Nishnawbe Aski Nation
Community Health Transformation

Nishnawbe Aski Nation
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"The systems as they are functioning now were not designed in a way that is in the best interest of First Nations, and that's exactly what we've acknowledged by saying we need a new approach, the system needs a transformation."

- Jane Philpott, Health Minister, Canada

"For the first time in Ontario's history we're talking about a complete transformation of the system to one that is under the guidance and leadership of NAN. It's First Nations planned, developed and implemented... It's a pretty profound change."

- Eric Hoskins, Health Minister, Ontario

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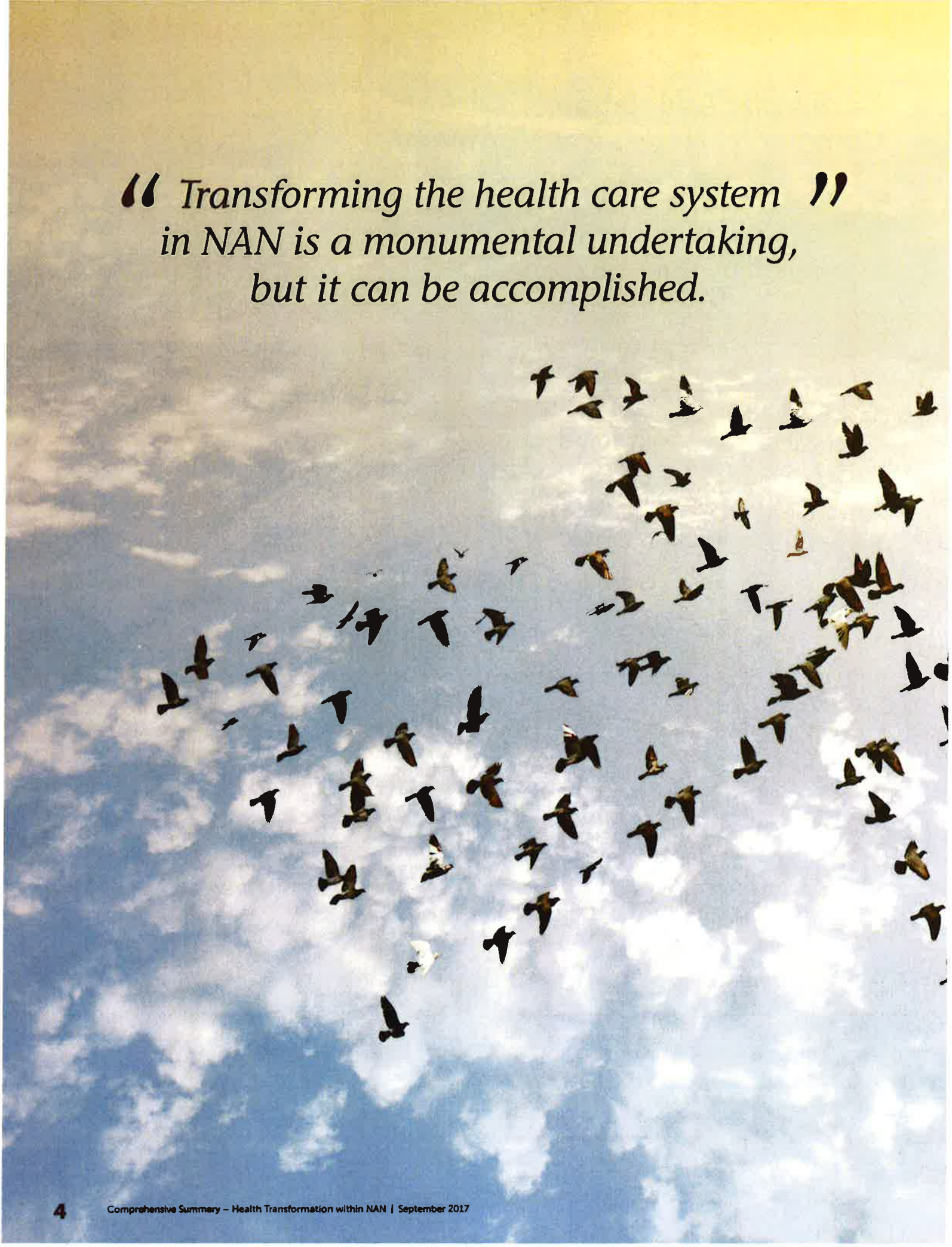
“ Transforming the health care system in NAN is a monumental undertaking, but it can be accomplished. ”



1.0 INTRODUCTION

1.1 PURPOSE

Health transformation means change. Nishnawbe Aski Nation (NAN) believes that transformational change is needed between First Nations, Canada, and Ontario to achieve self-governance in First Nation health systems.

Creating the next generation of health care requires new approaches, policies, systems and legislation between First Nations, Canada, and Ontario to refocus on providing supports and services that reflect the needs of our people and communities.

As a Nation, we know that transformation is the only pathway to rebuilding our inherent wellness systems, eliminating health disparities and achieving the objectives of lower costs, improved outcomes and people-centered care.

Transforming the health care system in NAN is a monumental undertaking, but it can be accomplished. Canada and Ontario have committed to transforming the system; NAN (the organization) is committed to seeing health transformation realized. For transformation to be achieved it is important for the people and communities of NAN to see themselves as a true partner in the process. That is why NAN intends to methodically engage all of the key health partners: the policy makers, the health care administrators, the health care providers and, most importantly, the patients who are the people of NAN. Meaningful community engagement whereby NAN First Nations drive the process will ensure that health transformation is built upon community voices and is truly responsive to community needs.

1.0 INTRODUCTION

1.2 WHY HEALTH TRANSFORMATION?

"Losing Breath: 'She Didn't Have To Die'."

Laura Shewaybick had been struggling to breathe. It was a cool night in Webequie First Nation. She and her husband Norman were desperately waiting for medevac.

Norman decided she needed to go back to the nursing station. On their way, Laura fainted twice. The oxygen tank that had been alleviating some of her distress had emptied. Other tanks sat empty in the hallway of the nursing station, operated by Health Canada.

"Why is this happening?" her aunt pleaded after being told there was no more oxygen.

Paramedics arrived 15 minutes later. Laura was flown to Thunder Bay. She was sedated and remained unconscious for the first two days in the intensive care unit (ICU). She spent a few weeks there until she was transferred out of the ICU.

With the move, the quality of her care dropped dramatically. Norman quietly sat beside his wife's bed as the nurse pushed the monitor near his face and told him, "There's nothing wrong with her."

Laura stood up then and collapsed into her husband's arms.

"I watched her run, that nurse, watched her use her little radio: 'Code blue! Code blue! Code blue!'"

Then everybody showed up, he recounted with a grimace. "They tried to revive her."

"I lost my wife," he said. "She wasn't supposed to die. She fought hard to stay alive."

In memory of Laura Shewaybick, Webequie First Nation

"I Am A Change Maker."

My grandfather told me 'There's going to be a day, a time, we must make a statement about who we really are. And there'll be a time when you will be pushed too far. You'll know who you are.'

"I am change maker."

After losing his wife, Norman believes his role is to help improve the quality of health care delivered to First Nation communities. He doesn't want anyone else to experience what he did.

"Look at our reserves. There are mould problems – that's a big health problem. Look at the Elders losing their loved ones, their wives or their husbands. I know that feeling. It's like half of yourself is gone."

Norman said First Nation community members shouldn't have to leave their homes to access health care, such as those who are forced to move away for dialysis treatment.

"It's the system that's got to change," he said.

In honour of Norman Shewaybick, Webequie First Nation

"Is That Too Much To Hope For?"

These issues have been studied for years, and government decisions about what is best for Mushkegowuk People are simply not working. The gap in services is wider, and more harm is being done than good.

As Provincial Minister of Health Dr. Eric Hoskins puts it 'we have failed you. We have failed the north. We have always know this all along and for too long. The current policies and legislation have marginalized First Nations.

