Self-Determination in Health: A Road to Community Wellness?

A Critical Look at Island Lake's Evolving Model of Health Service Delivery

by

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Abstract

The disproportionate burden of disease in the Aboriginal population in Canada has become so great that it is now being referred to as a health 'crisis'. Evidence suggests that the answer to these ills lies not in the western biomedical model of health care, but within the Aboriginal traditions of self-determination and holism (RCAP, 1996; O'Neil, Lemckuk-Favel, Allard and Postl, 1999; Romanow, 2002; CIHI, 2004; Maar, 2004; First Nations and Inuit Regional Health Survey, 2004). To this end, First Nations communities have been negotiating with the federal government and transferring responsibility for their community-based health services since 1986, despite the limitations of the federal Health Transfer Policy (Gregory, Russell, Hurd, Tyance and Sloan, 1992; Lavoie, et al, 2005; RCAP, Vol 3, Chp 3, 1996; Speck, 1989). These self-determination initiatives in health attempt to improve the health status of community members. Thus, determining an approach to health service delivery that contributes to positive health outcomes is of particular significance. Examining Island Lake's evolving model of health service delivery indicates the success of the intergovernmental, interdepartmental, and intersectoral partnership approach they have taken; as evidenced by the Regional Renal Health Program, with dialysis treatment services, that has been established, perhaps for the first time in the country, in a remote First Nations community without existing hospital services. There remains work to be done in creating a holistic system of health service delivery that reflects their unique worldview within a context of health promotion and self-determination; however, their accomplishments to date, established processes, willingness to put their dreams into action and build what has not been built before demonstrate a potential to improve community health and well-being.

Acknowlegements

This work would not have been possible without the vision of Andy Wood, Executive Director of Four Arrows Regional Health Authority, who recognized the need for new approaches; who extended his hand and embraced an intergovernmental, interdepartmental, and intersectoral relationship: a relationship and process which I had the privilege of contributing to and exploring. I would like to thank Andy, the FARHA board, the FARHA staff, and all the partners for their significant contribution to this project.

I would also like to acknowledge Mae Louise Campbell, whose words have underpinned and balanced my approach. As I was investigating models of health service delivery I was reminded that *until the spirits of Aboriginal people are healed, their circumstance will not significantly change*. Thus, I looked for evidence of 'healing the spirit' underpinning the health programs and services being delivered and planned.

I must also acknowledge God the Creator, who used this opportunity to set me on a path of spiritual growth, and my family who are taking this journey with me. My heartfelt gratitude goes out to my husband and children who supported me in a multitude of indescribable ways as I attempted to balance the complexities of life with life as a graduate student.

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Chapter 1: Introduction

The disproportionate burden of disease in the Aboriginal population in Canada has become so great that it is now being referred to as a health 'crisis'. The current levels of illness, injury, and mortality are manifestations of historical trauma due to colonization, westernization, and residential schools (RCAP, 1996; Centre for Aboriginal Health Research, 1998; Lux, 2001; Martens, et al, 2002; Romanow, 2002). Evidence suggests that the answer to these ills lies not in the western biomedical model of heath care, but within the Aboriginal traditions of self-determination and holism (RCAP, 1996; O'Neil, Lemckuk-Favel, Allard and Postl, 1999; Romanow, 2002; CIHI, 2004; Maar, 2004; First Nations and Inuit Regional Health Survey, 2004). The incongruence between the reductionist western medical philosophy and the holistic Aboriginal worldview contributes to the unresponsiveness of the mainstream healthcare system. It is believed that Aboriginal people must build their own systems of health and healing: systems that are responsive to their values, needs and aspirations, and congruent with their definition of health (NAHO, 2001). First Nations communities have been negotiating with the federal government and transferring responsibility for their community-based health services since 1986, despite the limitations of the Health Transfer Policy (Gregory, Russell, Hurd, Tyance and Sloan, 1992; Lavoie, et al, 2005; RCAP, Vol 3, Chp 3, 1996; Speck, 1989). These self-determination initiatives in health attempt to improve the health status of community members. Given the high incidence of communities establishing control of health services through transfer agreements and other mechanisms, determining an approach to health service delivery that contributes to positive health outcomes is of particular significance. This research, therefore, examines Aboriginal

models of health service delivery, focusing on Island Lake's evolving model of primary health care, in an attempt to determine whether this model has the potential to improve the health status of community members. Because the system remains in development and changes in health status are long term outcomes, quantitative measurement is not possible at this time. The following research objectives were therefore used to provide data for this analysis.

1. Reviewed principles and best practices of Primary health care;
2. Explored models of primary health care that are being used in First Nations communities and reported in the literature, including the Island Lake (IL) model;
3. Explored the synergy of indigenized primary health care models for First Nations;
4. Reviewed how positive health outcomes are being measured;
5. Reviewed evaluation criteria in relation to First Nations Health; and
6. Critically analysed Island Lake's model based upon above data.

A description of the community and the evolving Island Lake model is warranted at this time.

The Community

The four Oji-Cree communities of Island Lake; Garden Hill, Red Sucker Lake, St. Theresa Point, and Wasagamack, while distinct, originated from one community, and their current circumstances remain similar. They are, in many ways, one people, sharing common history, language and family ties, (Wood, personal communication, February 26, 2004). As the population increased, some families moved across the lake, remaining

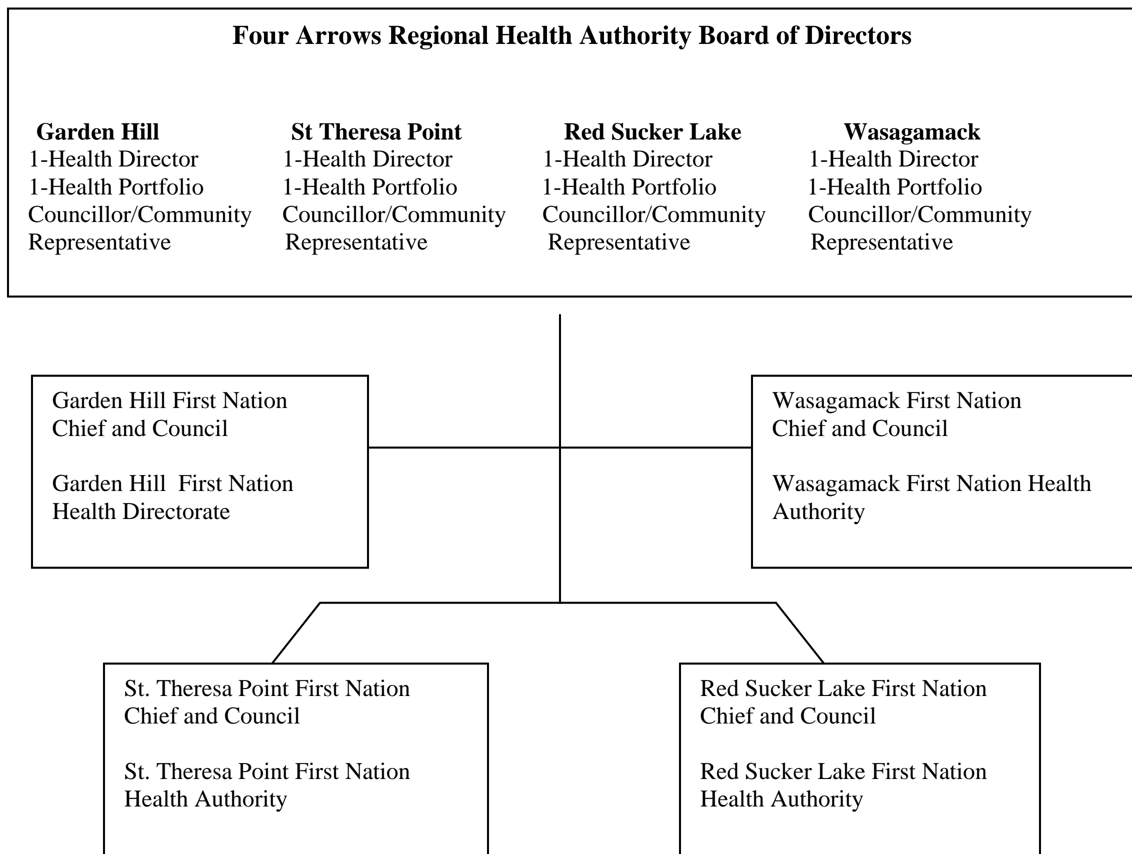
in close proximity to trap lines or fishing camps, establishing the other communities according to religious affiliations. The combined population in the area is currently estimated to be in excess of 7,000 (Riese, Robson and Nadwidny, 2003). Each community has entered into a transfer agreement with the federal government's First Nation and Inuit Health Branch (FNIHB) of Health Canada, assuming control of their community-based health programs. In February of 1999, the health directors and community-based workers came together to plan ways for improving the health status and health services in the region. In recognizing and acknowledging their collective strength they lobbied the Island Lake Chiefs to create a regional health organization. In January of 2000, their vision of a regional health initiative was realised when Four Arrows Regional Health Authority (FARHA) was given its official mandate by the Chiefs of Island Lake to work cooperatively with the local community health organizations to improve the health conditions and services in the region (Riese, Robson and Nadwidny).

The Evolving Model

In fulfilling this mandate, FARHA began establishing relationships with a variety of stakeholders. The University of Manitoba's Northern Health Research Unit was commissioned to review and report on the existing health and health services in the region, providing expertise in their recommendations and the data necessary for planning. Additionally, FARHA's pursuit of social justice resulted in a tripartite partnership with both federal and provincial governments, and a commitment to improving the health status in Island Lake to a level comparable with other rural Manitobans (Riese, Robson and Nadwidny, 2003). The Joint Health Governance Working Group (JHGWG) was

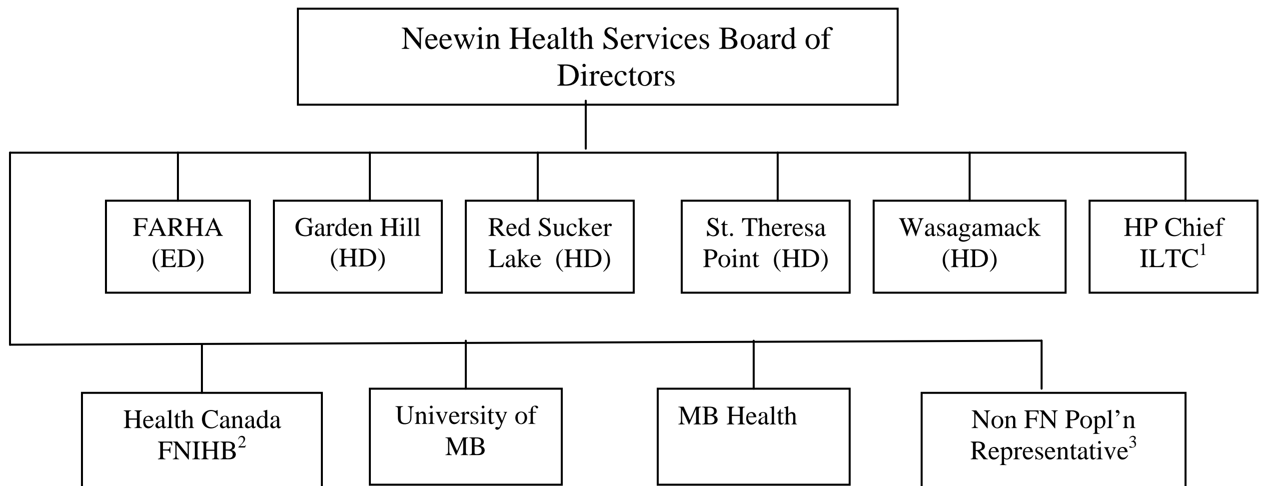
thereby established to work cooperatively, across jurisdictional boundaries, to fulfill this objective. The local health directors and health portfolio councillors represent their communities on the FARHA board (see Figure 1) as well as the working group, which has evolved into the Neewin Health Services Board.

Figure 1: FARHA's Board of Directors



It is important to note that figure 2 depicts the Neewin Health Services Board, Inc., which does not include Indian and Northern Affairs Canada (INAC) as the JHGWG did. INAC does however continue to participate as an ex-officio partner.

Figure 2: Neewin Board



1Health Portfolio Chief, Island Lake Tribal Council
2 Non First Nations Rep Designated by Aboriginal and Northern Affairs
3 First Nation and Inuit Health Branch

As figure 2 illustrates, the executive director (ED) of FARHA, the community Health Directors (HD), and the ILTC Health Portfolio Chief give voice to Indigenous concerns and decision-making when working with government and university partners. The board is indigenized with 60% of the members representing the First Nations. FARHA, the regional organization, is the community of study, as it represents and is comprised of the four community health organizations.

FARHA's efforts have resulted in the transfer of Public Health nursing to the communities, and urban support to band members living off reserve. The success of the inter-jurisdictional partnership approach, as subsequently recommended by Romanow (2002), is demonstrated by the establishment a provincially funded Regional Renal Health Program, with a dialysis treatment component, in the community of Garden Hill's federal nursing station. The Neewin Board is now focusing its efforts on the

establishment of a Regional Primary Health Care Centre, to be located between the communities of St. Theresa Point and Wasagamack. FARHA's ongoing efforts in realizing self-determination in health and improving the health status of community members provide the focus for this research project.

This work will not solve the health crisis, but it will provide evidence to support the FARHA's ongoing efforts in health care delivery and will, therefore, assist in the realisation of their vision for a healthy community. Furthermore, if the research informs other communities seeking to design models of service delivery that are responsive to their community needs, then it will have made an important contribution.

In keeping with the concept of the medicine wheel, which the FARHA has chosen to represent their organization and its values, it is necessary to look back before forging ahead. The next chapter will therefore, provide more detailed information related to my involvement with FARHA, their evolution, accomplishments to date, and their proposed initiative.

Chapter 2: Looking Back

Working as a health care provider in remote First Nations communities allowed me to witness first hand the devastating effects of colonization on once autonomous peoples. Substance abuse, family violence, and suicide attempts were overwhelmingly common clinical presentations in relation to non-First Nation communities. Historically, assimilation was considered the only means for Aboriginal people to achieve health. The British North America Act of 1867 made Indians and their lands a responsibility of the federal government; therefore, when Indian health care needs were such that intervention was required, the federal government began providing Indian health care. Kelm (1998) discusses how the provision of health care provided moral justification for colonialism by describing it as "simultaneously humanitarian and racist" (p. 102). For example, western medicine, such as immunization against infectious disease, while necessary and humanely provided, was also used to undermine the relationship between Aboriginal people and their traditional healers/leaders. Furthermore, the need for health promotion and disease prevention education helped rationalize residential schooling, and health preservation arguments were cited in the criminalization of traditional ceremonies (Kelm). Kelm suggests this notion of humanitarianism is what allows Canadians to sleep at night. It is a reality constructed by colonial ideology that "obscures the power relations inherent in internal colonialism as it existed (and still exists) between Canadian society and the First Nations" (Kelm, p 127).

While working in Island Lake in the early 1990's, I soon began to incorporate power sharing strategies in client interactions, as it became apparent that clinical expertise was not going to make any difference to the overall health and well-being of the

community. Treating minor episodic illnesses, injuries and providing emergent care prior to medical evacuation was not addressing the underlying causes of poor health in the community. I began to search for ways in which to address these. I was witnessing first hand the devastating effects of internalized colonialism: dependency, loss of identity, and a variety of self-destructive behaviours such as suicide attempts, family violence, spousal and substance abuse. In response, I began to focus much of my attention towards health teaching and empowerment; teaching new mothers, for example, how to care for common childhood ailments, such as teething and fever, and acknowledging their expertise in recognizing more serious symptoms that required clinical assessment. This empowering primary health care approach made a small contribution to the process of decolonisation through sharing power and validating women's knowledge and ways of caring for their children.

In contrast, the biomedical model of Western medicine views health as an absence of disease or illness and tends to isolate its concerns to the physical aspects of health. (NAHO, 2003). Furthermore, it reduces the individual into component parts, focusing specifically on the area(s) of illness or disease. This reductionist model is not only incongruent with a holistic perspective of health but also fails to consider the health of Aboriginal peoples within the colonial context. Adelson (2000) states that "health is political," and can only be understood "within its historical, cultural, and social context" (p. 9.). In her study of health and the James Bay Cree she concludes that their perception of 'being alive well' "transcends the individual, and … is linked to a larger strategy of cultural assertion and resistance in a dynamic balancing of power between the State, the disenfranchised group, and the individual" (Adelson, p. 9).

Examining health out of context perpetuates colonialism in health care by failing to address the underlying causes of Aboriginal ill health, including the social determinants. The inaccessibility of mainstream health care is, therefore, related not only to physical access, but also to cultural and psychological impediments, involving language, cultural appropriateness, the scarceness of Aboriginal health providers, and the lack of community involvement (Lemchuk-Favel and Jock, 2004). It is, according to the World Health Organization's definition, unresponsive to the needs of Aboriginal people. Responsiveness relates to the degree to which individuals' interactions with the healthcare system impact their well-being, irrespective of health improvements (Gostin, Hodge, Valentine and Nygren-Krug, 2003).

In their work with Aboriginal women in British Columbia, Browne, Fiske and Thomas (2000) report on both the affirming and invalidating encounters the women had with the healthcare system. Affirming encounters were those in which the women received that which mattered most: health care providers who cared for them, who shared knowledge and empowered them to participate in the decision-making related to their care, and who, by treating them with respect, validated their self identity and cultural pride (Browne, et al.). Other experiences illustrate how unresponsive the system can be to Aboriginal women's needs; their concerns were dismissed or trivialized, they were judged and treated in accordance with negative stereotypes, subtle forms of discrimination left them feeling alienated, and their socio-economic circumstances were disregarded (Browne, et al., 2000). Browne et al. describe how an Aboriginal woman, sporting a black eye received playing baseball, took her daughter to the hospital when her acute, episodic illness, for which she had been seen by the family physician, exacerbated.

The child, without the mother's knowledge, was apprehended by Child and Family Services upon being notified by hospital personnel. The family physician was not contacted to corroborate the history provided by the child's mother. Such judgments illustrate just how significant unresponsiveness can be, and highlights the necessity for Aboriginal health care systems to be built on the Aboriginal definition of health; to be holistic, flexible and responsive, not just to the disease or condition, but to the individual, family, community and environment, and their roles in restoring the balance necessary for health.

