Working within the Territorial Health Context

A Framework to Understanding and Applying a Northern Lens

July 2019

Indigenous Services Canada
Services aux Autochtones Canada
Canada

www.canada.ca/indigenous-services-canada
1-800-567-9604
TTY only 1-866-553-0554

QS-6556-000-EE-A1
Catalogue: R5-740/2019E-PDF
ISBN: 978-0-660-32191-2

This publication is also available in French under the title: Travailler dans le Contexte du système de santé des territoires Un cadre pour comprendre et appliquer l'optique du nord Juillet 2019 (pdf)

Table of Contents

Executive Summary

Improving the overall health and wellbeing of First Nations and Inuit is an important mandate of Indigenous Services Canada (ISC). Despite progress, the health status of First Nations and Inuit, as measured by most major indicators of health, remains below that of the Canadian population. These discrepancies are rooted in a range of historical, political, cultural, geographical and jurisdictional factors.[1]

Indigenous people make up the largest shares of the population of Nunavut (NU) and the Northwest Territories (NWT). This provides the foundation for great strengths as Indigenous cultures and traditional practices remain strong in communities. The territories rank better in some measures of wellbeing than the rest of Canada, with 71% to 83% of territorial residents feeling a "strong" or "somewhat strong" sense of belonging to their local community vs. only 64% for Canada[2]. However, the legacies of colonization and residential schools, and other important factors such as lack of access to adequate housing, high rates of food insecurity and limited resources in small communities, have contributed to high rates of suicide* and widespread physical, sexual, verbal and emotional abuse affecting the health of First Nations and Inuit in the North†. This has contributed to poor health outcomes and makes health service delivery challenging due to the geography and vastness of the territories.

The territories encompass almost 40% of the land mass of Canada, however, only 0.3%[3] of the Canadian population lives there. Communities are generally small, varying in size from a population of 140 to just over 8,000, with the majority having approximately 500-1,000 residents. They tend to also be spread out over hundreds of kilometers, often in remote and isolated areas and only linked to other communities and/or parts of the country by air transportation and sometimes seasonally by winter road or barge. There is snow and ice cover for seven to ten months, and permafrost in the soil.

These exceptional conditions create challenges in establishing and maintaining basic infrastructure (i.e., transportation, communications, water and sewage, etc.). With absent highway access, the transportation of goods, as well as travelling to and from communities, can be costly and time consuming. It also impacts service delivery due to a heavy reliance on travel in and out of the territories.

The health service delivery context in the territories differs from other provinces. Territorial governments are responsible for delivering insured health services to all of their citizens, including First Nations and Inuit. Unlike other provinces, there are

* For more information on the risk and protective factors related to suicide in the North, refer to the National Inuit Suicide Prevention Strategy, Inuit Tapiriit Kanatami, 2016. https://www.itk.ca/wp-content/uploads/2016/07/ITK-National-Inuit-Suicide-Prevention-Strategy-2016.pdf

† In this context, "North" refers specifically to the territories.

no First Nations reserves in the territories. Therefore, the federal government does not have a direct primary health care service delivery function for Indigenous communities. That being said, ISC provides funding for a variety of programs, such as home and community care, health promotion and disease prevention programs, Indian Residential Schools Resolution Health Support Program, and the Health Services Integration Fund for First Nations (including those that are self-governing) and Inuit in the territories. There is variation in the delivery of Non-Insured Health Benefits (NIHB). In the Yukon (YT), ISC delivers the full NIHB Program to eligible First Nations, whereas in NWT and NU, a portion of the program is delivered in partnership with territorial governments. In NWT, the territorial government provides equity of service delivery to Métis.

Purpose of this Framework

To support the responsiveness of the federal program and policy development to the unique Northern context, ISC's Northern Region developed this document with input from partners. This Framework aims to build greater awareness across ISC and other federal departments of the health context across the territories. This is meant to ensure the unique needs and service delivery context of the North are considered in the development of policies and programs, and that Indigenous governments and organizations, and territorial governments are consulted and included in the development, implementation, enhancement, and/or evaluation of programs and services. The ultimate purpose of this Framework is to reduce barriers to improved health outcomes for First Nations and Inuit in the North.

The Framework is an evergreen document, which will be updated every second year to ensure its continued relevance. Should you wish to provide feedback on the utility of the Framework, and/or how it could be improved in the future, please contact ISC's Northern Region at 1-866-509-1769 or sac.regiondunord-northernregion.isc@canada.ca .

Key Drivers – Why Now?

On August 28th, 2017 the Prime Minister announced the creation of two new departments and the dissolution of Indigenous and Northern Affairs Canada (INAC); and on December 4th, 2017, ISC was created by joining service-delivery sectors from INAC with the First Nations and Inuit Health Branch (FNIHB). Though the development of the Framework stems in part from the FNIHB Strategic Plan, a new ISC strategic plan is currently being developed to better align with the department's priorities. The ISC strategic plan will be referenced in the next revision of the Framework.

ISC continues to strengthen its working relationship with First Nations, Inuit and Métis based on an approach of mutual respect and enhanced collaboration aimed at sustaining strong partnerships. *The First Nations and Inuit Health Branch (FNIHB) Strategic Plan (2012-2017)* outlines its commitment to work with First Nations and

Inuit partners in the development, delivery, and management of programs and services.

More specifically, FNIHB (now ISC) is committed to "explore possible north of 60 approaches with First Nations, Inuit and territorial governments where there is a shared interest to improve service delivery and population health challenges". *Working within the Territorial Health Context* supports this commitment.

Developing the Framework

This inaugural version of the Framework was developed by ISC's Northern Region, in consultation with key partners delivering health services in the territories, to describe the unique territorial contexts, roles and responsibilities, program strengths, and gaps and opportunities in each territory. As this is an evergreen document, ISC will continue to engage partners to maintain its accuracy and relevance.

The Framework is divided into five sections:

1. **Northern context** – examines the legislative, policy, socio-historical and geographical context and considerations for ISC health services and programs.
2. **Health overview** - provides an overview of the health system in the territories, the context for delivering health services, and the common challenges for health service delivery amongst the territories that need to be addressed through coordinated action.
3. **Challenges delivering health services in the North** – describes challenges shared by all three territories.
4. **Territorial profiles** – provides a profile for each territory, including: demographics; health status; role of key health partners; unique challenges/gaps/barriers; and, priorities.
5. **Implementation** – describes how ISC can work with territorial partners to improve the health status of First Nations and Inuit in the territories. It includes an analytical tool (the "Northern Lens") that supports consideration of the unique territorial context in policy and program development by policy makers.

Northern Context

This section provides an overview of the principles which guide ISC's work in the territories, how wellness is defined in the North, and elements which are common to all three territorial health systems, which may differ from south of the 60th parallel ("south of 60")‡. The next section includes a profile of each territory, including roles and responsibilities of key partners.

Guiding Principles

ISC-Health's work is guided by the following principles, as described in the *First Nations and Inuit Health Branch Strategic Plan*:

Wellness - promoting holistic perspectives that help protect and promote the health, safety and well-being of First Nations and Inuit

Excellence - striving for continuous quality improvement, learning and innovation

Reciprocity and trust - working together with First Nations, Inuit, territorial, provincial, and federal departments and other partners in a circle of shared responsibility, accountability and stewardship

Fiscal Stewardship - practising sound fiscal management, complying with fiscal accountability measures and ensuring value for money

Flexibility - responding to the needs of individuals across their lifespans, and to the needs of families and communities, taking into account distinct regional circumstances and gender differences

Culture – recognizing that cultural practices and traditions are essential to the health and well-being of First Nations and Inuit

Communications and Engagement - communicating transparently and involving First Nations and Inuit in the development, delivery and management of national and regional policies and programs

The ISC Roles: Funder, Advocate and Strategic Enabler

Improving the health of First Nations and Inuit is a shared undertaking among federal, territorial and First Nations and Inuit partners. ISC works with these partners to promote wellness and support healthy Northern individuals, families and communities.

‡ When referring to the south of 60, it does not include Sanikiluaq which is part of Nunavut.

ISC funds the following programs:

- community-based health promotion and disease prevention programs;
- home and community care programs; and
- supplementary health benefits and other targeted initiatives.

Targeted initiatives include:

- Indian Residential Schools Resolution Health Support Program;
- Climate Change and Health Adaptation Program; and
- Health Services Integration Fund.

To facilitate relationships with territorial and Indigenous partners, ISC's Northern Region has offices in Yellowknife and Whitehorse, and a main office in Ottawa, where the administration and policy functions largely reside. The Yellowknife office provides program management for community-based programs for both NWT and NU, and the Whitehorse office provides program management for community-based programs for YT, coordination of the Indian Residential Schools Resolution Health Support program for all three territories, and an NIHB call centre for Yukon First Nations.

As a ***funder,*** ISC has an arrangement with each territorial government based on the needs and priorities of its population. Long-term flexible funding arrangements have been established in NWT (five years) and NU (ten years). These arrangements, referred to as the Northern Wellness Agreement and Nunavut Wellness Agreement, respectively, consolidate community-based health promotion and disease prevention programming under three program clusters[§]: healthy children, families and communities; mental health and addictions; and, chronic disease and injury prevention. These Agreements allow the territorial governments the flexibility to re-allocate resources among clusters based on community/territorial wellness plans.

Specifically in NU, Nunavut Tunngavik Incorporated (NTI) is engaged in decision-making for funding through a memorandum of understanding. It was signed alongside the 10-year Nunavut Wellness Agreement.

In the YT, the three First Nations without self-government agreements receive funds directly for eligible community-based health promotion and disease prevention programming; whereas, for the 11 self-governing First Nations, those program funds have been permanently transferred.

The NIHB Program remains outside of the wellness agreements and is delivered in a variety of ways. In NWT and NU, the NIHB Program is administered jointly by ISC and the territorial governments. ISC has contribution agreements with both of the territorial governments to deliver medical transportation, vision care and dental service provider travel. Northern Region's Ottawa office administers the medical supplies and equipment benefit directly and the drug and dental benefits are

[§] The breakdown of the clusters varies slightly from NWT to NU

administered by ISC Headquarters in Ottawa. The joint delivery of this program means that ISC relies heavily on territorial government staff, including physicians, nurses and administrators, to coordinate benefits for clients at the community level to support seamless service delivery.

