# THE DEVELOPMENT OF HEALTH SERVICES IN PEGUIS FIRST NATION: A DESCRIPTIVE CASE STUDY

BY

BENITA E. COHEN

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# ABSTRACT

This study--which is a combination of a history, contemporary case study, and ethnography--describes the development of community health services in Manitoba's largest reserve, Peguis First Nation, located approximately 170 kilometres north of Winnipeg. Using several sources of data--documentation (both contemporary and archival), participant observation, and key informant interviews--the development of health services in Peguis is explored within the context of the overall development of the community as a whole, and within the context of the major stages of federal Aboriginal health policy and health services delivery in Canada over the past century.

Beginning with the circumstances surrounding the relocation of the reserve to its present site, the study traces the shifting locus of control over health care in Peguis from the late 1800s to the summer of 1993. The period before 1980 was characterized by the loss of the traditional medical system in Peguis, and increasing government hegemony over medical services--coinciding with a period of social and economic underdevelopment of the community as a whole. By contrast, the past fifteen years have been characterized by relatively rapid community development in Peguis due to increased political organization and a determination to achieve local autonomy in the community's everyday affairs.

It is within this context that the locus of control over health care has begun to shift back to the community--beginning with local administration of its Health Centre in 1980 and then, in 1991, the signing of a Health Transfer Agreement with the federal government. Peguis' experience with Health Transfer is examined in detail, and the conditions which allowed it to be a generally positive experience--in spite of the limitations of the Transfer initiative--are identified. However, it is noted that two of the most innovative examples of health programming in Peguis have occurred outside the mandate of the Health Transfer initiative--the Peguis Mental Health Program and the Traditional Program--and these cases are highlighted separately. The salient feature of both these initiatives is that, as the locus of control over health care has shifted back to the community, there has been a concurrent revival of the traditional medical system--which is now being integrated into Peguis Health Services' community health programming in a variety of ways.

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of information and provided much insight into the workings of the community. Finally; I would like to thank Nora Cochrane for her hospitality, and for making my stay in the community a very memorable one.

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| | |
|---|---|
| AA | Alcoholics Anonymous |
| AMC | Assembly of Manitoba Chiefs |
| BFT | Brighter Futures Trainee |
| CHDP | Community Health Development Program |
| CHN | Community Health Nurse |
| CHNA | Community Health Needs Assessment (Peguis) |
| CHP | Community Health Plan (Peguis) |
| CHR | Community Health Representative |
| CIH | 'Community Involvement in Health' |
| CRBHSS | Cree Regional Board of Health & Social Services |
| DIA | Department of Indian Affairs |
| DIAND | Department of Indian Affairs & Northern Development |
| DNHW | Department of National Health & Welfare |
| FRH | Fisher River Hospital |
| FRIH | Fisher River Indian Hospital |
| HC | Health Committee (Peguis) |
| JBNQA | James Bay Northern Quebec Agreement |
| LPN | Licensed Practical Nurse |
| MHSC | Manitoba Health Services Commission |
| MIB | Manitoba Indian Brotherhood |
| MSB | Medical Services Branch (DNHW) |
| NADAP | Native Alcohol and Drug Abuse Program |
| NIHB | Non-Insured Health Benefits |
| NMHOP | Northern Mental Health Outreach Project |
| NMU | (J.A. Hildes) Northern Medical Unit |
| PADAP | Peguis Alcohol and Drug Abuse Program |
| PEM | Percy E. Moore (Hospital) |
| PHN | Public Health Nurse |
| PHS | Peguis Health Services |
| PMHSC | Peguis Mental Health Steering Committee |
| RD | Regional Director |
| RN | Registered Nurse |

# CHAPTER ONE

# INTRODUCTION

During the past decade there has been an escalation in the struggle of Canada's First Nations peoples for greater control over their own destinies--including their health. The fact that Aboriginal people bear a shockingly disproportionate burden of ill-health in Canadian society, in spite of the provision of government health services, is well-documented--with death rates for the registered Indian population being at least twice, and sometimes four times, as high as the Canadian average for almost every age group--including infants (Canada 1991).

First Nations have responded by identifying increased control over both the process of health care--i.e. the planning, administration and delivery of health care services--**and** the conditions affecting health as being areas of critical concern for their survival and development (Canada 1983; Fontaine 1991; O'Neil 1993a).

## 1.1 A Review of the Literature

### 1.1.1 Aboriginal Health Policy and Health Services Development and the Struggle for 'Local Control'[1]

While the literature on the health problems of Aboriginal people in Canada is voluminous, there is much less coverage of the historical development of formal health services for indigenous peoples in this country.

Graham-Cummings (1967) provides one of the earliest and perhaps best-known reviews of the development of Aboriginal health services during the period from Confederation to 1967. To his credit, Graham-Cumming begins by acknowledging that Aboriginal people had an impressive medical system, which served them well until the nineteenth century, and he blames the destruction of this traditional system on the combined effects of conversion to Christianity and the impact of exposure to new infectious diseases from European settlers. While acknowledging both the detrimental impact of colonization on the health of indigenous peoples and the tardiness of the federal government's involvement in the provision of health services, Graham-Cummings nevertheless views that initiative as purely humanitarian in nature. He

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[1]Although virtually all of Canada's indigenous peoples share a common experience of societal disruption due to the negative impact of colonization, there are enough differences in the historical circumstances of various groups--especially between those of the Arctic and sub-Arctic--to warrant separate treatment. Unless otherwise indicated, the review of the literature will focus on the populations of the sub-Arctic.

focuses on the achievements made in gaining control over epidemics that were ravaging the indigenous population and the public health efforts made to help these people adapt to 'modern' society.

Young (1984) links the development of Aboriginal health care services with historical changes in social policy. He begins, appropriately, with a discussion of the conflict surrounding the interpretation of federal responsibility for the provision of health services to Aboriginal Canadians. The issue in question here is whether the so-called "medicine chest clause" in Treaty No. 6, and paragraph 73 of the Indian Act, can be interpreted as charging the federal government with a fiduciary responsibility to provide comprehensive illness/health services to Aboriginal Canadians. The former gave the federal government the responsibility of providing a medicine chest in the house of each Indian Agent, and of protecting the people against pestilence and famine, while the Indian Act empowers the Minister to "prevent, mitigate and control the spread of disease on reserves..., to provide medical treatment and health service for Indians, to provide compulsory hospitalization and treatment for infectious diseases..., and to provide for sanitary conditions...on reserves" (quoted in Young, p.258). The federal government has always rejected anything more than the most literal interpretation of these clauses, arguing that its provision of health care services to Aboriginal people is a matter of

policy, based on humanitarianism, and not an obligation. First Nations representatives, on the other hand, interpret the above-mentioned provisions as the basis for a full federal obligation for the health of First Nations people (O'Neil 1993b). This conflict over interpretation has major ramifications for any discussions involving 'transfer of control' of health services (see Chapter Five for further discussion).

Young (1984) describes the period before the Second World War as one of 'benign neglect' of Aboriginal health in Canada. He suggests that the early provision of health services was an integral part of the federal government's policy of assimilation (rather than pure humanitarianism), and that those services were characterized by the dominant philosophy of 'benevolent paternalism' (p.261). A similar point of view is also expressed by Hodgson (1982), who argues that the policies of the Canadian government regarding tubercular Aboriginal patients reflected federal perceptions of native society rather than the clinical nature or needs of the disease. Young describes the post-war expansion of Aboriginal health services simply as part of the general trend toward social welfarism. Hodgson is more skeptical, suggesting that public concern about the menace of uncontrolled tuberculosis in Aboriginal communities to surrounding white populations (and the belief that eradication of TB in Canada would only be possible if it was eradicated in the Aboriginal population)

was the major stimulus toward increased native health services. The following statement, made by the Acting Superintendent of Indian Health Services for the Department of National Health and Welfare in 1946, tends to confirm Hodgson's theory:

> Neither law nor treaty imposes...a duty...[but] the Federal Government has, for humanitarian reasons, for self-protection, and to prevent spread of disease to the white population, accepted responsibility for health services to the native population. (Moore 1946)

By the late 1960s there was an extensive (although far from comprehensive or evenly distributed) network of health care services for Aboriginal people across Canada. However, the 1970s were characterized by increasing dissatisfaction on the part of First Nations with these health services and with the federal government's policies related to the provision of services. The tabling of the White Paper on Indian Policy in 1969 was the catalyst for this discontent, as it was widely interpreted by First Nations as an attempt by the federal government to abrogate its responsibility for providing services to Aboriginal people (Weaver 1981; Young 1984).

A document produced by the Manitoba Indian Brotherhood (MIB) in 1971 is one of the earliest comprehensive statements of the First Nations' perception of their health and health care needs. Aside from providing a review of inadequate health services and poor health status among Manitoba's Aboriginal population, the MIB shows how the underdevelopment of health in First Nations communities was a product of

colonialism and oppressive government policies. They demand that the federal government take full responsibility for the provision of comprehensive health services for Aboriginal Canadians, but with the full involvement of First Nations in all decisions affecting their health care. Although making specific recommendations for the improvement of Aboriginal health services, the MIB also makes it clear that the current poor health of their people is the direct result of impoverished socioeconomic and environmental conditions, and that improvement of health cannot occur without improvements in these other areas.

In one of the few in-depth regional histories of health and health services development, Young (1988) comes to the same conclusion. He traces the impact of colonization on the health of northwestern Ontario's Aboriginal population, and the epidemiological transition from infectious to largely chronic (and preventable) health conditions, and concludes that more and better health services will not automatically result in improved health status. Instead, the achievement of political, economic, and social power by First Nations is seen as a pre-condition for improvement of Aboriginal health status.

Andrew and Sarsfield's (1984) brief, but powerful, description of the impact of colonialism on the health of the Labrador Innu also leads them to a similar conclusion. However, they are more critical of the role of the medical

care system, arguing that it has been part of the broader colonial system which has created powerlessness and dependence among the once self-reliant Innu. Andrew and Sarsfield suggest that neither the expansion of the medical care system, which they describe as self-serving, nor increased administrative control of those health services are enough to solve the problem of poor health among the Innu. Since the problem was caused by a loss of control over conditions affecting their health, then the achievement of self-determination in all areas of Innu life--including control over land and resources--is seen as a precondition for improved health.

The contemporary phase of health services development for First Nations peoples began in 1979 with the implementation of a new Indian Health Policy (Canada 1979a), which claimed to reaffirm the traditional relationship of Aboriginal people to the federal government, acknowledged the importance of socioeconomic, cultural, and spiritual development to attack the underlying causes of ill-health and encouraged the participation of Aboriginal people in the health care system. Young (1984; 1988) offers a brief description of some of the initiatives of Health and Welfare Canada's Medical Services Branch (or MSB) to seek consultation and involvement of First Nations in their health care.

Garro, Roulette, and Whitmore (1986) focus on one of these initiatives--a Community Health Demonstration Project

(CHDP) in Manitoba--which centered on setting up a structure for transferring control of health services to the Sandy Bay First Nation and developing health programs that would be sensitive to the community's needs. Garro et al point out that, although Sandy Bay exercised more control of its health services than prior to the CHDP, the short-term pilot approach meant that they were far from assuming complete control over planning, program delivery, and budgeting.

Whitmore, Postl and Garro (1988) arrive at a similar conclusion. They describe the various initiatives that were either implemented, or escalated, following the introduction of the new Indian Health Policy in 1979--such as health career training programs, the establishment of a Native Alcohol and Drug Abuse Program (NADAP), the transfer of a number of services (e.g. patient transportation) to Band administration, the transfer of Community Health Representatives (CHRs) and some Community Health Nurses (CHNs) to Band employment, and the funding of pilot community-based health demonstration projects. However, Whitmore et al acknowledge that First Nations aspire to more than increased 'participation' in health care.

In 1986, MSB announced a new "Indian Health Transfer Policy" (Canada 1986), which was presented as a positive response to demands by First Nations for more control of their health care services. The three-stage Transfer process (details of which will be discussed in Chapter Five) was

presented as an optional initiative for all First Nation communities within provincial boundaries, which would permit health program control to be assumed at a pace determined by a community's individual circumstances and health management capabilities.

The literature reveals that this policy has been the subject of great controversy and criticism. Culhane-Speck (1989) provides the most comprehensive critique of the 'Health Transfer Policy',[2] arguing that it represents an intensification of the federal government's longstanding intent to abdicate responsibility for the provision of health services to First Nations. She argues that, at best, Transfer offers limited administrative responsibility over health care, but without a corresponding transfer of power whereby that responsibility could be reasonably and effectively assumed by First Nations. This point of view is also expressed by Dion-Stout (1991), who suggests that the Transfer policy illustrates how the federal government and First Nations differ about the meaning of empowerment. Delisle (1988) goes so far as to warn those contemplating Transfer that it might end up **restricting** their ability to control their health services, pointing out that, in Kahnawake, they obtained control of the Kateri Memorial Hospital Centre without Transfer.

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[2]Throughout the remaining text this policy will be referred to as Health Transfer, or simply, Transfer.

There is very little information about the experience of First Nations that have entered into Health Transfer agreements with the federal government. One of the first cases to have been documented is that of northern Saskatchewan's Montreal Lake Band, which opened a Band-controlled Health Centre on the reserve in 1988 (Moore, Forbes and Henderson 1989). In a brief review of the first two years of its operation, in-depth interviews were conducted with ten community members representing a cross-section of the community (including five people originally opposed to the Health Centre). Their perceptions are summarized and indicate that, aside from providing more comprehensive and culturally-appropriate health care, the Band-controlled Health Centre has generated a sense of pride and community cohesiveness.

The Nuu-chah-nulth Health Board in British Columbia signed one of the first Health Transfer agreements in Canada in early 1988 (Read and Watts 1991). The Health Board has reported a number of positive features of the Transfer process: an active seeking of direction from Nuu-chah-nulth leaders, including elders, with the Administrator reporting at all meetings of the fourteen Chiefs and Councillors (the first time that health issues have become a regular part of the agenda at these meetings); communities setting their own health program priorities; active encouragement of health careers among students; development of a role-model program with educational material focusing on success stories of

individuals who have overcome addictions, low self-esteem, suicidal feelings, etc.; and development of a Core Training Program for community workers emphasizing essential community skills (Read and Watts 1991).

However, the Nuu-chah-nulth Health Board reports that there are still numerous challenges facing them, including: getting more Aboriginal people into the health professions; and maintaining staff morale in a changing work situation, especially among health care providers used to working in a policy-directed setting. Perhaps the most serious problem identified by the Board relates to a critical need for a full spectrum of mental health programs. They note that, due to the fact that the Transfer policy doesn't cover these services, they have had to shift resources to try and meet some of the mental health concerns--but the limited resources have resulted in only partly meeting those needs (Ibid).

A description of the Swampy Cree Tribal Council of Manitoba's pre-Transfer (research and development) experience also identifies a number of positive features of that process: a cooperative approach and pooling of resources--including the use of established expertise and management structures--permitted hiring of qualified staff from the communities and contributed to continuity; the process of Health Board and Committee development was successful in bringing the project under community control; the Health Needs Assessment process was effective in building community awareness, ownership, and

involvement in the pre-Transfer phase; and the fact that the process was firmly under the direction of the Tribal Council Chiefs meant that the project was well-integrated with related initiatives in economic development, child and family services, justice and training (Comell, Flett and Stewart 1991).

However, like the Nuu-chah-nulth Board, the Swampy Cree Tribal Council acknowledges that the pre-Transfer process also presented serious hurdles, including: dealing with federal/provincial jurisdictional disputes and questions of nursing liability insurance and the authority of Bands to regulate health on individual reserves; and dealing with extensive, time-consuming documentation required to receive pre-Transfer funds, which detracted from the already-limited time allowed for this purpose (Ibid). The Swampy Cree Tribal Council conclude that it is important to recognize that Health Transfer "is not a solution to all the health problems we face in the communities...[but]...only administrative control. Once that fact is accepted, we can get on with pursuing other objectives to resolve our health needs in other ways" (Ibid, p.46).

Some of the major questions and issues that confronted Saskatchewan's Onion Lake First Nation while it was considering the Transfer option are discussed by Gibbons (1988). At Onion Lake there was general agreement about the need for local control of on-reserve health services and the

presence of a Band-employed Health Coordinator, in order to balance the economic development occurring in the community. However, a number of concerns were raised about the Transfer process, including: complex pre-Transfer requirements and too short a time frame to prepare a comprehensive community health development plan; post-Transfer funding arrangements (e.g. How will Bands handle deficits? Will the Band have sufficient resources to attract qualified staff? Will there be sufficient funds available in the future to respond to new community needs?); the potential for conflict between Band by-laws and provincial regulations in the health care field; the effect on the practice of traditional Aboriginal medicine; the apparent lack of an opportunity for managerial and operational integration of health services with other social and community services, thus perpetuating bureaucratic divisions and fragmentation; and the recognition that local control of community health services does not preclude linkages to district and regional health agencies or programs--necessary for achieving the economies of scale required to provide various specialized health services. Gibbons notes that the Transfer initiative treats the various levels of the system--such as Bands, Districts, and Indian hospitals--as discrete planning approaches, with little attention being devoted to the potential functioning of an integrated, comprehensive system (Ibid).

A review of the pre-Transfer phase at Gull Bay (Gregory

et al. 1992) revealed that the community health assessment process was perceived to be beneficial, in that health committee members actively participated in all aspects of the research process and that community awareness about the Transfer process and health issues was raised. However, it became clear to community leaders that virtually all the health care needs identified during the pre-Transfer process were beyond the scope of changes in programming possible under the Transfer policy. As a result, Gull Bay First Nation halted all further Health Transfer proceedings and instead began working on a comprehensive community development plan that addresses the poor socio-economic conditions which are causing health problems at Gull Bay reserve.

A short term evaluation of Health Transfer (Gibbons 1992), prepared for Medical Services Branch and based on interviews with key informants in eight communities that had signed Transfer agreements prior to March 31, 1991, found that most communities believed that locally-administered health services were more responsive to local needs and had resulted in a greater awareness of health issues. However, there was a general concensus that Health Transfer alone would not result in improvements in the general well-being of First Nation communities.

Another concern about the Transfer process is worth mentioning here. In 1983, the report of the Special Committee on Indian Self-Government in Canada acknowledged the important

role that traditional medicine could play in locally controlled health care services (Canada 1983). Indeed, as Young and Smith (1992) have noted, traditional medicine has played a major role in a number of participatory models of community-based Aboriginal health services in Canada. Most recently; at the Royal Commission on Aboriginal Peoples' second round of public hearings, the panel heard from numerous First Nations intervenors who called for greater acknowledgement and acceptance of Aboriginal concepts of health, treatment, medicine and healing. They suggested that the full range of traditional practices were not only valuable for individual recovery, but equally valuable as a basis for new systems of health, justice and social services (Canada 1993).

However, it should be noted that many Aboriginal people have voiced concerns about the relevance of traditional healing to the Health Transfer initiative. Arguments against inclusion of traditional healing include: the belief that healers are a unique part of the original Aboriginal health care system and, therefore, cannot be 'transferred'; that the traditional medical system should be self-regulated, and not be subject to the evaluation provisions of the Transfer initiative; and that inclusion of traditional healing might interfere with local customs regarding payment of healers (Young and Smith 1992).

It is important to acknowledge here that there are a

number of models of community-based Aboriginal health care which have developed independently from the federal government's Transfer (and other devolutionary) initiatives. In Young and Smith's (1992) review of the literature on the subject **sixty** models were identified, including: regional/national support mechanisms (e.g. National Native Advisory Council on Alcohol and Drug Abuse); local/regional Aboriginal Health authorities (e.g. Blood Tribe Board of Health and the Alberta Indian Health Care Commission); regional Transfer-based (e.g. Swampy Cree) and non-Transfer-based (e.g. Northeast Saskatchewan Community Health Development Process) empowerment approaches; and a variety of local initiatives (e.g. Kateri Memorial Hospital Centre, Anishnawbe Health Toronto, Alkali Lake Alcohol Prohibition Strategy, and the Hollow Water Reserve Group). Perhaps the most interesting model of Aboriginal health care--at least in terms of lessons to be learned--is that of the James Bay Cree, whose experience is worth examining at greater length.

The Cree Regional Board of Health and Social Services (CRBHSS) was established following the 1975 James Bay and Northern Quebec Agreement (JBNQA) and represents the first regional Aboriginal health authority to develop within the context of a 'self-government' model (Young and Smith 1992). In return for turning over some of their traditional land to the province, the JBNQA gave the Cree a cash settlement, hunting and trapping rights on the land that remained, and the

right to control most of the services delivered to the people. One condition of the agreement imposed by Quebec was that health care for the Cree would come under provincial jurisdiction--making them the first group of First Nations people in Canada to have signed away their traditional health care relationship with the federal government (Moffatt 1987).

The CRBHSS directly controls the primary care hospital and nursing stations in seven communities. It has established a culturally-appropriate nursing program and created the positions of Public Health Officer, Public Safety Officer, and Local Environment Administrator (Ouellet and Sutherland 1988), and its Community Health Representatives (CHRs) have developed quite a sophisticated First Aid program for the bush-oriented Cree population as well as carrying out preventive activities in the context of the Cree Methylmercury Surveillance Program (Young and Smith 1992). According to Bearskin and Dumont (1991), in the first twelve years of its existence, the CRBHSS has had a significant impact on health policies and priorities, and the priority given to hiring Cree personnel has had a positive economic impact on communities.

As far as improvements in health status among the James Bay Cree since the JBNQA was signed are concerned, local control of health services occurred simultaneously with major economic development and control of other human services. As Moffatt (1987) notes, any improvements in health status may be attributed as much to those other changes as to control of

health services. Running water and sewage systems have now been installed in all communities, and many new houses built. The James Bay Agreement also resulted in the establishment of an Income Security program, or guaranteed income, for Cree hunters and trappers spending more than four months per year in the bush (40-50% of Cree families were reported to be participating). Robinson (1988) reports that this program has strengthened traditional hunting and trapping pursuits and has had positive health-related spinoffs, such as increased use of nutritious country foods.

However, the degree to which increased control over health and social services has resulted in improved health status for the James Bay Cree is questionable. While it has been noted that they have lower rates of alcohol abuse, injuries and suicide than other Aboriginal groups in Canada (Robinson 1988), the health status of the James Bay Cree still remains much lower than that of non-Aboriginal Canadians, and the Chief of the Chisasibi Band states that after her people were relocated in 1981 there was a great rise in alcoholism, drug use, family violence and family breakups (Dwyer 1992).

Clearly, a number of challenges remain to be met before one can say that the James Bay Cree have achieved self-determination in the area of health. Several observors have noted that there is still a great need to train Cree Board members, health professionals and administrators at all levels (Moffatt 1987; Robinson 1988), and that the high turnover of

non-Cree staff has had a significant impact on the cost of running the Board as well (Bearskin and Dumont 1991). In reference to the CRBHSS' apparent lack of progress in becoming fully participatory, former Grand Chief of the James Bay Cree, Billy Diamond, has charged the Quebec government with sabotaging their part of the James Bay Agreement related to health (and other parts as well) by withholding the resources required for the CRBHSS to adequately carry out its role (quoted in Lechky 1991). Moreover; complex and insidious health problems have emerged as a result of the James Bay hydroelectric development, with fish (the staple of the Cree diet) having been contaminated by the natural release of mercury because of flooding (Lechky 1991).

The JBNQA has resulted in the James Bay Cree having a level of control over their health care system which probably surpasses that of most other First Nations. Even so, they are far from having achieved complete self-determination in the area of health. The fact that the James Bay Cree agreed to provincial jurisdiction over health care and the extinguishment of territorial rights to their lands, and their subsequent inability to adequately protect remaining lands and resources, suggests that the CRBHSS is unlikely to be chosen as a model by other First Nations.

For many First Nations, the struggle for self-determination and community control does not preclude federal government responsibility, and the traditional relationship

between the two parties is considered sacred. The Assembly of Manitoba Chiefs (1992) have stated that any proposal for First Nations to take over maximum control of their health services must be based on several fundamental principles, including: recognition of the right to health services as an inviolable treaty obligation on the part of the federal government; and federal responsibility for provision of financial, human, and physical resources sufficient to make any change process successful and a First Nation health system viable.

In a statement on behalf of the Alberta Indian Health Commission, Clayton (1991) maintains that, in order for self-determination leading towards health to become a reality, resources from the federal government must be made available in a manner consistent with the inherent Aboriginal and Treaty rights of First Nations to self-government and self-determination. She argues that the federal government's current efforts to transfer existing health programs and resources to administrative control of communities have little in common with First Nations' concept of self-determination relating to health--the latter being possible only within the context of overall political, cultural, social and economic development, whereby First Nations gain control of land and other economic resources and real political autonomy.

Finally; after reviewing the literature on First Nations community health programs in Canada, Young and Smith (1992) conclude that it is largely fragmentary and non-theoretical,

and that there is a need for comprehensive, substantive case studies providing details about specific community-based health program initiatives involving First Nations. They also suggest that more case study research is required to determine the relevance and potential role of traditional medicine in the development of community-based health programs.

In summary; the existing literature on Aboriginal health policy and health services development suggests that there is a need for more substantive case studies which trace the development of community-based programs within the broader context of the changing relationship between those communities and the dominant Canadian society. These case studies should focus on the perspective of community members involved in the process of health services development, whenever possible, and should attempt to assess the degree to which current community-based health initiatives are perceived to be empowering--in the sense of providing real control over the process of health care--as well as exploring the community's ability to control the conditions that affect their health.

### 1.1.2 Conceptual Framework

The following case study of health services development in one Aboriginal community--Peguis First Nation--will draw on several theoretical and conceptual frameworks which flow logically from the preceeding literature review. Underlying these, however, will be the following assumptions: a) that

'whole health' (as defined by First Nations) involves social, spiritual, and mental well-being, as well as the absence of disease (Canada 1983); and b) that the level of health of any community is intimately related to the access and control over basic resources--material and non-material--that promote life at a culturally defined level of satisfaction (Baer, Singer and Johnsen 1986).

The latter assumption stems from a theoretical perspective which suggests that health-related issues, such as patterns of disease and even the development of health services, can only be understood within the context of the historical political and economic conditions that produced them (Baer 1982). In the case described here, loss of control over the process of health care and over the conditions of health occurred within the historical context of 'internal colonialism' (Graburn 1981; O'Neil 1986), which resulted in the expropriation and exploitation of the lands and resources of Canada's indigenous populations and their subsequent political, economic and cultural subordination to an immigrant population.

There is, as yet, no single comprehensive framework for assessing First Nations strategies for empowerment, or control, related to health from a broad 'political economy' perspective. Young and Smith (1992) have developed a conceptual framework which outlines processual indicators that can be used to assess and interpret the involvement of First

Nations communities in their health care programs. They base their framework on a World Health Organization definition of "community involvement in health development" (or CIH) as a process to establish participation in the planning, implementation and use of health services and to have greater responsibilities in assessing health needs, mobilising local resources and suggesting new solutions (Oakley 1989). The problem with this conceptual framework is that there is no distinction made between 'participation' and 'control'. Cassidy (1991), on the other hand, does make a distinction between these two concepts, arguing that there are many forms of participation which fall short of actual control and that self-determination involves more than self-management.

In this study it is proposed that a high level of CIH may be a **necessary** condition for empowerment, or self-determination, leading toward health--but that it is **not** a **sufficient** condition by itself. In its broadest definition, empowerment goes beyond increasing participation in decisions affecting the delivery of health services. It is a multi-level social-action process whereby individuals, organizations and communities assume control and mastery over the determinants of health through actions that create a healthier environment (Wallerstein 1992).

The assumption here is that access to, or control over, quality health care services is only one factor that influences health outcomes. Evans and Stoddart (1990)

recognize four groups of factors, or determinants of health, including: biological (genetic endowment), physical environment, social environment, and the quality and availability of health care. There is growing evidence of the centrality of social, economic, and even psychological determinants of health (Hertzman 1993; Keating and Mustard 1993; Thompson 1993). From this perspective, the process of empowerment, or self-determination, leading to health must involve the ability of First Nations to take control over and improve those conditions in their community which affect their health and way of life. As one Aboriginal person stated:

> For a person to be healthy, [he or she] must be adequately fed, be educated, have access to medical facilities, have access to spiritual comfort, live in a warm and comfortable house with clean water and safe sewage disposal, be secure in their cultural identity, have an opportunity to excel in a meaningful endeavor, and so on. These are not separate needs; they are all aspects of the whole (Henry Zoe, quoted in Canada 1993, p.52-brackets in original).

In summary; this case study of health services development in Peguis will attempt to identify the ways that historical political, economic and social factors have affected, a) the health of the community (in its broadest sense--e.g. social, emotional, cultural, and physical health), b) the control and distribution of government health care services, and c) the local-level attempts to gain control of the process of health care and conditions affecting health.

## 1.2 Methodology

### 1.2.1 Research Design

A qualitative design, using a case study approach, was chosen to explore and describe the experience of health services development in Peguis. A qualitative design is indicated for research that delves in depth into complexities and processes, and where the importance of context, setting and the subjects' frame of reference is to be stressed (Marshall and Rossman 1989).

There are two major reasons for choosing a single-case research strategy. First; Peguis has been identified as a First Nation community that is actively attempting to regain control over the process of health care, but one which there is little information about (Young and Smith 1992). It is, therefore, a "revelatory case" (Yin 1989), in that it offers an opportunity to document a phenomenon that has not previously been studied.

The second reason relates to the broader issue of generalizability. There are significant differences among First Nations--in the history of contact and settlement, geographic location and environmental context, size of population and land base, development of health services, level of political and economic development, etc.--not only regionally (e.g. northern vs. southern Manitoba), but also between communities in the same region. Peguis First Nation

Reserve may not be statistically 'representative' of Manitoba's First Nation communities, but this is irrelevant in a study of this sort. The purpose of the case study is not to use it as a 'sampling unit' in order to make inferences about other First Nation communities. A case study relies on analytical (rather than statistical) generalization, with the investigator's goal being to generalize findings to theoretical propositions--just as the scientist generalizes from experimental results to theory (Yin 1989).

### 1.2.2 Sources of Data

In keeping with the principle of using multiple sources of evidence in order to improve the construct validity of the case study (Yin 1989), attempts were made to utilize the following three sources of data during the period that field work was carried out (in Peguis from April to August of 1993, and at the National Archives in Ottawa in October of 1993): a review of documents (archival and contemporary), observation of key community health development events, and interviews with key informants.

Several types of documents were identified for review, both to help frame interview questions and to corroborate and augment information from other sources. It was hoped that federal government documents would provide comprehensive information about the major periods of government-administered health services at Peguis, and that records such as annual

reports might help to identify major health trends in the community. Unfortunately, finding these documents proved to be a complicated process. It was not until early August of 1993 that the National Archives was able to determine the probable location of the documents. Research carried out at the Archives in October of 1993 did unveil some historical records of the organization and provision of medical services to the people of Peguis. However, the documentation was fragmentary, with large gaps in information, especially relating to the provision of public health nursing services between 1940 and 1980. As a result, certain sections of the chapter describing the period of health services delivery prior to 1980 rely heavily on interviews with key informants.

Although there were also large gaps in the administrative records kept by Peguis Health Services (PHS) since the Band took over the local administration of its Health Centre in 1980, a review of available letters, memoranda, minutes of meetings, written reports of events, proposals, progress reports, documents related to the 1991 Health Transfer, and newspaper clippings, did help to reconstruct the major stages and issues involved in the contemporary period of health services development in Peguis.

A second source of data was the observation of, and participation in, key community health development events. These included: attendance at a two-day community health workshop on AIDS, attendance at PHS staff and mental health

committee meetings, and participation in an annual Pow-Wow event sponsored by the Peguis Health Centre.

However, in keeping with the stated purpose of exploring the community's interpretation of events, interviews with key informants were the focus of the data collection phase, and they did provide the richest source of data (see next section for further discussion).

### 1.2.3 Sampling Strategy

The selection of informants (and documents and events, for that matter) was carried out using a 'purposeful sampling' strategy, which involves sampling those people (or documents or events) who will "provide the **greatest opportunity** to gather the **most relevant data** about the phenomenon under investigation" (Strauss and Corbin 1990, p.181--original emphasis). The aim of this type of 'theoretical' (as opposed to 'random') sampling is to sample **events**--including the conditions that give rise to them, the consequences, etc.--rather than sampling persons per se (Strauss and Corbin 1990, p.177).

Since the purpose of the research was to reconstruct the historical development of health care services in Peguis within the context of community development as a whole, interviews began with key elders who were identified (through consultation with several community advisors) as being able to give the broadest history of events in the community.

Sampling then branched out from there, in 'snowball' fashion. According to Strauss and Corbin (1990), purposive sampling proceeds with a concentration on development, density and saturation of relevant categories of information, noting variation and process and gradually increasing in depth of focus until no more variation or detail emerges from informants. While every effort was made to do this, both the nature of the subject under investigation (i.e., health services development in the context of community development), and limitations of time available for carrying out interviews, meant concentrating on those people who were **most** likely to provide information about the various stages of health services and community development in Peguis. This fact, combined with the gaps in documentary evidence, means that there are certain time periods and events (which will be identified in the text) about which we were able to obtain only limited information--and, occasionally, no information at all. It must also be stressed that, due to the need for purposive sampling of key informants who might provide information about the **process** of health services development, the community perspective presented here is that of those informants only and cannot be stated to represent all of the community members in Peguis.

### 1.2.4 Implementation of the Research Plan

The first stage of the research plan began in 1992. From

the outset, the objective was to choose a research topic related in some way to community-based health initiatives that would be considered useful by the community. Therefore, I began by consulting with the Director of Peguis Health Services, Cecilia Stevenson. One of the suggestions made by Mrs. Stevenson during our discussions was that the implementation of the community's new mental health program might be an interesting process to follow, and she encouraged me to visit Peguis whenever possible in order to get more of a sense of what was happening in the community. During September and October of 1992, I met with one or more of the Peguis Health Services staff on eight separate occasions (five of those involving site visits and observation of community health program activities)--which aided in establishing some rapport, becoming more familiar with the general dynamics of the community, and learning about relevant community health issues.

After several months of observation and discussion, it became apparent that the time frame for implementation of the new mental health program would not allow me to follow the process to a point of completion. At the same time, it was becoming more and more apparent that the mental health initiative was part of a broader process occuring in Peguis. As a result, in November of 1992, Cecilia Stevenson and I discussed the idea of shifting the focus of the research away from the development of the mental health program to a broader

study of the development of health services in Peguis as a whole--a project which the Director of Peguis Health Services indicated would be an interesting contribution to the community.

Early in 1993, a formal letter requesting permission to carry out this study was sent to Peguis Chief and Council. Aside from outlining the nature of the research project, this letter included a commitment to share information collected with the community, and the issue of reciprocity was discussed. In addition; application was made to the Royal Commission on Aboriginal Peoples for research funds to support this project. The Royal Commission had expressed interest in a comparative study of case histories of community health development, of which this study would be a component. Both permission from Chief and Council to carry out the study and funding from the Royal Commission were received, and the formal field work phase of data collection began in April of 1993.

In keeping with the principle of carrying out collaborative community health research, early in the field work phase, an on-site advisory committee (consisting of two elders and the Director of Peguis Health Services) was established in order to periodically review the progress of the project, deal with any problems that might arise, and review drafts of final reports. As it turned out, this committee only met formally on one occasion, mostly due to

difficulty in finding a suitable time where committee members were available to meet again. At that time, the committee members indicated approval of the research plan, made suggestions regarding the elders in Peguis who could best provide information, and discussed certain 'sensitive' issues in the community that the researchers should be aware of.

The second step taken to maintain a collaborative approach was the hiring of a student from the community to act as a research assistant. The guidelines used by the Band for advertisement and selection of job applicants were followed, including: posting of the position in major public locations; and formal interviews by a committee consisting of myself, a representative of the Band Council, and the Director of Peguis Health Services (except in one case where an applicant was a relative of the Director and a substitute was therefore found). Applicants were rated on a variety of criteria, including: familiarity with the people (especially elders), physical layout, and services available in the community; openness to both traditional and contemporary approaches to healing; and communication skills. The primary function of the individual chosen was to act as a guide and liason between the researcher and the community. In addition to providing summer employment, it was hoped that this would be an opportunity for a student to learn more about the history of her community and to participate in the research process.