The Health Transfer Policy

Historically, health services have been delivered to most First Nations reserve communities, including the Island Lake communities, by the federal government. In the wake of the international human rights movement, and the Canadian First Nations' defeat of the 1969 'White Paper,' discussions between the federal government and Aboriginal people resulted in the 1979 Indian Health Policy. The overall goal of the Indian Health Policy was to improve the health in First Nations communities and was built on three pillars: community development, the trust relationship between First Nations and the Federal Government, and the interrelated Canadian health care system (Health Canada). From this broad policy statement, transfer demonstration projects were piloted and in 1986 the Health Transfer Policy was announced. As the health transfer process became entrenched, however, "the broader context of the Indian Health Policy… virtually disappeared from the national agenda" (Lavoie et al, 2005, p. 38).

The Health Transfer Policy has been widely criticized. The Assembly of First Nations, a political organization that represents the majority of First Nations in Canada,

interprets the policy as an attempt by federal government to reduce expenditures and abrogate both their treaty obligation and legal responsibility to provide health services to First Nations peoples (cited in Gregory et al, 1992). Speck (1989) cites the no-enrichment clause as evidence of the government's cost containment strategy and argues that the Health Transfer Policy "continues to deny First Nations self-determination and by doing so denies them the opportunity to create conditions under which the health of the members could improve or be maintained, and appropriate, locally-controlled health services developed" (p. 207). Despite these criticisms, however, First Nation communities are choosing to enter into transfer agreements, gain some degree of administrative autonomy over their health programs, and make their health services more responsive to their needs. In fact, the ten-year health transfer evaluation indicates that, in 1999 "244 communities, or 41% of the eligible communities, had signed Health Services Transfer Agreements" (Health Canada). This process did not, however, evaluate the impact such transfers had on the health status of community members. As of December 2004, 79% of eligible communities were involved in transfers (FNIHB, 2005). The March 2005 transfer evaluation reviewed the mandatory five-year evaluations completed by transferred communities. This report discusses how problems associated with analyzing community level health outcomes are largely due to the lack of access to "reliable longitudinal health information" (Lavoie et al, 2005, p. 79). Communities rely on surveys to measure their success, and 78.1% of transferred communities anecdotally report improvements in health status since the community engaged in the transfer of health services (Lavoie, et al).

In the absence of readily available, reliable health information, transfer evaluations for the Island Lake communities utilized surveys and focus groups as a means to gather data regarding the transfer of their health programs. In Wasagamack, 43/111 respondents rated the services they received as being good to excellent with an additional 51 rating them as fair. 9/107 stated the services had improved with transfer while 97 reported no change, and 1 respondent reported a decline (Kangas and Associates, 2002). In Garden Hill client feedback was obtained through the completion of a rating questionnaire. All 35 respondents indicated a high level of satisfaction with the services offered (Mcfayden, 2004). The level of client participation in the survey conducted in St Theresa Point was extremely limited, however, the responses indicate that what was most appreciated was the availability of health staff and the respondents ability to speak openly with them (Robson, 2003).

The transfer initiative is limited, providing flexibility in First Nations' administration of pre-existing federal health programs rather than facilitating true self-governance. Additionally, many new health programs are non-transferable. These targeted programs are federally defined, some defined to such a degree that they become inflexible; thereby restricting the ability for programs to be responsive to community-specific needs. Communities undertake administration of these non-transferable programs through a series of agreements, each with their own reporting requirements, resulting in high administrative costs to both the communities and the government. This demonstrates how federal policy has failed to renounce its imperialistic approaches. In keeping with federal paternalism, the transfer initiative allows First Nations to take control; however programs must be approved by the government.

As a result of these limitations, new approaches to federal-First Nations relationships are being established. As a member of the former Joint Health Governance Working Group, and Nurse Manager for the Island Lake Nursing Stations, I have been an active partner in the efforts to improve the health and health services in Island Lake. FARHA is moving forward with their vision for self-determination and equity in health outcomes. The Island Lake Regional Primary Health Care Centre Board, now the Neewin Health Services Board, has been incorporated and the partners continue to work towards comprehensive primary health care becoming a reality in the region. My involvement continues through this research.

Chapter 3: Summary of Relevant Literature

Health Status

Colonial policies and practices, which banned traditional healing methods and ceremonies, prosecuted elders and healers, and initiated mission/state run residential schooling, led to the multitude of health problems known collectively as the diseases of colonization and westernization (RCAP, 1996; Centre for Aboriginal Health Research, 1998; Lux, 2001; Martens, et al, 2002; Romanow, 2002). Aboriginal people, noted by early settlers to be in "excellent health, of strong physique" (NAHO, 2001, p. 14), currently comprise a population suffering a disproportionate burden of illness. The Royal Commission on Aboriginal People (RCAP, 1996) summarizes the change in health status, in relation to colonial policies, in the following statement:

> The transformation of Aboriginal people from the state of good health that had impressed travelers from Europe to one of ill health, for which Aboriginal people were (and still are) often held responsible, grew worse as sources of food and clothing from the land declined and traditional economies collapsed. It grew worse still as once mobile people were confined to small plots of land where resources and opportunities for natural sanitation were limited. It worsened yet again as long-standing norms, values, social systems and spiritual practices were undermined or outlawed. (Vol 3, p. 113)

The Romanow (2002) report cites Indian and Northern Affairs Canada statistics from 2000 indicating the life expectancy of First Nations males as 7.4 years on average less than Canadian males and 5.2 years less for First Nations females. In Manitoba the premature mortality rate for First Nations is double that of other Manitobans, 6.6 versus

3.3 premature deaths per thousand (Martens, et al, 2002). In addition, the Potential Years of Life Lost indicator, which gives greater weight to deaths occurring at a young age, is 2.5 times higher for First Nations males, and 3 times higher for First Nations females (Martens, et al). Diabetes treatment rates are over 4 times higher for First Nations than for all other Manitobans, hypertension, twice as high, and injury hospitalization rates 3.7 times higher (Martens, et al). The main cause of injury hospitalization for First Nations was in the violence category, with 17.1% due to violence by others versus 4.1% for other Manitobans and 14.5% due to violence to self versus 6.3% for other Manitobans (Martens, et al). While the Island Lake First Nations have significantly less injury hospitalizations related to violence than the total for Manitoba On-Reserve populations, they remain significantly higher than all other Manitobans (Martens, et al). Other health indicators for the Island Lake region reported by Young, O'Neil, Orchard and Hiebert (2000), indicate, "relative to the total provincial experience, there is excessive hospitalization for most causes with the notable exception of cancer and circulatory diseases" (p. 11). Risks of death from infectious diseases amongst First Nations are greater than six times higher than provincial rates, and two to three times higher from injuries, respiratory diseases /pneumonia, and endocrine diseases/diabetes (Young, et al, 2000).

Mainstream health services do not adequately cover the spiritual, mental, social, and emotional aspects of health. Maar (2004) reiterates that while rates of infectious diseases have improved, the impacts of colonization have emerged as significant community health concerns. The higher rates of unemployment, welfare dependency, overcrowding, inadequate housing and water/sewer infrastructure, lower family income,

and educational achievement indicate the need to address the broader determinants of health (CIHI, 2004; Lemchuk-Favel and Jock, 2004; Maar 2004; NAHO, 2001; O'Neil, et al. 1999; RCAP 1996). Aboriginal people have recognized this gap. A report dealing with Inuit peoples stated that: "Until housing shortages are gone, until there is an economy that can support the growing number of young people reaching working age, until the education system can produce more high school graduates, and until a wide range of post-secondary opportunities are available in the north, the situation is unlikely to change" (quoted in CIHI, p. 98). In addition, an Innu Director of Health and Social Services is quoted in the RCAP (1996) as saying: "But even though more and more health and social services were being put into place, we had more and more sick people" (section 2.1), thus, supporting a demonstrable need to develop Aboriginal-controlled health systems; systems that are responsive to community-specific needs and based upon community values and aspirations. Overall, the literature supports Aboriginal control, positing it as a requirement for regaining autonomy and improving the health status of Aboriginal peoples (RCAP, 1996; O'Neil, et al., 1999; Romanow, 2002; Lemchuk-Favel and Jock, 2004). Unanswered questions remain regarding the models or frameworks for health service delivery that best meet the needs of this population.

Primary Health Care

Interestingly, the study conducted by Martens, et al. (2002) indicates that in Manitoba, the poorest health status among First Nations Tribal Councils is in southern areas, where secondary and tertiary level health care services are in closer proximity. The research does not, however, provide reasons for this disparity. As a nurse who has been a health care provider in the fly-in communities of Island Lake and a nurse manager

who has supervised the practice of nurses working in both remote, northern and southern communities, it appears to me that the primary health care model of service delivery may contribute to the better health status experienced in remote areas of Manitoba. Martens, Martin, O'Neil and MacKinnon (in press) highlight the different service delivery models in northern and southern Manitoba.

> In northern communities, nurses are the primary care givers working in an extended scope of practice, and client care is centrally coordinated by nurses working within inter-disciplinary teams. In contrast, transferred communities in the south often work within a public health model. The community health nurse does not work as the primary care giver nor is responsible for ongoing coordination of primary and secondary care, but rather works with limited scope of practice and professional autonomy.

Defining primary, secondary, and tertiary levels of care is important in understanding primary health care. Primary care is the first level of health care usually provided by family physicians and/or nurses which includes assessment, diagnosis, and treatment of common conditions and illnesses. Secondary care usually refers to hospital based services provided by specialized health care professionals. Tertiary care involves highly specialized diagnostic and treatment services provided by medical specialists in large referral centres. Patients are referred to tertiary level care by other hospitals or physicians. Primary health care is defined as,

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that

> the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (WHO, 1978)

Primary health care includes provision of primary care and coordinates access to secondary and tertiary level care.

The Principles of Primary health care

The WHO (1978) defines health as a state of complete physical, mental and social well-being, and as a basic human right. The participants of the 1978 International Conference on Primary health care at Alma-ata declared the gross inequities in health status existing between and within countries to be politically, socially and economically unacceptable. Primary health care was identified as a model to address these inequities. According to Ee-Ming and Kidd (2002) the philosophy of primary health care "includes the interconnecting principles of equity, access, empowerment, community self-determination and inter-sectoral collaboration. It encompasses an understanding of the social, economic, cultural and political determinants of health" (p. 59).

Alma-ata marked the beginning of a new international understanding of the actual dimensions of health care needs, bringing to an end the era in which technical assistance and disease eradication activities were deemed sufficient (Vendiktov, 1998). According to Vendiktov, demonstrating both the necessity and possibility of redesigning health systems on the basis of primary health care was the most significant contribution of Alma-ata.

The principles of primary health care remain valid today, despite global demographic and epidemiologic change. Populations around the globe are ageing, largely due to the success of primary health care, and, as a result, people are living with

non-infectious chronic diseases. Other contributing factors to the ageing population are urbanization, healthy lifestyles, and global marketing of health risks like tobacco. The WHO (2002) estimates that by the year 2020 chronic conditions will be the leading cause of disability throughout the world, posing a significant threat to the health and economies of nations worldwide. In the Non Communicable Disease report (2002), the WHO states:

> Both high and low income countries spend billions of dollars on unnecessary hospital admissions, expensive technologies, and the collection of useless clinical information. As long as the acute care model dominates health care systems, health care expenditures will continue to escalate, but improvements in populations' health status will not. (p. 7)

In this environment the need to strengthen primary health care is essential, not only to reduce the incidence of non-infectious diseases, but also to better manage the care of those individuals living with them.

It is important here to distinguish between primary care and primary health care, as these terms are often used interchangeably. They do not, however, mean the same thing. Their values and goals are different, and therefore, they should not be deemed equivalent. Primary care is primarily concerned with the prevention and treatment of illness (Lewis, 2004). It is what many Canadians visit their family physician for. Primary care, often the entry into the health care system, is care of individuals and families. In primary care the community is not considered a unit of intervention.

Primary health care is much more comprehensive, incorporating primary care as an essential component. Primary health care "strikes a balance between health promotion and health care; health and social services; individuals and communities. It entails the

transfer of power from professionals to citizens" (Lewis, 2004, p. 5). The core activities of primary health care proposed at Alma-Ata demonstrate primary care as a component of primary health care. These essential services include illness prevention education; treatment and control of prevailing health problems; promotion of food security and adequate nutrition; potable water and basic sanitation; maternal/child health programs; immunization; communicable disease prevention and control; treatment of common diseases and injuries; and provision of essential drugs (WHO, 1978).

The WHO's four strategic directions include reducing excess mortality of poor, marginalized populations; reducing the leading risk factors to human health; developing sustainable health systems; and developing an enabling policy and institutional environment (WHO, 2003a). From these emerge clear strategic imperatives for primary health care. Firstly, primary health care must ensure the most disadvantaged have access to services which directly impact the major causes of their morbidity, mortality and disability, and the associated risk factors addressed by preventative primary health care programs. Access to care is impeded by a variety of factors, including poverty; a condition in which individuals lack the capacity to satisfy needs, fulfill aspirations and participate fully in society. Lack of political empowerment, lack of education, and discrimination are additional factors that exclude people from health care and contribute significantly to inequities in health status (WHO, 2003b). The development of primary health care programs must be facilitated to ensure they are acceptable to the community, financially sustainable, and integrated with other policy domains. In this way primary health care contributes to the broader social, economic, and environmental determinants of health (WHO, 2003a) in the pursuit of social justice.

Primary Health Care and Aboriginal Epistemology

Shestowsky (1993), while acknowledging and respecting the diversities of traditional systems of Indigenous medicine, speaks to some commonalities and outlines several similarities in philosophy and values between primary health care and these traditional systems. She notes that each focuses on health promotion and disease prevention; value personal responsibility for health; involve the client in their own care; view health holistically; and define health broadly (Shestowsky). Traditional medicine, from an Oji-Cree perspective, addresses the four elements of an individual; the body, mind, emotions, and spirit (Wood, 2005; Flett, 2005, Munroe, 2005, Harper, 2005). "Good health is maintained when one lives in a balanced relationship with oneself, one's family, one's community, the earth, and the world." (Shestowsky, p.7). Primary health care, as discussed above, encompasses the activities that contribute to health. Thus, the Aboriginal holistic approach to health and healing is congruent in many ways with the philosophy of primary health care, and has, therefore, been recognized as an appropriate approach for addressing the health needs of Aboriginal communities. This is evidenced by the first two objectives of the Manitoba Primary Health Care Conference on First Nation's Health and Well-Being, hosted by Manitoba's Intergovernmental Committee on First Nations Health. Those objectives being:

1. To build upon the principles of Primary health care to incorporate First Nation values, cultures, health needs and priorities to assist in building the foundations of First Nation primary health care.

2. To explore areas that operationalize mainstream primary health care principles to meet the needs, circumstances and practical realities faced in First Nation communities. (Synthesis document by Grimes, 2005a)

It has also been recognized that Aboriginal communities require the resources and capacity to make this vision a reality (CIHI, 2004). Knowledge related to models of health care delivery, which improve health outcomes, will contribute to that capacity. The next chapter outlines the methods used in this project to gain some of this knowledge.

Chapter 4: Methodology and Methods

General Methodological Approach

Many Aboriginal epistemologies embrace the belief that all aspects of life, physical, mental, emotional, and spiritual, must be lived in balance and respect to achieve wellness. The circle represents this balance; the inseparability of the individual, family, community and world (RCAP, 1996); the integration of mankind with the physical, social and spiritual environment (O'Neil, et al. 1999). Traditional healing systems based upon these principles existed in distinct, self-governing Aboriginal societies prior to colonization. O'Neil, et al. report,

> Individuals had special abilities in maintaining the ecological, social, and spiritual balance through ceremony, others had specialized knowledge regarding the medicinal properties of plants and animal parts used to cure common ailments. However, all members of the community shared the responsibility to live balanced lives and all had some knowledge of traditional medicines. (p. 134)

While the historical policies of civilization and assimilation eroded or forced many of these traditional practices underground, the Aboriginal ways of knowing have not been forgotten (Maar, 2004; Lux, 2001). They continue to provide the foundation for the holistic Aboriginal view of health and well-being.

The vision of FARHA and the local health organizations is to improve the health and well-being of their collective community. It is an initiative of health promotion and self-determination. This research project will analyse Island Lake's model to determine if it is a holistic system of health service delivery that reflects their unique worldview within this context of health promotion and self-determination.

The World Health Organization defines health as "a state of complete physical, mental and social well-being, and a basic human right" (WHO, 1978). The definition of health, which underpins the concept of health promotion, is consistent with the Aboriginal holistic view of health, although it fails to address the emotional and spiritual aspects. Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). Self-determination, therefore, is also encompassed within the concept. The World Health Organization (1986) claims that, "People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health". Empowerment is the key to health promotion, and empowerment theory embraces concepts critical to Aboriginal research and Aboriginal epistemology. Because it involves collaboration and reciprocal, interactive relationships (Fawcett, et al., 1995; Pyett, 2002), is respectful and inclusive, and provides for capacity building, community participation, collaboration, and control, empowerment underpins the methodological process I am engaging in. As Ritchot's (2004) research indicates, and consistent with empowerment theory, it will be important to remain cognizant of the differing worldviews of Aboriginal peoples, as the Aboriginal sense of 'community connectedness' led the women in this study to perceive empowerment differently than Euro-Canadian women who reflect a more "individualistic way of being in the world" (p. 187).

Methods

A review of the literature and the National and Manitoba First Nations Primary Health Care Conference presentations provided the principles, best practices and evaluation criteria of primary health care, addressing research objectives one, four, and

five. The literature and conference proceedings also provided data related to models of primary health care currently used in First Nation communities and the synergy of these indigenized models. This information, which addresses objectives two and three, was augmented by conducting interviews with the consultant involved in the integration of health services in James Bay and Norway House, as well as individuals in Norway House affiliated with the Health Integration Initiative.

In exploring Island Lake's health service delivery model (objective 3) and planned implementation process I conducted in-depth, open-ended interviews with the Executive Directors of both FARHA and Neewin Health Services and the Chairperson of the FARHA Board, acquiring qualitative data which described their vision and allowed me to gain an understanding of the services they plan to offer, the methods they plan to employ in delivering those services, and how they intend on implementing their plan. The broad method of inquiry revealed the community's values, beliefs and practices and how they are integrated into the system design. To accurately convey their vision, I have recorded many of the participants' own words. Semi-structured, open-ended interviews were employed when interviewing FARHA's staff and partners regarding program specific strategies and Elders regarding the cultural and spiritual aspects of health. Observation was also employed when interacting with research participants.

Each of the participants, whose words are incorporated, were provided copies of the findings to ensure their message was accurately and comprehensively captured. All requested changes have been incorporated into the text and redistributed for further validation.

The analysis in Chapter 6 discusses how the evolving Island Lake model of health service delivery, the community based health promotion programming as well as the proposed Regional Primary Health Care Centre, incorporates best practices, addresses the specific cultural needs of the Island Lake population, and plans to evaluate their success. The analysis also speaks to the challenges currently experienced by FARHA and the local health organizations and makes recommendations for overcoming these barriers.

