Mino Pimatiseewin:

A Content Analysis of the

Aboriginal and First Nations Submissions

to the

Commission on the Future of Health Care in Canada

By Rose McIvor-Girouard

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirement of the degree of

MASTER OF SOCIAL WORK

University of Manitoba

Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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Of

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Acknowledgements

To my husband, Lenny Girouard – Thank you for your love and support. I have appreciated your constant understanding and encouragement throughout my graduate work, which has resulted in the completion of this thesis.

To my son, Hayden Girouard – you are the best helper a mom could have. Thank you for helping me with my filing and for stapling all those folders for my research. You are a great son!

To my sister, Rita McIvor, thank you for "being there" when I needed to ask you questions about our culture and language. To my sisters, Sarah McIvor and Alice McIvor - thanks for your understanding while I completed my thesis. To my brother, Doug – Thank you for wisdom and endless support. To my friend, Natalie Wood – Thank you for your encouragement.

To my thesis advisor, Dr. Sharon Taylor-Henley. Thank you! I cannot express my appreciation enough for all your help and support so I could get this thesis done. To my thesis committee members, Dr. Sid Frankel and Dr. John O'Neil. Thank you for your time and work on my committee.

To my employer, West Region Child and Family Services, Inc (WRCFS) - Thank you for your support of educational pursuits under the leadership of the Board of Directors – WRCFS Chiefs.

To my friends and colleagues at WRCFS – Stella Bone, Angela Everett, Bert Crocker, and Leanna Flett. Thank you for your support while I worked on my thesis. Thank you to Doreen Fleury who graciously translated French documents to English. Thank you to Virginia Taypaywaykejick for helping me to format my document. To

Verna McIvor – Thank you for all your kindness and your time spent listening to me about my studies. To the WRCFS staff - Thank you for the many moments of kindness, caring, and sharing when I needed it most as I finished my thesis.

To my friend and colleague, Marilyn Bennett – Thank you for your help and advice. To Ciuineas Boyle, Co-ordinator Access to Information and Privacy at the Privy Council of Canada – Thank you for sending me the documents that I needed for my research.

Ekosi,

Rose McIvor-Girouard

In Memory of

My parents,

Don and Nancy McIvor

Abstract

This research supports the assertion that First Nations peoples and their organizations have suggestions and potential solutions for addressing the future of health care in Canada as it relates First Nations Canadians. First Nations understand and know what changes are needed to improve their poor health status within Canada. This research, based on a First Nation perspective, used content analysis to explore the needs identified by the First Nations organizations that responded to the Commission on the Future of Health Care in Canada (the Romanow Commission). The Romanow Commission was established in April 2001 and one element of its mandate was to engage Canadians in a national dialogue on the future of heath care and make recommendations to the health care system. This research examined the written submissions to the Romanow Commission by the thirty–two (32) Aboriginal organizations. The main interest and focus of this research was on the written submissions of eighteen (18) First Nations organizations.

The Aboriginal Life Promotion Framework (Bartlett, 2004) was developed by a Metis woman and sensitized the researcher in the direction and organization of the research data. The research analysis revealed twenty-one (21) themes among the Aboriginal submissions. Four (4) of these themes were common to all five identified Aboriginal categories [First Nations, Inuit, Metis, Metis & Aboriginal, Aboriginal Interest/Focus] created by the researcher to assist in the organization of the research data. The researcher examined these four themes with the major focus being First Nations health concerns with respect to: (1) relationships with federal and provincial governments; (2) policy and program development; (3) fiscal resources; and, (4) accessibility issues.

This research found First Nations did not echo the same approach to change the health care system as the Romanow Commission did in its final report regarding Aboriginal Health. It is important for First Nations people to put forth their own ideas about the direction for First Nations health to offset the pan-Aboriginal approach that the Romanow Commission has offered. Therefore, this research supports the need for increased participation by First Nations peoples, including their respective governments and First Nations health organizations in health research. From their own perspectives, First Nations identified their own solutions, which they believe may likely lead to a better health care system for First Nations. This research has advocated for the future development of a "Miõo Pimâtisiwin or Mino Pimatisiwin First Nations Conceptual Framework" developed by First Nations for First Nations Health Research. "Mino Pimatisiwin" in the Swampy Cree language [Miõo Pimâtisiwin in the Woodlands Cree] translated infers the meaning "good survival/living, "healthy survival/living". The results of this research will be of interest to those engaged in policy development as it relates to First Nations health.

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I. INTRODUCTION

This research focused on what First Nations[1] wanted from Canada's health care system. First Nations health status remains "deficient relative to the general population" of Canada (Helin, 1993, p.158; Assembly of First Nations, [AFN] 2002; Metis National Council [MNC], 2002). This research examined what First Nations stated they wanted changed in Canada's health care system in 2001 – 02. First Nations provided recommendations regarding the health care system to the Commission on the Future of Health Care in Canada (the Romanow Commission). This research found First Nations firmly believe that they know what needs to be changed in the health care system.

In 2001, The Government of Canada established the Romanow Commission to review medicare, to engage the Canadian public in discussion about the health care system throughout the country. The Commission was charged with responsibility to make recommendations to enhance the system's quality and sustainability and to outline policies and measures that would ensure the long-term sustainability of a universally accessible, publicly funded health care system. (Romanow, 2002) The Romanow Commission provided Aboriginal people[2] a national venue to express what changes they wanted from Canada's health care system. Across Canada, various First Nations organizations participated in the Romanow Commission; they voiced concerns about issues affecting First Nations regarding Canada's health care system. The recommendations put forward by First Nations were efforts to possibly address the continued concerns regarding the poor health status of First Nations, a fact often cited in

[1] The term, First Nations in this research is interchangeably used with the term "Indian" which refers to individuals that have a right to be registered under Indian Act of Canada.

[2] The term Aboriginal is used as outlined in the Canadian Charter of Rights and Freedoms: Aboriginal people are Indians defined under the Indian Act, the Metis and the Inuit of Canada.

literature. (Helin, 1993; Royal Commission on Aboriginal People [RCAP], 1996, Romanow, 2002).

First, the purpose of this research was to identify what First Nations people wanted from Canada's health system in 2001 – 02. The main research activity entailed a content analysis of documents submitted by various Aboriginal organizations to the Romanow Commission. The research used an Aboriginal conceptual framework, the Aboriginal Life Promotion Framework (ALPF) developed by Judith Bartlett to examine the submissions of Aboriginal organizations. (Bartlett, 2004, p. 154).

Second, the purpose of this research was to make a First Nations contribution to Aboriginal health research and to influence future policy direction on First Nations health in Canada. I firmly believe that "we" as First Nations people determine our own course of life and determine what makes sense for us in health care. First Nations people need to continue to advocate for change to address the health status gap in Canada. I have direct experience with the health care system as a First nation woman. Issues related to access, portability, and navigation within the health system has been difficult. This research was an effort to advocate for change to improve the health services to First Nations in Canada.

This report includes some review on Canada's health care system, the duties of the Commission on the Future of Health Care in Canada, and Aboriginal/First Nations participation in the Romanow Commission. There is a discussion about the cultural context of Aboriginal health and the Aboriginal Life Promotion Framework (Bartlett, 2004) presented. This framework was used as a sensitizing framework for the researcher. A content analysis of the Aboriginal submissions to the Romanow Commission was undertaken. Themes are identified and recommendations put forward with respect to

First Nations health. The value and contribution of this work to the social work is discussed in the final chapter.

II. LITERATURE REVIEW

This literature review consists of two parts as follows. The first part discusses the Canada's health care system, the Commission on the Future of Health Care, Aboriginal participation in the Romanow Commission, and First Nations health status. The second part identifies the cultural context of health and presents an Aboriginal conceptual framework.

i. Canada's Health Care System

Canada has a publicly funded heath care system. The health care system is guided by the following principles: public administration, comprehensiveness, universality, portability, and lastly, accessibility. (Health Canada, 2004) Public administration means the heath care delivery is administered and operated by a public authority, and the provincial government is responsible for health care administration. Comprehensiveness means that provincial health care insurance plans insure that "medically necessary hospital services, physical and surgical-dental services are provided to the insured persons." (Health Canada, 2002) Universality states that all residents except the Canadian Forces, the Royal Canadian Mounted Police [RCMP], and federal prisoners are entitled to provincially insured health services. The federal government's role in health care is to provide services directly to the following, veterans, First Nations living on reserve, the military, the RCMP, and federal prisoners. Portability allows the province's health insurance plan to continue to cover a resident temporarily traveling outside of their home province. There are some categories of resident, which require a waiting period before they can receive health care services. Accessibility requires that health care delivery be without discrimination based on age, lifestyle or health status;

services should be available at a comparable level for all Canadians. (Health Canada, 2004)

First Nations organizations continue to question whether these principles have made their way into First Nations communities. Evidence of this position was noted in First Nations submissions to the Romanow Commission. (AFN, 2002; Assembly of Manitoba Chiefs [AMC], 2002; Dakota Ojibway Tribal Council [DOTC], 2002; Romanow, 2002, Southern Chiefs Organization [SCO], 2002) First Nations people argue that they have not experienced the same level of health services as their fellow non-Aboriginal Canadians. Provinces have primary responsibility for health care delivery but the federal government has a responsibility in publicly funded health care, including the protection and promotion of health. (Health Canada, 2004) First Nations argue that the federal government has not fulfilled responsibilities in the health care system. Many First Nations put forth the argument that the issue of health is not just one of policy; it is a treaty and an inherent right. For example, Manitoba First Nations cited in Wahbung (1971) their position "that the Medicine Chest of treaty-signing days, interpreted in the light of today's context, applies to all Indians of Canada to mean all medical services, medicare, public health services, medicines, hospital services, laboratory services, eye care, dental care, and medical appliances."(1971, p. 74.) This position was repeated to the Royal Commission on Aboriginal People [RCAP] and to the Romanow Commission by the Assembly of First Nations and other First Nations organizations such the Alberta First Nations, Assembly of Manitoba Chiefs, and by Southern Chiefs Organization of Manitoba to name a few. (Alberta First Nations, 2002, AFN, 2002, AMC, 2002, DOTC, 2002, SCO, 2002, RCAP 1996)

The release of the Commission on the Future of Health Care in Canada's Final Report in November 2002 coincided with Saskatchewan's 40th anniversary of medicare. (Romanow, 2002, p. xxi). For First Nations people, those 40 years of medicare translate into a reminder that Canada has not adequately met the needs of First Nations' health care. In Wahbung (1971), First Nations identified issues such as accessibility to health services, rights to health care, and transportation that needed to be address by the federal government. These issues are consistent with what First Nations people identified to the Romanow Commission. (Mackinnon, 2005, Romanow, 2002) Canada purports that the federal government is responsible for providing quality health services to First Nations and Inuit along with other groups. (Romanow, 2002, p.3) Many First Nations argue that the federal government has not fulfilled its responsibility to provide health services adequately to First Nations. (Romanow, 2002, RCAP, 1996; Wahbung, 1971,)

ii. The Commission on the Future of Health Care in Canada

In April 2001, the Government of Canada established the Commission on the Future of Health Care in Canada. The Romanow Commission's mandate was to review the heath care system, engage in a national dialogue with Canadians on the future of medicare and make recommendations to improve the health care system's quality and sustainability. Further, the Commission's mandate was to recommend policies and ways to make sure of the long-term sustainability of a universally accessible, publicly funded health system. (Romanow, 2002, p. xv)

The Romanow Commission carried out its mandate in two stages. The first stage was fact-finding [June 2001 to Dec 2001]. At the end of this stage, the Romanow Commission produced an interim report, which was a synthesis of the Commission's

findings. During the first stage, Canadian organizations have participated by submitting written submissions to the Romanow Commission. The second stage of the commission's work was to dialogue with the Canadian public and interested stakeholders throughout the country. During the second stage, there was a consultation period where public hearings were held [March 4, 2002 to May 31, 2002]. Aboriginal organizations participated in both stages of the Romanow Commission, the fact-finding phase and the consultation phase.

iii. Aboriginal/First Nations Participation in the Romanow Commission

Aboriginal/First Nations organizations throughout Canada participated in the Romanow Commission in an effort to create awareness about their experiences with the health care system and to influence change in Aboriginal health.

During the first stage of the Romanow Commission, ten (10) Aboriginal organizations participated by submitting written submissions. In the second stage, thirty-two (32) Aboriginal organizations participated in the public hearings held across the country. The Romanow Commission worked with the National Aboriginal Health Organization (NAHO 2002) and hosted a national forum [June 26, 2002, Aylmer, Quebec] on Aboriginal health issues. First Nations, Métis, Inuit, urban Aboriginal people and communities came together to share their successes, challenges, and views on the future of health care. (Romanow, 2002, p. 211) The Romanow Commission tabled a final report with forty-seven (47) recommendations regarding the health care system and its direction. There were two (2) recommendations regarding a new approach to Aboriginal Health, which were as follows:

"Recommendation 42 – Current funding for Aboriginal health services provided by federal, provincial and territorial governments and Aboriginal organizations should be pooled into single consolidated budgets in each province and territory to be used to integrate Aboriginal health care services, improve access, and provide adequate, stable and predictable funding.

Recommendation 43 – The consolidated budgets should be used to fund new Aboriginal Health Partnerships that would be responsible for developing policies, providing services and improving the health of Aboriginal peoples. These partnerships could take many forms and should reflect the needs, characteristics, and circumstances of the population served." (Romanow, 2002, p.253)

Some examples of the Aboriginal Health Partnerships as suggested in the Romanow Commission's Final Report included; a regional partnership model targeting all individuals who want to benefit from integrated and culturally appropriate health services; or a community initiative model for individuals or communities, and a local partnership model where heath care providers and others are concerned with services for urban Aboriginal people. (Romanow, 2002, p.229)

iv. First Nations Health Status in Canada

The First Nations and Inuit Regional Health Survey [FNIRHS], (1999) was undertaken because First Nations and Inuit people had been left out of the three major national surveys related to health; the National Population Health Survey, the National Longitudinal Survey of Children and Youth, and the Survey of Income and Labour Dynamics. (FNIRHS, p. 185) The timing of the FNIRHS (1999) is significant as First Nations and Inuit people had a growing concern that the present health system was not

meeting their needs, issues related to limited resources affecting program priorities and the concerns regarding health transfer agreements with the Federal governments. (p. 185)

The FNIRHS survey asked First Nations and Inuit if they believe that they had the same level of health service as the general population of Canada and 47 percent of respondents reported services were not at the same level as the rest of Canada. (1999, p. 193). First Nations and Inuit want a different health care system than the one they currently have. (Romanow, 2002, FNIRHS, 1999)

First Nations live in a county where Canada's federal health department wants Canadians to be the healthiest in the world. However, the First Nations Regional Longitudinal Health Survey hereafter, (RHS) in 2002-03 identified significant gaps regarding the living conditions and health of First Nations compared to Canadians in general. (FNIRHS, 2003, P.11) Some health issues faced by First Nations that RHS (2003) reported are that their diabetes rates are three times the Canadian average, residential schools have had negative impacts on First Nations health and well being, obesity rates in First Nations are twice as high as for Canadians, smoking rates are more than double the Canadian average, and that water is considered unsafe in many First Nations homes. First Nations were more likely to be living in crowded homes in 2002 than Canadians in 1991; and mold and mildew affected a large number of First Nations homes. (RHS, 2003, p. 11)

Health Canada (2003) reported that Aboriginal health status, which includes First Nations, has improved in some areas such as life expectancy and the reduction of infant mortality. However, this improvement in health status is not as good as that of non-Aboriginal Canadians. Health Canada stated that Aboriginal people face higher rates of

chronic disease, such as diabetes, which affects First Nations people at a rate of three to five times higher than the general Canadian population. Infectious diseases, such as tuberculosis where Aboriginal Canadians have rate ten times higher than for other Canadians. There is a gap in life expectancy of Aboriginal people compared to the non-Aboriginal population. On average, First Nations men live seven years less than other Canadian men, and First Nations women, five years less than other Canadian women. Higher rates of suicide, especially among Aboriginal youth with a suicide rate for First Nations youth that is five to six times higher than the national average and for Inuit youth eleven times higher. The living conditions and health of First Nations people continues to be dismal. (Health Canada, 2003; NAHO, 2002; Young, 1988)

Martens, Sanderson, and Jebamani (2005) noted that First Nations Canadians experience greater mortality and morbidity rates than the general Canadian population and should therefore access services at a higher rate. However, 18 % of First Nations Manitobans report needing care and not receiving it, only 13% reported adequate availability of primary care and 6% reported adequate availability of specialists. The inadequate availability of health professionals is just one example of a barrier faced by First Nations when they access health care services. (Martens, et. al. 2005, p. S44). First Nations continued to identify to the Commission on the Future of Health Care (2002) the ongoing barriers they face in the health care system.

This researcher remains optimistic that First Nations will continue to advocate for changes to the health care system to address the First Nation health status gap. As a First Nations Canadian, I continue to remain confident that First Nations have their own

solutions to meet their health care needs at an individual level and at community levels services.

III. METHODOLOGY

This research explored what First Nations people told the Romanow Commission about what was needed from Canada's Health Care System. It reviewed all English Aboriginal/First Nations' submissions to the Romanow Commission. This research used .content analysis to explore the ideas presented in documents. By conducting a content analysis, inferences were drawn from the research data, which will be discussed later in this section. .

Further, the researcher used a conceptual framework – the Aboriginal Life Promotions Framework" [ALPF] developed by Judith Bartlett. (Bartlett, 2004) as a sensitizing framework, which allowed the researcher to organize the data from a cultural perspective. The ALPF offered a sensitizing framework for the researcher that provided a beginning guide and starting point for my research. Using ALPF offered a way to organize data in a holistic manner and to make some decisions as to what to extract. (Patton, 2002, p.278) This researcher created data collection tools, which used the ALPF sixteen elements of human existence to review the recommendations from that reference point; a holistic perspective.