After an initial period during which available documents

were reviewed for background information in order to help frame interview questions, the interview phase began (see section 1.2.3 for sampling strategy). Forty-three interviews were conducted with thirty-eight individuals--i.e. more than one session was required for several of the informants. Thirty-three of those interviewed were members of Peguis First Nation, with twenty of these individuals being either currently or formerly involved in the development and/or provision of health-related services in the community. Ten of the community members were elders. There were two refusals to participate.

Based on advice received by community advisors, individuals who were **not** employees of Peguis First Nation or of the federal or provincial governments were eligible for an honorarium for their participation (the amount which was also suggested by community advisors), and this was explained to every potential interviewee as part of the informed consent process (see Appendix 1 for a copy of the consent form used). Informants were given the option of remaining anonymous. Twenty-one out of the thirty-eight informants gave permission for their comments to be attributed to them.[3] All those

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[3]Direct quotes may or may not be followed by the individual's name in brackets. In the latter case it should be assumed that either the individual did not given permission for comments to be attributed to them, or that identification of that person may have indirectly revealed the identity of others who had requested anonymity. There are also several instances where, even though the informant gave permission to be identified, it was decided not to use a name--usually due

(continued...)

interviewed were given the option of rescinding that permission (or permission to use any of their comments) at any time before, during or after the interview. No one chose that option at the time of the interview. However, one informant approached me several weeks after an interview, requesting to review the written transcript and to delete certain comments that were originally made. This request was honoured and the original data was destroyed. All but one of the informants agreed to have their interviews taped. All but one of the interviews were conducted by me (the other one being conducted by the research assistant). Due to the specific historical circumstances of this community (see Chapter Two), all of Peguis Band members speak English fluently, and there was no need for an interpreter to be present during interviews. However, the research assistant set up the interviews and accompanied me to most of the interviews with community informants.

The only problem encountered during the interview phase of the field work related to timing. Due to the fact that this phase of the study (June, July and and the beginning of August) coincided with the busiest time of the year in the community (e.g. Treaty Days, Pow-Wows and, in general, a lot

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[3](...continued)
to the potential sensitivity of the issue being discussed or in cases that may have made the person vulnerable in some way. It should also be noted that, in cases where more than one individual is cited, informants' comments will be separated by three asterisks (* * *).

of movement in and out of the community), a considerable amount of time was spent trying to track people down. Unfortunately, there were several key informants--including Chief Louis Stevenson--whom we were not able to interview.

### 1.2.5 Data Collection Methods and Analysis

In this case study, both the data collection and analysis were shaped by questions that arose from the literature and the theoretical perspective outlined (in sections 1.1.1. and 1.1.2) above. Based on these questions, general interview guides were developed (see Appendix 2) in order to keep interviews focused on the following issues: individual and community experience of sickness and perceptions of contributing factors to health/sickness in the community; attitudes toward, and experiences with, both traditional and government-controlled medical systems; and the contemporary period of community-controlled health programs, focusing on perceptions of control over the process of health care and conditions affecting health. However, it is important to stress that all informants were not asked to provide information on each topic. As sampling proceeded, and the depth of focus increased, data gathering became more focused on specific areas.

In qualitative studies, data collection and analysis go hand in hand, by continually questioning the data and reflecting on the conceptual or theoretical framework

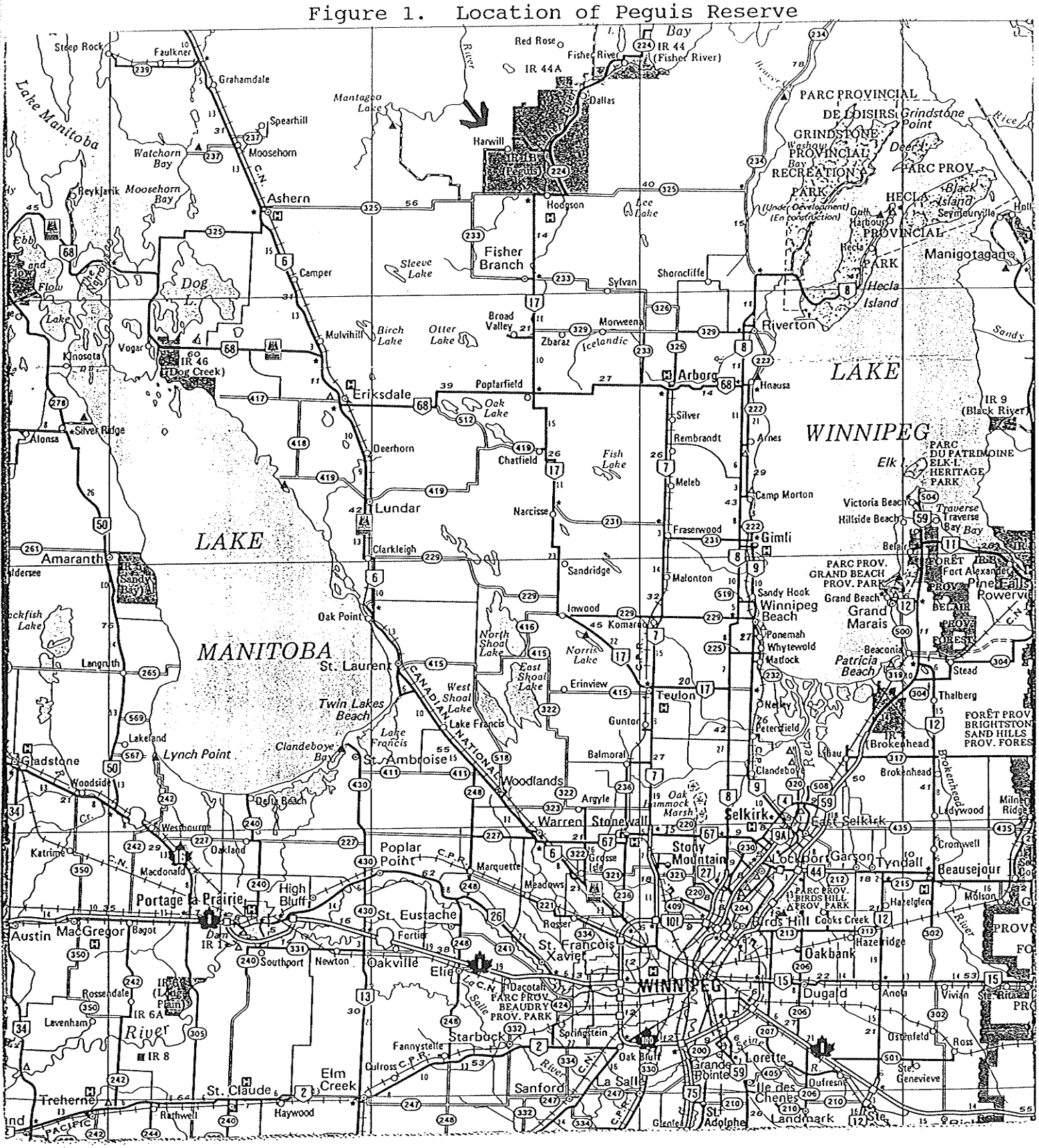
(Marshall and Rossman 1989). The general analytic strategy used in this study was to describe the various stages of health services development, and to identify the community's involvement in, perception of, and control over, that process as well as conditions affecting the health of the community. The data classification scheme outlined in Appendix 3 was designed with this general analytic strategy in mind, in order to facilitate data collection and analysis. The categories reflect the desire to trace the chronological development of health services within its broader political economic context, with a focus on the community's perspective. All interviews were transcribed by the researcher, then the information was coded using the classification scheme and entered into a data base. As the field work progressed, several of the categories in the classification scheme expanded and contracted, but the overall organization did not change.

## 1.3 Structure of the Case Study

The case study of the development of health services in Peguis will be divided into the following sections. The first of these will provide a brief historical overview of the key events in Peguis Reserve's development as a community. The next section will describe the development of government-controlled health services in the community, followed by chapters describing the contemporary period of local administration of community health services from 1979 to 1991,

the Health Transfer experience, and health program development beyond Transfer. The latter chapter will highlight two of the most interesting initiatives that have occurred in recent years--initiatives undertaken to fill identified gaps in community health services in a manner unique to the specific needs of the community. Where appropriate, chapters will begin with an introduction, which will provide specific background information that was not discussed in the more general literature review in section 1.1 above. Also, where appropriate, charts will be provided at the end of chapters to summarize the major developments in health services during the particular time period under discussion.

Figure 1. Location of Peguis Reserve



# CHAPTER TWO

# A BRIEF HISTORY OF PEGUIS FIRST NATION

Although the primary focus of this case study is on the development of health services at Peguis, it is important to recognize that health-related issues do not occur in a vacuum. They need to be understood within the broader social, cultural, political and economic context that shapes them. What follows is a brief description of some of the key events in Peguis Reserve's development as a community.

## 2.1 Origins of Peguis First Nation

Peguis Reserve is located about 170 kilometres directly north of Winnipeg in the central Interlake region of Manitoba (see Figure 1). The total land base is 76,000 acres (roughly the size of the city of Winnipeg), making it the largest Reserve in Manitoba. As of the summer of 1993, there were approximately 2300 people living in Peguis.[4]

Peguis First Nation is a signatory of Treaty #1, signed in 1871. However, the Reserve was not always called Peguis, nor was it always located at its present site.

In the 1830s, the British Colonial Office decided on a

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[4]Figures provided by the Peguis Band Office.

policy of 'assimilation' in order to deal with the indigenous peoples whom European settlers encountered as they moved westward across (what is now known as) Canada (Titley 1986). Under the guidance of government agents and missionaries, Aboriginal people were to be settled in permanent villages and educated in English, Christianity and agricultural methods. One of the earliest examples of this policy being carried out took place in the region south of Lake Winnipeg in Manitoba, where the Anglican Church Missionary Society set up a network of parishes--including the parish of St. Peter's (Czuboka 1960). The difference between this parish and the others was that it was located in an area that had been inhabited in the late 1700s by a group of Aboriginal people and their leader--Chief Peguis.

References to Chief Peguis in the literature refer to him as being Saulteaux-speaking, and most of the older informants whom we spoke to in Peguis referred to Chief Peguis and his descendants as being Saulteaux people. A few of the younger informants used the terms 'Ojibwa' or 'Anishinaabe'--but use of the latter term was rare. According to Steinbring (1981), the term 'Saulteaux' has been used widely historically as an exact synonym for 'Ojibwa'--especially when referring to the Aboriginal peoples in the area around Lake Winnipeg, who are thought to have migrated to the area at the end of the eighteenth century from the Sault-Ste-Marie region of Ontario.

While there appears to be general agreement that Chief

Peguis and his descendants were Saulteaux, certain historical circumstances have led to confusion about the ethnographic composition of the Aboriginal community which developed at St. Peter's during the 1800s. At the same time that the Anglicans were setting up parishes in the 1830s, many Cree people began to move down from the Norway House area of central Manitoba--via the boats which transported trade goods between York Factory on Hudson Bay and the Lake Winnipeg lakehead. The Cree settled with Saulteaux groups who were living south of Lake Winnipeg. There is evidence that this was the case at St. Peter's, resulting in an intermixture of Saulteaux and Cree peoples (Czuboka 1960; Steinbring 1981).[5]

The Anglican Church Missionary Society encouraged the Aboriginal peoples of the area to convert to Christianity and to permanently settle in agricultural pastoral communities, such as St. Peter's. Schools were set up to teach the children English and religion. Chief Peguis was one of the first of the area's indigenous people to convert to Anglicanism in 1838 and to take up agriculture, followed by

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[5]Steinbring notes that "at times the degree of intermixture makes it difficult to classify a band as either Cree or Saulteaux, the people themselves not being completely sure which English label is appropriate" (p.245). This appears to be the case at Peguis today. One person whom we talked to was adamant that the people who moved to the present site of Peguis were Saulteaux. However, several of the elders who were born at St. Peter's and moved to the new Reserve told us that their parents and grandparents spoke Cree. Sorting out this issue of cultural identity will ultimately be up to the people of Peguis to resolve. In the meantime, the large signs at the southern entrances to the Reserve welcome visitors to the "home of the Ojibway and Cree peoples".

his family--except for one son, who was strongly opposed to the conversion and committed suicide shortly after (Thompson 1973).

The tendency of the Saulteaux to be more resistant to both religious conversion and farming than the Cree in the region has been noted elsewhere (Hallowell 1936). There is evidence that, while many of the Cree people in the area followed the lead of Chief Peguis, many of his own Saulteaux people resisted the conversion to both Christianity and agriculture for some time (Czuboka 1960).

While there has apparently been some criticism of Chief Peguis for his conversion to Christianity and acceptance of agricultural settlement (noted in Van Der Goes Ladd 1986), some historians have argued that the Chief was motivated by the recognition that only a transition to farming could stave off starvation in the face of rapid depletion of wild game due to the influx of European settlers (Thompson 1973; Van Der Goes Ladd 1986). In fact; the push to occupy the lands of the North West in order to claim sovereignty did accelerate greatly after 1867, decimating the buffalo herds and resulting in widespread destitution among the indigenous people of the Prairies. Between 1871 and 1877, the first seven numbered treaties secured for the federal government the Indian title to most of the fertile lands in the southern prairie provinces (Titley 1986).

The predominantly Aboriginal settlement at St. Peter's

was officially set aside as a Reserve under Treaty #1 in 1871. The salient feature about St. Peter's Reserve was that it was located on prime agricultural land and, by that time, a significant percentage of its Aboriginal population was engaged in farming, supplemented by small-scale hunting and fishing and occasional contract work. However, the last quarter of the nineteenth century saw a rapid expansion of European settlement as the Canadian Pacific Railway reached the Prairies, and St. Peter's would not escape the negative consequences of that colonization drive.

There is evidence that the health of the community suffered considerably from the introduction of alcohol and large epidemics of diseases such as smallpox during this time, but that complaints by some of the Aboriginal people of St. Peter's in 1873 about a lack of medical services appear to have gone unheeded (Czuboka 1960). Not only is this shocking, given the fact that a physician was situated in the nearby town of Selkirk, but it appears to have been in violation of an agreement made with St. Peter's during Treaty negotiations in 1871.

While only the terms of Treaty No. 6 make specific reference to federal responsibility for provision of medical care, research into the records of the negotiations of other Manitoba Treaties suggest that similar agreements were concluded (Canada 1979b). For example; members of the St. Peter's Band who were present at the negotiations of Treaty

No. 1 (signed at Lower Fort Garry, 3 August 1871) swore an affidavit in December of 1872 regarding agreements made during the Treaty negotiations. An excerpt follows:

> "....That on the day when said Treaty was signed the chiefs did enumerate the articles which they demanded in addition to Treaty money.
>
> That these articles enumerated were agricultural implements for the chiefs and headmen; waggons, horses, harness and suits of clothing; work oxen, bulls, cows, hogs, sheeps, turkeys and fowls; **on each reserve, medical aid** [emphasis mine] and a school and school master; If they wished to take their treaty money in goods they would be supplied at Canadian prices.
>
> That Governor Archibald and Commissioner Simpson did both promise to the Indians that the things demanded should be given, but said that we will not put all these things in the Treaty paper, but we will promise to make a separate paper which will do as well, and you will be sure of these things.
>
> That these things have not been given, and that when they were demanded by the Chief, Henry Prince, at the payment of this year, he could not get no right answer from the Commissioner...." (Source: Canada. Sessional Papers, No. 23A, 1873, p.9. Quoted in Canada 1979b).

It was not until 1897 that a Dr. J.R. Streep of Winnipeg was appointed 'Medical Attendant to the Indians of Clandeboye Agency'--of which St. Peter's was a part (Canada 1897). However, this arrangement seems to have been far from adequate. In 1904, a petition was sent from St. Peter's to the Indian Commissioner in Winnipeg, requesting that a doctor be stationed in the nearby town of Selkirk because many people in the Reserve were "diseased and suffering"--but the request was denied (Canada 1904). Although no reason for turning down the request was given, it seems safe to assume that the government simply did not wish to spend the money--especially since Titley (1986) notes that the government specifically

hired only those physicians who could be relied on "not to attend to Aboriginal people except in cases of necessity," in order to prevent demands for free treatment (p.18).

While there appeared to be little concern for the physical well-being of the people living in St. Peter's Reserve, there was increasing interest in the extremely fertile land on which St. Peter's was situated. During the last quarter of the nineteenth century the Indian Act, which contained specific guarantees to protect Aboriginal lands, was gradually amended to accomodate settlers, municipalities, railways and resource companies who sought cheap land. This trend accelarated after the 1890s when the federal government, disillusioned with the Reserve system--which had come to be seen as a hindrance to assimilation--changed its policy and began to actively encourage the 'surrender' and sale of Reserve lands across the Prairies (Carter 1990).

In 1907, pressure from land speculators and unscrupulous politicians and government bureaucrats--including the Deputy Superintendent General of Indian Affairs, Frank Pedley, who had already participated in no fewer than four fraudulent schemes to personally profit by Indian land sales--culminated in the 'surrender' of St. Peter's Reserve land.[6] Before describing what happened, it is interesting to note that one

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[6]The circumstances surrounding this historical event are discussed in detail in a 500-page document (Tyler et al 1983). Most of the information that follows on the 'surrender' and its aftermath is taken from this source.

of the unscrupulous politicians actively involved in the scheme to buy out St. Peter's was none other than Dr. O. Grain--a recently elected Conservative provincial Member of Parliament with considerable business interests, who had also been the Health Officer for the town of Selkirk for many years. Dr. Grain's apparent lack of concern for the medical needs of the people of St. Peter's is not surprising, given his testimony to the Royal Commission investigating the 'surrender' several years later:

> "....[the surrender] was considered a very good thing for the town of Selkirk, and I am a pretty good Conservative, and it was a Liberal government that was doing this, and I thought if there was anything doing I wanted to have a finger in the pie"....It would be a "good thing"...if that land was opened up to people "who would make good settlers"...(quoted in Tyler et al. 1983, p.293)

Dr. Grain was present at the now-historic meeting which took place in September of 1907 in St. Peter's. According to the terms of the Indian Act of 1876, sale of Reserve land could only proceed after being voted for by the majority of a Band's adult male members. The meeting at St. Peter's was held on very short notice, when many men were out hunting. Many of those who did show up could not fit into the room in which the meeting was held, and it is estimated that about two-thirds of the people who were present did not understand the conditions of the surrender. There is also evidence that alcohol was offered as a bribe. The vote was held with the local Inspector of Indian Agencies, Reverend John Semmes, asking all those who wanted ninety dollars to go to one side

of the room. The vote passed, 107 to 98--according to the government officials who did the count. In spite of witnesses' accounts of mass confusion in the room as Indians were driven around "like cattle" (Tyler et al. 1983, p.324), as well as the fact that the assent of the majority of potential voters had not been obtained, St. Peter's was surrendered for the price of $5000. In 1909, a full two years after the surrender, Band members received six dollars each--a far cry from the ninety dollars that was promised. In that same year, a small number of Band members began to relocate to the new site chosen for the Reserve in the Interlake area. However, the majority refused to accept the surrender.

After much protest by many of the people of St. Peter's, a House of Commons debate in 1910 revealed that, after the federal government bought the St. Peter's Reserve land (eighty-five percent of which was considered the best quality land in Manitoba), it sold 35,000 of the 48,000 acres for less than one-third of its actual value to 'political friends' in what was to become the thriving city of Selkirk. The controversy led to a call by a federal Conservative M.P. in 1911 for a federally-appointed Royal Commission to investigate what had happened at St. Peter's, but this request was turned down by Frank Oliver, the Superintendent General of Indian Affairs. The same day, Manitoba's Premier Roblin appointed three County Court Judges to a provincial Royal Commission to investigate the surrender and sale of the St. Peter's Reserve.

The opinion of the majority was that the surrender of the Reserve had been completely illegal and should be annulled. However, no opinion was rendered regarding the validity of the land sales. The people of St. Peter's were informed that they would be given an opportunity to air their complaints of false representation and fraud at a later date--but this promise was never kept.

As for the federal government's response; the Department of Indian Affairs ignored the conclusions of the Royal Commission, stepping up their efforts to convince the people of St. Peter's to relocate to the new site. Finally; in April of 1916, the House of Commons (also ignoring the recommendations of the Royal Commission) passed legislation allowing the sale of St. Peter's land to proceed.

## 2.2 Relocation and the Development of Underdevelopment

The new Reserve on the Fisher River--named after Chief Peguis--was far more isolated than St. Peter's, but it was chosen by Band representatives because of the abundance of whitefish in the area and the potential for farming. Several elders in Peguis who were born at St. Peter's still have vivid memories of the move to the new location. Most people appear to have taken the northern route, by boat, to Fisher Bay, and then they travelled south along the Fisher River by oxen because the bush was too rough for horses. They had few supplies, and the task of clearing the land and building homes

was not an easy one. In addition; one of the conditions of the surrender of St. Peter's Reserve had been a promise by the government to provide agricultural implements and seed to those people who relocated to the new site. According to a great-grandson of Chief Peguis, Chief Albert Thompson, this never happened (Thompson 1973).

Nevertheless; despite all the hardships, the elders recall that, at least until the 1940s, most families managed to eke out a living through small-scale farming. Some people raised hogs, chickens, and even cattle. Everyone had gardens and grew their own vegetables, and fish, wild meat and wild berries were plentiful. Most of the houses were built from tamarack and spruce logs. There was no running water and indoor plumbing, but the elders remember that the Fisher River was clean and clear, and everyone would haul water from its springs.

After the railway line came to the nearby town of Hodgson (around 1914), men would cut cordwood and sell it in town, and families also harvested and sold seneca root for extra income. Seneca root and its extracts were once used in as many as fifty types of medicines, including cough remedies and laxatives. Apparently, the Interlake region of Manitoba was the main source of the world supply of seneca root for many years, until the 1950s, when a replacement was found for its original uses and the market for the herb began to steadily decline (Interlake Spectator 1986). The elders recall that

everyone had to work hard and keep busy in order to survive. Then, things began to change.

Without access to any documented evidence, it is hard to say for sure when--or why, exactly--conditions began to deteriorate in Peguis. From what the elders told us, the 1940s appear to have been a turning point in the community's history. Many of them recall that, when people began to receive regular social assistance payments, they stopped making their own gardens and began to buy less-nutritious food at the store in Hodgson.

However, there is at least some evidence of a more active form of underdevelopment of the economy in Peguis. Several informants remember that you could not sell or trade livestock or produce without receiving permission from the Indian Agent, and they suggested that certain Indian Agents may have had an influence on the closing of economic opportunities. Unfortunately, it was not possible to review Department of Indian Affairs archival records during the time available for this study--nor was it within the scope of this study to do so. However, even without documented evidence, the allegation that Indian Agents undermined economic development on the Reserve is entirely plausible.

A recent historical study of Aboriginal involvement in agriculture on the Prairies during the latter nineteenth and early twentieth centuries shows how Canadian government policy actively restricted and undermined Reserve agricultural

development (Carter 1990). Beginning in the 1880s, a series of amendments to the Indian Act severely restricted Aboriginal peoples' ability to sell their products and purchase goods by requiring a permit from the local Indian Agent. The rationale given for these restrictions was that Indians were utterly helpless in managing business transactions and that they needed to be protected from unscrupulous merchants, but it was also believed that they should not be permitted to sell anything as long as they accepted government rations and did not raise enough to feed their own families. A pass system, restricting movement of Aboriginal people in and out of their Reserves, was utilized well into the 1930s in some areas, while use of the permit system also restricted access to credit and kept operations small and implements rudimentary.

The official rationale for encouraging Aboriginal farmers to adopt small-scale 'peasant' farming was that it was "the manner best calculated to render [the Indians] self-supporting when left to their own resources" (Carter 1990, p.210). However, the motivations behind the government's Reserve farming policies after 1880 had little to do with the encouragement of agriculture on Reserves. Carter suggests that the government's central concern was to erode the Aboriginal land base until eventually Reserves were abolished altogether--which, combined with a fear of successful agricultural Band units that might have a competitive advantage over nearby non-Aboriginal farmers, were probably

the major motivating factors.

It is not unrealistic to speculate that similar concerns existed regarding Peguis--especially since the people of St. Peter's had a history of being relatively successful farmers--and that certain Indian Agents may have blocked economic opportunities. One informant in Peguis referred to the Indian Agent as the "Supreme Commander". This is interesting, since a Department of Indian Affairs official compared the role of the Indian Agent in 1935 to a military Unit Commanding Officer--"responsible for every matter affecting the interests of the Indians under his charge, including the development of agriculture or other local industry..." (Stone 1935, p.82). The fact is that Indian Agents continued to have complete authority over all business transactions in Peguis (and other Reserves) until the 1950s. This, combined with a lack of financial resources needed to compete with other farmers in the area, and the closing of the railway line in Hodgson in the 1970s, would cause a further decline in the economy of Peguis and had a further social impact on the community (see Chapter Three for further discussion of this period).

In 1966, the federal government published the results of a two-year study, which was undertaken in order to determine the social, economic and educational situation of Aboriginal people in Canada (Hawthorn 1966). This document became known as the 'Hawthorn Report'. The following information about Peguis is taken directly from that report. Peguis was one of

thirty-five Reserves across Canada that were selected for a more detailed study. The results were startling. By 1964, the per capita income in Peguis was only ninety-nine dollars--the third lowest of the thirty-five Reserves surveyed--and one hundred percent of the households were receiving welfare assistance. Only one percent of the households had running water (by this time, according to informants, the Fisher River was seriously polluted, causing frequent outbreaks of diarrhoea) or indoor toilets, and only forty percent of the houses had electricity. Almost forty-eight percent of the population of Peguis was under the age of sixteen, and only four percent of the population were educated past grade nine. Peguis was classified as a depressed, under-developed community--one of the poorest in Manitoba.

Living conditions do not appear to have improved significantly during the 1970s. One twenty-year old informant recalls that, in 1979, her family lived in a small rat-infested house with no indoor plumbing. She and her sister used to carry five-gallon pails of water to the house at least three times each day from the well that fed the cows.

## 2.3 Community Development in the Contemporary Period

By contrast, the 1980s and early 1990s have been a period of dramatic community development in Peguis. Some of the accomplishments that have been achieved include[7]: a new

[7]Information provided by Peguis Band Office.

community hall and recreation centre; new Emergency Centre (ambulance and fire); a shopping mall (containing a laundromat, I.G.A. supermarket, several businesses operated by Peguis residents, and--as of July 1993--the first Royal Bank branch on a Reserve in Manitoba); a new Health Centre, drug and alcohol Treatment Centre, and Personal Care Home (see Chapter Three for details of the latter three initiatives); special housing for elders; and more than 266 new houses, additional roads and hydro lines. Most households on the Reserve now have indoor plumbing.

Many new permanent jobs have been created during this period, and the unemployment rate appears to have dropped to an estimated fifty- to fifty-five percent (official figures were not available, and there are still seasonal fluctuations). While this level of unemployment is excessive compared to Manitoba's non-Aboriginal communities, it does compare favourably to other Manitoba First Nations. However, according to the Band's Economic Development Officer, Larry Amos, Peguis still receives approximately four million dollars in welfare payments each year.

This contemporary period of economic development in Peguis is a fascinating one. Unfortunately, it is beyond the scope of this study to deal with the subject in detail. However, it seems safe to say here that the leadership of Chief Louis Stevenson and his administration since 1981 has been a key factor in much of the economic progress that has

been made in Peguis.[8] The implications of this period of rapid community development on the development of health services in Peguis will be discussed in more detail in Chapter Four.

To summarize; this brief community history of Peguis offers a classic example of internal colonialism in Canada--whereby the expropriation of land and subsequent cultural, political, and economic subordination of this group of Aboriginal people resulted in the transformation of a once-self-sufficient community to a state of almost total dependence in less than half a century. However, it also provides an example of the contemporary struggle of First Nations to regain control over their lives. In the next chapter we will explore the development of formal health services in Peguis within this historical context, beginning in the years following relocation to the new Reserve.

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[8]For a detailed account of Louis Stevenson and his (often-controversial) administration, see; York 1990, pp.235-246; and a biographical article in the Winnipeg Free Press, 19 October 1986, p.9.

# CHAPTER THREE

## DEVELOPMENT OF GOVERNMENT HEALTH SERVICES

As we have seen, the period before relocation to the new Reserve was characterized by neglect (which could not be described as 'benign') of the health of the Aboriginal people of St. Peter's--during a time when health status was deteriorating significantly in the face of rapid European settlement of the Red River region. The St. Peter's experience was not an anomaly, but rather a typical example of the low priority given to the provision of medical services to Aboriginal people by the federal government in the latter nineteenth and early twentieth centuries (Graham-Cumming 1967; Young 1984).

Before exploring the development of formal[9] medical services in the new Peguis Reserve from 1909 onwards, it is important to note that there had been a well-established

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[9] The word 'formal' is used here to describe those medical services provided by non-Aboriginal practitioners as part of the bureaucratic, Western or biomedical care system. Use of the term is not intended to suggest the superiority of the biomedical system over the traditional Aboriginal medical system--which was well-organized and equally 'formal' in traditional Aboriginal societies.

indigenous, or traditional, medical system operating among the Aboriginal peoples of the southern Lake Winnipeg and Red River regions during the 1800s. However, this system also suffered under the impact of colonization.

## 3.1 Subjugation of the Traditional Medical System

For the Lake Winnipeg Saulteaux (as for the southern Ojibwa people in general) there is evidence that the Midewiwin Lodge, or Grand Medicine Society--often referred to simply as the Midewiwin, or Mide--was a major institution in their society at the time that European settlers arrived in the Lake Winnipeg-Red River region (Hallowell 1936; Steinbring 1981). While the origin of the Midewiwin is a matter of some debate--'ancient tradition' vs. a social movement which developed among the Ojibwa in response to the social disintegration caused by colonization during the eighteenth century (Harrison 1982)--it is clear that the central focus of the Society was on the maintenance of good health through training in the traditional medical arts. However, numerous non-medical activities were associated with annual gatherings, and there was a strong spiritual emphasis in many of the Midewiwin rituals and ceremonies (Steinbring 1981).

There is no doubt that many of the Saulteaux people in St. Peter's were active members of the Midewiwin Society--including Chief Peguis before his conversion to Christianity--and there is evidence that many of the Mide healers put up the

greatest resistance to both religious conversion by the Anglicans and agricultural settlement at St. Peter's (Czuboka 1960; Hallowell 1936). Unfortunately there is no evidence of Midewiwin ceremonies being conducted at St. Peter's after the 1870s (Hallowell 1936; Steinbring 1981), and it is unclear what happened to those people who were members of the Society.

It was during the last quarter of the nineteenth century that efforts to assimilate Aboriginal people accelerated, and it is possible that many of the remaining holdouts who were resisting conversion at St. Peter's eventually bowed to the pressure or else died out naturally. However, the fact that the son of one of the Mide leaders from St. Peter's later became headman of the Midewiwin near the Bloodvein Reserve (Hallowell 1936) suggests that at least some of the Mide leaders who resisted assimilationist efforts may have left St. Peter's during this period and gone to some of the Reserves in the region where Midewiwin ceremonies and resistance to Christian conversion persisted through the first quarter of this century.

According to both written sources (Thompson 1973; Van Der Goes Ladd 1986), and interviews with elders, the people who relocated to the new Reserve on the Fisher River were those who had already converted to Christianity and there is no evidence that a Midewiwin ceremony was ever held on the Peguis Reserve in the years following relocation (see Chapter Six for discussion of contemporary events). However, as we

will see, this does not mean that traditional medical knowledge had been entirely lost.

## 3.2 Early Medical Services: Prior to 1940

Before 1932, it appears that medical services provided by the federal government were limited. Records show that, in 1909, Dr. J.R. Steep (the physician from Winnipeg who had acted as the Medical Attendant to the people of St. Peter's since 1897) requested that he be allowed to continue to serve the people of St. Peter's after they relocated to the new site on the west side of Lake Winnipeg because the railway would reach within forty miles of the new Reserve (Canada 1909a). Several months later, it was recommended that Dr. Steep visit Peguis and the nearby Fisher River Reserve quarterly (Canada 1909b), but there is no written evidence that this actually occurred. Department of Indian Affairs (DIA) records do list the names of several medical practitioners who, between 1912 and 1924, received ten dollars per day for visiting the Interlake Reserves and accompanying the Indian Agents on Treaty payment trips (Canada n.d(a))--including Dr. O. Grain, who participated in the illegal surrender of St. Peter's Reserve in 1907 (see Chapter Two).

Many of the elders who were interviewed remember that a doctor would occasionally travel to Peguis on horseback from either Arborg or Selkirk and provide medical services out of a local dwelling, or sometimes go from home to home visiting

the sick (through word-of-mouth). They also recall that some medicines were kept at the Anglican Mission House on the Reserve. However, they suggested that, more often than not, there was no doctor available--a perception which is supported by a series of DIA memos in 1917 indicating that arrangements for a doctor to go to the Fisher River Indian Agency (the DIA's administrative designation for the area around Peguis) had fallen through (Canada 1917). In December of 1919, Dr. J.S. Sutherland of Fisher Branch (a town approximately thirty kilometres south of Peguis) was appointed to serve the three Reserves of the Fisher River Agency (the other two being Fisher River and Jackhead) on an 'on-call' basis--i.e., when called by the Indian Agent. However, Dr. Sutherland resigned this position within six months of his appointment and Dr. O. Grain was then assigned to provide services 'on call' from Winnipeg--170 kilometres to the south (Canada 1920)! The fact that it was up to the Indian Agent to decide who should see a physician and to send for one may partially account for the fact that visits from physicians seem to have been limited. However, it is likely that Deputy Superintendent of Indian Affairs Duncan Campbell Scott's emphasis on restraint in spending on Indians in 1913 (Titley 1986) was also a factor.

Many of the elders recall that, when there was no doctor visiting the Reserve, people would make a four- to six-day round trip on horseback through the bush to the town of Arborg in order to see the nearest physician. Once the train reached

the nearby town of Hodgson, the Indian Agent might authorize a trip to Winnipeg in the case of very serious illness. However, given the following account of one woman's experience as a child, it was lucky that anyone survived such a journey:

> ...I took sick at home and my dad put a mattress on a wagon and drove me from Dallas [north end of Peguis Reserve] to Hodgson. I had to stay there overnight for the train. They put me in a box car the next morning with my mom. They put me on some boards and a pail turned upside down for my mom to sit by me....At that time, you got on the train in the morning and you got to Winnipeg in the evening. It was when the train first came to Hodgson the first year. The train would have to stop at every station to pick up cord wood....Then, when I got to Winnipeg, they sent me on to the Selkirk General [hospital in Selkirk, fifty kilometres north of Winnipeg].

As far as the general health of people in Peguis is concerned, the earliest documented references found relate to a smallpox epidemic in 1915 that was sweeping through St. Peter's and other Reserves in the Lake Winnipeg region--including the Fisher River Reserve to the north of Peguis. While it appears that no one in Peguis had yet developed the disease, the fact that people were beginning to arrive in greater numbers from St. Peter's, and that they had to pass through the Fisher River Reserve to reach Peguis, led to efforts to vaccinate the people in the latter reserve. The physician who initially went to carry out the vaccinations apparently met with some resistance from a group of people at Peguis who refused to be vaccinated, and he suggested that the Mounted Police accompany the physician who went back to the

Reserve (Canada 1915a). A report written a few months later indicated that vaccination at Peguis was proceeding without incident, although no mention is made of the role that Mounted Police may have played (Canada 1915b).

The first references--both written and oral--to serious disease in Peguis relate to the outbreak of Spanish influenza that swept many parts of the world during 1918 and 1919. Unfortunately, it was in 1918 that the position of Chief Medical Officer for the Department of Indian Affairs was officially abolished "for reasons of economy", and so there was no one to coordinate a medical response to the epidemic, which killed over four thousand Aboriginal people in Canada (Titley 1986, p.87).

In a letter to the Secretary of Indian Affairs in early November of 1918, Dr. O. Grain stated that many physicians (including himself) were ill and unable to attend to the sick in the Reserves, but that some evangelists had offered to go to Peguis and Fisher River Reserves to act as nurses (Canada 1918a). One of the physicians who did manage to visit Peguis in November of 1918 reported that 200 people in the community were sick with the Spanish flu, the schools and churches on the Reserve were closed, and thirty-three deaths from the flu had occurred (Canada 1918b). The Indian Agent for the Fisher River Agency, T.H. Carter, reported in April of 1919 that a total of forty-four people died in Peguis during the influenza epidemic (Canada 1919). The elders who were alive in 1918/19

recalled that at least one or more family members had been seriously ill or died during that outbreak.

