The Assembly of First Nations

Wellness Foundational Model

Safe, Secure, Sustainable Communities Unit

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Executive Summary

The Assembly of First Nations (AFN) First Nations Wellness Foundational Model seeks to achieve a number of ambitious tasks. It begins with the recognition that First Nations (w)holistic worldviews and the responsibility to care for one another come from the Creator. Secondly, the Foundational Model articulates that First Nations self-determination over health systems is fundamentally rooted in treaty, inherent and international Indigenous and human rights to health. From this understanding, the model articulates six interrelated pillars fundamental to the functioning of comprehensive, responsive, and culturally rooted First Nations health systems. These pillars stand apart from the functioning of politics or changes in policy and programming by any outside structure including the First Nations and Inuit Health Branch (FNIHB); they are designed to stand the test of time. One step below the Pillars is the Components of Well-being/Systems Strengthening section. Each of the overarching Pillars must be addressed within any work on the more subject-area specific Components found here. Each of these components, in turn, must be considered in the daily file activities of the AFN’s Safe, Secure, Sustainable Communities (S Unit).

Alongside the model itself themselves, this document articulates the governance structure that guides our efforts on health-related files. This structure identifies where and how direction is provided by communities via regional organizations, the National First Nations Health Technicians Network (NFINHTN), the Chiefs Committee on Health (CCOH), the AFN Executive Committee, the National Chief, and ultimately Chiefs in Assembly.

While this model was generated primarily as a guiding document for the AFN health staff, it may be a resource for First Nations leadership in pursuing their policy objectives and building/supporting their own unique First Nations health systems.

What is Health + What is Wellness?

Though the question over what it is that we mean when we say “health” may seem straightforward, this question has actually formed the core of years of debates between First Nations and governments. As a concept “health” has become intrinsically tied to the dominant Western biomedical model that sees health as simply ‘free from disease’. The consequence for health programming and policy analysis is that policy responses cannot speak to the myriad of determinants of health outcomes that are not strictly biomedical. Thankfully, the dominance of the “health as the absence of physical illness” model is declining in favour of one more closely aligned with First Nations perspectives on health. The goal of this emergent model is one of wellness.
There is not a single definition of wellness, even from within diverse First Nations cultures; however, First Nations worldviews share a common understanding of the interconnectedness between the physical, mental, emotional and spiritual realms. This includes a vast array of health determinants such as environmental health, education, gender, income, meaningful access to culture and land, access to justice, and individual and community self-determination, among others. In addition, First Nations health is profoundly shaped by the context of colonization and the resulting mental and physical dislocation. Perhaps the clearest example of this is the ongoing psychophysical effects of Indian Residential Schools (IRS).

As such, the AFN First Nations Wellness Foundational Model provides a broad framework for understanding and responding to health issues from a wellness perspective, grounded in the collective wisdom of centuries of First Nations knowledge. For a more detailed discussion around the AFN’s work on the determinants of health (DOH) see, “First Nations Wholistic Policy and Planning: A Transitional Document on the Social Determinants of Health” (the Transitional Document). The Transitional Document aligns with the AFN Wellness Foundational Model, but where the Foundational Model provides a high level discussion about how the DOH can be incorporated into the AFN’s work and in First Nations health systems broadly, the Transitional Document goes into much greater detail about the determinants themselves and their relation to health outcomes.

Note

Given the breadth of the topic and its intersectional nature, the AFN First Nations Wellness Foundational Model should not be considered comprehensive. Rather, this work is intended to provide a broad framework that speaks to the complexity of First Nations understandings on health within the contemporary health programming context.

Additionally, it is important to note that the AFN First Nations Wellness Foundational Model is not meant to be a final product. While efforts have been made to develop a document that speaks to long standing and culturally rooted health principles this piece will be treated as a living document.

The Status Quo

Health Outcomes

First Nations health is in profound crisis. By nearly all metrics, a significant gap in health outcomes exists between First Nations and the general Canadian population. We must work to close the gap! For example, First Nations peoples, when compared with the general Canadian population, face much higher rates of chronic and communicable diseases and are exposed to greater health risks because of poor housing, contaminated water and limited access to healthy foods and employment opportunities. Despite gains in life expectancy, the gap with the general population remains, with an average life expectancy of First Nations about 5 to 7 years lower than the non-Aboriginal population. Similarly, infant mortality has shown improvement, but it is still about 1.5 times higher than the general Canadian population, while the First Nations suicide rate is 5 to 6 times higher. These statistics are clearly unacceptable.
The Current System

Health Canada- FNIHB’s stated mandate is to:¹

- ensure the availability of, or access to, health services for First Nations and Inuit communities;
- assist First Nations and Inuit communities address health barriers, disease threats and attain health levels comparable to other Canadians living in similar locations; and,
- build strong partnerships with First Nations and Inuit to improve the health system.