Program after program have been studied. Process after process to study a particular department has on for far to long. We have read research after research of the demographics. By putting aside the real tangible solutions, we are taking a very high risk if status quo is the only option.

Government decisions on what's best for Mushkegowuk Ininiwuk is not working. Instead, the gap in services is getting wider and wider and doing mare harm than good.

Now is the time to roll up our sleeves and put aside political stripes. We must begin moving the yardsticks forward. We must begin a plan that is sustainable and viable. We must approach this crisis as Nation-to-Nation.

I have been overwhelmed by the outpouring of support from people across Canada and around the world who are saddened by the situation of the Mushkegowuk Ininiwuk.

They expect this government to step up to the plate and work with us. They want my people to live with hope and certainty without despair and hopelessness. They want my people to have optimism. They want my people to thrive.

Is that too much to hope for?

- Jonathan Solomon, Grand Chief of Mushkegowuk Council, from presentation to the Standing Committee on Aboriginal Affairs and Northern Development, April 14, 2016.

"The System Failed My Son."

Brody Meekis and his siblings came home from school in Sandy Lake First Nation with fevers and sore throats. Their father took the children to the nursing station and the nurse advised him to give the boys Tylenol and to rub their chests with Vicks VapoRub.

While the siblings slowly returned to health, Brody did not and his health continued to worsen. His father attempted to take him back to the nursing station for a follow-up but was told there were no available appointments for at least a week.

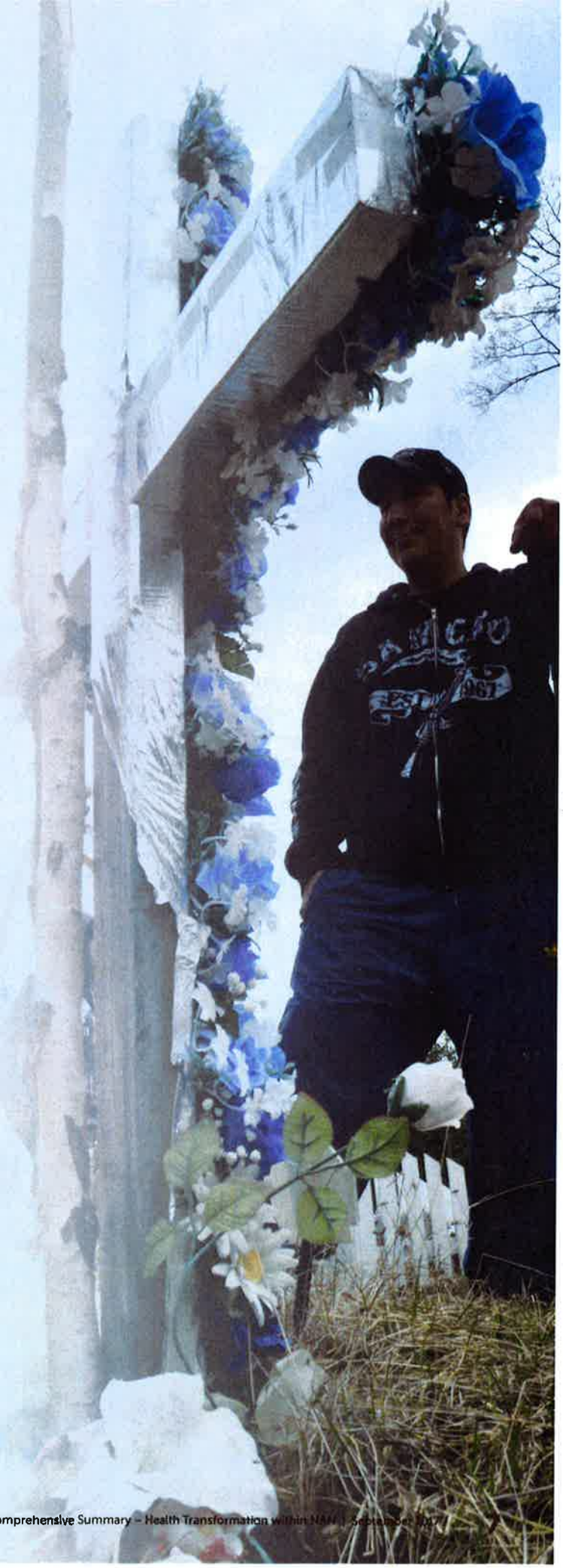
A few days later Body woke up early because he was feeling very sick. His father immediately called for a medical vehicle to take him straight to the nursing station.

Five-year-old Brody Meekis later died of strep throat - a common bacterial infection that is easily cured with antibiotics when properly diagnosed.

"I just remember being so angry, I was just in shock," said his mother.

Many things went wrong in the treatment of Brody Meekis, many of them related to a shortage of medical resources in the remote community. Brody wasn't the only First Nations child to die in the past few years of strep.

In memory of Brody Meekis, Sandy Lake First Nation.



1.0 INTRODUCTION

1.3 WE ARE IN CRISIS

The First Nation health care system is in everlasting crisis. The NAN Chiefs declared a health and public health emergency for First Nations across NAN territory on February 24, 2016 in Toronto.

"The chronic failure of the health care system for First Nations across NAN territory has left our communities in a state of crisis," Grand Chief Fiddler said.

"Children are dying and lives are at risk. The fact that many First Nations still lack access to even the most basic health services is nothing short of a national tragedy. The many urgent and long-standing health issues that plague our communities are well-documented and the time for action is now. We are calling on all levels of government to commit to a plan of action to begin to address this crisis," continued Grand Chief Fiddler.

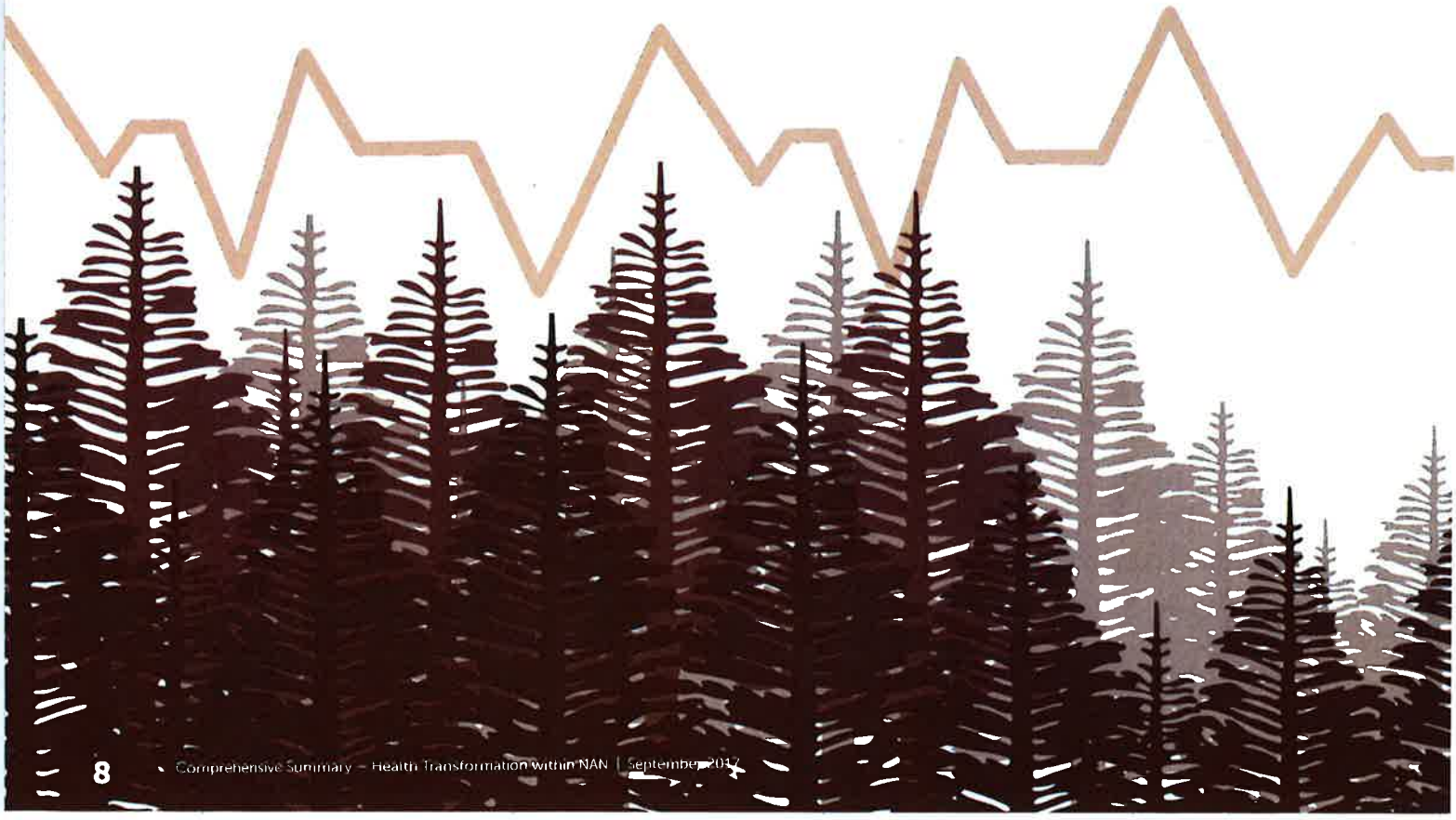
Many reports have highlighted the inadequacies of health care delivery by the federal government to NAN First Nation communities. Clearly, the First Nation health system is not producing desired health outcomes.

