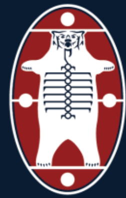

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Submission to the Standing Committee on Indigenous and Northern Affairs

Government of Canada's Response to COVID-19 Pandemic

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June 12, 2020

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1.0 Preface

Nishnawbe Aski Nation (NAN) is pleased to present to the Standing Committee on 'Indigenous and Northern Affairs Inquiry into the Government of Canada's Response to COVID-19 Pandemic.'

We acknowledge the work of this Committee to receive evidence related to the COVID-19 pandemic as it pertains to First Nations, Inuit and Métis Peoples and northerners. For this purpose, we present this written submission and testimony via videoconference.

From the date that the World Health Organization declared COVID-19 a worldwide pandemic, NAN has been working tirelessly to support its member First Nations, many of which did not have an operable pandemic plan in place. For the past three (3) months we have focused the majority of our efforts on ensuring the health and safety of NAN citizens, and that work continues to this day.

That said, and given the time constraints in preparing this submission, we would respectfully request a further opportunity to present more detailed information and recommendations to this Standing Committee in the future. While we were able to prepare this submission with the limited time and resources available to us, we are confident that we have more to share, and hope that you will afford us that ability in the future. We are also mindful of the likelihood of further waves of the virus, and that comprehensive work is ahead of us which hopefully builds on best practices developed during the first wave.

The NAN response, as discussed in our submission, has not been specifically funded in any way by the federal or provincial governments. NAN submitted proposals initially through the outlined funding processes, however, immediately retracted those proposals after it became apparent that NAN would be competing for very limited funds with its member First Nations. This is obviously unacceptable.

It is abundantly clear that this pandemic has exacerbated very longstanding issues and grave realities in NAN territory and has made responsive efforts even more challenging. We cannot continue to ignore these challenges. If anything, the pandemic should highlight to the Government of Canada the absolute urgency of this work.

Finally, it should be noted that this submission is not intended to be a complete and/or comprehensive review of the Government of Canada's response to the pandemic, but a general and initial overview from the perspective of NAN. It is important to begin this submission with the observation that a coordinated government approach with clear and transparent communication, accountability mechanisms, and an understanding that health and safety of citizens is far more

important than government rhetoric and funding parameters and must continue as we move forward.

We simply cannot afford to go back to the status quo, and we have a real opportunity to build on the strategies and processes learned during this difficult time together as long as we are willing to use this as a true learning opportunity of what is necessary versus what is just an administrative and policy burden.

We cannot stress enough the importance of collaboration and coordination of efforts and hope that this willingness that we have seen to work together as true partners continues to lead our work long after the pandemic.

2.0 About Nishnawbe Aski Nation

2.1 Mandate & Background of NAN

Nishnawbe Aski Nation (NAN) was established in 1973, and was originally known as Grand Council Treaty No. 9 until 1983. Grand Council Treaty No. 9 made a public declaration – A Declaration of Nishnawbe-Aski (The People and the Land) – of our rights and principles in 1977.

NAN territory encompasses James Bay Treaty No. 9 and the Ontario portion of Treaty No. 5, a landmass covering two-thirds of the Province of Ontario, spanning 210,000 square miles.

NAN represents 49 First Nations with a total population (on and off-reserve) of approximately 45,000 people grouped by Tribal Council. Six of our member Nations are not affiliated with a specific Tribal Council. Our people traditionally speak Cree and Algonquin in the east, OjiCree in the west, and Ojibway in the central south area.

NAN advocates on behalf of our member First Nations for self-determination with functioning self-government through partnerships and agreements with our Treaty partners - the governments of Canada and Ontario.

2.2 Treaty Right to Health for First Nations

NAN First Nations have always asserted a Treaty Right to health care. Ontario was a direct signatory to Treaty No. 9; as such, NAN First Nations and Ontario are regarded as having a government-to-government relationship as Treaty partners.
The signatories of the Treaty and its adhesion understood that the Treaty contained a promise of health care. In fact, in 1905 and 1906, a physician who performed medical exams and assistance was part of the Treaty. This created a reasonable understanding and expectation that the Treaty included the provision of indefinite, quality health care.

2.3 First Nations Right to Self-Determination

NAN First Nations have a right to self-determination, including the right and responsibility to have their own health and wellness programs and services, which includes the inherent right to lead a First Nations health system.