These mandate statements are further bolstered by FNIHB’s Health Strategic Plan that is comprised of four key goals. These goals are:

- the provision of quality health services,
- working collaboratively with partners and stakeholders to achieve our goals,
- providing a supportive work environment, and
- continually improving performance and efficiencies.²

The current FNIHB compliment of programs include those focused on health promotion and disease prevention, primary care, public health protection, primary care, health systems capacity, health system transformation and supplementary health benefits (the Non-insured Health Benefits program). These programs are currently delivered using a number of models including direct services from FNIHB and contribution agreements to communities or aggregate groups with varying degrees of flexibility.

Based on health outcomes alone it seems clear that significant investments and program improvements must be made in order to meet FNIHB’s stated objectives. In addition, focus must turn towards developing innovative ways to fundamentally transform health systems from the current paradigm of reactive and disjointed services to one that generates healthy First Nations by supporting the entire spectrum of health determinants. In addition, the persistent poor health outcomes and inadequate health programming for First Nations challenges the federal government’s stated commitment to reconciliation with First Nations. Simply, the principle of reconciliation means very little if First Nations continue to receive inequitable health programs and services.

System Innovations

Despite the shortcomings identified above, significant developments have occurred in the advancement of First Nations control of First Nations health over the last decade. Most notable among these developments is the emergence of the First Nations Health Authority in British Columbia (BC) that began over ten years ago with the signing of the Leadership Accord in 2005 between the three BC First Nations political organizations. Since that time, numerous agreements have been signed articulating the gradual transformation of the relationships between First Nations, the province of BC and the federal government including Transformative Change Accord: First Nations Health Plan (2006), the First Nations

Health Plan Memorandum of Understanding (2006), the Tripartite First Nations Health Plan (2007), the Basis for a Framework Agreement on First Nation Health Governance (2010), the British Columbia Tripartite Framework Agreement on First Nation Health Governance (2011) and the Health Partnership Accord (2012). The development and operationalization of the First Nations Health Authority (FNHA) has been in a phased process. FNHA assumed responsibility for formerly FNIHB programs on October 1, 2013.

Beyond the BC model, tripartite tables in some form are underway in a number of other regions including Saskatchewan, Quebec and Alberta. The pace with which FNIHB regions are working with or even engaging with First Nations on trilateral-type agreements and processes varies significantly. In addition, First Nations regional perspectives are not uniform when it comes to their willingness or ability to engage in these types of discussions based on many factors including regional governance context, the presence of treaties, relationships with FNIHB regions and provinces/territories, and internal capacity to engage. These formalized moves towards greater First Nations control of First Nations health are exciting and are fully supported by the AFN; however, they are certainly not one size fits all. As such, FNIHB must respect the pace set by First Nations themselves in order to achieve success.

**AFN Health Governance**

The AFN First Nations Wellness Foundational Model articulates the governance model followed by the SSSC Unit on issues of health. This governance structure has been designed, despite the challenges of geography and regional variations, to ensure the highest degree of input from regions as well as accountability to leadership.

At an operational level, AFN health staff takes guidance from the NFNHTN and direction from the CCOH and the National Chief/ AFN Executive Committee. The NFNHTN works the closest with AFN staff. This group is comprised of one health technician from each region across the country who in turn takes their direction from First Nations communities themselves, guided by their own regional processes. The NFNHTN meet face-to-face at least 4 times per year and maintains steady contact between these meetings. Additional efforts to include regional input include the consideration of regional health plans and regional resolutions into AFN work.

Recommendations from the NFNHTN are then considered by the CCOH. Similar in structure to the NFNHTN, the CCOH is comprised of a representative Chief from each of the ten regions across the country and is chaired by the AFN Executive Committee member who holds the portfolio for health. Decisions taken at both the NFNHTN and CCOH direct the work of AFN health staff. CCOH subsequently reports back and is accountable to Chiefs in Assembly through the biannual general assembly process.

Further, the AFN SSSC’s activities benefit from the political impact of the National Chief and the AFN Executive Committee to leverage their influence in moving priority issues forward. In addition, it is ultimately Chiefs in Assembly which is the highest level of accountability within the AFN structure.
**The Way Forward**

*Looking Back to Look Forward*

First Nations people and communities have survived and thrived on these lands since time immemorial. Despite the profound impact of colonization in disrupting the knowledge systems that produced physically, emotionally, spiritually and mentally healthy First Nations people, sacred knowledge has survived. First Nations know that the solutions to the persistent health challenges within our communities can be found in the teachings of our ancestors, from the land and from ceremony.

As a national organization aimed at driving and influencing policy at a national level there are inherent limits on the ways in which the AFN can participate in the task of reinvigorating First Nations knowledge systems related to health. We should not and cannot speak for the diverse First Nations cultures from coast to coast. As such, the AFN First Nations Wellness Foundational Model seeks to broadly reflect the wisdom of First Nations worldviews within the contemporary policy context in which we work, and to make space within the policy sphere for First Nations to articulate their own unique worldviews. This is a project of decolonization.

