



# **First Nations Health and Wellness in Manitoba**

## *Overview of Gaps in Service and Issues Associated with Jurisdictions*

Prepared for:  
Inter-governmental Committee on First Nations Health

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The conclusions and recommendations are those of the author. No official endorsement by federal or provincial departments or First Nations organizations is intended or should be implied. This report is presented for information purposes only and consideration of ICFNH partners in their discussions aimed at developing innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people.

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## *Executive Summary*

Many long-standing unresolved jurisdictional issues and service gaps in Manitoba are symptomatic of a First Nations health and social service system which does not work. This review examines selected issues and proposes a means to restructure the service system in a manner that meets the unique needs of Manitoba First Nations people.

The report consists of nine sections. The introduction describes the methodology which is a combination of literature review and interviews with provincial, federal and First Nations officials. The review is intended to document gaps, and areas of jurisdictional debate and disparity, as well emerging trends and issues. The overall objective of the report is information which will contribute to the development of a long term First Nations health strategy in Manitoba.

Section 2 provides a contextual overview of the health status of Manitoba First Nations including demographics, health concerns, socioeconomic challenges as well as the historical context and jurisdictions of service delivery to First Nations in Manitoba. This section looks at non-medical determinants of health, such as education, income, employment, and housing issues including housing quality, crowding, water and sewer services, and mould. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. This perspective is the key to understanding patterns of health and illness in Manitoba First Nations communities.

An analysis of an urban trend and Bill C-31 impacts and the long term implications of these on service delivery are also provided in section 2. As a result of Bill-C 31 impacts, there is the prospect of a future where an ever-increasing share of Manitoba First Nations descendants will not be entitled to Indian registration. The outlook is growth in the size of the non-registered health and social service caseload on reserves. Furthermore, the trend of an ever increasing First Nations urban population will require the provision of adequate support services, safe housing and strong linkages between the urban and reserve service systems.

Section 3 reviews a number of continuing care services including Personal Care Homes, Palliative Care, Mental Health, and services for children and adults with physical and mental disabilities. As well, issues associated with diabetes, Fetal Alcohol Spectrum Disorder and oral health are considered. A recurring theme in the analysis is jurisdictional ambiguity and the lack of clarity on the respective roles and responsibilities of the federal and provincial government vis-à-vis health and social services to First Nations peoples. Ample documentation attests to the fact that the long standing conflict between the provincial and federal governments has negatively impacted First Nations peoples and has resulted in the patchwork of fragmented services, problems with coordinating programs, under-funding, inconsistencies, service gaps, and lack of integration. Gambling addiction is identified as a serious emerging health issue for First Nations people in Manitoba and many gambling opportunities now exist – casinos,



electronic gambling machines, bingos, and lotteries. There is a policy vacuum and service gap in this area. A study specific to First Nations youth to identify gambling addiction issues is recommended.

Section 4 includes a discussion on the role of Regional Health Authorities (RHAs) and service gaps in First Nations communities. Under the Canada Health Act, the Manitoba government is required to provide insured services (i.e. medically necessary hospital and physician services) to all insured persons covered by its provincial health insurance plan, including First Nations on and off reserve. The Manitoba government has taken the position that the federal government is responsible for certain non-CHA health services to First Nations people who are Status Indians under the Indian Act. As a result, some health services not covered by the Canada Health Act but otherwise provided by the province through the RHAs are not provided to First Nations communities – for example, mental health, prevention of illness, promotion of health, residential care and support services for the elderly and disabled. Funding gaps are discussed in this section as well, and a process is proposed to resolve the long standing conflict between First Nations and the First Nations and Inuit Health Branch (FNIHB) over the administration of the Non Insured Health Benefits (NIHB) program. Observations and recommendations are also proposed on funding policy issues between federal and provincial departments.

Section 5 looks at the Health Human Resources (HHRs) and lack of documentation to provide a clear picture on First Nations human resource needs in Manitoba. The Inter-Governmental Committee on First Nations Health is proceeding with its action plan aimed at contributing to the overall regional HHR strategy. In the interim, specific action is recommended to begin multi-sector discussions for development of the education component of the regional HHR strategy.

Section 6 takes a brief look at a number of promising trends, practices and partnerships which contribute to the advancement of First Nations health. For example, it is encouraging to note an increasing recognition and respect of Traditional practices. Manitoba's new midwifery education program is a case in point. There also appears to be an increasing trend in First Nations people utilizing both Traditional and Western medicine. The Northern Aboriginal Population Health and Wellness Institute (NAPHWI) involving 65 partners is an excellent 'best practices' model on collaborative partnerships to address unacceptable health outcomes. The Kahnawake Schools Diabetes Prevention Project is presented as another 'best practice' model which Manitoba First Nations may want to consider in the development of their own prevention programs. The main objective of the Kahnawake approach is prevention of the onset of Type II diabetes among present and future generations through the promotion of healthy eating, physical activity and positive attitudes among children and youth.

Section 7 entitled 'towards governance' proposes that the architects responsible for crafting the Manitoba First Nations health 'Blueprint' consider lessons learned from existing health and social service models, in Manitoba and elsewhere. An overview is presented of the following models: Island Lake Renal Centre / Regional Primary Health

Care Centre Model; Manitoba Child and Family Services Model; and The First Nations of Quebec and Labrador, Health and Social Services Commission.

Section 8 highlights several overarching conclusions and recommendations which stem from the review. A proposal is made to create a Manitoba First Nations Health and Wellness Commission as a means to restructure the existing First Nations health and social service system. It is clear that youth issues are not getting the attention they deserve from the federal, provincial, or First Nations leadership. Despite comments such that youth are the key to the future and that youth suicide is a priority, sadly, it appears that youth issues in Manitoba will remain on the ‘backburner’ (until something happens at the magnitude of the recent tragedy at Red Lake, Minnesota). The presence of only a few First Nations youth representatives at recent general regional meetings on health is testimony that they are not connected to nor considered in the debate.

Section 8 concludes with key messages coming out of this review. First, there is a strong message that individuals have responsibility to themselves and their relations (family) to achieve a balance of the body (physical), mind, and spirit. Second, it is equally evident that First Nation individuals, families, and communities require additional support, services and resources to improve overall health status. Third, more attention is required to social determinants of health which determine whether individuals stay healthy or become ill and determine the extent to which a person possesses the physical, social, and personal resources to achieve health.<sup>1</sup> Social determinants of health are the quantity and quality of a variety of resources that a society makes available to its members, including – but are not limited to – income, availability of food, housing, employment, social services, water quality and education.<sup>2</sup> It is therefore imperative that governments direct policies and resources in a manner which supports the whole First Nations population of Manitoba. Housing is provided as an example of the fundamental link between government policy, resources, and population health.

Section 9 recommends the following ten strategic options, in order of priority, as a pragmatic approach to addressing gaps in services and issues associated with jurisdictions.

1) That senior officials of the ICFNH take action to resolve long-standing jurisdictional disputes and ambiguity. It is recommended that a task group be established by the senior officials with a mandate to develop a document which lists the full inventory of health and social services (on and off reserve) and which clarifies:

- the responsible service delivery agency;
- funding responsibility;
- applicable standards; and
- relevant procedures, level of benefit, and rules of entitlement.

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<sup>1</sup> Raphael, Dennis (2004) *Social Determinants of Health: Canadian Perspectives*, 1

<sup>2</sup> Ibid

It is further recommended that the target date for completion of this exercise including approval of the document by the relevant senior officials be set for March 31, 2006

2) That a Manitoba First Nations Health and Wellness Commission be created; that lessons learned from existing models and the proposed negotiation model be incorporated into the Commission and First Nations health Blueprint; that health and social service policy coordination, identified as a gap in the current system, be incorporated as part of the mandate of the Commission; and, that priority for transfer of health and social programs to First Nations control be given to the following:

- Off-reserve Income Assistance, Employment and Housing Program (service currently provided by Manitoba Family Services and Housing);
- FNIHB programs such as Brighter Futures, Building Healthy Communities, Aboriginal Diabetes Initiative, and Head Start; and,
- INAC programs such as Family Violence Prevention, Income Assistance, and Assisted Living.

3) That the Education Component of the Health Human Resource Strategy be developed.

4) That the Manitoba Government clarify the role of Regional Health Authorities vis-à-vis First Nation communities.

5) That the financing approach for reserve-based health and social services be streamlined and simplified and replaced with some type of per capita formula.

6) That FNIHB and First Nations undertake to develop jointly a new regional policy and procedures manual for Non Insured Health Benefits.

7) That the federal and provincial governments clarify their respective roles and responsibilities regarding funding of Primary Health Care, healing, and wellness centers in First Nations communities.

8) That INAC and Manitoba Health take steps to establish a formal protocol for the construction of new Personal Care Homes on reserves.

9) That a regional conference on remote service delivery in Palliative Care be held in 2006.

10) That opportunities for Elders in traditional teaching / mentorship / apprenticeship of young people be encouraged.

## ***Section 1: Introduction***

### **1.1 Background**

In November 2002 the Commission on the Future of Health Care in Canada released its Final Report, “Building on Values: the Future of Health Care in Canada” with 47 recommendations. The Romanow Commission Report dedicated a chapter to Aboriginal Health. One recommendation concerned integrating Aboriginal health care services, improve access and provide adequate, stable, and predictable funding. Another called for the funding of new Aboriginal Health Partnerships responsible for developing policies, providing services and improving the health of Aboriginal people. A December 2002 meeting among the three Manitoba Grand Chiefs, the Manitoba Minister of Health and the Manitoba Minister of Aboriginal and Northern Affairs resulted in mutual support to establish a Romanow Joint Working Group (RJWG) to, among other things, develop innovative solutions and strategic proposals with respect to health systems using common decision making processes. The group was expanded to include the Federal Ministers of Health Canada and Indian and Northern Affairs Canada. Technical meetings began in March 2003 on a regular basis. Since then the name of the RJWG has changed to the Inter-Governmental Committee on First Nations Health (ICFNH). Appendix A provides an overview of the objectives, role and structure of the ICFNH.

### **1.2 Purpose / Methodology**

This report was developed for information purposes and consideration of ICFNH partners in their discussions aimed at developing innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people. The objective is to identify gaps in service, duplication, and issues associated with jurisdictions. It is also intended to identify emerging trends, promising approaches, and to provide recommendations for future strategies.

The process for gathering information included:

- Telephone and personal interviews with federal, provincial, and First Nations health and social service representatives;
- a review of government policy manuals and other key documents;
- a number of internet searches; and
- a review of pertinent literature

Appendix B provides a list of federal, provincial, and First Nations representatives who were either interviewed or consulted for purposes of developing this report – their participation and assistance is appreciated. There is also a need to acknowledge the contribution of the technical representatives on the ICFNH for their advice and guidance throughout the process. The views and recommendations contained in this report do not necessarily reflect those of persons interviewed or consulted.

## ***Section 2: Overview of Manitoba Situation***

Before any recommendations can be made regarding delivery of health and social services to First Nations of Manitoba, it is necessary to consider demographics, health concerns and socio-economic challenges, as well as the historical context of service delivery to First Nations in Manitoba. A complete understanding of First Nations health issues would of necessity include current health status and social determinants of health that impact on health status.

### **2.1 Health Profile of First Nations in Manitoba**

Overall, the story of the health of Manitoba's First Nations people is not a good one. Consistent findings across many studies have indicated that First Nations experience substantially greater mortality and morbidity rates, and poorer self-rated health compared to other Manitobans.<sup>3</sup> They can expect to live a startling eight years less than other Manitobans and the rate at which they die young is especially troubling. They are three times more likely to be hospitalized for injury. Of particular concern is the rate of diabetes - more than four times higher than for other Manitobans.<sup>4</sup>

#### ***Selected Health Status Measures***

<b><i>Population Size/structure</i></b>	Size and structure of a population directly influence the health problems encountered in that population and hence its health status. INAC cites a Registered First Nation (RFN) population count in Manitoba as 118,410 (2004). The Manitoba First Nations population largest age group is comprised of those under 30 years of age (60.5%). <sup>5</sup>
<b><i>Fertility</i></b>	The First Nation population in Manitoba generally reflects a high fertility rate. <sup>6</sup>
<b><i>Birth Weight</i></b>	The rate of High Birth Weight babies is rising consistently in Manitoba, particularly among First Nations. The high incidence of diabetes is a contributing factor. Both low and high birth weights have been associated with the rising epidemic of diabetes among First Nations. <sup>7</sup>

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<sup>3</sup> Centre for Aboriginal Health Research. (1998) *Manitoba First Nations Regional Health Survey Final Report*. Winnipeg: CAHR.

<sup>4</sup> Martens PJ, Bond R, Jebamani L, Burchill CA, Roos NP, Derkesen SA, et al. (2002) *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

<sup>5</sup> INAC (2004) Basic Departmental Data

<sup>6</sup> Manitoba. (2003) *The Delivery of Health Programs and Services to Northern Residents with an Emphasis on Aboriginal and Other Remote Communities*. Winnipeg: Manitoba Health, 5

<sup>7</sup> Ibid, 6

<i>Infant Mortality</i>	In Manitoba infant mortality rates for FN people range from 2.1 - 2.9 times higher than the rate for other Manitobans. <sup>8</sup>
<i>Mortality Rate</i>	A recent study found that Manitoba First Nations population had double the Premature Mortality Rate (PMR - death before age 75) of other Manitobans. <sup>9</sup>
<i>Life Expectancy</i>	Life expectancy is the expected length of life from birth. In Manitoba, FN people live approximately eight years less than other Manitobans. <sup>10</sup>
<i>Potential Years of Life Lost</i>	Potential Years of Life Lost (PYLL) measures the years of life lost when a young person dies. In Manitoba the PYLL for First Nations is significantly higher than for other Manitobans, 2.5 times for males and 3 times higher for females. <sup>11</sup>
<i>Diseases</i>	The incidence and prevalent rates of diseases, such as diabetes, circulatory and respiratory diseases, and some cancers are increasing in First Nations. As the First Nation population ages, morbidity and mortality due to chronic diseases will continue to increase. <sup>12</sup>
<i>Injury/Suicide</i>	<p>First Nations persons also experience higher rates of injuries, poisonings, and suicide.<sup>13</sup> Deaths from all types of injuries – falls, unintentional motor vehicle accident, drowning, suffocation, fire and burns, among First Nations is consistently significantly higher than other Manitobans. Injury is a major cause of mortality and disability. Injury is the leading cause of death for children and young adults. The injury death rate for First Nation teenagers is almost four times greater than the total Canadian population. Hospitalization rates due to injury are over three times higher for Registered First Nations compared with all other Manitobans.</p> <p>Manitoba First Nations were also significantly more likely to experience intentional injuries - assault and self inflicted injuries - compared with other Manitobans. First Nations are about 1.7 times as likely to die as the result of suicide than other Manitobans. The highest</p>

<sup>8</sup> Manitoba. (2000) *Diabetes A Manitoba Strategy. Diabetes Eye Symposium Proceedings*. Winnipeg: Manitoba Health.

<sup>9</sup> Martens PJ, Bond R, Jebamani L, Burchill CA, Roos NP, Derkesen SA, et al. (2002) *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

<sup>10</sup> Martens,PJ, Sanderson D, Jehamani L.S. (2005) *Mortality Comparisons of First Nations to all Other Manitobans: A Provincial Population-based Look at Health Inequalities by Region and Gender in Canadian Journal of Public Health*, Volume 96,33-35.

<sup>11</sup> Ibid

<sup>12</sup> Manitoba. (2003) *The Delivery of Health Programs and Services to Northern Residents with an Emphasis on Aboriginal and Other Remote Communities*. Winnipeg, Manitoba Health. Winnipeg: Manitoba Health.

<sup>13</sup> Manitoba Health. (2004) *Injuries in Manitoba, A 10 Year Review*. Manitoba: Minister of Health.

rate occurred among young males aged 15-19 at 95.9 deaths per 100,000, a rate 5.5 times that of other Manitoba males of the same age group.

Deaths and hospitalizations due to injuries are preventable, in fact, it is estimated that 90% of injuries are predictable and preventable.

## **2.2 Socio-Economic Determinants of Health**

A growing body of evidence confirms that socio-economic factors determine health. The Lalonde report set the stage in 1974 by establishing a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology, and health services.<sup>14</sup> Since then, much has been learned that supports, and at the same time, refines and expands this basic framework. In particular, there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. The availability of high-quality health care is only one, albeit important, factor in determining health status. Social determinants of health are the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole are also significantly important.

There are strong and growing indications that factors such as living and working conditions are crucially important for a healthy population. The evidence indicates that the key factors which influence population health are: income and social status; social support networks; education; employment/working conditions; income/poverty; social environments; food security; physical environments; crime; personal health practices and coping skills; healthy early child development; biology and genetic endowment; health services; gender and culture. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. This perspective is the key to understanding patterns of health and illness in First Nations in Manitoba.

### ***Selected Social Determinants of Health***

*Education* Educational attainment, as measured by the completion of high school, is much lower in Registered First Nation (RFN) groups than in the general Manitoba population. In 1996, only 33.5% of RFN (and 27.9% of RFN 'on-reserve') completed high school, in comparison with 58.7% of the general population. In Winnipeg, the high school completion rate for the general population is 64.9%, whereas RFN rates vary from 28.3% in Point Douglas to 61.6% in Fort Garry. There is a strong relationship between the health status (PMR) of the RFN in

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<sup>14</sup> Cook C. (2003) *Jurisdiction and First Nations Health and Health Care*. Winnipeg: University of Manitoba

Winnipeg and the proportion completing high school.<sup>15</sup>

- Income* The average income of ‘on-reserve’ Registered First Nations people in Manitoba for the year 1996 was substantially lower than the Manitoba average, whether it be compared by ‘household’ (\$25,687 RFN versus \$43,404 all Manitobans) or by ‘census family’ income (\$25,216 RFN versus \$50,236 all Manitobans).<sup>16</sup> All Tribal Council areas are well below provincial income levels, although there is some indication that northern Tribal Councils have slightly higher incomes than southern Tribal Councils areas.
- Unemployment* Unemployment rates among Registered First Nations people, whether they are in Winnipeg or ‘on-reserve,’ are generally at least twice as high as the overall Manitoba unemployment rate of 6.0%. For Tribal Council areas, the lowest unemployment rate is more than triple the provincial rate, and the highest is five times the rate. For most Winnipeg areas, RFN unemployment rates are at least double, with some areas having eight times the overall unemployment rate.<sup>17</sup>
- Isolation* A number of First Nations in Manitoba are located a considerable distance from urban centers that do not have direct or easy access to physicians and provincial health services. For example, 22 communities have no all-weather road access with additional communities that have road access, but are more than 90 kilometers from the nearest physician.
- Housing* In the Manitoba First Nations Regional Health Survey Community Consultations (1998/9), First Nations people interviewed about housing stated that there were many problems, including shortages in housing which resulted in overcrowding, illness, family tension, and unsanitary conditions. Housing conditions are directly related to the health of people, in terms of both physical and emotional illness.
- The indoor environment has the potential to expose occupants to health threats arising from the physical structure. Many of these threats have been well documented (for example: indoor air pollution caused by moulds). It is likely that dwelling condition – a housing indicator measured by need for major repair would also fit here.<sup>18</sup> Problems of contaminants such as mould and asbestos have forced First Nations

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<sup>15</sup>Martens PJ, Bond R, Jebamani Ls, Burchill CA, Roos NP, Derkesen SA, et al. (2002) *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

<sup>16</sup> Ibid

<sup>17</sup> Boyer Y. (2004) *Discussion Paper Series in Aboriginal Health: Legal Issues, No. 1 Aboriginal Health, A Constitutional Rights Analysis* Saskatoon: Native Law Centre, University of Saskatchewan

<sup>18</sup> Canada Mortgage and Housing Corporation (2004) *Housing and Population Health – Research Framework*, Research Highlights, Socio-Economic Series. CMHC, Ottawa



families in some Manitoba communities to abandon their housing for health reasons. As of March 2004, INAC, Manitoba Region reported a total of 14,674 dwelling units on reserve, of which 3,750 (25.5%) required major repairs and 1,319 (9.2%) needed replacement.<sup>19</sup>

*Household structure*

The average number of persons per housing unit in First Nations communities is twice the overall Manitoba rate, at 4.8 versus 2.6 persons per total housing unit. The potential situation of overcrowding for RFN ‘on-reserve’ becomes more evident when only habitable housing units are considered, at 7.6 persons per habitable housing unit.<sup>20</sup>

*Water and Sewer*

The 1998/1999 Manitoba First Nations Regional Health Survey concluded that 22 % of housing units in Manitoba First Nations communities lacked modern sewer and water facilities.<sup>21</sup> Subsequently, in 2000, an on-site assessment of all Manitoba First Nations water and sewage treatment facilities was undertaken by INAC in collaboration with Health Canada<sup>22</sup> with the following result:

	<u>Water</u>	<u>Sewage</u>
High Risk	6	6
Medium Risk	31	25
Low Risk	28	36

- High Risk: With potential health and safety concerns
- Medium Risk: Requiring some repairs to existing assets
- Low Risk: Experiencing minimal problems

***Selected Health Behaviors***

*Smoking / Alcohol Use / Diet*

Dietary practices/food choice, lack of exercise/body weight, and substance abuse/smoking/alcohol/drugs all contribute to increased rates and complications of diabetes, heart disease and other health conditions. A major Manitoba survey reports a relatively high level of awareness of the health problems associated with risk behavior such as alcohol consumption, smoking and diet, with a high proportion of people interviewed indicating they had made attempts to change these behaviors.<sup>23</sup>

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<sup>19</sup> Indian and Northern Affairs Canada (2004) *Housing and Infrastructure Inventory*, INAC, Manitoba Region

<sup>20</sup> Centre for Aboriginal Health Research (1998) *Manitoba First Nations Regional Health Survey Final Report*, Winnipeg CAHR

<sup>21</sup> Ibid

<sup>22</sup> Indian and Northern Affairs Canada (2004) *First Nations Water Management Strategy- Manitoba Region Update, September 2004*. INAC, Manitoba Region

<sup>23</sup> Centre for Aboriginal Health Research (1998) *Manitoba First Nations Regional Health Survey Final Report*, Winnipeg: CAHR,57

### **2.2.1 Gap**

It is estimated that Manitoba Health First Nations data set represents only 86 percent of the actual First Nations population. Because First Nations suffer from poorer health status than the rest of the population, it is of critical importance that information produced about First Nations health be of the highest quality possible.

### **2.2.2 Recommendations**

1) Health is the product of multiple levels of influence. These include genetic and biologic processes, individual behaviors, and the context within which people live - the social environment. Those who deliver health services have no control over these factors that nonetheless impact on their ability to achieve desired results. Therefore, a multi-sector approach to community health requires us to take into consideration these social determinants.

2) First Nations people in Manitoba are significantly poorer, less educated, and live in more crowded housing than other Manitobans. Rather than a disease-focused approach, a return to dedicated resources of public health, health promotion and community responsibility is an identified need so that the broad determinants of health can be addressed more effectively.

## **2.3 Historical Factors – Colonialism and Residential Schools**

The colonization process including the policy instrument of the residential school system has contributed significantly to the sad state of First Nations health seen today in Manitoba.

There is abundant historical evidence to support the fact that before the influx of Europeans in North America, indigenous peoples were of ‘excellent health and strong physique’.<sup>24</sup> Prior to Canada’s colonization by Europeans, the country’s indigenous population was organized into groups of hunting and gathering communities. Within these societies, inactivity and obesity were uncommon. Aboriginal people’s genetic make-up had evolved over time to cope with alternating periods of abundant and reduced food intake by producing increased insulin and by developing excessive insulin resistance.

The health of Aboriginal people experienced a decline after contact with Europeans for numerous reasons including the transmission of new diseases, loss of traditional lifestyle, change to a less nutritious diet, depletion of food sources caused by over hunting and

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<sup>24</sup> Bartlett, Judith G., Jock, Richard (2001) *An Examination of Aboriginal Health Service Issues and Federal Aboriginal Health Policy*. National Aboriginal Health Organization, Ottawa, 2

fishing, confinement to the reserve system, and the development of the residential school system.<sup>25</sup>

A rapid transition from hunting and gathering to sedentary, reserve-based lifestyles, as well as a switch from a high-fiber, low-fat diet to one based on low-fiber, high-calorie foods, has exacerbated the prevalence of obesity and diabetes among Canada's Indigenous peoples.<sup>26</sup>

The residential school system has been a major factor in the poor health status of First Nations people in Manitoba. In Canada, there are an estimated 90,600 former students alive today, based on Statistics Canada's 1991 Aboriginal Peoples Survey.<sup>27</sup> It is difficult to say precisely how many people in total attended these institutions in Manitoba, however it is estimated to be a high number as there were a total of thirteen residential schools which operated for many years, including:

**Table 1: Former Residential Schools in Manitoba**

<ul style="list-style-type: none"> <li>• Assiniboia (Winnipeg)</li> <li>• Birtle</li> <li>• Brandon</li> <li>• Cross Lake (St. Joseph's)</li> <li>• Dauphin (McKay)</li> <li>• Elkhorn (Washakada)</li> <li>• Fort Alexander (Pine Falls)</li> </ul>	<ul style="list-style-type: none"> <li>• Guy Hill (The Pas)</li> <li>• Norway House (Notre Dame Hostel)</li> <li>• Norway House</li> <li>• Pine Creek (Camperville)</li> <li>• Portage La Prairie</li> <li>• Sandy Bay</li> </ul>
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A 2003 comprehensive review by the Aboriginal Healing Foundation (AHF) on intergenerational links to residential schools concludes that Aboriginal people have suffered greatly because of the residential school system.<sup>28</sup> Widespread abuse at school, in its various forms, took an individual and collective toll on the health and well-being of large numbers of Aboriginal people. The resilience of former students and their communities, despite the toll, has been quite remarkable.

Concerning intergenerational links to substance abuse and pregnancy, and Fetal Alcohol Syndrome, the AHF report concludes that the residential school system contributed not only to the central risk factor, substance abuse, but also to factors shown to be linked to

<sup>25</sup> Canadian HIV-AIDS Legal Network (1996) *HIV/AIDS and Aboriginal People: Problems of Jurisdiction and Funding: A Discussion Paper*, page iii. Publication available at <http://www.aidslaw.ca>

<sup>26</sup> Campbell, Angela (2002) 'Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care'. *Health Law Journal* Volume 10, 150

<sup>26</sup> Residential Schools Resolution Canada, Website available online at <http://www.irsr-rqpi.gc.ca/english/questions.html>.

<sup>27</sup> Residential Schools Resolution Canada, Website available online at <http://www.irsr-rqpi.gc.ca/english/questions.html>.

<sup>28</sup> Aboriginal Healing Foundation (2003) *Fetal Alcohol Syndrome among Aboriginal People in Canada: Review and Analysis of the Intergenerational Links to Residential Schools*, xviii. Publication available online at <http://www.ahf.ca>

substance abuse. These include child and adult physical, emotional and sexual abuse, mental health problems and family dysfunction. The impact of residential schools is also linked to risk factors for poor pregnancy outcome among women who abuse alcohol, such as overall poor overall health, low level of education and chronic poverty.