Immediate action needs to be taken to identify, redesign and measure health system processes used to address First Nation health disparities, otherwise our crisis will continue. What is lacking is the collaboration across health partners – First Nation communities, medical organizations, health quality councils, government and others to align with our priorities.

There needs to be agreement on the root causes of health care gaps, the solutions that will address the root causes for the long-term, and the ways to implement these solutions collaboratively with approaches and systems that are First Nation led.

By aligning our partners to work collaboratively with our leaders and citizens, we can create the environment required for transformation and positive change.

We need to honour and incorporate our distinct ways of knowing and our unique experiences in order to build a health system that works for our people.



> *We're not asking for more than what the normal Canadian gets for health care... we're losing people needlessly.*
>
> *- Bart Meekis, Chief Of Sandy Lake*

> *The old system is not working... for our young ones, for the Elders, for the adult population in terms of accessing quality care based on their needs.*
>
> *- Norman Shewaybick, Webequie First Nation*

2.0 RECOMMENDATIONS

MADE TO STANDING COMMITTEE ON ABORIGINAL AFFAIRS & NORTHERN DEVELOPMENT – APRIL 2016

1. Health Canada and NAN jointly develop a course of action to fully implement the recommendations made by The Auditor General of Canada outlined in the 2015 Spring Report Access to Health Services for Remote First Nations Communities. This work will consider the relationship to any process arising from the NAN and Health Canada and MOHLTC Ministers meeting on March 31, 2016.

2. Health Canada to acknowledge that the present policies, service delivery and funding models are failing First Nations. The Auditor General of Canada supports that Health Canada does not consider the health needs of the community. An overall health system transformation is required. As per the March 31, 2016 meeting, Health Canada and MOHLTC must work collaboratively with NAN on a long term process towards solutions beginning with urgent priorities that need expedient solutions, intermediate and long term health and infrastructure needs in a framework to be designed and implemented across NAN and various First Nation health organizations within NAN territory. This collaborative framework will include a health transformation system component and will consider models envisioned by Weeneebayko Area Health Authority, Sioux Lookout First Nations Health Authority and other First Nation health entities.

3. The Minister of Indian Affairs Canada participates along with NAN and Health Canada in an ongoing political oversight body to the process as proposed by NAN at the March 31, 2016 meeting. It is imperative that INAC be part of this process as water and housing situations in the NAN communities are detrimental to the health of our people.

4. NAN and Mushkegowuk Council leadership work in collaboration with Health Canada, INAC and other departments to establish a Special Emergency Suicide Task Force to address the growing suicide epidemic in NAN territory. Health Canada and INAC must provide the resources to support this process.

5. NAN leads a collaborative process with Health Canada and Ontario that will redefine Jordan's Principle. The result of this work will form a basis for which Canada will create legislation that will compel other jurisdictions to a uniform implementation process. Health Canada and MOHLTC must provide the resources to support this process.

3.0 COMMUNITY CHALLENGES

TRAUMA AND SUICIDE

The legacy of Residential Schools and inter-generational trauma has resulted in devastating rates of suicide. Since 1986, there have been over 500 suicides across NAN territory. Few communities have access to mental health services.

OPIOID ADDICTION

Prescription drug abuse is rampant and First Nations are unequipped to deal with the epidemic of opioid addiction. Injection drug use is alarmingly high and has led to increasing rates of Hepatitis C. Resources are minimal and communities have to scramble to fund addictions counsellors and opioid substitution programs. Rates of addiction have been as high as 80% of the population in some communities with users as young as 11 years old.

CHRONIC DISEASE COMPLICATIONS

Complications related to chronic diseases like diabetes have taken a significant toll on our communities. Our communities have the highest amputation rate in Ontario due to diabetes complications.

CHILD DEVELOPMENTAL SERVICES

There are significant gaps in child developmental services. Families face many barriers in accessing screening for hearing, vision and multidisciplinary assessments for conditions such as FASD. Once diagnosed, it is difficult to access treatment. Jordan's Principle has been narrowly applied by the government. Barriers still exist for children who require services.

INFRASTRUCTURE AND MEDICAL SUPPLIES

Many First Nations lack the necessary infrastructure to support the delivery of health services. In addition to buildings, many communities lack basic diagnostic equipment and x-ray machines remain in disrepair for years. Basic medications are sometimes not stocked leading to complications or death, as has been the case with a few children.

HUMAN RESOURCES

Despite the complex needs in the communities, community-based workers and health staff are unsupported and lack basic training and resources. As a result, turnover is high and workers struggle with wage parity issues.

SERVICE DELIVERY GAPS

Jurisdictional barriers and gaps in service delivery lead to untreated illnesses, injuries and avoidable deaths. Two young children died tragically in 2014 from cases of rheumatic fever that went undetected by community primary care providers. Considered a third world disease, rheumatic fever is still present in many First Nations due to poor living conditions, overcrowding and lack of sanitization.

CULTURAL SAFETY

Colonization has resulted in ongoing and entrenched racism in policy and treatment against First Nation people and is manifested in hospitals by staff. Racist ideologies continue to significantly affect the health and wellbeing of First Nation people.

4.0 HEALTH TRANSFORMATION

4.1 DEFINITION OF HEALTH TRANSFORMATION

Health transformation is defined as a broad-ranging initiative to modernize and improve our health care system. Key themes necessary for health care transformation (as identified by the Canadian Medical Association & the Canadian Nurses Association) are: health promotion, effective management of illnesses, focus on quality outcomes and accountability to patients.

4.2 WHAT IS GOING TO BE DONE DIFFERENTLY?

ALIGNMENT

Alignment is defined as high-quality services that are designed and organized to match the needs of the patient/client. When alignment is achieved services will be more convenient, accessible and better coordinated. Each patient's individual health care needs will be aligned with the most appropriate health care providers in their community.

The *Alignment Process* which will be led by NAN First Nations is designed to create and enhance alignment at three levels. This will create a shared vision of the root problems, solutions and implementation strategies. To carry-out the *Alignment Process* capacity must be built within all three levels.