Aside from a letter from the Secretary of Indian Affairs to Indian Agent Carter in 1921, advising him that anyone who was working in Peguis must pay for medical services (Canada 1921), there are few references to either the provision of medical services or health status in Peguis until 1923. In January of that year, Dr. James Bird, who was visiting the Reserves of the Fisher River Agency from Winnipeg on an 'on-call' basis, reported many cases of tuberculosis. He recommended that the 1500 Indians living in the area should have regular medical visits twice per month and suggested that the services of a good qualified nurse would be helpful (Canada 1923a; 1923b). After visiting Peguis again in early March of 1923 during a flu epidemic, Dr. Bird indicated that he was trying to set up the Church of England dispensary (in the Anglican Mission House) more efficiently, and he requested "half a gallon of the best Brandy because it is the deciding factor in treating pneumonia which follows the flu" (Canada 1923c).

Increased funding under the Mackenzie King administration during the 1920s (Titley 1986) may explain why Indian Affairs agreed to hire a permanent Medical Officer for the Fisher River Agency. In May of 1924, Dr. Bird became the first physician to reside (at least part-time) in the 'Resident Halfway House'--'The Halfway' being the popular name for the

Fisher River Indian Agency buildings, located in the middle of the Peguis Reserve. According to Dr. Bird's contract, he was to receive a salary of $3000 per year, and he was responsible for providing medical care to the residents of Peguis and other Reserves in the region "in ordinary illness and epidemics and to perform operations when necessary" (Canada n.d(a)). The Department of Indian Affairs supplied the drugs to the doctor (and to the missionaries who ran a dispensary) upon receipt of a requisition.

In 1922, four travelling nurses had been hired by Indian Affairs for all of the Prairie provinces, and they were responsible for visiting Indian schools and communities to give instruction on hygiene, nutrition and infant care (Titley 1986). Official records of visits made by these public health nurses to the Fisher River Agency could not be located. However, a letter from the Reverend of the Fisher River Anglican Mission indicates that a Miss Brandon was sent as a nurse to the Agency beginning in the winter of 1924 (Canada 1925). It is not clear whether she was employed by the Mission or by Indian Affairs, but it appears that she also resided at the Halfway.

In 1927, a medical branch in the Department of Indian Affairs was finally established and Dr. E.L. Stone was appointed Medical Superintendent of Medical Services. It has been suggested that it was mainly the increasing friction between field doctors and the departmental accountant who

taxed their fees that motivated this development, and that Dr. Stone was hired mainly to "keep peace in the family" (Graham-Cumming 1967, p.125). Nevertheless, Dr. Stone is credited with developing a good foundation for future progress by implementing Public Health Regulations defining responsibilities and powers of Indian Agents and departmental physicians in handling outbreaks of communicable disease, greatly expanding personnel and facilities, and setting in action numerous surveys and studies to establish the health status of Aboriginal people (Moore 1946; Graham-Cumming 1967).

While it may be true that medical services became more organized after 1927, there is evidence that concern for the health of First Nations peoples remained a low priority among government officials--and that, at times, this resulted in what could only be described as **gross** neglect. Early in 1929, Dr. Bird, the Medical Officer for Fisher River Agency, wrote a letter to Dr. Stone in Ottawa. In this letter, Dr. Bird began by stating that it was his impression that the work of the Medical Officer (himself), the travelling nurses, and the missionaries had resulted in a decrease of infectious diseases in the Fisher River Agency. Nevertheless, he remained very concerned that people with active tuberculosis were being sent home to die. Dr. Bird suggested that, if active cases could be removed to sanitoria, then the spread of TB could be checked (Canada 1929).

While there is no record of a response to this particular

letter from Dr. Stone, miscellaneous DIA correspondence during the 1930s indicates that Dr. Bird's suggestion was ignored. For example; there is extensive documentation (RG 29, Vol. 2930) regarding the case of a tubercular Aboriginal girl (not from Peguis) who was considered a menace to the non-Aboriginal community that she resided in. It appears that this case set in motion a heated debate between municipalities that were reluctant to take on the expense of hospitalizing tubercular Indians, and Indian Affairs, which was rejecting all requests to put these people in sanitoria due to insufficient funds. In May of 1931, Indian Agents were advised that no tubercular Indians would be admitted to sanitoria. The cost of one year of treatment in a sanitorium was $1000 per person--the annual expenditure in 1931 for Aboriginal people with TB was less than ten dollars per person (Titley 1986).

There are no figures available for the incidence of tuberculosis in the Interlake region of Manitoba in the 1930s. However, the official tuberculosis death rate amongst First Nations people of the Prairies in 1930 was approximately 560:100,000 (Graham-Cumming 1967, p.126). The Medical Officer who worked in the Interlake region during the 1930s recalled in an interview shortly before his death that the Interlake region was seriously affected by the disease, and he estimated that the death rate was actually 700:100,000 in the area during the early 1930s (Interlake Spectator n.d.).

In 1936, Chief Asham of the Fisher River Reserve (north

of Peguis) wrote a letter complaining about the refusal of a doctor to treat a tubercular patient from his community. A memo from the Deputy Superintendent General of Indian Affairs written in response to Chief Asham stated:

> "...the Department has not sufficient funds at its disposal to enable it to authorize admissions to sanitorium or hospital of Indians suffering from Tuberculosis. The Doctor and Indian Agent at the Fisher River Agency are acting under instructions in accordance with this situation. The prospects are that the Regulations will have to be still further tightened up if a large deficit during this fiscal year is to be avoided. Similar applications from various Reserves are being refused almost daily." (Canada 1936)

While it is true that the Canadian economy was hit hard by the Depression in the 1930s--with widespread poverty and unemployment on the Prairies--the slashing of appropriations for Aboriginal health services during that time cannot be explained entirely by the recession. The fact that per capita health expenditure for Aboriginal people in 1934 was less than one-third of that spent on the non-Aboriginal population (Graham-Cumming 1967) suggests that the chronic underfunding of Indian health services had less to do with a real lack of funds, and more to do with a lack of will--which could only be explained by a general attitude that did not place the same value on the lives of Aboriginal people as on non-Aboriginal people.

The emphasis placed on decreasing health expenditures did have an effect on the provision of medical services to the people of Peguis. In 1930, the government had opened a

nursing station on the Peguis Reserve. It was referred to as the Fisher River Nursing Station because it was located on the banks of the Fisher River, which runs through Peguis from south to north. The Fisher River Nursing Station served all three Reserves in the Fisher River Indian Agency (i.e., Peguis, Fisher River, and Jackhead), as well as other First Nation communities in the region, and there is evidence that this was the first such facility to be built on a Canadian Reserve by the federal government.[10] It contained two adult beds and two or three cribs, but only a limited amount of medications were kept there.

Although no written documentation of this information could be found, several of the elders who were interviewed remember that Miss Brandon was the first--perhaps only--nurse to work out of the nursing station, and that she was often assisted by an aide from the community. According to Rita Dozois (who worked for Medical Services Branch (MSB)-Manitoba Region for many years), a nurse who was hired by Indian Affairs to work as a community health nurse (CHN) in Manitoba during the 1930s told her that there was only one policy ever written down at that time regarding a CHN's duties--she had to enter every Indian household in her area once a month and

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[10]Young (1984) states that the first nursing station on an Indian Reserve--a combined residence-clinic-cottage hospital for one or more nurses--was opened in Fisher River, Manitoba, in 1930. It seems likely that this is actually a reference to the Fisher River Nursing Station on the Peguis Reserve.

report that she had done so (what she did while in the home seems to have been irrelevant!). If this was the case, given the vast area that the Fisher River Agency covered, it is likely that Nurse Brandon was not present in the nursing station very often. In fact, several of the elders have strong memories of seeing Miss Brandon travelling around the area on horseback or by horse and buggy in the summer, and by horse-drawn sleigh in the winters. Sometimes she would be by herself, while at other times she would accompany the physician on home visits.

Unfortunately--whether due to the recession, a lack of political will, or a combination of the two--it seems that these efforts were often hampered by a lack of funds. For example; Nurse Brandon's request for a dentist to visit the area in 1931 (because she had been doing all the dental work herself since 1924) was rejected by Indian Commissioner Graham as a "large and unnecessary expenditure" (Canada 1931a). In addition; from early 1931 until late 1934, Nurse Brandon had less assistance from a physician. Early in 1931, Dr. Bird was forced to resign as the Medical Officer for Fisher River Agency due to poor health. The position was left unfilled until the summer of 1931, at which time it was downgraded to part-time status, in order that the doctor could generate his own income from serving the non-Aboriginal population of the area and "decrease expenditures" (Canada 1931b).

The new, part-time Medical Officer of Fisher River Agency

was Dr. Percy E. Moore. Seven months after Dr. Moore began his position, he was informed that he would be receiving a ten percent deduction in his $2100 per year salary, he could continue to have free use of the house but would have to pay for fuel and light, and he was advised to "exercise economy in every direction" (Canada 1932a). In addition; although he was still expected to spend one-half of his time serving non-Aboriginal people in the area, he would have to pay his own way for all expenses incurred (automobile, drugs, etc.) while doing his "White work" (Canada 1932a). In an angry letter to the Indian Agent in the fall of 1932, Dr. Moore made it clear that his salary was grossly insufficient for the work he was expected to do, especially since the non-Aboriginal people in the area were either unwilling or unable to pay for his services (Canada 1932b). However, it was not until November of 1934 that Dr. Moore's part-time position as Medical Officer to the Fisher River Agency was upgraded to a full-time position.[11]

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[11]There is evidence that Dr. Percy E. Moore was the only regional Medical Officer working for the federal government during this time (Interlake Spectator, n.d.) and, according to informants, he was well-liked by the people he served. Dr. Moore continued to work as the Medical Officer for the Interlake region until 1938, when he was appointed assistant to the federal government's Medical Superintendent, Dr. E.L. Stone. When Dr. Stone resumed his military duties (he was a Colonel) in 1939, Dr. Moore became the Acting Superintendent for the duration of the war, and was finally appointed as full Medical Superintendent of Indian Health Services in 1945 under the newly created Department of National Health and Welfare. He remained in that position until his retirement in 1965. Dr. Moore is credited with having set up a chain of about

(continued...)

## 3.3 Dual Medical Systems, 1909-1930s

It seems reasonable to assume that, in spite of there being a regional nurse and Medical Officer based in Peguis from 1924 onwards, the combination of several factors--a lack of resources from the federal government, restrictions on both access to, and provision of, services to Aboriginal people, and the wide area that these two medical care providers had to travel--resulted in only limited use of formal medical services in Peguis during this period. This hypothesis was, in fact, confirmed by several elders. However, it appears that an alternate medical system did exist in the area, and continued to function well into the 1930s.

From what the elders say, virtually all of the people who came to Peguis from St. Peter's were Anglicans, and there is no evidence of traditional spiritual ceremonies or activities being carried out on the new Reserve after the relocation. However, the curing aspect of traditional medicine did remain intact. Two of the elders describe the traditional medicines that were widely used:

> We used 'Indian medicine'...Indian roots....One kind was weh'kes [pronounced wee-kays], that's Indian ginger in

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[11](...continued)
sixteen hospitals and nursing stations throughout northern Canada (Graham-Cumming 1967).

> English.[12] You get that along the river. It's sort of under the water...and that was good for colds, headaches, tummy aches, toothache, aching joints....You wash them, brush them off good, hang them up to dry....They had a can. They put holes in there and turned it over...you'd take your weh'kes and rub it on there and it would come out like powder...you put that in hot water, and you could sweeten it if you liked...and that was our medicine. (Edith Thickfoot, 92 years)
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> * * *
>
> I remember that there was medicine for the heart, we called it [pronounced 'namaypin']....that grows down the back here....I don't know what you call it in English.... and there was medicine for fever and for if you couldn't stop the bleeding....There was also something from the spruce trees I used to use on my kids when they had a sore that wouldn't heal.... There was medicine for everything ...even for venereal disease....There was medicine too for women after they had their babies, to clean your system out and make you strong....it was black current root. You go in the muskeg and there's little...we used to call them 'tea pots'. You got five of them and boiled it in a kettle and that's what we used to drink after we had our babies. (Aurelia Thickfoot, 77 years)
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> * * *
>
> ...they would go in the bush and find the tree and bring it home and boil it, the juice from the tree. That's where we used to get medications for the stomach.

While many of the common herbal remedies were used in every household, there were also two types of traditional practitioners who provided specialized care--the 'Indian doctors' and the midwives:

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[12]It is interesting to note that all the elders used the term, 'weh'kes', which is a Cree word for 'ginger root'. This lends credence to the theory that there was considerable intermixing of Saulteaux and Cree people at St. Peter's, and that many people who came to Peguis from the former Reserve were of Cree descent.

> There were certain people who were the Indian doctors ....There was [name]. She was one of them. And there was a woman from Fisher River that knew heart medicine .... People from Peguis would travel all over for what they were looking for....The men knew the same kind of medicines too...like my dad...and my father-in-law. I helped him one time make this man sweat. Now they use the sweat lodge. Then they used medicine to make people sweat out...plus they used something in water, they called it juniper. (Aurelia Thickfoot)
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> * * *
>
> I remember we never ever went to a [white] doctor. My grandmother was an Indian doctor....My grandfather was the same. They used to work together, but he used to look after the men....I remember I used to follow her around and go different places where they would ask her to go if someone was sick. But I couldn't tell you what was wrong with them because that was confidential to them...she didn't tell me....I used to ask her, "Granny, why don't you show us what you're doing?" She answered, "No, my girl, by the time you grow up there won't be any of this around".

One of the elders remembers that her grandmother practised her medicine until shortly before her death--in fact, she remembers accompanying her grandmother to see her last patient in 1935. The female elders remember that women continued to have their babies at home with the help of a midwife--even after the Nursing Station opened. Sometimes the Indian doctors would assist them, and sometimes the nurse was in attendance as well. It seems that some women did deliver in the Nursing Station if they were at higher risk, or stayed there after giving birth if there were any problems. While the use of midwives during the 1920s and 1930s may have been partially out of necessity due to the fact that the nurse and physician had to travel widely during that time, some of the

female elders suggested that most women preferred the services of a midwife:

> They [the pregnant women] were more comfortable at home with their own kind of people.
>
> * * *
>
> I had twelve children, and I stayed home with most of them. I preferred it because there was a way that the midwives did it to help you and there wasn't too much suffering....If there was a little bit of trouble...then the healer would work with the midwife. (Aurelia Thickfoot)
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> * * *
>
> They all had their children, their babies born in the house without the [white] doctor....It was very seldom that they had any problems.

### 3.4 Hegemony of Government Medical System

It was not until the end of the 1930s that an improved operating budget was introduced for Aboriginal health services, and it seems likely that this development was not unrelated to the fact that Dr. Percy E. Moore had become the Acting Superintendent for Medical Services in 1939. Dr. Moore, after all, had worked as a Medical Officer in the field for several years and had experienced the lack of resources firsthand--unlike his predecessor, Dr. Stone. In any case, the number of federally-run 'Indian Hospitals'[13] rose to fourteen by 1943 (from seven in 1936), with a total bed capacity of 540--half of which were occupied by tuberculosis

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[13]This is the term that is used widely in the literature and by those interviewed in Peguis.

patients (Young 1984, p.259). One of these Indian Hospitals was built on the Peguis Reserve.

### 3.4.1 The Fisher River Indian Hospital, 1940-1973

Even though construction of the Fisher River Hospital (FRH) was begun the same year that Dr. Moore left his job as the Medical Officer for the Fisher River Agency, it is likely that he had a lot of influence on the decision to build the hospital on Peguis Reserve. One of the elders recalled that he spoke enthusiastically about the possibility of such a facility being built when he was still working out of the Nursing Station, and that he even asked her if she would like to work in the new hospital when it was built. One of the unique (and, apparently, unusual) features of the FRH was that it was constructed almost entirely using Aboriginal labour from the area (except for the plumbing). Construction was halted for some time at the outbreak of the war in 1939. Finally; during the summer of 1940, the old Nursing Station was closed and the new Fisher River Indian Hospital was officially opened by Dr. Moore.

The facility--referred to by most people in Peguis now as 'the old Indian hospital'--was intended to serve all the Interlake Reserves. According to notes prepared by Dr. E.L. Ross of the Sanitorium Board of Manitoba for the Official Opening, the primary purpose of the hospital was the eradication of tuberculosis from the Interlake region (Canada

1940). However, the FRH was to provide general medical services as well. The beds for tubercular patients were located on the ground floor, while the rest of the beds were up on the second floor. The FRH was initially staffed by a resident doctor, a Director of Nursing (referred to as 'Matron'), two additional Registered Nurses (RNs), and trained auxiliary nurses and ward aides from the community (see following pages for further discussion). According to one elder:

> The hospital was busy from the day it opened. There was no cars, no roads, everyone came with horses. It was always full. I seen sometimes when they had beds down the hallway upstairs.

There is considerable discrepancy in the figures given regarding the patient capacity of the FRH. The notes prepared for the Official Opening (as well as other government documents) indicate that the facility initially had a twenty-four bed capacity and that twelve beds were for tubercular patients. Yet the descriptions provided by elders who worked there, including one person who helped to build the facility, are remarkably similar and suggest that there were over thirty beds (the figures given ranging from thirty-two to thirty-eight). Perhaps the discrepancy can be explained by the frequent references made by former employees to overcrowding and the need to put extra beds and/or cribs onto the wards--i.e., twenty-four beds may have been the official number only. The beds were divided between pediatric, maternity, nursery,

adult men, adult women, isolation and the terminally ill. There was a combined delivery/operating room, but only minor surgery was conducted there.

The physical design of the hospital was quite odd, to say the least. The public entrance to the building was on the second floor, accessable only by climbing--or being carried--up a rather steep flight of stairs outdoors. There was no elevator in the building, and all supplies and patients had to be carried or hoisted between floors. However, none of the former employees complained about these things. The facility was one of the first buildings to have both hydro and a phone in the community, and there was one feature that the female employees considered a luxury. As one former employee explained:

> [There was] one bathroom with a tub and toilet for the females. The men just had a sink and toilet. Nobody had running water at home. We used to have our baths at the hospital. We used to have to go to work early, say, an hour and forty-five minutes early, so you could have a bath before you went to work.

During the early years, especially before roads improved, the only way to get mail or supplies was to pick it up from Hodgson, where the train arrived from Winnipeg three times per week. It appears that as many supplies as possible--including linen and hospital gowns--were made by the hospital staff themselves, and each morning someone milked the four cows which were kept by the hospital.

There are several important features about the Fisher

River Hospital's operation from 1940 to 1973 that are worth highlighting. One is related to community response to the new hospital and to the increase in formal medical services. According to one of the elders who worked at the FRH, at first there was some resistance among some community members about going to the hospital for treatment:

> When they first opened up the hospital, even though they were sick, you had a hard time to get them to come to the hospital....I don't know. It seemed like they thought once they were in the hospital the doctors would start chopping them up. A lot of them were afraid of that 'cause I can remember a young man dying not too far from here and there was no reason for him to die, but he wouldn't even allow the doctor to come and see him....The trouble we had most was getting the maternity cases into the hospital at that time. They didn't seem to want to come.

A letter from Dr. Moore to Indian Agent Carter, authorizing him to take the necessary legal steps to enforce the return of a tubercular patient to the FRH, and to use the RCMP (Canada 1942a), also confirms that there was some active resistance to hospitalization. However, for the most part, people increasingly turned to the hospital for medical care. There are at least three factors which might explain this phenomenon.

First, and perhaps most important; during the period that the hospital was developing its services in the early 1940s, the option of using traditional midwives and Indian doctors was disappearing as these old people died and their skills died with them. A second factor relates to general health

conditions in the community. Monthly reports from the Indian Agent in 1942 state that all patients with active tuberculosis were hospitalized and that many were making good recoveries (RG 29, Vol. 2930). However, while the incidence of TB may have been declining, the reports throughout 1942 and 1943 indicate that the general health conditions in Peguis were below normal, and there are frequent references to the large number of children with bad colds, and continued outbreaks of whooping cough, measles and--occasionally--encephalitis and polio (RG 29, Vol. 2930). From the stories that the elders tell about how Peguis has changed over the years, it appears that the period during which the old hospital functioned (1940-1973) was characterized by a declining local economy and an increase in certain social and health problems--e.g., problems related to a gradual switch to store-bought foods lacking nutrients, overcrowded housing lacking proper sanitation facilities and an increased use of alcohol. As a result, it is possible that the demand for medical services may have increased during this period.

Another interesting feature of this historical period which may account for the community's acceptance of the hospital is that the FRH provided employment to many residents of Peguis, some of whom were involved in its construction, others in its maintenance, kitchen and laundry services. As the following informant describes, some people worked in a variety of jobs over the years on an ad hoc basis:

> Myself, I first washed the walls of the whole hospital, and then they asked me to do the sewing so I had to make gowns, sheets. Then I got into the Matron's quarters to look after their rooms. Then one day the cook didn't show up for two days so they asked me to go and help in the kitchen. That's how I never left there for fifteen years.

The experience of the ward or nurses' aides, who were almost all residents of Peguis (with a few from the nearby Fisher River Reserve), is particularly important. Many of the ward aides started out working in the kitchen or laundry, then eventually were given the opportunity to train as aides, while others remained aides throughout their employment. The following informant's experience appears to have been typical:

> I was a nurse's aide. I started from the laundry...then they asked me if I'd go up in the wards. I was scared to go in the wards because I thought there was too many sick people, so they put me cleaning floors. Then after that they told me I was there long enough, I should go to be a nurse's aide. So I went, and there I stayed.

Although at least one of the ward aides took a nursing assistant course in Winnipeg, most of the aides received their training on the job from the nurses. According to former aides who were interviewed, aside from the Matron, there often weren't many RNs on staff. There were some auxiliary nurses, but it is not clear how many of the auxiliary nurses were actually Licenced Practical Nurses (LPNs). It seems that during the first ten to fifteen years of the hospital's operation, certain ward aides actually were trained on the job to become auxiliary nurses. However, there were also nurses

who had taken an LPN course in Winnipeg. There were at least two LPNs who were Aboriginal women who lived in Peguis, but the majority of RNs and LPNs were non-Aboriginal.

Both the ward aides and the auxiliary or LPNs were given tremendous responsibility for the care of the patients and they did tasks that they might not have done in another setting. Several of the former aides and LPNs describe their jobs:

> It was exciting. It was challenging to work in the old hospital. There we were allowed to do everything. Give out medications, injections, start IVs [intravenous], suture....Most women were having babies almost every year or so [in the early 1960s]. I remember we had four babies delivered in one night. It seemed the nursery was always full. At times, we had to deliver the babies ourselves because the doctor wouldn't get there in time. I was young and I didn't have too much experience in obstetrics. We sure had to learn fast out here though because there were so many deliveries. (Ann Bird, former LPN at the FRH)

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> I gained a lot of experience there because at that time ...we did everything, assisted the doctor in deliveries, give needles, even used to take x-rays and develop them. We did all that....I remember this one time I assisted with this lady who was in labour all night...I was supposed to be in charge so I called the doctor....By the time he got there this woman was really sick, so...he did a Caesarian and I assisted....he said to me: "This is the only sterile one [needle] we got here. I better not drop this." (Verna Spence, former aide at the FRH)

* * *

> There weren't many LPNs, maybe three. But there were quite a few ward aides, and there was an RN to cover every shift. Sometimes two RNs during the day...one RN and a ward aide or mostly an LPN and a ward aide worked the evening and night shift. So the LPNs had to deliver a lot of the babies that were born there. They didn't send them into Winnipeg then....My first day on the job, by first duty was to go in the delivery room and deliver

> a baby. I said "What? Me?"....me and one ward aide, we delivered the baby. We called the doctor but by the time he got there the baby was already born and the cord was cut. You had to be a nurse in those days. You couldn't say no, leave the mother laying there. So we did the best we could. (Eleanor Olson, former LPN at the FRH)

Eleanor Olson kept a little notebook with information about deliveries at the hospital, and the last time that she counted before leaving the old Fisher River Hospital she had delivered 125 babies. One former auxiliary nurse from the community described the old hospital as being more like a nursing station. The doctor wasn't always there because of the frequent need to travel to other Reserves in the area, there often were not many RNs on staff, and so the rest of the staff simply did what they had to do to care for the patients.

Virtually all of the informants who had worked at the FRH as either a nurse's aide or LPN stated that they remember the work being exciting and challenging, and that the working relationship with the non-Aboriginal nurses and physicians was a fairly good one. As one former ward aide described:

> We were equal. They [white nurses] weren't snotty. We got along....an RN or an LPN didn't care if they had to wash diapers or linen. They never complained. They'd do it...give us a hand if they knew we were overloaded...and if we saw them needing our help then we'd go help them too.

In addition; almost every informant who had been a patient in the FRH remembered receiving very good care. When former aides and LPNs were asked to comment about this, several people suggested that, because they were aware that

they weren't formally qualified to do a lot of their work, they always tried to do their very best. There was also the fact that the ward aides and some of the LPNs often knew the patients or their families. A report sent by the Assistant Superintendent of Medical Services after a visit to the FRH in 1942, which emphasized the "efficiency and spirit of cooperation shown by the staff", provides some external confirmation of the informants' perception about the quality of care and working relationships among the staff (Canada 1942b). However, in 1967, a different point of view was expressed in a report submitted by an anonymous MSB official (Canada 1967). This person noted that the turnover of nurses at the FRH had been tremendous. The hospital should have had a staff of nine RNs and nine ward aides, but the average number of RNs had been only two. Acknowledging that the ward aides had been more stable, this person then went on to state:

> This latter fact also presents problems for the continually shifting RN staff. The aides, having been exposed to numerous nurses throughout the years, tend to go their own merry way, paying little or short-lived attention to directions from the nurse in charge....Good and safe patient care is the goal of any hospital. This goal is indeed far off as conditions now are at the Fisher River Hospital (p.1).

Unfortunately, there is very little information available regarding the administration of the Fisher River Hospital. As far as the overall administrative structure is concerned; from 1940 to 1945, the hospital was administered through the Indian Health Services Division of the Department of Mines and

Resources (which had replaced the Department of Indian Affairs in 1936). In 1945, responsibility for the Indian Health Services Division was transferred to the newly created Department of National Health and Welfare. In the mid-1950s, this division became a separate Indian and Northern Health Services Directorate. Then, in 1962, Indian and Northern Health Services was amalgamated into the newly formed Medical Services Branch (MSB). Manitoba was designated part of the Central Region of MSB (along with northwestern Ontario and the Keewatin), with administration of services occurring through a Zone Office in Winnipeg. In 1967, Manitoba became part of the Prairie Region of MSB and finally, in 1970, a region according to its provincial boundaries (Canada 1973). However, the administration of medical services to Peguis through MSB-Manitoba Region's South Zone Office in Winnipeg remained constant until the 1990s.

From 1962 until the old Fisher River Hospital closed in 1973, there was a Hospital Administrator based in the South Zone Office in Winnipeg. Prior to that, it appears that administration was carried out from Ottawa, and that the bulk of the day-to-day administrative duties were handled by the Matron and the Medical Director. However, memos found in Department files (RG 29, Vol. 2775) suggest that, between 1940 and 1945, there were periods of time when there was no Medical Officer at the FRH. In 1954, a Regional Superintendent of Indian Health Services in Ottawa sent a letter to his

Director, Dr. Percy Moore, complaining about having considerable difficulty with the administration of the FRH in the past due to rapid turnover of Medical Officers and poor health of the Director of Nursing, or Matron (Canada 1954). Another report filed by the Chief Medical Records Supervisor of Indian and Northern Health Service in 1959 stated that record-keeping at the FRH was seriously inadequate (Canada 1959). One might assume that day-to-day administration of the hospital became a little more manageable once it was done through the Zone Office in Winnipeg, but no documentation could be found to confirm or deny this.

There is, however, a sizeable volume of archival documentation on the Fisher River Hospital related to another key period of its existence--that is; the final thirteen years of its operation. The story of how the FRH came to be closed in 1973 is a fascinating one, and worthy of more detailed consideration.

#### 3.4.1.1. The Closing of the Fisher River Hospital

In 1964, Judy LaMarsh, the Minister of National Health and Welfare, sent a memorandum to Cabinet to raise for consideration and approval in principle a proposal to replace the Fisher River Indian Hospital. The rationale given was that the existing hospital--which served 3,900 Aboriginal people in the immediate area and had a bed occupancy over the previous years that averaged 120 percent of its rated capacity

(down to fifteen beds by then)--was "obsolete and inadequate for the Department's responsibilities in the area" (Canada 1964a).

A second feature of the memorandum worth noting--which would have major ramifications for Peguis and the other First Nation communities served by the FRH--was the proposal that the old hospital not be renovated, but be replaced by a new facility at Hodgson, Manitoba (located along the southern border of Peguis Reserve). This was not an entirely new idea. In 1961, the Manitoba Hospital Survey Board (1961) had recommended that the FRH be replaced by a new, integrated hospital which would serve the needs of both Indian and non-Indian populations in the area, with twenty-six beds for Indian patients and fourteen for non-Indian patients. The rationale offered for an integrated facility was that the size of the integrated hospital would allow more economic operation than a solely Indian health facility and the population at risk would provide a comfortable workload for two physicians, thus raising the level of service to the Indian as well as non-Indian population (Canada 1964a, p.2).

A salient feature of the proposal was that the total capital costs, estimated at $1 million in 1964, be shared by the Department of National Health and Welfare (paying two-thirds) and the Manitoba Hospital Commission (paying one-third) of the expenditure. The Manitoba Hospital Commission was reported to have approved the proposal because it would

provide hospital care to a segment of the non-Aboriginal population which was not large enough to operate their own community hospital (Canada 1964a, p.2).

For the federal government, there is evidence that this initiative was more than a matter of improving cost-effectiveness. On the one hand, 1964 was the same year that the Royal Commission on Health Services submitted its report to the federal government. Among the many recommendations of the Commission were the need to improve standards of health care services and that Aboriginal Canadians should receive the same quality of health services as those enjoyed by other Canadians (Canada 1964b). Certainly, the proposal for a modern new facility at Hodgson with an increased number of beds, out-patient clinic and dental clinic appears to have been in keeping with this objective, and this may partially account for the fact that the Chiefs and Councils of the surrounding First Nations agreed to the new location--even though the new hospital would be farther away from the majority of its constituents as a result (but closer to the non-Aboriginal population). The Peguis Band Council actually agreed to cede the necessary land along the southern border of the Reserve for use by Medical Services Branch as long as the land was used for hospital services. The new facility would also be located closer to major roads connecting with larger centres to the south and east, which would no doubt make it more convenient in terms of provision of supplies and

transportation of patients to Winnipeg. It was also hoped that the new facility would better attract and retain professional staff.

However, it must be acknowledged that the 1964 Royal Commission Report also recommended that the administration of health services for Aboriginal Canadians be entrusted to the provinces and that health services be provided for them in the same manner as for other Canadians (Canada 1964b). In addition; a memo from the Regional Superintendent of Medical Services, Central Region, to the Director of Medical Services in Ottawa in April of 1964 made the real agenda emminently clear. Plans were to proceed with replacement of the FRH by a district hospital in Hodgson (projected to be completed by 1966/67), which would be more central to the district population. Moreover, the Regional Superintendent proposed that the operation of the new hospital would eventually be transferred to provincial control, and he noted that an arrangement for Selkirk Health Unit to provide public health services to Fort Alexander (now known as Sagkeeng First Nation) had worked out well (Canada 1964c). Therefore, the decision to close the old Fisher River Indian Hospital can also be viewed as an early example of a trend that would escalate in the late 1960s--that is, a desire on the part of the federal government to offload responsibility for Aboriginal people to the provinces wherever possible.

In February of 1965, Cabinet approved the construction of

a new forty-bed hospital to be built in Hodgson. During that same year, the Peguis Band Council recommended that the new facility be named the Percy E. Moore Hospital, in honour of the physician who had earned respect from the people during his years as Medical Officer of Fisher River Agency. However, it would be another seven years before construction would even begin on the hospital. The reason(s) for the delay are unclear. A Treasury Board submission made in 1970 for approval of the capital project states simply that financial restrictions had prevented implementation of the project since its initial approval in 1965, but does not provide any more details than that (Canada 1970). Notes made by a Staff Medical Officer at MSB on the historical development of the Percy E. Moore Hospital make reference to "nit-picking correspondence over items for cost sharing between Canada and Manitoba" following Cabinet approval in 1965 (Canada 1976, p.1).

As late as 1968, it appears that there was still a lack of agreement within MSB about what to do with the old Fisher River Hospital. At an MSB Regional conference held in Winnipeg in January of 1968, several options were discussed, including a proposal that the FRH should be closed and that the nurses' residence be converted into an eight-bed nursing station. However, a senior Administrative Officer argued that neither the proposed conversion nor renovation of the old hospital were appropriate. He recommended proceeding with

construction of the new hospital, closing the FRH subject to one year's notice, and requesting that the Province provide hospital facilities to the people of the area until the new building was ready. The fact that it took another two years for the Department of National Health and Welfare (DNHW) to make its submission to Treasury Board for approval of the project, and that the old hospital was not closed until virtually the same time that the new facility opened in June of 1973 is even harder to understand, given the fact that a damning report on the condition of the FRH had been submitted in 1967.

This report (Canada n.d.(b)), submitted by a federally-employed Maintenance Supervisor some time during 1967, underscores the seriousness of the situation. The "Report on Fisher River Indian Hospital (Fire Trap)" notes that the building was of wood frame construction, insulated with wood shavings, which "would be like gun powder and would easily ignite" (p.1), and also states that the electrical wiring was a major fire hazard. The official estimated that renovations to bring the building up to acceptable standards would cost at least $250,000, and he concluded that "to continue operating this hospital would be a liability to those responsible for its operation"(p.1). The fact that the hospital continued to operate for another five years speaks for itself.

Meanwhile, by 1970, enhanced accomodation standards and the inflation of construction costs had raised the estimated

cost of building the new Percy E. Moore hospital to $2.182 million. Manitoba was still only willing to contribute $500,000 which meant that the provincial share of the total current cost had fallen from one-third to approximately 21.7 percent of the total (Canada 1970b). However, in a memo regarding the upcoming submission to the Treasury Board, one MSB official pointed out that the Province would be bearing the brunt of operating costs of the new hospital, which would be greater than the capital costs (Canada 1970a).

By 1970, there was also evidence of growing impatience and even resentment among the community members of Peguis and the other Reserves in the area. In a letter to Allan J. MacEachen, Minister of National Health and Welfare, in early 1968, Eric Stefanson, the Member of Parliament for Selkirk, stated that it "appears that the project is being set back further and further" and he warned that the people in the area were becoming "thoroughly disgusted" with the delays (Canada 1968).

#### 3.4.1.2. Development of Hospital Advisory Committee

In the spring of 1969, MSB created a lay Hospital Advisory Committee, consisting of seven representatives from the three local Reserves--four from Peguis, two from Fisher River, and one from Jackhead--and one representative each from the towns of Hodgson and Fisher Branch. Medical Services Branch was represented by Mr. R. Honer, the Administrator of

the Fisher River Hospital. Chief Albert E. Thompson of Peguis was the Chairperson of the Advisory Committee.

At the first meeting of the FRH Advisory Committee held in the community hall at Peguis in April of 1969, the participants were told by Dr. Eng (the resident physician at the time) that construction of the new Percy E. Moore Hospital was due to begin in the fall of that year--in spite of the fact that a submission to Treasury Board for capital funds was not even made until October of the following year! By far the most important piece of information given to Committee members at that first meeting, however--in terms of future expectations--was that the Percy E. Moore Hospital would be turned over to a local Board of Trustees, and that the Advisory Committee (with seven Aboriginal representatives) would gradually develop into that Board. Until that time, the Committee could not make policy decisions, but would act as a liason between the communities to be served and the hospital administration. It is interesting to note, however, that Committee members did try to actively influence policy decisions on a variety of issues whenever the opportunity arose. For example, at the second meeting, members of the Committee stated that they disagreed with the proposed 'barracks-style' nurses' residence at the new hospital, and they requested that family type accommodation and self-contained single units be considered (a request which was

actually accepted).[14]

Other interesting issues were raised at the first Advisory Committee meeting which indicate the different interests of the Aboriginal and non-Aboriginal communities. Representatives from Fisher Branch expressed concern about hearing that the cottage hospital in their town would be closed when the new facility opened. They claimed that they had been told by the Manitoba Hospital Commission that the two hospitals would be run in conjunction with each other.