This research undertook a qualitative approach that allowed flexibility when trying to understand complex issues Morse and Richards (2000) outlined various situations when qualitative approaches might be the best or the only way to address some research questions. My purpose was to understand what First Nations wanted from the health care system, to discover themes and to provide an analysis. (pp. 27 & 28) York (1997) indicated, "Qualitative research methods employ a flexible means of observation." and "qualitative measurement is more suitable to the development of theory and the

subjective description of social phenomena". (p. 261) Further, it is reported, "Qualitative measurement is also more suitable if the purpose of the study is the description of the subjective meaning of human processes or events as opposed to the precise description of them." (p. 261). The literature notes that another researcher cannot duplicate this type of research as another researcher may ask the same question but may use a different analytic technique or different research method. (Morse & Richards, 2002)

i. Cultural Context

This research was based on the premise that changes to the health care system for First Nations must come from First Nations people. It is with this shared belief that this researcher supports the notion of a holistic approach to health care advocated by First Nations. (AMC, 2002, DOTC, 2002, Romanow, 2002) I have worked in various First Nation organizations[3], which have embodied holistic approaches that paid attention to the physical, mental, spiritual and emotional aspects related to policy/program development and service delivery by the organizations.

As First Nations, we want control regarding the future direction of the health care system. First Nations have stated that they want a different system to meet their health needs. (Romanow, 2002; DOTC, 2002, AMC, 2002) This thesis presents research from a First Nations perspective regarding First Nations health issues and advocates a more holistic approach that would present a paradigm shift in policy direction and policy making regarding health care. This shift involves First Nations' people making decisions in health care funding, program design, program service delivery, and First Nations' government health structures.

[3] In Manitoba, I have worked at the following First Nation organizations, Awasis Agency of Northern Manitoba, Cree Nation Child and Family Caring Agency, Assembly of Manitoba Chiefs and West Region Child and Family Services, Inc.

This research utilized an Aboriginal conceptual framework as sense of reference and it provided some direction as to how to look at the research. (Patton, 2002, p.456) This conceptual framework was grounded in the belief of a holistic approach and the culture of Aboriginal people. First Nations cite that the cultural aspects must be attended to when there is development of any programs and services for First Nations communities. (AFN, 2002, AMC, 2002, DOTC, 2002). This research attempted to bring forward a First Nations perspective of what First Nations wanted regarding the health care system. Boldt (1993) sees research undertaken from an Aboriginal perspective/framework as important if Canada is to gain a further understanding of First Nations. (p. 183).

As a First Nations woman, I was able to relate to the framework's underlying principles and in particular, its holistic approach to life. The Aboriginal conceptual framework helped the researcher to organize the First Nations' ideas and recommendations about the health care system. Using the Aboriginal conceptual framework affected the researcher spiritually, emotionally, physically and intellectually when examining the data.

ii. Aboriginal Life Promotion Framework

This research used an Aboriginal conceptual framework to sensitize the researcher, which allowed for the organization of the research data. The following section discusses the Aboriginal conceptual framework.

Judith Bartlett, a Metis woman, hypothesized a culturally appropriate holistic construct for describing Aboriginal well-being. She developed the Aboriginal Life Promotion Framework (ALPF) (Bartlett, 2004, p.6). Bartlett (2005) used ALPF in a

study to gain understanding of the perception of health and well-being for Metis women in Manitoba. (p. S22) She (Bartlett, 2005) has suggested that ALPF is a tool that can be utilized when reflecting on life by organizing thought that already exists. (p. S22) This framework was used as a tool to sensitize the researcher in the organization of research data.

The ALPF begins with the premise that there are sixteen elements of human existence. This framework is grounded in Aboriginal philosophy and principles. The elements of human existence are grouped in four circles and each circle consists of four elements in each. The circles are significant as they are representations of the holism used by Aboriginal people. The first circle consists of the following terms, spiritual, emotional, physical, and intellectual. The second circle consists of four different age categories, child, youth, adult, and elder. The third circle consists of systems size groupings, individual, family, community, and nation. The fourth circle consists of terms that refer to the cultural, social, economic, and political environment. (Bartlett, 2004, p.7)

The ALPF used sixteen elements of human existence to describe life as a whole. It is a holistic view regarding life. The four circles containing the elements of human existence are separate but elements are seen together to understand life/phenomena.

iii. Content Analysis

Content analysis allows for text documents, a mode of communication about social phenomena that reflects a point in history, to be generally examined. (Berg, 2001, p.240) Content analysis is a systematic approach to transforming the symbolic content of a document or a statement or a presentation. It allows for a form of coding. It allows for

documents, which were developed for other purposes, to be accessible for research (Monette, Sullivan, Dejong, 1989, p. 212)

Northey, Tepperman, and Russell (2002, p. 95) has stated that content analysis bridges qualitative and quantitative research and allows for generalizations. Frankfort-Nachmias & Nachmias (2000) stated that content analysis provides a systematic approach to analyze data. Content analysis allows inferences to be made and specific characteristics of messages to be identified. There are three applications of content analysis, to describe the traits of the message, to make inferences about the message and its causes, and to make inferences about the effects of the message. (pp. 296-298). The research has used the application of making inferences about what was written by First Nations in a text document.

Berg (2001) described content analysis as a technique, which is helpful when text is reviewed. Content analysis is an approach that can be used for the identification of themes. Content analysis began by the researcher reading the documents that were presented to the Romanow Commission by the Aboriginal/First Nations organizations. The purpose of reading the documents was to identify in the text the recommendations made by First Nations and other Aboriginal groups to Canada's health care system present in the Aboriginal/First Nations submissions. As I identified the recommendations in the body of the document, I highlighted the written passages. (Padgett, 1998, p. 78) This methodological approach to data analysis was described by Prior (2003, p. 149) as the examination of document content with a defined set of procedures, so the researcher, can produce conclusions. The approach used can be described as a systematic review methodology.

As I identified each of the recommendations, I collapsed the recommendations further by recording the main idea that was being conveyed alongside the initial recommendation. For example, if a First Nations organization recommended more fiscal resources to build capacity, I would have collapsed the text to the following shorter phrase, "fiscal resources for capacity building." Given the voluminous nature of the documents in this research, collapsing the data to shorter text phrases allowed for greater data management for retrieval and organization purposes. Sarantakos (1998) described qualitative data analysis and its management as data reduction where data is coded, summarized and categorized to identify important aspects. (cited in Alston & Bowles, p. 207) Data reduction helped the researcher decide how the data were recorded and how the method of analysis was used and to arrive at conclusions. The goal of data reduction was achieved as the main themes emerged from the research and the information was categorized. (Sarantakos, 1998, p. 207) The second component of data analysis is data organization. This is the process of assembling information around certain themes in a written document. The third component is to interpret the data. This process involved looking for patterns, trends, and explanations, which lead to conclusions. (Sarantakos, 1998, p. 207)

"Sequentially numbering the categories starting at 0 or 1 helps to minimize the risk of miscoding" (Frankfort-Nachmias & Nachmias, 2000, p. 305) For the purposes of this research each of the recommendations of the Aboriginal organizations was placed in a category. As Frankfort-Nachmias & Nachmias indicated, a coding scheme can take a long time and this researcher went back and forth between the raw data and the evolving scheme until the categories emerged. The preliminary code schemes enabled the

researcher to arrange and classify the raw data and reduce the voluminous data to analyze. (2000, pp. 307-308)

Content analysis allows for the use of documents, which endure and also give a historical perspective. (Hodder, 1994) The First Nations provided challenges and offered recommendations in 2001 – 2002, a particular period for the health care system. From a different perspective, this researcher reviewed the documents for another purpose than that for which the documents were intended. This research was viewed from a First Nation perspective, which gave the documents analyzed a different meaning than other readers might have found. (Hodder, 1994) "Accurate production of meaningful information relies upon beginning with a conceptual framework and measures grounded within a cultural context." (Bartlett, 2004, p. 10) This research reviewed documents from a sensitizing framework, ALPF. Each of the Aboriginal and First Nations recommendations were recorded by the researcher and were placed in one of the four circles, which contained the sixteen elements of human existence in the ALPF.

iv. Data

The data were the written documents tabled by Aboriginal and First Nations organizations, which represented their views/recommendations in 2001- 02 to the Commission on the Future of Health Care in Canada.

In the fact-finding phase of The Romanow Commission, Canadian organizations responded by sending in written submissions related to health care issues up to December 31, 2001. The Romanow Commission continued to accept organizations submissions after the formal submission phase. The Commission on the Future of Health Care final report listed four hundred and forty-four (444) submissions from Canadians

organizations. Ten (10) Aboriginal organizations were among those organizations that sent in formal written submission representing .02 percent of the total number of organization submissions received by the Romanow Commission. (Romanow, 2002, p.259-266) Please refer to Appendix C for a list of the Aboriginal organizations that participated in the open public hearings and the fact-finding phase. There were 142 organizations' submissions available on the Commission on the Future of Health Care in Canada internet site. Two Aboriginal organization submissions [Aboriginal Nurses Association of Canada and National Aboriginal Health Organization] are available on the Romanow Commission internet site. (Health Canada, 2003)

In addition, organizations had the opportunity to make presentations and tabled submissions during the Public Hearings, which took place from March 4, 2002 to May 30, 2002 in Canada. The public hearings were held in Toronto, Iqaluit, Sudbury, St. John's, Victoria, Regina, Ottawa, Calgary, Yellowknife, Winnipeg, Montreal, Halifax, Vancouver, Quebec City, Edmonton, Charlottetown, and Whitehorse. In the public hearing phase, three hundred and sixty-five (365) Canadian organizations participated. Aboriginal organizations that participated in the public hearings were .08 percent of the total number of organization presentations. Thirty-two (32) Aboriginal organizations that participated in both, the fact-finding phase and the public hearing phase where assigned to one of the five (5) organizational categories [First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal] created by the researcher. Refer to Table 1.

a. Organizational categories

In the following section, there will be a discussion regarding the categories with a brief description of each category formation listed in Table 1.

Table 1 – Aboriginal/First Nations organization – assigned categories

First Nations	Aboriginal –Interest/Focus	Inuit	Metis & Aboriginal	Metis
Abegwit First Nations	BC Aboriginal Network On Disability Society	Inuit Tapirii Kanatani	Ontario Metis Aboriginal Association	Metis National Council
Assembly of First Nations	Tree of Peace Friendship Centre	Nunavut Tunngavik Incorporated		
Assembly of Manitoba Chiefs Council	Western Arctic Aboriginal Head Start of Canada	Pauktuutit – Inuit Women's Association		
Council of Yukon Nations	Aboriginal Nurses Association	Qikiqtani Inuit Association		
Dakota Ojibway Tribal Council	Native Women's Association of Canada	Labrador Inuit Health Commission (LIHC)		
Dene Nation	National Aboriginal Health Organization			
Eskasoni Health Centre	Institute of Aboriginal Health, Division of First Nations Health Centre			
Federation of Saskatchewan Indians Nations				
First Nations Chiefs Health Committee				
First Nations Health Programs Committee				
First Nations of Quebec Labrador Health and Social Services Commission				
First Nations Treaties: 6, 7, 8				
Government of First Nations				
Six Nations of Grand River				
Southern Chiefs Organization				
Yukon First Nations Health & Social Commission				

i. First Nations

The first organizational category was defined as the First Nations category. There were 18 (eighteen) First Nations organizations placed in this category. Seventeen First Nations were political organizations representing various First Nations in Canada and one was a health centre that provided services to First Nations people. When the primary interest of the organization was identified by the organization, itself, as providing services to or on behalf of First Nations, then the organizations was placed in the First Nations category. This category contained the largest number of organizations to this to the remaining four categories.

ii. Aboriginal - Interest/Focus

The second organizational category was titled Aboriginal Interest/Focus which, had seven (7) organizations in it. This Aboriginal Interest/Focus category included those Aboriginal organizations that represented Native women, Disabled Aboriginal People, Aboriginal Head Start Program, Aboriginal Nurses, Aboriginal Health organization, Friendship Centres and lastly, an Institute for Health Care. These organizations that were sorted the Aboriginal Interest/Focus category contained the second largest number of organizations assigned to this category comparatively. This category represented non-governmental organizations, lobby groups, special interests and a professional body comprised of Aboriginal People.

iii. Inuit

The third organizational category was defined as the Inuit. There were five (5) organizations assigned to this category third largest number of organizations assigned to

any category. This category was representative of a political organization, and non-governmental lobby organizations, special interests, and a lobby group.

iv. Metis

The fourth organizational category was the Metis category, which had only one (1) organization. In this category, there was one national political organization.

v. Metis & Aboriginal

The fifth category was developed to accommodate one Ontario organization's presentation that represented Metis and Aboriginal. The researcher has labeled this category Metis and Aboriginal. This organization represented special interests of the Metis and Aboriginal people.

Each of the Aboriginal organizations placed in the categories were assigned a number sequentially from one to thirty-two (1 to 32) for data retrieval and data organizations purposes. For example, Organization #1 refers to the Chiefs of Ontario. Appendix B contains a complete list of the organizations in each of their assigned categories.

b. Documents used in analysis Most of the documents were obtained through a written request to the Access to Information & Privacy Co-ordinator, Privy Council Office in Ottawa, Ontario. Two of the Aboriginal submissions were available from the Romanow Commission website. One First Nation submission was obtained from the organization directly.

There were twenty-five (25) written submissions [twenty-three (23) written submissions were in English and two (2) were in French] available to the researcher from the overall thirty-two (32) organizations that participated. Some of the submissions

included supplementary documents. The researcher reviewed the supplementary documents and included them in the analysis. Six (6) organizations submitted supplementary documents to the Romanow Commission. [Refer to Appendix C]

There were four joint submissions, which involved nine Aboriginal/First Nations organizations, which were the following:

i. Joint submission - Assembly of Manitoba Chiefs Organizations and Southern Chiefs Organization

ii. Joint submission - Assemblee Des Premieres Nations du Quebec et du Labrador & Commission de la Sante et des services sociaux Des Premieres Nations du Quebec et du Labrador

iii. Joint submission - First Nations - Treaty 6, Treaty 7, and Treaty 8

iv. Joint submission - Council of Yukon First Nations & Yukon First Nations Health and Social Services Commission

c. Public hearings presentation summaries

The researcher used the public hearing presentation summaries when the submissions were unavailable. The reasons why the submissions were unavailable will be discussed in the next section. Five (5) presentation summaries were obtained from the Romanow Commission website, which are the listed as follows: the Eskasoni Health Centre, Dene Nation, Council of Yukon First Nations, Yukon First Nations Health and Social Services Commission, and lastly, the Government of First Nations.

d. Documents unavailable

There were documents that were unavailable to the researcher from the public hearing presentation and the fact-finding phase where formal written submissions were tabled by Aboriginal/First Nations organizations. Prior (2003) identified that the justification of a sampling is required and suggest that there needs to be reasons for including and excluding data. Prior (2003) stated that the researcher should identify in detail why data was selected and what limits were placed on the selection process. (2003, p. 154) The researcher has provided the following explanations:

There were two submission that were not available to the researcher in the English language which were two (2) First Nations organizations; Assemblee des Premieres Nations du Quebec et du Labrador [APNQL] and Commission de la Sante et des services sociaux Des Premieres Nations du Quebec et du Labrador. [CSSSPNQL]. The two (2) organizations, APNQL and CSSSPNQL submitted a joint presentation at a public hearing in the French language. The Privy Council of Canada advised the researcher that the English translation tapes of the public hearings were available at a monetary cost to the researcher. The Privy Council of Canada could not guarantee that the English translation tapes were the organizations' presentation in its entirety. Given the monetary and time constraints to transcribe the tapes, the researcher sought out two avenues to get the French language documents translated. Therefore, the researcher elected to used only the recommendations. The researcher used the public hearing presentation summary available in English.

The researcher was not able to locate two presentation summary documents for the content analysis. The explanation for the missing/unavailable documents from two

Aboriginal organizations follows. The first organization, First Nations Health Program Committee, made a public hearing presentation on May 2, 2002 in Whitehorse. (Commission Report, Page 282). The first organization's presentation summary was unavailable from the First Nations Health Program Committee. This organization may have only presented an oral presentation and, possibly, no report was tabled with The Romanow Commission. The researcher was able to determine the First Nations Health Program Committee was housed at the Whitehorse General Hospital. The researcher contacted the Whitehorse General hospital directly to verify the existence of a report. Despite several attempts by the researcher to verify and obtain a copy of the presentation, the researcher was not successful. There was no public hearing presentation summary listed for First Nations Health Program Committee, neither on the Romanow commission official web site nor in its final report.

The second, the Six Nations of the Grand River presentation was also unavailable. A public hearing presentation summary was not available from the official internet site of the Romanow Commission. The researcher contacted the Six Nations of the Grand River directly to verify the existence of a presentation and to obtain a copy of their organization's presentation. However, the researcher was not successful in getting a copy or in verifying that one existed.

The official internet site of the Romanow Commission listed "Six Nations of Grand River" organization as one of the organizations at the Commission Consultations held in Toronto, Ontario on May 30, 2002 and May 31, 2002. The researcher has documentation that Six Nations of the Grand River did a presentation on May 30, 2002 in Toronto as indicated in the Romanow Commission's Final Report (P. 285). The Six

Nations of the Grand River organization may have completed an oral presentation, but there appears to have been no report tabled. There was no response received from the organization to verify the preceding statement when it was contacted.

IV. ANALYSIS

During the course of the data analysis, it became necessary to create a series of data collection tools to assist the researcher. The researcher organized the findings for the purposes of both; data retrieval and data review, which proved to be an effective means of data management. (Padgett, 1998, p. 75) The researcher found it quite useful to develop the following eight summary documents to organization the data:

i. Data Summary document #1 contained a list of the thirty-two (32) Aboriginal/First Nations organizations and the Public Hearings location in which the organization participated [March 4, 2002 to Toronto on May 30, 2002]. Please refer to Appendix A. The researcher used this summary document to track the number of presentations received throughout the data collection phase in an organized manner. The researcher subsequently placed the documents in file folders with a label that had a corresponding assigned organization number and organization name.

ii. Data Summary document #2 is a list of the ten (10) formal submissions made by the Aboriginal Organizations during the Fact Finding Phase when the Romanow Commission called for submissions. Please refer to Appendix B.

iii. Data Summary document #3 contained a list of the following items: an assigned file folder number and the organization's assigned number, the Aboriginal organization's name, location and open public hearing date, type of submission – [formal or public hearing], Aboriginal category/representation and last, title of the submission, date and number of pages. Each of the recommendations was numbered sequentially. Each of the Aboriginal organizations was provided with an assigned number sequentially.