1. Within NAN First Nation communities
2. Between First Nation health care partners
3. Between NAN First Nations and non-First Nation health care partners

The *Alignment Process* is completed through meaningful engagement at each level. Engagement is the ongoing participation between collaborators to understand each-others point-of-view. Moving together requires an ongoing and dynamic understanding of each other. We will always recognize that the key perspective is the focus of the community

THE NAN APPROACH CALLS FOR:

Northern First Nation organizations to support community-led transformation of the health system in NAN Territory, including:

- The Charter of Relationship Principles and what it means for health system transformation;
- The priorities and role of the Joint Action Table regarding health system transformation;
- The NAN Health Transformation Work Plan and community engagement.

4.0 HEALTH TRANSFORMATION

CHANGE THEMES

Several critical themes have been identified that need to be addressed:

- Community needs are not being prioritized and problems are not being defined from a community perspective. Communities are forced to choose one or two solutions as part of a program instead of solutions that will address the root cause of problems. The power to choose solutions does not currently reside within the community.
- The narrow range of solutions selected through the current processes are not working and health outcomes are not tracked.
- Outcomes are defined by the program and not by the community so evaluations seldom identify the disconnect between what is being done and the outcomes needed to change root causes. Program "successes" are based on program compliance, not how the program positively impacts health outcomes of people in communities.
- There is no data to show that we are addressing the right problems, using the right solutions or have any improvement in health outcomes.

A First Nation-led transformation of health systems would ensure that these critical elements would be handled differently.

4.3 THE JOURNEY TO HEALTH TRANSFORMATION

Health is the foundation for healthy individuals, families and communities. Our communities are in crisis and there needs to be a different approach to confront it.

First Nation health transformation will be achieved at the community and regional levels.

First Nation health also has transformation challenges in safety, quality improvement, and patient-centered care. Today, we do not have clear strategies for these transformations in First Nation Health.

Nishnawbe Aski Nation can begin to transform through an *Alignment Process*.

THE *ALIGNMENT PROCESS*: 9 STEPS

1. Mapping Health Care Partners
2. Assessing Value of Each Health Care Partner
3. Establishing a Comprehensive Accord
4. Gap Analysis
5. Third-Party Validation
6. Creating A Business Plan
7. Outlining Underlying Fundamentals
8. Plan Implementation
9. Exit Strategy

4.0 HEALTH TRANSFORMATION

COLLABORATION

Health transformation is achieved through the *Alignment Process*. Health is a complex decision-making enterprise with specific roles for decision-makers and influencers; patients, funders, clinicians, administrators, and academics. When there is no alignment, root causes go unaddressed.

The *Alignment Process* supports strengths and remediates weaknesses. It is suggested that the following strengths of the existing First Nation health system be respected by:

- Supporting First Nation Regional organizations, Tribal Councils, and communities in defining the problems, solutions and implementation strategies to create alignment towards a safer, higher quality and patient-centered First Nation health system; First Nation communities must be recognized as the owners of the First Nation health system.
- Recognizing this is a negotiated way forward to First Nation health transformation with decision-makers and influencers supporting similar revolutions in safety, quality improvement and patient-centered care/ culturally-safe care.
- Ensuring that health equity is a driving principle of this initiative; there are far too many needless deaths in our communities, late diagnosis of disease and late treatment of illness.
- Ensuring collaboration is a driving principle of this initiative; working together within, between and outside of our Territories is necessary for health transformation.
- Committing that negotiated funding is new funding and not reallocated from currently funded health transfer delivery programming.
- Viewing this transformation process as supportive and not competitive; health transformation is about enhancing existing services to become safer, higher quality and patient-centered at all levels within First Nation health systems.
- Acknowledging that First Nation health includes both wellness and disease intervention; prevention, traditional healing, community wellbeing and common disease interventions are equally valued and utilized as directed by First Nation communities, families and patients.

4.0 HEALTH TRANSFORMATION

4.4 TIMELINE OF HEALTH TRANSFORMATION OF NAN, MANITOBA KEEWATINOWI OKIMAKAAAK, FEDERATION OF SOVERIEGN INDIGINOUS NATIONS (COLLABORATIVELY CALLED INDIGENOUS HEALTH ALLIANCE OR IHA)

- **JUNE 28, 2016**

  Formal letter sent from the Indigenous Health Alliance, requesting a meeting with Ministers Bennett and Philpott to discuss health transformation.

- **JULY 12, 2016**

  Letter sent to Minister Bennett from Health careCAN, the national voice of health care organizations and hospitals across Canada to support the Indigenous Health Alliance.

- **JULY 13, 2016**

  Meeting with Minister Bennett to discuss health transformation at the AFN Summer Assembly in Niagara Falls.

- **OCTOBER 7, 2016**

  The Indigenous Health Alliance submits its proposal for health transformation to Ministers of Health and Indigenous Affairs.

- **NOVEMBER 4, 2016**

  Letter from the FSIN Senate expressing its displeasure of having almost a billion dollars of INAC monies returned to the Federal Government Treasury unspent. Mention that the health transformation process remains unfunded.

- **DECEMBER 8, 2016**

  Motion to support health transformation is passed at the AFN Winter Assembly.

- **JANUARY 18, 2017**

  In light of the youth suicides, a letter is sent to PM Trudeau emphasizing the need to fund the health transformation proposal.

- **FEBRUARY 6, 2017**

  Meeting with multiple Federal departments, chaired by Sony Perron, ADM Health Canada. The health transformation proposal was presented and discussed.

- **FEBRUARY 7, 2017**

  Meeting with Ministers Philpott and Bennett to discuss the Indigenous Health Alliance *Alignment Process*.

- **FEBRUARY 9, 2017**

  Meeting with Minister Hoskins to discuss the *Alignment Process* and hand-deliver health transformation proposal.

- **FEBRUARY 15, 2017**

  Follow-up phone call with ADM of Health Canada Sony Perron regarding 6/7 meetings.

- **FEBRUARY 16, 2017**

  Testimony to the Standing Committee on Indigenous and Northern Affairs by Dr. Alika Lafontaine for the study "Suicide Among Indigenous Peoples and Communities." The IHA Proposal for Health Transformation is formally submitted as evidence to the Committee.

- **MARCH 13, 2017**

  Response from Minister Bennett regarding the February meetings with government, copied to several Ministers and the Prime Minister's Office.

- **MARCH 22, 2017**

  Budget 2017 is released with no health transformation funding.

- **APRIL 13, 2017**

  Follow-up call with ADM of Health Canada Sony Perron regarding lack of funding for health transformation in 2017 Budget.

- **MAY 5, 2017**

  Letter from the Minister of Health requesting a meeting with the Indigenous Health Alliance.

- **JUNE 6, 2017**

  The Indigenous Health Alliance begins circulating a one-page summary of their project proposal.

- **JULY 24, 2017**

  Ontario, Canada, and NAN signed the Charter of Relationship Principles Governing Health System Transformation in the NAN territory.

5.0 JOINT ACTION TABLE PROCESS

On July 24, 2017, NAN, Ontario and Canada signed the Charter of Relationship Principles Governing Health System Transformation in NAN Territory ("The Charter of Relationship Principles") which expresses the political commitments of the Parties to develop and sustain a renewed relationship to transform the existing health system in NAN territory. This will result in a new, responsive and system-wide approach to health for NAN territory.

This system-wide change will see First Nations have:

- Equitable access to quality care delivered within their community and in NAN territory that will include holistic models of care, focusing on wellness planning, population health and health determinants.
- The system will be patient centred, responsive to community and patients' voices, and ensure that health care providers funded by federal or provincial governments would have the skills required to provide responsive, effective and culturally safe care.
- Communities will be engaged at all levels using the *Alignment Process* to ensure that voices are heard and incorporated into community-based programming.
- The *Alignment Process* will bring decision-makers together to move health transformation forward in a deliberate, planned and measurable way.
- In addition to achieving transformation through alignment, the process will ensure the development of capacities within NAN communities and within NAN including: advocacy and relationship building, mapping priorities and project management.

