

Implementing the Vision

BC First Nations Health Governance



Reimagining First Nations Health in BC



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Health Governance**

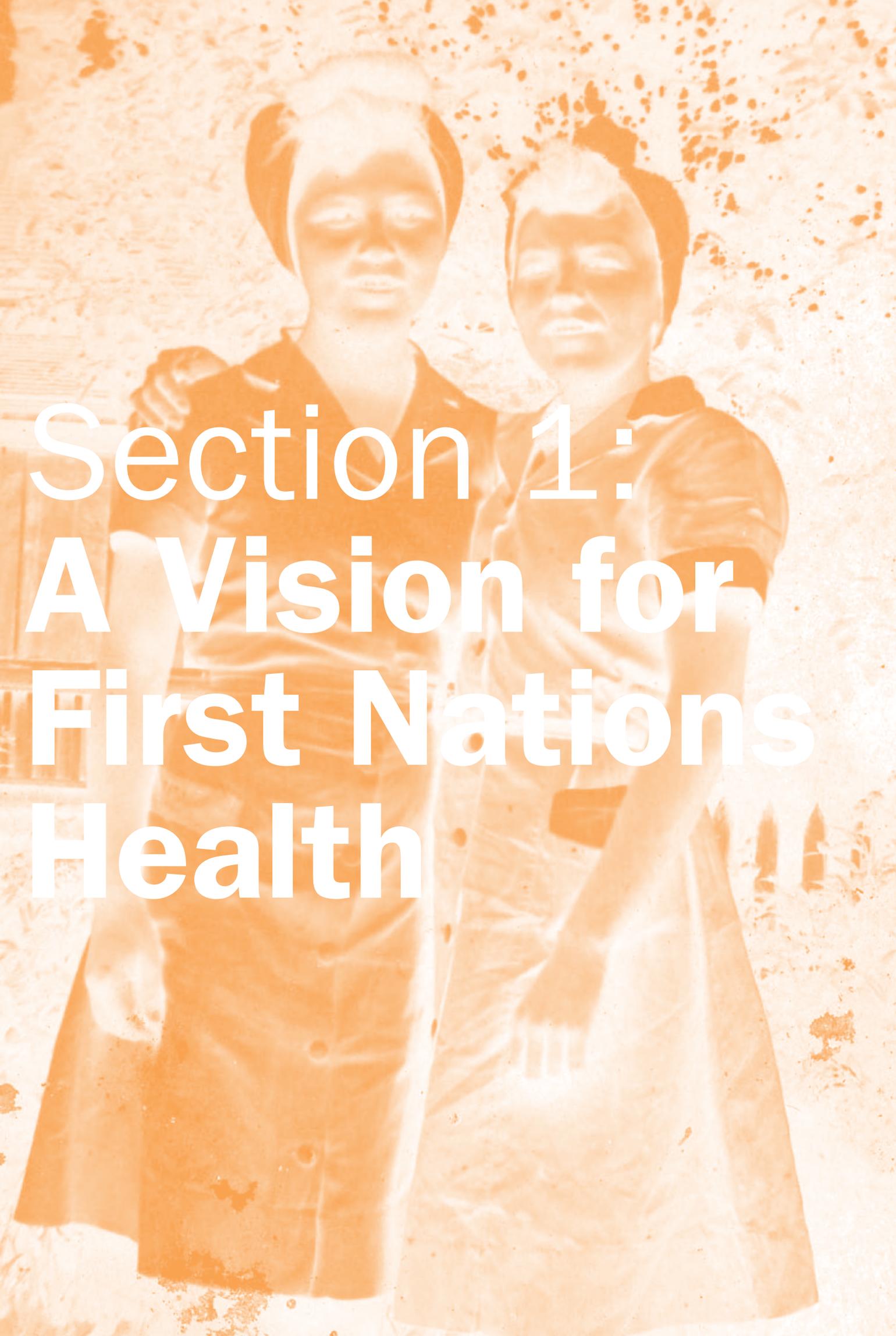
Reimagining First Nations Health in BC

Implementing the Vision: BC First Nations Health Governance

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Section 1: A Vision for First Nations Health

