

BC FIRST NATIONS HEALTH BLUEPRINT FORUM

SUMMARY OF PROCEEDINGS

June 22, 2005

Tsleil-waututh First Nation, North Vancouver, BC

Introduction

On June 22, 2005, over 80 British Columbia First Nations people participated in a Forum to discuss the development of a *Blueprint* for changing the health care system of British Columbia in ways that improve services to their people through improved relationships with Canada and British Columbia. The Forum was initiated by the BC First Nations Leadership Council, which is a partnership of the BC Assembly of First Nations (BCAFN), the Union of British Columbia Indian Chiefs (UBCIC) and the First Nations Summit (FNS).

Objective

The objective of the Forum was to seek advice and input into the submission of a *First Nations Health Blueprint for British Columbia*. This *Blueprint* is being prepared by the BC AFN through an agreement between Canada, the Provinces and five national Aboriginal organizations, including the Assembly of First Nations (AFN), in September 2004 (see Media Release, attached as Appendix "A"). These parties have prescribed a *Working Outline*¹ for use in the completion of the *Blueprint* (attached as Appendix "B"). The *Working Outline* identifies six main action areas² and asks questions related to each. Once completed, the *Blueprint* will be transmitted to the AFN for inclusion in a submission to a First Ministers meeting with the national Aboriginal leadership in the fall of 2005.

Forum Process

Forum participants from First Nations communities and First Nation/Aboriginal health organizations from across British Columbia were welcomed to the territory of the Tsleil-waututh people by Chief Leah George-Wilson. Regional Chief Shawn Atleo of the BC AFN thanked Chief George-Wilson and welcomed the Forum participants. He introduced Grand Chief Doug Kelly of the FNS Task Group, who provided background information on the work of the Leadership Council and its progress towards the implementation of government-to-government relationships with British Columbia and Canada. He referred to the collaboration with British Columbia that has led to the development of the document, *The New Relationship*³ (attached as Appendix "C"). He also briefed the Forum on the recent meeting between the national Aboriginal leadership and the Aboriginal Affairs Committee of the federal Cabinet in Regina earlier in June, 2005. He expressed confidence that the directions that are being taken at both federal and provincial levels will lead to a greater likelihood of meaningful change than has ever been achieved before. He thanked the Forum participants for their willingness to help and encouraged their ongoing involvement in working towards the changes that will result in an improved health status for First Nations in British Columbia.

¹ *Working Outline of The Aboriginal Health Blueprint*, April 20, 2005.

² *Working Outline of The Aboriginal Health Blueprint*, April 20, 2005, pages 5, 6.

³ *The New Relationship*, April 13, 2005. A statement of vision, goals, principles and action plans and, an undertaking by First Nations and the Province of British Columbia "to work together in this new relationship to achieve strong governments, social justice and economic self-sufficiency for First Nations".

The National Blueprint process was summarized in a presentation by Cynthia Stirbys of the National AFN Health and Social Secretariat (attached as Appendix “D”). Marilyn Van Bibber presented the Vision and Principles of the BC First Nations Health Blueprint (attached as Appendix “E”) and invited Forum participants to comment on them throughout the day.

Small Group Discussions

Forum participants were asked to join one of six small group sessions that would be facilitated during two time segments over the course of the day. Each small group was asked to address the questions posed under the six main action areas of the *Working Outline*.

The proceedings of each of the six small group sessions have been edited⁴ and are summarized below. *Please note that all comments and examples given in this report were received directly from Forum participants.*

1. DELIVERY AND ACCESS

a) Analyze gaps and barriers in service delivery and coverage

Numerous challenges dealing with Regional Health Authorities were raised in the small groups, including:

- Regional Health Authorities have shifted many services to larger centres resulting in a loss of easy access for small community hospitals and local health services,
- Little or no First Nation community input into Regional Health Authorities’ Five Year Plans,
- Lack clarity about services available from Regional Health Authorities (e.g. access to public health nurses),
- Reporting requirements for project funds are very burdensome which takes time away from actual service to community (e.g. Northern Health Authority’s Aboriginal Health Initiatives Fund changed the reporting format every 6 months over a span of three-year project).

Barriers to Non-Insured Health Benefits result in not meeting needs:

- Travel budget is inadequate; cuts have caused many difficulties,
- Access to dental services is a major gap. Upfront payment of services and dental reimbursement policies are major barriers to accessing preventative dental care and dental services,
- Challenge to access full range of pharmaceuticals (e.g. chemotherapy for young cancer patient).