Ensuring equitable access to health care requires the removal of jurisdictional barriers through the development of trilateral partnerships that do not abrogate or derogate from Aboriginal or Treaty Rights protected under section 35 of the Constitution Act, 1982.

2.4 Auditor General Report on First Nations Health

In April 2015, the Auditor General of Canada released a scathing report detailing how the perception in Ottawa is far from the reality of what's happening at the community level when it comes to access to and the delivery of health care services in remote First Nations.

The Auditor General's report shows how First Nations living in remote communities are severely marginalized when it comes to access and the delivery of health care services. The report documented the continued failure by Health Canada to address the heath care needs of First Nations communities, which has resulted in the health of the First Nations people being considerably poorer than that of the rest of the Canadian population.

The Auditor General has concluded that Health Canada did not take into account community health needs when allocating support to remote First Nations, and had not implemented its objective of ensuring that First Nations individuals living in remote communities have comparable access to clinical and client care services as other provincial residents living in similar geographic locations.

2.5 NAN Declaration to Health and Public Health Emergency

In February 2016, the NAN Chiefs, and the Sioux Lookout Area Chief Committee on Health (CCOH) declared a health and public health emergency. The declaration stated that the entire health system for NAN First Nations is in a state of crisis.

As a result of the current system, we have seen devastating health outcomes due to inadequate diagnosis and treatment of preventable diseases (diabetes, hepatitis C, rheumatic fever, and invasive bacterial diseases, etc.). NAN First Nations suffer multigenerational trauma from residential schools, social conditions including an ongoing suicide epidemic and high rates of prescription drug abuse.

These issues are exacerbated by interjurisdictional squabbling leading to inequitable access to health care that is unfathomable to the general population in Ontario.

2.6 Health Transformation

In response to the Declaration of Health and Public Health Emergency, a trilateral commitment to transform the health system in NAN territory was developed between NAN, Ontario and Canada. To mark their commitment and set out a vision for change, the parties signed The Charter of Relationship Principles Governing Health System Transformation in NAN Territory in July 2017.

On November 14, 2017, NAN announced the appointment of former Assembly of First Nation National Chief Ovide Mercredi to lead NAN's work with the governments

of Canada and Ontario for the transformation of health systems across NAN territory. The NAN Health Transformation process will be First Nation-led with process and operations oversight from the Chiefs Council on Health Transformation (CCHT) with guidance from the Health Transformation Advisory Council (HTAC) alongside the NAN Health Transformation team internally.

NAN developed the Health Transformation process in order to create transformative change in First Nations health for NAN citizens. This process sets out a vision for system-wide change, whereby NAN First Nations have equitable access to care delivered within their communities. This involves disbanding from the current colonial system and exercising self-determination by bringing back accountability, responsibility, and resource allocation to our communities.

The goal of NAN Health Transformation is to build a First Nations health and wellness system that includes three models:

1. Operations Model
2. Fiscal Model
3. Governance Model

A new system is required to replace the current colonial health system to improve the health and wellbeing of First Nations in the NAN territory. It remains to be determined what each of these components will look like and how the system will be organized. The goal of NAN Health Transformation is to have communities as decision makers with the system designed based on community needs. The NAN Health Transformation process is based on community wishes; the system will be made up of both regional and NAN-wide components and service delivery models.

In order to achieve self-determination and develop a NAN health and wellness system, the work of the Health Transformation team is guided by the following five pillars:

1. Community Participation
2. Immediate Needs
3. Fiscal Review and Funding Model(s)
4. Policy and Legislative Review
5. Reclamation of Indigenous Law

In May 2019, NAN Chiefs-in-Assembly passed a resolution directing NAN to proceed with health self-determination and develop a wholistic health framework that would form a NAN health system outside of the provincial system. A NAN-wide entity such as a "Commission" is being explored and will be presented to the Chiefs-in-Assembly in 2020. This entity would support the NAN-wide system and would be the vehicle to carry the ongoing process of Health Transformation forward.

3.0 Coronavirus Pandemic

3.1 NAN's Pandemic Response

In order to decrease the risks to our communities from the COVID-19 pandemic, NAN took extraordinary steps to ensure that everything possible was done to keep our First Nations and members safe and supported.

Emergency Management Response Specialist

Following the declaration of a global pandemic, NAN secured the services of a professional Emergency Management Response Specialist to assist with our pandemic response.