In YT, ISC provides NIHB benefits directly to eligible clients. The Northern Region's Whitehorse office administers medical travel and vision care benefits. The Northern Region's Ottawa office administers medical supplies and equipment benefits for YT clients, and remaining benefits are administered nationally from ISC Headquarters in Ottawa. The Government of Yukon does not fund medical travel benefits for First Nations and Inuit, with the exception of emergency ground transportation (ambulance) within the territory. In YT, First Nations and Inuit clients are fully reimbursed for medical travel.

As an ***advocate*** and ***strategic enabler***, ISC plays a key role in:

- cultivating and maintaining informal and formal relationships with First Nations, Inuit and territorial governments and organizations;
- exploring and implementing innovative approaches to health issues in the territories;
- leveraging and brokering the sharing of knowledge and best practices with partners; and
- working across ISC and with Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC) to support the inclusion of health considerations in Northern initiatives, as well as to advance and implement self-government in the territories.

Culture as a Foundation

Culture is a social determinant of health. The revitalization of Indigenous communities and cultures, especially given the historical context of colonization, residential schools, forced relocation and other traumas, is essential to improving health outcomes[4]. To support improved health outcomes, culture must be central, and health services must be delivered in a culturally relevant and safe way. "On-the-land" and traditional healing practices have been beneficial in contributing to improved mental wellness and healing[5]. Health care providers must be supported to develop an understanding of the cultural realities and environments of the clients they serve. Culture provides the foundation from which wellness blossoms[6].

What is Wellness?

Wellness is "a holistic balance of physical, spiritual, mental and emotional well-being[7]". Wellness thrives on positive relationships with families, friends and communities; respect, caring, sharing, and working together are some of the ways these relationships are strengthened. Living well together helps to develop a sense of belonging and purpose. Families, friends and communities and political, social

and cultural contexts have an influence on the health and well-being of Indigenous Peoples.

To support wellness, ISC takes a population health approach that considers the social and economic conditions where people live and work. These factors that affect health are known as the determinants of health. Through taking a population health approach, ISC aims to provide programs and services that will reduce the health disparity, or gaps in health status, currently experienced by Indigenous people living in the North and the general Canadian population.

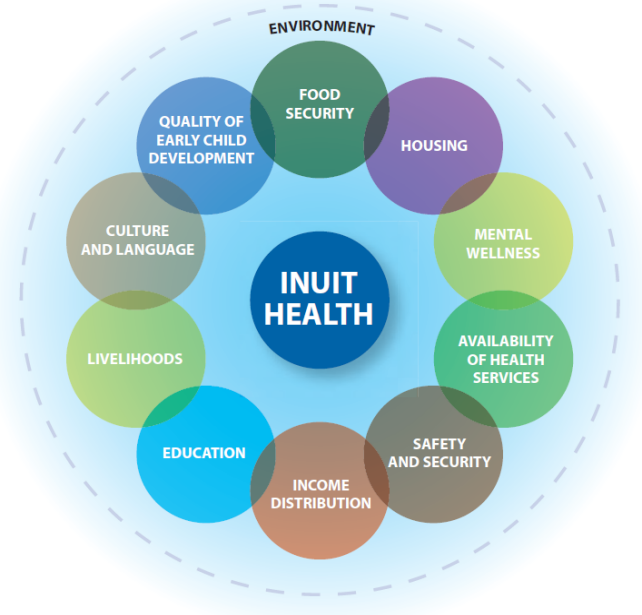
What Determines Health?

Health is shaped by the socio-cultural and historical context in which individuals live and work. The context of people's lives matters and determines their health and contributes to outcomes. The determinants of health, as defined by the World Health Organization[8], are: income and social status; education; physical environment; social support networks; culture; genetics; health services; and gender.

Given the historical and current circumstances of First Nations and Inuit, there are specific determinants of health for First Nations and Inuit. Both the Inuit Tapiriit Kanatami[9] and the Assembly of First Nations[10] have developed determinants of health that are specific to Inuit and First Nations in Canada.

Inuit Tapiriit Kanatami, the national representative organization for Inuit in Canada, has defined a set of Social Determinants of Inuit Health. These determinants highlight that culture, language, the impacts of colonization and residential schools, and connection with the environment are particularly critical in influencing the health of Inuit. It is also important to note that rapid socio-cultural changes in the last 60 years have negatively affected the well-being of Inuit.

Social Determinants of Inuit Health



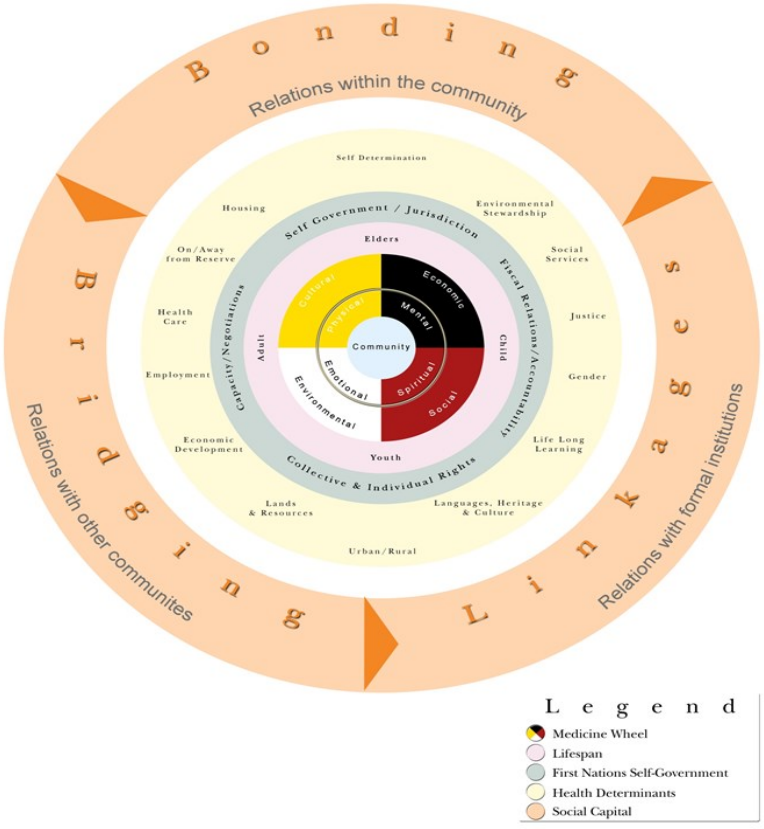
Source: "Social Determinants of Inuit Health in Canada", Inuit Tapiriit Kanatami, 2014

Indigenous Specific Determinants of Health

The *First Nations Wholistic Policy and Planning Model*, first developed by the Assembly of First Nations in 2005 and updated in 2013, identifies 16 *Indigenous-specific determinants of health* that extend beyond issues of health care and service delivery and augment the social determinants of health.

The 16 Indigenous-specific determinants of health consist of income and social status, education and literacy, social support networks, social environments, physical environments, personal health practices and skills, healthy child development, biology and genetic endowment, health services, gender, and culture.

This model was updated to support the development of a more inclusive, health-continuum approach. The model: puts the community as its core; incorporates four components of well-being (spiritual, physical, emotional and mental); four cycles of the life span; five key dimensions of First Nations self-government; social determinants of health; and three components of social capital (bonding, bridging and linkage).



Examples of differences in the determinants of health amongst people living in the North and the general Canadian population are captured in the following indicators.

Housing

A greater proportion of people in the North live in overcrowded homes and/or homes requiring repair. Amongst Indigenous peoples living in dwellings in the territories[11], in NWT, 33% of dwellings require minor and major repairs; in NU, 62% of dwellings require minor and major repairs; and in YT, 41% of dwellings require minor and major repairs – the core housing need of Indigenous people in the North is between 26% and 47% compared to 12.5%[12] for Canada.

Education

Many First Nations and Inuit adults in the North have lower levels of educational attainment – between 29% and 59%[13] do not have a high school diploma compared to only 13% of the general Canadian population.

Employment

Lower rates of employment contribute to poor health outcomes. In 2016, both NU (14.9%) and NWT (7.4%) had unemployment rates above the Canadian average (7.1%)[14].

Food Security

Food security is a significant challenge for many Northerners, due to the high cost of food and hunting and fishing equipment and supplies, as well as the high rates of poverty. In addition, the decline of herds and fish stocks, possibly linked to climate change, has further diminished access to country foods, which are for many the preferred choice.

Household food insecurity occurs when there is no access or insecure access to food due to financial constraints, and is of particular concern among Indigenous Peoples. Data from the 2012 *Aboriginal Peoples Survey* showed that in NU, 48.6% of Indigenous households were food insecure (low food security and very low food security)[15]. In NWT, 20% were food insecure[16], and in YT, 21% were food insecure.

Personal Safety and Security

Rates of violent youth crime are 2.6 to 4.5 times higher in the territories. More than one-quarter of residents of the territories (28%) reported being the victim of at least one crime in 2014. This is lower than the proportion reported in 2009 (34%), but remains higher than in the provinces (18%)[17].

In addition, the territories have the highest rates of police-reported family violence. In 2014, NU had the highest rate of family violence (2,491.0 per 100,000 population), which is almost ten times the national average (243.1), followed by NWT (1,897.1) and YT (911.6).[18]

As stated, health outcomes are influenced by the social determinants of health. First Nations and Inuit in the territories generally experience worse health outcomes than their Indigenous counterparts south of 60. Their health status is particularly low in some areas, such as mental health, suicide and addictions, chronic diseases, and communicable disease.

Mental Health and Addictions

Mental health and addictions issues are significant across the territories, and most acute in NU. Statistics are not always available, but the territories ranked lowest in Canada in terms of self-reported mental health, with 66.4% of people aged 12 and over reporting their mental health status as "excellent" or "very good" in YT, 65.3% in NWT, and only 55% in NU (2013)[19]. Territorial rates of hospitalizations entirely caused by alcohol in 2015-16 were the three highest in the country (1,315 per 100,000 in NWT; 421 per 100,000 in NU; and 676 per 100,000 in YT. The Canadian rate is 239 per 100,000.).[20]

A high proportion of the Indigenous population attended residential schools in the territories. There were 15 schools in NWT, 13 in NU and six in YT[21]. In 1964, 75% of Inuit children aged six to 15 years were enrolled in residential schools[22]. Residential school attendance has had significant impacts on health, contributing to high rates of addiction and mental health issues among First Nations and Inuit in the North.

