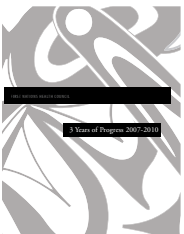




FIRST NATIONS HEALTH COUNCIL

3 Years of Progress 2007-2010



Our Story - A three year progress report 2007-2010

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1. Getting to the TFNHP

1.1 Getting to the TFNHP

The Leadership Accord [2005] In 2005 the Union of BC Indian Chiefs, First Nations Summit, and BC Assembly of First Nations signed the BC First Nations Leadership Accord. The Accord, “formalized a cooperative working relationship of the Parties to politically represent the interests of First Nations in British Columbia and develop strategies and actions to bring about significant and substantive changes to government policy that will benefit all First Nations in British Columbia.” (Leadership Accord, 2005)

The New Relationship [2005] Mandated by BC First Nations through the Leadership Accord, the First Nations Leadership Council, comprised of representatives of the Union of BC Indian Chiefs (3), First Nations Summit (3) and BC Assembly of First Nations (1) entered into a New Relationship with the Province of British Columbia. This new relationship committed the Parties to “...Restore, revitalize and strengthen First Nations and their communities and families to eliminate the gap in standards of living with other British Columbians, and substantially improve the circumstances of First Nations people in areas which include: education, children and families, and health, including restoration of habitats to achieve access to traditional foods and medicines.” (New Relationship 2005).

The First Nations Health Blueprint [2005] From the Assembly of First Nations (AFN) – Federal Crown Political Accord and the Recognition and Implementation of First Nations Governments, May 30 2005, the First Nations Health Blueprint for British Columbia was developed in 2005. The purpose of the Blueprint was to document First Nations Health priorities and also the disparities that exist between First Nations and other British Columbians. A forum for representatives of British Columbia’s First Nations provided detailed input into this Blueprint on June 22, 2005. Although there was a short time frame, the technical team worked with a variety of Chiefs and elders to complete the Blueprint document. While it was completed without the benefit of direct participation of all First Nations leaders, Elders, health workers, advisors, and the users of health services in BC, every attempt was made to ensure that the values, principles and directions of BC First Nations were reflected in the Blueprint document.



The Transformative Change Accord [2005] At the First Ministers meeting held in Kelowna in 2005, the First Nations Leadership Council (FNLC), Province of British Columbia (BC) and Government of Canada (Canada) signed the Transformative Change Accord, committing the parties to:

- Establishing a new relationship based on mutual respect and recognition;
- Reconciling Aboriginal title and rights with those of the Crown; and
- Closing the social and economic gap between First Nations and other British Columbians, in the areas of relationships, education, health, housing and infrastructure, and economic opportunities.

The Transformative Change Accord (TCA) called upon the Parties to negotiate a ten-year implementation strategy in each of the 4 areas. In addition, the Premier of BC also agreed to host the next First Minister’s meeting on Aboriginal Health in BC.

The Transformative Change Accord: First Nations Health Plan [2006]

In early 2006, the Federal election resulted in a new Government which, in its initial days, was uncertain about entering into the TCA agreements. Despite this, the Province and the FNLC agreed to continue working on a bi-lateral plan to be released at the first Ministers meeting. The TCA: First Nations Health Plan was developed between January and November of 2006, through a high level political process drawing from the First Nations Leadership Council's submission on the Ten Year Blueprint for Aboriginal Health which was produced by the Assembly of First Nations, and the Provincial Health Officers report of 2001.



The Transformative Change Accord: First Nations Health Plan was released on November 26, 2006 by the FNLC and BC. This ten-year Plan includes twenty-nine action items in the following four areas (full list of actions can be found on page 9):

- Governance, Relationships and Accountability;
- Health Promotion/Disease and Injury Prevention;
- Health Services; and
- Performance Tracking.

Tripartite Memorandum of Understanding [2006]

Although the Federal Government had not entered into the original Kelowna commitment in early 2006, it became interested by the summer of 2006. By then, the negotiations for content for the TCA: FNHP between the First Nations Leadership Council and the Province was advanced, and including the Federal Government at that late stage was difficult.

It was therefore agreed upon to proceed with completing the TCA: FNHP in order to meet the deadline. The parties also agreed upon a Memorandum of Understanding (MOU) to commit the federal government to work with the province and First Nations to turn the bi-lateral TCA: FNHP into a tripartite plan within six months. The MOU committed the parties to negotiating a set of agreements for inclusion in a tripartite plan and to demonstrate ongoing support for the efforts that had occurred between First Nations and the Province of BC. To this end, a First Nations Health Plan Memorandum of Understanding was signed by the First Nations Leadership Council (FNLC), Canada and BC on November 27, 2006 (a day after the TCA: FNHP release). This document included the same sections and action items as the Transformative Change Accord: First Nations Health Plan and proposed a number of new action items. It required the Parties to develop a Tripartite First Nations Health Plan (TFNHP) by May 27, 2007.



Tripartite First Nations Health Plan [2007]

In February 2007 the First Nations Health Council was established, thereby implementing one of the agreed actions from the TCA: FNHP. After the release of the Memorandum of Understanding, a tripartite process was established to develop a Tripartite First Nations Health Plan (TFNHP) to build on the TCA: FNHP. An important part of this work was to engage First Nations in the development of the TFNHP and provide communities a chance to review the TCA: FNHP.

The technical team hosted the inaugural "Gathering Wisdom for a Shared Journey" forum in April 2007 to initiate the 10 year conversation with BC First Nations on the TCA: FNHP and the soon to be concluded TFNHP. It was also an important objective of the first Gathering Wisdom forum for the First Nations Health Council to affirm to First Nations communities that this was just the beginning of the dialogue and that it would continue for the 10 year duration of the plan(s).

1

Getting to the Tripartite Health Plan

“The collective vision of the Province of BC, the Government of Canada and the First Nations Leadership Council is that the health and well-being of First Nations is improved, the gaps in health between First Nations people and other British Columbians are closed and First Nations are fully involved in decision-making regarding the health of their peoples”

Tripartite First Nations Health Plan
(2007)

On April 10-11, 2007 the first annual Gathering Wisdom for a Shared Journey (GW) was held in Vancouver. The forum brought First Nations leadership, health professionals, and health managers together with government officials to consider both the TCA: FNHP and the TFNHP Memorandum of Understanding and to initiate dialogue towards improving First Nations health outcomes.

Direction was obtained from the GW Forum, which specifically informed the development of the Tripartite First Nations Health Plan, and supplemented actions and agreements from the TCA: FNHP. Technicians from the First Nations Leadership Council, Health Canada and the Province further developed the TFNHP based on directions from BC First Nations received at GW.

On June 11, 2007, on the territory of the Musqueam First Nation, a ten-year Tripartite First Nations Health Plan was signed by the political executive of the Union of BC Indian Chiefs, First Nations Summit, BC Assembly of First Nations, BC and Canada.

Through the ‘Governance, Relationships and Accountability’ section of the TFNHP, all parties committed to develop a new structure for BC First Nations health governance by 2010. This structure was to be comprised of a number of essential elements including:

- A First Nations Health Governing Body
- A First Nations Health Council
- A Provincial Advisory Committee of First Nations Health, and
- A First Nations Health Directors Association.

Part of the TFNHP was a requirement for the parties to develop a work-plan within six months for approval by the Oversight Committee. This work-plan was approved on December 20, 2007 and covered all of the action items (from TCA: FNHP), some additional actions, and a description of processes for implementation (such as the establishment of the Tripartite Management Team).

1.2 Vision of the TFNHP

“The collective vision of the Province of BC, the Government of Canada and the First Nations Leadership Council is that the health and well-being of First Nations is improved, the gaps in health between First Nations people and other British Columbians are closed and First Nations are fully involved in decision-making regarding the health of their peoples”

1.3 Key Health Indicators from the TCA: FNHP

- Decrease the gap in life expectancy between Status Indians and other British Columbians by 35% to less than 3 years difference by 2015 (a gap of 7 years as at 2005);
- Reduce the gap in mortality rates between Status Indians and other British Columbians by 35% by 2015 (currently First Nations are dying at rates 1.5 times higher than others in BC);
- Reduce the gap in youth suicide rates between First Nations and other British Columbians by 50% by 2015 (currently five times that of non-First Nations youth);
- Reduce the gap in infant mortality between First Nations and other British Columbians by 50% by 2015 (currently 8 per 1,000 Status Indian children die in the first year of life compared to 4 per 1,000 other children)
- Reduce the gap in prevalence of diabetes between First Nations and other British Columbians by 33% by 2015 (currently 6% in Status Indians compared to 4.5% in the rest of the population)
- Decrease rates of childhood obesity and develop ongoing mechanism for collecting data
- Increase the First Nations health care workforce and develop ongoing mechanism for collecting data
- The TFNHP identified key ‘health action’ indicators as appropriate that included the measurement of new and improved health governance, management and service delivery relationships at all levels.

1.4 Key Goals of the TFNHP

Planning:

1. First Nations and mandated health organizations will have or be part of a comprehensive health and wellness plan;

Service Delivery:

2. First Nations health services will be delivered in a manner that effectively meets the needs, priorities and interests of First Nations communities;
3. First Nations will have access to quality health services;
4. First Nation mandated health organizations will be central to the design and delivery of all health services at the community level;
5. Health services delivered by First Nations, when appropriate, will be effectively linked to and coordinated with provincially-funded services;
6. First Nations health services will be delivered through a new governance structure that leads to improved accountability and control of First Nations health services by First Nations;
7. Health Canada in cooperation with the First Nations Leadership Council and the Province of British Columbia, will continue to evolve its role from that of a designer and deliverer of First Nations Health Service to that of funder and governance partner;

Collaboration:

8. First Nations, Health Canada and the provincial government (including its regional health authorities) will maintain an ongoing collaborative relationship based on respect, reconciliation and recognition of each other's roles as governance partners.

1.5 Principles Underlying the TFNHP

Respect and Recognition:

- Evolve jurisdictional and fiduciary relationships and responsibilities,
- Recognize the role of cultural knowledge and traditional health practices and medicines,
- Respect the diversity, interests and vision of First Nations,
- The coordination of federally and provincial-funded health programs and services will be more effective and include the increased participation of First Nations in the governance, management and delivery of services.

Commitment to Action:

- Take a holistic approach to health;
- All Parties to this Plan will contribute financially and/or in-kind to the implementation of the new First Nations health service governance and delivery structures;

Nurture the Relationship:

- Reciprocal accountability;
- Capacity development requirements of the First Nations health sector will be paramount, through planned growth, knowledge and skill transfer.

Transparency:

- Changing programs and services (including the transfer of programs and services)
- Information sharing

1.6 Implementing the Work-Plans

2007 - INITIAL WORKPLAN –the formation of Health Actions committees and a coordination team to direct implementation of the health actions, while the FNHC worked with the tripartite partners on the health governance structure. During this period the FNHC also had to maintain Chiefs Health Committee relationships with federal programs

2007-2008 – Health actions work focused on the provincial health services with MOU's between First Nations and health authorities plus the formation of the first 10 Hubs.

2008-2009 – Governance was the primary focus during this period with the formation of FN Interim Health Governance committee and the regional Caucuses. Health Actions were restructured into 4 components, population health, health and human resources, performance tracking and health systems.

2009-2010 – Governance was again at the fore, with negotiations between BC, Canada and First Nations aimed at developing the scope, structure and roles of a new First Nations governing body. The formation of the FN Health Society, as the implementation arm of the FNHC, continued to move the Health Actions work forward.

The table on the next page provides a 'snapshot' of the actions arising from the TFNHP that have been, are being, or will be implemented by the First Nations Health Council / Society and its Government partners. This is provided for a 'ready reference' point rather than a detailed overview of all of the actions that need to be undertaken. More detail on each action is contained within the plans themselves. What the table does indicate however are several things:

- that there is a significant amount of work to be done;
- that new priorities have emerged (and will likely continue to emerge) since the plans were signed (e.g. H1N1);
- that by clustering the work into logically grouped inter-connected areas, we have an opportunity to utilize our scarce resources better, and
- that achievement of these ambitious actions will require the full weight of First Nations participation and the commitment of the Federal and Provincial governments to resource the implementation appropriately over the ten year term.

FIGURE 1.0: SUMMARY OF TCA: FNHP AND TFNHP ACTIONS

(HIGHLIGHTING ‘CLUSTERS’ OF LINKED ACTIVITY AND LINKAGE OF HEALTH ACTION NUMBERS FROM THE TCA: FNHP)

GOVERNANCE ACTIONS		POPULATION HEALTH – Maternal & Child Health
1	Establish a new First Nations Health Council	10 Improve childhood Vision, Hearing, and Dental Screening for First Nations children
2	Appoint an Aboriginal Physician in the Provincial Health Officer's Office	11 Follow up on 2005 Child Death Review Report with the BC Coroner's Office
4	Establish a First Nations Health Advisory Committee	14 Introduce Campaign to raise awareness on Seatbelt Use and Safe Driving
5	Establish a Province-Wide Health Partners Group	21 Improving Access to Maternity Services
6	Develop a Reciprocal Accountability Framework to address gaps in health services for FNs	HEALTH HUMAN RESOURCES 18 Dedicate Post-Secondary Seats for Aboriginal Health professions
TFNHP	Establish a First Nations Health Directors Association (TFNHP)	19 Develop a Curriculum for Cultural Competency for Health Authorities
TFNHP	Establish a First Nations Health Governance Body (TFNHP) <i>including new administrative arrangement for FNHIH services</i>	20 Designate Senior Staff in Health Authorities Responsible for Aboriginal Health
TFNHP	Ensuring and supporting First Nations in developing Community Health and Wellness Plans (TFNHP)	24 Develop role of Nurse Practitioners & Physician participation in Ab. Health & healing centers
HEALTH SERVICE ACTIONS		25 Increase the number of professional and skilled trades First Nations in health professions
POPULATION HEALTH – Primary Health		26 Increase the number of Aboriginal Hospital Patient Liaisons/Navigators
7	Lead the development of a specific Aboriginal ActNow BC Program	
12	Improve Primary Care Services on reserve to match or exceed off-reserve services	HEALTH SYSTEMS
13	Improve the First Responder Program in Rural and Remote Communities	16 Develop a new Health Centre at Lytton
17	Implement a Northern Region Chronic Disease Prevention and Management Pilot	23 Create a fully integrated clinical Tele-health network
22	Introduce Integrated Primary Health Services and Self-Management Programs for Chronic Health Conditions	TFNHP Develop a Multi-Jurisdictional Planning Framework that provides service delivery linkages between goals and activities described in First Nations community health plans with those of regional health authority service plans (TFNHP)
TFNHP	Develop and implement an Injury Prevention Strategy (TFNHP)	3 Each Health Authority to develop an Aboriginal Health Plan
NEW1	Develop and implement an HIV / AIDs Strategy (new 2008)	TFNHP Support the process of developing Capital Infrastructure with First Nations (TFNHP)
NEW2	Pandemic Planning and H1N1 (New 2009)	
NEW3	Traditional Medicines and Practices (new 2009)	
POPULATION HEALTH – Mental Health & Addictions		RESEARCH & PERFORMANCE TRACKING
8	Develop and implement a Mental Health and Addictions Plan	27 Issue Provincial Health Officer's Report on Aboriginal Health every 5 years
9	Host a forum to support and encourage cultural learning and to develop models for Youth Suicide Prevention	28 Renew the Tripartite Agreement to ensure First Nations information is shared
15	Develop new culturally appropriate Addiction Beds for Aboriginal Peoples	29 Expand the Community Health survey to include First Nations
		TFNHP Develop indicators to complement the 7 existing indicators (TFNHP)

2 First Nations Health Council Report

2. Report of the First Nations Health Council



2.1 Establishment of the First Nations Health Council

One of the key agreements of the TCA: FNHP was to establish a BC First Nations Health Council. In February of 2007, there was a two-day session for the political executives of the three organizations to discuss the formation of the First Nations Health Council. The Council was subsequently established through consensus of the political executive of the First Nations Summit, Union of BC Indian Chiefs, and BC Assembly of First Nations, and their respective committees with responsibility for health. The outcome of the two day session was a decision to form the First Nations Health Council, which would mirror the membership of the Leadership Council [UBCIC (3), FNS (3), and BCAFN (1)]. The first appointees to the FNHC were:

- Chief William Starr - FNS
- Chief Willard Martin - FNS
- Chief Harvey Alphonse - FNS
- Debbie Abbott - UBCIC
- Chief Fabian Alexis - UBCIC
- Chief Jennifer Bobb - UBCIC
- Chief Alan Claxton - BCAFN

The First Nations Summit agreed to become the interim administrative host agency for FNHC activities, including managing its finances and entering into any legal arrangements on its behalf.

A Terms of Reference for the Health Council was developed and considered by the three political executives and then passed by resolution at the BC Assembly of First Nations (Res #62007), Union of BC Indian Chiefs (Res #2007-06), and First Nations Summit (Res #0307.07) in July 2007. The Terms of Reference incorporated agreed terms for the operation of the First Nations Health Council including:

- Purpose and Activities
- Membership
- Roles and Responsibilities of First Nations Health Council members
- Roles and Responsibilities of First Nations Health Council technical support
- Appointment
- Meetings and Decision-Making
- Term
- Reporting and Accountability
- Cooperation and Partnership
- Funding

The First Nations Health Council was not developed as a legal entity. Its sole purpose was to provide a forum for appointees selected by each of the three political bodies to focus on delivery of the TCA: FNHP and the TFNHP.

During 2007, while the TOR was being developed, the FNHC developed the TFNHP and the initial work plan. The Council also hosted the first Gathering for Wisdom as a forum for communities to collaborate with leadership and government agencies, and held the first staff retreat. During this period the Chiefs Health Committee continued to operate as did the Social Development Committee. The provincial work on health actions was also advanced, particularly in maternal and child health. The new relationship principle of achieving efficiencies in decision making and institutional change was becoming evident. The Aboriginal Maternal Child Health Steering Committee was formed including First Nations, Federal, and Provincial representatives in maternal and child health. The Committee has made significant gains in dental, vision and hearing screening of First Nation children, and these gains continue to grow as the screening program is rolled out.

On March 7th 2008, the First Nations Chiefs' Health Committee (FNCHC) was dissolved through resolution of the First Nations Summit Chiefs in Assembly, with all FNCHC staff and resources being relocated under the First Nations Health Council umbrella. Effective April 1st, 2008 the former Chiefs' Health Committee office at 1205- 100 Park Royal South became the offices for the First Nations Health Council, supported by the First Nations Summit (FNS) as the Council's corporate, financial and operational arm. In the 2008 – 2009 year the FNS continued to provide this support for the Council however this ended on March 31, 2009. From April 1, 2009 the First Nations Health Council received its corporate and operational support from the newly established FN Health Society, which was registered in March 2009.

As of March 2010, the members of the First Nations Health Council were:

- Co-Chair – Debbie Abbott, UBCIC
- Co-Chair- Chief Lydia Hwitsum, FNS
- Chief Elmer Moody, BC AFN
- William Starr, FNS
- Shana Manson, FNS
- Chief Fabian Alexis, UBCIC
- Jennifer Bobb, UBCIC

Grand Chief Doug Kelly was the ex-officio appointment from the First Nations Leadership Council

A Terms of Reference for the Health Council was developed and passed by resolution at the BC Assembly of First Nations (Res #62007), Union of BC Indian Chiefs (Res #2007-06), and First Nations Summit (Res #0307.07) in July 2007

2 First Nations Health Council Report

First Nations Health Council Strategic Objectives

The FN Health Council Business Plan 2008-2013 identifies 3 strategic directions:

- ***FNHC committed to implement the Tripartite First Nations Health Plan and support First Nations to determine and achieve their own health outcomes***
- ***FNHC committed to support capacity building in First Nations communities for planning, collaboration and communication including developing community health plans***
- ***FNHC committed to building effective partnerships with all 203 First Nation, Canada, BC and health service providers***

At the time, the core business of the FNHC was governance and strategic direction. The FNHC received administrative support, policy guidelines, and legal arrangements from the First Nations Summit.

While the FN Summit provided unquestionable support to the First Nations Health Council, the Council determined that the policies, procedures and infrastructure required by the FNHC had evolved beyond the structures and mandate of the First Nations Summit. The development and implementation of a transition plan to opt out of the FNS arrangement was agreed in 2008.

The transition plan enabled the development of administrative and financial systems and policies necessary for the incorporation of a new legal entity. As the FNHC is a mandated body charged by First Nations to provide leadership to implement the TCA: FNHP & TFNHP and not a legal entity, the FN Health Society was established to act as its corporate governance and operational arm.

To address the Political & Governance issues, a First Nations Interim Health Governance Committee (FNIHGC) was formed in February 2008 and comprehensive strategy was developed and implemented to address the NIHB issues. Regional Caucus sessions in each health region were held and a communication strategy was developed to link BC First Nations to regional caucuses.

To address the implementation of the TCA: FNHP & TFNHP, the FN Health Society Board appointed a CEO and a Senior Management Team to oversee the implementation the TFNHP and a three year strategic implementation plan for 2009-2012 was developed. The Strategic Plan for the First Nations Health Council identifies several strategic priorities:

- Develop a new structure to govern First Nations health services
- Oversee implementation of the TFNHP 2007 – 2017
- Develop and implement a transition plan to incorporate the Council following transition of FNS technical support to the FNHC
- Develop and implement a comprehensive strategy to resolve all NIHB issues
- Develop and implement a Youth Wellness Strategy
- Develop and implement a strategy to achieve a coordinated and integrated service delivery model

First Nations Health Council Meeting Discussions and Outcomes

The First Nations Health Council met officially nine times in 2007-2008, eight times in 2008 – 2009 and six times in 2009-2010 to discuss various issues during the year and to develop a Strategic Plan for its activities.

FIG 2.0- FIRST NATIONS HEALTH COUNCIL MEETINGS 2007-2010

FNHC meetings held 2007-2008	FNHC meetings held 2008-2009	FNHC meetings held 2009-2010
April 25, 2007 (after GW1) *	May 13, 2008	April 21, 2009
May 17, 2007	June 9, 2008	May 5, 2009
June 5, 2007 *	September 22, 2008	July 2, 2009
June 25, 2007	November 14, 2008	December 14, 2009
September 17 – 18, 2007	December 22, 2008	January 8, 2010
November 26, 2007 *	January 16, 2009	March 15, 2010
January 16, 2008	February 18, 2009	
February 19, 2008 *	March 11, 2009	
March 11, 2008 *		

* **No Quorum achieved therefore FNHC was unable to formally decisions forward**

The Co-Chairs role was identified at the June 9, 2008 meeting with Debbie Abbott and Chief Lydia Hwitsum being appointed to this role. At the very first meeting they held on April 25, 2007 members William Starr, Debbie Abbott, Jennifer Bobb, Harvey Alphonse, and Allan Caxton, were in attendance along with Joe Gallagher. Members made a number of statements that indicate how they thought about proceeding with implementation of the TCA: FNHP:

'We need to support our small and remote communities'
'Communications with communities will be essential'
'We need to speak with one voice'
'The FNHC is a step forward to closing the gaps'

By the second meeting, the FNHC was already discussing the establishment of a website, the startup of newsletters to communities and the development and communication of a workplan. At this meeting the FNHC also began reviewing the draft Tripartite First Nations Health Plan, which would eventually be initiated in May and signed in June of that year.

By the third meeting in June, the Provincial and Federal partners were already coming to the table to talk about vision screening; eHealth; youth suicide; data sharing agreements; ActNow and Aboriginal Health Human Resources Initiative (AHHRI). The small technical team had hardly been established and was still aligning work with the FNS Chiefs Health Committee and the UBCIC Social Development Committee.



By the second meeting, the FNHC was already discussing the establishment of a website; the startup of newsletters to communities and developing and communicating a work-plan

2 First Nations Health Council Report

The FNHC and its small technical team were literally inundated with new issues to discuss, as government partners who were already working on these areas suddenly saw an opportunity to acquire First Nations input, all while the FNHC was still trying to get up and running. In addition, the technical team had not had the opportunity to find out how things were currently working, in order to strategically plan how to best engage with the partners and to create the space needed for BC First Nations community input to the various processes and activities that were occurring.

In an attempt to be proactive and not be absorbed into Government agendas, the technical team developed an initial six month work-plan which was approved by the FNHC in late June 2007. Included in the work plan were:

- Establish oversight and planning structures and implementation mechanisms;
- Establish a multi-jurisdictional approach to planning;
- Establish processes that ensure effective First Nations direction in governance;
- Implement actions of the TCA:FNHP;
- Develop an implementation plan for a multi-jurisdictional health planning framework;
- Identification or creation of First Nations models of excellence to highlight and acknowledge key innovations that communities had developed and to provide a mechanism for sharing best practices. These models of excellence aimed to build on current expertise and to identify leaders in specific subject matters that the FNHC could work with to advance the actions of the TFNHP for the benefit of all First Nations;
- Environmental Scan of all programs and services affecting First Nations;
- Develop effective indicators of wellness including evaluation framework and data management system.

By September 2007 the FNHC agreed to adopt the recommended community engagement strategy and gave the mandate for the technical team to create Community Engagement Hubs

By September 2007, the FNHC agreed to adopt the recommended community engagement strategy and gave the mandate for the technical team to create Community Engagement Hubs. The Hubs were created for the purpose of better communication on the TFNHP by the FNHC, collaboration between First Nations communities and with health authorities, and to provide a vehicle for communities to undertake more effective community health planning.

Further, with the signing of the TFNHP in June 2007, there was some urgency for the FNHC to begin to establish a process to work on the development of the new BC First Nations health governing body. Along with the need to continue progress with the original 29 Action Items from the TCA: FNHP, the FNHC was also tasked with leading a process to engage BC First Nations on the governance agenda.

The FNHC made the decision to create a First Nations Interim Health Government Committee in January 2008. The interim governance committee was formed with the UBCIC, BCAFN and the FNS appointing their representatives to the three co-chair positions.

Over the next six months, work involved developing the TFNHP work plan and health governance preparations including dialogue at Gathering Wisdom that led to a regional caucus process for leaders to come together to consider health governance issues. There were also many provincial and federal committees on the TCA: FNHP / TFNHP operating, which required FNHC participation.

During the first two years, the FNHC and the technical team were busy responding to a number of key issues:

- Beginning the process of engaging BC First Nations on the governance model;
- Working with the federal and provincial governments on the 29 action items from the TCA: FNHP – some of which were highly active at the time since governments were already part way through their own implementation processes when the TCA: FNHP was signed;
- Building a model of community engagement so that communities could effectively participate in the TFNHP implementation;
- Responding to urgent and immediate community crises. For instance in February 2008 there was a crises of youth suicide in the north and communities were pleading for help. The FNHC allocated funding for these types of crises in order to support communities to overcome and work through their own solutions;
- eHealth was emerging as a very significant issue because of federal and provincial strategies in this area;
- Implementing programs handed down from the Chiefs' Health Committee and functions that they had contracted with federal government including AHHRI, Aboriginal Diabetes funding and Aboriginal Health Transition Fund dollars. AHHRI funding was being widely disseminated across the country and the BC share needed FNHC involvement to ensure that BC First Nations health workforce benefitted from those investments;
- Ministers from the Federal and Provincial Government were engaging with the FNHC;
- The FNHC was trying to build its own strategic plan, vision, mission and direction along with an accountability framework and by-laws for operating such as code of conduct and conflict of interest guidelines;
- Planning was continuing for the Gathering Wisdom forum, and actions needing follow up had arisen from the Gathering Wisdom of May 2008;
- Issues such as Bill C51 and the United Nations Declaration on the Rights of Indigenous People were high on the agenda for political leaders among BC first Nations, and affected the FNHC's ability to engage effectively when health was not always a number one priority for all nations;
- Responding to calls from other organizations wanting to form relationships with the FNHC such as the Native and Inuit Nurses Association;
- Reporting out to political assemblies and responding to information requests from political executives and individual nations.

As part of the FNHC's 2008 strategic planning process, it had been identified that the FNHC would 'develop and implement a transition plan to incorporate a business arm to transition FNS technical support to the FNHC. By late 2008, the FNHC and the FN Summit realized that the workload of the FNHC was growing at an exponential pace and that the corporate and administrative needs of the FNHC had outgrown what the small technical team within the Summit could support. Additionally, the potential legal and financial risks to the Summit were increasing as time went by, and it was necessary to limit and manage this exposure. The FNHC decided then to establish the FN Health Society as a legal entity, solely dedicated to supporting the FNHC and to implementing the TFNHP with the partners and other stakeholders who were involved. This then achieved one of the FNHC's key strategic objectives.

By late 2008 the FNHC and the FN Summit realized that the workload of the FNHC was growing at an exponential pace and that the corporate and administrative needs of the FNHC had outgrown what the small technical team within the Summit could support

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2.3 Reporting at Political Assemblies

Since the formation of the First Nations Health Council in February 2007, FNHC Co-Chairs have been providing update reports of Council activities at the political assemblies of each of the First Nations Summit and the Union of BC Indian Chiefs.

The Health Council also provides technical and policy support to each the Union of BC Indian Chiefs, First Nations Summit, and BC Assembly of First Nations as required.

Funding was also provided to UBCIC, as required through their resolution, in order to participate in FNHC activities and to cover policy support for UBCIC, when reporting out at political assemblies.

2.4 Engagement with Principals

An important role for the FNHC is engaging with Principals to advocate for TFNHP and maintain relationships such as convening meetings with the Ministers of Health, at both the Federal and Provincial level. These meetings enable the Council members to continue their advocacy for the TFNHP and to secure funding for BC First Nations to implement the plan. Three principals meetings have been held:

February 17, 2009: Grand Chief Doug Kelly and Chief Fabian Alexis met with Morris Rosenberg, Deputy Minister, Health Canada and Anne Marie Robinson, Assistant Deputy Minister, FNIHB to provide an update on the progress and process of implementing the Tripartite First Nations Health Plan.

August 31, 2009: Grand Chief Doug Kelly, Chief Lydia Hwitsum and Grand Chief Ed John met with Chair Minister Ida Chong, the Minister of Health Minister Aglukkaq and Deputy Minister Rosenberg. Discussions on the Tripartite work, accomplishments to date, implementing the vision and timetable for Governance were the main issues.

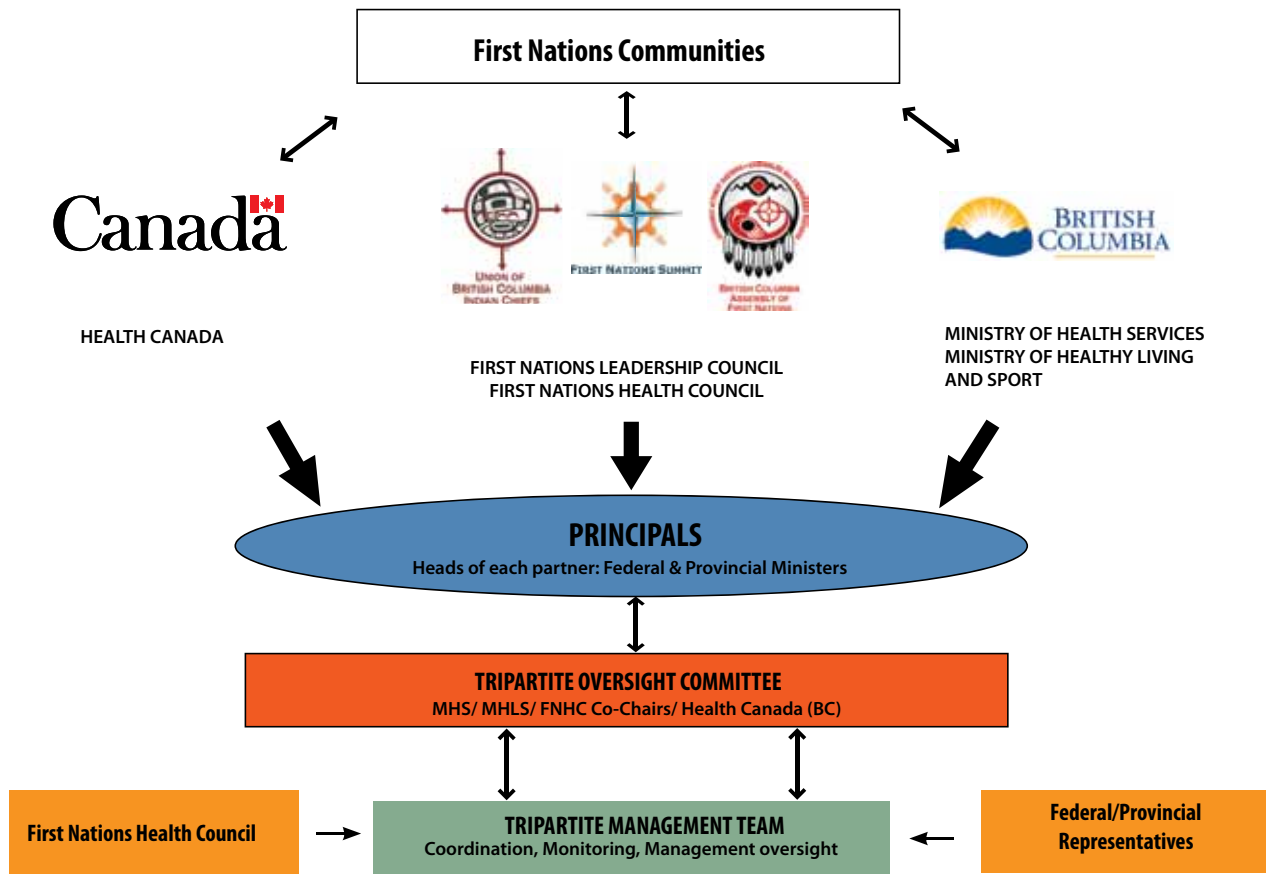
September 25, 2009: Grand Chief Doug Kelly, Chief Lydia Hwitsum, Debbie Abbott, Grand Chief Ed John, and Chief Shane Gottfriedson along with members of the Interim Health Governance Committee met with Minister Ida Chong, and Minister of Health Minister Aglukkaq to discuss Health Governance.



In order to maintain oversight of all of the activity, an accountability structure was implemented that included a Principal's meeting of Ministers with First Nations leadership, an Oversight Committee of Deputy Ministers and Assistant Deputy Ministers along with FN Health Council Co-Chairs, and a day to day management level committee known as the "Tripartite Management Team"

(TMT) comprised of senior executives from the provincial, federal and FNHC organizations. The reporting and accountability model is expressed in Figure 2.1.

FIG 2.1- TRIPARTITE ACCOUNTABILITY AND OVERSIGHT MODEL



2.5 Provincial Advisory Committee on First Nations Health

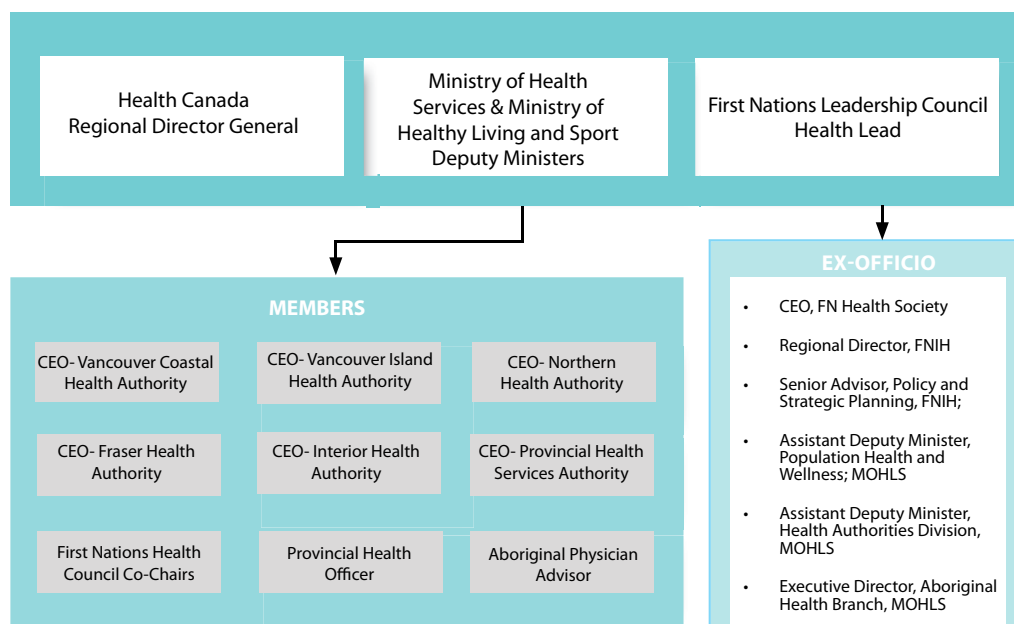
This Committee was established in response to TCA: FNHP Action No. 4. The purpose of this Committee, as identified in the TFNHP, is to “review and monitor Aboriginal Health Plans of the regional health authorities, monitor health outcomes in First Nations communities, and recommend actions to the Parties on closing the health gaps.”

The first meeting was held on September 18, 2008 with a number of Health Authority representatives, Provincial Deputy Ministers, Federal representatives and FNHC members, along with the technical team. At this meeting all three parties committed to begin work on a Reciprocal Accountability Framework (also one of the goals of the TFNHP) which will “address gaps in health services for First Nations in British Columbia and should clarify responsibility for health service delivery, resulting in a more seamless and responsive health care system”.

The purpose of this Committee, is to “review and monitor Aboriginal Health Plans of the regional health authorities, monitor health outcomes in First Nations communities, and recommend actions to the Parties on closing the health gaps.”

2 First Nations Health Council Report

FIG 2.2- PROVINCIAL COMMITTEE ON FIRST NATIONS HEALTH



In addition to moving forward on reciprocal accountability, the five Regional Health Authorities provided the Committee with a two page summary of their progress in implementing their Aboriginal health plans. Each summary details how health authority initiatives in Aboriginal Health relate to the TFNHP. These summaries are available on the FNHC website and an analysis of Health Authority Aboriginal Health Plans against the TFNHP is contained in the 'Year in Review 2008-2009' report available from the FN Health Society.

In January 2009, the Health Council co-chairs attended the second meeting of the Provincial Committee on First Nations Health (formerly the First Nations Health Advisory Committee). At this meeting all three parties committed to continue work on the Reciprocal Accountability Framework which will "address gaps in health services for First Nations in British Columbia, and should clarify responsibility for health service delivery, and result in a more seamless and responsive health care system". They also agreed that the CEO of the FNHC would visit with health authorities along with the executive director of Aboriginal Health from the Province, to discuss the TFNHP and health authority roles and expectations under the plans.

2.6 Restructuring the First Nations Health Council

On March 17th, 2010 the Union of BC Indian Chiefs passed a resolution calling for the seven member, politically appointed First Nations Health Council to transition from its current makeup (politically appointed representatives from the UBCIC, FNS & BC-AFN) to one that is comprised of regional representatives. The resolutions required that each region (Fraser, Interior, Vancouver Coastal, North, and Vancouver Island) appoint three representatives to a new 15-member First Nations Health Council. The new council structure has a two year mandate and is inclusive of the First Nations Interim Health Governance Committee.

The resolution brought forward at the Union of BC Indian Chiefs and the First Nations summit called for the following substantive actions:

1. That the First Nations Summit Chiefs in Assembly & the Union of BC Indian Chiefs call for presentation of the Basis for a Framework Agreement on Health Governance to First Nations, Tribal Councils, the UBCIC Chiefs Council, the First Nations Summit, and the BC Assembly of First Nations for a full review of the risks and benefits associated with this agreement.
2. That the First Nations Summit Chiefs in Assembly & the Union of BC Indian Chiefs replace the current structure and appointment of the First Nations Health Council which was set out in the Health Council Terms of Reference. The new membership structure will provide for 15 members. Nations within each of the five Regions (North, Interior, Fraser, Vancouver Coastal and Vancouver Island) through their own processes will appoint three representatives at the All Chiefs Assembly in the month of May 2010. In the interim, the existing First Nations Interim Health Governance Committee structure shall continue until the full establishment of the newly structured First Nations Health Council or May 30, 2010. The term of this transitional structure shall be for two years. This 15-member First Nations Health Council will be responsible for reporting to Nations in their regions, accountable for progress and processes at all levels, representation, and ensuring that ratification processes and decision making process that are community driven and Nation based.
3. The newly appointed First Nations Health Council will oversee the health governance negotiations pursuant to the Basis for a Framework Agreement on Health Governance. The new First Nations Health Council will appoint a negotiation and support team, and continue to provide resources for a community engagement and ratification process.

This new First Nations Health Council structure was initiated to provide a more direct reporting and accountability link to individual regions and Nations. The new First Nations Health Council is an interim body and will operate for a two-year period. Appointments to the new First Nations Health Council occurred between March and May of 2010 through regionally determined processes.



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Report of the Technical Team

3. REPORT OF THE TECHNICAL TEAM

3.1 Chief Executive Officer's Report

When the technical team was established for the FNHC, after the signing of the TCA: FNHP, the environment was new to all parties involved. There was no precedent for the type of partnership relationship envisaged in the plan and for undertaking the extensive amount of work that was to ensue from the plan's implementation. Additional to adapting to this new environment and beginning to work on the TCA: FNHP, there was also the requirement for both parties to begin engagement with the federal partner towards building the Tripartite First Nations Health Plan. There were a number of challenges for all parties to address which are discussed further below.

FIG 3.0: MOVING TOWARDS A NEW ENVIRONMENT



No Precedent for the Work

There was no precedent for this work. No other province in Canada has signed a Tripartite agreement in health with both the federal and provincial governments for the kind of change anticipated under these agreements. No other First Nations organization had undertaken such a huge role, tasked with influencing change in an industry worth over \$15.4billion [2010-2011 Service Plan MHS] with over 100,000 personnel involved, including multiple institutions and agencies. The provincial health ministries and health authorities are large multi-layered organizations with executives and managers at many levels. Health authorities alone have 94,000 staff.