The specialist has extensive experience as a project manager, developing, coordinating, delivering, and revising Fire and Emergency Service programs and has been a vital asset to our pandemic planning. She has worked to update and ensure our operational guidelines, procedures and policies are in accordance with standards and regulations implemented by the Province of Ontario, the Government of Canada, and International best practices.

NAN COVID-19 Task Team

Internally, NAN organized several coordination teams to monitor issues across sectors. Leads were identified in Housing and Infrastructure/Emergency Response, Social Services, Community Wellness, Education and Health and Urban Planning. NAN also assembled a dedicated team of medical and field experts to support our internal team. These experts include:

- Dr. Natalie Bocking, Public Health & Preventative Medicine Specialist
- Dr. Jane Philpott, NAN Special Advisor on Health
- Dr. Michael Kirlew, Family Physician
- Lynne Innes, Nurse Practitioner, CEO & President of Weeneebayko Area Health Authority
- Mae Katt, Nurse Practitioner
- Michelle Gervais, Emergency Management Response Specialist

Trilateral Table

A Trilateral Table (see Section 4) was established with representatives from the federal and provincial governments and members of the NAN COVID-19 Task Team. Through weekly calls, NAN has raised issues that are brought forward by the Task Team, NAN Leadership, Tribal Councils, and Health Authorities.

This table has allowed NAN to work collaboratively with both levels of government throughout the pandemic, identifying gaps in planning and an opportunity to truly collaborate on relevant issues to NAN communities. The table is not intended to circumvent any government communication with First Nations, Health Authorities, or Tribal Councils, but instead to build upon the work being done and to ensure consistent and reliable information flow. Further information is provided below on the importance of this table.

NAN COVID-19 Emergency E-mail

NAN established a specific emergency email (emergency@nan.ca) to ensure that community leadership and members both on and off-reserve have access to assistance when needed and information on COVID-19. This e-mail is monitored constantly, and inquiries are directed to the appropriate departments, or the COVID-19 Task Team, for a response.

NAN COVID-19 Website

NAN also created a new website (www.nancovid19.ca) to provide our communities and members with the latest public health information. The website includes updates from NAN, federal, provincial, and municipal governments, and information on supports for our members living in urban centres during the pandemic.

3.2 Emergency Management Planning

In January, Grand Chief Fiddler wrote to Indigenous Services Canada (ISC) Minister Marc Miller to express concern with his government's unwillingness to continue forward with an agreement that would see NAN engaged in two (2) pillars of emergency management: Mitigation and Preparedness. The letter also outlined the need for a review of the ISC-Ontario bilateral agreement and a new approach to addressing emergency management in NAN territory more generally. It is unfortunate that the work that should have been underway in respect of preparation for emergencies, such as a pandemic, was left stalled. It has become more than apparent that a review and overhaul is needed on an urgent basis. A copy of that letter is attached to this submission.

Specifically, beginning on the first day of the declaration of the pandemic, NAN became aware of a complete lack of any functional master emergency plan at the community level, inclusive of a pandemic annex response plan. Standardized templates proved to be wholly insufficient for community-specific needs, given for example, that the templates did not identify community strengths and weaknesses.

Emergency management training specific to First Nation communities is not available from Emergency Management Ontario. The courses and training offered by Ontario First Nation Technical Services Corporation do not match the Provincial

standards that municipalities follow and additionally, are only offered in limited capacity across the province. There is also a gap between these two streams of training which does not allow for appropriate and adequate learning and support.

Other major areas lacking in emergency management planning include:

- Lack of emergency management human resource capacity within communities: Emergency Management work is often undertaken by other community positions (i.e. Fire Chief) as communities lack human resource capacity and/or the funding required to fill these Emergency Management-specific positions.
- Lack of established emergency management service within communities. First Nations are often forced to rely on external resources and partnerships to meet basic emergency response needs. This results in overstretched resources and overall inadequate emergency management support.

3.3 Emergency Management Recommendations

1. A large-scale assessment of the current emergency management supports provided to First Nations and with a view to re-designing this system to provide adequate and comparable supports as those provided to municipalities in line with Grand Chief Fiddler's January letter.

2. That in partnership with NAN, the federal and provincial governments work collectively to support NAN in developing a NAN Emergency Management Service Model to be implemented in communities. There simply cannot continue to be a top-down approach to emergency management. This would include an increase to resources, both human and physical, which would meet community-specific demands.

