, services are delivered by health care professionals (nurses, personal care workers, etc.) that are employed by the band or community.[124] The list of services deemed "essential" within the FNIHCC program is huge. It includes:

- a structured client assessment process that includes on-going reassessments and determines client needs and service allocation. Assessment and reassessment processes can involve the client, family and other care givers and /or service providers;
- a managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement;
- home care nursing services that include direct service delivery as well as supervision and teaching of personnel providing personal care services;
- the delivery of home support personal care services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing Indigenous and Northern Affairs Canada (INAC) adult care services (e.g. bathing, grooming, dressing, transferring, care of bed-bound clients including turning, back rubs and routine skin care, etc);
- the provision of in-home respite care;
- established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with hospital service providers, physicians, nurse practitioners, advanced practice nurses, respite and therapeutic services; ƒ provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care;
- the management and supervision of the program regarding the capacity to manage the delivery of the home and community care program in a safe and effective manner, if existing community infrastructure exists; and,
- a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.[125]

In addition to this extensive list, a number of supportive services may be provided, though there is no additional funding to support them. These include: rehabilitation and therapy services; respite care in a facility; adult day care; meal programs; mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counselling and healing services, and medication monitoring; support services to maintain independent living, which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services; home-based palliative care; social services directly related to continuing care issues; and, specialized activities to promote health, wellness and fitness.[126] Home-based palliative care is the most in-demand service in communities.

EXISTING CHALLENGES WITHIN FNIHCC

According to a 2014 audit, the federal government provided funding to 674 First Nations and Inuit communities (including 197 through the British Columbia Tripartite Agreement) under the FNIHCC

[124] There are a few exceptions including most notably the First Nations Health Authority in British Columbia and in Nunavut and Northwest Territories where HCC dollars flow to the territories via contribution agreement.

[125] First Nations of Quebec and Labrador Health and Social Services Commission, "Assessing Continuing Care Requirements in First Nations and Inuit Communities," (July 2006): pg. 18.

[126] Ibid., 19.

program[127] with roughly 35,000 clients within the program.[128] The initial annual investment in 1999 was a global annual budget of $90 million (including administration and FNIHB staff salaries). Despite increases in program costs, there has never been an increase to the FNIHCC budget. Funding is calculated based primarily on population figures for operating costs and an adjustment for remoteness. While the program claims that allocations are based on need, First Nations have repeatedly testified to the inadequacy of the funding in meeting First Nations' needs. Home care staff often report that their allocations run out long before the year's end and that one emergency, such as an influenza outbreak, can eat up large portions of community home care budgets.

Jurisdictional issues complicate addressing the reality of the increasing demand for services and play a detrimental role in the operationalizing a true continuing care system for First Nations, particularly on-reserve. There are challenges in terms of establishing and operationalizing a continuum of care between on-reserve services and provincial/territorial services. In addition, many nurses working within the Health Canada-FNIHB Home and Community Care program report increasing impacts of offloading due to squeezed provincial/territorial budgets. For example, many report that hospitals are more quick to discharge patients that would previously been kept in the hospital for care. In addition, they are not provided the required medical supplies and equipment at the time of discharge. These patients often return to their communities without the necessary medical supplies outside of business hours when it is not possible to access medical supplies and equipment through Health Canada-FNIHB's Non-Insured Health Benefits Program.

There is also a jurisdictional struggle between federal departments that can cause service gaps and delays. For example, Indigenous and Northern Affairs Canada (INAC) administers the Assisted Living program which has the authority over non-medical/social in-home and institutional (types 1 and 2 using the federal definition) care while Health Canada, administers the FNIHCC program. However, there is not always a clear line between those needing assisted living supports and those needing home care.

Just as in primary care, many First Nations experience significant challenges in recruiting and retaining staff for their home and community care programs. Perhaps the most obvious source of nursing recruitment and retention challenges relates to remuneration, particularly in conjunction with overburdened workloads. Home care staff members are worried about the demands placed on them and potential liability issues they face given the conditions in which they operate with increased caseloads with no increased funding to compensate. Home care staff burnout is common. As a result, the burden of care falls on family members, many of whom already face economic insecurity and face their own health challenges.

First Nations patients, particularly Elders, are often moving in and out of provincial and territorial systems via hospital stays. The challenge is ensuring the necessary information is being passed between systems in order to ensure the safe continuity of care. There are many times that First Nations clients are left to communicate with the home care program on their reserve about their ongoing health care needs, which are often complex and technical. What is required is the development of formal discharge protocols between jurisdictions to ensure vulnerable patients are not falling between the cracks.

[127] Health Canada and Public Health Agency of Canada, *Home and Community Care Audit*, pg. 1.

[128] Fav Com, pg. iii.

PALLIATIVE END-OF-LIFE CARE (PEOLC)

One of the longstanding challenges faced by First Nations within the FNIHCC program is the lack of support for palliative end-of-life care (PEOLC). The need for palliative services are perhaps more acute for First Nations than non-Indigenous Canadians for a number of reasons. For example, many First Nations are still living with the legacy of Indian Residential Schools, a symptom of which includes distrust for medical professionals and discomfort residing in institutions. Some First Nations are also faced with linguistic barriers and, given the remoteness of some communities, they also face the prospect of spending their last days very far from their homes and families. This would also certainly impact the ability to access culturally safe care, traditional medicines and protocols. In addition, studies demonstrate that:

> *Persons with access to palliative care have fewer symptoms, better quality of life, and greater satisfaction with their care. Referrals are more appropriate, there are less use of hospitals and fewer visits to emergency departments. Importantly, there are fewer intensive hospitalizations in the last days of life. By contrast, taking patients out of the community to receive PEOLC disrupts family life and creates emotional, social, spiritual and economic burden. The disruption in the grieving process caused by this dislocation has negative effects on overall community, social and economic wellbeing.*[129]

When it comes the Health Canada-FNIHB program, full and flexible funding for PEOLC is required. It is estimated that required funding for palliative care, end-of-life care, aging-in-place supports, and maintenance care is $50 million annually.

There are also implications for PEOLC that go beyond the FNIHCC program, most notably in the NIHB program. A major complaint with NIHB is the amount of time that home care nurses spend seeking approvals and navigating appeals that is taking away time from their patients. In addition, FNIHCC nurses report concerns that the poor-quality equipment that is provided under NIHB affects the quality of patient care, as well as their own personal liability. Moreover, a recent report commission by FNIHB notes the following challenges related to NIHB:

- Persons cannot obtain nutritional supplements from the NIHB Program, unless they have been designated as palliative and not expected to live longer than six months. This designation must come from the family physician who may be reluctant to make that diagnosis.
- Persons on dialysis are not designated as palliative, even though they need end-of-life support.
- The NIHB Program will not provide the equipment and supplies needed to provide IV therapy as part of caring for persons at the end-of-life. Hydration is an extremely important comfort measure. Note: some communities may have agreements with RHAs for these costs, so that care can continue in the home, and,
- The limit assigned by the NIHB Program regarding the amount of oxygen that a person can receive is tailored to home use, and may not be sufficient for persons with multiple health needs who are traveling distances from their community to access specialists or therapies.[130]

[129] Fav Com, 2-3.

[130] Fav Com, pg. 16-17.

A VISION FOR HOME AND COMMUNITY CARE

Home and Community Care (HCC) patients, including palliative patients, must have access to interdisciplinary teams that may include physicians, specialists, nurses, pharmacists, mental wellness supports, social workers and traditional healers. In the case where remoteness is an issue, FNIHB must provide the resources to meet these needs, which may include using technology such as telehealth.

An adequate funding formula would include, as a starting point, an accurate baseline population calculation. It is estimated that updating the funding formula with current population numbers would require $152.1 million in funding annually for home and community care[131] which is an increase of $62.1 million over 1999 funding. In addition, remoteness, levels of community infrastructure, and demonstrated need should be considered when contemplating increases to funding. “Demonstrated need” must account for caseload, client base and reflect complexity of needs. Funding must be extended to PEOLC and traditional supports. In terms of an escalator, funding must account for the years of “catch up” required due to years of no funding growth.

FNIHCC workers must be paid equitably to those working in provincial/territorial systems. An emergency fund must be established by Health Canada-FNIHB that communities can tap into if and when they face unexpected needs such as an influenza outbreak. Finally, the program, working with First Nations, must develop a system to support the inclusion of traditional healing within home care programs.

Related to the provision of long-term institutional care, the best people to deliver culturally safe care are First Nations themselves. However, less than 1% of First Nations on-reserve communities have long-term care facilities. The AFN recommends that the federal government, where demonstrable need is established, provide the necessary supports to First Nations to establish and operate long-term care facilities. Many of the current generation of First Nations seniors were forced to leave their communities and to attend Indian Residential Schools. Forcing First Nations seniors to leave their communities again for palliative, end of life or long term care at the end of their lives is unacceptably cruel.

THE ROLE OF PROVINCIAL AND TERRITORIAL HEALTH SYSTEMS IN FIRST NATIONS HOME CARE

While First Nations leadership has identified the need for supporting First Nations to age at home (on-reserve), a growing population of First Nations people are living in urban centres. This increasingly urban Indigenous population should compel provinces and territories to take the needs of First Nations people seriously within their respective home care systems and work with First Nations to help meet those needs appropriately. Provincial and territorial systems need to consider the unique characteristics of First Nations including the need for culturally safe care of a largely youthful demographic with higher risk for instances of disease and poor health. In terms of an escalator, funding must first account for the years of “catch up” required due to years of no funding growth. It is estimated that catching up the funding formula would require $72.5 million.[132] This amount represents the amount of funding that should have been provided to home and community care between 1999 and 2016.

[131] Aboriginal population increased from 976,305 to 1,400,685 between the 2001 and 2011 Census, representing a 3.337% compounded growth rate. This growth rate was applied to the $90 million in funding in 1999 to determine the updated funding formula for 2016.

[132] Used the aforementioned growth rate to determine how much funding would have compounded if the funding formula had been updated every year since 1999.

As mentioned previously, First Nations home care clients often transverse between provincial/territorial and on-reserve systems. It is therefore necessary to ensure continuity of care through open dialogue between systems facilitated by established systems of communication.

ACTION

ON HOME AND COMMUNITY CARE

- That Health Canada-FNIHB provides an immediate investment to account for the investments lost as a result of no program growth since 1999 (catch up investment). The AFN estimates this at $79.5 million.
- That Health Canada-FNIHB update the population numbers used to determine investments in First Nations Home Care to current levels. The AFN estimates this at $62.1 million beginning in 2017 and ongoing.
- That Health Canada-FNIHB fully fund Palliative/End of Life Care within the First Nations and Inuit Home and Community Care Program. The AFN estimates this at $50 million annually of new investments.
- That Health Canada-FNIHB work with First Nations to determine a needs-based funding formula that accounts for remoteness, levels of community infrastructure, and demonstrated need. Demonstrated need must account for caseload, client base and complexity of needs. In addition, funding must be extended to PEOLC and traditional supports.
- That Health Canada-FNIHB work with First Nations to determine an appropriate and respectful method to ensure funding support for traditional healers and family supports.
- That Health Canada-FNIHB develop an Emergency Relief Fund that communities can tap into in the event of unforeseen circumstances, to ensure continuity of services.
- That Health Canada-FNIHB, where demonstrable need is established, provide the necessary supports to First Nations to establish and operate long-term care facilities.
- That the provinces and territories work with First Nations within their jurisdictions to ensure that provincially and territorially-run home care programs and services meet the specific needs of First Nations clients.
- That the provincially and territorially-run health systems work with First Nations within their borders to facilitate systems of communication between on and off reserve systems to enhance client-centred continuity of care.