The number assigned to each category name is not weighted nor is there any value assigned to the sequential numbering.

The summary document #3 identified as Appendix C. The researcher utilized the summary documents throughout the data collection and data analysis process. The summary document #3 provided a quick overview and ongoing information regarding the data available.

iv. Data Summary document #4 was primarily used by the researcher to capture the content analysis of the data. This document provided the following information in two sections: the first section detailed the name of the Aboriginal organization, assigned a file number, type of submission, location on & date of the open public hearings, organization category, title of the submission, date of the submission and number of pages of the written submission. The second section of the summary document #4 presented the conceptual framework, which was the Aboriginal Life Promotion Framework, which was utilized to complete the content analysis. Summary document #4 listed the sixteen (16) elements of human existence as identified in the Aboriginal Life Promotion Framework. In this research, recommendations were sorted into one of the four (4) domain categories created by the researcher. The sixteen (16) elements of human existence were categorized into four (4) Domains by the researcher as follows:

Domain – 1: Spiritual, Emotional, Physical, and Intellectual

Domain – 2: Child, Youth, Adult, Elder

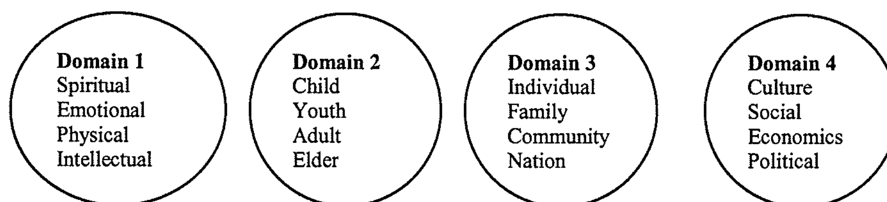
Domain – 3: Individual, Family, Community, Nation

Domain – 4: Culture, Social, Economics, Political

The summary document #4 identified the recommendations by all the Aboriginal organizations regarding the health care system in Canada. The next category of information recorded the identification of themes identified within each of the recommendations. The recommendations were then sorted into a category from Domain 1 through Domain 4 using the Aboriginal Life Promotion Framework as explained below. Please refer to Appendix D.

The conceptual framework was used to sensitize the researcher to what First Nations wanted from Canada's health care system. The Aboriginal Life Promotion Framework [ALPF] identified that there are sixteen (16) elements of human existence. This research utilized the sixteen (16) elements to assist in the content analysis. Figure 1 (below) identifies the elements of human existence in the Aboriginal Life Promotion Framework [ALPF]. (Bartlett, 2004, P. 24) The researcher has chosen to represent the sixteen elements of the ALPF in four circles labeled Domain one (1) through four (4). The researcher chose to represent the Domains in a circle format because as a First Nation person; the circle is representative of the circle of life, which has been a teaching shared with me by others. The elements of this conceptual framework purport to be having elements of human existence, which is ultimately, the circle of life.

Figure 1 – Aboriginal Life Promotion Framework:



v. Summary document #5 Themes from the individual Aboriginal organizations' presentation/formal submissions/presentation summaries. The summary

document #5 had the following information: the name of the Aboriginal organization, assigned file number, type of submission, location and date of the open public hearings, organization category, the title of the submission, the date of the submission and number of pages of the presentation/formal submission and a heading identified as Themes. The summary document #5 allowed for quick review and collapsed the amount of paper the researcher would have to sift through to identify the themes. Please see Appendix E.

vi. Summary document #6 – This is a table, which lists all the thirty-two (32) Aboriginal organizations in each of the five (5) Aboriginal organization categories: First Nations, Aboriginal Interest/Focus, Inuit, Metis, and Metis & Aboriginal along with the number of organizations in each category. Please refer to Appendix F.

vii. Summary document #7 - This contains themes from the five (5) Aboriginal organization categories placed in the Domains 1 through 4 created by the researcher to reflect the elements of human existence presented in the Aboriginal Life Promotion Framework. (Bartlett, 2004) Please refer to Appendix G.

viii. Summary document #8 – This is a table of the thirty-two (32) Aboriginal organizations placed in the Aboriginal categories. Please refer to Appendix H

Once created, the researcher found the data summary documents quite useful to begin to sort and identify the emerging themes for each of the thirty-two (32) Aboriginal organizations. The researcher was sensitized by ALPF.

V. FINDINGS

i. Themes Identified

The researcher reviewed the recommendations from the Aboriginal Organizations' submissions and used the summary document #4 to place the recommendations into the ALPF framework. Please refer to Appendix D.

First, the researcher identified themes from the Aboriginal organizations' presentations. The researcher then sorted the themes into one of the five organization categories. From this process, the researcher was able to identify 21 overall themes and four themes present in all the five organization category.

The researcher completed a content analysis on the Aboriginal organizations' documents. Through a systematic approach to document review, the researcher identified themes. The list of themes identified reflects Aboriginal organizations suggested recommendations about what is needed from the Canadian health care system for Aboriginal people.

The researcher identified twenty-one (21) themes listed in Table 2 below:

Table 2

Themes identified from the Aboriginal/First Nations organizations submissions

Four (4) themes common among five organization categories			
1.	Relationship with Governments	2	Policy & Program Development
3.	Fiscal Resources	4.	Accessibility
Remaining Themes			
5.	Culture	6.	Capacity Building
7.	Consultation	8.	Jurisdictional
9.	Sustainability	10.	Control
11.	Health Status	12	Rights
13.	Research	14.	Disabled People
15.	Health Strategy	16.	Land Claim

17. Infrastructure
18. Address socio-economic
19. Public Awareness
20. Universality
21. Involvement & Participation

The researcher found themes one through four inclusive were common to participating groups from all organization categories. These themes were viewed to be of central importance to the researcher and they will be discussed in the next section.

The seventeen (17) remaining themes numbers five through twenty-one inclusive in the above list, were present in a number of submissions of some organizations. These seventeen (17) themes are briefly discussed in next section.

The researcher listed the seventeen (17) themes and what follows is a brief identification of what First Nations/Aboriginal wanted from the health care system: I have chosen to list the themes identified prior to discussion of any one. The researcher created a list of collapsed words and phrases that represent the general idea conveyed in each of the recommendations by the organizations. This list was subsequently sorted into the seventeen based on the theme headings to be discussed in the next section. What follows is the list of those collapsed words/phrases, which were sorted under the theme headings in Tables 3 through Table 23 accompanied the organization category, and the organization's assigned number. Please refer to Appendix C for the assigned number, which will identify the name of the organization in the Tables 3 through to Table 38.

ii. Culture

Table 3 Culture Theme - First Nations Recommendations

Organization & Number	Recommendations
Organization #15 FN	Integration of First Nations systems and western medical systems
Organization #15 FN	Integration of ideas from western medicine and First Nations traditional medicine
Organization #15 FN	Holistic approaches to treatment and preventative services
Organization #1 FN	FN Cultural restoration
Organization #8 FN	Traditional healing values and practices restored
Organization #18 FN	Establish traditional healing centres

Organization # 22 & 23 FN	Integrate traditional aboriginal health practices with Western medicine
Organization # 26 FN	Aboriginal health issues and traditional practices awareness

a. First Nations

First Nations organizations identified, in Table 3, the need for the present health care system to incorporate both traditional medicine and western approaches. First Nations stated that that there needed to be a return to traditional practices for health care services and increased awareness regarding the existence of these traditional practices. First Nations further felt that health care must use holistic approaches in treatment and prevention. One organization suggested that the establishment of traditional healing centres.

b. Metis & Aboriginal

Table 4 Culture Theme - Metis & Aboriginal Recommendations

Organization & Number	Recommendations
Organization #5 M & AB	Culturally sensitive medical care needed
Organization #5 M & AB	Culturally sensitive approaches need to be effective
Organization #5 M & AB	Screening/assessment tools should reflect Aboriginal values/social norms

In Table 4, the Metis and Aboriginal organizations identified the need for culturally sensitive approaches to health care services along with screening/assessment tools to reflect the Aboriginal values and social norms. They did not comment on the integration of the traditional and western approaches to health care delivery as the First Nations suggested.

c. Aboriginal Interest/Focus

Table 5 Culture Theme - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #17 AB	Integrated Therapeutic Options for Healing Addictions and Emotional Problems
Organization #17 AB	Culturally appropriate services
Organization #17 AB	Aboriginal Health Best Practices Information Sharing
Organization #17 AB	Men to relearn their traditional parenting and teacher roles
Organization #17 AB	Accommodation for Visiting Elders and Traditional Healers within Hospitals and other Institutions
Organization #17 AB	Support Access to Traditional Healers and Elders – under the knowledge and within aboriginal organizations
Organization #17 AB	Aboriginal Cultural Awareness
Organization #17 AB	Incorporation of Holistic Aboriginal concepts into Education and Training
Organization #17 AB	Cultural Orientation
Organization #10 AB	Culturally appropriate and culturally sensitive
Organization #10 AB	Culturally appropriate services
Organization #9 AB	Improved Communication through cultural awareness workshops
Organization #9 AB	Appropriate services to Aboriginal people needed
Organization #9 AB	Language Barriers – appoint a family spokesperson
Organization #7 AB	Development of culturally appropriate programs
Organization #19 AB	Integration of western and traditional medicine

The Aboriginal organizations in Table 5 recommended the integration of western and traditional approaches to the health care system. They advocated for the sharing of Aboriginal health best practices among health care professionals. These organizations identified the need for culturally sensitive programs and specifically suggested that that men need to re-learn their traditional roles of parenting and teaching. They recommended that the education sector incorporate holistic aboriginal concepts into its education and training aspects, and that there needed to be more cultural awareness workshops.

d. Inuit

Table 6 Culture Theme - Inuit Recommendations

Organization & Number	Recommendations
Organization #4 IN	*Qaujimajatuqanqit – Inuit knowledge – is another such qulliq. There are seven quilliqs of Inuit health renewal*
Organization #4 IN	Integrate traditional approaches into medical system
Organization #4 IN	Inuuqatigittarniq – the #1 priority (Inuuqatigittarniq – healthy interconnection of mind, body, spirit, and environment)

Organization #4 IN	Qaujimajatuqanqit – is important to the success of programs and services
Organization #4 IN	Qaujimajatuqanqit – Inuit knowledge
Organization #4 IN	Inuuqatigittarniq – healthy interconnection of mind, body, spirit, and environment
Organization #4 IN	Credit for Inuit Qaujimajatuqanqit *(Inuit knowledge)*
Organization #4 IN	Incorporate Inuit Qaujimajatuqanqit and Inuktitut into health care programs and services
Organization #4 IN	Production of a variety of materials in various forms in plain language
Organization #2 IN	Information in own language & plain English
Organization #2 IN	Culture and traditional manner
Organization #2 IN	Balance between traditional knowledge of medicine/healing & western
Organization #2 IN	Own cultural values and traditions
Organization #2 IN	Services in own language

Inuit organizations in Table 6 conveyed what they want from the health care system. They identified that their own Inuit knowledge was critical to Inuit Health Renewal. The Inuit, along with the First Nation and Aboriginal organizations, recommended the integration of the traditional and western approaches to health care. The Inuit acknowledged the requirement for balance between the traditional and western approaches. Inuit had a strong belief that what was needed was a healthy interconnection among the mind, body, spirit, and environment for Inuit health renewal.

iii. Capacity building

a. First Nations

Table 7 Capacity Theme – First Nations Recommendations

Organization & Number	Recommendations
Organization #8 FN	Capacity building
Organization #13 & 14 FN	Capacity – Training Requirements
Organization #15 FN	Capacity building - Development of a Canada-wide health human resources strategy
Organization #18 FN	Building Capacity - Strategic planning for medical careers
Organization #18 FN	Building Capacity - Training and development of health authorities/professionals
Organization #18 FN	Capacity Building - Training of Human Resources
Organization #21 FN	Capacity Building
Organization #21 FN	Capacity Building – training & development
Organization # 22 & 23 FN	Translated - Increase native suppliers, training programs
Organization # 22 & 23 FN	Recruitment and retention of health care professionals
Organization # 22 & 23 FN	Programs to increase skills and resources
Organization # 22 & 23 FN	Capacity building and education
Organization # 22 & 23 FN	Health care professionals sensitive to the holistic health model of First Nations and to their cultures
Organization # 24 FN	Education in health careers

Organization # 24 FN	Capacity building
Organization # 24 FN	Capacity Building
Organization # 26 FN	Culturally sensitive professionals – capacity

First Nation organizations in Table 7 identified consistently the need to increase capacity in the medical/health care professional field among the First Nations. The health care professionals needed to be sensitive to the holistic health care models of First Nations and their communities. First Nations identified a nation wide need for a human resource strategy to address the issues of building capacity among its First Nations population. The building of capacity in health care was critical for First Nations to assume more control over their own health care services. First Nations recommended a long-term human resource development strategy.

b. Metis & Aboriginal

Table 8 Capacity Building - Metis & Aboriginal Recommendations

Organization & Number	Recommendations
Organization #5 M & AB	Education and training opportunities
Organization #5 M & AB	Medical/health care training opportunities
Organization #5 M & AB	Recruitment and Retention

The Metis and Aboriginal organization in Table 8 recommended more education and training opportunities, for example, in medical and health care. They recommended the need to recruit medical/health care professionals into the health care field and a need to develop a way to retain them in the field.

c. Inuit

Table 9 Capacity Theme – Inuit Recommendations

Organization & Number	Recommendations
Organization #4 IN	Inuit-specific training programs
Organization #4 IN	Recruitment and retention problems
Organization #4 IN	Capacity building
Organization #4 IN	develop and support Inuit mental health workers
Organization #4 IN	Support to build capacity
Organization #4 IN	Capacity building
Organization #4 IN	Training in the North and delivered in Inuktitut
Organization #4 IN	Capacity building

Organization #4 IN	Capacity building in various areas from transitional arrangements to education and training
Organization #4 IN	Mental health workers needed
Organization #4 IN	Capacity
Organization #4 IN	Strong people empowered
Organization #4 IN	More staff for promotion and prevention
Organization #4 IN	Capacity building
Organization #4 IN	Prepare our young generations
Organization #4 IN	Capacity building
Organization #4 IN	Capacity – medical field
Organization #6 IN	Capacity – recruitment
Organization #6 IN	Capacity – training
Organization #2 IN	Capacity building - Substantial and Sustained Support
Organization #2 IN	Community Health Representatives and Workers treated with respect - more likely to maintain employment and advance in service
Organization #2 IN	Training for caregivers
Organization #2 IN	Consistent Nursing
Organization #2 IN	Train more Inuit to ensure culturally sensitivity and reduce vulnerability of transient health care worker
Organization #2 IN	Education important-community to educate Inuit & formal education levels play role to improve health status

Inuit organizations in Table 9 wanted to build capacity through Inuit specific training programs. They recommended more training for community based people that remain in their communities as Inuit experienced recruitment and retention problems in the northern communities. They wanted consistent nursing in their communities. There was a strong recognition that education is important in the need for community to educate the younger generations to improve the Inuit health status.

d. Aboriginal Interest/Focus

Table 10 Capacity Theme – Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #7 AB -	Capacity – education
Organization #7 AB	Capacity –increase numbers education
Organization #7 AB	Capacity – Training
Organization #7 AB	Training developed and implemented by aboriginal disabled people
Organization #7 AB	Education – life skills training
Organization #7 AB	Employment counselors to be trained re: special needs
Organization #7 AB	Program development
Organization #7 AB	Training
Organization #9	More Trained professionals
Organization #17	Investing in Women and Children
Organization #17	Analyze and Respond to Change Management Capacity Gaps
Organization #17	Education
Organization #17	Retention of professionals
Organization #17	Capacity Building
Organization #17	Building capacity

Organization #17	Community Based Education
Organization #17	Further development of Access Programs – Education & Training
Organization #17	Capacity Building
Organization #19 AB	Train 10, 000 workers

Aboriginal organizations in Table 10 recommended the need for education and training requirements to build capacity. They indicated the need for development of training and implementation by Aboriginal persons with disabilities. They identified the need to investment in women and children. One organization recommended that education should be community based and to increase the number of Access programs for education and training needs.

iv. Consultations, involvement & participation

a. First Nations (Consultation)

Table 11 Theme (Consultation) - First Nations Recommendations

Organization & Number	Recommendations
Organization #15 FN	Participation and consultation in decisions
Organization #18 FN	Consultation needed
Organization # 22 & 23 FN	Only First Nations can get to the root of their problems
Organization # 24 FN	Engage First Nations directly on issues

First Nations in Table 11 wanted to be consulted and engaged on issues the affect them. First Nation organizations identified that only First Nations can get to the root of their problems. First Nations want to be part of the decision making process regarding the health care system.

b. Inuit (Consultation)

Table 12 Theme (Consultation) - Inuit Recommendations

Organization & Number	Recommendations
Organization #4 IN	Need to work together to share information, experience, expertise
Organization #4 IN	Need to be part of the solutions
Organization #2 IN	Need to build support for Inuit women
Organization #2 IN	Necessary conditions to enable Inuit women to be informed and participate in policy and program

	development, implementation, priority setting and access related to health care
Organization #2 IN	Consult with Inuit Women on health issues
Organization #2 IN	Acknowledge Inuit Women's role in the support of primary health care
Organization #2 IN	Inclusive, effective, and accountable to Inuit Women
Organization #2 IN	Women involvement in policy-making process, to determine limits and costs for women
Organization #2 IN	Women involvement to negotiate with government appropriate levels of support
Organization #2 IN	Meaningful consultation process and establishing consultative mechanisms with Inuit women at the community, regional, and national levels
Organization #3 IN	Consult closely
Organization #3 IN	Partnership and cooperation to deal with problems
Organization #16 IN	Work closely with Inuit

The Inuit in Table 12 advocated that they wanted to be closely consulted regarding decisions related to the health care system, and in particular, wanted to ensure that Inuit women are involved when negotiations occur at government levels. The involvement of Inuit women in decisions needed to be meaningful, and therefore, they recommended fiscal resources for travel purposes to ensure Inuit women had a voice . The Inuit organizations were the only Aboriginal organizations that identified the strong role of women in the decision-making process. Inuit organizations identified that Inuit women need to be part of the decisions that determine the direction of Inuit health as Inuit women are the primary care givers in the health care system.