3. Development of a standardized and annual method for First Nation outreach in consultation and engagement with First Nations. This will provide an appropriate structure for First Nation engagement and consultation that supports the community in alignment with community level needs and solutions, once again speaking to the failure of the current top-down approach to engagement and consultation. The current method of ad hoc conference calls has demonstrated a clear lack of ability for Emergency Management Operations to engage with First Nation communities comprehensively and adequately.

4.0 Trilateral Table

4.1 Formation & Function

Grand Chief Fiddler initiated the Trilateral Table process in March with key officials from the Ministry of Health (MOH), Indigenous Services Canada/First Nations Inuit and Health Branch (ISC/FNIHB), and Indigenous Affairs Ontario (IAO). He proposed the convening of the Table as a strategic tool to address NAN communities' concerns relating to the COVID-19 pandemic in a meaningful way. The Table was also intended to address the serious communication gaps witnessed at all levels of government with respect to the distribution of relevant COVID-19 information when the pandemic was declared.

It is worth noting that both levels of government were very supportive of this approach given the unique considerations in NAN territory, and their support is apparent to this day.

The first Trilateral Table meeting was held via conference call on March 31, 2020. Since then, calls have been held on a weekly basis.

Membership includes senior officials from NAN (including the NAN COVID-19 Task Team), ISC/FNIHB, IAO, Ontario Health (North), and MOH.

Senior level government representatives have also brought in their respective team members to provide support and contribute to the discussions.

NAN has taken the lead in facilitating, chairing, and developing agendas for Trilateral Table meetings based key issues raised by NAN leadership and NAN Task Team members. Draft agendas are shared in advance with provincial and federal liaisons to inquire about feedback and/or any suggested additions to the agenda.

NAN representatives hold weekly preparation meetings with Task Team members to review each agenda item and identify the appropriate person to speak to specific issues.

An Accountability Sub-Group, made up of technical representatives from NAN, Ontario, and Canada, meets weekly to review the items discussed and assign responsibilities to representatives, ministries or departments for each action item identified.

4.2 Successes & Shortcomings

Success: Engagement of Federal Government

Since the inception of the Trilateral Table, there has been consistency and enthusiasm in participation by senior level government representatives. When the Trilateral Table was formed, NAN sought a commitment by the federal government to engage, and we believe this process has assisted senior level government officials in better understanding the serious community-level issues that are raised at these weekly meetings so that priorities can be tailored. Additionally, NAN senior officials and staff have benefitted by better understanding some of the complex government undertakings and challenges faced related to pandemic response, and have thus been able to better support NAN-member Nations with tangible, transparent, and factual information.

The Trilateral process has proven that issues that are addressed collaboratively and quickly have a much greater chance of success.

Success: Transfer of Responsibility for Contact Tracing to First Nations Health Authority

One of the key policy changes announced at the Trilateral Table included the transfer of responsibility for COVID-19 contact tracing from FNIHB to the Sioux Lookout First Nation Health Authority (SLFNHA). SLFNHA and NAN strongly advocated for this shift and appreciates that FNIHB prioritized this request.

Success: Improved Transparency

NAN and ISC were able to develop a more organized process to exchange information and provide updates on actions taken. For example, FNIHB began providing weekly reports on the breakdown of Personal Protective Equipment (PPE) supplies allocated and distributed to each community.

Shortcoming: Interjurisdictional Barriers

It took some time to have conversations that included both levels of government on many issues because historically, most if not all health matters respecting First Nation people fall within the jurisdiction of the federal government. While there was a verbal commitment to ensuring that "jurisdictional barriers should not inform any government response", the longstanding history of the policies and methods continue to inform much of the response. It is important to continue to collaborate to ensure a coordinated health response and to end the unequal treatment and gaps in care made prevalent by these jurisdictional arguments.

Shortcoming: Personal Protective Equipment

From the beginning, NAN raised concerns with process by which NAN communities can access PPE - and when they should access PPE - in order to ensure the safety of community members. NAN has been seeking clarity on the process for First Nations to access PPE since the Trilateral Table held its first meeting on March 31. This information was being sought in an effort to support First Nations in navigating these extraordinary circumstances.

Despite best efforts by federal partners at the Trilateral Table to assist in resolving this question - and diligently attempting to follow up week after week - the process for NAN First Nations communities to access PPE remains an ongoing source of widespread confusion, especially since the transfer of responsibility to the provincial government.