MENTAL WELLNESS AND ADDICTIONS

CURRENT CONTEXT

The Health Canada funded National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) are the primary programs in place to respond to First Nations substance use issues among First Nations in Canada. This network of on-reserve programs has since evolved into 49 alcohol and drug abuse treatment centres, more than 550 NNADAP community-based prevention programs, and since 1995, a network of NYSAP residential treatment centres which now includes ten solvent abuse treatment programs across Canada. Some of these programs have also partnered with provinces health services to serve off-reserve First Nations people and receive a portion of funding from those local health authorities.

In recent years, the urgency and complexity of issues facing communities has increased considerably. Prescription drug abuse has emerged, for example, as a major issue in many communities, and the recognition of the unique treatment needs of certain populations (e.g., youth, women, and people with mental health issues), has also become more defined. Likewise, the number of people who specifically link their trauma and associated substance abuse issues to Indian Residential Schools and child welfare experience has also increased. There is broad recognition of the need for strong health promotion, prevention, early identification and intervention services defined within Indigenous knowledge frameworks and developed within the context of community development for the rapidly growing First Nations youth population. These factors have dramatically changed the landscape upon which systems were originally designed. With diverse systems across various jurisdictions and increasingly complex needs, a challenge for First Nations communities, regions, and all levels of governments is to coordinate a broad range of services and supports to ensure First Nations have access to a culturally safe, comprehensive client centered continuum of care.

In response to this need, in 2007, the AFN, the National Native Addiction Partnership Foundation (NNAPF), and the Health Canada-FNIHB oversaw a comprehensive, community-driven review of substance use-related services and supports for First Nations people in Canada. This led to an extensive process of engagement and feedback, culminating in the publication in 2011 of *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada.*

Addressing substance use issues among First Nations people in Canada is incomplete without attention to mental health and intergenerational trauma that underlies and co-exists with substance use issues. However, the deficit-based approach to addressing substance use and mental health issues of individuals does not go far enough to realize outcomes needed for First Nations families and communities. To build on the work of the *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada,* First Nations people in Canada have articulated the relationship between substance use and mental health issues within a strengths-based concept of “mental wellness” that is rooted in identity and culture.

With this in mind, First Nations communities and leadership called for the development of a coordinated, comprehensive approach to mental wellness programming. In response, the AFN, Health Canada-FNIHB, and Indigenous mental health leaders from various First Nations non-government organizations including the National Native Addictions Partnership Foundation and the National Native Mental Health Association,

jointly developed the First Nations Mental Wellness Continuum Framework (the FNMWCF). The FNMWCF, released in 2015, is not an inventory of what is required in each and every First Nation. It is up to First Nations themselves to identify what they need to support mental wellness. Rather, the FNMWCF describes how First Nations can work to enhance service coordination and support culturally safe delivery of services. Essentially, the Framework supports First Nations communities in planning and driving culturally-relevant programs and services for wellness that include health promotion, prevention, community development and education, early identification and intervention, crisis response, coordination of care and care planning, detox, trauma-informed treatment, and support and aftercare.

A critical characteristic of the FNMWCF is the primary reliance on Indigenous cultures for facilitating mental wellness. Implementation programs and services with Indigenous "culture as the foundation" requires a paradigm shift from a deficit focused approach to one that relies on Indigenous knowledge and culture to support a strengths-based approached to care. Simply, addressing First Nations mental wellness requires change in the way governments do business. This includes working horizontally work across governments and between departments, with First Nations as key partners in governing mental wellness.

CULTURE AS THE FOUNDATION FOR MENTAL WELLNESS PROGRAMMING ACROSS THE LIFE SPAN

In most Indigenous cultures there are "Stages of Life" teachings that focus on the path of life from birth to death. To address the current environment of mental wellness among First Nations in Canada, it is critical to ensure that we draw upon these teachings to inform practice, including mental wellness programs and services across the life span. This includes the need for supporting culturally-based programming in pre-natal development, birthing, childhood, adolescence, adulthood, as Elders, as well as through death and post-death. Stated simply, communities should be supported to develop their own culturally-defined standards of care related to the design, development and ongoing monitoring of mental wellness programs and services across the lifespan. Culturally defined standards of care ensure First Nations expectations guide the use of indigenous knowledge to design, develop, and monitor the continuous improvement of services to promote mental wellness.

The following describes some examples of what "culture as foundation" could be used in the planning and operationalizing (as standards of care) of mental wellness programs across the lifespan.

1. **Pre-birth** – cultural practices that focus on connection with family, lineage and clan family through visiting the fetus and care for mother. Before birth, cultural practices included important activities to ensure a good and safe journey of the baby into the world are especially critical even if there are pregnant women with addictions to alcohol or drugs, including opioids. These cultural practices can occur alongside other treatment methods Cultural practices alongside the use of opioid agonist treatment can include: singing cultural songs about identity to the fetus, cultural teachings from Grandmothers about the developing fetus, talking to the fetus about their identity as defined by their nation, clan, land, lineage and singing to the fetus using indigenous language, use of cultural foods and teas, and ceremonial practices focused on giving thanks to creation for the new life that is coming are some examples.

   Hearing is the second sense to develop in the womb and is critical for attachment to family and identity prior to birth.

2. **At Birth** – cultural practices that focus on connection to the earth, early bonding with family, and expose the baby to culture and languages. For example, the placenta and umbilical cord are returned to the earth to ensure bonding with the land and for long term connection to a place of belonging. Skin to skin contact through breast feeding is important for attachment of the spirit of the newborn to mother and the physical world. Birthing and early life is also a vital opportunity for the transmission and nurturing of Indigenous languages. This relates to life promotion in that Indigenous language-use is a marker of cultural continuity, which is proven to be a protective factor for suicide.

   Other aspects of life promotion in early life include the use of a cradle board or moss bag to promote secure attachment. The cradle board/moss bag allowed the baby to observe all of life around them and is a critical method for learning. The cradle board is dressed with the identity of the family and community in both design of the cradle board or moss bag, the beadwork and decoration. Anything that is part of the cultural identity derived from the family lineage, linguistic nation, the spirit name of the baby is crafted in articles or beadwork, some of which is hung from the cradle board hoop above the baby's face similar to musical mobiles hung about a baby's crib, except in the case of the cradle board/ moss bag, are directly connected to identity and a sense of belonging.

3. **Childhood: Good life** – cultural practice and teachings for the childhood years focus on developing a sense of self in relation to others. The use of Indigenous language is important for supporting a connection to indigenous world view. During this stage of life, it is important that children are validated for their cultural vision and that they have access to Elders and cultural teachers that can teach them about life from a cultural perspective during their "why" stage of development. It is also at this stage of life that cultural practices focus on teaching children their lineage and connection to creation around them.

4. **Adolescents: Fast Life** – cultural practices for adolescents focus on teaching skills for patience while developing a sense of social belonging and a connection to physical sense of self. This is done through specific cultural practices that teach youth about their identity and specifically facilitate processes to explore purpose of their life. Every nation has unique cultural practices specific to the rites of puberty. It was through these rites of puberty that adolescents became connected to a vision for life – and these types of activities facilitate the development of delayed gratification skills, understanding spiritual meaning and purpose in life. Family and community can nurture the inherent gifts towards expression. As an example, there has been demonstrated success in decreasing teen pregnancies and sexually transmitted infections through the inclusion of cultural teachings on physical development and rites of puberty delivered by community "Grandmothers" in schools.[133]

5. **Young Adult: Wandering/Wondering life** – cultural practices related to young adulthood grounded in family and community, identity, worldview and beliefs support exploration of other worldviews and how life is lived by others. This process of moving from the original source of life (family and community) is about integrating or negotiating other ways of thinking and being in the world to establish a sense of meaning about life. Throughout this process of exploration, there is a need for continued connection with culture, such as Elders, to process two world views and how to live life grounded in cultural identity in a contemporary context. The risk at this stage of life is not being able to find "meaning" to life either at home in family and community or elsewhere. If there is no meaning, then there is a risk that the person may begin to think there is no worth in continuing life, or they may move towards drug or alcohol misuse.

[133] Tina Gargan, Fort Providence, NWT (2016). Community Discussions of Cultural Practices that make a difference.

6. **Adult: Truth life** – cultural practices support processes to apply the meaning in an environment that celebrates cultural identity, promotes cultural safety and ensures Indigenous knowledge is translated into practice. At this stage of life, it is said that truth is anchored in the physical and spirit world via identity, worldview, values, beliefs, family, community, relationships, and an attitude towards living that includes knowing that answers are always possible even in the most difficult times. Truth life is about practicing life, trying out answers and ways to solve life's dilemmas, and through discovering the truth of one's own capacity. Without a strong grounding in culture, the risk is that we allow our truth be defined by someone else's teachings and worldview.

7. **Continuity: Planting life** – cultural practices at this stage of life are about ensuring continuity of culture and identity. This requires supports for Indigenous parenting, including the extended family and relying upon Aunts, Uncles, and Elders for cultural teachings about family and child rearing. An essential aspect of programs and services is supporting activities for "cultural ways of doing and being." Culturally-based mental wellness services are provided within First Nation school environments. Knowing oneself supports how one acts on their responsibilities defined within cultural identity, or other ways of giving life and supporting the continuity of life. Nurturing and expression of life are critical at this stage of life.

8. **Fulfilling Purpose: Doing life** – Cultural practices at this stage of life focus on supporting the expression and use of the developed gifts, potential, capacity and purpose. In practice, the workforce is acknowledged and compensated for cultural knowledge and skills. First Nations communities have capacity for applying cultural knowledge and skills across programs and services promoting mental wellness. Having a strong sense of hope, belonging and meaning in life, now you are ready to live life fulfilling your purpose to family, community, and creation.

9. **Elder: Give away life** – cultural practices at this stage of life are about ensure that culture-based knowledge and skills continue to the next generations, teaching and giving to all those coming behind. This requires that Elders, cultural practitioners, and cultural teachers are a critical part of the workforce addressing substance and mental health issues. Without connection to culture as the foundation, the risk at this stage of life is loneliness. If there is no connection to family and community or no one who wants to carry the culture to the next generation, then Elders become lonely which can impact their cognitive ability (dementia) or their emotional wellness (generating anger and resentment)

10. **Death and the Journey of the Spirit** – cultural practices at this stage of life focus on care for the spirit journey and care for the family that is left behind. There are cultural protocols regarding burial and timing for such.

CONTINUUM OF ESSENTIAL BASKET OF SERVICES

"We take care of our own people. We need to be able to see what they need. If they need a medicine, if they need a song. That is our responsibility on this side – to walk as far as the grave. From there the other side takes over. That is where we are supposed to walk with our people."

-Elder Elva Jamieson, Traditional Healer, Six Nations of the Grand River

LAND BASED SERVICES

First Nations worldviews are said to be "wholistic," that means that they encompass all aspects of life: the physical, mental, emotional and spiritual. The understanding that First Nations people need to have a "connection to land" expresses that wholistic vision of interconnectedness: we have a dependency on the land not only for food and shelter *but also for a place of belonging that informs both our individual and our collective identity*.[134]

The term "land-based services" has been used primarily in northern Canada to describe cultural-based activities that facilitate healing and wellness and are being relied upon more and more with the resurgence of cultural practices within formal programs and services such as NNADAP/NYSAP treatment centers and First Nations communities. They are based on the notion that "***being on the land itself heals.*** This traditional knowledge is further supported by current biomedical research documenting in detail the many health and healing benefits of spending time in the outdoors including improved cognition, memory and mood."[135]

INNOVATION

In Trauma, Justice and Healing in Hollow Water

Underlying both opioid addiction and suicide is the issue of sexual abuse. Sexual abuse in First Nations communities is an expression of intergenerational trauma.