Chief Thompson of Peguis expressed concern about whether job priority would be given to Treaty Indians during and after the construction period. His understanding from an initial meeting with MSB officials in Winnipeg was that the staff would be approximately two-thirds Indian. Chief Thompson requested a written agreement on this issue--stating that verbal agreements in the past had meant nothing. He was informed that this decision would have to be made in Ottawa (there is no evidence that this agreement was ever put in writing).

One year later, an official from MSB's regional office in Winnipeg informed an Advisory Committee meeting that they had requested that fifty percent of the labour force used to construct the hospital be of local origin. He also stated

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[14]All references to the Fisher River Lay Advisory Committee are taken from the minutes recorded at meetings held between 1969 and 1973. These were found in RG 29, Vols. 2607-08, 800-1-X298. National Archives of Canada.

that they had asked for money to train local people as technicians, LPNs, etc. However, he suggested that pressure would have to be exerted on Indian Affairs by the local Chiefs and Councils and members of the Advisory Committee in order for these requests to be granted. It is not clear whether the word 'local' used in MSB's request referred specifically to Treaty Indians or if it applied to local non-Aboriginal people as well. It is therefore interesting to note that the minutes of an Advisory Committee meeting held in June of 1972 (three months after construction of the new hospital began) refer to discussion of a letter from the Band Administrator of Peguis Reserve complaining about the fact that (as of May 1972) only three men from Peguis and Fisher River Reserves had been employed in the construction of the new hospital.

The minutes of these meetings also reveal, however, that different interests weren't entirely limited to those between the Aboriginal and non-Aboriginal communities. At one meeting in the summer of 1969, the representative from Fisher River Reserve complained about Peguis residents getting most of the jobs at the Fisher River Hospital. Dr. Eng explained that availability and proximity to the hospital were the prime factors influencing that situation, and the matter does not appear to have been discussed further.

By early 1971, frustration with the delay in construction of the new hospital was mounting. In a letter sent by Peguis Chief Albert Thompson, on behalf of the Fisher River Hospital

Advisory Committee, to John Munro, Minister of National Health and Welfare in February of 1971, the Chief noted that Dr. Percy E. Moore had approached him in 1964 for consent to build a new hospital and told him that construction would begin in several months. Chief Thompson now requested a definite start date for construction to begin (Canada 1971a). In April of 1971, Treasury Board finally gave its approval to go ahead with the project. However, it would be another eleven months before construction of the Percy E. Moore Hospital began.

In the summer of 1971, A.M. Schreyer, a resident of Hodgson sent a letter to the federal government, which set off an interesting exchange of correspondance. The man expressed concern that the proposed new hospital facility would likely end up being a "white elephant", and he suggested that "it would better serve Indians to rebuild the hospital at its present site" (Canada 1971b). In September of 1971, the Executive Assistant to the Minister of Health, Mr. C.A. Pearson, sent a memo to Paul Woodstock, the Executive Assistant to the Deputy Minister of Health, noting that the government's response to Mr. Schreyer made the argument about a centralized health care facility being necessary in order to provide more cost-effective and efficient care to the people. Mr. Pearson then asked Mr. Woodstock, "Does it [the response] fit in to our objectives in medical service about greater Indian involvement (which might be accomplished by a series of small institutions closer to the population)?" (Canada 1971c).

Paul Woodstock responded:

> It is a departmental objective to bring health institutions closer to the people. However, when we are talking about health institutions we are not talking about hospitals as they exist now, but community health centers....I do not feel personally that the community health concept is practical in a sparsely populated community or in a community made up of small isolated or semi-isolated groups such as is the case at Hodgson (Canada 1971d).

It is interesting to note the different perceptions about the role of the new facility. For MSB, it was largely a matter of improved cost-effectiveness and efficiency in provision of medical services. As the notes for a response to Mr. Schreyer's letter indicate, from the federal government's point of view, "it is a known fact that the smaller the hospital the larger the deficit....the operating deficit in the 1970/71 fiscal year for the Fisher River Indian Hospital was $211,000.00" (Canada 1971e). The document goes on to state that the intent behind the proposal to build the hospital at Hodgson, Manitoba, was two-fold:

1. To attract to the community and district several doctors who would be able to provide both medical and surgical care and make unnecessary the many referrals to Winnipeg that now take place.

2. To centralize a modern health care facility, capable of meeting not only hospital bed needs, but also out-patient, public health and dental requirements (Canada 1971e).

No doubt, from a perspective of cost-effectiveness and efficient provision of services, this proposal made sense. However, as Mr. Schreyer had tried to point out, the proposed

new modern facility could easily become a 'white elephant' if it did not meet the needs and/or expectations of the majority of its consumers--i.e., the Aboriginal population. As we will see, the minutes of Advisory Committee meetings between 1971 and 1973 suggest that Mr. Schreyer's prediction was inevitable.

In April of 1971, at the same meeting where Committee members were informed about Treasury Board's decision to proceed with building the Percy E. Moore Hospital (PEM), they were also told by the MSB representative that the plan was for the PEM to remain a federal hospital, but with a local Board running it. In March of the following year, Committee members were told that the new hospital would **not** be a government hospital--it would be **their** hospital. Advisory Committee members would become the Governing Board of Trustees and would receive training for these positions. Again, in September of 1972, an MSB official reiterated that the purpose of the lay Advisory Committee was to train people to run the new hospital. In November of 1972, an official from MSB's regional office told the members of the Advisory Committee that all positions at the Percy Moore Hospital, from top to bottom, should eventually be filled by local residents.

At an Advisory Committee meeting held in late January of 1973, the Manitoba Regional Director of MSB, Dr. L. Black, informed the members that, since the intention was for the PEM to become a community hospital, the hospital board should be

representative of the population that it would serve--that is, two-thirds Treaty Indian and one-third other (the existing Committee consisted of seven representatives from the local Reserves and three non-Aboriginal members). However, in July of 1973--following the opening of the new hospital--DNHW's Acting Director General of Program Management informed Dr. Black that authority would **not** be granted for members of the lay Advisory Committee to sit on the governing Board of the hospital, as long as the hospital was Crown-owned and staffed by federal public servants. The memo suggested that two members of the Advisory Committee be appointed to the Hospital Management Committee as non-voting observors, and that the lay Advisory Committee be given "an increasing number of areas of concern, problems, etc., for their opinion and advice" (Canada 1973b). In November of 1973 the Constitution of the PEM (Canada 1973d) outlined the new Hospital Authority, consisting of nine members:

(1) Regional Director, MSB, Manitoba
(4) members from MSB (selected by RD)
(2) members selected by Indian communities
(2) members selected by non-Indian communities

Then, in December of 1973, the composition of the lay Advisory Committee was changed, to allow for the inclusion of one representative from each of the four Reserves on the east side of Lake Winnipeg (in spite of the fact that the Committee had been repeatedly told that the new hospital would serve local Reserves only)--reducing the representation from Peguis

and Fisher River Reserves to one member each. Less than one year after being informed that the Percy E. Moore Hospital would be run by a truly representative local Board, local Aboriginal involvement had been diminished to a mere token presence.

### 3.4.2 Percy E. Moore Hospital (1973→): Birth of a 'White Elephant'

In its first full year of operation in 1974, the Percy E. Moore Hospital (PEM) reached the peak of its utilization with more than 250 percent of the admissions logged in the last full year of the operation of the old Fisher River Hospital. However, community participation and utilization declined dramatically in 1975. By the middle of 1976, the average occupancy rate was only thirty-nine percent (!), and there was serious consideration being given to closing the 'state-of-the-art' hospital (Canada 1976a). There appear to have been several contributing factors to this phenomenon.

Until early in 1975, patients admitted to the PEM came not only from the local district, but also from Reserves on the east side of Lake Winnipeg (Berens River, Little Grand Rapids, Pauingassi and Poplar River). However, because of the lack of a satisfactory air-strip nearby, which made the journey difficult and uncomfortable for patients, and because air services between those Reserves and Winnipeg improved and were less expensive, patients from those reserves were increasingly routed to Winnipeg (Canada 1976b). While this

factor accounts for some of the decrease in utilization, there is evidence that this was not the primary factor.

Until the middle of 1975, physician services at the PEM were provided by the Interlake Medical Clinic (based in Arborg) under contract with Medical Services. This arrangement had actually begun in 1971, following the departure of Drs. Eng and Pan from the old Fisher River Hospital. MSB was having serious difficulty in recruiting physicians. The contract with the Interlake Clinic had ensured the availability of two physicians at the FRH at all times. Soon after the new hospital opened in 1973, the Acting Chief of Finance and Administration Services for MSB Manitoba Region sent a memo to the Director General of Program Management at Medical Services headquarters in Ottawa, requesting an immediate commitment in principle to negotiate a new contract with the Interlake Medical Clinic (Canada 1973c). The group had requested that MSB guarantee them a minimum gross revenue of $250,000 for continuing the practice at the PEM, and were apparently threatening staffing action if they did not receive a firm answer. Mr. Cale noted that a minimum of four resident physicians were required to provide adequate medical services at the hospital--including one general surgeon, one anaesthetist, and one obstetrician (with all being good general practitioners as well)--and that the Arborg group was of sufficient size to ensure complete coverage of the hospital on a continuing and emergency basis.

Mr. Cale was particularly concerned that, if MSB did not agree to finance the Interlake Clinic physicians, they might begin to refer their non-Aboriginal patients from Fisher Branch (where the Interlake Clinic continued to operate a satellite clinic) to Arborg instead of the Percy E. Moore Hospital. Mr. Cale warned that "there is an underlying resentment towards the P.E. Moore Hospital because of the closing of the Hospital in the town of Fisher Branch. This resentment can only be overcome by the success of the P.E. Moore Hospital" (Canada 1973c, p.2). The contract was renegotiated with the Arborg group of physicians, who continued to provide medical services at the PEM until the spring of 1975.

DIA documents indicate that, in April of that year, two urgent meetings were held at the Percy Moore Hospital, with representatives attending from Peguis and Fisher River Reserves, the Manitoba Indian Brotherhood, Medical Services Branch, DIA, as well as the PEM's Assistant Director of Nursing, the three resident physicians and three partners of the Interlake Medical Clinic (DIAND 1975). Apparently, there had been complaints to the Manitoba Indian Brotherhood about inadequate medical services--including a shortage of RNs--at the PEM. There were also allegations of malpractice. When asked to explain the nursing shortage, the Assistant Director of Nursing stated that there were four major reasons: differences in pay scale between federal and provincial nurses (the latter earning much higher remuneration), administrative

problems between nursing and the hospital administration, nurses' lack of confidence in the physicians, and poor staff morale (DIAND 1975, p.2). She went on to state that the hospital required fifteen RNs to operate fully. At the time of the meetings, there had been five immediate RN resignations, and it was expected that there would only be four RNs on staff by June of 1975--without a recruitment in sight (Ibid.). As a result of the two meetings, the contract with the Interlake Medical Clinic was terminated--effective from the 20 May 1975. Surgical services were suspended, until a surgeon could be hired and there was adequate support staff. It is also interesting to note that a decision was made at this time to re-route patients from the east side of Lake Winnipeg to Norway House or Winnipeg for treatment--which suggests that the loss of these patients was not simply due to more efficient and economic travel opportunities opening up in the fly-in communities.

After the Interlake Clinic physicians left, MSB contracted with the University of Manitoba's J.A. Hildes Northern Medical Unit to provide physician services (an arrangement which continues to this day). Unfortunately, the hospital experienced a high turnover rate in physicians after the University of Manitoba took over staffing and, by 1976, the Hospital Board was seriously concerned about the lack of confidence in the hospital being expressed by members of all the communities being served (Canada 1976b). The Arborg group

of physicians, who continued to operate their satellite clinic in Fisher Branch, now referred their patients to the hospital in Arborg.

Finally; as one MSB document noted (Canada 1976b), a fall in bed occupancy was predictable if the hospital did not become a true community hospital with a full range of services--including public health programs to the non-Aboriginal population (who did not have access to these services)--and with the communities controlling their own health services. This document noted dissatisfaction among the people of Fisher Branch as a result of the apparent provision of a greater quantity of outreach services by the Northern Medical Unit to the local Reserves than to the residents of Fisher Branch.

In spite of a general agreement that the Percy E. Moore Hospital was costly and inefficient, the decision was made to keep the facility open (Canada 1977). Unfortunately, it appears that the disenchantment with the PEM only grew worse after this time. In the fall of 1982, Chief Louis Stevenson sent a letter to the Manitoba Regional Director of MSB, complaining about poor medical care:

> Our local nurses are having difficulty in persuading patients to return to the hospital for treatment and some of them are remaining at home seriously ill until it becomes an emergency....There is such a high turnover of doctors at this hospital that patients never establish any rapport, relationship or confidence in these doctors. (Source: PHS Archives)

By 1983, the PEM's bed capacity had been reduced from

thirty-eight to sixteen due to underutilization. In that same year, an independent consultant's report on the hospital concluded that the Percy E. Moore Hospital was "one of the finest, most inefficient medical complexes in all of Canada" (Canadian Executive Services Overseas 1983, p.3). The report noted widespread dissatisfaction with the hospital, and recommended that the PEM be converted into a Community Hospital, providing both acute and long-term care, with total control in the hands of a Community Hospital Board. None of the recommendations of this study were ever implemented.

In 1987, MSB headquarters in Ottawa reviewed all (eight) Branch hospitals in Canada, and concluded that the success with which MSB operated its hospitals was qualified. Problems identified in the Executive Summary of MSB's study included: hospitals were required to adhere to a bureaucratic system which was designed for large, centralized programs; they lacked client involvement in decision-making; they operate in a conflicting legal framework; utilization is low and costs are high; and they offer services which do not entirely meet clients' needs and desires (MSB 1987). Yet, in spite of these problems, the report notes that services were judged to be good by the Canadian Council on Hospital Accreditation in seven out of the eight hospitals--including the Percy E. Moore Hospital, which was described in the MSB review as "clearly the best hospital facility in Medical Services Branch and it is in better condition than a good many Canadian Hospitals"

(MSB 1987, p.57).

It is also significant that the PEM's Hospital Advisory Board appears to have been inactive since early 1984. According to MSB's report, at that time the Regional Director of MSB advised constituent Bands and the local government district of Fisher Branch that this Board "had not been functioning satisfactorily and that other methods would be used for consultation" (MSB 1987, p.55). It is not clear what these 'other methods' were, and MSB's 1987 report notes that "there is at present no body in place with whom to pursue discussions" (p.56). This situation appears to have persisted until June of 1993, when a Clinical Services Committee was established. This Committee--which is expected to meet on a monthly basis--consists of one representative each from the three local Reserves, the Local Government District of Fisher Branch, MSB, the PEM Hospital administration, and Dr. Cathy Cook (the Medical Program Director from the University of Manitoba's J.A. Hildes Northern Medical Unit). However, the purpose of the Committee appears to be dealing with issues related to out-patient services only, and this structure cannot be said to constitute a Hospital Board.

Current issues related to the Percy E. Moore Hospital will be discussed in Chapter Five. At this point, however, it is important to note some of the views expressed by Peguis residents related to the closure of the old Fisher River Hospital and the operation of the new Percy E. Moore Hospital.

Interviews with informants from Peguis suggest that the closing of the old hospital was perceived as a major loss by the people of the community for several reasons. The fact that the hospital was no longer centrally located was definitely an inconvenience, but does not appear to have been a major objection. Almost every informant referred to the old FRH as "their" hospital, a "community" hospital, a "real Indian hospital". One person stated that the doctors at the FRH were "more like family doctors", and that there was a "closeness" because they would come and visit you in your home. The new hospital was different.

For the ward aides and LPNs (who all moved over to the new hospital initially), the new standards of practice that were brought into effect meant that they could no longer perform the duties that they had done for years at the old hospital--making their jobs less challenging. New RNs (some from the old hospital in Fisher Branch) took over many of the aides' and LPNs' former tasks. Several former employees from Peguis stated that the working relationship between the RNs and the aides/LPNs at the new hospital was strained. One person described the atmosphere as being "like cat and dog up there". Several people pointed out that the RNs were mostly from Fisher Branch, and one informant stated that "it was like we weren't good enough for them". Only one informant, a former employee at the PEM, expressed the belief that "the white staff at the hospital have an attitude problem toward

native people". As for the nursing care at the PEM, most of the informants who had either worked or been a patient in both the old and new hospitals expressed the belief that the quality of care was not as good as it had been at the FRH.

For community members at large, the fact that, within only a few years of the new hospital opening, there were no surgical services being offered, only a few low-risk deliveries were being done, and the number of beds had been cut by over half, left many people feeling that they were being poorly served. Informants repeatedly expressed a lack of understanding as to why a modern facility such as the Percy E. Moore Hospital was not providing these services.

The most common complaint voiced by informants was the perception that, with the occasional exception, there has been a high turnover of medical staff at the PEM. Although several physicians over the years appear to have gained the trust of Peguis residents, many informants described negative experiences which made them lose their faith in the Percy E. Moore Hospital, and it was suggested that a substantial number of Peguis residents prefer to see a family physician in Arborg or even Winnipeg for continuity of care. A community health worker confirmed that many women prefer to deliver their babies in Winnipeg:

> ...from talking to some of our moms...it's because of the doctor changeover. There are new doctors in and out [of the PEM] all the time. They don't call your doctor to come and deliver your baby. It's usually whoever is on call who delivers it. A lot of our moms are uncomfortable with that. The majority of them have

> doctors in Winnipeg who they go to...and the majority of them do have their doctors there for the delivery.

According to Dr. Sharon MacDonald, Medical Director of the NMU, there are at least four major factors which contribute to the difficulty in retaining physicians at this rural hospital. First; the multi-jurisdictional nature of the hospital--with physicians employed by the University of Manitoba's J.A. Hildes Northern Medical Unit, the province paying the per diem, and overall administration of the hospital in the hands of the federal government Medical Services Branch--makes problem-solving difficult, and physicians may feel that they are caught in the middle at times. Second; due to the fact that the MSB-run hospital is not part of the overall health care system in the surrounding Interlake region, physicians are professionally isolated--e.g., they are salaried (as opposed to the fee-for-services received by their counterparts in other Interlake hospitals)--and there is no shared 'on call' system. Third; with funding for only four physicians (one of those being primarily responsible for provision of services in Fisher Branch), physicians are on first call one in every four nights, and back-up every second night. The rigourous call system, combined with a high level of demand for service, may lead to burn-out. Finally; physicians have experienced both physical and social isolation in the area. The lack of available housing off the grounds of the hospital has contributed to a

difficulty integrating into the local Aboriginal community.[15]

Another opinion that was expressed frequently was a belief that, ever since the University of Manitoba took over provision of medical services, they were dealing with young, inexperienced doctors. One elder expressed resentment that "these young greenhorns only come here to practise on us, and then when they get enough practice they go somewhere else". Several informants spoke about their frustration over a recent incident where the people in the community had signed a petition in an effort to keep a popular physician whose contract had been terminated by the Northern Medical Unit, but their efforts were to no avail. It was suggested that many people had said that they would not return to the PEM if this doctor left, but it is not known whether this has occurred.

In summary; for the people of Peguis, even though the old Fisher River Hospital was run by the federal government, there was a sense of it being 'their' hospital, a place where they felt at home. In contrast, the modern new Percy E. Moore Hospital was run in a more bureaucratic manner, and it was no longer seen as being part of the community.

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[15]Dr. MacDonald acknowledges that there is room for improvement in the orientation provided to new physicians. One possibility that she has suggested is that each doctor be assigned to a community sponsor, or family, in order to learn more about the Reserve communities that they serve. However, Dr. MacDonald also suggests that the communities themselves have some responsibility for creating a welcoming atmosphere to new physicians who are entering a new environment.

### 3.4.3. Public Health Services (1940-1980)

Unfortunately, only a very sketchy history of public health services during the period from 1940 to the 1970s could be obtained from informants. A search of government archival material also failed to turn up more than a few isolated references to public health services at Peguis prior to 1980.

It appears that in 1940, when the old nursing station closed, community health services operated largely out of the Fisher River Hospital--at least until the mid- to late-1950s. However, public health programs do not appear to have been offered in any organized fashion during that time. In fact; former staff at the FRH recall that, during those years, the Director of Nursing (or Matron, as she was referred to) was also responsible for public health in the community. Eleanor Olson, who began working as an LPN in the out-patient clinic at the FRH around 1957, stated that she often went out with the physicians to conduct immunization clinics in the schools at Peguis, Fisher River and Jackhead Reserves. Eleanor also remembers that, around 1959, she went every morning (before she started work at the hospital at 8:00 am!) to give an insulin injection to the first known diabetic person in Peguis.

Aside from the public health work carried out by nursing staff who were based at the Fisher River Hospital, several informants remember that, as early as 1940, a nurse came to the community on Treaty Day each year to assist the physician

in taking x-rays for TB control purposes. There were also memories of a nurse coming into the school and giving pills to the children in the 1950s. One informant remembered that the pills looked like dog biscuits (probably a vitamin pill), and that many children thought that they were being punished. However, it is not clear where these nurses came from. Rita Dozois, a former MSB Nursing Officer, believes that a provincial public health nurse may have served the area at some time during the 1950s--but this could not be confirmed.

It does not appear to have been until the late 1950s that the federal government began to provide organized public health services on a regular basis to Peguis and the surrounding reserves. However, these services were very limited, with one public health nurse serving all of the Reserves in the surrounding Interlake region. The nurse worked out of an old house next to the FRH (one informant believed that this was actually where the original nursing station had been located), and this public health office was officially known as the Fisher River Health Centre.

In 1962, public health services in the area were further developed when Dorothy Stranger, who was born and raised in Peguis, was hired as the first Community Health Worker at the Fisher River Health Centre. The Community Health Worker Training Program was the largest of a number of government-initiated training programs for Aboriginal health auxiliary workers and para-professionals (Whitmore et al. 1988). Begun

in 1960 in Norway House, Manitoba, the purpose was to teach basic concepts about health and sanitation to these auxiliary health workers, who would then go back to their communities and teach their people. Dorothy Stranger was actually one of three Aboriginal people in Manitoba to be trained in the first year of the program in 1961.

Soon after Dorothy began working, Anna Pothorin, who had formerly been a Matron at the FRH, became the community health nurse (CHN)[16] at the Fisher River Health Centre. For a number of years, Anna and Dorothy worked alone together, not only visiting homes in Peguis, but also travelling to the surrounding Reserves to immunize babies and school children and to do basic health teaching in peoples' homes. Dorothy recalls that poor sanitation was a major problem in Peguis during the 1960s and 1970s. When she first started working in the early 1960s some people were still using water from the Fisher River, which was full of raw sewage by this time, and there were frequent outbreaks of diarrhoea (especially among infants). Dorothy had to do a lot of teaching about the need to boil water until community wells were drilled to draw on cleaner water from springs. Overcrowding in houses that had no running water or indoor plumbing caused many health problems. An increase in the use of alcohol also contributed to poor health in the community--a situation which was noted

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[16]The terms community health nurse (CHN) and public health nurse nurse (PHN) will be used synonymously in the remainder of the text.

with concern in the few monthly reports from the late 1970s which could be located in the archives.

At some point in 1970 or 1971, formal public health services were expanded in the Interlake region, with more nurses being hired, so that there was one CHN for each of the Interlake Reserves. Anna Pothorin became the Nurse in Charge of the Fisher River Health Centre and dealt primarily with Peguis after that time. In 1977, more auxiliary health workers were hired for the Interlake region. They were now known as Community Health Representatives, or CHRs. Verna Spence, who had worked as a nurse's aide in the old hospital, joined Dorothy Stranger, and the two CHRs then worked primarily in Peguis.

Both the CHRs and many other informants have fond memories of Anna Pothorin, who continued to work as the Nurse in Charge at the Fisher River Health Centre until 1980, when the Band took over local administration of the Health Centre and hired its own nurses (see next chapter). As one woman recalled:

> I remember Miss Potherin travelled back and forth to Jackhead now and then and she would stop by...just to see how I was doing and how the kids were. She was very well liked. And Dorothy Stranger too. They were very kind people. I remember one time when [daughter] was sick ...she [Anna] left her car at the road and she walked in, snow blowing, cold and everything....We very seldom took our children to the hospital. She would come to the house. Miss Pothorin was like family. She fit right in.

This same informant recalled that she was brought up using red willow for a medicine, and she would give it to her

kids if they had colds. When she told Anna Pothorin and Dorothy Stranger about this, both Anna and Dorothy said that this was good, and Anna never discouraged her from using her traditional medicines. According to Rita Dozois, a former MSB Nursing Officer, Anna Pothorin had certain personal qualities that contributed to being a good community health nurse:

> ...somebody who had an even temperament and who was accepting of other people...who was more than willing to sit and listen and who was not a pushy character. And that certainly was Anna....in the long run, Anna was more effective in doing things than a lot of other nurses were, who were always demanding. Anna was liked everywhere she went because she was so understanding.

Unfortunately, Anna Pothorin died in 1989, and with her, a wealth of information about this period of health services development in Peguis. What can be said is that, under her guidance, and with the assistance of the CHRs, the foundation was laid for the provision of public health services in the community. The health needs of Peguis during the 1960s and 1970s reflected the state of community development--i.e., many of the problems related to the high level of unemployment and poor living conditions on the reserve--and the public health staff did their best to respond to those needs. However, by the late 1970s, and escalating into the 1980s, the community began to undergo a transition, and the resulting changes in the provision of health-related services would reflect this phenomenon.

## 3.5 Summary

The period from 1940 to 1979 in Peguis was one of dramatic economic decline. During this time, the community's transformation from self-sufficiency to dependency and underdevelopment was completed--resulting in the loss of community control over conditions affecting health. The development of health services during this stage reflected a similar trend, and was characterized by the gradual hegemony of the bureaucratic government medical system and loss of community control and a sense of ownership over the process of health care. See Tables 1 and 2 for a summary of major developments during this period.

TABLE 1

SUMMARY OF PEGUIS COMMUNITY/HEALTH SERVICES DEVELOPMENT: PRIOR TO 1940

| | |
|---|---|
| Community Development | Relocation and economic subsistence |
| Aboriginal Health Policy/ Services | Lack of comprehensive Aboriginal health care system<br><br>[BNA Act, Indian Act, Treaties]<br><br>▮Government's position: provision of services based on 'humanitarian' policy rather than fiduciary or legal responsibility<br><br>▮period of fiscal restraint/chronic underfunding of Aboriginal health services |
| Peguis Health Services | 'Dual Medical Systems'<br><br>▮ →1923: intermittent physician services to Fisher River Agency<br><br>▮ 1924→: permanent Medical Officer for Fisher River Agency<br><br>▮ 1924→: nurse working out of Fisher River Agency (hired by Anglican Church?)<br><br>▮ 1930-1940: Fisher River Nursing Station (resident nurse)<br><br>▮ →mid-1930s: 'Indian doctors' and midwives active |

TABLE 2

SUMMARY OF PEGUIS COMMUNITY/HEALTH SERVICES DEVELOPMENT: 1940-1979

| | |
|---|---|
| Community Development | 'Underdevelopment'<br><br>▮economic decline<br>▮social problems↑ |
| Aboriginal Health Policy/ Services | 'Organized Aboriginal Health Services'<br><br>▮1945: responsibility for Aboriginal health services transferred to newly created DNHW<br>▮1962: MSB created<br>▮1970s:[First Nations demand ↑ involvement in health services delivery] MSB transfers some community health services to Band, Tribal Council administration (local medical transport, CHR, etc.)<br>▮1979: new 'Indian Health Policy' |
| Peguis Health Services | 'Government Control of Medical Care System'<br><br>▮1940: Fisher River Indian Hospital (Nursing Station closed)<br>▮1950s: public health services for region out of Fisher River Health Centre<br>▮1962: lrst CHR at Health Centre<br>▮1972: contract for local medical transportation transferred to Band administration<br>▮1973: new Percy E. Moore Hospital opens (old hospital closed)<br>▮1979: CHR, nursing positions transferred to local Band management |

# CHAPTER FOUR

## LOCAL ADMINISTRATION OF COMMUNITY HEALTH SERVICES (1979-1991)

During the 1970s, the federal government began to transfer the administration of a number of health-related services--such as local medical transportation, CHR, and some nursing services--to individual Band or Tribal Council operation through contribution agreements. While the motivation behind this initiative may be debated, there is no doubt that it coincided with the growing calls by First Nations peoples for more control over their lives.

In its 1971 document, Wahbung, the Manitoba Indian Brotherhood (MIB) had concluded their discussion of the dismal state of health among Manitoba's Aboriginal peoples with the following statement regarding health services delivery:

> The effectiveness of the health services program has historically been hampered by both the lack of understanding and the lack of involvement of Indian people. Externally controlled hospitals and nursing stations, externally developed programs of curative or preventive medicine have left little room for local participation....It is essential...that we have a more direct role in defining our needs, in establishing programs and priorities and in the implementation of programs and services (MIB 1971, p.172).

The MIB proposed that a regional Health Services Board be established, with equal representation from Manitoba First Nations and the federal government. This Board would be responsible for evaluating and assessing existing health care

services; recommending policy with respect to program adaptation, new program development, and methods of delivery; and facilitating the establishment of hospital boards and health committees at the community level (MIB 1971). Again, in early 1974, the Chiefs of Manitoba submitted a proposal for a Health Services Review and Restructuring Committee--consisting of three First Nation representatives and three federal representatives--to the Minister of National Health and Welfare (Canada 1974). The MIB's proposals appear to have been overlooked. Instead, in June of 1974, MSB set up a Federal-Provincial Liason Committee on Health Services to Indians and, in early 1977, a Tripartite Planning Group--consisting of representatives from the MIB, federal, and provincial governments was formed. There were only scattered references to this group found in MSB archives, but it appears that they met regularly for approximately one year--then abruptly stopped (Canada, RG 29, Vol.2933).

In early 1978, however, MSB-Manitoba's Regional Director reported that there had been considerable activity in Manitoba in the areas of Indian involvement and transfer of control of health services. He listed several examples:

> -For the first time representatives of the Indian people throughout Manitoba, the Manitoba Indian Brotherhood and Medical Services staff took part in a Health Planning meeting at the Norway House Reserve, 7 and 8 September 1977, to discuss present and future health programs for Manitoba Indians. Meetings of this nature will be on-going.
>
> -The majority of bands in Manitoba are contracted to provide CHR and Transportation services.

> -The Pas Band, Fort Alexander Band, Sandy Bay Band are contracted to provide nursing services, and The Pas Band is anticipated to assume complete control over their health program in the next fiscal year.
>
> -It is also anticipated that Peguis Band would be requesting contracting to provide nursing services in the upcoming fiscal year (Canada 1978).

Whitmore et al. (1988) have suggested that, although the transfer of administrative responsibility for certain health-related services built useful experience in program management and local administration, it did not constitute a transfer of control since MSB retained overall fiscal control and significant programmatic leverage. In the following section we will explore what happened in Peguis, in order to determine the relevance of this criticism.

### 4.1 Public Health Services under Local Administration

As we have seen, Peguis' experience with government-administered public health services from the mid-1960s to 1979 had not been a bad one, largely due to the fact that the public health nurse seemed to have gained acceptance by the community. However, beginning with the takeover of education services in 1977, a desire to take over management of community services appears to have steadily gained momentum in Peguis. MSB had already contracted with Peguis in 1972 to allow the Band to arrange and pay for local medical transportation in their area and to the nearest Medical Centre. By early 1978, Peguis Chief and Council had initiated

discussions with MSB regarding taking over the administration of further health services. In a document outlining MSB-Manitoba Region's interpretation of the new 1979 Indian Health Policy, it was stated that "the focus of the future will be in supporting the role of Indian bands and organizations in providing services directly" (MSB n.d.). In that same year, public health nursing and CHR services were transferred to Peguis Band administration. Then, early in 1980, Peguis took over local management of its Health Centre--which was re-named, the Peguis Health Centre.

Anna Pothorin and the nurses for the Jackhead, Fisher River and Lake Manitoba Reserves were moved into a small office in the Percy E. Moore Hospital, where they continued to provide public health services for the other Interlake communities. When the Band took over the administration of the Health Centre early in 1980, Kathy Bird (originally from Norway House, but a resident of Peguis since 1970 after marrying a Peguis Band member) had been working as an RN at the Percy E. Moore Hospital for about one year after graduating from the Brandon General Hospital School of Nursing in 1978. Her dream had always been to work as a public health nurse. In April of 1980, Kathy was hired as the first Band-employed community health nurse at Peguis Health Centre. When the second, senior nurse hired by the Band retired in June of 1981, Kathy became the Nurse-in-Charge of Peguis' public health services--a position that she holds to this day.

The initial reaction from community members to the new Band-operated Health Centre is difficult to gauge. It appears that there may have been some initial disappointment about Band-operated public health services, especially from those people who had become accustomed to Anna Pothorin over the years. As one woman (who remembered Anna giving needles and conducting baby clinics in living rooms) put it:

> It was hard at first....It was nice that our own people ran it [the Health Centre], but it was very small, and you had to sit and wait....It wasn't the same atmosphere as at home...

However, the mandate of public health programs was changing. Anna Pothorin had functioned during a period when control of infectious diseases was still the major focus, and when a lack of personal automobiles and poor roads in Peguis meant that she did a lot of her work in people's homes. When the Band took over the Health Centre, the focus of public health had shifted to prevention of disease and health education, with an emphasis on taking responsibility for one's health. In spite of the few criticisms that were expressed, there was a general concensus among those interviewed that having 'our own people' operating the Health Centre was an important development. The following comments made by two community members were typical:

> It's our people, which is very good....The only disadvantage was when you had to travel back and forth yourself. But now that they have a vehicle to pick up people who don't have cars, that's excellent...

* * *

> Well at least you always know that they are there....You feel more at home with them [nurses from Peguis] when you talk to them....When they ask you something you feel free to tell them....You can relate to them more than some of the outsiders...

What difference did the administrative transfer make to the delivery of public health programs in Peguis? An important point to note is that, when MSB transferred the CHR and community health nurse (CHN) programs to Band administration, it was a person-year (PY) **with MSB program content** that was transferred. The following comment from a former MSB Nursing Officer who was familiar with Peguis summarizes MSB's position:

> The only concerns that people would have had at that time were that if they [Peguis] were going to take over the program, then they had to take over the entire program, and not be selective....Maternal/child health was our number one priority....Our second priority was control of communicable diseases, which really meant immunizations ...and then we had school health, care to the elderly and chronic disease....Those were our five priorities at the time...so they were the programs that really were not negotiable when they took over....If they had another way of providing the care that was fine.

In theory, then, the Peguis Health Centre staff were now free to provide public health services in their own way. However, they were still required to deliver programs designed by MSB according to the government's priorities, and to report regularly to MSB. As Verna Spence, the CHR, comments:

> I just continued doing what I always did...no difference after 1980....We still had to give monthly reports to MSB...

Kathy Bird describes the shift to local administration of

public health programs this way:

> ...the only control there was, the Bands hired their own [staff] and they paid us. They got a lump sum from Medical Services to pay us...everything else, they [MSB] still wanted to control...

In spite of the lack of control that characterized local management of public health services, there were some advantages to the new arrangement. The local orientation of the health service, with the health workers reporting directly to the Chief and Band Council, meant that Peguis Health Centre could respond more quickly and effectively to community needs. Kathy Bird states:

> ...if we saw a need in the community...if there was nothing in the guidelines about Medical Services being able to cover the health needs, we made sure we went out and went after it...We had a good working relationship with the Chief and Council, and they supported us in whatever we needed to do.

The local orientation also resulted in increasing involvement in community activities to promote public health programs and public health awareness. Nurses' narrative reports and the CHRs' monthly reports[17] from this period indicate that the public health staff participated on various local committees, such as the Child Care committee, and Kathy Bird promoted health education in the school as a member of the local school board. When a Seniors' Residence was

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[17]Unless otherwise indicated, references to miscellaneous Health Centre documents (e.g., nurses' notes, monthly reports, etc.) are based on material found in the Peguis Health Services' archives.

established (see section 4.2), the Health Centre staff provided training to the attendants. When the local Native Alcohol and Drug Abuse Program (NADAP) began a series of Personal Awareness workshops in the community in the mid-1980s, the Health Centre staff were involved. In other words; the local orientation of public health services allowed more integration with other community and social services.