The numerous policy changes regarding the distribution of PPE, and the sporadic communications accompanying those amendments, indicates that the PPE component of the federal government's COVID-19 pandemic response was being developed during the pandemic. From these exchanges, NAN has observed the disturbing fact that the federal government did not have a plan in place to supply remote northern First Nations with PPE in an organized and automated manner, nor did they have a way to ensure those processes were communicated in an efficient manner.

Overall, the success of the Trilateral Table cannot be overstated in terms of a coordinated and transparent approach. We would encourage that the federal government to continue with this commitment so that we can address priorities beyond the pandemic and thank those who have participated for their dedication to ensuring the health and safety of NAN citizens.

While exceeding the scope of this submission, the successes of this process are worthy of future consideration.

5.0 Federal Funding

5.1 Providing Ongoing, Required Funding to Communities

NAN First Nations are dealing with social, economic, and other issues due to COVID-19. Resources are scarce and communities need immediate support to access programs and benefits. Individual members and businesses need additional support to access and apply for benefits and subsidy programs. We echo the request made by other Indigenous communities to access funding to procure the necessary advice and resources to assist with this.

At the beginning, the government was able to efficiently flow funding to communities, even if it had been on hold due to overdue reporting or other administrative requirements. We need ways to ensure that capacity at the community level to complete reports is not a barrier to accessing crucial funding.

When announcing the Indigenous Community Support Fund (ICSF) on March 18, ISC stated that, "…Canada recognizes that First Nation, Inuit and Metis are among the most vulnerable, and that during this crisis, in particular, those in remote and fly-in only parts of the country are uniquely vulnerable" so a distinction-based measure was introduced to be administered at the community level.

In aggregate, the ICSF was a significant amount. The $305 million is shared among 600 Indigenous communities and urban Indigenous serving organizations, so the amount the community will receive is less impressive. For example, Ontario First Nations were to receive $37,500,000, but this is shared among 133 First Nations. This means Nations will receive, on average, no more than $280,000 to care for the physical, mental, spiritual, and economic wellbeing of their whole community.

The ICSF was formula-based and the allocation was left to the Regional Director General's discretion; however, it was effective in getting much needed funding into the hands of a community for spending on important measures as determined by the community. This was an important initiative to get money to those who are most vulnerable and empower the community as a decision-maker. Yet, as we enter day 94 of COVID-19, Indigenous communities are left with the prolonged effects and impacts of COVID-19 measures, with no similar funding announced until recently (with details still outstanding).

While the initial funding may have helped communities through the initial preparedness phase of the COVID-19 pandemic, those funds have long been spent. It appears there has been little thought or consideration to the continued cost of the sustained lockdowns, how Nations will cope with a second wave, how they will deal with a subsequent emergency (i.e. flood/fire), or how they will resume the education of their children.

The April 3 announcement of $100 million to support food banks and food organizations does not meet the need of NAN First Nations. The bulk of this funding is earmarked for organizations including Food Banks Canada, the Salvation Army, Second Harvest, Community Food Centres Canada, and Breakfast Club of Canada. Few, if any, NAN communities are served by these charitable organizations. A portion (i.e. $30 million) of the $100 million remains unallocated. As a national response, this will not be sufficient to support on-reserve members, especially given the high cost of living in remote and isolated communities in NAN. Additional funding is re required to address food security in the remote north of Ontario.

With respect to supporting our First Nations, we would like to see the following:

1. Immediately implement ongoing recovery funding to address the prolonged impacts of COVID-19 and the subsequent economic fallout.

2. Ensure that programs are needs or formula-based and not proposal-based. A needs/formula-based application model similar to other subsidy programs would ensure more fairness among groups, as compared to a limited pot of funding for a large group of diversified organizations in a competitive situation. A proposal-based model creates a competitive environment to access funding – rewarding those with more capacity to manage and address such requests quickly. Specifically, in context of the pandemic, those groups/Nations with less capacity were less successful, despite the clear articulation of their needs.

5.2 Including Indigenous Businesses & Communities from the Beginning

The benefits and subsidy measures introduced by the federal government to date are a welcomed and appreciated step in the right direction to support Indigenous communities during this challenging time. We applaud the tireless efforts of the government and we appreciate their work to remedy issues with the emergency programs when they initially lacked consideration of Indigenous experiences.