Community members within the Hollow Water First Nation in Manitoba recognized that sexual abuse was a major issue in their community that wasn't being addressed, so a few women and one man took it upon themselves to start having quiet coffee conversations to determine plans of action. A community walk was organized in attempts to lift the veil of secrecy. Following that, they came to the conclusion that sending perpetrators/victimizers to jail was doing little to neither rehabilitate them nor provide adequate healing for the victims. As such they began using restorative justice circles and founded the Community Holistic Circle Healing (CHCH) process. The CHCH program based its program on Midewiwin teachings to develop a 13-step program. Midewiwin means "way of the heart" and is a sacred society of the Anishinabe people. It is a medicine society as well as a teaching center of an Indigenous world view and teachings about all aspects of life.

A program evaluation found that, "for every $2.00 the Provincial and Federal government spends, the community receives well over $6.21 to $15.90 worth of services and value-added benefits."[1]

[1] Native Counselling Services of Alberta (2001). A Cost Benefit Analysis of the Hollow Water Community holistic circle healing process. Published by the Solicitor General of Canada and the Aboriginal Healing Foundation.

[134] L.J., Kirmayer, C. Tait and C. Simpson C. (2009), The Mental health of Aboriginal Peoples in Canada: Transformations of Identity and Community, In L. J. Kirmayer & G. G. Valaskakis (Eds.), Healing Traditions: The Mental health of Aboriginal Peoples of Canada, Vancouver: UBC Press, 2009.
[135] Redvers, Jennifer. 2016. "Land-Based Practice for Indigenous Health And Wellness In Yukon, Nunavut, And The Northwest Territories". Graduate Program in Environmental Design, University of Calgary.

An environmental scan of land-based services across communities and treatment centers revealed a variety of practices; included repeated weekend cultural camps designed for youth leadership development, week-long cultural camps designed to teach cultural life skills to prevent suicide, and land based camps as the milieu for more structured healing and wellness programs within national mental wellness teams, within NYSAP treatment programs, community based programs and within child welfare programs. Research found that land-based practice is a highly effective way of supporting Indigenous youth and adults' reconnection to the land, their identities, and cultures in a rapidly changing world.[136] The following recommendations to support land-based wellness initiatives have been adapted from the work of Jennifer Redvers:[137]

- Expand definitions of mental health and wellness to include the land.
- Recognize at a policy level that colonial disruption and rapid relocation of Indigenous people from the land has led to the negative health problems we see today (addictions, diabetes, and suicide) and thus returning to land practices to reconnect with cultural identity can work to correct these health outcomes.
- Provide opportunities for ongoing core funding of initiatives, including the cost of capital and minor capital resources.
- Provide more flexibility for all employees and students to access the land.
- Provide evaluation support/training for program leaders to capture the benefits and improve programming over time.
- Make Indigenous youth land engagement a priority so that youth at a young age develop cultural resilience, active lifestyle, and healthy diet as prevention of further health challenges later in life.
- Allow for flexibility in program design and outcomes to support culturally appropriate learning and Indigenous knowledge transfer while on the land.
- Support training for those who want to design, lead, run and evaluate these programs, especially young adults (engagement, coursework, land-based skills, safety training, mentorship by Elders and others).

CRISIS RESPONSE & PREVENTION

"It is becoming increasingly clear that many approaches to addressing the problem of suicide are less about implementing discrete suicide prevention programs, and more about creating the conditions for Indigenous communities to flourish, preserve their languages, reclaim their land, recover their cultural and spiritual practices, and exercise their sovereign rights to be self-determining, These are compelling life promoting practices that also hold the seeds for social transformation and deserve serious consideration"

-Dr. Jennifer Whyte, Dr. Chris Musquash, (2016)

International Forum on Life Promotion to Address Indigenous Suicide Discussion Paper

Related to suicide crises, the current paradigm of flying "saviours" into First Nations communities is not based on evidence that this helps with the long term stability for communities. Long-term community stability can only be created through comprehensive community based approaches that aim to strengthen community resources, including cultural resources.

The ability to respond effectively to crises is dependent on effective crisis planning and timely access to necessary resources, supports, and services. At the community level, this may involve access to external supports to help communities respond to the immediate needs of individual clients and families beyond

[136] Ibid.

[137] Ibid.

what the existing community workforce can provide. It may also mean defining a plan to address the underlying causes of the crisis and facilitate ongoing care and support. At the individual and family level, crisis response requires access to community-based and external supports to respond to urgent needs, assist with stabilization, and where needed, transition clients to other services or aftercare. A crucial component of crisis response is coordinated and timely follow up and debriefing at both an individual and community level. The establishment of crisis response plans was one of the most critical gaps identified across regions.[138] The traumatic impact of crisis on a community cannot be underestimated.

Building capacity for community based crisis response and prevention requires resources to support First Nations in implementing a First Nations Service Delivery model that:

- Differentiates crisis and emergency;
- Builds capacity from within First Nations communities for safety;
- Promotes community healing through restorative justice over criminalization;
- Identifies roles and responsibilities within the community;
- Identifies roles and responsibilities with external support;
- Articulates culturally based principles and practices for intervention;
- Provides resources to ensure effective communication systems;
- Ensures post crisis/emergency support; and,
- Includes First Nations youth in designing life promotion strategies.

COMMUNITY-BASED OPIOID TREATMENT & CAPACITY

In Ontario between 1991 and 2007, the number of prescriptions for oxycodone increased by 850%.[139] Regarding the use of opioids without a prescription, one study in Ontario confirms "the extraordinarily high prevalence of opioid addiction in First Nations communities. Among adults age 20-50 years, 28.0% were on buprenorphine-naloxone, double the rate of adults in these communities who have been diagnosed with Type 2 Diabetes (14.1%)."[140] Other First Nations community-led surveys in several northern Ontario communities reported a prevalence of prescription opioid abuse between 35% and 50%. Other studies report that "a three-fold increase in the number of Aboriginal people (mostly First Nations) seeking treatment for addiction to prescription opioids in Ontario occurred from 2004 to 2009."[141] While we do not have any similar studies in southern Ontario we know the issue is growing there as well. In contrast, in 2012 the number of Canadians reporting having misused opioids in the past year was just .9% of the population.[142]

Certainly, the challenge of opioid addiction is present in many First Nations across Canada, complicated by the recent spike in fentanyl and carfentanil use that is moving from the west coast, eastward. Greater capacity is required within First Nations and First Nations-mandated organizations to develop culturally-relevant community-based opioid programs/ services and strategies from prevention,

---

[138] Health Canada and the Assembly of First Nations, *First Nations Mental Wellness Continuum Framework* (Health Canada: 2015). Page 16

[139] Irfan A. Dhalla, et. al., "Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone," *Canadian Medical Association Journal* (December 2009): pg. 893.

[140] Mamakwa, S. et al (2015). Evaluation of six remote First Nations community-based buprenorphine programs in Northwest Ontario (in press).

[141] Dinah Kanate et al., "Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence," *Canadian Family Physician* 61 (February 2015).

[142] Health Canada, "Canadian Alcohol and Drug Use Survey: Summary Results for 2012," Accessed Dec 14, 2016 < http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/summary-sommaire-eng.php>.

harm-reduction, treatment and after-care/ongoing supports. In addition, given their unique perspectives, there must be capacity to support the inclusion of youth, Elders and women in the development and administration of these programs.

Rather than utilizing treatment centres far away from communities, there must be support for the development of Community-Based Treatment as a Best Practice. First, this requires support capacity within First Nations in developing, implementing and governing opioid treatment and prevention activities. For example, capacity support must also be available to communities to engage and develop governance around opioid misuse strategies. Capacity funding must be flexible to ensure support for cultural and clinical practices in a multi-disciplinary fashion.

Beyond capacity development needs, communities must be provided the resources to offer better treatment options for opioid misuse including:

- core funding for First Nations governed harm reduction strategies and land-based opioid treatment programs;
- supporting people in opioid agonist treatment to have an active role in community and for the community through employment and skill development; and,
- supporting a “community of practice” for health directors and program staff engaged in addressing opioid misuse to share/collaborate/discuss difficulties and successes.

INNOVATION

In Early Intervention and the Buffalo Riders Program

A training module developed and administered by the Thunderbird Partnership Foundation, the Buffalo Riders program uses a train-the-trainer model to support youth ages 11-13 that are indicated as at risk for substance misuse. The five-day training program for facilitators includes the latest research and culturally specific teachings about youth resiliency, risk and protective factors, and developmental assets/factors which research has identified as critical for young people’s successful growth and development.

WORKFORCE CAPACITY & WAGE PARITY FOR NNDAP COMMUNITY BASED AND NNADAP/NYSAP TREATMENT CENTER

Studies have shown that there is a significant social return on investments (SROI) on capacity building investments as described in this report. For example, one pilot program at a treatment centre found that every dollar of funding invested in a year provided a social return of $3.85 over three years. [143] Another study calculated the SROI of providing trauma-informed, culture-based treatment for pregnant and

[143] Health Canada and the Public Health Agency of Canada, Office of Evaluation, *Evaluation of the First Nations and Inuit Mental Wellness Programs 2010-2011 to 2014-2015* (Ottawa: July 2016) pg.35.

parenting women for one year, followed by support for two more years, was $4.21 per $1 invested. The study also noted that, "given the profile of the women involved, and their likelihood of success with the right support, the SROI may well be closer to $25 per $1 invested." [144]

Data drawn from the national reporting systems for the National Native Alcohol and Drug Abuse Program (NNADAP) and the Substance Abuse Information System, provides a profile of clients in the NNADAP. The data indicates that for at least 51% of clients in NNADAP over a 16-year period, alcohol was the primary substance abused and that 34% of clients presented with a cross addiction between alcohol and narcotics. Data from 1989 to 2000 indicates a national recidivism rate of 30.6 %. Other key findings including:

- Majority of clients (82.2%) entering treatment use more than one substance. 90.3% are addicted to alcohol, followed by cannabis, cocaine, opioids,
- 71.2% of clients terminate use of alcohol post-treatment, 67.4% terminate use of cannabis,
- 81.8% terminate use of cocaine and 72% discontinue misuse of opioids,
- Of those who did use post-treatment, 94.9% use less than pre-treatment use,
- Post-treatment supports most used are cultural /social 71.4% and cultural spiritual 72.2%
- Post-treatment clients report in average of 90% they have more control over their life, improved positive relationships, can ask for help when needed, have a sense of purpose,
- 33.6% of opioid using clients have diagnosed or suspected mental health disorder, and,
- 28.2% of non-opioid using clients have a diagnosis/ suspected mental health disorder.

NNADAP and the Youth Solvent Abuse Program (YSAP) have expanded their scope of practice to respond to the changing needs of First Nations and Inuit. Treatment methodology has also changed thus expanding their approach from a generic residential program to include community-based day treatment, outpatient care, land-based treatment, and more linkages to support clients entering treatment with opioid agonist prescriptions, prescriptions for psychological diagnosis and for chronic health conditions. NNADAP and YSAP have also modified their existing treatment programs to be more reflective and relevant of population needs, specifically for addressing intergenerational trauma by formalizing their approach to address concurrent disorders, partnering with child welfare to be more responsive to the needs of women and families addressing addictions issues as a measure of conditions for getting their children back from foster care, and finally in response to the changing legislation for conditional discharge sentencing which mandates treatment for some criminal offenses.