Rates of Chronic Disease

Respiratory diseases and certain types of cancer are among the highest in the country. For example, both NU and NWT have lung cancer rates higher than the national average, 206.8 and 72.1 per 100,000 respectively, compared to 56.9 for Canada (2013)[23]. A contributing factor to the high rates of cancer and respiratory illnesses is the high numbers of smokers in both territories. In NU, the rate of daily and occasional smokers is almost 3.5 times the national average (62% versus 18.1% for Canada[24]), and NWT's rate of daily and occasional smokers is almost twice the national average, at 33.3% (2014)[25].

Rates of Communicable Diseases

Tuberculosis is a significant concern. The average incidence rate for YT from 2006 to 2013 was more than double the national rate over the same time period[26], and the age-standardized rate of tuberculosis in NU was nearly 40 times higher than the pooled rate for the rest of Canada[27].

Oral Health

Oral health is a key concern in the territories. The number of children who are treated annually under general anaesthetic for cavities in NU is the highest in the

country at a rate of 97.2 per 1,000 population. The rate in NWT is second highest in the country (51.8 per 1,000 population)[28]. Compared to southern Canadians, more Inuit reported poor oral health and higher frequency of food avoidance and oral pain[29]. In addition, there are lengthy waiting lists for children seeking dental treatment in NWT and NU.

Life expectancy

In the territories, life expectancy is the lowest in Canada, ranging from 77.4 years in YT to only 71.8 years in NU[30]. The average Canadian life expectancy is 81.5 years[31].

Health Services Overview

Health services are a social determinant of health and critical for improving health outcomes. This section provides an overview of the health system in the territories, the context for delivering health services, and the common challenges for health service delivery amongst the territories that need to be addressed through coordinated action.

No Reserves

ISC programs and policies are generally developed in the context of on-reserve south of 60 communities. This can result in programs and policies that need to be adapted to fit the territorial context or that may not fit at all. Also, the diversity of the populations in the territories (First Nations, Inuit and Métis) can make targeted initiatives difficult to implement given the one health system and collaborative approach to health in the territories.

One Health System

Health programs and services for First Nations and Inuit in the territories are delivered in the context of a complex and dynamic health system in each territory. South of 60, ISC provides primary care services on-reserve in remote and isolated areas where provincial services are not readily available. Provincial governments provide health services to all other residents. In contrast, in each territory, there is **one universal health care system** that provides services for all territorial residents, including First Nations and Inuit. As a result, ISC does not have a direct primary health care service delivery function for First Nations and Inuit communities in the territories.

ISC supplements and supports territorial health programs for First Nations and Inuit as it does in the provinces. This ensures access to health services, and strives to achieve a standard of health services for First Nations and Inuit that is comparable to that of other Canadians.

Territorial health systems came about through universal health transfer, a process whereby Canada officially transferred responsibility for primary health care to each territorial government (responsibility was transferred to NWT in 1988 and to YT in 1997, and NU acquired universal health services when it was established in 1999).

Although the health care system is set up differently in the territories, these differences do not preclude First Nations and Inuit in the North from receiving new or enhanced ISC health programs. The NWT, NU, and YT transfer agreements include "no prejudice" clauses, which are meant to ensure that First Nations and Inuit in the territories can participate in, and benefit from, health policies and programs designed for Indigenous people in Canada.

The transfer of universal health services to the territories did not include NIHB, the First Nations and Inuit Home and Community Care Program or community-based health promotion and disease prevention programming, which ISC continues to administer. These programs have territory-specific delivery arrangements.

The sizes of territorial governments, Indigenous governments and community organizations delivering programs on behalf of ISC are very small compared to provincial counterparts. Generally speaking, each territory has a small health system that faces significant need over a vast geography.

Expanded Role of Health Care Providers

The role of community nurses in the territories is different from the role of nurses in urban centres. In most communities, where no hospitals or resident physicians are present, clinical nurses have an expanded scope of practice.

Self-government

Self-government agreements set out the parameters for First Nations and Inuit groups to govern their own internal affairs and assume greater responsibility and control over the decision making that affects their communities. The context of self-government in the territories shapes the delivery of health programs and services. For example, under the implementation of self-government agreements, First Nations and Inuit communities are able to assume the responsibility, and associated resources, for the delivery of ISC's community-based programs. This aligns with Canada's approach to nation-to-nation/Inuit-Crown relations, Canada's *Inherent Right Policy*, and the *First Nations and Inuit Health Branch Strategic Plan*. The context of self-government varies by territory and is described in each territorial profile within this Framework (page 18).

Challenges to Delivering Health Services in the North

There are several challenges to delivering health services in the North that are shared by all of the territories. This section provides a brief overview of these challenges.

Health Human Resources

Persistent health human resource challenges, including high vacancy rates, high turnover, difficulties in recruiting, lack of housing for health professionals, and higher rates of compensation (required to cover the higher cost of living) lead to instability in the health workforce. Sometimes, this results in the territories' need to rely on costly out of territory professionals (e.g., agency nurses, locum** physicians), and can create challenges in accessing timely and culturally appropriate health care. However, progress is being made as initiatives such as primary health care models strive to improve service delivery in the North. One such example is the Northwest Territories Health and Social Services Authority[32].

Reliance on Medical Travel

As a result of the population size and geography, each territory relies heavily on medical services provided in their capital city as well as other jurisdictions in order to provide access to health services (e.g., diagnostics and treatment). This can present barriers to access for some clients, such as long wait times, a lack of continuity with health providers, challenges around cultural competency in other jurisdictions, and the extensive travel that is sometimes required. Inuit Tapiriit Kanatami has illustrated what a client's journey might look like when travelling south to access medical services through scheduled flights (emergency travel would be more direct).

** Locum is when someone fills in for another on a temporary basis.

Source: Inuit Tapiriit Kanatami Presentation to Health Minister by Natan Obed on January 20, 2016 in Vancouver, British Columbia

Lack of Connectivity

Up until March 2013, most internet and phone services in the territories were provided via satellite[33], rather than fibre optic cables. The result is generally slower service due to bandwidth limitations and vulnerability to interference and regular outages resulting in service disruptions. In addition, the lack of sound technological infrastructure affects Northern partners' ability to work efficiently with colleagues in other communities or jurisdictions. All communities in NU are expected to have access to a high-speed broadband satellite network by the end of 2019[34].

Lack of Infrastructure

The lack of reliable infrastructure impacts the availability and cost of maintaining health services across the territories. Basic infrastructure (e.g., roads, ports, energy transmission and buildings) is limited in NWT and YT, and while there are roads in NU, there are no roads connecting its communities. Road access for transporting goods between communities is limited or lacking entirely in some regions. Goods must be flown in or shipped in during the summer season. The construction of a sea port that would improve sea lift operations is expected to be completed by 2020. The impacts of climate change (including rising temperatures, thawing permafrost, changes in freeze-up and break-up of bodies of water and extreme or unexpected weather events) can result in an even shorter winter road season and increased cost of highway maintenance.

Access to Health Data

Available health data for the territories is generally limited. Territorial governments do not always have the capacity or infrastructure to collect the same complement of vital statistics that may be available south of 60, and First Nations and Inuit specific data may not always be available. This undermines the evidence base for decision-making and can result in a less effective use of limited funds. Inadequate data also impacts the evaluation of current initiatives, making progress difficult to track. Possible sources of territorial data include NIHB records, Census data, and the Canadian Institute for Health Information (CIHI). There are also Indigenous specific institutes collecting information, such as the First Nations Information Governance Centre.

For additional health data on Northern First Nations and Inuit, please consult the following resources:

- Statistics Canada: Census, Aboriginal Peoples Survey, National Household Survey Aboriginal Population Profile (https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-011-x/99-011-x2011001-eng.cfm)
- CIHI: Health Indicators (https://www.cihi.ca/en/health-system-performance/performance-reporting/indicators)
- The Conference Board of Canada: How Canada Performs – Health (http://www.conferenceboard.ca/hcp/provincial/health.aspx)
- Inuit Health Survey (https://www.mcgill.ca/cine/resources/ihs)
- First Nations Information Governance Centre: FNIGC Data online (https://fnigc.ca/dataonline/)
- Nunavut Bureau of Statistics (http://www.stats.gov.nu.ca/en/home.aspx)
- Canadian Community Health Survey (https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs.html)

Climate

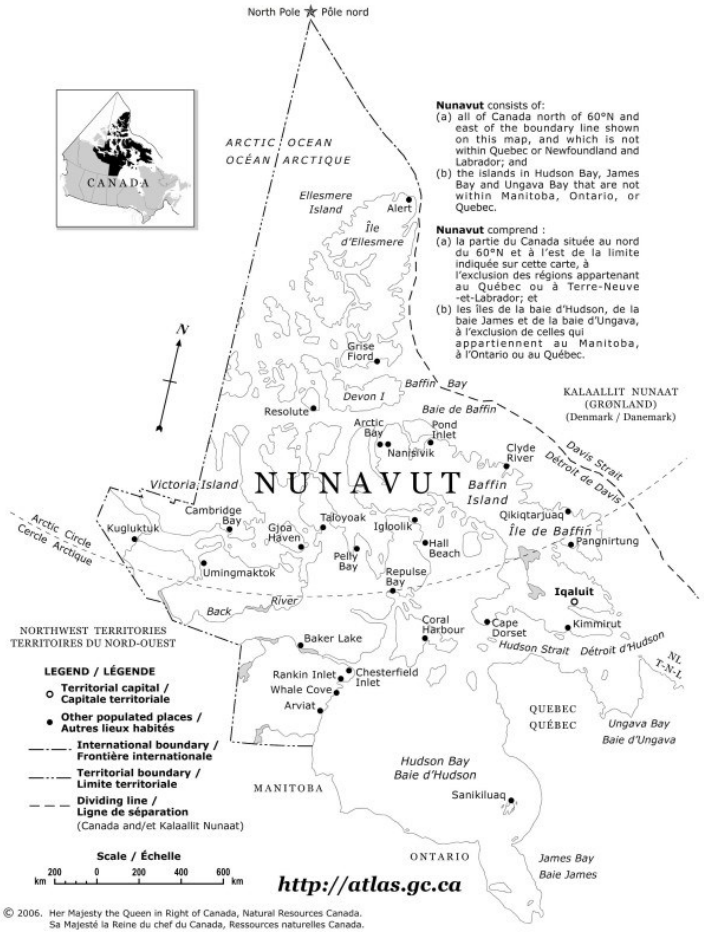
Weather conditions can have a significant impact on efficiency of territorial health care systems. Inclement weather may result in delayed shipment of medications, delayed or cancelled flights for medical or staff, and impacts to scheduled clinics. In the North, climate change has caused decreased weather predictability, melting permafrost, changes in wildlife behaviour, etc.. It can affect the social determinants of health of First Nations and Inuit in the North, including clean air, safe drinking water, access to country foods, and housing. Climate change is also linked to changes in population and distribution of disease vectors, as well as animals that are consumed, which can have impacts on both health and culture.

