Northern Inter-Tribal Health Authority

2011/2012 Annual Report

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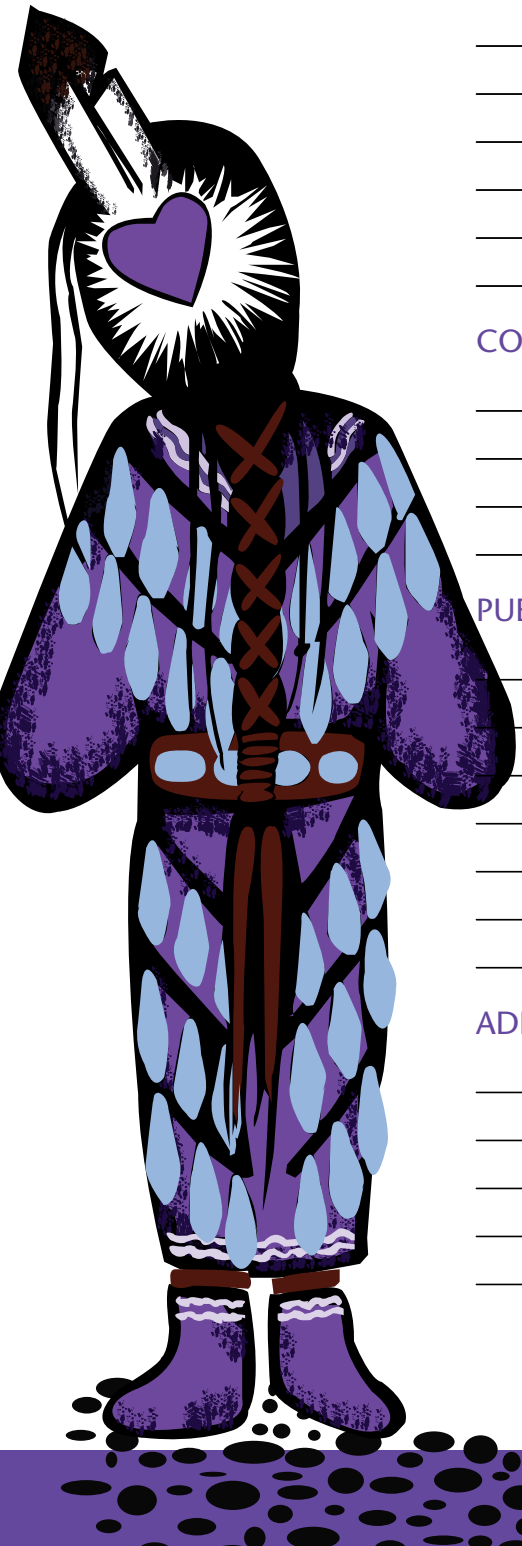

VISION STATEMENT

Partner communities will achieve improved quality health and well-being, with community members empowered to be responsible for their health.

MISSION STATEMENT

The NITHA Partnership, a First Nations driven organization, is a source of collective expertise in culturally based, cutting edge professional practices for northern health services in our Partner organizations.

PRINCIPLES

- NITHA's primary identity is a First Nations health organization empowered by traditional language, culture, values and knowledge.
- The NITHA Partnership works to promote and protect the inherent Aboriginal and Treaty Right to Health as signatories to Treaty 6.
- NITHA is a bridge between the diversity of our Partners and the external world of different organizations, governments, approaches and best practices.
- The NITHA Partnership has representation at the federal and provincial levels.
- Partner communities are on the inside track of changes and developments.
- Through innovation and experimentation, the NITHA Partnership builds health service models that reflect First Nations' values and our best practices.
- NITHA provides professional support, advice and guidance to its Partners.
- NITHA contributes to capacity development for our northern First Nations health service system.
- NITHA works collaboratively by engaging and empowering.

ABOUT NITHA

Northern Inter-Tribal Health Authority

The Northern Inter-Tribal Health Authority Inc. is a First Nations' Partnership organization comprised of Meadow Lake Tribal Council, Lac La Ronge Indian Band, Prince Albert Grand Council and Peter Ballantyne Cree Nation. The four health organizations have more than 20 years of combined experience in the provision of health services in the Health Canada 'transfer environment' and in the delivery of nursing, public health, and primary care treatment services in 33 First Nation communities throughout northern Saskatchewan.

NITHA Partners are "northern", sharing the same geography, attachment to the land and related traditional activities, along with common challenges in accessing and providing health services.

The four Partners established NITHA because of joint needs for services that were not feasible for each organization to provide alone. NITHA does not try to direct the development of the Partners' health services but rather, to support and advise.

The Chiefs have the ability to speak with one united voice, thereby being stronger and more powerful in the insistence for health services responsive to the needs of northern communities. The Partners want a "First Nations health service" model that is different from the mainstream model. NITHA needs to continue building services on this evolving First Nations model.

The Partnership

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Prince Albert, SK
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Meadow Lake Tribal Council
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Meadow Lake, SK
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Fax: (306) 236-6485

Lac La Ronge Indian Band
PO Box 1770
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Peter Ballantyne Cree Nation
PO Box 339
Prince Albert, SK
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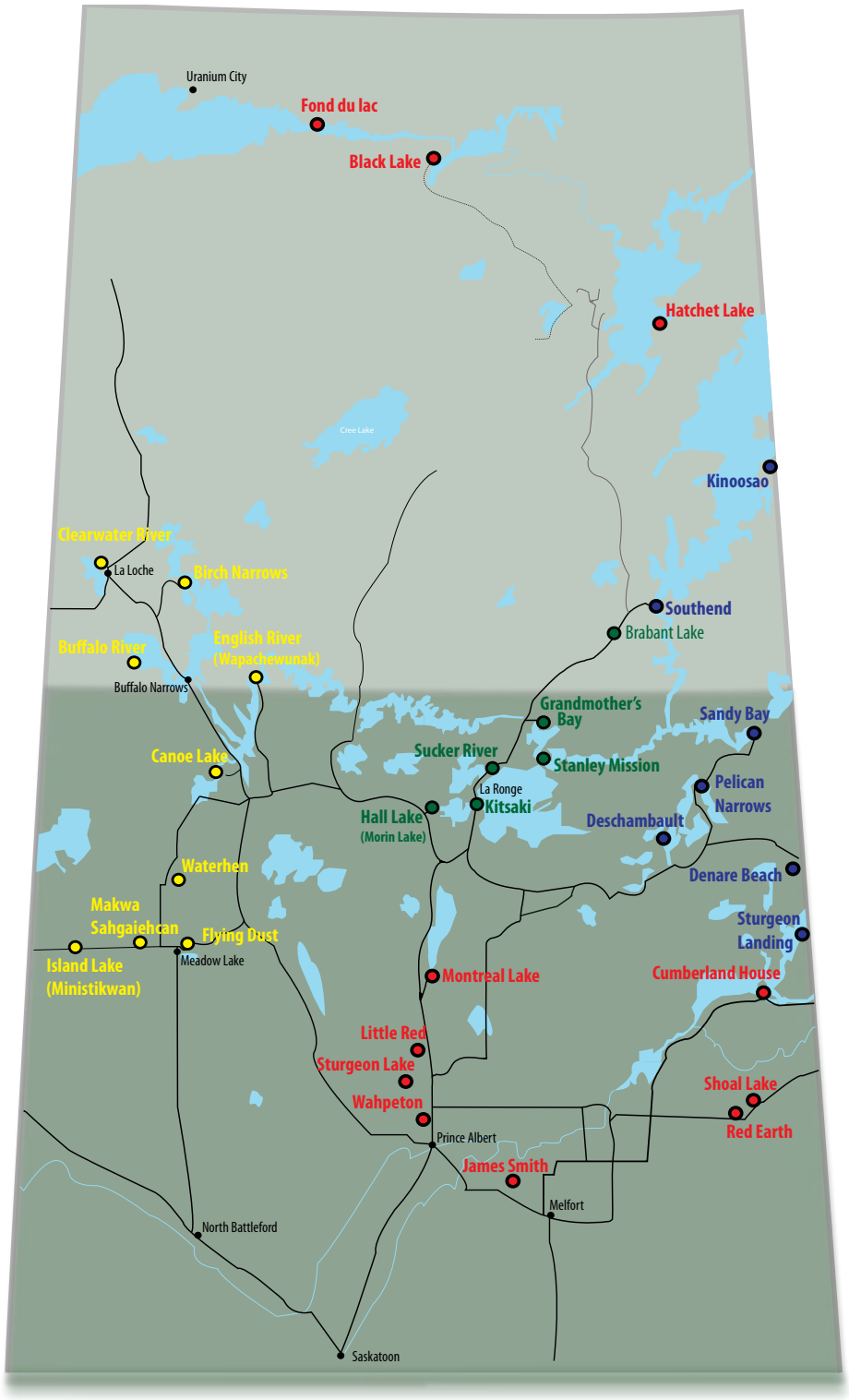
Fax: (306) 922-4979

Partnership Communities



NORTHERN INTER-TRIBAL HEALTH AUTHORITY

Lac La Ronge Indian Band	Prince Albert Grand Council
Peter Ballantyne Cree Nation	Meadow Lake Tribal Council

Legend

NITHA Board of Chiefs

GRAND CHIEF
RON MICHEL
PRINCE ALBERT
GRAND COUNCIL

TRIBAL CHIEF
ERIC SYLVESTRE
MEADOW LAKE
TRIBAL COUNCIL

CHIEF TAMMY
COOK-SEARSON
LAC LA RONGE
INDIAN BAND

CHIEF DARREL
McCALLUM
PETER BALLANTYNE
CREE NATION

NITHA Executive Council

JENNIFER CONLEY
PRINCE ALBERT
GRAND COUNCIL

FLORA FIDDLER
MEADOW LAKE
TRIBAL COUNCIL

MARY CARLSON
LAC LA RONGE
INDIAN BAND

ARNETTE
WEBER-BEEDS
PETER BALLANTYNE
CREE NATION

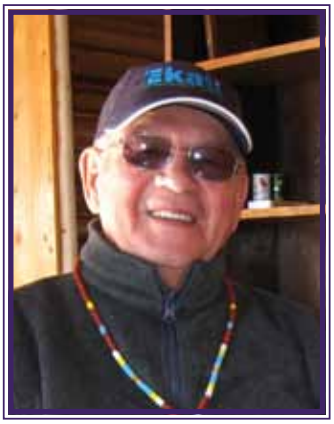
The Role of Elders

Elders provide mentoring to the Board of Chiefs and the NITHA Executive Council with education in First Nations' values and approaches in working with each other in providing services to the Partnership communities.

The NITHA Board of Chiefs will have one Elder from each respective Partner present at all meetings. The NITHA Executive Council will have one Elder at all meetings and this role will alternate among the Partners.

ELDER
VITALINE READ

ELDER
GERTIE MONTGRAND

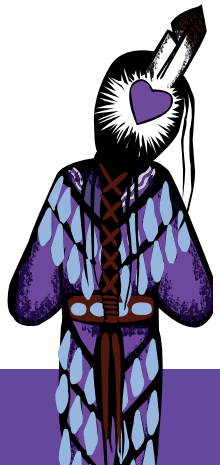


ELDER
JOHN MORIN

ELDER
MIKE DANIELS

ELDER
ROSE DANIELS

ELDER
KATE HAMILTON



Message from the Chairperson

Tansi.

As Chairperson of the NITHA Board of Chiefs, I am honoured to present the 2011-2012 Annual Report of the Northern Inter-Tribal Health Authority. I have been a member of the Board for the past 7 years and have served as Chairperson for 4 of those years. During that time I have witnessed many changes in our communities as we strive to overcome the historical impact of colonization, including the health and social well-being of our community members. There are many factors that affect health outcomes of communities, families and individuals including education, housing, socio-economic status and safe drinking water; not just the availability of health care services.

NITHA was formed in 1998 from a partnership between Prince Albert Grand Council, Meadow Lake Tribal Council, Lac La Ronge Indian Band and Peter Ballantyne Cree Nation; in response to public health needs that could not be met by the organizations individually. Since that time the programs and services offered through the NITHA team have expanded in response to the diverse health care needs of our community members and is reflected in the Mission Statement of NITHA: ***The NITHA Partnership, a First Nations-driven organization, is a source of collective expertise in culturally based, cutting edge professional practices for northern health services in our Partner Organization.***

NITHA's Strategic Priorities are reflective of the needs identified by the 4 partner organizations; Sustainability, Political Advocacy, Health Human Resources and Program Development Expertise and Support. We continue to take a strategic approach with careful planning in deciding how best to use the resources available to NITHA.

There has been a change in leadership at NITHA, Dennis Moore retired in June 2011, after serving NITHA for 4 years. Taking his place as CEO is Dr. Rose Roberts, a Lac La Ronge Indian Band member originally from Stanley Mission. We welcome Dr. Roberts to NITHA and the Board looks forward to working with her and the rest of the NITHA team as we strive to fulfil the NITHA vision statement: Partner communities will achieve improved quality health and well-being, with community members empowered to be responsible for their health.

Teniki

Chief Tammy Cook-Searson
Lac La Ronge Indian Band

Message from the Chief Executive Officer (CEO)

Tansi ekwa!
As I finish my first year as CEO of NITHA, I am reflecting back on the many changes that have occurred in – what feels like – a relatively short period of time. Not very many people like change however change is inevitable, for without change there is no growth. As First Nations people, change has been a constant in our lives for many generations – and resiliency and adaptability have been two of our many strengths that have seen us through. NITHA is a First Nations organization and through the adaptation of First Nations values, we have also become stronger through the process of change.

Many of the staff in this annual report are new and so are some of the positions as a result of the restructuring that occurred in 2010-11. We are building a strong team, Bev Peel as the Director of Community Services and Tolu Babalola the Human Resources Advisor are new staff members that are welcome additions to the management team. Patrick Hassler the Emergency Response Coordinator and Marlene Larocque the HIV Strategy Coordinator are also two new staff members in new positions. NITHA continues to attract the expertise in professional practice that will assist in carrying out NITHA's mission statement.

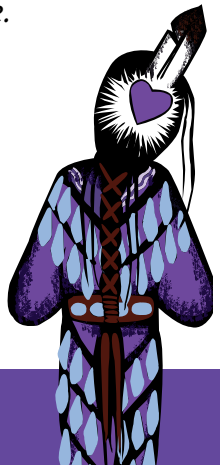
NITHA will be negotiating funding renewal with FNIH in the fall of 2012. As part of that process, we have been going through our evaluation process along with an updated Health Status Report. Both reports will be completed by June, 2012. I would like to thank NITHA staff, internal and external stakeholders for providing their support during the evaluation and the health status report data collection phases. These two reports will provide the foundation of the Organizational Health Plan and along with the Strategic Priorities will be the road map for NITHA in the next few years.

NITHA's mandate is determined by the communities needs and those needs are conveyed to us through the Board of Chiefs, the NITHA Executive Council and the Elders. While we cannot meet every request, our focus is to provide services and programs that will benefit the greatest number of people; the essence of public health which is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals" (1920, C.E.A. Winslow).

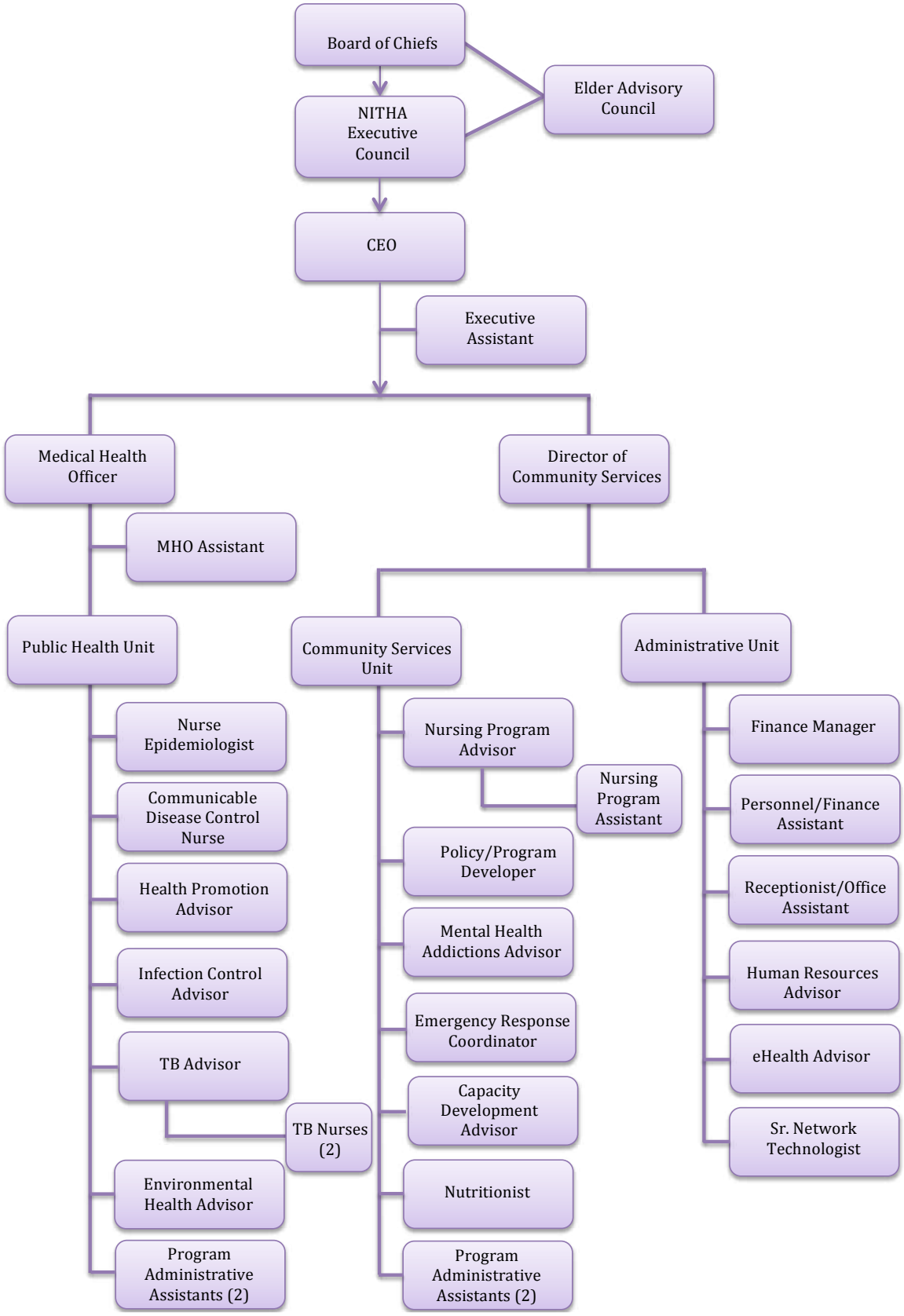
As indicated in the Audited Financial Statements contained in this report, NITHA continues to be in a good financial position as a result of careful budgeting and accountability practices. Support services to our Partners will continue to be sustained only as a result of spending within our means and good accountability practices. I would like to thank the NITHA Executive Council for their dedication and foresight in planning for NITHA's financial future and for their guidance and support this past year and in the future.

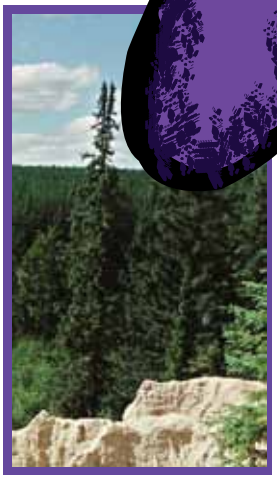
Ninanaskomoon.

Dr. Rose Roberts
Chief Executive Officer



NITHA Organizational Chart





NORTHERN INTER-TRIBAL HEALTH AUTHORITY

Dr. Rose Roberts

Chief Executive Officer

Bev Peel

Director of Community Services

Heather Gunville

Executive Assistant

Yollanda Bear

Executive Assistant (Term)

Tolu Babalola

Human Resources Advisor

Lisa Lepine

Finance Manager

Glenna Thomas

Personnel/Finance Assistant

Deanna Brown

Program Admin. Assistant

Cindy Sewap

Program Admin. Assistant

Charles Bighead

e-Health Advisor

Eric Xue

Sr. Network Technologist

Linda Nosbush

Capacity Development Advisor

Patrick Hassler

Emergency Response Coordinator

Lesley Budd
Receptionist/Office Assistant (Term)

Shirley Woods
Nurse Epidemiologist

Marlene Larocque
HIV Strategy Coordinator

Linda Rogozinski
Program Admin. Assistant

Ramona Caisse
Program Admin. Assistant

Maxine Ballantyne
Receptionist/Office Assistant

Leslie Brooks
Communicable Disease Control Nurse

Brenda Ziegler
Environmental Health Advisor

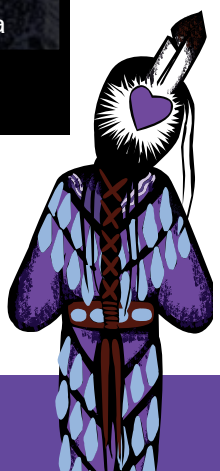
Linda Gilmour-Kessler
Health Promotion Advisor

Ewelina Dziak
Infection Control Advisor

Sheila Hourigan
TB Advisor

Eileen Oliveri
TB Nurse

Vi Petrinka
TB Nurse



COMMUNITY SERVICES UNIT

Program Overview

BEV PEEL
DIRECTOR OF
COMMUNITY SERVICES

The Community Services Unit provides program support and knowledge in the areas of nursing education/training, capacity development, mental health and addictions, nutrition and emergency preparedness. The Unit partially reduces the residual role for FNIH in a post-transfer environment while maintaining working relationships through open communications and mutual respect. The Unit is tasked with providing up-dated information on the availability or shortfall of the regional or national programs and ensuring coordination of support to assist the Partners in the development of financial proposals. Community Service Unit staff participate in Partner and community working groups as directed by the Partners to assure that the North is proportionally represented at strategic planning meetings that may impact the resources or appropriateness of health policies for the North. This year the Community Service Unit worked with the Partners to draft letters of intent and proposals in order to access new national funding under the Health System Integration Fund (HSIF).