My own personal experience as FNIHB employee and manager working with a variety of both remote and southern First Nation communities in both Manitoba and North-western Ontario offers a unique perspective to the analysis. I not only have extensive knowledge of the management, policies, and practices of FNIHB, but I have also learned much from the diverse communities I have had the pleasure of working with. In addition, during the course of this study, I worked with Assembly of Manitoba Chiefs and the Intergovernmental Committee on First Nations Health, where I became privy to many of the priority health initiatives being undertaken.

Chapter 5: Findings

The preceding chapter outlined the principles and best practices of Primary health care. This chapter now looks at how primary health care is being implemented in a variety of First Nations communities. It begins with a discussion of reported commonalities in successful First Nations health systems, which reveals the synergy of these indigenized primary health care models. Then the health systems of several First Nations communities from a variety of geographic locations are highlighted, including Island Lake. Lastly, this chapter outlines how health and wellness are measured and reviews the criteria being used in First Nations health. This evaluation criterion will be utilized in the final analysis in conjunction with those characteristics found to be common to successful Aboriginal health systems in Canada.

Characteristics of Success

Lemchuk-Favel and Jock (2004) explored Aboriginal health systems in Canada and report that those communities who have successfully created "sustainable, accessible, and client focused health systems share many common characteristics" (p. 28), including self-empowerment. They suggest that community control contributes to self-empowerment, based upon Chandler and Lalonde's (1998) study which provides evidence that communities who have taken active steps in preserving and revitalizing their cultures are positively associated with dramatically reduced rates of youth suicide. Lemchuk-Favel and Jock pose that a holistic approach is among these characteristics, referring to a multisectoral approach to program planning, as well as integrating health and social service delivery. They also report that the integration of traditional healing or

Elder services have complemented the primary care services provided in some communities; however note that this is dependant upon community needs and desires.

Primary care is included in this list of common characteristics as some areas may not have accessed, or had access to, culturally appropriate or responsive treatment services. Furthermore, linkages to external health resources are essential, making collaboration with provincial services necessary (Lemchuk-Favel and Jock, 2004). Many First Nations leaders are hesitant to engage the provincial government however; being concerned provincial involvement will allow the federal government to further abrogate its responsibilities (Speck, 1989). Integration of health service delivery is also discussed by Lemchuk-Favel and Jock in the context of large tribal council areas centralizing services, taking advantage of the economies of scale and transferring control of such provincial or federal services as dental health, medical officer of health, nursing supervision, and/or environmental health. They caution that these economic considerations be balanced with "the need for community capacity development and local service delivery" (Lemchuk-Favel and Jock, p. 30).

The need for administrative reform is identified as yet another characteristic of success, which speaks to the patchwork of funding arrangements First Nations communities are subjected to as they transfer control of local and regional health services, and the accompanying administrative burden. Lemchuk-Favel and Jock (2004) call for merging programs to reduce this administrative burden. Lavoie detailed this funding patchwork in her presentation at the First Nations Primary Health Care Conference in Winnipeg, March 2005, based upon findings of the national health transfer evaluation. The presentation highlighted the variety and complexity of funding

arrangements for community-based health services, with many programs not being eligible for transfer and funded under individual agreements. These additional programs are often rigidly designed, with strict reporting requirements, making it difficult for communities to integrate them with other programs to meet their community-specific needs. The national health transfer evaluation also documented inequitable financing to regions. The experience of increasing impoverishment over time for those communities that transferred in the early years as compared to more recent transfers was another important finding of the transfer evaluation. Lavoie recommends long-term, evidence-based funding formulas with the flexibility to respond to changing local priorities and to take advantage of new opportunities.

Lavoie's (2005) presentation also highlighted various definitions or levels of integration. At one level, integration can simply involve improving communication between organizations regarding areas of mutual concern, or it can coordinate seamless negotiation between organizations or systems. Again at a more basic level, integration can reduce differences in the way separate systems operate and or eliminate duplication of services. Further along the continuum, integration can result in the adoption of jointly supported common practices/structures where there were separate practices/structures before. The most complex form of integration can result in the amalgamation of two separate systems. Lavoie also made it clear that what integration is not is the establishment of parallel systems.

Primary Health Care in First Nation Communities

Aboriginal communities in Canada have implemented the principles of primary health care, integrating services in a variety of ways and incorporating many of these

characteristics thereby reflecting the diversity in their populations. There are examples of comprehensive primary health care systems with varying degrees of intersectoral collaboration as well as targeted programs such as the Aboriginal Diabetes and Head Start Initiatives. The discussion here will be limited, however, to the more comprehensive models of primary health care, where First Nations community leaders have transferred the responsibility for the administration and delivery of health programs from the Federal Government.

Shibogama

In remote North-western Ontario, the Shibogama communities of Kingfisher Lake, Wapekeka, and Wunnimun Lake transferred their health programs from the federal government to the individual First Nations. They then chose to delegate certain functions to the tribal council level, thus establishing the Shibogama Health Authority. In keeping with the principles of primary health care, the Shibogama Health Authority integrated their health and social services into a single administrative and service delivery system, which pools resources and facilitates the implementation of multidisciplinary, client-oriented teams (Angees, et al., 1999). The model, therefore, combines community control with tribal council planning and support. A five year evaluation notes the difficulty in measuring improvements in health status due to the small population and rate of significant health occurrences, however, highlights many process successes (Angees, et al.). Their ability to recruit and more importantly retain well qualified, experienced nurses illustrates the success of several of these processes, including the level of support for continuing education and training and high quality professional and administrative support. As a result, the evaluation of local service utilization indicates 95% of

community members used the services at least once in the previous year, with 50% using services five times or more. Additionally, the communities and the Health Authority have accessed diverse funding sources to supplement the federally transferred dollars to meet the identified health needs in the communities. They are also addressing broader determinants of health by considering business ventures and revenue-generating initiatives to promote economic development (Angees, et al.).

Eskasoni

The Eskasoni First Nation, in Cape Breton, Nova Scotia, exemplifies the development of a community controlled, integrated approach to health service delivery; one which addresses their high rates of morbidity and mortality from substance abuse, diabetes, heart disease, and respiratory conditions (Lemchuk-Favel and Jock, 2004). In this case, the community determined it had adequate access to services and resources as demonstrated by a physician utilization rate four times the provincial average and a high rate of prescription drug abuse; however, the service delivery model was uncoordinated and ineffective (Lemchuk-Favel and Jock). Therefore, in addition to transferring their health programs from the federal government, they also partnered with Dalhousie University and the province of Nova Scotia, submitting a proposal to Health Canada's Health Transition Fund, which supported their initiative (Sims-Jones, 2003). The project "was designed to improve access and coordination of local health services," emphasizing "prenatal care, diabetes management, and prescription drug abuse" (Lemchuk-Favel and Jock, p. 40). Salaried physicians, recruited by the university to replace the former fee-for-service physician, became part of the community-based, multidisciplinary team. The success of this integration allowed pregnant women to be considered less than high risk,

due to 96% of women accessing appropriate antenatal care, including labour and delivery preparation (Lemchuk-Favel and Jock; Sims-Jones). Partnerships were forged with regional health centres to facilitate referrals and other health services, and Eskasoni was established as a teaching practice site as well as the only community-based telemedicine site in the province. Project evaluation reports a greater range of community primary care services, including visiting specialists and access via telemedicine. More appropriate physician and hospital utilization is evidenced by a reduction of average number of physician visits per resident from eleven to four and a 40% reduction of hospital emergency room (ER) visits, and a significant reduction in prescriptions (Sims-Jones). Additionally, Sims-Jones claims that 89% of the community residents reported improved quality of healthcare services. Despite the inability to transfer the significant provincial health care budget savings, resulting from reduced physician and ER visits, the Eskasoni model of health service delivery is sustained through provincially funded physician contracts and federal community program funding (Sims-Jones). More importantly, it is successfully meeting the health needs of the community.

Dilico Ojibway Child and Family Services

The Dilico Ojibway Child and Family Services organization in the Thunder Bay-Algoma region of North-western Ontario has evolved from a social services agency into a fully integrated health and social service network serving 13 First Nations communities. Guided by their vision of "balance and well-being for Anishinabek children, families and communities" (Pitawanakwat and Crawford, 2004), this agency expanded their mandate to include health service delivery. In addition to child welfare, they offer services for addictions, children's mental health, home and community care, primary care, and tele-

psychiatry. These integrated programs emphasize quality and embrace the principles of community governance and collaborative practice (Pitawanakwat and Crawford).

Kahnewake

Kahnewake First Nation presents a whole new dimension to the discussion of community governance and integrated services. The Kahnewake Health and Social Services Commission plans, coordinates and reviews all health and social programs in this community of 8,000 Mohawk residents. With its thriving business sector, five schools, museum, library, gymnasium, and arena, Kahnewake resembles a small Canadian town with an Aboriginal focus (Lemchuk-Favel and Jock, 2004). Their health system consists of public health programs operating out of the community health unit, a tertiary care hospital, specialty care services, dental services, a nationally recognized school-based diabetes education program, and a community service centre offering comprehensive mental health and social services including drug and alcohol treatment. "Kahnawake's vision of an Aboriginal health system is one where holistic practices supersede the medical model and prevention strategies provide the means for community members to be responsible for their own health" (Lemchuk-Favel and Jock, p 41). Managing change and dealing with the apathy of community members who prefer to rely on the health system to fix their ailments have been key issues for Mohawk leaders in establishing the community governed health system. It has created tension between the leadership and health professionals as services are restructured in accordance with Kahnewake's vision to create a system "encompassing Aboriginal health practices and philosophy". (Lemchuk-Favel and Jock, p. 42). Their future plans will eliminate these tensions as all institutions and health care providers become internally regulated and

licensed according to Mohawk law. In Kahnewake, "health is seen as integrally connected to nation building and self-determination" (Lemchuk-Favel and Jock, p. 42).

The above examples of primary health care in Aboriginal contexts, with the exception of Shibogama, are all based in settings where secondary and tertiary level care are in closer proximity. Like these other models, Island Lake has also transferred community based programs to the local First Nation health organizations with some regional program delivery, taking advantage of the economies of scale. The Island Lake communities, like those of the Shibogama Tribal Council, are remote and isolated, accessible only by air and, weather permitting, ice road for a few short weeks in the winter. They are unique however in their pursuit of a local Primary Health Care Centre, which will provide secondary level inpatient services and enhance existing diagnostic and outpatient service provision.

The Island Lake Model

The existing Island Lake health service delivery model and primary health care initiative originated with the transfer of health programs to the four individual communities. During pre-transfer intercommunity conferences, the benefits of a regional organization were acknowledged and resulted in the establishment of the Four Arrows Regional Health Authority. Coincidentally, a CBC News Magazine documentary regarding diabetes in Island Lake was aired nationally in 2000, shortly after the chiefs had sanctioned the regional health organization. As Andy Wood, Executive Director of FARHA explains, this dictated where their energies would be focused.

> All of a sudden this news magazine thing came up and the Chiefs decided, well, Four Arrows has already got some kind of a vehicle for working with Manitoba

> Health and FNIHB. Let's task them with looking at coming up with a strategy to deal with the diabetes issue in Island Lake. So that's how the Joint, it was called the Joint Health Governance Working Group, that was how it came to be. And that was its mandate. The mandate was to look at ways and strategies of, first of all, providing dialysis services in the Island Lake community… it sort of fell out of a pre-election promise that the NDP had made up in Island Lake on their campaigning. They had promised Garden Hill that they would look at setting up a dialysis centre in one of the communities. (personal communication, September 6, 2005)

Political will provided the impetus for the newly established regional health organization. Furthermore, the Chiefs identified other longstanding priority issues for the tripartite group to address on behalf of the Island Lake communities.

> The other task was looking at ways and possibilities of setting up an MOU [Memorandum of Understanding] that included a local hospital. We have since toyed with that and it has become a Primary Health Care Centre that we are striving to gain. Now the third mandate was to try and find ways and means, strategies in helping out the Island Lake First Nation membership that were living in the city for health and medical reasons, specifically diabetes and dialysis. So those were the three main tasks. (Wood)

The signing of the Memorandum of Understanding (MOU) June 23, 2000 launched FARHA's trajectory for the next several years. All parties agreed to work towards improving the health status and health services available to Island Lake community members. The political push to address the diabetes and dialysis in the community

facilitated the realisation of dialysis services, however it "didn't give us [FARHA] much time to plan other interests, we were focusing first of all on the Memorandum of Understanding and the three levels of government" (Wood, 2005).

The Regional Renal Health Program

Discussions at the intergovernmental, interdepartmental, intersectoral partnership table, convened by FARHA, lead to the establishment of the Island Lake Regional Renal Health Program, which is co-located in Garden Hill's federal Nursing Station and governed by the Neewin Health Services Board Inc. FNIHB, Manitoba Health, the provincial Renal Health Program, as well as the Winnipeg Regional Health Authority, all played significant roles. The importance of integrating health and social services is illustrated by INAC's participation in the process, which was significant in relation to water quality and housing requirements for the repatriation of clients who had been forced to move to Winnipeg to access dialysis services. Dust is another issue that arose which requires INAC's participation for resolution. Dust interferes with the sensitivity of the dialysis equipment, and while it must be controlled for that purpose, dust control also has important health benefits for the community in general.

The Island Lake Renal Health Program has six dialysis beds, including an isolation bed, with a total capacity for 36 clients, although is currently funded for 18. The program became operational in January of 2005, with five clients repatriated from Winnipeg receiving dialysis in Island Lake. The challenge of nurse recruitment was overcome by successfully recruiting five international nurses, who agreed to sign a two year contract. According to Wendy Whalley (personal communication June 15, 2006), Program Manager of the Renal Health Program, sixteen clients are currently receiving

dialysis in Island Lake three times per week. The majority of these were repatriated from Winnipeg, where they were required to live to access dialysis services. The most recent clients initiated treatment in Winnipeg but were transferred back home once medically stable. This program was uniquely conceived as, and therefore named, the Island Lake Regional Renal Health Program, with a significant prevention outreach program envisioned. The Island Lake program is one of twelve 'local centres' and is unique to the Manitoba Renal Program because outreach is not offered outside of Winnipeg (Whalley). The outreach component however has yet to be fully realised. In keeping with the principles of primary health care, health education sessions have been held, although restricted to Garden Hill. The plan is to implement the initial phase of the outreach program in the fall of 2006 which will involve screening individuals with existing, or at risk of developing, chronic kidney disease. From there the outreach program will expand to its full complement of screening, education, and treatment services (Whalley).

Nurse recruitment and retention in this isolated community is considered by Whalley (2006) as an ongoing challenge. Three of the four nurses originally recruited and hired by the University of Manitoba's Northern Medical Unit have indicated they are leaving at the end of their contracts; however, four additional nurses have been recruited for the fall. To provide for unexpected staffing requirements, due to illness for example, staffing levels have at times exceeded what is necessary in the absence of the outreach program. Additionally, locum coverage is provided by advertising upcoming opportunities in other Manitoba dialysis units, where nurses have demonstrated significant interest in providing short term relief.

The Holistic Vision:

The Renal Health Program represents one component in the spectrum of primary health care services proposed for Island Lake. The proposal for the Island Lake Regional Primary Health Care Centre describes the Centre "as part of an Island Lake prevention-treatment health care continuum" (Reise, Robson and Nadwidny, 2003, p. 9). How FARHA and the Primary Health Care Centre will actively support the health promotion and disease prevention activities carried out by each of the four community health organizations is outlined. The four Health Directors will sit on the boards of both the Island Lake Regional Primary Health Care Centre and FARHA, as they currently do with the Renal Health Program. "Thus, the total health system in Island Lake will have governance and communication links at virtually all levels" ((Reise, Robson and Nadwidny, 2003, p. 10). Dr. Bruce Martin summarizes the governance discussions held between the Health Directors and FARHA.

> My understanding [is] that the approach is to have all programs governed by one organization, but decentralized, one might say, to the four communities for the manner in which their programs are locally administered. But I would think that the policies and procedures or over-arching goals would be common to the four communities. But because of geography and other factors, local administration, accountable to the communities but also accountable to the broader umbrella organization - would be the way it would be implemented. And the fact that there would be an in-patient facility wouldn't interfere with integration, in any way, of the resources and, in fact, would probably facilitate greater integration. (Martin, personal communication, August 21, 2005)

This understanding is congruent with what each of the partners described as the governance structure envisioned for Island Lake's comprehensive model of primary health care.

The Primary Health Care Centre will offer outpatient clinical services as well as in- patient care. Six short stay acute care beds, three birthing beds, and "three special care beds for palliative care, respite care, complex pediatric care, and the occasional 'visit' of Winnipeg long-term inpatients" (Reise, Robson and Nadwidny, 2003, p. 10) are proposed. Care is to be provided by a multidisciplinary team consisting of nurse practitioners, family physicians, midwives, pharmacists, social workers, technicians, and other professionals. Visiting specialists and rehabilitative services will complement this onsite team. In keeping with a primary health care model, clients will be seen by nursing staff initially and referred to other allied health professionals as appropriate (Reise, Robson and Nadwidny, 2003). Wood describes their goal as providing as many services as possible within the Region: "We realise that there are still some things that will have to be transferred to Winnipeg for treatment, that can't be handled here. But our goal is to try and cut that down as much as possible" (Wood, 2005). To that end, a multipurpose advanced procedures suite is incorporated into the plan, where minor surgical, orthopedic, diagnostic and dental procedures could be performed under conscious sedation. Additionally, itinerant services such as the provincial screening mammography unit will be able to utilize this space to deliver their programs.

Due to the geography and climate of this remote, northern area, transportation to the facility poses many challenges. The Working Group addressed these in a preliminary fashion, the need to establish suitable road and water ambulance services are discussed in

the proposal. Furthermore, it has been deemed necessary to maintain an outreach clinic in Red Sucker Lake, staffed by nurse practitioners, who will be hired and supported by the Primary Health Care Centre through regularly scheduled physician visits.

The vision is to have the Primary Health Care Centre eventually staffed with doctors, nurses, technicians, allied health professionals, and paraprofessionals from the local communities; therefore, FARHA has been struggling to implement a human resources strategy. The first initiative of that strategy was a Health Careers Symposium, held in St. Theresa Point in the spring of 2004. High school students and community members were given a chance to hear first hand from Aboriginal health professionals and students currently enrolled in health careers. Post-secondary institutions outlined program entrance requirements. Presentations by health professionals and students addressed the benefits of health careers, the challenges associated with post-secondary education and how to overcome them. Opportunity for additional one-on-one dialogue was also provided. The goal of the Symposium was to motivate students to complete high school and apply for post-secondary education in the health field, armed with the knowledge that, with the Primary Health Care Centre opening in 2010, there would be jobs available to come home to. The local Education Authorities were invited to the Symposium; however, prior commitments prevented their attendance. Health human resources continue to be an area of concern for FARHA and the local health organizations.