The small FNHC team has taken on a huge challenge to influence these large complex systems and to create the space for First Nations to sit at the table with decision-makers in order to



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Report of the Technical Team

It is a fine line between engaging First Nations expertise into regional and provincial processes and system changes, while not removing this expertise from each community where it is also needed.

make sustainable changes for the benefit of First Nations people. While the outcomes will be hugely beneficial to First Nations communities, it will be a long process of change and system transformation never before seen in Canada.

Preparing the FNHC technical team for a new way of working

The FNHC had inherited responsibilities from the former Chiefs Health Committee, which included staff and some programs that had been funded by Health Canada. The initial technical team was comprised of resources available from the UBCIC Social Development Committee, the First Nations Summit's Chiefs Health Committee and a few new staff. The initial challenge was to bring these resources together to build a team under one health plan and to build unity and consensus about how to implement the TCA: FNHP and TFNHP.

The First Nations Health Council was a new body established specifically to address Action #1 in the TCA: FNHP; to provide leadership for the TCA: FNHP, and eventually the TFNHP. The FNHC has always had the challenge of ensuring ongoing engagement with First Nations communities, while maintaining a focus on advocacy with government leaders. They have a mandate to advocate for the vision and direction set by First Nations communities in the TFNHP but not to speak directly for First Nations. The ongoing challenge will always be that the FNHC must show leadership as well as create space for First Nations leadership. This is crucial in determining the appropriate direction at individual nation, regional and provincial levels.

The technical team (now the FN Health Society) had to find the balance between keeping its own staff capacity to a minimum, so as not to create another bureaucracy, while maintaining sufficient capacity to work on all of the actions in the TCA: FNHP and TFNHP. Over the past 3 years, the team has begun to build some capacity to address the many issues, but it has not been easy. The government health systems are largely foreign to First Nations; their language, jargon, layers of bureaucracy and complexity often make the systems difficult to understand and engage with for a small team.

The FNHC technical team needed to evolve from being program managers to becoming transformative leaders. This evolution is an ongoing challenge as we develop more knowledge on how the systems work. This type of change has not happened in this country before so the FNHC has accepted that we have much to learn. We have taken the approach of developing

knowledge, so we can respond accordingly and learn from others internationally who have been through this sort of change process. The technical team has had to learn new skills specific to providing transformative change leadership and implementing a plan of this magnitude. It has not been a critical success factor for people to have prior skills in this area, but it has been essential that our staff be willing to learn and engage with government in a way that they may not be accustomed to. In order to make this type of change, staff have had to learn the jargon, legislation, and policy frameworks, as well as familiarize themselves with the barriers within the system.

As much as possible, the technical team tries to lead, while finding room for First Nations to undertake different pieces of the work without





Since the size, scope and jurisdictions of the partner organizations were vastly different, there were no obvious 'equals' among the partners to work together in a collaborative fashion.

placing an extra strain on local resources. It can be difficult to include First Nations expertise in regional and provincial processes and system changes, whilst not removing this expertise from each community where it is also needed. With only a few hundred First Nations people working in health across 203 communities, it is important to ensure that these health professionals are able to participate in the process at both a policy/systems change and community level.

Diverse and Unequal Structures between the partners

The FNHC and the technical team were established solely to implement the plans and so structured its organization to reflect the key areas of the TCA: FNHP and later the TFNHP. However, provincial and federal partner organizations are both large bureaucracies whose structures have been in place for some time and are not equally positioned to begin implementation of the plans.

There was no precedent for how government structures should be organized in order to participate in these types of health partnerships. In addition, during the past three years, the Ministry of Health restructured and split into two ministries – the Ministry of Healthy Living and Sport and the Ministry of Health Services. Suddenly the technical team had to deal with two provincial ministries, 6 health authorities and Health Canada at both the federal and provincial level. To further complicate matters, the federal system is largely focused on First Nations on reserve, while the provincial system has a broad 'Aboriginal' health mandate. The technical team advocates purely from a First Nations perspective and aims to ensure the First Nations voice is included in all discussions, regardless of the jurisdictional issues this may place on the partners.

Since the size, scope and jurisdictions of the partner organizations were vastly different, there were no obvious 'equals' among the partners to work together in a collaborative fashion. Vice presidents in one partner would have to work with executive directors in another; assistant deputy ministers in the provincial system had to engage with regional directors in the federal system. The executive lead of the FNHC had to find a way of balancing engagement at the right levels, with both partners.

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Without a history of working in a tripartite way, there was a significant need for education and awareness for all parties.

The ongoing need for greater understanding, appreciation and context for all partners continues to be a key area that the technical team plays a role in supporting.

An added complexity was that the government personnel assigned to partner with the CEO of the (now) FN Health Society as the lead for the FNHC had little or no authority to actually make decisions or change within their respective systems. This has provided a further challenge for the FNHC, since our technical lead was not engaging directly with those who have the responsibility and authority to address health concerns of First Nations communities.

There was a need to engage with the CEO's and VP's of the regional health authorities, as well as ensure engagement with each of the executive leads, but as senior aboriginal personnel were positioned in different places within the organization, ongoing engagement was a challenge.

Suffice to say, the challenges of different stakeholders and decision-makers, operating at different levels in the partner organizations (including First Nations), continues to be an ongoing challenge for the technical team, but one that is improving year by year, as relationships and shared understanding on the TFNHP builds.

Catching up to Work in Progress

Another challenge of the new environment was that many of the Action Items from the TCA: FNHP and TFNHP involved the design, planning and delivery of health services which were already in a state of change.

After the TCA: FNHP was signed, the provincial managers were keen to engage with the FNHC and the technical team. The Province sought involvement in projects, change processes and new initiatives which had been initiated long before the TCA: FNHP was signed. These included initiatives such as mental health and injury prevention. The managers knew that the TCA: FNHP meant they needed to engage with First Nations, and they were active in trying to enlist this support immediately. The technical team was trying to build its own capacity and understanding while being asked to engage as quickly as possible in processes that were already underway for which First Nations participation was being sought. While the FNHC and the technical team did its best to provide some initial feedback on how those processes should move forward, there is no doubt that this was not the optimal way of approaching a true tripartite relationship in the design and planning of services.

Organizational and Cultural Challenges

The technical team was also faced large governmental bureaucracies with staff who were unfamiliar with the close working relationship between Canada, BC and First Nations communities required of the new Tripartite Agreement. There had been some initiatives that required engagement with First Nations (such as the 2001 PHO Report, Medical Services Plan and Non-Insured Health Benefits issues) but nothing as extensive as envisaged under the health plans. Much of the Tripartite plan work was always going to be a new journey for all of the partners, including First Nations communities and the technical team of the FNHC.

Without a history of working in a tripartite way, there was a significant need for education and awareness for all parties. Partner governments needed to understand the implications and intentions of the TCA: FNHP and the TFNHP and to work effectively with First Nations communities. First Nations needed to learn how to engage with governments in a constructive way, where previously there may have been historical issues preceding this type of new relationship. The ongoing need for greater understanding, appreciation and context for all partners continues to be a key area for the technical team.

It was also necessary to recognize what each partner was going to need in order to move forward. There is a responsibility for senior executives in each of the partner organizations to educate and raise awareness amongst its own staff about the TFNHP and the goals of a tripartite relationship.



The implementation plan for the TFNHP has evolved as partners needs and challenges have been communicated.

While building a technical team, and developing ways of working with partner governments, there was also a requirement to find ways of engaging First Nations communities in the implementation of the TFNHP. The following describes some of the strategies that were developed to address this need.

FIG 3.1: FACILITATING FIRST NATIONS PARTICIPATION IN THE PLAN



There is an internal responsibility for senior executives in each of the partner organizations to educate and raise awareness amongst its own staff about the TFNHP and the aspirations of a tripartite relationship.

Creating space for a Dialogue

When the FNHC and the technical team were established the first task was to engage with BC First Nations to seek guidance and direction on how to move forward with the TCA: FNHP and the TFNHP.

This resulted in the FNHC hosting 'Gathering Wisdom for a Shared Journey' forum in May 2007, and subsequently in May 2008 and November 2009. The first forum was held before the TFNHP was completed, in order to ensure that forum feedback could be incorporated into the TFNHP. Participants at Gathering Wisdom I (2007) made it clear that First Nations communities needed resources in order to effectively engage with each other and with the government partners. The communities expressed a need for opportunities to be able to work together, share experiences

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and learning, and to provide support to one another. Communities also said that the Tripartite partners needed to ensure they took a holistic and culturally-based approach to the actions in the plan and to strengthen First Nations roles in decision-making.



When the FNHC and the technical team were established the first task was to engage with BC First Nations to seek guidance and direction on how we should move forward with the TCA. This resulted in the FNHC hosting the first 'Gathering Wisdom for a Shared Journey' (GW) forum in May 2007.

The continued use of GW as a forum for First Nations leaders, health directors and community representatives to dialogue with partner governments has been a key strategy for the FNHC and the technical team to provide a mechanism for building relationships and shared understandings. First Nations participation in these forums has increased year by year revealing that First Nations engagement is growing and continues to increase.

Ensuring that implementation is supported at the political level

Political level engagement for First Nations leaders is occurring at a number of levels. With the FNHC's mandate to provide 'leadership' for the TCA: FNHP and the TFNHP and to create new models of First Nations health governance outlined in the plans, the task for leaders on the FNHC has been challenging. The technical team has supported the FNHC with secretariat functions, and technical and policy advice, as it has moved forward over the past 3 years. Additional resources were needed to support the FNHC when it established its sub-committee (the First Nations Interim Health Governance Committee – FNIHGC) to support its broader engagement with FN leadership on health governance issues. The resolutions of First Nations leaders to form Regional Caucuses for First Nations leadership to engage on health governance further brought with it a need for more technical and logistical support from the technical team. Over the past 3 years, the technical team has therefore developed a team of up to 9 personnel solely dedicated to supporting First Nations leadership at all levels.

A significant goal of the TFNHP is to develop a new health governance model for BC First Nations. The model itself incorporates a number of elements including:

- A new governance structure to assume management of Health Canada – FNIH functions in BC, along with agreed upon provincial programs and services;
- A new First Nations Health Directors Association
- A Provincial Committee on First Nations Health involving the tripartite partners and health authorities

Over the past 3 years, the work on the new governance structure has consumed a great deal of time by the technical team, especially in ensuring that there is a formal means of engaging BC First Nations political leadership in a fair and meaningful way. In 2008, political leaders sent a clear message that the process of engaging political leaders needed to be Nation-based and regionally structured. The formation of Regional Health Governance Caucuses (Regional Caucuses) in each region has provided a mechanism for leaders to come together to discuss a number of issues and considerations as the work around the Basis for a Framework Agreement has advanced. The First Nations Interim Health Governance Committee and the Regional Caucuses are beginning to build their own capacity to engage in governance discussions, and have been engaging actively in the discussions. It is only through continued dialogue and learning that we can advance the TFNHP agenda. While barriers have presented themselves, the fact that mechanisms have been created to debate, discuss and dialogue shows success and a forward trajectory. The regional caucuses and governance committees for political leadership have been created to address an absence of investment in this area historically by governments in health.

Accountabilities

Within the First Nations Health Council model of leadership for the plan, there are several inherent accountabilities. Until recently, the FNHC was accountable to the 3 political executives who appointed them, and in turn the political executives was accountable to the leadership of 203 communities. The FN Health Society Board is accountable to the 7 members of the FNHC and, with recent changes, will now be accountable to the 15 regionally appointed FNHC members. The 15 member Health Council will report out to their regional caucuses and the members of the caucus are then responsible to report out to their respective communities.

These layers of accountability create additional complexity and opportunities for misinformation and confusion to occur. There is a significant responsibility on the technical team to produce consistent and comprehensive information while not overwhelming communities and leaders with too much information.

The technical team must find a communicate key messages and information effectively, while not overburdening communities. A great deal of activity has been shared over the years through Gathering Wisdom forums, newsletters, websites, communiqué, email news, reports, Year in Review reports, political assemblies, Community Engagement Hubs, and regional caucuses. The technical team does a great job of disseminating as much information as possible. Still, at some stage communities and leaders themselves must also take responsibility for reading this material, asking the right questions, and providing feedback to the technical team about how communication methods might be improved.



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First Nations mandated health service organizations engagement: health directors

From the outset, First Nations health directors commented that they did not want the implementation of the TFNHP to become politicized. There was a recognition that other failed processes in BC had suffered by becoming overly politicized. While recognizing the need for political advocacy and leadership for the plan, they did not want to see community-level initiatives and solutions held up or hampered by situations where political leaders could not agree. The establishment of the First Nations Health Directors Association (FNHDA) to encourage, promote and support service level changes has provided an appropriate forum for relationship building between health directors across the province and the FNHC. The technical team has provided a significant level of logistical and facilitation support for health directors' to work towards the creation of the FNHDA. This work culminated in the legal registration of the FNHDA in April 2010.



The establishment of the FNHDA is a key action from the TFNHP and provides a mechanism for health directors and community-based First Nations health organizations to participate in the design and planning of services in their areas. The technical team has spent the past 3 years making space for First Nations health directors to engage with government partners through its health actions work. In the coming year the FNHC see an expanded role for the FNHDA as the voice of their communities in strategic discussion on service design and delivery. Health directors not only have a role in leading the delivery of their own services in their communities – they also have a key role in

influencing the government's planning, funding and delivery of services that they provide in First Nations communities. The technical team within the FNHC will be a key resource for the FNHDA to provide service, research and policy advice for their active participation at strategic tables with partner governments.

First Nations health directors also play a key role in their own Community Engagement Hubs. The hubs were created to provide a vehicle for mandated health organizations to come together to collaborate, plan and communicate with each other about service changes they need in their communities. Health directors knowledge of community-level client and family health issues will be critical as the FNHDA plays an expanded role with government decision-makers and policy-makers over the coming years.

First Nations health directors also play a key role in their own Community Engagement Hubs. The hubs were created to provide a vehicle for mandated health organizations to come together to collaborate, plan and communicate with each other about service changes they need in their communities. Health directors knowledge of community-level client and family health issues will be critical as the FNHDA plays an expanded role with government decision-makers and policy-makers over the coming years.

Supporting First Nations communities to engage in the TFNHP

A key focus for the technical team has been to support First Nations communities to engage in the TFNHP. This remains a challenge when communities have so many issues facing them on a day to day basis particularly in health centers. It has been a balancing act for the technical team to support communities and health centers, and work to ensure their involvement in the TFNHP, while not burdening them with additional activities to address within their limited resources.

Community Engagement Hub resources were offered to communities so that they did not have to undertake extra work with existing staff. However, support for collaborative planning by communities is only one aspect of the plan, the many projects and action items from the plans all demand First Nations involvement, and the technical team has often been required to occupy these spaces until First Nations representation can be facilitated.

From the outset, many Health Directors have commented that they did not want the implementation of the TFNHP to become politicized as the process has become under other failed processes.

The technical team has tried very hard to create multiple mechanisms for sharing information so that communities can access current information and engage where they wish to. These have included the FNHC website, quarterly newsletters, email “blasts” of new or emerging issues or information, community liaison personnel to support communities and create opportunities for dialogue and exchange, the Gathering Wisdom forums and the use of a FNHC Youtube channel to help reach the younger audiences. This work will continue in earnest so that information sharing can continue to improve and reach as many as possible.

Building collaboration between communities

Historically First Nations communities have not been actively encouraged or resourced by governments / funders to work together. The Health Canada model of funding dealt with each community individually meaning that there were no incentives or encouragements for communities to come together to plan, collaborate and build relationships with their health authorities.

Additionally there was no formal network within the BC Region where Health Directors could come together regularly at a Provincial level, to provide peer support, share ideas, develop solutions to common problems, and work more collaboratively with Health Canada and the regional health authorities. This absence of a formal network meant the FNHC was faced with trying to develop a practical means of working collaboratively with all communities while ensuring there was a means of communicating in a way that could reach everyone.

The technical team established a number of strategies in response to the needs outlined by communities. The first was to support the formation of Community Engagement Hubs. These were not intended to be ‘structures’ – but a means for communities to communicate, collaborate and plan. Health directors had made it very clear to us at the May 2007 Gathering Wisdom forum that they could not participate in the collaborative work required of the Health Plan, in addition to their existing responsibilities at home. The technical team provided resources to support the cost of engaging additional human resource in order to enable the level of collaboration that communities had requested. The hubs have also provided a means for more structured communication and information sharing with communities. Communities now have a vehicle to discuss how they want to approach issues by addressing their common needs.

In our first year, 2007 – 2008, there were 10 community engagement hubs established, involving 100 First Nations communities. In 2008 – 2009 a further 9 community engagement hubs were added and by March 31, 2010 there were 25 hubs across the province representing some 160 communities (79% of 203 communities). These have all been established by First Nations communities and are hosted by central organizations chosen by each hub. This is a remarkable achievement for First Nations communities and a large step in supporting their continued collaboration, communication and coordination.

Historically First Nations communities had not been actively encouraged or resourced by governments / funders to work together.



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Community initiatives, innovations and stories that First Nations tell are important as they contribute to building a strong perspective from the right place.

The FNHS has supplemented the hubs with the appointment of Community Engagement Liaison positions in the Interior, Vancouver Island and Northern regions to further strengthen communications between the technical team, the hub members and the health authorities in each region.

Identify Best Practices and Models of Excellence to build on

The TFNHP is grounded in a number of principles, including ‘nurturing the relationship’, and further defines that ‘the capacity development requirements of the FN health sector will be paramount, through planned growth, knowledge and skills transfer’.

As well as supporting community collaboration the technical team had to find a way to support immediate needs and to engage with communities to ensure ongoing participation as the implementation of the action items in the plans rolled out across the province. From past experience, the management of the technical team knew that leaders, Health Directors and staff would find it hard to engage in a new tripartite plan if they could not deal with the immediate crises and issues facing them on a daily basis in their communities. The FNHC had funding available for

ensuring First Nation participation in the plan and to support communities moving forward in their health initiatives. This funding was used to support community initiatives and to help communities address crises such as suicides. One purpose of the funding was to meet the immediate needs by bringing good initiatives, innovations and leaders to the forefront. It was very important to the technical team to be able to identify expertise, role models, effective health initiatives and innovations while at the same time helping communities to overcome immediate needs. This way, space was created for these models to expand and develop.

Funding of these kinds of projects in communities was in no way an attempt to displace federal and provincial responsibilities for services. Rather it was an initial strategy to draw out positive models and stories that could contribute to the implementation of the plans. Community initiatives, innovations and stories that First Nations tell are important as they contribute to building a strong perspective from the right place. They were a strategic investment to begin engagement with communities while supporting them to overcome immediate obstacles to that participation.

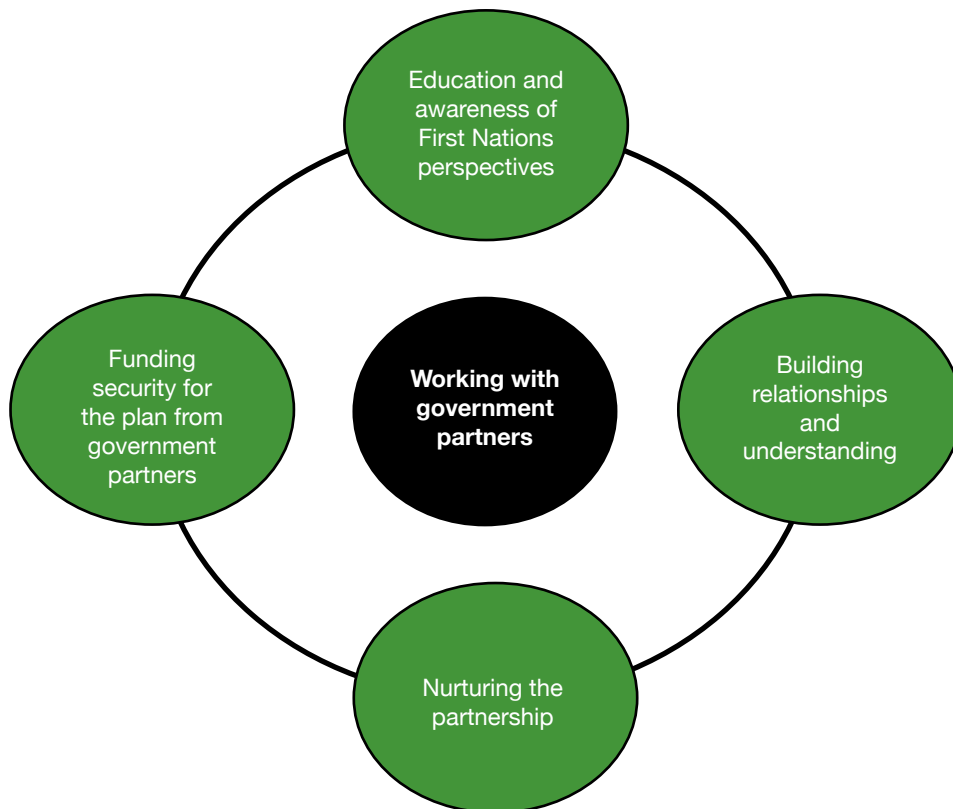
The technical team also allocated funds for acknowledging the good work already being done in communities through funding best or better practice and health promotion initiatives. This funding allowed communities to better resource their own innovations and to look at how they could further incorporate their own cultural perspectives into health service delivery. Funding was also provided in a number of crisis situations as many communities identified that in times of crisis, there was nowhere they could go to get immediate resources in order to meet an immediate need. The funding for crisis circumstances often revolved around youth suicide events in communities. Therefore funding was aimed to support communities by resourcing the ASCIRT (Aboriginal Suicide and Critical Incident Response Teams) in various areas.

Through this opportunity for communication with FN communities we learned that in order for communities to think about how they engaged in the TFNHP from a strategic long term perspective, they first needed help to come together to support one another. They needed the



immediate health needs in their communities addressed, if they were be able to participate fully in the health actions and dialogue. Such is a common international experience, that before communities can participate in strategic change, they need to be supported to overcome their immediate concerns first. Otherwise, people cannot look to the future because they are so consumed and challenged by what is facing them now. Additionally, people need and want to work with other people who share their concerns. The support for collaboration through the hubs, was seen to be a vital step to encouraging peer support and a feeling of connectedness. The technical teams role in helping to overcome these immediate concerns, and to build the relationships between communities, has meant BC First Nations are now much better positioned to engage in looking forward, as the TFNHP continues to be implemented.

FIG 3.2: WORKING WITH GOVERNMENT PARTNERS



A great deal of time is spent by the technical team educating the “systems” about the health plans. Government agencies (including health authorities) and ministries are large bureaucracies, who unlike the FNHC, were not set up specifically to address the TFNHP.

Education and Awareness of First Nations perspectives

A great deal of time is spent by the technical team on educating the our parters “systems” about the health plans. Government agencies (including Health Authorities) and Ministries are large bureaucracies, who unlike the FNHC, were not set up specifically to address the TFNHP. Each has a role to play in implementing actions from the plan but many personnel do not know where to begin or how to effect the changes needed. For many this is an entirely new way of working with First Nations communities.

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Governments were not prepared, and in many areas are still not prepared, for effective engagement with BC First Nations on matters of health, despite the TCA: FNHP and TFNHP being in place since 2007. Many staff within the 'systems' do not understand their role or obligations under the TFNHP and the technical team spends much of its time translating and interpreting their commitments for them, to ensure they uphold what their leaders have agreed to. Establishing a First Nations perspective, and creating the space for First Nations to take up positions at strategic and planning tables with government decision-makers, is a key activity of the technical team. However, preceding the establishment of these decision-sharing tables is a great deal of work done to educate and raise awareness among executives and program managers about the kind of change that First Nations expect to see, as a result of the TFNHP. This work is critical to the overall success of the plan, and places considerable demands on the small technical team to conduct this education and dialogue with partner organizations.

Nurturing the Partnership

The TCA: FNHP and TFNHP both stress a number of fundamental principles which include:

- Nurturing the relationship;
- Respect and recognition;
- Commitment to action; and
- Transparency.

Bringing these principles to life is a key role for senior management and the technical team. For the CEO's office, nurturing the Tripartite partnership started at the Tripartite Management Team (TMT) level. For the FNHC this involved participation in the Oversight Committee and the Principals meetings. These forums provide the opportunity for political and management level relationships to be made between First Nations leaders and Government partners.



The TMT forum developed an initial work-plan outlining issues it would focus on and actions the forum wanted to achieve, but it was challenging, as the decision-making authority of the TMT members was different within each system. The province put forward an executive director to TMT and the federal government created a tripartite manager position, but neither of these positions had ultimate authority to make many decisions without consulting higher level executives first. On the other hand, the FNHC had their CEO at the table who could make decisions on how to move forward. This meant that in order to advance the work, the CEO often had to work upward to engage with executives, ADMs and VPs in the systems, as well as with the TMT forum.

The TMT also worked to address the issue of how each partner would guide their systems toward implementing the TFNHP when each had different spheres of influence. The technical team placed some of its staff in key government reference groups, committees and other forums, to help bring First Nation perspectives into their infrastructure and to pave the way for more extensive First Nation participation. Often the participation of FNHC managers and staff was focused on educating partner staff about the TFNHP, the Transformative Change Accord and the expectations of First Nation communities as expressed at Gathering Wisdom. This was crucial so that the systems could prepare themselves appropriately to engage with First Nations in BC.

A 10 year plan with no funding certainty

When the TCA: FNHP were signed, there was a political understanding between the Province of BC and First Nations Leadership Council that it would cost \$24m to implement the 29 action items. This included:

- \$4m which the Province would re-allocate internally, plus
- \$10m of new money that the Province would commit to fund the plan, plus
- \$10m of new money that the parties expected the Federal Government to bring to the table to implement the plan.

When Health Canada signed onto the TFNHP, there was no clear agreement that they would annually provide \$10m of new money to specifically implement the 29 action items. They also brought forward additional priorities, such as the commitment to design and implement a new structure to govern health services in BC. With all that being said, resources were needed to support First Nations involvement in participating in the implementation of the health plan as well as top cover the cost of establishing and running a FNHC and any subcommittees required to implement the Plan.



By the end of 2007-2008 the FNHC had secured a 4-year funding agreement from the Federal Government but nothing from the Provincial Government. Instead the Province advanced annual grants of various sums in year 1 and 2. In year 3 and year 4, the Province did not provide any funding but has since agreed to restart the clock on the TFNHP and to fund the plan for a renewed 10 year period.

It was also clear in the initial phases that the FNHC and the government partners had different expectations about the funding. The government partners had an expectation that they would have a role in deciding how it was spent. The FNHC had the view that the funding was for investing in the capacity of First Nations to support and participate in the TFNHP, and to minimize risk by ensuring there were reserves for ongoing years. Since the province had not been forthcoming with its share of the TFNHP funding in the earlier years, this was very important.

The FNHC was therefore faced with the position of having a signed 10 year agreement, but without any funding security from the partner governments for the 10 year period. This challenge has affected the FNHC's ability to make strategic investments in the implementation of the plan, or to assure BC First Nations communities that they will be resourced effectively to participate in the plan over the 10 year period. Securing funding certainty has been one of the FNHC's priorities.

As a result of effective advocacy, in 2009-2010 the FNHC received a written commitment from the Provincial Government stating that it would provide funding support for the 10 year period, although none of this has been forthcoming yet.

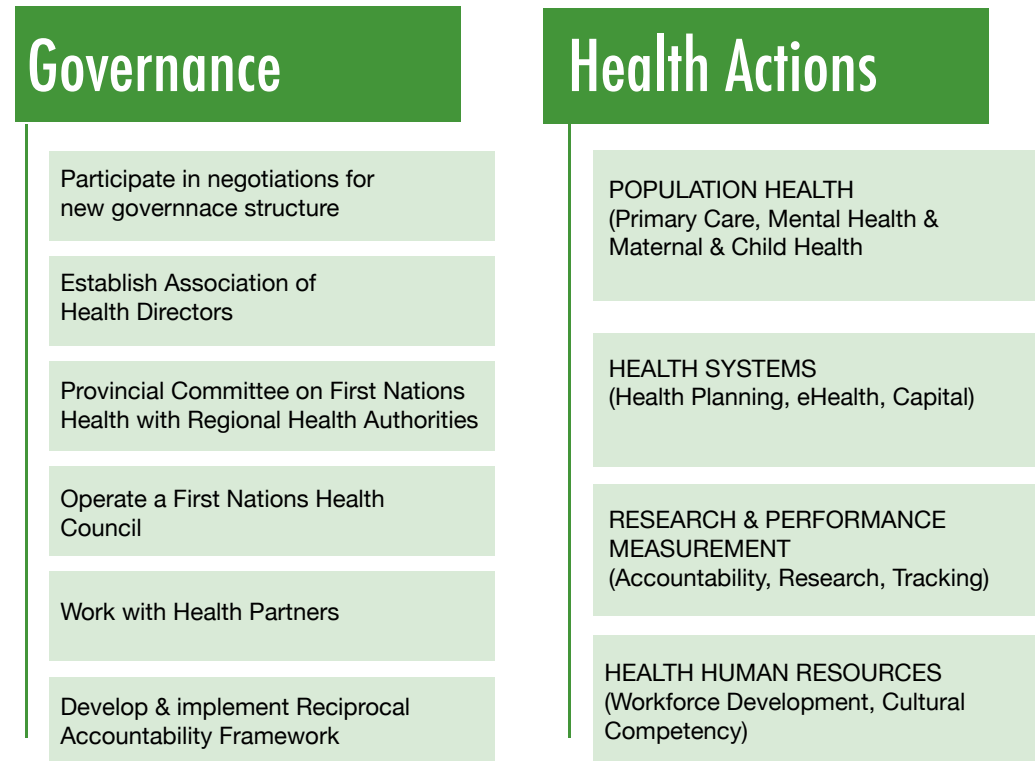
The FNHC was therefore faced with the position of having a signed 10 year agreement, but without any funding security supporting it from the partner Governments for the 10 year period.

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Report of the Technical Team

FIG 3.3 -PROGRESS WITH THE TCA: FNHP AND TFNHP

The 2 core components of the Tripartite First Nations Health Plan are as follows:



Government systems need to be ready for change and ready for engagement with First Nations, just as First Nations need to be organized and ready to engage with government on an equal level, and from an informed basis.

The work arising from the TCA: FNHP and the TFNHP has been grouped into these two key areas for ease of oversight, implementation and coordination of the technical team's resources.

One of the reasons that the work is organized this way is to ensure that the health directors' concerns, about the non-politicization of health services, are addressed. Another reason for the chosen organizational strategy is to ensure separation between the area directly related to building capacity within First Nations communities and the area directly related to affecting system change within governments. Both are linked, but it has been important to ensure that the Health Actions work does not suffer or stop because of the extensive commitments to advancing the governance agenda. Government systems need to be ready for change and ready for engagement with First Nations, just as First Nations need to be organized and ready to engage with government on an equal level, and from an informed basis. It has been an important strategy for the FNHC and the technical team to work on these parallel agenda to ensure they can come together at various points in time as people on both sides of the partnership are ready.

Building Increased First Nations Governance in Health

As reported, there has been significant progress implementing other aspects of the TFNHP including:

- Formation of the Health Directors Association - This Association was registered in April 2010 after much hard work by health directors, and the FNHC was honored to sponsor their gathering and development as they developed their constitution and membership;
- Establishment of the Regional Caucus structure for First Nations leaders to engage with each other, with the FNHC, and with government, to develop the new First Nation health governance model to assume management of First Nations and Inuit Health, BC region, and other agreed upon Provincial programs and services;
- Restructuring of the FNHC from appointment by the 3 political executives to appointment by the 5 Regional Caucuses;
- Convening of Principals meetings and the Provincial Committee on First Nation Health
- Development of a draft Reciprocal Accountability Framework
- Strengthening relationships with Health Partners such as the Native Nurses Association and urban health organizations such as the Vancouver Native Health Society.

In the past, all or most of these types of discussions that Dr. Adams now participates in, occurred without any First Nations physician voice.

Transforming the System through Health Actions

Substantial progress has been made in the implementation of the TCA: FNHP since 2007, particularly with the appointment of the Aboriginal Physician Advisor to the Provincial Health Office (PHO). This fulfilled one of the key actions of the plan (TCA: FNHP # 2) and has provided First Nations with a strong voice within the PHO and the Ministry of Healthy Living and Sport. Dr Evan Adams has provided a comprehensive report on his activities (page 100 of this report) since he began his role, and the breadth and scope of his involvement in a number of areas serves to highlight just how much a role such as his is needed. In the past, all or most of these types of discussions that Dr. Adams now participates in, occurred without any First Nations physician voice.

Other health actions achievements related to the TCA: FNHP and TFNHP include:

- Opening of the Lytton Health Centre in mid 2009; achieving one of the key action items from the TCA: FNHP (#16);
- Signing of the Tripartite Data Sharing and Quality Agreement to support the sharing of First Nations information in health so that we can monitor progress and further share previously inaccessible data, with communities (TCA: FNHP #28);
- Release of the 2nd edition of the Provincial Health Officer's Report on Aboriginal Health. Although this report still does not go far enough to report out on specific First Nations health issues, it is a reasonable start and is more than we ever had before to support planning and prioritization (TCA: FNHP #27);
- Further progress with vision and hearing screening for Aboriginal children. This has been very successful and our partnering with the First Nations Schools Association has made these screening programs effective, and begin to show some promising results (CA: FNHP #10);
- Improved maternity access initiatives for Aboriginal women including establishment of the Aboriginal Maternal and Child Health Committee with majority First Nations representation (TCA: FNHP #21);
- Successful rollout of the H1N1 Action Plan for First Nations communities across the Province due to excellent collaboration between the tripartite partners and great leadership by Aboriginal physicians;
- Progress with the ActNow and chronic disease management programs including innovative food skills; nutrition and exercise resources which we supported for First Nations communities (TCA: FNHP # 22);
- Achievements in workforce development through the First Nations workforce survey and AHHRI-funded Health Careers and Post-Secondary institution recruitment and retention initiatives (TCA: FNHP #25).



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Report of the Technical Team

Additionally we continue to hear from communities that traditional methods of healing and wellness must gain greater recognition within the health sector and by the federal and provincial governments. Traditional medicine has been added as a new priority for FN communities to be worked on by the partners with communities.

In the 2008-2009 year we added several new action areas arising from the signing of the TFNHP (2007) and two new priorities; HIV / AIDS prevention and treatment, and Traditional Medicine. These new priorities have arisen because First Nations communities have identified these as issues in need of attention by the tripartite partners. Communities continue to tell us, at forums like Gathering Wisdom, that the issue of HIV/AIDS is a priority for many communities despite the fact that it is not specifically mentioned in the TCA: FNHP or the TFNHP. Additionally, we continue to hear from communities that traditional methods of healing and wellness must gain greater recognition within the health sector both federally and provincially. Traditional medicine has been added as a new priority for First Nations communities, to be worked on by both the partners and communities.

A more extensive report on each of these areas is included in the annual 'Year in Review' reports available from the FNHC. http://www.fnhc.ca/pdf/Year_in_Review_Report_2009-web.pdf

Learning from international models

While advancing the work on Governance and Health Actions, the FNHC and technical team have been cognizant of the need to learn from other indigenous peoples about implementing change in the health sector. It is widely acknowledged that Indigenous people in the US, New Zealand and Australia have accomplished a great deal within their own health systems and these lessons are often shared at various international health conferences. The technical team has identified these lessons and experiences and worked to draw from them aspects which can inform the implementation of the TCA: FNHP and the TFNHP.

Lessons in Governance

USA Models and what they have to offer

The USA models, especially in the State of Alaska, provide some very good learning for the governance work that is being undertaken by First Nations in BC. Native American and Alaska Native tribes have been in a model of 'self-governance' for upwards of 20 years now. Some initiated self-governance in health in the mid-1990s and some were in self-governance with Bureau of Indian Affairs (BIA) programs for at least 10 years prior to this. When the US Department of Health and Human Services branch of the Indian Health Service (IHS) decided it would devolve program oversight and delivery from IHS to tribes under their Self-Governance legislation, many tribes in the US took this opportunity.

The **Indian Health Service (IHS)** maintains a presence on many reservations in America but many nations have had service delivery either partially or fully devolved to them under a systematic process of transferring health care authority (contracting or compacting). This is a voluntary process and no Native American tribe is forced to accept devolution. They may choose to have the IHS remain as the agency responsible for managing hospital, primary, mental health and addiction and other health care services on their behalf.

For those tribes who have taken responsibility over health services, they may be operating their own secondary care hospitals, primary care centers and public health programs for their entire populations. All this under a Self-Governance arrangement (known as a 'Compact' agreement) or under a normal 'contract' agreement where IHS defines the programs and services that the tribe must deliver. Compact arrangements are managed by the Office of Tribal Self Governance (OTSG) based in IHS Washington. The OTSG retains a 'Tribal Self



Governance Advisory Committee' (TSGAC) made up from Compact tribal representatives who lead and give advice to the IHS Director and OTSG on self-governance issues.

The IHS also retains a group called the Office of Direct Service Tribes (ODST) and a 'Direct Service Tribes Advisory Committee' (DSTAC) for those tribes who are only contracting and / or still receiving services directly from the IHS. IHS still employs around 15,000 people and continues to deliver services to tribes who have not compacted. The DSTAC ensures their interests are represented at IHS tables as well. DSTAC participates in budgets, planning and policy meetings with IHS as if they were part of the IHS, rather than just receivers of IHS services.

Under a Compact the tribe has full authority to move money between budget lines and to re-design services and programs. Under a contract agreement the tribe cannot move money between budget lines and they cannot re-design or re-scope services in any way. As each tribe assumes it's tribal 'share' of headquarters and the area office, IHS down-sizes and re-orient itself to managing the arrangements rather than delivering services and programs. The IHS therefore changes its role to become an advocate for tribal interests and providers of technical assistance for tribes.

The following table provides an overview of self-governance arrangements with IHS today:

SELF GOVERNANCE IN US TODAY	1994	2010
Compacts	14	76
Funding Agreements	14	97
Funding Level for SG (Mil)	\$51	\$1,205
IHS Budget (Mil)	\$2,125	\$4,052

Lessons from the Alaska Tribal Health System

The Alaska Tribal Health System (ATHS) is the network for the entire Alaska Native health care delivery system. It is a voluntary affiliation of 40 Alaskan tribes and tribal organizations providing health services to Alaska Natives/American Indians formerly provided by the Indian Health Service (IHS). Each tribe or tribal health organization is autonomous and serves a specific geographical area. In March 2004, members of the Alaska Tribal Health System signed the Alaska Tribal Health System Memorandum of Understanding setting out common goals. In total an \$800 million budget from state and federal sources including Medicaid and Medicare and sanitation funding supports the ATHS.

The ATHS has almost full control over program delivery, policies, services and design, and controls 99% of the Alaska area budget from the IHS today. This said, it still must access its federal funding through the Indian Health Services. There are still around 37 residual positions in the Alaska Area IHS that perform inherently federal functions and cannot currently be contracted to Tribes or Tribal Organizations.

Between all of the tribes involved, the ATHS network serves approximately 130,600 Alaska Natives. A number which is projected to reach 160,000 by 2015. The ATHS has a range of medical care service levels that it delivers. There are 180 small community primary care centres, 25 sub-regional mid-level centres, 4 multi-physician health centres, 6 regional hospitals, as well as the Alaska Native Medical Centre tertiary care in Anchorage. The ATHS also provides referrals to private medical providers and other states for complex care.

It is widely acknowledged that the US, New Zealand and Australia have accomplished a great deal in many areas within their own health systems



Under a Compact the tribe has full authority to move money between budget lines and to re-design services and programs.

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Report of the Technical Team

Maori have been hugely successful with growing their health workforce. Data from New Zealand workforce census for instance showed they had over 3,000 Maori health professionals in the workforce including over 2,000 Nurses; over 200 Medical Practitioners; over 500 Social Workers; over 200 psychologists; over 40 dentists and pharmacists and over 10 surgeons.

The ATHS is made up of 40 organizations:

- A state-wide service provider (Alaska Native Medical Centre in Anchorage) operated by the Alaska Native Tribal Health Consortium (ANTHC) which was created in 1998 with congressional authorization through Section 325 of Public Law 105-83, in partnership with the South Central [tribal] Foundation; and
- Regional Service Providers / Corporations / Consortia who operate regional hospitals; physician centres and sub-regional centres such as South Central Foundation; Norton Sound Health Corporation and Cooper River Native Association; and
- Individual village health centres.

The Alaska model provides a very good reference point for BC First Nations since First Nations political leaders could potentially negotiate similar arrangements for as they build their First Nations health governance model in BC.

Some of the benefits to Alaska Native tribes from their arrangements with the Federal government include:

- ✓ Protecting their self-governance rights and ongoing funding through embedded legislation,
- ✓ Retaining benefits of federal employees for their own staff after the transfer occurs,
- ✓ Accessing federal purchasing benefits (cheaper prices for pharmaceuticals) after they assume self-governance,
- ✓ Designing and planning their own services without any government interference, and
- ✓ Being covered by Federal insurance protection against medical mal-practice claims.

The experience of the Alaska Tribal Health System provides some useful ideas which can be considered by BC First Nations as they develop their own governance structure and negotiate with principals and executives in partner governments.