Health Canada’s First Nations and Inuit Health Branch is not effective:

- FNIHB must move away from rigid funding formula to better support community needs and priorities,
- No national plan to narrow gap of health status of First Nations and other Canadians.

Limited prevention resources:

⁴ Editing included the removal of points that were repeated more than once; and, to correct spelling and missing words or phrases.

- Lack of resources for prevention programs like dental health, prenatal, child health,
- Community workers busy with treatment and delivery of home care resulting in no time for prevention and health promotion activities.

Services for Elders:

- Lack continuing care facilities, hospice and respite beds,
- “our Elders are important to us but we can’t take care of them”.

Qualified staff:

- Recruitment and retention of qualified staff that are also culturally competent.

Culturally appropriate programs:

- Lack of programs that are culturally appropriate and tailored to the uniqueness of each First Nation,
- Need programs that are developed by First Nations people.

b) Identify successful initiatives and practical measures that are already in place

- Urban Aboriginal Health Centres offer a range of prevention and treatment services. These centres are associated with Friendship Centres,
- Hartley Bay, “Brighter Smiles” initiative is a partnership with UBC Faculty of Medicine and Faculty of Dentistry that includes specialist pediatric and dental services as well as health promotion to school children. It has been a highly successful collaboration that has also served to raise awareness within the university about opportunities to practice in First Nation communities. See www.brighersmiles.ca,
- Aboriginal Health Research Network offers more opportunities for community driven research,
- Gitxsan Health Society has a Home and Community Care program that is working well,
- Community gardens are examples of effective health promotion programs where young families can learn skills and gain knowledge of whole foods.

c) Identify new initiatives that will improve delivery of and access to health services for all Aboriginal peoples

- E-health has great potential,
- Aboriginal advocates and liaison workers in hospitals,
- First Nation run dental clinic,
- University of Victoria School of Nursing is offering new distance education course entitled, “Nursing in the First Nation Community”,
- More urban health centres,
- More mobile/satellite clinics,
- Use of sessional arrangements for physician services to communities (e.g. half day per week arrangement with the Health Authority),

- Clarify services, programs and funding initiatives offered to First Nation communities by Regional Health Authorities,
- Build communication with Health Authority Boards, Medical Health Officers, Hospital Administrators, etc.),
- Amend Canada Health Act to ensure improvement of First Nations health through policy development, program delivery, clarity of roles and responsibilities, commitment to culturally appropriate services, recruitment and retention of staff, and performance measures,
- Regional Health Authorities should distribute their five year plans to First Nation communities,
- First Nations Chiefs Health Committee should approve Regional Health Authorities' Aboriginal Health Plan,
- Put resources towards development of emergency response plans based on other emergency plans (e.g. World Health Organization website has good information and sample plans).

d) Identify what Aboriginal health human resource and infrastructure development are required and how could it be achieved

- “we need our own people to work in our communities”,
- Health Transfer agreements must address training needs,
- Promote health careers through career days and other strategies, such as local role model programs (rather than national role models),
- Regular networking opportunities for health directors in First Nation communities,
- Use media to communicate to public,
- Collect our own community health statistics.

2. SHARING IN IMPROVEMENTS TO CANADIAN HEALTH CARE:

a) Identify existing mainstream initiatives that require participation of Aboriginal peoples

Participation in policy making within Regional Health Authorities and Health Canada:

- “We must be heard, our concerns seen as legitimate; we need a strong voice in policy making”,
- First Nations need to have a strong voice within the Regional Health Authority Boards; and the support and resources to influence policy issues,
- Designated First Nation representation on Provincial and Regional Health Authorities (someone with a health background),
- First Nation board representatives must have support to fulfill their role by way of improved access to information as well as communication tools (such as computers, email access),
- Training support for FN Chiefs Health Committee in health policy and health systems to enable them to provide a strong and effective advocacy on health issues,
- Create policies that address the needs of First Nations people who are living off-reserve and fall within cross jurisdictional responsibility,

- Create policies that address the inadequate funding and human resources affecting health care of both Aboriginal and other British Columbians,
- Restructure Regional Health Authorities in order to facilitate First Nation involvement beyond consultation,
- Developing cultural competency from policy making to program and service delivery,
- Clarity on mandate of Health Canada and mandate of Regional Health Authorities.

Holistic models of health systems:

- First Nations traditional models of health systems must be accepted; we must define our own concepts of health,
- First Nations health policies must be based on our own concepts and models of health,
- Wholistic models that balance all elements and together build healthy Nations,
- Seabird Island Health Centre is an example of an integrated model of health care where a multi-service integrated health team provide medical, dental, community/public health, elder care and chronic care services,
- Community wellness models that use health and wellness committees for direction.