> We tried talking to the communities, the education authorities. Why don't they try sponsoring people, nursing, doctors, lab technicians? Our people have a problem with looking that far ahead. And I think that what would be needed right

> now would be an announcement saying, yes, the proposal has been approved and you can start drawing up your blueprints and all that. And I think that's what will be needed too, for us to be able to talk to the councils and education authorities. Look, this is going to be built in ten-fifteen years, start now, start training doctors and nurses and x-ray technicians, whatever we need. (Wood, 2005)

The overall vision for the region's healthcare delivery system is comprehensive with health promotion and illness prevention activities integrated with acute, rehabilitative, and long term care services. This approach is congruent with the community's holistic worldview of health and well being. John Peter Flett, former Health Director and current Health Portfolio Councilor in St. Theresa Point, describes the Island Lake model as meeting community needs by "going back and bringing the four aspects together again" (personal communication, August 5, 2005); the physical, mental, emotional, and spiritual aspects of being, which are represented in the medicine wheel FARHA uses as its logo. Further, Flett states, "We are not whole, therefore we are not healthy. There is imbalance now". He suggests that the community has a collective responsibility in achieving that balance and agrees with Andy Wood that the sense of community can be built upon to improve the well being of the people.

> How we survived as Aboriginal people is through family supports and community members supporting each other. If someone is sick the family or community is always there to help out, and not just physical problems, but also mental, emotional and spiritual. (Flett)

Oberon Munroe, Health Director for Garden Hill and Chairman of the FARHA Board, discusses his holistic vision of health service delivery, and specifically how the

physical, mental, emotional, and spiritual aspects of health are addressed by a variety of members comprising an integrated health services team.

> The basic thing is to teach people how to take care of themselves… I think you have to look at a circle… in that circle there are services all around. It does not matter which part of the circle you enter, whether it would be prevention, treatment, or other services. These people [members of the health team] will have an idea how to help you in whatever way. And they would work together with other individuals …so it's a full circle. (Munroe, personal communication, September 13, 2005)

The concept of the circle and the interconnectedness of all things are also embedded in the management philosophy of the health organization. The values of respect, reciprocity, and collectivity underpin their management principles. Wood (2005), is confident that these community values will continue to guide the organization as the organization evolves and grows. The FARHA's (2004) *Personnel Policy Manual* demonstrates these underpinnings. It states:

> The intent of the Board and Management is to create and maintain a working environment where:
>
> - All staff are valued for their contributions;
> - Teamwork and support of colleagues is a normal practice; and
> - All people dealing with the organization, whether visitors or clients, are respected and treated courteously. (FARHA, 2004)

In addition, their *Personnel Policy Manual* acknowledges how hard and effectively the employees work to achieve the goals of the organization. Furthermore, it declares that,

"Personnel policies and management actions will strive always to balance the need for work productivity with personal and family needs of staff" (FARHA, 2004).

Principles and Best Practices of Primary Health Care

Integration and coordination of health services are reflective of the principles of primary health care and Island Lake is already working towards integration of those programs already under community control. The proposal for the Primary Health Care Centre states,

> FAHRA is creating a cooperative model where the most appropriate functions are carried out at the most appropriate levels. At the prevention level, the four community health services and FARHA have already started significant changes designed to make them the strongest possible partner they can be when this prevention-treatment model becomes a reality. (Reise, Robson and Nadwidny, 2003, p. 9)

What is being referred to here is the continuum of services already controlled by the community. At the outset of this research, each of the four communities had transferred all eligible programs from FNIHB to the First Nation. Each community or FARHA also entered into Contribution Agreements for those programs not eligible for transfer, thereby accepting responsibility for the administration of these programs and achieving some level of community control over program delivery. Renovation or construction projects to the federal nursing stations allowed many of the community-based programs to be administered from under the same roof, thereby facilitating greater integration and coordination of services. FNIHB continues to provide treatment services delivered by nurses working in an expanded role and itinerant physicians, specialists, dentists,

physiotherapist and, until very recently, psychologists. The transfer of Public Health Nursing augmented the existing health promotion programs, whereas the Home and Community Care Program offered an entirely new scope of services to the communities addressing a significant void in service delivery. "As of April 1, 2003 the citizens of Island Lake can access a range of Home Care services, including Home Care nursing and personal care by certified Health Care Aides" (Reise, Robson and Nadwidny, 2003, p. 9).

Service coordination and integration are essential when one considers the complexity and interrelatedness of the issues facing families in Island Lake. These complexities are illustrated in the following statement by the Executive Director of FARHA, Andy Wood, and demonstrate the need for holistic health services.

> It's pretty hard for families in those communities where there's not much employment. They have to rely on welfare. A lot of times too the families are not doing any budgetary planning. I'm talking about shopping here. Everything seems to be tied in together. There's not much in the way of recreation programs. So the parents are spending all their money trying to make more money on bingo, or playing cards, on poker, hoping that they're going to hit the jackpot so they can buy more things. And, of course, that doesn't happen. So the kids are always hungry, then they're not learning properly at school. (2005)

The need for holistic services, which incorporate the physical, mental, emotional, and spiritual aspects of health, and primary health care, which addresses the broader determinants of health such as poverty, food security, and educational attainment, is clearly evident. Hazel Harper, former Health Director of St. Theresa Point and member of the Joint Health Governance Working Group, speaks to how the governance of the

Regional Primary Health Care Centre will facilitate the further integration of community-based health promotion activities with acute care treatment services.

> When we talk about the Primary Health Care Centre it creates connectedness within the treatment area for all of Island Lake. Having regular programs stem out from there. I guess that would be having Four Arrows having accountability over community-based programs. When we have the Primary Health Care Centre then we should make that switch. It wouldn't work now but having a Primary Health Care Centre connects everyone together. This doesn't mean community-based programs would be located with the Primary Health Care Centre but stem out and be administered from there. (Harper, personal communication August 4, 2005)

Oberon Munroe, Health Director of Garden Hill, addresses the need to integrate local services with the broader health care services. He acknowledges communication technology as one of the current challenges related to coordinating local services with external resources, stating "one of the things that we are trying to do is get the communication technology strengthened, meaning that we can communicate with major hospitals from the community" (Munroe, 2005)

The Mental Health program. The Island Lake Mental Health program initially amalgamated all federal funding for community-based mental health related services and integrated them into a more comprehensive program to be enhanced and supported by professional psychology services when they were able to successfully negotiate the transfer of these funds from the Non-Insured Health Benefits program of FNIHB. In the interim, the integration of funds allowed FARHA to hire a husband and wife team of

mental health professionals to coordinate and support the community-based para-professionals. These professionals also participated in and assisted with the transfer negotiations. Now that funding has been secured and visiting psychologists hired, the Regional Mental Health Coordinator also provides their professional supervision. Wood (2005) describes the initial process as follows:

> What we did here, internally, from the funding that we get through the Transfer Program, there's some programs that are set aside for Brighter Futures. And of course, in the Brighter Futures and Building Healthy Communities there's monies for mental health. So we've done away with the Brighter Futures, BFI/BHC [Building Healthy Community] boxes, and we said mental health. Mental health encompasses everything. Mental heath can touch all the BFI components: child development, solvent abuse, injury prevention, all those. So rather than keeping the BFI/BHC boxes, we said mental health. So that's what we did first of all. Second of all, we have been for the last year and a half developing a mental health psychology program for the Island Lake communities. We have been negotiating a transfer with FNIHB to take over the psychologist and mental health therapist programs.

The federal government's FNIHB has imposed programs, designed by Ottawa bureaucrats without community consultation, on First Nations communities. While the funding is desperately needed with the health needs being so great, the programs, as they are designed, are not necessarily responsive to community needs, and thus fail to improve the health status of community members. Wood describes the rationale underpinning Island Lake's pursuit of the professional therapist program.

> We had no control or were not consulted on who was being hired in the communities. We had a couple of people over the years… that we felt were exceptional. But they couldn't work within the FNIHB policies. They wanted to be able to try out other things like healing circles, but they were told to just do the one-on-one counseling. (Wood, 2005)

Wood also describes the frustration of negotiating for transfer of programs given the lack of flexibility in government policy and practice.

> We have been negotiating a transfer with FNIHB to take over the psychologist and mental health therapist programs… what we keep on running into [are] their very, very stringent guidelines. They tell you yes, you can take over, but you have to do it this way. And we are saying no, we've been doing and trying different things in the communities where we're not just sending people to therapy and counseling. We're trying to use, for example, creative arts to get people busy, keep their minds busy, keeping their minds off some of their addictions… People are very interested in that. So that's where we are sort of running into a stone wall with FNIHB. They say, well, you have to follow the guidelines. Send in therapists that will do one-on-one counseling. And in their policies there doesn't seem to be much room for group or healing circles. And we're very much about getting the families together to sit around and talk about their issues… And the other problem that we are having that is there doesn't seem to be room in the FNIHB model for skills transfers. We would like to be able to teach/work with the community-based mental health workers, solvent abuse worker… So this is where we're running

> into a road block with FNIHB, with the very stringent guidelines that they have. Yes we will give you the programs but you have to do it our way. (Wood)

This rigidity is typical of many of the targeted programs not eligible for transfer to First Nations communities but funded through separate funding agreements. FARHA's vision of well-being is holistic, involving physical, mental, emotional, and spiritual health and healing. They utilize a community development approach where the strengths and talents of the community are identified and put to use. Inflexible programming and funding silos impede their ability to design and deliver the services that they feel will most effectively meet the needs of the communities. Project funding, such as the Aboriginal Healing Foundation's community projects which augmented community based funding and contributed to community healing, is also problematic. These particular project-based funds have been extended for an additional year, leaving the communities scrambling to determine how to sustain their programs. Time is therefore invested in such activities as writing funding proposals and negotiating with the government for increasing levels of control.

> I guess that speaks to our vision again, that we're not just sitting around and following the FNIHB stove piping and saying this money is for this, this is for NADAP. We're taking that whole pot of money and we're applying all over the place for different pots of money: We got funding from the National Crime Prevention Strategy, we got funding from the United Church, we got funding from a few other places. Not big pots, but every little bit helps you know. And we are trying to look at innovative ways that we can make use of all the community resources. That includes the Elders, the land… (Wood, 2005)

FARHA believes mental health can be addressed more appropriately at the community level through the innovative programming implemented by the regional coordinators and community-based mental health workers. For example, a Creative Arts Summer Festival was held featuring 12 local artists, including three Elders who are accomplished beaders. The artists demonstrated their talents and assisted participants to learn mask-making, beading, photography, painting, and making dream catchers. In the words of the mental health coordinator, this gathering provided an opportunity where, "in the safety of the circle, this circle of wellness, people spoke of their pain" (Ravinsky, personal communication September 20, 2005). This type of programming, gives individuals who live in poverty with no prospects for employment, something meaningful to do with their time. It gives purpose to their lives while validating their culture and identities. In this way it promotes well-being; it provides opportunities for individuals to gather, to tell their stories, to express their pain, and begin the process of healing (Ravinsky and Miller, personal communication September 20, 2005).

Wood uses the story-telling tradition to describe the degree of isolation he sees in the communities today and to stress the importance of creating these opportunities for coming together.

> I used to see this. My uncle, every once in awhile would come over to our house, and my dad would give him a haircut. It took a long, long time for the haircut. They were visiting, and they were talking and they were close, of course, in physical contact. That would happen every once in awhile. But you don't see that anymore. People are just not even visiting anymore... they're sitting at home watching TV, or if they want to talk to somebody, they pick up the phone, ask

> what they want to ask them then they hang up. So you know those times of celebration, I think the communities need to build up more on that. There needs to be more celebration in the communities. Wass [Wasagamack] has this, and this has been going on for a long time now. They have a fall gathering feast, and they have a spring gathering and feast. I guess that goes back to the days when the people would come to Wass in the spring, all of them would come back from their winter traplines to come and sell their furs, buy their tools or whatever, and they'd stay for the summer. And just before they'd go back at the end of the fall they would have another feast. They still do that in Wass. But the young people wonder why it's being done. They think it's just a time to go and eat, square dance or whatever. Events like that, I think, need to be explained to the communities why this is happening. That doesn't happen in any of the other communities. I don't see that happening. That one and the haircut are my stories. (Wood, 2005)

These stories speak to the importance of passing on community knowledge and cultural values which underpin the programs FARHA is designing. Additionally, they provide insight into the ways the local health organizations and FARHA have identified and built upon community strengths in their programming. This is described in greater detail in the following discussion.

> In times of grieving, in times of death, the traditional methods are there. And I think we can build onto those traditional methods to expanding them into other areas where support is needed. I think the caring will always be there between the community members and between friends and families. That will always be there.

> But I'm thinking, we can build on those traditional methods, those traditional grieving mechanisms that are there. Instill that into the areas where the family is dysfunctional and needs some additional support. (Wood, 2005)

When asked how they are evaluating these innovative programs, Robert Miller, one of the Regional Mental Health Coordinators, states the program is "based on the model of reflection, action, reflection," using "engagement and participation" to determine success (personal communication September 20, 2005). He qualifies his statement with the following observation:

> This is a strength of the culture, I think. They're not pretending they're interested in something when they're not. Some people are very good at just not showing up to meetings, not helping you to organize something. That to me is a very clear message, a measure, that we are not being very effective here. So to me the positive venture is when people come, engage, participate and take initiative on their own; contribute, take control. (Miller)

And people did participate. "We had 70 people in the bush for three days, from morning till night doing art" (Ravinsky, 2005). They also took ownership of different aspects of the Creative Arts Festival. The community-based workers identified their local artists and extended invitations to them to participate, illustrating the principle of community development that "the gifts are within" (Ravinsky). One of the community-based workers, formerly reluctant to take on any kind of leadership role stepped forward on the day of the event and led the demonstrations in one of the tents.

Miller and Ravinsky showed me the photo below, to illustrate their sense of success; a photo of one of the Elders demonstrating beading to a young girl. The youth is

Photo 1: Garden Hill Elder and Beader with Wasagamack Youth
Reprinted with permission from FARHA's Newsletter

obviously completely engrossed in the teaching. Ravinsky states, "this picture, to me, tells the truth. This is a picture - a real picture - of a real Elder with a real youth in the mentorship process" (2005). To Miller and Ravinsky, really connecting with people and having an experience resonate with the participants is also indicative of success. For example, during the Creative Arts Festival a couple participants from Red Sucker Lake were touched and empowered by mask-making. They have invited the mental health coordinators to come to their community and hold a mask-making workshop. Miller (2005) describes the impact of their request.

> This change that happens is a result of having an experience of an alternative that makes sense; that connects with people. They say, "oh yeah, this is good. Oh yeah, this was healing. Why aren't we doing this? We can do this!"

While not quantifiable, their healing through art initiative is having a positive impact on the lives of community members.

Other initiatives that are designed to promote the mental well-being of community members include the Elders Program at the school. Wasagamack and St. Theresa Point schools have Elders teaching in the elementary schools daily, working with the young children, ensuring their language and ways of knowing are incorporated into the academic learning environment. This program, viewed by many as essential for sustaining cultural continuity and positive self-identity, has been threatened by the new leadership in Wasagamack who passed a resolution in November, 2005 to eliminate the Elder program in the school. The rationale reported to me underpinning this decision was the fact that the children demonstrated less fluency in English, which was interpreted by the new leadership as detrimental for the children's futures (Joseph Harper, personal communication, November 4, 2005). The leadership has obviously not been informed of the efforts being made throughout Indigenous societies to revitalize their languages as a means of preserving the identity and lives of their youth. Chandler and Lalonde's (1998) work with British Columbia's First Nations communities demonstrated that "the communities that have taken active steps to preserve and rehabilitate their own cultures are also those communities in which youth suicide rates are dramatically lower" (p. 215). And while they admit that the relationship may not be causal and the results due to some unknown variable:

> The fact remains… that every band in British Columbia that has taken all of the protective steps outlined in this report has a youth suicide rate of zero, whereas bands in which all of these community actions are missing have youth suicide rates that are 5-100 times the provincial average. (Chandler and Lalonde, p 215)

This illustrates the importance of building linkages between program directors and the political leadership, which can facilitate informed decision-making.

Other mental health initiatives also involve the revitalization of culture, such as the proposed Story-Telling festival that FARHA is seeking to fund. The objective is to highlight the knowledge and wisdom that the Elders have and provide an opportunity for them to contribute to the community in a meaningful way. Many of their initiatives attempt to bridge the existing generation gap, resulting at least in part from residential school experiences, while giving direction and purpose to the lives of community members.

> Another thing we are working on, and here again, it's all back to the mental health, different ways that we are trying to get well in the communities. We've been talking to Erik Robinson's shop – Cultural and Heritage – about having a story-telling festival here in the community. And here again, we are thinking about telling the communities, the Elders have all this wisdom, all this stuff, they still can contribute to the communities. So we are working on that. And that is something that we will probably be doing during the winter season when the communities can visit among each other (Wood, 2005)

The Youth-Elder Gathering was initiated in Wasagamack to address some of the negativity that was being expressed in the community regarding the youth, especially by

the Elders. It too was designed to reconnect the generations and foster mutual understanding. Once the communities began working collectively through FARHA, this gathering was opened up to all the communities and FARHA became involved. Wood describes the first of these gatherings that he was involved with.

> The very first Youth/Elder Gathering that we were involved in was a very, very stressful session, cause we were trying things that they had never done in the community.... well, not for awhile, maybe they did that way back, but we were doing sharing circles. We were seating youth, Elder, youth, Elder, all the way around [the circle]... we knew there was a lot of problems between the youth and the Elders of the communities... They [the Elders] were saying, the kids are doing this; the kids are doing that; they're bad! Some of the youth there felt very stepped on in the communities. (Wood)

Wood illustrates the division between the generations as he reflects on how destructive the generation gap can be and why reconnecting youth and Elders has become an underlying theme to many of their programs. .

> They [some Elders] still feel that the youth should learn, shouldn't say anything. And we are feeling this is why Garden Hill has experienced a lot of youth crimes and is bothered with youth gang activity. They are rebelling, they're saying, look, we need to be heard. They are doing it the wrong way because they are forever being told: You're bad! (Wood)

This discussion also reveals the influence of residential schooling amongst community Elders.

Yet another story reveals how the healing circle facilitated a degree of resolution that has been nurtured in subsequent Gatherings. The story begins with Elders complaining about the music the youth were listening to.