**The AFN First Nations Wellness Foundational Model**

The following illustration presents a visual representation of the AFN First Nations Wellness Foundational Model. It begins with the recognition that First Nations self-determination over health systems is fundamentally rooted in treaty, inherent and international rights to health. It is grounded in the understanding that First Nations cultures have and do generate healthy First Nations people and communities.
From this understanding, the model articulates five interrelated pillars fundamental to the functioning of a comprehensive, responsive and culturally rooted First Nations health system. These pillars stand apart from the functioning of politics or changes in policy and programming by any outside structure including FNIHB. They are Accountability, Culture and (W)holism, First Nations Control, Interjurisdictional Coordination, and Equitable Outcomes.

Drawing from these pillars are the Components of Well-being/Systems Strengthening. Each component comes from, and is responsive to the pillars themselves. Stated simply, in order to be comprehensive, any work on each of the components must consider and incorporate each one of the individual pillars. Unlike the pillars, the components are more fluid depending on particular contexts. The Components of Well-being/Systems Strengthening are Health Governance, Capacity Building, Information and Research Management, Monitoring and Evaluation, Relationship Building, Continuum of Services, and Adequate and Sustainable Fiscal Resources. Each of these components, in turn, must be considered within all of the work undertaken on a day-to-day basis of the AFN’s SSSC Unit.

**Inherent, Treaty and International Human and Indigenous Rights to Health**

As illustrated above, the foundational model roots all First Nations health activities in the fundamental inherent, treaty and international legal right to health enjoyed by First Nations. However,
Canada continues to argue that the provision of health programs and services for First Nations is a matter of policy rather than a legal or moral obligation. This is reflected in the fact that First Nations health programs are not enshrined in legislation, rather they are contingent on the will of the government of the day. However, international human rights law, the Canadian Constitution and treaties between First Nations and the Crown mandate a much more fulsome obligation on the federal government towards First Nations health.

Many Elders have taught that First Nations understandings of wellness, the methods to achieve wellness, and the collective responsibility to care for one another, come from the Creator. These are the foundation of the inherent right of First Nations to First Nations health systems. They are truths that predate the treaties.

**Treaty and Inherent Right to Health**

Similarly, Elders teach us that treaties between First Nations peoples and the Crown are an articulation of the Creator’s gifts and wisdom; they are sacred. In addition, they established legally binding relationships and obligations. In the case of health, treaties both reaffirmed First Nations jurisdiction over their own health care systems and also established a positive obligation on the Crown to provide “medicines and protection.” Federal treaty obligations are found both in the text of the Treaties and the verbal commitments made.

Promises of non-interference were prominent in the negotiations of Treaties 4, 6, 7 and 8; for example:

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

While the most commonly cited reference to the treaty right to health is found in Treaty 6, there is significant evidence demonstrating explicit promises of health provision in numerous treaty negotiations. Yvonne Boyer notes that in “Treaties 6, 8, 9 and 10 in either wording of the treaties or in records of the oral negotiations surrounding treaties. Treaty 7 elders confirm the treaty right to medicines, medical care, and indeed health was negotiated.”

In the 1935 *Dreaver* decision, the federal Court clarified the extent of the medicine chest clause to include “all medicines, drugs, or medical supplies ... to be supplied free of charge to Treaty Indians.” Significantly, this judgement “has not been overruled.” Also significant is that the Supreme Court has ruled that, “any ambiguities about the language in a treaty or the negotiations must be resolved in favour of the Indian signatories. Further, any treaty limitations that restrict the rights of Indian

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4 Ibid., 142.
5 Ibid., 143.
6 Ibid., 147.
7 Ibid., 147.
signatories must be narrowly interpreted.” Stated simply, if there are doubts regarding the obligations found within the Treaties, the court ruled that the Crown must favour a broad understanding of Treaty obligations.

Beyond the Treaty right to health, all First Nations hold an inherent right to health. The Supreme Court has confirmed what First Nations have always known, that Indigenous peoples hold a set of unique rights based on their existence before contact with Europeans. Boyer notes:

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

When it comes to health, these inherent rights are predicated on the fact that pre-contact First Nations practiced complex and diverse health and wellness activities. Therefore, First Nations maintain the right of self-determination over their health practices and systems.

**International Indigenous and Human Rights to Health**

**United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)**

Further bolstering the First Nations right to health and to self-determination in health are a number of international obligations grounded in human and Indigenous rights. Perhaps most notable among these is the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) adopted by the United Nations (UN) General Assembly on September 13, 2007. At that time, Canada, along with the United States, Australia and New Zealand voted against the Declaration. Finally, on November 12, 2010, the Government of Canada issued a statement in support of the Declaration.