## 2.4 Jurisdiction

A recurring theme throughout this review is jurisdictional ambiguity and the lack of clarity on the respective roles and responsibilities of the federal and provincial government vis-à-vis health and social services to First Nations peoples. Ample documentation attests to the fact that the long standing conflict between the provincial and federal governments has negatively impacted First Nations peoples and has resulted in the patchwork of fragmented services which exists today. Despite the entrenchment of Aboriginal and treaty rights in Canada's Constitution (section 35), the federal government has not acknowledged the impact to health of such entrenchment on Aboriginal and treaty right.<sup>29</sup>

To a large degree, jurisdictional issues which impact on accessibility and comprehensiveness stem from the decades of a 'tug of war' over which level of government is responsible for services. Although the Manitoba government is required to provide equal access to health care services under the *Canada Health Act* for all residents of Manitoba including First Nations living on reserves, it takes the position that the federal government is responsible for certain health services to First Nations people who are Status Indians under the *Indian Act*. As a result, some health services not covered by the *Canada Health Act* but otherwise provided by the provinces through the Regional Health Authorities may or may not be provided to First Nations communities.

The provincial government's position is that the federal government has responsibility for certain health services to Aboriginal persons as Indians under the *Indian Act*. On the other hand, the federal government's position is that provincial services should extend to reserves under the cost-sharing arrangements that apply to the general population. This fundamental disagreement translates in a very real way into program fragmentation, problems with coordinating programs, under-funding, inconsistencies, service gaps, and lack of integration. Critics argue that the federal government routinely tries to rid itself, or limit, Indian programs and services by continuing to whittle down what it considers discretionary services. An example provided is Non Insured Health Benefits (NIHB), whereby various drugs and medical supplies are either dropped from the benefits lists, or transferred to the unpublished lists necessitating special permission to access.<sup>30</sup>

Appendix D provides a historical overview of legislative chronology in health care and Table 2 provides an overview of health programs and services provided by federal and provincial jurisdictions to First Nations people in Manitoba.

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<sup>29</sup> Boyer, Yvonne (2003) *Discussion Paper Series in Aboriginal Health: Legal Issues: No. 1 Aboriginal Health – A constitutional Rights Analysis*. Saskatoon: Native Law Centre, 6

<sup>30</sup> Webster, Andrew (2005) *Fiscal Responsibility for Programs and Services to Indians and the Forthcoming Premiers' Conference on Aboriginal Issues*, 22

**Table 2: First Nations Health Programs and Services by Jurisdiction**

	<b>Federal</b>	<b>Provincial</b>
First Nations people living <b>on-reserve</b>	Community health services: public health nursing, CHRs, NNADAP, HCC, ADI. Wellness programs: HIV/AIDS, FAS/FAE, CNCP, BF/BHC, AHS, dental health promotion, tuberculosis. NIHB Program. Some hospitals in northern locations. Emergency and non-urgent treatment services in remote and isolated communities in addition to the above.	Physician services and hospital services as covered under the <i>Canada Health Act</i> . First Nations People can generally access other provincial services in off-reserve locations.
First Nations people living <b>off reserve</b>	AHS ADI (health promotion) HIV/AIDS NIHB Program	All health services (not necessarily funded)
ADI: Aboriginal Diabetes Initiative AHS: Aboriginal Head Start BF/BHC: Brighter Futures/Building Healthy Communities CHR: Community Health Representative CPNP: Canada Prenatal Nutrition Program FAS/FAE: Fetal Alcohol Syndrome/Fetal Alcohol Effect HCC: Home and Community Care NIHB: Non-insured health benefits NNADAP: National Native Alcohol and Drug Abuse Program.		
Source: Romanow Final Report, FNIHB, and Lemchuck-Favel L and Jock R. (2004) 'Aboriginal Health Systems in Canada: Nine Case Studies.' <i>Journal of Aboriginal Health</i> .		

### 2.4.1 Framework for Current Health Service Delivery in Manitoba

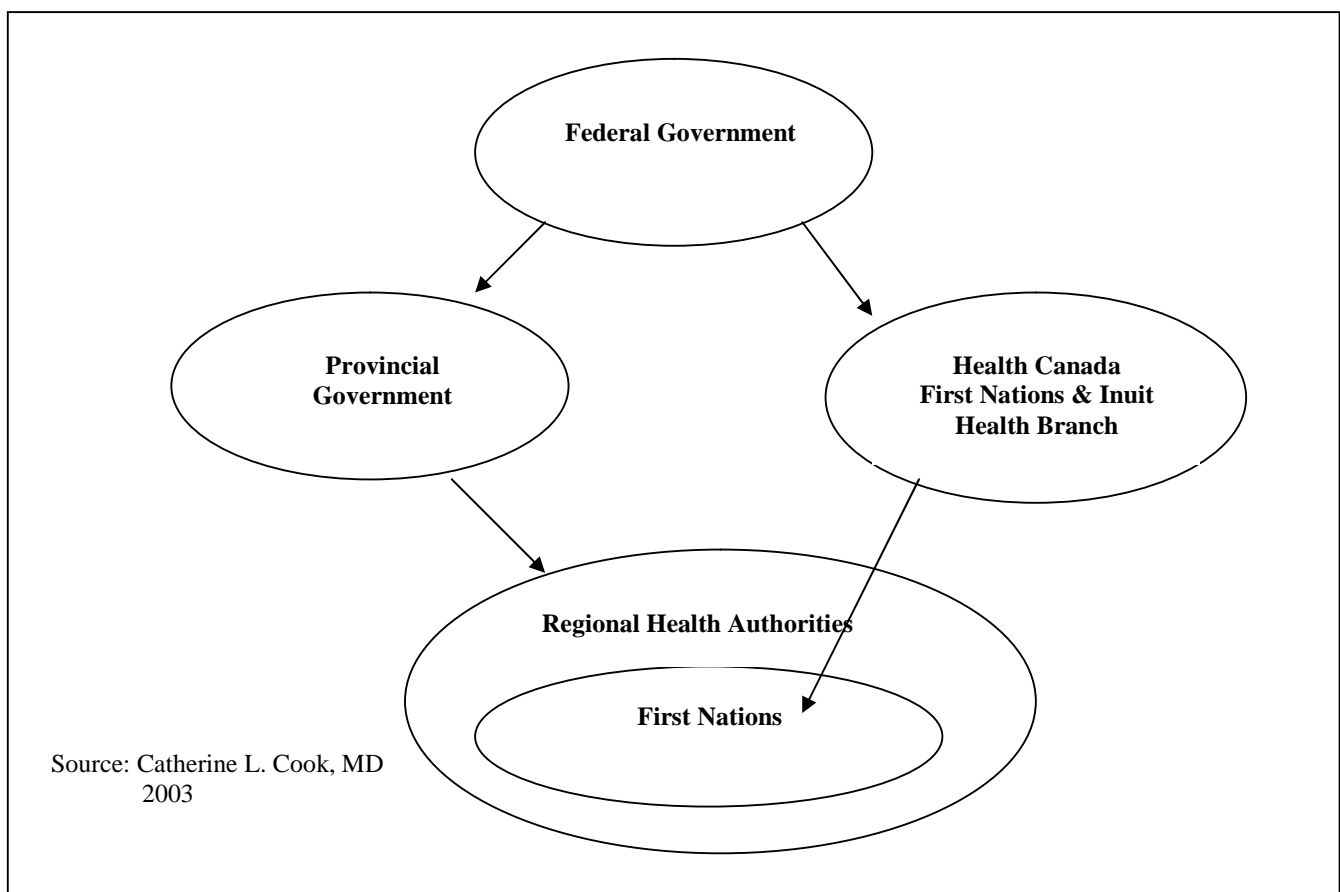
Dr. Catherine L. Cook describes a framework to understand the current First Nation health delivery system in Manitoba.<sup>31</sup> *Figure 1* illustrates how First Nation communities are situated on a federal land base geographically but within provincial health authorities. The First Nation communities receive funding from the federal government for community-based programs in health promotion and prevention and some primary care services, including drug and alcohol prevention. In addition, the Brighter Futures and

<sup>31</sup> Cook, Catherine L.(2003) *Jurisdiction and First Nations Health and Health Care, Masters Thesis*. Winnipeg, University of Manitoba, 12

Building Healthy Communities programs of Health Canada are aimed at addressing some of the social service needs of First Nations communities in the areas of mental health supports, healthy babies, child development, parenting skills, and injury prevention. More recently, the federal government [FNIHB] has begun to establish home care programs on reserve. The framework could easily be expanded to include INAC funded services such as homemaker services, personal care homes, family violence prevention, child and family services and income assistance.

Regional health authorities receive funding from the provincial government for the delivery of insured health services, including physician and hospital based services, in addition to home care and other allied health services. Global funding from the federal government to the provinces provides the basis for the delivery of insured health services for First Nation peoples and communities. In Manitoba, some insured services are delivered on reserve, but programs like home care and diabetes education are not.

**Figure 1: Framework for Current First Nation Health Service Delivery in Manitoba.**



## 2.4.2 Areas of Consensus

Despite jurisdictional disputes and ambiguity in many areas, there are some services which, to some degree, are not overtly contested in the public domain. Table 3 identifies the responsible department for a number of services. Caution is advised in interpreting this table as agreement on who delivers the service does not necessarily equate to agreement on funding responsibility (who pays), whose service standards apply (federal, provincial or First Nations), or whose rules of entitlement apply. Despite agreement on the delivery agency for services, there is often disagreement on who pays. An example of this complexity in the off-reserve context is provided in section 3.5.2 (Services for Children with Physical and Mental Disabilities) regarding funding responsibility for a wheelchair ramp.

The table identifies both FNIHB and Manitoba Health as responsible departments if there is shared responsibility and there does not appear to be much controversy e.g. Hearing Aids.

**Table 3: Responsible Department for Select First Nations Health Services**

<b>Professional Services</b>	<b>On-Reserve</b>	<b>Off-Reserve</b>
Physician	Manitoba Health	Manitoba Health
Audiology	FNIHB	Manitoba Health (if hospital based)
Oral Surgery	Manitoba Health	Manitoba Health
Regular Dental Treatment	FNIHB	FNIHB
Acute Care Hospital Services	Manitoba Health	Manitoba Health
Promotion of Health and Prevention of Illness	FNIHB	Manitoba Health
<b>Protection of Health</b>		
Immunization	FNIHB	Manitoba Health
Communicable Disease	FNIHB	Manitoba Health
<b>Home and Community Care</b>		
Care Coordination / Assessment	FNIHB	Manitoba Health
Nursing	FNIHB	Manitoba Health
Home Care	FNIHB	Manitoba Health
<b>Aids to Persons with Physical Disabilities</b>		
Hearing Aids	FNIHB / Manitoba Health	FNIHB / Manitoba Health
Visual Aids	FNIHB	FNIHB / Manitoba Health
<p><u>Source:</u> The information presented above is based on interviews and a review of information provided by Manitoba Health, FNIHB, INAC, AMC, the Romanow Report and a presentation by Josee G. Lavoie at the Primary Health Care Conference on First Nations Health and Wellness, Winnipeg (March, 2005)</p>		

### 2.4.3 Areas of Ambiguity

Jurisdictional ambiguity has allowed both levels of government to minimize respective responsibility for First Nations entitlement to health services. The *Indian Act* does not define the responsibility for the provision of health services for First Nations. Provincial governments have not explicitly asserted jurisdiction in relation to health, and, since jurisdiction carries with it financial responsibility, provinces have not contested the federal government's responsibility to provide health care to First Nations. As a result, neither government acknowledges a mandate to provide coordinated health care to First Nations on and off reserve.<sup>32</sup> The federal government maintains it provides health services for First Nations as a matter of policy and practice, and not as a result of constitutional or treaty obligation.

Table 4 provides examples of services where there is jurisdictional ambiguity – Who pays? Whose standards apply? What are the rules of entitlement? As mentioned in the previous section, although there may be agreement on who delivers the service, there may not be agreement on funding responsibility (who pays), whose service standards apply (federal, provincial or First Nations), or whose rules of entitlement apply. Section 4 – gaps in service and Non Insured Health Benefits identifies a number of grey areas, e.g. foot care, which create access issues for consumers of services and administrative problems for health care providers and managers.

An interesting finding of this review is that officials from either a provincial or federal department will sometimes assert emphatically that their department is responsible and provides a specific service while, at the same time, officials from the other department or First Nations technicians will indicate jurisdictional responsibility for the service is not clear. Part of the explanation for the confusion may be the fact that FNIHB operates from the policy stance that it is a 'provider of last resort'. This principle alone can lead to different policy interpretations at many levels. Another added complication arises if the person requiring assistance, such as non-insured health services, happens to be residing off reserve and on provincial Income Assistance. As income assistance is also a program of entitlement based on the principle of 'last resort', there may be difficulty in clients accessing service. Such complications account for some services being listed as an area of ambiguity in the table.

Other sections in this report, such as continuing care, elaborate on areas of jurisdictional ambiguity. Long-standing disputes and ambiguity over a wide range of services form part of the basis for the recommendation on the proposed negotiations via the creation of a Manitoba First Nations Health and Wellness Commission (section 8), the proposed joint (First Nation / FNIHB) initiative to develop a new regional NIHB policy and procedures manual (section 4), and the proposed project (section 2) to develop an inventory of services which clarifies jurisdiction and funding responsibility.

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<sup>32</sup> Cook, Catherine L.(2003) *Jurisdiction and First Nations Health and Health Care, Masters Thesis.* Winnipeg, University of Manitoba, 12



**Table 4: Services where there is Jurisdictional Ambiguity – Who pays?  
Which standards apply? What are the rules of entitlement?**

	<b>On-Reserve</b>	<b>Off-Reserve</b>
<b>Professional Services</b>		
Podiatry / Chiropody	Ambiguity	Manitoba Health
Chiropractic	Ambiguity	Manitoba Health
Optometric	FNIHB / Manitoba Health	Ambiguity
<b>Home / Community Based Services</b>		
Respite Care	Ambiguity	Manitoba Health
Palliative Care	Ambiguity	Manitoba Health
<b>Community Rehabilitation</b>		
Physiotherapy	Ambiguity	Manitoba Health
Speech & Language	Ambiguity	Manitoba Health
Audiology	Ambiguity	Manitoba Health
<b>Aids to Persons with Physical Disabilities</b>		
Communication Aids	Ambiguity	Ambiguity
Orthodontic / Prosthetic Devices	Ambiguity	Ambiguity
Respiratory Equipment & Supplies	Ambiguity	Ambiguity
Wheelchair, Mobility Aids & Seating	Ambiguity	Ambiguity
Medical Supplies & Equipment	FNIHB	Manitoba Health
<b>Public Health</b>		
Public Health Inspector and Monitoring	Ambiguity	Manitoba Health
Food and Drug Safety	Ambiguity	Manitoba Health / Health Canada
<b>Residential Long Term</b>		
Personal Care Homes (higher levels of care)	Ambiguity	Manitoba Health
Personal Care Homes (lower levels of care)	INAC	Manitoba Health
Residential Care Facilities	Ambiguity	Ambiguity
Independent Living Units with Support Services	Ambiguity	Ambiguity
Chronic Care Hospitals	Ambiguity	Ambiguity
<b>Mental Health Services</b>		
Crisis Counseling	FNIHB	Ambiguity
Prevention	Ambiguity	Manitoba Health
<b>Transportation</b>		
Medical Transportation	Ambiguity	Ambiguity
<b>Ambulance Services</b>		
Ground Ambulance	Ambiguity	Manitoba Health
Air Ambulance	Ambiguity	Manitoba Health

Source: The information presented above is based on interviews and a review of information provided by Manitoba Health, FNIHB, INAC, AMC, the Romanow report, and a presentation by Josee G. Lavoie at the Primary Health Care Conference on First Nations Health and Wellness, Winnipeg (March, 2005)

#### **2.4.4 Recommendation**

That senior officials of the ICFNH take action to resolve long-standing jurisdictional disputes and ambiguity. It is recommended that a task group be established by the senior officials with a mandate to develop a document which lists the full inventory of health and social services (on and off reserve) and which clarifies:

- the responsible service delivery agency;
- funding responsibility;
- applicable standards; and
- relevant procedures, level of benefit, and rules of entitlement.

It is further recommended that the target date for completion of this exercise including approval of the document by the relevant senior officials be set for March 31, 2006

### **2.5 Demographics / Urban Population**

The impact of Bill C-31 on First Nation communities demographically and subsequent provision of services in the future are identified. A number of concerns and issues relating to this demographic change are also stated. Lastly, the population growth and implications for future health and social delivery in urban centers are briefly presented in this section.

#### **2.5.1 Bill C-31 Impacts**

The 1985 amendments to the *Indian Act* (known as Bill C-31) have resulted in important changes affecting First Nations communities and populations. At the outset of this review, two questions were being asked:

- How is Bill C-31 likely to affect the future size and composition of First Nations population Manitoba?
- What are its impacts for the provision of health and social services to First Nations people?

Projections from the current research on Bill C-31 impacts suggest that over the next few generations, there will be an increasing number of Manitoba First Nation descendants who will not be entitled for Indian registration. A recent study on the First Nation in southern Manitoba concluded that descendants that qualify for Indian registration are expected to form a minority of all descendants within about 3.5 generations.<sup>33</sup> Plans are underway to conduct a complementary study in northern Manitoba. The synthesis of both north and south reports should provide a more accurate assessment of the provincial picture.<sup>34</sup> In the interim, the development of a First Nations Blueprint should consider implications of Bill C-31 based on current information.

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<sup>33</sup> Clatworthy S. (2001) *First Nations Membership and Registered Indian Status*. Manitoba, Southern Chiefs Organization

<sup>34</sup> Interview with Keely Ten Fingers, Policy Advisor at the Assembly of Manitoba Chiefs, February 11, 2005. Ten Fingers suggests caution in applying existing research conclusions to the whole of Manitoba. One limitation of the Clatworthy 2001 study is that it does not include northern communities. Also, there is a need to identify practices and policies which may result in incorrect registration.

The rules governing entitlement imply that future descendants may lose entitlement to registration through the process of out-marriage. Two successive generations of out-marriage will result in the loss of entitlement to Indian registration for the offspring of the second generation.<sup>35</sup> Rates of out-marriage among the Southern Chiefs Organization (SCO) First Nations population average about 44 % (32 % on reserve and 66 % off reserve) and are considerably higher than the national average.<sup>36</sup>

Bill C-31 creates different classes of First Nation residents. Indian registration rules and all types of First Nations membership rules contain descent provisions, i.e. eligibility is determined by the characteristics of one's parents. According to information presented at a 2002 policy research conference<sup>37</sup> four classes are possible:

1. Registered Indian Member
2. Registered Indian Non-Members
3. Non-Indian Members
4. Non-Indian Non-Members

### **2.5.2 Social and Political Implications**

This emerging trend within First Nation populations raises a number of concerns and issues related to:

- governance and accountability;
- equality, social inclusion, political and human rights;
- jurisdictional and financial responsibilities for program and service provision to differing classes of First Nation residents; and,
- potential for conflict within communities and between governments (First Nations, federal and provincial).

### **2.5.3 Future On-Reserve Service Impacts**

The following longer-term population impacts of Bill C-31 are based on a national picture and 75-year projection outcome roughly interpreted as three future generations.<sup>38</sup>

*Elementary and Secondary Education*      Non-registered students are expected to continue to form a small segment of the reserve student population for the next 15 years.

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<sup>35</sup> Clatworthy S. (2003) *Impacts of the 1985 Amendments to the Indian Act on First Nations populations, in Aboriginal Conditions' Research as a Foundation for Public Policy* edited by Jerry P. White, Paul S. Maxim and Dan Beavon. UBC Press.

<sup>36</sup> Clatworthy S. (2001) *First Nations Membership and Registered Indian Status*. Manitoba, Southern Chiefs Organization , 18

<sup>37</sup> Clatworthy S, Guimond E, Norris MJ. (2002) *Presentation at Indian and Northern Affairs Canada Aboriginal Policy Research Conference, Ottawa, November 25, 2002*

<sup>38</sup> Ibid

Issues related to funding for non-registered students may arise within 25 years when non-registered students are expected to form about 15 percent of all reserve students.

*Post-Secondary  
Education  
Support*

A growing share of First Nation descendants are expected to lose access to INAC post-secondary education resources.

Within 25 years, about one in six reserve high school graduates are expected to lack Indian registration and will not qualify for INAC post-secondary funding. This number is expected to grow to more than one-half of all graduates within 50 years.

*Child and  
Family Services*

Within 25 years, about one in five on-reserve children requiring support services are expected to be non-registered. This number is expected to climb to nearly one of every two children within 50 years.

Growth in the size of the non-registered caseload may result in pressures to develop new provincial/federal cost-sharing arrangements for child support services.

*Income  
Assistance*

Within 25 years, about seven percent of the on-reserve population needing income support is expected to be non-registered. This share is expected to climb to nearly 19 percent within 50 years.

Growth in the size of the non-registered caseload may result in pressures to develop new provincial/federal cost-sharing arrangements for Income Assistance.

*Reserve Housing*

Housing demand related to non-registered descendants is expected to remain modest over the next 25 years. Within 50 years however, about one in five new households is expected to be headed by a non-registered descendant.

*Health Services*

Community-based health services and programs are available to First Nations and other Aboriginal peoples, regardless of residency, registration or membership status.

Non-insured health benefits, however, are limited to Registered Indians. Within 25 years, about one in every eight First Nations descendants will not qualify for non-insured benefits. This number is expected to rise to nearly one in three descendants within 50 years.

#### **2.5.4 Urban Population**

Manitoba First Nations citizens living in urban centers currently experience a high population growth rate which is expected to continue. Currently, there are 30,000 First Nations people living in Winnipeg.<sup>39</sup>

In 1991 the Status Indian population located in Winnipeg was 15,900 and is projected to more than double to 39,600 by 2016.<sup>40</sup>

The implications of First Nation urban population growth for the future of health and social service delivery are significant. Key characteristics of the current situation facing urban First Nations citizens as outlined by a 2003 Manitoba First Nations Mobility Study<sup>41</sup> are:

- high unemployment
- low rate of home ownership
- high rate of income assistance recipients
- high drop out rate of school
- high number of children living in poverty

#### **2.5.5 Recommendation**

That the financing approach for reserve-based health and social services be streamlined and simplified and replaced with some type of per capita formula

This is critical for all levels of government as a means of adapting to impacts associated with Bill-C31 and urban population growth. On reserve, there will be a future growth in the non-registered caseload for health and social programs. The combination of Bill-C31 impacts and the trend of an ever-increasing First Nations urban population will create the need for new ways to organize and finance both on and off reserve services.

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<sup>39</sup> AMC (2004) *Assembly of Manitoba Chiefs Transition Center: Preliminary Feasibility Study*. Winnipeg: AMC

<sup>40</sup> Manitoba Bureau of Statistics (1997) *Manitoba's Aboriginal Populations Projected 1991 – 2016*

<sup>41</sup> Institute of Urban Studies (2003) *First Nations / Metis / Inuit Mobility Study: Interim Report Two*. Winnipeg: U of W

## **Section 3: Health Care Issues – Selected Examples**

### **3.1 Continuing Care**

Continuing Care refers to the range of holistic medical and social services for those who do not have, or have lost, some capacity for self-care. These services often begin in the home and progress through a continuum up to the more intensive levels of care normally associated with institutional care, including end-of-life and palliative care.<sup>42</sup> There are a number of definitions for continuing care. The definition used at Manitoba Health is as follows:

Continuing care refers to continuity in the meeting of care needs for the individual from the initial recognition of need for the individual living at home through temporary absences from home (hospitalization) and through placement into a care facility for those for whom such is required. The Continuing Care Program, as such, provides

- services to support the provision of care at home (Home Care) including family relief, Respite Care and Adult Day Care
- assesment for placement into a care facility.

Home Care is defined as the coordinated delivery of a broad range of health and social services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without Home Care is likely to deteriorate making it impossible for the person to stay at home in the community.

In the last 20 years, although a few new personal care homes have been built on Manitoba reserves and home care services have expanded, overall, little progress has been made to address gaps and issues in First Nations continuing care services. An evaluation of the INAC Adult Care program for elderly and disabled Indians on Manitoba Indian reserves conducted almost 20 years ago in 1986 identified many of the same gaps and issues which still exist today.<sup>43</sup>

A good description of the overall situation in Manitoba is best described by a national joint Health Canada/INAC working group established in 1989. The working group concluded that, "...significant gaps exist in the availability of community support programs in most communities and the lack of specific authority for adult care services...has discouraged the development of a comprehensive federal policy framework (and contributed to) unclear departmental responsibilities, lack of a program structure, fragmented service development and inconsistent standards."<sup>44</sup>

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<sup>42</sup> Definition included in background paper of Health Canada, INAC, First Nations Joint Working Group on Continuing Care Policy Development

<sup>43</sup> Harvey, T (1986) *An Evaluation of the Adult Care Program and its Component Health and Home Support Services for Elderly and Disabled Indians on Manitoba Indian Reserves*. Winnipeg, INAC, First Nations Confederacy, MKO, and Brotherhood of Indian Nations

<sup>44</sup> INAC (March 31, 2004) *Assisted Living, National Standards and Guidelines Manual* (draft) Ottawa, INAC, 17

A national joint First Nation-INAC-Health Canada research and costing project is currently underway. The exercise is intended to provide a greater understanding of continuing care services now provided in First Nations communities and the needs (through care level assessment), with the view to develop continuing care options, and costing.<sup>45</sup> Manitoba Region has been selected as a sample region for this project and some communities have been invited to participate. There is, however, no commitment to fill the gaps identified once the costing exercise is complete.

### 3.2 Overview of Issues on Personal Care Homes, Residential Care and Other Supportive Housing Options

Table 5 provides an list of some issues.

**Table 5: Overview of the issues on Personal Care Homes, Residential Care and Other Supportive Housing Options**

SERVICE	ISSUES
<b>Personal Care Homes (PCH)</b>	<ul style="list-style-type: none"> <li>✓ Service Gap</li> <li>✓ Jurisdictional Issues – lack of clarity in roles and responsibilities</li> <li>✓ INAC does not have authority for higher levels of care</li> <li>✓ Unlicensed facilities in First Nation communities</li> <li>✓ Option of First Nations licensing authority</li> <li>✓ No standard classification system for levels of care</li> <li>✓ Infrastructure upgrades, maintenance</li> <li>✓ No protocol for establishing new facilities</li> <li>✓ INAC Authorities are very restrictive for the funding of new institutions</li> </ul>
<b>Residential Care Services</b> (care and supervision for adults with mental disabilities, infirm aged, or for individuals who are unable to live independently)	<ul style="list-style-type: none"> <li>✓ Service Gap</li> <li>✓ Lack of policies and capital funding to construct alternative care facilities on reserves</li> <li>✓ INAC responsibilities are unclear</li> </ul>
<b>Independent Living Settings / Supportive Housing</b>	<ul style="list-style-type: none"> <li>✓ Service Gap</li> <li>✓ Limited policy and funding for alternative housing options</li> <li>✓ Jurisdictional Issues – lack of clarity in roles and responsibilities</li> </ul>

#### 3.2.1 Personal Care Homes

Although there are eight Personal Care Homes (PCHs) in Manitoba First Nations communities, many individuals requiring higher levels of care must leave their home community to access this service, either off reserve or at another First Nation’s PCH. This is an unacceptable practice as it leads to isolation from family support. As a result,

<sup>45</sup> Interview with Irvin Smith, Senior Negotiator/Policy Analyst, INAC, Manitoba Region

some clients remain in their community where they may receive inadequate levels of care, resulting in risks to health and safety.<sup>46</sup>

The eight PCHs, two of which are provincially licensed, are located in the following First Nation communities:

- Bunibonibee Cree Nation (Oxford House)
- Norway House Cree Nation (licensed)
- Nisichawayasihk Cree Nation (Nelson House - licensed)
- Opaskwayak Cree Nation (The Pas)
- Peguis
- Fisher River
- Fort Alexander (Sagkeeng)
- Sioux Valley

There is an increasing demand for PCHs in First Nations communities, and INAC and Manitoba Health are under increasing pressure to establish new facilities. Among First Nation communities which have expressed an interest in establishing a PCH are Cross Lake, Tataskweyak, God's Lake Narrows, Waywayseecappo, and Long Plain. An additional element of significance is the consideration of needs associated with aging First Nation people residing on reserve that have not been identified in the Manitoba Long Term Care Strategy.