5.1 THE SUBMISSION

On February 9, 2017, NAN submitted a 5-year submission to Minister Hoskins, Ministry of Long Term Care and Minister Philpott, Ministry of Health. The strategy draws on First Nation capacity for measured and data driven safe, quality improvement and patient-centered care. The engagement, alignment and collaboration process is capacity-building for First Nation communities to be their own leaders in safety, quality improvement and patient-centered care; with communities choosing strategies informed and aligned with non-First Nation health partners that have been successful in mainstream health transformation towards a safer, higher quality, patient-centered health system.

The objectives are to create an implementation strategy that will provide:

- A safe health system utilizing processes that monitor patient safety and is accessible;
- A culture of quality improvement that is data drive and;
- A patient-centered health care for First Nation communities, families and patients that is culturally safe.

6.0 HISTORICAL BACKGROUND

Health Canada's role in First Nations and Inuit Health began in 1945, when Indian Health Services were transferred from Indian Affairs. In 1962, Health Canada began to provide direct health services to First Nations people on-reserve and Inuit in the north.

By the mid -1980s, work began to have First Nation and Inuit communities control more health services. NAN First Nations self-governance over health services can build successfully on previous experience in managing health transfer agreements and navigating the Federal and Provincial health systems. This project will not interrupt the work of implementing health transfer agreements.

The health system for First Nations in northern Ontario has been in crisis for decades. The consequences of these health effects are well-documented in several reports with recommendations for action, including:

- The United Nations Special Rapporteur on the Rights of First Nation Peoples confirmed there is a health crisis affecting First Nation people in Canada and that significant improvements in funding and policy change are desperately needed.
- The Final Report of the Truth and Reconciliation Commission calls for Canadians and governments to play a role in healing and reconciliation in order to close the gaps in the quality of life between First Nations and other Canadians.
- The Auditor General of Canada Spring 2015 Report found that First Nations living in remote communities in northern Ontario and northern Manitoba did not have comparable access to clinical and client care services as other provincial residents living in similar geographic locations. It was also concluded that Health Canada had not assessed whether each nursing station was capable of providing essential health services and also that Health Canada did not take into account community health needs when allocating its support.
- NAN and Manitoba Keewatinowi Okimakanak urged the federal Health Minister to engage with First Nations on a course of action to address the issues identified in the Auditor General's report but no serious commitment has been received.
- In September 2015, SLFNHA Chiefs passed a Resolution calling for a declaration of a public health emergency. In January 2016, the NAN Chiefs-in-Assembly passed a similar Resolution.

By taking ownership over the design and control of health services through new health systems and processes, regions can achieve greater impact against the health problems that have plagued community members, and put in place health systems specifically designed to meet members' needs if given the proper resources and flexibility.

Documentation is being gathered to continually provide the context and background for discussions, both with the Federal Departments (the Prime Minister's Office, Health Canada and INAC), the Health Treaty Table Working Group, the Treaty Caucus Groups and Provincial government. Health transformation is a necessary step to transitioning from what is currently being done to what needs to be done.

SOCIAL DETERMINANTS

EFFECTS OF LEVELS OF EDUCATION ON HEALTH AND WELLBEING IN NAN

Within NAN First Nations, a major barrier to employment and adequate wages is level of education. Lower levels of federal education funding for NAN children, compared to mainstream levels has created challenges for the communities in the delivery of the same standard levels of education. The resulting low levels of income and education have a compounding effect on the health of a community. In order to further educational aspirations, many youth in NAN are

forced to disconnect from their familiar surroundings of family, friends, home and community and find themselves displaced and alienated within an urban setting for which they are not prepared. A large proportion of First Nation youth (23.4%) aspired to complete high school while just over 10% of First Nation youth wanted to complete graduate or professional degrees (First Nations Information Governance Centre, Preliminary report of RHS Phase 2, 2011).

Alienation is made even more apparent where English is a second language to First Nation youth; over 20% of First Nation youth use a First Nation language most of the time in their daily lives, and more than half can understand or speak a First Nation language. In addition, practicing traditional knowledge and values is not recognized nor encouraged by non-Aboriginal dominant society. Health Canada's May 2010 report Acting on What We Know: Preventing Youth Suicides in First Nations – the report of the advisory group on suicide prevention maintains that any breakdown in the transfer of cultural knowledge and traditions appears to contribute substantially to widespread demoralization and hopelessness of First Nation youth. While in pursuit of post-secondary education, students have lost their lives in city centres as demonstrated by the current Inquiry into the seven youth that lost their lives while attending high school in Thunder Bay.

HOUSING

The current housing situation in many NAN communities is unacceptable and has reached an acute level. The situation is not uniform in all NAN communities; rather a continuum of social deprivation and poverty exists. Currently, there are 29,805 people living on reserve in the NAN Territory with a present housing stock of 6,226 residential homes. NAN housing is at an immediate critical level requiring 5000+ units. The population is growing rapidly in every community and the backlog of required housing units is far beyond attainable under current policies.

Overcrowding, space and land requirements including inadequate infrastructure, and inadequate funding are all conditions that lead to high rates of chronic illness, high rates of suicide, and in general numerous issues dealing with health and safety.

DRINKING WATER

As of June 30, 2017, there are 35 Drinking Water Advisories in effect in 23 NAN First Nations, according to Health Canada First Nations and Inuit Health. There is also one Do Not Consume Advisory. According to a 2006 protocol designed to ensure safe drinking water for First Nations, it is the responsibility of INAC to provide funding to adequately maintain and operate water facilities. Pikangikum had a water distribution system built in 1995 and only 5% of the community's 387 households are connected. The situation requires many residents to travel to the water station every day to pick up water. Those who are unable to travel to the water station are often left to consume untreated water from the lake, which exposes them to a number of potential health risks. After their inspection of Pikangikum's water and sewage situation in 2005, the Northwestern Health Unit recommended immediate action by the appropriate government agencies to ensure that all residents of Pikangikum had access of to clean water in their home, at no expense to residents.

The lack of a proper water distribution system in the community does not meet the need of fire suppression measures and therefore cannot offer protection for the community members.

6.0 HISTORICAL BACKGROUND

CANADA HEALTH POLICY BARRIERS AND CHALLENGES

More than half of NAN First Nations are remote, only accessible by air year round, creating unique challenges that affect accessibility to health services, infrastructure materials and affordable healthy food contributing to overall health disparities. Health Canada's Non-Insured Health Benefit (NIHB) Medical Transportation Program has caused significant barriers to the access of quality health care through significant numbers of denials for travel for patients to their medical appointments in southern centers. NIHB clerks routinely deny and overrule physician referrals and a double standard exists in terms of how this program is delivered in comparison with the mainstream Northern Travel Grant Program that assists northern patients' travel costs. While there is presently a national NIHB program review, it is much too early for NAN to identify any benefits but past participation in other national reviews have demonstrated that NAN's recommendations are not identified in the final reports.

PRIMARY CARE AND NURSING STATIONS IN THE FIRST NATIONS

The Auditor General of Canada's Spring 2015 report found that nursing stations did not have the capacity to deliver essential services in First Nations, that nurses were not properly trained, and that they operated beyond their legislated scope of service. Nursing stations are often not properly equipped or stocked even with basic medications. These circumstances have led to deaths within the remote NAN Communities, one from a treatable infection and another due to lowered levels of oxygen. Waiting lists are long to see physicians that come only for several days each month at best, resulting in many people not being admitted and/or treated. A significant transformation is required in the way Health Canada operates and funds nursing and physician services, and stocks medical supplies and equipment.

Nishnawbe Aski Nation
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DECLARATION OF A HEALTH AND PUBLIC HEALTH EMERGENCY
IN NISHNAWBE ASKI NATION (NAN) TERRITORY and THE SIOUX LOOKOUT REGION

CODE BLUE

ORDER

WE

The Sioux Lookout Area Chiefs Committee on Health (CCOH) and Nishnawbe Aski Nation (NAN),

In accordance with the following directives:

Sioux Lookout First Nations Health Authority Chiefs Resolution #15-23 *Call for Declaration of Public Health Emergency.*

Nishnawbe Aski Nation Chiefs Resolution #16-04 *Call for Declaration of Public Health Emergency.*

Hereby declare

That effective, this 24th day of February 2016, the remote First Nation Communities in northern Ontario and the broader NAN Territory are in a state of Health and Public Health Emergency.