If one reviews the period of health services development from 1979 to 1991, it is clear that there were several obstacles that placed significant constraints on the Peguis Health Centre's ability to deliver a public health program that would totally satisfy both the consumers and the providers of these services. They can be summarized as follows:

1. Inadequate physical space

When Peguis took over the administration of their Health Centre it was located in an old building that had originally been the Indian Affairs office for the Fisher River Agency. The space was very small, which prevented staff from holding health education classes for groups such as prenatal clients and diabetics. A more serious problem was the poor condition of the building. Repeated flooding had caused serious damage to the structure. One employee who worked in the building recalls that "we got rained on together and we got cold together in the winter". By early 1984, the building had been condemned. There are repeated references in memos and monthly

reports from Kathy Bird to MSB, expressing serious concerns about the environmental health hazards at the old Health Centre, including: holes in the chimney causing a carbon monoxide leak, cracks in concrete walls, and non-functioning electrical outlets. Unfortunately, the problem was not resolved until July of 1987, when the Peguis Health Centre moved into the new facility where it is located today.

2. Administrative bind

Along with the discomforts caused by the physical environment, local administration of the Health Centre produced an added headache. On 12 November 1981, a letter was sent from the Peguis Health Centre staff and Chief & Council to MSB-Manitoba Region's South Zone Director. It was a request for a Co-ordinator or Administrator for the Health Centre, to be a direct liason with Chief & Council and MSB. The following excerpt makes Peguis's dilemma clear:

> ....As it is now, no one has any direct responsibility for the Peguis Health Program. Chief and Council are the employers, yet Medical Services guidelines are followed. The Health staff, it seems, are floundering with two indirect bosses and with no direct guidance or control. This guidance and control...must come from their own office, and should be someone who is aware of what must be done and will be an advocate for their needs and the needs they see in the community. Nurses are caught in the bind of attempting to administer the Health Office as well as carry out the necessary community health programs.... An Administrator, as we see it, would be a positive step towards native control of their own health needs and programs....[underlined in the original]

For Kathy Bird, the Nurse-In-Charge of Peguis Health Centre, the double role of administrator and health care

provider meant lots of paper work and meetings with MSB in addition to her nursing responsibilities. She recalls what it was like:

> What I found would happen was, I would really get into the administrative part, and my fieldwork would fall. Then I would get involved in the fieldwork and my administrative stuff would all pile up.... It was a good thing that there was enough of us. There was the other nurse, there were two CHRs, so I could do alot of delegating.... It was heavy, but I was able to do it.

Kathy recalls that several attempts were made to obtain funding for an Administrator, but she is not sure what happened with these requests. Correspondence from a Band official to Keith Cale, Acting Regional Director of MSB-Manitoba Region, in July of 1982 indicates Peguis' intention to apply for a Health Administrator position and part-time clerk for the Health Centre under the Community Health Demonstration Program (CHDP)--which was created to allow First Nations to develop pilot projects in community-based health planning and program delivery and to prepare for the transfer of existing services (Young and Smith 1992). Unfortunately, no further documentation was found on the subject. When asked to comment on the issue, a former MSB South Zone Director stated that, although she could not remember seeing a formal proposal from Peguis, it is unlikely that it would have been accepted, since the CHDP funds were supposed to be used in developing broader community-based program initiatives--not to create new administrative positions. It was not until 1990 that the problem was resolved (see Chapter Five).

3. Relationship with MSB

The added administrative responsibility was not the only problem faced by Peguis Health Centre staff. Unfortunately, an incident that occurred early in 1980 set the tone for the new relationship between Health Centre staff and MSB. As Kathy explains:

> ...just before I went there, Medical Services pulled out everything, all their equipment...furniture ....If one of the CHRs hadn't literally locked the door and not allowed them to take anything else, they would have taken everything.... Starting from that, and trying to build it up again to the things that we needed, that was a struggle.

According to a former MSB official, the items that were removed from Peguis Health Centre were required for the new clinic in Hodgson, where Anna Pothorin and the other MSB nurses continued to provide public health services to residents of the other communities in the surrounding Interlake area for several years. However, at least two Health Centre employees maintain that many of the items that were taken were put in storage, while some of the furniture was auctioned. Whatever the circumstances may have been, this incident appears to have been perceived as a form of punishment by the Health Centre employees, and it created some tension between the staff and MSB for some time.

From Peguis's point of view, the constant questioning of their administrative decisions and the endless red tape required before changes could be implemented was sometimes

perceived as an infringement on their desire for local autonomy. One incident that illustrates the struggle for control which characterized the relationship between Peguis and MSB during this period occurred in 1986 when the second community health nurse (CHN) position became vacant. The Band proceeded to hire Eleanor Olson, who had lived and worked in the community as an LPN (first at FRH and then at Percy E. Moore Hospital) since the mid-1950s. From MSB's point of view, this was not acceptable, since the contribution agreement called for employment of two CHNs, both minimally qualified at the RN level. According to a former MSB Nursing Officer:

> At that time, LPNs were not allowed to give injections and Eleanor had never worked out in the field before as a public health nurse...and we just felt that she didn't have enough background to work in public health...

However, from Peguis' point of view, Eleanor Olson's employment as a CHN made sense. Kathy Bird explains:

> Eleanor had already been a nurse for 20 years and more. She lived through, she saw the epidemics...she delivered babies, she sutured.... being a member of the community, being a native woman, her experience is invaluable.... I don't think that her getting the title of RN behind her name could even cover all the experience she has. I don't have any problem with her being hired. Sure there was the legalities, according to public health law...as to what she can do, but she went out and got her certifications that she needed for IMs [intramuscular injections] and stuff like that. She always upgraded herself through workshops...

For Peguis this was not simply a matter of a logical choice, but a matter of self-determination. In a letter dated

1 August, 1986, Chief Louis Stevenson responded to MSB's concerns in a letter:

> ...we are exercising our right to self-government and self-determination...we are deciding what is best to suit our needs and the needs of our people.... I consider this arrangement as being conclusive for as long as Eleanor is available and willing to serve our community.

Eleanor Olson continues to work as a CHN at Peguis Health Centre today.

4. Funding

The monthly nursing reports and minutes of meetings for this period indicate that inadequate funding and large deficits were a constant source of concern. Kathy Bird recalls that the Band had very little control over the funding process:

> ...usually there wasn't any consultation with us before things were done. The contribution agreement was pretty well decided by Medical Services, as to what we were going to get.... Most times it was sent out at such a late date, that in order to get the funding for the next fiscal year, it didn't leave any time for negotiation.

Charlotte Johnson, who was the MSB-Manitoba Region South Zone Director from 1982 to 1987, agrees that contribution agreements were often sent out very late, leaving little time for negotiation. However, she states that Zone Administrators had to wait for an allocation of funds from the Regional Office, which in turn had to wait for an allocation of funds from Ottawa--a process which took some time.

In November of 1988, members of Peguis Health Services

(PHS)[18] staff and Chief & Council met with MSB officials to review the Band's health-related programs. Concerns about inadequate funding dominated the discussion. The workload was increasing as the number of programs run out of the Health Centre increased, but there had been no increase in funding for support staff, leaving the Band to bear the costs for these positions. For example; when the new Peguis Health Services facility opened in 1987, Dental Services also moved into the new facility from its previous location in an old trailer near the school. This placed an additional strain on the receptionist and clerk positions. Another concern expressed by the Band at the November 1988 meeting was the 0% increase for Operations & Maintenance in the Contribution Agreement for that fiscal year.

Workers from Peguis's Native Alcohol & Drug Addiction Program (NADAP) attended the meeting and complained that they were unable to do the necessary preventive programs or workshops because they were so underfunded. An MSB representative explained that the base was maintained from year to year and increased a little bit for salaries, but acknowledged that the budget was designed five years earlier. When a Peguis Band councillor asked if the budget could be re-prioritized at the end of that fiscal year, one of the MSB

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[18]When the Health Centre moved into its new quarters in 1987, it became known officially as Peguis Health Services (PHS). The two names may be used interchangeably in the remainder of the text.

officials responded that the Band could "re-prioritize within the budget" while another suggested looking for funds from the Family Violence program. The minutes indicate that, at this point in the meeting, the two NADAP workers left the meeting.

It was this sort of interaction that produced a feeling of frustration among Peguis's community health workers and the Chief and Council, and contributed to the perception that they were constantly having to fight with an inflexible bureaucracy that did not meet the needs of their community.

At a meeting of the Peguis Health Committee (see Chapter Five), held in early 1989, the discussion centred around the "meagre budget" provided by MSB to the Health Centre, which was placing severe limitations on the staff's ability to do anything beyond regular tasks. At this meeting, one of the participants expressed the hope that the upcoming Health Transfer negotiations would produce "at least a slightly better financial status".

To summarize; while local administration of the Health Centre and public health services after 1979 did increase the Band's level of involvement in the health care delivery process, lack of overall control over finances and programming restricted Peguis' ability to control that process in a meaningful way. According to MSB-Manitoba Region's interpretation of the 1979 Indian Health Policy, the appropriate role of MSB would be to enhance the ability of Indian people to develop and manage the full range of direct

and supportive services that were necessary to maximize health potential (MSB n.d.). It would seem, from Peguis' perspective, that this goal had not been achieved as a result of local administration of its public health services after 1979.

Before proceeding to a discussion of Peguis' experience with the Health Transfer program, which began in the late 1980s, it is essential to explore several related health services initiatives that occurred in the community during the 1980s. The following examples indicate that the development of community-based public health services did not occur in a vaccuum, but were part of a broader phenomenon occurring in Peguis at the time.

### 4.2 Meeting the Needs of the Elderly

One issue which continued to be a serious problem for both the community at large and Health Centre staff in the early 1980s was the inability to adequately meet the needs of the chronically ill in Peguis. The provincial Home Care program did not include Treaty Indians, nor did the federal government provide funding for Home Care nursing services. This put a lot of pressure on the public health staff to provide these services, even though their mandate was to focus on public health programs. With only fifteen beds in operation at the nearby Percy E. Moore Hospital, many chronically ill elders were being sent to facilities far away

from the community. By 1983, residents of Peguis decided that the situation was no longer acceptable.

In November of 1983 a Seniors' Residence (Level 1) opened in two donated houses on the reserve. Elva McCorrister, who was born and raised in Peguis and who is presently the Director of the Peguis Personal Care Home, describes how the original Seniors' Residence (or Seniors Centre, as it was also known) developed:

> ...there were elders that were living alone in the community at that time who were unable to look after themselves...or they were staying home with no one to care for them...with no proper meals cooked for them.... They really needed the supervision. So...we decided that we would use a couple of houses.... We just took them in and hired some health care aides...ladies from the community to come in and provide the basics for them, like meals, and cleaning and bathing. Just sort of a safe place for them...

Elva recalls that the community's initiative was met with less than enthusiastic support from either provincial or federal levels of government:

> We were told by different government officials, government agencies, that we were not supposed to be doing this thing because we weren't licensed and we didn't have proper staff, and the facility was not built to code...and you name it. This is when we started approaching Indian Affairs and Canada Mortgage and Housing for a Personal Care Home.

Indian Affairs did agree to provide a $50 per diem for the eight initial residents through its Social Services- Adult Care budget. However, the fact was that the Seniors' Residence only partially met the need in the community. By March of 1984 there were 20 people on the waiting list.

Moreover, the greatest need at Peguis was for levels 3 and 4 care, which could not be provided by the Seniors' Residence.

The people of Peguis found themselves caught in a jurisdictional 'gray' area. Personal Care Homes are usually licenced by the provincial government. However, in the case of a reserve, provincial governments will not licence a facility, since health-related services are considered a federal responsibility. Unfortunately, the problem is more complicated than a jurisdictional dispute between the provincial and federal governments. It extends into the federal bureaucracy itself. Elva McCorrister explains:

> There is still that gray area. There is still argument between Medical Services Branch and the Department of Indian Affairs about whose responsibility it is to provide adult care/long term care [on reserves]. Indian Affairs says it's not really their mandate, and MSB says it's not their area and they are only into hospitals and that sort of thing.

A good example of the problem faced by the community occurred at a meeting held between representatives of Peguis, MSB and DIA on November 30, 1983. According to the minutes, when a Peguis Band councillor indicated that a Licenced Practical Nurse (LPN) was needed for the Seniors Centre, the DIA official stated that they were not in a position to respond to this need in the short-term. The Peguis councillor proceeded to ask if MSB could address the interim need until DIA funding came through, to which the MSB officials responded that they did not have the jurisdictional authority to do so.

At this same meeting Peguis made an alternative proposal

to MSB. At that time there was discussion of turning a vacant wing of the hospital into offices. Peguis requested that six (unused) acute-care beds be converted to levels 3 and 4 care, and that fourteen staff residence units be converted to levels 1-2 (semi-ambulatory) care. This was not a new idea. In May of 1983, a consultant's report had recommended that the Percy E. Moore Hospital be converted to the delivery of both acute and level 4 (possibly level 3) nursing care (CESO 1983). The report also recommended that a study be done to determine the feasibility of converting some part or all of the staff residence to level 1 and level 2 nursing care beds.

The result, according to Elva McCorrister, was the following:

> We had meetings and meetings, and nothing ever came of it either.... I can't remember there even being a letter or response. There was nothing done.... They turned it [the wing] into offices.

What happened next is characteristic of how Peguis responded to perceived needs in the community during this period- they went ahead and built an extension onto the existing Seniors' Residence in the fall of 1984, expanding the capacity to fifteen beds. Although part of the costs for the expansion was paid by Indian Affairs, in April of 1985 DIA suddenly cut all funding to the Centre, claiming that it failed to meet Manitoba Health Services Commission standards for health and safety and that the expansion had never been approved in the first place (Interlake Spectator, 3 July

1985). However, in an interview with a local newspaper, the federal MP for Selkirk-Interlake, Felix Holtmann, suggested that the real problem was that Indian Affairs was reluctant to set a precedent by continuing to fund the Peguis Seniors Centre:

> They may fear that other bands may just go ahead (and build similar centres) and ask for funding afterwards (Interlake Spectator, 3 July 1985, p.3).

Once again, Peguis went on the offensive. The Band could not afford to keep the Centre running on its own. To protest the withdrawal of funding, Chief Louis Stevenson applied for a permit to hold a demonstration in front of DIA offices in Winnipeg. A few days before the protest was scheduled to take place, Indian Affairs approved over $350,000 in funds for the operation of a Personal Care Home at Peguis. Elva McCorrister comments:

> It [the threat of political protest] had alot to do with them approving our proposals...ultimately, it was up to Indian Affairs to give their final stamp of approval.... I definitely depended on them [the Band leadership]...for that final shove with Indian Affairs ....We were always able to depend on the leaders to help us.

The Band continued to push for improved personal care services and, in 1988, the Peguis Personal Care Home moved into a new 22-bed facility subsidized by Canada Mortgage and Housing. At the moment, funding from Indian Affairs allows them to operate 20 of the available beds. MSB covers the cost of drugs or any specialized services at a physician's request.

Having this facility in Peguis has several benefits. The

obvious one is that elders requiring a high level of care can now remain in the community rather than being sent to an institution far away. Another major benefit is that it creates employment. With the exception of a couple of casual workers, all the staff are from Peguis. A third, perhaps unexpected, benefit has been that the Personal Care Home has become a focus for community involvement. Elva McCorrister explains:

> We have a senior citizen's club. They meet here every week...Thursdays for bingo...and we have an exercise program.... Also we have services, church services, where the community is invited to attend.... So it is sort of a drop-in.... We do deal with all the seniors in the community. I am also an advocate for alot of them in dealing with their pensions...and stuff like that. So they are always in and out of here for various reasons.

Elva made a point of emphasizing that, ideally, Peguis would like to have as many of its elders maintained at home as possible. The fact that neither Medical Services Branch, nor the provincial government, provides funding for a Home Care Nursing program for Aboriginal people living on reserves poses a problem, in terms of maintaining chronically ill elders in their homes. However, a lot of effort has been made to improve services for the well elderly and maintain them in their homes. The Personal Care Home took over operation of (non-nursing) home care services, which were formerly administered by the Band's Social Services workers. A coordinator does the assessments and homemakers are hired from the community to provide basic cleaning and cooking services

to an average of twenty homes in the community. This, according to Elva McCorrister, helps a lot of people stay at home.

In addition; Peguis has taken steps to meet the housing needs of its elders by building a ten-unit apartment block for people who can still live alone. Located next to the Personal Care Home and a five-minute walk from the mall, residents can easily access all the services that they need. Elva McCorrister is very pleased with the outcome:

> This just works beautiful here.... There is a waiting list for that place. They really like living in that apartment.... They sort of work together and help each other and socialize with each other. We sure need another unit like that.

After ten years, Peguis has made tremendous progress in meeting the needs of its elders (as well as elders from other First Nation communities). This involved the dedication and persistence of people like Elva McCorrister and the commitment of the Band's political leadership to obtain the needed services one way or another.

### 4.3 Confronting Alcoholism in the '80s

A recurring theme in many of the interviews with key informants, when asked to identify the motivating factor for their personal involvement in community health-related services or to identify a major turning point in community development as a whole, were the frequent references to the early 1980s. "It was when people started sobering up" was a

common statement heard.

Informants offered several reasons why alcohol abuse had become such a widespread problem in Peguis. Loss of economic self-sufficiency was an important factor. Cutting and selling wood, and grain farming, were two important sources of income for community members in the early years. The loss of these economic opportunities--at least partially due to an inability to compete with non-Aboriginal people in the region who had more resources, such as bigger trucks--was identified as having a major impact on the people of Peguis. The introduction of social assistance in the mid-1940s appears to have exacerbated the problem. As one informant described it:

> I remember around the early fifties. I can remember when my parents started to get welfare, or rations, as we knew it at that time.... They were able to go up to the Agency [local Indian Affairs office] up here with their teams of horses and wagons and load up with tomatoes, milk, bacon, tea, lard...and they would come back home. I would always wonder how could they afford these things? Times before, we always went out in the bush and got deer and moose...rabbits...and that's where I started to see people sit back, not taking any initiative.... As time went on and people started to get welfare cheques...they just continued to not do anything.... When people start sitting back with nothing to do then that's when they start getting into something else to occupy their time. That's where they started getting into alcohol.

Low self-esteem, resulting from bad experiences in residential schools and negative stereotyping of aboriginal people, was also emphasized by a number of informants. Until the 1960s, only primary school education was available on the Reserve. Beyond grade seven, children had to go away to

residential schools--Brandon, Birtle and Portage la Prairie were the ones most frequently named by informants. One man, who has been sober since the early 1980s, described how his childhood experience affected his self-esteem:

> When I was in school here in Peguis, we couldn't speak our own language.... I learned a few words of Cree because another guy that I knew spoke it.... One day [the teacher] comes over and says: "What did you say?" I repeated the word in Cree...and she never asked me what it meant. I tried to tell her that it meant 'hello'. She said: "You go in there and wash your mouth out with soap".... Yes, that's all we were taught- 'you dirty Indian'...you didn't want to be that because you were treated so miserable.... I think that a person has to establish an identity, and if they're going to establish an identity, it might as well be their own. For a long time, I wanted to be a white man. That's crazy.

Another key informant described how a terrible experience in a residential school led to alcoholism later in life:

> I was in one of those residential schools, and what I went through there is something that I'll never forget. It will always be within me, with all the abuse that happened. When I left that system, I buried that deep inside, hoping it would never surface again....They used to say, "You're just a bunch of lazy Indians, you'll never amount to anything". I grew up believing that, and I started acting it out.

Regardless of the root cause, alcoholism was certainly taking its toll in the community. As one young man recalls:

> I can still drive along the roads and remember all the accidents...alcohol-related...where alot of my friends, my peers, died.

In the early 1970s, several community members formed an Alcoholics Anonymous (AA) group in Peguis, but it was not until the early 1980s that a movement toward sobriety gained

momentum in the community. For most of the people whom we interviewed, there is no question about when the turning point occurred. The following comments were typical:

> I found a big difference in the early eighties. Alot of other people were sobering up at that time. One of the biggest things that happened at that time was, Chief Stevenson got in as Chief...and I think that it was about three months after he got in as Chief that he announced he was joining AA...that he was stopping drinking. I think that had a big impact on the whole community when he publicly said that at a Band meeting.... At that time there was a big enthusiastic group of AA members that kept doing sober socials and dances...and he was a big part of those activities...always got up there and reinforced sobriety.

* * *

> I think that the changes started when Louis got in as Chief, for the main reason that Louis don't drink...and most of the Council don't.... That was a big thing in my life as well. I quit drinking in the early eighties. He [the Chief] set a precedent.... That is the difference here. The leaders on the reserve who have respect for themselves gain respect. The ones who don't drink have one hundred percent more respect.

One key informant credits the progress made in Peguis over the past twelve years to the movement toward sobriety among community leaders:

> I've seen our community move ahead so fast in the past twelve years that it is almost unbelievable. When I was with [names community program] I'd go out to other communities and do workshops and tell them how we overcame certain problems. I went as far as Fredericton, New Brunswick, and they had heard about Peguis, about our leadership being sober.... I believe we need leaders who are straight and sober in their lives to set that example for their people.

In 1982, a resident of Peguis was hired by MSB to work as a Native Alcohol and Drug Abuse Program (NADAP) counsellor in

the community. Over the next few years, the NADAP worker, a very active group of AA members, and the Band's political leadership worked to deal with the alcohol problem in the community. One of the steps taken was to remove the liquor licence from the community hall. Although the reserve was not 'dry', and alcohol could be easily obtained in surrounding communities, many informants felt that this was a positive step. Several of the respondents who were involved in the sobriety movement during that time recall that it was not always easy, especially if people remembered them from their earlier alcoholic years. They realize that it took awhile to earn respect back and to become trusted.

In spite of the positive developments that had occurred, there was still a great need for treatment services for people with addictions- not just in Peguis, but in many of the surrounding Interlake communities as well. Members of the local AA group had started writing letters requesting a treatment facility for the area in the early 1970s. There was only one treatment centre on a reserve in Manitoba by the late 1970s (Sagkeeng Alcohol Rehabilitation Centre in Fort Alexander), which was operated through MSB's NADAP program. As Jean Buck, the current Executive Director of the Peguis Al-Care Treatment Centre, recalls:

> A group of people- sober people- got together, some with the Chief and council, some with the school board, and we just sort of wrote up proposals and got the idea across that we wanted a treatment centre for Peguis. We submitted those to Medical Services...through our NADAP program at the time. It wasn't until we got the economic

> development officer involved that he was able to get a more formalized feasibility study done on it...how we could serve...not only this community, but the surrounding communities.... Through that, we were able to establish one. The council put alot of work into that as well, and they did alot of pushing to get one put here.

It is interesting to note that the federal government's approval of funding for an alcohol and drug treatment centre for Peguis came during a period of intense political protest during 1986--including demonstrations and occupation of Indian Affairs offices in Winnipeg--by Peguis and other Manitoba First Nations. They were protesting against the Department's failure to correct wrong-doing outlined in a report by an independent auditor, which confirmed that the Manitoba office of Indian Affairs had mismanaged its financial affairs, leaving First Nations in debt and facing further program reduction (Winnipeg Free Press, 15 August 1986; Interlake Spectator, 20 August 1986).

In September of 1987, a new 20-bed facility for the treatment of alcohol and other addictions opened in Peguis. While intended to primarily serve the local Interlake reserves, the Peguis Al-Care Treatment Centre can take clients from surrounding non-aboriginal communities if the need is there. However, the focus of the program is definitely on meeting the needs of the Aboriginal client. The Centre's Executive Director, Jean Buck, describes the program:

> The program is six weeks long, and it's for residential as well as non-residential clients.... We may have about three or four from the community who come in during the day, or sometimes it's more than that, it varies.... [At

> the moment] about thirty percent of the residents are from Peguis.... The program is based on the '12 steps' of Alcoholics Anonymous [but] there are options for those that are into the traditional ways of life, as well as the Christian way of life.... We have six counsellors in all. They have gone through a two-year training program and they are certified counsellors.... We have nine support staff, including myself, so we have fifteen permanent staff altogether, and we have about seven part-time staff. All are native people and all are from the community.

One of the counsellors, Dave McPherson, believes that the program is effective in meeting its clients' needs because of the different orientation or approaches that are used by the various workers:

> We're all from different backgrounds. There's a Pentecostal minister, another's an atheist, one's Anglican, one's Catholic, and a traditional person. We need all these things to help people because each person that comes to treatment will probably be looking for something. So, if I can't offer it, then we'll make the referral. As time went on, it became natural. We all know a little about each other's ways [of counselling].

According to Jean Buck, the Al-Care Centre's staff serve as role models for the community:

> Our staff are all sober.... It is important that we portray a sober life, and not only portray it, but live it. People do watch you. You are a role model whether you like it or not.... Our policy is to wait a year, have persons sober for a year before they can work here.... Our part-time staff is growing... we have people coming in here that want to work in the Treatment Centre.

Another advantage for the Peguis Al-Care Centre is that it can utilize the large number of locally-run resources in the community, including social services, ambulance and emergency services, the Health Centre, and cultural speakers

(see Chapter Six for a discussion of the role of Peguis's Mental Health and Cultural programs in the Al-Care Centre).

As in the case of the Personal Care Home, community involvement and the support of community leaders are important factors in the Al-Care Centre's successful operation. Although funding comes from MSB through annual contribution agreements, the Centre is incorporated and has its own Board of Directors, (currently) made up of seven community members. Jean Buck explains:

> We have full support of the Chief and council, in terms of running this place.... What we do is, we evaluate our program every year.... We have our clients do an evaluation on us, when the program is complete. Like, what did they like best about it, what did they like least?...some of the program content, was it any use to them?.... We sit down, the whole staff and board and we look at it and see where we could improve in areas.

She thinks that it is a combination of the program, the atmosphere, and the location that makes the Peguis Al-Care Centre popular with clients:

> Our 'P.R.' [public relations] is through the clients.... They like it here...and tell [others] what the program is about and how it helped them. Other people want to come and find out for themselves...and it just sort of goes on like that.

Problems with addictions still exist in Peguis- just as they do in other communities (see Chapter Six for a discussion of other community-based programs that are currently dealing with this problem). However, Jean Buck believes that sheer determination has helped Peguis to at least be able to begin to address the needs of its community (and others):

> It took us a long time to get a treatment centre here....you have to fight for it...get together and give each other encouragement. Just don't give up.

## 4.4 Control of Ambulance and Emergency Services

A third example of a community health-related initiative during the 1980s--this one involving the takeover of a previously existing service--is worth mentioning briefly. In July of 1985, Peguis took over the operation of the regional ambulance service serving Peguis, Fisher River and Jackhead Reserves, as well as the surrounding non-Aboriginal communities of Fisher Branch, Harwill and Red Rose. According to Larry Amos, the Band's Economic Development Officer, Peguis believed that it could run a service that could better meet the needs of those it served.

The new Fisher Ambulance Service was located in the Peguis Emergency Services building, where both the police and fire departments for the reserve worked out of, and the three services shared a 24-hour emergency telephone system. In addition to vehicles and dispatchers for the three services now being in the same building, the service was now in a location that was more central to the majority of the population served. According to an official at Fisher Ambulance Service, this has resulted in quicker response times.

Another obvious benefit of Band-controlled ambulance services has been the creation of jobs for Peguis residents (4

full-time and 4 part-time dispatchers, and 10 drivers and attendants). Less obvious, perhaps, is the fact that the ambulance service has become another source of community involvement and community pride. As Larry Amos explains:

> As a community project, I think that the ambulance service deals alot with the community....[it]became a focus for those individuals who were involved in it. It was a job...very demanding...but it gave the people that were involved gratification, and acceptance in the community. They've done great!

Unfortunately, the initiative has not been without its problems. According to Cecilia Stevenson, Director of Peguis Health Services, MSB has never fully recognized the operation of the ambulance service as being part of their mandate and, therefore, the Band has had to absorb a large part of the costs involved in its operation.

## 4.5 Summary

To summarize this period of health services development; by the late 1980s, several conditions existed in Peguis which help to explain the context in which Health Transfer and the subsequent health program initiatives developed. First; the 1980s had been a period of dramatic economic development, fuelled by a political leadership that was fiercely committed to the principle of self-determination and which took every opportunity to exercise that option. Second; a cadre of active community members and workers had developed who took the initiative to meet the health needs of the community in

the absence of government services. Finally; while responsibility for operating the community's Health Centre did build up useful experience in local administration and program management, there is no doubt that MSB still retained significant programmatic leverage and overall fiscal control. The question to be answered now is: "Did the Health Transfer initiative shift the balance of power to Peguis's advantage?"

# CHAPTER FIVE

## THE HEALTH TRANSFER EXPERIENCE

The 1979 Indian Health Policy supported the goal of Aboriginal people to be self-determined, and called for increased participation of Aboriginal people in the planning, budgetting, and delivery of health services in Canada (Canada 1979). In line with this new policy direction, Medical Services Branch initiated a three-year demonstration program in 1982, which was intended to encourage First Nation communities to gain experience in the operation of their own community health programs. Two of the thirty-one projects that were funded under the Community Health Demonstration Program (CHDP) were in Manitoba--at Sandy Bay and the Northeast Indian Health Council. While Sandy Bay's demonstration project paved the way for the eventual full transfer of its health programs to Band control, the authors of a study of the Sandy Bay project concluded that the CHDP did not allow adequate time, training resources, and the flexibility required to develop a community planned and operated health program (Garro et al 1986).

In early 1985, a Sub-Committee on the Transfer of Health

Services was established to propose policy options for the control and provision of health services by Aboriginal people. The Sub-Committee submitted an interim report in November of 1985, indicating the intent to transfer health programs to the control of First Nation communities south of the sixtieth parallel (Canada 1986a). This report also recommended the initiation of a consultation process with Aboriginal leaders and other interested members of First Nation communities to consider practical community concerns about health service transfers. In March of 1986, the Sub-Committee sent out a discussion paper to First Nations representatives--which was, ostensibly, developed for their consideration--outlining the main features of a proposal to transfer health programs (Canada 1986b). Less than one month later, the Minister of Health and Welfare formally announced the government's intention to initiate the Indian Health Transfer Policy. Many First Nations leaders were outraged, claiming that they had never been consulted on the details of the Transfer initiative (Culhane Speck 1989).

The main features of the 1986 Health Transfer Policy will be discussed in relation to Peguis' experience in the following sections. Before doing so, however, it is interesting to note some of the major criticisms of the Transfer Policy which were expressed by First Nations in response to the initiative. In November of 1987, the Assembly of First Nations organized a National Indian Health Transfer

Conference to examine issues related to the transfer of health services from federal government to First Nations. Although some First Nations saw Transfer as a positive development which would allow them more input into their health services, numerous delegates at the conference expressed suspicion at the government's motivation in pursuing Transfer at that time, suggesting that the government's primary intent was to rid itself of its fiduciary obligations to First Nations while implementing federal cost cutting measures (AFN 1988). These representatives cautioned other delegates about pursuing Transfer without a clear federal recognition of health as an Aboriginal and Treaty right and without a guarantee of future health care funding.

Specific concerns about the Health Transfer Policy expressed at this conference included: the "no enrichment" clause, meaning that health services and budgets are frozen at the time of transfer; the ineligibility of several programs for Transfer--especially non-insured services; insufficient time and funds (two years) to complete the required pre-Transfer activities of conducting needs assessments and designing a community health plan; the exclusion of training for health care workers; the calculation of funding based on the number of registered Band members living on Reserve at the time of transfer only; and a lack of funding to support the integration of traditional healers into First Nations health care systems (AFN 1988).

Commenting on the "no enrichment" clause, Culhane Speck (1989) points out that existing services are inadequate and underfunded and that there are major differences between First Nations in the number and quality of services available--thus, the "no enrichment" clause amounts to freezing inequality between communities (p.200). In addition; Culhane Speck argues that, despite what real needs might be established by the needs assessments carried out as part of the Health Transfer process, the "no enrichment" clause ultimately determines how and if these needs can be met (p.202). As for the exclusion of non-insured benefits as a transferrable program, Culhane Speck warns that this leaves open the possibility that these benefits might be withdrawn, and the certainty that they would be administered by MSB criteria (p.200).[19] Let us turn now to an examination of Peguis' involvement in the Health Transfer process to determine the relevance of these criticisms to this community's experience.

## 5.1 Motivation for undertaking Health Transfer[20]

Cecilia Stevenson, who is the current Director of Peguis Health Services, grew up in the Cree community of Norway House in central Manitoba and later married a member of Peguis First Nation. She was working at MSB in Winnipeg in 1987 when she

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[19]See section 5.5.1 for a more detailed discussion of non-insured health benefits.

[20]The terms 'Health Transfer' and 'Transfer' will be used interchangeably throughout the remainder of the text.

was approached by Peguis Chief and Council and asked if she would be interested in coming to work for the Band as their Transfer Coordinator. Peguis was interested in submitting a proposal for pre-Transfer funding, and they had heard that Cecilia and her husband were planning to move back to the community that summer after living in Winnipeg for several years. Cecilia's background made her an ideal candidate for the job:

> I started at Medical Services as the 'Transfer of Control Officer'. After that, they changed my title to 'Community Development Advisor'.... Basically, I worked in the health pre-Transfer area. So it was an excellent preparation for the job that I came to here in Peguis.

Peguis Chief and Council were eager to get the project started as soon as possible. The first task was to submit a proposal for funding of the research and development, or pre-Transfer, phase of the Transfer process (see section 5.2 for details of this phase). Although she continued to work for MSB until October of 1987, and did not officially become a Band employee until funding was received in January of 1988, Cecilia began to work with the Band on a voluntary basis in the summer of 1987. Her experience meant that she was able to assist them in developing their proposal fairly quickly, and this was submitted to MSB in September of 1987.

In the introduction to the proposal the following statement indicates that Peguis had no illusions about the process that they were becoming involved in:

We are acutely aware of the limitations under which the

> transfer process exists. It is not the mode under which we would prefer to deal, the ideal that is envisioned would be an arrangement enshrined in the Self-Government concept. The concept would see us establishing our own institutions and systems independent of government interference save fiscal appropriations by virtue of entitlement under our treaty, aboriginal and inherent rights as found in the Treaties, Royal Proclamation of 1763, Canadian Constitution, International Law and other foundations. In spite of the shortcomings of the transfer process, however, we value the opportunity it presents and we recognize it as a tangible step towards Self-Government and Self-Determination (Peguis 1987, p.2)

Cecilia suggests that participation in the Transfer initiative was a matter of taking advantage of an opportunity that made sense, given the stage of social and political development that Peguis was at:

> It was a whole series of...developmental experiences over the years that got them [Peguis leadership] to that point where...they had all the tools and so that's what they went with.... We all knew that our eggs were not in that one basket. We knew enough to recognize it for what it was, and we were going to take advantage of that, and in business that's what you do. You look at whatever initiative there is, and you analyze it and if you come out with more positives or if it looks like a good risk, you go with it.

Funding for Peguis' proposal was approved swiftly, and the first phase of the pre-Transfer period began in January of 1988, with Cecilia Stevenson working full-time as a Transfer Advisor for the Band.

### 5.2 Research and Development Phase: Jan/88 to Sept/90

During this pre-Transfer period (which, at the time that Peguis was involved in this phase, was limited to twenty-four months), communities have the opportunity to conduct the

necessary research in preparing their Community Health Plan (CHP). This might include research of existing services and resources, a community health needs assessment, and community health status assessment. The overall objective of this phase, according to MSB guidelines, was the development of a Community Health Plan that would outline the health status, needs, priorities and resources required for delivery of health programs. The other major task required during this phase was the development of a new management structure at the community level (Canada 1987). These two processes will be discussed separately.

### 5.2.1. Determining the Community's Health Needs

Although very time-consuming, in some ways this was the easiest part of the pre-Transfer process for Peguis. With the assistance of consultants in the University of Manitoba's Department of Community Health Sciences, a Community Health Needs Assessment (CHNA) was designed and conducted in 1988. The actual development of the CHNA questionnaire involved the input of all PHS staff, Percy E. Moore Hospital medical and administrative personnel, and other health-related Band employees (e.g. Personal Care Home). Five community members were then hired and trained as interviewers to work for a 20-week period.

According to Cecilia Stevenson, the CHNA did not necessarily tell them anything new. She sums up the

experience this way:

> We viewed this as an exercise.... The major positive outcome of the community health needs assessment, in my mind, was that it documented what we already knew.... The data that we gathered has given us sort of like a synoptic view of our needs, and it helps us to plan ahead.... It gave us some statistical data upon which we can base our arguments for hopefully gaining more resources later on ...in fact, it helped us already, in our negotiations...