Lessons from New Zealand Maori Treaty partnership with the Crown

The New Zealand Maori tribes' Treaty of Waitangi partnership with the Crown also provides some useful lessons about working with the Crown and influencing all levels of government, from ministers through to ministries and health authorities. Maori tribal participation in the health sector has been growing exponentially since 1990 after major health reform, and they too have some lessons to offer about health system transformation, particularly with large health authorities. Tribal leaders' engagement with principals in their system offer some valuable lessons for First Nations leaders in BC and the technical team continue to gather evidence which can contribute to this learning.

There are around 190 Maori / tribal service providers. These groups developed innovative models of health care delivery that offer some knowledge and experience to BC First Nations service providers. Also of importance is the Maori experience of transformative change within their District Health Boards that can be shared with BC's health authorities.

The NZ Maori health sector also benefits from considerable Maori research expertise led by academic and independent Maori research entities. Additionally Maori have been hugely successful with growing their health workforce. Data from the New Zealand workforce census showed they had over 3,000 Maori health professionals in the workforce including over



2,000 nurses; 200 medical practitioners, 500 social workers, 200 psychologists, 40 dentists and pharmacists and 10 surgeons. Given these numbers, the workforce development strategies of New Zealand can provide important insight to BC First Nations in developing its own First Nations health workforce.

Where to from here

The past 3 years have been both challenging and successful for First Nations in a number of areas. The building blocks for First Nations health governance are in place through the FNHC and its linkage with Regional Caucuses and BC First Nations, the First Nations Health Directors Association, the Community Engagement Hubs with their 80% inclusion of First Nations communities. Also in place are the mechanisms for high level political, strategic and planning level engagement with government partners through the Principals Meetings, Oversight Committee, TMT and the Provincial Committee on First Nations Health. The next few years should see some meaningful engagement and subsequent change occur, as these vehicles for change influence the system at all levels.

The First Nations Health Directors have a significant role to play at the service level in encouraging planners and program managers and executives to transform their services to further benefit First Nations communities.

The role of the FN Health Society technical team will be to continue to support First Nations governance operating at a political level, and First Nations Health Directors and their hubs operating at a service design and delivery level. The FNHC will also continue to influence and transform health services in BC in alignment with BC First Nations communities priorities and aspirations.

We can learn from others as we continue the journey. This may help us to make faster progress in key areas where we do not need to reinvent the wheel. Many other indigenous people around the world have faced the same issues as BC First Nations. Our common problems and diverse solutions offer many avenues for BC First Nations to explore.

Financial Performance

The financial reports for 2007- 2008, 2008-2009 and 2009-2010 are included in this report in section 8. The FNHC has reconciled all of our income and expenditures with the First Nations Summit's audited reports for fiscal years 2008 and 2009, a detailed account can be found in section 8 of this report.

In the year ended March 2008:

- 0% of our expenditure was program-related
- 20% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 29% of our expenditure was allocated to operating the First Nations Health Council and staffing, along with operating costs
- 14% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 37% of our expenditure was allocated to governance work

In total, around 71% of our expenditure has been on direct costs associated with capacity development with First Nations communities, and just under 25% of the expenditure on maintaining the FNHC and its operations, in order to undertake the work needed to progress the implementation of the Health Plans.

Many other indigenous people around the world have faced the same issues as BC First Nations and our common problems and diverse solutions offer many avenues for BC First Nations to explore further.

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Report of the Technical Team

The financial report for 2008-2009 reveals that:

- 28% of our expenditure was program-related
- 25% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 22% of our expenditure was allocated to operating the First Nations Health Council and staffing, along with operating costs
- 15% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 10% of our expenditure was allocated to governance work including the Health Directors Association and FNIHGC / Regional caucus costs

In total, around 78% or just over $\frac{3}{4}$ of our expenditure has been on direct costs associated with capacity development with First Nations communities and just under $\frac{1}{4}$ of expenditure on maintaining the FNHC and its operations in order to undertake the work needed to progress this work.

The financial report for 2009-2010 reveals that:

- 26% of our expenditure was program-related
- 23% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 15% of our expenditure was allocated to operating the First Nations Health Council and staffing, along with operating costs
- 25% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 11% of our expenditure was allocated to governance work including the Health Directors Association and FNIHGC / Regional caucus costs

In total, around 85% of our expenditure has been on direct costs associated with capacity development with First Nations communities and 15% of expenditures on maintaining the FNHC and its operations in order to undertake the work needed to progress this work.

3.2 Evolution of the Technical Team

Establishing Technical Support for the First Nations Health Council

The Terms of Reference for the FNHC (Section 5) required that the FNHC establish technical support, starting with a senior director appointed by the First Nations Leadership Council, to direct a technical team. The team must include staff and human resources to ensure the effective implementation of the TCA: FNHP and the TFNHP. The technical team is responsible for providing administrative, technical, research and policy support for the FNHC activities.

The agreed Terms of Reference stated that *‘the technical staff of the First Nations Leadership Council member organizations, UBCIC Social Development Committee and the First Nations Chief’s Health Committee provide support to the First Nations Health Council’*. The Terms of Reference also stated that the *‘First Nations Leadership Council technical lead on health will serve as the senior technical staff person to the First Nations Health Council’*. The individual appointed to fulfill this role was Mr Joe Gallagher, who at the time, was employed through the Summit and worked through an inter-change directly with Health Canada. The envisioned role for Mr. Gallagher to serve as the technical lead on health. He was directed to oversee the implementation of both the TCA: FNHP and the TFNHP and to work with technical staff of the three political bodies to *‘coordinate the development of the First Nations Health Council and the effective implementation of the TCA: FNHP and TFNHP.’*

FIG 3.5 -ORGANIZATIONAL STRUCTURE 2008



On March 7th 2008 the First Nations Chiefs’ Health Committee (FNCHC) was dissolved through resolution (Res #0308.07) of the First Nations Summit Chiefs in Assembly due to concerns about duplication of services between the Chiefs’ Health Committee and the First Nations Health Council. The resolution directed the First Nations Summit Executive to reallocate the resources, staffing and infrastructure of the First Nations Chiefs’ Health Committee to the First Nations Health Council, for the continued implementation of the Tripartite First Nations Health Plan. Effective April 1st, 2008 the former Chiefs’ Health Committee office at 1205- 100 Park Royal South became a part of the First Nations Health Council (including the technical lead role held by Mr Gallagher).

3 Report of the Technical Team

Along with the need to support communities, the technical team also had to learn what the partner governments were doing in relation to activities outlined in the TFNHP in order to create the space for First Nations involvement.



Technical Support for the First Nations Health Council: 2007 –2009

The FNHC Terms of Reference required that funding would rest with ‘one of the First Nations Leadership Council member organizations’. The organization identified to play this role was the First Nations Summit. The functions provided by the First Nations Summit for the FNHC included managing funds, making payments and paying expenses, organizing legal advice for contractual and other legal matters, coordinating FNHC meetings (agendas, minutes) and generally providing administrative support. This service continued to be provided by the First Nations Summit for the FNHC formally until March 31, 2009 when the FNHC established its own legal entity.

In 2007, the technical team began with only 4 staff including the senior director. The workload demands grew when the TFNHP was signed in 2007; so too did the need to increase the size of the technical team in order to respond to the demands.

Additionally, the FNHC assumed responsibility for a number of program responsibilities from the former Chiefs Health Committee through agreements with Health Canada including the Aboriginal Health Human Resource Initiative (AHHRI), Health Careers, and the Aboriginal Health Transition Fund (AHTF). The new technical team therefore had to take on responsibilities for these programs as well as the staff that came with them.

After Gathering Wisdom in May 2007 and May 2008 it was clear that communities were expecting a great deal from the FNHC and the technical team. The plans signaled a huge amount of work ahead and a need to support communities in effectively engaging in the implementation of the TFNHP.

Along with the need to support communities, the technical team also had to learn what the partner governments were doing in relation to activities outlined in the TFNHP, in order to create the space for First Nations involvement. Both partner governments were already implementing work in some of the priority areas that required involvement of First Nations. With additional program and services responsibilities coming from the Chiefs Health Committee, and a need to get involved quickly with current activity already in progress, the technical team was pressured to respond. This left little time for proactive forward planning in establishing a technical team that could cope with the breadth of work ahead.

Transfer of Technical Support from the First Nations Summit Society to a new FN Health Society – April 2009

Due to the increasing volume of administrative work and resources required to effectively implement the TCA: FNHP and the TFNHP, The FNHC decided to establish an interim legal entity which would assist them to:

- Work more effectively the 203 First Nations communities in BC;
- Manage the growing workload demands involved in implementing the TCA: FNHP and TFNHP;
- Provide an apolitical organization that could manage technical and funding tasks for the FNHC;
- Ensure the legal and financial risks involved in implementing the TCA: FNHP and the TFNHP could be managed; and
- Ensure that the FNHC had an interim operational body solely focused on supporting the Council to implement the TFNHP.

The FNHC needed an interim legal entity to continue to provide technical support for the FNHC until tripartite negotiations around the new health governance model for First Nations were concluded. An independent entity could also carry and manage the financial and legal risks associated with the agreements entered into with government.

Agreement to establish a FN Health Society

A motion made at the June 2008 First Nations Health Council meeting directed a sub-committee, composed of one representative each from UBCIC, BCAFN, FNS – to explore options towards creating a new interim corporate and administrative body to assume these responsibilities. The resulting investigations resulted in a proposal to develop a ‘FN Health Society’. The proposal was presented at a FNHC strategic planning meeting on July 24, 2008. During the strategic planning session, the Health Council approved the direction of the subcommittee and transitional planning was initiated in the fall of 2008. It was further agreed that the 7 members of the First Nations Health Council, as initially appointed by the 3 political bodies, would become the members of the Society.

Agreement to appoint Directors to the Society

In a September 2008 FNHC meeting, the members considered structural options for the creation of the independent entity, giving consideration to such issues as:

- Reporting / accountability;
- Political direction from First Nations leadership;
- Strategic direction and advancing the TFNHP, and
- The need to clearly determine the roles and responsibilities of the new administrative body.

It was determined that in order to effectively work with First Nations, the new Society would need a dedicated Board of Directors, and that these Directors would need to be apolitical since they would have authority over spending decisions impacting First Nations communities. It was agreed that direct reporting to First Nations on the work of the new society would remain the responsibility of the First Nations Health Council members, and that this reporting would occur at political assemblies of each of the UBCIC, FNS, and BCAFN.

Appointment Process for the Society’s Board of Directors

During subsequent meetings, the First Nations Health Council set criteria for a recruitment process and determined that potential directors to the new society should have expertise in governance, legal, human resources and financial areas. It was also determined that potential directors should not have a current tie to potential recipients of funding. A call for directors was widely distributed through media and sent directly to BC First Nations in January of 2009. A second call, directed specifically at BC First Nations was circulated in February of 2009.

Call for BC First Nations Directors
The First Nations Health Council is seeking 3 BC First Nations Directors

RESPONSIBILITIES
Under the direction of the First Nations Health Society Members, the Board of Directors will be responsible for the following key activities:

- Develop the strategic plan with input from the FNHS members
- Select, monitor and annually review the Executive Directors performance against the agreed upon objectives
- Provide input to the Executive Director for the development of the operational plan
- Approve annual action plans, operating and capital budgets
- Monitor progress towards the FNHS strategic objectives and performance against operating and capital plans as well as budgets
- Power to delegate both decision-making and signing authority by resolution to Directors, Officers or others (e.g. Exec Director)
- Guide and oversee the development, implementation and maintenance of a reporting system that accurately measures the FNHS performance against its strategic plans and action plans
- Participate on sub-committees as required

FIRST NATIONS HEALTH COUNCIL
The role of the First Nations Health Council is to support and assist BC's diverse First Nations by:

- Serving as an advocacy voice of BC First Nations in achieving their health priorities and objectives;
- Conducting health-related policy analysis and research;
- Participating in policy and program planning processes related to First Nations health; and
- Providing leadership in the implementation of the Transformative Change Accord; First Nations Health Plan, and the Tripartite First Nations Health Plan.

TIME COMMITMENT
It is anticipated that the Board of Directors will be required to attend a minimum of 4 meetings per year with additional meetings called as required. In addition, Members of the Board of Directors are required to attend the FNHS annual general meeting. The term of office for the Board of Directors will be three years.

DEADLINE for applications: March 6th, 2009 | For more information please visit: www.fnhc.ca |

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Report of the Technical Team

Recruitment was competitive, with over 60 submissions received for 7 seats. A subcommittee of the First Nations Health Council scored potential recipients based on a pre-determined list of criteria

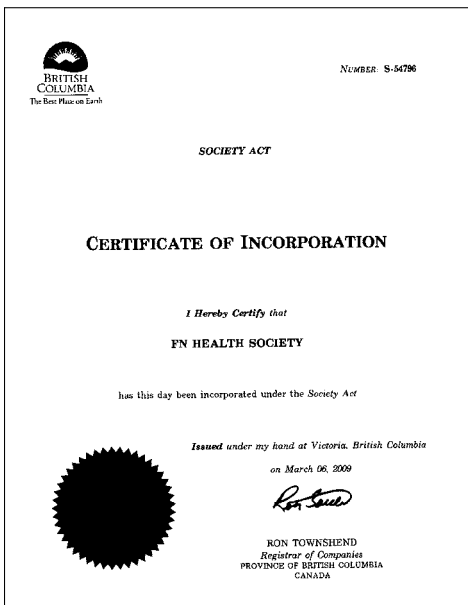
Recruitment was competitive, with over 60 submissions received for 7 seats. A subcommittee of the First Nations Health Council scored potential recipients based on a pre-determined list of criteria developed by the FNHC members. The current Board of Directors consists of:

- Pierre Leduc (Chairperson)
- John Scherebnyj
- Madeleine Dion-Stout
- Marilyn Rook
- Matt Pasco
- Carol Anne Hilton, and
- Ruth Williams.

4 out of the 7 Board members are of Aboriginal ancestry. Board members collectively hold experience in health authorities, the private health sector, First Nations health, education, and economic and business development fields.

Registration of the Society as a legal entity

The FN Health Society was registered on March 6, 2009 (File No S-54796) and started as a new legal entity on April 1, 2009 as the interim 'operational arm' of the First Nations Health Council. Effective March 6th 2009, the political representatives of the First Nations Health Council became the members of the FN Health Society. The FN Health Society Constitution and Bylaws were established and now form the basis under which the Society operates. The Society provides corporate and administrative support to the First Nations Health Council. The FN Health Society receives strategic direction from the First Nations Health Council while the Directors ensure the Society meets its obligations to the FNHC members and supports further implementation of the TFNHP.



3.3 Establishing the new FN Health Society Organization

The FN Health Society Role

The purposes outlined in the FN Health Society's Constitution are to "promote and advance health and health service issues on behalf of the First Nations of BC," including, but not limited to, supporting the implementation of the TCA: FNHP released on 26 November 2006 and the TFNHP signed on 11 June 2007. These purposes are:

- Operating as the administrative and funding arm for the First Nations Health Council that has been mandated to advance First Nations health issues in BC;
- Providing health services to First Nations;
- Receiving and administering funds and other assets from the Government of Canada, the Government of British Columbia and from any other source, and to apply such funds and assets for the attainment of the purposes of the Society; and
- Doing all things that are incidental and conducive to the attainment of the above purposes.

It is important to understand the context in which the Society was established, and is now working. The FNHS did not begin as a 'blank slate', as technical team had been operating since 2007. The TFNHP set the high level vision, principles, priorities, action items and indicators. The Society's role is to support' implementation by working with the First Nations Health Council, First Nations communities and the tripartite partners. This required the Society to have the ability to be flexible and adaptable to changing circumstances, for example the emergence of H1N1 in fall 2009. It is also acknowledged that the Society is an 'interim' body until a First Nations governance structure is developed and negotiations for this are concluded.

When the Society started, little opportunity had previously existed for an effective corporate structure to be designed and implemented. In addition the Society was still operating programs that did not 'fit' the true role of the FNHC and the technical team in supporting the implementation of the TFNHP. The technical team made a decision to divest itself of most of the programs, enabling government to fund these program within First Nations communities. This allowed the technical team to refocus on the work under the TFNHP.

The new FN Health Society took over its financial records and systems from the FN Summit. As a new entity it was necessary to establish new systems and a new way of working. With the appointment of a VP Finance and Administration, the Society was able to establish the new corporate systems, and put in place a number of policies and procedures for carrying out the business of the Society.

The new Board adopted a Strategic Implementation Plan to show how the Society intended to approach the implementation of the TFNHP. The implementation plan had 2 key priority areas (Governance and Health Actions) and 4 supporting strategies:

1. Continue to support First Nations communities to build capacity, knowledge and aspirations for their effective participation in the TFNHP;
2. Provide BC First Nations political leadership with the technical, research and policy support that they need to develop their own health governance model;
3. Work with partner governments to ensure they continue to meet their obligations under the TFNHP; and
4. Operate an efficient and professional technical team to support the FNHC.

The FNHS did not begin as a 'blank slate', as technical team had been operating since 2007. The TFNHP set the high level vision, principles, priorities, action items and indicators.

The Society's role is to support' implementation by working with the First Nations Health Council, First Nations communities and the tripartite partners.

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Report of the Technical Team

Our internal systems and processes for employing staff, managing funds and running an organisation must be operated at the highest quality level according to acknowledged best practice and the law.

Our internal systems and processes for employing staff, managing funds and running an organization must be operated at the highest quality level in accordance with acknowledged best practice and the law. Activities in our first year of operation reflect the fact that the Society is not a 'brand new' operation, but has assumed responsibility for people, systems, structures, assets and processes from the First Nations Summit, which previously supported the FN Health Council. The year 2009-2010 was focused on completing this transition.

The Society's Strategic Implementation Plan sets out a number of key goals for 2009-2010 in terms of establishing the FNHS as an efficient, professional and accountable organization, capable of implementing the TFNHP. The key goals included:

- Aligning and allocating appropriate human resources to achieving FNHS strategic priorities;
- Completing the transition of the FN Summit finance system and embedding a well functioning and accountable financial management system;
- Managing all other corporate administration activity, including information technology and information management, contracts, and administration; and
- Providing corporate support to the Board.



Human Resources and Structure

The FN Health Society assumed the human resources (positions, people, skills, competencies, qualifications) from the first 2 years of TFNHP activity. These staff represented a mix of program, policy, and planning staff, a staff complement which wasn't properly aligned with our overall strategic direction. As a result, one of the key goals identified for the Society's first year of operations was to ensure that its human resources were properly aligned and allocated to achieve the Society's strategic priorities.

In order to meet this goal, the Society focused on two main areas during 2009-2010:

- Completing a review of the organization’s structure and roles and responsibilities, human resource capacity inherited by the Society, existing job scopes, job descriptions and salary structure and determining changes that were necessary to better support implementation of the TFNHP; and
- Ensuring the Society has a comprehensive HR framework that includes policies and procedures, creating a productive work environment, a professional development system to grow staff capability and competency and a performance management system to monitor performance of staff against the objectives in the TFNHP.

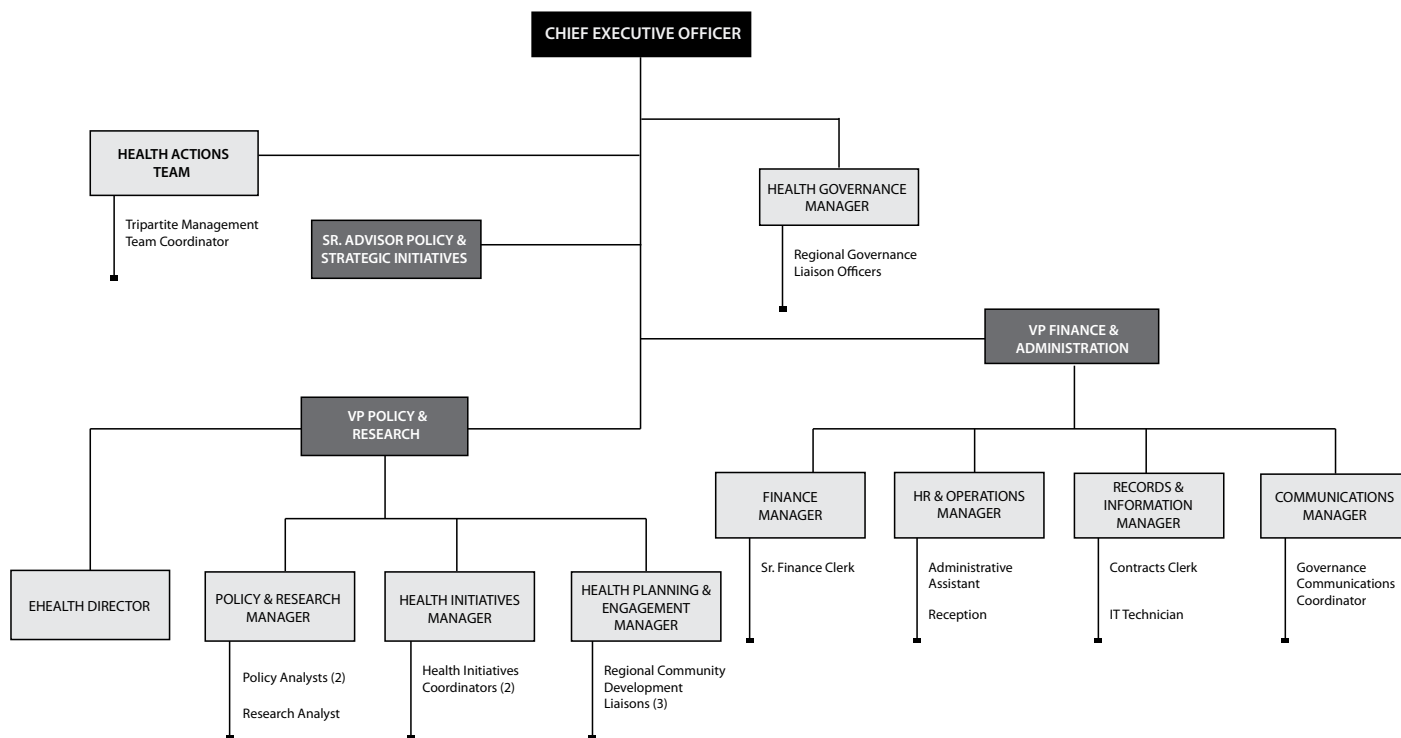
Human Resources Realignment

Redefining the FNHS structure, and roles and responsibilities in order to support the Society’s Strategic Implementation Plan was a critical first step in realigning the Society’s human resources. Since the Society inherited human resources, programs, salaries and structures, the work of the Society to align itself to implement the TFNHP was challenging.

The work necessary to define the structure of the organization and roles and responsibilities of staff included a complete a review of existing human resource capacity. This required a review of individual job scopes, creation of new job descriptions, and the creation of a corresponding salary structure for the Society.

One of the key goals identified for the Society’s first year of operations was to ensure that the human resources were properly aligned and allocated to achieve the Society’s strategic priorities.

FIG 3.6 - ORGANIZATIONAL STRUCTURE 2010



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Report of the Technical Team

On April 1, 2010 a new organizational structure was implemented. This redesign resulted in significant improvement in the Society's ability to meet its mandate of implementing the TFNHP.

The new organizational structure achieved 6 objectives

1. Eliminating positions which did not contribute to the FNHS's mandate;
2. Creating new positions that will strengthen the FNHS's ability to meet its mandate;
3. Eliminating the delivery of programs and services which was inherited from the Summit's Chief's Health Committee, thus clearly focusing the Society's resources on the implementation of the TFNHP;
4. Providing the CEO and VPs with a management team to assist them in meeting their responsibilities under the TFNHP and allowing the SMT to take a more strategic, rather than operational role in the organization;
5. Clearly defining CEO and VP roles and responsibilities and aligning their units to the priorities set out in the Strategic Implementation Plan; and
6. Providing significant, dedicated resources to the implementation of Health Actions.

Based on the new organizational design, new hierarchies within the Society, a review of job scopes and descriptions, and the creation of new positions, and a salary classification structure was implemented. This salary classification structure realigned salaries across the Society to ensure:

- Consistency among employees working in similar roles;
- Recognition of the value of different roles and responsibilities within the organization; and
- Integration of the different salaries that the Society inherited when the Chief's Health Committee was integrated with the FN Health Council salaries and structure.

It is expected that this salary classification structure will allow the Society to attract and retain employees necessary to implement the TFNHP, eliminate disparity within the salary levels that currently exist among staff and provide a strong framework for salary administration going forward.

Human Resources Framework

One of the first orders of business for the Society was to adopt a set of human resource policies which set the basic framework for human resources management; including provisions relating to code of ethics and workplace standards, conflict of interest, employment privacy, salary administration, hours of work and overtime, vacations and leaves of absences, and discrimination and harassment.

Over the course of the year, additional pieces were added to the human resources framework and improvements were made to the human resources policies. This created the dynamic and positive human resource environment capable of achieving high expectations of efficiency, effectiveness and professionalism. Work was undertaken to develop a set of organizational values aimed to set the tone for the organization and clarifying our roles and responsibilities as a First Nations health organization working for BC First Nations. In addition, a set of People Values was developed, creating an environment that ensures people within the organization are treated well, and have the proper instruction and direction to be successful, and understand their obligations in terms of performance and behavior.

A performance management system was developed to assess employees in terms of competencies identified as necessary for people to achieve high levels of performance. These competencies focus on core functional responsibilities, personal leadership and organizational requirements. In addition, starting in 2010/2011 employee performance will be assessed based

Work was undertaken to develop a set of organizational values to set the tone for the organization and to clarify our roles and responsibilities as a First Nations health organization working for BC First Nations.

on the achievement of specific goals identified at the beginning of the year. The goal is to ensure that everyone within the Society is contributing to the implementation of the TFNHP.

The final piece of the human resource framework is the development of a professional development system which allows management and staff to identify areas for professional improvement, set development goals and implement development plans to ensure that the Society is constantly learning and gaining new skills and abilities. This is important in meeting the challenges of implementing the TFNHP.

In only its first year of operation, the development and implementation of this human resources framework and the realignment of human resources was a major undertaking for the Society. This work lays the foundation for the Society to recruit, retain and develop the people necessary to implement the TFNHP and to assure that the organization is aligned to maximize its capacity and resources.

Financial Management System

Prior to April 1, 2009, the Summit provided corporate and operational support to the First Nation Health Council, including the financial management system. This system was primarily set up to support a political organization rather than to meet the needs of an organization whose mandate was to implement the TFNHP. With the creation of the Society, there was an immediate need to establish and implement a financial management system within the Society, to provide effective and efficient financial management support to the organization and be accountable to First Nations for the funding related to the implementation of the TFNHP.

In order to transition from the First Nation Summit finance system to an independent system that supports the implementation of the TFNHP, the Society set out a number of key goals for 2009/2010. These goals are:

- Implement a financial management framework that includes: establishing a financial management system that ensures maintenance of a reputable payment record with First Nations, suppliers and creditors; establishing and implementing financial policies, including a delegation of authorities document; development of annual budgets, and a system to monitor budgets against actual expenditures; and regular financial reporting;
- Finalizing the transfer of TFNHP funding from the Summit to the new Society; and
- Completing the first audit of financial statements as an independent Society.

Financial Management Framework

Upon becoming operational on April 1, 2009, the Society implemented a financial management system (ACCPAC) to process, control and maintain financial information. This system facilitates the payment of expenditures and allows for financial budgeting and the creation of custom and standard financial reports to support the financial decision making necessary to implement the TFNHP.

Another key goal of the Society was to develop and implement financial policies that set out the basic framework for financial management including provisions relating to: administration of financial controls, delegation of financial authorities, cash management, account receivable and receipts, accounts payable, payroll planning and budgeting, accounting procedure and documentation, and financial reporting and auditing. Prior to the approval of financial policies for the Society, the technical team had limited financial authority, with the bulk of financial decision making and control held by the Society's Board of Directors. The Society's technical worked to establish its own financial management system independent from the First Nations Summit. In February 2010, FN Health Society Board of Directors approved a complete set of financial policies and procedures, addressing all of the items set out above and specifically

Prior to April 1, 2009, the Summit provided corporate and operational support to the First Nation Health Council, including the financial management system. This system was primarily set up to support a political organization rather than to meet the needs of an organization whose mandate was to implement the TFNHP.

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Report of the Technical Team

In addition to major pieces of work outlined above, the Society also established an annual budget for the implementation of the TFNHP and implemented a budget cycle that allowed the Society to develop an annual budget for 2010/2011 prior to the end of the 2009/2010 fiscal year.

delegating some financial authorities to the Society's technical team. These authorities related to commissioning financial audits, tendering, expenditures and payments (with limitations) and day-to-day financial matters, including the leasing of property.

In addition to major pieces of work outlined above, the Society also established an annual budget for the implementation of the TFNHP and implemented a budget cycle that allowed the Society to develop an annual budget for 2010-2011, prior to the end of the 2009/2010 fiscal year. With the development of a budget, a system was implemented to allow for the regular monitoring of the budget against actual expenditures, allowing the technical team to report to the Board of Director's on a regular basis. In addition to standardized reporting, a custom report was developed within the financial management system, allowing information to be presented within a manner aligned to the strategic implementation plan.

In its first year, one significant challenge for the Society was to unwind its financial affairs from the First Nations Summit. In order to separate out its financial affairs, the Society and the Summit had to determine and agree on assigning funding agreements requiring legal agreements and negotiations with funding agencies, assigning property leases, expenditures relating to the TFNHP for prior years, identifying and transferring assets purchased through TFNHP funds, investments and interest relating to TFNHP funds, accounts receivable and payable to funding agencies, creditors, First Nations, contractors and staff, and identifying year end balances. In order to begin working out the details of the financial transfer owed to the Society, the Summit's financial transactions for 2008-2009 had to be closed and their audit approved. The Summit's audit was approved in late 2009 and work began immediately afterwards to determine and agree on the transfer of funds to the Society.

In addition to there were many instances of transactions taking place during the initial transition period which did not recognize the separation of the Society and the Summit. These transactions, subsequent to April 1, 2009, significantly added to the complexity of fully determining funds owed to the Society and securing agreement on an amount. Agreement was finally reached between the Society and Summit and funds transferred prior to the start of the 2009-2010 audit.

Financial Audit

As an independent society within the Province of British Columbia, the FN Health Society is required to provide its members with audited financial statements each fiscal year. The Society's fiscal year ended on March 31, 2010. Through a Request for Proposal process the Society's Board of Directors appointed Deloitte & Touche LLP as its first auditor. The approved audit will be presented to the members of the Society before the end of September 2010, in accordance with the Societies Act.

Managing other corporate and administration activity

With the Summit providing the FNHC with corporate and administrative support prior to April 1, 2009, the transition to an independent entity meant that the Society had to develop a wide range of corporate and administrative capacities in a short period of time in order to maintain its operations and continue to implement the TFNHP. During its first year of operations the Society set a number of key goals:

- Create a contract management framework that includes: standardized contracts; a standardized tendering process; a system to effectively manage and monitor contracts; and a payment processes for contractors and suppliers that reflected contract stipulations;
- Implement and manage of a comprehensive information management system that allows for effective tracking and reporting of progress related to the TFNHP; and
- Implement and maintain an information technology system that supports the effective and efficient operations of the Society.

Contract Management Framework

An effective and efficient contract management framework is one of the key functions of the Society's operations. The framework is made up of tendering and contracting policies, processes and systems. The framework allows the Society to purchase goods and services (expertise), to implement the TFNHP, fund community engagement hubs, fund health initiatives throughout BC linked to the TFNHP, and support governance discussions and negotiations.

The transition from the Summit meant that the Society had to create tendering and contracting processes to ensure timely creation and execution of tenders and contracts, as well as a system to monitor and manage contracts and tenders throughout their lifecycle. Early in its first year of operations, the Society created a contracting process that allows goods and services to be purchased and key community engagement, health and governance initiatives to be supported. Since then, the Society has implemented a standardized tendering process throughout the organization and has developed tendering and contracting policies. These are expected to be implemented in 2010/2011. During 2009/2010, a simple contract management system was used to monitor and manage the Society's contracts. Given the volume of contracts handled by the Society, this system proved to be inadequate in managing this critical function. As a result, a new contract management system is under development and expected to be implemented in June 2010.

During 2009/2010 the Society created and managed over 275 contracts valued at over \$8.4 million dollars. Of these contracts, more than \$6.5 million went directly to support First Nation communities and to organizations supporting health related initiatives, community engagement hubs and health governance activities and discussions.

Information Management

A significant challenge for the Society, is to manage its information in order to: meet day-to-day operational requirements, be responsive to information requests, track progress in implementing the TFNHP, and be accountable to BC First Nations. The amount of information created, exchanged and required to successfully implement such a complex health plan is significant. In order to manage that information, the Society created a unique information management classification system, a system to file and maintain corporate records, and electronic information systems to support operational requirements. Another important role in managing information is ensuring that management and staff are properly trained to maintain a standardized system throughout the organization.

Recognizing the importance of information management and the communication of timely information in successfully implementing the TFNHP, the Society enhanced its information management capacity in 2009/2010 by employing a records and information management manager. Since then, significant progress has been made to lay the foundation for a strong and effective information management structure within the Society which meets the needs of management and staff.

The transition from the Summit meant that the Society had to create tendering and contracting processes to ensure timely creation and execution of tenders and contracts and a system to monitor and manage contracts and tenders throughout their lifecycle.

During 2009/2010 the Society created and managed over 275 contracts valued at over \$8.4 million dollars. Of these contracts, more than \$6.5 million went directly to support First Nation communities or organizations to support health related initiatives, community engagement hubs and health governance activities and discussions.

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Report of the Technical Team

Information Technology

Becoming its own entity on April 1, 2009 meant that the Society had to implement its own information technology (IT) system. This included installing and maintaining servers to ensure that the Society's website, printers, handheld devices and computers continue to operate and that remote users have access to the Society's systems at all times, installing and maintaining computer hardware and software, including software licensing, website development and maintenance, and developing and maintaining video-conferencing capabilities.

In order to ensure that the Society's IT system is up-to-date and continues to operate and support the day-to-day activities of Society staff and operational systems throughout the organization, the Society implemented an IT Strategy that set out priorities and goals for implementing and maintaining an IT system that would continue to meet the Society's needs, as it continues to grow and evolve.

Facilities

The FN Health Society currently occupies office space at 100 Park Royal, sufficient for the staff employed by the organization with two smaller size meeting rooms. Since there are a large number of meetings of the Board, the FNHC, the tripartite partners working in different governance and health action areas and other parties involved in the implementation of the TCA: FNHP, it was agreed that a specific meeting room be reserved for tripartite work in Vancouver. This 'TFNHP Tripartite Meeting Space' in downtown Vancouver provides a more cost-effective way for various leaders, partners and staff to meet with government partners on tripartite actions, without incurring expensive hotel conference room costs. The space has been funded by the Ministry of Healthy Living and Sport (MoHLS) who have provided the funds to the FNHC to lease the space on behalf of the tripartite partners. MoHLS provides the coordination for bookings of the space and records over the past year show it has been used regularly for gatherings, governance meetings, Regional Health Authority Aboriginal Health Lead meetings, management and staff meetings and tripartite partner meetings.

Operate a well functioning governance Board

The First Nations Health Society Board of Directors is a body appointed by the First Nations Health Council. In preparation for the Society’s separation from the Summit, the First Nations Health Council appointed 7 directors to the First Nations Health Society’s Board. Throughout the year, the Board provided the Society’s technical team with direction, advice and leadership related to the efficient operation of the Society.

Early in its first year of operation, the Society’s Board of Directors maintained the majority of decision-making, and financial authorities whilst the Society’s technical team developed the policies, procedures, infrastructure and human resource capacity necessary for a establishing and operating a well-functioning organization.

Some of the key decisions made by the Society during 2009/2010 include:

- Approved initial employment agreements for Society staff
- Appointed the Senior Management Team of the Society (CEO & VPs)
- Approved initial Human Resources and Financial Management policies
- Approved the Society’s initial Strategic Implementation Plan, Annual Business Plan and Communications Plan.
- Approved contracts over \$25,000, prior to delegations of authority to Society’s technical team
- Approved first auditor of the Society

The First Nations Society Board of Directors meetings were held throughout 2009/2010 as follows:

FIG 3.7 - FN HEALTH SOCIETY MEETINGS 2009/2010

First Nations Health Society Meetings 2009/2010			
March 20, 2009	May 4, 2009	September 4, 2009	March 26, 2010
March 25, 2009	June 19, 2009	November 5, 2009	
March 30, 2009	July 3, 2009	December 11, 2009	
April 20, 2009	August 7, 2009	February 5, 2010	

The FN Health Society supports the Board by arranging Board meetings (preparing agendas and Board papers for decisions and information), preparing financial reports for the Board, preparing minutes and reporting on Board meetings and processing Board expenses / travel.

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Report of the Technical Team

Building the Regional Caucuses for First Nations political leadership to come together, and resourcing First Nations collaboration through the Hub initiative, along with sponsoring the establishment of the Health Directors Association – have all been actions and strategies used to help build capacity of BC First Nations.

3.4 Taking a Strategic Approach to our Work

There was and is no precedent for this work in Canada. BC First Nations are making significant change to large health systems for the benefit of First Nations people, and enacting plans towards sustainable and tangible results for communities on the ground.

Building the Regional Caucuses for First Nations political leadership to come together, and resourcing First Nations collaboration through the Hub initiative, along with sponsoring the establishment of the Health Directors Association – have all been actions and strategies used to help build capacity of BC First Nations and to provide mechanisms for sharing knowledge, information and learning.

The FN Health Society has government partners who are largely still undeveloped when it comes to being responsive, and committed, to making lasting change in their systems that benefit BC First Nations. They continue to progress their agendas, often without First Nations participation. Often they are not aware of need to include First Nations, and until recently First Nations lacked the networks to enable participation. The coming together of a more responsive government system and a better informed and prepared First Nations constituency – continues to be a challenge as we move forward with implementing the TFNHP.

In developing the Strategic Implementation Plan for the FN Health Society, the Board was acutely aware that the TFNHP had already been in the ‘implementation phase’ since 2007. This meant that much work has already begun and been accomplished by the technical team and FN Health Council, prior to the outlining of strategic direction by the Board.

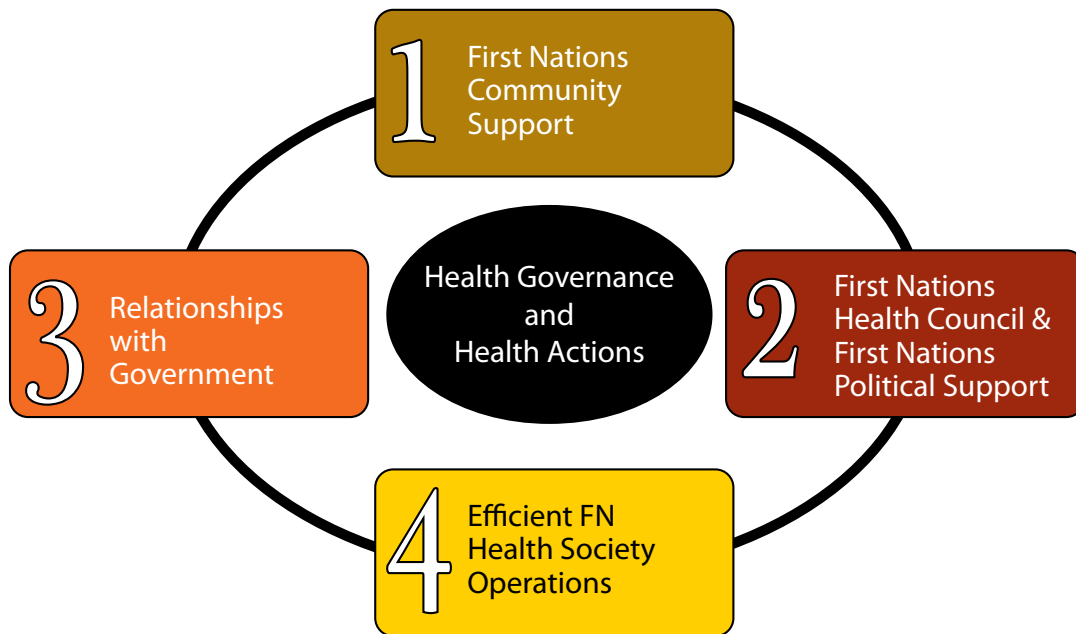
The formation of the First Nations Interim Governance Committee and Regional Caucuses for the Governance work had already begun; Community Engagement Hubs were in place and the Health Directors Association was well underway. These activities incurred expenditure and financial commitments for the Society based on decisions that were made prior to the Board being put in place. Those investments that had already been committed to, were proving to be effective, and needed to continue and sustained wherever possible.



The Society was also bound by existing legal agreements with federal and provincial funders that were negotiated prior to formation of the Society, some of which placed constraints on the Society as far as how funds are applied and what activities may be performed within those agreement specifications. The Society will continue to work with funders to ensure that funding agreements will support the strategic directions of First Nation communities whether at community, health center or political level.

The strategic priorities and supporting strategies expressed in Figure 3.8 are aimed at describing both existing activities already in effect at the time the Society was formed, as well as identifying new strategies intended to support implementation of the TFNHP. The remainder of this report discusses how we have implemented these strategies in the priority areas.

**FIG 3.8 - STRATEGIC IMPLEMENTATION APPROACH-
FN HEALTH SOCIETY STRATEGIC PLAN 2009-2012**



Vision of the FN Health Society

Healthy, self determining and vibrant BC First Nations children, families and communities

Mission of the FN Health Society

The mission (purpose) of the FNHS is focused on supporting the FNHC to implement the plan at an operational level:

To provide professional and effective corporate management and operational support for health plan resources to facilitate and implementation of the TFNHP with our partners – on behalf of the First Nations Health Council.