c. Aboriginal Interest/Focus

Table 13 Theme (Involvement & Participation) - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #9 AB	Involve in regionalization process
Organization #7 AB	To be involved in all aspects of government
Organization #7 AB	First Nations leaders must participate in the new regional health structures

Aboriginal organizations in Table 13 identified that First Nation leaders must participate in the new regional health structures. They must be involved in all aspects of governance of the health care system.

v. Jurisdictional

a. First Nations

Table 14 Theme Jurisdictional - First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	FN Jurisdictional and fiscal disputes
Organization # 24 FN	Reconciliation of jurisdiction issues
Organization #21 FN	Resolve jurisdictional issues
Organization #18 FN	Need Federal leadership for jurisdiction issues
Organization # 22 & 23 FN	Aboriginal people do not through the jurisdictional cracks

First Nations indicated in Table 14 that there needed to be the presence of strong federal government leadership to address the jurisdictional issues facing First Nations people. There was also an indication that the jurisdictional and fiscal disputes needed to be resolved to ensure that Aboriginal people do not fall through the jurisdictional cracks of the health care system

b. Metis

Table 15 Theme Jurisdictional - Metis Recommendations

Organization & Number	Recommendations
Organization #11 M	Canada recognize Metis and acknowledge jurisdiction
Organization #11 M	jurisdictional issues

The Metis recommended in Table 15, that the federal government recognize the Metis and acknowledge that the federal government has a responsibility to provide health care services in the same way as to the First Nations and Inuit.

c. Aboriginal Interest/Focus

Table 16 Theme Jurisdictional - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #9 AB	jurisdictional issues should cease
Organization #9 AB	Jurisdiction
Organization #17	Complete a comprehensive inter-jurisdictional review of the health care services available to various populations of Canadians in all three tiers
Organization #10 AB	Jurisdictional issues
Organization #10 AB	Resolve jurisdictional issues
Organization #19 AB	Leadership role needed from Federal government regarding jurisdictional issues

The Aboriginal organizations in Table 16 wanted a Federal government leadership role regarding jurisdictional issues, which was similar to the First Nations recommendation. Aboriginal organizations wanted the jurisdictional issues to cease and be resolved, which is a view shared by the First Nations organizations.

vi. Sustainability

a. First Nations

Table 17 Theme Sustainability - First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	Sustainability
Organization #15 FN	Sustainability
Organization # 22 & 23 FN	Community development requires social, economic, cultural, spiritual development
Organization # 24 FN	Development of long-range employment and economic development
Organization # 24 FN	Funding to address poverty and poor health status
Organization #18 FN	Infrastructure – redesign facilities, accommodate
Organization #18 FN	address socio-economic issues

First Nations identified in, Table 17, the need for sustainability where long range employment and economic development strategies are in place. The First Nations indicated a need for more funding to address poverty and poor heath status. First Nations wanted their socio-economic issues addressed.

b. Metis

Table 18 Theme Sustainability Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Sustainability

Metis recommended in Table 18 the need to address the sustainability of the communities to begin improve their poor health status and close the gap with other Canadians.

c. Aboriginal Interest/Focus

Table 19 Theme Sustainability – Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #10 AB	Economic opportunities
Organization #32 AB	Sustainability

Aboriginal organizations in Table 19 indicated that economic opportunities are required for the issue of sustainability to be addressed, similar to recommendations by the Metis, Inuit, and First Nations organizations.

vii. Control

a. First Nations

Table 20 Theme Control - First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	Community control
Organization #1 FN	First Nation control in policy and program development in all levels
Organization #15 FN	First Nations control/surveillance of financial management
Organization #15 FN	Divestment of control
Organization #15 FN	Aboriginal control of services; and Diversity of approaches that respond to cultural priorities and community needs
Organization #18 FN	Transferring programs must be done with communities/First nation governments
Organization #18 FN	Full transfer of funding
Organization #18 FN	Control by First Nations
Organization #18 FN	Transfer of health governance
Organization #21 FN	Have ownership of the governance, planning, development, management and delivery of health services

	and programs
Organization #21 FN	First Nations involvement
Organization # 24 FN	Controlled by First Nations
Organization # 24 FN	Need more flexible transfer initiative

First Nations indicated, in Table 20, that they wanted full control of the health governance within Canada regarding First Nations people's health. They wanted community control over the programs and services enter their communities. They wanted control over all aspects of First Nations health policy and program development. First Nations wanted financial management over the fiscal resources related to health care. In short, they wanted comprehensive control over health care service delivery for First Nations.

b. Metis

Table 21 Theme Control - Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Public administration transfer to Aboriginal governments/organizations
Organization #11 Metis	Devolution of an Aboriginal-specific primary health care system services the Aboriginal People, inclusive of Metis

The Metis wanted control over the public administration of the health care system, specific to the Metis. They wanted control over publicly funded health care programs transferred to Aboriginal governments and organizations and favoured devolution of delivery of health services to Aboriginal people, including the Metis.

c. Aboriginal Interest/Focus

Table 22 Theme Control - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #7 AB	Control & deliver social & economic programs
Organization #7 AB	For Health Transfer, negotiations and agreements must proceed from rational and evidence-based program planning.
Organization #7 AB	Administered
Organization #7 AB	Delegation to First Nation regarding medical equipment

	authorization
Organization #12 AB	Health care dollars be controlled and administered by First Nations

The Aboriginal organizations in Table 22 wanted control over health care resources and administration to be exercise by the First Nations. Aboriginal organizations also stated they wanted the capacity to deliver social and economic programs. These recommendations made by the Aboriginal organizations are similar to those made by the First Nations and Metis organizations.

viii. Health status

a. First Nations

Table 23 Theme Health status - First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	Balance between address the health determinants on health status/health system organization to immediate respond to access appropriateness and comprehensiveness of services
Organization #1 FN	FN Population health approach
Organization #15 FN	Population Health approach
Organization #15 FN	Equivalent Health care standards
Organization #18 FN	Guaranteed First Nations health care package
Organization #21 FN	Identify barriers and develop strategies for improved health status
Organization #21 FN	Improved health status
Organization # 22 & 23 FN	Develop policy for the longitudinal health of First Nations and Inuit
Organization # 22 & 23 FN	Develop programs centered on holistic strategy to promote First Nations health
Organization # 24 FN	Address health determinants

First Nations, as noted in Table 23, wanted to address the health status gap that exists between First Nations and non-Aboriginal people. They wanted equivalent health care standards. First Nations desired to develop a holistic strategy to promote First Nations health through addressing the health determinants. One First Nations organizations called for guaranteed First Nations health care package offered to First Nations people.

b. Metis

Table 24 Theme Health status - Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Investment in improved health care
Organization #11 Metis	Enhancement of heath care performance indicators

A Metis organization recommended investments into improving health care systems to improve health status. Specifically, they indicated that what to develop further what is used to determine health care performance indicators

c. Aboriginal Interest/Focus

Table 25 Theme Health status - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #7 AB	Broadly based, multi-factor strategies are needed – gap in health status
Organization #7 AB	Challenge to develop and implement policies that promote good health
Organization #7 AB	Prevention needed – address poor health determinants
Organization #9 AB	Federal and Provincial continue to full its health mandate
Organization #9 AB	Reflect health needs of this population
Organization #17 AB	Balanced Investment in Health and Illness
Organization #19 AB	Cultural and linguistic factors as health determinants

Aboriginal organizations recommended the need to address the gap in health status with broadly based and multi-factor strategies. Aboriginal organizations recommended that federal and provincial government should continue to fulfill their health mandates. This is an interesting point when the goal of the federal government's health care program is to make Canada one of the healthiest populations in the world. Aboriginal organizations indicated a need for balanced investment in health and illness. Furthermore, they argued that the determinants of health be expanded to include the cultural and linguistic factors of a population

ix. Rights [treaty right, human right, health right]

a. First Nations

Table 26 Theme Rights - First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	FN Recognition health is a treaty right
Organization #18 FN	Fiduciary responsibility
Organization #18 FN	Fiduciary obligation and treaty based rights of First Nations to have quality access to health
Organization # 24 FN	Federal government's fiduciary and treaty obligations to First Nations

First Nations as described, in Table 26, stated that they consider health to be a treaty right. The Federal government has a fiduciary responsibility to First Nations people to ensure that they have quality access to quality health care. The researcher believes that any negotiations regarding First Nations health care must begin with the premise that health care is a treaty right. To ignore this premise may delay the improvement of First Nations health status.

b. Metis

Table 27 Theme Right – Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	National approach to the development of a health care system to serve Metis better
Organization #11 Metis	Development of a comprehensive government policy to address Metis Health
Organization #11 Metis	Health care rights - fiduciary responsibility
Organization #11 Metis	Federal responsibility for Metis health
Organization #11 Metis	Similar rights as Indians and Inuit
Organization #11 Metis	Federal responsibility of Metis Health
Organization #11 Metis	Canada's fiduciary responsibility

The Metis as alluded to, in Table 27, stated that the Federal government has a fiduciary responsibility to the Metis and, therefore, a direct responsibility to provide health services for the Metis. They advocated for a national approach to the development of a health care system to serve better Metis. The Metis wanted similar rights as First Nations and Inuit as they relate to health.

c. Inuit

Table 28 Theme Right –Inuit Recommendations

Organization & Number	Recommendations
Organization #2	Issue of human right – standard of living
Organization #2	Canada has obligation to respect human rights

Inuit recommended as described, in Table 28, that the issue of health must be viewed as an issue of human rights. Inuit stated they have human rights to health and an adequate standard of living. Inuit stated that the federal government has an obligation to respect human rights. First Nations and the Metis did not state this view in their recommendation to the Romanow Commission.

x. Research

a. Metis

Table 29 Theme Research – Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Collection of Metis health information
Organization #11 Metis	Develop a strategy for Metis health research
Organization #11 Metis	Metis Health Research
Organization #11 Metis	Development of health information systems

The Metis, in Table 29, indicated that there was limited research specific to Metis health area. They recommended that there needed to be a Metis health research strategy which included the collection of Metis health information.

b. Inuit

Table 30 Theme Research –Inuit Recommendations

Organization & Number	Recommendations
Organization #2 IN	Need for gender analysis in policy development and restructuring of health system
Organization #16 IN	Inuit demographic pattern essential that health care changes
Organization #16 IN	Active in health research

Inuit, in Table 30, recommended that they needed to be more actively involved in health research. As the health care system changes, Inuit expressed that Inuit demographic patterns needed to be attended to as they affect health care delivery. Inuit recommended a need for gender analysis in policy development and restructuring of the health care system. First Nations and Aboriginal organizations did not make any recommendations to the Romanow Commission in this area.

c. Aboriginal Interest/Focus

Table 31 Theme Research - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #10 AB	Aboriginal controlled research
Organization #19 AB	Systematic collection of health information
Organization #19 AB	Remove barriers from fully accessing information in government databases

Aboriginal organizations as stated in, Table 31, wanted Aboriginal controlled health research. One organization recommended the systematic collection of health information for Aboriginal people and that there should be full access to government databases.

xi. Persons with Disabilities

a. Aboriginal Interest/Focus

Table 32 Theme Research - Aboriginal Interest/Focus Recommendations

Organization & Number	Recommendations
Organization #7 AB	Long term planning needed - Aboriginal Persons with Disabilities
Organization #7 AB	Flexible work schedule for disabled people
Organization #7 AB	Aboriginal People with disabilities need to be recognized
Organization #7 AB	Provincial Premier's Council on People with Disabilities needs to become more informed and aware of the diverse issues of disabled people from an aboriginal perspective
Organization #7 AB	Service Needs – family members need to be included re: transition
Organization #7 AB	Review of public transportation services for the client
Organization #7 AB	Address the needs of the disabled
Organization #7 AB	Support for disabled individuals, spouses, and family members need to be developed and implemented immediately.
Organization #7 AB	First Nations Governments have to acknowledge disabled

The Aboriginal organizations in Table 32 recommended long term planning for Aboriginal Persons with disabilities. They recommended that First Nations Governments acknowledge and recognize Aboriginal persons with disabilities. Aboriginal organizations identified that the needs of Aboriginal persons with disabilities must be addressed. The following recommendations were made: that Provincial Premier's Council on People with Disabilities needed to become more informed and aware of the diverse issues of disabled persons with disabilities from an aboriginal perspective that the public transportation system for Aboriginal persons with disabilities be reviewed. That flexible work schedules for persons with disabilities and that support services be developed for individuals with disabilities, spouses, and family members.

xii. Health strategy

a. First Nations

Table 33 Theme Health strategy – First Nations Recommendations

Organization & Number	Recommendations
Organization #1 FN	Support for primary health care models
Organization #8 FN	Develop a strategy for health and well-being
Organization #8 FN	Vision for a healthy First Nations
Organization #8 FN	Integrated community-based planning approach
Organization #8 FN	Comprehensive health and social development is our response to Health Canada's health renewal initiative
Organization #8 FN	Develop a comprehensive First Nation Health and Social Development System
Organization #13 & 14 FN	Undertake a Health Reform Community Needs Assessment Review
Organization #13 & 14 FN	Proactive mode of action to develop/implement prevention and intervention programs
Organization #13 & 14 FN	A team approach – central coordinating such as a health director or coordinator
Organization #15 FN	System dynamics approach
Organization #15 FN	Health strategy
Organization #18 FN	Long-term framework for First Nations health
Organization #18 FN	First Nations Health Model
Organization #20 FN	Use Eskasoni Health Centre pilot project as a model for the entire health care system
Organization # 22 & 23 FN	Transfer policy response to specific needs of First Nations
Organization # 22 & 23 FN	Interpretive services
Organization # 24 FN	Co-Management Review as a reference for health reform

First Nations indicated, in Table 33, that a comprehensive health and social development was their response to Health Canada's health renewal initiative. First Nations reported that they had a vision of a healthy First Nations. This vision needed to include a long-term framework for First Nations health. The vision would include the development of strategies for health and well-being and supported primary health care models. First Nations recommended the development of a First Nations Health Model and that there needed to be integrated community-based planning approach to health.

xiii. Land claim

a. Inuit

Table 34 Theme Land Claim - Inuit Recommendations

Organization & Number	Recommendations
Organization #3 IN	Canada to fulfill Land Claim obligation
Organization #3 IN	Treat Inuit fairly
Organization #3 IN	Federal responsibility to Nunavut
Organization #6 IN	A successful resolution to our Land Claim

Inuit recommended as described, in Table 34, that the federal government needed to fulfill the land claims obligations and facilitate a successful resolution. Inuit indicated that the federal government has a responsibility to Nunavut. Inuit simply stated that they want to be treated fairly. The Inuit organizations were the only ones that identified the issue of Land Claims settlement required to improve the Canada's health care system.

xiv. Infrastructure

a. Inuit

Table 35 Theme Infrastructure - Inuit Recommendations

Organization & Number	Recommendations
Organization #2 IN	Development of infrastructures including child care facilities
Organization #2 IN	Dev. Housing policy that considers communities needs
Organization #2 IN	Develop Inuit-specific housing policy
Organization #2 IN	Adequate housing
Organization #4 IN	Infrastructure needed
Organization #4 IN	Infrastructure

Organization #4 IN	Health Centres/schools need to be renovated/expanded
Organization #6 IN	Adequate community infrastructure

The Inuit indicated, in Table 35, that they required adequate infrastructure in their communities. They recommended expansion and renovations to existing health centres and schools. Inuit identified the need for adequate housing and, therefore, they recommended an Inuit specific housing policy.

xv. Address socio-economic conditions

a. Inuit

Table 36 Theme Address socio-economic - Inuit Recommendations

Organization & Number	Recommendations
Organization #2 IN	Community-based multi-purpose centres to address violence
Organization #2 IN	Governments address the socio-economic conditions
Organization #4 IN	address life circumstances by linking population health with community development
Organization #4 IN	Improve living conditions
Organization #4 IN	Equal or Better Inuit Health Status
Organization #6 IN	Adequate and meaningful employment

While other Aboriginal organizations identified the need to address socio-economic conditions as they related to health status, the Inuit as indicated in, Table 36, made specific recommendations for the governments [federal, provincial/territorial] to address socio-economic conditions. The Inuit identified the need for adequate and meaningful employment and improvements in living conditions, which might lead to Inuit Health status equal to higher than the Canadian average. The Inuit made specific recommendation to develop community-based approaches to address violence in their communities.

xvi. Public awareness

a. Metis

Table 37 Theme Public awareness – Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Inform the public Metis health care issues

The Metis organization recommended, in Table 37, that public awareness needed to be created regarding Metis health care issues.

xvii. Universality

a. Metis

Table 38 Theme Universality – Metis Recommendations

Organization & Number	Recommendations
Organization #11 Metis	Universality of Aboriginal health care to Metis
Organization #11 Metis	Address inequities
Organization #11 Metis	Need for a catch up phase for Metis

The Metis organization was the only Aboriginal organizations in Table 38 that identified a need for a catch up phase for Metis, related to the health care system. The Metis identified that socio-economic and health care inequities exist need to be addressed. Overall, there needed to be universality of Aboriginal health care extended to the Metis. The Metis organization identified that the Metis population do not have the same health care provisions as the First Nations and Inuit under the federal health care plan.

A. Four Themes Identified

From the list of twenty-one themes, there were four held in common among all the Aboriginal organization categories identified.