A 2001 study by INAC identified a number of the challenges associated with PCHs<sup>47</sup> including:

- INAC has taken on responsibility for funding Types I and II institutional care (lower levels of care) without a clear authority to do so. Complicating this is the fact that many facility residents require and receive higher level of care considered a provincial responsibility;
- Most of the existing PCHs are not licensed or regulated by provincial regulatory bodies, raising questions about standards of service and potential liability risks for both the PCH operators and INAC;
- Both Types III and IV institutional care on reserve are seen by federal departments as perhaps the greatest gap in the continuum of care for the elderly and persons with disabilities. This is beyond the social services mandate of INAC, and considered by Health Canada to be a provincial responsibility; and
- The INAC Community Infrastructure and Housing Program applies to residential areas only and does not allow construction of enhanced housing options which would provide communal areas for recreation, eating and cooking.<sup>48</sup>

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<sup>46</sup> Lavoie, J. (in progress) *Background, Continuing Care Research and Costing Project. Manitoba Regional Report 2004-06*. Winnipeg, Manitoba: Centre for Aboriginal Health Research.

<sup>47</sup> Lemchuck-Favel, L (2003) *Integration of Continuing Care in First Nations Communities: A Draft Model for Discussion*. Ottawa: Assembly of First Nations, 17 (includes a summary of a 2001 study commissioned by INAC)

<sup>48</sup> Ibid, 18



### *Recent developments*

There is an identified requirement of more than \$12 million to upgrade existing on-reserve Personal Care Homes to meet provincial standards. INAC has yet to identify a funding source.

As a condition of funding for PCHs, INAC has asked the Manitoba Government to license the six unlicensed PCHs. The province is proceeding cautiously as it perceives this request as a potential 'offload' attempt by the federal government and would rather work with First Nations to establish a First Nations licensing regime.

The INAC national standard which applies for the construction of new PCHs is very restrictive.<sup>49</sup> Some of the requirements according to the draft standards include that:

- where required, types III, IV and V care (higher levels of care) will be provided by another authority (provincial or regional health authority);
- the facility will be licensed and/or recognized and monitored by a recognized authority (provincial, territory, or other licensing or recognized body); and,
- operating funding must be available within existing regional allocations.

The Manitoba First Nations PCH representatives have been meeting with provincial and federal representatives on the PCH licensing on-reserve issue. The goal of the First Nations is to establish their own licensing regime within the federal jurisdiction.<sup>50</sup>

### **3.2.2 Residential Care Services**

Residential Care Services is identified as a service gap as it is provided off reserve by the provincial government, but, is generally not available in Manitoba First Nations communities. The Manitoba Government provides the service for individuals living with a mental disability, the aftermath of mental illness, or the infirmities associated with age, in a licensed or approved residential care facility at a level of care.<sup>51</sup> Key to this discussion is that definitions of levels of care for residential care facilities are different than definitions for levels of care in PCHs. In other words, the provincial structure for approved levels of care which residential care facilities are licensed to provide is different than the provincial structure of level of care for PCHs. Residential care facilities are licensed by the province to provide levels of care ranging from Level 1 to Level 5. The Manitoba Government covers monthly board and room rate for income assistance recipients in these facilities, currently ranging from \$527 per month for Level 1 to \$779 for level 5.<sup>52</sup>

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<sup>49</sup> INAC (March 31, 2004) *Assisted Living, National Standards and Guidelines Manual* (draft) Ottawa, INAC

<sup>50</sup> Assembly of Manitoba Chiefs (March 27, 2005) *Motions arising from Executive Committee Meeting*, Winnipeg, AMC

<sup>51</sup> Residential Care Services of Manitoba Family Services and Housing Services are described on-line at [http://www.gov.mb.ca/fs/pwd/supported\\_living.html](http://www.gov.mb.ca/fs/pwd/supported_living.html)

<sup>52</sup> Board and Room rates payable through the Manitoba Income Assistance program are available on-line at <http://www.gov.mb.ca/fs/ei/manual/20.html>

A few Manitoba First Nations including Cross Lake and Fisher River have established residential care-type services. Interviews suggest these facilities have been established and maintained by combining resources from programs such as capital housing, homemaker, homecare, and income assistance programs. A review of the *INAC Assisted Living National Standards and Guidelines Manual* indicates INAC has the authority to fund the same board and room rates as the province for services in such facilities.<sup>53</sup> In that these facilities are not licensed could be problematic. Although it is not clear in the INAC national standards, the wording suggests that, in a similar manner as Personal Care Homes, residential care facilities would have to be licensed or recognized and monitored by a recognized authority in order to qualify for funding.

### **3.2.3 Independent Living Settings / Supportive Housing**

Commonly called supportive housing in the literature, Independent Living Settings (ILS), can range from self-contained apartments featuring full, private living units where a common dining and social space is available, to shared housing, where the private area is generally a large bed / sitting room and all kitchen, dining and social areas are communal. In addition to reduced housekeeping and home maintenance, ILS housing offers an element of safety, social interaction and proper nutrition, and can be an attractive option for persons who live alone even if home support and nursing services are available in the community. Similar to home environments, ILSs can be serviced in the integrated continuing care system via nursing and health care professionals.<sup>54</sup>

In Manitoba, supportive housing is known as Assisted Living and refers to the following:

Housing with a care alternative that provides personal support services and essential homemaking in permanent, grouped, community residential settings, for frail and/or cognitively impaired elderly persons; persons with physical disability or other chronic conditions requiring extensive long term care, when their care requirements justify the need for the availability of 24-hour on site assistance (MB Health Supportive Housing Policy Guidelines March 1999).

The MB Health Supportive Housing Policy Guidelines also identify 24 hour on-site staffing in a supportive housing arrangement and outlines separate responsibilities for the resident and the provider of this health care service. The resident pays for shelter and basic services while the personal care and professional health services are funded by Manitoba Health through the Regional Health Authorities.

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<sup>53</sup> INAC (March 31, 2004) *Assisted Living, National Standards and Guidelines Manual* (draft) Ottawa, INAC

<sup>54</sup> Lemchuck-Favel, L (2003) *Integration of Continuing Care in First Nations Communities: A Draft Model for Discussion*. Ottawa: Assembly of First Nations, 43

Finally, prerequisites for supportive housing are also identified in the Policy Guidelines as follows:

Before any supportive housing initiatives are implemented, communities should have in place a comprehensive range of services available to match individual needs with appropriate service including:

- appropriate housing
- support services for seniors
- home care including block care
- congregate/delivered meals
- “for purchase” basic services; e.g. meals, laundry, maid service

The implementation of Supportive Housing 1999 Guidelines may still be relevant in most communities. However, they may not pertain to others. As a result, it is necessary to determine what resources exist in the community to determine the nature of supportive housing that could best ‘fit’ the needs of residents in the community. For example, it may be more appropriate to design a 24 hour supportive housing complex inclusive of necessary services rather than trying to access separate components such as congregate meals.

The literature cites very few references to this type of service in Manitoba First Nation communities. Examples are Long Plain which has an independent living unit and Tataskweyak which offers supportive housing.<sup>55</sup> First Nations communities are at differing stages in relation to their readiness and ability to make progress in obtaining these services. Need demographics are a significant factor for consideration.

### **3.2.4 Recommendations on Personal Care Home, Residential Care and Other Supportive Housing Options**

#### *Personal Care Homes*

- That INAC and Manitoba Health take steps to establish a formal protocol for the construction of new Personal Care Homes on reserves.
- This option complements the broader discussion required on the matter of jurisdiction in this area. It is anticipated that negotiations, proposed by AMC through the Manitoba Framework Agreement Initiative process on the matter of First Nations jurisdiction over Personal Care Homes in its entirety, including licensing, will be a long process. In the interim, the parties involved are encouraged to focus on operational matters such as the required upgrading of existing facilities to meet provincial standards, funding for higher levels of care, and a protocol for construction of new facilities.

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<sup>55</sup> *Continuing Care Research and Costing Project*, untitled

### *Residential Care Facilities and other Housing Options*

As the issue of licensing Residential Care is closely related to the PCH licensing issues, it is recommended that this issue also be included in negotiations on PCH licensing.

### **3.3 Palliative Care**

The limitations to availability of Palliative Care services in Manitoba is most evident in First Nations , especially those in remote areas. Many Aboriginal people living in remote communities are transported to large urban centers to die, isolated from friends, family and their culture. This is despite the fact that the majority of Aboriginal people living in remote communities would prefer to die at home.<sup>56</sup> The research suggests that gaps in palliative services are an issue for all remote communities – not only First Nations. Health professionals also indicate that communities with road access also experience similar issues.

A 2003 study of remote Aboriginal communities in northern Manitoba explored obstacles related to palliative care service delivery. Findings from surveys was that most service providers (northern physicians and nurses) felt having a closer connection to Cancer Care Manitoba and other organizations in Winnipeg would facilitate the provision of palliative care. Palliative care specialists in Winnipeg identified concerns related to jurisdictional issues and limited resources.<sup>57</sup>

Table 6 provides an overview of the issues associated with Palliative Care service issues for First Nations people living in remote communities of Manitoba.

**Table 6: Overview of the Palliative Care Issues in Remote Communities.**

<b>SERVICE</b>	<b>ISSUES</b>
Palliative Care	<ul style="list-style-type: none"><li>✓ Service Gap</li><li>✓ Jurisdictional Issues – lack of clarity of roles and responsibilities</li><li>✓ Connection between service providers in the community and external specialists</li><li>✓ Lack of training</li><li>✓ Lack of home oxygen</li><li>✓ Culture Sensitive Standards</li></ul>

<sup>56</sup> Hotson KE, Macdonald SM, Martin BD. ‘Understanding Death and Dying in Select First Nations Communities in Northern Manitoba: Issues of Culture and Remote Service Delivery in Palliative Care’, in *International Journal of Circumpolar Health* 63:1 2004, 25

<sup>57</sup> Ibid

A recent NAHO Discussion Paper identifies a number of barriers to providing palliative care in communities.<sup>58</sup> Service gaps and issues include:

- caregiver relief/in-home respite care;
- education and training for caregivers;
- lack of multi-purpose care facilities;
- lack of access to appropriate equipment or lack of space within the house to use it (e.g. a wheelchair);
- access to basic sanitation, such as unlimited water and indoor plumbing; and
- access to affordable, wholesome foods

### **3.3.1 Recommendations on Palliative Care**

- That a regional conference on remote service delivery in Palliative Care be held in 2006.
- This option provides an opportunity to begin addressing gaps and issues in this area. The conference would focus on improving and integrating services, information sharing, and examining the role of technological support. Overall, this option would assist in building a bridge between urban palliative care specialists and community health care professionals.

### **3.4 Services for Persons with Disabilities**

A major AMC study in 2001 of 51 First Nations communities in Manitoba identified 1618 First Nation adults aged 15 years and older as having a disability.<sup>59</sup> It reported that 58% of First Nations adults in northern Manitoba and 42% in the south live with a disability, with a large number of these individuals using a range of continuing care services. Disability is more prevalent in older age groups with the average age of a First Nation person with disability 52 years of age. However, 25% of First Nations with a disability were between 25 and 44 years of age. The most prevalent form of disability was mobility impairment.

It is important to note that the major cause of disability is illness, with diabetes alone accounting for 32%. Amputation rates related to diabetes complications is 16 times higher for First Nations compared to all other Manitobans (3.1 vs. 0.19 per thousand ages 20 through 79).<sup>60</sup>

Adequate, accessible housing was also identified as a major barrier for First Nations persons with disability. It is also important to note that the study found that in households that reported no household members with a disability, there were more adults

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<sup>58</sup> NAHO (2002) *Discussion Paper on End of Life / Palliative Care for Aboriginal Peoples*. Ottawa, NAHO

<sup>59</sup> Elias B and Demas D. (2001) *First Nations People with a Disability Needs Assessment Survey Findings - A Profile of Manitoba First Nations People with a Disability*. Winnipeg: Assembly of Manitoba Chiefs.

<sup>60</sup> *ibid*

working, incomes were higher, and the experience of food insecurity was less. A majority of persons with a disability depended upon income assistance.<sup>61</sup> Approximately 33% of First Nations persons with a disability regularly left their community to see a specialist for their disability or to access specialist services.<sup>62</sup> First Nation people with a disability are reliant on a number of continuing care services, aids, and equipment supposed to be provided by the Non-insured Health Benefits Program. The survey revealed that 40% of First Nations people with a disability have experienced difficulties in accessing these services or aids for their disability.<sup>63</sup> Respondents reported feeling that outside service agencies including federal department regional offices e.g. INAC were not very helpful in promoting, supporting, nor, maintaining efforts toward independent living.

Of significance to our purposes here, the AMC study finds that to date federal and provincial initiatives in Manitoba have not comprehensively addressed the problems experienced by First Nations people with a disability. Among the major determinants identified as the cause of poor health for this target group are jurisdictional problems in health and social service delivery, poverty, inadequate living conditions and poor access to health services.<sup>64</sup> A major contributing factor is the lack of support services on reserves compared to what is available off reserve.

The Manitoba First Nations Disability Multi-Sectoral Working Group (MFNDMWG), involving the same partners as the ICFNH has been examining these issues and made eleven recommendations on the topic.

### **3.4.1 Recommendations**

- That a First Nations Service/Support Centre be established for persons with disabilities living on and off reserve in Manitoba and that specialized care agencies provide on-going follow-up services once a person returns to the reserve. This recommendation is in support of the work and recommendations of the MFNDMWG.
- That socio – economic determinants of health which are significantly correlated with disability among First Nations be addressed, including unemployment, poverty, food insecurity, social isolation, and inadequate housing.
- That further study be undertaken to fully understand the social-cultural-economic context of disability.

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<sup>61</sup> Ibid

<sup>62</sup> Ibid

<sup>63</sup> Ibid

<sup>64</sup> Ibid

### 3.5 Children Services

#### 3.5.1 Children with Complex Medical Needs

Concerning services to northern Manitoba First Nations children with lifelong complex medical needs (and their families), in all but rare cases, these children have been required to leave their homes and families and live in either medical foster homes or medical institutions in order to access the medical services (primary, secondary, and tertiary) they require to survive and develop. In August 1999, an 18 month agreement was signed with INAC, Health Canada, Manitoba Health and the Awasis Agency for the establishment of the Children with Lifelong Complex Medical Needs pilot project. The project was extended until December 2001, at which time Manitoba Health and First Nations and Inuit Health Branch gave written notice the pilot project would not be extended. In November 2000 an evaluation of the project resulted in a number of recommendations the first two of which are of particular concern to this scan: 1) the need to address historical service gaps that exist at the community level for First Nations children with complex medical and/or special needs and 2) the need to resolve ongoing jurisdictional debate regarding who is fiscally responsible to provide required medical and therapeutic services to First Nations children and their families on reserve.<sup>65</sup>

#### 3.5.2 Services for Children with Physical and Mental Disabilities

A significant service gap in Manitoba First Nation communities is the equivalency of the provincial Children's Special Services Program. This provincial program provides support to families for the care of children who have physical and/or mental disabilities. The objective is to reduce stress encountered by families and, more importantly, to help them maintain their children with disabilities in their own homes to the greatest extent possible.<sup>66</sup> Table 7 provides a list of some issues.

**Table 7: Overview of Issues Associated With Children's Special Services.**

SERVICE	ISSUES
<p><b>Special Services for children with physical and/or mental disabilities</b></p> <ul style="list-style-type: none"> <li>• Counseling</li> <li>• information and referral</li> <li>• respite care</li> <li>• child development</li> <li>• therapy services</li> <li>• supplies and equipment</li> <li>• home modifications</li> <li>• transportation</li> <li>• training</li> </ul>	<ul style="list-style-type: none"> <li>✓ Service Gaps</li> <li>✓ Jurisdictional Issues – lack of clarity on roles and responsibilities</li> <li>✓ Relocation to urban center to access special services – impact on provincial programs</li> </ul>

<sup>65</sup> Ibid

<sup>66</sup> Description of the Manitoba Government Children's Services Program is available online at <http://www.gov.mb.ca/fs/pwd/css.html>

An unsatisfactory option for many on-reserve families requiring special services is to leave their community to seek these services. Moving off reserve is not necessarily a trouble free option. Challenges facing families who choose this option include access to housing, employment, education, and family support services. Interviews with provincial officials indicate that the additional cost to the Manitoba Government for social and health programs can be substantial when a family moves off reserve to access services not available on reserve. For example, when a family moves to Winnipeg to access children's special services and doesn't have financial means of support, they likely will need to access the provincial Income Assistance program to cover basic food and housing costs. As a matter of policy, INAC would not reimburse the province, as the family is considered living off reserve.

Another possible complication arises if the child requiring special services, such as home modifications for a wheelchair ramp, is in the care of a Child and Family Services (CFS) agency. For example, if the child is deemed to be a federal responsibility, for CFS funding purposes due to the reserve residency of his/her parents, the family may encounter difficulties in getting either the Manitoba Government or FNIHB to cover the cost of a wheelchair ramp.<sup>67</sup> If such a case on reserve, the cost of the wheelchair ramp would be covered through other programs such as housing and special needs funding available through the Income Assistance program.

### **3.6 Diabetes**

In Canada, the prevalence of Type II diabetes among aboriginal people is two to five times greater than in the general population.<sup>68</sup> More than 20% of Registered First Nation women and 13% of Registered First Nation men in Manitoba have been diagnosed with diabetes.<sup>69</sup> Diabetes also increases with age, with nearly one-half First Nations over the age of 45 report diabetes as a health condition,<sup>70</sup> although a surprisingly high proportion of people in the 25-44 year old age group, 13%, report diabetes. Rates of complications are often higher including increases in the age-adjusted mortality from Type II diabetes, higher rates of end stage kidney disease, eye damage, lower extremity amputations and ischemic heart disease. Type II Diabetes is an illness that usually starts in adulthood, and until ten years ago, did not affect children. Although previously known as 'adult onset diabetes, recent research indicates that this form of the illness now affects an increasing

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<sup>67</sup> Discussion with Trudy Lavallee, AMC, Child and Family Services Policy Advisor

<sup>68</sup> Martens PJ, Bond R, Jebamani L, Burchill CA, Roos NP, Derkesen SA, et al. (2002) *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

<sup>69</sup> Manitoba. (1999) *Diabetes A Manitoba Strategy. Diabetes Foot Symposium*. Winnipeg: Manitoba Health

<sup>70</sup> Elias B and Demas D. (2001) *First Nations People with a Disability Needs Assessment Survey Findings - A Profile of Manitoba First Nations People with a Disability*. Winnipeg: Assembly of Manitoba Chiefs, 73



number of children and adolescents.<sup>71</sup> This is particularly true for Aboriginal youth, who suffer from Type II diabetes at seven times the rate that Caucasian children are afflicted with type I diabetes.<sup>72</sup> The health implications presented by Type II diabetes necessitate the development of strategies for preventing, managing and treating the illness among First Nation people.

### *Historical context*

A rapid transition from hunting and gathering to sedentary, reserve-based lifestyles, as well as a switch from a high-fiber, low-fat diet to one based on low-fiber, high-calorie foods, has exacerbated the prevalence of obesity and diabetes among Canada's Indigenous peoples.<sup>73</sup>

### *Prevention*

For Type II diabetes the risk factors include: family history of diabetes; age (over 45); unhealthy eating habits (patterns, food choices, portion sizes); obesity; physical inactivity; and race/ethnicity. The Manitoba First Nations Regional Health Survey Final Report shows 50% of those interviewed were overweight, with a significant 36% obese.<sup>74</sup> A disturbing finding with possible impact on diabetes prevention is food insecurity: 60% report cost a food a problem and almost one-third indicated that running out of money for food occurred at least once a month.<sup>75</sup> The promotion of healthy family lifestyles - healthy eating and family recreation- to children, youth and adults is an integral part of diabetes prevention. On the positive side, a major Manitoba study reports that 50% of FN people interviewed indicate they are making major dietary changes to improve their health.<sup>76</sup>

### *Care and Treatment*

In every area of the province, there are significant differences in diabetes treatment prevalence rates between Registered First Nations and other residents. Treatment for diabetes is over four times as high for RFN population (3.1 vx 0.19 per 1000 for ages 20-79). Diabetes treatment prevalence (age- and sex-adjusted) in the Tribal Council areas ranges from 150 per thousand (15%) in KTC to 250 per thousand (25%) in DOTC, with many southern Tribal Councils having the highest rates in the province. Diabetes treatment prevalence (age/sex adjusted) among RFN in Manitoba is over four times higher than for all other Manitobans (189 versus 45.4 per thousand, or 18.9% versus

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<sup>71</sup> Campbell A. (2002) 'Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care. *Health Law Journal* Vol. 10, 2002

<sup>72</sup> Ibid

<sup>73</sup> Campbell, Angela (2002) 'Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care'. *Health Law Journal* Volume 10, 150

<sup>73</sup> Residential Schools Resolution Canada, Website available online at <http://www.irsr-rqpi.gc.ca/english/questions.html>.

<sup>74</sup> Centre for Aboriginal Health Research. (1998) *Manitoba First Nations Regional Health Survey Final Report*. Winnipeg: CAHR.

<sup>75</sup> Ibid

<sup>76</sup> Ibid

4.5%). The differential between RFN and all other Manitobans within RHAs ranges from just over twice as high in Burntwood and Churchill, to over six times as high in Central and South Westman. Overall, 'on-reserve' RFN have slightly higher diabetes treatment prevalence than 'off-reserve' RFN (203 versus 170 per thousand, or 20.3% versus 17.0%), and for some RHAs, the difference is as much as 50%.<sup>77</sup>

There are two concerns about obtaining diabetes rate using provincial physician/hospital claims. First, claims may be missing from northern and remote regions, and secondly, diabetes rates may appear 'high' in areas where there are active surveillance and screening programs, so true diabetes rates may be under counted in areas where these programs are not active.<sup>78</sup>

### *Research*

Several researchers have undertaken studies in First Nation communities to further assess the impact of Type II diabetes and to develop strategies that help children, families, and communities to understand and cope with the illness. These initiatives have combined suggestions related to healthier and more active lifestyle modifications, diabetes screening programs, pharmacology treatment programs within communities.

### *Education*

Controlling diabetes requires an around-the-clock commitment from the individual with diabetes. The onset of complications due to diabetes (increased risk of cardiovascular problems and stroke, eye problems and poor blood circulation) can be delayed and even prevented through effective diabetes management. There is a need to raise diabetes awareness, conveying the seriousness of the disease, the preventability of the disease, and assessing personal risk of diabetes.

Education is the key to understanding and managing diabetes, however, research indicates among Manitoba First Nations people with diabetes, only 45% reported attending a diabetes education clinic.<sup>79</sup> This suggests that a high proportion of people either with diabetes or at risk of developing diabetes, one, may not be receiving appropriate health education to manage their illness and learn self-care, or two, that educational opportunities are not available to them. One Manitoba study shows a significant 86% indicate that health education services around diabetes are in need of improvement.<sup>80</sup>

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<sup>77</sup> Martens PJ, Bond R, Jebamani L, Burchill CA, Roos NP, Derkesen SA, et al. (2002) *The Health and Health Care Use of Registered First Nations People Living in Manitoba: A Population-Based Study*. Winnipeg: Manitoba Centre for Health Policy.

<sup>78</sup> Ibid

<sup>79</sup> Centre for Aboriginal Health Research. (1998) *Manitoba First Nations Regional Health Survey Final Report*. Winnipeg: CAHR

<sup>80</sup> Manitoba Health (2003) *The Delivery of Health Programs and Services to Northern Residents with an Emphasis on Aboriginal and Other Remote Communities*. Winnipeg, Manitoba Health

### 3.6.1 Barriers

The cause of diabetes is complex and involves both genetic and lifestyle considerations. Researchers have identified several factors that threaten the success of these diabetes initiatives. Potential barriers include social and cultural approaches to the illness, economics and poverty, geographical and environmental obstacles.<sup>81</sup> Geographical and environmental factors also play a significant role in the ability of First Nation families and communities to prevent and manage Type II diabetes. Living in isolated northern areas several factors contribute to inactivity: frigid weather, lack of exercise facilities, and scarcity of role models. Moreover, geographical and environmental considerations often preclude physical access to care.

Poverty constitutes a barrier in more ways than access to care and treatment. It prevents access to more nutritious food that is sometimes more costly and may involve more extensive time to make and prepare.

Access to care that guarantees well-being rests on more than simply location and the economic ability to acquire medical resources. In addition to these factors, historical, current social and cultural considerations also bar access to appropriate care for First Nations with diabetes. One study found that the primary obstacle to creating and implementing effective diabetes prevention programs is ensuring that such programs are meaningful and helpful to First Nations communities.<sup>82</sup>

### 3.6.2 Recommendations

That the recommendations for the early detection, prevention and treatment of diabetes have been put forth by the Clinical Practice Guidelines Expert Committee of the Canadian Diabetes Association be followed. They are as follows:

- Treatment of diabetes in Aboriginal peoples should follow clinical practice guidelines.
- There must be recognition of, respect for and sensitivity regarding the unique language, culture and geographic issues as they relate to diabetes care and education in Aboriginal communities across Canada.
- Culturally appropriate primary prevention programs should be initiated by Aboriginal communities to increase awareness of diabetes, increase physical activity, improve eating habits and achieve healthy body weights, and to promote environments that are supportive of a healthy lifestyle.

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<sup>81</sup> Campbell A. (2002) 'Type 2 Diabetes and Children in Aboriginal Communities: The Array of Factors that Shape Health and Access to Health Care.' *Health Law Journal* Vol. 10, 2002

<sup>82</sup> Manitoba Health (2003) *The Delivery of Health Programs and Services to Northern Residents with an Emphasis on Aboriginal and Other Remote Communities*

- Community-based diabetes screening programs should be established in Aboriginal communities. Urban people of Aboriginal origin should be screened for diabetes in primary care settings.
- Obese children  $\geq 10$  years of age should be considered for screening for type 2 diabetes every 2 years using an FPG test if they meet 2 of the following criteria:
  - Member of a high-risk ethnic group;
  - Family history of type 2 diabetes, especially if the child was exposed to diabetes in utero;
  - Acanthosis nigricans;
  - PCOS;
  - Hypertension; or
  - Dyslipidemia

### **3.7 Disabilities Associated with Prenatal Alcohol Exposure/Fetal Alcohol Spectrum Disorder (FASD) Related Disabilities**

FASD refers to a number of health problems that can occur when the ‘history of a community or family results in alcohol use by a mother during her pregnancy.<sup>83</sup> FASD is an umbrella term describing the range of effects that can occur in an individual whose mother consumed alcohol during pregnancy. These effects may include physical, mental, behavioral and learning disabilities with lifelong implications for the affected person, the mother, the family and the community.