4

Supporting First Nations Communities



4. SUPPORTING FIRST NATIONS COMMUNITIES TO PARTICIPATE IN THE TFNHP

The technical team has an important role in ensuring that First Nations communities are supported in having real and meaningful participation in the implementation of the TFNHP. Our role is not to be the First Nations voice at the table, but to advocate for First Nations communities to be represented in consultation and decision-making processes with government. Another important role is in supporting communities to build capacity, and to define their own priorities through Community Health and Wellness plans.

Our approach to supporting BC First Nations communities to participate in the TFNHP has involved a range of inter-linked strategies as presented below:

Our role is not to be the First Nations voice at the table, but to advocate for First Nations communities to be represented in consultation and decision-making processes with government.



4

Supporting First Nations Communities



4.1 Gathering Wisdom

When the Memorandum of Understanding between Health Canada, the Province and the First Nations Leadership Council was signed in November 2006, it was agreed that the Tripartite First Nations Health Plan (TFNHP) would be developed by May 2007. In order to successfully develop, complete and implement the new TFNHP, it was agreed that the partners needed to dialogue with First Nations communities and health professionals. Since the first Gathering Wisdom Forum in May 2007, there have been annual gatherings, continuing the opportunity to share information with each other and providing further direction to the FNHC in the implementation of the TFNHP. These forums have been very successful in attracting attendance and participation and providing a forum for peer support and knowledge sharing.

Gathering Wisdom I – May 2007

The first 'Gathering Wisdom for a Shared Journey' forum was hosted to engage leadership and health providers on how to pursue the TFNHP. The objectives of the dialogue were to:

- Establish a shared understanding on the purpose and content of the TFNHP;
- Identify key challenges, content and process for managing change in the health of First Nations;
- Explore how to communicate on an ongoing basis; and
- Establish the next steps for a follow-up gathering.

The May 2007 forum involved conversations on the main areas of the original TCA: FNHP and other key themes that should drive the FNHC's approach to implementing the plan(s). These themes were around finding solutions to common challenges, developing a common vision for wellness, taking a cultural holistic approach to health, ensuring there was a community-driven process and ensuring ongoing communication. Key challenges involved:

- Lack of resources for communities for sustainable services and infrastructure
- A need for recruitment and retention of qualified workers
- Addressing transportation and access issues
- Addressing the social determinants of health

The focus on wellness and a cultural, holistic approach to health was also a key theme to emerge from the May 2007 Gathering Wisdom forum. It was reiterated that the health system needed to be family-focused and culturally safe. Partnerships across jurisdictions and sectors were a common recommendation. The communities made a strong call for the TFNHP to support what is already being done in communities, to allow communities to have flexibility to establish their own priorities and share information and learn from one another by consolidating best practices and sharing resources and strategies. 'Communities of Practice' among service providers were suggested as a way to improve communications and information-sharing so that communities could support each other professionally and personally toward a common vision.

As a result of these recommendations from communities the technical team developed the strategy to establish community engagement hubs and to support best practices and health promotion initiatives.

Gathering Wisdom II – May 2008

From May 21-22 2008, the technical team hosted the 2nd Gathering Wisdom for a Shared Journey Forum. The purpose of the forum was to engage First Nations community health professionals and community members in an on-going conversation about the TFNHP, and to receive direction in the Plan's implementation. From keynote speakers to world cafe leaders, the 2008 forum saw First Nations take a larger role in Gathering Wisdom. In 2008, 312 people attended the forum. Of these 194 or 62% represented First Nations communities, with the remaining 118 consisting of staff, government, researchers and others. This reflected a significant change from the 2007 forum, where only 39% of participants represented First Nations communities.

Tina Keeper, Member of Parliament from Churchill Manitoba, was the opening speaker for the forum. She spoke of feeling privileged to be in her position and being able to work with youth and advocate in the area of suicide prevention. In speaking about health, she stated that self-determination was a critical factor and that government needed to realize and recognize the important role that First Nations played in finding solutions to their own issues.



In 2008, 312 people attended the forum. Of these 194 or 62% represented First Nations communities, with the remaining 118 consisting of staff, government, researchers and others.



4

Supporting First Nations Communities

Gathering Wisdom III drew greater First Nations participation than the 2007 and 2008 Forums. In total, 400 participants representing more than 130 First Nations came together in Vancouver, November 3, 4 & 5 to dialogue on the implementation of the Tripartite First Nations Health Plan. 80% of those in attendance were First Nations leaders or health technicians. This represents a 20% increase from last year's forum.

During the 2008 forum, day two was dedicated to professional development. Dr. Martin Brokenleg (Professor of First Nations Ministry and Theology, Vancouver School of Theology) discussed the 'Circle of Courage' psychology for dealing with youth and adults. He noted that in order to be whole, it was necessary to stop looking at woundedness and to instead focus on wholeness. He shared the idea that fundamentally culture was in place - not lost - although it could take some time to dig it out and find it again. Dr Brokenleg discussed four spiritual strengths that existed in all Aboriginal communities:

- **Belonging** – the need to be significant was important;
- **Mastery** – the ability of people to glance at problems, gaze to solutions and create resiliency;
- **Independence** – is not about being alone or self-sufficient, but being responsible for oneself – empowerment;
- **Generosity** – fulfilling the human need to know one's own goodness.

The common themes emerging from Gathering Wisdom II included:

- More must be done to ensure the long term sustainability of this effort and various strategies, initiatives and programs;
- There is a need and desire for significant enhancements to resources in order to expand the reach of existing programs, including funding and coordinated/holistic approaches;
- Develop opportunities and materials to support training and capacity, particularly in response to needs at the community/front line;
- Leadership needs to continually demonstrate its commitment and priorities in this area, including serving as health role models;
- The approach to implementing the TFNHP and responses to various health needs must be of practical use at the community level/front line;
- Increase efforts and supports for building cross cultural understanding between First Nations and their non-Aboriginal counterparts and colleagues;
- Provide adequate support to the critically important area of education and awareness within First Nations, Aboriginal and non-Aboriginal communities.

Renaë Morriseau teamed up with Dr. Evan Adams and actor Simon Baker for an interactive forum theatre presentation which encouraged participants to try their hand at acting and solve the problems facing our communities. In addition, workshops on Nutrition, Physical Activity, and Traditional Medicine were offered.



Gathering Wisdom III – November 2009

The 2009 Gathering Wisdom was originally scheduled for May 2009, but this was at a time when the H1N1 pandemic was at its peak and travel was being restricted. In addition many BC First Nations communities were involved in trying to control the spread of the infection in their communities by conducting education and the vaccination campaign. It was therefore decided to postpone the Gathering Wisdom forum for that year until November 2009.

Gathering Wisdom III drew greater First Nations participation than the 2007 and 2008 Forums. In total, 400 participants representing more than 130 First Nations came together in Vancouver, November 3, 4 & 5 to dialogue on the implementation of the Tripartite First Nations Health Plan. 80% of those in attendance were First Nations leaders or health technicians. This represented a 20% increase from the 2008 forum and provided a good illustration of how First Nations are taking up more space in the conversation about health.



Discussion at this year's forum was focused on three topics: Day 1: Health Governance, Day 2: Health Actions, and Day 3: Health Directors. This year's forum was webcast live on the internet, allowing First Nations leaders and health technicians who could not attend the opportunity to observe the proceedings.

Discussion at the 2009 forum was focused on three topics: Day 1: Health Governance, Day 2: Health Actions, and Day 3: Health Directors. The 2009 forum was webcast live on the internet, allowing First Nations leaders and health technicians who could not attend the opportunity to observe the proceedings.

As a result of the webcast, the FNHC received feedback from First Nations across Canada who tuned in to see what the Tripartite Health Plan is all about. All conference presentations, as well as video clips of keynote speakers, are available on the Health Council website and its YouTube channel.

The development of a new First Nations Health Governing body was the focus of Day 1 discussions with First Nations leadership. Over 350 participants, representing 136 communities, took part in Day 1 discussions that included:

- The opportunity to hear from an international panel of experts with experience implementing indigenous health governance in other jurisdictions;
- Remarks from the Federal Minister of Health Leona Aglukkaq, Provincial Minister of Healthy Living and Sport Ida Chong, and Grand Chief Doug Kelly;
- A tripartite governance update from Ian Potter, Andrew Hazelwood and Grand Chief Doug Kelly;
- Breakout governance sessions for each the North, Interior, Fraser, Vancouver Coastal and Vancouver Island regions providing the opportunity for communities to bring forward ideas, questions and concerns which help to shape a future First Nations Health Governing Body;
- Regional members of the First Nations Interim Health Governance Committee reported on feedback from the regional sessions.

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Supporting First Nations Communities

Day 2 discussions were focussed on Health Actions. Health Actions has been described as the place where “the rubber hits the road.” Health system transformation, in order to better meet the needs of BC First Nations, is the goal. In total, 430 participants, representing 139 communities, took part in Day 2, which included:

- Tripartite updates from First Nations Inuit Health, BC Ministry of Healthy Living and Sport, First Nations Health Council and regional health authorities in 5 key initiative areas:
 - o Mental Health and Addictions
 - o Maternal and Child Health
 - o eHealth
 - o Primary Health, and
 - o Cultural Competency.

Day 3 discussions focussed on the development of a First Nations Health Directors Association. In September of 2008, health directors held a two-day forum to begin dialogue about the development of a First Nations Health Directors Association, one of four governance components in the Tripartite First Nations Health Plan. This Forum laid the groundwork for a health directors survey administered this spring. The feedback from both the forum and the survey led to the development of a draft structure for the Association. Discussions during Day 3 included:

- An update on work of the AFN toward the development of a National Health Directors Association.
- A presentation from the First Nations Health Directors Subcommittee on both the 2008 BC Health Directors Forum and the Health Directors survey results.
- Presentation of a proposed model for a BC First Nations Health Directors Association, The 91 health directors in attendance voted 79-12 in favour of the proposed model.
- Professional development workshops on eHealth, Strategic Planning, Community Best Practices, and Freedom of Information.

4.2 Community Engagement Hubs

Background

When the TCA: FNHP and TFNHP were signed, there were no effective means in place for the FNHC and the technical team to communicate directly with communities in a practical way. Likewise there were no effective means for communities to collaboratively share experiences, knowledge, innovations, lessons and issues. As a result, little or no capacity had been developed within communities by previous governments that supported collaboration; First Nations communities were in need of mechanisms that made use of economies of scale, joint decision-making, advocacy and peer support.



First Nations Health Directors and Managers made it clear that implementing the TFNHP was not something that could occur “off the side of their desks.”

“the Hub model has an immediate and direct benefit to communities, creating the resources and time needed to ‘rise above’ daily health priorities and urgent needs while actively exploring various pathways for positive change.”

{Respondent, CeH evaluation}

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Supporting First Nations Communities

First Nations health directors and managers made it clear that implementing the TFNHP was not something that could occur “*off the side of their desks.*”

While the technical team was not resourced to fund every community and every health centre to engage in implementation of the TFNHP, there were sufficient resources available to invest in a more coordinated approach to supporting communities. Consequently, the FNHC responded to this issue by creating a vehicle for First Nations communities to take a coordinated and collaborative approach to being an integral partner in the implementation of the TFNHP. These resources have been channeled through the creation and funding of Community Engagement Hubs (CEHs).

Community Engagement Hubs (CEH) provide a vehicle through which First Nations communities can partner with the FNHC, health authorities and the federal government, to participate in the TFNHP. CEH's are collaborations between First Nations communities working through one agreed upon organization chosen by the members. The purpose of CEH's is to develop **communication, collaboration, and planning** opportunities for member communities to work together in health services and program areas to make improvements. Through communicating, collaborating and joint planning, there is more opportunity for communities to find common solutions to common problems such as sharing health professionals, sharing transportation arrangements, joint purchasing for systems and equipment and joint advocacy for additional services from health authorities. The formation of CEH's encourages natural collaborations based on tribal and geographical factors and provides resources for facilitating coordination work between communities.

Benefits of Community Engagement Hubs

- √ **Providing a mechanism for communities to work together** – Hubs enable a group of communities (usually through their mandated health organizations) to come together to discuss various common issues and to find common solutions. For instance – once members share their respective health plan aspirations with other communities, they may find needs that each has which could be solved through a joint solution. If some of the members are all having difficulties recruiting for and paying nurses for instance, then together they could recruit nursing capacity and share the resource and the cost.
- √ **Improving the linkage with the health authorities** – Health authorities have a responsibility to provide their services to First Nations on and off reserve but often they find it difficult to engage with First Nations and to develop solutions for service delivery that will work for communities. The hubs provide a forum for health authority personnel to meet with a group of linked communities, to look at ways of better serving those communities in the spirit of collaboration. This might include arranging outpatient clinics; providing mobile screening services; working to address public health and environmental health concerns. The hub members are also in touch with community members who use health authority services and often receive a high level of feedback from patients. Hub members can provide feedback to the health authority on issues that their communities are facing when entering hospitals and being treated there. These are problems which health authorities should remedy with the support and guidance of the hub.
- √ **Sharing Knowledge and Expertise** – within the hub membership, there will be a wide range of skills and experience among the member's work forces, from management through to health service expertise. Some member communities may be advanced in their community health and wellness planning while others may be finding it difficult – so there is opportunity to learn from one another and to help each other. Some communities may have made an arrangement with a service provider to bring them services (such as physicians or specialists) that other members can learn from and possibly adapt for their own situation. Some hubs have started their own newsletters and websites to make information sharing more accessible for the wider community.

- ✓ **Sharing Innovations** – Many hub members have developed new ways of doing things that they have trialed and tested in their various communities. Some communities have implemented best practices and formed relationships with other stakeholders to successfully implement their service innovations - such as the BC Cancer Agency or the BC Diabetes Association. Some communities have developed new resources and informational material for the families, schools and Band Councils in their communities. Hubs provide a mechanism for communities to share these innovations.
- ✓ **Providing Peer Support** – Many communities are isolated and as a result the health center workforce is often isolated. Health professionals, managers and health workers often do not have opportunity to speak with their peers from other health centers to share issues, challenges and innovations – and to give and receive support to each other.
- ✓ **Improving access to services** - Collaboration and joint planning create efficiencies, and will provide better health services for BC First Nations people. For example, where it may not be feasible to have a mental health expert in every community, the hub concept would allow for planning to have one expert available to serve the member communities of the hub. In this way, collaboration and resource sharing between the nations in a hub can fill health gaps that otherwise would not be addressed.
- ✓ **Improving communications** - Hubs also act as a communications vehicle, allowing the First Nations Health Council to effectively communicate in an accurate and timely manner with all 203 BC First Nations.

How Hubs are formed

In order to become a hub, First Nations mandated health centers and communities (and in some cases, urban organizations) come together themselves, at their own pace in their own time, where they see an opportunity to collaborate for the purposes outlined above.

Pre-Hub Developmental Phase: The process starts with the group submitting a letter to the First Nations Health Council including the names of those communities who have agreed to be members of the hub. A letter from each member or Band Council Resolution (BCR) is needed to confirm that the intended members agree to join the hub. Following the receipt of this letter, the FNHC makes contact with the group and provides initial funding to the group’s elected host agency, for the hub to come together over a 3 – 6 month period to create an annual work plan for the following year. Training is provided to the group by the FNHC to give information on how the work-plan should be developed. This ‘pre-hub’ developmental phase is important to identify if there are sufficient linkages and commonalities to make a hub successful in the long term.

Hub Phase I: If the group of communities decides to proceed to the next stage they will submit their annual work plan and budget. On occasion the host-agency for the Hub may change from the group who received the initial pre-hub developmental funding. The FNHC will then enter into an agreement with the Hub host-agency for 1 year’s funding to support the implementation of the work-plan. The host will be required to report to the FNHC on progress against the work-plan including reporting on their activities; new engagements with health authorities and others; communications, collaboration and planning activity they have undertaken - and to submit a final report, self-evaluation form and a financial report at year end. The Hub will then be considered for Hub Phase II funding.

Hub Phase II: If the Hub successfully completes Phase I, have submitted their required reports, and there have been no complaints from any members – the Hub will move into Phase II where they will be fully operational. The FNHC will then enter into an agreement with the Hub host-agency for further funding to support the ongoing operations of the Hub. Hubs need to maintain their accountability reporting in order to maintain their funding from the FNHC.

“asset mapping changed the way in which community people viewed their communities, focusing on identifying and building existing strengths . . . as opposed to focusing on deficits.”

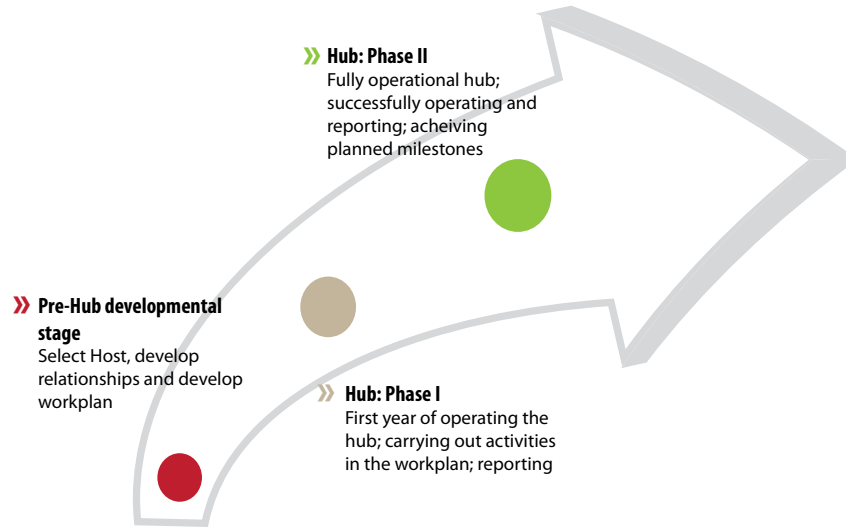
{Respondent, CeH evaluation}

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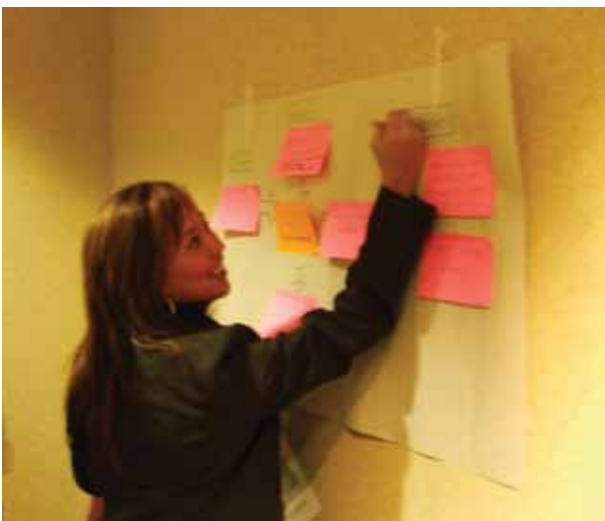
The developmental cycle of Community Engagement Hubs can be reflected as follows:

FIGURE 4.0 : GROWTH PATHWAY FOR COMMUNITY ENGAGEMENT HUBS



The long term intention for community engagement hubs is that First Nations effectively participate in the implementation of the TFNHP from a community-driven perspective.

No First Nation is forced to join or start a Community Engagement Hub. First Nations communities and health centers may prefer to operate independently and to engage in implementation of the TFNHP individually. However, this means that they cannot access hub funding that is dedicated to the costs of collaboration and the costs associated with meetings of multiple groups.



The Medium – Long Term Intention for Community Engagement Hubs

The long term intention for Community Engagement Hubs is that First Nations effectively participate in the implementation of the TFNHP from a community-driven perspective. As communities continue to collaborate and participate in each of the individual health action areas from their own perspectives, they will continue to grow in knowledge and understanding. This will help build capacity for communities to participate at higher levels within the health system and particularly within the federal and provincial systems. Right now it is difficult for communities to participate at all levels while capacity is still developing; our numbers of health professionals and experienced health managers grows, and the systems are becoming more familiar with 'sharing' information and decision-making authorities. This type of development on both sides – will take time.

In the last couple of years the new hubs have been developing their relationships and discussing the benefits of working together. This includes looking for ways in which they can use their collective strengths to coordinate services, share resources and knowledge, and collaborate together. While most are in the developmental or Phase I stage - some have already developed to the point where they are issuing their own communications, looking at joint initiatives, sharing

health resources and man-power, and coordinating service delivery between them.

Supporting communities to develop their health and wellness plans - The First Nations Health Council, through methods such as supporting the First Nations Health Directors Association, engaging Community Engagement Hub Coordinators, supporting hubs and assisting with health planning, sees its role as helping communities, where desired, to accelerate their planning so that they are more deliberate about specifying their requirements for much needed services.

Aligning health authority plans with First Nations community wellness plans - As work continues to strengthen individual community wellness plans which focus more holistically on the needs and aspirations of each community, there will be an opportunity for communities within hubs to share these plans and to look at further ways to collaborate, share resources and advocate for much needed services into their respective communities. It is intended that Aboriginal Health Plans, such as those developed by regional health authorities (RHA), will start to align themselves with First Nations community wellness plans, rather than having First Nations 'fit' with RHA plans. Health authorities should look to the community plans for information about what First Nations need from them in terms of services and respond accordingly. However, they will not be able to do this successfully until First Nations are clear on what their health and service needs are. Some communities are farther along this type of planning than others.

Focusing on the Social Determinants of Health - One key intention of hubs is to strengthen community wellness planning and for communities to support each other to develop plans which not only look at current First Nations and Inuit Health and First Nations provided services, but also look at the social determinants of health. At that point, there will be a need for other agencies and sectors beyond health to support communities in implementing their plans. These may include housing, education, justice, environmental agencies and Territorial authorities. All of the various sectors must be positioned to support First Nations communities in the implementation of their plans and to meet their health, social and service needs accordingly.

Playing a role in local and regional First Nations governance in health - The Community Engagement Hubs, working alongside their regional caucuses, have a role to play particularly in providing technical advice to the caucus in advocating for community health issues at political levels. Hubs will be gathering information about a range of issues, and when brought together by other hubs in the region, a regional caucus may find there are many common issues across the region which are in need of attention.

Hub Details

In the year 2007-2008 there were 10 hubs with around 100 communities involved. In the year 2008 - 2009 a further 9 hubs were established, bringing the total to 19 Community Engagement Hubs representing 135 First Nations Communities (66% of 203 communities) as at March 31st 2009. By March 2010 a further 6 hubs had been established so that there were 25 community engagement hubs in the province involving 160 communities (79% of 203 communities):



One Hub summed up these benefits, observing that “as individual communities, we stand on our own and our voice is small . . . [but] by teaming up with other Hubs, we begin to knit the region together.”

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FIGURE 4.1 : COMMUNITY ENGAGEMENT HUBS MARCH 2010

REGION	# Hubs	# Communities in hubs	# in Pre-Hub stage	# in Phase I stage	# communities not in hubs
Fraser	2	22		2	7
Vancouver Island	4	43		4	8
Interior	8	49	4	4	6
North	7	35	3	4	21
Vancouver Coastal	4	11	2	2	2
TOTAL	25	160	9	16	44

Of the 25 community engagement hubs, as of March 2010, it is noted that 9 were still in pre-hub stage of forming their working relationships, obtaining mandates and developing their initial work-plans.

The tables below outline the members of the developing hubs in each region as of March 31st, 2010. It should be noted that following the developmental stages, there are often changes made by the members. In 2010-2011, there continue to be some adjustments to the hubs as new members join, some existing members withdraw and some hub members decide to further discuss whether to join other hubs. The dynamic and flexible nature of the hubs is one of the features that makes them work for First Nations communities.

FIGURE 4.2 : COMMUNITY ENGAGEMENT HUBS DETAIL BY REGION

Community Engagement Hub Host-Agency / Affiliation	Number of Communities	Status
FRASER		
Seabird Island Indian Band	11	Phase I Hub
Sto:lo Nation	11	Phase I Hub
Subtotal	22	76%
# not in hubs	7	24%
TOTAL FOR REGION	29	100%
VANCOUVER ISLAND		
Inter Tribal Health Authority (ITHA)	15	Phase I Hub
Kwakiutl District Council (KDC)	10	Phase I Hub
Nuu-Chah-Nulth Tribal Council (NTC)	14	Phase I Hub
Cowichan Tribes	4	Phase I Hub
Subtotal	43	84%
# not in hubs	8	16%
TOTAL FOR REGION	51	100%

Community Engagement Hub Host-Agency / Affiliation	Number of Communities	Status
INTERIOR		
Okanagan Nation Alliance (ONA)	7	Phase I Hub
Q'wemtsin Health Society	15	Phase I Hub
Ktunaxa Nation Council (KNC)	4	Phase I Hub
Nlaka'pamux Services Society	4	Phase I Hub
Lillooet Tribal Council	5	Pre-Hub
Scw'exmx Community Health	5	Pre-Hub
Fraser Canyon Tribal Administration	4	Pre-Hub
Tsilhqot'in National Government	5	Pre-Hub
Subtotal	49	89.1%
# not in hubs	6	10.9%
TOTAL FOR REGION	55	100% (3 Fraser region)
VANCOUVER COASTAL		
Heiltsuk Tribal Council	4	Phase I Hub
Tsleil-Waututh Nation	2	Pre-hub
Lower Stl'at'Imx Tribal Council	4	Phase I Hub
Tla'amin Community Health Board	1 (+3)	Pre-Hub
Subtotal	11	85%
# not in hubs	2	15%
TOTAL FOR REGION	13	100%
NORTH		
Treaty 8 Tribal Association	6	Phase I Hub
Lake Babine Nation Health	5	Pre-hub
Skidegate Health Centre	2	Pre-Hub
Carrier – Sekani Family Services	9	Pre-Hub
Gitxsan Health Society	8	Pre-Hub
Kwadacha	2	Pre-hub
Iskut Valley Health Services	3	Phase I Hub
Subtotal	35	63%
# not in hubs	21	38%
TOTAL FOR REGION	56	100%

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4.3 Community Development Liaisons

One of the fundamental principles underlying the Tripartite First Nations Health Plan is that “*no community is left behind.*”

The purpose of the Community Development Liaison positions is to provide a wide range of community and organizational development skills to assist First Nations, either independently or in a hub, to communicate, collaborate and plan with the FNHC and health partners such as health authorities. The Community Development Liaisons assist First Nation communities in the development of community health plans and work plans when requested.

It was also acknowledged that liaisons were needed as a vital link between communities and health authorities. Since health authorities are charged with providing the majority of health services for First Nations communities, they needed to hear from communities, either directly or through the advocacy of the liaison personnel, what types of issues communities were facing in accessing and receiving their services. Additionally, communities needed to know what they were entitled to and how to access these services. Moreover, communities needed to know who to contact about specific service issues. It was therefore agreed that the liaison positions would be shared with health authorities as a joint resource; intended to bridge the gap between health authorities and First Nations communities.

Community Development Liaisons are unique positions because they are developed and planned by the FNHC, working with the Health Authorities. Both parties jointly develop the job description, work-plan and priorities. Each role takes about 6 months to develop, in order to agree on terms, arrange the recruitment and complete the orientation of the position into the health authority.

The positions are aimed at bridging communities and the health authorities by helping the health authority in areas such as community engagement. The position is integrated into the system so that the incumbent has access to all areas of the health authority. For instance, one task is to attend the health authority’s committee meetings for Aboriginal health. The employee is employed by the FNHC but has shared supervisors from both the FNHC and the health authority.

The first Community Development Liaison was appointed in 2008, in the Interior Health Region. The second liaison was appointed in 2009, in the Vancouver Island Region and the third in 2010, in the Northern Region. These positions continue to provide additional human resource and expertise in supporting First Nations communities, community engagement hubs and health authorities to strengthen their relationships and encourage alignment of their community health plans.

4.4 Supporting Community Initiatives

Best or Better Practices

Communities at Gathering Wisdom (May 2007) called on government partners to provide more support, and opportunities to share information, about their innovative approaches. In response, the technical team developed a temporary funding envelope to support innovative, community-based approaches to health program and service delivery.

The objective was to enhance services already working on the ground in First Nations communities, and for First Nations to be able to share this knowledge with other First Nations health service providers and professionals. In particular, the ‘Better or Best Practices’ initiative targeted innovation in addressing mental wellness, chronic disease management, and maternal and child health issues. Through the ‘Better or Best Practice Initiative’, the technical team relied on community wisdom to advance a key goal of the TFNHP; *First Nations health services will be delivered in a manner that effectively meets the needs, priorities and interests of First Nations communities.*”

In July 2008 the FNHC put out a call for proposals from First Nations communities interested in promoting and enhancing their “Best or Better Practices” (BoBP) as a pilot initiative. The maximum funding was \$100,000 in three specific areas; mental wellness, maternal and child health and chronic disease management. All of which support the key priorities in the TCA: FNHP and TFNHP.

Mental Wellness:

Mental Wellness is the balance between the social, physical, spiritual and emotional aspects of life. Mental Wellness is far more than the absence of mental illness. The BoBP in mental health was required to deal with prevention of and/or treatment for mental health issues, and disorders, such as mood disorders, dual diagnosis, post traumatic stress, residential school syndrome, youth suicide, schizophrenia, and depression. Some of the examples of such initiatives that received funding over the past 3 years include:

- *Indian Residential School Survivors Society (the IRSSS)* was funded in October 2008 to hold a regional gathering reviewing the Indian Residential School Support System and the Truth and Reconciliation Commission’s role. The objectives were to provide background information on the Commission and share practical tools with communities wanting to plan truth-telling activities. The gathering also served as a public lead off event before the Commission’s first national event in early 2009. There were 390 participants from across BC and delegates from across Canada. The conference was video-documented as well as broadcasted on local media, radio networks and the internet;
- *H’ulh-etun Health Society* – The ‘Warriors Wellness Group’ initiative was aimed at improving the emotional well-being of men; through facilitating open forums, one-to-one sessions, collaborations between member communities, resource sharing, developing programs tailored to men and incorporating the teaching of cultural practices;



Communities at Gathering Wisdom (May 2007) called on government partners to provide more support, and opportunities to share information, about their innovative approaches.

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The Seabird project focused on providing culturally appropriate health information and support. The initiative aimed at using emerging communication technologies to disseminate information to the communities on best practices in chronic disease management including developing a website.

- *Xeni Gwet'in First Nation (Nemiah Valley)* - This BOBP initiative involved a focus on mental health issues, such as family breakdown, relationships, self-esteem, depression, apathy and emotion volatility. The project looked at new ways of working as a team by focusing on the family rather than the individual. The project also involved traditional healing methods such as cultural services (cultural life skills camps, Ts'utanchuny Daadaben Camp and cultural counselling), alongside western-based mental health services and family life care plans. The initiative also involved the Anaham and Stone First Nations;
- *Okanagan Nation Alliance* – This initiative was for the further development of R Native Voice and the Okanagan Nation Youth Response Team by strengthening the linkages between the two programs, and by developing a handbook to be shared with other Nations. The activities involved a variety of initiatives, review of the curriculum, provision of training and 10 youth workshops;
- *Inter-Tribal Health Authority* – This initiative focused on developing two community suicide response team mentors. The ASCIRT team mentors were required to engage with ITHA's 29 member nations to support communities in the development of their Community-Based Response teams. This was done by facilitating gatherings, running training workshops, developing a curriculum for youth empowerment training and developing a youth and elders advisory committee;
- *Chehalis Indian Band* – Their initiative was related to the development of an Aboriginal Family Wellness Healing Program. The project included 5 residential beds for an effective and secure in-patient residential addiction treatment for young Aboriginal men residing in Vancouver's Downtown Eastside.

Chronic Disease Management:

A chronic disease is an ongoing or recurring illness, such as cancer, arthritis, diabetes, asthma, hypertension, lupus, fibromyalgia, emphysema. The priority prevention and promotion areas for the FNHC funding of BoBPs was for initiatives related to prevention of heart disease, lung and kidney disease, disabilities, cancer, arthritis and joint diseases, and diabetes. The one initiative funded in this envelope is described below:



- *Seabird Island* – This project focused on providing culturally appropriate health information and support. The initiative aimed at using emerging communication technologies to disseminate information on best practices in chronic disease management to the communities, this included the creation of a website. The initiative also involved exploring a web-based on-line health support strategy to provide opportunities for patients and health care providers to have access to First Nations doctors. The aim was also to incorporate a directory of support and services available to Aboriginal people, including a toll free information line.

Maternal and Child Health:

Supporting maternal and child health is about ensuring that women have a safe, healthy and fulfilling outcome to pregnancy and childbirth, as well as access to information and support on newborn care and child development. Preventative initiatives focus on improved reproductive health, prenatal and postpartum services, and early childhood development (physical, social and emotional, speech, hearing, vision) with a focus on 0 – 6 years old. While proposals were received in the 2008-2009 year, funding of maternal and child health initiatives did not commence until the 2009-2010 year.

- *Cowichan Tribes* – The initiative operated by the Ts’ewulhtun Health Centre involved focusing on an ‘iron deficiency’ campaign to improve the high rates of anemia within their population. It involved developing posters, resources and workshops aimed at helping community members learn more about ensuring they have iron in their diets. This is particularly important for pregnant mothers. The initiative was aimed at ensuring women had healthy pregnancies and that babies were not born with iron deficiencies.

Sharing our Strength Grants

Through events such as “Gathering Wisdom for a Shared Journey”, the FNHC consistently heard, from First Nations health service providers and leaders, that First Nations must look at addressing their health issues from a wellness perspective. In support of this goal, the FNHC developed a First Nations wellness grant program called ‘*Sharing Our Strength – Past, Present and Future*’ to support First Nations wellness in each of the First Nations communities in BC.

The amount offered to each of the First Nations communities was \$5,000. While 26 communities chose not to accept the grant, a total of \$885,000 was disseminated to First Nations communities. These funds were distributed directly to communities, and to community engagement hubs. Through this award, the FNHC hoped to acknowledge activities that promote wellness through First Nation history, culture and tradition.

The award could be applied to enhance current activities or to pursue a new community idea that promoted community wellness from that community’s perspective. It could be used to support activities celebrating First Nation identity, or to celebrate a community’s successes in supporting community wellness or incorporating traditional practices and knowledge into their programs. Cultural celebrations, elder & youth gatherings, sports tournaments and many other activities helped First Nations to celebrate who we are as individuals, families and communities.

The FNHC learned that by providing grants like these, communities are enabled to address immediate issues for themselves; issues which were determined within their own communities.

Approximately 30% of the grants went to activities that supported community expression of culture and identity. These activities included:

- The formation of traditional dance groups, where new members learned how to make drums, sing, dance, and be storytellers;
- Annual tribal journeys and tribal feasts that brought neighboring remote communities together; and
- A blending of traditional, alternative and/or contemporary practices (e.g. Hands on Healing, Acupressure, and fusion of traditional and modern music).

A total of \$885,000 was disseminated to First Nations communities. These funds were distributed directly to communities, and to community engagement hubs.

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Kwicksutaineuk Ah-kwaw-ah-mish First Nation

Sharing Our Strength Grant \$5000- Final Report

We would like to thank the First Nations Health Council for the funds that allowed us to host a community celebration in Gwayasdums - our home village on Sunday, December 7th, 2008.

Gwayasdums is an isolated community and our main village site that can be travelled to by seaplane or by boat only.

The decision to host a community event and bring everyone together was an easy one to make. We sent out invitations to the off reserve membership and neighbouring communities, Chiefs and Elders. Representatives from various communities attended.

The day began with boats bringing the participants to Gwayasdums, Gilford Island. The boat bringing the cooks for the catered feast went in early to prepare. The NIAID Explorer was hired to bring people in at 9:00 a.m. participants boarded in Port McNeill and Alert Bay. A boat was also hired to bring participants out of Kingcome Inlet.

Once in the village, the Elders, Chiefs and Cultural Leaders met and agreed on the blessing ceremony for the ground. The village is in the process of rebuilding completely and the new subdivision has been cleared in preparation for building. As well, the community suffered a massacre by a northern band in the 1800's. There was a cleansing ceremony done after the massacre but this ceremony reaffirmed that ceremony.

The blessing of the ground happened and then everyone gathered in the Bighouse for a feast. After the feast, there were feast songs and speeches and special presentations. Bill and Donna McKay of the NIAID were honoured as always being there for our people. After the day was done, people were brought back out of the community.

A large part of our healing process as a people includes coming together as one people with our various families and neighbouring communities. We are all one people and our strength is strongest when we are together.

Our community has seen several deaths in the last year, so this gathering was a way of bringing people together that is not for a funeral. We would like to thank your organization again for this opportunity. gilakasla.



The role of nutrition, sport, recreation, and regular physical activity was recognized by many communities as a priority. Grants went towards the development of health promotion initiatives including:

- Nutrition workshops, seminars, videos (e.g. how to make eulachon grease);
- Learning circles about diabetes;
- Traditional food projects, such as enhancing youth knowledge and skill in harvesting and preparing traditional foods and medicines, and developing community gardens.
- Renovations for community centers, fitness centers, and sport facilities, to improve equipment safety and sustainability.

Other communities used the grant to support community health planning and delivery. All these initiatives honoured and celebrated cultural values through education and experience.

Health Promotion Initiatives

The FNHC funded a number of health promotion activities during 2008 – 2009 to support First Nations communities in their health developments and to highlight possible best practices and innovations across the province. The fund was a temporary ‘one-off’ envelope of funds designed to provide support for the work being done in communities and to recognize that existing Government contracts did not support innovative health promotion models.

Many projects were funded through this fund in 2008 – 2009 including:

- *Nak’azdli Indian Band* – was funded in 2008 to develop a training program (including training materials and a DVD) to conduct training for community prevention and awareness in the subject of HIV/AIDs. The project was named the ‘HIV / HCV Northern Prevention Project’ and was done in partnership with Positive Living North. Activities included production of a video which was sent out to many communities and nations in the province. Material was also collated into a resource kit; including workshop material, power-point presentations, facilitation manuals, prizes, DVDs, pamphlets and ordering information. A total of 14 kits were produced, and training was provided to 15 of 35 communities in the North;
- *University of British Columbia* – was funded to host a conference for mental health service providers to discuss Aboriginal child and youth mental health issues and strategies. The Aboriginal CYMH forum for the Vancouver Coastal region took place in March 2009 and supported the development of partnership opportunities between the variety of providers to address the needs of children and youth. There were 149 participants and it became evident throughout the gathering that incorporating culture, wisdom and traditions was a key to addressing the needs of young people with mental health issues.

The technical team operated a small crisis intervention fund to help communities deal with crises in their areas and much of this funding went to communities experiencing multiple suicides. Some included:

- *Esketemc First Nation* – was funded to convene a 2 day Critical Incident Stress Management (CISM) and 2 day Trauma workshop
- *Ditidaht First Nations Community Services* – was funded to convene a Port Alberni Youth Wellness Gathering at Chehalis
- *Okanagan Indian Band* – were funded to convene an ASCIRT (Aboriginal Suicide Critical Incident Team) gathering at Westbank

Cultural celebrations, elders & youth gatherings, sports tournaments and many other activities let First Nations celebrate who we are as individuals, families and communities.

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It is notable that many NGOs carry a significant responsibility for developing resources and support mechanisms to support people with chronic diseases and other ailments, and that they can play an important role in First Nations communities sharing information, resources and providing support networks for individuals that need help.

- *Sulsila Lelum Wellness Center Society* – was funded to conduct a 5 day ‘Spirit of Aloha’ program under the guidance of Hawaiian healers (Kumu) Dane Kaohelani Silva and (Kahu) Wendell Kalanikapuaenui Silva. The gathering included teachings about lumilumi (native Hawaiian healing and massage techniques), a celebration feast, and Kumu instruction. The Pacific Association of First Nations women, the Vancouver Hawaiian community and the Musqueam long-house community were the groups involved;

The FNHC was also a sponsor for a group who produced a play, that was shown across Canada, exploring drug addiction and its effect on families. Another community brought in the Betty Ford clinic to do trauma training, while another community focused on first responder training for crises.

The Mental Health and Addictions program is concluding engagement work for the National Aboriginal Youth Suicide Prevention Strategy (NAYSPS) funded through FNIH. At the beginning of March, Treaty 8 hosted a Northern BC focus group where 45 participants shared stories about their successes and expressed concerns about gaps in mental health services in the Northeast region of British Columbia.

4.5 Working with Health Partners

The technical team has developed a number of strategic relationships, aimed at linking important partners to the implementation of the TFNHP. The Society agreed on an MOU with the Vancouver Native Health Society and signed the agreement in May 2010. This urban based organization provides essential services for urban-based First Nations peoples. The Society also signed an MOU with the BC Aboriginal Network on Disabilities Society to ensure the FNHC incorporated the needs of First Nations people with disabilities, when looking at the implementation of key strategies arising from the TFNHP.

Other important partnerships include health professional organizations such as the Indigenous Physicians Association of Canada (IPAC) and the Native and Inuit Nurses Association (NINA). In the case of NINA, the Society has agreed to support some of the costs of meeting the needs of their members and helping to inform the important work of growing the Aboriginal nursing workforce in BC. We also have arrangements with research centers such as the National Collaboration Center for Aboriginal Health, based at UNBC in Prince George. Additionally, our funding of First Nations student recruitment, retention and curriculum initiatives under the AHHRI program has enabled us to establish and build vital relationships with many of the post-secondary institutions in BC.

Much of the work on Health Actions has meant forging relationships with Non-Governmental Organizations (NGO’s) and other health partners such as the BC Diabetes Association and the Red Cross. It is notable that many NGOs carry a significant responsibility for developing resources and support mechanisms to support people with chronic diseases and other ailments. These organizations can play an important role in First Nations communities through the sharing of information and resources, and by providing support networks for individuals in need of help.