The competency of the workforce has also met these challenges by pursuing high quality, accredited education and training leading to certification. In a 2005 national workforce survey conducted by the Canadian Center on Substance Abuse, it was reported that rate of certification as an addictions counsellor was fairly low across Canada, from 3% in Ontario to 15% in Atlantic Canada and in other provinces the rate of certification ranged between 24% and 57%. For NNADAP and YSAP, the national rate of certification has been continuously increasing and in 2012, the national rate of certification as an addictions counsellor was at 71%.[145]

[144] Deborah Chansonneuve, *Business Plan for a Residential Treatment Facility Serving Indigenous Women and their Children in Ottawa,* (Minwaashin Lodge-Aboriginal Women's Support Centre: Ottawa, March 2011) pg. 4.

[145] Health Canada, First Nations and Inuit Health Branch, *NNADAP & YSAP Treatment Center Report*, 2012/2013 (unpublished).

INNOVATION

In Jurisdictional Collaboration: Onen'to:kon Healing Lodge

The Onen'to:kon Treatment Centre has been assisting clients with alcohol and drug dependence since 1987. Estimates place the number served at over 3500 clients, largely from Kanehsatake, Kahnawake, Akwesasne and Montreal's urban Indigenous population. Financial support has historically come via Health Canada's NNADAP program. The program centres on a six week rehabilitation program that is grounded in trauma-informed culturally-based care.

In recent years the Healing Lodge recognized a shift towards clients seeking treatment for the use of opioids such as fentanyl. This shift led the Healing Lodge to seek a partnership agreement with Montreal's St-Luc Hospital, part of the Centre hospitalier de l'Université de Montréal, to provide 48 hour detox for clients prior to entering the Healing Lodge program as well as ongoing support within the six-week program. For its part, Health Canada agreed to provide "***access to opioid detoxification, a doctor near the person's community, and alternative clinical support if necessary, once clients are released from the healing lodge and return to their communities.***"

- Daniel J. Rowe, "Kanesatake treatment centre, Montreal's St-Luc Hospital forge new path Montreal Gazette, April 6, 2016.

Numerous sources highlight the need for wage parity and workforce development, including an appropriately trained certified workforce which is financially compensated in accordance with provincial equivalents, and which recognize established First Nations standards.[146] For decades, wage parity between NNADAP/NYSAP and mainstream workers has been an issue in Canada. In 1991, Health Canada set out base financial compensation for treatment centres using a funding formula[147], which has not since been evaluated or reformulated, and at that time salaries had been directed at a level of at least 10% lower than mainstream programs.[148] At some point, funding formulas were abandoned and it appears the same amount of funding was disbursed each year with a small annual increase. In addition, the National Anti-Drug Strategy funding is not part of core funding and cannot be used for salary enhancements.[149]

A recent study of the financial needs of the NNADAP/NYSAP programs within Ontario alone demonstrated the need for immediate and significant investments. Additional investments required to provide wage parity to current workers (including counsellors, managers and administration staff, both treatment centre and community-based) totals over $6.14 million/year. To meet the additional human

[146] Assembly of First Nations, Health Canada, National Native Addictions Partnership Foundation, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada* (Ottawa: 2011). Chiefs of Ontario, *Ontario Region First Nations Addictions Service Needs Assessment Final Report*, (Williams Consulting: March 28, 2009).; Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario, *Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment: Final Report*, (March 2015).; AFN, Health Canada, *Mental Wellness Continuum Framework*.; Rod McCormick and Darryl Quantz, *Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program* (March 2010) < http://nnadaprenewal.ca/wp-content/uploads/2012/01/improving-mental-health-services-and-supports-national-native-alcohol-and-drug-abuse-program.pdf>.

[147] Government of Canada, *Memorandum: NNADAP Treatment Centres Formula- Meeting Minimum Standards* (February 12, 1991).

[148] Ontario Regional Addictions Partnership Committee (ORAPC), *Briefing Note for the Chiefs of Ontario*, (July 18, 2013).

[149] Ibid.

resources currently required within the Ontario region totals over $29 million/year. In addition, given the decades of consistent underfunding, supporting program operating costs that meet community-needs requires a new investment of over $13.7 million annually. In total, this represents a 47% increase in investments for human resources and a 52% increase for operational costs. Keeping in mind, once again, that these cost estimates represent the Ontario region only. Using these numbers as a baseline, the required investments on a national-level for wage parity, additional human resources and operational costs is $232.29 million/annually.

ACTION

ON MENTAL WELLNESS AND ADDICTIONS

- That the F/P/T governments work with First Nations within their jurisdictions to develop culturally appropriate policy and programming responses to substance use including prevention, early intervention, treatment services, harm reduction, clinical treatment, and after care and supports. This includes support for traditional healing and Elder support.

- That the F/P/T government work with First Nations to ensure there is a seamless continuum of care between jurisdictions.

- That Health Canada-FNIHB ensure wage parity for community-based workers within mental wellness and additions programming (specifically the National Native Alcohol and Drug Abuse Program and the National Youth Solvent Abuse Program), as well as ensuring adequate operational costs. This is estimated at an additional $232.29 million/annually.

- That Health Canada- FNIHB fully fund the implementation of the First Nations Mental Wellness Continuum Framework.

THE NON-INSURED HEALTH BENEFITS PROGRAM

The Non-Insured Health Benefits (NIHB) Program of Health Canada provides supplementary non-insured health benefits to eligible First Nations and Inuit individuals across Canada. These benefits include prescription and over the counter medications, medical supplies and equipment, dental services, vision care services, medical transportation and crisis intervention counselling.

In 2014/15 the NIHB program expenditures (excluding administration costs) were $1.029 billion. Utilization rates vary significantly across benefit areas. For example, in 2014/15 eligible clients utilize pharmacy benefits at a national rate of 61%, a 3% reduction from 2010/11. More problematic is the low utilization and expenditure rates of the dental and mental wellness benefits; the national utilization rate for dental was 34% in 2014/15 and the total expenditures for the mental wellness benefit across Canada were $15.3 million in 2014/15.[150] [151] These low utilization and expenditure rates can be attributed, in part, to poor overall communication about the available benefits and, particularly in the case of dental, a hesitation or unwillingness of First Nations clients to try to navigate the onerous NIHB approvals process. This is particularly problematic in the case of dental as prevention and maintenance is vital in terms of overall health, and in terms of long-term cost savings.

The NIHB program is perhaps the most frequently cited grievance related to Health Canada-FNIHB programming due to many factors including inadequate coverage, lack of timely access, inconsistent adjudication of claims and burdensome administrative processes. The fact that the NIHB program is virtually uniformly disliked by First Nations clients and leadership speaks to the need for fundamental changes. Improved services and access to NIHB is essential to addressing systemic inequities between First Nations and Canadians in health status and access to quality care, at individual, community and national levels.

The AFN is seeking commitment from Health Canada-FNIHB to implementing meaningful program and policy changes identified in the NIHB Joint Review.

[150] Identifying the utilization rate of the mental health benefit is difficult to determine as the benefit is administered through a combination of contribution agreements and management at Health Canada-FNIHB regional offices.

[151] Health Canada, First Nations and Inuit Health Branch, *NIHB Annual Report 2014/15*, (March 2016) < http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/non-insured-health-benefits-annual-report-2014-2015-rapport-annuel-services-sante-non-assures/alt/nihb-ar-2014-2015-ra-ssna-eng.pdf> (accessed December 1, 2016).

Many First Nations view the NIHB program as emanating from the fiduciary obligation of the Crown and the Treaty right to health. From this perspective, Health Canada's view of NIHB as supplementary coverage or the "Payer of Last Resort" is not in keeping with fiduciary or Treaty obligations. Further, a fixed funding envelope, and thus a program focused on cost containment, is not amenable to evolving demographic, health status and other trends. Funding must be matched to health needs on an ongoing cycle to ensure sustainability of the Program. In contrast, Health Canada views the provision of health benefits through NIHB simply as a matter of policy, rather coming from any moral, legal or Treaty obligation.

Added to the moral and legal problems with Canada's claim to be the payer of last resort, is that many provinces consider themselves the payer of last resort and have, at times, not provided coverage to First Nations with the expectation that NIHB is responsible. In this disagreement, First Nations clients can remain stuck in a cycle of delay and denial. As one example, the NIHB program claims to align with provincial and territorial health coverage in terms of what is on the formulary; while on paper this may be true, the difference is in the details. For example, the province of Manitoba provides immediate access to Aprepitant- a drug taken in advance of chemotherapy to prevent nausea and vomiting- to all Manitoba residents except for status First Nations. As a result these clients must access NIHB for coverage; however, unlike in Manitoba, access to the drug through NIHB requires prior approval. This is an unnecessary delay that risks deferring the start of treatment for First Nations cancer patients. This is just one example of numerous cancer-related drugs on listed as limited use benefits. In addition, there are many anti-neoplastic agents covered by the Manitoba plan and available without delay to all but status First Nations, which are not listed on the NIHB formulary. Accessing these life-saving drugs requires patients navigate through the Drug Exception approval process. These drugs include Dasatinib, Everolimus, Lenalidomide, Thalidomide, Nilotinib and Sorafenib.

Currently the AFN and Health Canada-FNIHB are engaged in a Joint Review of the NIHB program. The objectives of this review are to enhance client access to benefits, identify and address gaps in benefits, streamline service delivery to be more responsive to client needs, and increase program efficiencies. The Joint Review process is guided by a Joint Review Steering Committee comprised of First Nations leadership, members of the National First Nations Health Technicians Network and regional First Nations NIHB Navigation staff. FNIHB membership includes Deputy Ministers, Regional Executives, NIHB Headquarter Executives and NIHB Regional Directors. The review was initiated in May 2015 and is expected to be complete March 2017. The review includes data collection and analysis of all NIHB benefit areas including through literature reviews, client and service provider surveys, community visits, a service provider forum and a comprehensive review of previous program reviews and recommendations. In addition, the Joint Review reports will include a number of recommendations to improve the functioning of the NIHB program with the Steering Committee developing an implementation plan for each benefit area. The AFN is seeking commitment from Health Canada-FNIHB to implementing meaningful program and policy changes identified in the NIHB Joint Review. Implementation will also require significant new investments going forward. First Nations leadership and NIHB clients have invested significant expectations in the Joint Review and deserve to see the recommended changes realized. It cannot be just another report gathering dust.

The Joint Review is an important opportunity to make policy changes to the program as it presently exists. Indeed, the success to date of the Joint Review is in large part due to the willingness of both parties to set aside disagreements over the foundational aspects of the program. However, there remains a real desire and need to make more transformational changes to the form and functioning of the NIHB program. This requires moving beyond the current program mandate and authorities and address concerns around program accountability, alternative program governance models, program sustainability and funding mechanisms.

ACTION

ON THE NON-INSURED HEALTH BENEFITS PROGRAM

- That Health Canada-FNIHB commits to the full and immediate implementation of the AFN-FNIHB NIHB Joint Review recommendations. This will require significant new investments. Further, the recommendations must be enacted in partnership with First Nations.

- That Health Canada-FNIHB commits to working with the AFN to develop a compliance, reporting and accountability framework for the implementation of the AFN-FNIHB Joint Review recommendations.