Table 39 - Four themes Identified in Aboriginal &First Nations Submissions

1.	Relationship with Governments
2.	Policy and Program Development
3.	Fiscal Resources
4.	Accessibility

A discussion follows regarding these significant themes.

i. Relationship with Governments

a. First Nations

First Nations' organizations identified issues which surround a theme about the relationship between governments [federal, provincial/territorial] and First Nations. Some of the issues identified under this theme included the following as listed in Table 40 below:

Table 40 Theme – Relationship with Government – First Nations Recommendations

To have a relationship with government
The federal government to examine its relationship with First Nation
To eliminate the top-down approach
To have government to government negotiations
To have interchange agreements
Full partnership
Respect the role of provinces and territories
Recognize the Alberta First Nations – FNIHB, Health Canada Envelope Co-Agreement
Support for a more holistic approach
Industry accountability and responsibility though legislation

Several First Nations organizations; the Assembly of First Nations, Dakota Ojibway Tribal Council, First Nations Chiefs' Health Committee,[4] Assemblee des Premieres Nations du Quebec et du Labrador, Commission de la Sante et des services sociaux, Des Premieres Nations du Quebec et du Labrador and Council of Yukon First Nations identified various issues related to the First Nation working relationship with both levels of government - federal and provincial. The Assembly of First Nations identified the "need for Canada to examine the relationship with First Nations" and the need to "eliminate the top-down approach". The Assembly of First Nations indicated that failure to examine the federal government/First Nations relationship would not "produce the change required to meet the current and future generation's needs" and that with First Nations involvement and control would be there more appropriate direction for change to the health system. (AFN, 2002)

Dakota Ojibway Tribal Council hereafter, DOTC (2002) expects the government relationship with First Nations to build on the principle that "true negotiations must begin on a government to government basis between Health Canada and First Nations for the full transfer of adequate resourcing for the management and administration of health services". Further, Dakota Ojibway Tribal Council expects that the relationship with the government should include the notion that "a full partnership must be developed with honesty, integrity and transparency in all matters." (2002, p.6-7) DOTC recommends, "more interchange agreements between First Nations Inuit Health and DOTC for training

[4] In Romanow's Final Report, Page 275 lists First National Chiefs' Health Committee. It is the researcher's opinion that this is an error and should be the First Nations Chiefs' Health Committee. There is a submission authored by First Nations Chiefs' Health Committee sent to me by the Privy Council of Canada, Ottawa.

of human resources, which may be another way of developing a further relationship with government." (2002, p. 7)

The Assembly of First Nations of Quebec and Labrador – Health Commission "acknowledge the desire to work collaboratively with federal and provincial governments" and that this relationship should be interdependent and "respectful…of the role of the province and territories in health care organization and delivery." (Retrieved Public Hearing Report, p.5)

Alberta First Nations – Treaty 6, Treaty 7, and Treaty 8 identified that "the federal government must recognize the Alberta First Nations-FNIHB, Health Canada Envelope Co-Management Agreement in Alberta as a mechanism to help provide guidance to the health care reform debate as it impacts Alberta First Nations. The scope of Co-Management between federal government and Alberta First Nations partners provides a ready-made process to engage discussion regarding First Nations health services and programming and health reform." (2002, p.16) The Alberta First Nations indicated that "the principles of the Canada Health Act require reconciliation with the lack of equal comprehensiveness of the Indian Health Policy of the federal government" which may go a long way toward developing a better working relationship between First Nations and the government. (2002, p. 18).

What might be needed for another two First Nations organizations, regarding a working relationship with government, is a change in the resistance that they believe is evident in some of the bureaucrats as they "adhere rigidly to the medical model and to tell First Nations communities what they need rather than listening to what First Nations have to say about their health. (Council of Yukon First Nations and Yukon First Nations

Health and Social Commission, 2002, p. 10) (Whitehorse – Public Hearing – LLM – May 2, 2002)

b. Metis and Aboriginal

"Federal government leadership is needed to combat the complexity of the health care system serving Aboriginals." (Ontario Metis Aboriginal Association, 2002, p. 16). This organization went on to further state that "roles and responsibilities need to be clarified amongst Aboriginals and the federal government". This may foster a renewed starting point and a better working relationship. (2002, p. 16)

c. Metis

A position argued by the Metis National Council is that the federal government needs to take responsibility in the health area and "advocate for federal responsibility for Metis health" (Metis National Council, n.d., p. 2). This type of expectation may influence the type of relationship the Metis have with the federal government as they recommend that the "Government of Canada constitutionally recognize and acknowledge the jurisdiction of Metis as Aboriginal Canadians with similar rights to those of Indian and Inuit under Section 91 (24) of the *Constitution Act* of 1982", (Metis National Council, n.d., p.13) One of the impacts of the relationship between the Metis and governments may be the belief that their partnership is not equitable as it relates to the five principles of the *Canada Health Act* and the need to refine them and "apply the concept of basic democratic principles, and values, and individual rights and freedoms, to the health care system to better serve the health care needs of the Metis population especially in view that Metis governments were not equitable partners in Canada during the development of Canada Health Act legislation in 1966." (Metis National Council,

n.d. p. 13). The Metis urge "federal, provincial, territorial, and municipal and service agencies to move aside and create political and organizational space for Aboriginal initiatives" (Metis National Council, n.d. p. 13), which may create a change in their existing relationships. While the Metis may want the federal government to take constitutional responsibility for Metis Health, it also wants them to move out of the way in terms of development. The Metis want to be "equitable partners in the negotiation of policy and legislative changes that impact on the development, delivery, and transfer of health programs and serves [sic] to Aboriginal organizations" (Metis National Council, n.d., p. 13.

d. Inuit

An Inuit organization identified that Inuit's relationship with government should begin with respect and equality. The relationship also needs to respect their culture and collaborate with Inuit in any restructured design. (Dewar, 2002, p. 2) Inuit furthered identified "a need for direct representation and meaningful consultation that was, "more inclusive, effective, and accountable to Inuit women."(Pauktuutit, 2000, p. 33) The Inuit indicated that, "discussions on the issue of equity in relation to the health care system are still needed, both within Inuit communities and within all levels of government, and that Inuit women must be full participants from the onset." (Pauktuutit, 2000, p. 35). Further more, this Inuit organization identified that the housing situation was "deplorable" and remained a priority. Governments must implement a coordinated approach to the improvement of this situation." (Pauktuutit, 2000, p. 35)

Nunavut Tunngavik Incorporated hereafter, (NTI) is the successor to the organization that negotiated the Nunavut Land Claims Agreement between Inuit and the

Crown where Inuit agreed to the extinguishment of their Aboriginal title to lands and waters in Canada. NTI want a relationship with the federal government which entails partnership and cooperation. NTI stated that Canada seems content to permit the high levels of poverty, ill-health, poor housing, homelessness, illiteracy that exists in Nunavut. (NTI, 2002, p.2.) Canada needs to work on nation building with a vision and "understanding about what it means to have the North as part of Canada." (NTI, 2002, p.7)

The Qikiqtani Inuit Association (QIA) seeks Inuit health renewal and wants a relationship with government whereby "there is recognition of Inuit as one people, with a common language and culture and with a need to work together and share information, experience and expertise across provincial-territorial boundaries". (Qikiqtani Inuit Association, 2002, p. 4) There needs to be a shift in thinking and structure within First Nations Inuit Health Branch, hereafter, FNIHB to accommodate Inuit needs. QIA stated that there needs to be recognition of the different roles of Inuit organizations and governments in order to collaborate and cooperate with one another. The relationship between governments and Inuit should range from full partnerships to improved information sharing and communications. (QIA, 2002, p.7).

e. Aboriginal Interest/Focus

BC Aboriginal Network on Disability Society hereafter, [BCANDS] (2002) has managed to work cooperatively with the provincial and federal governments to address issues facing Aboriginal Persons with Disability. This cooperation must proceed with a concerted effort and genuine commitment on the part of each level of government. (p.2) BCNDS stated that there needs to be a "fundamental changes across each level of

government to the systemic and attitudinal barriers that have become the 'operating norm' and 'silent status quo within Canada's health care system". (p.4) One of BC Aboriginal Network on Disability Society's two supplementary documents stated "inter-sectoral cooperation, for example, between different levels of government, between health, social services, environmental, housing, labour, and economic development agencies is necessary to remedy the root causes of ill health." (The Chiefs' Health Committee & First Nations Summit Society, [Supplementary document to Romanow Commission] 2002, p. 44) In a second supplementary document to the Romanow Commission, BC Aboriginal Network on Disability Society (1993) indicated the need for government offices "to work in cooperation with one another, as well as with direction participation and consultation with the disabled Aboriginal people, to design and deliver the most efficient programs and services for disabled Aboriginal People."

Aboriginal Nurses Association of Canada (2001) recommend that there needs to be consider the development of aboriginal governments with new models for sharing responsibilities and ensuring accountability regarding the health care system. (p.4)

ii. Policy and Program Development

First Nations' organizations identified issues around a theme about policy and program development as identified, in Table 41, below:

Table 41 Theme Policy and Program Development – First Nations Recommendations

First Nations policy development
Community driven health care model
Development of a framework guided and developed by First Nations
First Nations needs based planning
First Nations development of a health system specific to First Nations people

a. First Nations

Alberta First Nations (2002) said that they "must be engaged and actively involved in the process of developing First Nations communities through participating at all levels of decision-making of governments, particularly policy development before implementation." (p. 17) The Alberta First Nations (2002) advocated for a community driven health care model. This model requires that "...adequate funding be redirected to address poverty and inherently poor health status in First Nations communities through the development of a primary health care model that is community driven..." (p.17.).

The First Nations Chiefs' Health Committee (2002) recommended that First Nations be involved in program health reform regarding programs such as the Non-Insured Health Benefits (NIHB). Additionally, they put forward that First Nations must develop a framework for a new model of health services. (p. 13) The Chiefs of Ontario (2002) provided recommendations that "First Nations must be primarily involved in strategies for design, development, and implementation a primary health care model that is sustainable.". (Chiefs of Ontario, 2002, p. 5)

b. Metis and Aboriginal

The Ontario Metis Aboriginal Association [OMAA], (2002) indicated that an "effective health care system for Metis and other off-reserve Aboriginal people needs to be simple, clear and understandable." (p.8) OMAA identified that more outreach is needed to encourage seeking treatment and that support for travel is necessary for care. (p.10) OMAA recommended, "supporting practical community-led strategies for diseases such as diabetes and cancer" and programming for 7 to 12 year olds. . (p.16)

c. Metis

The Metis National Council (n d.) recommend in the area of policy and program development for health care that the Government of Canada needs to constitutionally recognize and acknowledge the jurisdiction of Metis as Aboriginal Canadians with the same rights as Indians and Inuit. Furthermore, MNC recommended that the five principles of the Canada Health Act be refined to offer better health care to the Metis population and to encourage the development of a comprehensive government strategy to address the health needs of the Metis. MNC stated that the Metis want to be equal partners in the negotiation of policy and legislative changes regarding all aspects of health programs. Overall, the development of a heath care system for Metis needs to incorporate a holistic framework developed by Metis. (pp 13 – 14)

d. Inuit

Qikiqtani Inuit Association (2002) stated that federal, provincial and territorial governments are sometimes outside the realm of Inuit life and therefore, there needs to be Inuit-specific health policy developed by Inuit. For Inuit health renewal, the following lamps or quilliqs [Inuit traditional knowledge] are required:

- Inuuqatigittarniq is the number one (1) priority which is defined as "the healthy, interconnection of mind, body, spirit, and environment and is one of the lamps or quilliqs lighting the way for Inuit Health Reform." (QIA, 2002, p.3)
- Recognition that programs and services that work are Inuit-specific, Inuit designed, delivered, and administered;

- Recognition that Inuit Qaujimajatuqanqit [Inuit traditional knowledge - "the Inuktitut term for the notion of Inuit knowledge social, and cultural, beliefs, language, and world view" (QIA, 2002, p.11),] is as important to program and services as the knowledge/skills of medical professions
- Program and services that target Inuit should be accountable to Inuit
- Inuit solutions to Inuit wellness should be development of Inuit Health Policy.
- Community training programs relevant to Inuit must be developed this should leads to more Inuit delivering health services.
- An Inuit Secretariat
- Inuit Qaujimajatuqanqit be incorporated into staff hiring and promotion polices. (pp. 3 -12)

Ford (2002) indicated that there is a need for more home visits to elders and persons with disabilities. Programs , such as the following, should be developed

- teaching pregnant women about healthy diet and parenting education
- family planning on birth control to reduce teenage pregnancy
- education to reduce sexually transmitted diseases
- medical staff in schools to teach children about healthy life styles
- education about immunizations, i.e. TB, meningitis.

Nunavut Tunngavik Incorporated, hereafter NTI, (2002) argued that Inuit should be guaranteed the right to participate in the development of program and policies, which reflect communities in the health area. (p.1 & p.3) NTI (2002) stated that federal policy is unfair to Inuit when it provides programs and benefits to on-reserve Aboriginal people.

Inuit want to be allowed the same access to the same type of health programs as First Nations. (p.7)

Pauktuutit Inuit Women's Association of Canada (2002) that what is necessary is Inuit-specific programming, which meets Inuit community members' needs. Programs developed need to reflect Inuit Artic life and its reality. (pp. 2 - 3).

Nunavut Tunngavik Incorporated [NIT] recommends a need for legislation, policies, and programs to involve and reflect the northern community. (p.3). Further, Inuit Tapiriit Knantami noted that it is necessary to be full partners in the development of policies and programs that affect Inuit. (p.8)

Labrador Inuit Health Commission [LIHC] (2002) identified the following policy and program solutions: recruitment of professional staff, accessible and adequate health services at the community level, enhanced community education and awareness, and enhanced wellness strategies. (p. 39-40)

e. **Aboriginal Interest/Focus** Native Women's Association of Canada, [NWAC] (2002) recognized the need for a population health approach to be utilized, which considers the total environment. The following make up key elements of this approach: income and social status, social support networks, education, physical surroundings, biological and genetic makeup, child development, and health services. Furthermore, they argue that this approach should be completed within a contextual framework, which "acknowledges the continuing oppression of Aboriginal peoples and the impact of colonization." (p. 10). When assessing the needs and concerns of Aboriginal women health consideration should be given to policy and program development from of a holistic framework. (NWAC, 2002, p.3) NWAC (2002) further

identified the need to create and increase sex education programs in Aboriginal communities and a need for improvement of the health of Aboriginal children, this must be a high priority for government. (p.p.7 - 8).

The B.C. Aboriginal People with Disabilities, hereafter, BCAPD, (1993) recommend the development of an Aboriginal Advocacy Program with a toll free telephone line. There was a need identified that there be consultation with disabled persons in the design and delivery of programs and services for Aboriginal persons with disabilities. BCAPD (1993) further identified the need for program development by Aboriginal persons with disabilities listed in the following areas:

- job re-training programs to be developed with the direct involvement of aboriginal persons with disabilities along with programs developed to compensate employers for workplace renovations to recruit persons with disabilities
- child care programs for special needs children
- life skills training programs to address the needs of aboriginal persons with disabilities
- public awareness and education programs, along with the public school system.
- professional training and development of programs to increase the skill and knowledge of caregivers of disabled clients
- post-secondary curricula in the human services should take into consideration of the clients with disabilities

- Culturally sensitive information, available at no cost to the client, persons with disabilities about services available
- Development of culturally appropriate programs and services that medet existing provincial standards (pp.32-34)

BCAPD recommended a change in policy to delegate to First Nations communities to authorize medical equipment. They recommend that the current policies for medical supplies need enhancement. . There needs to be a revision to Department of Indian and Northern Development policies and the provincial Ministry of Social Services policies regarding "eligibility of disabled Aboriginal People on reserve to purchase bus passes at the rate available to off reserve disabled people" with a need to review the current hours and areas of services of public transportation services. There was a recommendation for outreach services for isolated aboriginal persons with disabilities. (BCAPD, 1993, p. 33) When Aboriginal persons with disabilities transition from a rehabilitation facility to a home setting, there needs to be follow up care provided on a regular basis and professional assessments. Family members need to be adequately trained and be part of the process prior to release from the medical centre when caring persons with disabilities. (BCAP, 1993, p.34) The development of a successful health strategy must include an improvement of employment and income conditions. (BCAP, 1993, p. 27)

The Western Arctic Aboriginal Head Start Council, hereafter, WAAHSC strongly recommended health prevention programs, such as the Aboriginal Head Start programs, for the future direction of the health care system. (p.4) The investment into children's early development is beneficial to future communities' capacity.

Aboriginal Nurses Association of Canada, hereafter, ANAC (2001) recommended that there be an implementation of the Primary Health Care model at the community level, development of a method to design community based health care services, development of new generalist services providers by training Aboriginal people, commitment to the need to further development of access nursing programs with a strong emphasis on community based education. (p.1) This organization suggested that Aboriginal cultural awareness be introduced into the basic education and cultural orientation of health care providers when they serve Aboriginal people. Furthermore, they argue that there should be support to, "Think Tanks" and Consensus workshops to develop innovative program models to meet community needs. A recommendation suggested that the federal government change its policies regarding how to access Traditional Healers and Elders under the control of aboriginal organizations. There should be integrated therapeutic models for healing, addictions and emotional problems with a focus on assistance regarding death, dying, and, grieving issues. . (Aboriginal Nurses Association of Canada, 2001, pp. 2-3) Governments need to use their authority to regulate the private sector health care service providers a recommendation by ANAC to ensure safe and affordable care in achieved. (2001, p. 3).