The following employees comprise the Community Services Unit: Director of Community Services, Emergency Response Coordinator, Capacity Development Advisor and Program Assistants (2). As part of its organizational restructuring in 2010-11, NITHA combined its primary care nursing, community health nursing and home care nursing initiatives into one position: Nursing Program Advisor. Due to the current nursing shortage, this position has been difficult to fill. However, the nursing services that NITHA has provided in the past have continued to be provided through a variety of creative methods. The new position of Director of Community Services was hired this year to focus on directing and supporting the planning, negotiations, proposal writing and implementation for programs within the Community Services Unit and the Public Health Unit.

The Community Services Unit provides support to the partnership through program development, policy and procedure development, capacity building, training and education. The direction for these developments are set by the NITHA Executive Council (NEC) and reflect the priorities established through the NITHA Board of Chiefs. NITHA works with the Partners to build linkages with government and various organizations using a community development approach, based on a set of principles that help to connect the northern people to local opportunities and build and increase capacity.

Home and Community Care (HCC)

Home Care is a mandatory health program that provides health services to patients of all ages based on a holistic nursing assessment and is guided by an individual care plan. Home Care programs and services were established to assist community members who suffer from chronic and acute illnesses to receive treatment in their homes, in familiar surroundings, close to family, friends and community and to maintain some of their independence as long as possible. Home Care provides services across the continuum, from prenatal and postnatal care, to children, young adults, elderly and palliative clients.

Essential elements provided by all NITHA communities include Assessment, Home Care Nursing, Case Management (referrals and linkages), Personal Care (like bathing and foot care), In-Home respite, access to Medical Equipment & Supplies, Program Management and Supervision and Data Collection. The First Nations and Inuit Home Care Programs include authority for additional support as required. These additional services can be accessed and obtained if there is sufficient funding in place for palliative care and rehabilitation services but this often is not the case.

Nursing Practice / Clinical Practice

In order for the Partners to be able to provide the nursing services within their primary care clinics, nurses working within these clinics must undergo additional training for an expanded scope of practice called Transfer of Medical Function (TMF). The training process includes several components: a one week session called Orientation and Skills Training (OST). This session is often held at NITHA and the cost of the training is absorbed by NITHA, although the Partners coordinate the training for their specific organizations. Preceptoring for up to 10 days for nurses following the OST session, in their respective places of employment (this cost is also absorbed by NITHA). The Preceptor is a nurse who works at the clinic and has already gone through the TMF training. Additional skills training can also occur in a hospital setting. Assessment and evaluation, both written and clinical is documented and a physician that is contracted by NITHA signs off the TMF for each nurse that has successfully passed the requirements. Each nurse who has undergone the TMF training is assessed and re-certified on a yearly basis through a personal assessment as well as an external assessment through chart audits.

The Pharmacy and Therapeutics Committee which had been chaired by the NITHA Medical Health Officer was resurrected by Colleen Bowen from the Prince Albert FNIHB office. Membership includes all nurse managers affiliated with a primary care clinic within the partnership, along with the respective Regional Health Authorities, affiliated pharmacists, a medical consultant, NITHA MHO and Nurse Program Advisor - for now the CEO represents NITHA. From previous work of this committee a Northern Formulary was established and has been the document from which pharmacies have been operating. FNIHB had completed an extensive review of their pharmacy formulary in 2010-2011, and the work of the committee has revolved around aligning the two documents. Any concerns or related changes to pharmaco-therapeutics are brought to this committee and this includes changes to the Non-Insured Health Benefits (NIHB) policies.

Upcoming Nursing Practice Challenges

Discontinuation of Transfer of Medical Function

In a recent review of their by-laws the College of Physicians and Surgeons of Saskatchewan (CPSS) have decided that legally they cannot 'transfer' any of their medical functions. They approached the Saskatchewan Registered Nurses Association (SRNA) and informed them that they would have to come up with an alternative solution within a specified time frame. The SRNA is the professional regulatory body for the registered nurse profession. The SRNA initiated discussions for a new certification program that will incorporate certain procedures that are currently being performed by nurses under the TMF. This new certification program will have an education and clinical component focusing on primary health care, and once nurses complete this program, they will then be able to add the (C) behind their RN initials.

Considering the TMF is the only process currently allowing nurses in the NITHA communities to provide the level of services they do provide, there has been a concerted effort by NITHA and Partners to ensure participation and input in the new program. The SRNA held a focus group of northern nurses, which NITHA hosted, in September 2011. Nurses expressed their concerns that the direction SRNA was currently pursuing would limit the ability for northern nurses to provide services. The recommendation was that SRNA incorporates the FNIHB clinical guidelines and Northern Drug Formulary into the RN(C) program. SRNA has complied with that recommendation. NITHA CEO is sitting on the SRNA provincial steering committee and the Prior Learning Assessment Review (PLAR) Education Committee. Ideally the PLAR process would be as accessible and timely as possible, to prevent absence from work and additional workload as much as possible. The northern Nurse Managers wrote a letter to SRNA, accompanied by a letter of support by NITHA and NEC late in Dec 2011, requesting a meeting early January to express their concerns on the rapid timeline. SRNA came to Prince Albert on January 13th and met with the northern nurse managers, FNIHB nurse managers, MLTC Health & Social Director and NITHA CEO. The response from the SRNA was a delay to the timeline by a year. NITHA and partners will continue to represent and advocate the needs for communities within the partnership as this initiative continues to unfold.

Home and Community Care Competency Development

As the services provided by the HCC program become more complex, there is a challenge to provide opportunities for ongoing education and skill development to ensure that all Home Care providers are competent to provide care within their defined role.

In support of nursing and clinical practice and in response to the Partner's needs for competency development and accreditation in continuing education, NITHA provided the following activities and educational opportunities in 2011/2012:

- Supervisors were brought together to discern HCC needs;
- A DACUM Process was undertaken with 31 people, most of whom were experienced home health aides to determine the knowledge, skills and attitudes required of them in First Nations context;
- The DACUM was validated with supervisors;
- The following courses were offered, which lead to certification as Home Health Aides through the SIAST Program;
    1. Personal Care (66 hours, 4 credits)
    2. Dementia Behaviour (45 hours, 3 credits)
    3. End of Life Care (17 hours, 1 credit)

Accomplishments

Collaborative Partnerships

- NITHA collaborated with employers, post-secondary institutions and three levels of governance: federal, provincial, First Nations and Regional Health Authorities for development of training programs.

- A workshop was designed and delivered in collaboration with FNIH HCC on November 29th and 30th with sessions on Infection Control, Lateral Violence, Fall Prevention and Traditional Healing.

- A collaborative partnership was established with Saint Elizabeth's First Nations, Inuit and Metis Program to discern how their distance learning modules could support the work of Home Health Aides in the North.

- SIAST delivered three courses of their Continuing Care Aide Program in a non-traditional delivery mode which combine correspondence and face-to-face training with a few online sessions 2011/2012 which enabled 56 Home Health Aides to pursue certification while continuing to work full time.

Challenges

One of the key concerns/issue identified with HCC is the inability to offer competitive salaries due to funding. First Nation nurses, including Home Care nurses and nurse managers are compensated much less than their non-First Nation counterparts working off reserve. First Nation communities have a very difficult time competing with other governments and their lack of resources has very often hindered the recruitment and retention of health care service providers. Wage parity remains a long standing cause for concern and major issue within HCC.

The services provided by the HCC have become more complex because their clients' needs have increased. Specialized treatments have resulted in a demand for nurses to take more training in the area of intensive treatments. Regionally, Health Canada was supported for five years of HCC Nurses Training dollars. This year it allowed the opportunity for Foot Care and Wound Care Training for HCC staff.

Priorities for the New Year

It is critical to close the gaps between existing continuing care services accessible to First Nations and those accessible to the general Canadian population. One of the priorities of the NITHA Partners is to develop a strategy to address the lack of long term and special care services on reserve.

One major program change that is being recommended is the proposed transfer of authority and funding for the "in-home care component" of the Assisted Living Program to Health Canada, to be integrated with the HCC Program. This aligns with federal ongoing work to develop a seamless continuum of care and will require further discussions and coordination between Aboriginal Affairs and Northern Development Canada and Health Canada. Unfortunately, the home care programs already face major sustainability issues due to limited funding and additional reporting requirements and the merger that is currently moving forward has had minimal First Nation involvement. Health Canada and AANDC have indicated that many steps need to be taken before integration could occur and have agreed that First Nations would be engaged prior to any action on integration. However, there have already been extensive discussions between the two federal departments (HC-AANDC) with minimal First Nation involvement. Neither the AFN nor First Nation regional representatives have been included in these discussions.

In recent years, communities/local HCC Programs identified the need for system changes to strengthen and enhance the program, and for guidance and direction in implementing these changes. In response a Quality Working Group was established. This year a resource kit is available to enhance the quality by doing the right thing (getting needed services); at the right time (when services are needed); by the right health care provider in the right way (using the right approach) to achieve best possible results. The Home Care Working Group (of which the Partners and NITHA belong) are developing a work plan to incorporate quality improvement (QI) in all their programs. This year will be a year to build awareness by launching the materials. It is hoped that quality improvement will be the short and long term result.

This year it is expected there will be forums on strategic planning in the area of HIV, TB, and Hepatitis Care. This will bring together Home Care Nurses & other Health Care Providers to explore issues of mutual concern as well as exchange knowledge, share evidence and ideas and generate solutions to this growing concern in our communities. It has never been more important to incorporate knowledge to action, by engaging nurses with others in knowledge exchange, enabling evidence informed practice, and inspiring excellence.

Capacity Development

Program Overview

LINDA NOSBUSH
CAPACITY DEVELOPMENT
ADVISOR

Capacity development is a process whereby community members come together to take collective action and generate solutions to common problems. Capacity development in the health sector seeks to unleash, strengthen, create, and adapt, as well acknowledge, the abilities that individuals, families and communities already possess as starting points for building professional capacity. Not only does this portfolio need to be aware of labour market demand generally, but it also has to be aware of the differences between and among Partners and communities across the North. Also, it needs to develop collaborative working relationships with First Nations Communities through NEC and with Regional Health Authorities across the North as well as with post-secondary institutions and professional bodies that accredit. To actualize the training, it needs to form relationships with funding bodies, both federally and provincially so that it can leverage funding to provide training and support. Finally, it must be able to creatively reduce or eliminate obstacles and barriers that arise for students and programs in a manner that is responsive to the needs of First Nations communities.

Priorities

The Capacity Development Working Group's (CDWG) priorities for 2011-12 were to strengthen the capacity of First Nations to deliver quality health services at the community level and strengthen leadership and management functions by managing the implementation of AHHRI (The Aboriginal Health Human Resource Initiative) through working collaboratively with the NITHA Partners, Post-Secondary Institutions, and the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS). The focus was on certified programs that lead to credentials that are recognized across the nation and are transportable in the following priority areas:

- Mental Health and Addictions
- Practical Nursing and Nursing
- Health Directors/Coordinators/Managers
- Home Health Aides with the support of NITHA and NLMHSTS funding

Furthermore, the CDWG envisioned that Career Paths would be developed that:

- Recognize Prior Learning and Experience;
- Support existing employees to upskill while maintaining full time employment;
- Enable employees to build career ladders that allow them to step 'on' and 'off' training ladders in ways that maximize transfer of credits and acknowledge essential skills across all health careers which, in turn, enable them to work inter-professionally as a health team;
- Develop prepratory programs that prepare students to make a smooth transition to certified programs;
- Honour First Nations ways of knowing, being, and interrelating; and
- Facilitate access to training through a blended distance model.

Achievements

Labour Market Supply and Demand

To respond appropriately in capacity development, there must be a keen awareness of the Health Sector Labour Market supply and demand in the North. Laurence Thompson was commissioned in 2007-08 by the Northern Labour Market Health Sector Training Subcommittee (NLMHSTS) and NITHA to do a baseline analysis of the Health Sector Labour Market with the understanding that this process would need to be repeated every four to five years to establish trends. The 2011-2012 Thompson study updated this data and involved ten Health Authorities. (NITHA; 4 Tribal Councils/Large First Nations: MLTC, PAGC, PBCN, and LLRIB; 4 Regional Health Authorities: Athabasca Health Region, Keewatin Yatthé, Mamawetan Churchill River, and Kelsey Trail; and FNIH). Thirty-three employers and 58 service sites (of which 47 reported their data) were contacted. This study reported data on 1,414 positions, which is an increase of 10% in the workforce from 2008. Thompson (2012) found that the following five positions would have the greatest demand for new hires over the next five years:

- Social and Community Service Workers;
- Registered Nurses;
- Nurse Aides;
- Early Childhood Educators; and
- Practical Nurses;

There is also an increased demand for Director/ Manager/Coordinator skills and training but since there has been a reorganization of the occupational code system comparisons are difficult. Thompson concluded:

- The Northern health workforce is very close to being representative of the 86% Aboriginal proportion of the Northern population except for positions requiring a university degree - a significant improvement from 2008;
- Projected demand over the next five years is 293 new hires per year, 24% of the current workforce;
- The workforce is growing by 2.5% per year;
- A shift has occurred from a medical focus to more of a community/social focus which explains the priority demands for social and community services workers over registered nurses from the 2008 data;
- Vacancies have eased slightly; and,
- There is increasing demand for managerial, program officer positions.

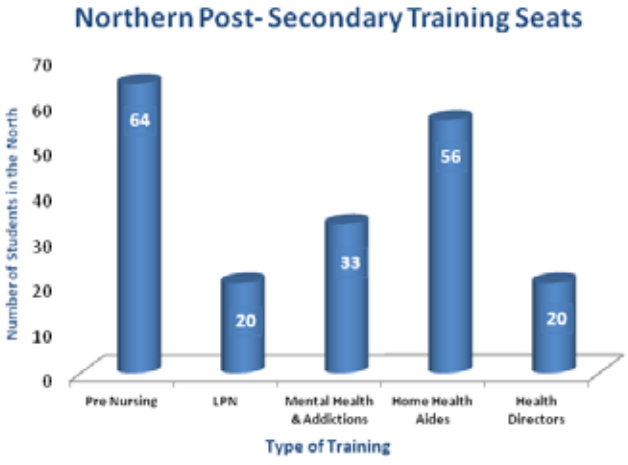
Thompson recommended:

1. Maintain the principles for a Northern Health worker training strategy already developed:
   - Build employment and training capacity at the community level;
   - While developing standardized training, curricula and certifications, provide community-based flexibility;
   - Base training for community workers as much as possible in the community where they live and work; and
   - Develop a multi-party training agreement, with the flexibility to accommodate the training needs of all the partners.
2. Strengthen links between the K-12 Northern education system, the Northern health services sector, and Post-Secondary health services education programs and organizations.
3. Based on the experience of piloting a laddered education system for community mental health and addictions workers, expand this training model to other community and social service workers as funds become available and training experience is gained.
4. Develop modular in-service education for community and administrative workers with credit towards a post-secondary certificate.
5. Simplify and repeat future data collection in four to five years (Thompson, 2012, p. ix – x).

It is studies such as Thompson's that have resulted in alignment of priorities among NITHA Partners, Provincial, and Federal Governments. In turn, this alignment enables leveraging of funds and maximizes the return on investment for all parties. NITHA's partnership with the NLMHSTS has enabled a powerful leveraging of funding; AHHRI contributed 46% and the NLMHSTS (through the Ministries of Health; and Advanced Education, Employment and Immigration) contributed 54% for post-secondary program costs this year. In addition, NITHA contributed funding toward Home Health Aide Training.

Professional Programs Leading to Certification

The past year has been very busy and productive for the joint ventures of the NITHA AHHRI partners and the Northern Labour Market Health Sector Training Strategy (NLMHSTS). The graph below shows 193 students were involved in Post-Secondary Training that leads to certification in Northern Saskatchewan this year.



Post-Secondary Training involved 193 students this year and included:

- Nursing (RN) - The Distributed Learning BScN was initiated this year with the enrolment of 64 students in the Pre Nursing Year in four Northern Communities; 15 – 20 students will be selected to move on to the first year of nursing in La Ronge and Ile a la Crosse next year;
- Practical Nursing - Twenty LPN students, 5 in the Face-to-Face Program (began Year 1 in September) in La Ronge and 15 in the Blended Distance Program (Began Prep Program in September and Year 1 in January).
- Mental Health and Addictions - Thirty-three students began the new Integrated Mental Health and Addictions Prep Program in February 2012 which they will complete in August. They will begin their Certificate program in September;
- Home Health Aides - Fifty-six Home Health Aides began their Continuing Care Aide certification program with four credits using a blended distance delivery model;
- Health Directors/Managers/Coordinators - Twenty Health Directors/Coordinators began training based on the NITHA DACUM/Job Profiles that have competencies in common with the First Nations Health Directors' Position Profile which will be used as the basis for national certification.

The NITHA Partnership and member communities have sacrificed to enable their full time Health Directors/ Coordinators/Managers, Mental Health and Addictions Workers, and Home Health Aides to pursue training. Thanks to all the communities for covering for those who were away on training. Others have taken on the role of mentoring our LPN's in training; your role model is forging a path others can follow.

Training can make an incredible difference; Howe (2006) calculated that:

- Females' lifetime wages grow by 3.3 times when they attain a high school diploma, by another 2.2 times when they complete a program at a technical school and by another 1.9 times when they complete a university program;
- Males' lifetime wages grow by 2.5 times when they attain a high school diploma, by another 1.4 times when they complete a program at a technical school and by another 1.2 times when they complete a program at university.
- As females gain more education, the disparity between male and female wages decreases:

  - Without a high school diploma males make 3.8 times more in their lifetime than females do;

  - With a high school diploma males make 2.9 times more than females do;

  - With a technical school diploma males make 1.8 times more than females do;

  - With a degree males make 1.1 times more than females do.

Career Ladders

Mental Health & Addictions Studies Career Ladder

In the 21st century, it is not only important to have initial training but also to have the opportunity to build on previous training, even to the point of changing career paths. This requires a broader look at Health Sector Training Programs, one that explores how various health careers are interrelated and how expertise can be built within and across career paths over time, in order to be responsive to the needs of individuals and communities. The Mental Health and Addictions Studies career path, developed across five institutions, is an example of how one might build a career path from the Prep level to the Post Graduate Diploma level; it does not, however, clarify how you could change career paths. For example, Home Health Aides enter the LPN Program and LPNs enter the RN Program. This requires institutions and employers to work together to honour how the skills and expertise of one profession can be used to build in another.

Throughout this work entrance requirements have to be carefully explored to find ways to screen students 'into' programs rather than 'out' of them. The development and refinement of Prep Programs has been a significant accomplishment. While reading, writing, communication and technology skills are important, it is also important to acknowledge the personal, professional, and community strengths individuals bring to their training. Students are now being given a chance to prove themselves by taking some introductory courses before formally entering a program; and a large number of our students are succeeding.

Future Directions

The priorities for next year will remain Mental Health and Addictions, Nursing, and Health Director/Manager training with an emphasis on building strong partnerships and innovative ways to deliver training that leads to certification. Collaborative approaches with the NLMHSTS, employers, and post-secondary institutions will be a key vehicle to facilitate this development.

While many barriers are being removed, challenges still remain in the planning, managing, and organizing of program services within the partnership. They include: communication practices, travel costs that consume major portions of budgets, capacity to respond to the broad range of community worker skills needed, and the lack of alignment between academic training years and budget years. While the funding streams are stabilizing provincially, the precarious nature of federal funding threatens the partnership and the leveraging that has enabled this work.