Indigenous businesses often have complicated corporate structures that are used for economic development and business activities. This is partly the result of Indigenous groups navigating and applying legislation in business dealings as created and required through statute and law, under the Indian Act, Income Tax Act, Partnership Act and Business Corporations Act.

Indigenous-owned businesses have to interpret and operate under special rules and guidelines, which resulted in additional complexity in assessing whether they are: i) eligible for CEWS and ii) whether they are filling out the Canada Emergency Wage Subsidy applications accurately and completely.

When CEWS was initially rolled out Indigenous-owned corporations were deemed ineligible, so too were the businesses that partnered with them. This was due to a technical tax definition. Through collective advocacy from communities, treaty organizations, and groups like the Canadian Council for Aboriginal Business, the CEWS program was amended to include indigenous-owned businesses. This has the potential to protect thousands of jobs that were otherwise at-risk.

Another example was in the original roll-out of the Canada Emergency Business Account, non-taxable pay was excluded from the application. This meant those businesses with staff on reserve were ineligible on another technicality. This has been corrected following a significant advocacy effort. In addition to the significant advocacy effort, we have also had to dedicate resources to tracking and navigating changes to community and business support programs.

Understanding the government was required to trade clarity for expediency, our request is that any additional program changes, or new program be communicated clearly from the beginning with an option to be notified when something changes.

As the government designs and implements further recovery programs our ask is that Indigenous representatives are engaged early. This will ensure that programs are effective, and that valuable time and limited resources can be fully utilized to protect our communities rather than advocate to the government for changes.

5.3 Funding Recommendations

1. Immediately implement ongoing recovery funding to address the prolonged impacts of COVID-19 and the subsequent economic fallout.

2. Ensure that programs are needs/formula-based, and not proposal-based.

3. Allow emergency assistance funding to be used for communities to proactively improve their COVID-19 and emergency expense tracking through technology.

4. Communicate any additional program changes, or new programs, clearly from the beginning with an option to be notified when something changes.

5. Engage Indigenous representatives early as the government designs and implements further recovery programs to ensure that programs are effective from the beginning, and that valuable time and limited resources can be fully utilized to protect our communities, rather than advocating to the government.

6. Decrease administrative and reporting burdens with respect to funding received at the community level.

6.0 Public Health

6.1 Lack of Pandemic Preparedness

Decades of underfunding meant that there was significantly limited public health capacity at the community level at the outset of the pandemic. For example, Community Health Representatives (CHRs) were important to communities for decades, but the government has not continued to support this role. These CHRs have also had to focus on acute care needs, such as dispensing medication.

There should be no expectation that health care workers who are focused on acute care can do public health on the side; there needs to be a dedicated public health workforce.

Jurisdictional issues in the public health response to the positive COVID-19 case in Eabametoong First Nation were initially challenging, as it was unclear whether SLFNHA, FNIHB, or Thunder Bay District Health Unit would lead the response. SLFNHA eventually received approval to be responsible for public health management of COVID-19 for the communities that it serves; however, it took six weeks and many hours of advocacy for the proposal to be approved.

The lack of recognition of First Nation Health Authorities leads to confusion, inefficiencies, and inequity in the provision of public health services. These issues are exacerbated by the utter lack of any relationship between First Nations and Public Health Units. The federal government should consider revising legislation to reflect that First Nations have jurisdiction over public health in their area, and for this to be recognized by the province.

6.2 Health Planning & Response

NAN moved quickly and efficiently to protect our First Nations and minimize the impacts of COVID-19 by increasing clear and consistent communication and collaboration across NAN territory. By focusing on First Nation-led responses and addressing community-identified needs, we demonstrated that Health Transformation can and does work.

For example, Wabun Tribal Council advocated for Mattagami First Nation to be approved as a COVID-19 testing site. This allowed for a more targeted, community-led approach to identifying needs, gaps and solutions. Significant advocacy by the Health Authorities also led to procurement of oxygen therapy equipment for remote nursing stations.

The federal government has been more accessible and communicative during the pandemic and has responded more quickly to emails and phone calls. The Non-Insured Health Benefits program has become more responsive and flexible during

this time, which has helped community members manage their health more effectively during the pandemic. The government was able to identify funding for SLFNHA for the purchase of critical care equipment for the entire SLFNHA region. They did this because bureaucratic processes at FNIHB were slowing down procurement; for example, three weeks after FNIHB said supplies had been ordered, nothing had actually been ordered.