As UNDRIP is a declaration rather than a convention, Canada, under Prime Minister Stephen Harper, is quick to call it “aspirational” and to point out that declarations are not legally binding. However, UNDRIP remains a strong advocacy instrument in demanding and protecting Indigenous rights, including the right to health and wellness. Further, domestic courts are free to rely on declarations in making their determinations. In addition, UNDRIP is, in large part, built upon on principles found in legally enforceable conventions and international treaties including the International Covenant on Economic, Social and Cultural Rights.

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9 Ibid., pg. 8
10 Conventions such as the UN Convention on the Rights of the Child are legally binding under international law; however, declarations such as UNDRIP are not directly legally-binding. Rather their weight is felt primarily as political instruments.
11 The new Liberal government has committed to UNDRIP implementation; however, in these early days of the new government, the promise of UNDRIP remains unfulfilled.
UNDRIP is comprised of 46 articles which describe specific rights held by Indigenous peoples and state obligations to protect those rights. Included is a number of articles that have profound implications for health and health programming. Chief among them is Article 18 which states:

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

In addition, Article 19 demands that governments:

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

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

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

Other International Mechanisms

In addition to UNDRIP First Nations maintain a human right to health, as do all Canadian citizens, based on Canada international commitments including the Universal Declaration of Human Rights (Article 25), the International Covenant on Economic, Social and Cultural Rights (Article 12), the Convention on the Rights of the Child (Article 24), the Convention on the Elimination of All Forms of Racial Discrimination (Article 5), the Convention on the Elimination of All Forms of Discrimination against Women (Articles 12 and 14), and the Convention on the Rights of Persons with Disabilities (Article 25).

In 2000, the UN Committee on Economic, Social and Cultural Rights issued a General Comment on the Right to Health in order to clarify the obligations to health found within the International Covenant on Economic, Social and Cultural Rights (ICESCR). The General Comment articulates the four elements of the right to health. These are availability, accessibility, acceptability, and quality. In meeting these elements, the ICESCR “imposes on State parties three types of obligations:

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

In addition, the General Comment advised on the minimum level of State obligations in the fulfillment of the Right to Health in what it called the Core Content. The Core Content includes essential primary health care, minimum essential and nutritious food, sanitation, safe and potable water, and essential drugs. In addition, it also obligates States to the development and implementation of a national public health strategy and plan of action.\textsuperscript{13}

\textit{Self-Determination}

Originating from the Creator and bolstered by the inherent, treaty and international rights to health is the principle of self-determination. To reflect its importance, the model identifies self-determination as a foundational principle from which the pillars of the plan derive. Simply, all work starts with an understanding of and belief in the principle that First Nations, individually and collectively, have both the right and the responsibility to determine their own politics, governance, relationships to the natural world, languages, education, and health systems, among others.\textsuperscript{14}

\textbf{Pillars of Effective First Nations Health Systems}

The plan identifies five pillars which undergird responsible and effective First Nations health systems. These are:

- Accountability
- First Nations Control
- Culture and (W)holism
- Interjurisdictional Coordination
- Equitable Outcomes

These pillars stand apart from the functioning of politics or changes in policy and programming by any outside structure including FNIHB. These pillars are designed to stand the test of time. Below is a brief description of each pillar in order to demonstrate its importance to the overall vision.

\textbf{Accountability}

First Nations organizations and communities must demonstrate accountability to First Nations citizens themselves. Similarly, the AFN SSSC Unit remains accountable to our own internal governance structure that includes the NFNHTN, the CCOH, the National Chief/AFN Executive Committee and ultimately to Chiefs in Assembly.

As previously noted, the federal government holds a fiduciary obligation to First Nations. In addition, FNIHB, the federal department tasked with First Nations health, is accountable to its own Strategic Plan and stated mandate including improving health outcomes for First Nations. In addition, FNIHB must demonstrate accountability in policy and programming to the First Nations which they serve.

\textsuperscript{13} Ibid.
\textsuperscript{14} Self-determination is often incorrectly conflated with self-government. It is important to note that self-governance is a political manifestation of the principle of self-determination.
These layers of accountability can properly be described as ‘reciprocal accountability’. This concept refers to the responsibility of each partner to ensure shared objectives are achieved. Trust and respect must run both ways aided by clear roles and responsibilities. Significantly, this concept takes into account the asymmetrical relationship of power that may be at play, including the power imbalance currently manifested in Crown/First Nations relationships.

First Nations Control

Very simply, First Nations have the right and responsibility, whether through domestic and international law and Treaties, to freely determine their own political status and freely pursue their economic, social and cultural development – and the right to maintain and strengthen their own distinct political, legal, economic, social, and cultural institutions. First Nations have the right and responsibility to drive health programming for First Nations people. This is incontrovertible. All work undertaken by the AFN on health must be founded on this fundamental premise.

Culture and (W)holism

Culture remains the bedrock of wellness for First Nations people. Access to culture, teachings, Elders, the land, medicines, and cultural self-esteem profoundly impact individual and community health. While First Nations cultures are diverse, what connects them is an understanding of wellness that is (w)holistic.