There are many opportunities that mobilize this work: collaboration, creative problem solving, critical reflection on past performance to set future goals, willingness to address barriers and obstacles, and a sense of hope and urgency abound in the working groups. When individuals grow and develop, they create positive energy in their families, workplaces and communities. Attaining credentials that are recognized nationally, not only enable First Nations professionals to assume leadership roles but also instills a deep sense of pride in their accomplishment. Role models are emerging and demonstrating positive life and career paths for children and youth. The Creator's gifts are recognized and celebrated as students see the strength and ability in those around them and, in themselves. Ongoing examination of the Northern Health Sector Labour Market coupled with strong leadership is enabling us to chart a positive direction for the future that acknowledges the great potential of the North.

Emergency Response

Program Overview

NITHA created and filled the Emergency Response Coordinator (ERC) position under the Community Services Unit and supervised by the Director of Community Services in September 2011. The ERC works with the Partnership to support and advise communities on emergency preparedness issues and planning. The position is evolving and beginning to encompass past initiatives such as community emergency response planning, pandemic planning (in liaison with the NITHA Public Health Unit), mask fit testing, public access to defibrillation and First Responding. The NITHA ERC is poised to assist the Partnership in any regard relating to the emergency response within a Partner community.

Achievements

A preliminary assessment of the state of emergency preparedness and capacity has begun and is ongoing. This assessment is being achieved by meeting with community members and leaders and perusing historical documents left from previous positions (eg. Pandemic Coordinator). It was noted quite early that the community leaders are very engaged on this topic and are very open to self-identify the need for more education/orientation on emergency response matters and processes.

A Policy and Procedures document was drafted to be used for the annual review of Community Emergency Response Plans (ERP) as well as a post review check list. Both documents are approved and in the implementation phase at this time. Although in the infancy stages, this process will help communities maintain their ERP`s in an updated fashion. This system will also incorporate a storage procedure that will ensure the ERP`s are available and producible during times of community emergencies. Cooperation at the community level is extremely important to the success of this process and to date has been obtained.

Information regarding First Responder initiatives is being gathered. It is the desire of NITHA to increase the number and utilization of this qualification. NITHA sees and understands the importance of First Responder initiatives within the Partner communities and will endeavour to support and advise communities in the implementation and sustainability of First Responder groups.

PATRICK HASSLER
EMERGENCY
RESPONSE COORDINATOR

Respiratory protection is also being addressed by the NITHA ERC. Many emergency contingencies will see health care workers entering environments that might be contaminated with infectious air borne particles. Policies and procedures must be in place to ensure that these persons are protected. Mask fit testing is the key procedure in maintaining this protection. The NITHA ERC will be assisting communities in completing mask fit testing as well as striving to implement policies and procedures (respiratory protection programs) that will see the Partner communities enhanced with the capacity to complete future fit testing as required by occupational health and safety regulations.

Training opportunities for Partner communities will continue to be a priority for the NITHA ERC. Many courses are available to communities to improve their state of emergency preparedness. Many communities have had training in the past (eg. Basic Emergency Management). This training should be repeated and built upon to ensure the information and skill set delivered is current and relevant.

Challenges

Training challenges have been identified within the Partnership. The standard course for orienting communities to the emergency response has been the Basic Emergency Management (BEM) program offered by Corrections and Public Safety. The challenge with this program is that currently there is no expiry date to the training. This presents a problem to the Partnership due to the funding procedures at Aboriginal Affairs and Northern Development Canada (AANDC). The current stand point is that once this training is delivered within a community that it will not be financially supported again. This approach does not take into consideration that persons change job titles, move or are simply no longer employed by the community. The NITHA ERC is attempting to elicit changes in this policy, however progress has been slow but will continue until a reasonable arrangement is achieved. The current situation is that the program is delivered by Corrections and Public Safety and will continue to be offered to communities free of charge for classes of 10-12 seats.

However travel expenses for community members will remain the responsibility of their respective community, which AANDC will not fund.

Emergency response plans and updated demographic numbers have been difficult and time consuming to receive from communities. It must be stressed that this is mainly due to lack of fulltime Emergency Coordinator positions at the community level. To date the large majority of emergency response planning and preparedness has fallen to already overworked and underfunded positions within the communities. This is problematic in prioritising when, where, who and how this work is achieved. This situation will continue to be addressed by the NITHA ERC by advocating for these community positions.

Priorities for Next Year

As the industry standard is changing in regards to emergency response plans the NITHA ERC is committed to ensuring partner communities are aware of and compliant with the changes. We are seeing a trend of an "all hazards" approach to community ERPs and the future will see the NITHA Partnership moving in the same direction. The "all hazards" approach is evidence based and is a sound approach to emergency planning. The theory of this approach is that many plans are rarely accessed and therefore are not familiar to the community. Taking an "all hazards" approach will ensure that the document is accessed for all community contingencies not just for pandemics or major community disasters. Thereby, having the ERP become more familiar and more easily used by community members.

Many organizations are mobilized during a large emergency response such as evacuations. The NITHA ERC will continue to engage these organizations and ensure that the Partner community voices and concerns are heard and addressed. Northern communities are very unique and require a tailored approach during emergent events that differ, in many ways, from First Nations communities in the South. The NITHA ERC will continue to ensure that the "North" is not made to fit in the "Southern" box in regards to emergency response.

First Responder groups are an extremely important part of the community response and pre hospital treatment on reserve. The NITHA Partnership in many cases finds themselves many hours from definitive care and pre hospital emergency medical services. Functioning First Responder groups can help shorten this window in getting basic life support care to their community much faster than outside agencies. They also enhance the emergency medical system by being local "experts" in language, terrain, resources and access to the sick or injured. First Responders become important resources in times of community disasters and pandemics, they are also able to continue their training and assist in the delivery of injury prevention information and community emergency medical training. For these reasons the NITHA ERC will continue to support and assist communities in the development and sustainability of First Responder initiatives.

PUBLIC HEALTH UNIT

Program Overview

The Public Health Unit continues to move forward and has now completed 15 years of providing services to the NITHA partnership communities.

From NITHA's inception in 1997, this unit has provided direct services and support to NITHA Partnership communities in the areas of all communicable disease requiring public health follow-up and immunization. The unit has expanded since then to provide environmental health services, emergency preparedness, health promotion and infection control. This year the position of emergency preparedness has moved to NITHA's other unit, the Community Services Unit but continues to work collaboratively to provide coordinated services to the partnership. The PHU unit has a broad goal of improving the health and well-being of the NITHA population through increased health promotion and primary prevention. Ideally, one would like to prevent disease or ill health from occurring rather than having to deal with ill health once the condition has developed.

This year staffing continues to remain a challenge for this unit. Dr. Mandiangu Nsungu continues to provide MHO services on a contractual basis as NITHA continues to work on recruiting a full time MHO. The Infection Control Advisor resigned in January leaving this position vacant. Recruitment continues for this position. The position of the Communicable Disease Nurse has been vacant for a number of months with Leslie Brooks doing part-time work until February of this year. A new nurse has been recruited and will begin early in the new fiscal year.

The Public Health Working Group, with representation from all partners and independent bands continues to meet regularly. This group provides direction and guidance to the unit in moving public health issues forward. Provincial and National work is reviewed and reworked to be appropriate for the NITHA partnership. The NITHA PHU working group is working to align the NITHA Public Health Strategy with the provincial Saskatchewan Population Health Council (SPHC) and their focus areas of Healthy Communities, Communicable Disease, Safe Environments and Public Health Infrastructure. NITHA has been involved with various provincial strategies within these four areas that will help improve the health of NITHA populations. Tuberculosis and HIV are two areas where considerable work has been done and further involvement with the strategy development and interventions continue. These will be expanded further in later sections.

One of the mandated roles of the PHU is to support the NITHA Partnership in Communicable Disease Control. Presently NITHA uses a system called iPHIS for electronic data collection of notifiable disease information. In the future the Ministry of Health will be replacing iPHIS with the public health system, Panorama. Panorama will provide many benefits to individuals, communities and populations as electronic records improve accuracy, confidentiality, portability and more accurate and timely reports.

Although, NITHA uses an electronic system for communicable diseases, Panorama will provide many more benefits but probably the most important is better coordination of care. Although electronic records provide many benefits there are still many limitations to the collection of this information. This information only reflects those who have sought testing or routine medical care, it depends on whether the health professional provides the testing and therefore represents only those cases and is not a picture of true incidence

or prevalence (the number of new cases or existing cases). This is especially important for those diseases in which there may be no symptoms for a long time. HIV, Hepatitis C, Syphilis and other sexually transmitted infections may go undetected for years. The data presented later reflects these caveats.

Nurse Epidemiologist

Epidemiology is the study of health and illness patterns and all factors associated with health and illness. It helps us to identify risk factors for disease, best treatments and preventative measures. This information assists communities to plan programs in the areas needed most and to develop strong public health programs. This position also provides immunization coordination for the Partnership. Ongoing education in the area of immunization is provided to nurses and others working in the area of immunization.

Vaccine management is also provided as vaccines are ordered, shipped and monitored through this unit. The PHU distributes vaccine to all NITHA communities and ensures cold chain protocols are followed. In addition, PHU measures vaccine wastage and provides feedback and education to communities to reduce vaccine wastage.

The Nurse Epidemiologist participates in a number of working groups related to Panorama. These groups consist of the First Nations Change Management Group, the Provincial SPRINT (Saskatchewan Panorama Redesign, Implementation & Networking Team) and SPRINTER(Configuration work groups for Immunization and Family Health) Working Groups as well as the Panorama Deployment Information Sharing Group. Much of the work in these groups is to ensure the system will meet the needs of First Nations.

Other special projects may also be coordinated by the Nurse Epidemiologist.

Innovation Funding

In February 2009 NITHA became aware of the opportunity to submit proposals for "Innovation Funds" for nursing stations. A proposal was submitted for an ongoing education program as well as personal data assistants or PDAs and a pharmacy scanning system. The latter two were approved and preliminary work was done to begin the process of implementing these 2 components in the nursing stations.

SHIRLEY WOODS
NURSE EPIDEMIOLOGIST

Personal Data Assistants

For both primary care and community/public health nursing alternate methods of ongoing education and support are needed. The use of personal data assistants has proven to be a successful means of providing and supporting education and nursing practice. In many emergency rooms in North America, PDAs are used by health care practitioners providing quick and easy access to many critical resources.

There are many medical/nursing applications available for the PDAs. There are several pharmacological calculators available as well.

PDAs can also be used for client teaching, providing a color visual aid to help in explaining procedures. Technology can be daunting for some nurses and training and support services are being developed. This continues to be a challenge as there are no dedicated staff to the program and support is not provided as quickly as one would hope. This project has been well received by nurses in the field. Baseline surveys have been completed by all nurses receiving the ipods. This project is in an evaluation stage with a second user satisfaction survey presently being done.

Immunization

Immunization continues to be the best protective intervention for the prevention of vaccine-preventable diseases. This year also brought immunization program changes. A 2nd dose MMRV became part of the provincial routine immunization program. The two doses are to be given at the 12 and 18 month old visits. The addition of the second dose of varicella will increase protection to children and decrease the likelihood of chicken pox outbreaks.

The Hepatitis B vaccine program for grade 6 students returned to a two dose schedule. The dose schedule had to be changed to a 3 dose schedule due to an international vaccine shortage last year. This year introduced a Meningococcal Conjugate ACYW-135 program for grade 6. This vaccine protects against 4

types of meningococcal diseases and provides broader coverage. Prior to this the grade 6 program included a single valent meningococcal catch-up program.

BCG for tuberculosis was discontinued in Saskatchewan in September of this year.

Statistics on all programs are collected at different times of the year depending on logistics. Preschool statistics are collected on a calendar year and this report reflects 2011. Influenza statistics are collected on a fiscal year or flu season. The other statistics are collected on a school year and will reflect the 2010-11 school year.

Presently data is collected manually from most communities.

The AHA First Nation communities and James Smith First Nation are using the Saskatchewan Immunization Management System (SIMS) and are able to run electronic reports. This is the paperless client immunization record system used by the provincial health system. SIMS is a legacy system that has worked well but is being replaced by Panorama. For those communities using SIMS their data will be moved to Panorama. As Panorama will be replacing SIMS the Province and FNIH will no longer support other First Nations who might want to utilize SIMS.

Preschool

The preschool program is the one immunization program that people are most familiar with. Infants begin immunization at two months of age with Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae B and Pneumococcal (13 serotypes). It is important that children start their immunizations as soon as possible and to stay on schedule as this provides them with the earliest and best protection against serious disease. These are provided in 2 needles at 2, 4, and 6 months of age. The rates of immunization for this age group ranged from 45% to 100% in some communities. Once a child reaches one year of age they receive 3 injections. These are for Measles, Mumps, German Measles (Rubella), and Varicella (Chicken Pox) (MMRV), Meningococcal, and Hepatitis A.

At 18 months of age children are eligible to receive a boost of the same immunizations they received in infancy as well as an additional MMRV and Hepatitis A. Immunization rates for individual communities ranged from 26% to 100%. Again, work needs to be done in those communities with low immunization rates to bring them up to protective levels.

In 2011, 77% of infants received immunization during their 2nd month of life. This is a positive increase from the 58.6% of last year. Unfortunately, by 7 months, less than half of children (47.1%) had received the required 3 doses. This is similar to last year. Immunizing children as early as possible is important as their immune systems are not fully developed and are more likely to have serious disease.

School Immunization

Immunization against Human Papillomavirus (HPV) was launched in September 2008. The program is for grade 6 girls. Cervical cancer commonly develops after the fourth decade of life and therefore will take at least 20-30 years before one is able to tell whether this vaccine has an impact on decreasing cervical cancer.

Grade 6 students also receive meningococcal, varicella (chicken pox if they have not previously had the disease), and hepatitis B vaccine. This year 85% of eligible students received their meningococcal immunization while last year 75% of students received their meningococcal vaccine. There were 306 students eligible for varicella vaccine with 230 (75%) receiving it. This is up from only 45% last year. Hepatitis B vaccine for this year only was a three with only 53% (285) students receiving all 3 doses.

Grade 8 students receive Tdap (Tetanus, Diptheria and acellular Pertussis) and for those students not previously having 2 doses of MMR this was recommended as well. There were 481 eligible students with 389 (81%) receiving the Tdap immunization. Prior to grade eight the last pertussis immunization is given at 4 years of

age. Protection starts to decrease after this time period causing the adolescents to not be protected, which could lead to increased disease in the community, placing infants too young to be immunized at great risk. Grade 8 students who did not previously have 2 doses of MMR were also eligible. There were 349 students eligible with 329 (94%) of students receiving the vaccine.

Adult Immunization

Immunization is required throughout the lifespan. For most adult immunizations, statistics are not collected. However, statistics are kept for the Pneumococcal and Influenza vaccines. These are vaccines which are publicly funded. Pneumococcal vaccine is offered to all individuals over the age of 65 and all individuals 2 years of age and older who are considered at higher risk due to medical conditions. For those with more severe disease a booster dose is offered 5 years after the first for those 10 years of age and older and after three years after for those under the age of 10.

In the 2010/11 influenza season vaccine was publicly funded for all residents of Saskatchewan who requested it. Although everyone can benefit from this vaccine it is important that those most at risk continue to receive the vaccine. These are:

- People 65 years of age or older.
- Children 6 to 23 months of age.
- Pregnant women.
- Adults and children with chronic heart or lung disorders.
- Adults and children with chronic conditions (diabetes and other metabolic diseases, cancer, immunodeficiency, renal disease, immunosuppression, anemia and hemoglobinopathy).
- People of any age who are residents of nursing homes and/or special care homes.
- Adults and children with conditions that compromise respiratory function or the management of respiratory secretions are associated with an increased risk of aspiration (e.g. muscular dystrophy, cerebral palsy, multiple sclerosis, and acquired brain disorders).
- Children and youth from 24 months to 18 years of age who have been treated for a long period of time on acetylsalicylic acid (ASA).
- Individuals directly involved in the destruction of poultry infected with avian influenza (bird flu).
- People working with poultry and/or swine.
- Health care workers.
- Health science students working in hospital, community or other health care facility as part of a practicum experience, and have direct contact with patients.
- Individuals volunteering in health care facilities.

Due to the expanded eligibility for the influenza vaccine, statistics were only collected under two categories, those individuals over 65 and under the age of 64. There were 4828 doses provided to individuals under the age of 65 and 523 doses given to those over age 65. These numbers are lower than last year. The latter number is a little low and increased awareness of the need for this vaccine in high risk groups needs to occur. As our number of influenza doses given decreased this year it is very important that efforts be made to immunize everyone and particularly those at risk. Influenza can cause serious long-term illness and death and is preventable.

Pertussis vaccine is offered to adults once in adulthood. This is generally given 10 years after the grade 8 booster. This program was implemented to try and decrease the overall number of cases of pertussis in the province. The cocooning pertussis strategy provides pertussis vaccine to new mothers and to those living in the household if they have not had a pertussis vaccine in recent years. A total of 436 mothers received vaccine either in the hospital or their home community. An additional 80 household members also received vaccine.

Sale Vaccines

NITHA continues to work with the Saskatchewan Association of Health Organizations to purchase those vaccines not publicly funded. The amount of sale vaccine had decreased again this year due to changes in the Ministry of Health guidelines. Previously health care

workers and health care students were responsible for their own vaccine costs but this is now covered under the publicly funded program leaving the need for sale vaccine only for those travellers requiring additional vaccines.

Inoculist Exams

This year 90 inoculist exams were received and processed. Immunization is considered a special nursing procedure as the procedures involved in immunization may not be taught in the basic nursing education program. NITHA provides the education and theory while the Partners provide the experience needed to perform the procedures. Safety of the client demands that a Registered Nurse perform these procedures only after successfully completing an education program of theory and practise. After the initial program, registered nurses must write an annual exam to maintain competency.

NITHA also provides support to the nurses in the field when they are uncertain about vaccine scheduling or other immunization questions. Ongoing education is provided regarding new or changing immunization programs.

Cold Chain

NITHA continues to work towards minimizing costs related to cold chain breaks (periods of time in which the vaccine is not stored between 2 and 8 degrees celsius). Each year NITHA coordinates the servicing of all biological refrigerators, purchases new refrigerators as needed and provides battery back-up to those communities without generators as well as repairs of existing equipment.
The Ministry of Health provided an in-service on their LEAN system used to minimize vaccine loss. This session was provided in person and by video conference to a number of communities. Vaccine loss has also declined not only because of better cold chain management but the guidelines for wastage have changed. In the past if vaccine was involved in more than one cold chain incident it was wastage. New guidelines calculate total time out of range regardless of the number of incidents.

Power outages contribute to the number of cold chain breaks in our communities and in some cases generators were not working or hooked up or battery backups did not work. Additional coolers, warm mark, cold mark monitors and thermometers have been purchased. There were a total of 1240 wasted doses reported to NITHA and an additional 2319 doses lost due to cold chain. This is largely due to improper inventory management and vaccine outdating. The proposed Panorama system has an inventory system and this may facilitate better management within the communities.

Communicable Disease Control Nurse

LESLIE BROOKS
COMMUNICABLE DISEASE
CONTROL NURSE

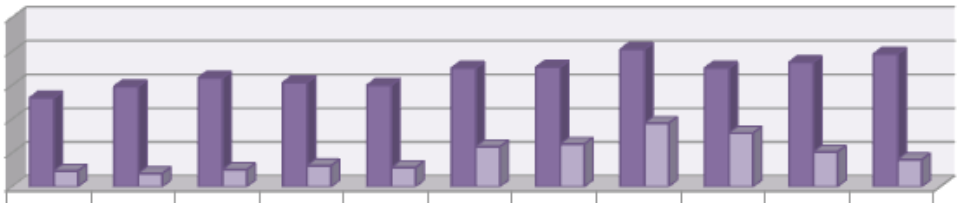
The Communicable Disease Control Nurse offers support to the NITHA Partnership by the timely reporting of Communicable Diseases in Northern First Nations. The reporting and notification of these diseases is mandated by provincial legislation and is a requirement of the Transfer Agreement. The Public Health Act of 1994 as well as the Communicable Disease Control Regulations that accompany the Act govern the reporting and follow up of these Communicable Diseases. Laboratory results are received from the Provincial Lab and entered in iPHIS, an electronic provincial data base. This process allows for reports to be produced electronically and timely.

Direct support to frontline health workers is an essential component of the CDC nurse's responsibilities. In the day to day operations of busy health facilities, the importance of timely communicable disease control is sometimes overshadowed by other activities. The role of NITHA is to respond to inquiries from field staff whenever they are requested, offer possible interventions when concerns are identified and be the resource for those health workers responsible for the communicable disease program in their respective communities.

Sexually Transmitted Infections

This year again saw a small increase in chlamydia and a decrease in the numbers of gonorrhoea. This is consistent with the last three years with chlamydia being fairly constant over the last several years with small increases some years and decreases in other years. This is the 4th year of decline for the gonorrhea cases and would be good if this trend continues. This is positive as across the country there has been increasing numbers of gonorrhea cases and antibiotic resistant gonorrhea which has resulted in the treatment for gonorrhea requiring the dosage to be doubled this year.