> So when that came out in the sharing circles, the Elders were saying, well, you know, the swearing and all that. The youth were saying, well, you listen to country music. And country music is all about drinking whiskey and stealing women, and what's the good of that?...That sort of paved the way for some of the more recent ones [Gatherings]…where they learned about more, there was more about talking together…This past summer we've done some things where the teachings go both ways. The Elders are teaching about story-telling, how to fish. The youth are telling the old people about hockey… they seem to be enjoying that. (Wood)

Again, we see here how the criteria for success revolves around the degree to which people are connected and experiences resonate within the participants.

The Public Health program. The Public Health initiative demonstrates how the core preventative activities of primary health care, such as health education, illness prevention, promotion of food security and adequate nutrition, and maternal/child health programs are being implemented in Island Lake. Public Health Nursing funds were transferred from FNIHB to the communities, giving the communities responsibility for public health programming. Although the retention of nursing staff has been problematic, the initiative has incorporated traditional teachings and approaches which are culturally significant and sustained by the Community Health Representatives and other para-professional staff who make up the public health team.

> In April 2003 the community health services and FARHA took over Public Health Nursing responsibilities from the Nursing Stations/First Nations and Inuit Health Branch. They now have a small cadre of nurses, some of whom are community members, and they are working to integrate other less formally qualified prevention workers (e.g. Community Health Representatives, et al) to form a dynamic prevention force. (Reise, Robson and Nadwidny, 2003, p. 9)

Additionally, negotiations are ongoing with Manitoba Health's Chief Medical Officer of Health as FARHA attempts to secure a part-time Medical Officer of Health to support and augment the Island Lake Public Health Team.

The integration of program goals is evident when you consider the Community Gardening project that was first introduced by the Public Health Teams in the summer of 2005. Gardening may seem to be a rather unconventional public health activity; however, it facilitates healthy eating and promotes physical activity. It also meets some of the objectives of the mental health program. While the Mental Health program coordinators do not feel that they have been able to successfully integrate their initiatives with Public Health, there is a common thread connecting and underpinning their work. Furthermore, there is a demonstrated consistency in the qualitative approach taken to measure their achievements.

> We couldn't believe the amount of interest there was in the communities. And at this point, we don't see the communities being able to subsist on their community gardens. But it is the interest. In Wasagamack they have an innovative procedure where they have the Elders doing the gardening and then they have the youth that are doing the work, the hoeing, and all that. That interaction between the Elders

> and the youth is something that we are trying to promote. And the Elders seem to really enjoy this. I think in the last little while, our Elders seem to feel that they've lost their place in the community. And that's because, like we were talking about - the teachings - not enough people are going to them and asking them to tell stories. So we are trying new things... (Wood)

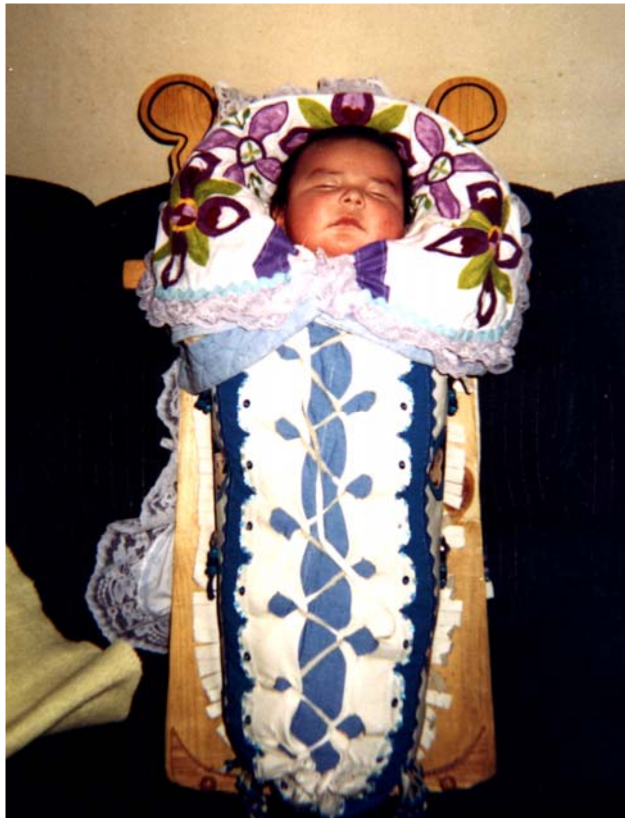
Similar to the community gardening project, the public health nurse in Wasagamack began exploring the idea of community freezers. These could be used for preserving the garden produce; however, the vision was broader, stemming from the traditional practice of hunters sharing their game. What was envisioned was a community repository for fish and wild game as well; hunters, fishers, and gardeners sharing their resources with each other and the broader community that supported their efforts.

The establishment of Chicken Grow operations is yet another unconventional public health activity that promotes food security and adequate nutrition. This economic development initiative being pursued by FARHA and their public health team demonstrates how their holistic approach to health is congruent with the principles of primary health care. Chicken Grow operations will address some of the broader determinants of health, such as unemployment and poverty.

The public health program also engages in more conventional programming such as maternal child health. These programs have also been made more responsive to community needs by incorporating the wisdom and teachings of the Elders. In Wasagamack for example, while prenatal clients are awaiting clinical assessments they are engaged by the public health team in learning to embroider their Tikinagan blankets. Tikinagans being the back board which women from Island Lake and other Ojibway

communities use to carry their infants on their backs. This photo below, of an Island Lake baby in his Tikinagan, depicts the beautiful and extensive blanket embroidery done by the women of Island Lake.

Photo 2: Island Lake Baby in Tikinagan



Used with parental and photographer's permission.

FARHA is hoping to further enhance the participation of Elders and incorporate traditional healing into their programming for the increasing numbers of individuals who want to access these services.

> The other thing that we recently started discussing with FNIHB is the Traditional Healers Program. And this was something that has sort of popped up all of a sudden in the Island Lake communities. Just St. Theresa was taking advantage of that program for the last, maybe, ten years. Previous to that, Red Sucker, Garden

> Hill, and Wasagamack didn't do too much in the way of traditional healing. But all of a sudden it's just growing, you know. So we were thinking maybe that's something else that we should be looking at transferring from FNIHB. We're trying to look at all areas. (Wood)

The Wasagamack public health team was also trying to engage Elders in their prenatal education programming. The plans included Elders taking women in their first and/or second trimester out on the land where they would teach them to pick medicines which would promote the health of their families. Time with the Elders/traditional midwives would also incorporate teachings about proper nutrition and exercise. Programming such as this would easily be integrated with the midwifery program that is envisioned for Island Lake communities and the Regional Primary Health Care Centre.

Manitoba's Aboriginal Midwifery Education Program (AMEP) is about to enroll its first students in September of 2006 and Island Lake is hoping to attract graduates to their communities to work with the other members of their primary health care team.

> For many years, Aboriginal organizations and individuals, particularly women living in the north, have called upon both the provincial and federal governments to provide funding and training to return Aboriginal midwifery back to their communities. They called for a program that would blend traditional Aboriginal knowledge with western methods of medicine. (AMEP, 2006)

Loretta Bayer, Director, Aboriginal Health Branch and Manitoba Health's representative on the Joint Health Governance Working Group, now Neewin Health Services, claims "The women of the Island Lake area were very actively involved in contributing to the legislative changes related to traditional midwifery" (personal communication October

18, 2005). Their efforts and the efforts of many others culminated in the Manitoba Midwifery Act which was passed in June 2000. Upon receipt of funding from the Aboriginal envelope of the federal Primary health care Transition Fund the AMEP began a consultative process with Aboriginal communities and Elders to develop the curriculum, which will be delivered for the first time in two northern First Nation communities this fall. The program was described as "an integral approach towards re-establishing our social and cultural heritage" by the Assembly of First Nations' Grand Chief Phil Fontaine during a Manitoba news release on December 13, 2004. Manitoba's former Grand Chief Dennis White Bird stated the program "will give the gift of sharing in the birth of a new life back to First Nation people" (MB, 2004).

Wood (2005) reiterates the need to return to traditional values; the need to incorporate those practices into their health services delivery to better meet the needs of people in the community.

> We have to create that balance and we have to use those [traditional] values, those standards, those ethics, and use them in some of the programs, [to address] some of the realities that are in the community right now. And I think this is happening, not only in Island Lake, it's happening all over the place. There's a resurgence, a going back to the traditional values. We value those teachings. (Wood)

The initial visioning exercise undertaken by the Island Lake Health Directors and workers in February 1999, the PATH, depicts other aspects of their health service continuum that have yet to be tabled for discussion. These include a Drug and Alcohol Treatment Centre and a Long-term Care Facility, both of which would be based upon traditional values and teachings.

Barriers

While the public health program is successfully incorporating the principles of primary health care by addressing broader determinants of health in ways that are meaningful to the community, it does have its challenges. The Public Health Evaluation, that was completed two years after the transfer of Public Health Nursing, indicates a lack of management and administrative support both locally and regionally (Grimes, 2005b). The public health nurses who left their positions in Island Lake cited this as one of the most significant contributing factors. The resulting vacant positions pose a significant threat to the success and sustainability of the program. As of June 2, 2006, all public health nurse positions are vacant, although two relief nurses are providing part time coverage in Wasagmack and Garden Hill. The Regional Public Health Coordinator, Grace McDougall (personal communication June 2, 2006), is confident that the Health Directors have learned the importance of supporting the nursing staff and public health initiatives; however, the challenge of recruitment has yet to be overcome. The inability of FARHA and the local health authorities to recruit and retain nurses has resulted in FNIHB employed, treatment nurses providing public health nursing services as workloads and time permit. Public health nursing resources were transferred to the First Nations, therefore, FNIHB nurses are no longer responsible for delivering these programs. The magnitude of treatment demands result in illness prevention activities being largely ignored. Instead individuals are offered treatment when they present to the clinic with preventable illnesses or communicable diseases. This is evidenced by the recent outbreak of tuberculosis (TB) in Garden Hill. The illness outbreak is being

managed and additional resources, such as a TB nurse and Directly Observed Therapy (DOT) worker have been hired by FNIHB to work in the community; however health education sessions regarding TB have been limited and are not integrated with outbreak management (McDougall, 2006).

The turnover in leadership, whether the leadership is from nurses, health directors, health councilors, or Chiefs, is the main challenge that limits FARHA's progress. The current global environment is experiencing a shortage of health care professionals, therefore it is not surprising that the recruitment and retention of public health nurses has been challenging for the communities. The Canadian Nurses Advisory Committee on Health Human Resources (2002) describes the extent of the nursing shortage in relation to the balance of those entering the profession with those leaving. The nursing workforce is aging therefore retirements are suggested to contribute significantly to the shortage. It is estimated that by the year 2010, 37.4% of the nurses registered in 2001 will retire along with 48.9% of their head nurses and supervisors (CNAC, 2002). The significance of this is realised when compared with the numbers of nurses graduating from nursing programs and the demand for nursing services. Between 1990 and 2001 the number of nurses graduating dropped by 26% whereas the Canadian population increased by 11%. The Canadian Nurses Advisory Committee (CNAC) made fifty one recommendations to improve the quality of nursing work life to address the Health Human Resource crisis. While the number of nursing education seats have been increased across the country, the Canadian Policy Research Network (CPRN) has conducted an evaluation which indicates that other recommended changes have not been implemented to a large degree. Reasons cited include lack of adequate, sustainable resources to make necessary improvements

(CPRN, 2005). The Island Lake Health Directors claimed inadequate resourcing during the Public Health evaluation in 2005. The financial resources transferred from FNIHB for Public Health Nursing were limited to salary dollars; additional monies for workplace supports were not included in the negotiated agreement (personal knowledge as former FNIHB, Nurse Manager involved in negotiations). Lack of non-financial supports from the health authority were however, cited as the most significant issues for the community-based Public Health Nurses (Grimes, 2005b).

The inability to retain nurses in the public health program impedes program delivery as time is constantly being diverted from healthcare delivery to orientation activities. This appears to be a fundamental consequence of instability at all levels. With the overwhelming burden of illness in First Nations communities, the workload and responsibilities associated with positions in health often lead to burnout. Recruitment and retention issues result. Political leaders have even greater levels of responsibility however burnout is not usually the issue. The two year terms for Chiefs and Councilors imposed under the Indian Act create instability in the political arena. The more frequent turnover of political leaders in some Island Lake communities has been due to community non-confidence and has resulted in even greater instability. Wood describes his experience in relation to the turnover of political leadership.

> One of the biggest problems that we keep running into when we are dealing with Chief and Councils is the cost of turnover in leadership. We get a Chief from one community that is totally supportive of our efforts and then six months later he is gone. Somebody else comes in and we start over again, that

> same old orientation. That seems to be a constant problem that we really can't do anything about. (Wood, 2005)

The mental health coordinator reiterates these concerns and the impact it has on realizing their vision for integration of programs and services.

> One of the challenges and one of the reasons why this [holistic integration] doesn't happen as quickly as we'd like is the instability or lack of continuity, longevity of health leadership in some of the communities, and political leadership. And that, I think, is a necessary condition for changing something as fundamental as a community's condition of health and well-being as it would be with the conditions of education or self-government, self-determination, politics…For an organization to move in the direction that you're talking about requires that a vision be part of the culture of the organization. And it's a cultural shift from the mainstream and the status quo. And to achieve that requires that steady presence of people that share a vision, talk about it and develop it, refine it. And that doesn't happen when faces keep changing around a table. So, it's there, there's movement, but it's little by little. (Miller, 2005)

Not having a shared vision is the other obstacle discussed by members of the FARHA staff and board. Wood sums up the issue by stating, "that's probably one of the main problems that we have is getting other program areas and other programs to share our vision" (2005). This was particularly evident in discussions related to the health human resource strategy and the need to educate health professionals.

> If we are going to be looking at our own health services, and primary health provision, we have to have our own people that are doctors and nurses. We have

> been running into a brick wall in trying to discuss this with the powers that be that control sponsorship monies, education authorities. I don't know, for some reason we can't seem to connect with them. (Wood, 2005).

The education authorities in the Island Lake communities have not made sponsoring students entering health careers a priority and have not responded to ongoing requests for meetings to discuss the issue. The collaboration required for FARHA to realise their vision does not end with the education authority, however. FARHA envisions all community-based organizations working together thereby ensuring that community decisions positively impact, or at least do not negatively impact, the well-being of community members. This encompasses education, housing, social assistance, child and family services, and economic development sectors. A current example involving First Nations in Manitoba relates to economic development initiatives and healthy public policy such as smoking bans in public places. FARHA would like to establish community linkages that provide opportunities to openly discuss, debate, and reach consensus around economic development initiatives or other policy decisions that could potentially compromise the health and well-being of community members. In keeping with the principles of primary health care, such a holistic approach would encourage a community process for addressing the broader determinants of health. The federal, provincial, First Nation partnership established with FARHA would support such community processes, enhancing the prospect of support for community-based initiatives.

Another Promising Approach for First Nations Health Care

Following the release of the Romanow (2002) Report three Manitoba Ministers and the Grand Chiefs met to discuss Romanow's recommendations regarding Aboriginal

health; recommendations which proposed new funding and institutional arrangements that could improve the poor health status of First Nation people. This dialogue resulted in the establishment of the Intergovernmental Committee on First Nations Health (ICFNH), similar to the Joint Health Governance Working Group, with representation from the First Nations, federal and provincial government departments. Specifically, the ICFNH representatives include the Assembly of Manitoba Chiefs (AMC), the Southern Chiefs Organization (SCO), Manitoba Keewatinook Ininew Okimowin (MKIO), Manitoba Health, Aboriginal and Northern Affairs (ANA), Health Canada, First Nations and Inuit Health Branch (FNIHB), and Indian and Northern Affairs Canada (INAC). The committee's objective is to develop innovative solutions and strategic projects to achieve better health outcomes for Manitoba First Nations people by working at resolving the inter-jurisdictional issues affecting program responsibilities and recommending solutions for a more seamless health service delivery system. The Technical Working Group, with the endorsement of the Chiefs Task Force on Health and support of the Manitoba First Nations Health Technicians Working Group, has recommended the establishment of an Intergovernmental Health Council, which would oversee the implementation of the *Manitoba First Nations Health and Wellness Strategy: A Ten Year Plan For Action, 2005-2015.* A strategy endorsed by the Manitoba Chiefs in Assembly, which provides broad strategic direction for the health and wellness of Manitoba First Nations. The ICFNH is implementing several priority areas of the ten year plan, including drafting a Primary Health Care Policy Framework for First Nation health; developing a comprehensive Health Human Resource strategy; and exploring funding arrangements for First Nation control and governance of health programs. The ICFNH, whose

technical working group is largely consistent with the partners at the FARHA's table, is striving to improve First Nations health through a primary health care approach.

Of the previous examples of primary health care delivery models in First Nation communities, none are comparable to what Island Lake is in the process of establishing. Shibogama, although similar with respect to geographic remoteness and multiple community-based organizations being supported by centralized regional services, has not incorporated the local provision of secondary level care in their model. I will therefore now turn to examples of First Nations community governed and community-based programs that are being integrated with hospital care in remote settings.

Weeneebayko Health Ahtuskaywin

Weeneebayko Health Ahtuskaywin (WHA) is the regional health authority for 'Mushkegowuk Territory', which is comprised of the six communities (Peawanuck, Attawapiskat, Kashechewan, Fort Albany, Moosonee and Moose Factory) located along the western Ontario shores of the James and Hudson Bays, and the inland First Nation communities of New Post, Chapleau Cree and Missanabie Cree (WHA website). In September of 2006 the health services currently administered by the federal government, Moosenee, Moose Factory, and the provincial government will be amalgamated and governed by a First Nations board representing each community. The Chief Executive Officer, to be hired by the new board, will be responsible for all health services in the region, including public health, the hospitals, non-insured health benefits, transportation, physicians, and the operation of all nursing stations and health centres.

The Weeneebayko Health Integration initiative is led by an Aboriginal steering committee whose members are chosen by the communities. The steering committee has

elders involved, is run by consensus, and is respectful of Aboriginal ways. Jim Harrold, the consultant working with the committee to realise the community vision, describes his work and the negotiations taking place as "principle-based, founded on Aboriginal teachings and Aboriginal world-view," although he claims the process is neither Aboriginal nor non-Aboriginal. "The 'culture' or climate of this process is inclusive, it doesn't ghettoize anyone. It is respectful of Francophones, northern Ontarians, rural and Aboriginal populations" (Harrold, personal communication December 6, 2005).

Harrold believes Primary health care is imperative for First Nation's communities, as the current health system is not working: "Primary health care's relationships are critical for Aboriginal Health: They need to develop linkages" (personal communication December 6, 2005). He claims that "if anything hallmarks Aboriginal health care currently, it is fragmentation," as illustrated by the five distinct jurisdictions that are currently involved in providing services in the Mushkegowuk region. The problem lies in the fact that "everyone thinks they have to control it [healthcare services] within their organization versus providing client-focused care" (Harrold).