4.6 BC First Nations Health Directors Association

The TFNHP created an opportunity for BC First Nations Health Directors to form a common voice and design an Association to support themselves and the communities they represent. Specifically the TFNHP states that:

'An Association of Health Directors and other health professionals will create and implement a comprehensive capacity development plan for the management and delivery of community-based services and support First Nations and their mandated health organizations in training, program development and knowledge transfer'.

A BC First Nations Health Directors Association is one of four governance components identified in the TFNHP. The Association will support and standardize training and competencies for health directors, establish a code of ethics and share information, resources and technology. The association will also serve as a recruitment agency, share information with leadership, and provide for a collective voice, while working to develop new relationships with provincial and federal government.

In the first half of 2008, a sub-committee of Health Directors worked with FNHC technicians to start some of the foundational work for the Association and to develop an agenda for the Health Director's Forum to be held later in 2008. The sub-committee consisted of Aileen Prince (Nak'azdli), Lauren Brown (Skidegate), Kim Brooks (Squamish), Laura Jameson (Little Shuswap), Carolyne Neufeld (Seabird Island), Louisa Willie (Heiltsuk), Shelley Henderson (KDC), Laurette Bloomquist (Sliammon), and Leyal Johnny (Ti'etinqox-T'in). The sub-committee held a number of meetings over the summer and set the direction for the forum.

The FNHC sponsored Health Directors forum was held from September 30th to October 1st, 2008, in Vancouver. The forum was attended by 120 health directors / administrators from across BC. Health Directors at the forum established a timeline for the development of a First Nations Health Directors Association. After the forum the committee was amended to add Jim Adams (Scw'exmx) and Juanita Nikal (Morisetown), and Leyal Johnny stepped down.

It has been critical for the First Nations Health Council to ensure that the Health Directors forum and the establishment of an Association is driven BY Health Directors FOR Health Directors and not by the First Nations Health Council. While the FNHC has set up meetings and funded the work being done, we have tried hard to ensure Health Directors have control of the process. For instance, Health Directors set their own agenda and run their own meetings.

Work completed at the 2008 Forum indicated the next steps in creating a Health Directors Association:

- Collate Health Directors Forum data into sub-categories/themes
- Develop and deliver a questionnaire that will present different options (both paper and online)
- Further develop the health directors page as a communications tool, on the www.fnhc.ca website
- Use the site to post summaries from forum, questionnaire results.
- Assess resources needed to operationalize the HDA

FIRST NATIONS HEALTH COUNCIL
Health Directors Forum

A two-day Forum for First Nations Health Directors and Administrators to strategize, network, and contribute to the creation of a First Nations Health Directors Association.

SEPTEMBER 30TH & OCTOBER 1ST
COAST PLAZA HOTEL (STANLEY PARK) VANCOUVER, BC

Travel Expenses provided for one Health Director/Administrator per First Nation

'First Nations Health Directors are the change agents responsible for leading the way to make things better in First Nations Communities.'

Gina Chud-Doug, Kelly
[Gathering Wisdom for a Shared Journey Forum 2008]



The Associations structure was developed through dialogue starting with the First Nations Health Directors forum held in October 2008. The structure was refined through a survey administered to Health Directors over the past several months. At Gathering Wisdom III, BC First Nations Health Directors voted overwhelmingly in favour of the development of a First Nations Health Directors Association. Ninety-one (91) Health Directors cast their ballots at the 3rd day of the Gathering Wisdom Forum on November 5th; 79 in favour of the Association and 12 opposed.

Following the vote on November 5th, a 13 member board of directors was appointed representing each of the five regions North (3 seats), Interior (3), Vancouver Island (3), Vancouver Coastal (2), and Fraser (2). The board members appointed were:

First Nations Health Directors Association Board of Directors

VANCOUVER COASTAL: Laurette Bloomquist (Sliammon), Allison Twiss (Lil'wat);

VANCOUVER ISLAND: Judith Gohn (Cowichan) Georgia Cook (Namgis), Nora Martin (Nuu-chah-nulth)

FRASER: Virginia Peters (Chehalis) and Jeanine Lynxleg (Sto:lo Nation),

INTERIOR: Patrick Lulua (Xeni Gwet'in), Jim Adams (Scw'exmx), Jackie McPherson (Osoyoos) and


NORTH: Aileen Prince (Nak'azdli), Hertha Holland (Gitxsan), Doreen L'Hirondelle (Treaty 8).

Kim Brooks, Health Director Squamish Nation, and member of the First Nations Health Directors Subcommittee stated: *"We are very excited about the formation of the First Nations Health Directors Association. The First Nation Health Directors Association represents a collective of the best First Nations health technical advisors in the province. This collective of experience and knowledge can provide analysis, advice and recommendations related to health planning, service delivery, measurable outcomes and much more. I look forward to the contributions that we can, as a group, make toward health governance discussions."*



Aileen Prince, Health Directors Subcommittee Member and Regional Appointment for the Northern Region adds: *"This Health Directors Association is a long time coming; a lot of hard work went into its formation. The biggest benefit of this Association for me as a health director is the ability to collaborate and cooperate with other health directors. I believe that collectively that we have tremendous knowledge, and together we are going to some amazing things for the communities in BC."*


"Looking across Canada, BC is the first province out of the gate to develop a First Nations Health Directors Association. It is quite powerful, I have already received calls of congratulations from several provinces, and we need to remember that what is going on here in BC is being closely watched by all of Canada. With respect to the process, I feel it was a very qualified process, both the survey and final poll showed strong support for the Association's development. For those of us who have been involved in providing First Nations health services for decades, this association long overdue" said Laurette Bloomquist, Health Directors Subcommittee Member and elected representative for Vancouver Coastal Region.



As an interim measure, the FNHC appointed a staff member to provide secretariat services for the new Association until they make decisions about their long term operational support mechanisms. The Health Directors Association was incorporated in April of 2010.

4.7 Health Advocate

Given the vast number of issues that First Nations individuals and communities experience when accessing services, in particular the Non-Insured Health Benefits (NIHB) program, Health Canada provided funding to the FNHS to employ an advocate for First Nations patients and families to help them resolve any issues with claiming or accessing NIHB. The advocate works with the FNHS, NIHB team and First Nations people, addressing queries and facilitating amicable solutions to issues. There is no doubt that the criteria for NIHB, set at national level, can be limiting for many First Nations. Part of the FNHS Health Actions work (especially in the primary care area) will be to formally identify the broader issues with NIHB and to develop improvements which will make support for accessing and receiving services easier for First Nations families.



5 Building & Maintaining Political Support with First Nations Communities



5. BUILDING AND MAINTAINING POLITICAL SUPPORT WITH FIRST NATIONS COMMUNITIES

Building and maintaining First Nations political support for the implementation of the TFNHP is critical. Any absence of such support will put the implementation of the TFNHP at significant risk. The FN Health Society intends to build and maintain political support for the implementation of the TFNHP through achieving two key objectives:

- Technical support for First Nations Health Council; and
- Policy Support for First Nations political leadership

5.1 Technical Support for the First Nations Health Council

The First Nations Health Council is supported by the technical team at the FN Health Society in order to achieve their obligation of providing leadership for the TFNHP implementation. The FN Health Society continues to provide secretariat level support for meetings, as well as support for advocacy and communications activities (e.g. newsletters, website, information for community engagement processes, qualitative and quantitative data and information, policy and strategic advice).

5.2 Policy support for First Nations political leadership

First Nations political leadership operates at a variety of levels, and in a variety of ways, in the province. The FN Health Society will aim to build and support First Nations political leadership to engage in the implementation of the TFNHP. This will be accomplished through providing health-related briefings for:

- First Nations political bodies; including local bodies, provincial and regional bodies and national bodies, such as the Assembly of First Nations,
- First Nations community leadership,
- First Nations Interim Health Governance Committee and Regional Caucuses,
- Political leaders to support their advocacy role (e.g. H1N1), and
- First Nations leadership in their 'Government to Government' relationships on health.

The FN Health Society employs a Senior Policy Analyst to provide policy support to the FNHC and leaders across the province.

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Building & Maintaining Political Support with First Nations Communities

5.3 A new BC First Nations Health Governing Body

The TFNHP added two new actions for First Nations governance improvements in health; the creation of a new structure of governance for First Nations health services in BC and the formation of a First Nations Health Directors Association. Through the TFNHP and the new governance structure, BC First Nations will have a “major role in the design, delivery, and evaluation of health services”. First Nations will be able to more effectively meet the needs of their own individuals and communities. The key governance areas:

- **FROM TCA: FNHP 2006**

- A First Nations Health Council (Health Council) to act as the advocacy voice of First Nations on health issues and to “provide leadership in the implementation of this Plan.”
- A Provincial Committee on First Nations Health (Provincial Advisory Committee on First Nations Health) to monitor the regional health authorities Aboriginal Health and Wellness Plans and to provide advice to the parties on closing health gaps.

- **FROM THE TFNHP 2007**

- A First Nations Health Governing Body, to be formed through the work of the tripartite partners. This Governance Body is expected to take over the management and direction of the services currently provided by the First Nations and Inuit Health (FNIH) Regional Office in BC, and other agreed upon provincial programs and services
- An Association of Health Directors and other health professionals, to provide a voice for the professionals working in First Nations health and to support training and knowledge transfer. The Association will represent professionals who work in First Nations health.

Through the TFNHP and the new governance structure BC First Nations will have a “major role in the design, delivery, and evaluation of health services” to more effectively meet the needs of their own First Nations communities and individuals.



As outlined and agreed in the TFNHP, a new First Nations Health Governing Body will take on the delivery of some or all of the programs and services currently delivered by First Nations and Inuit Health (FNIH), as well as other agreed upon federal and provincial health services. This new governing structure will reflect a new administrative arrangement between First Nations, BC and Canada where BC First Nations take the lead in designing and delivering programs and services. In order for this to take place, First Nations need to decide which programs and services will be transferred. They must also decide on a timeline for this transfer and the financial resources required to effectively implement it.

Creation of the FN Interim Health Governance Committee and Regional Caucuses

In January of 2008, to advance the work of creating a new First Nations Governing Body, the Union of BC Indian Chiefs, the First Nations Summit and the BC Assembly of First Nations appointed Chief Wayne Christian (UBCIC), Grand Chief Edward John (FNS), and Grand Chief Doug Kelly (BCAFN) to serve as co-chairs on the newly formed **First Nations Interim Health Governance Committee (FNIHGC)**.

At the Gathering Wisdom for a Shared Journey Forum 2008 participants supported the First Nations Interim Health Governance Committee (FNIHGC) Co-Chairs to engage in a dialogue on issues of health governance with each of the 203 BC First Nation communities, particularly with each Chief and senior health lead. This engagement work was supported unanimously through a formal resolution at the Union of BC Indian Chiefs (200825), the First Nations Summit (#0608.22), and the BC Assembly of First Nations (292008). Specifically, the resolutions supported the delivery of Regional Caucus Sessions to be held over a 6 week period, from October through to November 2008, within the North, Interior, Fraser, Vancouver Coastal, and Vancouver Island regions.

The purpose of these sessions was to inform BC First Nations of the governance provisions of the TCA: FNHP and the TFNHP, and to gain information, support, advice, and direction on the development of a First Nations Health Governing Body. In recognition of the unique health issues and concerns faced in each region of the province, a second objective of the regional sessions was to form Regional Caucuses on Health Governance and to appoint a regional representative from each caucus to champion this work on behalf of their regions. The Committee Co-Chairs felt that regional caucuses were best positioned to identify critical issues, gather information, and help prepare a mandate for this project.

Progress among the Regional Caucuses of First Nations political leaders

Throughout the summer of 2008, materials for engagement were prepared, dates were set, and in the fall of 2008 Regional Caucus sessions were held in Kamloops (October 14-15), Prince George (October 22-23), Terrace (October 27-28), Chilliwack (November 4-5), Vancouver (November 12-13), and Nanaimo (November 17-18). Key themes emerging from the Regional Caucus sessions included:

- √ BC First Nations are committed to working together;
- √ Culture is important - First Nations do not want to simply adopt the current FNIH system;
- √ Communication is critical - the negotiations process must be open and transparent; and
- √ The regions must be resourced and supported to do the important work ahead.

At the Gathering Wisdom for a Shared Journey Forum 2008 participants supported the First Nations Interim Health Governance Committee (FNIHGC) Co-Chairs to engage in a dialogue on issues of health governance with each of the 203 BC First Nation communities



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Building & Maintaining Political Support with First Nations Communities



In support of this feedback the First Nations Health Council and partners designated resource for the FNIHGC and the Regional Caucuses (funded through their chosen host agencies) to support the costs of continued dialogue and discussion of the member communities. The Council also designated staff to support the FNIHGC and Caucuses with communications, logistics and information sharing.

The Regional Caucus sessions have led to numerous follow-up meetings in each region between the FNIHGC and Regional Caucuses (see regional summaries). The Committee Co-Chairs began this process with the belief that BC First Nations must have a voice in the development of a new health governing framework. Many important conversations with BC First Nations have underpinned the development of a negotiations mandate to engage tripartite discussions. These follow-up meetings invited a more focused discussion on health governance which provided the FNIHGC Co-Chairs with regional issues checklist said in the formation of a negotiations mandate.

This new governing structure will reflect a new administrative arrangement between First Nations, BC and Canada where BC First Nations take the lead in designing and delivering programs and services.

Between October 2008 and up to April 2010 BC First Nations identified the following issues. These form the basis of a negotiations mandate:

- ✓ Integration
- ✓ Control over health policy
- ✓ Legislated authority
- ✓ Improved relationships with each of the provincial Health Authorities
- ✓ Non-insured Health Benefits
- ✓ Equal and fair representation
- ✓ Capacity building
- ✓ Communications
- ✓ Accountability
- ✓ Funding
- ✓ Fiduciary Responsibility
- ✓ Culture and Traditional Knowledge
- ✓ Mental Health and Addictions
- ✓ Service Delivery
- ✓ Elder Care

These general concerns encompass specific local matters of governance, relationships and accountability. Participants in each regional session talked about the need for greater authority to affect change in their communities. Matters of culture and language were discussed in relation to overall individual and community wellness. Many talked about the significance of the formal apology to Indian residential school survivors and the United Nations Declaration on the Right of Indigenous People. Leaders expressed anxiety about the mental and physical wellness of children and youth in their communities. Health managers spoke powerfully about their desires to have greater control over services and program development. Elders affirmed our ancestors and reiterated the need to always do things in a dignified and respectful way. All participants agreed that accountability and transparency must be present as we assume greater authority over health services and delivery for BC First Nations.



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Building & Maintaining Political Support with First Nations Communities



Regional Snap Shots

Each region is responsible for creating community-based process that works for that region. The First Nations Health Council provides resources to each region to cover meeting costs. The First Nation Health Council is in the process of hiring Regional Governance Liaisons to support the FNIHGC process. The liaisons will provide communication, and community engagement support between the First Nations Interim Health Governance Committee Members and each regional caucus. The following is a current description of each Regional Governance Caucus:

Northern Caucus

Members

- Chief Robert Mills, Chief Margery McRae, Warner Adam, Freddie Louie, Anne Sam, Doris Ronnenberg, and Justa Monk
- Former member Chief Willard Wilson and proxy Tanu Lusignan
- Proxy member Dave Richardson for Warner Adam

Meetings and Follow up meetings

- October 22nd-23rd, 2008, Prince George
- October 27th-28th, 2008, Prince George
- November 24th-25th, 2008, Vancouver
- January 15th-16th, 2009, Prince George
- September 3rd-4th, 2009, Prince George
- October 19th-20th, 2009, Burns Lake
- November 2nd, 2009, Vancouver

The FNIHGC Co-Chairs felt that Regional Caucuses were best positioned to identify critical issues for their own areas, to gather information from communities, and help prepare a mandate for this project.

The FNIHGC Northern Governance Caucus has determined seven (7) members representing the sub regions of the Northwest, North central and Northeast. They have also determined that the Caucus will be comprised of one (1) representative per BC First Nation in the Northern Region for a total of fifty four (54). From October 2008 to April 2010, the Northern Governance Caucus met nine (9) times and will continue to meet based on the direction of the Regional Members and Caucus Representatives. The FNIHGC and the First Nations Health Council (FNHC) have determined to establish a budget of \$110, 000.00. This funding is meant to carry out objectives regarding engagement and to create dialogue about region-specific concerns about the health governance process, particularly about the development of a new BC First Nations Health Governing Body. The host agency for the North is Carrier Sekani Family Services located in Prince George. The Health Governance Liaison position will provide a critical link , ensuring that all relevant and current information is disseminated to each BC First Nation in the Northern Region.

Interior Caucus

Members

- Chief Shane Gottfriedson, Chief Jonathan Kruger, Gwen Phillips, Chief Shelley Leech, Chief Ko'waintco Michel, Chief Bernie Elkins, and Chief Geronimo Squinas
 - Former members Chief Joe Dennis and Chief Darrell Bob

Meetings and follow-up meetings

- October 14th-15th, 2008, Kamloops
- November 20th, 2008, Kamloops
- January 22nd-23rd, 2009, Kamloops
- December 15th, 2009, Kamloops
- February 24th-25th, 2010, Kamloops

The FNIHGC Interior Governance Caucus has determined seven (7) members based on a nation-to-nation model; each member represents the distinct nations within the Interior Region. The Interior will determine a caucus that will adhere to their nation-to-nation model and likely determine 1 to 2 caucus representatives per nation for a potential total of 7 to 14. From October 2008 to May 2010 the Interior Governance Caucus met six (6) times and will continue to meet based on the direction of the Regional Members and Caucus Representatives. The FNIHGC and the FNHC have determined to establish a budget of \$110, 000.00 to carry out objectives regarding engagement and to dialogue about region-specific concerns and interests about the health governance process as these objectives relate to the *Tripartite First Nations Health Plan*, particularly to develop a new BC First Nations Health Governing Body. The host agency for the Interior is Okanagan Nation Alliance located near Westbank. The Health Governance Liaison position will provide a critical link to ensure that all relevant and current information is disseminated to each BC First Nation in the Interior Region.

Fraser Caucus

Members

- Chief Willie Charlie, Chief Maureen Chapman and Councilor June Quipp

Meetings and follow-up meetings

- November 4th-5th, 2008, Chilliwack
- December 15th, 2008, Seabird Island

The FNIHGC Fraser Governance Caucus has determined three (3) members based on a formal selection process. A caucus has not been determined for this region. From October 2008 to May 2010 the Fraser Region have met three (3) times and will continue to meet based on the direction of the Regional Members and Caucus Representatives, once the representatives have been determined. There was to be a Caucus meeting on November 23rd, 2009, however, key participants in this meeting fell ill and subsequently the meeting was cancelled. The FNIHGC and the FNHC have determined to establish a budget of \$110, 000.00 to carry out objectives regarding engagement and to dialogue about region specific concerns and interests about the health governance process as these objectives relate to the *Tripartite First Nations Health Plan*, particularly on developing a new BC First Nations Health Governing Body. The host agency for the Fraser has been discussed amongst the Regional Members and has not been decided. The Health Governance Liaison position will provide a critical link to ensure that all relevant and current information is disseminated to each BC First Nation in the Fraser Region.

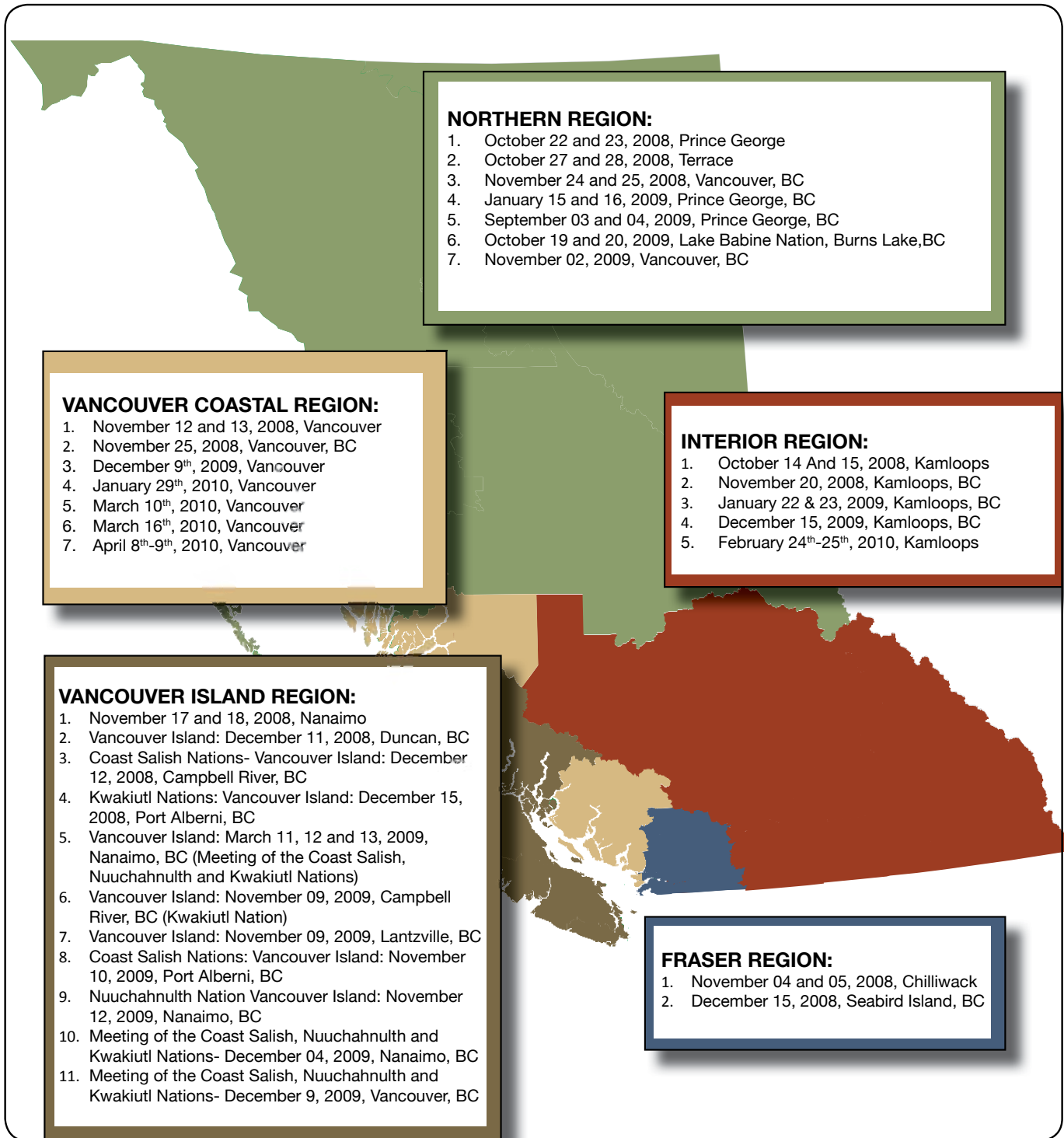
Leaders expressed anxiety about the children and youth in their communities. Health managers spoke powerfully about their desires to have greater control over services and program development. Elders affirmed our ancestors and to always do things in a dignified and respectful way.



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FIGURE 5.0: REGIONAL CAUCUS MEETINGS 2008-2010



Vancouver Coastal

Members

- Charles Nelson, Ernest Armann and Leonard Bob

Meetings and follow-up meetings:

- November 12th-13th, 2008, Vancouver
- November 25th, 2008, Vancouver
- December 9th, 2009, Vancouver
- January 29th, 2010, Vancouver
- March 10th, 2010, Vancouver
- March 16th, 2010, Vancouver

The FNIHGC Vancouver Coastal Governance Caucus has determined three (3) members based on a formal selection process. They also decided, at a meeting on December 9th, 2009, to begin a process to determine caucus representatives. A meeting scheduled for January 18th, 2010, determined caucus representatives would be from each First Nation within their region. From October 2008 to May 2010 the Vancouver Coastal Region met eight (8) times and will continue to meet based on the direction of the Regional Members and Caucus Representatives, once the representatives have been determined. The FNIHGC and the FNHC have determined to establish a budget of \$110, 000.00 to carry out objectives regarding engagement and to dialogue about region specific concerns and interests about the health governance process as these objectives relate to the *Tripartite First Nations Health Plan*, particularly on developing a new BC First Nations Health Governing Body. The host agency for the Vancouver Coastal has been discussed amongst the Regional Members and has not been decided. The Health Governance Liaison position will provide a critical link to ensure that all relevant and current information is disseminated to each BC First Nation in the Vancouver Coastal Region.

Vancouver Island

Members

- Cliff Atleo, Chief Russ Chipps, South Island Coast Salish, Chief Bob Chamberlin, Kwakiutl Nation
 - Proxy member Jennifer Williams for Chief Russ Chipps
 - Proxy member James Wilson for Chief Bob Chamberlin

Meetings and follow up meetings:

- November 17th-18th, 2008, Nanaimo (Coast Salish, Kwakiutl, Nuuchahnulth)
- December 11th, 2008, Duncan (Coast Salish Nations)
- December 12th, 2008, Campbell River (Kwakiutl Nations)
- December 15th, 2008, Port Alberni (Nuuchahnulth Nations)
- March 11th-13th, 2009, Nanaimo, (Coast Salish, Kwakiutl, Nuuchahnulth)
- November 9th, 2009, Campbell River (Kwakiutl Nations)
- November 9th, 2009, Lantzville (Coast Salish Nations)
- November 10th, 2009, Port Alberni (Nuuchahnulth Nations)
- November 12th, 2009, Nanaimo (Coast Salish, Kwakiutl, Nuuchahnulth)
- December 4th, 2009, Nanaimo (Coast Salish, Kwakiutl, Nuuchahnulth)
- February 22nd-23rd, 2010, Victoria (Coast Salish Nations)

The FNIHGC Vancouver Island Governance Caucus has determined three (3) members based on a formal consultative process, both collectively and as individual nations. They have also determined that the Caucus will be comprised of representatives from each nation of the Nuuchahnulth, Kwakiutl and Coast Salish. Each nation will determine their own process

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for deciding on caucus representatives. Currently, the caucus has fourteen (14) from the Nuuchahnulth, eight (8) from the Kwakiutl, and the Coast Salish have determined representatives from each sub-region of the north, central and south Island. From October 2008 to April 2010 the Vancouver Island Region (collectively and individually) have met thirteen (13) times and will continue to meet based on the direction of the Regional Members and Caucus Representatives. The FNIHGC and the FNHC have determined to establish a budget of \$110, 000.00 to carry out objectives regarding engagement and to dialogue about region specific concerns and interests about the health governance process as these objectives relate to the *Tripartite First Nations Health Plan*, particularly on developing new BC First Nations Health Governing Body. The host agency for Vancouver Island has been discussed amongst the Regional Members and has not been decided. The Health Governance Liaison position will provide a critical link to ensure that all relevant and current information is disseminated to each BC First Nation in the Vancouver Island Region.

FIGURE 5.1 GOVERNANCE ACTIVITIES SUMMARY TIMELINE: 2008 – 2010

JANUARY 2008	Creation of the First Nations Interim Health Governance Committee (Committee); appointment of Co-Chairs Grand Chief Ed John (First Nations Summit); Grand Chief Doug Kelly (B.C. Assembly of First Nations); and Chief Wayne Christian (Union of BC Indian Chiefs);
APRIL 2008	April 30th – The Committee Co-Chairs meet with Health Canada’s Assistant Deputy Minister Ian Potter, Project Manager for First Nations and Inuit Health and the BC Ministry of Health, to discuss moving forward on health governance;
MAY 2008	May 5-6th – The Committee Co-Chairs and the First Nations Health Council meet with the Government of Canada and the Government of B.C. in a Strategic Planning Session. The parties collectively discuss the following topics: governance models; collective goals and vision; the role and responsibilities of the Federal Government, the Province and First Nations; and a structure and road map to work together. Direction is sought by the FNIHGC from First Nations leadership present at Gathering Wisdom II held in May 2008, Regional Caucus sessions reconvene to explore the issues further and provide space for communities to have their own dialogue;
JUNE 2008	The FNIHGC and the First Nations Health Council submit a briefing note and resolution that is unanimously passed at the UBCIC, FNS, and BCFN to support the Regional Caucus Sessions that will be held over a six week periods from October through to November within the North, Interior, Fraser, Vancouver Coastal, and Vancouver Island regions.
JULY 2008	<p>The FNIHGC develops a comprehensive plan for Regional Caucuses Sessions; identified as two (2) day sessions for Chiefs and Health Directors in the five (5) regions of the Interior, North, Fraser, Vancouver Coastal and Vancouver Island First Nations communities. The Committee created an agenda and workbook to facilitate the selection of regional caucus members.</p> <p>July 21 - Introductory meeting is held with the Minister of Healthy Living and Sport, Honourable Mary Polak, Assistant Deputy Minister of Population Health, Andrew Hazelwood, the Health Canada Regional Director, Catherine Lappe, and Regional Director of First Nations and Inuit Health for BC Region, Yousuf Ali.</p> <p>July 24-25 – The Committee Co-Chairs meet with the First Nations Health Council for a Strategic Planning Session for the development of a five (5) year business plan.</p>

SEPTEMBER 2008	September 18th - The Committee Co-Chairs meet the Provincial Advisory Committee on First Nations Health for an introductory meeting with the CEOs of the B.C. Regional Health Authorities and the B.C. Ministry of Health.
OCTOBER 2008	Regional Caucus Sessions – the Committee meets for the recommended two (2) day sessions with the Chiefs and health leads, in each health region of BC, to discuss regional representation on the Committee.
DECEMBER 2008	Follow-up meetings to the regional caucus sessions – the purpose was to discuss regional representation on the Committee.
JANUARY 2009	On-going selection by each region of their own representation on the Committee; upon which the tripartite discussions can move forward in shaping the new health governance arrangement.
FEBRUARY 2009	February 9th – First Nations Health Council compiles recommendations from Regional Caucus sessions into community-driven checklists to evolve and inform tripartite negotiations.
MARCH 2009	On-going selection by each region of their own representation on the FNIHGC; upon which the tripartite discussions can move forward in shaping the new health governance arrangement.
JUNE 2009	FNIHGC members are invited by FNIHGC co-chairs to observe Tripartite Governance discussions
AUGUST 2009	August 25 th - FNIHGC holds a 2-day strategic planning session where the negotiations mandate document is refined. August 25 th - FNIHGC co-chairs meet with federal Health Minister Leona Agluuqaq, and provincial Minister of Healthy Living and Sport, Ida Chong, in Victoria. The Principals all reconfirm their commitment to the Tripartite First Nations Health Plan, and to advancing governance discussions.
SEPTEMBER 2009	September 25 th – FNIHGC members meet with Principals to the Health Plan; each member has the opportunity to address Health Ministers directly.
NOVEMBER 2009	FNIHGC Co-chairs and Committee host a day of governance discussions at the third annual Gathering Wisdom Forum. Each region presents on the process from a regional perspective.
DECEMBER 2009	Regional governance liaison job descriptions and hiring processes confirmed with regional representatives.
FEBRUARY 2010	Basis for a Framework Agreement is shared through regional caucuses
MARCH 2010	Union of BC Indian Chiefs and First Nations Summit pass resolutions rescinding the current political appointments of the First Nations Health Council replacing the seven (7) councilors them with fifteen (15) councilors, to be selected by BC First Nations from each region of the North, Interior, Fraser, Vancouver Coastal, and Vancouver Island (3 per region). The new council is charged with overseeing governance negotiations.
APRIL 2010	Regions participate in appointment processes for new Health Council.



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FNIHGC Meetings 2009-2010

- June 2nd, Vancouver
- June 14th, Vancouver
- June 15th, Vancouver (observers at the Tripartite Governance Committee)
- July 27th, Vancouver
- August 17th-18th, Vancouver (retreat)
- August 31st, Victoria (Co-Chairs meet with Principals)
- September 22nd (meeting cancelled)
- September 25th, Vancouver (Committee meets with Principals)
- September 29th (teleconference)
- October 27th, Vancouver
- November 3rd, Vancouver (Annual Gathering Wisdom for a Shared Journey Forum)
- November 5th, Vancouver
- November 20th, Vancouver
- November 30th, Vancouver (Committee Working Group on Structure and Functions)
- December 16th, Vancouver 2010
- January 11th, Vancouver (Committee Working Group on Structure and Functions)
- January 12th, Vancouver
- January 27th, Vancouver (Committee Working Group on Structure and Functions)
- January 28th, Vancouver (Committee Working Group on Structure and Functions meet with the FNHC and the FNHS Board of Directors)
- February 9th (video conference)
- March 8th (video conference)
- March 22nd-23rd, Vancouver (Committee Working Group on Structure and Functions)



Tripartite Governance Work and the Basis for a Framework Agreement

The Tripartite First Nations Health Plan, signed in 2007, called for a *First Nations Health Governing Body* to be developed, through the work of a tripartite committee, within three years of signing the plan. Over the past year and a half, BC First Nations, through the First Nations Interim Health Governance Committee and Regional Caucuses, have been engaging in this exciting opportunity for change.

Canada (represented by Health Canada), BC (represented by Ministry of Healthy Living and Sport), and BC First Nations (represented by the First Nations Interim Health Governance Committee Co-chairs) reached agreement on a Basis for a Framework Agreement in March 2010. The agreed upon approach, contained in the Basis for a Framework agreement, will secure funding commitments and provide the basis for drafting an agreement which describes a basic structure that enables First Nations decision-making in First Nations health services. Reaching a high-level political agreement signaled the beginning of, rather than an end to, the important work ahead. It provides a basis for further dialogue with BC First Nations, prior to reaching a legal agreement.

Progressing from the politically recommended Basis for a Framework Agreement to a legally binding agreement will be the next critical piece of work. A legally binding agreement would move BC Nations into a multi-year transition period. During this period, the governance structure will be refined, programs will transition to First Nations control, new relationships and partnerships with governments will be tested, and the operations and functions of First Nations Inuit Health BC Region and other agreed upon provincial programs and services will be transferred to a new First Nations governing body.

At a strategic and operational level the FN Health Society aims to work positively and proactively with the tripartite partners in order to advocate for continued involvement, engagement and decision-making by FN communities with regards to the TFNHP.



6

Relationships with Government



6. ENHANCING WORKING RELATIONSHIPS WITH THE FEDERAL AND PROVINCIAL GOVERNMENTS

6.1 Preparing to work together to implement the TFNHP

At the time the TFNHP was signed neither the federal nor the provincial governments were organized in a way that aligned with the TFNHP. Yet the First Nations Health Council was established solely as a result of the TFNHP, to facilitate its implementation. Health Canada – FNIH was established to provide services on reserve and continues to transfer the delivery of some of these programs and services to First Nations under their Health Transfer Pcheme. First Nations and Lunit Health’s organizational structure focuses on programs and relationships with First Nations are based on the type of agreement each nation holds. For instance, some staff manage only Set and Integrated Agreements across the Province while some staff manage full Health Transfer agreements. Federal partners are not structured to work with First Nations communities on a regional basis like provincial health authorities.

The Province is structured differently again, and in the past 3 years further complexity was created when the Ministry of Health split into two separate agencies; the Ministry of Health Services and the Ministry of Healthy Living and Sport. When this occurred the Aboriginal Health Branch remained with the Ministry of Healthy Living and Sport, leaving the Ministry of Health Services, whose primary role is to oversee health authority and primary care services, with no Aboriginal Health Branch (AHB) or group responsible for implementing the TFNHP. The AHB in the MOHLS is expected to support both organizations and with an ‘Aboriginal’ focus rather than a First Nations focus, its mandate will be less specific than that of the FNHC.

These large organizations and the 6 health authorities comprise around 100,000 personnel with vast numbers of programs and services under their control. None of them were positioned in a way that aligns well with the work required under the TFNHP.

The Province assigned responsibility for the TFNHP to the executive director of the AHB. Health Canada – FNIH established a tripartite position to engage with the Province and the FNHC, but this position came with little or no authority to affect change. This has been an added challenge for the FNHC.

Therefore, the task for the FNHC has been to find a way to operate a comparatively small team of around 30 personnel, to deliver a few inherited programs and to structure itself in a way that allows engagement with these large bureaucracies and affects the changes that are anticipated under the TFNHP. Difficulty arises from having to engage with different organizational and personnel, some of whom have no authority, responsibility or power to make the changes that are needed. It is also difficult when these bureaucracies continue “business as usual”, while the FNHC pushes to affect improvements and change that benefit BC First Nations. For the FNHC, the TFNHP is the number one priority. For the tripartite partners, the TFNHP is one of many priorities; therefore, our challenge is to advocate for the promotions of the TFNHP on the work agenda and for changes to be given priority.

It is also difficult when these bureaucracies have a requirement to continue performing their “business as usual” role while the FNHC pushes to effect improvements and change that benefits BC First Nations.

6

Relationships with Government

6.2 Working with Health Authorities

The FNHC has worked with health authorities to support their dialogue with First Nations communities. For example, the FNHC co-hosted a forum with the Interior Health Authority. This was a regional meeting for all of the First Nations communities to facilitate a discussions about health issues with the health authority. The FNHC also attends health authority forums, such as the Cultural Competency Forum hosted by the Vancouver Coastal Health Authority. This ensures that the FNHC remains in touch with the ongoing building of relationships between health authorities and First Nations communities, and that the FNHC personnel hear ‘first-hand’ the concerns, ideas and aspirations of First Nations.

6.3 Ensuring First Nations participation in provincial committees

An important role of the FNHC is to create space for First Nations participating on Provincial advisory committees. These committees give advice to provincial decision-makers on a variety of policy and service issues. The FNHC reviews Terms of Reference to ensure the committees acknowledge the important role of First Nations, and then facilitates First Nations representation on the committees.



Facilitating a process where First Nations have a voice on provincial advisory committees is critical to providing recommendation for and influencing the direction of programs and services affecting First Nations communities. The process of reviewing the scope of committees is important because it is vital that the First Nations play more than a supporting role. It is also seen as important that First Nations are able to influence the process when they sit at the table and are not out-numbered or overwhelmed with government representatives or western health system perspectives. In the 2008-2009 year, the FNHC ensured that First Nations held the predominant positions on the

Maternal and Child Health Committee. This committee now operates as a key advisor on maternal and child health issues affecting First Nations individuals and families.

6.4 Tripartite Management Team and Oversight Committee

The Tripartite Management Team is made up of senior executives from the FN Health Society, FNIH and the province. The TMT provides a forum for strategic and managerial decisions that support the implementation of the TFNHP under the direction of the First Nations Health Council.

The Tripartite Management Team has met many times over the past 3 years and meets on a face to face basis at least once a month and by teleconference between these meetings. The TMT has considered a number of issues and made decisions to overcome jurisdictional issues, progress with joint initiatives and ensure the ongoing day to day implementation of the TFNHP. Some of these decisions have included:

- Developing a Strategic Implementation Plan for Health Actions.
- Establishing and mandating a Tripartite Communications Committee to oversee and implement joint communications on key initiatives. Dr Evan Adams is chair of this committee.
- Reviewing and producing the Tripartite “Year in Review” reports for the annual Gathering Wisdom Forum.
- Joint planning of the Gathering Wisdom III forum in May 2008 and November 2009.
- Joint agreement and production of governance-related communication materials.
- Implementing a collaborative approach to the H1N1 pandemic and vaccination program.
- Reviewing terms of references to ensure First Nations participation in programs initiated by the provincial or federal governments which affect the TFNHP Health Actions.

6.5 Securing Funding Certainty

Of all the strategies and objectives within our plan, securing funding certainty is probably the most critical objective for the FN Health Society. Prior to 2009-2010 First Nations did not have funding certainty from either the federal or provincial governments for the life of the TFNHP. In 2009-2010, through strong advocacy by the First Nations Health Council members, the provincial government gave a firm 10 year commitment to fund the TFNHP as follows:

In 2009-2010, through strong advocacy by the First Nations Health Council members, the provincial government gave a firm 10 year commitment to fund the TFNHP

PROVINCIAL FUNDING COMMITMENT 2010-2020

Fiscal Year	Amount
2010/2011	\$0
2011/2012	\$4 million
2012/2013	\$6.5 million
2013/2014	\$8 million
2014/2015	\$10 million
2015/2016 through 2019/2020	\$11 million per year
Total:	\$83.5 million

This long term funding commitment from the provincial government allows the Society to improve its strategic planning for financial and human resource investments which are necessary to the successful implementation of the TFNHP, over the next 10 years.

However, at this time, funding from the federal government remains uncertain, as the current 4 year funding commitment, totaling \$29 million dollars expires in 2010-2011. In addition to the expiration of the funding agreement, federal funding remains inconsistent, with funds amounting to \$4,954,545 from 2007-2008 and 2008-2009 being received in 2009-2010 and \$8 million owed from 2009-2010 not being received by the Society until 2010-2011.

The renewal of federal funding, and ensuring the consistency of federal funding, is a key objective for the Society in the upcoming year. We will continue to advocate to the federal government for funding certainty in order to enable us to maintain a long term strategic investment strategy in guiding our implementation of the TFNHP. We do not want to fall into the trap of making immediate short-term decisions due to financial constraints.



6

Relationships with Government

Our ability to plan for investments for implementing the TFNHP and assign our financial and human resources is better now that First Nations have a more secure picture of the revenues supporting the TFNHP implementation.