» This book is meant to provide the reader with an overview of where we have come from and where we are going in terms of the collective goal of the **Tripartite First Nations Health Plan**: *to ensure First Nations are involved as equal partners in the planning and management of health services for our people. The work that BC First Nations are doing today will help us achieve that goal, and to ensure future generations have authority to enact policies, measure success, allocate resources, and establish service standards that are accountable to our communities. We need to work together to create healthy, strong, more vibrant communities now and in the future.*



Imagine the future, when First Nations people are considered the healthiest people in Canada. A time when visiting health professionals and planners are looking to our health care model, not only because we are providing the highest quality health services, but for the proven outcomes of those services. When the number of health professionals, including doctors, nurses, and midwives within our communities has increased tenfold. When the number of babies delivered at home safely, has increased with the assistance of First Nations midwives.

Envision a time when there are easily accessible accredited First Nations health centres providing pharmacy, laboratory testing, traditional medicines, dental treatment, and nursing services. A future that includes several Regional Medical Wellness Centers that act as centralized primary care ‘hubs’ and deliver more specialized services. That these First Nations facilities are culturally appropriate spaces, and also accommodate the needs of visiting Health Authority specialists and professionals. When two new data epicentres

17,870 BP

Evidence of Tuberculosis in Bison.

12,000 years ago

– earliest recorded archaeological evidence of First Nations in BC (to date).

7000 BC

Tuberculosis present in a human settlement in the eastern Mediterranean

1500 BC

The Ebers Papyrus – A medical text from Egypt, describes diabetic symptoms.

1350 BC

First recorded mention of smallpox – from the Egyptian-Hittite War

1157 BC

First evidence of smallpox – from Egyptian Pharaoh Ramses V's mummy

460 BCE

Hippocrates – Classic Greek Author – wrote of “Phthisis” (Greek term for tuberculosis) – the most common disease of the time – nearly always fatal.

1025

Canon of Medicine written by Uzbek scholar Ibn Sina – influential text widely studied – introduced concepts of Quarantine, contagious diseases, described diabetes, and hypothesized the existence of microorganisms. “The most famous medical book ever written”

Section 1: A Vision for First Nations Health

are established in Northern and Southern BC to build data and research capacity, and to support research partnerships with universities.

Visualize a time when 100% of BC First Nations communities are part of transfer agreements for an ever expanding range of community-based programs, a time when these agreements allow for health program design at the community level. That transfer agreements represent the First Nations Health Authority's biggest annual budget item. A time when 100% internet connectivity is achieved for rural and remote areas of our province, and a fully functioning community-driven network is providing tele-health and tele-medicine services to those who need them most.