TRENDS OF REPORTED STI'S IN NITHA COMMUNITIES 2001 - 2011

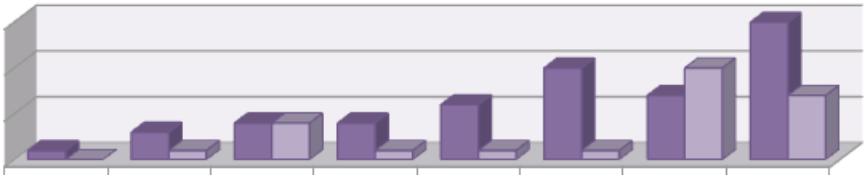


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Chlamydia	526	594	645	617	602	703	708	814	703	737	786
Gonorrhea	94	79	102	125	114	237	253	376	318	206	161

Rates continue to be well above provincial and national averages. Both chlamydia and gonorrhea are increasing nationally and the reasons are largely unknown. This increase may be due to the safer sex message no longer impacting people; the newer HIV drugs that prolong the development of AIDS; the lack of consistent sexual health education; not understanding the long-term consequences of sexually transmitted diseases or the increased use of legal and illicit drugs such as ecstasy, and Viagra.

Considerable amount of time is spent tracking and treating cases and contacts. All of the reportable diseases can result in long term consequences, such as infertility. A comprehensive multi professional sexual health initiative is needed to see positive changes in the area of sexually transmitted infections. The development of the NITHA HIV strategy will have outcomes in the broader STI issues.

TRENDS OF REPORTED CASES
HIV & SYPHILIS
2004 - 2011

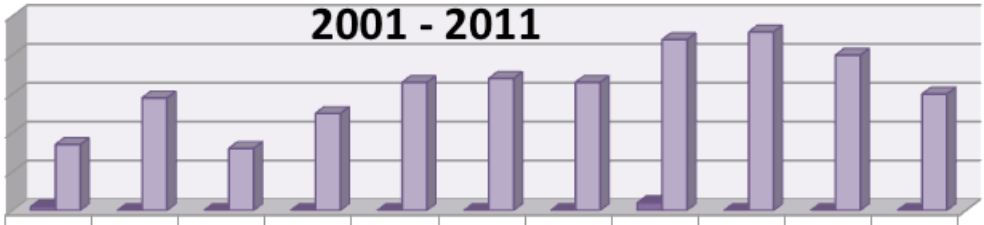


	2004	2005	2006	2007	2008	2009	2010	2011
HIV	1	3	4	4	6	10	7	15
Syphilis	0	1	4	1	1	1	10	7

These high rates of other sexually transmitted infections also increases the possibility of HIV infection occurring if exposed to the virus. If an individual has a sexually transmitted infection it is easier for the HIV to infect an individual. HIV has become more prevalent in the NITHA Partnership and throughout the province. Since 2004, there have been 53 cases of HIV reported in NITHA. This does not include individuals who may have been tested while residing in other jurisdictions. The Saskatchewan rate of HIV is twice the national average with 70% of all new cases in 2009 being of Aboriginal ancestry.

Syphilis is a disease that was rarely seen until the last 5 years. Follow-up for this disease is long-term to ensure the treatment has worked. This disease can have many effects and may be fatal. If untreated in a pregnant women this disease can also cause severe problems in the developing infant.

TRENDS OF HEP B & HEP C CASES
IN NITHA COMMUNITIES
2001 - 2011



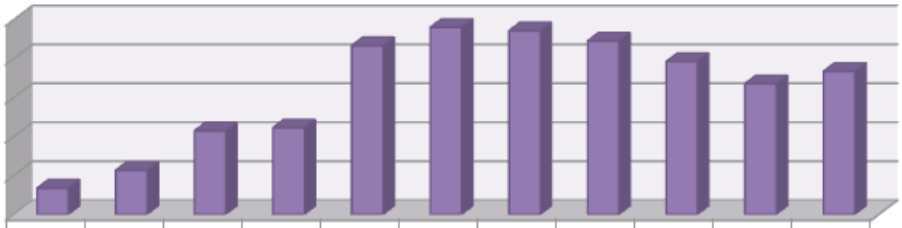
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Hep B	1	0	0	0	0	0	0	2	0	0	0
Hep C	17	29	16	25	33	34	33	44	46	40	30

Hepatitis C saw a decline this year. Individual year changes may not be long-term. Most cases of Hepatitis C are intravenous drug users or individuals who have used intravenous drugs even once in the past. This disease is serious enough on its own but this is the same risk factor for HIV and if the at risk behavior continues there remains the risk of contracting HIV as well. NITHA Partnership communities saw another 15 cases of HIV this year.

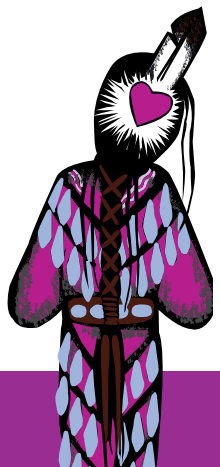
Commonly Acquired Methicillin Resistant Staphylococcus Aureus (CAMSRA) continues to be a challenge in the NITHA communities. The type seen in northern Saskatchewan is largely community acquired meaning there has been no recent contact with a hospital. The cases are often skin infections seen in children and are more common in the summer when there are many insect bites and cuts and scrapes. The accuracy of numbers and actual infections is challenging as many people are colonized (meaning they carry the bacteria in their nose with no symptoms) and it is difficult to know when a person has cleared the bacteria and a new infection has occurred.

The Northern Antibiotic Resistance (NARP) group reconvened to discuss possible future interventions. This group is comprised of a team of community members, healthcare professionals, educators and research scientists working in partnership to study antimicrobial resistant bacteria causing infections in northern communities. This group has a website www.narp.ca which includes a complete description of the earlier projects and educational material. Membership includes NITHA partnership including NITHA, Partnership and community members. The Ministry of Health is also looking at CAMRSA and is presently in an exploratory phase with representation from NITHA at this working group.

TRENDS OF CAMRSA CASES IN NITHA COMMUNITIES 2001 - 2011

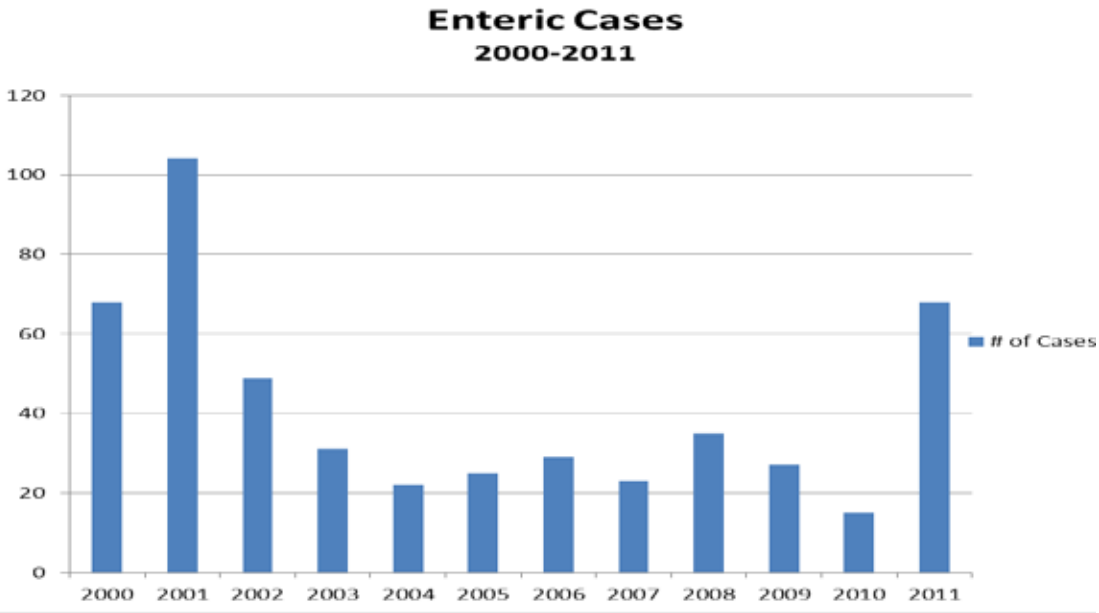


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
# of Cases	68	114	215	223	434	481	472	446	393	336	368



Only a small percentage of diseases that cause enteric illnesses are reportable under The Public Health Act and Disease Control Regulations. The enteric pathogens cause disease symptoms ranging from mild gastroenteritis to life-threatening systemic infections and severe dehydrating diarrhea. In addition to the acute risks of disease, long-term complications of enteric diseases can occur.

NITHA continues to provide education, support and assistance on timely reporting and follow up of enteric diseases to new nurses during orientation and to community nurses. The NITHA Nurse Epidemiologist and the Environmental Health Advisor participate on the provincial working group tasked with updating the Provincial Communicable Disease Control Manual. Work is progressing on updating the NITHA Enteric Disease Notification Forms and information handouts to reflect the updates and changes to the Provincial Communicable Disease Control Manual.
The trend identified in previous years continued in 2011, with enteric diseases being the least notifiable communicable disease reported in NITHA communities. Sixty-eight laboratory confirmed enteric cases were reported for



2011-2012.

Enteric Diseases

Of these cases, 50 were Shigellosis sonnei. This increase in Shigella was due to outbreaks in three of our communities. It was observed that Shigella sonnei cases reported throughout Saskatchewan had increased since October 2011. Investigations determined that transmission was person-to-person.

Animal Bites

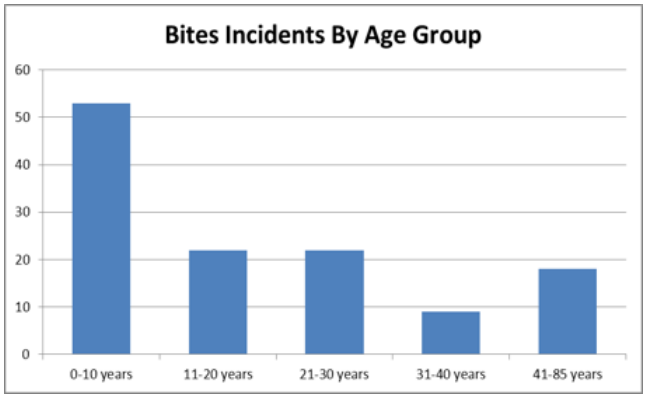
Animal bites, especially dog bites are a concern in many of our communities and pose unique health challenges. Animal bites are a health concern for several reasons, the most serious disease of concern is rabies.

Rabies is a viral disease that attacks the central nervous system of warm-blooded animals, including humans. Rabies is transmitted through saliva, primarily through bite wounds. It can also be spread when infected saliva comes into contact with a scratch, open wound or the mucous membranes of the mouth, nasal cavity or eyes. The incubation period (from initial exposure to clinical symptoms) may range from two weeks to many months. It can depend on a number of factors, including the strain of rabies and the location of the bite. However, it is important to note that an animal can transmit the disease a few days before showing any clinical signs. Once symptoms appear, rabies is almost always fatal in animals and people.

The dog bite incident itself can cause emotional trauma, long-term damage, or death if the bites are severe, especially in young children.

Human rabies deaths are rare in North America. Prompt treatment following exposure to a bite from an animal suspected of having rabies can prevent human illness.

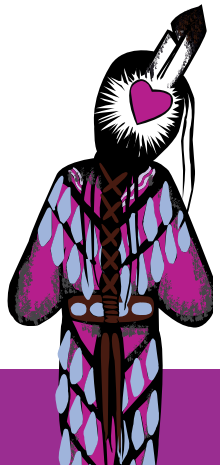
In Canada the animals that most often transmit rabies are foxes, skunks, bats, and raccoons. Saskatchewan had 34 samples submitted from animals test positive for rabies in 2011: 1 dog, 3 cats, 24 skunks, 6 bats and 1 horse.
The NITHA partnership received a total of 135 reports of bite incidents during the 2011-2012 year, which



required follow-up. Dogs were involved in 133 of the reported bite incidents and 59% were unprovoked bites. In sixteen of these incidents the bite was to the facial area. Fifty-two of the incidents involved children 10 years of age or younger.

In January of 2012, an information package was sent to all communities outlining health concerns and challenges posed by having dogs running loose. Information in the package included educational resources available, as well as contacts for "Team North", who may be able to offer free veterinary services such as spaying and neutering through temporary clinics.

Tuberculosis Program



Program Overview

SHEILA HOURIGAN
TB NURSE ADVISOR

In preparation for the release of the Canadian TB Strategy and the First Nation and Inuit Health Branch TB Strategy, the NITHA TB program spent considerable time this year working with the Saskatchewan Population Health Council (SPHC) in the development of a province-wide TB Strategy. In the fall of 2011, the BCG vaccination was discontinued across the province which required some changes in program emphasis. These changes will be discussed later in the report. All strategies recommend the focusing of additional resources on high incidence communities in order to implement aggressive strategies designed to reduce the incidence and transmission of tuberculosis over both the short and longer term. While these strategies have yet to be articulated, NITHA received some additional funds in the latter part of the year to begin some of this work in our 2 highest incidence communities.

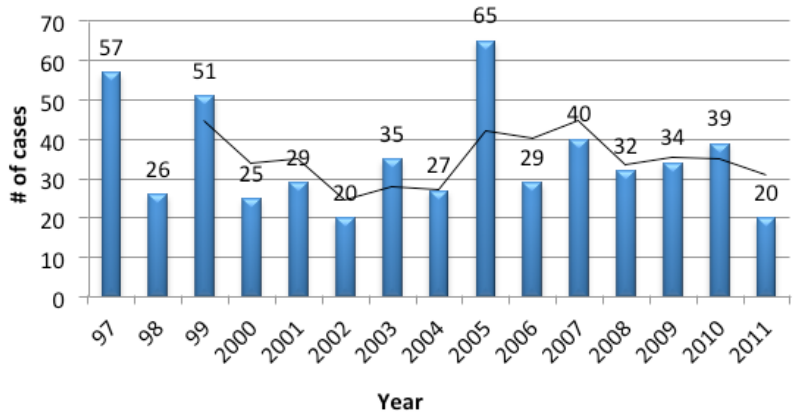
NITHA has continued to support the partnership communities in their efforts to control tuberculosis but this year there was an increased emphasis on the high incidence communities and on contact tracing, in part as a result of the discontinuation of the BCG. The NITHA TB nurses made a total of 44 visits to 16 communities. This is 9 more visits than were made in the previous year which highlights the increased workload that has been created with the changes. In addition, a contracted nurse was used on 4 occasions to conduct the new preschool screening program and the nurse that was hired to support the high incidence communities did six, 2 week community visits.

Tuberculosis in NITHA First Nations

In 2011 there were 20 cases of active tuberculosis in NITHA communities. This is nearly 50% less than the 39 cases that were diagnosed in 2010. It is too early to predict whether the increased emphasis on timelines in the contact tracing process that were implemented half way through the year was a factor in this decline or this was just a non- significant aberration. Our highest incidence community had 7 cases or 35 % of the total number of cases while the other high incidence communities only had one each.

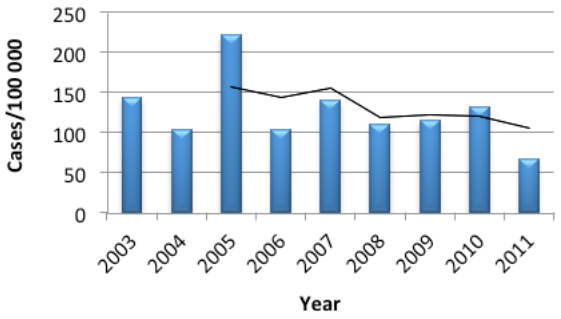
There were 6 cases however, in a community that normally has only 1 or 2 cases per year and 3 cases in a community that hasn't had any cases in many years. These 2 communities will be discussed in the outbreak section of this report.
Case rates are shown in Graph 2 below.

Graph 1: NITHA TB CASES



*Based on CWIS population figures

Graph 2: NITHA TB Case Rates 2003-2011 (Cases/100 000)



The age distribution of 2011 Active Tuberculosis cases is highlighted in Table 1 below.

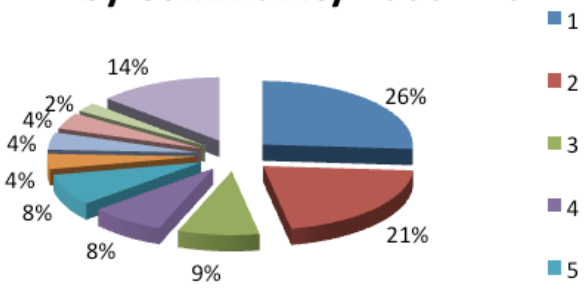
AGE	CASES
0-4 YRS	3
5-14 YRS	0
15-24 YRS	4
25-34 YRS	3
35-64 YRS	10
65+ YRS	0
TOTAL	**20**

The number of cases in the 15-24 year old age group, which has had the highest numbers for the past 6 years, had lower numbers this year. This may also be a factor in the overall lower number of cases because this younger age group have higher transmitters rates due to the fact they tend to have more advanced disease at the time of diagnosis and have large social networks to which they can spread the disease. The age group contributing the greatest number of cases this year was the middle age group, age 35-64. The cases in this age group were, for the most part, infected with TB at a much earlier time in their life and frequently had significant risk factors for progression to disease such as HIV, alcohol abuse and smoking. 60% of the cases in this age group were smear positive at the time of diagnosis meaning they were capable of transmitting the disease to others.

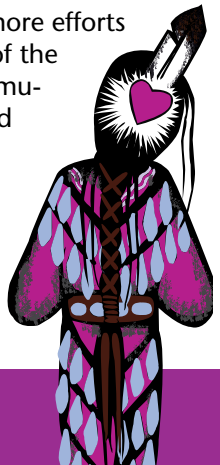
Graph 3 below shows that since 2000, 86% of all TB Cases were contained in 9 communities with 2 communities contributing close to half of all NITHA TB cases. Focusing additional resources in these communities has the potential in reducing the burden of disease significantly.

Graph 3:

Distribution of NITHA TB Cases by Community 2000 - 2011



There were 8 infectious cases last year which is 40% of all cases. Early detection is a key to reducing the incidence of infectious disease and though NITHA has implemented a number of strategies to increase early detection, it is clear that more efforts are needed in this area. Perhaps one of the biggest gaps in addressing this is community awareness. This has been identified as important activity for the additional resources that may be focused on the high incidence communities.



Professional and Community Education and Support

Community Health Nursing

The NITHA TB nurses oriented 28 nurses to the TB program this year, nearly double of the nurses oriented in previous years. This was in part due to the changes in the programs which required more orientation, as well as an increased effort on the part of the TB nurses to ensure new nurses to the program have the necessary skills and knowledge. 17 nurses attending the Orientation and Skills Training program participated in a presentation on TB diagnosis and treatment. Orientation of community nurses to the program is an important means of supporting the NITHA partnership communities. In addition to the early detection of disease, particular areas which need to be continually addressed and reinforced, include case management and support to the TB program worker.

A provincial TB day for primary care health providers which was sponsored by FNIH and organized by Saskatchewan TB Control with support for other stakeholders including NITHA, was held in October of 2011. This one day workshop aimed towards both physicians and nurses working in primary care and other settings, failed to attract any physicians and did not have great attendance from the NITHA high incidence communities.

Telephone consultation continues to be an important means of supporting nurses as they struggle with the day to day challenges presented by the TB program and its clients. There were significant changes in the support provided by the NITHA TB nurses this year. The NITHA nurses conducted all the screening in the preschool age groups while the communities were asked to conduct the school entry TST screening. The other big change was the support provided to contact tracing at the community level. In the past contact tracing had been largely the responsibility of the CHN's with support from the NITHA nurses only when they were available. Beginning in June 2011 the NITHA nurses responded to all requests for contact tracing, visiting the community and completing the majority of the initial testing within the first week of the date of diagnosis of the index case. Initially, the plan was to focus only on smear positive cases and to leave primary source traces to the CHN, but when there was considerable delay in a source trace being conducted that may have contributed to ongoing transmission, it was decided to attend to all trace requests whenever possible. The CHN still has an important role to play assisting with the compilation of the contact list and seeing any clients that were unavailable to the NITHA nurses during their visit. Follow-up testing was also done by the NITHA nurses. The NITHA TB nurses visited communities to assist with contact tracing on 16 occasions this year, more than double the previous year's, even though there were fewer traces this year.

TB Program Workers

Seven new TB program workers were trained in NITHA Communities, and 5 received updates. A new service delivery model for TB program workers that was proposed to FNIH and encouraged to go to a subcommittee for discussion was declined to be funded. This model, that would ensure there were stable full-time workers in the high incidence communities who could play an important part in the implementation of high incidence strategies including community awareness, may receive new interest by the SPHC sub committee looking at the high incidence piece.

Training TB workers, which focuses on the Direct Observed Therapy program is the most important way NITHA supports TB workers in the communities. There was a provincial TB worker workshop held in September with 15 workers from NITHA communities participating.