Territorial Profiles

Although there are a number of common factors which influence health service delivery across the territories, there are significant differences from one territory to another and even from one region to another within each territory. This section provides a profile of each of the territories, including: the health status of First Nations and/or Inuit in the territory; the roles of key health partners; unique circumstances, gaps and barriers; and health priorities.

Nunavut (NU)

Canada signed the *Nunavut Land Claims Agreement* (NLCA) with the Inuit of the NU settlement area in 1993, resulting in the largest Indigenous land claim agreement in Canadian history. As a result of the NLCA, NU officially separated from NWT on April 1, 1999 through the *Nunavut Act*.



The Land

- 1.9 million square kilometres
  - 20% of Canada's land base
- 3 time zones
- 25 communities – all isolated and remote; only accessible via plane or sea lift
- No roads connecting communities

The People

- 35,944 residents
- Median age of Inuit in NU was 21 vs. 39 for Canada
  - 57% of Inuit under age 25 (vs. 19% of non-Aboriginal population)
- Highest Aboriginal population of all the provinces and territories
  - 86% of residents are Inuit

Statistics Canada: Total Population Census data (2016)
All other data National Household Survey (2011)

NU has approximately 38,000 people in 25 communities spread over 20% of the land area of Canada. The communities range in size from 142 residents in Grise Fiord to 8,011 residents in Iqaluit (2018 estimates)[35]. Inuit make up the majority of the population (85%). NU has a young population, with a birth rate almost twice the Canadian average.

There is no road access between communities or outside the territory. Access is only by air, sea or land with a snowmobile, four-wheeler or dog team. Other infrastructure, such as buildings and ports, is also insufficient. Furthermore, information technology (IT) connectivity is by satellite throughout the territory, which is slow and costly – especially outside of Iqaluit.

The unique historical context in NU has contributed to poorer health outcomes in this territory. Significant events such as post-World War II colonization and attempts to assimilate Inuit through residential schools, the creation of permanent communities, and consequent limiting of traditional methods of subsistence severely impacted rates of education, unemployment, family violence, substance abuse, suicide, and poverty in Inuit communities. This has contributed to poor health outcomes. For example, NU has the highest suicide rate in Canada. Reported rates range from five to 40 times the national average, depending on age and gender group. In 2015, the premier of NU declared suicide a public health crisis in the territory.

Efforts to improve these adverse outcomes must include culture as a foundation of the health system. This is supported by Inuit Tapiriit Kanatami's *National Inuit Suicide Prevention Strategy* and research demonstrating the importance of cultural competence in delivering health services[36]. It was also echoed throughout the engagement process during the development of this Framework.

Health Status and Social Determinants

Health Status: Nunavut

Infant mortality per 1,000 live births (2013) 18.2 for Nunavut vs. 4.9 for Canada
Food Insecurity (2011-12) 36.7% for Nunavut vs. 8.3% for Canada
Lung cancer per 100,000 (2013) 206.8 for Nunavut vs. 56.9 for Canada
Current smokers, daily or occasional (2013) 62% for Nunavut vs. 18.1% for Canada
Suicides and self-inflicted injuries, deaths per 100,000 (2011) 63.9 for Nunavut vs. 10.9 for Canada
Life expectancy (2013) 71.6 years for Nunavut vs. 81.1 years for Canada

Sources for Table[37]

Other health status statistics include:

- There is overall poor oral health status in NU, especially in children, who are more likely to require general anaesthesia[38].
- NU has the highest suicide rate in Canada – higher than all other jurisdictions. In 2013, the rate of suicides and self-inflicted injuries in the territory was five times the national average - 52.2 per 100,000 compared to 10.2. In 2015, the Premier of NU declared suicide in the territory a public health crisis. A one-year Action Plan for suicide prevention was developed by local partners, including the Government of Nunavut, Nunavut Tunngavik Incorporated, Embrace Life Council and the Royal Canadian Mounted Police, followed by a five year Action Plan (*Inuusivut Anninaqtuq*) which was released in June 2017. These Action Plans support the implementation of the 2010 *Nunavut Suicide Prevention Strategy*.

Challenges related to the social determinants of health are also of significant concern. In NU:

- The median family income ($65,190) is lower than the Canadian average ($78,870)[39], and the 2016 unemployment rate in the territory is twice the national average (14.9% for NU compared to 7% for Canada)[40].
- In 2011, the core housing need in NU was more than three times the national rate. The situation is even more critical for Inuit - over 55% of Inuit in NU lived in homes that were not adequate in condition, suitable in size, and/or affordable, compared to 10.6% of Canadians[41].
- Many adults have lower levels of education. Between 29% and 59% do not have a high school diploma, compared to only 13% of the general Canadian population.
- NU experiences high rates of youth crime. There is also a very high rate of police-reported family violence, at ten times the national average, with 2,491.0 per 100,000 residents versus 243.1 per 100,000 residents.
- Access to physician services is significantly lower than elsewhere in Canada. Only 17.5% of residents reported having a regular medical doctor in 2014 vs. 85.1% of Canadians. Additionally, less than half (44%) of Nunavummiut (NU residents) reported contact with a medical doctor in the past 12 months compared to 79% of Canadians[42].
- There is, however, a very strong sense of community in the territory. 74% to 85% of territorial residents feel a “somewhat” or “very strong” sense of belonging to their local community. For Canada, the number is only 66%.
- In addition to strong communities, Inuit culture is vibrant in the territory with high rates of participation in traditional activities such as subsistence hunting and fishing, as well as a very high rate (89%) of conversational use of Inuktut across the territory[43].

a. Role of Key Health Partners

Government of Nunavut

Responsibility for universal health services was transferred to the Government of Nunavut as a result of the creation of the territory in 1999. The Government of Nunavut's Department of Health administers and delivers health care services to all residents. It directly manages the territory's only hospital and 24 community health centres. There is also one public health facility, one family practice clinic, and a rehabilitative treatment centre in the territory.

The Qikiqtani General Hospital in Iqaluit is currently the only acute care facility in the territory, providing a range of in- and out-patient hospital services. The hospital offers 24-hour emergency services, in-patient care (including obstetrics, paediatrics and palliative care), surgical services, laboratory services, diagnostic imaging (computerized tomography but no magnetic resonance imaging), and respiratory therapy.

Outside of Iqaluit, out-patient and 24-hour emergency nursing services are provided by local health centres in NU's 24 other communities. Telehealth services have been established in all 25 communities in NU, however, a tele-medicine program has yet to be established.

NU has health service agreements with medical centres in Ottawa, Winnipeg, Churchill, Yellowknife and Edmonton to provide insured services to territorial residents when they are unable to obtain them in NU, including access to specialists. Residents of Baffin Island may travel to either Iqaluit or Ottawa to access medical care. Given the vast size of the territory, residents of the rest of NU will travel outside the territory for care - rather than traveling to Iqaluit – because of both the distance and the limited size and scope of services at the Qikiqtani General Hospital. Flights are very expensive and may require several stopovers, including overnight stays.

The Department of Health plays a key role in the administration and delivery of ISC programs for First Nations and Inuit as part of the Nunavut Wellness Agreement and in administering portions of NIHB.

Nunavut Tunngavik Incorporated

Nunavut Tunngavik Incorporated (NTI) represents NU Inuit (who are beneficiaries of the Nunavut Land Claims Agreement (NLCA)) and ensures that federal and territorial government obligations (e.g., guaranteed harvesting rights, assessment of environmental impacts resulting from resource development, regulation of water use, and an obligation on the part of federal and territorial governments to promote a representative workforce through the hiring of beneficiaries of the NLCA) under the claim are met.

In collaboration with the Government of Nunavut, NTI plays a leadership role in addressing the health needs of Inuit through the design, development and delivery of Inuit-specific health policies, programs and services that foster, promote and protect health. NTI's role in health is articulated in Article 32 of the NLCA, which provides Inuit in NU the opportunity to participate in the design and development of social and cultural policies and programs in the territory, including federal health programs.

Regional Inuit Organizations affiliated with NTI exist in each of NU's three regions (Qikiqtani, Kivalliq and Kitikmeot). The President of NTI is one of the four voting members of the Inuit Tapiriit Kanatami Board of Directors.

b. Unique Challenges / Gaps / Barriers

Infrastructure, geography and weather:

Each of the 25 communities in NU is isolated and only accessible by air, water, or land with a snowmobile, four-wheeler or a dog team. It is not possible to drive by road to, or between, any of the communities. This means that food, medication and other supplies must be shipped exclusively by plane, except during the sea-shipping season of two to five months. Poor weather can delay both air and sea shipments. Services can also be affected by limited travel options since service providers (e.g., doctors and nurses) may be delayed in getting to communities, or residents may be delayed in getting out to access health services or in returning home. This adds to the already high cost of health services and contributes to operational uncertainties.