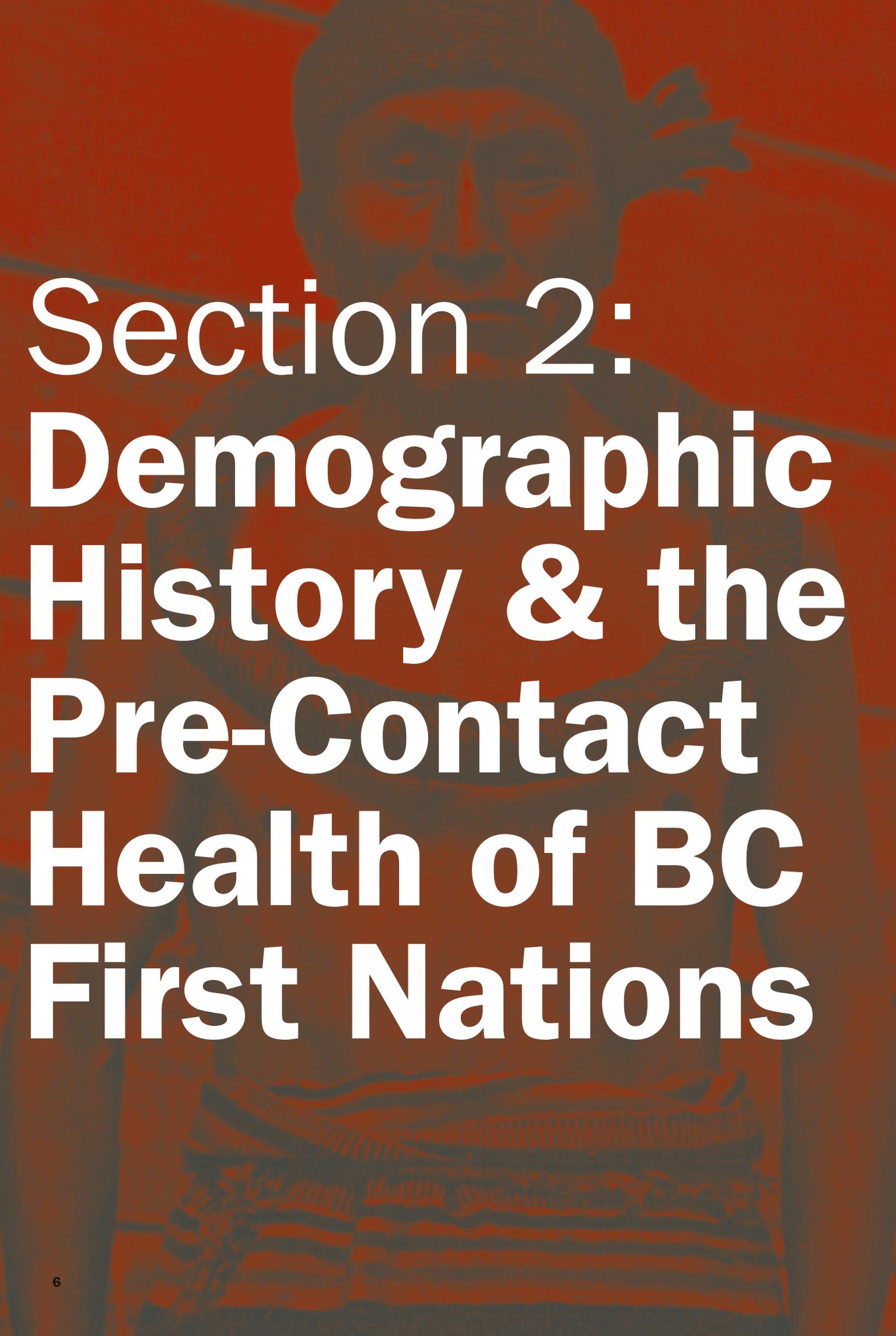
Imagine a time when our community health experts are the ones making health care decisions for our families and communities. A time when culturally safe health care is the norm and not the exception, and each Health Authority has two dedicated Aboriginal seats on its Boards of Directors. That all the future dealings between First Nations and the provincial and federal government are seamless.

This is our possible future if we work hard, strive for success, embrace change, and continue to work towards strengthening our relationship with the government as a whole. The first steps towards this future have already been taken, we now have the opportunity to work together to take control and responsibility over our health care programs and services.

In order to make informed decisions for our collective future, we need only look to our history. In the past, First Nations were well equipped to meet their health needs and to sustain their communities. They were aware of the many social determinants of health and valued taking a proactive, holistic approach towards health care. Indigenous people around the world have been initiating this change for their people for decades; the Tripartite First Nations Health Plan provides this opportunity for BC First Nations.

“We are here because our ancestors worked hard and planned...”