In contrast to the Western biomedical model, a (w)holistic view of wellness includes the understanding that individual and community health requires mental, physical, spiritual, and emotional wellness. This pillar requires that we account for the full spectrum of determinants of health including environmental health, education, gender, income, meaningful access to culture and land, access to justice, and individual and community self-determination, among others.

It is worth expanding on the notion of the centrality of land in a First Nations view of wellness. This is not empty rhetoric. The land is the very source of First Nations cultures, languages, spirituality and identity. The land provides healthy foods, shelter, medicines, and is the backdrop for intergenerational knowledge transmission (education). Therefore, economic development, resource extraction, treaty negotiations or any activities that may impact access to land for First Nations people are “health and wellness” issues.

Interjurisdictional Coordination

Today, most health systems for First Nations cannot truthfully be called “systems” at all. Rather, healthcare for First Nations is more accurately described as a patchwork that includes multiple federal departments such as FNIHB and Indigenous and Northern Affairs Canada (INAC) - formerly Aboriginal Affairs and Northern Development- provincial/territorial governments, and even sometimes inter-provincial/territorial health authorities. In addition, whether funded or not, First Nations practice health care provision at the community level through traditional medicine and cultural/spiritual practices, among others. First Nations residing North of 60 face unique challenges caused by multiple levels of jurisdictions.
A very high profile example of the failure of interjurisdictional coordination is that of Jordan River Anderson. The struggle of his family and community led to the development of Jordan’s Principle.\textsuperscript{15} His tragic life demonstrates the centrality of the principle of Interjurisdictional Coordination to the work of the AFN SSSC health unit.\textsuperscript{16}

Jurisdictional Coordination may be best served by First Nations working with federal and provincial/territorial governments towards a shared goal of First Nations control of First Nations health. This may require a piecemeal process where jurisdiction, responsibilities and authorities slowly shift to First Nations. Most regions are pursuing these objectives to some degree however it is fundamental to acknowledge that this process will look different in each region based on regional needs and realities, including existing relationships and governance structures. These processes will be determined by First Nations communities and regions themselves and therefore the role of the AFN is to support regions in this task.

Equitable Outcomes

There is ample evidence demonstrating the disproportionately poor health outcomes of First Nations people. In the face of these poor health outcomes, the federal government has continued to fund First Nations health programs at a level below that provided to the provinces and territories. This is an injustice of the first order.

In response, First Nations communities, tribal councils, provincial/territorial organizations and indeed the AFN have long fought for the provision of equitable funding. While equitable funding is certainly a laudable goal, the fact is that First Nations health outcomes are so challenging, that they actually require additional investments over and above those provided to mainstream systems. As such, this model posits Equitable Outcomes as a foundational pillar of effective First Nations health systems.

Components of Well-being/ Systems Strengthening

Flowing from these pillars are eight key principles termed Components of Well-being/Systems Strengthening. These are:

- Health Governance
- Capacity Building
- Information and Research Management
- Monitoring and Evaluation

\textsuperscript{15} Jordan’s Principle is a ‘child first’ principle that calls on the government of first contact to pay for health and social services for the child and seek reimbursement later. This ensures that the child’s access to services is not unnecessarily delayed due to jurisdictional disputes. On December 12, 2007, Members of Parliament in the House of Commons voted unanimously in support of Jordan’s Principle. Sadly, the implementation of Jordan’s Principle by the provinces and the federal government remains unsatisfactory.

\textsuperscript{16} This principle was formerly often termed “integration” however, more recently a shift away from that terminology has occurred given the close connection between the terms “integration” and the concept of “assimilation” particularly where integration is undertaken within relationships of enormous power inequity (such as First Nations health and provincial/territorial/federal relationships).
Collectively these principles work together to form a comprehensive and responsive First Nations health system. Policy staff must consider each of these principles on every single file they are responsible for within their daily work. Unlike the pillars, the Components of Well-being/Systems Strengthening may change if the context of systems changes.

For the sake of clarity and comprehensiveness, each of these areas of work is identified separately; however, it must be noted that practically speaking, none of these areas of work are ever stand alone. Rather, (w)holistic First Nations perspectives teach that each area is constantly informing and intersecting one another.

**Health Governance**

As the preceding analysis indicates, First Nations have the moral and legal authority to determine their own health priorities and programs. Similarly, the federal government and other jurisdictions have a corresponding moral and legal authority to support the development of governance institutions related to health self-determination. All policies developed by the jurisdictions must begin by recognizing these key facts, as a starting point.

Recognizing and respecting First Nations health governance requires governments and partners to respect the internal processes of First Nations organizations (national, regional and community-level). In addition, it means that government partners and stakeholders must fully and meaningfully engage with First Nations on all policies related to First Nations health and wellness. Meaningful engagement requires responsiveness to First Nations concerns.