Retaining qualified and culturally competent health workers:

- We need the resources to pay health workers the going rate. We have to compete for health workers in the face of wage inflation; we compete with FNIHB,
- Retention of community doctors, who provide more care to our people; “we must to a better job of keeping those that come into our communities”,
- Remote, rural communities can not afford to support their health workers to go out and take training, attend workshops and seminars, so there needs to be a way to bring continuing education to these communities,
- Better qualified professions for rural and remote communities,
- Training and education of health professionals on cultural and First Nation history, including local and regional knowledge,
- Continuing care workers from First Nation communities need to be trained. Volunteer care givers also need to be trained.

Culturally competent Regional Health Authorities:

- Hospitals are often insensitive to our ways; essential to have liaison workers to help our people to know their rights and have questions answered,
- Assumption that there is no difference between First Nation clients and other Canadians,
- Regional Health Authorities must respect and support healing practices and medicines of our traditional systems,
- Continuing care for Elders and disabled persons of all ages is a major challenge. Being placed in a care facility makes people feel isolated in an alien culture. There needs to be more flexibility to provide at home or closer home solutions,
- Hospitals must be able to accommodate end of life care that includes traditional ceremonies and supports. First Nation community leadership and strong Regional Health Authority support is needed to make this a reality,

- One community uses the traditional “house system” to appoint a caregiver to an ailing (critically ill) community member. This caregiver works with the person until they pass on or get better, then the worker is released from their obligation through a feasting ceremony. The local hospital and health care workers have received training so they can support this system.

Collaboration between First Nation health workers and Regional Health Authorities’ health workers:

- First Nation health workers (e.g. doctors, nurses) must have better integration with Regional Health Authorities health staff,
- In order for effective participation by First Nations, there needs to be support for good lines of communication among all First Nations and Health Directors and their regional chief, and support to build strong health committees and health portfolios in order that First Nations can effectively respond to major crisis in their communities,
- Cross jurisdictional transparency, including access to information and sharing organizational charts,
- Difficult for local First Nation communities to interact with a regional body (Regional Health Authorities), especially small communities.

Investing in health careers:

- Need a guaranteed level of investment in giving our people access to health careers,
- Focus of health careers should begin with a focus on building healthy children and youth through collaboration with health centres, schools and training institutions,
- Create cultural safety in universities as a way of increasing First Nations people taking nursing programs,
- Set up a tiered system to help entry level health workers go up a career ladder to reach top professions. This is helped when schools, colleges and universities are willing to come into our communities. There are examples where this model is helping our children grow towards success,

Proposal driven health initiatives:

- Small First Nations are at the greatest disadvantage to access new health initiatives; with extremely limited resources for administration, there is little resources to dedicate towards proposal writing,
- Need some central resource for sharing resources in order to enhance capacity,

Health Research:

- Need more studies on changes in disease patterns, such as cancer,
- Population health research on effects of broader environmental impacts to health, such as clear cut forests after pine beetle infestations and loss of traditional hunting and gathering (food and medicines),

Health priorities:

- Health program priorities are set by Health Canada (FNIHB) and other outside agencies. The programs are standardized, cookie cutter style and not at all responsive to unique situations or diversity of First Nations cultures.

Alcohol and drug treatment services:

- The needs are reaching crisis levels and the treatment services are extremely limited and what services exist, are disconnected with each other, for example detox services, treatment and after-treatment are not coordinated and often simply do not exist,
- Need more preventative programs to reach people while they are still healthy but nevertheless, at risk,
- Recognize “hot spots” for drug abuse and trafficking, for example along the Trans Canada highway. First Nations communities need to work closely with the RCMP as well as taking action themselves in pushing the drug dealers out of their communities. This is very important because the next threat is dealing with gangs,
- Education is the first step to stopping drugs. Communities must understand the nature of addictions, both chemical and process addictions and the historical reasons for addictions. This history is also the key to understanding those things often called mental illness,

HIV/AIDS services and programs

- The needs are great and on the increase and the funding for HIV/AIDS initiatives are pitifully small, especially for small First Nation communities,

Mental health services:

- Mental health is an enormous issue that is generally handled from a non-First Nations perspective. Diagnosis and assessment are limited due to lack of resources. Local public schools offer little help,

Non-insured health benefits:

- Oral health problems and appropriate eye care are impacted by limitations of the Health Canada NIHB policy and compounded by poverty. (e.g. NIHB pays for oral hygiene for only half of the mouth),

Environmental health:

- Water systems must be safe,
- Poisons kept off our lands,
- Environmental standards must be fully enforced,
- Mold and other contaminants in poorly constructed houses must be addressed to prevent major health problems such as asthma in children,

Culture and community leadership:

- One First Nation requires its leadership to participate in regularly scheduled sweat lodge ceremonies as a way of rebuilding and relearning their ceremonies.
- Training and education of local representatives to Regional Health Authorities.

b) Identify ways to improve health services to all Aboriginal peoples that flow from the First Ministers’ 10 year Action Plan

Access to services:

- Some First Nations people report they are being practiced on by dentists new to Canada,
- Accessing urban health services from rural areas is costly in time and money,
- Need continuity of care from health care providers,
- Advocacy for community members about how best to access services and make system work to their advantage (e.g. referrals to specialists, access medical equipment),
- Overcome racism through building self-esteem,
- Address stigma of mental illness, addictions, HIV and HEP C, so these people are comfortable to access services,
- People should have a choice of specialists, doctors, dentists, optometrists,

Pharmaceuticals:

- Over-prescribing can be addressed through collaboration with local health worker and pharmacists, (e.g. over prescriptions of anti-depressants),
- Vigilance of all health professionals and workers, including Home and Community Care workers,
- Access to improved specialty drugs such as Aricept and new antipsychotics.

Nursing:

- Shortage of nurses needs to be addressed,

Planning:

- Share load and divide tasks of planning, program delivery and evaluation,
- First Nation Summit leadership to encourage attendance of First Nations at health meetings,
- Need funding resources to carry out planning and evaluation activity,
- Prioritize and act on issues that can be addressed now, such as health and safety and water safety,
- Readiness: First Nations in health transfer have done a lot of work, and therefore should not be held back on funding restrictions

3. PROMOTING HEALTH AND WELL-BEING

a) Identify the priority areas for investment in Aboriginal health promotion and disease prevention.

Holistic models of health:

- Return to traditional healing, natural foods, and medicinal plants,
- Focus on the healing properties of whole food and nutrition to improve immune systems (e.g. berries, fish),
- Re-educate our young people,
- Educate about the effects of medical interventions such as radiation,
- Use this model for diseases such as cancer,
- Re-build traditional ceremonies and rituals (e.g. circles, sweat houses, vision seeking, storytelling),

Families:

- From preconception through all stages of life,
- Strengthening the people who care for children and elders, especially women in their child bearing years and women in their midlife,
- Good nutrition (e.g. for young mothers and children, and healthy eating on a budget),
- Parenting skills and basic life skills education that includes elders teaching young people,
- Need to invest in rebuilding family structure in communities, recover from impact of residential school, including connecting all generations through genealogy and family history,
- Address family violence,
- Support role of family when people come home to die,
- Focus on youth,
- Healthy alternative activities,
- Education on healthy sexuality.

Youth:

- Finding ways of keeping tract of youth
- Young parents,
- Advocacy for youth, (e.g. support for youth moving into the cities with no resources or plans),
- Youth addiction treatment services (e.g. youth detox, youth shelters),
- Health education on major risks such as HIV or crystal meth.,
- School cultural days including traditional foods, drumming, weaving, language,
- Strategies for lateral violence and bullying,

Women:

- Health and wellness strategies,
- Mental health issues such as self-esteem and depression,
- Address root causes such as impact of residential school,
- Utilize traditional methods of intervention and prevention such as healing circles,
- Support urban women who are without their family support systems,

Elders:

- Care for elders, especially those with illnesses and living in isolation,
- Elders as advisors and community resource (not all First Nations have access to elders),
- Residential school impact,

Chronic Illness:

- Cancer,
- Diabetes,
- Need higher levels of nursing care within the home and community care program (e.g. add more licensed practical nurses to the teams working in homes),

- Home and community care program needs to expend its mandate as some communities are ready to take on more responsibility for caring for our own people.

Recreation, culture and social activities:

- Physical fitness by returning to traditional diet and traditional practices,
- Walking programs,
- Address obesity,
- Honoring ceremonies (e.g. introducing new babies, first fish ceremony),
- Cross cultural sharing,

Housing:

- Homelessness,
- Increase the amount of adequate housing, (e.g. mold-free),
- Overcrowding

Addictions and mental health:

- Community collaboration with other agencies such as RCMP,
- Address extremely high death rates in our communities as a result of alcohol and drugs,
- Gambling,
- Prevention strategies as well as intervention and treatment, (e.g. educate effects of crystal meth, ecstasy, cocaine),
- Integration of addictions and mental health, (e.g. traditional interventions such as welcome home ceremonies for persons returning from treatment),
- First Nation governance to create by-laws that support action against alcohol and drugs,

Safety in the community:

- Safe houses for children, women,
- Child welfare,
- Motor vehicle safety,
- Strategies to protect youth,
- Strategies to decrease number of deaths in communities,

Wellness in the workplace:

- Safe workplace and systems that promote safety in the workplace,
- Strategies for addressing vicarious trauma,
- Wellness plans for staff (e.g. weekly debriefing plans)

Community health programs:

- The \$700 million should go directly to communities.