Medical Transportation:

Due to the isolation and size of most communities in NU, only basic health services are available on a regular basis (locum specialists may visit). Residents are often required to travel outside of their community to access more advanced and specialized medical care.

Health Human Resources / Access to Medical Professionals:

There are limited health professionals who are permanently established in the territory. The territorial government relies heavily on short-term medical staff from agencies. This can lead to a lack of continuity of care, reduced cultural competency of service providers, and service providers that are not trained or experienced to provide care in remote communities.

Language and Cultural Barriers:

Approximately 89% of Inuit in NU speak Inuktut, and a significant proportion of those are unilingual, particularly elders. However, due to a lack of medical

professionals who are proficient in the language, interpretation services are often required for Inuit accessing health care services both within the territory and when travelling south to access health services[44]. Cultural barriers also impact how Inuit access and experience health care services.

Barriers to Funding:

Federal funding for Indigenous populations is often for on-reserve initiatives – there are no reserves in NU. In addition, capacity in many communities is limited. There are few paid positions for community-based work and many initiatives are run by small groups of volunteers who may not have the same training or available time as a staff person would. Community-based capacity is further strained when applications for funding require extensive proposal writing and reporting. Territorial departments and municipal governments are also smaller than their typical south of 60 counterparts, and staff do not typically have the same available time or capacity to participate in proposal and report writing.

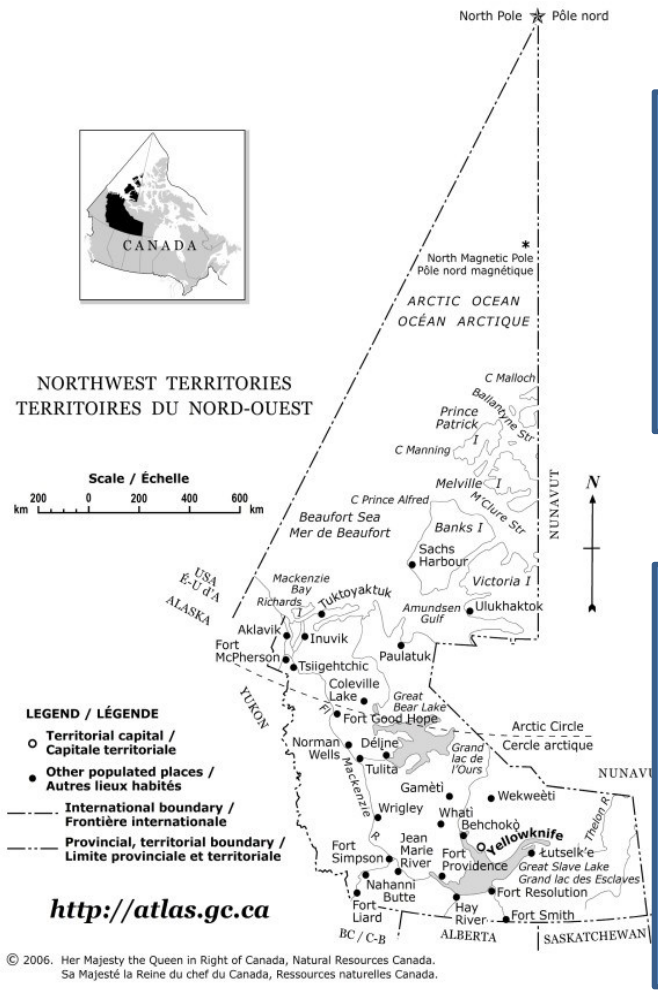
c. Priorities

Through the NU Partnership Table on Health, which includes the Government of Nunavut, NTI and ISC, a number of priorities have been identified:

- Mental wellness / suicide prevention
- Children's oral health
- Tuberculosis management
- Health human resources
- Shaping the health research agenda
- Strengthening collaboration among partners

Northwest Territories

NWT is the only territory with a significant population of all three groups of Indigenous peoples (First Nations, Inuit and Métis).



The Land

- 1.14 million square kilometres
- 33 communities – 1/3 of which are only accessible via plane or winter ice road. Some have sealift access.
- 17 of the communities have between 100-500 residents and two communities have fewer than 100 residents

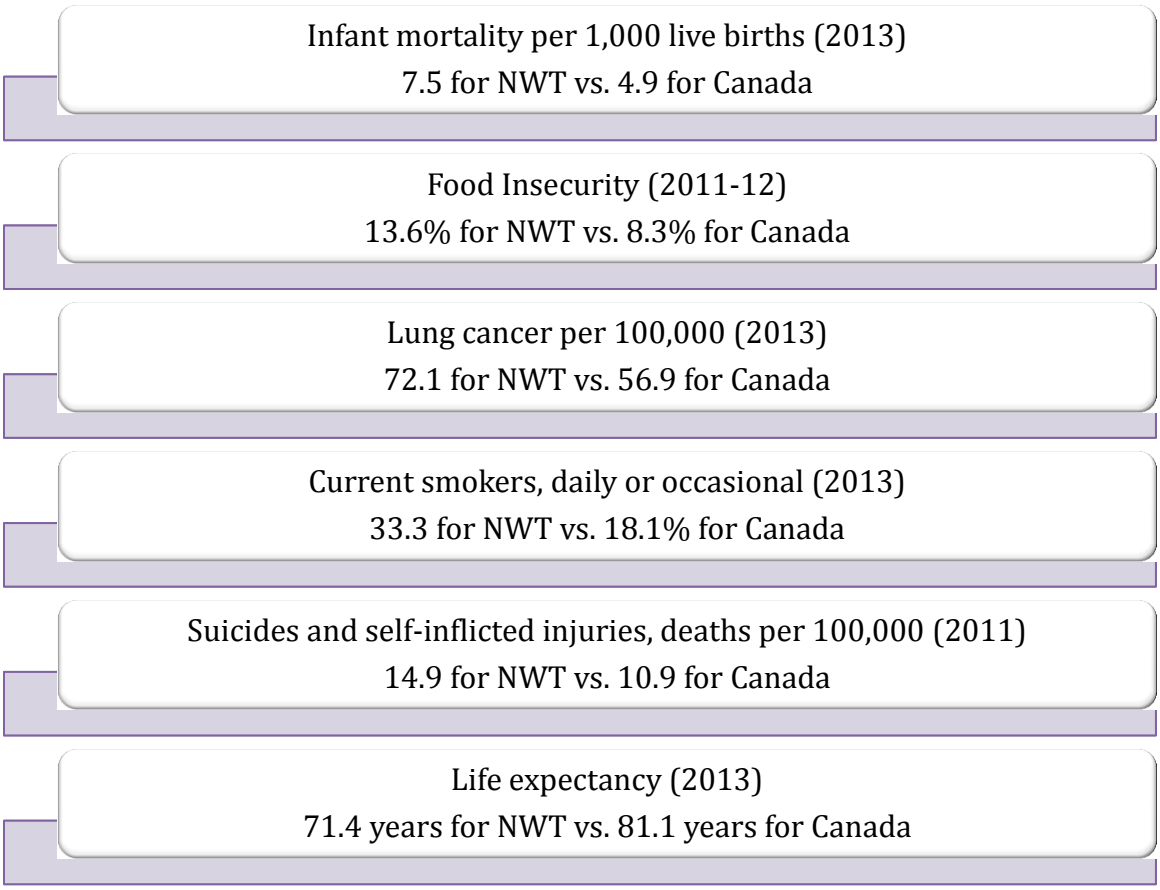
The People

- 41,786 residents
- 52% of residents are Aboriginal
  - 63% First Nations
  - 21% Inuit
  - 15% Métis
- Over 40% of residents live in Yellowknife

- *Statistics Canada: Total population Census Data (2016), others National Household Survey (2011)*

a. Health Status and Social Determinants

Health Status: NWT



Sources for Table[45]

Social determinants of health challenges are also a concern in NWT:

- In 2011, 23% of First Nations people and 15% of Inuit lived in crowded homes, compared to 3% of the non-Indigenous population. 29% of First Nations people and 26% of Inuit lived in homes in need of major repairs.[46]
- The food insecurity rate is 13.7% versus the Canadian rate of 8.3%.[47]

Poor health and social determinants of health outcomes are further compounded by health system and health human resources challenges.

- Access to medical professionals is considerably lower than elsewhere in Canada. This can impact continuity of care, diagnosis, and more. Only 42.3% of residents reported having a regular medical doctor in 2014, vs. 85.1% of Canadians. Additionally, only 69.2% of NWT residents reported contact with a medical doctor in the past 12 months compared to 79% of Canadians[48].

b. Role of Key Health Partners

There is a complex governance structure in NWT, including settled and outstanding Indigenous land claims and self-government agreements which impact the health system. Since negotiations began in 1975, a number of agreements have been reached with the Dene, Métis, and Inuvialuit to settle outstanding agreements on land and resources and to fulfil outstanding obligations under treaties 8 and 11. However, there are many active self-government and land negotiations underway in NWT, each at a different stage of progress.

In all instances of self-government agreements in NWT, either final or in negotiation, there is no Indigenous government jurisdiction over primary health care – it remains a territorial government responsibility. However, each agreement provides the Indigenous government with the opportunity to enter into agreements with the federal or territorial government for the management, administration, and delivery of eligible health promotion and disease prevention programs.

Furthermore, every agreement provides for jurisdiction over traditional healing, and the related training, regulations, and certifications for these practitioners and/or facilities.

Government of Northwest Territories

Universal health care services were transferred from the federal government to the Government of NWT in 1988. The Department of Health and Social Services administers and delivers health services to all territorial residents.

In 2016, Government of NWT amalgamated six of the eight existing regional health and social services authorities in the NWT into a single authority with regional representation (Tlicho Community Services Agency and Hay River Health and Social Services Agency remain). The intent is to improve the coordination of services, maximize human resources, and improve patient care by breaking down systemic barriers to efficient and effective care and service delivery, while building the foundation of a system with improved accountability and performance.

Health care services are delivered through one territorial hospital (Stanton) in Yellowknife and regional hospitals in Hay River and Inuvik. The remainder of communities have health centres, which are the first point of contact with the health system. Residents travel to Alberta for services not available in NWT.

The Department of Health and Social Services administers and delivers some ISC programs for First Nations and Inuit as part of the Northern Wellness Agreement and administers portions of NIHB.