– Kukpi7 Wayne Christian



Section 2: Demographic History & the Pre-Contact Health of BC First Nations

Origins

The lands in BC have been populated by the ancestors of First Nations since time immemorial. Oral Traditions across what has become British Columbia (BC) relate multiple Origin stories describing how the ancestors of BC First Nations peoples came into being. These stories often involve supernatural beings, animals and people in the founding of Tribes and lineages, as well as the creation of landforms and the foundation of customary law. First Nations in BC have incredible linguistic and cultural diversity, including some 32 different languages.

In BC, First Nations developed technologies and economies that were well adapted to the local environment, geography, and resources. Varying according to region and culture, First Nations generally practiced a mix of hunting, fishing and gathering foods. Also, they manufactured goods from local and imported sources. Complex social and cultural institutions existed within these communities. Sophisticated methods of harvesting, management and preservation of the food were developed to handle the seasonal abundance of resources.

The societies that existed prior to the first contact with the Europeans were based on oral traditions, and a deep connection and understanding of the land. Knowledgeable leaders could accurately predict tides, weather, animal behaviour, the timing of salmon runs, and other important events that enabled the people to flourish.

First Nations developed complex cultures that included strong, healthy populations with deep and abiding connections to their respective territories. Resources were carefully managed to ensure long-lasting abundance. Social relationships included hospitality and sharing as key concepts, which were bestowed upon the poor, the infirm, and the elderly.

“In our own governing systems it’s important that we take care of our own people”

– Charles Nelson

First Nations Pre-Contact Health

In pre-contact times First Nations enjoyed good health due to an active lifestyle and healthy traditional diets. Oral history suggests good health and longevity. Traditional health included ceremonial, spiritual, and physical elements. Specific types of healers

1507

Smallpox introduced to the Caribbean by Spanish – beginning of massive epidemics of “Old World” diseases that kill millions of Indians in North and South America.

1520

Postulated Continent-wide epidemic in North America – controversial theory.

1754 – 1767

Smallpox is used as a biological weapon during the French- Indian Wars in the U.S. by the British.

1774

Spanish Explorer becomes first recorded European to visit BC.

1775

Smallpox epidemic – sweeps the entire BC coast – high mortality rate.

1778

Captain James Cook – first voyage to BC – at ‘Nootka Sound’.

1793

First case of Tuberculosis is recorded among First Nations in BC among the Nuuchanuulth.

1796

Smallpox vaccine developed in Britain

included midwives, herbal healers, and shaman. In addition, there were customary laws regarding food and hygiene that assisted the people in staying healthy.

Traditional diets were balanced and varied; high in protein, healthy fats (Ooligan grease contains Omega3 fatty acids) and some vegetables and fruits¹. The seasonal nature of the food harvest coupled with fluctuations in resource abundance at times led to food shortages, though it was unlikely that people starved². Pre-contact lifestyles had many “health-protecting” characteristics including small size, comparatively low population density, reasonable mobility on land and water, seasonal relocations to different harvest locations, intimate knowledge of the local environment, environmentally friendly subsistence practices, and the availability of a variety of foods.

“winters were harsh so you had to work 9 months of the year to make sure you had enough food put away to get your entire family, your entire community, your entire nation through that winter... If you wanted to eat, then you had to contribute to the gathering and preparation of food”.

– Grand Chief Doug Kelly

The hunting, fishing and gathering lifestyle ensured that people were physically fit. Although there were some health problems related to work, such as arthritis. Prior to contact First Nations experienced virtually no diabetes and no dental cavities³, though abscessed jaw sockets were common⁴. Also there were some instances of First Nations people having a few infectious diseases and some dermatological problems⁵.

Traditional Healing

The roles of Spiritual Healers, also known as Shaman, were well understood in pre-contact times. Spiritual wellness is considered part of human wellness among First Nations in BC. Oral history and continuing practices confirm these deeply held beliefs.

First Nations throughout BC have developed intimate understandings of their environment and the healing qualities of many plants. Throughout history there have been specialist healers who use plants to heal a wide range of ailments. Although healing knowledge varies according to the availability of plants and medicines, and the distinct cultures of different Nations, there is a common understanding of the healing properties of plants. Additionally, plants are used during ceremonies and for spiritual reasons.