National Aboriginal Health Organization (2001) recommended the following changes in policy and program development for the health care system:

- Aboriginal values be included in the design and development of health care programs and services that would allow for the integration of western and traditional medicine
- Utilization of a population health approach critical to sustainability

- Appropriate and permissive policies be developed as incentives for the creation of integrated health system models encompassing federal and provincial services. (pp 3 -4)

iii. Fiscal Resources

First Nations' organizations identified issues around a theme related to fiscal resources for First Nations in the health care system. Some of the issues identified under this theme by First Nations' organizations included the following in Table 42:

Table 42 Theme Fiscal Resources – First Nations Recommendations

Fiscal Resources needed
Funding review of health care needs
Determine costs to bring up to par with the standards
Fiscal Resources for Management and Full Control
Program Development Funding
Transfer Payments to go to directly to First Nations
Sufficient funding for accessibility
Funding increases
Full Costs for the provision of quality health care must be borne by federal government
Replace National Envelop System with a new process
Consideration for projected population increases
Sufficient Funding needed
Funding – Full Restoration of federal cuts to First Nations Health
Transfer of control over funding
Funding needed
Funding to build capacity – manage and train
Raise awareness of the end of federal government funding for construction and major renovations to residences
Fiscal Resources for education institution for First Nations
First Nation Funding for Research
First Nation Funding for Capacity building

a. First Nations

The Assembly of First Nations (2002) has stated that the federal government must examine its relationship with First Nations as it also examines it expenditures. If that does not happen, it will not meet the required in the current and future generations needs. (p.2)

Saskatchewan First Nations [SFN], (2001) identified a need to develop a strategy for the health and well-being of its present and future members. SFN would like to develop a comprehensive First Nation and Social Development System, which requires a "monetary investment that cannot be filled by our current fiscal allocations." (SFN, 2001, p. 4)

Southern Chiefs' Organization hereafter, SCO (2002) recommended, "a funding review to determine all the health care needs of the First Nations should be undertaken to determine what is needed and the associated costs identified to bring up to par the standards adhered to within the general Manitoba communities." (p.6) When the funding review is completed, it should identify the fiscal resource requirements for effective management and full control over health services, identify training program requirements, program development needs, identify human resource requirements to manage and lastly, Canada Health and Social Transfer payments should go directly to First Nations

SCO (2002) reported that the federal government cost containment approach to health care provision has been difficult given the increasing costs of health care services for on reserve services and programs. First Nations communities try to meet the needs of their membership with limited resources. SCO stated that with the new Consolidated Contribution that were developed and implement by Health Canada-FNIHB that provides

fiscal resources to First Nations has very strict conditions which has made it hard for First Nations. The fiscal resources deemed inadequate fiscal resources for First Nations and SCO has recommended a funding review to determine all the health care needs and related costs to bring First Nations up to par regarding health care services and to determine fiscal resources for effective management and full control. (p. 6–7) Further, that "the Canada Health and Social Transfer payments should go First Nations directly to provide reimburse costs to the province for providing insured services in health and social costs." (SCO, 2002, p.7)

SCO (2002) stated, "immediate measure must be taken to streamline the delivery of health services with mechanisms to guarantee sufficient funding to ensure that First Nations have access to all levels of health'. (p.7)

DOTC (2002) affirmed the following in this presentation to the Romanow Commission regarding fiscal resources:

- "Adequate fiscal resources of any form of transfer for administration and management of the resources
- Yearly cost increases for any transferred programs/resources
- Full cost for the provision of quality heath care must be the federal government's responsibility to bore these costs
- The national envelope system must be replaced so that a new process can be developed and implemented with First Nations' consultation
- Due consideration to project population increases must be taken into account." (p. 6-7)

The full restoration of federal cuts to First Nations health through the Canada Health Transfer & Social Transfer (CHST), together with an appropriate escalator, is therefore an extremely modest and reasonable pre-requisite to Firs Nations funding for health." (DOTC, 2002, p.3)

Assemblée des Premières Nations du Québec et du Labrador and Commission de la santé et des Services Sociaux des Premières Nations du Québec et du Labrador [Assembly of First Nations of Quebec and Labrador, and First Nations Quebec and Labrador Health Social Services Commission], (2002) suggested:

- to modify the system policy of "closed envelopes" of uninsured health services budges basing these budgets on the actual needs of First Nations.
- To raise awareness that when the federal government has stopped financing for the construction and major renovations of residences for those who have lost their autonomy. (pp. iii - iv)

Alberta First Nations (2002) identified that adequate funding requires redirection to address poverty and the poor health status in First Nations communities. First Nations require resources to address the socio-economic issues like income, poverty, housing and education, which directly related to the poor health status of Albert First Nations. There must be funding to fully train and build health care services staff so that programs redesigned can meet the individual First Nations needs. Further, that funding should be directed for research, information management, and "consultation that is done by First Nations, for First Nations with First Nations holistic health goals." (pp. 16 - 17)

Chiefs of Ontario (2002) reported, "First Nations governments & organizations are trying to manage the allocated resources in a period of no new resources in the First Nation envelope. Costs are increasing, the population is increasing, needs are increasing, accountability is increasing, and the budgets are remaining static causing reactive programs/services instead of proactive programs and services." (p.3) Chiefs of Ontario (2002) recommended that the current health system needs to address access to health services experienced by First Nations caused by jurisdictional and fiscal disputes about who is responsible and what are they responsible for. (p.6)

b. Metis and Aboriginal

The Ontario Metis Aboriginal Association (2002) reported they saw an urgent need for more resources for Aboriginal health care delivery agencies/workers to hand this increased responsibility and increase resources for programming for youth, 7 to 12 age range. (p.7 & p.16)).This added responsibility refers to the transfer of health services from the Federal government to the Aboriginal organizations. OMAA (2002) stated that incentives and resources for Aboriginals to work in the health care in communities". (p.16) They is a need to provide more resources to "enable off-reserve Aboriginal to fulfill their growing health care delivery role." (OMAA, 2002, p.16)

c. Metis

Metis National Council (2002) recommended federal responsibility for Metis health services. Further, MNC stated that a comprehensive government policy strategy be developed to address the health needs "that is inclusive of equitable and sustainable funding based upon the Metis population in Canada and that will serve the Metis population towards the devolution of Metis health funding to Metis organizations." (p.13)

d. Inuit

Pauktuutit Inuit Women's Association of Canada hereafter PIWAC (2002) indicated that effective consultations facilitated with Inuit women when governments respond by providing financial and human resources for "Inuit women to build their capacity to participate in health policy discussions and planning." (p.5) PIWAC (2000) reported that adequate housing is a priority. Governments must have a coordinated way to address the intolerable housing situation. PIWAC recommended reinstatement of federal funding to at least the 1991 levels and secure, adequate and long-term funding. (p.35)

Qikiqtani Inuit Association (2002) reported that there is a definite need for capital, operation and maintenance resources to address the fundamental aspect of health capacity that is infrastructure. There needs to be health facilities and physical assets to carry out health service delivery. (p.9) QIA (2002) stated that to be fully accountable, funding directed to regional Inuit organizations determine how programs are designed, delivered, and administered. (p.12) The federal government has the responsibility and obligation to ensure the Inuit receive adequate and funding based on Inuit needs. Inuit want to be part of the solutions since they have identified the problems and make decisions on where funding should go to be most effective to improve the community. The professionals that work in the communities want education funding to keep updated with trends in medicine and technology. (QIA, 2002, p.2-3)

Nunavut Tunngavik Incorporated, NTI (2002) recommend that there is an oversight role when there is a transfer of Aboriginal resources to the Public Government of Nunavut. "The best way to reassure Inuit that Nunavut's Public Government is

'reflecting their needs' with aboriginal set-aside health monies is a regular accounting and 'sign-off' by NTI. (p.5)

NTI (2002) identified that the federal government provides funds for on reserve First Nations for health programs and Inuit are restricted from qualifying for these programs and funding. NTI recommended that Inuit to access the same type of First Nation health programs. Further to work with Inuit organizations to ensure accountability regarding for the Inuit health funding and spending. (pp. 5 -7)

Labrador Inuit Health Commission (2002) indicated that there possible solutions to health services and improvement is a need to ensure adequate capital to produce appropriate and programming space and adequate community infrastructure. (pp. 39-40).

e. Aboriginal Interest/Focus

Aboriginal Nurses Association of Canada (2001) identified that governments need to work with Aboriginal organizations to ensure that this is adequate nursing student financial assistance and provide additional funds to aboriginal nurses in need of resources to pursue advanced degrees. (p.2-3) ANAC (2001) recommended that funding that is determined between the preventative measures and treatment services must be at an optimal balance for long-term change in the health status of populations includes Aboriginal communities. (pp. l-3) The ANAC (200l) put forth that National Aboriginal Health Organization becomes a clearing for sharing best practices in the country and internationally but would require resources. There should be funding allocated for Aboriginal Health Research and curriculum development. ANAC identified for their organization for the establishment an Aboriginal Health Nursing as a recognized nursing specialty (pp.2-3).

B.C. Aboriginal Network on Disability Society (2002) identified a "financial need family assistance and an alternative support such as mutual aid and child care for lone parents, and those coping with illness in the family. (p.28) BCANDS (1993) indicated that "government funds designated for aboriginal people with disabilities should be directed without dilution to disabled aboriginal people for administration." (p. 34)

BCANDS (1993) indicated resources were needed for an Aboriginal Advocacy Program, for house modifications to meet the needs of disabled person should be included in the housing budgets all government levels. (p.32) BCANDS (1993) stated that "financial resources to be identified to assist disabled persons and their families when dealing with the trauma of disability; such as travel, accommodation, communication, child care, therapeutical counseling and legal costs, etc.". (p.33)

Institute for Aboriginal Health (2002) strongly urged that the federal government and provincial funding continue for FNHC [First Nations Health Careers] as it will contribute to the Aboriginals' overall health. (p.4) In keeping with a similar recommendation Western Arctic Aboriginal Head Start Council hereafter WAAHSC (2002) identified recommend that all health care resources for First Nations programs including diabetes, home care, early childhood initiatives, HIV/AIDS, Fetal Alcohol Syndrome and other health dollars for First Nations healthcare be First Nation controlled and administrated. WAAHSC recommended that there is an Aboriginal Head Start Program in each NWT community with multiyear funding. Further, that the health prevention program received additional dollars to meet community needs and allocation for funds for the special needs children. WAAHSC stated funds be provided to conduct long term, ongoing evaluations. (pp. 4-6)

NAHO (2001) reported Aboriginal health care expenditures increase to at least a minimum similar to provincial rates of increases to health care costs. (p.4)

The Tree of Peace Friendship Centre (2002) indicated more money for prevention programs to address social issues, alcoholism and homelessness. In order to address those social issues, there needs to be more coordination and financial resources to social service agencies. (pp. 2-4)

iv. Accessibility

First Nations' organizations identified issues, which surround a theme about the accessibility issues. Some of the issues identified under this theme about the accessibility for First Nations are listed in Table 43:

Table 43 Theme Accessibility – First Nations Recommendations

Address inequalities of access
Equitable access to health services and equitable outcomes in health status
Accessibility and quality for health care
Bridged provincial services
Accessibility
Lack of equal comprehensiveness
Accessibility to health services for First Nations & better adapted to their need

a. First Nations

Assembly of First Nations (2002) indicated that the quality and access to heath care services for First Nations is an urgent issue and requires resolution. AFN (2002) identified that many specialists in medical field are services that many remote and rural First Nations cannot access. If referred to a doctor and specialist First Nations often have to travel to "large urban centres to become medical refuges if their conditions are chronic.

Clearly, this is not what First Nations want or need. What they need is for their current services to be more consistently bridged to whatever is available provincially." (p.5)

DOTC (2002) recommended that immediate measures to streamline mechanisms to ensure that First Nations have access to all health services as needed. "The premise of any negotiations is the fiduciary obligation and treat based rights of First Nations to have access to quality health care provided by the federal government."(p.6) Alberta First Nations (2002) recommended that the "principles of the Canada Health Act require reconciliation with the lack of equal comprehensiveness of the Indian Health Policy of the federal government." (p.18) The Assembly of First Nations of Quebec & Labrador (2002) that they wish to ensure that Aboriginals have better access to health services and that these services are better adapted to their First Nation health needs. (p.5)

b. Metis and Aboriginal

Ontario Metis Aboriginal Associated stated, "equal accessibility and fairness suggest that Metis should be included as well. We believe that it is the responsibility of the federal government to provide equal treatment to all Aboriginal people in Canada by addressing this accessibility issue." (2002, p. 16) OMAA (2002) stated that an inequality exists to access health care for non-status Aboriginals. (p.6) For example, Non Insured Health Benefits (NIHB) benefits do not extend to non-status Aboriginals. MNC (2002) indicated that many Metis and off-reserve Aboriginal live in smaller and/or remote communities. There are limited services available including medical, counseling, rehabilitation and prevention services, particularly delivered in traditional languages. (p.9) Travel to access health services is an important accessibility issues to be addressed. (MNC, 2002, p.15)

c. Metis

Metis National Council (2002) requested that the application of the principles of the Canada Health Act extend to Metis and Aboriginal people in Canada. Further, that they advocate for health promotion and prevention programs targeted for Aboriginal people and more specifically, "the provision of and access to, Metis specific programs and services." (p.10) MNC (2002) has advocated for federal responsibility for Metis health; equitable access to Aboriginal health funding; access to health care services that is portable. (p.14) MNC (2002)further called for a "catch up" phase for Metis to access existing standards of health care available to mainstream Canadians, and which for themost part relating to Aboriginal specific health care, is accessible to First Nations and Inuit, exclusive of the Metis…" (p.12)

d. Inuit

Pauktuutit Inuit Women's Association (2002) required accessibility to health care services where Inuit women have the right to choose to give birth in their communities rather than traveling outside their communities to have their children. (p.3) PIWA (2000) indicate that one of the three primary concerns they had was access to health care services. They identified that they have lack of services in the communities. (p.1) PIWA identified that they have access to modern technologies and practices of modern medicine. Inuit should have access to culturally appropriate, home care services in their own language. (PIWA, 2000, pp. 33-34)

NTI (2002) indicate that "the real solution lies in allowing Inuit the same access to the same type of health programs that First Nations have, and in working with Inuit organizations to ensure that there is some accountability as to how health dollars." (p.7)

LIHC (2002) that a possible solution to address their health care issues at the community level is to have accessible and adequate health care services. (p.39)

e. **Aboriginal Interest/Focus** Institute for Aboriginal Health (2002) identified that the jurisdictional issues related to who is responsible between the federal and provincial governments for Aboriginal health is often interferes with the accessing of the health care system. (p.1)

Tree of Peace Friendship Centre (2002) indicated that if you are an individual who may be suffering from an alcohol and drugs, there is no detoxification or treatment in Yellowknife, therefore you access to this service delivery provision is non existent. (p.2)

B.C. Aboriginal Network on Disabilities Society (2002) indicated that the basic physical access issues exist and the strategies to address them continue to focus on short term and ad hoc initiatives. (p.8) BCANDS (1993) indicated, "there was a need to ensure that all community services buildings are fully accessible." (p.31) BCANDS (1993) recommended that the "development of culturally appropriate programs and services to clients should be developed; with a minimum standard of service that was equivalent of existing provincial standards." (p.34) The issue of accessibility to services remains a recommendation put forth by BCANDS in 1993 and subsequently to the Romanow Commission nine (9) years later in 2002.

Native Women's Association of Canada (2002) recommended "access to culturally appropriate and culturally sensitive services for pregnant women"... (p. 7) and the lack of accessible services for Aboriginal women needs to improve to meet the needs of Aboriginal women's health. (p.8)

V. Discussion

This section will with a commentary on the use of an Aboriginal conceptual framework to sensitize this researcher.

i. Sensitizing – use of an Aboriginal Conceptual Framework

As indicated in this Methodology section, this research used an Aboriginal conceptual framework, the Aboriginal Life Promotion Framework to sensitize the researcher.. As a First Nation person, I found I was readily able to relate to the Aboriginal conceptual framework. The ALPF has a frame of reference that encompasses a holistic approach to life that I share in aspects of both, my personal and professional life. At first glance, the Aboriginal conceptual framework appears to be a simple approach to reviewing data; however, once it was applied the complex nature of the framework evident for the researcher. As the researcher from the identified recommendations, it became clear that each recommendation reflected an element of human existence. I placed each of the recommendations in one of the four (4) domains of human existence utilized in the framework. This was not an easy process, as it was tempting to place any one of the recommendations into all four (4) domains since each recommendation could be argued to affect the elements of human existence. As the Aboriginal conceptual framework, holds to the fundamental beliefs that all the four (4) domains are interconnected - interdependently and independently - the task of placing recommendations in one of the domains created by the research is a linear process that separates and puts things in compartments which is difficult when dealing with a holistic approach. For example, the researcher saw some recommendations that addressed one or two elements of the domains while other recommendations had elements in all four

domains. This influenced how the recommendations were viewed within the ALPF framework. For example, I found that I had a tendency to place more intrinsic value in the development of a recommendation if it held more of the elements of human existence. I found that I became critical of a recommendation if I found it did not consider most or all of the elements of human existence. In hindsight, I realize that this criticism of some recommendations came from the expectation that all recommendations would be developed from a holistic approach. I expected the First Nations organizations to put forth their recommendations in a holistic manner. Recommendations that were identified appeared to address three domains [Domain 1, 3, 4] but I noticed that there was a tendency for the recommendations not to reflect the elements of human existence of Domain 2 [child, youth, adult, and elder].

Another factor, which affected the use of the Aboriginal conceptual framework as a sensitizing framework was the researcher's own personal knowledge and how I related to the framework. By using ALPF, it gave the opportunity to reflect on my understanding of my own existence while maintaining balance as a human being, as a researcher, as a wife, a sister, and as a mother.

Non-Aboriginal persons and Aboriginals can use this Aboriginal conceptual framework. The Aboriginal conceptual framework forces one to look at all aspects of policy and program development; to look at the whole and the sum of it parts, and how they are interconnected, interdependent, independent of each other while trying to achieve a sense of balance.

The Aboriginal conceptual framework required this researcher to review and make decisions regarding placement of the recommendations in relation the sixteen

elements of human existence. The Aboriginal conceptual framework offered the researcher an approach that emphasized a more holistic approach to future policy and program development.

This research required looking at all four (4) domains of human existence as a potential way of developing policy and programs. It is an inclusive process. For example, if one were develop a policy for First Nations children, in keeping with the principles of the ALPF, all aspects of the ALPF of the four (4) domains would require attention in relation to First Nations children. The researcher found the use of the framework application to policy and program development would be a culturally appropriate exercise. The researcher recommends that any organization striving towards cultural competence consider this tool as starting point as it stresses a holistic approach. A holistic approach is very inclusive in its nature. It has interdependent and independent components operating in a collaborative manner. The Aboriginal Life Promotions Framework allows policy and program development to be looked at from an inclusive holistic approach.

ii. First Nations Themes

This researcher was particularly interested from the onset in what First Nations wanted from Canada's health care system. The theme, Relationship with the Government identified what type of relationship with the federal and provincial government the First Nations desired. From a First Nations perspective, this researcher sees a relationship that is built on the principles and values of interdependence and independence. A top down approach is not what is required as indicated in the data findings.

The Romanow's Final Report outlined the following recommendations as it related to Aboriginal Health:

- Consolidate Aboriginal health funding from all sources and use the funds to support the creation of Aboriginal Health Partnerships to manage and organize health services for Aboriginal peoples and promote Aboriginal Health
- Establish a clear structure and mandate for Aboriginal Partnerships to use the funding to address specific health needs of their populations improve access to all levels of health care services, recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers.