Indigenous Partners

In NWT, there are currently seven regional Indigenous governments (Akaitcho Territory Government, Dehcho First Nations, Gwich'in Tribal Council, Inuvialuit Regional Corporation, Northwest Territory Métis Nation, Tlicho Government) and three community-based Indigenous governments (Acho Dene Koe First Nation, Salt River First Nation and Kátł'odeeche First Nation). There is no one entity that represents all of these or even a large number. While NWT First Nations governments are affiliated with the Assembly of First Nations, they have expressed that it does not represent them in relation to health matters and would prefer to be engaged individually.

This has led to a more complex operating environment for ISC. In the past, partnerships were developed on a more ad-hoc basis, depending on what relationships existed. Since 2016, ISC (formerly FNIHB) has implemented a new engagement strategy – a more systematic approach, with timelines, to engaging Indigenous governments across the territory, which aims to enhance partnerships and empower First Nations and Inuit to participate in priority setting.

First Nations

ISC's Northern Region maintains regular engagement relationships with NWT's First Nations organizations (Dene Nation: the Regional Representative of the Assembly of First Nations, the Deline Gotine Government and the Tlicho Government) through bilateral fora. The Tlicho Government was the first Indigenous group in NWT to become self-governing, and it has received the transfer of health promotion and disease prevention community-based programs. ISC will continue to work with First Nations governments in NWT to support negotiations and the implementation of self-government agreements.

Inuvialuit Regional Corporation

The Inuvialuit Regional Corporation was established in 1984 following the signing of the *Inuvialuit Final Agreement* (IFA), a comprehensive land claim agreement between the Government of Canada and the Inuit of Canada's Western Arctic (the Inuvialuit). The settlement area encompasses six communities, including: Aklavik, Ulukhaktok, Inuvik, Paulatuk, Sachs Harbour, and Tuktoyaktuk. The Inuvialuit, Canada, and Government of NWT are currently negotiating an Inuvialuit self-government agreement that will not include and impact the status of communities. The Inuvialuit Regional Corporation is responsible for the overall management of the IFA and has a mandate to continually improve the economic, social and cultural well-being of the Inuvialuit through implementation of the IFA and by all other available means.

c. Unique Challenges / Gaps / Barriers

Geography and Weather:

Seventeen of the 33 communities in NWT are only accessible by plane or ice road in the winter. Some, but not all, communities receive supply by barge in the summers. Although many of the communities are accessible by road, they are often very small (less than 1,000 residents) and the communities are spread out across the vast geography of the territory. The majority of Indigenous peoples in NWT (78%) live outside of Yellowknife, the capital city of NWT[49].

Self-government Implementation:

With two self-governing Indigenous governments in place (Tlicho and Deline Gotine) and advancing negotiations with other Indigenous entities, the self-government context is complex. Given that the bulk of federal programs potentially eligible for negotiation with Indigenous governments are currently administered by the Government of NWT, a coordinated implementation approach is essential. It is also important to understand what funding and programming is eligible for transfer and the implications of this when new funding is allocated or new programs developed.

Language Profile:

There are 11 official languages in NWT: three Inuit languages, five Dene languages, Cree, English and French. Due to the significant number of languages spoken, accessing medical services in one's language of choice can be challenging, and this can impact health service delivery and outcomes.

Diversity and Representation among Indigenous Groups:

In addition to the Inuvialuit and Métis, there are six distinct Dene groups in NWT (Yellowknife, Dogrib, Chipewyan, South Slavey, North Slavey and Gwich'in). There is not currently a single organization representing them, nor has a forum been established where they come together to discuss health issues. Northern Region remains committed to seizing opportunities to engage with the diverse groups within NWT.

d. Priorities

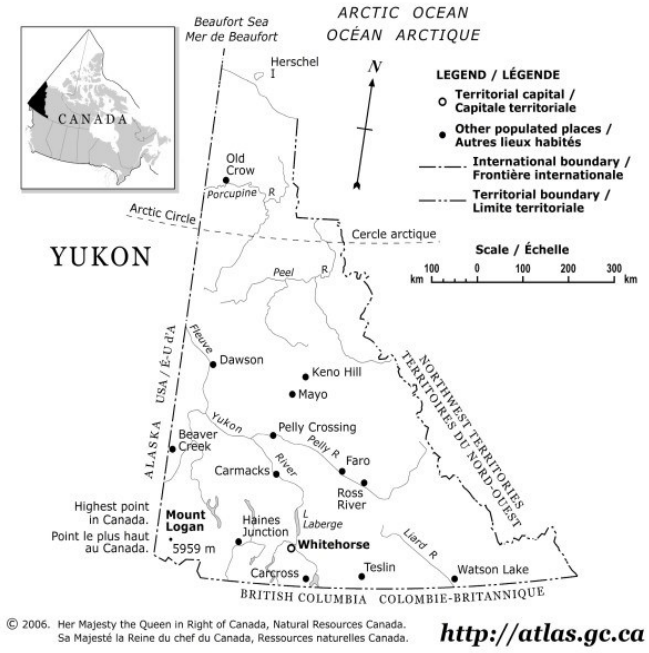
Through bilateral meetings with the Government of NWT and engagement with stakeholders, a number of priorities for collaborative work have been identified:

- Mental health and addictions
- On-the-land programming
- Strengthening collaboration among partners

- Supporting healthy lifestyles – such as smoking cessation
- Supporting the implementation of self-government agreements

Yukon (YT)

The majority of YT First Nations (11 of 14) have self-government agreements. Community-based health promotion and disease prevention programming has been permanently transferred to those 11 First Nations along with some elements of the First Nations and Inuit Home and Community Care program.



The Land

- 480,000 square kilometres
- 17 communities – all but one accessible by road
- 73% of residents live in Whitehorse

The People

- 35,874 residents
- 23% of residents are Aboriginal
  - 86% First Nations
  - 11% Métis
  - <1% Inuit

Statistics Canada: Total population Census Data (2016), all other data National Household Survey (2011)

a. Health status

Health Status: Yukon

Sources for Table[50]

Health status in YT is, for many indicators, on par, or in some cases, better than Canadian averages. However, these indicators typically represent the total YT population, and are often not available for the Indigenous population exclusively. For those indicators where disaggregated data is available, health outcomes are generally poorer for Indigenous Yukoners and it is likely that this is the case for other outcomes as well.

- Life expectancy (2013) was 76.7 years for Yukon versus 81.1 years for Canada. In 2006, Indigenous Yukoners had life expectancies of 8.8 and 7.3 years less than non-Indigenous Yukoners for males and females respectively.
- In 2013, the rate of suicide and death by self-inflicted injury in Yukon was 8.9 per 100,000 compared to 10.2 for Canada.

Social determinants of health also contribute to poor health outcomes:

- In 2011, 25.7% of Indigenous people in YT lived in homes that were not in adequate condition, suitable in size, and/or affordable (defined as core housing need), compared to 14.6% of non-Indigenous Yukoners. The Canadian rate is 12.5%.
- Yukon's rate of food insecurity was 12.4% compared to the Canadian average (8.3%) in 2011/12.

In addition, health system and health human resources challenges remain. Access to medical professionals remains below the Canadian average, impacting continuity of care, diagnosis, and treatment. Only 73.9% of residents reported having a regular medical doctor in 2014, vs. 85.1% of Canadians[51].

b. Role of Key Health Partners

Government of Yukon

The transfer of universal health services in YT was completed through four agreements, starting in 1993 and ending in 1997. The Department of Health and Social Services operates health facilities throughout the territory. The hospitals in Dawson City, Watson Lake, and Whitehorse are managed by the Yukon Hospital Corporation.

The Whitehorse General Hospital operates a unique First Nations Health Program that provides and supports compassionate care for First Nations, Inuit and Métis. The Program includes the incorporation of cultural practices, traditional foods, medicine and other support services for First Nations.

11 community health centres provide a wide range of health and medical services, delivered mostly by community health nurses. The Department of Health and Social Services (HSS) also provides vital statistics, communicable disease control, health promotion, dental health, environmental health, hearing services, and mental health and addictions services.

Positive oral health outcomes for children and youth may be attributed to the YT's Children's Dental Health Program that HSS delivers. This Program provides diagnostic, preventative and restorative dental services to all YT children from newborn to Grade 8 or Grade 12, depending on the child's place of residence[52].

Unlike territorial health departments in the NWT and NU, the Government of YT does not administer ISC health programs.

Health Priorities for the YT Government

In January 2017, Minister Frost's mandate letter highlighted the following priorities for Health and Social Services:

- Invest in people, in alternative methods of care, in people's mental health and the healthiest possible living
- Maximize benefits for children, including seamless services related to child care, early childhood development and education
- Regulate and fund midwifery to provide a safe and more affordable childbirth options in communities
- Improve the provision of mental wellness services in communities
- Promote aging in place and a full spectrum of care
- Improve front-line health care services through a collaborative care model
- Increase housing for vulnerable populations using a Housing First model (working with Yukon Housing Corporation)
- Improve services for victims of violence and sexual assault in the YT (working with Justice and the Women's Directorate)

YT First Nations

Eleven of the 14 YT First Nations have self-government and land claims agreements in place. A 1997 Agreement specifically provides that the YT First Nations Comprehensive Land Claim Final Agreement and Self-Government Final Agreements will not be prejudiced in any respect by the transfer of federal services to the Government of YT. To date, all of the self-governing YT First Nations have assumed responsibility for eligible First Nations and Inuit community-based programs. Although these programs have been transferred, ISC maintains relationships with these communities through the ongoing delivery of non-eligible programs such as those that are time-limited (e.g., Indian Residential Schools Resolution Health Support Program).

The three First Nations that are not self-governing (Liard First Nation, Ross River First Nation and White River First Nation) are not currently in negotiations for self-government agreements, and receive funding for ISC programs through contribution agreements with ISC's Northern Region.

The Council of Yukon First Nations (CYFN) currently represents nine Yukon First Nations (Carcross/Tagish First Nation, Champagne and Ashihik First Nations, Kluane First Nation, Little Salmon Carmacks First Nation, First Nation of Na-Cho Nyak Dun, Selkirk First Nation, Ta'an Kwach'an Council, Teslin Tlingit Council and Tr'ondek Hwech'in First Nation).