Harrold (2005) suggests that there is urgency in Aboriginal health, due to poorer health status of Aboriginal populations combined with the failure of the current system to meet their needs. The lack of a health surveillance system or health information system exemplifies this failure. A priority of the new board will therefore be to hire a health planner, experienced in Population Health, to capture health data for planning and evaluative purposes (Harrold). Increasing life expectancy will demonstrate the success of the initiative. Harrold states, "our goal is to improve health status. No other measure is acceptable." He does, however, discuss the validity of assessing access as an indicator

of short-term success. A change in utilization patterns can provide some indication of the appropriateness or responsiveness of the programs and services offered.

Norway House's Health Integration Initiative

The community of Norway House is comprised of the Norway House Cree Nation (NHCN) governed by the Chief and Council and the provincially recognized, adjacent municipality of Norway House, governed by the Mayor and Norway House Community Council (NHCC). As with the Island Lake communities, the Norway House health services are made up of a complex array of multi-jurisdictional funding and service providers, although many have been transferred to or are administered and delivered by the First Nation. The federally funded, band administered programs include Public Health Nursing and Community Health Representatives (CHR's), Home and Community Care, the Aboriginal Diabetes Initiative (ADI), the Native Alcohol and Drug Abuse Program (NADAP) which they have combined with community-based mental health funding and is referred to as their Community Wellness Program, the First Nations Drinking Water Safety Program, HIV/AIDS, the Canadian Prenatal Nutrition Program (CPNP), and hospital security. In addition to insured services, limited provincially funded programs are also available to the off reserve population such as home care and the northern transportation program (NHHS website).

First Nations and Inuit Health Branch (FNIHB) has also owned and operated the existing acute care facility, the Norway House Indian Hospital, since 1952. Currently, however, the inpatient beds are closed, and have been since early 2005. The Physician's Clinic, located next to the hospital, is jointly funded by FNIHB and Manitoba Health. NHCN has contracted the University of Manitoba's Northern Medical Unit (NMU) to

provide physician and consultant services (NHHS website). In the last two years the NMU has been unable to sustain physician services, therefore nurses practicing in an expanded role have been hired to provide ambulatory and primary care and make referrals to tertiary care as necessary (MacKinnon, Director of Health, NHCN, personal communication, May 18, 2006). The Norway House Ambulance Service supports the provision of acute care, as does the Treatment Access Program (TAP), which provides medical transportation within the community and as well covers the expenses for clients referred or medically evacuated to receive care in urban centres. In addition to transportation, NHCN's TAP program provides boarding home accommodations and transportation in Winnipeg for those community members referred to city-based programs and/or services. Finally, NHCN owns and operates a dental clinic in partnership with the University of Manitoba (NHHS website).

The Norway House's Health Integration Initiative (HII) was one of eight HII projects funded through FNIHB and Health Canada's Health Systems Renewal Initiative. According to Health Canada's website, the objective of these initiatives was to establish "efficient, effective and sustainable health services and programs for First Nations and Inuit through improved integration of federal and provincial/territorial health systems" (2004a). FNIHB Manitoba Region approached Norway House to participate in the HII as a mechanism to address some of the issues they were experiencing, namely the shortage of physicians. It is also important to note that FNIHB was mandated to transfer responsibility for all federally funded hospitals as quickly as possible. Thus, the initiative was to meet the goals of not only the community but also of FNIHB.

The first step in the HII process involved the formation of an incorporated Health Board, Norway House Health Services Inc. (NHHSI) with both NHCN and NHCC equally represented. This major accomplishment was initially somewhat compromised as until very recently the NHCC was unable to legally make decisions as members of the health board. NHHSI has however demonstrated their commitment to working together to achieve seamless, comprehensive health services to all community residents, regardless of status. Community consultations were attempted to develop a shared vision for the community's health service delivery. Broad community consultation had limited participation therefore targeted consultations involving Elders, health care professionals, and youth were conducted (Williamson, personal communication May 19, 2006). Despite these forums and regular communication through newsletters, David Williamson, Vice President of NHHSI, suggests that the questions tabled at a recent community meeting indicate the need to increase the community's understanding of the HII. He is concerned that the public perception, although not based upon fact, is that the nurses and doctors left when the Band took over (Williamson). This is problematic as the entire HII initiative is based upon community governance. Community support will not be forthcoming if these misconceptions persist. Success hinges on individuals and families trusting the community-governed health care system, accessing its programs and services, and responding to the messages delivered by its health promotion/illness prevention team.

A Master Service Plan was developed after identifying the health needs of the community, the services required to meet those needs, and the linkages required to facilitate seamless access to services not available in the community. Williamson describes the model of health service delivery envisioned as, "a working model that

meets the needs of the community" (2006). He claims the Primary health care approach was appropriate because it "provides greater flexibility in services offered, including home care, rehabilitation, palliative care, pre and postnatal care" (Williamson). It also "allows for or facilitates client focused care, providing opportunity for more holistic assessment of clients, families and groups within the community" (Williamson).

Elections for both NHCN and NHCC occurred as the HII project was ending, all of which challenged the sustainability of the process. HII project funding ended as of March 2006, however NHHSI, the HII coordinator, and the partners are continuing their efforts while negotiating for ongoing funding. The new leadership has been oriented to the goals of the initiative and has provided endorsement. The new Chief of NHCN has adopted what has been described as a more consultative, transparent approach to the initiative. The functional plan, which establishes the template for integrating the continuum of health services, is to be drafted next. Williamson describes the functional plan as the process of "assessing clients and making appropriate referrals – an assessment, treatment, and referral plan." Furthermore, Williamson suggests that while the Social Division has not yet been involved in the process, the determinants of health and primary health care approach makes their involvement a logical future step. The capital construction of the will follow the functional plan; however both are subject to securing appropriate funding.

The discussion regarding the successes of the Norway House model related more to process successes, as this model is also in a state of evolution. That being said, improving health status, measured through morbidity and mortality statistics, was viewed by Williamson (2005) as the ultimate success criterion. Williamson suggests that "there

is no singular definition of success, that success is not an endpoint, but rather a doorway" to additional opportunities for success. He describes the HII process as "a web of successes." The success, in his estimation, was in "bringing people together, moving past historical anger and fear", to work together for common goals, with respect for diversities. He describes success in terms of the NHCN/NHCC collaboration which sets the stage for generations to come: "It's the difference between administration and stewardship, where there is an obligation to address the problem, as you are accountable to the community, to those you encounter on a daily basis – your neighbour, co-worker, mother-in-law, relatives…" (Williamson).

For Lisa Clarke, HII Coordinator, success will be measured through morbidity and mortality statistics, but initially with the opening of the new building. She also has additional criteria upon which she will evaluate success, including community understanding of wellness, starting to see things holistically, and reduced dependency on the hospital (personal communication, May 19, 2006).

Evaluation Criteria

In the September 2000 Health Communiqué, Health Canada made a commitment to Canadians "to provide comprehensive and regular public reporting of health system performance" (Health Canada, 2004b). Thus, the federal, provincial and territorial governments began developing comparable performance indicators, which are measurement tools to assist with monitoring, evaluating, and improving the health programs and services of the Canadian healthcare system. The first *Federal Report on Comparable Health Indicators*, measuring health status, health outcomes and quality of service, was completed in 2002. Life expectancy, infant mortality, low birth weight and

self-reported health status measurements were used to indicate the health status of the Canadian population. Changes to life expectancy measured by rates of specific forms of Cancer were used to indicate health outcomes. Quality of life indicators consist of hip and knee replacement rates and the reduction in the burden of illness, injury and disease, such as diabetes. Quality of services indicators include wait times for diagnostic and treatment services, the percentage of the population having a family physician as well as measures of public health surveillance and protection such as rates of communicable diseases, and measures of health promotion and disease prevention, such as rates of teen smoking and physical activity.

The Auditor General's assessment, appended to the 2002 report, was favourable with respect to 43 of the report's 58 indicators, however indicated that data inconsistencies for the remaining 15 indicators made it impossible for her to draw any conclusions regarding their accuracy or adequacy (Health Canada, 2002). Furthermore, inconsistencies were reported in the First Nations data collected. First Nations indicators, drawn from multiple sources, lacked common data standards and definitions. Additionally, the "quality assurance processes for these indicators are inadequate to ensure accuracy of the data" (Health Canada, 2002). The report admits that investments are required to improve the quality and availability of First Nations data. Data reported in the *Federal Report on Comparable Health Indicators 2004* features 18 indicators selected based upon their significance to Canadians as determined through a variety of public forums held across the country (Health Canada). These indicators relate to timely access, quality of care, and the health and well-being of the Canadian population. FNIHB reported on 10 of these same 18 indicators. As previously discussed, the data

indicate continued disparities in health status between First Nations and the general Canadian population. Furthermore, the data indicate that First Nations are not engaging in healthy behaviours at a rate equivalent to the general population; evidenced in significantly higher rates of First Nations teenagers smoking.

Interpretations such as this, which occur out of the historical, political, and socio-economic context of First Nations health, often reinforce negative stereotypes and constrain the responsiveness of the healthcare system by "mistakenly reduce[ing] social inequities to lifestyle choices" (Browne and Syme, 2002, p. 38). With the exception of self-reported health status measurements, this approach leaves little room for cultural differences in health. And while understanding the cultural influences on health is crucial in the provision of competent healthcare, Browne and Syme pose that it "is only one aspect of the complex nexus in which people's experiences are located" (p. 36). Appropriate measurements of First Nations health are needed.

The investments to date have not been directed towards the development of First Nations specific indicators. In April 2002 a report produced for FNIHB identified that the lack of performance indicators limited the ability of First Nation communities to make informed decisions related to the needs for or efficacy of programs, services, and resource allocations (Gibbons). Bartlett (2005) states, "Little academic effort has been expended for research on the meaning – conceptions and dimensions – of Aboriginal health and well-being for the purpose of program development" (p. S25). The result is that the four aspects of life are neither targeted in program development, nor are they considered potential resources or sources of strength to be drawn upon (Bartlett). Maar (2004) summarizes the problem with not having indicators appropriate for First Nations

when she writes, "It is difficult to develop a self-sufficient, needs-driven and evidenced-based approach to health programs in First Nations communities because there is a lack of appropriate culture-based health indicators to measure the impact of new programs" (Maar, p. 59). Bartlett has developed an Aboriginal Life Promotion Framework, by combining a number of medicine wheels, as a "tool for reflecting on life by *organizing thought that already exists*" which "can be used for individual, group or community assessment and planning. (original emphasis, p. S22). Ten Fingers is also addressing this gap in her work with urban Dakota and Dene populations. She has engaged members of these populations living in Winnipeg to identify what well-being means and to develop Quality of Life (QOL) indicators which are meaningful and appropriate for them (Ten Fingers, 2005). Ten Fingers believes that gaining greater understanding of the overall experience of First Nation peoples, including the impact of services, facilitates more informed decision-making and planning. Indicators such as these can provide a report card for progress. Her findings indicate that "culture is an important and key theme of quality of life for urban Dakota and Dene people living in Winnipeg" (Ten Fingers). Ten Fingers' research has led her to conclude that separate and distinct QOL indicators must be respected and maintained for each distinct First Nation population.

This concludes the findings of this research project. The next Chapter will discuss these findings in relation to the stated research objectives, offering a critical analysis of the evolving health care system in Island Lake.

Chapter 6: Analysis

The Principles and Best Practices of Primary Health Care

The first objective of this research required a review of the principles and best practices of primary health care to facilitate an evaluation of the degree to which FARHA is incorporating these into their existing and planned health care delivery system. To review, Primary health care is defined by the WHO (1978) as:

> Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

The principles of primary health care therefore include access, empowerment, and community self-determination. Primary health care balances health promotion with health care, integrates health and social services, and serves both individuals and communities, thus, intersectoral collaboration and addressing the broader determinants of health are important elements. This section assesses these principles in relation to Island Lake's evolving model of health service delivery.

Community Control and Accessibility

The leadership and health organizations in Island Lake are hoping to achieve equity in health outcomes, and while this is the ultimate effect of successful models of health service delivery, this long term goal is not one that can currently be measured. To reach their goal the Island Lake communities transferred control of a variety of health programs from the federal government to the four local health organizations. Other

federal programs, not eligible for transfer, have come under First Nations administration through a variety of alternative funding agreements. These however, often offer little flexibility in terms of program design and deliverables, therefore are not as responsive to community priorities and needs. The local health authorities and FARHA are continuously increasing their level of influence and control over the health care services community members receive by transferring additional programs and proposing the establishment of a Regional Primary Health Care Centre, which will be governed by a board representing each of the four communities. This will improve access to local primary health care services. Primary care is currently delivered through federally employed, expanded role nurses, augmented by visiting physicians and referral to external services. The Regional Primary Health Care Centre will not only enhance the number of services available locally but will also enhance the responsiveness of those services, as they will be designed and delivered to a large extent by community members.

Retaining an outreach clinic in Red Sucker Lake provides evidence of the health leadership's commitment to improved access; although, without road access between Garden Hill and the Primary Health Care Centre, the largest community in the region may have significant concerns regarding their level of accessibility. The proposal for the Island Lake Regional Primary Health Care Centre acknowledges the need to develop transportation services, such as equipped ambulances and the availability of large, fast, safe 'water shuttles' to accommodate travel to and from the Centre. Additionally, the specific spring and fall challenges are recognized: "Transportation experts will need to be involved extensively to decide on best options; and this could include airships,

hovercrafts or the more conventional helicopters" (Reise, Robson and Nadwidny, 2003, p. 26). Community consultations will also be imperative in this decision-making.

As you may recall, accessibility not only relates to physical access, but also to responsiveness; cultural and psychological impediments, involving language, cultural appropriateness, the scarceness of Aboriginal health providers, and the lack of community involvement, can prohibit access. It appears that the principles of community control and access in its broader sense are for the most part being addressed in the Island Lake model. The degree of community involvement is the only element identified that requires additional attention. I turn now to the question of intersectoral collaboration.

Intersectoral Collaboration

As discussed, to make this dream a reality the Island Lake leadership, FARHA, and the local health organizations have collectively established intergovernmental, inter-departmental, and intersectoral partnerships. This level of collaboration provides the linkages necessary to ensure seamless access to those services not available within the community. The partnership approach taken is different from the process of Health Transfer, however; Alex McDougall, Executive Director of Neewin Health Services Inc. (personal communication, October 25, 2005), puts it succinctly, "In this model, First Nations are leading the process." The Island Lake response to the health crisis is a process of decolonization. Similar to the projects Smith (2002) describes as intervening in her book *Decolonizing Methodologies*, FARHA initiated discussions with the governments, set the parameters of the various projects and ensures they remain aligned with their vision. The partners work with them, in new ways, to make the First Nations' vision a reality. Bayer (2005) illustrates this concept in the following discussion:

> INAC is there as well, and that role is just being sorted out because it's a shift for INAC to be involved in health initiatives, and it's long overdue. But it's challenging too, because the role of those individuals, or those civil servants I guess, needs to be clarified and they need to get their authorities.... in line with the goals of the organization. And that shift, it's interesting because the bureaucracy is experiencing that shift.

The shift involves focusing on the social impact of health, the broader health determinants, which is consistent with the primary health care approach.

FARHA has successfully engaged a variety of federal and provincial government departments, the Winnipeg Regional Health Authority, and the University of Manitoba. As previously noted, it is the level of community engagement that remains questionable; an element particularly important when taking a primary health care approach.

Promoting Community Health and Well-being

As mentioned, health promotion and illness prevention activities are the essential underpinnings of a primary health care approach. In Island Lake the health promotion programs are already under First Nations administration and to some extent control, and while FARHA and the local health authorities are subject to the funding formulas dictated by Treasury Board, their transfer agreements provide some flexibility to overcome the rigidity and short-sightedness of project and program specific funding. Evaluations of the community-based health transfer initiatives generally indicate that the community-based transferred services are more responsive to community needs. The public health evaluation (Grimes, 2005b), however, identified that public health initiatives were not considered a priority amid the multitude of responsibilities

shouldered by the many of the Health Directors. Financial accountability continues to be a priority of the federal government and this was reflected by the local health administration, who were devoting greater attention to government accountability than being accountable to the community by supporting the delivery of quality programs and services.

Wood (2005) discusses how the political leadership has inadvertently diverted FARHA's attention to the tasks outlined in the MOU, securing dialysis and hospital services, rather than focusing on building healthy communities through health promotion and disease prevention activities.

> We have been focusing, maybe a little too much, on getting the government's go ahead for the Primary Health Care Centre. We seem to be focusing all our energies on that… Maybe we've been sort of concentrating too much on, focusing on the Primary Health Care Centre. Maybe we need to take a step back and say, well that's still quite a ways away, in the meantime, maybe we should prepare. Do more public health, more awareness; education programs… we need to develop a public health model along with the traditional teachings to a point where people don't have to be lining up at the nursing station for treatment every single day. (Wood)

The issue of political will driving the agenda will be discussed further in a subsequent section. Here, however, the discussion remains focused on community well-being.

FARHA and the local health administrators in Island Lake appear to have neglected the health promotion/illness prevention aspect of the health system to varying degrees, resulting in the loss of public health nurses. While the community-based para-

professionals continue to deliver health promotion and illness prevention programming, the lack of nursing leadership and professional services significantly reduces the effectiveness of the program and the ability to achieve the overall goal of promoting community health and well-being.

Determinants of Health

The population health/health promotion philosophy includes addressing the broader determinants of health, which are largely outside the realm of the healthcare system. The intergovernmental, interdepartmental approach, which FARHA engaged in, a full two years prior to being recommended in the Romanow (2002) report, has demonstrated significant merit with respect to addressing the broader determinants of health. Under the leadership of Andy Wood, partnerships were forged with departments of both federal and provincial governments as well as the University of Manitoba. The partners came together in a unique way, facilitating resolution of some of the broader determinants of health. For example, Loretta Bayer (2005), representative for Manitoba Health, suggested that by having Indian and Northern Affairs Canada (INAC) representatives present, the other partners were able to:

> Involve INAC representatives in a different way than in the past. These representatives could now take issues that have been raised at the boardroom table and influence the bureaucracy in Winnipeg (and subsequently Ottawa), have them talk to their colleagues such as the funding service officer, their housing people, their water people.

The importance of such intersectoral collaboration was concretely demonstrated by the role INAC played in issues related to the provision of dialysis to clients in Island Lake.

Bayer (2005) discusses how she views the impact of the interdepartmental process, the collaboration between health and social services, and suggests that approaching issues intersectorally, from a health determinants perspective, will influence the perceptions of different sectors of community resources and agencies. Once individuals realise that community health and well-being are affected by much more than the availability and delivery of health services they will embrace this much more holistic view, and intersectoral community collaboration will begin.