Recommendations from Romanow's Final Report and First Nations submissions regarding health care system are distinctly different in approach. For example, First Nations indicated that the funding levels of First Nations health were inadequate and called on the Federal Government of Canada to look at increases in this area. In the Romanow's Final Report, one of three recommendations regarding Aboriginal health stated that there should be a consolidation of all health funding for Aboriginal peoples. Consolidation does not translate into more fiscal resources; it means to make do with the existing resources despite the fact that First Nations have repeatedly indicated that there is a need for additional funds for health. Consolidation of funding does not address the issues facing First Nations people when it comes to infrastructure in their communities. There are limited health centres equipped to meet the needs of the communities. This is an example of how policy direction is limited, as it does not take into account the

economic, social, cultural, and political aspects of First Nations. This approach is not a holistic approach to First Nations issues rather it is a Pan-Aboriginal[5] approach to resolve the problem. In this recommendation, existing funding is utilized to form the Aboriginal Health Partnerships.

Romanow's second recommendation called for the establish a clear structure and mandate for Aboriginal Partnerships to use the funding to address some specific health needs of their populations and to improve access to all levels of health care services, to recruit new Aboriginal health care providers, and increase training for non-Aboriginal health care providers. First Nations people have their clear mandate on how to deal with the health issues facing their communities and the nations. It is the belief that health is a treaty and inherent right and linked to the Treaties and therefore, a fiduciary responsibility. The Assembly of First Nations, which is a national organization, has clearly identified a mandate, which is more reflective of the needs for First Nations. Romanow's recommendation is shortsighted when the existing health care funding levels are clearly inadequate according to the First Nations' submissions to Romanow Commission. First Nations people live in poor socio-economic conditions and First Nations have stated in past that they are living in Third World conditions. How can the federal government expect to raise the poor health status of First Nations when operating on health funding that does not take into account the clear inequities of social life and economic life faced by First Nations. The Canada's federal health department wants the country to have the healthiest people in the world; this clearly cannot happen without adequate funding and attention to current inequities as indicated by First Nations people

[5] Pan-Aboriginal refers to the federal governments approach when dealing with Aboriginal People as one large group without its cultural, community, economic differences, etc in the development of policy and program development, fiscal resources, etc. The Assembly of First Nations opposes this approach.

[Romanow Commission's Aboriginal forum]. Some First Nations argue that the Romanow Commission's recommendations appeared more rhetoric regarding a new direction of Aboriginal Health. Each of the recommendations did not indicate take a strong leadership role because they have a constitutional responsibility for First Nations Health and other Aboriginal groups also desire a federal role. This researcher believes at a minimum that with a partnership as suggested by the Romanow Commission must begin with an expectation of what each partner is responsible and not solely from a moral obligation but rather from the premise of First Nations treaty rights.

The Romanow Commission held an Aboriginal Forum on June 26, 2006 on Aboriginal health issues. The event was co-hosted by the Romanow Commission and the National Aboriginal Health Organization (NAHO). The following are the recommendations identified common among the First Nations, Inuit, Metis, and Urban Aboriginals that attended the Aboriginal Forum:

- "long-term, stable funding e.g.: block funding that allows for being able to design and deliver programs that fits the needs of a community;
- a massive education push in health careers;
- recognition and acceptance of federal responsibility to ensure First Nations, Metis, and Inuit health care needs are met, regardless of geographic location;
- health policy that is specific to each of the First Nation, Metis, Inuit;
- ensure a process for meaningful participation in the development of health policy;

- development of strategies to care for the well-being of the environment as it significantly impacts health;
- sufficient resources be allocated to increase public understanding of the uniqueness of different Aboriginal cultures
- technology, infrastructure and capacity development to be addressed; and
- increased recognition and use of traditional practices."(Health Canada, 2003)

The researcher placed each of themes under one of the five (5) Aboriginal categories. Please refer Table 44 which are the themes sorted by the organizational category which represents a collapsed list of recommendations.

Table 44 – Themes sorted by Organizational Category

First Nations Organization Category	**Aboriginal Interest/Focus Organization Category**	**Inuit Organization Category**	**Metis & Aboriginal Organization Category**	**Metis Organization Category**
Government Relationships	Government Relationships	Government Relationships	Government Relationships	Government Relationships
Policy & Program Development	Policy & Program Development	Policy & Program Development	Policy & Program Development	Policy & Program Development
Fiscal Resources	Fiscal Resources	Fiscal Resources	Fiscal Resources	Fiscal Resources
Accessibility	Accessibility	Accessibility	Accessibility	Accessibility
Culture	Culture	Culture	Culture	----
Capacity Building	Capacity Building	Capacity Building	Capacity Building	----
Consultation	Involvement & Participation	Consultation	----	----
Jurisdictional	Jurisdictional	----	----	Jurisdictional
Sustainability	Sustainability	----	----	Sustainability
Control	Control	----	----	Control
Health Status	Health Status	----	----	Health Status
Treaty Right	----	Human Right	----	Health Right
----	Research	Research	----	----
----	Disabled People	----	----	----
Health Strategy	----	----	----	----
----	----	Land Claim	----	----
----	----	Infrastructure	----	----
----	----	Address Socio-economic	----	----
----	----	----	----	Public Awareness
----	----	----	----	Universality

Table 44 is glance into what each of the Aboriginal organizations categories recommended to the Romanow Commission. The format allowed the researcher to infer

the possible political agenda and policy directions facing each of the Aboriginal organizations during the time of their submissions to the Romanow Commission. For example, in Table 44, the theme, Culture is not listed the Metis organization category. It may suggest that the Metis current political direction in 2001 – 02 was concerned with the government relationships, policy and program development, fiscal resources and accessibility recommendations regarding the future of health care. 4

Another inference that may be drawn from Table 44 is that health is on the political agenda or political importance to the five (5) Aboriginal organizations groups. In the Table 44, it is clear that the issue of health in relation to rights is different among First Nations, Inuit and Metis organizations. In Table 44, the theme, Rights was listed as a treaty right, a health right and a human right. Under the First Nations category, the theme, right is listed as a Treaty right and under the Metis Category, it is listed as a health right. The Metis have expressed that health should be a health right for the Metis People. This is a similar position that is held by the First Nations that their health rights are viewed as Treaty and Inherent rights. Whereas, the Inuit claim that health is a fundamental basic human right.

The theme, Disabled People was listed once in Table 44 under the Aboriginal Interest/Focus category. The identification of the theme in one of the organizations grouping may mean that there more awareness for disabled people issues are needed. It might mean that the political pressures for the remaining four (4) organizations were elsewhere and did not specifically comment on a recommendation for the disabled people.

The following themes, Land claims, Infrastructure, Address socio-economics were listed only under the Inuit category in Table 44. In their submissions, the Inuit identified that the land claims needed to be resolved. The Inuit identified that there was a need to address the socio-economic issues. Interestingly, there were no specific recommendations among the remaining four Aboriginal categories regarding socio-economic issues. The researcher has speculated that there were other political pressures faced each of the Aboriginal groups face and that they responded to the Romanow in their own distinct way. The Romanow Commission's two recommendations suggested a pan-Aboriginal approach despite the First Nations recommendations to the contrary. .

VI. Conclusions & Recommendations

It is my belief that First Nations need to be involved in decisions to influence and change the health care system for First Nations. "First Nations need to take active participatory roles in health research. "(Roscelli, 2005, pp. S58 & S59) As First Nations, we face the federal government's contention that health care is a policy and moral obligation. First Nations' emphatically believe that health is a treaty and an inherent right. (AFN 2002, AMC 2002, Alberta First Nations 2002) The federal government's position that health care services to First Nations are merely a policy needs to be continually challenged. First Nations involvement in health research can lead to a mutual understanding and potential solutions that better First Nations' health status. As First Nations, we need to continue to improve our universal right to access health services. Overall, First Nations need to participate in research to play a role in First Nations health. We need to have a stronger voice or even control in the future policy direction of First Nations' health in Canada.

By participation in this research, I brought a subjective view given I belong to one of the Aboriginal groups studied. As a First Nation woman registered with Opaskwayak Cree Nation in Manitoba I have a vested interest in First Nations health research. I am a Treaty Indian [Opaskwayak Cree Nation] and grew up in The Pas, MB. I currently reside in an urban setting. My extended family live in various communities: The Pas, MB, Opaskwayak Cree Nation, Pelican Narrows, SK. Tataskweyak Cree Nation [Split Lake], Nisichawayasihk Cree Nation [Nelson House], Pimicikamak Cree Nation [Cross Lake], Wabowden, MB, South Indian Lake to name a few. My immediate/extended family has varied experiences with the Canadian health care system ranging from difficulty

accessing health services – specialists, dental services, to transportation from a rural area to an urban area to receive health services because they were not available in the rural area, and to a hospital stay in an urban centre from a remote community.

This research presented a First Nations' perspective and used an Aboriginal conceptual framework. Research considerations require first that First Nations need to continue to be active participants in First Nations health research. Second, an Aboriginal conceptual framework such as the Aboriginal Life Promotion Framework needs development by First Nations and should be utilized in First Nations Health Research.

Using an Aboriginal conceptual framework in research, such as the Aboriginal Life Promotion Framework, highlighted the continued need for First Nation participation, control and development of health policy. The ALPF reflects values, culture, and traditions of Aboriginal people in general. It allowed the research to be seen from a First Nations perspective and offered change to the present health care system. Keely Ten Fingers (2005) stated that "First Nations people are working to shape the direction of research and policy development. These efforts include a process of rejection, revitalization, and reclamation. First Nations are rejecting colonial frameworks, and instead working within our own indigenous frameworks, from research to policy development" and further, that "using indigenous methodologies is not necessarily about rejecting Western approaches, it is about awakening to what our own cultural legacy offers us." (pp. S60- S62) DOTC (2002) identified "quite clearly that the current health status of First Nations is a testament to the lack of direction in the past regarding health

[7] The researcher consulted the spelling of the Cree word, Miõo Pimâtisiwin from the Castel's English-Cree Directory with recognition that he refers to the Woods Cree spoken in the community of Pukatawagan, MB. I have also seen the Cree word spelled Mino Pimatisiwin. For the meaning of the Cree Word, I consulted my sister, Rita McIvor who is fluent in her Swampy Cree dialect. My late parents, Donald A. McIvor [Donald X.] and Nancy McIvor were both spoke fluently in the Cree language and had great influence on my sister's ability to speak her language present day. My father lived in Pukatawagan, MB during part of his life. Mathias Colomb Cree Nation [Pukatawagan, MB] affiliated with Swampy Cree Tribal Council located at Opaskwayak Cree Nation.

care services…" (p.19) My interest in this research was to influence direction to change First Nations health status. I want my health status, my child's health status, my husband's health status, and extended family members' health status to change to better than "poor". Surely, this can happen as Canada has one of the best health care systems in the world. (Health Canada, 2004)

Limitations of the research data existed. First, the relatively low number of participating Aboriginal/First Nations groups in the Romanow Commission. The research was limited to the number of Aboriginal organizations that participated in the Romanow Commission. There were thirty-two (32) Aboriginal submissions, which represented less than one percent (1%) of the total organizations that participated. This relatively low participation of Aboriginal organizations resulted in small numbers categorized in the groupings [eighteen (18) First Nations, seven (7) Aboriginal – other, five (5) Inuit, one (1), Metis & Aboriginal, and one (1) Metis]. Second, the research sample may not be representative of all Aboriginal groups in Canada.

This research adds to social work knowledge as it provides social workers an opportunity to look at social issues from another frame of reference - an Aboriginal conceptual framework. This framework offered a holistic approach to looking at life. It challenged policy makers to develop solutions for programs and services with the premise that the elements of human existence (Bartlett, 2004) are interconnected, interdependent, and independent. Social workers solutions to problems I suggest should consider these principles. This Aboriginal conceptual framework is based on more than an individualistic approach to helping a single client but rather a way of looking at solutions where the individual is living with in a community that may be struggling with

harsh socio-economic conditions. This approach is at broader scope of working with First Nations people and respecting that they have ideas for solutions to their own issues and problems at an individual, family, community level, and national level.

Using the Aboriginal conceptual framework as a frame of reference to address, for example, the recommendations that did not have some of the elements contained in Domain 2. [child, youth, adult, and elder]. There appears to be a trend within some First Nations organizations that overlooks the elements of human existence specifically those related to woman and children. It has been the researcher's experience that males dominate the First Nations political leadership. I think that we need as First Nations woman to continue to advocate for ourselves and for children, it did not appear to the researcher that has been woman and children were adequately addressed in the recommendation. First Nations male leadership state that they are concerned with the woman and children issues however; these issues become part of a larger issue like the social and economic situations facing First Nations. I think that the First Nations leadership needs to pay more attention to this arena for better First Nations health for woman and children. Research into how to develop a national First Nations approach to health is needed that takes into account the First Nations recommendations to the Romanow Commission.

First Nations understand their own health needs and can build on that knowledge to influence change in First Nations' Health Research. The development of First Nation methodologies has started and needs to continue for First Nations' health research specifically. (Ten Fingers, 2005, pp. S60 - S62). Miõo Pimâtisiwin[7] translated to convey the meaning – "good living" or "healthy living." (R.M. McIvor, personal

communication, August 14, 2006, Castel's (2001) First Nations need to develop research methodologies for such as a Miõo Pimâtisiwin First Nations Conceptual Framework This research calls for further research into the development of a "Miõo Pimâtisiwin or Mino Pimatisiwin First Nations Conceptual Framework" developed by First Nations for First Nations Health Research. "Mino Pimatisiwin" in the Swampy Cree language [Miõo Pimâtisiwin in the Woodlands Cree] translated infers the meaning "good survival/living, "healthy survival/living". I believe that when we take control of our own research, we will set our own direction and free us from the legacy of a poor health status in Canada. As First Nations, we deserve better lives for our future generations, our children, and our grandchildren. Ekosi. [That is all.]

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APPENDICES

Appendix A Aboriginal/First Nations organizations public hearing presentation to the Romanow Commission

	Aboriginal/First Nations organizations	Public Hearings - Place & Date
1.	Federation of Saskatchewan Indian Nations	Regina - March 4, 2002
2.	Assembly of Manitoba Chiefs	Winnipeg – March 6, 2002
3.	Southern Chiefs Organization	Winnipeg – March 6, 2002
4.	First National Chiefs' Health Committee	Vancouver – March 12, 2002
5.	BC Aboriginal Network on Disability Society	Victoria – March 14, 2002
6.	First Nations of Quebec and Labrador Health and Social Services Commission	Quebec City – March 25, 2002
7.	Inuit Tapiriit Kanatami	Montreal – March 26, 2002
8.	Chiefs of Ontario	Toronto – April 2, 2002
9.	Assembly of First Nations	Ottawa – April 4, 2002
10.	Nunavut Tunngavik Incorporated	Iqaluit – April 8, 2002
11.	Pauktuutit – Inuit Women's Association of Canada	Iqaluit – April 8, 2002
12.	Qikiqtani Inuit Association	Iqaluit – April 8, 2002
13.	Ontario Metis Aboriginal Association	Sudbury – April 11, 2002
14.	Labrador Inuit Health Commission (LIHC)	St. John's – April 15, 2002
15.	Eskasoni Health Centre	Halifax – April 17, 2002
16.	Abegwit First Nations	Charlottetown – April 18, 2002
17.	Metis National Council	Calgary – April 30, 2002
18.	Council of Yukon First Nations and Yukon First Health and Social Commission	Whitehorse – May 2, 2002
19.	First Nations Health Programs Committee	Whitehorse – May 2, 2002
20	First Nations Treaties 6, 7, and 8	Edmonton – May 14, 2002
21.	Dene Nation	Yellowknife – May 16, 2002
22.	Government of First Nations	Yellowknife – May 16, 2002
23.	Tree of Peace Friendship Centre	Yellowknife- May 16, 2002
24.	Western Arctic Aboriginal Head Start Council	Yellowknife – May 16, 2002
25.	Aboriginal Nurses Association	Ottawa – May 28, 2002
26.	National Aboriginal Health Organization	Ottawa – May 28, 2002
27.	Native Women's Association of Canada	Ottawa – May 28, 2002
28.	Six Nations of the Grand River	Toronto – May 30, 2002
29.	First Nations Programs Committee	Whitehorse – May 2, 2002
30.	Government of First Nations	Yellowknife – May 16, 2002
31.	Six Nations of the Grand River	Toronto – May` 30, 2002
32.	Tree of Peace Friendship Centre	Yellowknife – May 16, 2002

Appendix B — Aboriginal/First Nations organizations - formal submissions to the Commission on the Future of Health Care in Canada's Final Report, p. 259 to 266

Organization	**Category**
Association of Canada	Aboriginal Interest/Focus
Dakota Ojibway Tribal Council[8]	First Nations
Federation of Saskatchewan Indian Nations	First Nations
Institute for Aboriginal Health, Division of First Nations Health Centre	Aboriginal Interest/Focus
Métis National Council	Metis
National Aboriginal Health Organization	Aboriginal Interest/Focus
Native Women's Association of Canada	Aboriginal Interest/Focus
Ontario Métis Aboriginal Association	Metis & Aboriginal
Qikiqtani Inuit Association	Inuit
Western Arctic Aboriginal Head Start Council	Aboriginal Interest/Focus

[8] In Romanow's Final Report, p.262, an organization was listed as Dakota Ojibway Tribal Council des premières nations due Québec et du Labrador. I believe an error has occurred and the name of the organization should be "Dakota Ojibway Tribal Council.

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category: First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
1	Chiefs of Ontario	Toronto – April 2, 2002	Public Hearing	First Nations	Address to the Commission on the Future of Health Care in Canada, April 2, 2002, 7 pages
2	Pauktuutit – Inuit Women's Association of Canada	Iqaluit – April 8, 2002	Public Hearing	Inuit	The Future of Inuit Women's Health, Presentation by Veronica Dewar, President, Pauktuutit Inuit Women's Association of Canada to the Commission on the Future of Health Care in Canada, April 8, 2002, 5 pages
3	Nunavut Tunngavik Incorporated	Iqaluit – April 8, 2002	Public Hearing	Inuit	Presentation to the Commission on the Future of Health Care in Canada. John Lamb. Chief Executive Officer, Nunavut Tunngavik Incorporated, April 8, 2002, 8 pages.
4	Qikiqtani Inuit Association	Iqaluit – April 8, 2002	Formal & Public Hearing	Inuit	The Seven Quilliqs of Inuit Health Renewal, The submission of the Qikiqtani Inuit Association to the Commission on the Future of Health Care in Canada, April 8, 2002, 13 pages and supplement document, 4 pages.
5	Ontario Metis Aboriginal Association	Sudbury – April 11, 2002	Formal & Public Hearing	Metis & Aboriginal	Ontario Metis Aboriginal Association to the Commission on the Future of Health Care in Canada, Open Public Hearing, April 11, 2002, 16 pages.