When looking at the social determinants of health for First Nations cultures during these times, it appears that communities and families greatly valued holistic approaches for preventative health care. When a

member of a community fell sick, the family and community would provide support and comfort, a practice that is very much in evidence today as it was in the past. Custom and wise leadership ensured that people had roles in their communities to take advantage of their particular skills and to contribute to the overall well-being of the group. A sense of place and belonging is recognized as one of the factors affecting health.

In terms of child-rearing, it was commonly understood that children were raised and nurtured not only by their parents, but by their extended families, especially grandparents, uncles and aunts. This ensured that the child's growth and education was properly addressed by knowledgeable members of the family and community. These communities thrived by working together to ensure their members were cared for and the Nation remained strong.

Population Estimates

Prior to contact with Europeans, the province now known as British Columbia, particularly the coastal portions, had one of the densest and most linguistically diverse populations within what is now Canada. It is estimated that one third of the pre-contact population of Canada resided within British Columbia.

Pre-contact population estimates for BC vary widely with some estimates ranging from a conservative 200,000 to more than a million⁶. Earlier estimates of 80,000 have now been discredited as far too low. Oral traditions of many First Nations give a much higher original population than what is generally accepted by western academics. From oral history and ongoing research it is clear that the European diseases that ravaged the Central and South American populations spread in advance of actual contact to First Nations in BC. Therefore early explorers and traders who considered the populations quite low were witnessing populations of people who had already experienced drastic decreases. What is clear is that the population was of ancient origins, large, varied and relatively healthy prior to the introduction of European diseases.

1801

Smallpox epidemic – Vancouver Island and Lower Mainland – spread from the Plains through the Columbia and up the coast to Coast Salish people.

1811

Permanent post established by Americans on the lower Columbia River.

1821

HBC 'rule' in British territory – what is now BC.

1824 – 1825

"Mortality" epidemic – unknown disease along the coast

1836 – 1838

Smallpox epidemic – Northern and Central Coast of BC – originating from Russian traders among the Tlingit the epidemic killed about 1/3 of the population of the North and Central Coast of BC.

1843

Victoria established.