6.7 Working with Provincial Health Office

This Action Item was achieved when Dr Evan Adams from the Sliammon First Nation, was appointed in 2007, as the Aboriginal Physician Advisor to the Provincial Health Officer (PHO). Dr Adams plays a major role in the production of the PHO's 5 yearly Report on the Status of Aboriginal Health [TCA: FNHP Action # 27]. He also continues to be a resource for both the PHO as well as the Tripartite partners and is chairing the Tripartite Communications Committee. In his role as the Aboriginal Physician Advisor for the PHO, Dr Adams has participated in many activities alongside the First Nations Health Council. The following is the report of the Aboriginal Physician Advisor position which has been jointly resourced by the Province and the FNHC:

Aboriginal Physician Advisors Report

Chronic Disease

In the chronic disease area, Dr Adams supported the ActNow BC - Honor Your Health challenge which is a provincial initiative with an Aboriginal component called Honor Your Health. In supporting the ActNow public health initiative there has been a strong focus on prevention and health promotion. For example, the First Nations ActNow Provincial team did a mini-tour in Fort St John (June 2008) in a First Nations community, to promote Act Now principles. Dr Adams is also on the leadership council for ActNow BC. He participated in the development of a chronic disease self-management framework, alongside Dr Len Roy and Dr Carole Williams (BC College of Family Physicians) who worked with the First Nations Health Council to disseminate the framework to physicians and First Nations communities. Moreover, Dr. Adams was also on the organizing committee for International Diabetes in Indigenous Peoples Forum.



Diabetes affects First Nations peoples in disproportionate numbers. Dr Adams was on the organizing committee for the International Diabetes in Indigenous Peoples Forum. He was a key-note speaker at the BC Aboriginal Diabetes Conference presenting on 'Diabetes 101' and appeared in a series of diabetes support videos produced by Vancouver General Hospital called 'Diabetes and my Nation' which were aimed at presenting a First Nations perspective. As diabetes affects eyesight, Dr Adams has been working with the Provincial retinal scanning program, through the Primary Health Care Medical Services Division of the Ministry of Health Services, in order to ensure that retinal scanning is available in First Nations communities. The program tries to target rural and remote communities with poor access to ophthalmologists and optometrists. A big focus for Dr Adams was on ensuring that retinal screening was used for diabetes diagnosis among First Nations and not just to treat diabetes complications.

The First Nations Health Council and Dr Adams worked with the *Healthy Hearts Society* to do an Aboriginal engagement session. This led to the Society being asked by a number of First Nations organizations, including the Victoria Friendship Center, to do Healthy Heart screening.

Cancer is also a significant health issue among First Nations peoples. Even though general cancer rates among First Nations are lower than the rest of the BC population, they are higher for First Nations in some specific areas, so primary health care screening and mammography needs to be improved. Dr Adams was a keynote speaker at the Northern Cancer Control Strategy meeting, as part of the Health Authorities Division in the province. Through this work, an alliance was formed, to ensure that First Nations, the health authority and the province worked together on the issue of cancer treatment and prevention. Dr Adams worked with the 'Telus Tour for the Cure', a public health event promoting the prevention of breast cancer through effective breast screening. He requested that the group visit First Nations reserves, particularly in the North, to bring breast cancer information and mammography screening to light.

The BC Cancer Agency has also met with the First Nations Health Council to discuss cancer surveillance and research into traditional health practices to treat cancer. It has been difficult to implement surveillance initiatives because of problems with accessing relevant data on Aboriginal rates of screening; however, once the Data Quality and Sharing Agreement has been signed it is hoped that this barrier can be overcome. On behalf of BC First Nations, Dr Adams attended a number of meetings and forums about cancer in Aboriginal populations. These include:

- Canadian Cancer Cohort Initiative
- Canadian Partnership Against Cancer
- Canadian Breast Cancer Foundation
- Community Cancer Summit
- Canadian Cancer Society
- National Forum on Cancer Care

All of these groups wanted a First Nations perspective on how to make their materials and information more relevant for First Nations populations, while not losing critical medical messages.

Child and Womens Health

Dr Adams sits on the Child Death Review Unit (CDRU) panel to review deaths of Aboriginal children. Due to the 2008 annual report of the CDRU, he participated in the review of unresolved cases of early child deaths where a number of Aboriginal child death cases were reviewed. This review involved an in-depth examination of the full conditions of the child and their circumstances, so that lessons could be learned to prevent avoidable deaths in the future.

Dr Adams and the First Nations Health Council met many times with Dr Laura Arbour at the University of Victoria regarding a genetic disorder causing deaths among some Aboriginal children. The disorder is a genetic mutation in metabolic functions and causes early infant death. There is a low incidence overall but a higher prevalence of the disorder in First Nations infants, so Dr Adams and his colleagues discussed how to study the disorder, whether there should be screening, and how this would work to lower infant mortality among First Nations infants.

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Relationships with Government

Reducing infant mortality is also a focus of the TCA: FNHP and the Provincial Health Officer's report. In 2008, infant mortality was higher for First Nations. Unfortunately data complications have often prevented in-depth research into the causes and rates in specific areas. Dr Adams worked with the Canadian Institute for Health Research (CIHR) to begin exploring an initiative which would look at First Nations infant mortality by conducting a small number of infant mortality reviews on Vancouver Island. This initiative has since been approved and more extensive research will be done in a year's time.

Dr Adams is a member of the provincial committee for vision, hearing and dental screening. One exciting initiative that he promoted is the creation of public service announcements on First Nations oral health (dental spots) encouraging First Nations people to attend to their children's oral health. Dr Adams also sits on the BC Perinatal Health Committee at the BC Children's and Womens Hospital to provide an Aboriginal perspective.

Dr Adams has worked with the BC Center for Disease Control (BCCDC) on the HPV Vaccine strategy which aims to protect women against cervical cancer through vaccinations. He worked with the BCCDC to get information out to First Nations communities. The focus was on ensuring their information was accessible by First Nations communities and encouraged young First Nations women to get vaccinated.

Growing the First Nations Health Workforce

Dr Adams is very passionate about promoting health careers wherever he goes. He was a member of the Tripartite Health Human Resources (HHR) team and has attended many of their events as a speaker or participant. He is also a key advocate for the Indigenous Physicians Association of Canada and has helped the Aboriginal HHR initiative operated by the Division of Aboriginal Health at UBC.



Dr Adams has often supported the First Nations Health Council's Health Careers Recruitment Officers by making appearances at career fairs and meeting with career faculties at various post-secondary institutions to discuss how to attract more First Nations students to a career in health.

BC Medical Association

Dr Adams is on the Aboriginal Advisory Committee for the BC Medical Association. His role in the committee is to incorporate Aboriginal perspectives and attempts to address Aboriginal health issues through the Medical Association's public health initiatives.

Mental Health and Addictions

Part of Dr Adam's role is to respond to any specific issues from First Nations communities. Often he is asked to speak at public health events, coordinated by First Nations communities, to address particular initiatives, and/or crises; such as mental health and addictions, outbreaks, suicides and sudden deaths. Often, these communities are seeking user-friendly advice on specific strategies, as they want to be sure that what they are doing is not only culturally safe – but medically safe. Dr Adams sees crises intervention as playing an important role in supporting First Nations communities.

Dr Adams is also a member of the team working on the Province's 10 year plan on Mental Health and Substance Use, as this plan has an Aboriginal component.

Health Governance

Dr Adams has been involved in investigating the possibility of a First Nations Medical Health Officer (MHO) position as well as looking at public health responsibilities which may be part of the new First Nations Health Authority. He has held discussions with the Provincial Health Officer on what this might look like and how public health duties may be assumed by First Nations in their respective areas particularly around vaccination rates and environmental health. Another issue that needs to be explored is the legislative capabilities that a First Nations MHO may hold.

PHSA Cultural Safety Curriculum

Dr. Adams reviewed the cultural competency curriculum developed by Provincial Health Services Authority (PHSA) for use by all health authorities.

Dental Health

Dr Adams met with the Faculty of Dentistry at UBC to review admissions and to discuss how UBC could attract more First Nations students into the dentistry field. He also met with FNIH Non-Insured Health Benefits personnel and the BC Dental Association to discuss ways of improving dentist's involvement in oral health strategies in First Nations communities and improving service provision.

HIV / AIDS

In 2009-2010, the 'Seek and Treat' initiative was announced. Dr Adams sits on the Stop HIV/AIDS leadership committee. The committee has two pilot programs, in Vancouver and Prince George, aimed at bringing care to people who are 'hard to reach' or 'hard to treat'. This is a \$40m initiative, funded by the province through health authorities, which includes the BC Center for Excellence in HIV/AIDS, the FN Health Society and Aboriginal stakeholders. Dr Adams is also participating in the development of the HIV/AIDS Reference Group which will oversee continued work on HIV/AIDS prevention and treatment within First Nations populations.

Pandemic Planning / H1N1

When the H1N1 Swine Flu virus hit Canada, it was expected to have a devastating effect on First Nations, unless rapid steps were taken to arrange for the vaccination that could protect communities against infection. Dr Adams co-chaired the BC First Nations H1N1 Working Group with Dr Shannon Waters, to cope with the pandemic. The group developed an H1N1 Action Plan for First Nations, and had a number of initiatives established, primarily around the positioning of First Nations surveillance and response to the epidemic by health authorities. Work also included extensive communications to ensure that vaccination was a priority for remote First Nations communities. As a result, the First Nations rate of mortality and morbidity were comparable to provincial averages. This was a success for BC, but was unfortunately not the case for First Nations in many other provinces across Canada. In fact, vaccination rates in BC First Nations communities were 3 times the provincial average as a result of effective work done by First Nations communities, the FN Health Society, the tripartite partners and health authorities.



6

Relationships with Government

The GLE is a description of government's expectations and responsibilities of health authorities with respect to the planning, administration, delivery and monitoring of health services across BC (including for on and off reserve First Nations).

6.8 Reciprocal Accountability

The 2005 Health Blueprint developed by BC First Nations Leadership, describes the concept of Reciprocal Accountability as follows: *"For every increment of performance I demand from you, I have an equal responsibility to provide you with the capacity to meet that expectation. Likewise, for every investment you make in my skill and knowledge, I have a reciprocal responsibility to demonstrate some new increment in performance."*

An important Action Item of the Health Plan is the development of a Reciprocal Accountability Framework (RAF). This framework will lay out the responsibilities of each party (BC, Canada, regional health authorities, a new First Nations Governing Body, and First Nations communities) toward improving the health of First Nations in BC. In 2008, a senior management team, composed of representatives from the Province, Health Canada and the First Nations Health Council, met with the Executive Leads of each health authority. The purpose of these meetings was to begin regionally focused discussions on how each health authority is accountable to the local First Nations populations they serve and how they reflect this in their planning, funding and decision-making processes. What was learned from these discussions is that formal accountability by health authorities, for improving health of First Nations, is not to First Nations themselves but to the provincial government. Currently, the main accountability mechanism is the Government Letter of Expectations (GLE) issued by the Government of British Columbia. The letter is addressed to each health authority and requires each health authority to report to the province against a Performance Agreement. The GLE is a description of government expectations and responsibilities of health authorities, with respect to the planning, administration, delivery and monitoring of health services across BC. This includes both on and off reserve First Nations.

Since the signing of the TCA: FNHP, the GLE has included provisions with that requires Health Authorities to reflect an alignment with the TCA: FNHP. Current Health Authority Aboriginal Health Plans demonstrate some alignment with the TCA: FNHP and TFNHP. However, still lacking is a formal accountability for delivery of the Aboriginal Health Plans by health authorities directly to First Nations regionally or provincially. There is also a lack of alignment between Health Authority Aboriginal Health Plans and local First Nations Community Health and Wellness Plans. This is partly because all First Nations have not yet developed comprehensive plans. This is also related to the fact that the province drives the planning process through the GLE. The expected transition over time should see First Nations determining what should be in their local Health Authority's Aboriginal Health Plan and being in a position to hold a Health Authority accountable for delivery of those plans in their respective communities.



The FNHC has identified one of its priorities is to support First Nations with developing comprehensive community health and wellness plans. Over time it would be expected that these plans identify the services needed or expected from various jurisdictions (health included but also child and family services, education, language, land management; water and air quality, and all areas that affect the social determinants of health) to support the implementation of the community plans.

Regional health authority plans would then be derived from what was expected of them in terms of supporting those plans. At that point, multi-jurisdictional planning can happen between the parties. This can occur when it is clear what services First Nations communities need to support the implementation of their own wellness plans.

In the following year, the FNHC hopes to work with the new Health Directors Association, the Community Engagement Hubs and with the First Nations mandated health organizations to develop tools for community health planning and to support First Nations communities with sharing best practice in this area.

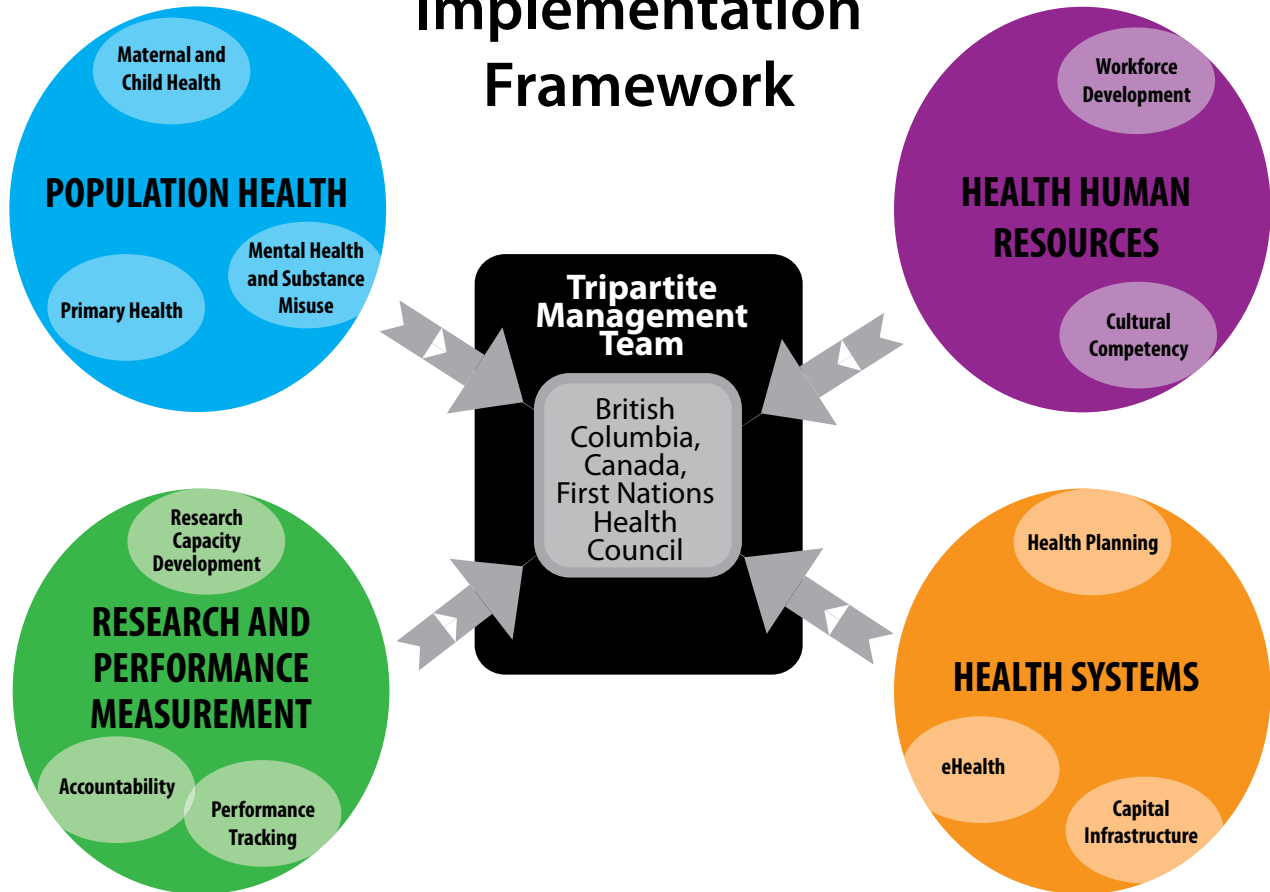
In December 2009 the First Nations Health Council issued a call for prospective First Nations community members to join a Community Health and Wellness Plans Committee. The role of the committee is to lead the way to develop better models of Health and Wellness plans with First Nations communities in the province. Members will have knowledge and experience in community health planning and will be supported by their First Nation.



7

Transforming the System through Health Actions

Health Actions Implementation Framework



7. TRANSFORMING THE HEALTH SYSTEM THROUGH HEALTH ACTIONS

The role of the FNHC is to ensure that all work done to improve health services and systems include First Nations at the planning, analysis, research, design, delivery and implementation stages. The ideas and decisions for improving these areas must come from First Nations, and the role of the Council is to facilitate this process. Additionally, the role of the FNHC is to ensure that the partner governments engage effectively with First Nations at the table, to ensure they listen to First Nations concerns, ideas and aspirations, in order to bring about the necessary changes through policy, legislation and funding processes. This is all in support of the goal of the TFNHP to support First Nations having greater governance and decision-making over their own health care. The following identifies how the FNHC has supported First Nations to achieve their influence and decision-making role in the Health Actions area.

A comprehensive report on each of the TFNHP Health Actions is contained in the ‘Year in Review’ report produced by the Tripartite partners for Gathering Wisdom III in November 2009 (copy available from the FNHC). The following sections provide an overview of specific activities and outcomes achieved specifically by the FN Health Society with its own funding, as well as activities we have undertaken that are not reported in the Tripartite ‘Year in Review’ summary.

FIGURE 7.0 - OUR APPROACH TO HEALTH ACTIONS IMPLEMENTATION.



7

Transforming the System through Health Actions

7.1 Primary and Public Health

In the long run it will be through maintaining good health, that we will see improvements in the overall health status of First Nations people.

Primary and Public Health - Action items & priorities		
TCA: FNHP	Action 7	Lead the development of Aboriginal ActNow program
TCA: FNHP	Action 12	Improve primary care services on reserve
TCA: FNHP	Action 13	Improve the first responder program in rural and remote communities
TCA: FNHP	Action 14	Introduce campaign to raise awareness on seatbelt use and safe driving
TCA: FNHP	Action 17	Implement a northern region chronic disease management pilot
TCA: FNHP	Action 22	Introduce integrated primary health services and self-management programs for chronic disease conditions
TFNHP	-	Develop and implement an Injury Prevention strategy
New priority	2008	Develop and implement an HIV/AIDs strategy
New priority	2009	Support pandemic planning in First Nations communities (including H1N1)
New priority	2009	Support and advocate for Traditional Medicines and Practices

Primary and Public Health actions arising from the TFNHP revolve around two key objectives:

- √ Improving access and availability of these services / programs for BC First Nations (whether delivered by FNIH or health authorities or private providers)
- √ Ensuring services and programs are culturally appropriate and responsive

Primary care and public health programs are the services / programs that seek to keep people well and avoid illness or at least address the early detection or diagnosis of illness. It is vital for BC First Nations communities that all community members have good access to appropriate primary care and public health programs. In the long run it will be through maintaining good health, that we will see improvements in the overall health status of First Nations people. Preventative programs are also able to be more holistic since they can incorporate other measures of well-being, such as revitalization of culture and language, incorporation of traditional customs and practices, and strengthening the linkages between the people and the environment. Improving primary care and public health programming is an overall goal of the FNHC's work in this area.

Some examples of the initiatives and work that the FNHC has done (in addition to the activity reported in the 'Year in Review' report) is described below.



First Nations ActNow

The First Nation Health Council, BC Association of Aboriginal Friendship Centers, Aboriginal Sport and Recreation Association and Metis Nation BC came together to create the following vision:

To create a long term, sustainable Aboriginal sports and recreation strategy that will provide opportunities for Aboriginal youth in BC to maximize their physical, emotional and social potential through sport, recreation and physical activity.

The goals for the council are as follows:

- Identify existing capacity and needs with respect to sport and recreation opportunities in BC;
- Provide a forum for individuals and representatives of organizations to discuss, debate, and strategize on the structure of a long term sports and recreation strategy;
- Identify other opportunities for political, financial, and moral support for the strategy;
- Support the Aboriginal Sports and Recreation Association (ASRA) to increase its capacity and fulfill its mandate;

The partners council are following direction given by the Youth Declaration which was developed and signed by the youth who attended the BCAAFC youth forum held in Victoria, March 2008. Political support was given during an event held in August 2008 and attended by First Nation and Métis leaders from across the province.



Healthy Role Model Posters

The First Nations Health Council and the Four Host First Nations Society developed a joint initiative to recognize 5 everyday heroes from First Nations communities across BC. The Healthy Role Model Poster series was born from the idea that "our greatest inspiration comes from our families, neighbors and friends". The five individuals chosen are an inspiration to all of us and a great example of role models around us. They are peers, family, and community members. The five role models were nominated by their friends, family, and communities; graded and scored by a selection committee and selected based on their involvement in their communities, their healthy balanced lifestyles, and their ability to promote healthy lifestyles in their families and their communities. Copies of the posters have been produced and sent out to all First Nations communities in BC.

Improve Primary Care Services on Reserve

The FNHC conducted an environmental scan of Chronic Disease Management programs and services in 2008-2009. The scan, while not focused specifically on primary care services, has identified and raised a number of issues related to physician and nursing services for First Nations populations both on and off reserve. The First Nations Health Council will be working with the Ministry of Health Services to advance the issues raised in this study and to facilitate First Nations engagement with MoHLS and FNIH to address the issues of inequities in access to primary care services for communities.

The Penticton Indian Band

Youth Leadership

Healthy Role Models



The Penticton Indian Band Youth Leadership

The Penticton Indian Band Youth Leadership has grown over the past few years and has created healthy environment and lifestyle programs for youth. The members are role models within the Okanagan Nation and they carry their message of positive health and well-being to other communities around the world.

Each year the group trains for the 200 kilometer "Canoe Journeys". Training takes place on Okanagan and Skaha Lakes and the group welcomes anyone that wants to join in, provided they are clean and sober two weeks prior to training. In the off-season they participate in dry land training with local RCMP. The group has also worked with

nutritionists to determine the benefits of an active healthy life. They will soon be traveling to the Orkney Islands, Scotland, and will paddle for two weeks as representatives of aboriginal youth in Canada.

The Penticton Indian Band Youth Leadership has been featured in two documentaries and in a number of newspaper articles. The attitude and energy of these young leaders has provided them with many opportunities to drum, sing, and meet with other youth at National and Provincial Youth Conferences.

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Transforming the System through Health Actions

Improve First Responder Services in Communities

The FNHC has met with the Canadian Red Cross regarding the next steps in our plan for First Responder training. We are developing questions to gather information about the existing level of training in communities and developing an action plan. As we need community input on the level of training that will be required, First Nations community participation in the survey is crucial. The FNHC is also continuing its work on Water Safety training.



Injury Prevention

The FNHC has been working with its partners and the BCAA Traffic Safety Foundation to improve road safety. The FNHC calls on the parties to, “develop an informational campaign to increase awareness about seat-belt use and safe driving”, recognizing that child car seats protect young family members.

For over 100 years the BCAA Traffic Safety Foundation has been helping drivers and their families. They are now working with the Tripartite Injury Prevention Working Group to develop practical tools and tips that can help families and communities be safer on our roads. Training has occurred in communities to increase awareness of the importance of using infant, child or booster seats. Additionally, options will be explored to increase access to seats within communities as well as the expertise needed to guide safe installation. An interactive DVD workshop for parents and family members of teen drivers is also in development.

The Tripartite Injury Prevention working group includes representatives from the Ministry of Healthy Living and Sport, FNIH, and FNHC. In the next year the FNHC aims to facilitate First Nations representation on the group so that our own staff can ‘step down’ and enable First Nations to make their own contributions and decisions at the table.

Chronic Disease & Management / Diabetes

The First Nations Health Council has received funds from the Aboriginal Diabetes Initiative (ADI) to develop initiatives in this area with First Nations communities and to promote improved physical activity, nutrition and food security.

Physical Activity

Dr. Rosalin Hanna, Physical Activity Specialist was contracted to the First Nations Health Council with ActNow funding. In her tenure with FNHC Dr. Hanna developed several First Nations specific resources that were well received by BC First Nations. These resources included, but were not limited to: Annual Health & Wellness Diaries, Adult and Youth workout DVD's and exercise cards, pedometers, and a comic book on importance of physical activity. Additionally, Dr. Hanna organized a Fitness Knowledge Courses which builds First Nations capacity in this area.

Dr Hanna presented on March 18th, 2008 at Gathering our Voices on “enviro-active” a discussion called, “Be Physically Active by Restoring Our Land”. She also presented on March 10th, 2008 at the BC Aboriginal Diabetes Conference on “Pedometer Challenge- Using them to your Benefit”. At both venues FNHC administered a survey to scan sports, recreation, fitness and physical activity involvement and interests. 350 youth and over 100 adults completed the survey which is the first of its kind in BC.

We are very excited to have received a box of pedometers and so quickly! This kind of gesture is key to maintaining momentum. Thank-you for [your] generosity.
-Ellen

Ellen Duncan
Registered Dietitian
Qwemtsin Health Society



The information collected provides data critical to the enhancement of physical activity programming in First Nations communities. Data analysis tells us:

- The barriers to participate in these activities are mainly due to lack of resources such as equipment, funding, players, coaches, programs, club, venue, and transportation;
- The other barriers appear to be more personal, for example, being too old, low self esteem, self conscious, no experience, dealing with personal problems, worry of getting injured, no motivation, and the feeling of no support.

The responses highlight that the First Nations youth are aware that their self concepts prevent them from participating in sports. These personal barriers, related to internal perceptions, are significant and should be further explored. This also demonstrates that First Nations youth need support and to be motivated intrinsically in order to be more active. To read the full report, please visit www.fnhc.ca.

Dr Hanna has developed key collaborative opportunities with Provincial partners in health promotion sports, recreation and fitness; such as, the BC Aboriginal Sports and Recreation Association, and the BC Association of Aboriginal Friendship Centres. Dr. Hanna participated in the Aboriginal task group, was instrumental in reviewing BC Aboriginal Sports policy and assisted in the development of a BC Aboriginal Youth Sports Declaration.

Food Security in BC First Nations

A community enjoys food security when all people, at all times have access to nutritious, safe, personally acceptable and culturally appropriate foods. These foods are gathered, hunted, fished and produced in ways that are environmentally sound and socially just. First Nations often look at food security differently as we consider factors that are unique to us such as geographic isolation, high food costs, poverty and preference or reliance on traditional foods as well as the responsibility as stewards of the lands and water that support our access to food. The gathering of health statistics and information is starting to quantify the disproportionately low level of food security in our communities. A recent national health survey reported that 1 in 3 off-reserve aboriginal households were experiencing food insecurity and that just under half of these households were families with children.

‘By taking this course I have gained capacity to help community members understand the importance of active and healthy living. I believe that we will see a decrease in preventable diseases and health disparities related to physical activity, healthy eating, and fitness knowledge by continuing to encourage and facilitate opportunities for participation in active and healthy living.’

Erica Marsden- Gitanyow
Fitness Knowledge Course Participant

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Transforming the System through Health Actions

Food Skills for Families Training in First Nations Communities

Gathering Wisdom 2008 identified many actions that could be taken to improve First Nation peoples' access to healthy foods. One action directed at increasing knowledge involved the concept of peers teaching peers. The Food Skills for Families Program is being led by the Canadian Diabetes Association (CDA) and is one of the healthy eating strategies supported by the BC Healthy Living Alliance, with funding from the Ministry of Health. The First Nations Health Council and the Aboriginal Diabetes Initiative have had the opportunity to partner with the Canadian Diabetes Association to make the training for this program available to more First Nations communities. First Nations trainings have included participants from Alexis Creek, Lillooet, Ktunaxa Kinbasket, Ooakane Friendship Centre, School district 67 (Penticton), Office of the Wet'suwet'en, Quatsino, Fort Rupert, Gwa'sala-'naxwaxda'xw, whe-la-la-u, and Alert Bay. Several other nations have been involved in training through the Canadian Diabetes Association.

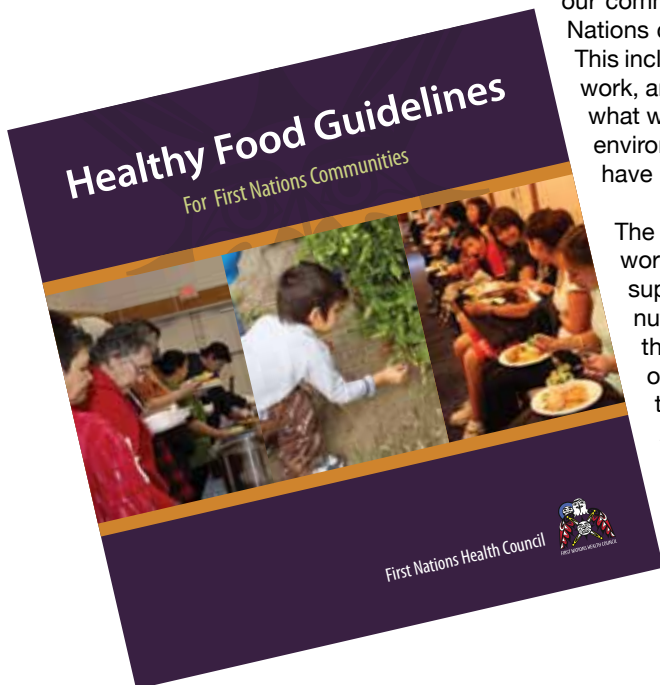


Participants gained core cooking and nutrition skills in order to facilitate a once weekly, six week program in their respective communities. The program includes recipes and resources that have been designed to meet the needs of First Nations and low income families.

Nutrition

The FNHC contracted nutritionist, Suzanne Johnson, to support the diabetes work. Through her role the FNHC has been learning what is needed to promote healthy eating in order to reduce our communities' risk of chronic disease. Promotion of healthy eating in First Nations communities involves changing the community nutrition environment. This includes changes we can make individually, in our family, in our schools, at work, and all throughout the community. To work toward the goal of changing what we eat, we need to hear from health workers about the current nutrition environment as well as information about any changes or barriers which have been encountered on the path to healthier eating.

The FNHC nutritionist developed a questionnaire for community health workers. The purpose was to gain information about the types of nutrition support, nutrition training and resource needs that can help ensure proper nutrition in our communities. The results of this survey are summarized in the Community Nutrition Needs and Assets Assessment report available on the FNHC website. Johnson developed a number of community tools in her tenure at the FNHC, including *Healthy Food Guidelines for First Nations Communities* and *Traditional Food Fact Sheets*.



HIV / AIDS Prevention And Treatment

HIV/AIDS is a priority issue that has been raised continually by First Nations at various forums, including Gathering Wisdom. HIV/AIDS is not identified specifically as a priority within the TCA: FNHP or the TFNHP, but the tripartite partners have agreed this issue needs to be identified as a new priority for the partners.

The BC Aboriginal HIV/AIDS Task Force was created 1997 to address the disproportionately high rate of HIV infection among BC's Aboriginal people. The impact of risk factors such as intravenous drug use and the sex trade, and the high percentage of Aboriginal cases of HIV among Aboriginal women were also concerns. The taskforce's work raised awareness of jurisdictional issues as well as the need for a province-wide strategy. Also needed is an organization to build capacity and serve as a coordinating body across BC. As a result of the work of the Taskforce there has been a growth in organizations serving First Nations people and communities affected by HIV/AIDS, increased awareness promotes disease prevention and regular check-ups leading the way for healthier communities. The Taskforce's work also resulted in the development of both the Red Road Strategy and the Red Road HIV/AIDS network to oversee implementation of the strategy.

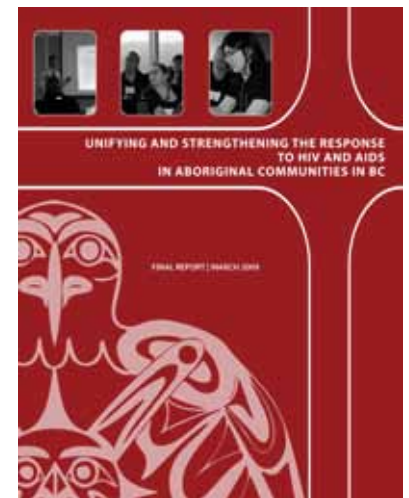


In 2005, the 'Renewing our Response' conference brought together Aboriginal and non-Aboriginal service providers, health funders and policy developers, and Aboriginal people with HIV/AIDS. The participants reviewed the historical response to HIV/AIDS in Aboriginal populations and in particular the rise of infections among Aboriginal people. Twenty-four recommendations arose from this review and a Renewing our Response Leadership Team was established to oversee implementation of the recommendations.

In 2007, when the TFNHP was signed, it was agreed that the HIV/AIDS work should form part of the TFNHP's list of priorities. On May 6th and 7th, 2008, the Renewing our Response Leadership Team and the Government met to identify ways to improve the response of all parties, to reduce the rising rates of HIV infection. They also looked the various ways partners and organizations could raise awareness and better reflect this priority in other areas such as mental health, addictions and chronic disease programs and services. The report of the gathering highlights priorities the group determined and how the parties will continue to work together to address this important issue.

In March 2009 the FNHC produced a report entitled 'Unifying and Strengthening the Response to HIV and AIDS in Aboriginal communities in BC'. This report is available from the FNHC.

Dr Evan Adams, as one of our contracted health professionals, will play a key role in the area as a senior physician within the tripartite relationship and will work with First Nations communities and the Centre for Communicable Disease control (PHSA) to pursue improved services for First Nations in this area.



Transforming the System through Health Actions

Traditional medicine is a very important part of Aboriginal health that is almost always overlooked by the health care system. Traditional medicine not only embodies the use of native plants, but it is a whole philosophy and spiritual practice surrounding health and well-being. It takes a holistic approach using natural remedies to address medical conditions.



Traditional Medicines and Practices

Traditional Medicine has been a key area of interest in First Nation health and First Nation health policy documents. Due to the high level of interest in this area, the Tripartite partners, and in particular the FNHC, added traditional medicine as a priority to the TFNHP agenda, in the 2008-2009 year.

Traditional medicine is a very important part of Aboriginal health and is almost always overlooked by the health care system. Traditional medicine not only embodies the use of native plants, but it is a whole philosophy and spiritual practice surrounding health and well-being. It takes a holistic approach using natural remedies to address medical conditions.

Dr Georgia Kyba has been contracted to the First Nations Health Council, as a health professional, to lead the work with First Nations on shaping a policy and advocacy agenda for traditional medicine. There have been several discussion groups and surveys taken to engage communities around the subject of traditional medicine. Discussion with Health Directors at Gathering Wisdom and the Health Directors Forum has helped to outline barriers to needs for current practices of traditional medicines. Community engagement has also been done through video conferencing and through specific community health forums, such as the Kwakiutl District Council Health Forum.

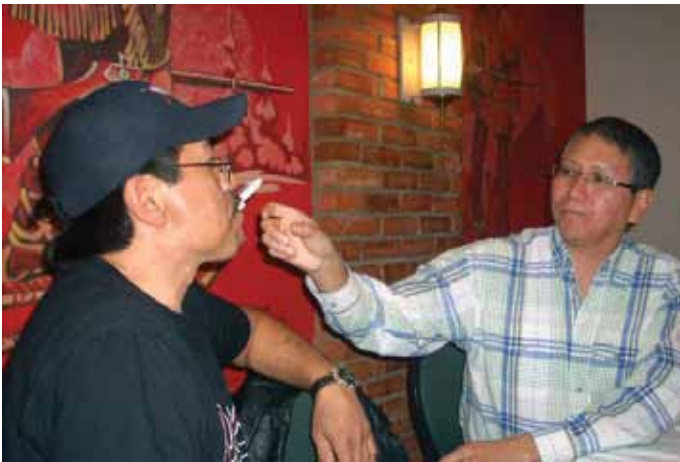
The FNHC commissioned an environmental scan of Traditional Models of Wellness in 2009-2010. The resulting report (available from the FNHC) demonstrated that the vast majority of First Nations communities define traditional models of wellness as “having a healthy mind, body and spirit”. Some communities responded to the scan by stating that it was often difficult for communities to maintain wellness from this perspective because of the impacts of alcohol and drugs, residential schools and other external influences. They also said that learning and sharing the knowledge of healers and elders was an important element in the practices being undertaken but often this was challenging because there were few healers and elders left who held the knowledge. The scan also showed that the province has over 287 healers (as defined by communities) operating in communities although about 60% of these did not practice in, or were not integrated with, the local health center. However, the majority of respondents believed that healers should be part of local health centers and have recognition like physicians and other health professionals practicing in the community.

The key message from the Environmental Scan was that the FNHC should continue to advocate for recognition and funding of traditional medicines and practices. The FNHC should also develop policy and advocate to federal and provincial governments to have traditional practices recognized in funding arrangements as a legitimate element of health care from a First Nations perspective. The FNHC will take the results of the Environmental Scan as a source of direction from First Nations communities, to continue the role of advocacy and policy development with the tripartite partners.

Pandemic Planning / H1N1

Responding to BC First Nations health human resource concerns, the First Nations Health Council, First Nations Inuit Health and JEL Protection Ltd partnered to offer H1N1 Trainings in approximately 18 central venues across BC. Due to the urgent global circumstances of H1N1, the trainings were delivered and offered within a very short time frame giving communities only a short window of time to prepare. Although communities would have liked to have had more time to organize and prepare, feedback from people who attended the trainings are very positive.

The trainings were successful and the program has been able to cover training, travel expenses, accommodation, and catering costs for lunches.



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Transforming the System through Health Actions



7.2 Mental Health and Addictions

7.2 Mental Health and Addictions		
TCA: FNHP	Action 8	Develop and implement a Mental Health and Addictions Plan
TCA: FNHP	Action 9	Host a forum to support and encourage cultural learning and to develop models for youth suicide prevention
TCA: FNHP	Action 15	Develop new culturally appropriate addictions beds for Aboriginal peoples

Mental Health Wellness And Addictions Planning

The FNHC has been working with the Province to build a Mental Health and Addictions Plan for British Columbia. Being a part of this process allows FNHC to be a part of the bigger picture and support communities as they begin the process of creating their own Community Mental Wellness Plans.

The FNHC is conducted an environmental scan of Mental Wellness plans across the Province to provide us with a clearer picture of what is currently being done. Once the literature review was completed, work was commenced on integrating these findings with findings from the community wellness initiatives. This will help form the basis of the Mental Health and Addictions Plan which is currently being developed.

The FNHC is also working with FNIH on a needs assessment for addictions programs in British Columbia under the NADAP program and has established a steering committee of community members to guide the work. The work will be done over the next fiscal year and a document will be produced when the findings have been completed.

Youth Suicide Prevention

The TFNHP Action # 9 states that *'The First Nations Leadership Council and the province will host a forum for all health authorities (Aboriginal Health Leads and Executive members) and First Nations Elders and youth to support and encourage learning about First Nations' heritage, cultures and spirituality, and to develop models for youth suicide prevention'*.

First Nations youth experience suicide rates are four-five times higher than the non-Aboriginal population. Although youth suicide is not an issue in every First Nations community, The target of the TCA: FNHP is "to reduce the gap in youth suicide rates between First Nations and other British Columbians by 50% by 2014.

A Youth Committee was formed in August 2008 to plan a Youth Wellness Gathering which would empower First Nations youth and provide opportunities for them to learn to positively express themselves. The gathering, called "Finding the Strength Within", provided the youth with the opportunity to learn and experience traditional teachings, cultural activities and to participate in empowerment workshops. The gathering provided a foundation for the regional Youth Suicide Prevention Camps that were delivered in the summer and laid the foundation for the upcoming Provincial Youth Suicide Prevention forum.

The First Nations Health Council (FNHC) supported 38 First Nations communities to deliver youth camps reflecting a total investment of over \$550,000.

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Transforming the System through Health Actions

The gathering, “Finding the Strength Within”, was held at *Sts’sailes Lhawathet Lalem*, the Chehalis Healing House, Harrison Mills, from October 24th to 26th, 2008. The participants experienced a positive atmosphere of traditional culture, inspiring speakers, and friendship. A final report with recommendations was produced and copies are available from the FNHC.

In partnership with regional health authorities, and the FNHC, First Nations communities hosted regional Youth Suicide Prevention Camps. The focus of these camps was to address high risk youth suicide prevention through objectives such as:

- The development of Promising Practices in youth suicide prevention. One camp from each health authority region will be highlighted as a Promising Practice at the Provincial Youth Suicide Prevention forum (2009);
- To build a foundation for First Nations youth to become our next leaders; and
- The development of a Youth Mental Health Camp Final Report summarizing the lessons learned.

The First Nations Health Council (FNHC) supported 38 First Nations communities in facilitating high-risk youth suicide prevention camps. The unique, innovative and meaningful camps were designed and facilitated by the community. Communities developed and delivered a wide variety of day camps and overnight camps which captured the youth’s interest and created opportunities for them to experience and connect with traditional teachings and cultural practices. In total, 1 camp was held in the Fraser region, 6 camps in the Vancouver Island region, 11 camps in the Northern region, 7 camps in the Vancouver Coastal region and 14 camps in the Interior Health region. Total investment in the youth camps by the FNHC was over \$550,000. A snapshot of each of the youth camp initiatives is as follows:

Fraser region

- **Sto:Lo Youth Council / Xyolhemeylh Child & Family Services:** 92 youth attended the 2 day 6th Annual ‘Watching Young Eagles Soar’ conference. The theme was “understanding our relationship to the land and that all living things are interconnected”. The community held workshops, team building exercises and hands-on activities. A DVD was made to capture the essence of the conference and give the youth a chance to express some of their needs and concerns regarding youth issues, community support and what it means to be Xwelme wx.