There are no national statistics on the rates of FASD in Canada, although studies have estimated its prevalence in small populations. Alcohol intake, especially binge drinking during pregnancy, appears to be much more common for First Nation women. In northeast Manitoba, an incidence of 7.2 per 1000 live births was found.<sup>84</sup> Another study on a First Nations reserve in Manitoba reported an alcohol related birth defects rate of 100 per 1000 live births, compared to a world wide incidence estimate of 2 per 1000 births.<sup>85</sup> In another Manitoba study in a First Nation community, the prevalence of FAS and partial FAS was disturbingly estimated as high as 55-101 per 1000.

#### *Recent Efforts*

The challenges for prevention and diagnosis of FASD and intervention to assist those affected by this disorder are evolving and dynamic. A number of programs aimed at prevention are established in Manitoba.

1) In 1999, Health Canada’s First Nations and Inuit Health Branch (FNIHB), in partnership with the Assembly of First Nations, launched the FAS/E Initiative with the

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<sup>83</sup> Health Canada. (2003) *Fetal Alcohol Spectrum Disorder (FASD) Program Guidelines*. Ottawa: Minister of Health

<sup>84</sup> Williams RJ, Odaibo FS, McGee JM.(1999) Incidence of fetal alcohol syndrome in northeastern Manitoba. *Can J Public Health* 1999; 90(3):192-4.

<sup>85</sup> (MB May 2003)

goal to raise awareness about how an unborn baby's health could be affected if its mother drinks alcohol when she is pregnant. Expanded under the Early Childhood Development Strategy announced in 2002, the initiative is now called the Fetal Alcohol Spectrum Disorder (FASD) Program with an annual budget of \$16.7 million. The FASD program, developed with advice from experts on FASD, First Nations and Inuit persons with experience of this issue at the community level, has two goals: prevention - to reduce the number of babies born with FASD; and intervention - to help make life better for children with FASD and their families. The program recognizes that every community is different - with different strengths, different levels of knowledge, different access to services, so communities can choose the kinds of activities they think will work best for them. Two types of funding - capacity building and pilot program - facilitate activities that: support parents, families and caregivers of children with FASD; help those who may be at risk of having a baby with FASD; help to identify, assess, and diagnose children with FASD; and provide education and training about FASD.<sup>86</sup>

2) Healthy Child Manitoba (HCM) has prioritized both the prevention of FASD and provision of supports for individuals and families affected by FASD. Working with community partners, a cornerstone of the prevention strategy is the Stop FAS Program, a one-on-one mentoring program to encourage high-risk women to stop drinking during pregnancy.<sup>87</sup>

3) Also in cooperation with community partners, HCM provides information to families, communities, educators and health professionals and helps develop programs at the community level.<sup>88</sup>

4) Along with Health Canada, Healthy Child Manitoba, funds FAS Information Manitoba (1-899-877-0050), a toll-free line for families and professionals who want information on FASD.<sup>89</sup>

Survey data suggests that the number of women, including First Nations women who report drinking during pregnancy has decreased. In the Fall 2002 Survey of First Nations People Living on Reserve, 53% of respondents said that cutting down or stopping alcohol use was important for women to have a healthy baby.

### **3.7.1 Recommendations**

- That improved access to diagnostic services be made a priority, and
- that health professionals be given specialized training to provide services specifically targeting the unique needs of each individual and family in a culturally sensitive manner using appropriate language.

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<sup>86</sup> Health Canada. (2003) *Fetal Alcohol Spectrum Disorder (FASD) Program Guidelines*. Ottawa: Minister of Health

<sup>87</sup> Healthy Child Manitoba (2004) *Programs and Services*. Manitoba: Minister of Health

<sup>88</sup> Ibid

<sup>89</sup> Ibid

### 3.8 Mental Health and Addiction Services

In First Nations communities across Manitoba today, there is an acute awareness about the urgent need to address mental health problems and issues in the light of high rates of suicide, family violence, mental illnesses, and substance abuse.

Mental health is an area that First Nations people agree lacks services and sufficient funding.<sup>90</sup> Readers interested in the topic of mental health should refer to the 2003 study on Manitoba First Nations mental health services conducted by the Centre for Aboriginal Health Research.<sup>91</sup> The main problem identified is that the current system appears to force communities and professionals to respond to bureaucratic needs instead of structuring itself to fit the needs of individuals, professionals, and communities. Another conclusion is that FNIHB Manitoba Region requires a clear programmatic definition on its scope of responsibility in mental health services, as well as a clear definition of the scope of the mental health continuum and required linkages with other agencies and health programs. Again, socio-economic determinants impact mental health – poor living conditions combined with childhood antecedents, grief from suicides of family members and friends, drug and alcohol abuse, and relationship difficulties.<sup>92</sup>

Alcohol and other drug abuse are other major health issues and symptoms of the continuing and complex issues related to the psycho-social health and wellness of First Nation individuals and communities. The level of alcohol and substance and solvent abuse is disproportionately high among both on and off-reserve First Nations populations.<sup>93</sup> This health issue is a priority for First Nation people in Manitoba and current strategies include a number of community treatment centers as well as community based prevention programs.<sup>94</sup>

The Hollow Water Community Healing program is considered a ‘best practices’ model in contemporary blending of tradition and modern healing approaches. The Hollow Water program is revolutionary for several reasons: the program successfully maintains a deeply rooted sense of the individual in connection with the complex dynamic that makes up the self-family-community triad; and the program successfully facilitates and ensures that both victim and victimizer proceeds at their own pace in learning accountability to self, family and community.

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<sup>90</sup> Lavoie JG, Sanderson L, Elias B, et al. (2004) *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report, Draft*. Winnipeg, Centre for Aboriginal Health Research

<sup>91</sup> Mignone, J, O’Neil JD, Wilkie C. (2003) *Mental Health Services Review First Nations and Inuit Health Branch Manitoba Region*. Winnipeg, Centre for Aboriginal Health Research

<sup>92</sup> Brown I. *Mental Health Programs and Projects*. National Indian and Inuit Community Health Representatives Organization Website at <http://www.niichro.com/mental%20health>

<sup>93</sup> Centre for Aboriginal Health Research. (1998) *Manitoba First Nations Regional Health Survey Final Report*. Winnipeg: CAHR.

<sup>94</sup> Ibid

### 3.8.1 Gambling Addiction

Problem gambling is emerging as a serious mental health issue within the Manitoba First Nations community and many gambling opportunities now exist – casinos, electronic gambling machines (VLTs), lotteries, and bingos. Again, one of the limitations is resources to address the issue. It has been determined that gambling addiction requires special therapeutic interventions and while FNIHB has an addictions program, gambling addiction is not recognized.<sup>95</sup>

Although growth is seen in problem gambling research, very few studies have focused on problem gambling in relation to poverty, isolation and cross addictions among Aboriginal peoples.<sup>96</sup> One study compared the active gambling behaviors of American Indian adults, living on or near a reservation with those of non-Indian adults adjacent to or within the reservation. Results indicate that a variety of factors including economic status, unemployment, increased alcohol use, depression, historical trauma, and lack of social alternatives may predispose American Indian adults to greater problematic and pathological gambling behaviors.<sup>97</sup> In North America Aboriginal adolescents have higher rates of problem gambling, as do Aboriginal adults for both problem and pathological gambling than their non-Aboriginal counterparts. The Aboriginal population has a problem gambling behavior rate 2.2 to 15.69 times higher than the non-Aboriginal population.<sup>98</sup>

In 2001, the Addictions Foundation of Manitoba (AFM) conducted a study on problem gambling in Manitoba which included a cross-section sample population within the province, including First Nations people.<sup>99</sup> The sample size was 4,500 high school students and 3,000 adults. Findings specific to First Nations included:

- First Nations people gamble at a much higher rate than non First Nations, and when they do gamble they are also spending much more money than non First Nations.
- First Nations people were also more likely to have kids in the home, and their unemployment rate was also much higher than non First Nations (18.8% of the First Nations people were unemployed, compared with 2.6% of non First Nations).
- First Nations are more likely to play slots (25.6% vs. 17.7%) and those who play are much more likely to spend over \$100 monthly (52.2% vs. 12.5%).

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<sup>95</sup> Lavoie JG, Sanderson L, Elias B, et al. (2004) *The Evaluation of the First Nations and Inuit Health Transfer Policy: Final Report, Draft*. Winnipeg, Centre for Aboriginal Health Research

<sup>96</sup> Odawa Native Friendship Centre. *Program information: Aboriginal Responsible Gambling Research Project*. Ottawa, available online at <http://www.odawa.on.ca/programs/argrp.htm>

<sup>97</sup> Zitzow, D (1996) *Comparative study of problematic gambling behaviors between American Indian and non-Indian adults in a northern plains reservation*. American Indian Alaska Native Mental Health Research, 7(2):27-41

<sup>98</sup> Wardman, d, el-Guebaly N. Hodgins D. (2001) *Problem and pathological gambling in North American Aboriginal populations: a review of the empirical literature*. Gambling Studies J. Summer; 17(2):81-100.

<sup>99</sup> Patton D, Brown D, Dhaliwal J, et al. (2001) *Gambling Involvement and Problem Gambling in Manitoba*. Winnipeg, Addictions Foundation of Manitoba

One of the general findings was that 7% of youth said they had moderate or serious problems resulting from involvement of other family members in gambling. Given the findings of a higher prevalence of gambling within the First Nations populations, one of the questions is – To what extent do First Nations youth in Manitoba have problems associated with gambling?

### **3.8.2 Recommendations for Mental Health and Addiction Services**

- That mental health issues be addressed in a holistic manner and not seen as a problem separate from the other aspects of an individual's life
- That the following areas be examined to identify gaps, areas of jurisdictional debate and emerging trends and issues:
  - Out-patient mental health and addictions assessment and treatment;
  - In-patient psychiatric treatment;
  - In-patient addictions treatment;
  - Crisis services (telephone, mobile crisis, crisis stabilization, etc.);
  - Self-help; and,
  - Mental health promotion.
- That a gambling study specific to Manitoba First Nations be conducted with a focus on youth.
- That lobbying efforts continue to address policy and service gap in the area of First Nations gambling addictions.

## **3.9 Oral Health**

### **3.9.1 Links to Overall Health**

Oral health is integral to general health and is essential to the overall health and wellbeing of all individuals. (Oral health, however, means more than healthy teeth and includes gums and supporting tissue, the hard and soft palate, the mucosal lining of the mouth and throat, the tongue, the lips, the salivary glands, the chewing muscles and the jaw.) Periodontal diseases have been linked to a variety of conditions with systemic implications – cardiovascular diseases, stroke, diabetes, osteoporosis, HIV/AIDS, and adverse pregnancy outcomes (premature birth).<sup>100</sup>

### **3.9.2 Dental services for Aboriginal people**

Although dental health varied for Aboriginal groups, historically, poor dental health is a serious problem among Canada's Aboriginal population in the modern era, deteriorating in the latter half of the 20th century, as diets changed. Recent research clearly identifies

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<sup>100</sup> National Aboriginal Health Organization (NAHO). (2003) *The Profession of Dental Therapy Discussion Paper*. Ottawa: NAHO.



serious ongoing dental health problems and profound and consequential disparities in the oral health among all the Aboriginal populations of Canada, including First Nations in Manitoba.<sup>101</sup> Those at risk further jeopardize their overall health when oral health is neglected due to socioeconomic factors, physical disability or a lack of understanding and awareness of the importance of oral health. Several recent studies point to high rates of tooth decay among children, even those who had seen a dentist. The 1997 First Nations and Inuit Regional Health Survey found that 48 % of adults said they needed some dental care.<sup>102</sup> This proportion did not vary with community size, location (remote or not), or whether respondents lived in a community with a transfer agreement.

### 3.9.3 Prevention

Both the Canadian Dental Association and the AFN also point to Health Canada's failure to address prevention in dental health. A number of studies conclude that prevention is important and that in isolation from preventive services, treatment alone has been insufficient to control ongoing dental decay.<sup>103</sup> Prevention is increasingly important in policy thrusts. In 1998/1999, Health Canada funded five First Nations communities to implement water fluoridation systems including Tataskweyak in Manitoba. In 1999/2000, three Manitoba communities received further funding for fluoridation including Sandy Bay and Opaskweyak.

#### *Recent Efforts*

1) Baby tooth decay, affecting a disproportionate number of First Nation children, significantly impacts quality of life for these children and their families. More importantly, however, the effects of poor oral health also have the potential to extend to other facets of life. The serious problem of early tooth decay in babies and young children was the focus of an 18-month, \$260,000 Dental Health Promotion demonstration project announced in 2002 by the Manitoba Government along with other partners including the Winnipeg Regional Health Authority; Burntwood Regional Health Authority; the Children's Hospital Foundation; and Health Canada (the First Nations and Inuit Health Branch).<sup>104</sup>

2) The Manitoba Collaborative Project for the Prevention of Early Childhood Tooth Decay has been using an inter-sectoral and community development approach to guide oral health promotion in four Manitoba First Nation communities.<sup>105</sup> The partners, including representatives from St. Theresa Point First Nation, have developed educational material that is culturally relevant and focuses on the prevention of tooth decay in infants and very young children. It is recognized that the ultimate challenge will be in sustaining long term behavioral change among parents, caregivers and the community at large.

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<sup>101</sup> Lance/Times (December 5, 2004) *Study focuses on aboriginal diabetes sufferers*. Winnipeg: The Lance/Times

<sup>102</sup> Centre for Aboriginal Health Research. (1998) *Manitoba First Nations Regional Health Survey Final Report*. Winnipeg: CAHR

<sup>103</sup> Ibid, 15

<sup>104</sup> Ibid, 16

<sup>105</sup> Ibid, 16

3) The Manitoba government has also begun an Oral Health Initiative aimed at improving dental health through better access to care. The goals are to promote dental and oral health and prevent dental and oral disease. Goals are achieved through pre/post natal, school health, community education, and promotion programs and consultation with health care providers. Programs include instruction in personal oral hygiene, nutrition and feeding injury prevention, tobacco use reduction, and maximizing the benefit of fluoride use.

### **3.9.4 Gap / Barrier**

As recently as 25 years ago, there were few dental services for people living in remote locations and access to all dental services continues to be a problem. Federal expenditures for dental services increased through the NIHB dental health program through the 1990s up until 1996, when ceilings/caps were placed on the frequency of certain dental services. Other problems identified with the program include that the utilization of the NIHB dental health program dropped from 43 % in 2000 to 39 % in 2001.<sup>106</sup> In 2002, the Canadian Dental Association (CDA) and the AFN criticized the NIHB dental health program for its failure to guarantee equal access to dental care; increasing numbers of dentists are dropping out of the plan and asking for payment up front, which many Aboriginal people cannot afford. According to Dr. Tom Breneman, many Inuit and status Indians have stopped going to the dentist as a result.<sup>107</sup>

### **3.9.5 Recommendation**

That oral health be integrated into the overall First Nations health strategy.

The basis for this recommendation is that dental and oral disease and injuries are almost entirely preventable if education and promotion programs are provided and access to care services is readily available. Also, early identification of oral disease may contribute to the early diagnosis and treatment for a number of systemic diseases.

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<sup>106</sup> National Aboriginal Health Organization (2003) *The Profession of Dental Therapy: Discussion Paper*. Ottawa, NAHO, 14

<sup>107</sup> Ibid

## ***Section 4: Community Service Gaps, Policy, and Funding***

### **4.1 Community Service Gaps**

One of the conclusions of this report is that making generalized statements about gaps in service in First Nation communities is not appropriate. Gaps vary from community to community. Community health plans provide some insight, however, to fully appreciate gaps and barriers in any meaningful way, one has to examine each community with particular attention to unique factors which contribute e.g. relationship with RHA, history and nature of funding arrangements with INAC and FNIHB, staff competency, First Nation community's financial stability, and remoteness. Following are some of the more common gaps identified by Tribal Council health directors:

- Diabetes care and prevention
- Professional service providers
- Elder services
- Quality housing and infrastructure
- Employment services
- Foot care
- Dialysis
- Funding for dietician services
- Ophthalmologist (eye care) services
- Ambulance services
- Children's special medical services
- Community environmental health officers
- Education services
- Professional development funding (staff)
- Family support, including counseling
- Communication between programs

#### *Other Findings*

Although the government of Canada is seen as having primary responsibility to address these gaps, so too are the governments of First Nations and Manitoba perceived as having responsibility. It is believed that Governments must start looking at health issues in a holistic fashion. For instance, if a person affected with complications as result of diabetes were to move to an urban area to receive treatment, there would also likely be a need to access services outside the jurisdiction of health and these could include justice, social and education. All required services are under varying jurisdictions however, linkage is vital for providing service in a more comprehensive manner.

Despite limited services and funding, communities want to be and are involved in health. People are very resilient. For example, although there is minimal support and funding for children with special medical needs, families do with what they have.

Unfortunately, this often results in a lot of hassles with various jurisdictions and added to this problem, people do not push for their right to care, e.g. foot care.

## 4.2 Role of Regional Health Authorities

The role and responsibilities of Regional Health Authorities (RHA) vis-à-vis First Nations needs to be clarified. As discussed in Section 2: An Overview of Manitoba Situation on the topic of jurisdiction, one of the barriers to the provision of health services to First Nations people arises from having two jurisdictions involved. Under the Canada Health Act, the Manitoba government is required to provide insured services (i.e. medically necessary hospital and physician services) to all insured persons covered by its provincial health insurance plan, including First Nations, both on and off reserve. The Manitoba government interprets the Canada Health Act to state that the federal government is responsible for certain non-CHA health services to First Nations people who are Status Indians under the Indian Act. As a result, some health services not covered by the Canada Health Act but otherwise provided by the province through the RHAs are not provided to First Nations communities – for example, mental health, prevention of illness, promotion of health, residential care and support services for the elderly and disabled. The following is a discussion on some of the issues associated with the role of RHAs.

The Regional Health Authorities Act<sup>108</sup> states that RHAs have a “responsibility for providing for the delivery of and administering health services in specified geographic areas”. The RHA Act also states: “This Act shall be administered in a manner that complies with section 7 of the *Canada Health Act*, which sets out the criteria of comprehensiveness, universality, portability, accessibility and public administration...”. A map of the RHA regions is included as Appendix E and Table 8 identifies the health services listed in the RHA Act.

**Table 8: Health Services Listed In the RHA Act**

<ul style="list-style-type: none"> <li>✓ community health services</li> <li>✓ emergency medical response services</li> <li>✓ home care services</li> <li>✓ hospital services</li> <li>✓ medical services</li> <li>✓ medical laboratory services</li> <li>✓ mental health services</li> </ul>	<ul style="list-style-type: none"> <li>✓ nursing services</li> <li>✓ personal care services</li> <li>✓ provision of drugs, medical supplies and surgical supplies</li> <li>✓ public health services</li> <li>✓ diagnostic imaging services</li> <li>✓ other goods and services</li> </ul>
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<sup>108</sup> The Regional Health Authorities Act, Assented to November 19, 1996 is available online at <http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php>

Section 23 (2) of the Regional Health Authorities Act elaborates on the duties of RHAs. The most relevant to this discussion is that RHAs shall "...ensure that the prescribed health services are provided or made available."

Based on discussions with key informants, a review of minutes from a 2004 meeting on the Role of First Nation People and Regional Health Authorities<sup>109</sup> and a brief review of the content of RHA websites, it appears, however, that RHA involvement with First Nation communities varies across the province – from very low involvement to high involvement. On one website, it was striking to note the RHA acknowledges that a number of First Nations are included in its region, yet, there is no indication of active engagement with First Nation communities.

The situation of overlapping jurisdictions often results in confusion. For example, First Nations leaders sometimes give mixed messages on health issues creating confusion for their staff regarding their working relationship with RHAs. In one case a First Nation gave a (political) message to the Manitoba Government that it wanted nothing to do with the RHA. Yet, in practice, First Nations staff members were asked to attend RHA meetings. One suggestion is that First Nations must make clear decisions in terms of their involvement with RHAs. The Island Lake Tribal Council (ILTC) is an example whereby the leadership appears to be providing a somewhat consistent message to the Manitoba Government on the limited relationship it wishes to have with the RHA in its area. One reason for the ILTC decision to limit its involvement with the RHA is its long term aspiration for its own health authority to be recognized by the Manitoba Government.

For exploratory purposes, a few Tribal Council and First Nations health technicians were asked to rate progress made by RHAs on their Aboriginal deliverables<sup>110</sup> in their area. Responses were mixed, ranging from negative (not satisfied at all) to positive (very satisfied) with the other responses in between (satisfied). Success factors appear to be related to management style and attitude of RHA officials and interpersonal relationships cultivated over time.

### **4.3 First Nations Concerns**

Following are specific comments and issues identified in interviews with Tribal Council health directors. In some cases, the comment or issue applies to one Tribal Council area and, in other cases, the comment or issue applies to two or more Tribal Council areas.

- Lack of health services provided to First Nations by the Regional Health Authorities.

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<sup>109</sup> Minutes from meeting held in Winnipeg on the March 10 and 11, 2004 hosted by AMC and Manitoba Health. The theme was *Role of First Nation People and Regional Health Authorities*.

<sup>110</sup> According to the minutes of the meeting held in Winnipeg on the March 10 and 11, 2004 hosted by AMC and Manitoba Health, one of the Aboriginal Health deliverables from the 2003/2004 RHA performance agreements is a requirement for an action plan to engage Aboriginal groups in the development of a regional Aboriginal-specific Health Strategy.

- First Nations should have direct access to RHA services as their funding is allocated based on population for geographic area.
- RHA need to adopt First Nations needs assessment and strategic plans.
- RHA is starting to invite First Nations to meetings on some area issues e.g. physician recruitment and retention. First Nations, however, not involved in needs assessment and strategic planning.
- Need for more First Nation involvement in RHA planning activities. One RHA is involving First Nations in needs assessment, strategic planning, and accreditation. An advisory body with First Nation involvement is being established.
- First Nation participation on RHA boards has not been a positive experience but, it is changing. Some First Nation board members have resigned as First Nations concerns were not being addressed. Some positive movement e.g. Parkland RHA has started joint chairing of meetings.
- Need for increased First Nation representation on RHA board. Southeast Resource Development Council is advocating for representation based on population.
- Need for increased awareness on both sides. RHAs need to be aware of services and issues on reserve and First Nations need to be aware of RHA services and issues.
- RHAs need to be aware of limitations in services available from health centers. This would assist in cases where follow-up treatment is required.
- Need to inform First Nations about RHA clinics and programs.
- Clientele of RHA is different than that of First Nations due to differences in demographics. For example, one RHA has a high number of retired/aged people, while First Nations in the RHA area have a young population.
- Some indication by RHA that they want to work in partnership; lines of communication are opening.
- First Nations leadership needs to make decisions i.e. should a Tribal Council or First Nation oversee portion of RHA funding for First Nations? Currently, First Nations have no decision making authority over RHAs. Need to explore co-management as an option.
- It would be useful for communities to develop an inventory of available health and social services in each community (include services from both RHA and FN Health Authority).

Some First Nations currently experiencing difficulties in accessing provincial RHA services are exploring their options on how best to proceed. An example is Keeseekoowenin First Nation, which has been significantly impacted by a recent reduction in services at the Erickson Hospital. Out of frustration, necessity, and concern for the needs of its community members, the Keeseekoowenin leadership has decided to

develop its own Primary Health Care Center based on its priorities and unique needs and consider elements of the Primary Health Care model which the Manitoba Government financially supports in five non-First Nation communities.<sup>111</sup>

NOTE: Caution is advised in interpreting findings from this review as it is exploratory in nature and does not include the RHA perspective. RHAs have their own challenges. For example, while RHAs are responsible for delivering health services according to the needs of their populations, their budgets are almost completely determined by government and their performance targets are set by government.<sup>112</sup> A more rigorous, in-depth study which is broader in scope is needed to clarify issues between First Nations and RHAs.

#### **4.3.1 Recommendations**

- That the Manitoba Government clarify the role of Regional Health Authorities vis-à-vis First Nation communities. This option will facilitate the working relationship between RHAs, First Nations, and FNIHB. First Nations leaders also need to clarify direction to their staff in relation to working with RHAs.
- One Tribal Council health director emphasizes the need for RHAs and First Nations to work together. There is a need for the First Nations to list unresolved issues and to prioritize, then work together with RHA on long term – mid term – and short term goals.
- There is a need for First Nations, the Manitoba Government and RHAs to review RHA areas where little progress is being made and to discuss how best to proceed.
- Where there is a long established working relationship with First Nations, consideration should be given for the joint management of the RHA.
- First Nation RHAs be established under the RHA Act where there is a need.

#### **4.4 Non Insured Health Benefits (NIHB)**

One of the most contentious issues in the Manitoba First Nations health service system relates to the policy and administration of FNIHB's Non Insured Health Benefits (NIHB) program. The First Nations perspective is that FNIHB unilaterally imposes policy changes without consideration of client needs. FNIHB's perspective is that its responsibility is to administer the program in accordance with national standards. This includes having to change regional policy and practices so that Manitoba is brought in line with the national policy.

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<sup>111</sup> Interview with James Bone, Health Director, Keeseekoowenin First Nation. James was referring to the five new primary health care centers announced by Manitoba Health to be located in The Pas, Flin Flon, Waterhen, Camperville and Riverton which will provide a wide range of health care services including primary health care, mental health services, health promotion, prevention, and education programs.

<sup>112</sup> The Standing Senate Committee on Social Affairs, Science and Technology (SSCSAST) (2002) *The Health of Canadians – The Federal Role: Final report on the state of the health care system in Canada*. Ottawa: SSCSAST, 68

Benefits provided under the NIHB program include prescription drugs, medical transportation, dental care, medical supplies and equipment, vision care, provincial health care premiums and crisis mental health counseling.

Examples of First Nations comments regarding their dissatisfaction with the NIHB program include:

- policy changes are unilaterally imposed;
- lack of First Nations involvement in policy development and budget preparation;
- budgets are not based on need;
- FNIHB continues to cut drugs, dental, and optometrist services;
- need a fair appeal mechanism;
- no incentive for effective management;
- investment in prevention could reduce NIHB expenditures;
- FNIHB continues to determine funding based on most cost efficient means rather than needs; and
- change will come only once FNIHB recognizes that FNIHB and First Nations can and must work jointly to address needs.

#### **4.4.1 Recommendation**

That FNIHB and First Nations undertake to develop jointly a new regional policy and procedures manual for Non Insured Health Benefits.

This would provide administrators (First Nations and FNIHB) with needed clarity and promote mutual understanding of regional policies and procedures for the program.