ISC's Northern Region has a strong working relationship with the CYFN through the Yukon Trilateral Table on Health as well as the Yukon First Nation Health and Social Development Commission. Relationships also exist with the other five First Nations (Kwanlin Dün First Nation, Vuntut Gwich'in First Nation, White River First Nation,

Ross River Dena Council and Liard First Nation) through funding agreements for various ISC programs.

The Yukon Trilateral Table on Health is a renewed version of the Yukon Health Table that was first established in 2011. It has an updated Terms of Reference, reflecting First Nations and YT Government's shared interest to work trilaterally at a non-political level to address common issues. The Table is chaired by the Executive Director of the CYFN and includes federal, territorial and First Nations membership. The purpose of the Table is to jointly explore, identify, and recommend actions to improve the relevance, responsiveness and effectiveness of YT First Nations' health status. ISC provides funding to CYFN (approximately $100,000 per year) to coordinate Health Table meetings, which the Terms of Reference require be held a minimum of twice per year.

The Yukon First Nation Health and Social Development Commission is made up of Health Directors of all 14 First Nations in Yukon. The Commission meets approximately every two months and is coordinated by CYFN. Its purpose is to provide a forum for members to share information and discuss areas of concern. While not a member, ISC is invited to meetings to discuss issues of mutual concern/benefit. The Commission is the central point of contact for governments and health-related organizations to engage YT First Nations and address issues of mutual interest.

c. Unique Challenges / Gaps / Barriers

Self-government:

Although the delivery of health care services in all three territories is the responsibility of the territorial governments, in YT some of these responsibilities have been transferred to self-governing First Nations. This can mean that in some cases a First Nations client/patient may need to go to more than one organization to access the full range of services they need. For example, a partial transfer of home care services has been completed and related services must be accessed from both Indigenous and territorial governments.

d. Priorities

Through bilateral meetings with the Government of YT and engagement with the Yukon First Nations Health and Social Development Commission, the following priorities have been identified:

- Improving mental wellness and mental health services
- Strengthening collaboration among partners
- NIHB: supporting alternative service delivery mechanisms

Collaboration is a key principle of all of the work undertaken by ISC in the territories.

Key Takeaways
The ISC Northern Region Partnership Approach

ISC continues to strengthen its working relationship with First Nations and Inuit based on an approach of mutual respect and enhanced collaboration aimed at a strong partnership. ISC's Northern Region works in partnership with First Nations, Inuit and territorial government partners to advance issues of mutual interest and concern. Existing bilateral and trilateral tables present an opportunity to engage with partners. ISC's Northern Region has regular bilateral meetings with each of the territorial governments and trilateral partnership tables are in place in NU and YT.

Partnership tables in the territories are focused on First Nations and Inuit community-based programming. However, other health-related issues of interest are discussed. These tables also seek to better align, coordinate, and integrate efforts between and among partners. ISC staff should contact Northern Region to discuss bringing new initiatives to these forums for discussion as a way to efficiently engage with Northern partners on program and policy development.

Models of success

A. **Nunavut Partnership Table on Health**
This table is made up of senior representatives of Nunavut Tunngavik Incorporated (NTI), Government of NU and ISC as well as the Public Health Agency of Canada, and supports continued work to advance shared priorities. Meetings are held 3-4 times per year in Iqaluit. Federal and Government of NU participation is at the Assistant Deputy Minister level, to permit decision-making, and is most often in-person. Chaired by NTI, the table has been praised by Natan Obed, the President of Inuit Tapiriit Kanatami, as a model of success for engaging Inuit.

B. **Yukon Trilateral Table on Health**
The Yukon Trilateral Table on Health is a renewed version of the Yukon Health Table that was first established in 2011. Its objective is to jointly explore, identify and recommend actions to improve the relevance, responsiveness and effectiveness of YT Government and Northern Region funded programs and services to YT First Nations and Inuit. It has an updated Terms of Reference, reflecting First Nations and YT Government's shared interest to work trilaterally at a non-political level to address common issues. The Table is chaired by the Executive Director of the Council of Yukon First Nations and includes federal, territorial and First Nations membership. Recent key accomplishments include advancing a crisis response model for Yukon First Nations.

How Funding is Delivered: Flexible Multi-year Funding Models

The unique challenges and realities that exist in the territories should be considered in the design and delivery of programs. A pan-Canadian program that is successful in the south will likely need to be altered in order to achieve success in the territories. For example, the remoteness of many communities and the lack of infrastructure may impact the ability to host programs that serve several communities from a central location.

Engagement with stakeholders in all three territories (including territorial governments and Indigenous organizations and governments) clearly identified greater flexibility in funding as essential to making progress in improving health outcomes for First Nations and Inuit in the North. Ensuring that ISC health program Terms and Conditions allow for Flexible and Block funding approaches would be a first step. Specific items identified through engagement include:

- Greater flexibility to move funds between program service areas ("clusters")
- Carry-over of funds from one fiscal year to the next
- Longer-term agreements (up to ten years)
- Collaborative approaches

ISC supports recipients in increasing their capacity to deliver programs, and with demonstrated growth, additional flexibility may be provided. Overall, greater funding flexibility allows each organization to adapt the funding to their needs and circumstances, with the ability to re-adjust as needed when a crisis arises or priorities change.

Promising Practices

Northern Wellness Agreements
Five-year Northern Wellness contribution agreements with the Government of NU and the Government of NWT consolidate a number of programs (ISC and Public Health Agency of Canada) by clustering them according to their programmatic objective (i.e., Healthy Children, Families and Communities; Mental Health and Addictions; and Chronic Disease and Injury Prevention). This approach provides the Governments of NU and NWT with the flexibility to allocate resources across programs according to their community/territorial wellness plans and simplifies reporting and evaluation requirements. The Governments of NU and NWT then enter into contribution agreements with communities based on their community health plans.

Victims of Violence
Through a collaborative process with the Council of Yukon First Nations (CYFN), ISC and the CYFN were able to leverage funding from three sources (Victims of Family Violence, Heath Services Integration Fund and NIHB Mental Health Crisis Counselling) to develop a comprehensive mental health crisis response approach in YT.

YT First Nations 101
YT First Nations 101, delivered by Yukon College, educates participants on the culture and history of the First Nations Peoples of the YT, the cultural values shared among YT First Nations today, and how to communicate respectfully with First Nation individuals and communities. To support the cultural competency of its employees, this course is mandatory training for all Northern Region employees.

Implementation

Northern Lens

The Northern Lens is a tool comprised of a series of policy questions designed to assist staff within ISC, as well as other federal departments and agencies, in considering unique territorial contexts when developing policies and programs. It aims to reduce barriers to access and support programming that is responsive to the needs and concerns of territorial populations. It is intended to be applied horizontally across ISC during policy and program development, similar to tools for gender-based analysis, environmental assessment and official languages. Applying the Northern Lens is the first step in developing policies and programs which are inclusive of the territories. ISC officials are encouraged to do additional research and to consult Northern Region to develop a fulsome analysis.

Culture is the foundation of all the services, program and policies for Indigenous peoples in the Northern Region.

Design and Eligibility

1. Is the intention that territories be eligible for any or all components of this policy or program? If not, what is the rationale for their exclusion, keeping in mind the no prejudice clauses that prevent exclusion of First Nations and Inuit in the territories from health policies and programs designed for Indigenous people in Canada? If so, have program parameters, requirements, etc. taken into account territorial contexts to ensure barriers to territorial access do not exist?

2. How have resource allocations (human, financial and capital) taken into account the greater resource costs for the delivery of health programs in the territories?
    - E.g. Medical travel, lower health status/greater need, greater cost of goods and services, remoteness of communities, health human resources challenges, etc.

Engagement

3. How have key Northern partners, including territorial and Indigenous governments and Indigenous organizations, been engaged in the design and development of this initiative?
    - i.e., in alignment with ISC's partnership approach (see page 30) and Article 32 of the NU Land Claim Agreement (see page 17)
    - See the "Territorial profiles" for additional information on key partners in each territory
    - Engagement should begin early and with the right partners. Consultation with staff from the Northern Region is recommended.

Delivery and Implementation

4. How will this initiative be delivered in the territories (program design and implementation) given health transfer (one health system in each territory) and the unique social, cultural and historical circumstances of First Nations and Inuit in the territories?
    - E.g. No reserves, lack of connectivity, less available capacity for proposal writing/reporting, self-government and land claims agreements, etc.

Conclusion

The core goal of ISC's work is to ensure "First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs and that improve their health status"[53] (p. 8*). Working within the Territorial Health Context* was developed to support ISC staff to be more responsive to the needs of First Nations and Inuit clients in the territories.

There is great diversity among First Nations people and Inuit across Canada. Those residing in the territories have unique geographical, social, cultural and historical realities which impact their health and well-being. This Framework has illustrated many of the differences between First Nations and Inuit living in the territories and their southern counterparts and Canadians more generally. However, the Framework and Northern Lens are only a starting point. It is important for ISC staff to contact Northern Region for greater input on new initiatives and for assistance in seeking out the views of key territorial partners.

Together, all of these elements will support policies and programs that are more inclusive of First Nations and Inuit in YT, NWT and NU and responsive to their health needs. This will ultimately contribute to improved health outcomes for Indigenous peoples across the North.

Bibliography

[1] Health Canada. 2012. *First Nations and Inuit Health Strategic Plan: A shared path to improved health*. Ottawa: Health Canada. Accessed via: http://www.hc-sc.gc.ca/fniah-spnia/pubs/strat-plan-2012/index-eng.php

[2] Statistics Canada, Shields, M. (2008). *Community belonging and self-perceived health*. Accessed via: https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2008002/article/10552-eng.pdf?st=GCBMfGdj

[3] Statistics Canada, CANSIM Table 105-0501 (2014). Accessed via: http://www5.statcan.gc.ca/cansim/a26?lang=eng&retrLang=eng&id=1050501&pattern=health+indicator+profile&tabMode=dataTable&srchLan=-1&p1=1&p2=-1

[4] Statistics Canada, CANSIM Table 105-0501, 2014.