4. MONITORING PROGRESS AND LEARNING AS WE GO

a) Identify how we can determine if we are making progress

- The end goal is healthy First Nations people,

- First Nations must set up their own reporting mechanisms that are good for us and not just numbers (e.g. decrease in diabetes, death and disease),
- We need to design our own health programs and the reporting systems,
- We need to develop planning and evaluation processes that measure community-designed programs (e.g. measuring success of purchasing of canoe for youth or community raising money to buy a van for elders),
- Community designed programs must be its own set of criteria for assessing qualifications of workers,
- Home and community care and diabetes programs must be moved out of targeted programs because of the increased reporting requirements for targeted programs,
- Measure success of First Nation health organizations in administering programs such as NIHB as compared to government administering the same programs,
- Need accurate and consistent means of data collection at the community level and at all levels, (e.g. tracking immunizations, stats for cancer, diabetes, nursing services, clients with alcohol and drug issues),
- Develop evaluation criteria based on community information rather than Health Canada policies and procedures,
- Evaluations should be based on strategic plans,
- Hard to measure success of programs because they are so short-lived and under-funded. “We run out of money before the end of the year. We lose good workers this way”.
- Due to political instability, it is best to have a long term plan in health, that is reasonable, resistant to political changes and follows a good governance model such the Carver Model,
- First Nations should also be held accountable for progress as well. Often we blame others for our problems but all of us (the people, First Nations leadership, agencies and communities) have some responsibility for our health.

b) Identify how can we proceed respectfully and effectively to monitor and evaluate programs

- Do our own monitoring,
- Monitor the impact of cutbacks (e.g. had Red Cross outposts-now services taken over by VIHA and now they are cutting services),
- There must be reciprocal accountability and accountability at all levels,
- There needs to be First Nation representation on the Regional Health boards to participate in the allocation of resources (e.g. mental health resources),
- Less bureaucratic control and more community level decision making,
- Develop a community reporting system that is accessible to its membership, (e.g. Evaluations should be based on physical, mental, social and spiritual measures and not just numbers),
- Proper guidelines are needed for travel benefits. How do FNIHB figure out their rates for travel. (e.g.15 cents per kilometer for patient travel at a time when travel costs are increasing),
- Need access to information in order to properly monitor,
- Need capacity to provide proper monitoring (e.g. computers, training, etc.),

- Need resources to properly monitor, such as an evaluation division to free up health care providers to do monitoring,
- Each region should have a First Nation Health Authority who's agenda could be set by communities rather than a central body, where best practices can be shared,
- Set targets and goals on the strategic plan,
- In our community, we have joined four other First Nations to develop an integrated service delivery model that includes health, social development, child welfare and education,
- Right now there are too many reports. "I spend all of April, May and June writing reports. We should measure the time we spend writing reports as compared to our regular duties.
- Do not get enough money from Health Canada to carry out monitoring of their programs. This lack of sufficient resources for managing and monitoring programs really affects small communities because the core funding and resource base are so small.
- Monitoring should include the success stories such as the younger men going for treatment or counseling, or the impact of culture events and activities on raising self-esteem,

c) Suggested measures of success for health programs (health indicators)

- Participation levels for programs and services,
- Changing social determinants (e.g. education and employment levels),
- Use 2001 report from Provincial Medical Officer as baseline data on health status of First Nations people,
- The standardized measures of quality of life could be adapted for use by First Nations,
- All the political leaders/policy makers adopt a holistic approach to health. They are beginning to talk the talk but there is still a tendency to put everything in little boxes. Our health is affected by everything around us so if you have health, social development, child welfare, housing, economic development, etc. in separate boxes, you can't be effective in addressing community health issues. Similarly, in our culture, there is no separation between mental health, physical health and spiritual health. However, you still hear people saying, if you have a mental health problem, you need to see a psychologist, if you have a physical problem; you need to see a doctor. Residential school has made us sick but these are not our ways. Mental health cannot stand alone.
- Levels of use of traditional medicine practitioners/medicine, including use of space in health facilities dedicated to traditional medicine,
- Measuring local control through the number of local people participating in leadership roles, program planning, development and evaluation,
- Measuring communication by measuring amount and types of communication approaches such as newsletters, videos, community health meetings,