#### **4.5 Duplication of Services**

The literature does not directly address duplication within the realm of health and social service systems. Instead the focus appears to be on the need to improve efficiency of the systems. For example, in September 2001, at the annual general meeting of the Canadian Chamber of Commerce in Winnipeg, Roy Romanow stated: “There are many features of a successful business that could improve our health care system, such as ...cutting out waste and inefficiency”.<sup>113</sup> Although the Romanow report provides general examples of inefficiencies in areas such as hospitals, physician services and data collection, it cites very few clear or concrete examples on duplication. Despite this, Romanow does make a convincing argument on the potential cost saving benefits in reorganizing and integrating service delivery. To that end, a 2002 Senate Committee report recommends the introduction of incentives to deliver, manage and use health services more efficiently.<sup>114</sup>

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<sup>113</sup> Health Canada Media Release ( September 2001) *Medicare Is The Business Of All Canadians, Romanow Tells Canadian Chamber of Commerce*, available online at <http://www.hcsc.gc.ca/english/care/romanow/hcc0142.html>

<sup>114</sup> The Standing Senate Committee on Social Affairs, Science and Technology (2002) *The Health of Canadians – The Federal Role, Interim Report Volume Five: Principles and Recommendations for Reform - Part I*, Ottawa, SSCSAST, 14



The consequences of having two jurisdictions involved in delivering health services include program fragmentation, problems with coordinating programs and reporting mechanisms, inconsistencies, gaps, possible overlaps in programs, lack of integration, the inability to rationalize services, and impediments to developing a holistic approach to health and wellness.<sup>115</sup>

Most involved with the mainstream health and social service system can probably give examples of duplication and inefficiencies. Interviews with First Nations, federal, and provincial representatives make it clear that efficiencies can also be found within the First Nations systems. What seems to be missing, in many cases, is an incentive for change to occur. For example, technicians from a Tribal Council presented a report which showed that, under a pilot project, they were able to reduce NIHB medical transportation costs through a reduction in rates and a mix of delivery options.<sup>116</sup> Had the project continued, the Tribal Council could have used the savings for other health services. However, after the pilot project came to an end, according to information presented, the Tribal Council returned to the former arrangement in which it was reimbursed for actual approved expenses, and there was no incentive for the Tribal Council to continue with cost containment measures.

#### **4.5.1 Recommendation**

That the federal and provincial governments build incentives into their programs to reward effective and efficient management

#### **4.6 Changes in Funding Policy and Practices which Impact Other Levels of Government**

There is a continuing trend of changes in policy and practices by federal and provincial departments in Manitoba, without appropriate notice or discussion with the parties affected. Recent media examples are:

1) *The 2004 decision by FNIHB to change its funding practice for medical transportation of patients.* According to Manitoba Minister Tim Sale, this was a unilateral decision, without any negotiation, which will result in an additional \$10 million expense this year for the Manitoba Government. Provincial officials further stated they didn't receive a proper explanation of why the policy in this province changed.<sup>117</sup>

2) *The January 2005 announcement by the Manitoba Government to increase Income Assistance northern allowance rates by an additional 20 %.* The increase is for

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<sup>115</sup> The Standing Senate Committee on Social Affairs, Science and Technology (2002) *The Health of Canadians – The Federal Role, Interim Report Volume Two: Current Trends and Future Challenges*, Ottawa, SSCSAST, 69

<sup>116</sup> Optima Aboriginal Affairs Group (May 2001) *Draft Final Report AMA Interlake Evaluation of Pilot Project*, 20

<sup>117</sup> Winnipeg Free Press, Online Edition. Tuesday, January 18, 2005

households with low incomes in northern and remote communities.<sup>118</sup> The new rate took effect February 1, 2005. The INAC policy is to fund the First Nations Income Assistance Program according to the same basic rates as the province. INAC became aware of the province's intention to increase the rates after reviewing the Provincial Speech from the Throne. The province did not notify INAC of the substance of the increase until one week before the effective date, February 1, 2005. There wasn't much time for INAC and First Nations to adjust to the change. The additional funding requirement for INAC is approximately an additional \$6 million a year. Should INAC Headquarters decide not to adjust INAC's base budget for this increase, it could have implications for INAC, Manitoba Region's funding in other areas.<sup>119</sup>

#### **4.6.1 Recommendation**

That some type of protocol be established to provide appropriate notice and discussion, prior to a change in policy or practice thereby minimizing any negative impacts, and that senior officials consider establishing a small Working Group to recommend a protocol.

This recommendation is intended to meet the need for increased dialogue by the stakeholders involved in funding and policy decisions which impact other parties.

#### **4.7 Gap in First Nations Health and Social Policy Coordination**

An issue which is virtually ignored in the literature is the lack of effective policy coordination in the area First Nations health and social services. Off reserve, an important feature of the Manitoba Government's health care strategy is policy coordination between departments. On reserve, coordination of health and social service policy is almost impossible given the context of fragmented jurisdictions and multiple departments involved. Coordination is further complicated by the fact that the federal government itself has not integrated its programs, even within ministries, and has not demonstrated a commitment to integration.<sup>120</sup> There is little on the horizon which suggests that things will change in the near future.

One of the roles of Manitoba Health is to advocate, educate, and work with other provincial departments to ensure coordination of resources, activities, and policies. For example, in the off reserve context, should Manitoba Health conclude there is a need for a policy changes in four program areas – CFS, Income Assistance, Housing (all Family Services and Housing programs) and Home Care – a program delivered by Manitoba's Regional Health Authorities in order to further Manitoba's Health agenda, it can pursue the policy change with its sister department, namely, the Manitoba Department of Family Services and Housing. Combined, these two provincial departments have the necessary program, policy, and funding mandate to revise or introduce new Family Services,

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<sup>118</sup> Manitoba News Release available online at <http://www.gov.mb.ca/chc/press/top/2005/01/2005-01-26-02.html>

<sup>119</sup> Discussion with Patti Skillen, Senior Negotiator / Policy Analyst, INAC, Manitoba Region

<sup>120</sup> Lemchuck-Favel, L (2003) *Integration of Continuing Care in First Nations Communities: A Draft Model for Discussion*, Ottawa, Assembly of First Nations, 29

Income Support, Housing, and Home Care policies and regulations. Manitoba's Regional Health Authorities would be included in this collaboration as the RHAs are responsible for home care service planning, delivery and accountability in each of the Regions. As both these departments are under the umbrella of the Manitoba Government it is likely that the interest of each in coordinated policies is similar. In this context, there is a better chance for cooperation and therefore more effective policy coordination.

On reserve health policy coordination is much more complex. In a similar scenario where Chief and Council conclude there is a need for policy change in the same four program areas – CFS, Income Assistance, Home Care and Housing, it is much more complicated. The complexity is that the health policy change would involve multiple jurisdictions and competing needs and interests. To change the policy on reserve, the First Nation would have to involve one provincial department (Family Services and Housing) and possibly three federal departments [INAC for Income Assistance policy, HC (FNIHB) – for Home Care Policy, and CMHC, for housing]. The major disadvantage of First Nation policy change is that the First Nation likely would have little influence as it does not have control over the programs involved, the policy or the funding. First Nations which are block funded by INAC would have less difficulty as they have authority for policy decisions in housing, Income Assistance and homemaker services. The First Nation's ability to change their home care policy in the scenario discussed would depend on the flexibility they have through their funding arrangement with FNIHB. Regardless of the type of funding arrangement a First Nations has with either INAC or FNIHB, however, they would need to consult with the Manitoba Government on the CFS aspect of the proposed policy change.

#### **4.7.1 Recommendation**

It is suggested that the need for policy coordination be considered in the development of a broader regional plan for First Nations to assume greater control and authority over health and social programs. An option is discussed in section 8.

## **Section 5: Health Human Resources**

### **5.1 Health Human Resources / Community Capacity**

There is a critical need to develop a First Nations Health Human Resource (HHR) strategy in Manitoba. This section is intended to complement the HHR work-in-progress by the Manitoba Intergovernmental Committee on First Nations Health. Views on HHR issues from the perspective of Tribal Council health technicians are included.

### **5.2 The National Picture**

A 2002 Canadian Senate Committee report states "...addressing the supply of professionals in all health care disciplines and finding ways to increase their individual and collective productivity are two of the most pressing yet complex problems facing health care policy makers."<sup>121</sup> Prior to this, RCAP recommended that governments and educational institutions undertake to train 10,000 Aboriginal people in health including professional and managerial roles, over the next decade.<sup>122</sup>

Very little information is available regarding the number of Aboriginal health care professionals.<sup>123</sup> For example, the number of Aboriginal traditional healers, midwives and Elder advisers is not known.<sup>124</sup> RCAP notes that those numbers are not likely to rise fast enough to meet the demand for services, in light of the resurgence of interest for Aboriginal people to access this option of health care. This also implies the need for exploring the demand for training and/or apprenticeship programs.<sup>125</sup>

### **5.3 Northern Manitoba – Aboriginal Issues**

A 2003 Manitoba Health discussion paper on programs and services to residents of northern Aboriginal and other remote communities confirms that difficulty in recruiting and retaining health care providers has resulted in a serious shortage of health care providers.<sup>126</sup> Factors which contribute to Manitoba Health's difficulty in recruitment and retention include:

- difficulty in maintaining competitive remuneration levels;
- shortage of residents from the communities who have the requisite education or qualifications to enter professional training programs;
- professional competency factors;

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<sup>121</sup> The Standing Senate Committee on Social Affairs, Science and Technology (SSCSAST) (2002) *The Health of Canadians – The Federal Role: Final report on the state of the health care system in Canada*. Ottawa, SSCSAST, 185

<sup>122</sup> *Report of the Royal Commission on Aboriginal Peoples*, (RCAP) (1996) Volume 3, Gathering Strength. Ottawa, 265

<sup>123</sup> Downey, B. (2003) *Aboriginal Health Human Resources "A Pillar for the Future"*, Draft. Ottawa, National Aboriginal Health Organization, 4 [www.naho.ca](http://www.naho.ca)

<sup>124</sup> *Ibid*, 6

<sup>125</sup> RCAP, 290

<sup>126</sup> Manitoba (2003) *The Delivery of Health Programs and Services to Northern Residents with an Emphasis on Aboriginal and Other Remote Communities*. Winnipeg, Manitoba Health, 11

- attaining and maintaining required /appropriate competencies;
- lifestyle considerations;
- remoteness;
- cultural differences;
- social, personal and professional isolation;
- lack of supports / backup in the community (e.g. relentless on-call); and
- inadequate infrastructure (e.g., housing).

In Manitoba, there are currently more Aboriginal physicians, nurses and health care providers than ever before. Often, these people would like to go back to communities after they have finished their professional training but find that salaries are neither adequate nor competitive enough to make this a viable or attractive option.<sup>127</sup>

#### **5.4 Community Issues**

Critical issues identified in interviews with Tribal Council health directors include:

- funding for health career promotions;
- lack of training and support for community-based health staff, e.g. BFI, BHC, CHR;
- lack of funding to address barriers to retention of nurses;
- improved housing and services needed to retain staff in communities;
- adequate funding to ensure competitive salaries and benefits;
- improved support services for community nurses;
- increased funding for tribal area nursing officer; and
- need a formula for number of nurses.

Tribal Councils are finding their own innovative approaches to address recruitment and retention issues. For example, Southeast Resource Development Council (SERDC) has organized a ‘meet and greet’ event to establish a working relationship with new doctors.

Inadequate funding creates complications in service delivery. Other funding pressures may influence a Tribal Council or First Nation to pay less for a position than the approved FNIHB funding. Case in point, a valuable staff member resigned due to inadequate salary. A strong message is necessary on the need to pay appropriate salaries.

Suggestions on ways to increase youth participation in health careers include:

- arrange for career symposiums;
- more support for students taking professional training;
- promoting health career day / fairs (2 to 3 a year in each community);
- health representatives having a higher profile in schools to create awareness on health careers;

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<sup>127</sup> Ibid, 12

- career counseling and Pathway to target health training; and
- introduce health issues at community schools.

No documentation is available which provides a clear picture of First Nations HHR needs in Manitoba. However, many First Nations and First Nations organizations have conducted needs assessments in conjunction with the FNIHB transfer process or for other purposes. Information from these assessments has been important for development of community health plans. This will also be critical information for development of a regional HHR strategic plan.

### **5.5 Need for Action on the Education Component of the Health Human Resource (HHR) Strategy**

There is consensus on the part of the Manitoba Government, the Government of Canada, and First Nations on the need for a First Nations HHR strategy. Many participants at the February 2005, multi-sectoral meeting on First Nations organized by the ICFNH highlighted the point that education is critical to the success of any HHR strategy. An issue is how to get First Nations people to the level of education necessary to meet the community demand for health care professionals.

### **5.6 Recommendations**

That the Education Component of the Health Human Resource Strategy be developed. This option is presented as a medium term strategy to address the inadequate supply of First Nations professionals in health disciplines. It is recommended that the AMC initiate a meeting of key stakeholders to begin discussions on an education strategy. A follow-up meeting of senior officials of relevant partners would identify resources required to implement the education strategy. As a first step it is recommended that the AMC initiate a meeting of key stakeholders of its choice to begin discussions on an education strategy. To make it manageable, AMC may want to consider inviting only a few of the stakeholders for the initial meeting. Some of the key stakeholders include:

- health representatives from AMC, MKIO, and SCO;
- Dr. Cathy Cook, Director Aboriginal Center for Education, University of Manitoba;
- University College of the North;
- Peter Nunoda, Director & Assistant Professor ACCESS Programs, University of Manitoba;
- Darrell Cole, Executive Director, Career Trek Inc.;
- Manitoba First Nations Education Resource Centre;
- education representative from Indian and Northern Affairs Canada;
- First Nations and Inuit Health Branch; and
- Health Canada.

That links be formed for the purpose of identifying and addressing issues and concerns that impact various Aboriginal professionals in health disciplines who are providing health care services to First Nations people in Manitoba; and,

Incorporate issues and recommendations identified by Tribal Council health directors into the regional HHR strategy.

## **Section 6: Promising Trends, Practices, and Partnerships**

### **6.1 Traditional Healing / Medicine**

Interviews with key informants suggest a number of positive forces converging in Manitoba resulting in increasing awareness, respect and use of Traditional Medicine as an alternative to Western medicine. Much more effort, however, is required to demystify traditional medicine and to create awareness for practices to be widely respected and accepted by a majority of First Nations people and mainstream health care professionals. Cooperative partnerships, information sharing and promotional activities are recommended as elements of a needed strategy.

What is Traditional Medicine? Terminology such as Elder, Healer, Traditional Healing, and Traditional Medicine provide a beginning for insight into the concept. Within the literature, the terms ‘Elder’ and ‘Healer’ are used interchangeably since traditional teachings are considered healing for the mind. ‘Elder’ is a term attached to traditional medicine that is discussed in a vague and inconsistent manner.<sup>128</sup> Elders are keepers of tradition, guardians of culture, wise people and teachers. While most of those who are wise in traditional ways are old, not all old people are elders, and not all elders are old.<sup>129</sup>

RCAP uses the term ‘healer’ to include a wide range of people whose skills, wisdom and understanding can play a part in restoring personal well-being and social balance, from specialists in the use of healing herbs, to traditional midwives, to elders whose life experience makes them effective counselors, to ceremonialists who treat physical, social, emotional and mental disorders by spiritual means.<sup>130</sup> The World Health Organization and related literature defines *Traditional Medicine* as the sum of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance, and relying on practical experience and observation handed down from generation to generation, whether verbally or in writing.<sup>131</sup>

*Traditional Healing* has been defined as practices, designed to promote mental, physical and spiritual well-being, that are based on beliefs dating back to the time before the spread of western ‘scientific’ bio-medicine. Traditional healing includes a wide range of activities, from physical cures using herbal medicines and other remedies, to the

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<sup>128</sup> Hill, DM, (2003) *Traditional Medicine in Contemporary Contexts Protecting and Respecting Indigenous Knowledge and Medicine*. Ottawa, NAHO, 13

<sup>129</sup> Ibid

<sup>130</sup> Report of RCAP, Appendix 3A: available online at [http://www.ainc-inac.gc.ca/ch/rcap/sg/sin3a\\_e.html](http://www.ainc-inac.gc.ca/ch/rcap/sg/sin3a_e.html)

<sup>131</sup> Report of RCAP, Appendix 3A



promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders.<sup>132</sup> Appendix F provides a brief description of the following specialized fields of practice within Traditional Medicine:

- Spiritualist
- Herbalist
- Diagnosis specialist
- Medicine man/woman
- Healer
- Midwife

Relevant research on this topic is the recent focus group study with Elders and healers by the National Aboriginal Health Organization (NAHO).<sup>133</sup> The study acknowledges that the children are no longer being taught by their grandparents and are therefore unable to respect Indigenous knowledge of medicines. Also, Elders and healers consider schools to be a primary place to begin teaching children healthy lifestyle habits and attitudes. The high rate of diabetes in children is a common concern and elders note that schools were often bringing in pizza, hot dogs and candy for sale as fund-raisers. Elders thought school is the place to learn good diet and traditional knowledge of medicines. Several grandmothers expressed concern about low self-esteem, suicide and self-destructive behavior that may be due to the lack of love and positive encouragement in the schools. One Elder suggested that elders be recruited as volunteers to work in schools as grandmothers to offer the children emotional and psychological support. She felt Elders were underutilized by educational and health systems. This would restore elders their traditional roles as mentors, offer them something positive to do and provide higher self esteem.

Another key theme to emerge from these consultations is the loss of Indigenous knowledge pedagogy of experiential learning and apprenticing with medicine people as helpers. The elders/healers said that they were losing valuable knowledge because of lack interest from youth in Indigenous knowledge or pursuing careers as medicine people. "...no one is interested in what we know, there is no way to pass it on"(Mi'kmaq healer: Nova Scotia).<sup>134</sup> It was suggested that schools could credit young people for apprenticing with Elders. NAHO's role could be to facilitate a data bank of students interested in traditional medicine and to match them with interested elders/healers.

## **6.2 Positive Trends Associated with Traditional Medicine**

### **6.2.1 New Midwifery Education Program**

In December, 2004, the Manitoba Government announced the establishment of the first Aboriginal Midwifery Education Program in Manitoba. This degree-based education program will be delivered by the University College of the North and will provide

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<sup>132</sup> Ibid, 7

<sup>133</sup> Ibid, 25-26

<sup>134</sup> Ibid, 27

students with a blend of Traditional Aboriginal and Western methods of practice. In 2005, ten students will be enrolled in the first year of the program with five students enrolled in each subsequent year. One of the benefits of midwifery care is provision of one-to-one care that helps teach women healthy living so they will give birth to healthy babies. When a healthy mother gives birth to a healthy baby with a normal birth weight that is breast-fed and provided with appropriate newborn care, the baby has a much greater chance of living a healthy life, thereby reducing costs to the health care system.<sup>135</sup> Although questions remain as to the degree to which the program will meet demand, the announcement is a positive start.

### **6.2.2 Increasing Recognition of Traditional Practices**

According to First Nations Health care representatives many people utilize both Traditional and Western Medicine.<sup>136</sup> It is the opinion of Laurel Gardiner, who worked a number of years as a nurse in a number of nursing stations in northern Manitoba, traditional healers sometimes provide better treatment than what nursing services located at Nursing Stations can offer – for example - treatment of diarrhoea and mouth ulcers.

### **6.2.3 Efforts in Northern Manitoba to Establish a Working Relationship Between Traditional Healers and Western Medicine**

In October 2004, the Northern Aboriginal Population Health and Wellness Institute (NAPHWI) held a workshop involving over 50 Traditional Healers. The purpose of the gathering was to respectfully determine from Traditional Healers, how they work in the community and how traditional healing practices and western medicine in the Burntwood Regional Health Authority (BRHA) can complement each other. Further meetings are planned.<sup>137</sup>

### **6.2.3 Traditional Healing Services Within Hospitals**

Traditional Healing clinics currently held twice a month at the Health Sciences Center (HSC) with Mark Thompson and Cathy Bird for in or out patients is an example of demand for such services. The HSC staff person who coordinates the appointments with the Healer says that this is a popular service and people have to book well in advance to be accommodated.

Sakoieta Widrick is the Spiritual/Cultural Care Coordinator, Aboriginal Health Services of the Winnipeg Regional Health Authority. In this capacity, he is responsible for coordinating spiritual care support to patients, including referral to traditional healers. Elder Widrick has participated in a number of meetings with his peers to discuss topics such as establishing an elders council and a code of ethics and is currently working on a discussion paper on these topics. This is consistent with National Aboriginal Health

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<sup>135</sup> Manitoba Government News Release available online at <http://www.gov.mb.ca/chc/press/top/2004/12/2004-12-13-02.html>

<sup>136</sup> Interviews with Manitoba First Nation and Tribal Council Health Directors

<sup>137</sup> Discussion with Cal Albright, NAPHWI

Organization (NAHO) recommendations that traditional healers and related practitioners develop means of self-regulation as well as discuss the need to develop and publish codes of conduct to govern their relations with Aboriginal clients, health authorities and governments, and with mainstream health practitioners and institutions.<sup>138</sup>

One of the NAHO findings of focus group consultations with Elders and healers is a need for active outreach by mainstream health professionals and their associations to initiate contact, demonstrate their respect for traditional practitioners, and show their willingness to take steps to sensitize their members and prospective members (students in professional training programs) to the value of traditional healing practices.<sup>139</sup>

### 6.2.5 Recommendations

- That opportunities for Elders in traditional teaching / mentorship / apprenticeship of young people are encouraged.  
This option would assist in ensuring that valuable knowledge of Elders is retained and passed on. Such activity could stimulate the interest of young people to pursue careers in traditional medicine.
- That Manitoba Health incorporate *Traditional Medicine Expectations* as a Deliverable for RHAs  
Although RHAs currently have deliverables which include engagement with First Nation communities, the recommendation is that an additional expectation be included regarding Traditional Medicine. Expectations such as establishing working relationships with Traditional healers or awareness initiatives should be considered.
- That a gathering be held in Manitoba with the view to build a bridge between traditional and western medicine.  
Discussions with First Nation health representatives, Elders and healers suggest a need for ongoing dialogue to bridge the gap between traditional and western medicine practitioners. There is a need to establish mutual respect, to share information, and to discuss areas of possible collaboration. It is recommended that a regional conference be organized with the view to share information and to explore how traditional and western medicine practitioners can work together into the future. The conference would involve health care providers and decision makers from both systems and be jointly sponsored and funded. Discussions with healers suggest they would be pleased to assist in organizing such an event.

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<sup>138</sup> Hill, DM, (2003) *Traditional Medicine in Contemporary Contexts Protecting and Respecting Indigenous Knowledge and Medicine*. Ottawa, NAHO

<sup>139</sup> Ibid

### **6.3 Telehealth**

Telehealth is the use of videoconferencing technology to link people to health care expertise at a distance. Individuals are able to see, hear and talk to the person at a distant site.<sup>140</sup> In other words, telehealth is a broad term used to include a wide array of technical applications, tools and processes but is generally defined as the use of information and communications technology to deliver health care, health education and health information over large and small distances. First Nations in Manitoba are vastly underserved by Telehealth services compared to other communities in the province. This is in part due to the challenges First Nations communities face such as capacity issues. Of the 21 locations listed on the Manitoba Telehealth website, only two are First Nations - Norway House and Berens River. In reality, however, there is only one First Nations site as the Berens River location was only operating on a pilot project basis, which although successful, has now terminated.

The biggest barrier to making progress in Telehealth is the lack of telecommunication infrastructure in First Nations communities. Although all First Nations in Manitoba have some form of connectivity, it is inadequate for Telehealth applications.<sup>141</sup> Slowly, through collaborative efforts, the connectivity gap appears to be closing. For example, negotiations are in the final stages of discussion on a tripartite Memorandum of Understanding (MOU) which should result in Telehealth access in the Keewatin Tribal Council (KTC) communities in the near future.<sup>142</sup> Appendix G highlights the planned new Telehealth sites in the KTC area. The partners include FNIH, MBTelehealth, and Keewatin Tribal Council (KTC). The objective is to provide assistance to KTC communities with services and support to delivery of health services through the MBHealth network. The benefits of Telehealth include improved access to quality health care and health education and reduced travel for patients and providers.

#### **6.3.1 Recommendation**

Given the many benefits of Telehealth, that ICFNH partners continue lobbying other partners interested in connectivity, such as those involved in Education, to form partnerships necessary to bring Manitoba First Nations into the 21st century of health care.

### **6.4 Residential School Healing Initiatives**

The Royal Commission on Aboriginal Peoples (1996) articulated the legacy of physical and sexual abuse at residential schools and strategies to bring about healing and growth for strong, health Aboriginal communities.<sup>143</sup> Many survivors are involved in their own

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<sup>140</sup> MBTelehealth presentation at Manitoba's Primary Health Care Conference on First Nations Health and Wellness in Winnipeg, March, 2005

<sup>141</sup> Discussion with Dr. Shannon McDonald, Medical Director, Community Wellness and Health Surveillance, Health Canada, First Nations Inuit Health Branch, March 4, 2005.

<sup>142</sup> Ibid

<sup>143</sup> The Commission (1996). Royal Commission on Aboriginal Peoples vol. 5. Ottawa, Canada.

healing journey and many and it is clear is that they benefit from additional supports available through the many healing initiatives available throughout the province.

As of January 2005, the Aboriginal Healing Foundation (AHF) had 43 active healing projects in Manitoba. To date, the AHF had provided 168 grants for healing projects in this province with a total contribution of \$48 million. A list of projects, project description and contacts is available at the AHF website at <http://www.ahf.ca>. A June 2003, evaluation report of AHF program activity is also available on their website.

Unfortunately, the \$350 million which was initially provided by the federal government has been committed. In February 2005, the federal government announced an additional \$40 million to extend some of the projects.

The Manitoba First Nation Education Resource Centre is actively working at incorporating some aspects of residential school issues into school curriculum.<sup>144</sup> This is a positive step, but more needs to be done in education to address the past legacy.

#### **6.4.1 Recommendations**

- That institutions involved in the education and training of health and social service professionals incorporate knowledge gained from healing research into their curriculum,
- that health and social service professionals who are already working in the system inform themselves on the history of residential schools and healing strategies to address intergenerational impacts, and
- as residential school projects contribute to the healing and health of First Nations of Manitoba, that the leadership of AMC, SCO, and MKIO maintain their lobbying efforts for continued federal support of healing initiatives.

#### **6.5 First Nations / INAC Income Assistance Policy Reform Project**

The bilateral initiative in Manitoba Region to develop a new policy and procedures manual for the INAC Income Assistance (IA) program is an excellent example of how a joint effort can bring about positive changes in a program affecting the lives of many First Nations people.<sup>145</sup> The project, which is in its final stages, provides valuable lessons for resolving long-standing conflict between a funding agency and First Nations who deliver the program.

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he author of this report represented INAC (Manitoba Region) for over 15 years on Manitoba residential school healing issues.

<sup>144</sup> Information presented by Manitoba First Nations Education Resource Center staff at the Multi-Sectoral Meeting on Health Human Resources in Winnipeg, February, 2005

<sup>145</sup> Cindy Marsden, Kathy Avery Kinew, Robert Allec, Presentation on First Nations – INAC Social Assistance and Policy Reform at the Collaborative Policy Development Conference in Edmonton Alberta, April 28-29, 2004.

The context is that for over 30 years First Nations in Manitoba have been administering the INAC Income Assistance program based on a regional policy and procedures manual developed by INAC, without First Nations input.<sup>146</sup> Over the years First Nations became quite dissatisfied with the program. The frustration was articulated in negative comments such as:

- policy and procedural changes are unilaterally imposed;
- inconsistency in policy interpretation by INAC staff;
- First Nations have no active involvement in changes to regional policy or procedures; and
- appeal system is not fair as INAC is reviewing its own decisions.