At the community level, health governance involves developing and supporting systems and policies that ensure effective programming and demonstrate accountability to the community itself.

**Capacity Building**

The First Nations health workforce must be competent, knowledgeable, appropriately educated, and adequately resourced. Investments are required in cultural competency, accreditation of First Nations training institutions, partnership development, academic standards, new education opportunities including innovative approaches to providing community-based training offering minimum relocation or disruption to the student, school counseling, and replacements to fill positions while incumbents are taking training.

There is also a profound need to ensure First Nations have the necessary capacity when it comes to technology, governance, financial, among others. In fact, achieving wellness requires equitable capacity for First Nations in all determinants of health including infrastructure, community safety and the transmission of language and culture, among many others.
Information and Research Management

First Nations perspectives must be considered in the various initiatives combining to create the national health infrastructure including broadband connectivity, telehealth, common standards, interoperability, and health indicator identification. These systems must be driven by the needs of individual First Nations community health systems and of First Nations authorities/organizations.

Related to health infrastructure is ensuring First Nations have the capacity to manage, house and direct their own data and research in line with the First Nations own ethical obligations. This may include supporting and adherence to the OCAP® principles of Ownership, Control, Access, and Possession.

Monitoring and Evaluation

Effective health programs and systems require monitoring and evaluation. First Nations have many negative experiences with governments engaging in monitoring and evaluation processes without adequate consultation, engagement and input from First Nations and for self-serving needs. These bad experiences, however, do not undermine the very real need for responsible monitoring and evaluation that is led and directed by First Nations and serves First Nations needs aimed at effective policy and programming improvements.

Relationship Building

The (w)holistic nature of First Nations health and the numerous jurisdictions with some level of responsibility to First Nations health requires relationship building. Primarily this refers to building relationships with provincial and territorial governments, as well as the federal government. This must include all ministries and departments within the respective jurisdictions that have responsibilities to First Nations generally, and First Nations health specifically. Focus must be on developing positive working relationships with each of these responsible parties.

Finally, advocacy efforts are strengthened by creating both formal and informal partnerships with allied non-governmental organizations (NGOs) in order to strengthen our collective voice. Again, with a view towards wellness, this includes relationship building with a broad spectrum of groups including those related to housing, infrastructure, justice, water, education, language and culture and youth programming.

Continuum of Services

Based on insights provided by the pillar of (W)holism, First Nations health systems must work to break down the artificial barriers between file work, programs and departments. These structural barriers ultimately manifest in material barriers in service to First Nations citizens.

The principle of Continuum of Services demands the provision of services in a way that actually reflects the lived realities of First Nations individuals seeking care; that is, supporting the development of programs and services that provide uninterrupted care across the lifespan, across health needs and across the determinants of health. This includes preventative care to acute care, and from maternal
health to palliative care. Further, this concept connects determinants of health such as housing, water and food security, among others.  

**Adequate and Sustainable Fiscal Resources**

As previously discussed in the Equitable Outcomes pillar, effective and responsible First Nations health systems require adequate and sustainable fiscal resources.

Sustainable programs require a funding system that factors in health demographics and need, has established equity in core programs and services among communities and acknowledges existing and/or required capacity. A funding process that is aimed at achieving better outcomes must be grounded in community-based realities – both population need and community resources/infrastructure, and ideally, in the context of modern provincial and territorial health service delivery. It should also adequately support a management and delivery system based on First Nations control. Further, funding must include an annual escalator accounting for population growth, inflation and aging, indexed to match per capita provincial/territorial health enrichment adjusted for higher First Nations need.

**Traditional Knowledge**

The principle of Traditional Knowledge recognizes the need for First Nations health systems to reflect First Nations culture(s) and support traditional knowledge related to health and wellness.

The fact is that First Nations peoples lived and flourished in these territories for thousands of years before contact. Despite colonization, the knowledge that allowed First Nations peoples to survive and thrive has not been lost. However, Western medicine and bureaucracies have historically been hesitant to acknowledge the legitimacy of traditional knowledge and medicine as a wellness method. The AFN First Nations Health Foundational Model recognizes the need to support cultural practices and traditional knowledge in any and all activities.

The AFN First Nations Health Foundational Model, notes that the daily work of the AFN on health and wellness files flows directly from the Components of Well-being/Systems Strengthening. For the purpose of this project, naming the individual files is not necessary for a number of reasons. First, identifying files specifically risks reifying the kinds of silos the AFN has been working to dismantle. In addition, the purpose of the Foundational Model is to articulate the systemic principles that must be addressed in all file areas. Finally, this document was created to remain relevant regardless of political changes both within First Nations and mainstream politics or programming changes at FNIHB.

What is worth repeating is that File Priority Areas are determined by the NFNHTN, the CCOH, the National Chief/AFN Executive Committee and ultimately Chiefs in Assembly.