Case management issues were supported on a number of occasions both over the telephone and in person. A significant amount of time is spent ensuring that funding is requested to cover workers wages and that they receive timely remuneration for their services. This is instrumental in keeping the program running smoothly and efficiently.

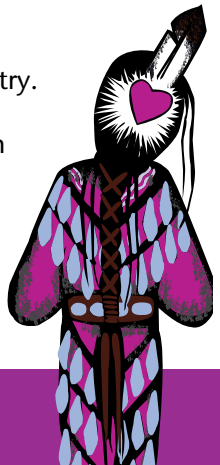
Contact Tracing

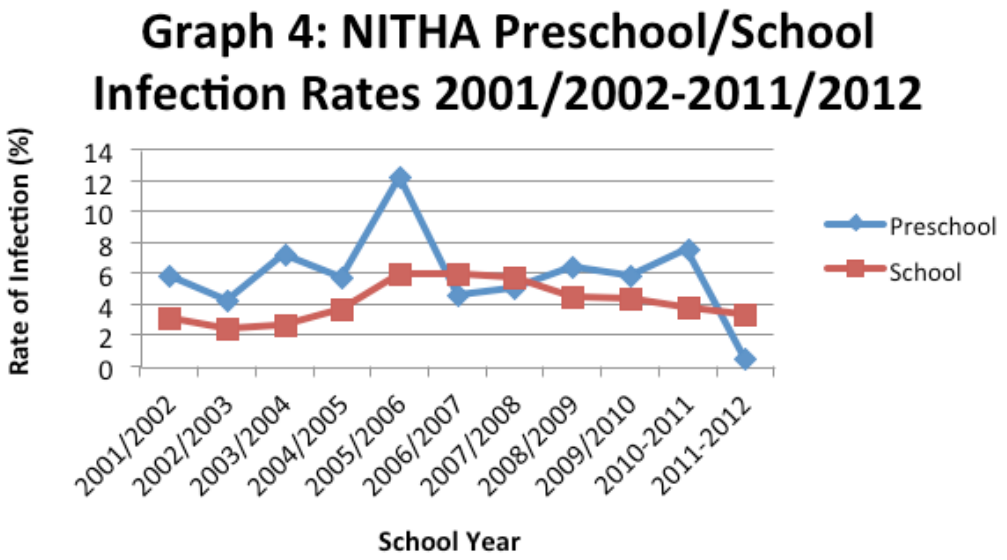
There were 12 contact traces required in NITHA partner communities in 2011, 8 infectious traces looking for spread and 4 primary traces looking for a source. As previously mentioned the NITHA TB nurses took a more active role in the contact tracing this year. When the BCG vaccination program was discontinued it was decided that contact tracing efforts needed to be stepped up, particularly for the youngest contacts, less than 5 years of age. Though the community health nurses did their best in the past to do the contact tracing, their heavy workload and frequent shortage of staff meant there were frequent delays in getting the necessary work completed. Since contact tracing, when done in a timely and thorough fashion, is one of the most effective means to find and prevent cases it was felt that shifting the TB Nurses emphasis to this activity and away from school screening would be beneficial to the overall effort to reduce TB incidence.

Childhood Screening Program

This year there was a dramatic change to the childhood screening program that came about as a result of BCG discontinuation. Instead of screening all 2 year olds in all NITHA communities, it was decided, with the support of the SPHC, to screen non BCG vaccinated children at age 1 and 2 years in all communities with a 3 year average annual incidence of smear positive TB greater than 15/100 000. The NITHA nurses took the lead role in conducting this screening to ensure timely completion and good coverage. The NITHA nurses and contracted nurses visited the 11 communities meeting these criteria on 31 occasions to prepare for and/or conduct screening. This is a huge increase from the 11 visits that were made in the previous year. 189 children were screened in these age groups with one having a positive skin test. The infection rate or the rate of TST positivity of 0.5% is considerably less than the average of the previous 10 years of 6.6%. See Graph 4 below. This change is likely due, in large part, to not testing children who had a BCG vaccination since the vaccination may impact the TST result. The coverage rate of the number of children tested on time, out of the number eligible was 85%. Those children that were caught up at a later time are not included in this coverage rate. Low incidence communities were not required to screen any children at this age.

For the most part the CHN's were asked to be responsible for the testing of children at school entry. All children were to be tested regardless of BCG status. Eighteen on-reserve schools in partner communities conducted tuberculin skin testing of students at school entry (age 4 or kindergarten depending on the community's preference). 348 students were tested in all and 12 children had significant tests, for a rate of infection of 3.4%. This rate is similar to previous years.





All children found to have significant skin tests in the school entry tuberculin skin testing program were offered treatment of Latent TB Infection. Compliance and completion of treatment rates are reported by TB Control in their annual report and remain high in this age group.

Surveillance

Collecting and analyzing TB data to identify disease and infection trends as well as monitoring program activities are important to ongoing tuberculosis program planning and evaluation. This year some analysis of the preschool and school age screening data was done as we prepared for an examination of the screening programs in relation to BCG discontinuation.

BCG Vaccination

As mentioned, BCG was discontinued in all Saskatchewan communities effective September 2011. The SPHC TB Partnership Working Group made this decision based on the national recommendations and local epidemiology. It was decided that in correlation with the discontinuation, contact tracing efforts would be intensified and screening of young children particularly in high incidence communities would be enhanced. These changes were communicated to NITHA Partner Health Directors, the Nursing Managers and the CHN's. A pamphlet regarding the discontinuation was developed and distributed to the communities so the nurses could use the information when educating prospective parents about this and other ways they could protect their children against tuberculosis. There were no concerns verbalized to our program by any of these parties about the changes to the BCG vaccination program.

Outbreak/ High Incidence Community Management

Community 1

There were 3 active cases in this community that had not had any active disease for many years. Two of the cases were also infected with HIV and were smear positive. There was one additional case in a young child who was a contact. There were a number of complicating factors to this situation which resulted in a heavy demand on resources. It took 8 weeks of work by the NITHA TB nurses and others to fully conduct the contact tracing required. No additional cases have been diagnosed since September 2011. There are several contacts receiving treatment of Latent TB Infection due to their exposure to the infectious cases.

Community 2

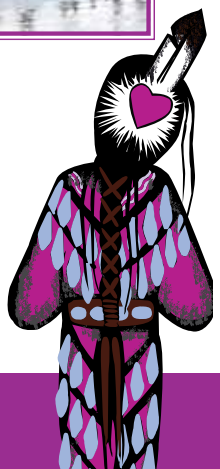
Community 2 is a community that has 1 or 2 cases almost every year, but with little evidence of transmission. This year there were 6 cases, 5 of whom were eventually identified to be connected. The first case, a 3 year old child, was identified in June of 2011, through the school entry screening program source tracing was requested. A second case was identified in August in an adult female, age 28. Source tracing was again requested, at which time it was decided that the NITHA nurse would go to the community to do this trace as well as the first as it had not been completed. Another case in an older male was quickly identified as the source for these cases. As well, there were 2 other cases in the contacts to this source, including a 3 month old infant. Latent TB infection was found in another 12 contacts. No new cases were identified after September until April of 2012. Two more cases have occurred at the time of writing this report (April 2012) and we will be moving forward to seek additional resources to support the ongoing efforts that will be required.

Community 3

This community has the highest incidence of TB in the NITHA communities and it had 7 active cases this year. There was an additional nurse hired for the last half of the year to support this community as well as one other. In addition to doing all of the contact tracing and screening, this nurse conducted key informant interviews which she used to develop a high incidence community strategy. The strategy included, among other things, a number of educational initiatives. Her efforts were highly successful and well received by all stakeholders. The details of her activities will be provided in a follow-up report.

Conclusion:

As efforts to step up the fight against TB are renewed both nationally and provincially, NITHA is poised to take an active leadership role for the communities under our jurisdiction. It is already clear that the additional efforts required to reach the goal of a reduction in TB Cases by 50% in 5 years will result in a considerable increase in the workload of the NITHA TB program. It is imperative that we insure we have the necessary resources to meet the demands and we are hopeful that our partners and stakeholders in the TB program, especially the SPHC and FNIHB, will support our efforts to secure those resources.



Environmental Health

Program Overview

The Environmental Public Health Program (EPHP) in the NITHA Partnership works to identify and prevent environmental public health risks that could impact the health of community residents. This program is delivered by Environmental Health Officers (EHO's) working for Prince Albert Grand Council, Meadow Lake Tribal Council, Lac La Ronge Indian Band and Peter Ballantyne Cree Nation. EHO's provide advice, guidance, education, public health inspections and recommendations to NITHA communities and their leadership to help manage public health risks associated with the environment. Chiefs and Councils are responsible for addressing the recommendations provided.

Activities that may be undertaken through the EPHP, as identified based on the needs of the communities, are:

- Drinking Water
- Food Safety
- Health and Housing
- Waste Water
- Solid Waste Disposal
- Facilities Inspections
- Communicable Disease Control
- Emergency Preparedness and Response
- Environmental Contaminants
- Research and Risk Assessment

Environmental Health Advisor

BRENDA ZEIGLER
ENVIRONMENTAL HEALTH
ADVISOR

The Environmental Health Advisor (EHA) position is a part of the Public Health Unit within NITHA, and works under the supervision of the Medical Health Officer.

The major role/responsibility is to provide internal and external support to the Environmental Health Officers in the development and delivery of Environmental Public Health Programs within their communities, and act as consultant to the NITHA Medical Health Officer and NITHA Executive Council on environmental health issues.

The EHA participates in a number of meetings, both internal and external. These meetings provide the opportunity for NITHA to identify and discuss issues, provide input in the development of guidelines and/or policies, ascertain the need for EHO training sessions and professional development and ensure effective communication and coordination with all agencies, partners and staff. Participation in these meetings also provides the opportunity to network with Federal, Provincial and Municipal agencies.

An important part of public health is to promote and advocate for healthy lifestyles, the EHA assists the EHO's by researching best practices on environmental health issues and preparing or providing promotional and educational material. The EHA has also provided coverage within the partnership when EHO's are away or in emergency situations. This position also provides communicable disease support for community nurses and EHO's for notifiable food, waterborne and zoonotic diseases. This support is essential to ensure that timely reporting and follow-up is conducted as mandated by provincial legislation.

As in previous years, the PHU continued to raise awareness of West Nile Virus and motivate communities to implement preventative activities. Ten First Nation communities applied for funding under the West Nile Virus Disease Reduction Strategy for Saskatchewan to cover activities they initiated to educate, prevent and control West Nile Virus. One Tribal Council used the funding to provide Structural Pesticide Application training to seventeen community members through SIAST. There were no reported cases of West Nile Virus for the 2011 surveillance year.

The EHA continues to participate on the Saskatchewan Biomonitoring Study Steering Committee overlooking the on-going project to gather baseline data on the prevalence of contaminants in the population residing in areas of future oil-sands development in Northern Saskatchewan. At this point in the project, samples are being collected from Northern Saskatchewan for analysis, which will continue into the Spring/Summer of 2012.

In February, NITHA hosted a meeting between Partner Environmental Health Officers, Medical Health Officers and Public Health Inspectors with Mamawetan Churchill River/Keewatin Yathe/Athabaska Health Authorities, Environmental Project Officers with Ministry of Environment and Aboriginal Affairs and Northern Development Canada. This joint meeting provides a forum for sharing information on drinking water and

sewage disposal systems, discussing issues and solutions, with the common goal of providing safe drinking water and safe disposal of waste. Some of the systems within the NITHA partnership are shared with neighbouring communities. Since 2008, NITHA and our Partner EHO's have participated in yearly joint meetings.

Work continues with Partner EHO's, communities and NITHA program staff to support the EPHP. Providing education and information on environmental health issues plays an important role in assisting communities in identifying and preventing public health risks that could impact the health of community residents.

EWELINA DZIAK
INFECTION CONTROL ADVISOR

Infection Control Advisor

Program Overview

This is a new position to NITHA and was filled for several months by Ewa Dziak. Although the position is now vacant there was significant work done in the development of this position and work within the partnership.

Infection prevention and control measures are needed to ensure the protection of everyone by preventing infections both in the general community and while receiving healthcare in clinics, homes and other settings. The basic principle of infection prevention and control is hygiene. An infection control working group was established to identify needs within the partnership. A number of infection control policies were developed and approved by this working group. Policies for hand hygiene, glove selection, processing and reprocessing of patient care equipment, guidelines for selection and use of cleaners/ disinfectants in health care facilities are examples of some of the policies developed. Eva provided a number of training sessions in-person and by videoconference to the partnership.

Being a new position there were certain challenges that needed to be acknowledged and worked with. One of the challenges for this position is that there are not comparable positions in the partnership for the Infection Control Advisor to work with. The working group consisting of a variety of health care workers provided this link. The different communities are also at different stages of infection control practice and education and training was required to raise the level of knowledge. One example of the difference in practice is the sterilization equipment. The sterilization equipment used across the partnership is not standard and guidelines and training needed to be individualized. The development of the policies provides for consistent infection control practices in the partnership. Although there were considerable advances in infection control during this time period there remains a need for additional policies, training and education.

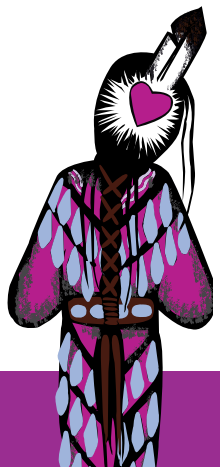
Health Promotion

Program Overview

In the past year, the NITHA Health Promotion Advisor, in collaboration with the NITHA partners has had the opportunity to begin to plan, develop, enhance and implement health promotion strategies and initiatives. The goal of the NITHA Health Promotion program is to provide comprehensive support to the NITHA partners in the area of Health Promotion.

LINDA GILMOUR KESSLER
HEALTH PROMOTION ADVISOR

The goal of Health Promotion is to create the conditions that support good health. The Medicine Wheel teachings of balance – emotional, spiritual, physical and mental define good health. Good health is holistic and is more than the absence of disease.



Health Promotion creates the conditions that support *"Healthy Children, Healthy Families and Healthy Communities"*. Strategies emphasize *"upstream"* approaches that work to address root causes of poor health by changing the conditions and environments in which people live, work and play.

Health promotion takes into account that the overall health of communities is influenced by many factors beyond access to health services and individual behaviours. Some of these factors include: chronic stress, income, employment, early childhood development, food insecurity, social exclusion, housing and the effects of colonization.

The Health Promotion Advisor's Role:

- Work with the NITHA partners and other partners to develop health promotion strategies.
- Mentor and collaborate with NITHA partners to identify and plan capacity building opportunities to build the health promotion skills required to deliver health promotion programs.
- Provide support, guidance, and advice regarding health promotion to the NITHA Partners.
- Develop partnerships at the local, provincial and federal levels to ensure evidence based health promotion practice and to effectively deliver health promotion programs.

Health Promotions:

- Respects the worth and dignity of each individual while at the same time giving priority to the common good
- Supports community decision making
- Shares resources to meet the needs of all members of our society
- Pursues social justice to reduce health inequities
- Cares for the environment, so that the health and prosperity of the present generation is not at the expense of future generations.

Health Promotion Strategies

Health promotion strategies are *strengthening community action, creating supportive environments and building healthy public policy.*

Health Promotion strategies are interrelated and complementary to each other and to initiatives in other programs and disciplines. Effective health promotion strategies are multi-faceted, long term and usually require multi-sectorial partnerships and strategies.

2011/2012 Program Highlights and Achievements

In the past year, the Health Promotion Advisor has provided leadership and worked collaboratively with the NITHA partners and the Northern Health Regions to plan, develop, and implement north-wide health promotion strategies and initiatives. The health promotion initiatives focus on *"Healthy Children, Healthy Families and Healthy Communities".*

New Health Promotion Initiatives

NITHA Health Promotion Working Group

The Health Promotion advisor established a NITHA Health Promotion Working Group with Health Promotion representation from the NITHA Partners and other NITHA staff. The purposes of this committee are to work collaboratively regarding health promotion strategies and to act in an advisory role to

make recommendations regarding health promotion to the NITHA Executive Council (NEC).

Northern Early Years Coalition

The Health Promotion Advisor is the co-chair of the *Northern Early Years Coalition*. The goal of this coalition is to collaborate to enhance and broaden supports to prenatal to age five children in Northern Saskatchewan. Health Promotion is a key focus area, specifically creating healthy environments and raising the awareness of the critical importance of early childhood development to lifelong health and wellbeing.

Child & Youth Health and Well-Being

The NITHA Advisor health promotion work with children and youth builds on the work of the Northern Healthy Communities and the 40 Developmental Assets. Strategies include Comprehensive School Health, the 40 Developmental Assets Project and the Provincial Youth Surveillance Survey. Several important partnerships have developed with education recently – one with MLTC and the other with PAGC (PBCN, LLRIB, PAGC and AHA). Youth and community engagement and additional community based strategies will be critical.

Northern Tobacco Strategy

The Northern Tobacco Strategy is co-chaired by the NITHA HPA and a representative from the Population Health Unit, Northern Regional Health Authorities. The Northern Tobacco Strategy also has representation from the NITHA partners' health promotion coordinators. The goals are to develop northern strategies for tobacco prevention, cessation and control while respecting the First Nation traditional use of tobacco for spiritual and ceremonial purposes. Strategies are focusing on pre/post natal women and children/youth.

Enhanced Health Promotion Initiatives

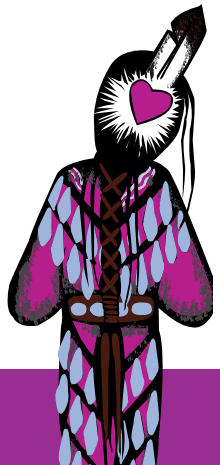
Northern Healthy Communities Partnership (NHCP)

The NHCP has membership from a variety of Northern Saskatchewan Agencies (including NITHA partners) who are working collaboratively to plan and implement health promotion strategies. The action teams of the NHCP include Healthy Eating, Active Living, Books Babies and Bonding, Youth Development (40 Developmental Assets), and Promotions and Media.
The Health Promotion Advisor is a member of the NHCP core group which provides the overall coordination of the NHCP and health promotion initiatives in northern communities. The HPA has the opportunity to become co-chair of this partnership which will allow NITHA and the NITHA partners to have a stronger and equal voice in these collaborative health promotion initiatives.

Challenges

The NITHA Health Promotion Adviser has encountered several challenges in the past year:

- Several of the NITHA partner health promotion positions were vacant due to leaves or resignations. This has limited the ability of the NITHA HPWG to meet and plan collaborative health promotion initiatives. It has also limited the ability for the NITHA partners to have representation on other regional health promotion committees/task groups.
- The NITHA Nutritionist position (a new position) has not yet been recruited and filled. This has impacted the potential of NITHA and the partners to enhance and develop nutrition-related health promotion initiatives.
- Resistance from the Saskatchewan Population Health Council to having the NITHA HPA involved in the Healthy Communities task group and related strategies. The NITHA CEO has worked on behalf of the HP Advisor to attempt to resolve this issue.



Opportunities/Future Directions

The Health Promotion Advisor will continue to work collaboratively with the NITHA partners, and the Northern Health Regions to plan, develop and implement north-wide health promotion strategies and initiatives. There is much to look forward to and there are many opportunities for health promotion to have a positive impact on the health of children, youth, families and communities.

This will include:

- Continuing to target health promotion strategies at children and youth who will be the leaders of the future.
- Continuing to align health promotion initiatives with Saskatchewan Population Health Council, Healthy Communities task group, while considering the unique needs of the NITHA partner First Nations communities.
- Building health promotion capacity of the NITHA second level partners and other NITHA staff to plan, implement and evaluate health promotion initiatives.
- Working with and providing guidance and support to NITHA second level partners and NITHA staff for the Health Promotion component of their health/work plans.