Aside from the CHNA being a useful exercise that helped to highlight problem areas, Peguis was also fortunate that, during this same period of time, Medical Services Branch invited participation in an assessment of the health status of all residents in the Percy E. Moore Hospital cachement area. This was intended to assist in the planning and delivery of the services within the MSB's mandate. The results of the assessment were made available to Peguis early in 1989, allowing them to compare and combine results with the CHNA.

The Peguis Community Health Plan contains a summary of the major findings of both assessments. Several important features are worth mentioning here. MSB's health statistics show that Peguis' crude mortality rate was much greater than that expected if Peguis band members had the same age and cause-specific death rate of all Manitobans, with the excess appearing to stem largely from diseases of the circulatory system, neoplasms (cancer) and endocrine/metabolic/nutritional disease (diabetes). The crude rates for these three causes of death in Peguis were also greater than for the two aboriginal comparison groups. The fourth most common cause of death was

injury and poisoning. This rate was also greater than that of all Manitoba residents, but less than the two aboriginal comparison groups (Peguis 1990, Table 4).

From a subjective point of view, key informants interviewed in the CHNA identified alcohol and drug abuse as the major health concern in the community, especially among younger people. Informants generally indicated that substance abuse was both the cause and effect of a multiplicity of other problems, including: lack of knowledge and motivation to seek help, unemployment, depression, abuse cases and teenage pregnancies (Peguis 1990, p.14).

Finally; the general survey of community members suggested that significant numbers of people in Peguis were experiencing a high level of stress in their lives. In fact, a check with Percy E. Moore Hospital revealed that 29 suicide attempts (all unsuccessful) were treated in the 21-month period between July, 1987 and April, 1989 (Peguis 1990, p.7). Key informants stressed an urgent need for community mental health workers and the development of community mental health services.

It should be noted here that the Peguis Community Health Plan identifies two major priorities for delivery of a community-based health program that emerged from the needs assessments. The number one priority is to improve existing health programs and services. Many of the recommendations listed in the CHP are aimed at achieving this goal by

improving the coordination and administration of existing services and use of innovative approaches. In other words, they would not necessarily involve extra resources. However, the second priority identified is the need to develop a comprehensive community mental health program. Since there was no formal, organized mental health program being delivered by MSB during the pre-Transfer period, this goal would require the designation of new resources- and therefore, by definition, would be beyond the scope of the Health Transfer initiative (see Chapter Six for a detailed discussion of this issue).

### 5.2.2. Developing a Community-based Management Structure

The second major task to be completed during the pre-Transfer phase was the development of a management structure at the community level that would be responsible for health program delivery following transfer. According to MSB guidelines, the structure designed would depend on the size of the operation and how the Band envisioned the integration of the program into existing operations. The health authority could take a variety of forms. This might involve the training of a Health Committee or Board of Directors, and might also involve the training of a Health Administrator to provide ongoing direction to health staff. Ultimately, the powers of the health authority would be those delegated by the Chief and Council and could include: the power to propose

local by-laws; the powers assigned to health providers (for example, to require action to be taken to correct an environmental hazard); and the authority to commit funds or pay accounts (Canada 1986b, p.4; Canada 1987, p.7).

As it would turn out, the training of a Health Administrator would not pose a problem, since Cecilia's experience as the Peguis Transfer Coordinator allowed her to make the transition easily later on to the new administrative position. In addition; since taking over the management of the Health Centre in 1980, the Chief and Council had been functioning as the health authority in Peguis, with the Health Centre staff reporting directly to them. However, the Band did enter into the Transfer initiative with the long-term intention of developing an autonomous Health Board.

One of the first steps taken during the first year of the pre-Transfer period was an attempt to establish a Health Committee (HC). It was hoped that this structure would become a permanent health authority, or Health Board, after Transfer. Early in 1988, Chief and Council were approached for direction regarding the selection of HC members. The method chosen was to call for volunteers at a public band meeting (nine signed up), then to invite those people to another meeting to measure the real interest and to provide more information. Four of the original volunteers responded to the invitation. Along with the Health Portfolio Band Councillor, this constituted the five-member HC as planned. It was intended that the

Health Portfolio Councillor be the chairperson of the Health Committee, acting as a liason between Chief and Council and the HC members. Initially, it appears that the Chief himself held the Health Portfolio, but another member of the Band Council assumed the Portfolio in the fall of 1988. Unfortunately, one of the four community members could not continue, and a decision was made to have a seven-member committee in order to avoid having to retrain as often if someone withdrew. Potential candidates for the remaining vacant positions were sought by approaching PHS staff and HC members for recommendations, and then ratification was obtained from the Chief and Council. It is significant to note here that most of the HC members were people who were working in one of the community's human service organizations.

Progress reports and HC meeting minutes throughout 1988 indicate that a tremendous amount of time and effort was expended by Cecilia Stevenson and several PHS employees to develop the Committee. Training sessions included detailed presentations on the historical organization and provision of health services to aboriginal people in Manitoba, explanation of the Transfer initiative and the overall plan of activities for the pre-Transfer period, and familiarization with common terminology used in the health care field.

The HC met regularly during 1988, and a progress report submitted to MSB in March of 1989 indicates that the growing confidence and involvement of members had resulted in their

acting on several issues to encourage healthy practices in the community- especially in relation to garbage disposal and sanitation. However, it is also clear that the development of the HC was being hindered by the constant turnover of its members. It appears that, in almost all cases, people could not continue to participate due to increasing or new work commitments locally or elsewhere. Each time someone resigned, a replacement had to be sought and trained in order to bring them up to the level of the other members.

Some time after April 1989, the decision was made not to pursue formal HC activity at that time. Cecilia recalls that this decision was not taken lightly:

> I'm a strong believer in community development principles ...community involvement being one of the main principles of community development...involving people in decision-making.... The people who had the opportunity to be on the committee contributed to our overall development.... [but] we couldn't keep on with it. Helping people to develop takes alot of effort and commitment and time, and that could have been a whole job in itself. It was taking up alot of my time. Because of the demands of the pre-Transfer process...the fact that we had to get the work done in a short time frame...and so a choice had to be made....in essence, we had to put aside those honourable principles...

After the spring of 1989, Cecilia and the PHS staff continued --and still continue to this day--to consult directly with Chief and Council regarding major decisions involving the Transfer process. The formation of an autonomous Health Board remains a goal of both Peguis Health Services and the Chief and Council. Unfortunately, most of the time since the Transfer Agreement was signed has been

spent on developing the administrative infrastructure required to operate Peguis' community health programs effectively (see Chapter Six). However, it is anticipated that the issue of developing a Health Board will be addressed in the near future. In order to avoid the problem that occurred with the former Health Committee, Cecilia Stevenson would like to see more lay people from the community become involved in the process this time.

While the establishment of a Health Committee did not work out as planned, Cecilia was able to complete the other tasks involved in laying the groundwork for the anticipated new management structure of Peguis Health Services. Most of these tasks involved the development of policies and procedures related to the administration of programs and services. Perhaps the easiest one for Peguis was the development of an Emergency Response Plan--one of the four mandatory programs that must be continued following Transfer (the others being communicable disease control, environmental/occupational health and safety, and treatment services). This simply involved revising the plan that was already in place in the community. The development of job descriptions was also straightforward. With input from the employees, all existing job descriptions were revised to better reflect the specific activities required to meet the needs of the community.

During this time, Cecilia also developed a new Health

Personnel Policy Manual. Although this was not an absolute requirement of pre-Transfer planning, it was felt that it would be more beneficial to seize the opportunity to address and enhance this area prior to Transfer, so that PHS would be in a better position to meet the upcoming challenges of implementing new program initiatives. Cecilia acknowledges that, although she attempted to involve the staff in this process by circulating drafts and requesting feedback, there was some resistance to this initiative at first. Perhaps policies, procedures, rules and regulations were associated with the non-aboriginal, bureaucratic services that had ruled people's lives in the past. However, the initial resistance appears to have dissipated over time as the value of certain policies and procedures has been demonstrated. As Cecilia explains:

> An example of a policy that we have is the flexible hour policy...you put in your eight hours or whatever...you give it your best, and take a little break now and then .... If you need to take off from the office for two hours...let's say it's personal...you just take it. It's what we call 'comp time'. You just pay it back. So it is much fairer. It gives people a better feeling inside.

Several PHS employees mentioned the 'flexible hour' policy as a positive feature of the work environment. One individual, who had worked at the hospital at one time, noted a big difference in the two workplaces:

> When you're employed by the government you have to sign in by the clock, sign out by the clock. If you were a few minutes late everybody would know about it. They would say, "You get paid for eight hours of work and

> that's how long you have to work"....This is home....We know that we're getting paid to do the work, but nobody stands there watching you. By feeling good about where you work, you do your work better.

Although there were definitely some growing pains involved in the establishment of a new management structure at Peguis Health Services, all the employees interviewed who were involved in the process acknowledged that they were consulted throughout the pre-Transfer phase. Verna Spence, who has worked as a CHR in Peguis since 1977, made the following comment:

> Cecilia really got us involved in that [process]. Anything she did she'd have a meeting and discuss with us and she'd ask for our opinions, because she felt that we had been here longer than her, and she really used us that way. She'd get ideas and suggestions from us. I found that good because it was something that Medical Services would never do. They would just go ahead and do something.

Cecilia Stevenson believes that the management structure that ultimately evolved reflected the dynamics present in the community:

> [Peguis] is a mixture of traditional structures, still very much present in the way things are done in an Indian community...with it is the modern way of doing things.... According to traditional custom...it's a hierarchical system. The way that an Indian person looks at that hierarchical system, or the way that the chain of command works is that the Chief got there because he earned the right to be there, by the wisdom he shows, by his actions, his respect for his people.... People trust that this person, and the councillors, have taken on the commitment of taking care of their people.... There are many communities where nothing happens unless the Chief says so. In this community and many others, the Chiefs have modified that a bit.... In our case, they have given over some of that decision-making power to organizations such as ours. That can be summarized by one line that

> the Chief told me several years ago: "I trust your judgement".... It is never a relinquishing of authority. It's like a sharing, a delegating of responsibility.

When asked to summarize the major obstacles during this period of the pre-Transfer process, Cecilia Stevenson suggested that the very limited time frame given to do all the pre-Transfer work was a big problem. Trying to develop a Transfer budget was also a difficult task, without receiving a breakdown of the actual dollars that would be available for transfer (in fact, the Band only received a detailed breakdown of the budget **after** the Transfer Agreement was signed in 1991!). In addition; she believes that there was a lack of guidance in developing the evaluative component of the proposed health programs. However, Cecilia went on to state that at least some of the problems were due to the fact that MSB staff were learning as they went along, and she acknowledges that MSB now provides better evaluation guidelines and financial information than they did earlier. In fact, there is evidence that, at the time that Peguis was developing its Community Health Plan, MSB was asking Peguis (and other communities involved in the pre-Transfer phase) to do something which they themselves had not been able to do very well. In a document outlining MSB's Strategic Plan for the 1988-1993 period, it was acknowledged that "current Branch Information Systems...are inadequate for measuring accurately the effectiveness of Medical Services Branch programs" (MSB 1988, p.1).

## 5.3 Transition Period and Negotiations: Sept/90 to July/91

In September of 1990, a three-month interim agreement came into affect, which was intended to be a bridge from the pre-Transfer 'Research and Development' phase to the negotiation phase. At this same time, Cecilia Stevenson became the Acting Health Director of Peguis Health Services, responsible for the implementation of the new health management structure and preparations for the Transfer negotiations. In a report to MSB in October of 1990, Cecilia stated bluntly that the "temporary or fragmented approach" to the management funding process was making it difficult to implement long-term initiatives. Nevertheless, a gradual transition to the new management structure had been implemented, with the CHP and general plans having been reviewed by all PHS staff. In conclusion, Cecilia stated that, in the time remaining under the interim agreement, attention will focus on "deciphering the barrage of requests and requirements from MSB and determining how we will or if we can meet them".

The actual Health Transfer negotiations took place during seventeen meetings from January to July, 1991. Cecilia Stevenson suggests that there were a number of factors which facilitated the negotiation process:

> We [Peguis negotiating team] agreed that we would use a diplomatic approach- actually I would prefer to call it a nation-to-nation approach- even though the process didn't warrant it.... We were prepared to spell things

> out to them if necessary and this is what we did several times. That diplomatic approach helped us a lot. Also, good organization in terms of the material that we presented, preparation of the material, research.... The other thing that helped [was] the fact that we have our own legal advisor, and myself as health advisor, both from the community, working with the main negotiators, the Chief and Council... who have alot of experience in negotiating and dealing with governments, and they are very progressive.... The fact that I had all this prior experience with the government and working in the area of Transfer really helped- not just within the negotiation process, but all throughout the pre-Transfer process- I was at ease.

While it is true that the starting point for negotiations was set at the Band's existing resource level, with no allowance for major program enrichment, it appears that the factors mentioned above did give Peguis some leverage during negotiations. Peguis Health Services' existing operating budget (i.e. prior to Transfer) was just under $298,000. In the first full year following Transfer this amount more than doubled to $678,000. A large part of this increase involved new funds for portions of MSB regional and zone positions (see section 5.5 for further discussion), administration and training (short-term workshops, skills upgrading, etc.). However, Cecilia gives one example of where Peguis was able to negotiate better funding in pre-existing programs:

> We wrote pages and pages of substantiation, of arguments showing that our health education budget was only $66 a year. That was what our budget was- five bucks a month, yes.... What it boiled down to was to put it right in front of them and say, "Look, this what you are giving us for health education, and yet your 'Three Pillars' of the Indian Health Policy and your Mission Statement says that you are going to go for quality assurance".... I wanted to make them look at themselves and show them what was really happening....And that's what it took.

In other areas, it was a question of negotiating for the best possible conditions within the limits of existing resources. For example; Peguis demanded, and received, funding for the highest level nursing position (in terms of the salary range), thus avoiding having to go back and re-negotiate this at a later date. Cecilia states that they consciously negotiated for "little edges here and there, which all built up".

On July 23, 1991, Peguis signed a five-year Health Transfer Agreement--the third such agreement in Manitoba.[21]

## 5.4 Perceived Benefits of the Transfer Agreement

Interviews with key informants suggest that the perceived benefits of the Transfer Agreement can be classified into two, often overlapping, categories- technical/administrative improvements and an increased sense of ownership among health care providers.

Perhaps the major benefit of Transfer was the provision of new management funding, allowing the Band to hire Cecilia Stevenson as the permanent Director of Health Services to oversee the Public Health program, the Alcohol and Drug Abuse

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[21]Theoretically; Peguis' Health Transfer Agreement was among the first four to be signed in Manitoba--the first one being at Pukatawagan (formerly Mathias Colomb), followed by Sandy Bay. Swampy Cree Tribal Council signed their agreement at roughly the same time as Peguis did.

Prevention program (formerly NADAP), patient services and ambulance services. In addition, a Coordinator of Patient Services was hired to oversee medical transportation services and patient information. This has been especially beneficial to Kathy Bird, the Nurse in Charge of the Health Centre, who previously had to carry alot of the administrative responsibility and deal with problems related to patient services in addition to her clinical responsibilities. As we will see later, the presence of an Administrator also allowed Peguis to better take advantage of additional opportunities for health services development that arose following Transfer.

Several aspects of the new financial arrangements were also cited as being beneficial and increasing local control. The shift from monthly to annual reporting to MSB was a welcome change. One informant described monthly reporting as "degrading- that's all you spend your time doing". The switch from rigid to flexible budget lines allows PHS to shift resources to concentrate on program priorities as they see fit. As for the switch from surplus-reversion to surplus-retention, one informant summed it up this way:

> It's such a big relief to know that you don't have to say, "Well- I got this much, and I have to spend it on this, and if I don't spend it they'll take it away.

All of the PHS staff interviewed indicated that the Transfer process had provided them with an increased sense of ownership of their community health programs. The comments from informants in two separate programs convey this feeling:

> I think that we have more freedom locally to do what we have to do to design or develop programs to meet our needs. We don't necessarily have to take them from Medical Services. We work together on that with the Chief and Council and come up with plans that better suit our own community. I think that's one of the best changes that have taken place since the Transfer.

* * *

> Having our own administration...running our own programs, making our own guidelines... not having Medical Services hand you this great big list of things telling you to do this and that. We're free to do the things that we want to do the best way that we know how and the way that we think is best for our clients.

Several informants made positive references to the collective nature of the program-planning and program-review process at PHS. One of the CHRs stated:

> We don't plan programs by ourselves...we kind of sit down and brainstorm...we're like one big family, we do it together.

The author had the opportuntiy to observe two such program review and planning sessions. On both occasions the PHS staff sat for two days, using the 'brainstorming' technique, and systematically reviewed every aspect of their programs until complete. When asked to comment on this, Cecilia Stevenson states that a bureaucratic management approach would not work well in a setting such as PHS. Instead, they use the 'people approach':

> Being small really helps alot. You are able to say, "Let's huddle".... It's so much easier to say, "Do this, do that", you know, "don't ask any questions". But then you risk negative results.... This makes people feel better about themselves, it makes them feel part of the decision-making process.... It just makes sense, even though it takes a long time.

Finally; another feature of the Transfer Agreement that should be mentioned here was the transfer of extra dollars for training purposes. This came at an opportune time for Peguis- just as momentum was building to develop a new program (see next chapter for details).

Some examples of health program developments since Transfer will be discussed in Chapter Six, but first, we will look at the perceived limitations of the Transfer experience.

## 5.5 Limitations of Transfer Agreement & Future Initiatives

One feature of the Transfer Agreement highlights the disadvantage for Peguis (and other First Nations) due to diseconomies of scale. MSB calculated, and transferred, what amounted to Peguis's portion of both regional and zone support programs and positions. The full list of parts of positions transferred includes: Regional and Zone Program and Medical Officers, Regional and Zone Nursing Services, Regional and Zone Environmental Health Services, Regional and Zone Nutrition Program, Regional and Zone Health Education Program, NADAP Regional Consultant, CHR Regional Consultant, and Zone Maintenance Services.

With only a portion of the resources or salary available for each position, this makes it very difficult to retain the necessary 'experts', and training dollars for these transferred positions are not included. One example of the problem that this poses relates to environmental health.

Although this is an area that has seen dramatic improvements in Peguis, largely related to economic development over the past decade, it remains one of the mandatory programs required by MSB. Before Transfer, a regional Environmental Health Officer (EHO) provided consultative and support services to Peguis, along with the other Interlake First Nations. After Transfer, Peguis would have to make arrangements for its own EHO. With the money that they received from MSB, they would only be able to hire someone for six days per year. At the time of writing, Peguis was expecting to work out an arrangement for assistance from the Swampy Cree Tribal Council, which was able to transfer a full-time EHO because it represents a group of First Nations.

Another example of the problem faced by individual First Nations transferring a portion of zone and regional positions relates to the Medical Officer position. Peguis received enough money to hire a Medical Officer for twelve days per year (half of what Peguis had requested). PHS staff had hoped that a Medical Officer of Health would work with them in developing certain aspects of their community health programs --especially the evaluation component and monitoring of health status. It was only in the spring of 1993 that a contract was finalized with the University of Manitoba's Northern Medical Unit to provide such services. Cecilia Stevenson says that a tremendous amount of time and energy was involved in developing contracts for both of the positions described here

and she realizes now that, ideally, it would be much better if those positions were transferred to a regional or district level.

It appears that most of the problems that Peguis has experienced following Transfer involve the administration and/or delivery of health services that have not been transferred. For example; an official in the Band Office confirmed that Contribution Agreement payments involving non-transferred services continue to arrive late (including advances), forcing the Band to dip into other budgets.

Under the terms of the Transfer Agreement, MSB agreed in principle that the transfer of a number of identified resources could be negotiated in the future at the request of Peguis and as mutually agreed to. The full list includes: contract Dental Services, contract Optometric Services, Drugs and Medical Supplies, contract Lease agreement, the Percy E. Moore Hospital, Non-Insured Health Benefits, and the NADAP Treatment Program (i.e. the Al-Care Treatment Centre). The two major problem areas related to these future considerations for transfer will be discussed separately in the following sections.

### 5.5.1 Non-Insured Health Benefits

Before looking at the issue of non-insured health benefits as it relates to Peguis, some background information may be helpful. Non-insured health benefits (NIHB), are

extended health services which have been provided by the federal government to Aboriginal people for many years. The benefits package includes: vision and dental care (excluding contracts for professional services), prescription drugs, medical supplies, medical equipment and transportation for medical care. These non-insured services are considered to be a Treaty right by Aboriginal people, and there has been considerable concern that the federal government intends to limit or withdraw these services. This concern is not unfounded.

In late 1978, Medical Services Branch issued a 'Policy Directive' to its Regional and Zone officials, which effectively eliminated payment of non-insured services for all those Aboriginal people who were not indigent. According to the Minister of National Health and Welfare, Monique Begin, this Directive did not in fact represent any change in federal policy, but it was merely delineating the federal government's long-standing policy in a more specific manner--i.e., that those Aboriginal people who are in a position to pay for their own health or health-related services should do so, and that those indigent people residing on reserves would be assisted (Canada 1978b). The Manitoba Indian Brotherhood's (MIB) response was blunt:

> The Manitoba Indian Brotherhood, representing the 44,081 status Indians of the province, has rejected the federal government's recent "Uninsured Health Services to Registered and Treaty Indians" guidelines....The M.I.B. maintains that protestations of "fiscal restraint", the

> alleged rationale of the cutbacks, cannot justify a breach of faith or the denial of federal trustee responsibility to the Indian people. The M.I.B. believes that these cut-backs are a thinly-veiled disguise to implement the 1969 White Paper on Indian Policy; by shirking its constitutional responsibility, the federal government will no doubt look to the province to fill the gap which will be created by the cut-backs....The recent guidelines will fall heaviest on the marginally or seasonally employed, who can barely make ends meet. The M.I.B. considers the cut-backs in transportation and drugs as particularly irresponsible.... (Canada 1979)

The widespread protest from Aboriginal groups across the country led the Minister to **officially** suspend the guidelines early in 1979. However, it is important to understand that the Regional offices of MSB have considerable autonomy in setting specific NIHB guidelines in their jurisdictions. It is most interesting to note that, in November of 1978, the Regional Director of MSB-Manitoba Region sent a memo to the Acting Director General of MSB Program Management in Ottawa "in order to clarify that, in fact, the Policy is being and has been applied in Manitoba quite substantially and perhaps to a greater extent than in other Regions" (Canada 1978a, p.2). Regional Director Campbell explained that Manitoba Region had recently taken the initiative of tightening up the supply of free prescription drugs to Indian people in the City of Winnipeg and in rural areas. After being informed by the MIB that, in rural areas, people were suffering hardship as the result of the initiative, he had agreed to suspend the 'Guidelines' in respect of prescription drugs only and in rural areas only. All other guidelines in the 'Policy on

Uninsured Services' were already being applied (Canada 1978a, p.1).

In 1989, MSB once again unveiled new guidelines for the administration of NIHB which further limited coverage and, once again, there was considerable opposition to many of the proposed changes by First Nations. One of the major concerns appears to have been MSB's intention to continue transferring administration of uninsured services to the Blue Cross Corporation. MSB had contracted with Blue Cross in 1989 to administer dental services, and this privatization process was seen as further removing First Nations from self-government, with economic benefits of administering health services going to a non-Aboriginal corporation (Assembly of Manitoba Chiefs 1993).

Medical Services Branch responded by establishing a Working Group with First Nations representatives to review the whole NIHB program. By early 1991, organizations such as the Assembly of Manitoba Chiefs (AMC) felt that the government was trying to push through the changes without seriously considering many of the Working Group's recommendations, and they demanded that MSB postpone implementation of the new guidelines until adequate revisions and recommendations had been made by the NIHB Working Group and the AMC's Chiefs Health Committee had sanctioned the proposed NIHB procedures (AMC 1991). While these protests appear to have been successful in postponing the implementation of the new

guidelines for over a year, in the end it appears that MSB did not accept the Working Group's advice. In September of 1992, the new NIHB package came into effect, and prescription drugs were transferred to the Blue Cross Corporation in early 1993.

That is the background. It is interesting to note that several key informants at PHS stated that they were not opposed to many of the changes in the guidelines per se, but rather the manner in which the changes were implemented by MSB. At the moment, services included in the NIHB package are not available for transfer.

The largest portion of NIHB in Peguis consists of the medical transportation budget (in fact, this budget is equal to approximately half of the whole Transfer budget!) and, it seems, this is the area that has caused the biggest headaches to PHS staff (and probably to MSB as well) in the past. Nurses narrative reports and other PHS documents contain numerous references to MSB's constant questioning of the staff's requests for patient medical travel, and Kathy Bird recalls that a lot of her time was taken up dealing with the paperwork involved.

Before the spring of 1990, Peguis had to cover the costs for medical travel and then submit a bill every month to MSB for reimbursement. In April of that year, the Band entered into a Contribution Agreement to allow local administration of the medical travel program, which means that the Band now receives the funds according to a payment schedule, and then

submits monthly invoices to account for the money spent. As a result, PHS had greater responsibility for making decisions related to patient travel, but they still had to follow MSB guidelines and they also had to manage the huge deficit which that program had always entailed. In addition, MSB was starting to limit funding for this program, leaving Peguis with a greater responsibility for a shrinking budget.

It is interesting to see how PHS has dealt with this dilemma. Cecilia Stevenson explains that their philosophy was simple. Peguis considers non-insured health benefits to be a treaty right. Therefore, PHS has a responsibility to respect that treaty right. First; they took some steps (such as refining their record-keeping methods) in order to make the operation of the program as efficient as possible. Following Transfer in July, 1991, a Patient Services Coordinator was hired to manage the program. At the same time as PHS was streamlining the operation of the program, they set out to prove to MSB that funding was not adequate to meet their medical transportation needs and that their utilization of the funds had been legitimate by conducting their own review. According to Cecilia Stevenson, this took a tremendous amount of time, including writing letters to doctors to obtain proof that patients had been seen by them in the past, but the effort was worth it:

> Now that they [MSB] have finally seen the proof, they are coming through- they've restored our base. What I mean by restoring the base is that...MSB has said it will cover for all those deficits in the last three or four or

> five years...they have agreed that these [deficits] were actually part of program costs...so now the budget is up to what it should have been all along.

Unfortunately, even after all this, PHS is still running a deficit each month. However, Cecilia feels that they have now proven to MSB that PHS can run the medical travel program efficiently, and that this program should be considered for transfer. She believes that, by having full control over the use of funds, Peguis could implement more economical ways of providing this service. Cecilia would like to see the Band have an opportunity to run a pilot project to simulate a Transfer. In the meantime, PHS plans to conduct a survey of community members to determine if the various options that they are considering regarding future operation of a transferred program are practical.

The other major problem areas related to NIHB concern dental and optometric services. In both cases, MSB has agreed in principle to transfer the contract for these professional services to Peguis.

From the mid-1970s to 1987, dental services for residents of Peguis, Fisher River and Jackhead reserves were provided out of a trailer situated in Peguis. Originally, the contract for professional services was with the University of Manitoba, with dental students doing most of the work (under a dentist's supervision). In 1987, dental services moved into the new PHS facility. The arrangement with the university ended, and MSB then contracted with a dentist directly, leaving the dentist

and an assistant from the community to provide the services. While the new Dental Services facility was an improvement over the trailer, the staff were unable to keep up with the demand for dental care. In 1991, PHS put their case before MSB, requesting additional funds in order to hire a dental hygienist. Their statistics showed that Peguis Dental Services' dentist/patient ratio was double that of the provincial average. In December of 1992, a reply came in writing from MSB. It stated, in part:

> In the spring of 1992, Medical Services Branch, Manitoba Region, completed a detailed review of a request from Peguis First Nation for additional funding for your dental program...This review was then forwarded to Medical Services Branch in Ottawa for further analysis....Your request has been accepted as being logical and appropriate for the dental health needs of your community. However, unfortunately it constitutes a major restructuring and redirection of dental health care funds within the current NIHB system. At present, the system is not structured such that your request can be addressed (MSB 1992).

Although an interim arrangement has now been made to ease some of the current overload in service demand, it is clear that a long-term resolution of the problem is required. Cecilia Stevenson states that they are eager to take over the Dental Services contract from MSB, but that it would be irresponsible to do so unless the resource base is improved.

As for optometric services, Peguis believes that they could offer a much better service under a Transfer arrangement than the one which currently exists. At the present time, a team of two optometrists and their two assistants make two 2-3

day trips to Peguis each year to hold clinics. MSB pays the costs for the non-insured services (including travel expenses), while Manitoba Health Services Commission (MHSC) covers professional fees. Since it is virtually impossible for the optometry team to see everyone who needs service during the regular eye clinics, the Band ends up sending people to optometrists in Winnipeg. According to Cecilia, if the (roughly) $36,000 that is currently being spent annually on travel to Winnipeg for optometric services was transferred to PHS, they could provide monthly eye clinics and avoid sending residents off the reserve (which adds to the Medical Travel costs). The problem is that MSB cannot transfer the $36000 to Peguis under current Treasury Board regulations. As a result, this is another situation where Peguis feels that they could run a better service if the program was transferred, but they see no point in proceeding unless they are guaranteed an adequate resource base.

In summary; the current administration of non-insured health benefits, and the federal government's perceived reluctance to transfer these services, are viewed as obstacles to greater self-determination over community health programs in Peguis. Several key informants at Peguis Health Services expressed confidence in the Band's ability to manage NIHB programs more effectively than the government. One person stated bluntly that "we are being forced to stay back because of MSB's archaic policies".

The frustration surrounding this issue appears to be intensified by a sense that they are caught 'between a rock and a hard place'. On the one hand, there is a recognition that the government is cutting costs and there is a desire to get the NIHB transferred while the dollars are still there. However, the impatience to take over is tempered by the realization that, if the existing resource base is not enough, then the transferred programs could cause even more problems.

### 5.5.2. Percy E. Moore Hospital

By far the most complex unresolved issue facing Peguis is the future of the Percy E. Moore Hospital (PEM), which is eligible for transfer under the terms of the 1991 Agreement. There are several reasons why this is such a complicated issue.

First, there is the multi-jurisdictional nature of the facility. The external consideration here is that, although the hospital is situated on Peguis land, it serves all three local reserves, as well as surrounding non-aboriginal communities. Internally, although the facility is administered by Medical Services Branch, the Manitoba Health Services Commission (MHSC) continues to pay the per diem and, since the late 1980s, it pays the salaries of the physicians who are hired by the University of Manitoba's J. A. Hildes Northern Medical Unit (NMU). While most of the hospital's nursing staff are payed by MSB, nurses in the out-patient

clinic are paid by the NMU. Although the multi-jurisdictional factor is not considered an absolute deterrant to taking over the operation of the hospital, it seems safe to conclude that any negotiation process will be a complex one, involving a number of parties.

A much more serious problem concerns the resource base that would exist should a transfer occur. Although the Percy E. Moore Hospital was designed to be a 38-bed facility, the capacity was reduced to 16 beds by the early 1980s (see Chapter 3, Section 4.2). There are no surgical services available and only a few low-risk deliveries are done each year. As was discussed earlier (in section 3.4.2), a number of informants from Peguis stated that, due to the lack of services and frequent physician turnover, they prefer to go elsewhere for elective medical care. Considering that the operating budget for the Percy E. Moore Hospital is only slightly over half a million dollars, the question arises as to whether or not it makes sense to transfer control of a facility that is viewed as being inadequate. Key informants acknowledged that this is a serious problem. At the very least, Peguis wants a guarantee that the current operating budget is maintained as the existing base for transfer negotiations and that the person-year (PY) level not be any less at negotiation time.

Just prior to the signing of Peguis' Health Transfer Agreement in 1991, MSB-Manitoba Region decreased the

operations and maintenance base of the Percy E. Moore Hospital by 5.7 percent. In a letter to the federal Finance Minister at the time of Transfer, Chief Louis Stevenson made the following comments:

> We are planning on taking over the control of the Percy E. Moore Hospital within the next few years but already we are experiencing the counter effects of the government restraint policy on our plan....If anything deters Peguis from even contemplating a takeover of the magnitude of the Hospital with its already inadequate resource base, it is this [budget cut] (Source: PHS Archives).

Chief Stevenson went on to urge the government to restore the PEM's resource base to its original budget with the original PY years remaining as the existing base for transfer. The letter concludes with a request:

> We propose that you establish a moratorium on further cutbacks and person-year reductions on all transferable resources. To do otherwise will surely discourage other First Nations from accepting your offer of Health Transfer.

Apparently, Chief Stevenson never received a reply to this letter. However, even with a guarantee to restore the original resource base, Cecilia Stevenson doubts that the people of Peguis (and others) would be satisfied with settling for the status quo:

> When we do the pre-Transfer work, it will be with a plan, with that same conviction that we had two years ago... that we have to take over that hospital because it's part of our progress as Indian people, that we have to take control of our own affairs.... We could make it into the hospital that it used to be a long time ago, that people talked about...a much-improved hospital because, it would be at that point, a community hospital where there would be input from community members...and there would be a sense of real ownership. I'm convinced that could work,

> but only with agreement from the provincial and federal governments. Otherwise, we would have to settle for the mediocre, which is to carry on existing [services], and whether we want that or not is something that we are going to have to decide at the time when we finish the pre-Transfer work.... There's no way that we will let ourselves take on a white elephant and just sort of perpetuate it.

## 5.6 Summary

In summary; Health Transfer is viewed as having been a generally positive experience by key informants in Peguis, who see it as a limited, but nevertheless useful, opportunity to increase control over the development of community health programs. Most of the problems experienced by the Band relate to resources that have not been transferred. As far as future transfer of NIHB and the Percy E. Moore Hospital are concerned, there is concern about inheriting what is perceived to be an already inadequate resource base. In the next section we will explore developments in Peguis's community health programs in more detail.

# CHAPTER SIX

# HEALTH PROGRAM DEVELOPMENT BEYOND TRANSFER

## 6.1 Shifting Focus

During the two years since the signing of the Health Transfer Agreement, a lot of effort has been focused on developing the administrative infrastructure required in order to operate Peguis's community health services effectively. The review and streamlining of the medical travel program has already been discussed. The PHS staff have also begun the task of developing a health information management system. At this point, statistics are being collected on all public health activities in order to build a data base which will help in program evaluation at a later date. One of the staff is completing computer training so that PHS doesn't have to depend entirely on outside expertise while developing their computer program.

Cecilia Stevenson readily acknowledges that they are just now getting to the point where they are ready to sit down,

sort out the health priorities identified in the Community Health Plan and do the necessary program planning. In fact, she states that it may be another year until they are at the point where they would have liked to have been at the time of Transfer- a situation which she blames on the very limited pre-Transfer time frame that Peguis was operating under. In spite of the slow pace of progress, however, there are several examples of health service initiatives which indicate a shift in focus to better meet the needs of the community. One example is the changing role of the CHR.

Verna Spence explains that, when she first started as a CHR in the late 1970s, her role could be described as "jack-of-all-trades, master of none". The CHR's duties included assisting the nurse with basic health teaching (especially regarding infant care and sanitation), dealing with mental health and substance-abuse related problems, and carrying out the required tests (such as water sampling) under the mandatory environmental health regulations. However, both the community and its health services have developed to the point where many of the tasks previously done by the CHR are no longer required. Improved housing conditions and sanitation (e.g. indoor plumbing and garbage pick-up), a decreased incidence of infectious diseases, increased prevalence of breastfeeding, a very high immunization rate and high level of attendance at Well Baby clinics, and the development of substance abuse and mental health services (see section 6.3

for discussion of the latter) in the community are some of the factors which have combined to change the role of the CHR.

Over the last couple of years, CHRs have moved towards specialization. Each CHR is teamed with one of the nurses, with one team focusing on diabetes and other chronic diseases, while the second team focuses more on child and maternal health programs. Both of the CHRs stated that they find this arrangement more satisfying than doing a little bit of everything.

Diabetes is becoming a growing concern in Peguis, with about one hundred diagnosed cases so far. One of the projects that the 'chronic disease' team have been working on during the past couple of years is the development of a new Diabetes Education Program. As Eleanor Olson, one of the CHNs, explains:

> The reason why we're doing that is, the government diabetic education program is not made for native people. They don't understand all those big words. So what we're trying to do is to use plain language...we're trying to meet the needs of this community, not necessarily others.

According to Eleanor, they have been quite successful in promoting self-care, with the majority of diabetics now being non-insulin-dependent, and approximately two-thirds of the known diabetics attend clinics for monitoring purposes. However, Kathy Bird acknowledges that the PHS Diabetic Clinic is still a long way from functioning as they had hoped. She would like to see a regular clinic where people come in, have their blood checked, feet checked, and get some teaching.