Three years ago, First Nations (through the AMC) and INAC agreed to set up a process which would result in a new regional program manual which would be jointly developed. A Statement of Understanding was signed and a structure with three levels was established. An advisory Committee was formed, made up of First Nations and INAC technicians involved in the day to day administration of the program. A Management Committee made up of three representatives from each was set up to negotiate contentious issues and decide on the content of the new manual. The Management Committee included a policy representative from INAC headquarters. This was critical as the role of INAC Region is to implement policy. Policy issues beyond the control of the region were referred to the Headquarters office for direction. Issues which could not be agreed upon by the Management Committee were referred to the highest level in the structure – the Regional Director General of INAC and Chiefs representing AMC.

Although the process was not always a smooth one, discussions with participants in the project suggest that it was effective and a step in the right direction.

### **6.5.1 Lessons Learned**

- Policy begins with First Nations. In this example, First Nations initiated this process through the AMC.
- Sign a Statement of Understanding before embarking on a joint journey for change.
- Involve policy representatives from the federal department at Headquarters (National Office) to address issues which are beyond the scope of authority for Regional Office.
- Involve all parties affected in joint task groups.
- Tackle issues in ‘chewable chunks’.
- Tackle easier issues first – for early success and to build trust.
- Document and diagram the issues clearly.
- A process mapping exercise is a useful way to identify problem areas in the system.
- Utilize an outside mediator to tackle contentious issues.
- Contract a writer with knowledge and experience with manual writing.
- Follow through is necessary at all levels.

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<sup>146</sup> The INAC policy and procedures manual applies to all First Nations except those with block-type funding arrangements.

- Implementation of new policy and procedures manual requires training for users of the manual.

## **6.6 Northern Aboriginal Population Health and Wellness Institute**

The Burntwood Regional Health Authority (BRHA) and Manitoba Keewatinowi Okimakanak Inc. (MKO) have taken the lead in developing a population health institute in northern Manitoba. The Northern Aboriginal Population Health and Wellness Institute (NAPHWI) is a group of 65 partners, including Non-Government Organizations (NGOs) and various federal and provincial government departments, working in partnership with the Institute's board and staff working together to address unacceptable health problems that exist in northern Manitoba.

NAPHWI's objectives are:

- to establish collaborative partnerships;
- to develop integrated community driven approaches and action plans;
- to facilitate the development of multi-jurisdictional action plans; and
- to promote and facilitate inter-jurisdictional approaches to primary health care issues.

Since NAPHWI has only been operational for one year, it is too early to assess its effectiveness. Feedback from provincial and federal representatives, however, suggests there is optimism on NAPHWI's ability to address the three areas it has chosen as priority i.e., diabetes, traditional healing, and youth suicide.

A lesson learned from this project is that it takes time and effort to build credibility and trust in establishing multiple partnerships.<sup>147</sup>

## **6.7 Integration**

Many of the recent major reports on the future of health care in Canada, including Romanow, propose integration as one of the solutions in closing existing gaps in services. This review explored views of First Nation representatives on the topic of service integration.

One of the findings is that integration activities were taking place before the Romanow report. South East Resource Development Council (SERDC), for example, was having discussions with the North East Health Authority (NEHA) on integration issues 18 months prior to Romanow. SERDC communities have also integrated the FNIHB home

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<sup>147</sup> NAPHWI presentation at Manitoba's Primary Health Care Conference on First Nations Health and Wellness in Winnipeg, March, 2005

care and INAC homemaker programs. In the case of West Region Tribal Council (WRTC), it has an integrated Environmental Health program which it delivers to all communities.

Integration is described by First Nations technicians in many ways, including:

- establishing relationships, communication, and working together for results;
- all health services from all governments amalgamated into one pool;
- case managed services provided through a single window, integrated at community and Tribal Council level;
- all levels of government involved;
- consensus by all parties in terms of a plan;
- having all levels of government play a role in addressing First Nation health and social needs;
- First Nations would deliver both provincial and federal health programs, i.e. insured and non - insured health benefits;
- envision own First Nation Health Authority working in cooperation with RHA, FNIHB and Manitoba Health; and,
- access to RHA programs.

As a prerequisite to effective integration, a consistent view shared by technicians is that First Nations have to take total control of their health care system. First Nations need to be the lead on integration and require support from the provincial and federal government. Also, First Nations need to have more flexibility. If services were integrated under one umbrella, First Nations would have more flexibility and therefore needed services would be easier to access e.g. psychologist services. One of the recurring messages is that politics and service delivery do not mix. At the community level the challenge is to separate politics from administration of services. An example is that, in cases of water contamination, the boil order decision is now left with Chief and Council.

## **6.8 Primary Health Care in Manitoba**

The Action Plan for Health System Renewal adopted by First Ministers in September 2000 identified Primary Health Care (PHC) reform as a priority for the renewal of



Canada's health care system. Table 9 defines the Primary Health Care concept.

**Table 9: Primary Health Care Defined**

**Primary Health Care (PHC)** is the first level of contact with the health system where services are mobilized to promote health, prevent illnesses, care for common illnesses, and manage ongoing health problems. PHC extends beyond the traditional health sector and includes all human services that play a part in addressing the interrelated factors that affect health.

Primary Health Care is an umbrella for many services, and includes:

- Primary Care (physicians, midwives & nurses);
- health promotion, illness prevention;
- health maintenance and home support;
- community rehabilitation;
- pre-hospital emergency medical services;
- coordination and referral to other areas of health care;
- services generally provided in the community; and,
- services provided in hospitals.

Source: Manitoba Health Website at <http://www.gov.mb.ca/health/primaryhealth.html>

The advantage of Primary Health Care is that it goes beyond the health sector and encompasses all sectors that affect health such as housing, sanitation, water supply, education, nutrition and employment. This inter-sectoral approach uses a team of service providers, often referred to as a multidisciplinary team. Members of the team vary depending on the needs and issues affecting the health of the individual, family, and community. These teams could consist of a variety of professionals – a doctor, nurse and /or nurse practitioner, physiotherapist, pharmacist, dietitians/nutritionists, social workers and community outreach worker- depending on the particular needs of the community or health issue.

One of the stated goals of the 2002 Manitoba Government Health Policy Framework is to promote the development of PHC organizations delivering service to Manitobans. In December, 2004, the Manitoba Government announced the construction of five new PHC centers in rural and northern Manitoba. These will be located in The Pas, Flin Flon, Waterhen, Camperville and Riverton, and will provide community residents with access to a wide range of health care services including primary health care, mental health services, health promotion, prevention, and education programs.<sup>148</sup> Although the source of funding for these centers is the federal government's Primary Health Care Transition Fund, none of these new centers will be located on reserve. This decision by the Manitoba Government is not surprising given its stance of federal responsibility for First Nations. This does raise fundamental questions on the future direction of PHC in this province. What is the federal policy regarding establishment of comparable PHC centers on reserve? Will FNIHB be expected to fund the equivalent of PHC centers in First Nations communities?

<sup>148</sup> The December, 2004 announcement is available online at <http://www.gov.mb.ca/chc/press/top/2004/12/2004-12-01-03.html>

The Aboriginal Nurses Association of Canada (ANAC), in its submission to the Romanow Commission, recommended implementation of the PHC model at the community level. This would be realized through the development of a Health Centre and the building of secondary and tertiary services, defined in Table 10, to support the priorities of communities. ANAC's view is that the PHC model, with its focus on individuals, family and community, is consistent with traditional knowledge about the structure of society and the importance of family members as first teachers, and is therefore well suited to Aboriginal populations.

**Table 10: Secondary and Tertiary Care Defined**

**Secondary Care** includes assessment, diagnosis, treatment and prevention services associated with more complex problems, and is generally provided by specialist physicians and other specialized health professionals. Most secondary care is provided in larger acute care settings such as large community, regional, or teaching hospitals. An example of secondary care provided in the community is office visits to specialist physicians.

**Tertiary Care** refers to highly specialized diagnostic and treatment services where patients are referred from other hospitals or physicians. Tertiary care involves fewer patients and is usually concentrated in large hospitals because the care provided requires specialized service providers, sophisticated equipment and support services. An example of tertiary care provided in the community is home based services for technology-dependent patients.

Source: Manitoba Health

### 6.8.1 Adaptation of the Primary Health Care Model to First Nations Needs

Although the provincial and federal governments promote PHC, their documentation makes little reference to the potential role of traditional healers in interdisciplinary teams. Despite this, it is clear that the model has merit and is flexible enough to incorporate traditional healers and helpers.

The topic of Primary Health Care comes alive and exciting once people start talking about how the concept can be adapted to their community and their needs. An example of this enthusiasm is Dr. Marlyn Cook speaking about the Wholistic Health Development of the Mohawk Council of Akwesasne. This model includes access to culturally based professional services including community clinics with a traditional healer working side by side with the physician.<sup>149</sup> Another example is Dr. Barry Lavallee speaking about the team approach used at Aboriginal Health and Wellness Center of Winnipeg. Marge Nepinak, social worker at this center, also speaks with passion about social support services which patients need that are sometimes more important to a patient than their health issues.<sup>150</sup> Marge describes the situation of a young woman who attended the

<sup>149</sup> Presentation at Manitoba's Primary Health Care Conference on First Nations Health and Wellness: Connecting with all our relations to build bridges in Primary Health Care. March 22, 23 and 24, 2005 at Winnipeg Convention Centre.

<sup>150</sup> Ibid

Centre, with her diabetes out of control. Despite her health condition, this woman's priority was to deal with a child welfare custody issue involving her daughter. It was only once the matter of her daughter was resolved that this woman was ready to address her own health issue.

### **6.8.2 Recommendations**

- That the federal and provincial governments clarify their respective roles and responsibilities regarding funding of Primary Health Care, healing, and wellness centers in First Nations communities
- That a First Nation planning to develop its own health center consider the Akwesasne and Weeneebayko Health Authority models.

### **6.9 Prevention / Health Promotion / Healthy Living**

Discussions with health care technicians suggest there are a multitude of activities on Manitoba reserves associated with health promotion and healthy living. Examples include recreation and fitness activities, sports tournaments, walking and lunch programs and health education in schools. The Neechi Foods diabetes prevention program is noteworthy example of the contribution which the private sector can make. An out-of-province example of a fairly comprehensive 'best practices' community initiative is the Kahnawake Schools Diabetes Prevention Project.

#### **6.9.1 Neechi Foods**

Neechi Foods, a grocery store in Winnipeg's North End, has received an international award for an innovative program designed to prevent diabetes. The store's 'It's About Choice' healthy living strategy, 'shelf talkers' are located along aisles that offer suggestions on how to prepare healthier meals, e.g. buying cereal that is high in fiber and low in sugar; adding tuna to Kraft Dinner. Store personnel also provide information to customers on diet and exercise. In the words of Neechi president Louise Champagne, "It's one thing to go to a clinic to get information, but people usually end up there when they're already in crisis. We think information needs to be naturalized in a place where people are living and making choices on a day-to-day basis. It's about trying to present it in way that's really helpful to people."<sup>151</sup>

#### **6.9.1 Kahnawake Schools Diabetes Prevention Project**

The Kahnawake Schools Diabetes Prevention Project (KSDPP) near Montreal is a prevention program focusing on elementary school children, their families and the entire community. It began in 1994 in response to concerns about the perceived increases of obesity in children combined with the Mohawk tradition to care for future generations.<sup>152</sup>

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<sup>151</sup> Times. (December 29, 2004) *Store honored for diabetes prevention effort*. Winnipeg: Lance/Times.

<sup>152</sup> Kahnawake Mohawk Nation (2004) *Kahnawake Schools Diabetes Prevention Program* available online at <http://www.ksdpp.org/aboutus.html>

A combination of private foundations, federal government and the community continues to fund the project. The main objective of the program is to prevent the onset of Type II diabetes among present and future generations in Kahnawake through the promotion of healthy eating, physical activity and positive attitudes among children and youth. Other important objectives are mobilization of the community to foster community empowerment and ownership through participation in all aspects of the project and to build community capacity to ensure sustainability of goals, objectives and activities in the future.

The KSDPP program of intervention activities takes a holistic approach to preventing diabetes in the community by embedding intervention activities which include a health education program, recreational activities, and community based activities all within the overall goal of living in balance including:

- Promoting Active Living – participation in regular physical activity into daily living and fitting physical activity into daily living. Promoting Eating in Balance – having regular eating patterns (meal pattern), making healthy food choices, and eating healthy meals (portion size, food groups).
- Raising Diabetes Awareness - conveying the seriousness of the disease, the preventability of the disease and assessing personal risk of diabetes.
- School Based Intervention - The KSDPP school-based intervention involves introducing new lessons (Health Education Program), increasing physical activity and strengthening nutrition policy within community schools. A hands-on, interactive approach, congruent with native culture and learning styles is used. Also the schools have adopted a hard line on junk food. The school canteen only serves healthy snacks now. Any food or drinks considered unhealthy, like soda pop, candy or chips, end up in the garbage, or are sent back home. Students, parents and teachers took a few months to adapt, but now healthier lifestyles are routine.
- Community Based Intervention - The community-based intervention supports the parents who, in turn, reinforce what the children have picked up in school. To encourage family recreation and healthy eating, new activities were also organized. Families were involved in monthly events including sledding, bowling at the local lanes, ice-skating and hiking. The arena was taken over for a day of family broomball. At all the events nutritious foods were served.

## ***Section 7: Towards Governance – Lessons Learned in Health and Social Services***

In September, 2004 at a special national meeting in Ottawa, First Ministers and Aboriginal leaders agreed on the need for an action plan to improve health services for all Aboriginal peoples. More than six months later, now that the confusion over what was actually agreed upon has been clarified somewhat, it appears that, nationally and provincially, efforts will focus on development of a health ‘Blueprint’. Although details on the process have yet to be finalized, it is clear that Manitoba First Nations leaders are taking action to ensure they design their own health ‘Blueprint’. Indications at this point are that the Manitoba and the Federal Government are in support of developing a joint First Nations health action plan. In this context, it is recommended that the architects responsible for crafting the Manitoba health ‘Blueprint’ consider lessons learned from existing health and social service models, in Manitoba and elsewhere. While none of the models discussed in this section can be considered true governance models, those who have been involved in these ‘best practice’ models have something to contribute from lessons learned to those who will be designing the health ‘Blueprint’.

### **7.1 Child and Family Services Model**

The community-based First Nations Child and Family Services (CFS) program in Manitoba is an example of how First Nations can work with the federal and provincial governments to achieve administrative control over a program on reserve. The real change in CFS for First Nations in this province began once there was a tripartite commitment for joint action. The most significant impetus for change was the completion of tripartite negotiations on CFS and signing of a Master Agreement in 1982.<sup>153</sup> The Master Agreement outlined the obligations and responsibilities of the tripartite parties, established guiding principles for the operation of CFS on reserve, and specified the way in which the agencies would be funded.

Further discussions of expanded First Nations jurisdiction (law making authority) are underway under the Manitoba Framework Agreement Initiative (MFAI). All Manitoba First Nations, Canada and Manitoba participate in this negotiation sub-table of the MFAI.<sup>154</sup> It is anticipated that an Agreement-In-Principle may be signed during 2005/06. Subsequent negotiations could occur, leading towards a Final Agreement for Child and Family Services on reserve jurisdiction (under federal legislation). Canada has been requested to expand the scope of such legislation to include off reserve jurisdiction (law making authority) for all First Nations.

In a further development in 2000 (affecting off reserve child and family services), the AMC (for Southern First Nations), the MKIO (for Northern First Nations), Manitoba Métis Federation (MMF) (for all Métis) and the Province signed separate memorandums

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<sup>153</sup> *Report of the Aboriginal Justice Inquiry of Manitoba, Chapter 14 – Child Welfare*, 19, available online at <http://www.ajic.mb.ca/volumel/chapter14.html#10>

<sup>154</sup> Interview with Brian Gudmundson, Aboriginal and Northern Affairs

of understanding to expand delivery of child and family services to First Nations people living off-reserve and all Métis peoples in Manitoba, in keeping with a recommendation put forward by the Aboriginal Justice Implementation Commission (AJIC). These parallel arrangements between First Nations and Manitoba and between the MMF and Manitoba, referred to as the AJIC-Child Welfare Initiative (AJI-CWI), have resulted in services being provided under the new legal authority of First Nations agencies to all band members off reserve as well as all Métis under its parallel new legal authority, transferred through provincial legislation. Under this off reserve model with parallel arrangements for First Nations and Métis, standards are set by the provincial government. First Nations and Métis authorities are responsible for their respective service delivery agencies. Funding for off reserve services is provided by the provincial government. Although aspects of the AJI-CWI model are worth examining for governance mechanisms of health service delivery, the model would not be completely transferable as this aspect of the AJI-CWI model has not involved the federal government in the off reserve context.<sup>155</sup> Questions also remain as to how separate health authorities with concurrent jurisdiction could operate parallel services (First Nation and other service agencies) within the same geographic regions in Manitoba.<sup>156</sup>

The AJI-CWI model does not constitute First Nations' governance (law making authority transferred from Canada) for program standards and regulations. Despite this current limitation of law making authority First Nations have been building their AJI-CWI authorities (North and South), agencies, budgets, and human resource capacity. These building blocks will make the transition to sectoral governance of child and family services much easier when the time is right for Canada to legislate transfer of law making authority to First Nations on and off reserve. From that perspective, even without law making authority (from Canada), the AJI-CWI model can be considered as governance off reserve.<sup>157</sup>

Lessons from the CFS model for consideration in the design of the health 'Blueprint' include:

- Progress occurs when there is clear political will of all parties involved;
- Enter into a tripartite agreement or MOU to clarify roles, responsibilities, and funding matters;
- Establish a formal tripartite negotiation process with capable representation for each partner at the table;
- Establish a realistic workplan for multi-stage sign-off by all partners;
- Joint development of a detailed implementation plan (blueprint) for all funding and service arrangements;
- As an interim step towards governance, First Nations can design administrative models to establish their institutions, budgets, and human resource capacity; and
- Monitor and measure success of negotiations and celebrate significant events in the change process.

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<sup>155</sup> Interview with Brian Gudmundson, Aboriginal and Northern Affairs

<sup>156</sup> Ibid

<sup>157</sup> Ibid

## 7.2 Island Lake Renal Centre / Regional Primary Health Care Centre Model

The poor health conditions (especially diabetes) and health service deficiencies for the residents of the Island Lake Tribal Council (ILTC) region<sup>158</sup> of northeastern Manitoba are well documented. The Four Arrows Regional Health Authority responsible for ILTC health services was established in January 2000. A major turning point was a March, 2000, CBC National news report on the diabetes crisis in the ILTC area. The response was a partnership which has seen remarkable progress over the next five years. The CBC news story was the impetus for a tripartite meeting between the ILTC Chiefs, Manitoba Minister of Health, Manitoba Minister of Aboriginal & Northern Affairs, and senior officials of Health Canada.<sup>159</sup> A Joint Health Governance Working Group was also created and formed the basis for an MOU to establish an action plan. In 2002, following extensive community consultation, the ILTC Chiefs declared their consensus decision that a Primary Health Care Centre, serving all First Nations in the district, should be built at the location of the soon to be built airport on an all weather road joining the two communities of St. Theresa Point and Wasagamack. They further stated “This centre would include the dialysis services”.<sup>160</sup> Manitoba Health has now built the Renal Centre and it is operational. The long term plan of ILTC is to have the Four Arrows RHA as the governing body over the Renal and Primary Health Care Center providing provincially mandated services by 2010.<sup>161</sup> The realization of this plan depends on a number of things including; 1) Canada and Manitoba approving the conceptual plan and future funding formulas; 2) the new all weather road construction (between St. Theresa Point and Wasagamack); and 3) construction of the planned new airport. As the Primary Health Care Center will be located adjacent to the new airport any delays in the road and airport construction would also delay the start up for the new Primary Health Care Center.

The ILTC is allowing for reasonable period of time to resolve inevitable start-up problems.<sup>162</sup> The new local dialysis service has allowed some patients to return from Winnipeg but both inter-community transportation for patients as well as housing for returning band members was found lacking. Such community supports are essential for the normal operation of the new local dialyses program.<sup>163</sup>

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<sup>158</sup> Member First Nations of ILTC are St. Theresa Point, Wasagamach, Red Sucker Lake, and Garden Hill.

<sup>159</sup> Nadwidny, M (presentation – no date) *The Joint Health Governance Working Group, The Island Lake First Nation Renal Care & Dialysis Centre*

<sup>160</sup> Riese, Dr. N, Robson, J, Nadwidny, M, (2003) *A proposal from Joint Health Governance Working Group in Support of Developing A Primary Health Care Centre in the Island Lake Region*. Winnipeg: ILTC

<sup>161</sup> Interview with Andrew Wood, Executive Director, Four Arrows Health Authority Inc. (February 2005)

<sup>162</sup> Mike Nadwidny presentation

<sup>163</sup> Interview with Brian Gudmundson, Aboriginal and Northern Affairs

Although still in the early stages, the lessons for development of the health 'Blueprint' offered by this model are:

- Media coverage on serious First Nations health conditions brings the stakeholders together;
- A clear vision shared by the First Nations' leadership is important;
- First Nations need to serve as a full partner at the negotiations table;
- The Working Group requires a clear mandate for combined planning and negotiations;
- A Workplan is needed to formalize the plan and check on progress;
- INAC serves a key role on reserve for health determinants such as housing, sewer and water, income maintenance and education; and
- Jurisdictional issues must be resolved, with clear funding roles for Canada and Manitoba.

### **7.3 First Nations of Quebec and Labrador, Health and Social Services Commission**

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) is unique in Canada in that 1) its mandate is region-wide in scope and involves both health and social services, and 2) it is cost-shared by the Quebec Government, Health Canada, and INAC. The Commission received its mandate from the Assembly of Chiefs of Quebec and Labrador in 1994. Initially, according to its 1997 by-laws, its role was to provide technical support and advocacy for First Nations and the Assembly of First Nations of Quebec and Labrador in the area of health and social services.<sup>164</sup> Its role has evolved to include:

- strategic planning and negotiation support to the management and sectors;
- technical support to the organization's sectors;
- analysis of the government's policies and programs;
- statement of the directions to develop health and social services authorities;
- technical support to communities; and
- to develop and recommend political strategies for various files and situations.

Alain Leveille (INAC, Quebec Region) indicates that the FNQLHSSC has been a very positive force in resolving complex policy matters. For example, the process was useful to address cooperatively the Quebec Government's decision to cut welfare rates in 1997/1998. Since each First Nation community appoints a health and social services delegate to the Commission, INAC and First Nations were able to resolve the matter quite effectively. From that perspective, the Commission is a useful structure for all the parties involved when consultation on policy and service is required.

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<sup>164</sup> The FNQLHSSC website is available online at <http://www.cssspnql.com>



Discussions are now underway in Quebec for First Nations to assume control of social services including the Income Assistance program. The relevance of this model to Manitoba is that the First Nations leadership in this province is seriously examining its options for a mechanism to address major problems in the health system.

### **7.3.1 Recommendation**

That the architects of strategic plans and the First Nations health 'Blueprint' consider lessons learned from existing models discussed above and models from other countries, including USA, Australia, and New Zealand.

## ***Section 8: Conclusions / Recommendations***

Although specific recommendations are included within many sections, several overarching recommendations are highlighted here.

### **8.1 Demographics / Urban Population**

The combination of Bill-C31 impacts and the trend of an ever-increasing First Nations urban population indicate a future whereby on and off reserve services will need to be organized and financed differently than what exists today. Current projections on the impacts of Bill C-31 show a future where an ever-increasing share of Manitoba First Nations descendants will not be entitled to Indian registration.

On reserve, there will be growth in the size of the non-registered caseload for health and social programs. This suggests an increasing need to streamline and simplify financing of reserve-based health and social services with some type of per capita formula.

Manitoba First Nations citizens living in urban centers currently experience high population growth rates. In 1991 the Status Indian population located in Winnipeg was 15,900 and is projected to more than double to 39,600 by 2016.<sup>165</sup> This trend of an ever increasing First Nations urban population will necessitate the provision of adequate support services, safe housing and strong linkages between urban and reserve service systems.

#### **8.1.1 Recommendation**

Architects of the Manitoba First Nations Health ‘Blueprint’ consider impacts of Bill C-31 and urban growth.

### **8.2 Governance**

Compelling evidence shows that the current health system, however well-intentioned, is not meeting the needs of First Nations people in Manitoba. First Nations leaders acknowledge positive initiatives to address diabetes and other diseases. However, it is not enough. First Nations want to pursue their own holistic approach to health, one that encompasses the physical, emotional, intellectual, and spiritual aspects of people. One strong message coming out of the recent Primary Health Care conference is that the current system neglects the spiritual element which is vital to achieve a balance of health.<sup>166</sup> Another message said that solutions must be based on the principle ‘by First Nations, for First Nations’. To that end, it is recommended that the First Nation leadership in Manitoba develop a strategic plan to achieve governance in health. As part of the strategy, it is suggested that First Nations leaders initiate discussions with provincial and federal departments with the view to 1) take control and authority over

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<sup>165</sup> Manitoba Bureau of Statistics (1997) *Manitoba’s Aboriginal Populations Projected 1991 – 2016*

<sup>166</sup> Manitoba’s Primary Health Care Conference on First Nations Health and Wellness: Connecting with all our relations to build bridges in Primary Health Care, March 22 - 24, 2005 Winnipeg.

existing health and social services and, 2) design a system which meets the unique needs of First Nations people. Given federal and provincial government renewed commitments to First Nations health, one can be confident of their cooperation.