1846

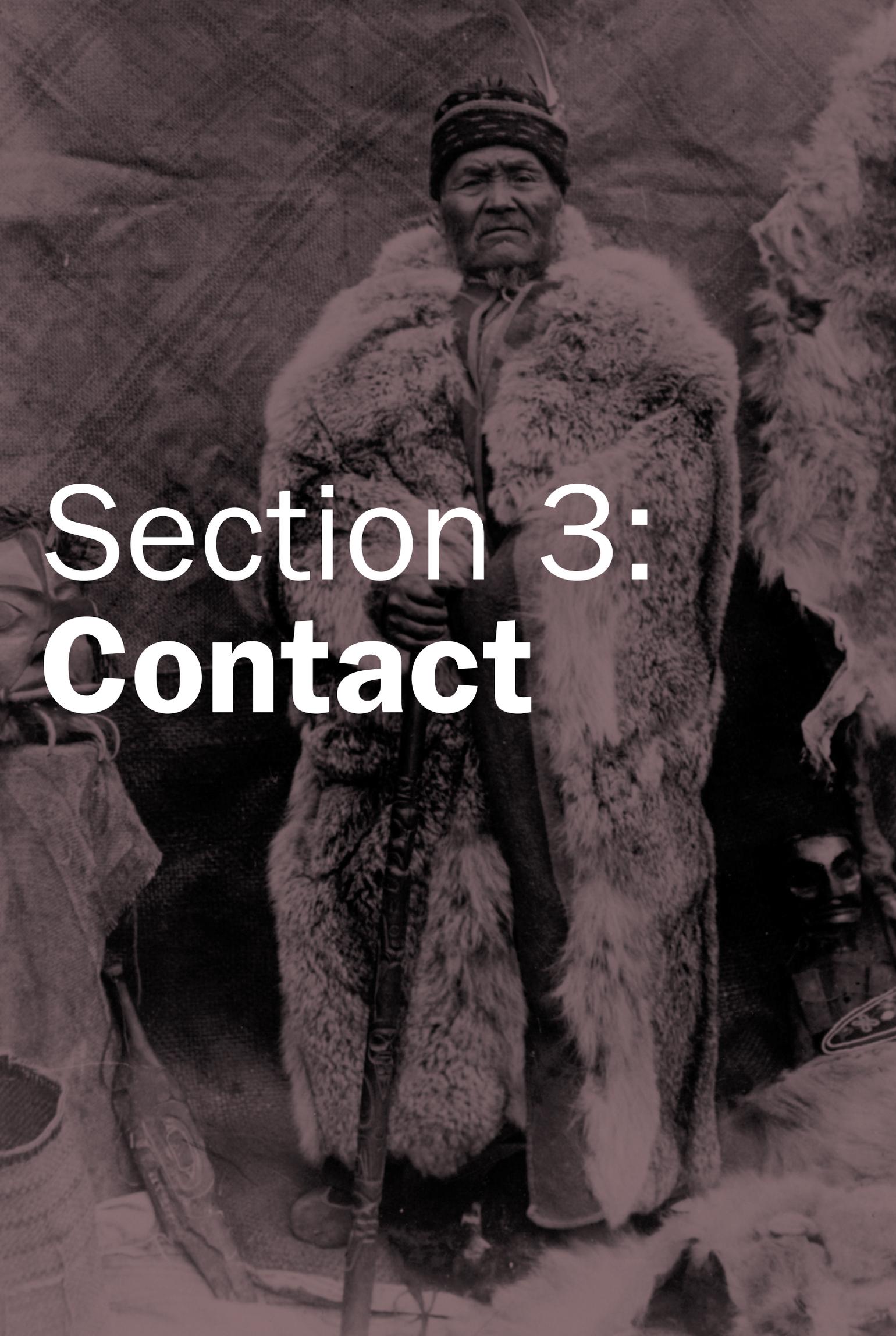
Oregon Boundary Dispute settled between US and Britain – establishing the border in southern BC.

1848

Measles epidemic along the coast.

1850

Measles epidemic spreads to the Interior.



Section 3: Contact

Contact

Contact between First Nations and non-Aboriginal people occurred rather late in BC, with some of the earliest recorded contacts occurring in the late 1700s, with Russian, French, Spanish and British traders and explorers all visiting parts of the coast during this time⁵. Inland contact was primarily through traders (Hudson's Bay Company) and explorers (Alexander McKenzie and Simon Fraser)⁸. It is also possible that other earlier unrecorded contact occurred on the coast⁹.

The question of when contact occurred is of interest because of the timing of potential introduction of epidemic diseases prior to those that occurred in the 1770s.

Population Collapse

The spread of epidemic diseases preceded actual European contact, with a widespread smallpox outbreak occurring in the 1770s along the coast. Epidemics spread through First Nations communities in advance of explorers. Some researchers have suggested epidemics reached the Northwest Coast as early as the 1500s, believing the well-known epidemics from the Caribbean and Central America may have spread to the Pacific Coast through native trade networks and social contact. Some of the recorded epidemics in the Interior were known to have originated on the prairies during the historic period (early 1800s).

The introduction of infectious diseases from Europe and Asia¹⁰ into the Northwest Coast, and adjacent areas, and an increase in the severity of warfare had devastating effects on the people¹¹. Lacking biological defences or cultural adaptations to these diseases, First Nations were overwhelmed. Smallpox, influenza, measles, and whooping cough were recorded epidemics, with smallpox particularly recurring with devastating effects. First Nations health systems had



Smallpox is a contagious disease caused by the variola virus and is believed to have emerged more than 3,000 years ago in either Egypt or India (World Health Organization).