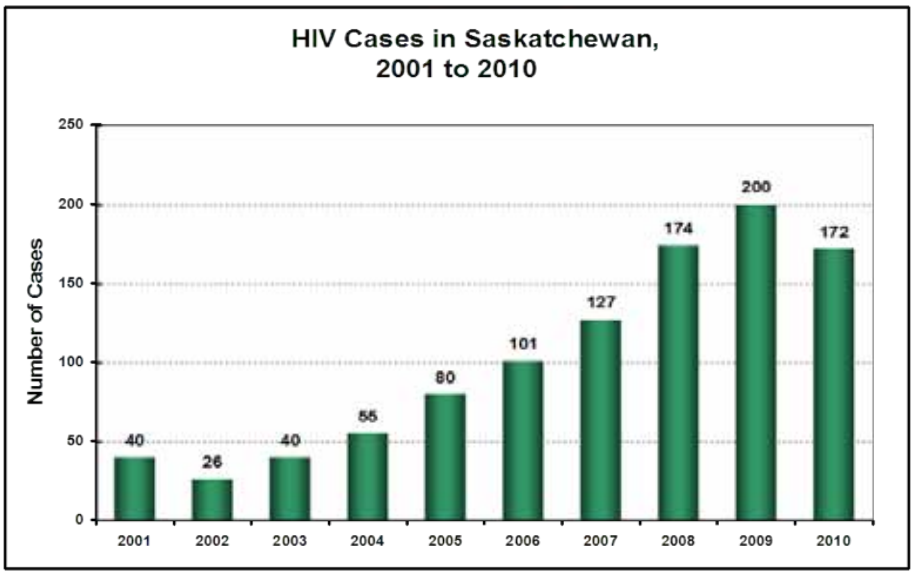
MARLENE LAROCQUE
HIV STRATEGY
COORDINATOR

HIV Strategy

Program Overview

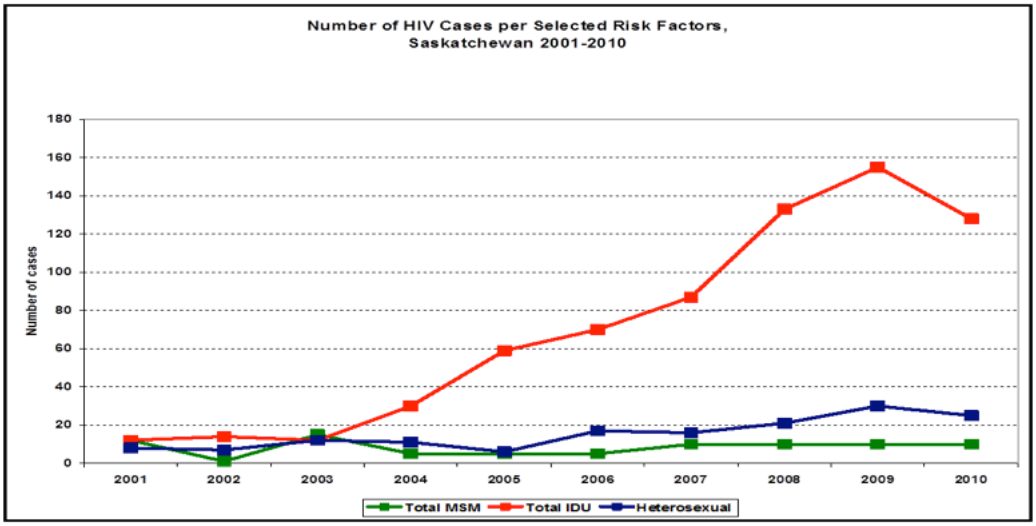
NITHA received one-time funding to hire an HIV Strategy Coordinator in 2011-12. The primary mandate of the HIV Strategy Coordinator is to formulate a strategy that will assist NITHA and partners in beginning to tackle the increased rates of HIV being seen in the north.

HIV in Saskatchewan is disproportionately concentrated in the First Nations population affecting individuals, families and communities. HIV incidence in Saskatchewan is a significant public health concern as the rates of new infections continue to reflect double the rates of the national average (19.1/100,000 for SK vs. 9.3/100,000).

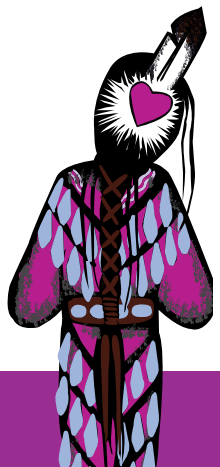


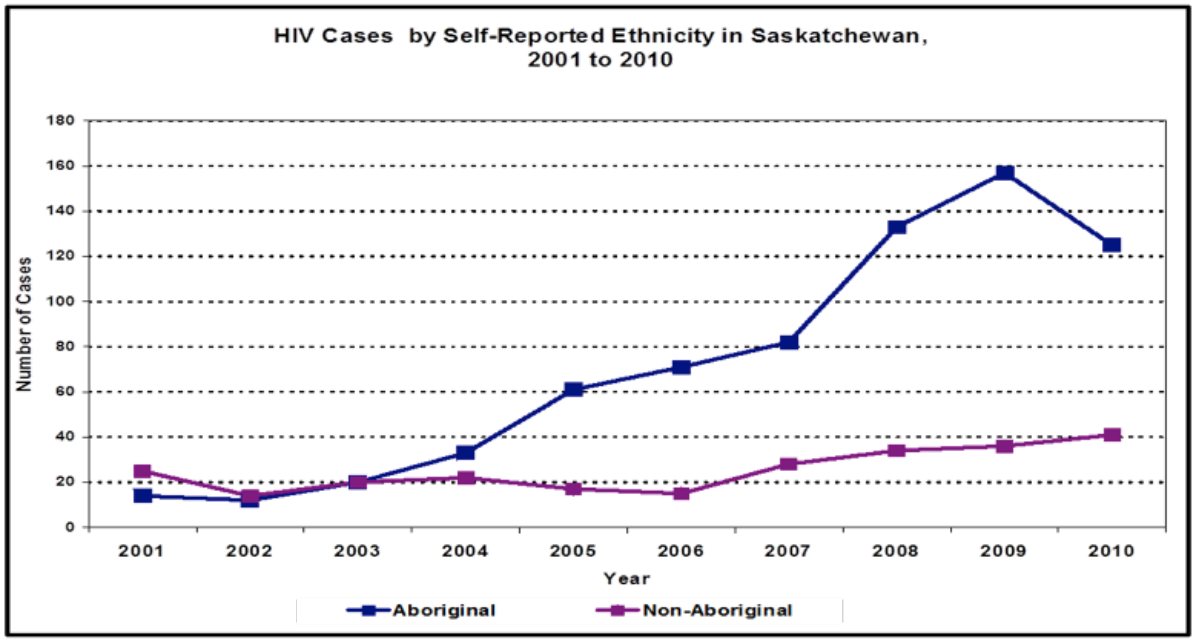
Source: Saskatchewan Ministry of Health

The principle driver of HIV acquisition in Saskatchewan is shared needles for injection drug use followed by unprotected sexual contact (both heterosexual and men who have sex with men). Initiating risk reduction practices are widely promoted and include using clean needles for drug use and condom use for sexual activity; these protective practices can become routine with access to the tools.



Source: Saskatchewan Ministry of Health





The NITHA HIV Strategy

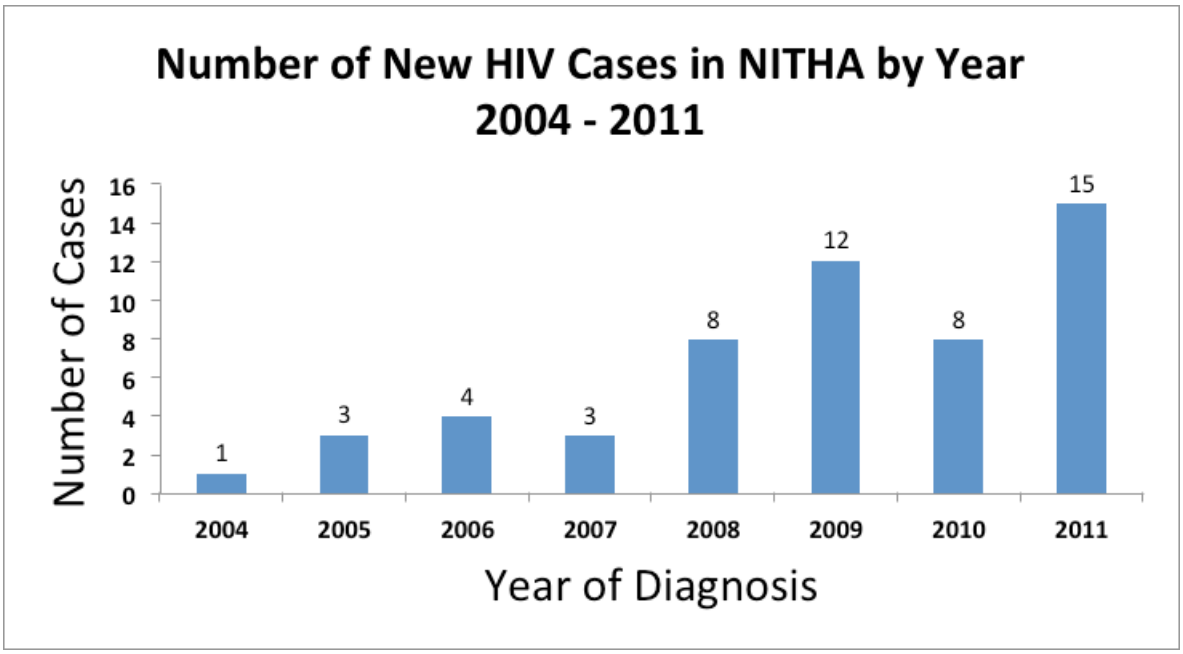
The position of HIV Strategy Coordinator is new to NITHA and collaborates with the public health unit staff to work with communities on *HIV prevention, education and clinical support*. The HIV Strategy Coordinator supports health care workers, leaders, elders, educators, youth and parents to get the current HIV information they need to make a difference in their community. The HIV Strategy Coordinator is available to provide HIV resources, plan workshops for various audiences, link health care workers to training opportunities and work with health professionals in the treatment, care and support for clients.

HIV Issues IDENTIFIED AS Priority

Aboriginal people in Canada are over-represented in the HIV statistics across Canada. In Saskatchewan, First Nations account for approximately 75% of those individuals newly diagnosed with HIV each year prompting a renewed urgency for culturally appropriate and clinically sound interventions to limit the spread of HIV/AIDS.

In response to the high rates of HIV in the province of Saskatchewan, the Saskatchewan HIV Strategy 2010-2014 was articulated and now being implemented and focusses on three main goals: to decrease the number of new infections; to improve the quality of life of those living with HIV and to reduce risk factors for the acquisition of HIV. Four strategic pillars anchor collaborative action across jurisdictions to strengthen investments in community engagement and education, prevention and harm reduction, clinical management and surveillance and research.

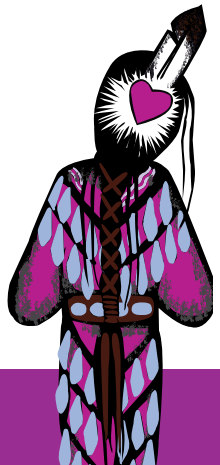
Although HIV has no cure, HIV is now categorised as a chronic condition, meaning it is life-long and manageable. Clinical advances in HIV medications permits for the increased longevity of those living with HIV and combined with support to address the underlying factors that make people vulnerable to contracting HIV (poverty, homelessness, traumatic life events, addictions, inter-generational residue from residential schools, etc.), people with HIV can live long and healthy lives.



In Saskatchewan, as with many other provinces, HIV is a reportable communicable disease; the identity of people living with HIV remains confidential and is not made public. Surveillance data (demographics, risk factors, contacts and follow-up) are collected to monitor trends, understand disease dynamics and obtain accurate numbers of HIV positive cases across the province. Within NITHA communities, there has been an incremental increase of new HIV positive cases since 2004. In the most recent year, 2011, there were 15 newly diagnosed HIV cases in NITHA communities, the highest yearly number recorded to date. An abbreviated profile of HIV in NITHA communities is as follows:

- The male to female ratio was 1.5:1 with more males than females testing positive for HIV.
- Although most age groups are represented in the HIV cases, the median age at diagnosis for females was 29.6 and 38.2 for males, which is consistent with the provincial median age at diagnosis.
- The principle risk factor for contracting HIV was recorded as injection drug use, particularly through shared needles, followed by unprotected sexual contact.
- Almost half of the positive HIV cases in the NITHA 2011 snapshot of HIV are individuals that are co-infected with Hepatitis C.

These numbers reflect those HIV positive cases who list a current on-reserve address belonging to NITHA communities. Additionally, it is estimated by the Public Health Agency of Canada that approximately 25% of people with HIV are unaware of their status.



Challenges and Opportunities

Access to information about the social and clinical dynamics of HIV/AIDS can challenge misconceptions that often propel stigma about how people contract and live with HIV. Reducing the stigma associated with HIV is an important aspect of HIV awareness and helps to create supportive health and community environments that are capable of caring for and supporting HIV clients in their life-long path to wellness.

Improving the overall health status of First Nations in Saskatchewan remains a challenge; simultaneous priorities such as housing and infrastructure, funding arrangements, improved education, chronic health conditions (diabetes, arthritis, hyper-tension, cancer, etc.) are on the First Nations agenda. Adding the complexities of HIV/AIDS education, treatment and support can be overwhelming, but incremental steps about awareness, prevention and long-term care needs can harmonize with the First Nations wellness journey.

Increasing HIV literacy in communities to combat misconceptions about those living with HIV and aim to create supportive environments for our collective wellness journey is an initial goal. Establishing reciprocal relationships with the range of clinical health care and social work practitioners, who diagnose, treat and ensure continuity of care with our clients remains a priority; there exists a strong working relationship that can be maximized to include HIV themes.

Future Directions

The HIV Strategy Coordinator's primary mandate was to create a NITHA HIV Strategy; the strategy is yet to be reviewed by the NEC and the Board of Chiefs. Meanwhile, NITHA now has an established presence on the Provincial Leadership Team and a working relationship with colleagues in the Health Regions, the clinical care for HIV clients and assistance to caregivers and families of those living with HIV can be supported by culturally appropriate services.

Planting the seeds for culturally relevant HIV education and supportive intervention with clients who reside in NITHA communities; the complex synergy between contracting and living with HIV and the cumulative social drivers of HIV (poverty, addictions, mental health, inter- generational trauma and residential school, etc.) is well documented and understood and NITHA will continue to work in supporting the partners and their communities .

ADMINISTRATION UNIT

Program Overview

The Administrative Unit is responsible for the ongoing daily operations of the organization in the areas of financial management, human resources and information technology and management. This unit provides the operational foundation for the health program services of the Community Services and Public Health Units.

The following staff are part of the Administrative Unit: Chief Executive Officer, Executive Assistant, Finance Manager, Personnel / Finance Assistant, Receptionist / Office Assistant, Human Resources Advisor, e-Health Advisor, and the Sr. Network Technologist.

This unit is responsible for:

- Maintenance of accurate financial records;
- Development of financial policies and procedures;
- Development of human resources policies and procedures;
- Human resource staffing through effective recruitment and retention policies and procedures;
- Planning and development of electronic health (e-Health) information systems; and
- Standardizing Information Technology (IT) hardware and software within the Partnership.

Human Resources

Program Overview

TOLU BABALOLA
HUMAN RESOURCES
ADVISOR

At NITHA, our most valuable assets are our employees. Labour is an important factor of the delivery of public health advisory services and the HR Unit manages this important factor. Human Resource Management (HRM) is the term used to describe the management of people within an organization. According to Armstrong, it is "a strategic approach to the acquisition, motivation, development and management of the organization's human resources. It is devoted to shaping an appropriate corporate culture and introducing programs which reflect and support the core values of the enterprise and ensure its success" (1999).

The Human Resources (HR) Unit at NITHA works as a business partner that aligns human resource initiatives with the strategic goals and objectives of NITHA. The HR Unit deals with issues related to people such as recruitment and retention, compensation, performance management, organizational development, occupational health and safety, employee wellness, employee group benefits, employee relations, communications, HR administration and record keeping, and employee training and development.

The management of Human Resources at NITHA is the responsibility of the Human Resources Advisor who is supported by the Finance/Personnel Assistant.

Achievements

The Human Resources function has evolved into an effective strategic business partner that understands the nature of the business at NITHA and has become a necessary part of an effective team managing the organization.

The Human Resources team at NITHA has been able to adequately support the organization by continually accessing the labour market for a talent pool needed to accomplish the business strategies of hiring the right people with the right skills and at the right time. A year ago staff strength at NITHA was a total of 21 employees. As of March 31, 2012 staff strength is now a total of 24 employees and the employee turnover rate stood at 13% as of March 31, 2012.

The Human Resources team has contributed to the bottom line by reducing operating expenses. Total recruitment advertising costs was $170,013.00 in 2011 which dropped to $112,249.50 in 2012 representing a 34% decrease in recruitment advertising expenses. This has been achieved by assessing the effectiveness of the various recruitment and advertisement sources NITHA uses to recruit its employees and streamlining advertising recruitment activities to include productive resources only.

With the support of professionals and experts in various fields of specialization from the four partnerships, NITHA has maintained effective resume screening activities and effective interviewing in selecting the right candidates to fill vacant positions.

The Human Resources team continuously and proactively searches for initiatives that will create value to NITHA and not function in a reactionary mode.

The Human Resources team actively promotes employee training and development that has facilitated the process of systematically developing expertise in individuals for the purpose of improving performance. The Human Resources team initiated the establishment of a Corporate Employee Orientation Program for new hires and also ensures that each new hire is provided *Job Specific* orientation to enable them to succeed in their new positions at NITHA.

At NITHA, we strive for excellence at all times. In order to achieve this goal, NITHA is able to maintain a performance management system coordinated by the Human Resources team. Performance management is geared towards ensuring that each employee is performing the tasks intended at the expected level to support the strategic business objectives of the organization. Each employee is fully aware of his or her role in the organization, what type of output is expected, how the output will be measured and areas for improvement. The performance management activities are supported by other Human Resources activities such as the development, review and update of job descriptions through effective job analysis.

While NITHA wants to become a highly competitive employer to attract and retain the best talent, NITHA also recognizes the following:

- NITHA is predominantly funded by government sources as a non-profit organization and as such its compensation rates must gain funders' approval;
- NITHA must be responsive to the different labor markets of the partners and communities it serves.
- NITHA attempts to find a balance between market realities and funding realities.

An understanding of the compensation philosophy at NITHA, in addition to an analysis of the current needs of the organization, has enabled the establishment of suitable guidelines for the management of a base salary and non-cash compensation for employees at NITHA.

The Human Resources team has continued to ensure NITHA's compliance to employment legislation through maintenance of Human Resources policies and procedures and the compliance to employment legislation including the requirement of the Canada Labour Code for employers with twenty or more employees by establishing an Occupational Health and Safety Program.

At NITHA, there is the desire to maintain continuous flow of information between management and staff to ensure adequate employee communications. This is achieved through joint management and employee activities including retreats for team building, establishment of social and employee wellness committees, maintaining avenues for feedback from staff on various issues and promoting an open door policy. Employees are kept informed about current developments at NITHA through monthly staff meetings, regular correspondence via intranet, letters to staff, memos, billboard notices and information provided to staff on the *shared* drive.

Challenges

In today's Canada, the health care sector is plagued with recruitment challenges resulting in an urgent need for innovation in the ways of attracting health professionals. Workforce exits and entries will dramatically change the landscape for healthcare organizations and their leaders in coming years. As the baby boomers retire, the workforce will contract. The supply of replacement workers is projected to be insufficient to fill the void. To mitigate the loss of organizational memory and its related impact on performance, healthcare leaders must devise strategies to fill the skills gap. The aging of Canada's population is not the only reason for Canada's emerging skills shortage, but the fact that the demand for skills needed in the health industry is yet to be met by supply. NITHA operates in an environment where there is a shortage of skilled healthcare professionals. The supply of health professionals in Northern Saskatchewan does not meet the demand; hence there is a constant recruitment drive to hire health professionals to meet the shortages or skills gap.

The challenges created by the shortage of skills have not made it possible for NITHA to operate with a full complement of staff. Currently, NITHA is either able to maintain skeletal services or not able to provide certain services to the 33 First Nation communities due to vacant positions waiting to be filled. In some instances, staff members have to share the responsibilities of certain vacant positions where services for such vacant positions need to be carried out in maintaining operational efficiency.

Priorities for next year and the future

- To strive to achieve a full complement of staff for business operations.
- To promote and implement Human Resources initiatives that would facilitate employee recruitment and retention.
- To continue to promote employee welfare and wellness.
- To promote fairness, equity and respect at NITHA
- To foster increased "team spirit" at NITHA.
- To explore avenues to develop Human Resources professionalism at NITHA and within the Partnerships.
- To initiate automation of Human Resources processes through the establishment of a Human Resource Management Information System.
- To continue to hire the right people with the right skills and at the right time.

e-Health

Program Overview

CHARLES BIGHEAD
e-HEALTH ADVISOR

e-health is the application of Information Technologies (IT) to support health business. Examples of e-Health solutions are:

- Panorama which is an electronic information system for public health.
- Telehealth which is the delivery of health-related services over a distance using remote access and video conferencing technologies.
- Microsoft Office for word processing, spreadsheets, and managing emails, contacts and calendars.
- Internet access for research, social networking, and online collaboration.

One of the more interesting and beneficial e-Health applications would be the Electronic Medical Record (EMR) which has the potential to improve efficiencies with client record management, support health programming and services, automate reporting, improve the referral process and sharing of health information, and for monitoring health status and supporting decision making. An EMR is costly and complex to implement though and would require significant investment and capacity development.

Accomplishments

This past year the NITHA Partners did a lot of planning and developmental work to upgrade the health facility data networks. NITHA provides expert IT support as requested and also supports the Partners and communities with other activities such as coordinating multi-site video conferencing for employee recruitment purposes.

The "*CommunityNet*" services fees for the Partners and communities are still being paid directly by NITHA through an annual proposal submission process with FNIHB. CommunityNet is a high quality internet service that is more secure and reliable than ordinary residential internet services.