Vancouver Island region

- **Kwakiutl Band:** Had a 2 day high risk Suicide Prevention Youth Camp for ages 15+. Activities included Elders presentations, workshops, evening entertainment and leadership skills.
- **Tsawataineuk Band Council:** Provided a one week event for the youth of their community aimed at addressing suicide prevention and helping youth to work toward better lifestyle choices. Activities included workshops on life skills, suicide prevention, alcohol and drug awareness, traditional foods and cultural and recreational activities;
- **Kwakiutl District Council Health Transfer:** Provided a 2-day camp for Teen Peer Support Training to educate teens on suicide and suicide prevention. The camp involved 40 youth. Activities included workshops on cultural identity, enhancing social development, suicide risk and prevention and networking and support.
- **Whe-Le-La-U Area Council:** 30 youth were involved in a week long holistic and traditional camp aimed at developing peer support, participating in healing opportunities, developing healthy coping skills, creating a sense of belonging and building self esteem. Activities included workshops for weaving, traditional games, food harvesting, sharing family origins, canoeing & kayaking, a cleansing ceremony, peer training and mentors.

- Hilye'yulelum (House of Friendship) Society:** Youth from Cowichan Tribes and from Nuuchaltnulth from (Ahousaht and Thesliat) attended 15 days of training for the canoe journey and 11 days of paddling on the journey. In total there were 32 paddlers. The journey provided physical, mental, emotional and spiritual challenges as well as an opportunity to learn and to connect youth, in a culturally appropriate manner, to their heritage and environment, through ocean travel and teamwork. When the youth were asked if they would do this again, everyone said they would. Adults involved in the journey concluded that there had been a change in awareness amongst the youth. They were a cohesive unit that sang and paddled into communities together. Self-discipline had been gained through training before the journey and good planning and resources improved the quality of the experience for the youth paddlers.
- Ka:yu:'k't'h/Che:k'tles7et'h' Nation/Kyuquot Rediscovery:** Communities included Ehattesaht, Kyuquot / Cheklesahht, Mowachat / Muchalaht and Nuchatlaht. The expected short-term outcome was to provide a cost-neutral camping experience for at least 5 family groupings of Nuuchaltnulth members. The camp was aimed at providing a healthy culturally based camping experience for at least 20 First Nations youth. What resulted was that 7 families and over 20 youth attended the Family Camp, although some youth came for day visits only. The camp director worked with a Kyuquot youth to mentor him throughout the year to take over the reins of the Kyuquot Rediscovery and continue with the camps in the future.



Northern region

- Tahltan Health & Social Services Authority:** The purpose of the camp was to increase awareness of suicide among their young people and to reduce the risk of suicidal and high-risk behaviours. Two, 3-day camps consisting of 6 – 8 workshops, were conducted under the theme of “*meeting unmet needs*”. Another camp, addressed by the theme of “*combating boredom; things you can do here*” consisted of 4 outdoor recreational activities: river tours, hiking, scavenger hunts and canoeing.
- Gitksan Child & Family Services Society:** The objective of this camp was to demonstrate to Gitksan high risk youth the practice of sharing knowledge and experience to others, and to provide a sense of belonging. 20 – 30 youth were involved through workshops including: basket weaving, traditional song and dance, a Care Givers presentation and Drying Our Grandmothers tears.
- Dze L K'ant Friendship Centre Authority:** This camp created an opportunity for 30 youth to seek healthy, cultural, contemporary means of building their world view, awareness, history and safety and transition to adulthood. Camp activities included hunting skills, self-defense, motivational concepts and land and history appreciation.
- Gitanyow Human Services:** Activities were held during spring break for the youth from Gitanyow and Gitwangak. Activities included tribal leagues, life skills building, a spring dinner, workshops, spring fling, a field trip and Sun Run support. The activities brought together neighbouring communities with 80 youth participants in the Tribal leagues, 150 for the spring dinner, 100 at the spring fling and 27 successfully participated in the Sun Run.

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Transforming the System through Health Actions



West Moberly First Nations Youth Camp

Youth and Elder Nenan Camp

Nenan camp was a very good experience. I learned so much. I've never been to a youth and elders camp and for me it was a good experience. It was awesome listening to the elders and taking notes, I think that it was good that we had journals because I wouldn't of listened so much if we didn't have to take notes. I loved dancing and hearing stories around the fire, that was probably my favourite part about Nenan camp. I also had so much fun. It was a really happy and good feeling there. Out of all the things we did this summer I thought Nenan was the funnest. I really liked meeting new people and learning things that I didn't know about my culture. When I went to that camp it made me have a different outlook on life, it made me want to be a different person, or a better one. The elder stalked about how when they were our age and had to hunt, cook, and everything and that's how they know so much about animals and everything. That's how they got so wise. I realize that our generation has changed so much from back then, youth are so different now. I also realized that it's up to us to keep our culture and to teach when we are elders. I would definitely go to Nenan camp again. I would love to learn more about my culture because I realized I had a positive attitude after that camp.

Willow Napoleon

- **Nisga'a Valley Health Authority:** Four FN communities (Gitlakdamix, Gitwinksihlkw, Laxgalts'ap and Gingolx) were involved in a youth camp. Themes were increasing youth's abilities and comfort in looking at issues of 'self', awareness of needs of 'others', increasing exposure to positive 'life-affirming' activities with their peers, and growth in the 4 corners of the circle of courage – mastery, independence, generosity and belonging. Activities included workshops, cedar weaving, sharing circles and a canoe journey.
- **West Moberly First Nations:** Youth from 6 First Nations and 2 urban agencies/communities participated in (2) 4-day Youth & Elder camps and (1) 3-day Twin Sisters camp. The short-term outcomes were to provide youth and children in the Northeast with activities that would increase cultural awareness, physical activity and community development, to connect youth with Elders, and to reconnect the youth to the land through camping, fishing, hunting, meat cutting, trapping, berry-picking and hiking. Longer term outcomes were to strengthen the connection of youth and Elders and for the youth to gain the valuable knowledge and opportunities needed to improve in all 4 directions of health; physical, mental, spiritual and emotional. Most of all, the community aimed to give the young people 'hope'.
- **Kwadacha Band:** The community's focus was to emphasize the importance of healing, providing extra support and resources for youth in order to help them become strong, healthy, vibrant individuals who would eventually help to build healthier nation. Activities included workshops during camps for 25 to 30 youth.
- **Carrier Sekani Services:** The idea behind the camp initiative was 'Pay It Forward' (after the movie of the same name) Youth would go into communities and engage in acts of kindness toward the Elders. It was expected that in turn the Elders would spend an evening with the youth, sharing language and culture.
- **Gitwangak Education Society:** A 5 day camp was held aimed at building a connection between communities by promoting healthy/active lifestyles and creating cultural awareness opportunities. The activities included recreational activities, self esteem workshops, team building exercises, healthy eating and cultural activities.
- **North Caribou Aboriginal Family Program Society:** This community hosted a 4 day family and youth suicide prevention wilderness camp at Little Fishpot Lake for a total of 19 youth, 9 Elders and 5 parents/chaperones. The activities included workshops on suicide prevention, harm reduction, empowerment and cultural activities. Cultural activities included a sweat lodge, a medicine walk and smudge ceremony. Many found it gratifying to see the youth begin to connect with the Elders and felt was a good way to introduce them to their culture and history as well as learn about their mental health.
- **Skidegate Health Centre:** Communities included Skidegate, Old Massett, Sandspit, Queen Charlotte and Masset. The short-term outcome was engagement of youth on a physical, emotional, mental, cultural and spiritual level by connecting them with healthy adults in the community. There was a 3 day youth camp, (10 youth / 5 adults / 2 Elders) with the incorporation of the 8 module Canoe Journey Life's Journey curriculum into a Traditional experiential wilderness setting. There was also a 1 day Haida Fire ceremony which was an educational opportunity for youth to participate in a spiritual, ritualistic setting, modelling open communication and supporting the youth in making healthy choices. There was also 1 day for the feast.

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Transforming the System through Health Actions

The biggest success story from the boys camp was the completion of the canoe journey from Old Fort to Donald's Landing, comprising 95 kilometers. Four days were set aside for the journey but the boys pushed on and completed it in three. Each boy was provided with a paddle with the inscription Nits'a keigh Babine Lake 2009 (nits'a keigh translates to we travelled by boat). The sense of accomplishment in the boys was overwhelming.

Carrier Sekani Family Services

Vancouver Coastal region

- **Heiltsuk Kaxla Child & Family Society:** Provided youth with a sense of security, belonging and hope for the future, for youth in grades 10 – 12. Activities included life skill workshops, health education and awareness, and cultural ceremonies.
- **Sechelt Indian Band:** There was a (1) 5-day girls 'I Am' camp and (1) 5-day boys 'I Am' camp as well as a 1 day 'I Am' camp awards dinner. In total 57 girls and 58 boys and 60 adults attended the awards dinner. The short-term outcomes were the creation of a safe environment whereby the voice and self-expression of each youth could be heard, respected and honored through the utilization of the traditional sharing circle as a framework. Youth were asked to talk about who they were through the lens of the camera, with each one sharing with the group. This was displayed at the Art and Dinner show and Elders and adult community members were invited into the circle to share their traditional knowledge and expertise in various fields. This gave the youth a strong sense of connectedness to culture, past and present.
- **Xit'olacw Community School:** Provided a suicide prevention camp for 10 at risk youth. The camp built on the rediscovery framework, focusing on resiliency, resistance to adversity, self efficacy and coping capacity. There was a 6 day overnight camp, personal and group therapeutic activities, peer support, leadership skills and lessons on traditional food gathering.
- **Southern Stl'atl'imx Health Society:** Provided a camp at Tofino for 30 youth, aged 13 – 17 years, to have an experiential learning opportunity with the underlying focus on supporting youth at risk. Activities included a camping trip to Tofino, cultural activities, communication skills and warrior training.
- **Tla'Amin Community Health Board Society:** 3 camps were held. Camp #1 was a 2 day Loon Lake Wilderness Journey with 8 families (12 children) attending. Camp #2 was a 2 day Wilderness Journey with 20 youth and 4 youth leaders. The third was Camp Apookum Wilderness Camp which was held for 7 days, 6 nights with 18 youth, and 12 adults and Elders. Youth learned about their culture through elder teachings and sharing of stories.
- **Qqs (Eyes) Projects Society:** 21 youth from Heiltsuk, Oweekino, Kitasoo, East Vancouver and Terrace attended a 6 day Wellness Camp. Heiltsuk graduates and university students mentored the youth. Through the opportunity to live in an environment dedicated to a healthy lifestyle these youth formed new social relationships, developed a new appreciation for healthy eating and the value of traditional foods, found a sense of who they are and their relationship to their culture, and developed a new relationship with their environment. Activities included recreational swimming, canoeing and hiking, instructive sessions on environment, learning about medicines, exploring their own personal ecosystem and talking circles. The camp ended with a cultural event and feast.
- **Skatin First Nation:** Provided a 3 day camp for 20 youth, aged 14 – 18 years, to promote participation and educate youth on respect for others and for themselves, hygiene and inclusion. Activities include life skills workshop, traditional teachings and cultural capacity building.

Interior region

- **Adams Lake Indian Band / Sexqueltqin Health Centre:** 16 youth participated in a 5 day camp. The short-term outcome were to increase awareness of the signs, symptoms and responses to suicide in the community and to provide resources that were age appropriate and easy to access. A pre/post suicide awareness questionnaire demonstrated an increase in recognizing signs when someone was considering suicide, who to contact when worried about someone and where to go to learn more about understanding suicide and helping to prevent suicide.
- **Bonaparte Indian Band:** Provided a camp to help strengthen the unique partnership amongst the elders and youth in the community to promote harmony and well-being of the youth. Activities included Aboriginal Day festivities, community campout, traditional gathering and a hunting camp.
- **Coldwater Indian Band:** Held (2) 5-day camps. The first camp involved 25 youth and the second camp involved 20 youth. The short term outcomes included developing relationships with peers and provide an awareness of suicide prevention through workshops, cultural teachings by elders, sharing circles, making drums and dip net fishing. As a result of this the youth wanted to start a drum group and have a singing night.
- **Esketemc First Nations:** Youth participated and learned about health and nutrition, boot camp exercises, self esteem building and survival camp at a camp for youth which involved some 45 youth attending activities.
- **Little Shuswap Indian Band:** Camps consisted of traditional teachings and fishing (14 youth), constructing a sweat lodge (10 youth) and a canoe trip (4 youth). Youth learned about their culture and felt great satisfaction with their accomplishments and built a strong relationship with elders.
- **Shuswap Nation Tribal Council:** Provided a safe physical, social and emotional, recreational environment that allowed First Nations/Aboriginal Youth with disabilities to develop the skills (social and physical) to encourage them to take necessary opportunities to increase prospects for success. In total 20 youth with disabilities ages 6 – 16 years attend a 5 day camp. Activities include modified exercises, cultural component, fishing, planting, canoeing, life skills, and focus on their ability not their disability.
- **Xeni Gwet'in First Nations Government / ?Eniyud Health Services:** Two camps were held – the first a Youth & Elder Gathering and the second was the 2nd Annual Youth Gathering. In total 55 youth, aged 18 – 30 years, participated. Activities included cultural teachings, knowledge sharing by elders, recreational activities and learning opportunities about nature, camping and caring for horses.
- **Three Corners Health Services Society:** A 4 day youth culture camp with 87 youth attending was held. The short-term outcome was the change in youth awareness of suicide prevention. Activities included education about water safety, promotion of healthy relationships, cultural awareness, traditional medicines, elders sharing stories, traditional language teaching and playing lahal. The pre and post questionnaire demonstrated that there was an increase in awareness and knowledge of identifying when a friend was depressed and the different ways to help relieve stress.

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Transforming the System through Health Actions

- **Tl'etinqox-t'in Government Office:** Two camps were held – one for 18 youth aged 8 – 29 years, and one for 28 youth aged 8 – 18 years. The short-term outcome was that youth worked closely with elders to learn the Tsilhqot'in Cultural traditions such as hunting, basket making, beading and traditional games. The camps included suicide prevention workshops and a cultural camp involved dip netting and cultural activities. It was noted that youth displayed strong enthusiasm to learn traditional teachings and cultural activities and displayed teamwork during camp set up.
- **Upper Nicola Indian Band:** 24 youth participated in the Upper Nicola Band Youth Suicide prevention camp which consisted of various workshops, hands on activities, learning cultural and traditional teachings and for youth to learn the Syilx language.

On the last day of our camp, we had a mini feast and each of the participants were given an invitation to bring home for their parents to attend. At the feast the youth demonstrated the skills taught and reaffirmed throughout the week of the camp. The blankets and art work were put on display for family and guests to view.

Throughout the week we had the youth practice singing and drumming for the "Welcome" and "Farewell" that they performed for the guests before and at the conclusion of the mini feast. Two of the youth blessed the food and opened with a prayer daily and before the mini feast and Tyrell did the blessing of the food in Gitxsenimax.

The youth seated our elders and chiefs and each youth was instructed to ask each guest what clan they belonged to, where they sat and at which chief's table. For the feast we purchased items for the children to serve and each child had the opportunity to serve our guests, and perform their songs. The guests were given the opportunity to share what they witnessed and were very pleased and overwhelmed at what had transpired that week with a grand finale of a mini feast. All of the children and youth were presented with Certificates of Completion at the conclusion of the mini feast.

Gitxsan Child and Family Services Society

- **First Nations Friendship Centre, Vernon:** Youth from the Okanagan Indian Band, Vernon urban area and Spallumcheen Indian Band attended camps. The short-term outcome was to change awareness about topics of concern and learning about art and culture. The camp focus was on putting up and painting tipis. Mini workshops were also held on cultural and traditional activities, as well as arts and crafts. The evaluation showed that participants felt empowered, experienced success and were given the opportunity for self expression.
- **Lytton First Nation:** 40 – 50 youth aged 5 – 30 years attended the camp. The focus was on having the youth connect to their culture with the elders. They learned new skills and activities included workshops on life skills, mask making, lateral violence, fishing, arts and crafts and the impacts of residential school. Elders also shared stories.
- **Okanagan Nation Alliance:** The camps for youth in Okanagan focused on training for the Unity Run. There was a period of 2 months to train and 5 days for the run and 35 youth from the 7 Okanagan bands participated. The Okanagan Nation response team collaborated with the Aboriginal RCMP in the Okanagan to organize the Okanagan Nation Unity run to promote awareness of Youth Suicide. The run also raised youth awareness of their territory and connecting them to the land. A celebration was held on completion of the run;
- **Xaxli'p Health Centre:** A 5 day camp was held to promote personal growth, knowledge transfer of cultural ways/history/customs/stories and to build a sense of pride and community. Activities included workshops on prevention of joining 'bad' groups, appropriate education on HIV/AIDs, having dreams, celebrating their gifts, cultural activities and celebrations of drumming, dancing and stories.

In addition to the youth camps, and provincial activities, there has also been a focus on suicide crisis responses. Aboriginal Suicide Crisis Incident Response Teams (ASCIRT) are being set up throughout the Province. There are currently 7 ASCIRT model programs through the Province:

- Okanagan Nation Crisis Response team – Westbank
- Inter Tribal Health Authority – Nanaimo
- White Buffalo – Kamloops
- First Nations Action and Support Team – Gitxsan
- Cowichan Spirit of Kweyulus Mustimuhw - Duncan,
- Living Is For Everyone - Merritt and
- Sto:lo

A number of ASCIRT's are being funded by FNIH with others receiving funding by the Province or local Health Authorities.

Due to the scope of work that these teams will undertake, FNHC has been advocate for joint funding by Health Canada and the province, to ensure that the programs are funded appropriately and that the province is involved in the planning. FNHC is sitting on a committee to evaluate two of the Assisted Critical Incident Response Team's (ASCIRT) Inter-Tribal Health Authority (ITHA) and Okanagan Nation Alliance (ONA). The FNIH hired an evaluator to conduct this evaluation process and the report was completed April 2009.

The FNHC also organized a gathering for all the ASCIRT teams on November 18 & 19 2008 at the Cove Resort in Westbank to discuss the ASCIRT team's successes, gaps in services, provide discussion workshop and activities that promoted team building and self care. The ASCIRT Gathering report can be accessed on the FNHC website.

Through workshops and activities around camp we were able to have youth engage in their own personal pursuit to wellness; they found activities they were involved with fun especially cedar weaving, they made gifts for family members and actually taught some of the volunteer supervisors to weave. Some of the youth paddled a canoe for the first time and others taught newcomers how - this was a great show of working with their peers, togetherness and camaraderie.

Nisga'a Valley Health Board

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Transforming the System through Health Actions



7.3 Maternal and Child Health

7.3 Maternal and Child Health		
TCA: FNHP	Action 10	Improve child vision, hearing and dental screening for First Nations children
TCA: FNHP	Action 11	Follow up on 2005 Child Death Review report with BC Coroner's office
TCA: FNHP	Action 21	Improve access to maternity services for Aboriginal women

Screening For Children

Action # 10 states that 'Aboriginal children under age six (on and off reserve) will receive hearing, dental and vision screening'. To undertake this work the technical team partnered with the First Nations Schools Association; the Aboriginal Maternal and Child Health Committee and provincial screening services.

Vision Screening

Improving screening services by health authorities

Work on this action started in late 2007. The FNHC participated in the provincial committee. Their role was to assist health authorities to develop relationships with First Nations communities as some communities had not accessed vision screening previously. In order to ensure that screening activities and associated data collection occurred in a safe manner for First Nations communities, the FNHC insisted on an OCAP-based process for data on vision screening. The FNHC also worked with the committee to develop documents such as protocols for provincial screening providers to ensure that the screening process was done in the appropriate way. It was important that the screening staff did not just turn up in communities and expect families and schools to participate in the program without any prior information.

The FNHC worked with the First Nations Schools Association and health authorities to develop appropriate tools for engagement. These included: a template for the province and health authority's letters to Chief and Council which provided information, and sought permission to come onto reserve to conduct screening; and, a template information letter to parents. These tools allowed for a consistent process to be implemented across the province. A joint letter from the FNHC and the province was also sent out to all First Nations schools to inform them about the screening program.

The FNHC also played a role of facilitating solutions to problems raised by schools about health authorities – particularly because many health authorities had not worked with First Nations Schools before. Alongside this work, the FNHC worked with the Ministry of Education in order to ensure compliance with the School Act about accessing data for Aboriginal self-identified children from schools so that vision screening could be organized for them. This was a lengthy but valuable process to ensure that First Nations children could access screening and that their data was identifiable to show improvements in screening rates. Vision screening for kindergarten children has or currently is taking place in all health authorities.

The FNHC has also played a role of facilitating solutions to any problems raised by schools about health authorities – particularly because many health authorities had not worked with First Nations Schools before.

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Transforming the System through Health Actions

In some areas First Nations mandated health organizations preferred to undertake the vision screening process, rather than have their children screened by the health authority. This approach was taken in the interests of self-governance and capacity building.

To ensure the data is analyzed correctly and under the OCAP principles, the FNHC contracted the National Coordinating Center for Aboriginal Health (NCCAHA) to analyze the data. Data on the 2008-2009 period was published in early 2010.

First Nations screening their own children

In some areas First Nations mandated health organizations preferred to undertake vision screening process, rather than have their children screened by the health authority. This approach was taken by First Nations in the interests of self-governance and capacity building. Additionally, some communities held concerns about the health authority and how they treated their children and operated within their schools.

The FNHC purchased 10 vision-screening machines and Randot screening machines for First Nations communities to utilize. A training curriculum was developed with the NCCAHA for members of communities so that training could be provided to communities before using the equipment.

Hands-on experience using the Sure-Sight Vision Screener was provided at several regional training sessions for First Nations community health representatives. The training provided First Nations vision screeners with the skills needed to identify and measure common vision problems such as myopia, hyperopia, astigmatism (asymmetrical focus), and anisometropia (unequal power between eyes) in pre-school children. The equipment and skills will provide valuable early diagnosis

of vision problems in those First Nations children who are otherwise missed by other screening methods. After the training session, community representatives have developed a clear understanding of eye anatomy.

The FNHC also commissioned the development of a Pre-School and Kindergarten Vision Screening Training Manual and worked alongside the Province to ensure it was appropriate and aligned with the mainstream Provincial Vision Screening Training Manual.

As well as training and customized training and operating manuals, the FNHC also took the provincial mainstream posters and resources that had been developed and produced versions that were more culturally appropriate. These were printed and dispersed to all health authorities and communities to promote vision screening.

Hearing Screening

The FNHC is a member of the provincial committee for hearing screening to ensure that their processes for First Nations child hearing screening improve.

In the first year the committee worked with FNIH Non-Insured Health Benefits in an attempt to improve payment for services that were more accessible for Aboriginal families. The FNHC advocated for the NIHB to support the costs for First Nations children that failed their hearing test at birth, to cover a further overnight stay so that families could have their child tested at a specialist center while in the city. This would save costs in the longer term by avoiding the family and child from returning home, just to come back for a specialist appointment later on. Currently work is under way with the BC Early Hearing Program to screen all newborn babies shortly after birth.



An issue that makes monitoring of First Nations hearing and vision screening rates difficult is that both use different data systems. This makes it hard to safely collect Aboriginal data and ensure there is sufficient coverage for all First Nations children. Data collection at present is a tedious process because it is done manually; there are often Informed Consent issues and the OCAP principles need to be applied within the provincial / health authority system for analysis and reporting of the data.

The FNHC has also supported the production of BC Early Hearing Program information pamphlets and the production of a DVD for First Nations communities.

Dental Screening

The FNHC is a member of the provincial committee for dental screening. In 2006-2007 a dental 'survey' was conducted to look at the state of oral health among First Nations kindergarten children at 5 years of age. In total, children from 20 schools out of 111 FN schools had their teeth assessed. The FNHC had input to the report on this study which is available from the FNHC.

The report is not comprehensive in that it only includes the result from children in 20 FN schools – the FNHC wants all the dental health of all First Nations children in FN schools surveyed so that an accurate picture of the current status, and targets for future improvements, can be determined. The dental survey report identifies that 230 First Nations kindergarten children attending 20 First Nations schools were screened for dental health. During the screening program, kindergarten children were assessed for:

- evidence of no visible dental decay (caries free),
- evidence of no visible decay but evidence of existing restorations,
- evidence of pain or infection at the time of screening,
- evidence of visible dental decay in one or more teeth, and
- location of decay by quadrant of the mouth.

Of the 20 First Nations Schools surveyed, Northern Health Authority (NHA), Interior Health Authority (IHA) and Vancouver Island Health Authority (VIHA) each surveyed six schools and Vancouver Coastal Health Authority (VCHA) surveyed two schools. No First Nations schools were surveyed in Fraser Health Authority. The following are suggested benchmarks for prevention of dental disease:

- 60% of school-entry children are caries free,
- Less than 20% of school entry children have unmet dental treatment needs.

The findings revealed that of the 230 First Nations children screened 17.8% had no visible decay; 44.7% had no visible decay present but restorations present, and 37.8% had visible decay.

Of the First Nations children with visible decay, 16% had urgent dental health concerns evidenced by visible decay and the presence of pain and/or infection in the mouth at the time of screening and Northern Health Authority had the highest percentage of urgent dental needs. First Nations children in Vancouver Coastal Health Authority (58.8%) and Vancouver Island Health Authority (58.5%) had higher rates of no decay and restoration present [comparatively to] than First Nations children in Interior Health Authority (31.0%) or Northern Health Authority (30.3%).

An issue that makes monitoring of First Nations hearing and vision screening rates difficult is that both use different data systems. This makes it hard to safely collect Aboriginal data and ensure there is sufficient coverage for all First Nations children.

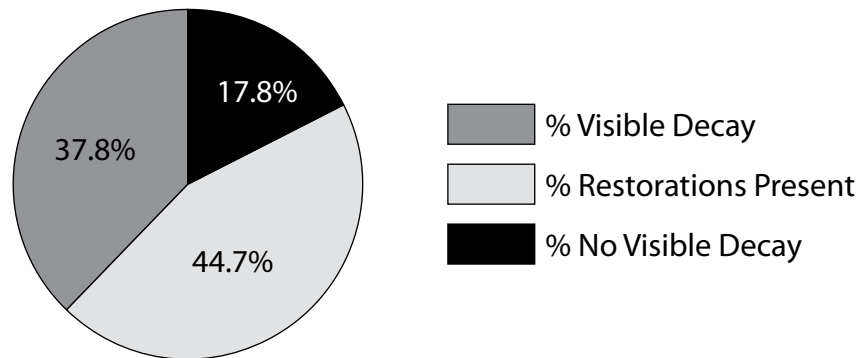


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Transforming the System through Health Actions

FIGURE 7.1 - 2006-2007 DENTAL SURVEY RESULTS FOR 20 FIRST NATIONS SCHOOLS IN FOUR HEALTH AUTHORITY REGIONS.

Of the First Nations children with visible decay, 16% had urgent dental health concerns evidenced by visible decay and the presence of pain and/or infection in the mouth at the time of screening and Northern Health Authority had the highest percentage of urgent dental needs.



Additional work is needed to address the disparities in early childhood dental health and close the gap between Aboriginal and non-Aboriginal children. This includes increasing the number of Aboriginal children who are caries free and reducing rates of early childhood dental decay. Continued collaboration is needed between tripartite partners to address early childhood dental health for First Nations children on and off reserve. Urgent priorities include reducing barriers to accessing dental services, improved coordination of service delivery and program monitoring, and making available culturally appropriate educational resources for Aboriginal families and care providers about prevention of early childhood caries.

At this time dental screening is the under an assessment review. The FNHC will collaborate on a follow-up dental survey that will be taking place in 2010.

Maternal & Child Health Committee

The Aboriginal Maternal and Child Health Committee was formed in July 2008 and is comprised of Aboriginal and First Nations communities as well as Metis and BC Association of Friendship Centers representation. The Committee is led by First Nations who have the most members on the Committee. The Committee's general role is to review any provincial or federal activity which will impact on First Nations maternal or child health and to ensure First Nations interests are protected. The Terms of Reference for the Committee state that the mandate of the group is to:

- ensure a regional, Aboriginal and First Nations perspective and advocacy support is provided during the implementation of the Tripartite First Nations Health Plan (TFNHP);
- assist in enhancing, and integrating culturally appropriate health services to Aboriginal peoples and communities in the province of BC;

The Committee focuses on activities derived from the Tripartite First Nations Health Plan including: hearing, dental and vision screening, an annual review of the British Columbia Coroners Service Child Death Review Report (2005), and improving maternity access.



The Committee is responsible for reviewing and making recommendations regarding the design, implementation, and evaluation of maternal and child health priorities. The Members of the Committee draw upon and share their experience, expertise and leadership skills to ensure that the activities and initiatives of the Committee are achieved.

The Maternal and Child Health Committee conducts activities that involve:

- ✓ Knowledge transfer
- ✓ Conducting environment scans
- ✓ Setting priority areas
- ✓ Making recommendations for policy and process changes
- ✓ Identifying jurisdictional overlaps or gaps in service delivery
- ✓ Sharing 'best' or 'better' practices
- ✓ Determining resources required to implement initiative(s)/ program(s) such as: planning, human resources, research, technological requirements
- ✓ Identifying, building and maintaining effective community partnerships and innovative practices
- ✓ Developing annual work and communications plans
- ✓ Building on existing programs and services and/or better or best practices
- ✓ Providing input into the tripartite process.



Child Death Review Report

The Child Death Review Unit (CDRU) of the BC Coroners Service reviews the deaths of all children age 18 and within B.C. The intent of these reviews is to better understand how and why children die, and to use those findings to prevent other deaths and improve the health, safety and well-being of all children in British Columbia. Specific initiatives of the Unit included making the BC Coroners Service Child Death Review Report (2006) easily available to communities by mail, internet, e-mail and fax. A hard copy of the 2008 and 2009 annual report was sent to all communities. It was also sent electronically, with a joint message from the First Nations Health Council and CDRU, to all communities, health directors, social development Managers and Tribal Councils.

First Nations Health Council staff members (including Dr Evan Adams) continue to sit on the review committee and are involved in the review of deaths of First Nations children. This process helps ensure appropriate protocols are followed and community stakeholder's interests are protected.

In 2009 the CDRU, BC Coroner's Service issued a report entitled 'Safe and Sound: A Five Year Retrospective' outlining a report on Sudden Infant Death in Sleep-related Circumstances. This report produced a review of 113 BC infants who had died suddenly and unexpectedly during their sleep between the period January 2003 and December 2007. Those involved in the report included a number of BC agencies such as the BC Medical Association; BC Perinatal Health program; FNHC; Health Canada; health authorities and the Province. The key findings reveal that 30% of the deaths involved Aboriginal infants (34 cases) – approximately four times their representation in the BC infant population. Vancouver Island and the Northern region had the highest number of sudden infant deaths. Over half of the infants had mothers who faced

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Transforming the System through Health Actions

economic challenges, either during pregnancy or during the lifespan of the infant. Economic challenges were more common for Aboriginal mothers and infants than other residents. A major finding was that inadequate prenatal care was an issue for over half of the mothers. The FNHC, CDRU and other partners have used this report as a basis for developing further strategies for addressing Sudden Infant Deaths (SIDS) among the Aboriginal population.

Improving Maternity Access

The TFNHP states that there is a need to improve maternal health services for Aboriginal women and 'bring birth closer to home and back into the hands of women'. This is to help reduce the need for First Nations women in rural and remote communities to travel to more urban centers up to two months prior to delivery because of a lack of maternal care in their home communities. The Maternity Access initiative includes:

- Diversity training for care providers
- Training of birth companions (Aboriginal Doula) and Aboriginal midwives
- Creation of a community guide (traditional birthing manual) and toolkit

The Aboriginal Maternal and Child Health Committee provides feedback, recommendations and guidelines on a number of maternal and child health initiatives including:

- *Aboriginal Perinatal Program* – a Committee has been established for this within the PHSA to help address Action Item #21. Already the Committee has developed two draft documents specifically for Aboriginal women and communities;
- *Doula Training* – An Aboriginal Doula Training program is being piloted that will train First Nation doulas and midwives practicing within a traditional and cultural context to support Aboriginal women, and to improve their birthing experiences. The doula training has been a collaborative approach with participation from Health Canada (FNIH), Health Authorities, the First Nation Health Council, and has been coordinated by the BC Perinatal Health Program of the Provincial Health Services Authority. Already sessions have been completed in two regions (Interior and North) and more are planned for remaining Health Authority regions in 2009-2010.

The TFNHP states that there is a need to improve maternal health services for Aboriginal women and 'bring birth closer to home and back into the hands of women'

In 2008-2009 Doula training was provided in the Interior and Northern regions supported by a curriculum that incorporated cultural and traditional context. This pilot training was developed by the FNHC along with FNIH and health authorities, and is coordinated by the BC Perinatal Health Program.

In 2008 – 2009 an Aboriginal Perinatal Committee was established to facilitate the inclusion of community voices in high level, broad initiatives that influence maternal (and child) health. In addition to community representatives, the Committee also includes representatives from the Province, FNIH, Public Health Agency of Canada, the FNHC and the Provincial Health Services Authority (PHSA) who operate BC Women's and BC Children's Hospitals. At a strategic level the Committee focuses on improving access to all aspects of pre- and post-natal care and supporting family inclusion.

In 2008-2009 Doula training was provided in the Interior and Northern regions supported by a curriculum that incorporated cultural and traditional context. This pilot training was developed by the FNHC along with FNIH and Health Authorities, and is coordinated by the BC Perinatal Health Program.



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Transforming the System through Health Actions

7.4 Health Human Resources

7.4 Health Human Resources		
TCA: FNHP	Action 18	Dedicate post-secondary seats for Aboriginal health professions
TCA: FNHP	Action 19	Develop a cultural competency curriculum for health authorities
TCA: FNHP	Action 20	Designate senior staff in health authorities responsible for Aboriginal health
TCA: FNHP	Action 24	Develop the role of Nurse Practitioners and Physician participation in Aboriginal health and healing centers
TCA: FNHP	Action 25	Increase the number of professional and skilled trades First Nations in health professions
TCA: FNHP	Action 26	Increase the number of Aboriginal hospital liaison staff employed by Health Authorities

Aboriginal Health Human Resource Initiative (AHHRI) Achievements

Through AHHRI funding post-secondary institutions (PSI's) had the opportunity to apply for funding from the FNHC that targeted strategies including: curriculum development, recruitment and retention strategies, bridging and laddering programs. In May 2008, a call for proposals was made to post secondary institutions (PSI's) in British Columbia. Fifteen PSI's submitted a total of 35 proposals for a total of \$3.9M.



A number of PSIs that applied for funding were successful. The FNHC convened a gathering of representatives from the post-secondary institutions in March 2009 at the UBC Long-House to discuss how well their AHHRI-funded initiatives were working to attract and retain Aboriginal students. There were a number of initiatives identified that related to curriculum development, student support and bridging / laddering programs that were highlighted. A report on this gathering is available from the FNHC however some examples are:

- **UBC Institute for Aboriginal Health** – UBC hosted a 5 day science fair called the 'UBC Summer Science Program' which focused on providing Aboriginal youth with opportunities to learn about health sciences and post secondary education and career prospects. There were 31 students admitted to the program, from grades 8 – 11, for all sessions in 2008. The program staff complement included: an Elder in residence, program assistant, counselor, dorm coordinator, recreation coordinators, youth worker and

education coordinator. The curriculum was delivered over a week long session. Activities included visits to a variety of departments at UBC and facilities on site: talking circles, guest speakers, traditional foods, elder teachings and activities that revolved around the Medicine Wheel concept.

- *Capilano University - CAP U's* project to develop a Home Support / Residential Care (HSRC) course was conducted in partnership with Mt Currie Band. The course involved 10 First Nations students from Mt Currie, and 2 non-First Nations students from Pemberton. Most of the course work was delivered on reserve and most of the clinical component was done in North Vancouver. They worked closely with Mt Currie band but there was a large turnover of staff and it lacked continuity. It was a face to face relationship that worked with Mt Currie. Repetition with staff provided a good foundation for the relationship and the program. The course included a training session on First Nations history which was beneficial for all students and was a very emotional process for many did not know about what has happened to First Nations communities in Canada. CAP U also held an Aboriginal Bridging program for students who needed to meet entry criteria. There were 4 courses.



Langara College used the funding to develop supportive and culturally appropriate strategies to facilitate the recruitment and retention of Aboriginal nursing students. This involved the nursing program looking at issues of retention – they knew for instance that a lot of Aboriginal students travelled far from their homes and they were very lonely and missed their families

- **Douglas College - Psychiatric Mental Health Nursing Careers** - This project involved a 3 year diploma offered at Douglas College. The vision was to increase access to the course for First Nations students and to capitalize on First Nations students knowledge to improve the course for all students. They honored the students as the experts to shift the way of thinking among the academic profession.
- **Northwest Community College - Development of First Nation HSRCA Program for 3 remote northwest First Nation communities** – AHHRI project funding for a First Nations Home Support Residential Care (HSRC) program worked with 3 communities targeted in the remote Northwest: Haida Gwai, Nisga'a and Gitwangak.
- **Langara College** - Development of supportive and culturally appropriate strategies to facilitate the recruitment and retention of Aboriginal nursing students. This involved the nursing program looking at issues of retention – they knew for instance that a lot of Aboriginal students travelled far from their homes and they were very lonely and missed their families. Langara tried to make it attractive for them. They wanted to access Grade 6 & 7 students to try and guide them into health care.
- **Northwest Community College** – Development of First Nations HSRCA Access to Practical nurse program in remote Northwest. This involved working with the Nisga'a nation, whose health director needed to change the service delivery model that they operated under. The health director wanted to remove the silo's that existed and have staff working across services in a more integrated manner. There was also concern that 10 HSRCA staff were doing more than they should and because of the health needs of the community, and the lack of nurses, the HSRCA's often operated outside of their scope. The initiative was to develop HSRCA's into LPNs.



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Transforming the System through Health Actions

Thompson Rivers University works with 5 First Nations who include 47 communities. They knew strength would be collaboration so they collaborated with them all. The project involves Recruitment; Practical supports; Faculty development – learning about cultural, history and about each other; and four stages of the continuum of health care education and practice.

- **Nuu-Chah-Nulth Tribal Council: Vancouver Island Centre of excellence for Aboriginal Nursing.** The project involved 14 First Nation communities in the Nuuchah-Nulth area on the west coast of Vancouver Island. The project is working towards a “Center of Excellence in Health” on Vancouver Island. The program focuses on strategies to get students into health professions. Cultural awareness workshops were provided as orientation for new nurses in community. Another project was to develop a curriculum and module to deliver training *in* the community *for* the community.
- **College of New Caledonia – Aboriginal Health Sciences Access Program** - Initiative was ‘Pathways to Success’ and involved 22 Aboriginal groups in area. They had reserved Aboriginal seats on their programs; however, it was found there were not enough qualified applicants to fill the seats so innovative strategies targeted at young people needed to be developed in order to encourage more Aboriginal participants. They held a Health science explorer camp in 2008 aimed at creating that interest for students to go into health sciences. Northern Health Authority provided extra funding as well. Outcomes were that 3 students registered in adult basic upgrade and practical nursing (2) and registered nurse program. Northern Health Authority have given extra money for honorariums for elders and for mentoring supports and student bursaries;
- **Camosun College: Road to Success** - The “Road to Success” strategy included 2 projects - BSN (Baccalaureate of Science Degree in Nursing) and Practical nursing. Camosun designated 10 of 190 seats for FN students and held a summer institute for First Nations students in August 2008. The summer institute involved: a study skills course, time management, reading, writing, learning from lectures, assisting memory skills, and exam preparation. English and Mathematics courses were offered at no charge for upgrading. Academic upgrading was offered after school. Camosun has a mandate that every single course has to be indigenized – not just specific courses. This means all of their curriculum had to be put into a culturally safe language. The learning circles involved a support group that was in place to work with other tribal councils on the island.
- **College of the Rockies: Aboriginal Bridge to Health and Technology program** - The ‘Bridge to Health and Technology’ program looked at how to bring foundation courses to remote communities as opposed to having students travel out to the institute. The PSI established this with their First Nations community partners and started the program in 2005. The goal was to deliver this program in face to face or class-based environment - all on-line courses are made available from post secondary level due to remoteness of communities. The purpose is to increase Aboriginal student access enrollment and success in health programs.
- **Thompson River University – Collaborating for success:** They work with 5 First Nations comprised of 47 communities. TRU knew strength would be found by collaborating with all of their communities. The Aboriginal Nursing project had been on-going since 2003. It was initially funded from Nursing Directorate and now receives funding from Ministry of Advanced Education and AHHRI. The project involves recruitment, practical supports, faculty development (learning about cultural, history and about each other), and four stages of the continuum of health care education and practice.
- **UBC Okanagan - First Nations curriculum development project 2008-2011:** The project aims to give the students a good introduction on who Aboriginal people are. There are 4 modules to the program and 4 departments at UBCO are involved (the modules are mandatory): nursing, social work, health studies and human kinetics. The Okanagan people are working with UBCO to ensure the study of First Nations people are included in the programs, to increase cultural awareness, and that all courses at UBCO include these developed modules.

The next step is to identify the initiatives that achieve the most success and to continue to work with post-secondary institutions to support their continued efforts in attracting and retaining Aboriginal students.

The FNHC conducted an environmental scan in 2008-2009 with AHHRI funding to review post-secondary health care programs offered for Aboriginal students and to assess the level of Aboriginal seats allocated for health professions. The scan indicated that there was a need for standardizing data collection to report enrolment of Aboriginal students so that data on enrolments and students completing courses is accurate. Out of 413 health education programs only 103 had any specific Aboriginal content or methods within their curriculum to attract Aboriginal students.