- That Health Canada-FNIHB Development of a long-term strategy for funding premised on realistic expenditure and utilization projections. This includes population growth, ageing projections, inflation trends and an annual escalator attributable to utilization, new treatments, changes in the delivery of health services (e.g. shift from hospital to community care), and geography, as well as other cost factors.

- Prior to the completion of this funding strategy, that Health Canada-FNIHB increases the annual escalator to the NIHB program from the current rate of 5% to 8% this will require an additional $35.4 million in 2017 for a total increase of $94.4 million.

- Related to the program as a whole, that Health Canada-FNIHB develop a joint strategic framework for accountability, ensuring First Nations are included in decision-making processes.

- That the F/P/T governments commit to ensuring that disagreements over the payer of last resort and coordination of benefits policies do no impact the delivery of service to First Nations clients and establish mechanisms for dispute resolution between jurisdictions.

FIRST NATIONS HEALTH DATA

CURRENT CHALLENGES

Across the country there is a lack of consistent approaches to collecting and collating First Nations health data for health planning purposes. This makes articulating the specific needs of First Nations related to health programming and impacting health outcomes at the population level exceedingly difficult. It also leaves First Nation communities without the tools and resources to do evidence-based health planning. However, many First Nations communities are recognizing the “Power of Data” in terms of its role in self-determination. First Nations health data is a vital element in determining priorities and measuring progress on health outcomes. Key elements include:

- Utilizing local data to support community health planning and targeting key investments.
- Utilizing local data to monitor and improve the quality and responsiveness of health programs and systems.
- Utilizing surveillance data that is continuous and ongoing to measure changes over time.

This is especially true when it comes to data gathered through community-directed research, and data held and managed by First Nations for First Nations. In order to address health inequities, governments must first work with and support First Nations data initiatives aimed at identifying, measuring and closing gaps in outcomes. These activities will require First Nations to be prepared with strong information management protocols and processes and most importantly, the capacity to respond to data inquiries and enter into effective partnerships and as full and equal participants.

Supporting First Nations capacity is critical to manage the demands for good data governance being placed on them by First Nations individuals and governments, by funders and government agencies, and in the interest of evidenced-based policy and program development.

PRIORITIES

Indigenous peoples have a long and often challenging relationship with research and researchers. The principles of Ownership Control Access and Possession (OCAP®) are fundamentally about supporting First Nations in the setting of standards in how their data is to be collected, protected, used and shared.[152] In addition, OCAP® provides direction to First Nations in the management of their own data as well as the development of their own laws or policies related to data stewardship. A key player in the governance of First Nations' data at a national level is the First Nation Information Governance Centre (FNIGC). The FNIGC is accountable to First Nations primarily through a First Nations Board of Directors which is appointed through regional First Nations governance processes. FNIGC also reports to the AFN Chiefs in Assembly.

Supporting First Nations capacity is critical to manage the demands for good data governance being placed on them by First Nations individuals and governments, by funders and government agencies, and in the interest of evidenced-based policy and program development. With this in mind, Resolution 57/2016 *Funding for Regional First Nations Information Government Centres* was passed at the recent AFN Annual General Assembly (AGA), and calls on Chiefs in Assembly to:

- Recognize Indigenous data sovereignty as a cornerstone of nation rebuilding and direct the federal government to fund the following:
  - Engagement on data governance between First Nations leadership within each respective region.
  - The establishment of a First Nation data governance champion in each region, identified by First Nations regions themselves.
  - The development of fully functional regional First Nations information government centres.
  - Coordination of First Nations regions, data governance champions and national partners to establish a national First Nations data governance strategy

A number of other resolutions were passed at the 2016 AGA which relates to First Nations health data and data governance including:

- Resolution 09/2016, *Support for Community-based Health Surveillance Systems* directs Chiefs in Assembly to:
  - Acknowledge that participating First Nations' inherent and Treaty rights provide for self-determination as it relates to data resulting from these initiatives;
  - Advocate to the federal, provincial and territorial governments to implement and financially support First Nation communities in developing Ownership, Control, Access and Possession (OCAP) compliant community-based tools such as Community-based Electronic Medical Records (cEMRs), First Nation led Client Registries, and Health Surveillance systems that provide an electronic source of truth to track health status, trends and outcomes. These systems will be developed at a standard that supports interoperability with federal/provincial eHealth/Health applications, and such systems will not infringe upon current community initiatives and mental wellness planning.
- Resolution 54/2016 *OCAP® Training Prerequisite for all Federal/Provincial/Territorial Government Employees and Researchers* recognizes the achievements of the FNIGC and the role that OCAP® plays in ensuring the protection of First Nations data rights. As such at the resolution:
  - Directs the National Chief to prepare a letter to the Federal Ministers of Health, Indigenous and Northern Affairs Canada, Employment and Social Development Canada and the various research funding agencies (Canadian Institutes of Health Research, Social Sciences and Humanities

[152] First Nations Information Governance Centre, *The First Nations Principles of OCAP®* < http://fnigc.ca/ocap.html>.

Research Council and others) to state the importance for all employees to take the Fundamentals of OCAP® on-line course to further their understanding of First Nations Data Sovereignty and Information Governance.

Related to mental wellness and addictions, there must be data initiatives that work to ensure the suitability and efficacy of programs through the measurement of culturally meaningful outcomes. First Nations communities and NNADAP/NYSAP programs need increased capacity in terms of staff skills in conducting assessments, using assessment results for care planning, and for using information from aggregate assessments for community health and treatment center planning. In addition, the Addictions Management Information System (AMIS) which is a case management system for NNADAP/NYSAP requires additional investments to support community access and to support relevant data sharing between systems, inform future direction, support program delivery, and ensure client outcomes in wellness are monitored.

ACTION

ON FIRST NATIONS HEALTH DATA

- **That Health Canada-FNIHB provide investments to support engagement with First Nations leadership within each respective region related to the establishment of a First Nation data governance champion in each region, identified by First Nations regions themselves and the development of fully functional regional First Nations information government centres.**

- **That Health Canada-FNIHB work with and support the First Nations Information Governance Centre (FNIHGC) and other relevant organizations in the development of a national First Nations data governance strategy.**

- **That Health Canada-FNIHB support capacity within First Nations communities and NNADAP/NYSAP programs in terms of staff skills in conducting assessments, using assessment results for care planning, and for using information from aggregate assessments for community health and treatment center planning.**

- **That the F/P/T governments work with First Nations in their respective jurisdictions, and the AFN and FNIGC at the national level to develop a set of key common indicators on First Nations health outcomes to measure progress on the Actions identified within this submission.**

CONCLUSION

The First Nations Health Transformation Agenda has sought to provide a menu of policy options and highlight innovative practices with the potential to transform health systems for First Nations. It also seeks to demonstrate the inherent wisdom of First Nations knowledge and systems of health and wellness that hold transformative potential for all health systems in Canada. We are in a new era in the relationship between First Nations and non-First Nations people, the provinces/territories and Canada. When it comes to First Nations in Canada, business as usual has changed. It is incumbent on all levels of government to work with First Nations to transform the relationship, towards one that reflects First Nations inherent and Treaty rights, that respects the *United Nations Declaration on the Rights of Indigenous Peoples* and meets the yardsticks set out in the Truth and Reconciliation Commission of Canada's Calls to Action.

This new era must be built on the recognition that it is First Nations themselves that maintain the right and responsibility to determine their own programming on health and wellness. Therefore, this submission is meant to encourage and facilitate dialogue and negotiations with First Nations, not replace them. Each recommendation towards Canada and the provinces/territories is premised on the idea that moving forward on implementation must be in full partnership with First Nations. Failure to do so would be nothing less than an extension of the kinds of paternalism that has led to the overall poor health outcomes of First Nations seen today. The first step is getting the relationships right!

The current crisis of First Nations health and wellness is Canada's greatest shame; however, working together in an honourable way provides the opportunity to see real and transformational changes within one generation! It is our collective opportunity and responsibility to seize this opportunity for the future generations of First Nations children!

We must collectively seize this historic opportunity to close the health outcomes gap now, and for the future generations of First Nations children!

Works Cited

Allan, B. and J. Smilie. First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada. Toronto: The Wellesley Institute, 2015.

Assembly of First Nations, (2010). *Maternal Child Health- Frequently Asked Questions*. Retrieved from http://64.26.129.156/article.asp?id=2270,

Assembly of First Nations, Health Canada, National Native Addictions Partnership Foundation. *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues among First Nations People in Canada* (Ottawa: 2011).

Assembly of First Nations. "Fact Sheet: First Nations Post-Secondary Education." Accessed November 5, 2016. http://www.afn.ca/uploads/files/pse-fact-sheet.pdf.

Assembly of First Nations. First Nation Elementary and Secondary Education A Discussion Guide. Ottawa, 2011. http://www.afn.ca/uploads/files/education/11-10-31_fn_education_-_a_discussion_guide_final.pdf.

Assembly of First Nations. *Teeth for Life: the First Nations Oral Health Strategy* (2010).

Berube, Kevin. "Why Traditional Healing Has a Place in Modern Health Care." April 25, 2015. Accessed September 10, 2016. http://www.theglobeandmail.com/life/health-and-fitness/health/why-traditional-healing-has-a-place-in-modern-health-care/article24126195.

Boyer, Yvonne. 2003. Aboriginal Health: A Constitutional Rights Analysis. Discussion Paper Series in Aboriginal Health. Saskatoon: University of Saskatchewan.

Boyer, Yvonne. 2014. Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers. 1st ed. Saskatoon: Purich Publishing Limited.

Canada, Government of, Treasury Board of Canada, and Secretariat. "Strategic and Operating Review." February 19, 2016. Accessed November 28, 2016. https://www.tbs-sct.gc.ca/ip-pi/trans/sor-esf-eng.asp.

Canada, Indigenous and Northern Affairs Canada. "Update on the Implementation of the Federal Framework for Aboriginal Economic Development." January 22, 2013. Accessed January 17, 2017. https://www.aadnc-aandc.gc.ca/eng/1357225364409/1357226235936.

Canadian Aboriginal Aids Network. "Aboriginal HIV and AIDS Statistics." May 13, 2012. Accessed November 17, 2016. http://caan.ca/regional-fact-sheets/.

Centre for Suicide Prevention, “Aboriginal Suicide Prevention Resource Toolkit”, 2013.

Chandler, M. J. and C. Lalonde. 1998. “Cultural Continuity as a Hedge against Suicide in Canada’s First Nations”. Transcultural Psychiatry 35 (2): 191-219.

Chansonneuve, Deborah. *Business Plan for a Residential Treatment Facility Serving Indigenous Women and their Children in Ottawa*, (Minwaashin Lodge-Aboriginal Women’s Support Centre: Ottawa, March 2011) pg. 4.

Chiefs of Ontario, *Ontario Region First Nations Addictions Service Needs Assessment Final Report*. (Williams Consulting: March 28, 2009).

Collin-Vézina, Delphine, Jacinthe Dion, and Nico Trocmé. 2009. “Sexual Abuse in Canadian Aboriginal Communities: A Broad Review Of Conflicting Evidence”. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 7 (1): 27-47.

I. A. Dhalla et al. “Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone” *Canadian Medical Association Journal* (December 2009): 891-896.

Dinah Kanate, David Folk, Sharon Cirone, Janet Gordon, Mike Kirlew, Terri Veale, Natalie Bocking, Sara Rea, and Len Kelly. “Community-wide measures of wellness in a remote First Nations community experiencing opioid dependence.” *Canadian Family Physician* 61 (February 2015): 160-65.