There are needless deaths and suffering caused by profoundly poor determinants of health. The people have experienced poor health outcomes and a substandard state of health and well-being as a result of inadequate medical diagnosis and treatment of preventable diseases, including:

- Diabetes
- Hepatitis C
- Rheumatic fever and
- Invasive bacterial diseases (group A strep and methicillin resistant staphylococcus aureus (MRSA))

Communities suffer multigenerational trauma from residential schools, social conditions including the suicide epidemic and high rates of prescription drug abuse.

Health Canada has failed to adequately respond to the *Spring 2015 Auditor General's Report on Access to Health Services for Remote First Nation Communities.*

People continually encounter the effects of federal and provincial jurisdictional squabbling leading to inequitable access to health care. The First Nations people experience a level of health care that would be intolerable to the mainstream population of Ontario.

Nishnawbe Aski Nation
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ORDER: It is hereby ordered that provincial and federal governments commence prompt and sustained action, with immediate, intermediate and long term strategies. The Chiefs order immediate actions to be completed in the next 90 days to include, but not limited to, the following:

a) Meet with provincial and federal Health Ministers to commence an investment and intervention plan on an urgent basis.
b) Indigenous and Northern Affairs Canada to provide detailed plans and timelines indicating how First Nations communities will be provided with safe, clean and reliable drinking water.
c) Health Canada to provide detailed plans and timelines on how they will follow all the recommendations in the Spring 2015 Auditor General Report including:
    a. addressing deficiencies in the Health Canada nursing stations infrastructure,
    b. ensuring all necessary supplies and equipment are available,
    c. ensuring that Health Canada nursing stations are capable of providing Health Canada's essential health services,
    d. ensuring that allocation of resources is based on community needs.
d) Federal and provincial governments to conduct an assessment of health system deficiencies and associated health liabilities.
e) Ministry of Health and Long Term Care (MOHLTC) to approve the proposal for a Long Term Care facility for the Sioux Lookout Region and that all existing beds at the Sioux Lookout Meno Ya Win Health Centre are in operation.
f) The governments shall comply with Jordan's Principle and that all children receive the health and developmental services that they require. This shall include the provision of specialists in the communities to conduct community-wide assessments and referrals.
g) Provincial and Federal governments to commit resources for the development of long term strategies to crisis situations including suicide prevention, mental health services, counselling, addiction treatment and after care.
h) Provincial and Federal governments to commit to and support SLFNHA's Approaches to Community Wellbeing (public health) model to address health inequity, determinants of health and prevention of infectious and chronic diseases.
i) Address the discriminatory and unethical policies and practices under Non Insured Health Benefits.

NEW GOVERNMENT TO GOVERNMENT RELATIONSHIP

We recognize that there are processes in place to address various aspects of health care; however, the urgency of the critical situation requires an immediate, stronger response and acceptable commitment. The Anishinabe Health Care System must be transformed to prevent further harm or damage to the safety, health and wellbeing of First Nations people.

Date: February 24, 2016

Grand Chief Alvin Fiddler
Nishnawbe Aski Nation

Grand Chief Jonothan Solomon
Mushkegowuk Council

Ontario Regional Chief Isadore Day
Chiefs of Ontario

Chief Clifford Bull
Lac Seul First Nation

Nishnawbe Aski Nation
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RESOLUTION: 16/04
CALL FOR DECLARATION OF PUBLIC HEALTH EMERGENCY

WHEREAS the United Nations Special Rapporteur on the Rights of Indigenous Peoples declared there is a health crisis affecting Indigenous peoples in Canada and that significant improvements in funding and policy change are desperately needed;

WHEREAS Health Canada and many researchers have documented that Indigenous Peoples in Canada face extremely high rates of suicide, mental illness, opiate and other addictions, increasing rates of chronic illnesses such as Type 2 diabetes and other conditions, and high incidence of infectious diseases;

WHEREAS in April 2015 the Auditor General of Canada reported on the state of health care in the remote northern communities of Northwestern Ontario and Manitoba and found deficiencies in facilities, access to training for healthcare workers, and other problems;

WHEREAS the Auditor General also noted that "Health Canada did not have reasonable assurance that eligible First Nations individuals living in remote communities in Manitoba and Ontario had access to clinical and client care services and medical transportation benefits," which leads to untreated illnesses and injuries, as well as avoidable deaths;

WHEREAS Indian and Northern Affairs Canada (INAC) has a fiduciary responsibility for First Nations people living on-reserve;

THEREFORE BE IT RESOLVED that Nishnawbe Aski Nation (NAN) Chiefs-in-Assembly call on the Office of the Chief Public Health Officer of Canada to declare a public health emergency for First Nations across NAN territory;

FURTHER BE IT RESOLVED that the NAN Executive Council is directed to work with INAC to create an implementation plan to address the recommendations from the Auditor General's 2014 report on health in First Nation communities;

FURTHER BE IT RESOLVED that Chiefs-in-Assembly also call on the Chief Public Health Officer of Canada to establish a new agency with a clear mandate to address the health gap between Indigenous people and their fellow Canadian citizens, and that this agency will work on the following:

1. increasing access to critical care on-reserve including physician services, nurse practitioners, and other health care providers;
2. ensuring that basic acute care equipment is available in all nursing stations;
3. ensuring that staff have adequate opportunity for training in all necessary health care skills;
4. ensuring the provision of childhood developmental services in the remote communities;
5. enhancing youth mental health services;
6. supporting improvements in both acute care and chronic disease management;
7. reforming all aspects of the Non-Insured Health Benefits program, including medical transportation;
8. obtaining quality drug and other health products, as opposed to generic brands;
9. vastly improving and maintaining community health care facilities and equipment;
10. preventing negligence and addressing malpractice experienced by First Nation patients, and securing independent legal advice to deal with claims; and,
11. improving the social determinants of health;

FURTHER BE IT RESOLVED that INAC should be involved in the declaration of a public health emergency and should work with the new agency to improve the health status of First Nations communities;

FINALLY BE IT RESOLVED that the implementation of the directives of this Resolution will be overseen by the Executive Council, the NAN Chiefs Committee on Health and the NAN Health Advisory Group, and an update will be provided at the next Chiefs Assembly.

DATED AT THUNDER BAY, ONTARIO THIS 21st DAY OF JANUARY 2016.

MOVED BY: Proxy Sol Mamakwa
Kingfisher Lake First Nation

SECONDED BY: Chief Wayne Moonias
Neskantaga First Nation

CARRIED

Grand Chief Alvin Fiddler

Deputy Grand Chief

Sioux Lookout
First Nations
Health Authority

SIOUX LOOKOUT FIRST NATIONS HEALTH AUTHORITY

Resolution #15-23

CALL FOR DECLARATION OF PUBLIC HEALTH EMERGENCY

WHEREAS, the United Nations Special Rapporteur on the Rights of Indigenous Peoples declared there is a health crisis affecting Indigenous peoples in Canada and that significant improvements in funding and policy change are desperately needed; and

WHEREAS, Health Canada and many researchers have documented Indigenous people in Canada face extremely high rates of suicide, mental illness, addictions, increasing rates of chronic illnesses such as Type 2 diabetes and other conditions, and high incidence of infectious diseases; and

WHEREAS, in April 2015, the Auditor General of Canada reported on the state of health care in the remote northern communities of Northwestern Ontario and Manitoba and found deficiencies in facilities, access to training for healthcare workers, and other problems; and

WHEREAS, the Auditor General of Canada also noted that "Health Canada did not have reasonable assurance that eligible First Nations individuals living in remote communities in Manitoba and Ontario had access to clinical and client care services and medical transportation benefits," which leads to untreated illnesses and injuries, as well as avoidable deaths; and

WHEREAS, Aboriginal Affairs and Northern Development Canada (AANDC) has a fiduciary responsibility for First Nations people living on reserve;

THEREFORE BE IT RESOLVED THAT, the Chiefs in Assembly call on the Office of the Chief Public Health Officer of Canada to declare a public health emergency for First Nations in the Sioux Lookout area.