Ministry of Advanced Education and Labour Market Development

The FNHC has also been working with the Ministry of Advanced Education and Labour Market Development (ALMD) to promote Aboriginal success in post-secondary education. Under the Aboriginal Post-Secondary Education Strategy, ALMD is working with B.C.'s post-secondary institutions and Aboriginal communities to help Aboriginal learners start, stay, and succeed in post-secondary education and training. This includes:

- Targeting of 100 new public post-secondary seats for Aboriginal learners in 2007, which was boosted to 200 in 2008;
- \$15 million to build culturally welcoming gathering places that will reflect the character, community and traditions of Aboriginal cultures;

\$15 million over three years for eleven public post-secondary institutions to develop and implement Aboriginal Service Plans in collaboration with Aboriginal communities. These plans match programs and services to meet the regional education and training needs of learners. Currently, institutions are implementing their final year of the plans.

In 2008- 2009, the Aboriginal Special Projects Fund supported 37 Aboriginal Special Projects totaling \$2.98 million to support the development and pilot of new programs and courses, cultural education support and transition programs, student recruitment activities, and student support services. To reduce financial barriers for Aboriginal learners, an additional \$0.5 million was contributed to the \$10 million Aboriginal scholarship endowment administered by the Irving K Barber Scholarship.

Recruiting Aboriginal Students into Health Careers

The FNHC hired two Health Careers Recruitment Officers (i.e. Recruiters) who were employed from 2008 until April 2009 through the AHHRI funding envelope. The recruitment officers focus was on visiting communities to promote health careers to Aboriginal students. During their tenure, the recruitment officers provided an abundance of health career information to prospective health care professionals and paraprofessionals to start researching their education options, being asking questions and applying for trade school, college or university seats in specific courses. Health Careers Recruitment Officers organized a 'Train the Trainers' workshop designed to train selected regional and community Aboriginal role models in the delivery of the Health Careers awareness module. The National Aboriginal Achievement Foundation delivers the workshop and certifies role models who will spread the message of staying in school and selecting careers in the Health fields.

Strengthening Connections is an initiative that provides education career fairs in First Nation communities on a continued and prolonged basis to ensure First Nation people, students, education coordinators have correct, up to date information on college/university programs,

The scan indicated that there was a need for standardizing data collection to report enrolment of Aboriginal students so that data on enrolments and students completing courses is accurate.

Out of 413 health education programs only 103 had any specific Aboriginal content or methods within their curriculum to attract Aboriginal students.

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Transforming the System through Health Actions

Snuneymuxw First Nation was funded in 2008 to hire a summer student who was interested in health careers. The student was interested in nursing and she worked alongside the First Nations community health nurse during the summer. She was later accepted into the Nursing Degree program at Vancouver Island University.

admission requirements, support services and scholarship and bursaries. The FNHC Health Careers recruiters joined up with Strengthening Connections to increase efforts in generating student prospects and develop mentorship relationships from point of interest to registration. Through interactive prize driven activities, staff members were able to identify 79 prospective aboriginal people interested in pursuing of a Health Career, ages ranging from 13 - 39.

The FNHC publishes an annual 'Health Career Guidebook' which is a First Nations specific resource developed to support students to make decisions about Health Careers. In 2009, FNHC also distributed the 'H.E.A.L.T.H.: Higher Education for Aboriginal Learners – Think Health' resource guide to assist prospective students in planning a career in the health field.

Health Careers Program

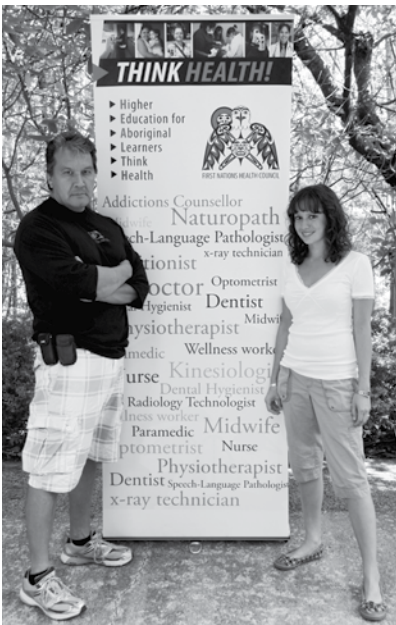
The FNHC Health Careers Manager was responsible for the Bursary and Scholarship Initiative, School Age Science and Math Program, and the Community Based Projects and to assist with the Aboriginal Health Human Resources Initiative (AHHRI). In 2008-2009:

- Bursary and Scholarships given out this year totaled \$98,000 for 46 students in Health Careers Programs;
- Community Based Initiatives (CBI) for 19 Communities who received \$120,000 throughout BC. Allocations for this initiative range from 3,000 to 10,000 per community; School Age Science and Math Program (SAMSAP) allocated a total of 130 Awards of \$150.00 per Award were distributed. A total of 2,212 student's names were submitted for this fiscal year 2006/2007.

Some examples of the community health careers initiatives include:

- **Northern Shuswap Tribal Council Society** - Northern Shuswap Tribal Council was funded in 2008 to run a Summer Children's program for 11 students over 3 days called the 'Eureka Science Camp'. The camp encouraged students to view science as an interesting topic and to study science and maths in order to attain the subjects necessary to enter many health careers;
- **Snuneymuxw First Nation** – Snuneymuxw First Nation was funded in 2008 to hire a summer student who was interested in health careers. The student was interested in nursing and she worked alongside the First Nations community health nurse during the summer. She was later accepted into the Nursing Degree program at Malaspina University College (VIU);
- **Association of BC First Nations Treatment Programs** – this organization was funded to develop a recruitment video for Aboriginal addictions counselors and health professionals into the treatment field. The project was called 'Recruiting Strategies for Addictions and Wellness Workers' and was designed with interactive media material that would inform and motivate students into addictions careers and residential treatment centers. The activities included developing a 'Career Opportunities in Addictions Services' brochure and video clips of career opportunities.

The resources for the Bursary and Scholarship Initiative, School Age Science and Math Program, and the Community Based Projects were transferred back to First Nations and Inuit Health as of March 31st, 2010.



Environmental Scan: First Nations Health Workforce

In 2008-2009 the FNHC commissioned an environmental scan (using AHHRI funding) of the First Nations workforce in BC to obtain a 'snapshot' of the current number of health human resources, issues, retention and cultural competence of Aboriginal health care workers. This information was aimed at contributing to the identification of key 'information gaps' and services. The report of this work was completed toward the end of the fiscal year but there was unfortunately a very low response rate to the workforce survey.

The FNHC re-ran the survey using other methods in 2009-2010 in order to gain a better picture of the size and scope of the First Nations workforce in BC. A total of 78 individual First Nations health centers and 19 umbrella organizations (total 97) were targeted for the scan and 74 (76%) responded.

The First Nations workforce scan revealed the following:

- A total of 1,076 people were working in the 74 First Nations health centers of which 73% identified as being of First Nations descent;
- A total of 1,265 positions were held within the 74 First Nations health centers with the majority being in the home care field and corporate / administration area, followed by Registered Nurses and Community Health Workers;
- The region with the highest number of positions was the northern region
- There are more full-time employees than part-time employees although this is the opposite in the Fraser region;
- The majority of workers in First Nations health centers have worked for less than 5 years although the majority of Community Health Representatives (CHRs) have worked for between 11-20 years in their roles;
- The majority of workers earn around \$16 - \$20 per hour in salaries

The results of this Environmental Scan have now provided the technical team with some useful baseline data to help support the development of a broader First Nations health workforce strategy in the future that will build on current activity. The FNHC will continue to work with the province's health workforce development team, FNIH and health authorities, and with post-secondary institutions, to continue to encourage First Nations recruitment, retention and development so that over the next decade we will start to see significant growth of the First Nations health workforce.

The First Nations workforce scan revealed that A total of 1,076 people were working in the 74 First Nations health centers of which 73% identified as being of First Nations descent



7

Transforming the System through Health Actions

Feedback on Workforce Development – Gathering Wisdom

The FNHC Health Human Resources team hosted a table at the 2nd Annual Gathering Wisdom for a Shared Journey Forum held May 21/22 2008 in Vancouver. The key messages arising from the discussion were that:



The majority of people employed in the health area are overworked and undervalued. Sometimes health care workers face an expanded scope of practice. In some of our remote areas, the first responder may be a Community Health Representative (CHR)

- The majority of people employed in the health area are overworked and undervalued. Sometimes health care workers face an expanded scope of practice. In some of our remote areas, the first responder may be a Community Health Representative (CHR);

- There is a cascade of cause and effect. For example, there is a lack of math and science focus in the K-12. This has a profound impact on the recruitment of First Nation students into science and health programs. First Nations are not fully aware of the range of health careers, or there is little interest in because industry jobs pay well, especially in the north. Further, high school education is usually the only requirement to obtain an industry job;

- Higher education is viewed as a waste of time because “you will end up with a minimum-wage job anyway”. Those who do continue their education face great financial challenges. For example, medical students have an average debt of \$150K by the time they finish school (although they

are able to quickly pay off this debt once they begin work). On a high note, in 2007, there were (309) First Nations students enrolled in health care programs and forty-one (41) students will graduate in the Spring of 2008. This is most likely due to inconsistent tracking systems and lack of self-identification.

- A post secondary institution strategy is only one piece of a larger strategy that is needed.

Develop Cultural Competency Curriculum For Health Authorities

In 2008, the Province commissioned a concept paper on cultural competency to explore the definitions of cultural competency from an international and national indigenous perspective and to look at best practice models for cultural competency. The paper revealed that the term “cultural competency” is often applied to individuals working in the sector such as physicians and nurses, but not from a broader perspective of improving the cultural competency of the organizations that operate in the health industry. It is clear from the research that efforts must be made to improve how all health organizations perform in respect of First Nations health in the province – including the provincial health ministries and health authorities. The need for culturally competent organizations also needs to encompass other mainstream service providers who deliver services to First Nations communities such as physicians.



The FNHC has continued to participate in the work to advance the improvement of cultural competency among health authorities particularly, since they are responsible for a vast majority of the services needed by First Nations communities. This work is closely allied with the work on reciprocal accountability where we need health authorities to be more accountable to their local First Nations for delivering culturally competent services that support the implementation of First Nations community health plans. The FNHC has continued its meetings with the Boards and CEOs of the regional health authorities to look at ways to improve reciprocal accountability mechanisms with First Nations and to identify practical ways in which health authorities can improve the cultural competency of their organizations. We have begun drafting an agreement with one health authority to ensure their commitment

to improving their responsiveness to their local First Nations and to working towards alignment of their Aboriginal Health Plans with local First Nations health plans.



Amanda Dixon's Story

Hi my name is Amanda Dixon. I'm currently a grade 12 student at Chatelech Secondary School, Sechelt B.C. I'm currently taking a variety of courses throughout this year to help encourage me towards post-secondary school. I attended the aboriginal career fair at school on October 6, 2009, to find out more information about furthering my education after high school.

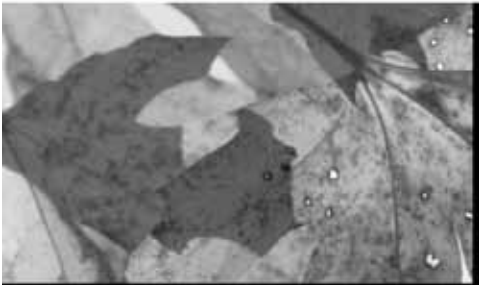


At the career fair my interest's were finding out more about a health career in the nursing field. I have been interested in having a career in nursing for 5 years. It all started when I volunteered as a candy striper at Totem Lodge, a care home for the elderly in our community.

My motivations were to give back to the community, have fun and enjoy volunteering. While volunteering I was getting support from my family and the staff who worked there. In the Health Career Guide Book, I found it very interesting and helpful to find out more of the career that i'm interested in. It provided me with certain details and information that were very useful and it helped me make a clearer decision in the health career I would like to pursue. The First Nations health careers recruiting team, Erin Mearns and Steve Sxwithul'txw, helped motivate me a lot in my educational journey towards nursing. It was a good experience talking to both of them. They provided me with advice, information and stories from their own experiences. My future still awaits and I'm planning on going to post secondary school and pursuing a health career.

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Transforming the System through Health Actions



7.5 Health Systems

Health Systems		
TCA: FNHP	Action 16	Build a new health centre in Lytton
TCA: FNHP	Action 3	Each health authority to develop an Aboriginal health plan
TFNHP	-	Ensuring and supporting First Nations in developing community health plans
TCA: FNHP	Action 23	Create a fully integrated tele-health network

Create a Fully Integrated Tele-Health Network

This action item has stimulated significant systems change for the tripartite partners. Close working relationships and mechanisms to advance First Nations eHealth initiatives have been instituted between First Nations, the Ministry of Health, the Ministry of Healthy Living and Sport, and First Nations and Inuit Health. It is recognized that the achievement of this action item, and the successful implementation of First Nations eHealth solutions generally, depends on a high level of integration and collaboration at strategic, planning and operational levels. Accordingly efforts during this period saw the creation of three important vehicles to advance First Nations eHealth: The Tripartite Strategy Council for First Nations eHealth, the Tripartite Working Group for First Nations eHealth, and the First Nation eHealth Centre of Excellence Society, and more recently a co-managed eHealth operations unit at FNIH.

Tripartite Strategy Council for First Nations eHealth: The purpose of the Tripartite Strategy Council for First Nations eHealth (TSC) is to create alignment of strategic direction and investments by the tripartite partners around eHealth. The following senior officials represent tripartite partners on the strategy council:

- First Nations Health Society - CEO and VP of Policy and Advocacy;
- First Nations and Inuit Health – Regional Director, Director of Health Surveillance, Manager e-Solutions;
- Ministry of Health Services – Portfolio Director for FNs eHealth, Telehealth EMR, Project Director Provincial Telehealth Office;
- Ministry of Healthy Living and Sport – Executive Director of Aboriginal Health; Aboriginal Health Physician Advisor; Director Public Health Informatics.

The efforts of the strategy council centre around the vision for “An integrated, interoperable and culturally appropriate First Nations eHealth system in which health care information is accessible, when and where it is needed, to support personal health, health care decision making, health system sustainability, and an empowered First Nations health services sector”. (TSC Terms of Reference, April 3, 2009)

...the successful implementation of First Nations eHealth solutions generally, depends on a high level of integration and collaboration at strategic, planning and operational levels

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Transforming the System through Health Actions

The alignment of strategy at a senior level by the tripartite partners represents a truly transformative change in the First Nations eHealth sector. In addition, the chair of the TSC also is a member on the provincial BC eHealth Strategy Council, creating an important link between tripartite eHealth and the BC eHealth strategy table. TSC meetings occurring during this time period:

- November 03, 2008 TSC Formation Meeting
- November 25, 2008 TSC Formation Meeting
- January 22, 2009 TSC Meeting
- April 03, 2009 TSC Meeting
- August 13, 2009 TSC Meeting
- December 1, 2009 TSC Meeting
- January 6 2010 TSC Meeting
- January 14, 2010 TSC Meeting
- February 10, 2010 TSC Meeting
- March 31, 2010 TSC Meeting

Tripartite Working Group for First Nations eHealth

At a tactical or planning level, the Tripartite Working Group for First Nations eHealth (TWG) was established in parallel to the Strategy Council. The TWG functions as a technical support to the strategy council and is responsible for the facilitation of day-to-day analysis and planning of non-strategic issues for tripartite efforts in First Nations eHealth. Importantly, the TWG seeks to foster alignment at a project level to maximize efficiencies, communication and sharing of knowledge and resources. The Working group is made up of core supporting technical resources to strategy council members, and includes, as required, participation of tripartite project specific resources. The TWG meets regularly and is contributing towards knowledge transfer between the differing partner strengths, building on each other's strengths, and collectively building momentum and on the ground commitment to advancing an integrated approach to First Nations eHealth.

First Nations eHealth Centre of Excellence (CoE)

At the operational level, the FNHS in the summer of 2008 reinitiated and provided leadership to a stalled business planning processes for the formalization of a First Nations eHealth Centre of Excellence (CoE). The First Nations eHealth CoE was envisioned as an entity, at an operational level, to advance: Development of BC First Nations eHealth skills and knowledge, the facilitation of innovative eHealth solutions, and support eHealth integration between and across First Nations communities, the province, Health Canada and other stakeholder groups.

By December of 2008 the First Nations Health Council and the Inter Tribal Health Authority established a CoE society jointly. Early setup and development work for the CoE was undertaken, including governance development. The two founding partners each selected two directors for a 7-seat governance model. The real challenge for CoE model was ensuring the CoE was driven by a province wide rather than a regional perspective. At the most basic level this was to take shape through the selection of the three additional at large Directors to the CoE Board of Directors. Despite concerted supporting efforts by the partners, this was not achieved, and further development of the CoE has ceased.

Co-Managed eSolutions-Unit

To continue to develop the operational level efforts of First Nations eHealth in BC, the tripartite partners have established the eSolutions Unit as an FNHS-FNIH co-managed operational unit. This represents an important systems change that will begin to align efforts on the ground with the progress that has been made at the tripartite strategy council and working group levels. It will also yield important transitional lessons learned for broader change being envisioned and advanced for FNIH and evolving First Nations structures, approaches, and direction. Working relationships at senior and management levels within eSolutions, and associated processes and mechanisms, have been developed and continue to evolve. The co-managed eSolutions unit will continue to move project and operational level activities and efforts forward for First Nations eHealth in a coordinated manner with strong linkage to Tripartite strategy direction.

While early development work for these new defining structures, forums, processes and relationships at the strategic, planning and operational levels has evolved, work on key eHealth projects continued to advance and become oriented to the changing landscape of First Nations eHealth - in particular, two tripartite projects with a BC wide scope: The BC First Nations Telehealth Expansion project, and the First Nations Panorama Implementation project. These projects will be key 'anchor' projects around which First Nations eHealth will continue to develop and take shape over the next two to three years. Both projects have strong tripartite linkages, and will provide the context for the development of First Nations infrastructure and capacity in the evolving eHealth sector in B.C.

Community Engagement

Discussions and consultations with community continue to affirm the importance of this action item and of First Nations eHealth efforts generally. Past Gathering Wisdom Forums and a recent feedback process initiated by the BC First Nations Health Directors Association have affirmed the developmental importance of eHealth for First Nations health services, and further identified key challenge areas where eHealth represents particular opportunities. Given that communities are juggling a broad range of health priorities, the perceived importance of eHealth speaks to a recognition that eHealth is an enabling tool which will contribute in important ways to helping community health services better achieve service goals and processes.

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Transforming the System through Health Actions

Other important aspects of moving eHealth development forward that have been identified by Health Centres include: sufficient operational resources at the Health Centre level; facilitation of broad skill development within Health Centres; the importance of cultural competency/safety development within the broader health services; and the ongoing challenge of recruitment and retention faced by Health Centres.

Key developmental priority areas emerging from community engagements:

1. **Access to Services** – using eHealth and telehealth as one way of mitigating the relative difficulty many communities face in accessing the range of primary health care services available to the rest of Canadians.
2. **Information Management** – many Health Centres currently struggle with the fragmentation of the client health record due to a lack of basic electronic charting tools to facilitate integrated records amongst Health Centre staff. Paper charting continues to be the norm for Health Centres, entailing inevitable fragmentation of information and administrative inefficiencies, and lost opportunity for more effective organizational management.
3. **Accountability-Reporting Burden** – eHealth is seen as an opportunity to help alleviate the perceived over-burden of accountability reporting to funders. The automation of reporting to align with information and charting efforts as part of practice is seen as an opportunity to both streamline and rationalize reporting frameworks, but to create efficiencies for all ready overly stretched Health Centre staff.
4. **Interoperability** - the interest and need of Health Centres to inter-operate with provincial and federal partners is seen as a critical systems change that will considerably advance First Nations health services. eHealth can advance these efforts in the technical (systems) and policy (privacy-security-data sharing) domains.
5. **Connectivity & Infrastructure** – foundational Health Centre infrastructure is essential for Health Centres to continue to improve their effectiveness and efficiency. This includes basic organizational information management / information technology (IM/IT) capacity in terms of local networks and maintained systems and workstations etc. For many First Nations communities it also includes establishing sufficient broadband connectivity required to enable such things as telehealth and secure information management across organizations / jurisdictions.
6. **Service Referrals** – development and improvement in the area of continuity of care across providers is an area of importance that eHealth is seen as able to make an important contribution. In particular it could assist in reducing the difficulties and inefficiencies encountered by Health Centres when referring clients to external service providers, both in terms of making referrals and receiving appropriate status or follow-up information.

Other important aspects of moving eHealth development forward that have been identified by Health Centres include: sufficient operational resources at the Health Centre level; facilitation of broad skill development within Health Centres; the importance of cultural competency/safety development within the broader health services; and the ongoing challenge of recruitment and retention faced by Health Centres.

Tripartite change efforts occurring under this action item have been significant over this time period, and eHealth generally is playing an increasingly important role in contributing to the system changes that are required to continue to move tripartite efforts in First Nations health forward.

7.6 Research and Performance Measurement

Research and Performance Measurement		
TCA: FNHP	Action 27	Provincial Health Officer will issue Aboriginal health status reports every five years with interim updates every two years
TCA: FNHP	Action 28	Review the Tripartite agreement to ensure First Nations information is shared
TCA: FNHP	Action 29	Expand the community health survey to include First Nations
TFNHP	-	Develop indicators to complement the 7 existing indicators in the TCA: FNHP
TCA: FNHP	Action 6	Develop a Reciprocal Accountability framework to address gaps in health services for FNs

Regional Health Survey (RHS)

The First Nations Regional Longitudinal Health Survey (RHS) is the only First Nations governed national health survey in Canada. It is longitudinal in nature and collects information based on both western and traditional understandings of health and well-being. The first RHS took place in 1997 and involved First Nations and Inuit from across Canada. At the time, reliable information on the health and well-being of First Nations and Inuit was severely lacking due to the exclusion of First Nations and Inuit from major national health surveys.

RHS headquarters is located at the Assembly of First Nations in Ottawa who coordinates the RHS on a national level. The national offices activities include preparing reports, serving as the data steward, and engaging in partnerships. In addition, ten independent RHS regional partners coordinate the RHS in their respective regions. In the BC Region, the First Nations Health Council acts as the AFN's partner for RHS. The national team and regional partners collaborate on collective issues as well as share ideas and knowledge. The RHS national team is mandated and authorized to report on national level statistics; they cannot provide or report on regional level statistics. Each region is completely independent and are responsible for their own respective databases and reporting.

The Assembly of First Nations (AFN) Chiefs Committee on Health (CCOH) appointed the First Nations Information Governance Committee (FNIGC) to provide oversight and governance over the RHS. FNIGC membership is derived from the RHS regional partner organizations, and thus, provides a solid regional and community based foundation for governance. The First Nations Health Council has a representative on the FNIGC. The First Nations Information Governance Committee (FNIGC) and the RHS is funded by the First Nations Inuit Health Branch (FNIHB) of Health Canada.

7

Transforming the System through Health Actions

In 2008 FNHC rolled out Regional Health Survey in British Columbia. The RHS Coordinator and assistants lead the work for the FNHC. Thirty eight (38) BC First Nations communities were chosen randomly to participate in the RHS along with the original 2002-2003 39 First Nations communities in BC (known as the 'core sample'). This brought the total to 77 First Nations communities who were intended to participate in the 2008 First Nations Regional Longitudinal Health Survey.



The next steps included recruiting the selected 77 First Nations communities followed by the posting, hiring and training of the RHS data collectors. The FNHC worked collaboratively with the selected First Nations communities in the hiring of data collectors (or 'data warriors'). These data warriors were exclusively selected from participating RHS First Nations communities.

By October 2008, 75% of the 'Core Sample' communities had signed the First Nations Regional Longitudinal Health Survey (RHS) consent forms and returned them to the FNHC. This was sufficient for the FNHC to launch the official RHS survey. Of the 38 First Nations core sample communities, 4 First Nations communities

opted not to participate in the 2008 RHS Phase. Data collectors (warriors) were hired and trained by the First Nations Health Council at no cost to the participating First Nations RHS community. Overall, 7400 Regional Health Surveys were targeted to be completed in total in comparison to the 1,944 Regional Health Surveys completed in the 2002/2003 RHS Phase. This was almost 4 times the amount of survey respondents for 2008 Regional Health Survey.

Both Canada and BC have Privacy Acts that are general and delegate the protection of information to the organization housing the data. A part of the First Nation Health Council's role is to create some rules around individual and community information, how to keep it secure, how to ensure that people's rights are being protected.

- RHS had a table at the 'Gathering Wisdom for a Shared Journey' Forum in November 2009 where they met Elders, Health Directors, Chiefs, and various community members that showed an interest in the RHS. The data collection was completed by March 2010. In 2010-2011 the data will be written up into a formal report for the BC region and released to communities once completed.

Tripartite Data Quality and Sharing Agreement

FNHC has negotiated a Tripartite Data Sharing Agreement with both BC and Canada to:

- Improve the quality of First Nations data,
- Facilitate data sharing, and
- Ensure that federally and provincially held information on First Nations is properly used and shared.

Put simply, such an agreement would allow for First Nation individuals health information to be shared between the federal, provincial, and First Nations governments. The rationale behind this is to improve health service delivery to First Nations by housing accurate and up to date information. Currently, the three parties have reached a draft agreement and each has sent it for legal review.

Each party have different priorities behind wanting increased access to data. For First Nations, access to their own data is paramount, along with the understanding and support of both governments to build the capacity of First Nations to implement the principles of OCAP. A huge driver behind this initiative is the governance aspect because research drives policy development. First Nations need to be armed with accurate information to effectively plan and implement programs and services at a community level.

An important function of the Tripartite Data Quality and Sharing Working Group is to develop templates for ethics review boards at provincial, regional and community levels, and to provide a legal perspective on research policy. Both Canada and BC have Privacy Acts that are general and delegate the protection of information to the organization housing the data. A part of the First Nation Health Council's role is to create some rules around individual and community information, how to keep it secure, how to ensure that people's rights are being protected.

The First Nations Regional Longitudinal Health Survey
Our Voice, Our Survey, Our Future!

Background
 The First Nations Regional Longitudinal Health Survey (RHS) is a unique national survey of Indigenous people from around the world. The 2002/03 RHS was unique in First Nations ownership of the research process, its explicit incorporation of First Nations values into the research design and in the intensive collaboration and engagement of First Nations people and their representatives at each state of the research process.
 (Harvard University Review)

**Ownership
 Control
 Access
 Possession**

It is acknowledged and respected that the right of self-determination of the First Nations and Inuit Peoples includes the jurisdiction to make decisions about research in their communities. Research should facilitate the First Nations communities in learning more about the health and well-being of their Peoples, taking control and management of their health information and assist in the promotion of healthy lifestyles, practices and effective program planning.
 (CIBC First Nations Bank)

We respect your privacy...

Personal & Community Well-being
 Demographics
 Income, Employment & Education
 Housing & Living Conditions
 Health Care Access
 Personal Wellness
 Residential Schools
 Language & Culture
 Community Wellness

Physical Health & Activity
 Health Conditions
 Chronic Diseases
 Injuries
 Activity Limitations
 Smoking
 Alcohol & Drugs
 Nutrition & Exercise
 Sexual Health Practices

FREQUENTLY ASKED QUESTIONS

“We need to teach children how to be healthy in mind, body and spirit and to look after mother earth as in return she will look after us. The spirit is the whole base of our life. Take care of our spirit and teach our children how to respect that. We all have the power to self-heal as we lived for thousands of years; the culture has been in us for thousands of years. It takes care of us. We are all medicine to one another.”
 (Lillian Savish-McIntyre)

8

Financial Report



8. FINANCIAL REPORT

Background

The funds of the First Nations Health Council, since inception of the Council, have been managed by the First Nations Summit and are therefore part of the Summit's financial system and audit processes.

On March 7, 2008, the First Nations Chiefs' Health Committee (FNCHC) was dissolved through resolution of the First Nation Summit Chiefs, with all FNCHC staff and resources being relocated under the First Nations Health Council umbrella.

Effective April 1, 2008, the former Chiefs' Health Committee became the administrative centre for the First Nations Health Council. As a result of this transition, the 2008/2009 financial statements include both the First Nations Health Council and Chiefs' Health Committee statements to show the winding down of the Chiefs' Health Committee affairs and the transfer of resources to the First Nations Health Council.

Included is the financial report for the First Nations Health Council's funding and expenditure for the years ending March 2008 and March 2009 from the First Nations Summit. These reports do not adequately reflect how the FNHC has managed or distributed the funding it has received and we have therefore included an analysis of the funding income and expenditures in categories that are more meaningful and aligned with the activities documented in this Year in Review.

Audit and Financial Report 1 April 2007 to 31 March 2008

FNHC - FINANCIAL REPORT FOR YEAR 2007-2008

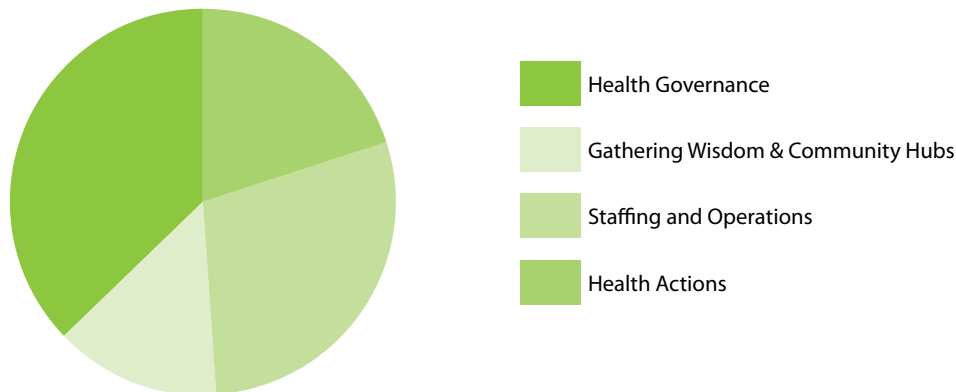
ITEM		AMOUNT
REVENUES		
Province of BC	\$9,500,000	
Health Canada – FNIH	\$5,000,000	
Other	\$344,492	
TOTAL REVENUES		\$14,844,492
EXPENDITURES		
Operating costs First Nations Health Council	\$249,184	
Health Actions expenditure	\$176,543	
Governance expenditure	\$318,078	
First Nations community support (HUBs, Gathering Wisdom etc)	\$117,924	
TOTAL EXPENDITURES		\$861,729
NET SURPLUS FOR 2007-2008		\$13,982,763

All figures have been confirmed against First Nations Summit Audit report for the items within the FNS ledger which belong to the First Nations Health Council.

- 0% of our expenditure was program-related
- 20% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 29% of our expenditure was allocated to operating the FN Health Council and staffing, along with operating costs
- 14% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 37% of our expenditure was allocated to governance work

In total – around 71% of our expenditure has been on direct costs associated with capacity development with First Nations communities and just under ¼ of expenditure on maintaining the FNHC and its operations to undertake the work needed to progress this work.

FIGURE 8.0- 2007-2008 EXPENDITURES



Audit and Financial Report 1 April 2008 to 31 March 2009

During 2008/2009, the FNHC operated only with the security of knowing it had a 4 year Funding Agreement with the Federal Government – but without any similar assurances from the Provincial Government whose funding has been inconsistent and without a long-term commitment.

The funding agreement with the Federal Government commits funding amounting to \$29M from 2007/08 to 2010/11 (\$5M in 2007/2008, \$6M in 2008/2009, \$8M in 2009/2010 and \$10M in 2010/2011). As of March 31, 2009, the Federal Government owed the First Nations Health Council \$454,545 from 2007/2008 and \$4.5M from 2008/2009 (These outstanding amounts were paid in 2009/2010).

In only its second year of operation, the uncertainty and inconsistency of funding from the Federal and Provincial Governments to support the Tripartite First Nation Health Plan (TFNHP) it a significant challenge for the First Nation Health Council. In order to address this reality, the First Nation Health Council must balance investment into implementing the TFNHP with the need to ensure the Council's continued financial sustainability until long-term federal and provincial funding can be secured.

In the year ended 31 March 2009, the FNHC spent a total of \$9,998,262 on the TFNHP as follows:

\$2,225,682	Operational costs of the FNHC, including personnel
\$2,460,102	Health Actions related work
\$986,399	Governance related work
\$1,511,101	First Nation community support related work
\$2,814,978	Program Funding and Initiatives

8

Financial Report

FNHC - FINANCIAL REPORT FOR YEAR 2008-2009

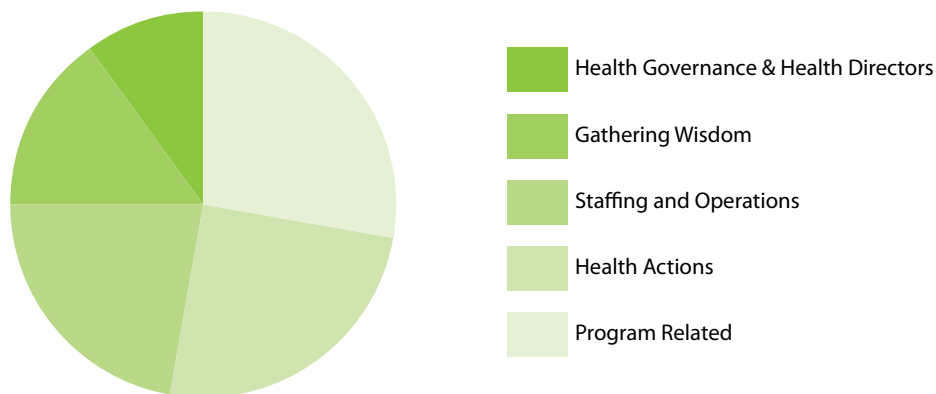
ITEM	Sub-total	AMOUNT
REVENUES		
Carry-over from 2007-2008	\$13,982,763	
Province of BC	\$6,000,000	
Health Canada – FNIH	\$6,000,000	
Other	\$5,836,843	
Interest income	\$550,572	
TOTAL REVENUES & CARRY-OVER		\$32,370,178
EXPENDITURES		
Operating costs First Nations Health Council		
General administration / staff	\$2,113,260	
Communications	\$112,422	\$2,225,682
Health Actions expenditure		
FN Communities: Sharing our Strength grants	\$871,084	
Maternal and child health initiatives including Committee	\$192,338	
Best or Better Practices initiatives	\$122,546	
Health promotion projects	\$575,955	
HIV/AIDs Committee	\$2,700	
eHealth initiatives and Committee	\$655,858	
Performance Tracking R&D	\$39,621	\$2,460,102
Governance expenditure		
General & Administration	\$466,641	
First Nations Health Council	\$92,057	
Health Directors Association	\$121,534	
FNIHGC	\$77,788	
Northern region – Caucus development	\$71,541	
Interior region – Caucus development	\$42,587	
Vancouver Island region – Caucus development	\$112,119	
Fraser region – Caucus development	\$0	
Vancouver Coastal – Caucus development	\$2,132	\$986,399
First Nations Community Support		
Community Engagement Hubs & community engagement	\$1,360,138	
Gathering Wisdom May 2008	\$150,963	\$1,511,101
Program Funding and Initiatives		
Health initiatives administration	\$345,290	
AHHRI / Health Careers initiatives	\$727,539	
Aboriginal Health Transition Fund	\$100,000	
Chronic Disease and Act Now initiatives	\$925,476	
IRS Apology & AFN Community gathering	\$163,699	
NNADAP	\$89,647	
Regional Health Survey	\$306,599	
Health Advocate and costs	\$156,728	\$2,814,978
TOTAL EXPENDITURES		\$9,998,262
TOTAL SURPLUS TO 31 MARCH 2009		\$22,371,916

The financial report for 2008-2009 reveals that:

- 28% of our expenditure was program-related
- 25% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 22% of our expenditure was allocated to operating the FN Health Council and staffing, along with operating costs
- 15% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 10% of our expenditure was allocated to governance work including the Health Directors Association and FNIHGC / Regional caucus costs

In total – around 78% or just over $\frac{3}{4}$ of our expenditure has been on direct costs associated with capacity development with First Nations communities and just under $\frac{1}{4}$ of expenditure on maintaining the FNHC and its operations to undertake the work needed to progress this work.

FIGURE 8.1- 2008-2009 EXPENDITURES



Audit and Financial Report 1 April 2009 to 31 March 2010

2009-2010 was the first year of operation for the First Nation Health Society (FNHS). In prior years, work had been undertaken by the FNHC through the administrative support of the First Nation Summit. As of April 1, 2009, operations of the FNHS began.

During the 2009-2010 fiscal year funding certainty and funding consistency continued to be an issue with the FNHS operated only with the security of knowing it had a 4 year Funding Agreement with the Federal Government, scheduled to conclude in 2010/2011 and without any similar assurances from the Provincial Government whose funding has been inconsistent and without a long-term commitment. In 2009-2010 the Federal Government paid the FNHS funds owed from prior years, but were unable to resource amounts owed for 2009-2010 until after year end.

The funding agreement with the Federal Government commits funding amounting to \$29M from 2007/08 to 2010/11 (\$5M in 2007-2008, \$6M in 2008-2009, \$8M in 2009-2010 and \$10M in 2010-2011). As of March 31, 2010, the Federal Government owed the First Nations Health Council \$8,000,000 from 2009-2010 (These outstanding amounts were paid in early 2010-2011.).

FNHC - FINANCIAL REPORT FOR YEAR 2009 – 2010

ITEM	Sub-total	AMOUNT
REVENUES		
Carry-over from 2008-2009	\$22,371,916	
Health Canada – FNIH	\$10,454,273	
Others	\$1,377,242	
Interest income	\$39,590	
TOTAL REVENUES & CARRY-OVER		\$34,243,021
EXPENDITURES		
Operating costs First Nations Health Council		
General administration / staff	\$1,993,002	
Communications	\$67,492	\$2,060,494
Health Actions expenditure		
Mental Wellness	\$1,692,892	
Maternal and child health initiatives including Committee	\$276,546	
Health Professionals	\$86,952	
Health promotion projects	\$116,606	
HIV/AIDs Committee	\$100,430	
eHealth initiatives and Committee	\$859,967	
Performance Tracking R&D	\$93,439	\$3,226,832
Governance expenditure		
First Nations Health Council	\$110,185	
Native and Inuit Nurses Association of BC	\$22,500	
Health Directors Association	\$50,542	
General administration	\$840,261	
Northern region – Caucus development	\$179,914	
Interior region – Caucus development	\$136,531	
Vancouver Island region – Caucus development	\$119,511	
Fraser region – Caucus development	\$248	
Vancouver Coastal – Caucus development	\$6,112	
Interim Health Governance Committee	\$76,768	\$1,542,572

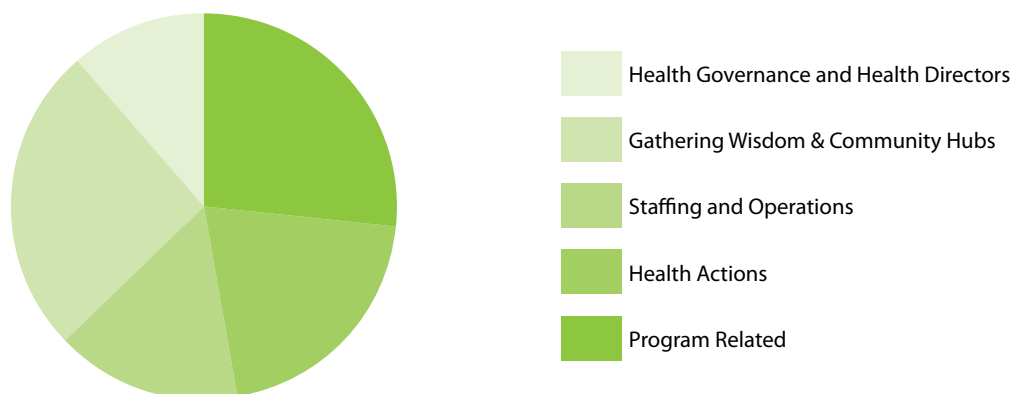
ITEM	Sub-total	AMOUNT
First Nations Community Support		
Community Engagement Hubs & community engagement	\$2,952,645	
Gathering Wisdom November 2009	\$505,184	\$3,457,829
Program Funding and Initiatives		
AHHRI / Health Careers initiatives	\$515,035	
AHHRI / Environmental Scan	\$75,000	
Aboriginal Health Transition Fund	\$100,000	
Chronic Disease and Act Now initiatives	\$987,110	
H1N1	\$289,065	
Aboriginal Diabetes Initiatives	\$348,049	
Aboriginal Health Human Resources	\$307,935	
Regional Health Survey	\$344,632	
Health Policy	\$317,113	
Senior Policy	\$100,000	
Advocacy	\$55,000	
Tripartite office	\$46,915	\$3,485,854
TOTAL EXPENDITURES		\$13,773,581
TOTAL SURPLUS TO 31 MARCH 2010		\$20,469,440

The financial report for 2009-2010 reveals that:

- 26% of our expenditure was program-related
- 23% of our expenditure was allocated to Health Actions with the vast majority of this funding being paid to First Nations communities for community health initiatives
- 15% of our expenditure was allocated to operating the FN Health Council and staffing, along with operating costs
- 25% of our expenditure has been used to sustain community engagement hubs and to pay for the Gathering Wisdom forum
- 11% of our expenditure was allocated to governance work including the Health Directors Association and FNIHGC / Regional caucus costs

In total – around 85% of our expenditure has been on direct costs associated with capacity development with First Nations communities and 15% of expenditures on maintaining the FNHC and its operations to undertake the work needed to progress this work.

FIGURE 8.2- 2009-2010 EXPENDITURES





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