**Conclusion**

17 ‘Continuum of Services’ is clearly very closely related and cannot be unlinked from the principle of ‘Interjurisdictional Coordination.’
First Nations continue to suffer poor health that has reached crisis levels. Clearly, current programs and services are failing. The AFN, and indeed all First Nations, envision First Nations living happier, longer and healthier lives. With this in mind, the AFN First Nations Health Foundational Model was developed with the ambitious goal of:

- Providing a model which articulates the sources of First Nations Right to health and the First Nations Right of self-determination over First Nations health systems;
- Articulating five interrelated pillars fundamental to the functioning of a comprehensive, responsive and culturally rooted First Nations health system;
- Identifying eight Components of Well-being/Systems Strengthening which build on the pillars;
- Demonstrating how both the pillars and the Components of Well-being/Systems Strengthening inform the daily activities within the AFN SSC Unit; and,
- Mapping health governance within the AFN, demonstrating the multiple levels of accountability.

Collectively, these tasks were designed to guide the way towards closing the gap in First Nations health outcomes. Undertaking a dedicated effort to closing the gap for First Nations is a responsibility of us all; the AFN as an organization, First Nations leadership and communities, provinces/territories, the federal government, and indeed all Canadians, in the interest of equity and justice.
Appendix A

As articulated above, the Foundational Plan is a stand-alone document meant primarily to guide the work of AFN health staff. However, AFN health staff is also responsible to a five-year workplan as part of a five-year contribution agreement with FNHB. The activities within the five-year workplan are rooted in the principles and pillars found within the Foundational model. The workplan also contains specific benchmarks to measure progress in achieving these goals. These benchmarks may be useful in providing a more concrete understanding of the high level principles found within the Foundational Plan.

Assembly of First Nations Multi-year Workplan (2014 – 2019) for the Flexible/Set Funding Models

**GOAL:** Increased opportunities for First Nations to participate in and influence national health policy, health systems and program development in all health related areas.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Core Activities</th>
<th>Outcome Measures</th>
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<tbody>
<tr>
<td>1.1 Pursue coordinated First Nations health system that ensures access to quality continuum of health care services that improves health outcomes regardless of residence.</td>
<td>1.1 Work to eliminate barriers and support improved coordination of service delivery across jurisdictions to create an environment for change where First Nations can achieve improved health outcomes.</td>
<td><strong>Stakeholders have the tools and the opportunities to better address First Nations’ health needs and priorities.</strong> The AFN provides input into a strategic direction for addressing First Nations’ health needs and priorities so that issues can be moved forward. This is achieved through the AFN and stakeholders having relevant tools to advocate and inform policy (for example: strategies, frameworks, information, cultural competency), as well as the opportunity to do so through forums (for example: meetings, working groups, task forces, agreements and memorandum of understandings).</td>
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<tr>
<td>1.2 Develop and provide policy advice and analysis on strategies and initiatives relating to First Nations health initiatives, needs and</td>
<td>1.2 Provide input into strategic approaches to address policy and program issues including program renewal processes.</td>
<td><strong>Policies, strategies and initiatives address First Nations’ needs and</strong></td>
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<tr>
<td></td>
<td>1.3 Provide policy advice, analysis, support and recommendations to various</td>
<td></td>
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</table>
1. Identify gaps in current health policies and systems and promote and influence change at all levels in First Nation health.

2. Create linkages, where appropriate, with regional, national programs and organizations to optimize First Nations participation in, and benefit from, health programs.

3. Develop approaches to bring a First Nations perspective to influence national policy.

4. Promote and facilitate increased expertise and capacity in First Nations communities to deliver, design, and/or implement comprehensive First Nations centred health programming.

5. Provide cultural safety and cultural awareness perspectives.

6. The AFN has effective partnerships with stakeholder groups.

7. The AFN contributes to facilitating interactions among stakeholders (community, regional, F/P/T, international) so that stakeholders with shared responsibilities can be identified and work together on similar issues/concerns. This is done by connecting and liaising with stakeholders, and ensuring that stakeholders have an opportunity to advocate and support First Nations’ interests in health. In doing so, it is expected that polices, strategies and initiatives will address First Nations’ health needs and priorities.
<table>
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<tr>
<th>2. Participate in, or create various stakeholder meetings in areas of health.</th>
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<tr>
<td>2.3 Participate in working group meetings and conference calls, provide feedback into draft documents, and provide guidance as required.</td>
</tr>
<tr>
<td>The AFN contributes to stakeholders having the information and support to advocate First Nations’ interests in health.</td>
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</table>

- **A systematic, single-voice/coordinated approach to supporting and advocating First Nations’ interests in health is in place.**

The AFN contributes to facilitating interactions among stakeholders (community, regional, F/P/T, international) so that stakeholders with shared responsibilities can be identified and work together on similar issues/concerns. This is done by connecting and liaising with stakeholders, and ensuring that stakeholders have an opportunity to advocate and support First Nations’ interests in health.