### **8.2.1 Recommendations**

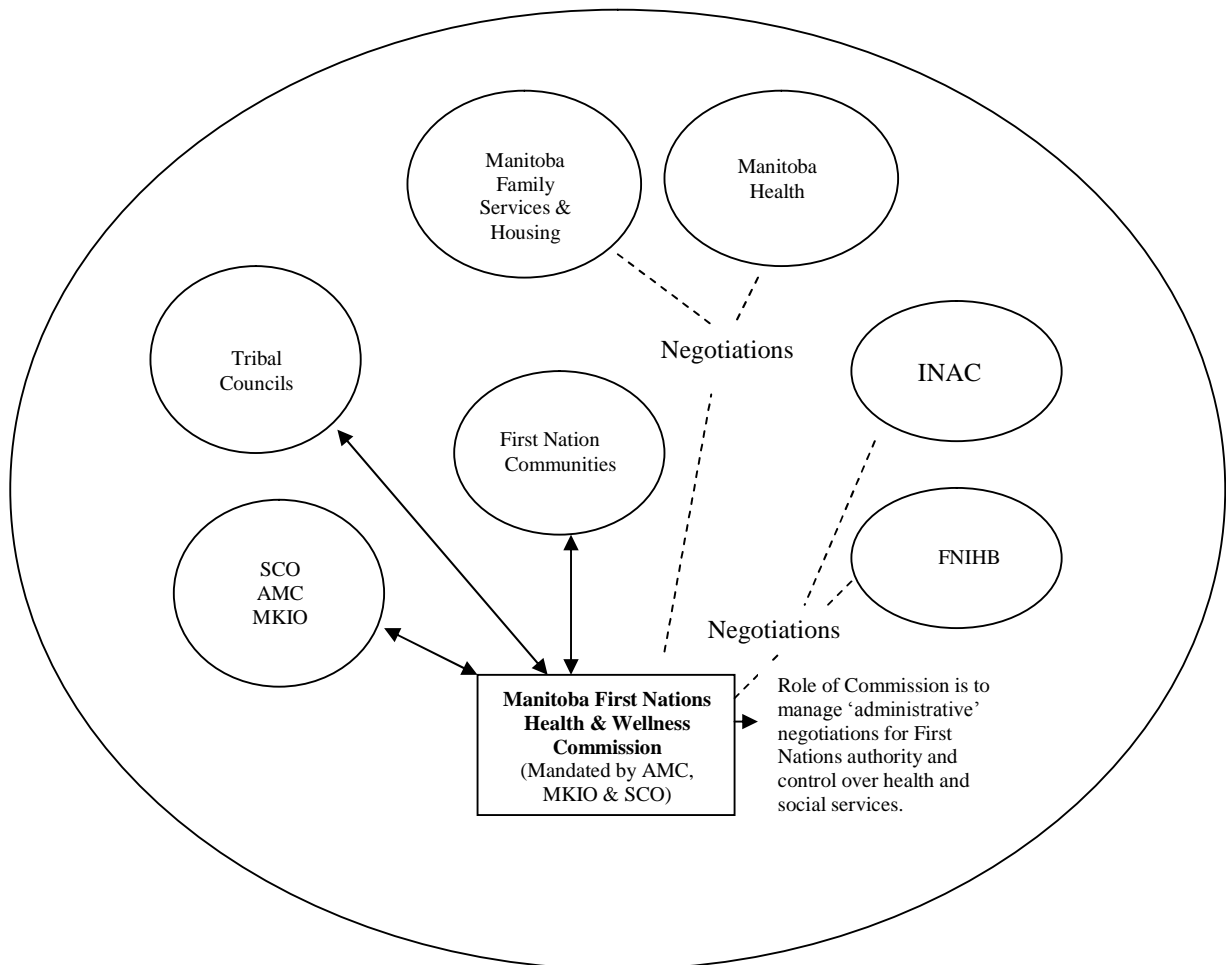
The following strategic option and recommendations provide a comprehensive and long term strategy to restructure the First Nations health and social service system in Manitoba.

- 1) That a Manitoba First Nations Health and Wellness Commission be created. Implementation would result in the creation of an entity mandated by the three Manitoba First Nations political organizations (AMC, MKIO, and SCO) to 1) develop and implement a strategic plan, and 2) manage ‘administrative’ negotiations in order to attain greater authority and control over a range of existing health and social services. The proposed structure would be a complementary process to the Manitoba Framework Agreement Initiative where negotiations on jurisdictional matters are contemplated to occur.
- 2) That the model for the Commission outlined in Figure 2 be considered to begin the dialogue.
- 3) That the leadership seek guidance from Elders and Healers at the outset of the process and involve them at every step on the journey of change
- 4) That lessons learned from existing models and the proposed negotiation model be incorporated into the Commission and First Nations health Blueprint.
- 5) That health and social service policy coordination, identified as a gap in the current system, be incorporated as part of the mandate of the Commission,
- 6) That priority for transfer of health and social programs to First Nations control be given to the following:
  - Off-reserve Income Assistance, Employment and Housing Program (This service is currently provided by Manitoba Family Services and Housing);
  - FNIHB programs such as Brighter Futures, Building Healthy Communities, Aboriginal Diabetes Initiative, and Head Start; and,
  - INAC programs such as Family Violence Prevention, Income Assistance, and Assisted Living.

The basis for the proposed order of priority is that these programs address social determinants of health. Ample evidence shows that health alone cannot create good health. Social supports and basic needs such as income, employment and housing are prerequisites to overall health.

- 7) The strategy must include the principle of respect for an individual First Nation’s right to determine its own future. To that end, implementation strategies resulting from any negotiations through the proposed Commission should provide the option to individual First Nations on whether they want to participate.

**Figure 2: Proposal for a Manitoba First Nations Health & Wellness Commission**



### 8.3 Integration

This review explored views of First Nation representatives as to integration of health services. For effective integration of services to work, a consistent view is that First Nations people must take total control of their health care system. Although First Nations need to assume leadership in the development of this renewal and integration of services, they require support from both the provincial and federal governments. In addition, First Nations require more flexibility in accessing needed services such as those provided by a psychologist. This would be better achieved if services were integrated.

Lastly, a recurring message is that politics and service delivery do not mix. Therefore, it is a necessary challenge to separate the political realm from administration of services at the community level.

## **8.4 Primary Health Care**

Feedback from a number of First Nations health professionals on the Primary Health Care model confirms it is well suited to First Nations, recognizing as it does, the importance of the individual, family, community, and joint responsibility. It is clear that many aspects of this model will be incorporated by First Nations in the future design of their own health authorities. Some fundamental questions are raised on the future direction of PHC in First Nations communities as it relates to a funding source.

### **8.4.1 Recommendations**

- Manitoba Health should review its PHC Policy Framework to determine if there are ways to incorporate and promote traditional healing practices into the provincial health system.
- The federal and provincial governments clarify respective roles and responsibilities regarding funding of primary health, healing, and wellness centers in First Nations communities.

## **8.5 Youth**

There is a lack of documentation on the needs and perspectives of First Nations youth as it relates to health. In addition, youth health issues do not get the attention they deserve from the federal, provincial, or First Nations leadership. Although media coverage of youth violence, drugs, prostitution, gangs, and suicide issues abound, there is no evidence that these problems are being seriously addressed in any meaningful way. Despite comments such that youth are the key to the future and that preventing youth suicide is a priority, sadly, it appears that youth issues in Manitoba will remain on the ‘backburner’ (until something happens at the magnitude of the recent tragedy at Red Lake Minnesota). Considering the theory of Maslow’s Hierarchy of Needs, a possible explanation as to why this issue is not being addressed by First Nations, is the multitude of other priority unmet basic needs faced by First Nations e.g. housing, water, and security. For the youth, however, it is as though they have no voice and therefore, they are not being heard. For example, according to one youth representative interviewed it is difficult to understand why government is willing to pay for treatment of individuals associated with a community suicide crisis or after a suicide, but is not willing to invest substantially in suicide prevention. The presence of only a few First Nations youth representatives at some of the recent general meetings on health is a testimony that they are not connected to nor considered in the debate.

### 8.5.1 Recommendation

- That First Nations, provincial and federal governments seek guidance from their elders and youth to find ways to involve elders and youth in a meaningful way on health issues such as suicide
- That elders, especially grandmothers, be involved in the school system to provide support to youth. (The section on Traditional Medicine highlights how involvement of grandmothers with youth fits with their traditional roles.)
- As one Traditional Elder, Dave Courchene, suggested, “To heal our people, we need to get out of the box and back into the circle.”

### 8.6 Individual Responsibility and Socio-Economic Conditions

In conclusion, the review confirms that health services, socio-economic conditions and individual responsibility all play a role in the well-being of First Nations in Manitoba. While arguably more funding is required for treatment of diseases, it is clear that, of these three factors, health services contributes the least to improving health status. Often, it appears that treatment facilities focus on the symptoms of disease. Three key messages come out of this review. First is a strong message that individuals have responsibility to themselves and their relations (family) to achieve a balance of the body (physical), mind, and spirit. Second, it is equally evident that First Nation individuals, families, and communities require additional support, services and resources to improve overall health status. Third, more attention is required to social determinants of health which determine whether individuals stay healthy or become ill and determine the extent to which a person possesses the physical, social, and personal resources to achieve health.<sup>167</sup> Social determinants of health concern the quantity and quality of a variety of resources that a society makes available to its members. These resources include – but are not limited to – income, availability of food, housing, employment, social services, water quality and education.<sup>168</sup> It is therefore imperative that governments direct their policies and resources in a manner which supports the whole First Nations population of Manitoba. Housing is an example of the fundamental link between government policy, resources, and population health. As noted in the Auditor General’s Report on First Nations housing (April 2003), numerous studies indicate that poor housing negatively affects the health, education and overall social conditions of individuals and communities on-reserve. The report notes that socio-economic conditions also contribute to the poor housing. The cyclical nature of poor housing generating poor social conditions, then poor social conditions generating poor housing, must be addressed before the overall social well-being of Manitoba First Nations can be improved.

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<sup>167</sup> Raphael, Dennis (2004) *Social Determinants of Health: Canadian Perspectives*. Toronto, 1

<sup>168</sup> Ibid

## Section 9: Priority Recommendations

### 9.1 Prioritized Strategic Options

In order of priority, the following ten key strategic options are recommended to the Inter-governmental Committee on First Nations Health. This set of strategic options is recommended as a pragmatic approach to addressing gaps in services and issues associated with jurisdictions. It is suggested that priority be given to the recommendations which address structural and operational issues within the current service delivery system. The proposed approach will directly improve First Nations access to comprehensive services and indirectly provide an impetus for improving their health status.

**1) That senior officials of the ICFNH take action to resolve long-standing jurisdictional disputes and ambiguity.**

**1.1) It is recommended that a task group be established by the senior officials with a mandate to develop a document which lists the full inventory of health and social services (on and off reserve) and which clarifies:**

- the responsible service delivery agency;
- funding responsibility;
- applicable standards; and
- relevant procedures, level of benefit, and rules of entitlement.

**1.2) It is further recommended that the target date for completion of this exercise including approval of the document by the relevant senior officials be set for March 31, 2006 (Jurisdiction – Section 2.4).**

**2) That a Manitoba First Nations Health and Wellness Commission be created (Conclusions / Recommendations – Section 8);**

**2.1) that lessons learned from existing models and the proposed negotiation model be incorporated into the**

**Commission and First Nations health Blueprint (Towards Governance – Section 8);**

**2.2) that health and social service policy coordination, identified as a gap in the current system, be incorporated as part of the mandate of the Commission (Community Service Gaps, Policy, and Funding – Section 4.7); and,**

**2.3) that priority for transfer of health and social programs to First Nations control be given to the following:**

- Off-reserve Income Assistance, Employment and Housing Program (service currently provided by Manitoba Family Services and Housing);
- FNIHB programs such as Brighter Futures, Building Healthy Communities, Aboriginal Diabetes Initiative, and Head Start; and,
- INAC programs such as Family Violence Prevention, Income Assistance, and Assisted Living.

This strategic option provides a comprehensive and long term strategy to restructure the First Nations health and social service system in Manitoba.

Implementation would result in the creation of an entity mandated by the three Manitoba First Nations political organizations (AMC, MKIO, and SCO) to 1) develop and implement a strategic plan, and 2) manage ‘administrative’ negotiations in order to attain greater authority and control over a range of existing health and social services. The proposed structure would be a complementary process to the Manitoba Framework Agreement Initiative where negotiations on jurisdictional matters are contemplated to occur.

**3) That the Education Component of the Health Human Resource Strategy be developed** (Health Human Resources – Section 5).

This option is presented as a medium term strategy to address the inadequate supply of First Nations professionals in health disciplines. It is recommended that the AMC initiate a meeting of key stakeholders to begin discussions on an education strategy. A follow-up meeting of senior officials of relevant partners would identify resources required to implement the education strategy.

3.1 That links be formed for the purpose of identifying and addressing issues and concerns that impact various First Nations professionals in health disciplines in Manitoba (Health Human Resources – Section 5).

**4) That the Manitoba Government clarify the role of Regional Health Authorities vis-à-vis First Nation communities** (Role of Regional Health Authorities - Section 4.2).

This option will facilitate the working relationship between RHAs, First Nations, and FNIHB. First Nations

leaders also need to clarify direction to their staff in relation to working with RHAs.

**5) That the financing approach for reserve-based health and social services be streamlined and simplified and replaced with some type of per capita formula** (Bill C-31 Impacts / Urban Population – Section 2.5).

This is critical for all levels of government as a means of adapting to impacts associated with Bill-C31 and urban population growth. On reserve, there will be a future growth in the non-registered caseload for health and social programs. The combination of Bill-C31 impacts and the trend of an ever-increasing First Nations urban population will create the need for new ways to organize and finance both on and off reserve services.

**6) That FNIHB and First Nations undertake to develop jointly a new regional policy and procedures manual for Non Insured Health Benefits** (NIHB – Section 4.4).

This would provide administrators (First Nations and FNIHB) with needed clarity and promote mutual understanding of regional policies and procedures for the program.

**7) That the federal and provincial governments clarify their respective roles and responsibilities regarding funding of Primary Health Care, healing, and wellness centers in First Nations communities** (Primary Health Care – Section 6.8).

This option builds on Manitoba Health’s Primary Health Care policy framework.



**8) That INAC and Manitoba Health take steps to establish a formal protocol for the construction of new Personal Care Homes on reserves.**  
(Continuing Care – Section 3.2)

This option complements the broader discussion required on the matter of jurisdiction in this area. It is anticipated that negotiations, proposed by AMC through the Manitoba Framework Agreement Initiative process on the matter of First Nations jurisdiction over Personal Care Homes in its entirety, including licensing, will be a long process. In the interim, the parties involved are encouraged to focus on operational matters such as the required upgrading of existing facilities to meet provincial standards, funding for higher levels of care, and a protocol for construction of new facilities.

**9) That a regional conference on remote service delivery in Palliative Care be held in 2006.** (Palliative Care – Section 3.3)

This option provides an opportunity to begin addressing gaps and issues in this area. The conference would focus on improving and integrating services, information sharing, and examining the role of technological support. Overall, this option would assist in building a bridge between urban palliative care specialists and community health care professionals.

**10) That opportunities for Elders in traditional teaching / mentorship / apprenticeship of young people be encouraged.** (Traditional Healing / Medicine – Section 6.2)

This option would assist in ensuring that valuable knowledge of Elders is retained and passed on. Such activity could stimulate the interest of young people to pursue careers in traditional medicine.

## 9.2 Additional Strategic Recommendations

The remaining recommendations identified in this report are viable strategic options as well, for consideration of the Inter-governmental Committee on First Nations Health or other relevant stakeholders. Other stakeholders or partners may choose to consider and implement one of these recommendations.

- 1) Given that effective management of Type II diabetes rests primarily on its early detection and treatment, that efforts be made to conduct screening of all First Nations children, including those living in urban centers (Diabetes – Section 3.6).**
- 2) That a review of causes of High Birth Weight be undertaken, and measures taken to reduce this rate tying into recommendations to reduce diabetes, including promoting appropriate nutrition and increased physical activity and developing a pre/post natal continuum of care plan (Diabetes – Section 3.6).**
- 3) That a multi-sector approach to community health which takes into consideration the socio – economic determinants of health be adopted (Socio – Economic Determinants of Health – Section 2.2).**
- 4) That socio-economic determinants of health which are significantly correlated with disability among First Nations be addressed including unemployment, poverty, food insecurity, social isolation, and inadequate housing (Services for Persons with Disabilities – Section 3.4).**
- 5) That improved access to diagnostic services be made a priority (Disabilities Associated with Prenatal Alcohol Exposure / Fetal Alcohol Spectrum Disorder Related Disabilities – Section 3.7).**
- 6) That institutions involved in the education and training of health and social service professionals incorporate knowledge gained from current healing research into their curriculum; and that health and social service professionals who are already working in the system inform themselves on the history of residential schools and healing strategies to address intergenerational impacts (Residential School Healing Initiatives – Section 6.4).**
- 7) That significant investments into health promotion and illness prevention be made by all levels of government and that traditional teachings including the spiritual elements of wellness and healing be incorporated into the health system (Youth – Section 8.5).**

**8) That oral health be integrated into the overall health strategy (Oral Health – Section 3.9).**

The basis for this recommendation is that dental and oral disease and injuries are almost entirely preventable if education and promotion programs are provided and access to care services is readily available. Also, early identification of oral disease may contribute to the early diagnosis and treatment for a number of systemic diseases

**9) That mental health issues be addressed in a holistic manner and not seen as a problem separate from the other aspects of an individual's life (Mental Health and Addictions Services-Section 3.8)**

**9.1) That the following areas be examined to identify gaps, areas of jurisdictional debate and emerging trends and issues: Out-patient mental health and addictions assessment and treatment; In-patient psychiatric treatment; In-patient addictions treatment; Crisis services (telephone, mobile crisis, crisis stabilization, etc.); Self-help; and, Mental health promotion (Mental Health-Section 3.8).**

**9.2) That a gambling study specific to Manitoba First Nations be conducted with a focus on youth (Gambling Addiction – Section 3.8.1).**

**10) That a First Nations Service/Support Centre be established for persons with disabilities living on**

**and off reserve in Manitoba and that specialized care agencies provide on-going follow-up services once a person returns to the reserve (Services for Persons with Disabilities – Section 3.4).**

This is in support of the work and recommendations stemming from the Manitoba First Nations Disability Multi-Sectoral Working Group.

**11) That the federal and provincial governments build incentives into their programs to reward effective and efficient management (Duplication of Services – Section 4.5).**

**12) That some type of protocol be established to provide appropriate notice and discussion, prior to a change in policy or practice thereby minimizing any negative impacts, and that senior officials consider establishing a small Working Group to recommend a protocol (Funding Policy and Practices Which Impact Other Levels of Government – Section 4.6).**

This recommendation is intended to meet the need for increased dialogue by the stakeholders involved on funding and policy decisions which impact other levels of government.

**13) Given the many benefits of Telehealth, that ICFNH partners continue lobbying other partners interested in connectivity, such as those involved in Education, to form partnerships necessary to bring Manitoba First Nations into the 21st century of health care (Telehealth – Section 6.3).**

### **9.3 Closing Comments**

Overall, the crystal ball shows a dismal future for First Nations health in Manitoba if the status quo is maintained. From the perspective of the author, the challenge for First Nations people in Manitoba is to 1) take control of their own personal health to achieve balance in life, 2) assume authority and control over health and social services which impact their lives, and 3) design and implement a sustainable health system which meets their unique needs. The role of the federal and provincial governments is to work in partnership with Manitoba First Nations on the journey to design and implement a new First Nations health system. As mentioned earlier, given federal and provincial government renewed commitments to First Nations health, one can be confident of their cooperation. In closing, although environmental health is not addressed in this report we have to be mindful of what elders tell us about Mother Earth, the circle (Medicine Wheel) and the connection between the physical, emotional, psychological, spiritual and the environment.

***Section 10: Appendices and References***

## Appendix A

### Inter-governmental Committee on First Nations Health (Manitoba Romanow Joint Working Group)

#### Objectives / Role / Structure

#### Objectives:

1. To develop innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people.
2. To undertake the implementation and completion of the annual approved work plan.

#### STRUCTURE:

#### Membership

The membership of the RJWG will encompass three layers of participants, each representing the levels of government as outlined in the chart below – the formal Political Body, the Senior Officials Steering Committee and the Romanow Joint Working Group technicians.

<p style="text-align: center;"><b>POLITICAL BODY</b></p> <ul style="list-style-type: none"><li>• Ministers of Aboriginal Northern Affairs, Health</li><li>• Grand Chiefs AMC, MKO, SCO</li><li>• Minister INAC, Minister of Health Canada</li></ul>
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<p style="text-align: center;"><b>ROMANOW JOINT WORKING GROUP SENIOR OFFICIALS STEERING COMMITTEE</b></p> <ul style="list-style-type: none"><li>• Deputy Ministers &amp; Assistant Deputy Ministers (Federal &amp; Provincial)</li><li>• RDG , Health Canada &amp; INAC</li><li>• RD FNIHB</li><li>• Executive Directors AMC, MKIO, SCO</li></ul>
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<p style="text-align: center;"><b>ROMANOW JOINT WORKING GROUP TECHNICAL GROUP</b></p> <ul style="list-style-type: none"><li>• Policy Analysts/Health Advocates (AMC, SCO, MKIO, FNIHB, HC, INAC, ANA, MB. Health)</li><li>• Directors (AMC, HC, FNIHB, MB. Health)</li><li>• Elder</li></ul>
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## **Reporting Structure**

The technical group reports to the Senior Official Steering Committee (SOSC) through the Chairperson/Vice-Chairperson.

### **Chairperson**

The RJWG technical group will function and operate with a Chairperson from the Assembly of Manitoba Chiefs and a Vice-Chair from either the federal or provincial government as determined by consensus at the technical working group level. The RJWG SOSC will function and operate with a Chairperson as selected by consensus at the SOSC level.

## **ROLES & RESPONSIBILITIES**

### **Senior Officials Steering Committee**

- Ensure existence of processes for overseeing technical group
- Approval of work-plan and objectives
- Financial accountability and funding
- Monitoring on a quarterly basis
- Policy decisions
- Provide ongoing briefings to respective political leadership and seek direction where necessary

### **Technical Working Group**

- Implement direction of SOSC
- Propose and implement work-plan and recommendations
- Administer budget
- Undertake ongoing problem solving

### **Secretariat**

The Assembly of Manitoba Chiefs has agreed to host the Secretariat, which consists of a full-time Project Coordinator and support staff. The Secretariat is responsible for facilitating and coordinating the operations of the RJWG technical working group and the SOSC, while ensuring the following:

- Functions under the guidance of the RJWG and the appointed Chairperson(s)/Vice-Chairpersons in implementing the work-plan;
- Researching relevant internal decision-making processes and policy frameworks that apply to the federal and provincial health care delivery;
- Identification and management of research projects and/or maintains collaboration with interim consultants;

- Coordinates monthly RJWG meetings and quarterly meetings with the Senior Official Steering Committee. Ensures that the administrative responsibilities for meeting planning and arrangements are met and that the received direction from the RJWG Chairperson(s)/Vice-Chairperson(s) is Actioned;
- Shares fiscal responsibility with the Assembly of Manitoba Chief's financial directorate and provides monthly financial reports to the RJWG technical working group and quarterly financial reports to the SOSC;
- Develops, facilitates and produces written reports, briefings, research reports and recommendations as per the direction of the RJWG and Senior officials Steering Committee;
- The minutes of the meetings be distributed to the members/delegates within a one week of the meeting;
- The Agenda items be distributed a week in advance of the meeting for input from all parties; and
- The main issues and action items be duly recorded as stated and agreed upon.

### **Communication**

Communication lines must remain transparent and open. The members will report to their respective leadership. Public communication regarding the RJWG would be reflective of joint RJWG decisions.

### **Frequency of Meetings and Participation:**

#### Frequency:

Meetings for the RJWG technical Group will be held monthly or at the call of the Chairperson and will be held in both north and south locations. Meeting for all SOSC will be held on a quarterly basis.

### **Amendment Process**

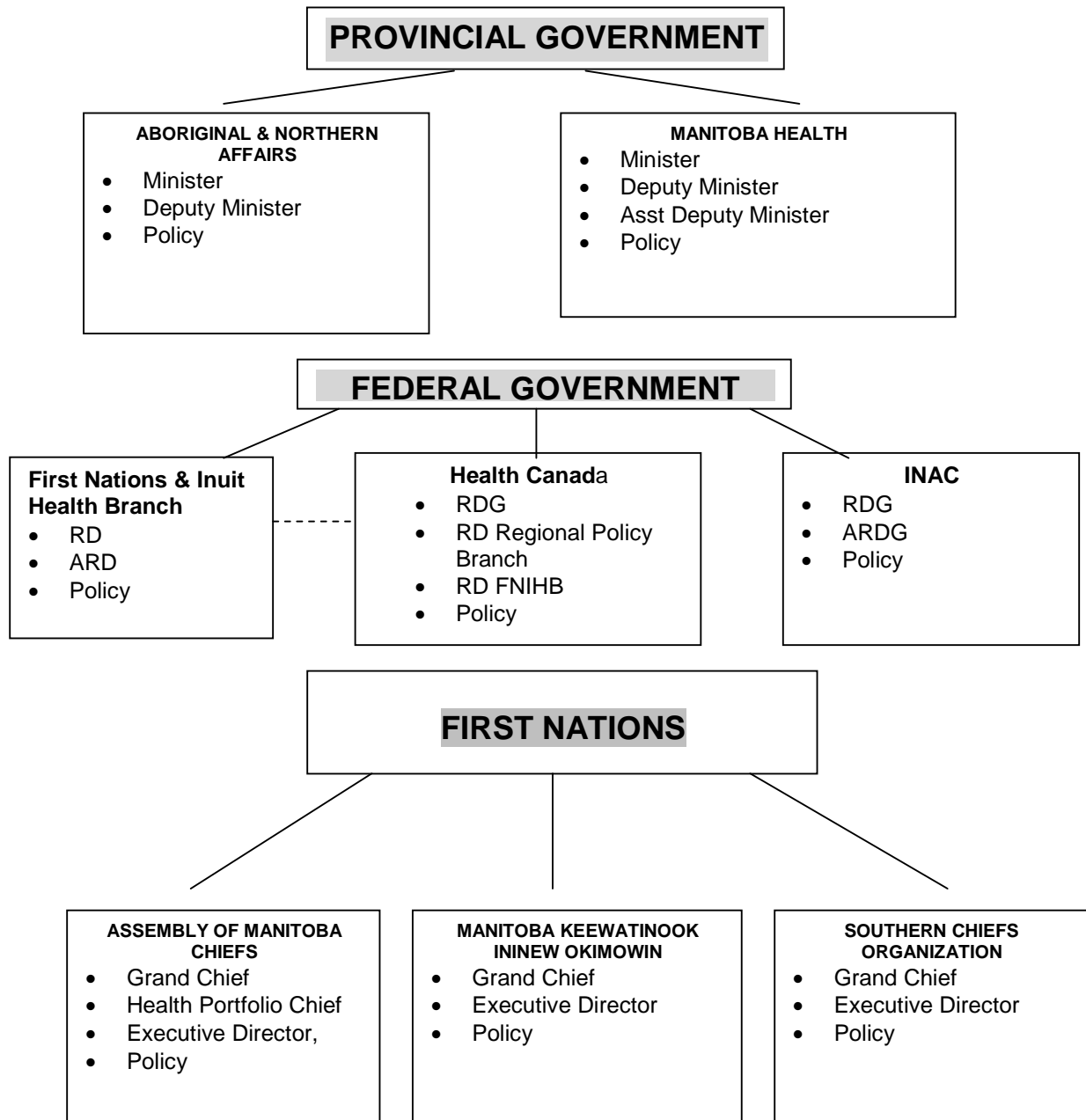
Decisions made by the RJWG Technical Group and the SOSC are to be made by consensus, representing all parties of the Romanow Joint Working Group.

The Terms of Reference may be revised based upon consensus from all parties of the RJWG from time to time as the need may arise. A motion will be requested and must be seconded by another to accept future amendments. One week's notice will be required to all members prior to a scheduled meeting with particulars to be included. Any and all Terms of Reference revisions must be reviewed and approved by the SOSC.

The Terms of Reference will be reviewed on an annual basis at the beginning of each fiscal year.



## Three Levels of Government and Appointed Representatives



\*RDG – Regional Director General; ARDG – Associate Regional Director General; RD – Regional Director; ARD – Associate Regional Director

\*Other technical representatives will be invited to attend on an “as needed basis” for their expertise. Each party may be required to consult with their constituents.

Source:

Excerpt from the Romanow Joint Working Group Terms of Reference (revised December 2004).