There was a significant time delay that caused the need to negotiate this funding; this delay meant that some equipment was sold out and unavailable to purchase by the time the funding was released. Given existing healthcare and infrastructure challenges and inadequacies in remote First Nations, northern communities should have been a priority for the government for any pandemic planning; instead, the lack of investment in Emergency Response at the community and regional level was readily apparent.

There was also a significant disconnect between the federal government and the reality in communities with respect to the government assumption that many First Nations had pandemic plans. For example, the FNIHB database claimed that some First Nations had pandemic plans, when in fact they did not. NAN was able to support a number of our communities in the development of pandemic plans, but this activity was not funded.

Additionally, the federal government did not have an adequate overall pandemic plan in place for northern First Nations. For example, FNIHB's initial plan was to fly community members out should there be a case of COVID-19 in a remote First Nation. There was no contingency plan should on-the-ground realities, such as aircraft issues or weather, prevent this from occurring.

If the government had supported NAN, Tribal Councils, and First Nations in managing the pandemic response, it would have led to more appropriate and timely action. Instead, the government initially tried to lead the response alone, resulting in NAN, Health Authorities, Tribal Councils and communities communicating with government and strongly advocating for why aspects of that response would be inappropriate for northern First Nations.

The pandemic highlighted previous failures and neglect by the government, such as its failure to provide adequate emergency management training and planning to First Nations, its failure to address the mental health crisis, its neglect of crumbling community infrastructure, and its failure to support First Nations with the enforcement and prosecution of Band bylaws. These ongoing issues drastically affect the ability of communities to plan for and respond to the pandemic.

As well, there continues to be an ongoing and significant lack of healthcare staff to address community-level needs. For example, it took approximately two weeks for FNIHB to establish surge capacity for nursing, especially in public health. When

gaps in human resource capacity were addressed through hiring, the new staff frequently lacked cultural competence and an understanding of the realities of life in the provincial north. There was a significant lack of sustainability planning to ensure ongoing capacity at the community level.

6.3 Mental Health & Addictions

The impacts of the pandemic response on community mental health were not something that was included in any government plan or in its initial response to COVID-19. Through advocacy work with our NAN COVID-19 Task Team, NAN has strongly voiced support for increased awareness at the government level and we have recently noticed an acknowledgement from the federal government that investments in mental health initiatives is desperately needed.

We have seen an increase in mental health issues in communities, as well as other social challenges such as domestic disturbances and an increase in substance abuse. This shows the need for pandemic planning in First Nations to include managing stress, fear and anxiety caused by the pandemic, as well as disruptions to programs and services. Recent tragedies, including youth suicides, emphasize that there needs to be consistent services over time for youth mental health.

More funding for mental health is urgently needed, with continuity of care and clinical oversight for at least five (5) years and a way for the client to evaluate the services that they received. This is especially pressing during a high-stress situation such as a pandemic; with the COVID-19 pandemic anticipated to last up to two (2) years, a high level of need in this area should be anticipated.

6.4 Infrastructure

Due to the significant ongoing infrastructure challenges with housing and water, many public health measures such as handwashing (some houses without running water) and self-isolation (22 people residing in one (1) home) have been difficult in NAN communities. The government should address immediate housing needs and take stronger actions to eliminate all drinking water advisories by March 2021.

NAN has advocated for a hospital to be built in one of our larger First Nations for years; the government should have looked at funding and building this hospital, especially in anticipation of a second wave of COVID-19. Because of this lack of investment, community members will still need to rely on evacuation to larger hospitals in urban areas should additional waves of COVID-19 reach NAN communities. This cannot be a sustainable model for the future.

There has been no funding to check machines/equipment used in health care (e.g. blood pressure machines) even though nurses rely on these readings. The government should provide maintenance funding for this equipment.

7.0 Conclusion

NAN is grateful for the opportunity to participate in this process, and thanks the Standing Committee for this important work.

The health and safety of NAN citizens is paramount. As we have worked so hard to ensure that the virus does not spread in NAN territory, we have noticed a true willingness and collaborative effort from our federal government partners in navigating this very difficult time. It is important that we do not lose the important lessons that we have learned, and always remember that we are stronger when we work together towards common goals and priorities.

Submitted, this 12th day of June, 2020
Nishnawbe Aski Nation