> Well, I think that's our hope, that people will realise that one affects the other and start to be involved in a different way, to start thinking differently because traditionally we haven't been able, as Aboriginal people, as First Nations people, we haven't given that a lot of opportunity or thought to lead in the changes that affect our wellness. As Aboriginal people, we are provided with housing and social programming based upon policy developed in a manner far removed from our reality: Just given allocations, not really having much choice in the matter or having much of a way to express our opinions and thoughts. We haven't been able to plan and lobby in that way… to pull plans together within a health determinants context. (Bayer)

In this respect, and in keeping with the principles of primary health care, the model of health service delivery that is evolving is also empowering for community members. Not only does it support their world view but it also provides a means of communicating their needs to the broader community in ways that are commonly understood. My interpretation is that it is also decolonizing, as it allows First Nations to define the terms of engagement as they enter into new relationships with government departments.

In Island Lake, issues such as housing, water and sewer infrastructure, education, unemployment, and poverty continue to have a significant impact on the health and well-being of community members. The intergovernmental, interdepartmental, and intersectoral partnership provides a vehicle for addressing these broader health determinants amongst funding partners. Community level intersectoral collaboration and the empowerment that comes with working collectively towards common goals have yet to be achieved. The integration of traditional healing and Elder services is an appropriate first step, and has begun.

Integration of Traditional Healing, Elder Services and Cultural Practices

The Executive Director of FARHA, Andy Wood, speaks to the impacts of colonization on the Island Lake communities and of the realisation that revitalizing the values and teachings of the Elders will assist in bringing wellness back to the communities.

> There was a generation or two, between the Elders and today's generation, where we were still combating the residential school stuff and the outside resource people coming into our communities and doing things for us. So, that generation there, we feel, well, our communities were lost. We were just getting things done for us. But now I'm feeling that this generation right now is trying to look and say; look at all the problems we have in the community. There are all these gang problems, these drug and alcohol problems, these teen pregnancies. Why is that? Maybe some kids haven't been taught properly. Somewhere along the line, the nuclear family, the growing up together, the

> closeness of a family, the traditional teachings… They are, well maybe not lost, but just sort of on the wayside. (Wood)

The incorporation of traditions, cultural practices and Elder services will be discussed in greater detail under the objective exploring the synergy of indigenized models of primary health care in First Nations communities. Wood continues, however, to discuss how the model of health service delivery that is being designed, is being done within the community, incorporating the traditional values and striving to create balance. Wood (2005) describes Island Lake's health service delivery as:

> A model that will encompass all four communities, encompass all four programs, and it would be developed by the communities, the people that live up there. I think we are starting to have more and more people that have lived in the communities and have also been maybe in the city or gone through the education system in the city, so they have seen both sides. So there's that awareness and that possibility of developing programs that would combine all this: traditional ways, ways of thinking, and also the Western model… we can still use those teachings that the Elders are espousing, but at the same time use the western technology, the western medicines. Somehow creating a balance, you know, where we are using both to develop the model that would be best for our community.

Community Participation

Wood speaks in future tense when discussing the development of Island Lake's model of health service delivery, when in fact the visioning exercise that directs much of their work took place in February 1999. The planning that has already occurred is quite extensive and has been based upon the vision shared by the health organizations and the

political leadership at that time. It is FARHA's vision and it was adopted by the Joint Health Governance Working Group, now the Neewin Health Services Board. This vision guides their considerable efforts and achievements; however, the broader community has not been engaged since the inception of FARHA. The result is a perceived lack of commitment to the process. In discussing the challenges they face, Wood claims "probably one of the main problems that we have is getting other program areas and other programs to share our vision" (2005).

Another principle of primary health care is starting where individuals or communities are at. Norway House has embraced this principle in their commitment to community consultation. When opportunities for input were not capitalized on by community members, a different, targeted approach was taken. The results of these sessions, while more successful, has still not resulted in information reaching and understanding gained by the broader community. The board is therefore planning other sessions, learning from previous attempts and trying new approaches to gain community participation, understanding, and feedback. Island Lake can learn from this example of best practice and undertake a series of community consultations; not only to inform community members of their plans, but also to gain their valuable feedback. This facilitates success, as the programs and services can be designed to meet the specific needs identified by their users. It will alleviate some of the challenges they have been facing, such as the Education Authority not supporting the Health Human Resource Strategy. When the entire community shares the vision of a healthy future, and has a common understanding of how they are getting there, many of the current barriers will cease to exist.

The findings indicate that to a very large degree the Island Lake model of health service delivery is incorporating the principles and best practices of primary health care. The model embraces the concepts of community control, access, empowerment, and population health, although nurse recruitment efforts and leadership supports must be heightened to ensure sustainability. Holism is achieved through addressing the broader determinants of health, intersectoral collaboration, and the incorporation of cultural practices which make services more responsive to community needs. The findings also suggest that FARHA and the local health organizations need to direct attention towards community engagement if they are to move forward. The impact of political will on self-determination will be addressed when analysing models of primary health care in First Nations communities.

Models of Primary Health Care in First Nations Communities

The second research objective was to explore models of primary health care that are being used in First Nations communities in order to compare Island Lake's initiatives with what others are doing. Furthermore, examining other models provided opportunity to discover how Island Lake's process can inform mainstream models of primary health care. Each of these areas will be discussed in turn. The discussion will then turn to the political influences in First Nations health; how, in spite of initiatives in self-determination, First Nations agendas can be driven by the will of politicians. Finally, this section will conclude with a discussion of lessons learned from exploring models of primary health care in First Nations communities. These are lessons which all First Nations can learn from as they strive to implement models of primary health care that will close the gap in health status between First Nations and mainstream populations.

Comparability to Other First Nation Models of Primary Health Care

As discussed in the findings, and reported by Josée Lavoie (personal communication September, 2005), the researcher responsible for the FNIHB *Health Transfer Evaluation, 2005,* there is no other community or group of affiliated communities that are moving towards establishing secondary level services in a geographically remote location, where such services were not previously existent. Weenabayko provides a remote, multi-community example of health integration, which includes the pre-existing federal hospital in Moose Factory. In this integration initiative however, the nursing station model is being retained, although the diagnostic services available in the stations will be enhanced. In Island Lake the nursing station model will largely be eradicated. Three of the four communities will access physician and treatment services at the regional centre. Red Sucker Lake will retain an outreach clinic, similar to a nursing station, and access enhanced regional services via air at the Primary Health Care Centre. Public health teams will continue to be located in each community, providing health education, illness prevention, and health surveillance activities, which will be integrated with the Primary Health Care Centre and services. Norway House, while undertaking the integration of existing federally provided hospital services with community-based, community-governed services, is a single, road-accessible community. As such, the complexities are of a different magnitude as are the challenges related to accessibility. What these models do have in common however, is an intergovernmental, interdepartmental, intersectoral partnership approach; an approach which, here in Manitoba, was introduced by FARHA.

Informing Mainstream

Mainstream models of primary health care can also learn significant lessons from Island Lake's indigenized model; however the lessons are grounded in their teachings, their spirituality, their epistemology and their ontology. The values embedded in Island Lake's regional health organization are indicative of their underlying world view, and are expressed in their policies and expectations for individual employee behaviour. Brant Castellano (2004), when discussing the context of Aboriginal ethics, uses the analogy of a tree to illustrate this concept.

> The leaves represent individual behaviours. Protocols and community customs are small branches while ethics, the rules governing relations, are the large branches. Values, deeply-held beliefs about good and evil, form the trunk of the tree. The world view or perception of reality underpinning life as it is lived, like the roots of the tree, is not ordinarily visible. (Brant Castellano, p. 100)

While mainstream Canadian society has a different world view, the values of wisdom, love, respect, bravery, honesty, humility, and truth (also know as the seven sacred teachings or seven grandfathers) are not foreign. They do not however, provide the foundation for management practice. Mainstream management principles refer largely to fiscal management and accountability. From a personal perspective, I would far rather work for an organization where the stated organizational values are aligned with my personal values and are evident in the everyday work environment than for an organization concerned primarily with the bottom line. When presenting these findings at a graduate student colloquium, I posed the question: Who would like to work in an

organization like FARHA, with personnel policies that strive to attain a balance between the personal and work-related needs of employees? The response, although tentative given the forum, was undeniably favourable.

I would suggest therefore, that the values embedded in FARHA's management philosophy have much to offer to mainstream administrative practices in general, rather than health care management and administration specifically.

Political Influences

I turn now to the political arena, where it is important to note the significant contribution of political promises to the momentum and the realisation of Island Lake's vision for local access to dialysis treatment services. Political will also contributed to the Weenybako and Norway House health integration initiatives. It appears that, in Manitoba, the response to the federal government's interest in devolving responsibility for the provision of hospital-based care shifted the momentum from Island Lake's proposal for a Regional Primary Health Care Centre to Norway House's Health Integration Initiative. This subject warrants further investigation. FARHA has technical members of the government departments at the table, whereas Norway House and the ICFNH also have a Senior Officials table. To what degree is the level of representation involved in these initiatives associated with their success?

I suggest that sustaining a level of political advocacy is essential for moving these initiatives and the First Nations agenda forward. Unfortunately, however, this often results in communities competing with each other rather than working collectively; succumbing to the longstanding federal tactics of dividing the interests of First Nations, thereby reducing the impact of their collective strength. This is where the capacity and

stability of the political leadership contributes so significantly to the process of achieving well-being in First Nations communities. A resolution to adopt the *Manitoba First Nations Health and Wellness Strategy: A Ten Year Plan For Action, 2005-2015* was passed by the Manitoba Chiefs in Assembly, providing broad strategic direction for First Nations health and wellness at a regional level, without infringing upon community level initiatives. This monumental accomplishment demonstrates what can be achieved when leaders are in office long enough to attend presentations and briefings, consider recommendations, consult with their council, voice concerns and debate, reach a consensual decision, ratify it and begin work towards making it a reality.

While the 'Ten Year Plan' provides broad direction for all First Nation communities, it does not overcome the competitiveness that results when government partners are unable to effectively participate in or fund joint processes with each individual community or tribal council area. The recommended Intergovernmental Health Council may serve as a mechanism to resolve or eradicate some of these remnant colonial 'divide and conquer' approaches as joint decision and policy making become the norm. Again, however, political support is required for First Nations to realise this vision; this step towards First Nations self-determination in health.

Like the Island Lake vision, the Ten Year Plan remains susceptible to the priorities of external partners. For the needs in Aboriginal health are so great that whatever the government priority, it is likely to be a First Nation's identified need. Thus, in the absence of core funding and vigilance the vision can be skewed or thrown off track. This too presents an area for further investigation. To what degree are First Nations agendas directed by external priorities? To what degree are First Nations able to

take advantage of funded government priorities without compromising their own overall vision? How is that balance achieved? Is core funding for essential primary health care services the answer?

Advocacy and lobbying efforts by First Nations leaders are essential for achieving the momentum required for success; however, caution must be exercised to prevent the insidious undermining of self-determination when capitalizing on external priorities.

Lessons Learned from First Nations Models of Primary Health Care

Political will can be viewed as a double edged sword; necessary to achieve results, yet a potential impediment to self-determination. The FARHA example illustrates how capitalizing on political promises diverted the attention and efforts of the regional health organization away from upstream investments in health promotion and illness prevention to the provision of dialysis treatment services within the community. In keeping with an Indigenous worldview, balance must be maintained. In keeping with the principles of primary health care, the promised dialysis unit was envisioned to be a Regional Renal Health Program, with an extensive outreach health education component planned. This part of the vision has yet to be fully realised. The political momentum seems to have expired now that the provision of acute dialysis treatment has become a reality. This exemplifies the WHO's (2002) concerns regarding the costs associated with the dominant role of acute care delivery in the Canadian health care system; costs which do not positively impact the overall health of populations. Whalley (2006) claims that the delay has largely resulted from the uniqueness of the outreach component and the interdepartmental discussions required to initiate this aspect of the program.

Although the Regional Renal Health Program was part of their overall vision, as is the Regional Primary Health Care Centre, the cornerstones of a primary health care approach are health promotion, health education, and illness prevention. These require ongoing investments. Strengthening public health teams, which provide the health promotion, health education and illness prevention programming, requires concerted effort in the recruitment and retention of nurses. Lessons learned from Shibogama offer insights into the processes required for staff retention; primarily leadership.

As with the Kahnewake experience, managing change and dealing with the apathy of community members who prefer to rely on the health system to fix their ailments are key issues for the leaders and health care providers in Island Lake's health system. The Island Lake health leaders must become competent in transformational change, as improvements to First Nations health involve transformational change. Administrators and program managers must become change agents, developing their capacities in this area, rather than focusing almost exclusively on financial management. This will address some of the turnover experienced in health administration. As the skills necessary to carry out their responsibilities are developed, administrators will become more competent, confident, and enjoy greater job satisfaction. It will also address program sustainability and nursing retention issues, as these are reportedly dependant on supportive leadership. Investing in transformational leadership capacity is therefore an investment in the future health of the community.

Transformational change is also dependant upon a shared vision and public accountability. Support flows when activities or initiatives connect with where individuals and communities want to go. By demonstrating these connections leaders

and health care providers alike gain continued support from the community and/or clients, which in turn facilitates stability in the leadership as well as the workforce.

The last lesson learned from examining First Nations models of health service delivery relates to the Indigenous values embedded therein. The next section will discuss the synergy achieved by indigenizing primary health care models in First Nations communities.

The Synergy of Indigenized Primary Health Care Models for First Nations Communities

The ways in which the evolving Island Lake model of primary health care can inform mainstream, discussed in the previous section, relates directly to this third research objective; exploring the synergy of indigenized primary health care models for First Nations. Here I discuss the ways in which Island Lake is indigenizing existing and evolving programs and services, thereby making them more responsive to community needs.

The Island Lake community, like many other communities, is revitalizing their cultural traditions; however the degree to which this occurring in each distinct community is very diverse. An empowering primary health care approach provides for such diversity. It allows First Nations to revitalize and incorporate whatever traditional knowledge and cultural practices they choose into the reality they are constructing, the vision they are realising. The health leadership in Island Lake and FARHA is respectful of that diversity and therefore the cultural practices that are being incorporated into their programming are either widely accepted in the communities or offered as an option for community members to access as they choose. As discussed, traditional knowledge is

already being incorporated into public health programming in Wasagamack. Prenatal education sessions include Elders' teachings and opportunities for infant blanket embroidery and harvesting medicines. Other initiatives, which address the broader determinants of health, include community gardens and the proposed wild meat and fish food banks. It is envisioned that the Primary Health Care Centre, when established, will offer these traditional foods to inpatients as well as traditional medicines and Elder services either on site or by referral. Additionally, they plan on indigenizing western medical practice. For example, the FARHA board and Neewin Health Services, Inc. (formerly the Joint Health Governance Working Group) envision incorporating traditional midwifery with western prenatal and obstetrical care. Bayer (2005), a member of the Neewin Health Services board suggests,

> Midwifery will be a different approach to birthing and pregnancy. And we medicalized birthing. It's no longer a community event, a family event. It's a medical situation and many of the traditions and activities had centered around the birthing process. Once you conceived and how that is communicated and experienced within the family, and the preparation leading up to the birth would involve the mothers, the aunts, the sisters, the grandmothers, the fathers, the brothers, and other significant others. Those roles have shifted so much that it's really contributed to this detachment that we experience from our parents and from our children.

The Aboriginal Midwifery Education Program will facilitate the practice of traditional midwifery in Manitoba First Nations communities and the Neewin board is confident that once the Primary Health Care Centre is operational, degree prepared, licensed Aboriginal

midwives will be successfully recruited to work alongside other members of the healthcare team.

Building on the Quality of Life Indicators research done by Ten Fingers where cultural continuity was found to be a significant contributor to quality of life, the degree to which Island Lake indigenizes their health services, will not only improve the systems responsiveness, but will also contribute to the community's definition of quality of life. Alex McDougall also discussed the need to indigenize mainstream practices. Being an administrator he speaks to administrative issues.

> Even management practices need to change. For example, non-First Nations policies and procedures don't take into account personal circumstances or the needs of employees. The partnership approach supports growth, so the organization matures into one that functions properly i.e. with sincere attempts and support from management to resolve issues versus discipline. (McDougall, 2005)

The mission statement and management philosophy of FARHA demonstrate these sentiments and reflect the community values of respect, collaboration, balance, and family.

The respect and latitude offered to the staff by incorporating community values into management practices serves to enhance rather than detract from productivity. The FARHA staff is comprised of dedicated, committed employees, who give of themselves for the benefit of the organization and the health of the community. Evidence of this lies in the staff retreat, which took place in the spring of 2005. Due to the demanding nature of their workload the employees did not feel they were able to be away from the office

for three consecutive days, although completion of their work planning necessitated three days. The staff, therefore, left the office early on a Thursday afternoon to drive out to Elkhorn, where they stayed Friday and Saturday returning home Sunday morning, giving equally of their own time to meet the needs of the organization.

Wood (2005) describes how some of the Elders, as a result of residential schooling, carry western values rather than those of respect, reciprocity, and the importance of family and the collective community. He believes that the failure to uphold their traditional values has contributed to some of the significant issues currently plaguing the community.

> They [some Elders] still feel that the youth should learn - shouldn't say anything. And we are feeling that this is why Garden Hill has experienced a lot of youth crime and is bothered with youth gang activity. They [the youth] are rebelling. They're saying, look, we need to be heard! They are doing it the wrong way because they are forever being told: You're bad! (Wood, 2005)

The Youth-Elder Gatherings and many of the public and mental health initiatives are geared towards reconnecting the generations, eliminating negative assumptions and providing opportunity for mutual understanding and growth, completing the circle so the community can regain balance.

Bringing birthing back to the community also facilitates achieving this balance, this wholeness, thereby creating opportunity for wholistic well-being (spelled intentionally with the 'w' to emphasize the whole meaning of holistic). For the circle of life to be complete, however, the end of life must also be returned to the community. The home and community care program assists Elders and their families with the care

required, enabling them to remain in their homes and in the community. Care requirements can however exceed both the family and the program resources available; therefore, expansions to Elder care programs are envisioned. The Regional Primary Health Care Centre will provide three beds for palliative care or respite, thereby supporting both clients who are nearing the end of their lives and their families. The *PATH for the Four Arrows of Health*, completed in February 1999, also depicts an Elders Lodge offering a full complement of Elder services including resident care and meals for those remaining in their family homes (see appendix A). As the *PATH* illustrates, the Elders lodge, with its large circular ceremonial room at the entrance, physically symbolizes their culture and the sacredness of their Elders.