BE IT FURTHER RESOLVED THAT, the Chiefs in Assembly also call on the Chief Public Health Officer of Canada to establish a new agency with a clear mandate to address the health gap between Indigenous people and their fellow Canadian citizens and that this agency will work on the following:

1. Increasing access to critical care on-reserve including physician services, nurse practitioners, and other health care providers
2. Ensuring that basic acute care equipment are available in all nursing stations

3. Ensuring that staff have adequate opportunity for training in all necessary health care skills
4. Ensuring the provision of childhood developmental services in the remote communities
5. Enhancing youth mental health services
6. Supporting improvements in both acute care and chronic disease management
7. Reforming the Non-Insured Health Benefits program
8. Vastly improving and maintaining community health care facilities and equipment

BE IT FINALLY RESOLVED THAT, AANDC should be involved in the declaration of a public health emergency and should work with this new agency to improve the health status of First Nations communities.

Dated this 17th day of September 2015 in Lac Seul First Nation, Ontario.

Moved by: _____
Chief Elizabeth Atlookan, Eabametoong First Nation

Seconded by: _____
Chief Connie Gray-Mckay, Mishkeegogamang First Nation

Decision: **CARRIED**

Signature of Meeting Chair: _____
Wally McKay, Meeting Chair

Nishnawbe Aski Nation
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RESOLUTION 17/21: CHARTER OF RELATIONSHIP PRINCIPLES GOVERNING HEALTH SYSTEM TRANSFORMATION IN NAN TERRITORY

WHEREAS the primary foundational relationship on health services and health jurisdiction is between First Nations and the Crown in right of Canada based on Treaties No. 5 and No. 9;

WHEREAS in January 2016, Nishnawbe Aski Nation (NAN) Chiefs-in-Assembly passed Resolution 16/04: *Call for Declaration of Public Health Emergency* due to the deplorable state of health in NAN territory;

WHEREAS on February 24, 2016, NAN and the Sioux Lookout Area Chiefs Committee on Health declared a State of Health and Public Health Emergency for First Nations in the Sioux Lookout area and across NAN territory;

WHEREAS following the Declaration, a meeting was held on March 31, 2016, between First Nations leadership and other parties, and it was agreed to continue with an ongoing relationship to develop and oversee transformative change in Indigenous health with a focus on NAN communities;

WHEREAS the parties agreed to establish a process, monitored by a senior-level committee comprised of NAN leadership and senior Associate Deputy Ministers from Health Canada and the Ministry of Health and Long-Term Care, that would work on a long-term process to work towards solutions that will consider urgent, intermediate and long-term needs;

WHEREAS NAN Resolution 16/44: *Exploration of Health System Transformation Models and Processes* mandated the NAN Executive Council, in consultation with the Tribal Health Directors, Sioux Lookout First Nations Health Authority, Matawa Health Cooperative Initiative and Weeneebayko Area Health Authority, to explore and consider health system transformation models;

WHEREAS all the parties, NAN, Health Canada and the Ministry of Health and Long-Term Care, have jointly agreed to work together to address the State of Health and Public Health Emergency for First Nations in the Sioux Lookout area and across NAN territory;

WHEREAS the implementation of this Resolution shall include the consideration of different health service funding models that emphasize direct funding to the communities, subject to approval by Chiefs-in-Assembly;

THEREFORE BE IT RESOLVED that Chiefs-in-Assembly mandate the Executive Council to sign the Charter of Relationship Principles Governing Health System Transformation in the NAN territory agreement, together with an incorporated Terms of Reference;

RESOLUTION 17/21: CHARTER OF RELATIONSHIP PRINCIPLES GOVERNING HEALTH SYSTEM TRANSFORMATION IN NAN TERRITORY

FURTHER BE IT RESOLVED that Chiefs-in-Assembly direct the Executive Council to convene a Chiefs Working Group to guide the principles governing Health System Transformation in NAN to ensure equitable access to quality care delivered within their community and in NAN territory including, but not limited to:

1. strategic planning and work plan development;
2. a process for the distribution of new resources;
3. an implementation plan;

FURTHER BE IT RESOLVED that Chiefs-in-Assembly direct the Chiefs Working Group and the Executive Council to report back to Chiefs-in-Assembly during the 2017 Keewaywin Conference;

FINALLY BE IT RESOLVED that this Resolution is without prejudice to independent and other NAN First Nation health processes with Canada and/or Ontario.

DATED AT THUNDER BAY, ONTARIO, THIS 28TH DAY OF FEBRUARY 2017.

MOVED BY: Chief Dinah Kanate, North Caribou Lake First Nation
SECONDED BY: Chief Connie Gray-McKay, Mishkeegogamang First Nation
DECISION: **CARRIED**

Grand Chief Alvin Fiddler

Deputy Grand Chief

6.0 HISTORICAL BACKGROUND

CHARTER OF RELATIONSHIP PRINCIPLES

CHARTER OF RELATIONSHIP PRINCIPLES
GOVERNING HEALTH SYSTEM TRANSFORMATION IN THE NISHNAWBE ASKI NATION (NAN) TERRITORY

-between-

Government of Canada

-and-

Government of Ontario

-and-

Nishnawbe Aski Nation (NAN) on behalf of the First Nations in NAN Territory

(Collectively "the Parties")

1.0 **WHEREAS,** Nishnawbe Aski Nation ("NAN"), the Ministry of Health and Long-Term Care, and Health Canada, jointly recognize the need for First Nations communities, Ontario, and the Federal government to work together to address the need for a new responsive and system-wide approach to health for NAN territory;

2.0 **WHEREAS,** this Charter expresses the political commitments of the Parties to develop and sustain a renewed relationship that is a partnership and that the Parties intend to result in immediate, medium, and long-term transformative change to the existing health system at the NAN community level;

3.0 WHEREAS

- Nishnawbe Aski Nation (NAN) is a political territorial organization representing 49 First Nation communities within northern Ontario. NAN's objectives include acting to improve the quality of life for First Nations people residing in its region, including the quality and effectiveness of their health care;
- Ontario, through the Ministry of Health and Long-Term Care, funds, administers and provides leadership for the delivery of health care services to all residents of Ontario pursuant to the province's legislative framework and guided by the provisions of the Canada Health Act; and
- Canada, through the First Nations and Inuit Health Branch of Health Canada, works with First Nations, Inuit and provincial and territorial partners to support healthy First Nations and Inuit individuals, families and communities. Canada also funds or provides a range of community-based health programs, services and non-insured health benefits to improve health outcomes and supports greater control of the health system by First Nations and Inuit.