5. CLARIFYING ROLES AND RESPONSIBILITIES BETWEEN GOVERNMENTS AND ORGANIZATIONS.

a) Identify where our current roles and responsibilities create barriers to improving health outcomes or services

Health Canada (FNIHB) policy development

- Creates policy without input from First Nations that do not address community realities (e.g. restrictive patient transportation policy creates many hardships),
- Need to change home and community care policy so that it better responds to the needs of elders and their families,
- Need recognition at the policy level of alternative healing (traditional),
- Conflicting policies of some targeted programs resulting in stove piping programs,
- Some targeted programs should not be targeted, but rather they should be considered essential,
- Decisions made in Ottawa,
- Policies are about money, not human need,
- Inequities between status and non-status Indians cause conflict in communities

Regional Health Authorities:

- Cutbacks mean people must travel further distances for health services, however the restrictions of Health Canada policies do not cover all transportation costs,
- 5 regions add complexity of service delivery,
- The health authority cannot effectively reach all the people (e.g. there are 40 communities in the Interior Health Authority),
- Lack of respect for First Nation communities reflected in funding for Aboriginal health programs and services (e.g. Aboriginal Health Initiative Program funding is only 750,000),
- Use of different doctors and records not shared,
- Need for more cultural competency in service delivery (e.g. translation services),
- There is a lack of First Nation involvement in Regional Health Authorities in service delivery and within the board membership,
- Gaps in accessing services/benefits between federal and provincial governments,
- Regional Health Authorities pull back on public health services if Health Canada (FNIHB) increases the nurse's hours in the community,

Lack of commitment for capital infrastructure:

- Communities lack funds to build health facilities to house their own health professionals (e.g. doctors, dentists, etc.),
- Lack facilities for youth,
- Alcohol and drug treatment facilities in communities,
- There is no treatment facilities for crystal meth

Youth services:

- Lack of services for alcohol and drugs (e.g. rehabilitation counseling),
- Lack of specialized services for youth in communities,
- Full time male and female counselors needed in communities,

Approval process for alcohol and drug treatment:

- Need to change Health Canada (NNADAP) system of approval, (e.g. recognize cross addictions),
- Different services for addictions provided by different governments,

Hiring health professionals:

- First Nations need to be involved the hiring of health care professionals,
- Funding too low for nurses and other health professionals, burn-out happens all the time,
- INAC needs to change its education policy. Restrictive education policy impacts on health career opportunities,

Funding:

- How much money is transferred to the provincial government for First Nation health?
- How much money reaches First Nation communities?
- If reporting is not done right, funding will be pulled, there is no flexibility,
- The process suits the governments and not the First Nations,
- No increase in funding for First Nations, but an increase in responsibility,

Government accountability

- Records on patient transportation should not only show those who accessed benefits, but also all the people rejected from the travel benefits,

b) Identify practical changes to achieve our goals, ways that address roles and responsibilities and to build solutions

Law-making:

- Amend Canada Health Act,
- Establish an First Nations Health Act that comes from section 35 of the constitution,
- Includes principles:
 - Publicly funded
 - Sustainable
 - universality
 - Accessible
 - Equity
 - Portability
 - Sensibility
 - Culturally distinct
 - Reciprocal accountability
 - Full partnership

Policymaking:

- More First Nation involvement,
- Decrease bureaucracy,
- Address national policies,
- Off reserve representation, count all our people no matter where they live,
- Policies need to reflect BC diversity (e.g. regional, cultural, isolation),

Funding:

- Collaboration rather than fighting for little bits of money,
- More global budgets, comprehensive funding,
- Streamline funding flow and on time rather than 6 months into fiscal year,
- Amalgamation of federal, provincial and regional dollars,
- Funding needs to fit regional circumstances (e.g. isolation factor),

Accountability:

- Streamline reporting to Health Canada (FNIHB),

Staffing:

- Staff turn over affects communities and continuity of services,

Communication:

- Health Canada needs better communication,
- Accessible community newsletters
- Need more than list of phone numbers of government staff, need to understand what they do.

b) Clarify the meaning of government-to-government relationships in this context

- Hold the new federal accord and recent provincial government promise as a basis for accountability of federal/provincial/and First Nation government action,
- The relationship should be proactive rather reactive,
- Provincial Ministry of Health working in cooperation with First Nations,
- Define the roles of the Leadership Council and First Nations,
- Government to government relationships should be built on existing infrastructures instead of creating new ones,
- Determine who represents First Nations in government-to-government negotiations (e.g. tribal councils, Union of BC Indian Chiefs, BC AFN, First Nations Summit)

c) Describe why reciprocal accountability is important and necessary, including mechanisms for achieving it