It is evident that Island Lake is incorporating traditional and cultural knowledge, values, and practices into their evolving system of health service delivery, thereby making programs and services meaningful to the population and improving the responsiveness of their health system. But how will this be measured? The next section speaks to objectives four and five; how success is measured both in mainstream health care and in an Aboriginal health context.

How Success is Measured in an Aboriginal Context

Baseline data, upon which to evaluate improvements in health status, are not available for most First Nation communities. Manitoba Health captures utilization of insured services data and the relatively new comparable performance indicators discussed in Chapter 5, which include the traditional morbidity and mortality data. The Manitoba Centre for Health Policy (MCHP) was able to cross reference the health utilization data with INAC's Status Verification System to isolate Manitoba First Nations data for the

1994/95 to 1998/99 period, allowing this cohort of anonymized individuals to be looked at retrospectively and prospectively to determine ongoing trends (Martens, et al, 2002); however, system linkages have not been maintained. The Assembly of Manitoba Chiefs is working with Manitoba Health, MCHP, INAC, and others to make the availability of First Nations data sustainable at a provincial level. While these efforts will greatly improve the ability of Manitoba First Nations to assess the effectiveness of primary health care services through health service utilization data, it will not provide the data necessary for health program planning and evaluation at the community level. Until significant technological investment occurs at the community level, providing databases and the human resource allocations for data entry, local evaluation of health programs will continue to rely on anecdotal accounts, such as that done for the community transfer evaluations; through participation rates, and level of engagement.

The issue of appropriate community-based indicators remains outstanding. Existing evaluation criteria, such as morbidity and mortality statistics, do not accurately reflect First Nations realities. Barlett (2005) poses that,

> Because of the propensity to measure such statistics, researchers, policy-makers, program providers, and society in general identify Aboriginal populations mostly from the perspective of having poor health status. Even helpful intentions, unfortunately, can also personify Aboriginal peoples as victims with limited capacity to address problems. (p. S25)

She also suggests that "options for policy and program framework development that are grounded in Aboriginal meaning and that draw on the strengths and culture of Aboriginal populations are critically needed" (Barlett, p. S26). When considered in conjunction with

Adelson's (2002) and Ten Fingers' (2005) work, it is recommended that First Nations health indicators be community or nation specific, grounded in the collective meaning of health and well-being. A systematic exploration of the meanings of health and wellness for the Island Lake population may therefore be necessary for the development of programs and services which truly respond to their specific health concerns and the criteria by which their success can be measured.

Currently, FARHA is gauging their success on community engagement and participation; the degree to which people are connected and experiences resonate with the participants. There is merit in this level of measurement; although some qualitative analysis of their programs is warranted to document the incredible success of their Creative Arts program for example. Additionally, other Aboriginal groups may benefit from learning of their experiences.

The degree to which others learn from their experiences is also a measure of success for FARHA. The fact that the Education Authorities and other agencies in Island Lake are recognizing the benefits of their collective approach is indicative to FARHA of success. "That's something that we're a little proud of, that the other program areas are looking at Four Arrows and saying, well, they seem to be working. Why don't the other program areas do the same thing?" (Wood, 2005). A further indication of their success is that FARHA implemented Romanow's (2002) recommendation for tripartite partnerships a full two years prior to the release of his Report. The establishment of the Island Lake Regional Renal Health Program with its dialysis treatment component, co-located with the Federal Nursing Station, illustrates the success of that partnership.

Island Lake is currently measuring their success in a variety of ways; although they have not given much consideration to formal evaluative processes other than to meet the requirements of the Health Transfer Agreements.

> We haven't really developed, yet, how we would do our own measuring. I don't think it's because we haven't thought about it. And I also don't think it will take that much for Four Arrows and four communities, the board, to come up with a way of measuring those successes and failures. The system - that we haven't really done much thinking on… I think at some point we will need to develop some formal evaluation processes. But right about now… we're just using the three and the five year evaluation requirements of FNIB. For our own purposes, internal purposes, we're using/gauging the interest and support from the communities for all the different little things that we are trying out. (Wood, 2005)

The FARHA's mission statement, however, speaks to improving health status. "As a regional organization created and governed by the four Island Lake First nations and working cooperatively with their community health services, we strive to improve health conditions and health services in the Island Lake region" (FARHA, 2003). The Memorandum of Understanding between First Nation/federal/provincial partners also highlights the need for comparable health indicators as the tripartite working group was tasked "To create an environment in a timely manner which will allow ILFN [Island Lake First Nation] community members to reach a health status that is comparable to other rural Manitoba residents in a timely manner" (Reise, Robson and Nadwidny, Appendix B, p. 2). In 2000, FARHA commissioned the Northern Research Unit of the University of Manitoba to study the health services and health status in Island Lake. This study

documents the morbidity and mortality data available at the time, including the gaps between the Island Lake and the general Canadian populations. Additionally, it compares immunization rates, and rates of communicable disease. This report as well as Marten's (2002) report, which provides information by tribal council area, can serve as a baseline to substantiate changes in health status over time.

Capturing comparable health indicator data will be important for measuring the success of their health system over the long term, and for monitoring its impact in reducing the existing disparities in health between Island Lake and the general population. Equally important, however, may be the development of community-specific, culture-based indicators that represent Island Lake community members' concept of health and well-being. This data can be significantly complemented by the qualitative documentation of individual's experiences related to specific activities such as the healing through art initiatives.

I turn now to the final research objective; to critically analyse Island Lake's model of health service delivery.

Critical Analysis of Island Lake's Model of Health Service Delivery

This final research objective, which speaks to analysing Island Lake's model of health service delivery, allows me to draw some conclusions related to the overall research question: Does the Island Lake model of health service delivery have the potential to improve health outcomes in the community members? The analysis of the preceding research objectives provides the answer to this question.

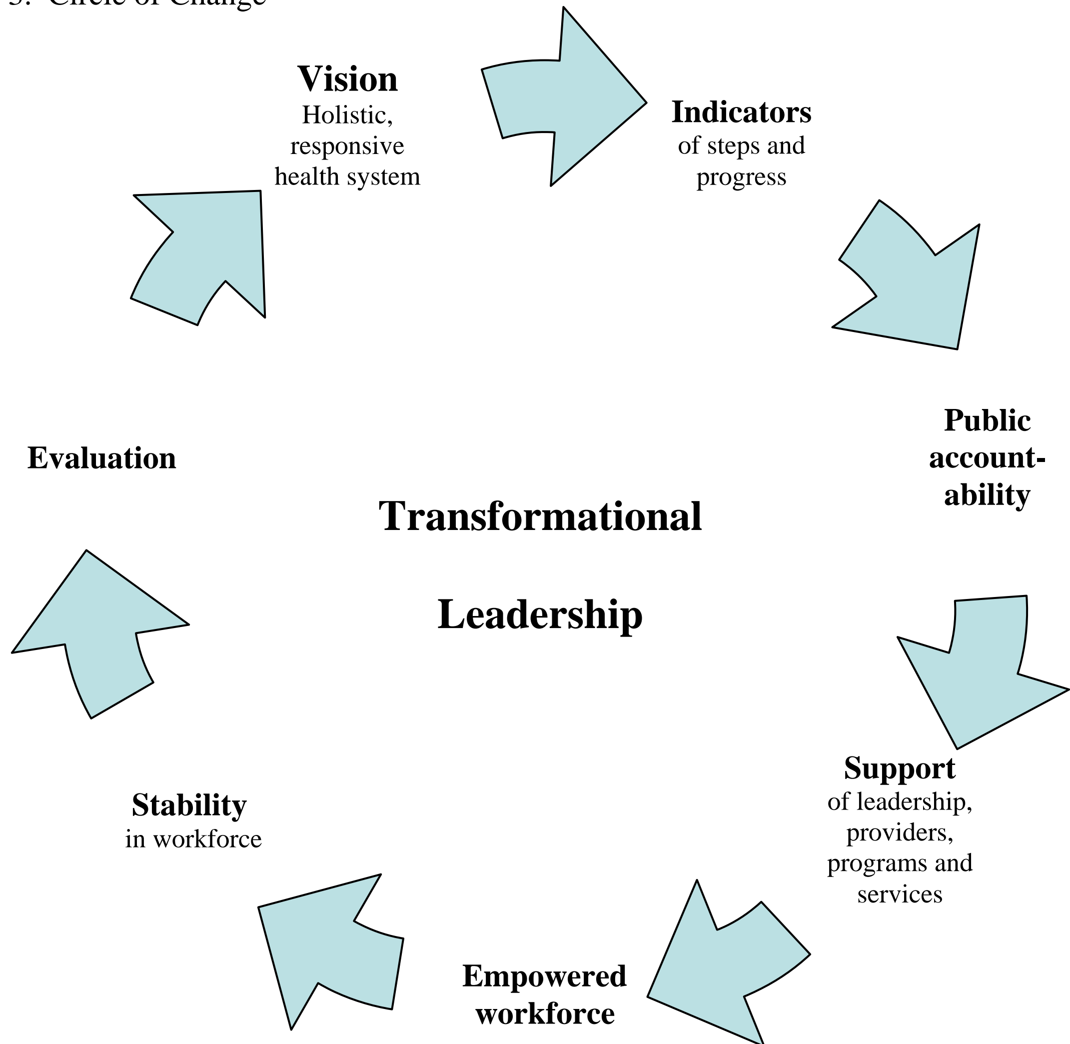
It is evident that FARHA and the local Island Lake health organizations have boldly moved towards realizing their vision, by coming together and working

collectively; by first acknowledging and then capitalizing on the benefits of expanding their circle to include federal and provincial partners; and by forging ahead to accomplish things never before imagined. The result is an evolving, uniquely indigenized model of primary health care that will respond to the needs of the community with investments in community engagement and transformational leadership capacity.

Achievements to date began with a vision; a vision shared by and worked towards by FARHA, its board of directors, and its partners. Future successes will be realised as the resources and networks of the broader community are tapped into. FARHA would be wise to engage the communities in the process they established for regional planning; first defining what health and wellness mean, determining what a healthy community looks like, and then identifying the PATH to getting there. Transformational leadership will ensure steps towards that vision are taken, measured, and reported back to the community, thereby strengthening support for the leadership, healthcare providers, and the programs and services offered. This in turn will empower the workforce and facilitate the stability necessary to progress from service delivery to program evaluation and continuous quality improvement.

This can be depicted as a circle of change resulting from transformational leadership. It begins with a shared vision. Like all circles there is no end, but rather continuous movement. While the circle provides an important visual, it may not capture the complexity of the process, which could be depicted by additional transecting lines. It does however allow for all elements to be addressed, regardless of where you may currently be situated.

Figure 3. Circle of Change



Community-specific indicators, in conjunction with indicators that allow for a comparison of health status with other populations will provide the much needed data for future planning as well as for monitoring the impacts of community control. Qualitative documentation of individuals' experiences will validate program successes and allow Island Lake to share models of best practices with others. Combined, this data will provide the supportive evidence for grant and other funding proposals, thereby enhancing innovative programming opportunities.

Concluding Remarks

In conducting this work with FARHA and the four Island Lake health organizations I have been reminded of the words of Chief Sitting Bull:

Let's put out minds together

and see what kind of future we can make for our children.

In assessing the ability of FARHA to work with the local health organizations, attend to the business at hand, and ultimately achieve the positive health outcomes they envision, the words of one of the partners come to mind. "Look at what they've accomplished so far. I think a lot of people thought there would never be a dialysis unit on reserve paid for by the Province of Manitoba. That's a miracle in itself! Compared to that, it's maybe a piece of cake".

It is not a piece of cake. But it continues to be a journey of exciting possibilities.

Is their model a holistic system of health service delivery that reflects their unique worldview within a context of health promotion and self-determination? Will this model for health service delivery have the potential to improve the health status of the Island Lake community?

FARHA, in partnership with the local health authorities, has demonstrated a capacity to overcome all odds and achieve great things. Certainly their accomplishments to date, established processes, and ability to put their dreams into action and build what has not been built before demonstrate potential. Island Lake has an evolving, uniquely indigenized model of primary health care that will respond to the needs of the community

when they tap into and mobilize the energy and resources of the community with leadership for transformational change.

Cree leader, Chief Poundmaker's words offer wisdom for today's leaders, as they attempt to balance acknowledgements of historical traumas with the need to move forward in self-determination towards community health and well-being.

We all know the story about the man who sat by the trail too long,

And then it grew over, and he could never find his way again.

We can never forget what has happened, but we cannot go back.

Nor can we just sit by the trail.

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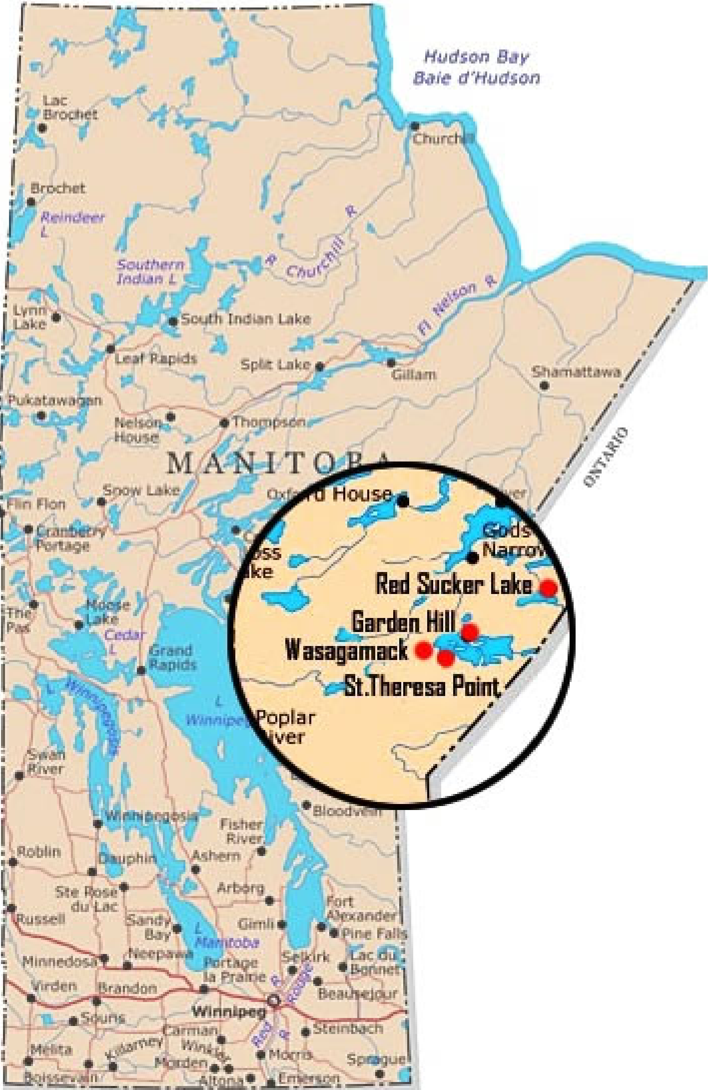
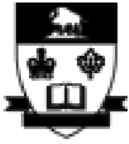
Appendix A: A PATH for the Four Arrows of Health

(Used with the permission of FARHA)

Appendix B: Map of Island Lake
(Copied with permission from FARHA)



Appendix C: Consent Form



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DEPARTMENT OF NATIVE STUDIES
CONSENT FORM

Four Arrows Regional Health Authority's Health Service Delivery Model:
A Critical Analysis
Researcher: Deborah L. Grimes Protocol # J2005:089

This work has been supported by a Masters Grant from the Social Sciences and Humanities Research Council

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of Research:
The research involves a critical analysis of the health service delivery model that the Four Arrows Regional Health Authority (FARHA) is planning, the Island Lake Regional and the associated community-based community health and mental health programs. It will explore how best practices of health service delivery are incorporated into the model and how it indigenizes mainstream Primary health care models, making it more relevant to the First Nations. Historically, health services have been delivered to the Island Lake community by the federal government. The communities have transferred administrative responsibility for their community-based health programs and are now proposing a new health initiative, one of self-determination, to improve the health status of community members. Their unique, collaborative approach may have the potential to improve health outcomes in the region and may serve as a model for other First Nations. This research will help determine this potential and will contribute to the body of knowledge related to Aboriginal health. It will not solve the health crisis but if it assists communities in designing models of health service delivery that are responsive to their needs, then it will have made an important contribution.

Procedures:
Interviews will be conducted with research participants affiliated with FARHA and their health service delivery model providing them opportunity to describe their vision, the services they plan to offer, the methods they plan to employ in delivering those services, how these methods are similar to and different from mainstream primary health care models, and how they intend on implementing their plan. It is anticipated that the interviews will last between one (1) and two (2) hours. One follow up session may be requested for clarification, and another for validation of transcriptions.

Elders will also be approached to offer teachings related to the holistic view of health and their thoughts on how it can be incorporated into health services delivery models. These sessions will be guided by the elders, and will therefore last as long as they feel is necessary. Follow up sessions will also be scheduled according to their teachings and to validate my interpretations.

As a token of respect, and in accordance with community protocol, the Elders will be offered tobacco and/or a small honorarium of fifty dollars for sharing their teachings.

With permission, a small hand held recording device with separate microphone will be used to record all interviews and sessions with Elders. The use of this recording device does not change or remove any of the participants' rights related to the research process. If participants choose, the device will be turned off for some or all of the questions asked during the interview.

Feedback:
Participants will be provided an opportunity to review their transcripts and make any additions, deletions, and corrections they wish. The final document will be provided to FARHA for their dissemination and use.

Associated Risks:
The risks of harm associated with participation are not anticipated to be greater or more likely than those ordinarily encountered in life.

Confidentiality:
Research participants will, upon signing this consent, have their words acknowledged and will be cited and referenced appropriately. Those who request anonymity by checking the box at the bottom of this form will have their identities protected by excluding their names from the interview transcripts, and text. Tapes will be kept on my person or secured in my home until the end of the research project, at which time they will be erased. A coded system will be used by the researcher to link interview with interviewee. No identifying information will be kept with the interview data. The code will be password protected under a separate password in my computer. All other data generated during this research project will also be password protected. FARHA will have access to all data, and because many interviewees will be affiliated with the organization, identities may be discernable amongst the FARHA partners through content. As the partnerships are open and transparent, this is unlikely to be problematic. It is unlikely that unaffiliated readers will be able to identify the participants.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and that you agree to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The researcher, Debbie Grimes, can be contacted at xxx-xxxx, her advisor, Dr. Wanda Wuttunee, at 474-6405. This research has been approved by the University of Manitoba's Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail margaret_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

☐ Check here if you wish to remain anonymous

☐ Check here if you wish to receive a copy of the final research findings

____
Participant's Signature Date

____
Researcher's Signature Date

Interpreter: I have translated all information contained in this consent form to the above named participant. Furthermore, I agree to hold in confidence all information relayed during this research process.

____
Interpreter's Signature Date