Enni, Rachel. “Health Disparities in Canada: A Focus on First Nations Children.” In *Canadian Supplement to The State of the World’s Children 2009*, by UNICEF, 11–20. Toronto: Canadian UNICEF Committee, 2009.

Exner-Pirot, Heather, and Lorna Butler. *Healthy Foundations: Nursing’s Role in Building Strong Aboriginal Communities.* Ottawa: The Conference Board of Canada, 2015.

Fav Com. *PEOLC in First Nations and Inuit Communities*. (January 2016).

First Nations and Information Governance Centre. *First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities*. (Ottawa: 2012).

First Nations Health Authority. Creating a Climate for Change: Cultural Safety and Humility in Health Services Delivery for First Nations and Aboriginal Peoples in British Columbia. n.p., n.d.

First Nations Health Council, “Consensus Paper: British Columbia First Nations Perspectives on a New Health Governance Arrangements,” (n.d.).

First Nations Information Governance Centre, “First Nations Regional Health Survey (RHS) 2008/10: National Report on Adults, Youth and Children living in First Nations Communities,” 2012.

First Nations Information Governance Centre. Our Data, Our Stories, Our Future: The National Report of the First Nations Regional Early Childhood, Education and Employment Survey,. Ottawa, 2016.

First Nations Information Governance Centre. *The First Nations Principles of OCAP®* <http://fnigc.ca/ocap.html>.

First Nations of Quebec and Labrador Health and Social Services Commission, “First Nations in Quebec Health and Social Services Governance Project Review of Health and Social Services Provided to Quebec First Nations and Inuit,” (2015).

First Nations of Quebec and Labrador Health and Social Services Commission. *Assessing Continuing Care Requirements in First Nations and Inuit Communities*. (July 2006).

Gargan, Tina. Community Discussions of Cultural Practices that make a difference. (Fort Providence, NWT: 2016).

Gottlieb, Laurie, Bruce Gottlieb, and Judith Shamian. “Principles of Strengths-Based Nursing Leadership for Strengths-Based Nursing Care: A New Paradigm for Nursing and Healthcare for the 21st Century.” Nursing Leadership 25, no. 2 (June 1, 2012): 38–50.

Government of Canada. *Memorandum: NNADAP Treatment Centres Formula- Meeting Minimum Standards* (February 12, 1991).

Health Canada and the Assembly of First Nations, *First Nations Mental Wellness Continuum Framework* (Health Canada: 2015).

Health Canada and the Public Health Agency of Canada, Office of Evaluation. *Evaluation of the First Nations and Inuit Health Branch Communicable Disease Control and Management Programs 2008-2009 to 2013-2014.* (Ottawa: March 2015).

Health Canada and the Public Health Agency of Canada, Office of Evaluation. *Evaluation of the Healthy Living (2010-2011 to 2012-2013) and Healthy Child Development Clusters (2008-2009 to 2012-2013)*. (Ottawa: November 2014).

Health Canada and the Public Health Agency of Canada. Office of Evaluation. *Evaluation of the First Nations and Inuit Home and Community Care Program 2008-2009 to 2011-2012.* (Ottawa: September 2013).

Health Canada. “Canadian Alcohol and Drug Use Survey: Summary Results for 2012.” Accessed Dec 14, 2016 <http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2012/summary-sommaire-eng.php>.

Health Canada, “First Nations and Inuit Health Facilities and Capital Program- Cluster Evaluation” (March, 2012) <http://www.hc-sc.gc.ca/ahc-asc/performance/eval/hfcp-evaluation-pesi-eng.php#share>.

Health Canada, First Nations and Inuit Health Branch, “Aboriginal Health Human Resources Initiative Presentation” for the Senior Management Committee (May 18, 2016).

Health Canada, First Nations and Inuit Health Branch, “Aboriginal Head Start on Reserve,” (June 15, 2011), <http://www.hc-sc.gc.ca/fniah-spnia/famil/develop/ahsor-papa_intro-eng.php>.

Health Canada, *First Nations and Inuit Health Program Compendium 2011/12* (Ottawa).

Health Canada. “Renewal of Community-Based Aboriginal Health Promotion Programming - Canada News Centre.” July 31, 2015. Accessed January 18, 2017. http://news.gc.ca/web/article-en.do?nid=1012699.

Health Canada. First Nations and Inuit Health Branch. *Draft Preliminary Assessment of Gaps in FNIHB Program Areas presentation*. (September, 2016).

Health Canada. First Nations and Inuit Health Branch. NIHB Annual Report 2014/15, (March 2016) <http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/non-insured-health-benefits-annual-report-2014-2015-rapport-annuel-services-sante-non-assures/alt/nihb-ar-2014-2015-ra-ssna-eng.pdf> (accessed December 1, 2016).

Health Canada. *Health Canada's Strategy Against Tuberculosis for First Nations on-Reserve*. Ottawa: Health Canada, 2012.

Kirmayer, L.J., Tait C., Simpson C. The Mental health of Aboriginal Peoples in Canada: Transformations of Identity and Community. In L. J. Kirmayer & G. G. Valaskakis (Eds.), Healing Traditions: The Mental health of Aboriginal Peoples of Canada (Vancouver: UBC Press, 2009).

Lavoie et al. (2013). Aboriginal Health Policies in Canada: The Policy Synthesis Project. Prince George, BC.

Lavoie. (2016). A Comparative Financial Analysis of the 2003-04 and 2009-10 Health Care Expenditures for First Nations in Manitoba: unpublished manuscript. Winnipeg, MB: MFN-Centre for Aboriginal Health Research.

Lavoie, Josée G., Amohia Frances Boulton, and Laverna Gervais. "Regionalization as an Opportunity for Meaningful Indigenous Participation in Healthcare: Comparing Canada and New Zealand." The International Indigenous Policy Journal 3, no. 1 (March 2012).

Lavoie, Josée Gabrielle, Evelyn L. Forget, Tara Prakash, Matt Dahl, Patricia Martens, and John D. O'Neil. 2010. "Have Investments In On-Reserve Health Services And Initiatives Promoting Community Control Improved First Nations' Health In Manitoba?". Social Science & Medicine 71 (4): 717-724.

Mamakwa, S. et al (2015). Evaluation of six remote First Nations community-based buprenorphine programs in Northwest Ontario (in press).

Mariette Sutherland and Dr. M. Maar for Chiefs of Ontario, *Update of the 2009 Ontario Region First Nations Addictions Service Needs Assessment: Final Report*, (March 2015).

Martens, Patricia et al. 2002. *The Health And Health Care Use Of Registered First Nations People Living In Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

Mathu-Muju, Kavita R., James Mcleod, Mary Lou Walker, Martin Chartier, and Rosamund L. Harrison. "The Children's Oral Health Initiative: An intervention to address the challenges of dental caries in early childhood in Canada's First Nation and Inuit communities." Canadian Journal of Public Health 107, no. 2 (2016): e188-e193.

McCormick, Rod, Dr., and Darryl Quanz. *Improving Mental Health Services and Supports in the National Native Alcohol and Drug Abuse Program* (March 2010) <http://nnadaprenewal.ca/wp-content/uploads/2012/01/improving-mental-health-services-and-supports-national-native-alcohol-and-drug-abuse-program.pdf>.

Mills, Jane, Donna Lennon, and Karen Francis. “Contributing to a Culture of Learning: A Mentor Development and Support Project for Australian Rural Nurses.” *International Journal of Nursing Practice* 13, no. 6 (December 2007): 393–96.

National Aboriginal Council of Midwives, “Aboriginal Midwifery in Canada.” Accessed September 26, 2016. http://www.aboriginalmidwives.ca/aboriginal-midwifery-in-canada.

National Aboriginal Council of Midwives. *The Landscape of Midwifery Care for Aboriginal Communities in Canada*. (March 2016).

National Collaborating Centre for Aboriginal Health. *…with Dad: Strengthening the Circle of Care*, (2011).

National Head Start Association. “Head Start’s Return on Investment.” <http://headstartva.org/wp-content/uploads/2014/08/Head_Start_Return_On_Investment_Brief_LAS-yv.pdf> (accessed August 23, 2016).

Nimkee NupiGawagan Healing Center. (2007). Annual Report. Ontario.

Ontario Regional Addictions Partnership Committee (ORAPC), *Briefing Note for the Chiefs of Ontario*, (July 18, 2013).

Olthuis, Kleer, Townshend LLP. Aboriginal Law Handbook, 4th ed. (Toronto, ON: Thomson Reuters Canada Limited, 2012).

Perron, Sony. Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health. Testimony at the Public Accounts Committee (Ottawa: June 1, 2015).

Place, Jessica. “The Health of Aboriginal People Residing in Urban Areas,” National Collaborating Centre for Aboriginal Health, (2012).

Redvers, Jennifer. 2016. “Land-Based Practice For Indigenous Health And Wellness In Yukon, Nunavut, And The Northwest Territories”. Graduate Program in Environmental Design, University of Calgary.

Robbins, Julian A. and Jonathan Dewar. 2011. “Traditional Indigenous Approaches To Healing And The Modern Welfare Of Traditional Knowledge, Spirituality And Lands: A Critical Reflection On Practices And Policies Taken From The Canadian Indigenous Example”. The International Indigenous Policy Journal 2 (4). doi:10.18584/iipj.2011.2.4.2.

Romanow, Roy J. , Q.C. Building Values: The Future of Health Care in Canada. Report. 2002.

Rotenburg, Christine. *Social Determinants of Health for the Off-Reserve First Nations Population, 15 Years of Age and Older, 2012*. Ottawa: Statistics Canada, 2016.

Smith, Dawn, Seraphina McAlister, Sara Tedford Gold, and Maureen Sullivan-Bentz. “Aboriginal Recruitment and Retention in Nursing Education: A Review of the Literature.” *International Journal of Nursing Education Scholarship* 8, no. 1 (January 2, 2011). doi:10.2202/1548-923x.2085.

Smylie, Janet, et. al., “A Review of Aboriginal Infant Mortality Rates in Canada: Striking and Persistent Aboriginal/Non-Aboriginal Inequities,” *Canadian Journal of Public Health*, (March/April 2010): 143-148.

The Auditor General of Canada. “Chapter 5—Promoting Diabetes Prevention and Control.” April 30, 2013. Accessed September 7, 2016. http://www.oag-bvg.gc.ca/internet/English/parl_oag_201304_05_e_38190.html.

The Auditor General of Canada. *Access to Health Services for Remote First Nations Communities* (Spring 2015).

The Auditor General of Canada. *Report 7: Establishing the First Nations Health Authority in British Columbia* (Fall 2015).

The Canadian Press. “Early Infant Mortality in Canada Called 2nd Worst in Developed World.” May 8, 2013. Accessed July 18, 2016. http://www.cbc.ca/news/health/early-infant-mortality-in-canada-called-2nd-worst-in-developed-world-1.1314423.

The Canadian Press. November 16, 2016. “First Nations Infrastructure Spending ‘Drop In The Bucket,’ Says Philpott “. *Macleans.Ca*. http://www.macleans.ca/politics/ottawa/first-nations-infrastructure-spending-drop-in-the-bucket-says-philpott.

The Jordan’s Principle Working Group (2015). Without denial, delay, or disruption: Ensuring First Nations children’s access to equitable services through Jordan’s Principle. Ottawa, ON: Assembly of First Nations.

The Truth and Reconciliation Commission of Canada. 2015. Final Report of the Truth and Reconciliation Commission of Canada, Volume One: Summary: Honouring the Truth, Reconciling for the Future. Toronto: James Lorimer & Company.