## Appendix B

### List of Representatives Interviewed or Consulted

Del Assiniboine  
Southern Chiefs Organization  
(ICFNH Representative)

Cathy McKenzie  
First Nations and Inuit Health Branch

Cal Albright  
Northern Aboriginal Population Health  
and Wellness Institute

Lorraine McLoed  
Anishinaabe Mino-Ayaawin Inc. (AMA)

Kathy Avery-Kinew  
Assembly of Manitoba Chiefs

Dr. Shannon McDonald  
First Nations and Inuit Health Branch

Loretta Bayer  
Manitoba Health – Aboriginal Health  
Branch  
(ICFNH Representative)

Garry Munro  
Cree Nation Tribal Health Centre

James Bone  
Keeseekoowenin Health & Wellness  
Centre

Marie O'Neil  
Manitoba Health

George Campbell  
(Elder Advisor to ICFNH)

Joseph Perch  
Manitoba Keewatinook Ininew Okimowin  
(ICFNH Representative)

Gloria Cameron  
West Region Tribal Council

Virginia Sanderson  
First Nations Inuit and Health Branch

Louisa Constant  
Manitoba Keewatinook Ininew Okimowin

Betty Anne Scott  
Manitoba Health – Aboriginal Health  
Branch

Crissy Courchene  
Assembly of Manitoba Chiefs

Patti Skillen  
Indian and Northern Affairs Canada  
(ICFNH Representative)

Kyleen Grubert  
Health Canada  
(ICFNH Representative)

Irvin Smith  
Indian and Northern Affaires Canada

Brian Gudmundson  
Manitoba Aboriginal and Northern Affairs  
(ICFNH Representative)

Larry Starr  
South East Resource Development Council

Charlotte Johnson  
Health Canada  
(ICFNH Representative)

Darrin Stevenson  
Assembly of Manitoba Chiefs

Trudy Lavallee  
Assembly of Manitoba Chiefs

Bev Swan  
Anishinaabe Mino-Ayaawin Inc. (AMA)

Irene Linklater  
Assembly of Manitoba Chiefs  
(ICFNH Representative)

Keely Ten Fingers  
Assembly of Manitoba Chiefs

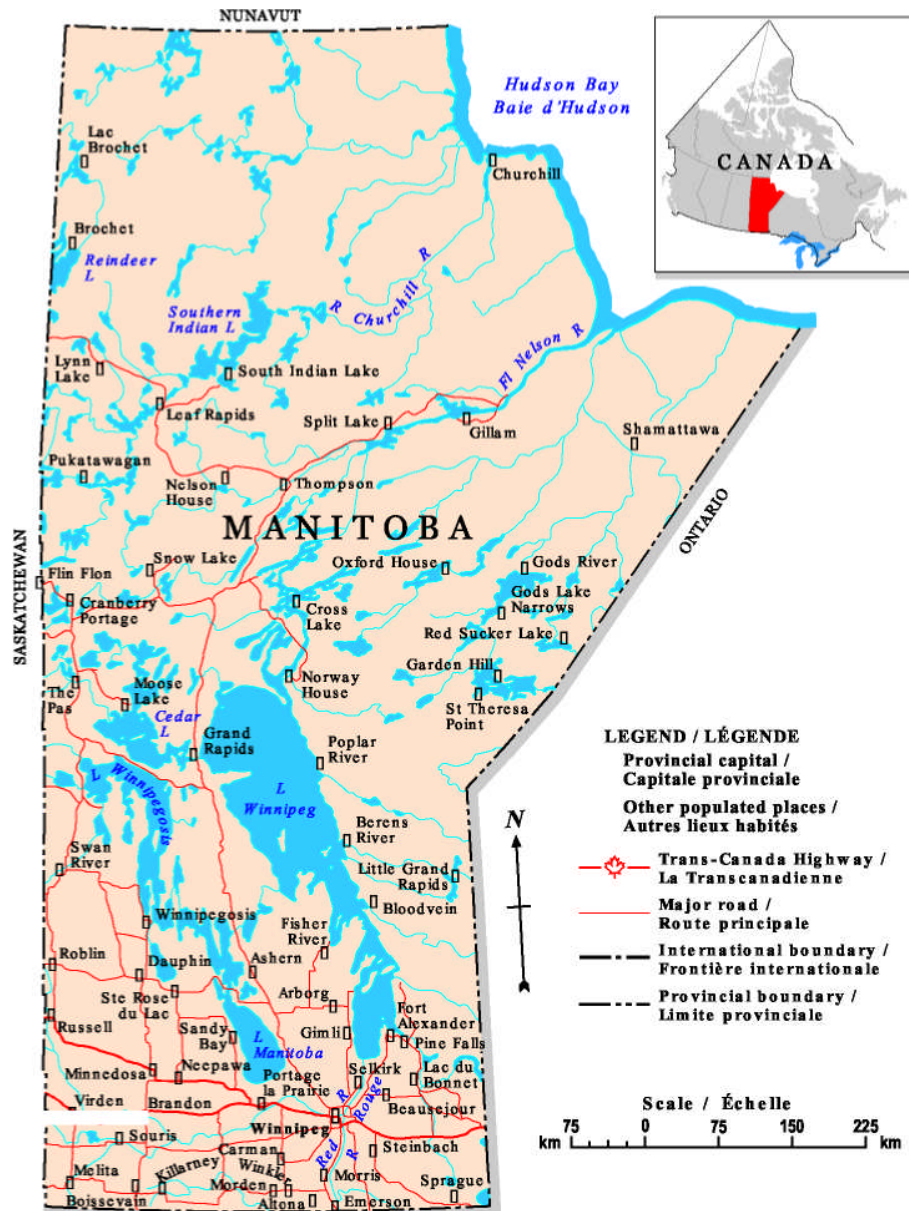
Melanie MacKinnon  
Assembly of Manitoba Chiefs  
(ICFNH Coordinator)

Andy Wood  
Four Arrows RHA (ILTC)

Jim Mair  
First Nations and Inuit Health Branch  
(ICFNH Representative)

# Appendix C

## Locations of First Nations in Manitoba



UNITED STATES OF AMERICA © 2001. Her Majesty the Queen in Right of Canada, Natural Resources Canada.  
 ÉTATS-UNIS D'AMÉRIQUE Sa Majesté la Reine du chef du Canada, Ressources naturelles Canada.

## Appendix D

# OVERVIEW OF LEGISLATIVE CHRONOLOGY: JURISDICTIONS IN HEALTH CARE

Within Manitoba, jurisdiction over health services for First Nations people remains ambiguous and an ongoing debate between the First Nations, the provincial and federal governments. The *Canada Health Act* of 1984 (CHA), with good intentions of providing insured and equitable health services for the country as a whole, has created confusion related to the responsible provider for First Nation health services. First Nations are unique in this regard, as they are entitled to medical care from the legislated provisions within the CHA as well as *The Constitution* of 1982. As jurisdiction is shared between federal and provincial governments with respect to health, it is important that a historical account is considered for understanding the origin of 'jurisdictions' in health care.

**Table 1: Historical Overview of Legislation and Policies affecting Jurisdiction in Health Care**

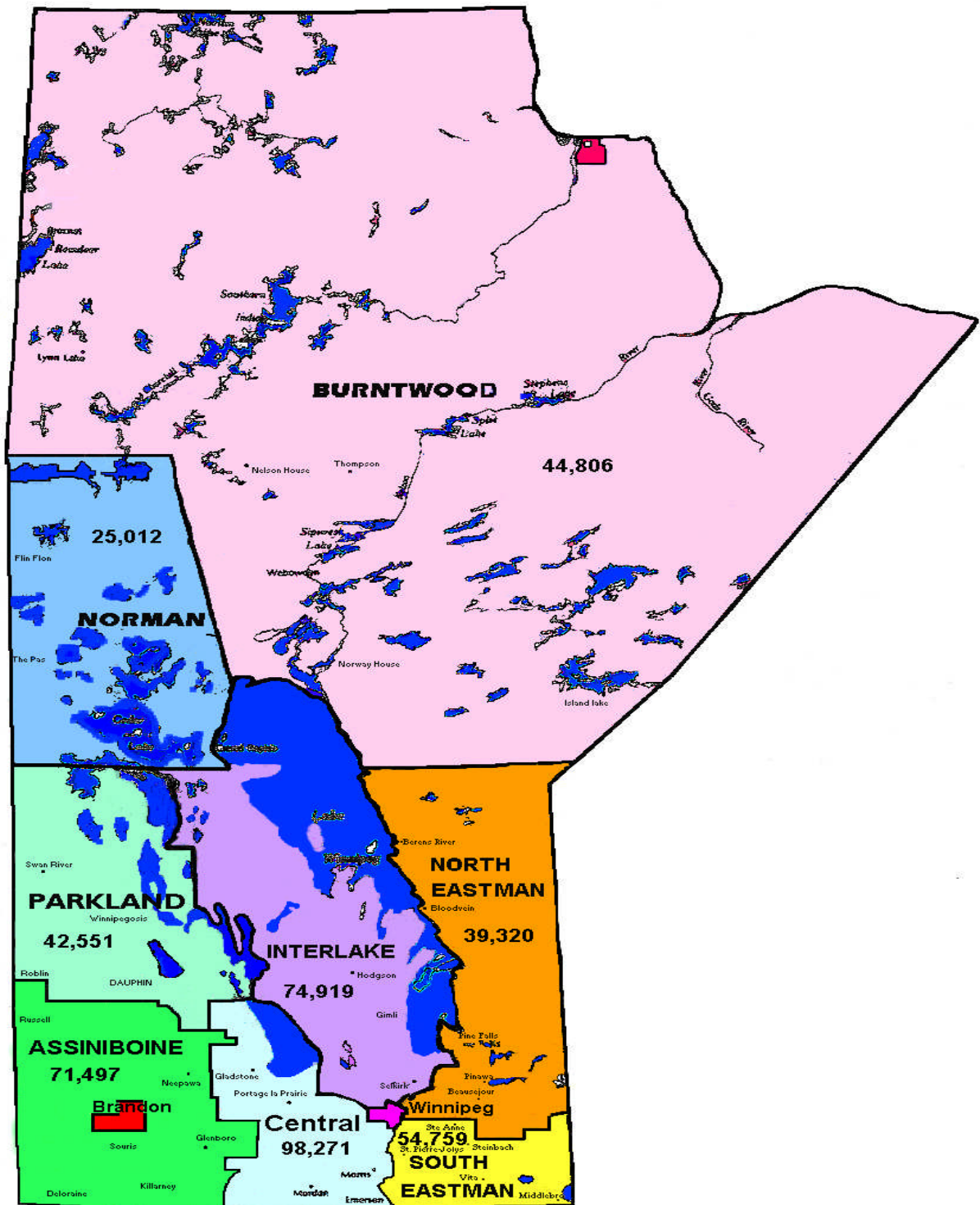
Landmark Legislation, Policy & Reports Affecting the Canadian Health Care System	Landmark Legislation, Policy & Reports Affecting Manitoba First Nations
<ul style="list-style-type: none"> <li>➤ <b>1867</b> BNA Act, provincial jurisdiction over health</li> <li>➤ <b>1919</b> Prime Minister, MacKenzie King promised national health insurance to Canadians.</li> <li>➤ <b>Up until 1953</b>, private health insurance or in cash/in kind services rendered usually by charitable or church run organizations/hospitals.</li> <li>➤ <b>1943</b>, The Canadian Medical Association (CMA) asked the federal and provincial governments to institute general medical care insurance due to high hospital and medical care costs that were not being paid by the families. The provinces originally rejected this since these costs would become the responsibility of the province.</li> <li>➤ <b>1948</b> Saskatchewan passed the <i>Universal Health Insurance Act</i>; the same year the federal government instituted the National Health Grants Program, money to the provinces, which was designated mainly to build hospitals. Tommy Douglas, elected Premier and infamous supporter/initiator of universal health care.</li> <li>➤ <b>1950's</b>, the CMA changed their resolution on medical care insurance to that of a <i>government funded but physician administered</i> health insurance program, recognizing if they did not control the insurance program, they would not be able to control their own income.</li> <li>➤ <b>1957</b> <i>Diagnostic Services Act</i>, 50-50 cost sharing between the federal and provincial governments but only covered costs for services provided in hospitals.</li> <li>➤ <b>1960's</b>, economic boom, funding for hospitals from</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>1763</b> Royal Proclamation 'Indians under the protection of the Crown'</li> <li>➤ <b>1867</b> British North America Act</li> <li>➤ <b>1867</b> Indian Act</li> <li>➤ <b>1876</b> Treaty 6 between the Cree of Alberta and Saskatchewan, and the Crown; included a Medicine Chest Clause. Treaty 1 also includes a Medicine Chest Clause but mention of this Clause was not made in any other Treaty. However "discussions" around 'medicine' and 'medical services' are referenced in Treaties 7, 8, 10, and 11.</li> <li>➤ <b>1927</b> the first Medical Branch was created within Indian Affairs and remained there until WWII. * During this era, First Nations appear to be the only insured persons receiving medical services in Canada.</li> <li>-<b>1940s</b> the Department of National Health and Welfare Act was passed and Indian Health Services became a part of this department.</li> <li>-<b>1962</b> the health services branch evolved into the Medical Services Branch and now stood on its own.</li> <li>➤ The introduction of the Diagnostic Services of <b>1957</b> and Federal Medical Act of <b>1968</b> began to affect the health service provision for First Nations as well as their relationship with the federal Crown. As the federal government began transferring money to the provinces for basic insured medical services for <b>all provincial residents</b>, the federal responsibilities for First Nations began to integrate</li> </ul>

Landmark Legislation, Policy & Reports Affecting the Canadian Health Care System	Landmark Legislation, Policy & Reports Affecting Manitoba First Nations
<p>the federal government. Hence all of the small hospitals in rural areas only short distances apart.</p> <ul style="list-style-type: none"> <li>➤ <b>1962</b> Saskatchewan passed their <i>Medical Act</i> over protests and a strike by 90% of the physicians, many left the province. Doctors were imported from Great Britain in large numbers.</li> <li>➤ <b>1968</b> <i>Federal Medical Act</i> was enacted to pacify the powerful medical profession. The act included a 50-50 cost sharing arrangement between the federal government and the provinces.</li> <li>➤ <b>1972</b> All provinces signed 'into' the Federal Medical Act due to this large financial cost sharing incentive.</li> <li>➤ <b>1970's</b> Economic recession and national health insurance becoming very expensive. Canada was becoming concerned with its 'open ended' liability to provide money to the provinces for health care.</li> <li>➤ <b>1974</b> The Lalonde Report, <u><i>A New Perspective on the Health of Canadians</i></u>, viewed as a landmark document around the world. It spoke to the concept that health-care was much more than medical and hospital care. It introduced the concepts of health promotion and illness prevention or community health care.</li> <li>➤ <b>1977</b> the 50-50 cost sharing between the governments was abolished and replaced by the Federal Provincial Fiscal Arrangements and Established Programs Financing Act known as EPF. This act introduced the formula for funding both health and post-secondary education programs which already existed. This funding decrease led to creative solutions to cover medical costs by physicians such as 'extra billing'.</li> <li>➤ <b>1980</b> The Hall Report on health services recommended an end to extra billing.</li> <li>➤ <b>1982</b> EFP and cash transfers to the provinces were frozen</li> <li>➤ <b>1984</b> The Canada Health Act was born and prevented any extra billing by medical practitioners. The beginning of Medicare with five national principles: Public Administration, Comprehensiveness, Universality, Portability &amp; Accessibility.</li> <li>➤ <b>1997</b> <b>Manitoba Regionalization Act</b> – Created non-profit corporations called Regional Health Authorities. Overseen by a Board of Directors, CEO ultimately reports to Manitoba Health.</li> </ul>	<p>with the provinces without the knowledge or participation of First Nations – this stems back to the BNA due to provincial responsibility over health.</p> <ul style="list-style-type: none"> <li>➤ <b>1964 Agreement</b> between Manitoba and Canada - affecting seven First Nation communities.</li> <li>➤ <b>1969 – White Paper</b> (devolution policy of Federal government)</li> <li>➤ <b>1971 Wabung: Our Tomorrows (Oct.)</b> – written by the Manitoba Indian Brotherhood.</li> <li>➤ <b>1979 Indian Health Policy</b> improving the health status of the 'Indian' population based on Three Pillars: (1) Community Development; (2) Relationship between Indian people and the federal government; (3) the interrelated Canadian health care system, with it's federal, provincial, Indian and private sectors.</li> <li>➤ <b>1982</b> The Constitution, Treaties Rights entrenched without or little mention to health.</li> <li>➤ The Berger Report of <b>1980</b> and the Penner Report of <b>1984</b> (Report of the Special Parliament Committee on Indian Self-Government). The Berger Report stated that "the matter of Indian health is 'critical' and recommended that the federal government engages in consultation with First Nations to effect the design, management and control of health services in their communities". The Penner Report stated, "Conditions of social disintegration and deprivation arising from the colonial treatment of Aboriginal peoples by the Government of Canada."</li> <li>➤ <b>1984</b> the Canada Health Act was enacted inclusive of an 'Aboriginal' exemption clause. This exemption is one of five; Aboriginals, RCMP, Armed Forces, Veterans, and Federal Inmates. All four of these groups (except FN) have legislative acts over health, which stipulates 'federal jurisdictions over health care, whereas FNs do not. Hence, the federal government exerts it 'public policy' versus 'treaty or constitutional right' to health care provisions.</li> <li>➤ <b>1986</b> MSB introduces the <b>National Health Transfer Process</b>.</li> <li>➤ <b>1988 Health Transfer Policy</b> intended to have First Nation communities assume control over the administration of health services in their communities.</li> </ul>

Landmark Legislation, Policy & Reports Affecting the Canadian Health Care System	Landmark Legislation, Policy & Reports Affecting Manitoba First Nations
<ul style="list-style-type: none"> <li>➤ <b>2002 Romanow Report – Chapter 10 on Aboriginal Health:</b> Recommendations #42 &amp; #43 (see attached handout)</li> <li>➤ <b>2003/04 Health Care Renewal –</b> numerous initiatives. 2003 First Ministers Health Accord; National Health Council; Renewing Medicare Reports/Initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>➤ <b>1991-1995 AMC</b> negotiations on the Health Framework Agreement (HFA) with Health Canada <ul style="list-style-type: none"> <li>- Government of Canada opposed the “<i>Treaty Right to Health</i>” clause. Health Canada’s position on health was based on public policy and a moral obligation. The parties do not sign the HFA as a result.</li> </ul> </li> <li>➤ <b>1994 Framework Agreement Initiative</b> signed</li> <li>➤ <b>1995 National Health &amp; Welfare Canada</b> changes name to “<b>Health Canada</b>” <ul style="list-style-type: none"> <li>- Introduction of the National Envelope System, leads to budget funding reductions</li> </ul> </li> <li>➤ <b>1995 Inherent Right to Self-Government Policy,</b> The Government of Canada recognizes the inherent right of self-government within section 35 of the <i>Constitution Act</i>, 1982.</li> <li>➤ <b>1996 RCAP</b>, recommendation for Aboriginal health: (1) equity to health &amp; healing services; (2) holistic approaches; (3) Aboriginal authority and community control (4) respective of cultural diversities.</li> <li>➤ <b>1998 Gathering Strength:</b> Canada’s Aboriginal Action Plan – Federal Governments Response to RCAP.</li> <li>➤ <b>1998</b> this branch was renamed First Nations and Inuit Health Branch (FNIHB). Is mandated to provide health care services that fall outside of the provincial jurisdiction as defined in the BNA Act of 1867.</li> <li>➤ <b>2004-05</b> Implementation of the <b>National Aboriginal Health Blueprint</b> process, mandated by the Federal-Provincial Accord (2003), to develop a national blueprint by Oct. 2005. <ul style="list-style-type: none"> <li>• <b>April 2004</b> Canada-Aboriginal People’s Roundtable</li> <li>• <b>Sept 2004</b> First Ministers Meeting: Special Session on Aboriginal Health</li> <li>• <b>Oct 2004</b> AFN Health Policy Summit in Winnipeg, MB.</li> <li>• <b>Nov 2004</b> Health Sectoral Session in Ottawa, ON.</li> <li>• <b>Feb 2005</b> AFN First Nation Health Strategic Session in Ottawa, ON.</li> </ul> </li> </ul>

Sources: AMC Documents & Research; Begin, M (2002); Cook, C. (2003); Craig, B. (1993); Gudmundson, B(1993); Hill, D (2004); Madore, O. (2001); Morris, A. (1991); RCAP (1996); Romanow, R. (2002).

## Appendix E (Regional Health Authority Regions)



Source: Regional Health Authorities of Manitoba Inc.



## Appendix F

### Specialized Fields of Practice within Traditional Medicine

***Spiritualist*** – a practice that focuses on the spiritual health of an individual and intervenes on his or her behalf. Diagnosis often includes lifestyle changes of the individual or family and offerings to various benevolent spirits. Also, this person often serves as a counselor, mentor or teacher to individuals and families. The primary focus is on the spiritual wellbeing of people. Their knowledge of cultural spiritual practices is expansive and highly respected by the community, and they often carry titles of honour such as ‘Faithkeeper, Holy Person or in South America, (Traditional) Priest.’

***Herbalist*** – a practice that emphasizes botanical and pharmacology knowledge of indigenous plants and fauna. Often these individuals work closely with other indigenous doctors and assist in providing remedies for individuals whom they or others have diagnosed. Their practice can be highly specialized in one field, such as remedies for snakebites, or as diverse as the illnesses themselves.

***Diagnosis specialist*** – a practice that often involves communication with spirits, the supernatural and the physical entities that assist in the diagnosis. Diagnosticians are often the “seers” or communicators through ceremony who identify the ailments, remedies or ceremonies that are required to restore good spiritual, emotional, and physical health, and well-being. Often they work as referrals to other specialists.

***Medicine man/woman*** – a practice that may and often does possess all of the above gifts and more. Their work usually engages in ritual, ceremonial activity and prayer. In some societies they are identified as ‘medicine men/women’ because they possess sacred bundles, sacred pipes, sacred masks, and the rights to rituals, songs and medicines that have been inherited from their parents, grandparents, or that they earned through apprenticeship with a respected medicine man or woman. Depending on their nation, they are also conductors of community ceremonies such as Sundance, Dark Dances, Horse Dance, False Face, Shaking Tent, and Sweat Lodge, to name a few. It is normative for these individuals to sacrifice their daily lives to ritual, prayer and healing.

***Healer*** – a gifted individual who may heal in a variety of ways, including all of the above and or by a ‘gift’ of touch, or energy work – meaning that ritual is not always needed. Healers can be ritualistic, but also may have an ability to use a variety of therapies to heal people spiritually, emotionally or physically.

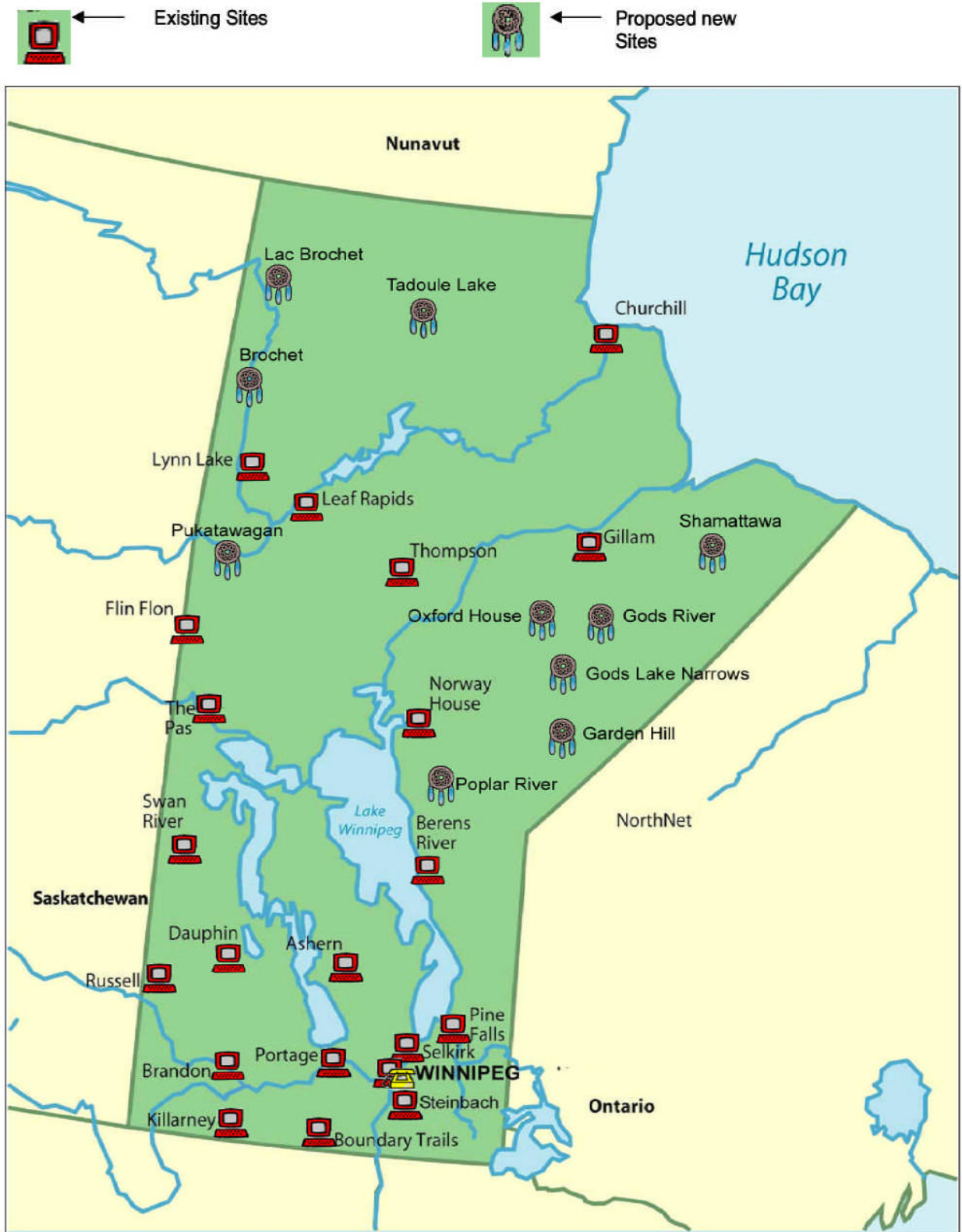
**Midwife** – Often, these practitioners are women with specialized knowledge in prenatal care, birthing assistance and aftercare. The midwife may employ the use of massage, diets, medicines and ritual, prayers and/or counseling. Traditional midwifery exists worldwide and involves a variety of skills, often biophysical, but can also include spiritual and ritual activity as well.

Source: Hill, DM, NAHO (2003) Traditional Medicine in Contemporary Contexts, 8;

The following is a note from the Author: *“None of the specialized categories are solely exclusive; rather, they are often interdependent and some practitioners may hold a number of specialized knowledges. In this sense, the literature suggests that traditional medicine is similar to Western medicine in the range and variety of special knowledge/training of caregivers (Coulehan, 1980; Waldram, 1990; McWhorter and Ward, RCAP: 1996). A word of caution – the focus groups with Elders and healers expressed concern regarding the “clinicalization” of traditional medicine as a means of transforming the practice from cultures to institutions”.*

# Appendix G

## MBTelehealth Sites – Planned First Nations Expansion



Source: Adapted from MBTelehealth

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