Part of the problem is that, due to the frequent turnover and shortage of physicians at the PEM hospital, there is not always a doctor available to attend the clinic at PHS, which means that people may have to make an extra trip to the hospital if there is a problem. In addition, since patients have to go to the hospital to have their bloodwork done and to receive their medication in any case, many of them simply decide to go through the out-patient clinic at the hospital for their care.

While these problems still remain to be worked out, the PHS staff are concentrating on increasing the community's awareness about diabetes. As Verna Spence, a CHR, explains:

> We're planning a workshop this fall on diabetes. This time we're going to invite anyone who's interested [not just diabetics], and we're going to use all the people from the community...we're not going to use outside resources. We're going to use Aboriginal people. We started a diabetic support group and we're going to put them to work. We [PHS staff] will just be there as resources.

As for the prenatal program, this is another high-priority area. According to Kathy Bird, there are roughly twenty-five to thirty pregnant women at any given time in Peguis. There is concern about the number of pregnancies among single teenagers, and this is an issue that remains to be dealt with. In the meantime, PHS has taken steps to make existing prenatal education more appropriate for the needs of the community. Prenatal classes have been held in the Health Centre periodically since moving into the new facility in

1987. However, it was found that the format- once a week for several weeks- was not working. During the past couple of years, the format has been changed to two-day workshops, with an interesting twist. As the CHR explains:

> Kathy came up with that idea. It has been terrific. We bring in a couple of grandmothers from the community to talk about their experiences, and the things that we have now that they didn't have. They encourage the parents to come to the Health Centre and get the babies' needles. Our moms and dads will sit and ask questions and the grandmothers will answer...everybody's involved.

Both the nurse and the CHR who are responsible for the maternal/child programs agree that something very interesting has happened in Peguis over the past few years. They have noticed a definite increase in the involvement and interest shown by fathers in their partners' prenatal health and in their children's health care. The CHR is quite pleased with this development:

> Our dads are getting quite good...they even bring their babies to baby clinic. They ask what the needles are for and whether there will be a reaction.... I'm hoping that they're passing it on to their friends.

Although neither of the public health providers could offer an explanation for this phenomenon, they both agreed that a general increase in awareness about health in the community may have played a part.

Another area that has seen a shift in focus is the Peguis Alcohol and Drug Awareness Program, or PADAP (as opposed to the old acronym--NADAP). While the staff still do assessments and referrals for treatment, and counselling, they are

attempting to put more emphasis now on education and prevention. One of the workers describes the changes:

> I guess that before [Transfer] it [NADAP] used to be more geared to adults.... After the transfer...Cecile [Cecilia Stevenson] said this is our program now, we can do what we want with it. So, I took the initiative...to change it around a little bit and focus more on youth. I figure, why work with adults, when the problem is there? Why don't I go a little bit further and work on the youth, and prevent...

The orientation to prevention has involved doing alot more work in the school, giving presentations, working with the local P.R.I.D.E. group (acronym for People Resisting Impaired Driving Everywhere), and promoting a variety of recreational activities as an alternative to alcohol and drugs.

In addition to a change in focus, one of the PADAP workers stated that another positive change since Transfer has been the integration of their program into the overall community health program:

> Before that, I was working across the road, in the old band office. Being away from the health office...we were apart...they didn't know what we were doing, and we didn't know what they were doing. But now that we are working here...we feel more connection, more supervision.... We are feeling more like a team.

Although both PADAP workers stated that they feel they have made some progress, they both acknowledged that there is much more work to be done- such as developing a more structured alcohol and drug education program for all target groups.

Finally; a good example of PHS's effort to increase both community awareness about, and involvement in, health issues in Peguis is the two-day A.I.D.S. conference held on the reserve in April of 1993. While the PHS staff had done a number of smaller workshops on A.I.D.S. in the school and other community organizations over the years, they weren't really sure just how much the community as a whole knew about the issue. It was one of the PADAP workers who initiated the idea of having a major community workshop. In January of 1993 a committee was formed to organize the event, consisting of representatives from the various Health Services programs, Social Services and the Al-Care Treatment Centre. In addition; a community member was invited to participate on the planning committee. One of the PHS workers explains the reasoning for this initiative:

> I guess in past workshops, we more or less sort of did it on our own, with our resource people. This time, we wanted a community aspect...the community to be involved as much as possible.... When he [community member] came in, he hadn't worked in the field...no training or anything like that, but he brought into our committee, enthusiasm.... It kind of gave us the extra push to get together and do something exciting, something new. I think it helped everybody to have a community member involved, and I'm sure it's something we will do again.

However, the community involvement did not stop with one person on the planning committee. An effort was made to involve a number of different sectors of the population in the actual event. The Chief was invited to give the opening address. A group of respected elders were invited to speak at

both the beginning and end of the conference. The school was approached for permission to invite all students in grades six to twelve to attend both days of the conference, and grade twelve students were asked to create and perform a play about A.I.D.S. Key informants were only aware of one (non-Aboriginal) parent who would not allow their child to attend the conference. Residents of the Al-Care Treatment Centre were invited to attend. Day-care services were offered to any parent who might not be able to attend otherwise. In the end, over three hundred community members attended each day of the conference.

Aside from the community's own resource people, guest speakers from outside the community included a member of the Manitoba Aboriginal A.I.D.S. Taskforce, who gave a very direct and explicit workshop about transmission of the virus, an Aboriginal woman whose son died of A.I.D.S., and a young Aboriginal man with A.I.D.S. who openly identified himself as being homosexual. He spoke emotionally about the trauma of being ostrasized and shunned in his home community. After he finished, the two male facilitators of the workshop spontaneously hugged the young man, followed by all of the elders. In the evaluations that were completed after the conference, respondents (including most of the school children) rated the event as having been very valuable, and most indicated that the young man with A.I.D.S. had been the most effective speaker. Key informants stated that they

believe the conference succeeded in raising not only the level of awareness about A.I.D.S. in Peguis, but also the level of tolerance and understanding.

As a participant-observer at the conference, the writer was struck by the emotional intensity and level of community involvement in the event. Frankly, it was difficult to imagine a similar process occurring in a non-Aboriginal setting. In addition; it challenged the popular myths that Aboriginal people do not recognize A.I.D.S. as being 'their' problem, and that Aboriginal people do not recognize homosexuality as existing in their communities.

In summary; the discussion so far has concentrated on examples of some new ways of organizing and delivering health information and services in Peguis that had previously (at one point or another) been provided by MSB. Perhaps the most interesting developments, however, involve innovative programs that were not traditionally provided by MSB. In the following sections, two examples will be highlighted.

## 6.2 Case #1 - Traditional Program

Throughout the 1980s, which was a period of dramatic social and economic development in Peguis, there was a second phenomenon occuring, as some community members began to explore traditional cultural values and practices that had been lost in the community. This phenomenon was not unique to Peguis, but can be viewed as a manifestation of a widespread

resurgence of traditional Aboriginal health care practices throughout Canada over the past decade. In Manitoba it is evident that, despite a long period of active suppression of the traditional Aboriginal medical system, there have been certain areas where these practices have persisted and/or are now being revitalized. For example; Garro's (1988) study of one First Nation community in southern Manitoba revealed active utilization of traditional healers, while Gregory (1989) suggests that traditional Aboriginal healers in northern Manitoba are at the center of the cultural renaissance in health care. Moreover, it appears that the increasing demand for, and active utilization of, traditional medicine is putting pressure on the western medical system to form a new relationship with traditional healers (Gregory 1989; Gagnon 1989).

In Peguis, due to a variety of factors--some of which were discussed in Chapters Two and Three--the loss of traditional Aboriginal language and culture has been quite extensive over the past century. As a result, the process of rediscovering traditional cultural roots has been a very slow and, occasionally, painful one in the community--so painful, that I was advised to use discretion in dealing with the topic. Suffice it to say that there was serious opposition to the traditionalists among certain sectors of the community. The conflict between the two groups appears to have reached its peak in the late 1980s. In fact; it is for this reason

that no mention was made in the Community Health Plan of the role that traditional healing might play in post-Transfer community health program planning. However, it is clear that the demand for traditional healing services not only existed, but was growing.

During the 1980s, there was a slow but steady increase in the number of people who approached the Health Centre staff requesting access to traditional healers. Kathy Bird, the nurse in charge at PHS, explains what happened:

> We approached MSB to see if they would support us in helping these people to get to see a traditional healer, because there was none here in our community.... We used their mission statement [1979 Indian Health Policy]...to justify why our people should go to see traditional healers or why traditional healers should come here. So we had quite a number of meetings with MSB and we were finally able to get that established.

In effect, the travel costs and expenses involved in visiting a traditional healer became a special category within the non-insured health benefits program. In May of 1985, Kathy Bird received a written policy statement from MSB-Manitoba Region's South Zone Director (who was relaying the directive that she had received from the Regional Director), clarifying the Department's three criteria for dealing with requests for 'Traditional Travel' reimbursement (MSB 1985). These were:

1. MSB should attempt to facilitate referral to traditional healers in the same manner in which we would to any other health professional...when appropriate.

2. Prior approval for arrangements is required if MSB

> is to be financially involved. If no approval sought, we would consider visits as self-referrals with appropriate reimbursement.
>
> 3. Payment can only be made on submission of all receipts.

Charlotte Johnson, a former MSB South Zone Director, acknowledged in a recent interview that Peguis did play a role in shaping MSB-Manitoba Region's policy regarding traditional healers, in the sense that the high volume of requests from Peguis highlighted the need for more formal guidelines to deal with the issue. However, she pointed out that Peguis was not the only community making such requests, but was part of a phenomenon that was emerging on a broader basis.

Essentially, from that point in time in the mid-1980s, referral to traditional healers became a service offered to clients of Peguis Health Services on request. According to Kathy Bird, this development was simply a matter of meeting an expressed need in the community:

> It was only a few to begin with, but it has been growing steadily.... The people should have the opportunity to choose whatever method of healing they want to go through ....if they want to know I explain to them what is available.... I do it [referral to healer] on request only, with the exception of, if I know that person follows traditional ways already, then I might suggest seeing a traditional healer for a certain thing.

The demand for these services has grown to the point where a traditional healer now travels to Peguis (at least) every three months (sometimes more often) to hold 'clinics' at the traditional grounds on Matootoo Lake--a site which has

become known (unofficially) as a traditional healing centre in Manitoba. Clients, healers, and even non-Aboriginal health care providers travel to Matootoo from all over to utilize the services offered there.

These grounds were established by Carl Bird, who recently changed his Christian first name to the Anishinaabe name, Mide Megwun--'Mide' meaning life, and 'Megwun' being a feather. Mide Megwun Bird, a former Child and Family Services worker and Band Councillor in Peguis, is a traditional teacher and one of seven traditional Chiefs appointed by the female elders of the Three Fires Society, a large North American spiritual organization, which is based on the teachings of the traditional Midewiwin Grand Medicine Society. Mide Megwun is one of a group of people in Peguis who are currently undertaking the lengthy process of becoming healers themselves. The site at Matootoo Lake was chosen because traditional teachers and elders tell stories of this being an area where healers came to pick medicinal plants and build sweat lodges in the past. In fact; the word 'matootoo' means 'sweat lodge' in the Ojibwa language.

Kathy Bird states that there are always at least thirty to forty requests to see visiting healers at these clinics, and the demand is sufficient enough that people continue to be sent out of the community for treatment in between these visits. Statistics kept by the nurses at PHS indicate that, between July,1991, and March, 1993, there were 325 client

contacts related to traditional healing.

While many Aboriginal people from outside the community continue to request services at Matootoo Lake, key informants stated that there is increasing interest from within Peguis. This has been especially true for those people suffering from emotional problems (see Case #2 for a more detailed discussion), and several key informants involved in alcohol and drug counselling indicated that more clients, especially among youth, are beginning to request information about the traditional healing approach. None of the key informants could identify precise reasons why this has happened, but all agreed that there has been a definite easing of tensions in the community over the past year or so, with a noticeable increase in tolerance for those choosing the traditional approach. Several informants suggested that the extensive positive coverage of Aboriginal culture in the mass media recently may have resulted in more people feeling comfortable with the idea. Others suggested that it was simply a matter of time before community members turned to explore their cultural roots and practices. However, they all agreed that the issue is still a sensitive one in Peguis, and that the number of community members who would identify themselves as traditionalists are still in the minority.

It should also be noted here that members of the advisory committee (and others) were consulted regarding informants who would be open to questions about traditional healing, and

those who might be upset by this line of questioning. In Peguis, I was informed, the greatest resistance has been among the elders of the community. However, it was interesting to discover in interviews with elders that there was more concern about the spiritual side of traditional healing than with the use of traditional medicines. In fact; almost all of the elders who were interviewed spoke about the use of traditional medicines when they were young, and indicated that they still use plants for a variety of ailments. Only one elder acknowledged that traditional healing in all its forms might be useful, and only one person stated categorically that they disagreed with all forms of traditional healing.

When asked to define the term, 'traditional healing', all of the key, traditionalist informants emphasized its wholistic nature. The following are some of the comments made:

> ...the traditional healer will look at the whole person. That means the physical, emotional, spiritual, and mental components of the person....
>
> * * *
>
> ...if I'm feeling stressed out, then I go to see a traditional healer for whatever it is. Like, if I need to ask for a physical healing, it may be addressed in many different ways. It might be through herbs. It might be through the sweatlodge. It might be through the ceremonies. But the ritual of the ceremony is also for the mind, and I know that my spiritual self is also being looked after.
>
> * * *
>
> There's always a follow-up that's given to any person seeking traditional help, whether it be to continue to make the medicine until it's all done, or to bless

> yourself with sweetgrass, or to go to the sweatlodge, or a referral is made to see another person. So there is always that continued support.
>
> * * *
>
> Traditional healing is also the getting together of people to discuss our needs, or to go back and remind us of some of the things that have passed, to rejuvenate a feeling that we once had that was good, and to share it with one another. That's traditional healing. With our people there was always some sort of gathering, whether it was a sun dance, a Midewiwin Lodge, a pow-wow, where we celebrated life. That was mental health.

In addition to dealing with existing health problems in a wholistic way, traditional informants suggested that traditional cultural teachings can play an important role in health promotion. For example; 'Young Women's Teachings' are offered at Matootoo, which prepare girls for the emotional, physical and spiritual transition to womanhood. The program is described as promoting self-respect and increased self-esteem in young women, which may result in the prevention of early pregnancy. Mide Megwun Bird described ceremonies and teachings to mark boys' transition to manhood, and stressed that, aside from promoting self-esteem among young men, they can play an important role in decreasing abuse of women in aboriginal society:

> A lot of people think in our culture that it's a man's world, that we control everything, but that's totally wrong. In our culture, women are the backbone of our community, and the women are the backbone of the Three Fires Society today. It is the women who make the major decisions in our lodge, and half of our sweatlodge, our teaching lodge, half of everything belongs to the women .... One of the things that happens to a lot of women, and especially Indian women, is abuse.... We as men are responsible for a lot of the abuse of our own women, and

> that has to stop, so that we can come together, we can work, then you know that cycle of abuse will be broken and we will build strong good circles again.

Several of the traditional informants spoke of how people have come to Matootoo Lake with very little understanding of either traditional culture or healing, but then something happens to them. According to Mide Megwun Bird, this phenomenon is easily explainable:

> A lot of times Indian people say, "I lost my culture, I lost my tradition, I lost my identity as an Indian person". I don't believe that.... The traditional elders say you don't really lose it. It's right here inside of you. And sometimes, when you smell the sweetgrass or the sage, or if you go to the sweatlodge, or if you hear the drums, you feel something go right through you, and sometimes you feel something stirring inside of you, like it wants to come out. The old people call that 'blood memory'...that's what it is...it runs in the blood. We've never lost it.

Finally; traditional informants stressed that the return to traditional values and teachings should not frighten people. As one person explained:

> We don't say you have to give up your car, your microwave and go out and live in the bush in a teepee, not that at all. We believe that you take the good things from western society, but you also take the good things from your own culture, and you can put them together and you can make them work for you.

Another informant suggested that returning to traditional cultural values and practices does not mean regressing, as far as community development is concerned, but rather moving ahead by looking at alternatives.

When asked about the implications of the growth in

interest in traditional healing for Peguis Health Services, both Kathy Bird and Cecilia Stevenson acknowledged that, in the past two or three years, MSB has become more supportive of their requests for Traditional Travel assistance. However, they both admitted that they are worried that MSB might try to impose more restrictions on the program as the number of people wanting to use the traditional program increases.

It appears that concern about the possibility of increased restrictions on funding for traditional travel is well-founded. In a memo sent to all MSB Regional Directors in April of 1991, the Assistant Deputy Minister (MSB) outlined a new policy regarding this non-insured service. This directive contained several new restrictions, including: to see a traditional healer, an individual would need a physician's referral; individuals who were granted approval to see a traditional healer would not be allowed to travel outside of Manitoba, if they wanted their travel costs to be covered by NIHB; and no travel costs could be applied for retroactively (MSB 1991). These conditions were rejected by the Assembly of Manitoba Chiefs' Health Committee, which recommended that the policy not be recognized by First Nations people. When the new NIHB guidelines came into effect in September of 1992, the proposed restrictions had been removed.

Commenting on the possibility of restrictions on traditional travel, Kathy Bird pointed out:

> In Alberta, one of their restrictions is that you cannot go and see a traditional healer outside your province.

> We are fortunate enough to still have access to Canada and the United States for traditional healers. It probably has to do with that increase in demand. It's not going to stop, it's just going to grow because our people are starting to look at their own healing wholistically.

In addition; more non-Aboriginal health care providers are showing an interest in traditional approaches to healing. For example; approximately twenty MSB nurses from one region of Manitoba recently attended a workshop on cultural awareness and traditional healing at Matootoo Lake. Apparently, some of the nurses were not even aware of the forms that are required by MSB for Traditional Travel assistance. Cecilia Stevenson is certain that the increased awareness of the nurses will result in an increased number of referrals to traditional healers.

When asked about the relationship between traditional healers and the dominant medical system, key informants stated that there has been a definite increase in the number of health professionals who are coming to Matootoo Lake for their own personal interest. According to Mide Megwun Bird, the University of Manitoba's Northern Medical Unit and the Health Sciences Centre in Winnipeg have sent staff to Matootoo Lake recently to learn more about traditional healing, and workshops have also been done with the Manitoba Medical Association. Apparently, the Health Sciences Centre has, on several occasions, requested assistance from Matootoo Lake in dealing with certain patients. Even the hospital in Gimli,

Manitoba, recently requested that a traditional person from Peguis bring sweetgrass, a pipe and a drum to an Aboriginal patient who was dying of cancer. However, all of the key informants involved in traditional healing stated that they had never received any requests for workshops or patient services from the local Percy E. Moore Hospital, and that only a few individual physicians at the hospital had ventured in to Matootoo Lake out of personal interest. Mide Megwun Bird, traditional teacher at Matootoo Lake, made the following comment about this situation:

> Well, you know, the ideal working relationship between us and the Percy Moore Hospital- first of all, it has to start with education. I think the doctors and the nurses and the people who run it have to be educated first. There has to be cross cultural workshops being done there.... I guess the ideal thing that could happen would be Percy Moore working more in a wholistic way of helping our people...there should also be a referral system.

While key informants all agreed that the ideal situation would be formal recognition of the role of traditional healers, and the development of a referral system between the traditional and western health care providers, they were adamant that the government should not have any involvement in regulation of their services. One person said: "Traditional healers don't want to be signing forms." Another explained:

> There is a network across Canada and into the States. Our people who are involved in a traditional healing program here know the medicine men, the traditional healers who are out there. They know which ones are credible and which ones are not, which ones have integrity, and so on. They have their own policing system...a surveillance and monitoring system of their own.

Mide Megwun Bird stated that he has frequently gone to check out traditional healers first, before referring anybody to them. He concluded:

> I think that we have to regulate ourselves.... We talk about local control and self-government.... We can't let the government decide anymore for us- they decided before.... We have to get together as traditional healers, we have to start networking across the country, and we do need the support of our leadership.

In fact; Mide Megwun acknowledged that this networking process has already started to happen. The Assembly of First Nations has been sponsoring a series of workshops for traditional healers across Canada, in order to network and share information. The most recent gathering occurred at Matootoo Lake in August of 1993.

In the next section, we will explore another innovative program that was initiated in order to meet a need in Peguis that was not being met by existing government services. In this case, unlike that of the Traditional Program, the gap in services was viewed as being an example of a failure by the federal government to meet its responsibility in the provision of a specific type of health care.

### 6.3. Case #2 - Peguis Mental Health Program

As we have seen previously, the Peguis Community Health Plan submitted in 1990 identified the need for a comprehensive mental health program to be developed. Before examining what happened in Peguis, it is worth discussing briefly the history

of mental health services for Canada's Aboriginal peoples, since it provides a classic example of federal/provincial jurisdictional wrangling in which Canada's indigenous population falls through the cracks.

Unlike general medical and nursing care, the federal government has never provided any organized mental health services to Aboriginal Canadians, and has overtly attempted to offload this responsibility to the provinces at every opportunity. For example; a regulation in the Indian Act makes First Nations peoples subject to the mental health laws and services which exist in the provinces. Then, in 1968, the federal government announced that it was ceasing payment for the treatment of Aboriginal people in provincial mental institutions (Canada 1968b).

The provinces, on the other hand, have always maintained that it is not their responsibility to provide these services to Aboriginal people, and have reacted strongly to federal government attempts to offload financial responsibility for provision of health and social services (Canada 1975;1976d). The Manitoba Mental Health Act, for instance, states that an Indian or Inuit patient may be refused admission to a psychiatric facility unless payment is guaranteed by the federal government--a stipulation which apparently has never been enforced. In the absence of either federally-run mental health treatment services MSB has contracted for itinerant psychiatric services to various First Nation communities

across Canada, but the day-to-day management of mental health problems has largely been left with local nurses and community workers.

The wrangling between the federal and provincial governments appears to have had a particularly detrimental effect in Manitoba, given the large Aboriginal population. A provincial Mental Health Task Force reported in 1982 that rural mental health services in Manitoba were grossly underfunded, and that certain groups had suffered disproportionately through neglect--including the Aboriginal population (Mental Health Working Group 1983). In 1985, a survey of fifty-seven First Nations communities in Manitoba (jointly sponsored by three tribal councils) revealed that mental health services to First Nations communities in Manitoba were 'hit-and-miss' (First Nations Confederacy et al. 1985).

As far as the provision of mental health services in Peguis is concerned, there have been a few independent therapists who have offered counselling services to community members in recent years, and the University of Manitoba's Northern Medical Unit had provided a psychiatric visit to the Percy E. Moore Hospital for one half-day every two weeks. However, according to key informants, this arrangement was hardly adequate to meet the needs of the community. People with major mental disorders would end up in institutions in Selkirk or Winnipeg, and then, when they came out, there

wouldn't be enough follow-up for them and they would either end up back in the institution- or, occasionally, in jail. Community health workers recall that they did their best to provide support to these people, but that they often felt helpless because they couldn't provide the special care that was required.

However, the problem was not limited to a lack of local services for the mentally ill. Although much progress was made during the 1980s in Peguis, in terms of economic development and an improvement in living conditions, this did not necessarily result in improved mental health among community members. As Kathy Bird explains:

> We are a lot more comfortable in our nice homes.... But our community, like any other native community, has been through a lot of negative things in the past.... In spite of all the things we have here, there are still many people out there who are hurting.... Thirteen years ago, people more or less looked at mental health as only mental illness. In the last ten years, people have become more open about what happened to them in the residential schools...about abuse. People have become aware of all these other things that are causing them unhappiness in their life, and affecting their mental health. People have started to realize that there is something missing in their lives, and they want to know who they are, where they come from, and it's all affecting them mentally and spiritually.... It has changed with the increase of people's awareness, and people willing to talk about these things. So there is a bigger demand for mental health workers.

In early 1991, some community members decided that, if government was not going to provide organized mental health services in the community, then they would have to do it themselves. A key person in this initiative was Elva

McCorrister, the Director of the Personal Care Home. She recalls:

> I was going through a difficult time myself, because I had a son that had a mental health problem.... I was sort of dealing with Selkirk [provincial mental health institution] and not getting anywhere with them.... There was nothing in the community..... I started approaching Cecile [Cecilia Stevenson] on the subject and she said, "Well, let's have a meeting". We talked about who should be involved.... We figured that we had these people in the community with mental health problems.... They were going to the Al-Care, they are coming here [Personal Care Home], they are going to Social Services, to NADAP workers, they are going to Public Health.... These are the organizations that the people are making the rounds to...so we invited all the key people [from these organizations]..... We set up the committee that way so that we could deal with it together.

This is how the Peguis Mental Health Steering Committee (PMHSC) was formed. Another PMHSC member describes how the committee functioned:

> It started off as, we sort of took on the role as mental health workers. I took on cases of the more severe cases in the community. So we sort of took on a supervision role, to watch them and to keep an eye out for them. If we had to intervene, we would, even if it was by visits or talking with other members of the family.... Then, if we needed help, we would call another member.... We would always like network together, keep in contact. We would have meetings once a month.

In September of 1991, Cecilia Stevenson received approval from the Chief and Council to start developing a proposal for a formal community Mental Health Program. When asked if Transfer gave the PMHSC confidence to pursue the mental health initiative, Cecilia responded this way:

> I don't want to oversimplify it, but to me it just made sense...and I think that is what guided us...we knew there was a need for it and we just went for it.

> Transfer was incidental, but not so incidental that it didn't help at all. Sure, it gave a bit of a boost. I think that the extra resources that we received...enabled us to respond earlier.... For one thing, the management structure or funding gave us that extra edge or ability for us to look at areas such as mental health.... It gave us that extra manpower that was needed for someone to oversee and do the strategic planning that could not be done in the old setting.

Although the Steering Committee provided support and on-going monitoring of people with serious mental health problems, it was clear that PMHSC members could not provide the counselling services that were needed by themselves. Early in 1992, the PMHSC took advantage of another opportunity which allowed them to move a step closer to their goal of establishing a comprehensive mental health program in the community. Peguis (along with the other two Interlake Tribal Council First Nations) was invited to take part in a community mental health project developed by the University of Manitoba's Northern Medical Unit, which had received funding support from Medical Services Branch to carry out a three-year demonstration project.

The Northern Mental Health Outreach Project (NMHOP) was designed as an alternative to the itinerant psychiatric model, which involved occasional visits by psychiatrists to First Nations communities. The NMHOP was based on a Public Health, or Community Mental Health, approach. One feature of this initiative was the establishment of a provincial NMHOP Steering Committee, through which participating communities had direct imput into the overall development and direction of

the program. The other major feature of this model was that nurse practitioners with extensive psychiatric and mental health experience would provide direct clinical services in the community approximately two days per month (with psychiatrists functioning as a back-up only). However, Gwen Armstrong (the nurse who was hired as the Peguis Mental Health Counsellor after being approved by the PMHSC) explains that the purpose of NMHOP was not simply to substitute nurses for the lack of available psychiatric services:

> The NMHOP program is designed as an enabling program. There are three things that we do. One is to provide a measure of direct clinical work to the people of the community. That's probably the least important component of the program. The other two aspects of the program are teaching, finding strong, interested, capable people in the community- either who are officially workers in the community, or unofficial lay counsellors- and transferring some of the skills that we have learned in our careers as nurse practitioners. And the third aspect is probably the most difficult to define, but the most important, and that is to, in a general sense, support the efforts of the Indian people themselves to improve the mental health of their communities...to support and, when asked, to give guidance or counsel on all sorts of initiatives that can make their community a happier and healthier place to live.

It was a commitment to these fundamental principles of the NMHOP program, rather than specific experience in either a community or Aboriginal setting, which made Gwen Armstrong (who is non-Aboriginal and had previously worked in a hospital setting) an ideal candidate for this position. In addition; Gwen believes that she was fortunate to have worked with mentors who used a management model which encourages people to develop their own skills and capabilities.

According to Cecilia Stevenson, the NMHOP initiative came along at just the right time and fit in well with Peguis's own vision of a community mental health program:

> We told NMHOP from day one that when they came into our community.... "This is the way we have planned it, this is the way we are going to do it, this is the way it will be. We are glad to have you on board."

Gwen Armstrong describes how she took direction from the Steering Committee:

> Originally when I first came out here I viewed my role as getting more involved in the preventive side. However, when there were people in such immediate need for counselling, you have to see them first and gain your acceptance, then you can carry on.... The Steering Committee have a very good sense of what is happening in their community and who the people in need are...they identified the people who they considered were the most acute cases.... We worked it out so that when the Steering Committee members referred somebody, they maintained the role of case manager. So I would be a consultant to them in doing the assessment initially, then they [PMHSC members] would either provide the counselling or keep in touch with the person until I got out there every four weeks or so.

Although the first few months of 1992 were spent primarily dealing with the people who were most in need of support in Peguis, the PMHSC decided to take the first step in building community awareness about mental health issues by organizing a workshop specifically aimed at the workers from all the community organizations. This was in response to an expressed need on the part of the community's resource workers for workshops that would enable them to be better able to help community members. Gwen describes the event:

The May 1992 workshop for community workers was sort of

> a general mental health workshop. It was a fascinating workshop, in that it contrasted the western and traditional Indian styles. One of the white speakers spoke very academically. Then the primary Indian speaker basically walked us through his life, and the evaluative response was extremely positive towards how the Indian speaker had really touched people and made them think about their own mental health and the work that they were doing in the community.... There was a lot of closeness at that session and a lot of desire to carry it beyond that one-day workshop.... We had about eighty participants...a very good cross-section. What surprised us were the number of people in education...they were feeling very challenged in working with the children in the community....

Another salient feature about the workshop that Gwen recalled vividly was that it was endorsed personally by the Chief, who opened the workshop on a very personal note by sharing his own life story, which was viewed positively by the group. In addition; the afternoon speaker enthralled the audience so much, and affected them so much in needing to share their own stories, that the Steering Committee decided to abandon the rest of the agenda and just to carry on with what was happening spontaneously.

One participant at the May 1992 workshop remembers that it became a "healing circle rather than a workshop". It was then that the PMHSC realized how much work needed to be done with the community resource people before they could turn to the general community awareness workshops. As Gwen explains:

> .... The traditional way when looking at the Medicine Wheel is what I'm taught again and again. One must look after one's own Medicine Wheel, and then next, one can help one's family, and then next, one's community, and then finally, help the Indian Nation.... There are many strong people here...and they have used their own internal resources to get into the position that they are

> in. However, they are undertaking very difficult work, and that requires growth and change for themselves individually. These are often people who feel that, because resources for counselling and therapy are so limited, they have been reluctant to use a counsellor's time for themselves when they feel that there are others that are more in need. So there is a great need for healers and helpers themselves to have help to balance and strengthen their own Medicine Wheels.

In addition to realizing the need to work with the community's resource people, the PMHSC made the decision to move on to the next logical step in the development of a community-based mental health program- namely, training people from the community to be mental health workers. Once the availability of counselling had become known in the community, the demand for services had grown rapidly, to the point that neither PMHSC members nor Gwen could carry the load by themselves. In many cases, it was not a matter of needing someone with extensive mental health experience, but rather, someone with the time to listen and provide support. It was at that point that the PMHSC proceeded to select three community members to be mental health worker trainees- without the structure of a training program to put them into, and without any assurance of funding.

In April of 1992, Peguis had submitted a formal proposal for a Mental Health Program to MSB. In October of that year, at the same time that the three community members were chosen to be mental health worker trainees, Cecilia Stevenson was informed that there were no funds available to support the proposed program, but that some money would be available

through the federal government's forthcoming 'Brighter Futures' initiative.

The selection of the trainees was an interesting process. After advertising the positions, applicants were interviewed by the PMHSC in September of 1992. Gwen describes the qualities that the Committee were looking for in prospective trainees:

> We were looking for people who had a respect for both traditional and contemporary ways of healing- that was crucial to us. We were looking for people who already had basic counselling skills, either through education or experience, or ideally, both. We were looking for people whose own life experience qualified them to be helping others...and probably the most important thing that we were looking for was...people whom other community members held in respect and to whom they would feel comfortable coming to...that they could trust to respect confidentiality.

When asked to describe why they felt that they had been chosen for the community mental health worker position, two of the trainees commented:

> I worked with alcoholics for two and a half years as a part-time counsellor at the Al-Care. One of the counsellors told me that there was an opening for three mental health workers. I didn't have the faintest idea what mental health was, but I applied.... I think that the qualities were that I'm a caring person...and I'm a sharing person. I share my own life story with other people. I care what happens to our people.... In order to work with people you have to understand where they're coming from. To do that you have to get your own life in order. I started that, healing, working on myself about three years ago. Ever since I started working on myself, doors have been opened.
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> I didn't really know too much about mental health, but I knew that there was a difference between mental health and mental illness. I said that I didn't have any

> certificates or high education to impress them [the PMHSC] with. What I had to offer them was the teachings that I received from the [traditional] elders through the last twelve years, like caring, sharing, love and kindness, honesty and respect.... I remember that they asked [in the interview]: "What is your definition of mental health?" I said that it had to do with a balance ...of the mind, body and spirit.

During the fall of 1992, using the training dollars received under the Transfer Agreement, the first phase of training began on an intermittent basis, usually during Gwen's visits to the community. The Steering Committee had looked into existing mental health worker training programs and felt that none were suitable to the needs of Peguis. Moreover, there was still no guarantee of on-going funding for the program. Nevertheless, as Gwen explains:

> The circumstances were such that...the need was so acute in the community, that we felt we were going to go ahead and set up some sort of program, with just very sporadic training provided by myself, and supervision provided by the professionals on the Peguis Mental Health Steering Committee. I felt that this was actually desirable, not to go into a program with a set curriculum. It's unexplored territory. We didn't know at the onset what their learning needs would be, so we didn't want to fit them into an existing program. We think that their role is pretty unique.

While all the trainees indicated that they felt quite comfortable with traditional approaches to healing, they expressed the need for basic training in the western approach to dealing with mental health problems. Gwen began by teaching what she calls the 'basic safety items', such as conducting a mental health assessment (including how to assess for symptoms of major mental illnesses and for risk of

suicide) and basic principles of crisis management. Over the past year, they have addressed a variety of topics, including: dealing with unresolved grief; sexual abuse; medications used to manage major mental illnesses; basic therapy issues, such as attachment and separation, confidentiality, structuring interviews; and time management.

In January of 1993, funding through the 'Brighter Futures' initiative did come through and the Peguis Mental Health Program moved on to the next stage of its development. Before looking at how this unfolded, it may be worthwhile to describe the 'Brighter Futures' initiative and how it has fit in to Peguis' community health programs. The 'Brighter Futures' program is based on six program elements: Community Mental Health, Child Development, Healthy Babies, Injury Prevention, Parenting Skills, and Solvent Abuse (the staff refers to the latter five elements by the acronym, 'CHIPS'). The fact that Peguis had already developed a proposal for its Mental Health Program, and had made recommendations in its Community Health Plan related to the other program areas, made it fairly easy to draw up a proposal for 'Brighter Futures' funding.

According to Cecilia Stevenson, program objectives that they have identified in the 'CHIPS' areas should be attainable using existing resources, as well as the extra nurse and/or health educator that they plan to hire in the near future. For this reason, the bulk of the 'Brighter Futures' monies are

being used for the Mental Health Program. When asked if this funding is adequate, Cecilia replied that, although the funding was very much appreciated, it still was not what was needed. In Peguis' case, their first year 'Brighter Futures' budget was $55,000 in total, or $9000 for each program element. In addition; there still appeared to be a problem with late payments from MSB. 'Brighter Futures' monies for the period beginning April 1, 1993, were not received until the beginning of September, 1993--leaving the Band to carry the costs for five months.

Once funding through the federal government's 'Brighter Futures' initiative was assured, the three trainees were hired as full-time employees of PHS. Gradually, the 'Brighter Futures' trainees (or BFTs, as they became known) started to take over the follow-up of people in the community between Gwen's visits. A Steering Committee member describes how this development has changed her role:

> Now that there are trainees and people to work with the clients, that leaves me free to do other things with my own workload.... I am assigned one mental health worker trainee who reports to me once a week. She tells me what's happening, what she's doing. It's a way for her to unload and for me to give feedback about what I see her doing good, and what I think she could do better.