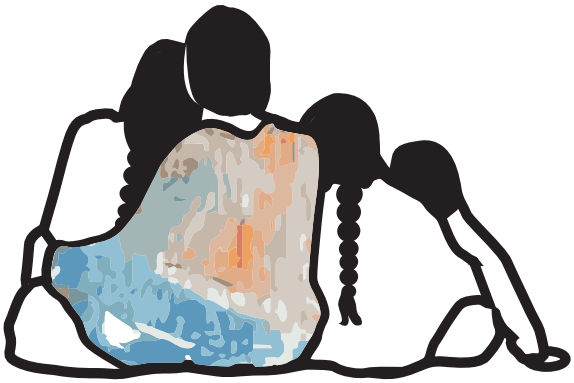
Tjepkema, Michael, Russell Wilkins, Sacha Senécal, Éric Guimond, and Christopher Penney. Mortality of Métis and Registered Indian Adults in Canada: An 11-Year Follow-up Study. Ottawa: Statistics Canada, 2009.

United Nations General Assembly, Our joint commitment to effectively addressing and countering the world drug problem, (S-30/1), Thirteenth special session, (April 19, 2016).

Withrow, Diana R., Jason D. Pole, E. Diane Nishri, Michael Tjepkema, and Loraine D. Marrett. 2016. “Cancer Survival Disparities Between First Nation And Non-Aboriginal Adults In Canada: Follow-Up Of The 1991 Census Mortality Cohort”. Cancer Epidemiology Biomarkers & Prevention 26 (1): 145-151.

World Diabetes Foundation Secretariat, *Expert Meeting on Indigenous Peoples, Diabetes and Development Report.* 2012.

World Health Organization “Health and Human Rights”. December 2015. Accessed July 9, 2016. http://www.who.int/mediacentre/factsheets/fs323/en/.



Appendix A: Compendium of Recommendations

AREA		FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
1	Health in All Policies	The AFN recommends federal, provincial and territorial governments (F/P/T governments) adopt a cross-ministerial Health in All Policies approach with specific attention to the impact on First Nations health.	✓	✓
2	Jordan's Principle	That all F/P/T governments and departments immediately and meaningfully implement Jordan's Principle, as called for the TRC, using the fulsome definition agreed to in the House of Commons in 2007.	✓	✓
3		That the federal government meets the standard set out in the Canadian Human Rights Tribunal including the definition and scope of Jordan's Principle, as well as in terms of collaboration with First Nations related to JP implementation.		✓
4	Overcoming Jurisdictional Chasms	That the federal government, where there is interest from First Nations, engage in a trilateral process with each provincial/territorial governments, and with the First Nations within those respective jurisdictions to come to a clear and actionable shared position on jurisdictional responsibilities.	✓	✓
5		That the F/P/T governments immediately commit to a patient-first principle, in line with Jordan's Principle, for all First Nations people, regardless of age or residency.	✓	✓
6	Supporting First Nations Capacity: Governance And Accountability	That provincial/territorial governments work with First Nations in a shared-decision making capacity when any decisions are taken made that may affect First Nations generally, but specifically in health programming. First Nations themselves will determine the extent of their participation.	✓	
7		That provincial/territorial governments and Health Canada-FNIHB engages with First Nations in their respective jurisdictions to jointly determine a model for working together on First Nations priorities for health services and closing programming gaps. This may include determining a model of authority and governance.	✓	✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
8		That provincial/territorial governments support- both in policy and through stable adequate resourcing- First Nations in developing health centres for the urban Indigenous populations.	✓	
9		That Health Canada-FNIHB restores the recent cuts to First Nations representative organizations, and allows flexibility to ensure that investments to First Nations and First Nations organizations for engagement and collaboration meet the demands on their time and resources.		✓
10		That Health Canada-FNIHB makes meaningful investments, in line with those provided in BC, to building First Nations health governance capacity.		✓
11		That Health Canada commit to working with First Nations and First Nations organizations in transitioning funding currently being provided to mainstream organizations that do work on behalf of First Nations, towards First Nations organizations that are mandated by First Nations themselves and that demonstrate the potential for and interest in taking on that work themselves.		✓
12		That F/P/T governments work with First Nations to explore the development of an Ombudsperson for Indigenous Health.	✓	✓
13		That Health Canada-FNIHB work with First Nations to determine funding levels based, in part, on community membership and citizenship, rather than based on “Indian Status” alone.		✓
14		That any new investments from the federal government on First Nations health must be extended to First Nations in the territories whether they are inside or outside existing self-government agreements.		✓
15	AFN-FNIHB Engagement Protocol	That Health Canada- FNIHB work with the AFN in developing Engagement Protocol accountability mechanisms. This can include requiring program areas to report on their engagement activities, as a deliverable, and to make that reporting available to First Nations and the AFN.		✓
16		That Health Canada-FNIHB work with the AFN to develop training, both for new hires and existing staff, on implementing the AFN-FNIHB Engagement Protocol.		✓
17	Economic Development and Health	That provincial/territorial governments work with First Nations to identify opportunities to support First Nations businesses working in the health care sphere. This support can take the form of partnership development, investment, strategic and pragmatic procurement and enhancing employment activities.	✓	✓

AREA		FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
18		That the federal government work to ensure their Procurement Strategy for Aboriginal Business meets the needs of First Nations businesses including expanding mentorship opportunities. Support should be aimed at capacity building and institutional support, rather than one-off projects.		✓
19		That Health Canada-FNIHB work with First Nations to identify how First Nations businesses can be supported within FNIHB's suite of programs.		✓
20	Supporting Traditional Healing	That the F/P/T governments support First Nations within their respective jurisdictions in (re)building traditional knowledge systems around healing and wellness.	✓	✓
21		That provincial/territorial governments work with First Nations to determine how best these knowledge systems can be included and supported within the provincial/territorial health systems.	✓	
22		That provincial/territorial governments support the establishment of First Nations advocates that can act as systems navigators and cultural translators within mainstream systems.	✓	
23		That Health Canada-FNIHB support, through policy and funding, the formal inclusion of traditional healing within programming including within mental wellness programming (which includes Non-Insured Health Benefits) and the First Nations and Inuit Home and Community Care program. This process must be led by First Nations. As a first step, the AFN recommends that this include an annual investment of $27.9 million.		✓
24	Cultural Humility and Safety	That provincial/territorial governments create financial incentives for universities and colleges to build, with First Nations, mandatory courses on cultural humility/safety for all faculties with a role in health care, including both direct service provision and public policy and administration programs.	✓	
25		That provincial/territorial governments and their respective healthcare regulatory bodies work with First Nations to develop and administer workplans related to ensuring cultural humility in the healthcare field.	✓	
26		That Health Canada work with the AFN to develop and administer cultural humility/safety training for headquarters staff.		✓
27		That Health Canada ensures all healthcare staff in their employ working with First Nations receives mandatory training in cultural humility and safety, particularly nurses.		✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
Health Infrastructure and Support				
28	Community Wellness Planning	That Health Canada- FNIHB work with First Nations to develop an appropriate funding formula for comprehensive community planning aimed at community wellness across program areas and departments, with support for data analysis and planning, and capacity building.		✓
29	Human Resources for Wellness	That all governmental efforts to increase First Nations Human Resources for Wellness build in flexibility that respects First Nations wholistic understandings of health and wellness. This may include engaging departments/ministries beyond departments and ministries of health.	✓	✓
30		That the federal government restore investments in the Aboriginal Health Human Resources Initiative (AHHRI) to 2005-2010 levels totalling $20 million annually, and work with First Nations to ensure the administration of AHHRI reflects First Nations priorities.		✓
31		That the federal government provide loan forgiveness on Canada Student Loans for health professionals (including midwives and doula care providers) working in First Nations communities, similar to what already exists for family doctors, residents in family medicine, nurse practitioners, and nurses who work in under-served rural or remote communities.		✓
32		That provincial/territorial governments develop or expand targeted funds for university and college healthcare programs to increase First Nations participation and success with strategies that may include equity seats, preparatory and transition programs, and bridging programs from licensed practical nurse to registered nurse and licensed nurse practitioner, mentoring and peer support programs, and Elders-in-residence, among others.	✓	
33		That provincial/territorial governments develop and/or expand scholarship and bursary funds for First Nations post-secondary students in healthcare fields.	✓	
34		That Health Canada-FNIHB takes immediate steps to ensure parity with provincial/territorial standards in wages, pension and employee assistance programs for all front-line staff.		✓
35		That Health Canada-FNIHB, in partnership with First Nations, develops a mentorship program including peer support network for nurses working in First Nations communities including providing access to an Advanced Practice nurse 24 hours per day.		✓
36		As a short-term measure, that Health Canada-FNIHB ensures an adequate supply of nurses to temporarily fill positions, allowing nurses to obtain mandatory course requirements.		✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
37	Health Facilities and Capital	That Health Canada-FNIHB increase investments in the Health Facilities Capital Program (HFCP) to reflect demonstrated need, beginning with the existing waitlist but also forward-looking, and to ensure adequate resources for maintenance. Specifically, this will require an initial investment of at least $350 million to clear the existing waitlist, as well as a minimum of $20.9 million ongoing to avoid future waitlists.		✓
38		That Health Canada-FNIHB affirms that the focus of the HFCP program is to build spaces directed towards wholisitic individual and community wellness. This requires built-in flexibility to allow for First Nations themselves to determine their infrastructure needs, which may go beyond simply clinical applications.		✓
39	eHealth	That Health Canada-FNIHB set aside dedicated funding to advancing eHealth initiatives in all First Nation communities based on community needs and priorities. At minimum this requires additional investments of $65 million in 2017 ongoing.		✓
40		That F/P/T governments leverage their authority within Canada Health Infoway (CHI) governance structures to ensure First Nations needs are met, both in terms of representation in governance and levels of investment, within CHI.	✓	✓
41		That provincial/territorial governments work with First Nations within their jurisdictions to develop solutions related to eHealth needs and priorities. This may include a joint strategy that compliments the provincial/territorial eHealth strategy.	✓	
42	Primary Care	That Health Canada-FNIHB work with First Nations, however they choose to constitute themselves (individual community, tribal council, treaty area, region), to ensure First Nations have timely access to an adequately funded comprehensive primary care system that includes inter-professional teams, inclusive of cultural practitioners, and capacity to support community-based opioid treatment.		✓
43		That the F/P/T governments work with First Nations to develop systems- including reporting and accountability mechanisms- that ensure the seamless link between primary and specialized care, including assessment, care planning and discharge planning.	✓	✓
44	Communicable Diseases	That Health Canada-FNIHB take steps to ensure alignment between the Communicable Disease Control and Management (CDCM) program with the mental wellness and addictions programming, including in the implementation of the Mental Wellness Continuum Framework.		✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
45		That the federal government ensure each First Nation has access to adequate resources to meet the 90-90-90 UNAIDS target. As a first step this requires increasing Health Canada-FNIHB's HIV/AIDS funding by a minimum of $16.8 M/year.		✓
46		That Health Canada-FNIHB support First Nations-created and directed communicable disease programs.		✓
47		That the provinces and territories adopt the 90-90-90 UNAID targets with specific investments to support First Nations, both on and off reserve, in achieving it.	✓	
48		That provincial/territorial governments support First Nations-led initiatives on communicable diseases, and ensure meaningful First Nations involvement in all aspects of the development, implementation and evaluation of provincial/territorial communicable disease frameworks including on HIV/AIDS.	✓	
49	Chronic Diseases	That Health Canada-FNIHB increase investment to communities to develop and administer long-term, sustainable and community driven programs on chronic disease prevention and treatment.		✓
50		That Health Canada and related departments account for chronic disease in policy and program work related to food security.		✓
51		Related to data on chronic disease, that F/P/T governments support First Nations data initiatives including, but not limited to, support for the First Nations Information Governance Centre(s).	✓	✓
52		That provincial/territorial governmentswork with First Nations within their jurisdictions to ensure provincial/territorial chronic disease promotion, prevention and treatment efforts meet the specific needs of First Nations.	✓	
53		That all efforts to address chronic disease be focussed on building capacity within First Nations communities.	✓	✓
54	Child and Family Health and Midwifery	Related to cultural safety, that provinces/territories work within their jurisdictions to ensure provincial and territorially-run hospitals provide the space and resources required to ensure ceremony and cultural practices around birthing are fully supported.	✓	
55		That Health Canada-FNIHB's Maternal Child Health Program includes dedicated funding for fatherhood programs.		✓
56		That First Nations children on-reserve/in community have universal access to Health Canada-FNIHB's Maternal Child Health program and expand the program to include children over age six years.		✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
57		That First Nations children on-reserve/in community in have universal access to Head Start programming, requiring an additional annual investment of at least $347 million.		✓
58		That First Nations children on-reserve/in community have universal access to COHI programming, requiring an additional annual investment of $3.5 million.		✓
59		That COHI eligibility be extended to include First Nations youth ages 8-18.		✓
60		That the Treasury Board of Canada should develop an occupational classification for midwives. This will enable Health Canada-FNIHB to hire midwives to work in federal jurisdictions.		✓
61		That F/P/T governments and educational institutions work with First Nations to support the development of Indigenous midwifery training programs.	✓	✓
62		That the Health Canada-FNIHB support First Nations in developing and administering midwifery programs.		✓
63	Home and Community Care	That Health Canada-FNIHB provides an immediate investment to account for the investments lost as a result of no program growth since 1999 (catch up investment). The AFN estimates this at $79.5 million.		✓
64		That Health Canada-FNIHB update the population numbers used to determine investments in First Nations Home Care to current levels. The AFN estimates this at $62.1 million beginning in 2017 and ongoing.		✓
65		That Health Canada-FNIHB fully fund Palliative/End of Life Care within the First Nations and Inuit Home and Community Care Program. The AFN estimates this at $50 million annually of new investments.		✓
66		That Health Canada-FNIHB work with First Nations to determine a needs-based funding formula that accounts for remoteness, levels of community infrastructure, and demonstrated need. Demonstrated need must account for caseload, client base and complexity of needs. In addition, funding must be extended to palliative care and traditional supports.		✓
67		That Health Canada-FNIHB work with First Nations to determine an appropriate and respectful method to ensure funding support for traditional healers and family supports.		✓
68		That Health Canada-FNIHB develop an Emergency Relief Fund that communities can tap into in the event of unforeseen circumstances, to ensure continuity of services.		✓