Appendix C Reference Sheet – Aboriginal/First Nations Participation to the Commission on the Future of Health Care in Canada – Final Report

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category: First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
6	Labrador Inuit Health Commission (LIHC)	St. John's – April 15, 2002	Public Hearing	Inuit	Labrador Inuit Health Commission. Labrador Inuit, Inositsiagittotigasuallugik kamkjet, April 15, 2002 date to fax, 42 pages.
7	BC Aboriginal Network on Disability Society	Victoria – March 14, 2002	Public Hearing	Aboriginal – other	Romanow Commission. Presented by Yvon Gesinghaus. Executive Director. BCANDS, March 14, 2002, 9 pages. two supplement documents: one: - 45 pages and second – 48 pages.
8	Federation of Saskatchewan Indian Nations	Regina – March 4, 2002	Formal & Public Hearing	First Nations	Comprehensive First Nations Health and Social Development System submitted by Saskatchewan First Nations, November 2001, 4 pages.
9	Institute for Aboriginal Health, Division of First Nations Health Centre	**Not listed in Final Report – Open Public Hearings**	Formal Submission	Aboriginal – other	No title. First Letter dated May 27, 2002, 3 pages & Second Letter dated May 27, 2002, 5 pages.
10	Native Women's Association of Canada	Ottawa – May 28, 2002	Formal & Public Hearing	Aboriginal – other	NWAC Submission: Aboriginal Women and Health Care in Canada To The Commission on the Future of Health Care in Canada, May 28, 2002. 13 pages.

Appendix C Reference Sheet – Aboriginal/First Nations Participation to the Commission on the Future of Health Care in Canada – Final Report

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category – First Nations, Inuit, Métis, Aboriginal Interest/Focus Metis & Aboriginal	Title of Submission, Date, Page Number
11	Metis National Council	Calgary – April 30, 2002	Formal & Public Hearing	Metis	Metis National Council Submission to the Commission on the Future of Health Care in Canada, No date, 14 pages.
12	Western Artic Aboriginal Head Start Council	Yellowknife – May 16, 2002	Formal & Public Hearing	Aboriginal – other	Presentation to the Romanow Health Commission Western Arctic Aboriginal Head Start Council, May 16, 2002, 8 pages.
13	Assembly of Manitoba Chiefs	Winnipeg – March 6, 2002	Public Hearing	First Nations	Joint Presentation by the Assembly of Manitoba Chiefs and the Southern Chiefs Organization – Southern Chiefs Organization Presentation to the Roy J. Romanow Commission, Q. C. Commission on the Future of Health Care in Canada, March 6, 2002, 9 pages.
14	Southern Chiefs Organization	Winnipeg – March 6, 2002	Public Hearing	First Nations	Joint Presentation by the Assembly of Manitoba Chiefs and the Southern Chiefs Organization – Southern Chiefs Organization Presentation to the Roy J. Romanow Commission, Q. C. Commission on the Future of Health Care in Canada, March 6, 2002, 9 pages.
15	Assembly of First Nations	Ottawa – April 4, 2002	Public Hearing	First Nations	Assembly of First Nations, Presentation Notes to the Commission on the Future of Health Care in Canada, April 4, 2002, 8 pages.

Appendix C Reference Sheet – Aboriginal/First Nations Participation to the Commission on the Future of Health Care in Canada – Final Report

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category: First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
16	Inuit Tapiriit Kanatami	Montreal – March 26, 2002	Public Hearing	Inuit	Address to the Commission on the Future of Health Care in Canada, Jose A. Kasugak, President, Inuit Tapiriit Kanatami, March 26, 2002, 13 pages and one supplement document: 5 pages.
17	Aboriginal Nurses Association of Canada	Ottawa – May 28, 2002	Formal & Public Hearing	Aboriginal – other	Submission to the Commission on the Future of Health Care in Canada. Commissioner: Roy J. Romanow, Q. C., No date, 25 pages.
18	Dakota Ojibway Tribal Council	**Not listed in Final Report – Open Public Hearing**	Formal Submission	First Nations	Dakota Ojibway Tribal Council Presentation: Commission on the Future of Health Care in Canada, March 6, 2002, 58 pages.
19	National Aboriginal Health Organization	Ottawa – May 28, 2002	Formal & Public Hearing	Aboriginal – other	Making A Difference, National Aboriginal Health Organization Submission for the Commission on the Future of Health Care in Canada, Final, November 1, 2001, 25 pages.
20	Eskasoni Health Centre	Halifax – April 17, 2002	Formal & Public Hearing	First Nations	Public Hearing Presentation Summary from Romanow website, 1 page
21	First Nation Chiefs' Health Committee	Vancouver – March 12, 2002	Formal & Public Hearing	First Nations	The Future of First Nations Health Services – First Nations Chiefs' Health Committee, March 12, 2002, 14 pages.

Appendix C Reference Sheet – Aboriginal/First Nations Participation to the Commission on the Future of Health Care in Canada – Final Report

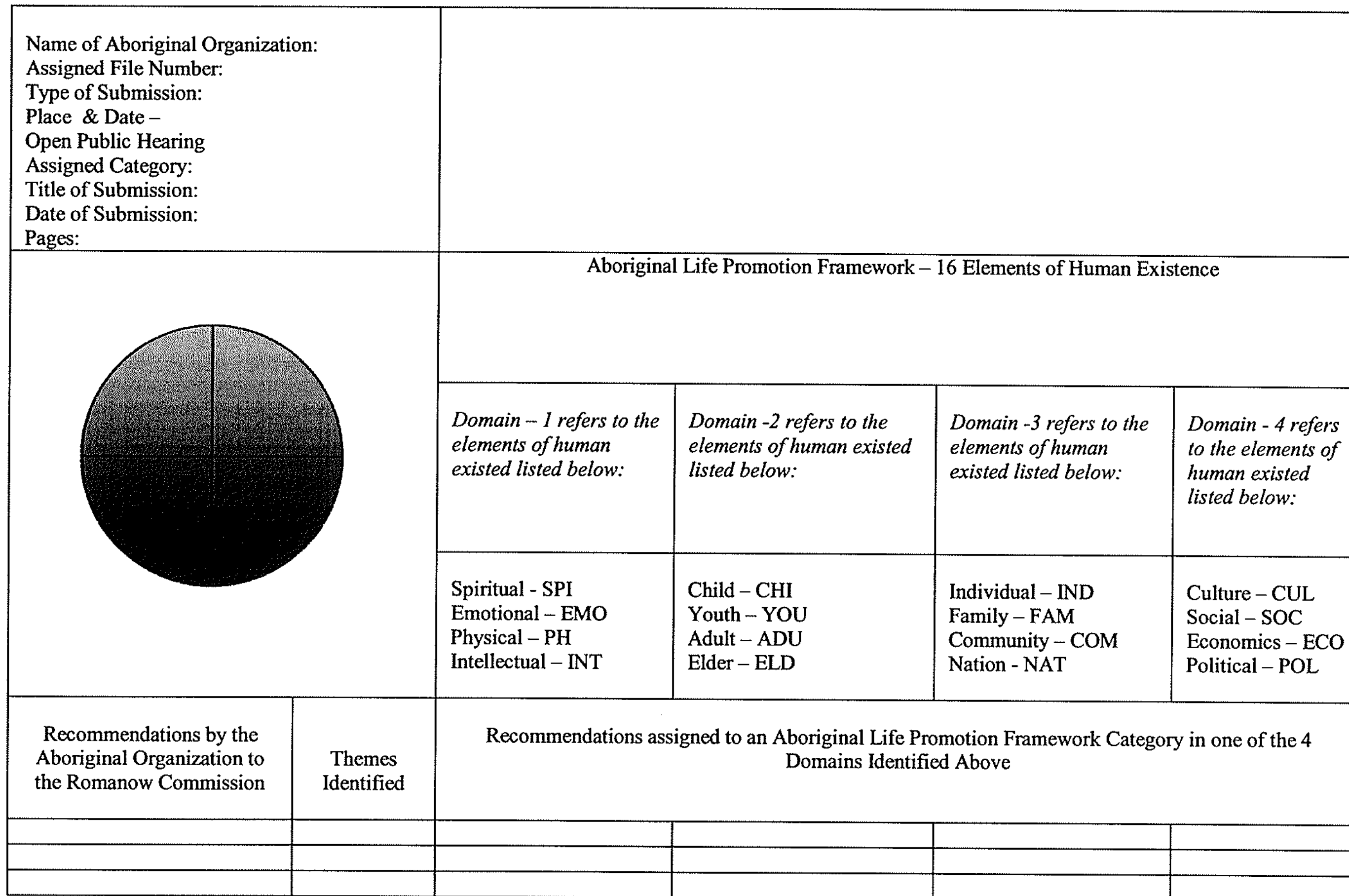
File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category: First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
22	Assemblee des Premieres Nations du Quebec et du Labrador	Quebec City – March 25, 2002	Formal & Public Hearing	First Nations	Commission Sur L'avenir Des Soins De Sante, Commission Romanow, Assemblee Des Premieres Nations Du Quebec Et Du Labrador, Commission De La Sante Et Des Services Sociaux Des Premieres Nations Du Quebec Et Du Labrador, Garbonnell, Garry, March 25, 2002, 22 Pages, 3 Supplement Documents: one – 3 pages, second – 14 pages, third – 30 pages.
23	Commission de la Sante et des services sociaux Des Premiers Nations du Quebec et du Labrador	Quebec City – March 25, 2002	Public Hearing	First Nations	Commission Sur L'avenir Des Soins De Sante. Commission Romanow. Assemblee Des Premieres Nations Du Quebec Et Du Labrador, Commission De La Sante Et Des Services Sociaux Des Premieres Nations Du Quebec Et Du Labrador. Garbonnell, Garry, March 25, 2002, 22 Pages, 3 Supplement Documents: one – 3 pages, second – 14 pages, third – 30 pages. ***Have Presentation Summary in English Language only**

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category: First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
24	First Nations Treaties 6, 7, and 8 – Alberta First Nations	Edmonton – May 14, 2002	Public Hearing	First Nations	Alberta First Nations Treaty 6 First Nations of Alberta, Treaty 7 First Nations of Alberta, Treaty 8 First Nations of Alberta, Chief Strikes With A Gun, Submission to the Commission on the Future of Health Care in Canada. May 14, 2002. 19 pages with appendices – Co-Management Review 2001 – 2002 and Co-Management Agreement/Terms of Reference
25	Dene Nation	Yellowknife – May 16, 2002	Public Hearing	First Nations	Public Hearing Presentation Summary from the Romanow web site, 1 page
26	Abegwit First Nations	Charlottetown – April 18, 2002	Public Hearing	First Nations	Presentation to the Royal Commission on the Future of Health Care in Canada Chaired by The Honorable Roy Romanow by Alma MacDougall, RN Abegweit First Nations, Prince Edward Island, April 18, 2002. 6 Pages.
27	Council of Yukon First Nations	Whitehorse – May 2, 2002	Public Hearing	First Nations	Public Hearing Presentation Summary from Romanow website, 1 page
28	Yukon First Nations Health and Social Services Commissions	Whitehorse – May 2, 2002	Public Hearing	First Nations	Public Hearing Presentation Summary from Romanow website, 1 page
29	First Nations Health Programs Committee	Whitehorse – May 2, 2002	Public Hearing	First Nations	No Public Hearing Presentation Summary from Romanow website

Appendix C Reference Sheet – Aboriginal/First Nations Participation to the Commission on the Future of Health Care in Canada – Final Report

File Folder Number	Name of Aboriginal Organization	Place and Date	Type of Submission – Formal, Public Hearing	Category - First Nations, Inuit, Métis, Aboriginal Interest/Focus, Metis & Aboriginal	Title of Submission, Date, Page Number
30	Government of First Nations	Yellowknife – May 16, 2002	Public Hearing	First Nations	Public Hearing Presentation Summary from Romanow website, 1 page
31	Six Nations of the Grand River	Toronto – May 30, 2002	Public Hearing	First Nations	No Public Hearing Presentation Summary - *Not listed on Commission Consultations on Romanow website, Toronto, May 30, 2002.
32	Tree of Peace Friendship Centre	Yellowknife – May 16, 2002	Public Hearing	Aboriginal – other	No Title of Submission to the Commission on the Future of Health Care in Canada, No Author, No Date, 4 pages.

Appendix D Sensitizing with the Aboriginal Life Promotions Framework (Bartlett, 2004)



Name of Aboriginal Organization: Assigned File Number: Type of Submission: Place & Date – Open Public Hearing Assigned Category: Title of Submission: Date of Submission: Pages:					
		Aboriginal Life Promotion Framework – 16 Elements of Human Existence			
		Domain – 1 refers to the elements of human existed listed below:	*Domain -2 refers to the elements of human existed listed below:*	*Domain -3 refers to the elements of human existed listed below:*	*Domain - 4 refers to the elements of human existed listed below:*
		Spiritual - SPI Emotional – EMO Physical – PH Intellectual – INT	Child – CHI Youth – YOU Adult – ADU Elder – ELD	Individual – IND Family – FAM Community – COM Nation - NAT	Culture – CUL Social – SOC Economics – ECO Political – POL
Recommendations by the Aboriginal Organization to the Romanow Commission	Themes Identified	Recommendations assigned to an Aboriginal Life Promotion Framework Category in one of the 4 Domains Identified Above			

Appendix E Summary list of themes in Aboriginal/First Nations organizations

Name of Aboriginal Organization:	
Assigned File Number:	
Type of Submission:	
Place & Date - Open Public Hearing	
Assigned Category:	
Title of Submission:	
Date of Submission:	
Pages:	

List of Themes:

Appendix F Assigned Category - Aboriginal/First Nations Organizations

Name of Aboriginal Organization	Category – First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal	Total Number of Organizations in each category
Abegwit First Nations	First Nations	18 First Nations organizations
Assembly of First Nations		
Assembly of Manitoba Chiefs		
Chiefs of Ontario		
Council of Yukon First Nations		
Dakota Ojibway Tribal Council		
Dene Nation		
Eskasoni Health Centre		
Federation of Saskatchewan Indian Nations		
First National Chiefs' Health Committee		
First Nations Health Programs Committee		
First Nations of Quebec		
Labrador Health and Social Services Commission		
First Nations Treaties 6, 7, and 8		
Government of First Nations		
Six Nations of the Grand River		
Southern Chiefs Organization		
Yukon First Nations Health and Social Commission		
Name of Aboriginal Organization	**Category – First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal**	**Total Number of Organizations in each category**
BC Aboriginal Network on Disability Society	Aboriginal - Interest/Focus	7 Aboriginal - Interest/Focus organizations
Tree of Peace Friendship Centre		
Western Arctic Aboriginal Head Start Council		
Aboriginal Nurses Association		
Native Women's Association of Canada		
National Aboriginal Health Organization		
Institute for Aboriginal Health, Division of First Nations Health Centre		
Name of Aboriginal Organization	**Category – First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal**	**Total Number of Organizations in each category**
Inuit Tapiriit Kanatami	Inuit	5 Inuit organizations
Nunavut Tunngavik Incorporated		
Pauktuutit – Inuit Women's Association of Canada		
Qikiqtani Inuit Association		
Labrador Inuit Health Commission (LIHC)		
Name of Aboriginal Organization	**Category – First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal**	**Total Number of Organizations in each category**
Metis National Council	Metis	1 Metis organizations
Name of Aboriginal Organization	**Category – First Nations, Aboriginal Interest/Focus, Inuit, Metis, Metis & Aboriginal**	**Total Number of Organizations in each category**
Ontario Metis Aboriginal Association	Metis & Aboriginal	1 Metis & Aboriginal organizations
Total Aboriginal/First Nations organizations is 32		

Appendix G Data Summary Document – Themes

Themes placed in Domains 1 to 4 – Aboriginal Life Promotion Framework (Bartlett 2004)			
Domain 1 – Spiritual, Emotional, Physically, Intellectual	**Domain 2- Child, Youth, Adult, Elder**	**Domain 3 – Individual, Family, Community, Nation**	**Domain 4 – Culture, Social, Economic, Political**
Accessibility Culture Capacity Health Status Land Claim Research Disabled People Infrastructure Universality	Culture Capacity Building Land Claim Health Status Treaty Right Human Right Health Right Universality Land Claim Consultation	Control Infrastructure Jurisdictional Research Disabled People Health Status Relationship with Governments Policy & Program Culture Capacity Building Treaty Right Human Right Health Right Universality	Relationship with Governments Policy & Program Fiscal Resources Culture Capacity Building Disabled People Universality Land Claim Infrastructure Public Awareness Research Health Status Consultation Jurisdictional Control Sustainability Treaty Right Human Right Health Right Health Strategy Socio-economic

Appendix H Aboriginal Organizations - Aboriginal categories headings

First Nations	Aboriginal Interest/Focus	Inuit	Metis & Aboriginal	Metis
Abegwit First Nations	BC Aboriginal Network On Disability Society	Inuit Tapirii Kanatani	Ontario Metis Aboriginal Association	Metis National Council
Assembly of First Nations	Tree of Peace Friendship Centre	Nunavut Tunngavik Incorporated		
Assembly of Manitoba Chiefs	Western Arctic Aboriginal Head Start Council	Pauktuutit – Inuit Women's Association of Canada		
Council of Yukon Nations	Aboriginal Nurses Association	Qikiqtani Inuit Association		
Dakota Ojibway Tribal Council	Native Women's Association of Canada	Labrador Inuit Health Commission (LIHC)		
Dene Nation	National Aboriginal Health Organization			
Eskasoni Health Centre	Institute of Aboriginal Health, Division of First Nations Health Centre			
Federation of Saskatchewan Indians Nations				
First National Chiefs Health Committee				
First Nations Health Programs Committee				
First Nations of Quebec Labrador Health and Social Services Commission				
First Nations Treaties: 6, 7, 8				
Government of First Nations				
Six Nations of Grand River				
Southern Chiefs Organization				
Yukon First Nations Health & Social Commission				

Created by Rose McIvor-Girouard