- Hiring health professional staff with understanding of First Nation culture and traditions,
- There is now a need for commitment from Regional Health Authorities to act on studies, research, and statistics,
- Important to know how money is spent by government on behalf of First Nations,
- First Nations can collect health information about themselves,
- Transparency,
- Flexibility and control over our own health services,
- Cross cultural training and awareness, including government officials to spend time in communities,
- Use the Health Transfer Evaluation Report recommendations on accountability,

- Need First Nation board representation on Regional Health Authorities,
- Funding local union agreements must increase as necessary,
- Establishment of employers association, including capacity development of board and agency.

6. DEVELOPING ON-GOING COLLABORATIVE WORKING RELATIONSHIPS

a) Identify how we can structure on-going collaborative working relationships in pursuit of our vision

Regular meetings:

- Quarterly meetings with Health Canada,
- Quarterly meetings with Regional Health Authorities,
- Community meetings to build collaboration, such as establish a homemaker society,

First Nation communication, cooperative and collaboration will take place at many levels and amongst many different groups and people:

- Collaboration within FN Community:
 - Natural collaborators like all the women in the community taking on their traditional role of family health leader,
 - Regular meetings amongst health staff from different programs (community health, addictions, mental health, environmental health, home and community care, etc),
 - All the departments, agencies and programs from all the different disciplines in the community working towards a common vision; (day-care, education, economic development, capital/housing, etc),
 - Increase communication between health staff and Chief and Council,
- Collaboration on key health issues:
 - Need to work together to deal with hot spot issues like HIV and HEP C,
 - Dental health, fewer people accessing due to upfront costs to access, resulting in the unused dental budget being taken away,
 - Health needs of elders and persons with disabilities,
 - Traditional medicine,
 - On and off reserve migration,
- Collaboration within urban First Nation community:
 - Health related urban agencies to work together with common vision and decision making on resources.
 - Negotiate partnership agreements between First Nation communities and urban First Nation and/or Aboriginal agencies, in order to formalize First Nation support of their people who are accessing urban agencies,
- Collaboration amongst First Nations:
 - Develop communication strategy and communication infrastructure,

- Biannual First Nation health directors meetings to share best practices and challenges,
- Regular communication with other regional First Nations and/or Aboriginal bodies (i.e. Native/Aboriginal Friendship Centres, UBCIC)
- “Internal secondment” where communities can share expertise. For example, trade nurses for a week, so the expertise of each nurse can be shared with another community
- Collaboration with Regional Health Authorities and Health Canada:
 - Each Provincial Health Authority should have an Aboriginal health manager (right now only two have managers, the rest have committees),
 - Regular meetings between First Nations and the Aboriginal Health Manager,
 - Regular meetings between Regional Health Authority and First Nation(s) with assistance from Aboriginal Health Manager,
 - Protocol agreement on what to share in terms of health data,
 - Need minimum standards around consultation,
 - Hospitals not respectful of cultural practices or their staff are generally not knowledgeable of cultural protocols,
 - First Nations Chiefs Health Committee should sign off on all provincial Aboriginal health plans (including resources to do this),
 - Demonstrate commitment to the vision of improving health; Regional Health Authority and Health Canada need to work together with communities in finding solutions rather than just saying no (e.g. lobbying to protect local health facility from being closed down),
 - Build a relationship with the Provincial Health Officer, Perry Kendall.

b) Identify the capacity that is needed to sustain these new relationships as well as how to develop it

- Core funding at community level designated for sustaining collaboration,
- Want federal money earmarked for First Nation health to come directly to First Nation, rather than funneling through the provincial government,
- Major pillar in the Blueprint should be to get resourced enough to deal with pervasive crisis situation in communities AND to move ahead on proactive plan of health promotion and prevention,
- Deal with the vast resource discrepancies between Health Canada and First Nations with regards to labour issues,
- Build regional First Nation health facilities, but first build collaboration and trust relationship amongst the nations,
- Deal with crisis health issues at home first, for example hospice needed, not enough food, “hard to lift head above all that, let alone try to collaborate!”
- Hire a communication analysis to assist in development of communication strategies,
- Need strategies to deal with “turf” issues amongst the various agencies,
- Build technical capacity at First Nations Chiefs Health Committee,
- Rebuild overall capacity of First Nations Chiefs Health Committee in order that it can act as main collaborative vehicle,