The arrangement works well, as far as the trainees are concerned. As one person stated:

> It's good because a lot of times you get a real tough case, and you don't know where to go, but these people [PMHSC members] have been here for quite awhile. Being the professionals that they are in their field, they can always help us understand more about our clients.

Gwen's role has also evolved. As she explains:

> I'm the second line of support for them [trainees]. Each of the 'Brighter Futures' workers has two supervisors identified from the Steering Committee, and the plan is to meet weekly with each of their supervisors to discuss their cases. Then, if there is a concern that their supervisor doesn't feel competent handling or needs another opinion, then they phone me.... Each month when I go out, I discuss with each of the workers each of their cases, the dynamics of the case. We talk about counselling being a planned process, so we make treatment plans for the sessions that will take place before we meet again.

The speed at which the process has evolved is quite remarkable. According to Gwen, by May of 1993, the Steering Committee began to make referrals directly to the 'Brighter Futures' workers. In fact, when Gwen arrived for her June visit to the community, for the first time there were no new referrals for her because the BFTs had already done their own assessments and felt that they could handle the cases themselves. Gwen feels that this experience has shown that Peguis does have the capabilities to deal with most of the issues that come up.

The trainees also expressed surprise at how quickly the program has developed and how their confidence has grown in such a short period. All three trainees stated that the acceptance from the community has been a major factor in their development as mental health workers, and that being community members themselves has not been a disadvantage. As the BFTs explain:

I think that a lot of that [confidence] comes from the

> people accepting us now. When we first started, we were afraid that people wouldn't come in and talk to us.... A lot of people are scared that if they talk about their personal problems, it's going to get out.... One of our biggest things is confidentiality.... We haven't had a problem
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> I usually talk to the person first, and ask them if they feel comfortable. I have one client who is related to me. I asked her if she would rather work with my partner, but she said that she'd feel more comfortable with me. There are times when we do have to give the client to a different worker. It's the person's choice.
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> I think that once we explain that we're training our own people to work with our people they would agree. The advantage is that Indian people are talking to Indian people or helping Indian people or listening to Indian people...knowing them...I think they feel more relaxed at the first contact.
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> I would say that a lot of people have greeted me or talked to me that have never talked to me before. I've met people, just anywhere in the hallway, in the mall... and they ask if they could come and see me.

One of the trainees stated that there may have been concern among community members at first about the trainees' ability to handle the work, because of past reliance on non-Aboriginal people for these specialized services. Gwen Armstrong acknowledges that, at first, there was some reluctance to see the BFTs, particularly among those who had started to see Gwen. However, lately there have been an increasing number of people whom, after being given the choice of seeing Gwen or the BFTS, have chosen the latter option.

As far as the approach used with clients of the Mental

Health Program is concerned, all of the key informants stressed that offering people as many options as possible in their own community is the main priority. Gwen Armstrong summarized their overall goal as follows:

> We want to be able to offer a variety of resources to people who are in need. If they want to see one of the therapists in the community who was operating here previously, that's great and we'll support that. If they want to see me, that's great and we'll support that. If they want traditional healing, then we'll make sure that they have access to that. If they want to see the religious counsellors, that's great. If they want to see the Brighter Futures workers, that's the best! We want people to be able to meet their mental health needs in an unrestricted sort of way. We're also aware that seeing multiple counsellors can be detrimental to a person's progress, so we try to have one primary person being identified as the primary counsellor.

One of the trainees describes the approach taken with clients:

> We don't make up our clients' minds. We are not here to do that. Each individual has a responsibility to make up his or her own mind which way they would like to be treated.... There's the European way and the cultural way, and whichever way they feel comfortable with, we respect that way.... There are some who have to be on medication, and you try and explain how important it is to take the medication. Then there is the cultural way. There are a lot of clients who do not need the European medicine. They can go to the traditional healer.

Two of the three BFTs stated that more than half of their clients were utilizing traditional healing services available at Matootoo Lake. Statistics kept by the Peguis Mental Health Program workers indicate that, while in many cases people are being followed by more than one type of service, an increasing number of clients are choosing traditional healing as a primary approach. None of the mental health workers are

surprised by this development. The fact that the majority of their clients are under forty years of age appears to be an important factor. As one BFT explains:

> ...our culture is coming back now, and a lot of our young people are aware of it.... People who are young want to experience new things. This, to them, is something new ...the culture.... If you take the elders, a lot of them were brought up with the churches, and to practise our culture was a no-no.

Gwen Armstrong agrees that it is the younger people who are more open to the traditional approach to healing, and she suspects that the older age groups in Peguis may be accessing the religious services more for their counselling:

> It seems that there's a generation or two...who, in order to protect themselves, in order to survive, they were required to reject their tradition. Many of them did it with a great deal of strength, so it's very difficult for them to do this about-face.

Both Gwen and the BFTs described an interesting event which suggested that there are many people who simply are not aware of traditional healing services that are available or how to access them. In May of 1993, a visiting traditional healer held a special workshop on mental health issues at Matootoo Lake. An invitation was extended to all of the clients of the Mental Health Program to attend. A number of clients who hadn't previously accessed traditional healing took part in the workshop, which included a sweatlodge ceremony and traditional teachings. Gwen saw three of these people for counselling the following day, all of whom were tremendously positive about the experience that they had at

Matootoo.

In addition to counselling, the Mental Health team has begun to do more community education and prevention. The BFTs now do a workshop with each new intake of clients at the Al-Care Treatment Centre, where they talk in general about mental health. Aside from providing information, the trainees state that each time they go to the Al-Care, two or three of the clients will approach them and request counselling.

After a second workshop was held for community workers in November, 1992, at Matootoo Lake, the BFTs decided to design and carry out a needs assessment survey of all the community's resource people, in order to determine what types of workshops are required in the future. They plan to conduct a series of specialized workshops to meet the specific needs of different groups, beginning with the teachers in the fall of 1993. The next step will be to organize workshops for the community at large. Gwen Armstrong states that, in terms of prevention, the team also has taken a different step recently by reacting to a crisis in the community in a pro-active manner. Whereas previously, the mental health workers had only seen clients who had been referred or who had approached them directly, this time the BFTs (with the endorsement of the PMHSC) went out immediately to provide support to the people involved.

When asked to describe the major achievements of the Mental Health Program so far, every worker gave examples of clients who had been stabilized as a result of their

intervention. One trainee stated that the greatest success has been with the newly-referred clients, as opposed to those with longstanding mental health problems who continue to receive treatment from outside sources. Gwen believes that there are a number of cases of people who would have experienced major breakdowns without the care that they have been receiving, and that there are many people who would have had to go elsewhere to get help. For Gwen, an extremely important achievement has been the process whereby, through the Peguis Mental Health Steering Committee, an awareness of an overwhelming need in the community has been translated into action.

In spite of the successes, there was a general acknowledgement by Mental Health workers that they have probably only hit the tip of the iceberg, in terms of meeting all the needs of the community, and there are concerns that they are still not accessing all the people who are in need. When asked what the implications are for the future of the program, Gwen acknowledged that the number of workers is going to have to grow. However, funding restraints have been a major concern. At the end of March, 1993, funding for the NMHOP program was cut. Peguis Health Services made the decision to keep paying Gwen out of their program funds, but they were forced to lay off one of the mental health worker trainees during the summer of 1993. Although it was felt that the two remaining BFTs could handle the workload for the time

being, this will obviously become a serious problem as the demand for services grows.

In July of 1993, the federal government agreed to re-instate funding of the NMHOP program--but only at seventy-five percent of the original funds.[2] Gwen describes the impact of uncertain funding on the development of the Mental Health Program:

> It's a very awkward situation to be in. The clients that I see, in order to be planning my therapy with them, in order for them to be planning their lives, they need to have some expectation about how long I'm going to be coming here. Because of the uncertain status of NMHOP, and the inadequate Brighter Futures funding for Peguis for this year, I would be unable to give any commitments to my clients, as well as commitments to the Brighter Futures workers, in terms of their training.... For the Steering Committee as well, it's difficult, in terms of preventive programs and things that need to be planned ahead.... I don't know how they [PHS] have been accessing the funds to pay me, but I do know that this is a hardship and that it should not have to come out of other sources.[3]

One of the problems with the Brighter Futures funding is that it is increased in increments over five years, with the first-year budget being limited to monies for research and

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[2]Gwen states that, due to a funding shortfall, the communities involved in the NMHOP project actually experienced five or six months without funds. She believes that, in the other communities that could not afford to retain the services of the NMHOP nurses, the long hiatus was a major setback--in terms of attachments and separations and the trust with the communities that the nurses were in various stages of developing. Gwen describes this as "a re-enactment of what has happened to Indian people in the past, so it brings up past hurts and disservices as well."

[3]Postscript: funding for the NMHOP project ended in March of 1994.

development. Both Gwen Armstrong and Cecilia Stevenson agree that Peguis was already at a stage by January of 1993 where they could probably have used the Year 3 or 4 funding level for programming. However, Cecilia Stevenson tries to be optimistic about the future of the Mental Health Program:

> My understanding is that MSB has made the commitment that they will continue funding the mental health program in the Indian reserves. Whether they will keep funding the other components of the Brighter Futures initiatives program or not, I don't know.

In the meantime, the Peguis Mental Health Program is viewed as being so important that both PHS and the Steering Committee are committed to keeping it going- one way or another. According to Cecilia Stevenson, PHS will continue to use the bulk of the Brighter Futures monies in the Mental Health area, and they are currently exploring the options available regarding payment for Gwen's services- including the option of billing for professional services through the NIHB program.

## 6.4 Summary

In conclusion; both the Traditional Program and the Mental Health Program developed through a resolve to meet expressed needs in Peguis that were not being met (for whatever reason) by the government's formal health services. In both cases, the initiatives were undertaken in spite of a lack of either policies to provide direction, or funding, or both. In both cases, the motivation appears to have come out

of a natural momemtum occuring in the community, quite independent of the Transfer initiative. However, in the case of the Mental Health Program, the extra administrative resources and general increased feeling of ownership of community health programs appears to have given Peguis a definite edge in terms of program development. See Table 3 for a summary of the major developments during the period from 1980 to 1993.

TABLE 3

SUMMARY OF PEGUIS COMMUNITY/HEALTH SERVICES DEVELOPMENT: 1980-1993

| | |
|---|---|
| Community Development | 'Towards Self-Determination'<br><br>▮early 1980s: sobriety movement among community leaders<br>▮1981→: rapid community development during administration of Chief Louis Stevenson |
| Aboriginal Health Policy/ Services | Transfer of Administrative Responsibility†<br><br>▮1986: 'Health Transfer Policy' |
| Peguis Health Services | 'Local Administration of Community Health Services†'<br><br>▮1980: Band administration of Peguis Health Centre<br>▮1985: Band takes over operation of ambulance services<br>▮1987: 20-bed Alcohol & Drug Treatment Centre opens<br>▮1987: Peguis applies for pre-Transfer funding<br>[Peguis Health Services moves into new facility]<br>▮1988: 22-bed Personal Care Home opens<br>▮(Jan)1988: pre-Transfer phase begins<br>▮1988-1990: preparation of Community Health Plan (CHP); new management structure<br>▮(Jan-July)1991: Transfer negotiations<br>▮July 23, 1991: Peguis Health Transfer Agreement signed<br>▮1991: Peguis Mental Health Steering Committee formed<br>▮(Feb)1992: NMHOP nurse begins working with PMHSC<br>▮(Oct)1992: PMHSC chooses mental health worker trainees<br>▮(Jan)1993: 'Brighter Futures' funding<br>▮1993: training of community health workers continues<br>[During this period, Traditional Program integrated into Public Health services] |

# CHAPTER SEVEN

# CONCLUSION

## 7.1 Summary of Major Themes

The development of formal health services in Peguis occurred within the context of historical circumstances unique to that community and, therefore, one cannot make any broad inferences based on that experience. However, the following is a list of the major themes and issues that emerge from Peguis' experience- some of which may have relevance to other First Nations who are involved in community-based health initiatives.

Development of Formal Health Services (prior to 1980)

1) There was a period of time, before government-sponsored medical services were provided in an organized way, when a dual medical system existed in Peguis- i.e. a time when traditional 'Indian doctors' and midwives continued to provide the most consistent care to people in the community. Due to a variety of factors, the western medical system became dominant in the 1940s. It is only in the last decade that the traditional aboriginal health care system has begun to emerge again in the community, once again creating a situation of a dual medical system- however, this time, some initial steps have been taken to integrate the traditional sector into the mainstream community health services.

2) From 1940, as a result of the construction of a federal hospital on the reserve, the development of treatment and public health services in Peguis has developed separately (although there appears to have been some overlap during the 1950s and 1960s). The major issue related to the provision of treatment services has been the loss of what was considered to be 'a community hospital' when the old Fisher River Hospital was closed down in 1973. The new Percy E. Moore Hospital is perceived by the community as being bureaucratic, not providing adequate services, and not being responsive to the needs of the community.

Community Health-Related Services since 1980: General Themes

1) The major developments in health-related community services since 1980 have occurred during a period of dramatic economic and social development in Peguis, which has been fuelled by a strong political leadership committed to the principle of self-determination. It appears that a general movement towards sobriety among community leaders in the early 1980s was also an important factor in this contemporary phase of community development. During this period, support from the political leadership was cited as being a crucial factor in the success of many of these community-based initiatives.

2) The development of the Personal Care Home, Al-Care Treatment Centre, and the Peguis Mental Health Program are examples of health-related services developing as a result of community members taking the initiative to meet the

community's needs in the absence of formal government services. In the case of chronic care and mental health services, there was the added problem of being caught in jurisdictional 'gray' areas, in which neither the federal nor provincial governments accepted formal responsibility for providing these services in an organized manner. The lack of funding for Home Care Nursing on reserves by either level of government is another example of this phenomenon, which continues to pose a problem for the public health staff in Peguis today.

3) While the period of local administration of public health services in Peguis did build up useful experience and allowed the public health providers to better respond to community needs, MSB still retained significant programmatic leverage and overall fiscal control, limiting the degree of self-determination that Peguis could achieve over the process of health care. However, there are examples (such as the hiring of an LPN rather than an RN as a community health nurse) which illustrate the Band's efforts to achieve a degree of self-determination--especially where government policies or standards were perceived as being incompatible with community needs.

The 'Health Transfer' Experience

The federal Health Transfer Policy has been viewed with some skepticism in the literature. There are those who have criticized the initiative for its limitations--such as

ineligibility of certain programs for transfer--while others have argued more vehemently against Transfer as merely one more example of the federal government trying to offload responsibility for provision of services to First Nations.

There is no doubt that the history of federal Aboriginal health policy since the 1960s--with a trend toward devolving responsibility for Aboriginal health services to the provinces and several attempts to cut non-insured health benefits to status Indians--and the introduction of the Transfer initiative without meaningful input from First Nations, all lend credence to the argument that Transfer represents a "revenge of the hidden agenda" (Speck 1989).

The findings of this study do not allow the author to draw definitive conclusions about the **intent** of the Health Transfer Policy. However, it is possible to state the following, based on Peguis' experience with the Transfer initiative:

1) Peguis entered into the Transfer process with no illusions about its limitations. Rather, it was viewed as an opportunity to take a small step toward the ultimate goal of self-government--and a logical step, given the Band's level of social, economic and political development and the fact that they had been involved in the local administration of public health services since 1979/80.

2) Certain factors (e.g. more than ten years of experience with local administration of public health services, a

relatively large resource base--both human and material--, experience and confidence in negotiating with the federal government, and a thorough knowledge of MSB policy) appear to have contributed to successful negotiation of a Transfer Agreement in July of 1991.

3) Transfer is generally viewed as having been beneficial, in the sense that it did result in improved financial resources, more fiscal control during the period of the Agreement, more flexibility in programming and an increased ability to respond to community needs, and a greater sense of 'ownership' of community health programs.

4) Most of the problems that Peguis has encountered have been related to issues that were not part of the Transfer Agreement. The administration of Non-Insured Health Services (NIHB), especially related to Medical Transportation, Dental and Optometric services are areas of particular concern. The Band believes that it could run these programs more efficiently if they were transferred to full Band control, but a guarantee of an adequate resource base is seen as a pre-requisite to such a transfer, and there is considerable concern that the resources available for transfer may be decreased. Late Contribution Agreement payments for non-transferred programs also continue to place a significant burden on the Band's resources, forcing them to borrow from other budgets.

Another complex issue relates to control of the Percy E.

Moore Hospital. Peguis has expressed its intention of eventually assuming control of the hospital from MSB. However, the inadequate resource base, multi-jurisdictional nature of the hospital's funding and administration, and the number of communities that are served by the hospital make this a daunting task that will require considerable discussion and planning.

5) The major innovations in health services programming have also occurred outside of the mandate of the Transfer process. The development of the Peguis Mental Health Program is an excellent example of a community-initiated program designed to meet the community's needs (in the absence of a formal government program) by developing skills within the community to deal with mental health issues.

6) As far as the implications for other First Nations considering Health Transfer are concerned; it must be stressed that the relatively positive experience in Peguis can in no way be taken as a sign of the 'success' of the Transfer policy. What I have tried to emphasize is that Peguis' ability to take advantage of the initiative was due to specific conditions (outlined in #2 above). In the absence of those conditions, First Nations might want to carefully weigh the risks and benefits of Health Transfer before initiating the process.

7) This case study suggests a number of issues related to Health Transfer which would be appropriate areas for future

research. First; a comparative case study of First Nations that have signed Transfer Agreements (preferably, after the completion of their first five-year plan) would be worthwhile, in order to determine which factors have contributed to the perceived success or failure of these initiatives. It would also be useful to compare the experience of First Nations with locally-administered community health services that are Transfer-based to those initiatives that have occurred outside of Transfer. Certainly, it would be interesting to reassess the situation at Peguis in the future to determine if concerns about achieving or maintaining an adequate resource base for various services are satisfactorily addressed. It would also be appropriate, after an adequate period of time has elapsed, to carry out both a qualitative and quantitative evaluation of PHS programs--including a survey of community residents, to determine their perceptions of the Transfer process. While an evaluation is scheduled to be carried in 1995 (as set out in the terms of the Agreement), this may be too soon to accurately assess the success or failure of the Transfer initiative at Peguis--given the fact that the health information system is only now being developed and that new programs, such as the Peguis Mental Health Program, are only in the early stages of development. In addition; changes in health status related to public health initiatives are likely to take longer than five years to become apparent and measurable. Finally; in Manitoba, there is some discussion of

transferring all health programs to First Nations in the context of a pilot project involving 'self-government' over all programs previously administered by the federal government. The implications and potential impact of such an initiative would be an extremely useful focus for future research.

Issues Related to Traditional Healing

1) During the last decade there has been a renewed interest in traditional healing, and cultural awareness in general, among certain community members. In response to increasing demand from the community, traditional healing services have gradually become integrated into the formal structure of community health services offered in Peguis.

2) The revival of traditional cultural practices has been a very contentious issue in the community and, although there has been a decrease in tensions recently, this issue is still a very sensitive one. Many key informants stressed that, in spite of the fact that traditional aboriginal culture (including 'Indian Medicine') is becoming increasingly popular in the broader society, First Nation communities must be allowed to deal with this phenomenon at their own pace and without any outside interference. Furthermore; traditional healing should be offered as one of a variety of options available to consumers of health care in the community.

3) There is a small, but active, group of people involved in traditional healing in Peguis. These individuals made it

clear that, while they would like to see the federal government and dominant medical system recognize the role of traditional medicine, they do not want any government regulation of their services whatsoever. They argue that traditional healers across the country are already involved in forming a network to share information and to discuss issues such as self-regulation. Several key traditional informants expressed concern about MSB increasing restrictions on funding for 'Traditional Travel' as the demand continues to grow.

4) In terms of implications for future research in this area; the literature on community health programs utilizing tradition medicine in First Nations settings is fragmentary, and so, more in-depth case studies of these initiatives would be useful in determining the potential role of Aboriginal medicine and healing methods in community health care models. It would be particularly interesting to compare and contrast the different ways in which traditional healing is utilized in First Nation communities (e.g. functioning completely separately from other community health programs; autonomous, but with some informal interaction; or fully integrated with other community health programs). Where possible, it would be useful to understand the contextual factors which have led to the development of these initiatives, the opinions of traditional healers regarding the optimal relationship with the biomedical system, and their perspective on regulation of traditional Aboriginal medicine and healing. The relevance of

traditional Aboriginal medicine and healing to Health Transfer is a controversial issue (since it is, by definition, not a program that is eligible for transfer), and so, the experiences of those First Nations who have entered into Transfer agreements would be particularly interesting. Having said all that, the extremely sensitive nature of this issue in some communities, and the desire for anonymity, may prohibit research in this area, and it should only be undertaken with the full approval and guidance of community advisors.

## 7.2 Theoretical Implications

Based on the theoretical perspective outlined in Chapter One, it was suggested that the development of health and health services in any community can best be understood within the context of the sociocultural, political, economic conditions which have shaped that community. It was also proposed that self-determination leading toward health in First Nation communities involves two elements. The first element is control over the process of health care--with 'control' meaning more than just increased participation in decision-making related to health care--while the second element involves control over the determinants of health.

A salient feature of the preceeding case study of health services in Peguis is that the development of these services mirrors the development of the community as a whole, and it is possible to trace the shifting locus of control over health

and health care through the various stages of community development. Prior to the Band's relocation to its present site early in the twentieth century, the arrival of European settlers in the region south of Lake Winnipeg had a major impact on both the health and social development of the people of St. Peter's. The combination of a shift to a sedentary pastoral way of life, conversion to Christianity, loss of language, encroachment on land, and exposure to infectious diseases, undermined both the physical and social health of the community. However, elements of the traditional Aboriginal medical system--largely the plant medicines, as opposed to the spiritual component--appear to have survived well into this century. In fact; it appears that a dual medical system--traditional and western--co-existed in Peguis until the 1930s.

Unfortunately, following the relocation of the Band to Peguis Reserve after 1909, it is possible to trace a steady decline in the economic and social development of the community. Although it was not possible to obtain accurate statistics which would have provided empirical evidence, the oral histories obtained (and some archival documentation) suggest that the Reserve's economic decline was accompanied by a gradual deterioration of the physical and social health of the community as well. There is also evidence (circumstantial and anecdotal, but nevertheless worthy of consideration) that the underdevelopment of Peguis Reserve was **not** due to an

inability of the people to adjust to a new way of life--but rather, that it was the result of government policies which undermined the economic and social growth of the community. Even if these policies were well-intentioned, the result was that Peguis was transformed from a once- self-sufficient community to an economically and socially depressed community in a relatively short period of time.

It was during that period of underdevelopment of Peguis Reserve that the locus of control over both health and health services shifted away from the community and the federal government's medical care system gained hegemony. This situation lasted until the late 1970s and early 1980s. It was at that time that Peguis First Nation entered a new period of political organization, fuelled by a movement towards sobriety by community leaders and a militant political leadership committed to the principle of self-government. As a result, the locus of control over health and health services has begun to shift back to the community over the past decade, and the developments in health-related services during this period must be seen within the context of the dramatic socioeconomic development of the community as a whole. One fascinating feature of this contemporary period is the re-emergence of a traditional medical system--thus, in a symbolic sense, bringing the community full circle.

If we look a little more closely at progress toward self-determination leading to health in Peguis, it seems safe to

say that the recent Health Transfer initiative has resulted in the Band having increased control over the process of health care delivery--including greater programmatic leverage and fiscal flexibility, and a sense of ownership of community health programs. Unfortunately, it is too early to make any conclusive statements, based on empirical data, about the impact of increased control over the provision of community health care on health status, since both the health information system and some of the health programs themselves are only in the early stages of development. However, anecdotal evidence suggests that the Peguis Mental Health and Traditional Healing programs have resulted in improved health status for a number of individuals in the community.

Having said this, it is clear that, until non-insured services (with an adequate resource base assured) are available for transfer, and as long as the federal government continues to control medical treatment services for Peguis and retains overall fiscal control of health services, then one must conclude that Peguis has achieved increased--but far from complete--control over the process of health care.

Similarly; the dramatic period of economic and social development of Peguis First Nation Reserve over the past decade or so has certainly increased the level of control over conditions impacting on the physical and social health of the community. However, it is important to keep in mind that the level of unemployment and social service transfer payments in

this community remain higher than would be acceptable in any non-Aboriginal community, and that both the physical and emotional health of the community remains less than optimal.

The Band's proposal for Health Transfer funding in 1987 stated clearly that Transfer was far from the ideal envisioned for control of their health care system, and it is worth repeating here:

> ...the ideal that is envisioned would be an arrangement enshrined in the Self-Government concept. The concept would see us establishing our own institutions and systems independent of government interference save fiscal appropriations by virtue of entitlement under our treaty, aboriginal and inherent rights...(PHS Archives 1987)

It is likely that, until this vision of Self-Government is achieved in Peguis, then self-determination leading toward health will be limited. Nevertheless, the experience of health services development in Peguis First Nation provides an interesting example of a community that is determined to achieve that goal, and which has taken advantage of every opportunity to regain control over both the process of health care and the conditions that affect health in the community.

# APPENDIX 1 - CONSENT FORM

Peguis Health Services Development Study

Over the next few months I will be studying the development of health services - both government and band-controlled - at Peguis First Nation Reserve during the period since the community was established in the early 1900s. The focus of the research will be on documenting the community's perspective on past and present health care, current efforts to take control of health services and changes that are desired in order to achieve self-determination in health.

This project has been approved by Chief and Council. It has also been selected to receive funding by the current Royal Commission on Aboriginal Peoples, which is sponsoring several case studies across Canada in First Nation communities where innovative approaches to health care have been developed that might serve as useful models for other Aboriginal communities. The results of the Peguis study will be submitted to the Royal Commission, and it is hoped that they will help to guide the Commissioners in making recommendations in their final report to the federal government. Before submitting a report to the Royal Commission, it will be presented to Chief and Council. A more in-depth analysis of the findings will be submitted in the form of a thesis, in order to fulfill the requirements for a Masters degree in Community Health Sciences at the University of Manitoba. All information obtained will be shared with the people of Peguis.

We would like to interview those people who have been involved in developing or providing health-related services at Peguis, as well as those people (especially elders) who are willing to share their experiences of the development of those services. The interview will require approximately 1-2 hours to complete, and we can provide a small honorarium to those people who are not presently employed by Peguis Band Council or by the provincial or federal governments. In order to record information accurately, we would like to tape the interviews. However, if you do not feel comfortable with this, we will take notes by hand only. You are also free to refuse to answer any questions and to discontinue the interview at any time. All responses will be kept strictly confidential, and will only be reported anonymously, unless you give written permission for your name to be used. Even after giving written permission on the consent form, this permission can be rescinded at any time before, during or after the interview if you change your mind.

This study is being conducted according to Ethical Guidelines for Research established by the Royal Commission on Aboriginal Peoples. Complaints about any aspect of the research process may be filed with the Royal Commission on Aboriginal Peoples, Research Directorate. Please feel free to contact me at Peguis Health Services (645-2169) if you have any questions.

Benita Cohen, Research Project Co-ordinator

# CONSENT FORM (cont'd)

## CONSENT FORM

The Peguis Health Services Development Study has been explained to me. I understand the nature of the study and that my responses will be kept anonymous, unless I give written permission for my statements to be attributed to me.

Signature:_____Date:_____

[Sign below only if you give permission for your name or other identifying features to be used]

I do give permission for my statements to be attributed to me.

Signature:_____Date:_____

Witness:_____Date:_____

Interviewer:_____Date:_____

# Appendix 2 - General Interview Guide

Community Health History and Development of Formal Health Services

›Can you tell me about any memories you have of serious sickness or health problems in your family? epidemics in the community? (Probe for specific diseases, year, family's role in care of the sick, treatment received by nurses, doctors, or others)

[For respondents over 40 years of age only]:
›Before the Percy E. Moore Hospital was built in 1973, where did people go when they had a physical or mental health problem? (Probe for location, type of health professional seen, how they paid for treatment before Medicare)

›What is your opinion of those health services that you received before the hospital was built? (Probe for accessibility, cultural appropriateness, effectiveness of services)

›What is your opinion of the health services that you have received at the Percy E. Moore Hospital since it opened in 1973? (Probe for accessibility, cultural appropriateness, effectiveness of services)

[For female respondents only]:
›How did young women learn about menstruation, pregnancy and birth when you were growing up? (Probe for family vs. professional advice)

›Where did they go for health care during pregnancy?

›Where did they deliver their babies before the P.E.M. hospital was built?

›Do you have children? (If yes) Can you describe your own experience of pregnancy and childbirth? (Probe for source of prenatal care; location of delivery(ies); opinion of accessibility, cultural appropriateness, effectiveness of care)

›How did young mothers learn about child care? (Probe for family vs. professional advice)

›Can you describe your experiences with public health nurses when your children were young? (Probe for accessibility, cultural appropriateness, effectiveness)

Towards Band Control of Health Services at Peguis (1980-present)[1]

[For all respondents, excluding Health Centre staff]:

›What is your opinion of the health services that you have received at Peguis Health Centre since 1980? (Probe for accessibility, cultural appropriateness, effectiveness)

›Can you describe any differences between these band-controlled services and the services available on the reserve when the federal government controlled them? (Probe for accessibility, cultural appropriateness, effectiveness)

›Can you give examples of ways in which awareness about health issues has changed in this community in recent years? (Probe for specific issues, perceived reasons for changing awareness)

›Is it important for Peguis to control its health services? If yes, why? If no, why not?

[For currently/previously employed health workers only, excluding Mental Health Worker trainees]:

›What is/was your position, and how long have you worked/did you work in that position?

›Where did you receive your training? Do you feel that it prepared you adequately to carry out your job?

›(where appropriate)What are the most important differences between being employed by the federal government and being employed by the Band?

›What was your involvement in the 'Transfer' process?

›What are the most important ways that the transfer of health programs to Band control has affected your job? (Probe for advantages, disadvantages)

›Can you describe how the community's awareness about health issues has changed since you began working here? (Probe for specific examples, perceived reasons for changing awareness)

# General Interview Guide (cont'd)

Innovative Health Programs, I - Mental Health

**[For Director of Peguis Health Services and those involved in the development of the Mental Health program only]:**

›What role/involvement have you had in the development of the Mental Health program?

›What were the reasons for developing this program? (Probe for previous availability of mental health services, mental health status in the community)

›Can you describe the process of implementing the program to this date?

›Can you give some examples of community interest and involvement in the development of the program?

›What have been the major benefits (to both the program developers and to the community) of the implementation process so far?

›What would you say are the major obstacles to the future development of a Mental Health program at Peguis? (Probe for both internal and external barriers)

**[For Mental Health Worker trainees only]:**

›Describe the most important things that you have learned about mental health as a trainee.

›What would you say are the major areas of knowledge and skills that you still need to master in order to feel comfortable in your role as a community mental health worker?

›What are the major advantages/disadvantages of being a trainee in your own community?

**[For all other respondents]:**

›Is it important to have a special Mental Health program in this community? If so, why? If not, why not?

›What is your opinion about using traditional healing practices to deal with mental health problems?

# General Interview Guide (cont'd)

Innovative Health Programs, II - Traditional Healing (General)

[For healers only]:
›How do you define 'traditional healing'?

›How can 'traditional ways' help First Nations peoples deal with the future?

›Would you give examples of the types of health issues or problems that you deal with as a healer? (Probe for methods of treatment, BUT DO NOT ASK FOR DETAILS ABOUT HERBAL MEDICINE)

›How has the community's attitude towards traditional healing practices changed over the years?

›How would you describe the current relationship between traditional healers and health practitioners in the dominant medical system? What would the ideal relationship be?

[For all other respondents]:
›What are your thoughts about the use of traditional healing practices to deal with physical/mental health problems?

General Questions (for all respondents, if the subject has not emerged during the course of the interview)

›What do you think are the major reasons for poor physical health in this community? for poor mental/spiritual health?

›What improvements would you like to see in health services on the Reserve? off the Reserve?

# Interview Guide for Informants Involved in the Health Transfer process since 1980[1]

Background

What were the reasons why Peguis took control of the Health Centre in 1980?

What was the impact of the takeover (on personnel, on services, on the community)?

›What role/involvement have you had with the transfer process in this community?

›Why did your community decide to undertake transfer?

›What is your response to the following concerns about the transfer initiative?
- *threat to treaty rights
- *lack of service enhancement potential
- *inadequate present service base
- *exclusion of non-insured services
- *lack of trained aboriginal health care workers

Pre-Transfer Process

›Can you outline the major steps involved in conducting your community health needs assessment?

›What were the problems or stumbling blocks during this phase?

›What were the positive outcomes of the needs assessment phase?

›Who had the primary responsibility for preparing the community health plan?

›How were community members consulted during the preparation of the community health plan?

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[1] Refers to those community members who were directly involved in the decision-making process related to the administration of health services - e.g. Health Transfer Coordinator/Director of Peguis Health Services. This interview guide is a modified version of the one used in the short-term evaluation of Health Transfer (see Gibbons 1992)

# Health Transfer Interview Guide (cont'd)

›How difficult was it to complete the following required parts of the Community Health Plan? Please discuss.

*goals and health priorities
*description of health programs
*emergency response plan
*staff and management structure
*professional supervision
*budget
*training plan
*liability
*evaluation

›Were you able to incorporate traditional aboriginal health practices within the scope of the community health plan? If yes, please give examples. If no, why not?

›What would you say are the critical factors/issues to be considered in the planning and design of locally controlled community health services?

›What factors assisted and/or hindered the negotiation process?

Post-Transfer Experience

›Please discuss your experience, including the identification of any difficulties or problems that remain unresolved, with the administration of transferred health services in the following areas:

*personnel issues
*liability (of health workers, Band Council)
*operation of the health committee
*development of policies and standards
*operation of specific health programs (mandatory, community health, NAADAP, dental, others)
*training of staff
*health records administration
*confidentiality of health information
*health status monitoring/evaluation planning
*emergency response plan
*reporting and accountability to the community
*financial management (including cost savings/increases)
*relations with Medical Services Branch

# Health Transfer Interview Guide (cont'd)

›In your opinion, what has been the impact of health transfer in the following areas:

*responsiveness to identified health needs
*interest in, and awareness of, health issues among community members
*health status of community members (please give examples)
*utilization/revitalization of traditional healing practices
*roles and responsibilities of community health staff
*integration of health services with other social and community services
*utilization of off-reserve health professionals
*authority of Chief/Council to make health-related decisions
*treaty rights and self-government

›Do you think that the scope of the transfer policy should be broadened to cover additional services? If yes, give specific examples. If no, why not?

›What is your response to the criticism that the health transfer policy is part of the federal government's attempt to dump responsibility onto First Nations without giving them the power required for real control of the process and conditions affecting health?

# APPENDIX 3 - DATA CLASSIFICATION SCHEME

Historical background (prior to relocation of band @1909)

101 impact of European colonization on aboriginal peoples south of Lake Winnipeg - the settlement of St. Peter's Reserve; Midewiwin Society, western medicine and health at St. Peter's; illegal surrender of St. Peter's, relocation to present site of Peguis Reserve

Community Development at Peguis (@1909-present)

201 economic and social development; local political organization; environmental/ecologic factors

Community Health History (@1909-present)

301 major health status patterns (epidemics, morbidity/mortality): documented evidence

302 experiences of personal/family/community sickness (including perceived contributing factors and management of sickness)

303 current beliefs about reasons for physical/mental illness in the community

Period of Externally-Controlled Health Services (@1909-1979)

401 development of formal health services: early period (before organized gov't services); expansion of organized treatment and public health services

402 experiences of community members with formal health care system: perceptions about accessibility, cultural appropriate-ness, effectiveness of services

403 experiences of community health workers in government-controlled system: CHRs, nurses, NAADAP

Toward Band Control of Health Services (1980-present)

501 Band-administration of Peguis Health Centre (pre-Transfer)

502 motivation behind, and stages of, 'Transfer' process: pre-Transfer activities, negotiation of agreement, post-Transfer development of programs, etc.

503 experiences of community members with band-controlled services: perceptions of accessibility, cultural appropriateness, effectiveness of services

504 experiences of community health workers with band-controlled services: CHRs, nurses, NAADAP

505 control of other health-related services: Personal Care Home, Al-Care Treatment Centre, PEM Hospital, NIHB (including Dental Care)

Innovative Health Programs

601 Mental Health: motivation behind initiative; process of program implementation: funding, development of Steering Committee, training of Mental Health Workers, role of traditional healing, community response, etc.

602 Traditional Healing/Cultural Awareness: healers' perspectives on the role of this program in community health; relationship with the dominant medical system; community response

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