<table>
<thead>
<tr>
<th>3. Develop First Nations awareness, expertise and build capacity on health matters.</th>
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<tr>
<td>3.1 Develop current and relevant health information that is culturally appropriate for the public including; background papers, fact sheets, discussion journals, and other public education materials as required.</td>
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<tr>
<td>3.2 Develop and assess public communications strategies.</td>
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<tr>
<td>3.3 Increase and improve communications with First Nations Leadership.</td>
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</tbody>
</table>
| **Stakeholders have the tools and the opportunities to better address First Nations’ health needs and priorities.**

The AFN provides input into a strategic direction for addressing First Nations’ health needs and priorities so that issues can be moved forward. This is achieved through the AFN and stakeholders having relevant tools to advocate and inform policy (for example: strategies, frameworks, information, cultural competency), as well as the opportunity to do so through forums (for example: meetings, working groups, task forces, agreements and memorandum of understandings).
| 3.4 | Increase and improve communications with and between First Nations Health Professionals. |
| 3.5 | Build and support training initiatives for First Nations at the community, regional and national level. |
| 3.6 | Increase First Nations knowledge base of priority health issues and interventions. |
| 4.1 | Build capacity in areas related to performance measurement and evaluation. |
| 4.2 | Support and improve the processes and quality of data collection and surveillance for First Nations. |
| 4.3 | Promote First Nations ownership, control, access and possession (OCAP™) of health information and health information systems. |
| 4.4 | Promote enhanced relations between Regional Organizations and provinces on information management. |
| 4. Promote increased capacity in communities and regions to design, conduct and implement research. | 4.1 Build capacity in areas related to performance measurement and evaluation. |
| 4.2 | Support and improve the processes and quality of data collection and surveillance for First Nations. |
| 4.3 | Promote First Nations ownership, control, access and possession (OCAP™) of health information and health information systems. |
| 4.4 | Promote enhanced relations between Regional Organizations and provinces on information management. |

- **Protocols on health information data collection and management reflect OCAP™ principles.**

  The AFN promotes and supports interactions and information sharing between stakeholders. In terms of information management and in light of OCAP™ principles, the AFN contributes to the development of protocols and systems that reflect OCAP™ principles and support First Nations’ interests.

- **First Nations have access/ownership/control of information to be able to advocate health needs, priorities, interests and matters.**

  The AFN promotes OCAP™ principles so that they are reflected in polices and processes. Through OCAP™ principles, First Nations can make decisions regarding research (for example: what will be done, for what use, where the information will be physically stored and who will have access). This contributes to First Nations having access to research and being more self-determined/self-reliant.

- **First Nations increase governance responsibility of health systems, policy**
or programming.

With the AFN’s input and support, First Nations increase their knowledge, expertise and infrastructure to support research, and implementation and management of health systems. As a result, First Nations are better equipped to reach their goals and become self-reliant.

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<tr>
<th>5. Pursue clarification on recognition of First Nations Inherent and Treaty rights to health, jurisdictional control, management and delivery of health systems.</th>
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<tr>
<td>5.1 Promote coordinated continuum of health services as essential to overcome the multitude of health programming gaps at federal, provincial and municipal levels.</td>
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<tr>
<td>5.2 Support improved coordination and control of service delivery across jurisdictions</td>
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<tr>
<td>5.3 Provide support and advocate for funding matched to population growth, health needs and cost drivers.</td>
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<tr>
<td>5.4 Clarify the roles and responsibilities of all levels of government (AFN’s Principles of Engagement).</td>
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<td>5.5 Promote new collaborative models implemented by First Nations.</td>
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<tr>
<td>5.6 Promote joint policy processes (such as Senior Management Committee).</td>
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<tr>
<td>➢ Multi-partite/multi-jurisdictional forums exist to address integration.</td>
</tr>
<tr>
<td>The AFN promotes collaborative models and joint policy processes so that stakeholders (community, regional, F/P/T, international) have the opportunity to address integration through forums (for example: meetings, working groups, task forces, agreements and memorandum of understandings).</td>
</tr>
<tr>
<td>➢ F/P/T and First Nations responsibilities and relationships are mapped.</td>
</tr>
<tr>
<td>The AFN contributes to facilitating interactions among stakeholders (community, regional, F/P/T, international) so that stakeholders with shared responsibilities can be identified and work together on similar issues/concerns. Mapping areas and responsibilities is a precursor to advancing strategies for the integration and coordination of health programming.</td>
</tr>
<tr>
<td>➢ Services and programs better reflect First Nations’ rights and health needs, priorities, interests and matters.</td>
</tr>
<tr>
<td>The AFN contributes to facilitating interactions among stakeholders (community, regional, F/P/T, international) so that stakeholders with shared responsibilities can be identified and work together on similar issues/concerns. In doing so, the AFN creates the opportunity for stakeholders to work jointly and collaboratively on models and processes that reflect First Nations’ rights and health issues.</td>
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