- Research international models of collaboration to find what works for them,
- Allocate time and resources to support this initiatives,
- Web-site to find best practices,
- Web-site to find what's happening around the province,
- Need strategic planning for collaboration to reach all levels and all departments, ministries, disciplines and sectors above and beyond the health system,
- BC First Nations should get its share of health plan funds directly from Ottawa rather than funds going to provincial government,
- BC Leadership Council should take the Blueprint forward

Summary of Some Key Points Raised

1. We need increased community capacity development that focuses on recovering and rediscovering our traditional ways of coming together to celebrate and to solve problems and not just on the development of mainstream technical skills (e.g. technological capacity, more nurses, etc.)
2. We need to begin to work together as Nations, treaty, non-treaty, etc. to share our successful programs with one another and to increase our ability to influence health structures and services that are currently outside of our realm of influence. However, we must be careful not to develop large bureaucracies that simply mimic current government structures. For example, the development of Regional FN Authorities was discussed. It was important to the people that these authorities not become copies of previous Regional structures under the FNIHB.
3. We need a collaborative relationship with Health Canada, the Province and the Regions that will promote a holistic approach to the planning, implementation, delivery and evaluation of programs used by First Nations people in all jurisdictions.
4. Together, as First Nations in British Columbia and individually, we need to develop long-term strategic health plans that include a shared vision. Such plans will give more authority to First Nations people and will make health services less subject to change in times of political instability at any level of government.
5. We need to develop our own reporting systems including developing our own health indicators, with a focus on quality versus quantity. We support the principles of OCAP in terms of health information systems. We need to be supported in this endeavor through funding that will provide us with timely access to accurate and consistent data on the health of our populations at the community level.
6. We need to hold all levels of government accountable for the health of our people and this includes accountability within and between First Nations communities/agencies and between First Nations governments and other governments.
7. We need a long-term approach to community-designed programs that are adequately funded, in such a way as to ensure that communities can provide sustainable health

programs that address community priorities. There should be no more targeted government initiatives. One idea is that the money for all health programs be turned over to First Nations so that they can provide and/or purchase the health services that they require, in a way that is similar to the funding of local education agreements.

8. Barriers to the promotion of traditional healing and the use of traditional medicine in the delivery of health services to First Nations people in all jurisdictions must be removed. These barriers include institutional racism and issues of legal liability.

Innovative Ideas

1. We need to be able to respond to health crises in our community: diabetes, HIV/AIDS, youth suicide, sexual abuse, residential school issues, and amputations – we are a third world country here in Canada. We are 3% of the population; we should get 3% of all Aid money provided to the developing nations by Canada. Canada should be challenged to clean up its own backyard first.
2. In our community, we have joined 4 other Bands to develop an integrated service delivery model that includes health, social development/child welfare and education. Our workers visit one community each day of the week and go out together to meet with people. Prevention is the basis of our programs, not health transfer. Originally we were too small for health transfer and this led us to this integrated service delivery model. It seems to be working very well, particularly for the youth. Amongst the youth who remain in our communities, we have had no school dropouts, no pregnancies, and no kids on pot or alcohol. Our kids don't steal and there is no youth crime. We put any extra dollars that we have into youth programs, e.g. ski trips. We had our young teenagers (11 and 12 year olds) go through a program where they took the "crying baby" home to look after it for a weekend. This showed these young people what it is really like to look after a baby. We have more problems with our 30 – 40 year olds than we do with our teenagers. (Chief Jennifer Bob of the Spuzzum First Nation speaking about the Nlakapamux Services Society, Yale, BC).
3. This program and its' success is an example that not only shows what can be done when 5 small Nations have the will to develop their own programs in spite of many obstacles; it also points to an unintended disadvantage of the health transfer may be the tendency for it to encourage the separation of health from the other service delivery areas that have the potential to have an even greater impact on health status than health services in and of themselves. We have a youth camp and a youth ambassador program that are working very well. We have an all Native Youth Ambassador program that focuses on public speaking, and other leadership skills. The youth who attend these programs make better choices, tend to volunteer more, and proudly represent our people at community and outside events. (Chief Janet Webster of the Lytton First Nation).

Conclusion

The participation of those who were able and willing to come together on June 22nd, 2005 is greatly appreciated. The notice for this Forum was short. The Blueprint process is being

conducted within a structure that is not ideal. The timeframe was very short and the planning categories and questions raised in the *Working Outline* are sometimes vague or ambiguous. Regardless, the participants in this process have given their time willingly and have provided important input. The ideas generated through the Forum will be incorporated into the *First Nations Health Blueprint for British Columbia* and this Summary of Proceedings will be appended.