The e-Health Advisor routinely provides advice and support for the NITHA staff such as guiding development of IT business requirements, providing introductory computers training, and coordinating multi-site video conferencing sessions for training and employee recruitment purposes.

In October, the NITHA Executive Council approved the development of an electronic tool to assist communities with their CBRT reporting obligations for the 2012-2013 reporting year. The plan was to have the tool ready by April 1, 2012. Unfortunately, analysis of the CBRT and development of the IT Business Requirements for an electronic tool were delayed because of expectations the CBRT would change. By the year end a Request for Proposals (RFP) was prepared to elicit a software development company to build the electronic CBRT tool which would be ready in the early part of the new fiscal year instead.

A substantive "e-Health Readiness Assessment" report was completed over the year. The purpose of the report was to give a snapshot of the North's readiness to implement e-Health and covers topics such as health services, policy and governance, project management, technology and operations/support. This report aligns with the direction of Health Canada's Health Infostructure Strategic Action Plan (HISAP) and would be useful for strategic planning.
NITHA received funding for a Telemedicine program developer position and the objective was to develop the process and procedures for integrating First Nations sites to the Telehealth Saskatchewan Network. For a number of reasons the position was not filled and instead the former Telehealth Manager for the Saskatoon Health Region was contracted to develop the following:

- A manual for adding First Nations sites to the provincial telehealth system.
- A manual for conducting clinical and educational telehealth sessions.
- A report on resource requirements for telehealth services.

NITHA collaborated with Telehealth Saskatchewan on this and the stage is now set for First Nations to be formally added to the Telehealth Saskatchewan network and gain status as official Telehealth sites. Official status opens the door for remote access to provincial services (educational, clinical) and would increase telehealth utilization.

Panorama is a new electronic public health management system that can be used for recording immunizations and managing communicable disease cases and

may be available by 2013. This year a lot of preparatory work was accomplished through the Information Governance Working Group. This group was directed by the First Nations Deployment of Panorama in Saskatchewan (FNDPS) Steering Committee to provide advice and recommendations on the development of an information governance framework and to ensure First Nations privacy concerns are properly addressed.

Challenges

The NITHA Partners require Telehealth Coordinators to promote telehealth and facilitate educational sessions and remote clinical consults with medical professions. The educational sessions are easy to coordinate compared to clinical sessions which requires coordination of the clients, health service facilitates and a multitude of providers. NITHA has advised the Partners to seek funding and propose new Telehealth coordinators positions for the New Year. There are still other minor business requirements to meet but all in all Northern First Nations sites are better positioned to interoperate with Telehealth Saskatchewan and increase Telehealth utilization.

Towards the end of the year, FNIH conducted a regional e-Health environmental scan. The purpose of the report was to summarize activities relevant to the development of an e-Health strategy for First Nations in Saskatchewan and included First Nations, Federal, and Provincial Stakeholders as well as MOU holders (i.e. NITHA, FSIN). Regionally the findings were there are many challenges and barriers but from the context of the north many of these were already addressed. For example the northern stakeholder environment is not complex or confusing, there is an e-Health developmental model and the North has created partnerships with the Province and FNIH for the collaborative development of e-Health.

Under the direction of the MOU on Health & Well-being Steering Committee, the Health Information Working Group was formed and began meeting this year. Most of the work was about developing the terms of reference and getting the group orientated to the issues. The purpose of the group is to provide recommendations about Health Information needs and to support First Nations e-Health initiatives. The challenge here is Northern First Nations are being grouped with south and central First Nations who are not collectively aligned like the North or as well developed. Also FSIN's mandate is not necessarily to develop First Nations e-Health systems. NITHA will continue focusing e-Health development in the north while Health Canada, the Province and FSIN take the regional approach.

Some First Nations have been requesting access to the Pharmaceutical Information Program (PIP). This is the provincial electronic system that contains patient medication information and is used by physician offices, pharmacies and other health professionals. The province would allow First Nations access to PIP provided First Nations privacy and information security policies are enhanced to meet certain specific HIPA requirements with regards to maintaining the privacy and confidentiality of personal health information.

The e-Health Advisor met with the NITHA Board and the MLTC Health Board to promote the concept of a First Nations "Data Trustee". A First Nations data trustee would be an (organizational) entity that is responsible and accountable for the privacy and security of the individual's health information that is entrusted to them. A data trustee would also have the authority to enter into data sharing agreements with other trustees for the purpose of im-

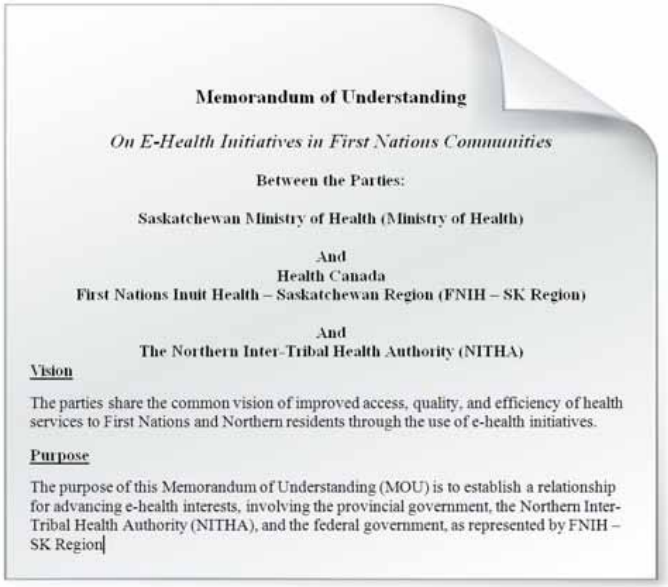
proving an individual's health care. The challenge is a data trustee is a relatively new concept for First Nations and there is still much communications and organizational developmental work to do.

Priorities for the New Year

NITHA will continue supporting the Partners and Communities' migration to the Telehealth Saskatchewan Network so that each First Nations Telehealth site will gain status as an official Telehealth site and increase telehealth utilization.

NITHA will continue development of an electronic CBRT tool and support its deployment and implementation. This will be the top priority for the New Year so that the tool is available as early as possible and any necessary back entry of data is minimized.

NITHA will continue advocating for a Community based EMR (cEMR). Considering the complexity, cost and integration requirements for a cEMR, the best approach may be to reconvene the NITHA E-Health MOU and make the cEMR a priority item.



Memorandum of Understanding

On E-Health Initiatives in First Nations Communities

Between the Parties:

Saskatchewan Ministry of Health (Ministry of Health)

And
Health Canada
First Nations Inuit Health – Saskatchewan Region (FNIH – SK Region)

And
The Northern Inter-Tribal Health Authority (NITHA)

Vision

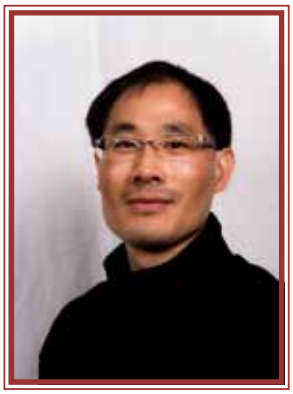
The parties share the common vision of improved access, quality, and efficiency of health services to First Nations and Northern residents through the use of e-health initiatives.

Purpose

The purpose of this Memorandum of Understanding (MOU) is to establish a relationship for advancing e-health interests, involving the provincial government, the Northern Inter-Tribal Health Authority (NITHA), and the federal government, as represented by FNIH – SK Region

NITHA IT Administration

Over the year NITHA switched email providers to Microsoft 365 Hosted Email Exchange service. The result was more features such as calendar sharing and corporate directory management while reducing the monthly costs.



ERIC XUE
SR. NETWORK TECHNOLOGIST

The NITHA Server crashed this year. Fortunately the design of network took disaster recovery and business continuity into account and there was minimal disruption to staff as the server was being replaced.

The Network Administrator's (Eric Xue) job title was changed to Sr. Network Technologist. The rationale was Eric has advanced IT skills and knowledge and is an important resource for the partner IT personnel.

Finance

Program Overview

Transfer Agreement Funding

In the 2011/2012 fiscal year, NITHA entered the 2nd year of the 3 year extension of the transfer agreement which was signed in September 2006 and which expires March 31st, 2013. The majority of NITHA's funding comes from its transfer agreement with Health Canada. This represented $2,640,175 or 95% of the total revenue this fiscal year. The Transfer Agreement funds are used to support the Public Health Unit (PHU), the Community Services Unit (CSU) and NITHA Administration. As recruitment and retention continues to be a challenge, vacant positions result in surplus funds that were budgeted for salaries. The NITHA Executive Council and the NITHA Board of Chiefs allocate

LISA LEPINE
FINANCE MANAGER

surplus funds to specific programs or projects to meet the needs of the Partner communities. This provision is a product of NITHA's unique framework.

Transfer Funding	$ 2,466,632
Community Health Plan	$ 30,500
Environmental Health	$ 143,043
TOTAL Transfer Funds	$ 2,640,175

Contribution Agreement Funding

Contribution Agreement funding is provided by Health Canada and is targeted towards specific programs and service needs of the Partner communities. These targeted programs are portrayed below.

Current Years Events

In June 2011, NITHA's Finance Policies and Procedures Manual was reviewed and updated. The current financial policies ensure best accounting practices are followed and to ensure accountability to NITHA's stakeholders. The NITHA financial policies and procedures are reviewed by management on an annual basis, and every three years by the NITHA Executive Council and the Board of Chiefs.

A request for proposals for the appointment of the NITHA auditor went out in July 2011. Deloitte was appointed as auditor for the 2011/2012 fiscal year. As good financial management practice, the appointment of NITHA's auditor will be competitively bid every 3 years.

Early in 2012, the NITHA operational, capital, and program budgets for the next fiscal year were developed and reviewed in detail with the NITHA Executive Council. The voice of the communities is translated by the NITHA Executive Council and reflected in the annual budget. The budget then goes to the Board of Chiefs for their voice, review, and approval.

Throughout the year, the detailed budgeted financial statements by program area are presented and reviewed by the NITHA Executive Council on a quarterly basis. The detailed financial statements then go to the Board of Chiefs for review and approval.

Annual Audit

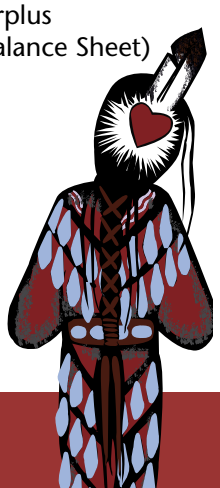
The audited statements were presented by management and an opinion was stated by Deloitte to the NITHA Executive Council and the NITHA Board of Chiefs. The statements were reviewed in detail by the NITHA Executive Council and then reviewed and approved by the Board of Chiefs.

NITHA received an unqualified audit; the financial statements were presented fairly, in all material respects. Alternatively speaking, the financial statements received a clean bill of health from the auditor.

Audited Financial Statements

The 2011-2012 audited financial statements report the financial results of NITHA's programs and services provided to the Partners and Communities and the financial position of NITHA at March 31, 2012. Included in the financial audit are:

- The Auditor's opinion of the fairness of the financial statements
- Statement of Revenue, Expenditures and Fund Balances reflecting the combined revenue, expenditures and accumulated surplus
- Statement of Financial Position (Balance Sheet)
- Statement of Cash Flows
- Notes to the Financial Statements



NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

FINANCIAL STATEMENTS

MARCH 31, 2012

Deloitte & Touche LLP
5 – 77 15th Street East
Prince Albert, SK S6V 1E9
Canada

Tel: (306) 763-7411
Fax: (306) 763-0191
www.deloitte.ca

INDEPENDENT AUDITOR'S REPORT

TO THE DIRECTORS OF NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.

We have audited the accompanying financial statements of Northern Inter-Tribal Health Authority Inc., which comprise the statement of financial position as at March 31, 2012, and the statements of revenue, expenditures and fund balances and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of Northern Inter-Tribal Health Authority Inc. as at March 31, 2012, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF REVENUE, EXPENDITURES AND FUND BALANCES
year ended March 31, 2012

	Operating Fund (Schedule 1)	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2012**	Total 2011
REVENUE						
Contributions, transfers and projects						
Health Canada - transfer agreements	$ 2,640,175	$ -	$ -	$ -	**$ 2,640,175**	$ 2,649,505
Health Canada - contribution agreements	2,135,289	-	-	-	**2,135,289**	1,746,581
Health Canada - flow through funding	-	-	-	-	**-**	35,500
Mamawetan Churchill River Regional Health Authority	-	-	-	-	**-**	29,679
University of Regina	-	-	-	-	**-**	36,857
Administration fees (Note 10)	84,600	-	-	-	**84,600**	163,186
Expense recoveries	22,661	-	-	-	**22,661**	6,326
Gain on sale of capital assets	-	-	-	-	**-**	59,654
Interest	55,393	-	-	-	**55,393**	38,743
Other	-	-	-	-	**-**	3,688
Transfer from deferred revenue	-	-	-	-	**-**	545,587
Transfer to deferred revenue	(444,869)	-	-	-	**(444,869)**	-
	4,493,249	-	-	-	**4,493,249**	5,315,306
EXPENDITURES						
Health Canada programs	3,844,076	-	-	-	**3,844,076**	3,774,531
Other programs	-	-	-	-	**-**	152,056
Expenses funded by appropriated surplus	-	415,249	-	-	**415,249**	509,849
Amortization of capital assets	-	-	-	335,012	**335,012**	367,884
	3,844,076	415,249	-	335,012	**4,594,337**	4,804,320
NET (DEFICIT) SURPLUS	649,173	(415,249)	-	(335,012)	**(101,088)**	510,986
FUND BALANCES, BEGINNING OF YEAR	1,422,201	2,737,922	356,974	773,540	**5,290,637**	4,779,651
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS	(42,393)	-	-	-	**(42,393)**	(38,743)
TRANSFER TO CAPITAL FUND	(53,888)	-	-	-	**(53,888)**	(271,818)
TRANSFER FROM OPERATING FUND	-	1,718,367	42,393	53,888	**1,814,648**	291,646
TRANSFER TO APPROPRIATED SURPLUS	(1,718,367)	-	-	-	**(1,718,367)**	18,915
FUND BALANCES, END OF YEAR	$ 256,726	$ 4,041,040	$ 399,367	$ 492,416	**$ 5,189,549**	$ 5,290,637

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF FINANCIAL POSITION
as at March 31, 2012

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**Total 2012**	Total 2011
CURRENT ASSETS						
Cash and cash equivalent	$ 1,590,662	$ 4,041,040	$ 399,367	$ -	**$ 6,031,069**	$ 5,282,940
Accounts receivable (Note 5)	15,671	-	-	-	**15,671**	385,929
Prepaid expenses	5,783	-	-	-	**5,783**	5,130
	1,612,116	4,041,040	399,367	-	**6,052,523**	5,673,999
CAPITAL ASSETS (Note 6)	-	-	-	492,416	**492,416**	773,540
	$ 1,612,116	$ 4,041,040	$ 399,367	$ 492,416	**$ 6,544,939**	$ 6,447,539
CURRENT LIABILITIES						
Accounts payable and accrued charges	$ 900,521	$ -	$ -	$ -	**$ 900,521**	$ 1,146,902
Deferred revenue (Note 7)	454,869	-	-	-	**454,869**	10,000
	1,355,390	-	-	-	**1,355,390**	1,156,902
FUND BALANCES						
Unappropriated surplus	256,726	-	-	-	**256,726**	1,422,201
Appropriated surplus (Note 8)	-	4,041,040	-	-	**4,041,040**	2,737,922
Surplus appropriated for scholarships (Note 9)	-	-	399,367	-	**399,367**	356,974
Equity in capital assets	-	-	-	492,416	**492,416**	773,540
	256,726	4,041,040	399,367	492,416	**5,189,549**	5,290,637
	$ 1,612,116	$ 4,041,040	$ 399,367	$ 492,416	**$ 6,544,939**	$ 6,447,539

SIGNED ON BEHALF OF THE BOARD:

Chair

Board Member

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
STATEMENT OF CASH FLOWS
year ended March 31, 2012

	Operating Fund	Appropriated Surplus	Surplus Appropriated for Scholarships	Capital Fund	**2012**	2011
CASH FLOWS FROM (USED IN) OPERATING ACTIVITIES						
Net (deficit) surplus	**$** 649,173	$ (415,249)	$ -	$ (335,012)	**$ (101,088)**	$ 510,986
Adjust items not affecting cash						
Gain on sale of capital assets	-	-	-	-	**-**	(59,654)
Amortization of capital assets	-	-	-	335,012	**335,012**	367,884
	649,173	(415,249)	-	-	**233,924**	819,216
Changes in non-cash working capital						
Accounts receivable	370,258	-	-	-	**370,258**	796,154
Prepaid expenses	(653)	-	-	-	**(653)**	(33)
Accounts payable and accrued charges	(246,381)	-	-	-	**(246,381)**	(1,607)
Deferred revenue	444,869	-	-	-	**444,869**	(565,332)
	1,217,266	(415,249)	-	-	**802,017**	1,048,398
CASH FLOWS FROM (USED IN) INVESTING ACTIVITIES						
Purchase of capital assets	-	-	-	(53,888)	**(53,888)**	(331,472)
Proceeds from disposal of capital assets	-	-	-		**-**	59,654
	-	-	-	(53,888)	**(53,888)**	(271,818)
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS	1,217,266	(415,249)	-	(53,888)	**748,129**	776,580
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	2,188,044	2,737,922	356,974	-	**5,282,940**	4,506,360
TRANSFER TO SURPLUS APPROPRIATED FOR SCHOLARSHIPS	(42,393)	-	-	-	**(42,393)**	(38,743)
TRANSFER TO CAPITAL FUND	(53,888)	-	-	-	**(53,888)**	(271,818)
TRANSFER FROM OPERATING FUND	-	1,718,367	42,393	53,888	**1,814,648**	291,646
TRANSFER (TO) FROM APPROPRIATED SURPLUS	(1,718,367)	-	-	-	**(1,718,367)**	18,915
CASH AND CASH EQUIVALENTS, END OF YEAR	**$** 1,590,662	$ 4,041,040	$ 399,367	$ -	**$ 6,031,069**	$ 5,282,940
CASH AND CASH EQUIVALENTS CONSISTS OF:						
Cash					**$ 804,818**	$ 1,102,308
Short-term investments					**5,226,251**	4,180,632
Cash and cash equivalents					**$ 6,031,069**	$ 5,282,940

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NOTES TO THE FINANCIAL STATEMENTS
year ended March 31, 2012

1. DESCRIPTION OF BUSINESS

Northern Inter-Tribal Health Authority Inc. (the "Corporation") was incorporated under the Non-Profit Corporations Act of Saskatchewan on May 8, 1998. The Corporation is responsible for administering health services and programs to its members.

2. SIGNIFICANT ACCOUNTING POLICIES

The financial statements have been prepared in accordance with Canadian generally accepted accounting principles ("GAAP") and reflect the following significant accounting policies:

Use of Estimates

The preparation of the financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the year. Actual results could differ from these estimates.

Fund Accounting

The Corporation uses fund accounting procedures which result in a self-balancing set of accounts for each fund established by legal, contractual or voluntary actions. The Corporation maintains the following funds:

i) The Operating Fund accounts for the Corporation's administrative and program delivery activities.

ii) The Appropriated Surplus Fund accounts for equity allocated by the Board of Directors to be used for a specific purpose in the future.

iii) The Surplus Appropriated for Scholarships Fund accounts for equity allocated by the Board of Directors to be used for payment of scholarships in the future.

iv) The Capital Fund accounts for the capital assets of the Corporation, together with related financing and amortization.

Cash

Cash consists of bank balances held with financial institutions and money market funds with maturities less than 90 days.

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Capital Assets

Capital assets purchased are recorded at cost. Amortization is recorded using the straight-line method over the estimated useful lives of the asset as follows:

Computers	3 years
Equipment and furniture	5 years
Leasehold improvements	5 years
Vehicles	5 years

Impairment of Long-lived Assets

Long-lived assets are tested for recoverability whenever events or changes in circumstances indicate that their carrying amount may not be recoverable. An impairment loss is recognized when their carrying value exceeds the total undiscounted cash flows expected from their use and eventual disposition. The amount of the impairment loss is determined as the excess of the carrying value of the asset over its fair value.

Revenue Recognition

Revenue received from funding agencies which pertains to future operations is recorded as deferred revenue and recognized as revenue in future years as the related expenditures are incurred.

Financial Instruments

The Corporation has elected to use the exemption provided by the Canadian Institute of Chartered Accountants ("CICA") permitting not-for-profit organizations not to apply Sections 3862 and 3863 of the CICA Handbook which would otherwise have applied to the financial statements of the Corporation for the year ended March 31, 2011. The Corporation applies the requirements of Section 3861 of the CICA Handbook.