[5] Redvers, J. November 2016. *Study: Land-based Practice for Indigenous Health and Wellness in the Northwest Territories, Yukon, and Nunavut.* University of Calgary. Accessed via: http://www.ichr.ca/wp-content/uploads/2016/11/Land-based-Research-Summary_2016.pdf

[6] National Collaborating Centre for Healthy Public Policy. *Yukon First Nation Wellness Framework*. May 2015. Accessed via: http://www.ncchpp.ca/docs/2015_SMP_PMH_WellnessFramework_May.pdf

[7] ibíd.

[8] World Health Organization. *The Determinants of Health*. Accessed via: http://www.who.int/hia/evidence/doh/en/

[9] Inuit Tapiriit Kanatami. September 2014. *Social Determinants of Inuit Health in Canada*. Accessed via: https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf

[10] Assembly of First Nations. 2013. *First Nations Wholistic Policy and Planning: A transitional discussion document on the social determinants of health*. Accessed via: http://health.afn.ca/uploads/files/sdoh_afn.pdf

[11] Statistics Canada. *Dwelling condition by housing tenure, 2016 counts, minor repairs needed, Canada, provinces and territories, 2016 Census – 25% Sample Data.* Accessed via: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/housing-logement/Table.cfm?Lang=E&T=11&Geo=00&SP=1&view=1&dwelling=3

[12] Canada Mortgage and Housing Corporation. *Characteristics of Households in Core Housing Need: Canada, P/T, CMAs.* Accessed via: https://www.cmhc-schl.gc.ca/en/data-and-research/data-tables/characteristics-households-core-housing-need-canada-pt-cmas

[13] The Conference Board of Canada. *How Canada Performs*. Accessed via: http://www.conferenceboard.ca/hcp/provincial/education.aspx

[14] http://www.conferenceboard.ca/hcp/provincial/economy/unemployment.aspx

[15] Statistics Canada. *Data Tables, 2016 Census*. Accessed via: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?LANG=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=0&GK=0&GRP=1&PID=110519&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=122&VID=0&VNAMEE=&VNAMEF

[16] Statistics Canada. April 27, 2016. *Criminal victimization in the territories, 2014, Statistics Canada Catalogue no. 85-002-X*, by Samuel Perreault and Laura Simpson. Accessed via: http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14470-eng.pdf

[17] Statistics Canada. January 21, 2016. *Family violence in Canada: A statistical profile, 2014, Statistics Canada Catalogue no. 85-002-X*, Canadian Centre for Justice Statistics. Accessed via: http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14303-eng.pdf

[18] Ibid

[19] The Conference Board of Canada. *Self-Reported Mental Health*. Accessed via: http://www.conferenceboard.ca/hcp/provincial/health/mental.aspx
http://www.statcan.gc.ca/pub/85-002-x/2016001/article/14303-eng.pdf

[20] Canadian Institute for Health Information. 2017. *Alcohol Harm in Canada:*

Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Accessed via: https://www.cihi.ca/sites/default/files/document/report-alcohol-hospitalizations-en-web.pdf

[21] Truth and Reconcilliation Commission of Canada. *Residential School Locations*. Accessed via: http://www.trc.ca/about-us/residential-school.html

[22] Pauktuutit Inuit Women of Canada. *Residential Schools*. Accessed via: https://www.pauktuutit.ca/abuse-prevention/residential-schools/

[23] Statistics Canada. *Heath Profile, December 2013*. Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health74b-eng.htm

[24] Statistics Canada. *CANSIM Table 105-0501, 2014*. Accessed via: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045101

[25] Ibid.

[26] Government of Yukon. *Yukon Health Status Report: Focus on Substance Abuse, 2015*. Accessed via: http://www.yukoncmoh.ca/files/health_status_report_2015.pdf

[27] Government of Nunavut, Department of Health. January 2016. *Reportable Communicable Diseases in Nunavut, 2007-2014.* Accessed via: https://www.gov.nu.ca/sites/default/files/reportable_communicable_diseases_in_nunavut_2007_to_2014.pdf.

[28] Canadian Institute for Health Information. *Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery Under General Anesthesia*. Accessed via: https://secure.cihi.ca/free_products/Dental_Caries_Report_en_web.pdf

[29] Government of Canada, Health Canada. *Inuit Oral Health Survey Report 2008-2009*. Accessed via: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/promotion/_oral-bucco/oral-inuit-buccal-eng.pdf

[30] The Conference Board of Canada. *Life Expectancy*. Accessed via: http://www.conferenceboard.ca/hcp/provincial/health/life.aspx

[31] Ibid.

[32] Government of Northwest Territories, Health and Social Services Authority. *About Us*. Accessed via: https://www.nthssa.ca/en/about-us

[33] Government of Canada. *Connectivity for Aboriginal and Northern Communities in Canada*. Accessed via: http://www.aadnc-aandc.gc.ca/eng/1352214337612/1353504776242

[34] Northwestel. September 17, 2018. *High-speed Internet comes to Nunavut: Northwestel officially launches new broadband satellite network*. Accessed via: https://www.globenewswire.com/news-release/2018/09/17/1571913/0/en/High-speed-Internet-comes-to-Nunavut-Northwestel-officially-launches-new-broadband-satellite-network.html

[35] Government of Nunavut, Nunavut Bureau of Statistics. *Population Estimates*. Accessed via: http://www.stats.gov.nu.ca/en/Population%20estimate.aspx

[36] Campinha-Bacote, J. May 31, 2011. Delivering Patient-Centered Care in the Midst of a Cultural Conflict: The Role of Cultural Competence. *OJIN: The Online Journal of Issues in Nursing,* Vol. 16, No. 2, Manuscript 5. Accessed via: http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-16-2011/No2-May-2011/Delivering-Patient-Centered-Care-in-the-Midst-of-a-Cultural-Conflict.html

[37] Statistics Canada. *Deaths and Mortality Rates, By Age Group*. Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm\

Statistics Canada. *Household Food Insecurity, 2011-2012*. Accessed via: http://www.statcan.gc.ca/pub/82-625-x/2013001/article/11889-eng.htm

Statistics Canada. *Health Profile, December 2013*. Accessed via: http://www12.statcan.gc.ca/health-sante/82-228/details/page.cfm?Lang=E&Tab=1&Geo1=HR&Code1=6201&Geo2=PR&Code2=62&Data=Rate&SearchText=Nunavut&SearchType=Contains&SearchPR=01&B1=All&Custom=&B2=All&B3=All

Statistics Canada. *Smokers, By Age Group*. Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health74b-eng.htm
The Conference Board of Canada. *Suicides*. Accessed via : http://www.conferenceboard.ca/hcp/provincial/health/suicide.aspx
[38] Government of Canada, Health Canada. *Inuit Oral Health Survey Report 2008-2009*. Accessed via: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/promotion/_oral-bucco/oral-inuit-buccal-eng.pdf
[39] Statistics Canada. *Median Total Income, By Family Type, By Province and Territory. CANSIM, table 111-0009.* Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/famil108a-eng.htm
[40] The Conference Board of Canada. *Unemployment Rate*. Accessed via: https://www.conferenceboard.ca/hcp/provincial/economy/unemployment.aspx?AspxAutoDetectCookieSupport=1
[41] Statistics Canada. *Core Housing Need*. Accessed via: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/chn-biml/index-eng.cfm
[42] Statistics Canada. *Health Indicators, Annual Estimates, 2003 – 2014. CANSIM Table 105-0501, 2014*. Accessed via: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045101
[43] Inuit Tapiriit Kanatami. *Inuit Statistical Profile 2018*. Accessed via: https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf
[44] Government of Northwest Territories, NWT Bureau of Statistics. *Home Language and Mother Tongue.* Accessed via: https://www.statsnwt.ca/language/
[45] Statistics Canada. *Aboriginal Peoples: Fact Sheet for Northwest Territories*. Accessed via: https://www150.statcan.gc.ca/n1/pub/89-656-x/89-656-x2016013-eng.htm
[46] Statistics Canada. *Aboriginal Peoples: Fact Sheet for Canada*. Accessed via: https://www150.statcan.gc.ca/n1/pub/89-656-x/89-656-x2015001-eng.htm
[47] Statistics Canada. March 25, 2015. *Food Insecurity in Canada*. Written by Shirin Roshanafshar and Emma Hawkins. Accessed via: http://www.feedopportunity.com/wp-content/uploads/2016/11/Stats-Can-Food-Insecurity-Report.pdf
[48] Statistics Canada. *Data Tables, 2016 Census*. Accessed via: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/index-eng.cfm
[49] Statistics Canada. *Aboriginal Population Profile, 2016 Census*. Accessed via: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/abpopprof/details/page.cfm?Lang=E&Geo1=CSD&Code1=6106023&Data=Count&SearchText=Yellowknife&SearchType=Begins&B1=All&GeoLevel=PR&GeoCode=6106023&SEX_ID=1&AGE_ID=1&RESGEO_ID=1
[50] Statistics Canada. *Deaths and Mortality Rates, By Age Group*. Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health21a-eng.htm
Statistics Canada. *Household Food Insecurity, 2011-2012*. Accessed via: http://www.statcan.gc.ca/pub/82-625-x/2013001/article/11889-eng.htm
Statistics Canada. *Health Profile, December 2013*. Accessed via: http://www12.statcan.gc.ca/health-sante/82-228/details/page.cfm?Lang=E&Tab=1&Geo1=HR&Code1=6201&Geo2=PR&Code2=62&Data=Rate&SearchText=Nunavut&SearchType=Contains&SearchPR=01&B1=All&Custom=&B2=All&B3=All
Statistics Canada. *Smokers, By Age Group*. Accessed via: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health74b-eng.htm
The Conference Board of Canada. *Suicides*. Accessed via : http://www.conferenceboard.ca/hcp/provincial/health/suicide.aspx
[51] Statistics Canada. *Health Indicators, Annual Estimates, 2003 – 2014. CANSIM Table 105-0501, 2014*. Accessed via: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045101
[52] Government of Yukon, Department of Health and Social Services. *Children's Dental Program*. Accessed via: http://www.hss.gov.yk.ca/dental.php.