HISTORICAL CONTEXT

4.0 **WHEREAS,** the Sioux Lookout Area Chiefs Committee on Health (CCOH) and the NAN Chiefs issued a Declaration of Health and Public Health Emergency on February 24, 2016. The Declaration called for a meeting between First Nations leadership and Provincial and Federal Health Ministers;

5.0 **WHEREAS,** on March 31, 2016, a meeting took place between First Nations leadership and Provincial and Federal Health Ministers. At this meeting, the Parties committed to work in collaboration to jointly identify NAN health priorities and undertake joint health planning and strategy development for health system transformation through direct dialogue by establishing a senior level committee of representatives of the Parties to be monitored by NAN's political leadership, the Federal Minister of Health, and the Ontario Minister of Health and Long-Term Care;

6.0 **WHEREAS,** the Truth and Reconciliation Commission Calls to Action call for the Federal and Provincial governments to play a role in closing the gaps in the quality of life and availability of health services between Indigenous Peoples and other Canadians;

7.0 **WHEREAS,** the United Nations Special Rapporteur on the Rights of Indigenous Peoples in a 2004 Report on Mission to Canada recommended that emergency measures be taken to address the critical issue of high rates of diabetes, tuberculosis and HIV/AIDS among Indigenous people; and that the suicides of Indigenous persons be addressed as a priority social issue by the relevant public social service and health institutions;

8.0 **WHEREAS,** the 2015 Auditor General of Canada's report on Access to Health Services for Remote First Nations Communities recommended that "working with First Nations organizations and communities, and the provinces, Health Canada should play a key role in establishing effective coordinating mechanisms with a mandate to respond to priority health issues and related inter-jurisdictional challenges";

9.0 **WHEREAS,** NAN communities have issued and developed numerous declarations, recommendations, resolutions, and studies providing specific and comprehensive solutions to the crises they face; and

10.0 **WHEREAS,** previous and existing bilateral and multilateral Agreements (namely, the Sioux Lookout Four Party Hospital Services Agreement, NAN/Canada Bilateral Agreement on Health Care Relationships, and the Weeneebayko Area Health Integration Framework Agreement) have committed to strengthening relationships among the Parties to those agreements, improving health and health care services, balancing health services between prevention and treatment of illness, and integrating services within communities.

INTENT AND MANDATE

The intent of this Charter is to formalize the commitment of the Parties to develop and sustain a renewed relationship, that is a partnership, and to articulate the Parties' support for a new, responsive and system-wide approach to health for the NAN territory.

This is a relationship-strengthening document, and is not intended to create or alter legal obligations on the part of NAN, First Nations, Canada, or Ontario, or to be a treaty, or to create, redefine, impact the interpretation of, prejudice or affect any rights, assertions of right, or jurisdiction of NAN, the First Nations, Canada, or Ontario. Furthermore, this Charter is without prejudice to any claim to a treaty right to health by any First Nation that is a member of the Nishnawbe Aski Nation. The Parties to this Charter commit to respecting the autonomy and diversity of tribal councils and communities. The parties do not intend for any future agreements flowing from this strengthened relationship to derogate from any First Nations' inherent or treaty rights.

This Charter has been created to acknowledge and guide the work of the Joint Action Table (outlined in the Terms of Reference attached to this document as Appendix A), and is not to be used for any other purpose.

GUIDING PRINCIPLES FOR A RENEWED RELATIONSHIP

The Parties therefore commit to a renewed multilateral nation to nation relationship that is guided by a mutual, collaborative approach to health planning in accordance with the following principles:

1) Any new approach is intended to address health, and health care service gaps;

2) First Nations must have timely access to culturally safe health services and facilities, regardless of where they live and have a right to equitable access to health services that meet the unique needs of the communities of NAN territory;

3) Joint strategies are needed to identify and address structural barriers to health care delivery to First Nations;

4) Health transformation is a community driven process that engages the expertise of First Nations communities and health care professionals, and collaboratively increases the involvement of First Nations to ensure decision making concerning health services for communities is at the community level;

5) Any new approach for addressing health and wellness would be guided by existing health plans and community directions;

6) The system is intended to be flexible, efficient and accountable;

7) New approaches would build on First Nations' capacities and strengths with an emphasis on local control and authority over health care services;

8) Continuous evaluation is important for measuring progress and systematically assessing, evaluating and improving the structure, process and outcomes;

9) Governance and management of the system is intended to be guided by clear roles and responsibilities at all levels and incorporate First Nations ways and other best practices;

10) Health partners and communities will work together in a coordinated and collaborative manner while respecting the autonomy of tribal councils and communities. Communities will be engaged at all levels (community workers, elders and youth) so that their voices are heard and incorporated into community-based programming;

11) First Nations have an inherent right to self-government and that the relationship between Canada, Ontario and the First Nations must be based upon respect for this right; and an inherent right to self-government may be given legal effect by specific rights recognized and affirmed by section 35 of the *Constitution Act, 1982*, or through negotiated agreements and legislation;

12) The jurisdiction and legal obligations of the Crown are determined by the Canadian constitutional framework, which includes common law and treaties entered into between First Nations and the Crown;

13) The Parties intend to maintain and strengthen a relationship that is based on (a) the special and the fiduciary relationship that exists between Canada and NAN First Nations; and (b) a commitment by Canada and Ontario to uphold the principles of the *Canada Health Act* including the accessibility criteria for First Nations people residing in the NAN Territory; and

14) This Charter is intended to strengthen the relationship between Canada, Ontario and NAN and the Parties will strive to ensure that their work together is respectful.

THE VISION: HEALTH SYSTEM TRANSFORMATION

This system-wide change would see First Nations have equitable access to quality care delivered within their community, in NAN territory, as a priority. The Parties intend the system to include holistic models of care, focusing on wellness planning, population health and health determinants. The system would be patient centred, responsive to community and patient voices, and ensure that health care providers funded by federal or provincial governments would have the skills required to provide responsive, effective and culturally safe care. Communities would be engaged at all levels (community workers, Elders, and youth) so that their voices are heard and incorporated into community-based programming.

The Parties intend to take all reasonable steps necessary to support health system transformation for the First Nations in NAN territory, including, but not limited to:

1) Supporting an alignment process that would bring decision-makers together to move health transformation forward in a deliberate, planned, and measurable way;

2) Creating a framework that would:

a) Include an immediate process that would review the urgent health needs identified by NAN and other First Nations health entities within NAN territory, prioritize actions, and implement a joint action plan with an evaluation program for transparency;
b) Include a joint review and implementation of commitments made by Health Canada in response to the Auditor General of Canada Spring 2015 Report on Access to Health Services for Remote First Nations Communities that are relevant for the NAN First Nations;
c) Include a joint review of the existing health system and funding model, and work towards health system transformation guided by existing system transformation models in the NAN territory that would create new models to improve access to health services;
d) Observe the principle that jurisdictional disputes should not prevent the timely provision of services to First Nations children.

3) Developing new approaches to improve the health and health access of First Nations people in NAN territory and associated communities, including increasing and improving services and access at the community level;

4) Supporting the ability of communities and First Nations institutions to deliver and plan health services;

5) Proposing policy reform, and considering whether legislative changes may be required, to design a new health care system for First Nations in NAN Territory that includes sustainable funding models within a new fiscal arrangement; decision making structures that provide First Nations with authority, control and oversight; and enable multi-sectoral approaches;

6) Removing barriers caused by jurisdictional, funding, policy, cultural and structural issues that negatively impact First Nations' ability to plan, design, manage and deliver quality health care services in their communities and for their members; and

7) Establishing tri-governmental political oversight such that the actions and decisions of all officials within their organization, Department or Ministry are consistent with the political commitments made by their leaders.

GOING FORWARD

The development of relationship principles between the parties is a component of the health transformation process. These principles are meant to guide discussions among the Parties respecting health system transformation. The Parties intend to identify their leads and the resources for an immediate and ongoing planning process and will finalize a structure and work plan for said planning process, including identifying frequency of meetings, as is outlined in the Terms of Reference and attached as Appendix "A".

As the work proceeds, the parties intend to provide regular written updates (at least once per year) to the Chiefs-in-Assembly of the NAN communities.

WHEREOF THE PARTIES hereto have executed this Charter of Relationship Principles as set out below, dated this 24th day of July, 2017

Grand Chief Alvin Fiddler
Nishnawbe Aski Nation on behalf of
The First Nations in NAN territory

Date July 24, 2017

Honourable Jane Philpott
Minister of Health on behalf of
Canada

Date July 24, 2017

Honourable Eric Hoskins
Minister of Health and Long Term Care on
behalf of Ontario

Date July 24, 2017

Nishnawbe Aski Nation
Community Health Transformation

Nishnawbe Aski Nation
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