Financial assets and financial liabilities are initially recognized at fair value and their subsequent measurement is dependent on their classification as described below. Their classification depends on the purpose for which the financial instruments were acquired or issued, their characteristics and the Corporation's designation of such instruments. Settlement date accounting is used.

Classification

Cash	Held-for-trading
Short term investments	Available-for-sale
Accounts receivable	Loans and receivables
Accounts payable and accrued charges	Other liabilities

2. SIGNIFICANT ACCOUNTING POLICIES (continued)

Financial Instruments (continued)

Held-for-trading

Held-for-trading financial assets are financial assets typically acquired for resale prior to maturity or that are designated as held-for-trading. They are measured at fair value at the statement of financial position date. Fair value fluctuations including interest earned, interest accrued, gains and losses realized on disposal and unrealized gains and losses are included in other income.

Available-for-sale

Available-for-sale financial assets are those non-derivative financial assets that are designated as available-for-sale, or that are not classified as loans and receivables, held-to-maturity or held-for-trading investments. Except as mentioned below, available-for-sale financial assets are carried at fair value with unrealized gains and losses included in fund balances until realized when the cumulative gain or loss is transferred to other income.

Available-for-sale financial assets that do not have quoted market prices in an active market are recorded at cost.

Interest on interest-bearing available-for-sale financial assets is calculated using the effective interest method.

Loans and receivables

Loans and receivables are accounted for at amortized cost using the effective interest method.

Other liabilities

Other liabilities are recorded at amortized cost using the effective interest method and include all financial liabilities, other than derivative instruments.

Interest rate risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in the interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk.

The Corporation is exposed to price risk with respect to its investments in guaranteed investment certificates and mutual funds. The exposure to price risk is not considered significant.

3. CHANGES IN ACCOUNTING POLICIES

Future Accounting Policies

The Accounting Standards Board has approved a new framework for not-for-profit organizations that is based on existing Canadian GAAP and incorporates the 4400 series of standards which relate to situations unique to the not-for-profit sector. The new standards became available December 1, 2010 as Part III of the CICA Handbook - Accounting and are effective for reporting periods beginning on or after January 1, 2012. The Corporation is currently evaluating the impact of the adoption of these new Standards on its financial statements.

4. ECONOMIC DEPENDENCE

The Corporation receives the major portion of its revenues pursuant to various funding agreements with the First Nations and Inuit Health Branch of Health Canada. The most significant agreement undertaken was a 5-year health transfer agreement, which expires September 30, 2011. An extension of the current transfer agreement was granted, which now expires March 31, 2013.

5. ACCOUNTS RECEIVABLE

	2012	2011
Health Canada	**$ -**	$ 349,082
Mamawetan Churchill River Regional Health Authority	**-**	24,789
Other	**15,671**	12,058
	$ 15,671	$ 385,929

6. CAPITAL ASSETS

	Cost	Accumulated Amortization	Net Book Value **2012**	Net Book Value 2011
Computers	$ 1,018,047	$ 785,965	**$ 232,082**	$ 446,753
Equipment and furniture	311,028	211,660	**99,368**	101,730
Leasehold improvements	405,082	352,045	**53,037**	57,963
Vehicles	275,550	167,621	**107,929**	167,094
	$ 2,009,707	$ 1,517,291	**$ 492,416**	$ 773,540

7. DEFERRED REVENUE

	2012	2011
Community Health Plan	**$ 30,500**	$ -
Aboriginal Human Resources	**390,131**	-
Telehealth - HSIF	**13,934**	-
CASET - HSIF	**10,304**	-
Glaxosmith Kline Project	**10,000**	10,000
	$ 454,869	$ 10,000

8. APPROPRIATED SURPLUS

The Corporation maintains an Appropriated Surplus Fund to fund program initiatives. The Board of Directors of the Corporation authorized the transfer of balances to and from the Appropriated Surplus Fund during the 2012 fiscal year. Funds have been allocated within the Appropriated Surplus Fund for future expenditures as follows:

	Opening Balance	Transfers In (Out)	Expenditures	Ending Balance
Capacity development iniatives	$ 67,133	$ 433,605	$ 65,078	$ 435,660
Capital projects	1,030,750	(189,750)	-	841,000
E-Health solutions	800,000	10,000	300,000	510,000
Human resource iniatives	63,454	(29,454)	-	34,000
Nursing support	310,800	18,500	-	329,300
Special projects	359,079	1,254,705	10,918	1,602,866
Strategic planning and long-term planning	106,706	220,761	39,253	288,214
	$ 2,737,922	$ 1,718,367	$ 415,249	$ 4,041,040

9. SURPLUS APPROPRIATED FOR SCHOLARSHIPS

The Directors of the Corporation established a policy that any interest earned by the Corporation be appropriated to fund scholarships for students entering post secondary education in a medical field. The transfer from the Operating Fund recorded in each year represents the interest earned less scholarship expenditure incurred in that fiscal year as follows:

	Amount
2003	$ 5,555
2004	22,140
2005	17,180
2006	22,658
2007	34,843
2008	116,065
2009	82,997
2010	16,793
2011	38,743
2012	42,393
	$ 399,367

10. ADMINISTRATION FEES

The Corporation charged the following administration fees to program activities based on funding agreements:

	Schedule	**2012**	2011
TB Initiative	5	**$ 14,810**	$ 42,986
Home Care	6	**5,965**	-
Communicable Disease Control / CDHE	7	**7,359**	-
Diabetes	8	**-**	5,259
Nursing Innovation Investments	9	**1,672**	4,278
Targeted Immunization Strategy	10	**3,953**	-
National Aboriginal Youth Suicide Prevention Strategy	11	**2,967**	5,350
Nursing Education - CHPC / NEPD	12	**-**	1,400
Aboriginal Human Resource	13	**1,000**	-
E-Health Solutions	14	**24,979**	6,057
HIV / STI Conference	15	**15,317**	14,059
Panorama	16	**6,152**	28,227
AHTF E-Health Project	17	**-**	51,024
Northern Health Strategy	19	**-**	1,441
Recognized Prior Learning	21	**-**	2,801
Other administrative amounts recorded in the current year		**427**	304
		$ 84,600	$ 163,186

11. CAPITAL MANAGEMENT

The Corporation's objectives when managing capital are to maintain sufficient Operating Fund, Appropriated Surplus Fund, Surplus Appropriated for Scholarships Fund and Capital Fund balances to achieve the purposes of the funds and to ensure compliance with internal and external restrictions placed on those funds.

In the management of capital, the Corporation includes fund balances in the definition of capital. As at March 31, 2012, the Corporation has $5,189,547 (2011 - $5,290,637) in capital.

Capital management objectives, policies and procedures are unchanged since the preceding year.

12. RELATED PARTY TRANSACTIONS

The Corporation works as a Third Level Structure in a partnership arrangement between the Prince Albert Grand Council, the Meadow Lake Tribal Council, the Peter Ballantyne Cree Nation, and the Lac La Ronge Indian Band to support and enhance existing northern health service delivery in First Nations.

At March 31, 2012, there was $3,126 (2010- $573) of receivables and $61,501 (2010 – $197,327) of payables with the Corporation's partners listed above. These transactions were made in the normal course of business and have been recorded at the exchanged amounts.

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
SUMMARY OF OPERATING FUND REVENUE, EXPENDITURES AND SURPLUS FROM PROGRAMS PRIOR TO INTERFUND TRANSFERS
year ended March 31, 2012

	Schedule	Health Canada Transfer	Health Canada Contributions	Other Revenue	Administration Fees	Transfer (To) From Deferred Revenue	Total Revenue	Expenditures	**Surplus (Deficit) 2012**	Surplus (Deficit) 2011
TRANSFER AGREEMENTS										
Public Health Unit	2	$ 975,127	$ -	$ 2,494	$ -	$ -	$ 977,621	$ 638,582	**$ 339,039**	$ 505,296
Administration	3	1,229,805	-	56,030	84,600	(30,500)	1,339,935	1,202,929	**137,006**	409,057
Community Services Unit	4	435,243	-	-	-	-	435,243	284,372	**150,871**	232,909
SET AGREEMENTS										
TB Initiative	5	-	451,766	-	-	-	451,766	451,766	**-**	2,682
Home Care	6	-	67,531	-	-	-	67,531	67,531	**-**	(36,289)
Communicable Disease Control / CDHE	7	-	91,000	-	-	-	91,000	85,620	**5,380**	-
Diabetes	8	-	-	-	-	-	-	-	**-**	-
Nursing Innovation Investments	9	-	18,395	-	-	-	18,395	18,395	**-**	-
Targeted Immunization Strategy	10	-	60,000	-	-	-	60,000	43,005	**16,995**	10,500
NAYSPS	11	-	53,500	-	-	-	53,500	53,500	**-**	-
Nursing Education	12	-	15,000	-	-	-	15,000	15,118	**(118)**	-
Aboriginal Human Resource	13	-	823,727	19,530	-	(390,131)	453,126	453,126	**-**	-
E-Health Solutions	14	-	288,704	-	-	(13,934)	274,770	274,770	**-**	-
HIV/STI	15	-	183,000	-	-	-	183,000	183,000	**-**	-
Panorama	16	-	67,666	-	-	-	67,666	67,666	**-**	2,406
AHTF E-Health Project	17	-	-	-	-	-	-	-	**-**	202,504
CASET - HSIF	18	-	15,000	-	-	(10,304)	4,696	4,696	**-**	-
TOTAL		2,640,175	$ 2,135,289	$ 78,054	$ 84,600	$ (444,869)	$ 4,493,249	$ 3,844,076	**$ 649,173**	$ 1,329,065

Schedule 2

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PUBLIC HEALTH UNIT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - transfer agreement	**$ 975,127**	$ 1,011,243
Expense recoveries	**2,494**	6,326
	977,621	1,017,569
EXPENDITURES		
Meetings and workshops	**2,200**	1,481
Personnel	**575,794**	472,438
Professional Fees	**400**	-
Telephone and supplies	**10,662**	13,901
Travel and vehicle	**17,018**	14,321
West Nile Virus Reduction program	**32,508**	10,132
	638,582	512,273
SURPLUS	**$ 339,039**	$ 505,296

Schedule 3

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ADMINISTRATION
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - transfer agreement	**$ 1,229,805**	$ 1,205,759
Administration fees	**84,600**	163,186
Expense recoveries	**638**	-
Interest Revenue	**55,392**	38,743
Other Revenue	**-**	3,688
Transfer (to) from deferred revenue	**(30,500)**	-
	1,339,935	1,411,376
EXPENDITURES		
Bank charges	**1,822**	3,719
Equipment lease and maintenance	**20,263**	18,366
Facility costs	**129,170**	97,596
Meetings and workshops	**123,733**	84,957
Personnel	**744,514**	598,908
Professional services	**40,042**	58,535
Scholarships	**13,000**	-
Telephone and supplies	**106,335**	110,573
Travel and vehicle	**24,050**	29,665
	1,202,929	1,002,319
SURPLUS	**137,006**	409,057
NET TRANSFER TO CAPITAL FUND	**(31,514)**	(113,381)
	$ 105,492	$ 295,676

Schedule 4

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNITY SERVICES UNIT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - transfer agreement	**$ 435,243**	$ 432,503
EXPENDITURES		
Meetings and workshops	**1,798**	10
Personnel	**215,408**	174,743
Professional services	**12,000**	12,000
Program costs	**51,989**	12,841
Travel and vehicle	**3,177**	-
	284,372	199,594
SURPLUS	**$ 150,871**	$ 232,909

Schedule 5

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TB INITIATIVE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada	**$ 396,550**	$ 494,944
Health Canada - TST Funding	**52,486**	-
Health Canada - TB Community Based ED	**2,730**	-
	451,766	494,944
EXPENDITURES		
Administration fees	**14,810**	42,986
Equipment lease and maintenance	**310**	285
Facility costs	**1,538**	1,384
Meetings and workshops	**165**	322
Personnel	**348,805**	299,610
Program costs	**55,215**	15,715
Program incentives	**6,793**	16,500
Outbreak services	**-**	78,394
Telephone and supplies	**8,420**	9,474
Travel and vehicle	**15,710**	27,592
	451,766	492,262
SURPLUS	**-**	2,682
NET TRANSFER TO CAPITAL FUND	**-**	(2,682)
	$ -	$ -

Schedule 6

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HOME CARE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 67,531**	$ 65,564
EXPENDITURES		
Administration fees	**5,965**	**-**
Meetings and workshops	**44**	659
Personnel	**2,028**	96,982
Program costs	**58,558**	1,103
Travel and vehicle	**936**	3,109
	67,531	101,853
DEFICIT	**$ -**	$ (36,289)

Schedule 7

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
COMMUNICABLE DISEASE CONTROL / CDHE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 91,000**	$ -
EXPENDITURES		
Administration fees	**7,359**	-
Personnel	**45,689**	-
Program costs	**32,572**	-
	85,620	-
SURPLUS	**5,380**	-
NET TRANSFER TO CAPITAL FUND	**(5,380)**	-
	$ -	$ -

Schedule 8

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
DIABETES
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Revenue	**$ -**	$ 57,845
EXPENDITURES		
Administration Fees	**-**	5,259
Meeting and workshops	**-**	48,971
Personnel	**-**	3,615
	-	57,845
SURPLUS	**$ -**	$ -

Schedule 9

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING INNOVATION INVESTMENTS
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 18,395**	$ 47,134
EXPENDITURES		
Administration fees	**1,672**	4,278
Personnel	**1,761**	5,333
Telephone and supplies	**14,962**	37,523
	18,395	47,134
SURPLUS	**$ -**	$ -

Schedule 10

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
TARGETED IMMUNIZATION STRATEGY
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 60,000**	$ 81,130
EXPENDITURES		
Administration fees	**3,953**	-
Equipment lease and maintenance	**24,718**	55,818
Program costs	**921**	8,325
Telephone and supplies	**12,784**	6,487
Travel and vehicle	**168**	-
Meetings and workshops	**461**	-
	43,005	70,630
SURPLUS	**16,995**	10,500
TRANSFER TO CAPITAL FUND	**(16,995)**	(10,500)
	$ -	$ -

Schedule 11

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NATIONAL ABORIGINAL YOUTH SUICIDE PREVENTION STRATEGY
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 53,500**	$ 53,500
EXPENDITURES		
Administration fees	**2,967**	5,350
Meetings and workshops (recovery)	**7,452**	-
Professional services	**42,132**	48,150
Travel and vehicle	**949**	-
	53,500	53,500
SURPLUS	**$ -**	$ -

Schedule 12

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
NURSING EDUCATION - CHPC / NEPD
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 15,000**	$ 10,670
EXPENDITURES		
Administration fees	**-**	1,400
Personnel	**5,225**	3,288
Program costs	**8,155**	971
Telephone and supplies	**1,155**	2,269
Travel and vehicle	**583**	2,742
	15,118	10,670
SURPLUS	**$ (118)**	$ -

Schedule 13

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
ABORIGINAL HUMAN RESOURCE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 823,727**	$ 337,965
Expense recoveries	**19,530**	-
Transfer from (to) deferred revenue	**(390,131)**	-
	453,126	337,965
EXPENDITURES		
Administration fees	**1,000**	-
Meetings and workshops	**13,526**	803
Professional fees	**34,584**	-
Program costs	**384,702**	297,985
Personnel	**-**	37,087
NLMHSTS	**18,530**	-
Telephone and supplies	**784**	-
Travel and vehicle	**-**	2,090
	453,126	337,965
SURPLUS	**$ -**	$ -

Schedule 14

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
E-HEALTH SOLUTIONS
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada	**$ 273,704**	$ 70,000
Health Canada - HSIF	**15,000**	-
Transfer from (to) deferred revenue	**(13,934)**	-
	274,770	70,000
EXPENDITURES		
Administration fees	**24,979**	6,057
Meetings and workshops	**1,092**	-
Professional fees	**11,853**	-
Personnel	**17,155**	-
Program costs	**218,613**	63,943
Travel and vehicle	**1,078**	-
	274,770	70,000
SURPLUS	**$ -**	$ -

Schedule 15

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
HIV / STI CONFERENCE
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 183,000**	$ 155,000
EXPENDITURES		
Administration fee	**15,317**	14,059
Meetings and workshops	**9,361**	-
Personnel	**39,320**	5,784
Program costs	**112,131**	135,107
Telephone and supplies	**445**	-
Travel and vehicle	**6,426**	50
	183,000	155,000
SURPLUS	**$ -**	$ -

Schedule 16

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
PANORAMA
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - contribution agreement	**$ 67,666**	$ 307,129
EXPENDITURES		
Administration fees	**6,152**	28,227
Meetings and workshops	**1,834**	230
Personnel	**55,181**	152,996
Professional fees	**-**	118,802
Travel and vehicle	**4,499**	4,468
	67,666	304,723
SURPLUS	**-**	2,406
TRANSFER TO CAPITAL FUND	**-**	(2,406)
	$ -	$ -

Schedule 17

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
AHTF E-HEALTH PROJECT
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - AHTF	**$ -**	$ 65,700
Transfer to deferred revenue	**-**	495,567
Transfer from deferred revenue	**-**	-
	-	561,267
EXPENDITURES		
Administration fees	**-**	51,024
Meetings and workshops	**-**	128
Personnel	**-**	25,184
Professional fees	**-**	151,910
Program costs	**-**	115,669
Telephone and supplies	**-**	12,697
Travel and vehicle	**-**	2,151
	-	358,763
SURPLUS	**-**	202,504
TRANSFER TO CAPITAL FUND	**-**	(202,504)
	$ -	$ -

Schedule 18

NORTHERN INTER-TRIBAL HEALTH AUTHORITY INC.
CASET - HSIF
SCHEDULE OF REVENUE AND EXPENDITURES
year ended March 31, 2012

	2012	2011
REVENUE		
Health Canada - HSIF	**$ 15,000**	$ **-**
Transfer from (to) deferred revenue	**(10,304)**	**-**
	4,696	-
EXPENDITURES		
Administration fee	**427**	**-**
Travel and vehicle	**4,269**	**-**
	4,696	-
DEFICIT	**$ -**	$ -

NITHA Scholarship Fund

NITHA's interest revenue is allocated to a Scholarship Fund.
In the 2010-2011 fiscal year NITHA developed the NITHA Scholarship fund guidelines.

The details of the fund are available on the NITHA website, under the Finance section, it includes scholarship fund details, guidelines and application forms.

In the fall of the current fiscal year NITHA distributed $13,000 to nine recipients who are pursuing a health career. These scholarship and award recipients were invited to the NITHA Annual General (AGM) meeting which was held on October 26th, 2011 for personal congratulations presented by their respective Chiefs. The AGM's successful attendance of community members contributed and added to the recipients' recognition.

The NITHA **Academic Award** was given to Theresa Dezelion, a Licensed Practical Nurse (LPN), from Hatchet Lake. She also received the Northland's College President Award for academic achievement. (No photo available)

Jerline Morin
Peter Ballantyne Cree Nation
Pre-Health Studies
First Nations University of Canada

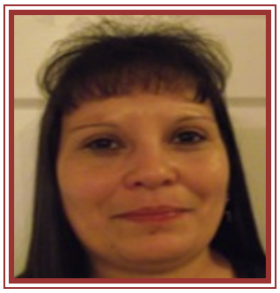
Mercedes Goulet
Cumberland House
Nursing Education Program of Sask. (NEPS)
First Nations University of Canada

Vivian Sanderson
James Smith
Practical Nursing
Northwest Regional College – Meadow Lake

Jolene Hanson
Clearwater River
Nursing Education Program of Sask. (NEPS)
First Nations University of Canada

Brayden Sauve
James Smith
Medical Doctor
Medical University of America, Massachusetts

Annie Crawford
Stanley Mission
Nursing Education Program of Sask. (NEPS)
First Nations University of Canada



Aaron McKenzie
Grandmother's Bay
Pre-Professional Nursing
Northern Professional Access College

Janet McKenzie
Stanley Mission
Nursing Education Program of Sask. (NEPS)
First Nations University of Canada

Eileen Smith
Lac La Ronge Indian Band
Nurse Practitioner Program
U of S College of Nursing

Simone McLeod - Artist Cover

Simone is Ojibway born in Winnipeg, Manitoba in 1962. She is a member of the James Smith Cree Nation in Saskatchewan.

Simone has been artistically motivated since the age of thirteen. She began experimenting with mediums, such as pencil, ink, charcoal and pastels.

Her paintings are enjoyed around the world.

"HEALING OUR HEARTS"

Symbolism

The jingle dress dance is a healing dance. A dance that began with an Ojibway woman's dream to heal her people. It is my belief that our young women dance to heal the hearts of our people.

The yellow colour has red, green and blue colors in the background which are spirits of our ancestors who gather to provide guidance and healing the people.

The sun represents our Creator/God.

Artist Statement

"When I did this piece, I wanted to do something that I felt was healing for the people. I painted this one until I could hear the jingles in my mind, then put all my prayers and hope and healing into each stroke. I love this piece and I believe in our future. This painting is a tribute to our strength as people... Thank you".

www.nitha.com

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