	AREA	FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
69		That Health Canada-FNIHB, where demonstrable need is established, provide the necessary supports to First Nations to establish and operate long-term care facilities.		✓
70		That provincial/territorial governments work with First Nations within their jurisdictions to ensure that provincially and territorially-run home care programs and services meet the specific needs of First Nations clients.	✓	
71		That provincial/territorial government-run health systems work with First Nations within their borders to facilitate systems of communication between on and off reserve systems to enhance client-centred continuity of care.	✓	
72	Mental Wellness and Addictions	That the F/P/T governments work with First Nations within their jurisdictions to develop culturally appropriate policy and programming responses to substance use including prevention, early intervention, treatment services, harm reduction, clinical treatment, and after care and supports. This includes support for traditional healing and Elder support.	✓	✓
73		That the F/P/T governments work with First Nations to ensure there is a seamless continuum of care between jurisdictions.	✓	✓
74		That Health Canada-FNIHB ensure wage parity for community-based workers within mental wellness and additions programming (specifically the National Native Alcohol and Drug Ab use Program and the National Youth Solvent Abuse Program), as well as ensuring adequate operational costs. This is estimated at an additional $232.29 million/annually.		✓
75		That Canada fully fund the implementation of the First Nations Mental Wellness Continuum Framework.		✓
		Supplementary Health Benefits		
76	Non-Insured Health Benefits	That Health Canada-FNIHB commits to the full and immediate implementation of the AFN-FNIHB NIHB Joint Review recommendations. This will require significant new investments. These recommendations must be enacted in partnership with First Nations.		✓
77		That Health Canada-FNIHB commits to working with the AFN to develop a compliance, reporting and accountability framework for the implementation of the AFN-FNIHB Joint Review recommendations.		✓

AREA		FIRST NATIONS HEALTH TRANSFORMATION AGENDA RECOMMENDED ACTION	RESPONSIBILITY	
			PROV/ TERR	CANADA
78		That Health Canada-FNIHB Development of a long-term strategy for funding premised on realistic expenditure and utilization projections. This includes population growth, ageing projections, inflation trends and an annual escalator attributable to utilization, new treatments, changes in the delivery of health services (e.g. shift from hospital to community care), and geography, as well as and other cost factors.		✓
79		Prior to the completion of this funding strategy, that Health Canada-FNIHB increases the annual escalator to the NIHB program from the current rate of 5% to 8% this will require an additional $35.4 million in 2017 for a total increase of $94.4 million.		✓
80		Related to the program as a whole, that Health Canada-FNIHB develop a joint strategic framework for accountability, ensuring First Nations are included in decision-making processes.		✓
81		That the F/P/T governments commit to ensuring that disagreements over the payer of last resort and coordination of benefits policies do no impact the delivery of service to First Nations clients and establish mechanisms for dispute resolution between jurisdictions.		✓
First Nations Health Data				
82		That Health Canada-FNIHB provide investments to support engagement with First Nations leadership within each respective region related to the establishment of a First Nation data governance champion in each region, identified by First Nations regions themselves and the development of fully functional regional First Nations information government centres.		✓
83		That Health Canada-FNIHB work with and support the First Nations Information Governance Centre (FNIHGC) and other relevant organizations in the development of a national First Nations data governance strategy.		✓
84		That Health Canada-FNIHB support capacity within First Nations communities and NNADAP/NYSAP programs in terms of staff skills in conducting assessments, using assessment results for care planning, and for using information from aggregate assessments for community health and treatment center planning.		✓
85		That F/P/T governments work with First Nations in their respective jurisdictions, and the AFN and FNIGC at the national level to develop a set of key common indicators on First Nations health outcomes to measure progress on the Actions identified within this submission.	✓	✓

Appendix B: Identified New Federal Investments

*** These investments represent an early marker of the kinds of federal investments required in First Nations health. This list is not comprehensive. In addition, as discussions around program and systems transformation progress, additional or different investments may be required.**

PROGRAM AREA	PROGRAMMING REQUESTS	NEW INVESTMENTS
Home and Community Care		$208M in 2017
Palliative Care	Currently not funded	$50M/year
Updated Funding Formula	• Revise funding formula to reflect updated population figures • 3% annual escalator in subsequent years	$62.1M in 2017
Catch-up escalator	• Provide funding that would have accrued if the formula had been updated based on population growth since 1999	$72.5M (one-time request)
Support for traditional healing	• Currently not funded	$23.2M/year
NIHB		$35.4M in 2017
Escalator	• Increase annual escalator from 5% to 8%	$35.4M in 2017
Joint Review Implementation	• The costs associated with Joint Review Implementation are yet to be determined.	
Mental Wellness		$121M in 2017
Supports for Comprehensive Community Planning	• Support for the planning of services across the mental wellness continuum and across jurisdictional barriers	$10M/year
Mental Wellness Teams (MWT)	• Fund 37 additional teams	$19M/year
National Aboriginal Youth Suicide Prevention Strategy (NAYSPS)	• Expand the number of First Nations communities with access to youth suicide prevention projects	$15M/year
National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres	• Infrastructure investments in existing NNADAP treatment centres • NNADAP capacity building and wage parity • Create 5 additional NNADAP treatment centres, including in the North, as per the TRC Calls to Action	$232.29M in 2017

PROGRAM AREA	PROGRAMMING REQUESTS	NEW INVESTMENTS
Healthy Child Development		$232M in 2017
Head Start On-Reserve (HSOR)	• Universal access to HSOR (excluding BC)	$230M/year
Child Oral Health Initiative (COHI)	• Universal access to COHI (excluding BC)	$2.2M/year
Health Human Resources		$15.5M in 2017
Restore AHHRI funding	• Restoration of 2005-2010 funding level of $20M/year	$15.5M/year
Communicable Disease Control		$14.2M/year
HIV/AIDS programming	• 57 new programs funded at $250K each	$14.2M/year
e-Health Infostructure		$65M in 2017
e-Health	• Universal access to e-Health (excluding BC)	$65.0M in 2017
PTO Capacity		$15M in 2017
Restore cuts to First Nations PTOs	• Restoration of previous funding level of $15M/year	$15M/year
Health Infrastructure		$350M in 2017
Infrastructure waitlist	• 50 major projects remain on the infrastructure waitlist after the 2016 budget announcement • 100% increase in health infrastructure funding in subsequent years to avoid future waitlists	$350M in 2017
Community Capacity Building		$369M in 2017
Corporate Operations	• Funding for First Nations health system administration, including board expenses, finance, human resources, and information management/technology operations	$289M/year
Governance and Engagement	• Funding for First Nations health system governance, including operations costs of the secretariat functions, remuneration and travel costs of the councillors/directors, regional caucus sessions, and regional tables	$80M/year
	• Total 2017/18 Budget Ask (New Investments)	$ 1,580,903,620.53

TEN YEAR FINANCIAL PROJECTIONS FOR IDENTIFIED NEW FEDERAL INVESTMENTS

Program	FY 17/18 ($)	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27
Palliative Care	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00	50,000,000.00
Updated Home and Community Care Funding Formula	62,145,000.00	64,009,350.00	65,929,630.50	67,907,519.42	69,944,745.00	72,043,087.35	74,204,379.97	76,430,511.37	78,723,426.71	81,085,129.51
Home and Community Care Catch-Up Escalator	72,461,661.40									
Support for traditional healing	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60	23,274,418.60
NIHB Escalator	35,400,056.40	38,232,060.91	41,290,625.78	44,593,875.85	48,161,385.92	52,014,296.79	56,175,440.53	60,669,475.77	65,523,033.84	70,764,876.54
Comprehensive community planning	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00	10,000,000.00
Mental Wellness Teams	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00	19,000,000.00
NAYSPS	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00
NNADAP	232,291,024.33	232,291,024.33	232,291,024.33	218,957,691.00	218,957,691.00	218,957,691.00	218,957,691.00	218,957,691.00	218,957,691.00	$218,957,691.00
HSOR	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00	230,447,059.00
COHI	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61	2,220,363.61
AHHRI	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00	15,500,000.00
HIV/AIDS programs	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00	14,250,000.00
e-Health	64,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00	83,980,000.00
PTOs	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00	15,000,000.00
Health infrastructure	350,000,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00	20,900,000.00
Corporate Operations	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70	288,572,167.70
Governance and Engagement	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49	80,361,869.49
Total	**1,580,903,620.53**	**1,203,038,313.64**	**1,208,017,159.01**	**1,199,964,964.66**	**1,205,569,700.31**	**1,211,520,953.54**	**1,217,843,389.90**	**1,224,563,556.54**	**1,231,710,029.94**	**1,239,313,575.45**

NOTES

NOTES