The disease initially has flu-like symptoms, followed by the emergence of lesions which

turn into pimple-like skin eruptions). In individuals who recover these eruptions scab over and heal – leaving pock-marked scars.

In some cases entire villages were significantly reduced in single disease events, with mortality rates ranging from 50% to 90% of the population.

1853

Smallpox epidemic – among the Nuu cha nuulth – 'Nitinaht'.

1858

Fraser Canyon War – Nklaka'pamux vs. White Miners.

1858

Colony of British Columbia founded

1861

First Indian Residential School opens in BC.

1862

Smallpox epidemic – Victoria – Spreads widely along the coast when colonial government forces First Nations to depart Victoria – carrying the disease to their home communities.

1866

Colonies of British Columbia and Vancouver Island united.

1867

Canadian Confederation – British North America Act

1868

Measles epidemic – along the coast from the Strait of Georgia and north.

1871

British Columbia joins Confederation as the 6th Province of Canada.

1871

Fish Canning Industry begins in BC – building of Fraser River Canneries. Indians not allowed to fish commercially (until 1923).

1874

Small pox epidemic in BC – limited to the Nuuchanuulth.

Section 3: **Contact**

never encountered these diseases and were unprepared to deal with them. These epidemics continued throughout the historic period and caused ongoing and dramatic population decline.

The extremely high level of fatalities is difficult to imagine in the modern era of universal health care and antibiotic medicines. When these epidemics struck, people died in such mass numbers that it was a common occurrence for bodies to remain unburied. In some cases, people who were sick may have otherwise survived if provided with basic care. With so many people affected by these diseases, at times regular food harvest was impossible. The disruption to the food harvest during these times made matters worse with a lack of available food supply for the remaining tribe members and further reduced the resistance to disease due to lack of nutrients. Chronic diseases also entered the population at this time and included Tuberculosis and venereal diseases.

William Denevan described the deaths associated with the introduction of Eastern Hemisphere pathogens as *“The greatest demographic disaster in the history of the world.”*¹²

As the original pre-contact population is not agreed on, it is difficult to accurately measure the population losses suffered by First Nations during this period. It is clear that in some cases entire villages were significantly reduced in single disease events, with mortality rates ranging from 50% to 90% of the population. Population loss of 90% from pre-contact to 1890 based on recent (still conservative) pre-contact population estimates is generally accepted¹³. The pattern of introduced disease decimating the population, associated with colonization, is one found throughout the Western hemisphere.

Oral history contains references to the intentional spread of disease by non-Aboriginal people, by throwing infected blankets into communities, or threatening to do so¹⁴. Threats of biological warfare have been recorded in some cases where settlers wished to dispossess First Nations from desirable land. First Nations blamed the sickness on non-aboriginals and threatened, in some places to attack “White establishments”¹⁵. During this time there was a vaccine for smallpox, which was discovered in Europe in the late 1700s; however it was rarely provided to First Nations people.

Without a written culture, First Nations lost large pieces of their oral knowledge when experts died off in large numbers during the epidemics. The population collapse seriously unbalanced traditional health care systems. These new diseases overwhelmed and infected the traditional healers themselves, while simultaneously discrediting their methods when they proved ineffective against new maladies. Healers were nearly powerless in the face of the new diseases.

If at one point you drew a circle, the medicine people were aboriginal, the medicine was aboriginal, nurses, teachers were aboriginal, as colonization evolved and you looked at the circle there were no aboriginals, we were totally powerless

– Chief Robert Joseph

The 1860-62 smallpox epidemics were greatly exacerbated when colonial officials denied health care to First Nations and drove them from the Victoria area, forcing them to return to their homes, further spreading the epidemic throughout the coast. During this time, the smallpox epidemic undermined the power of many coastal First Nations, clearing the way for the colonization and repression that followed. The concept of terra nullius, or settlement of ‘empty land’ was advanced at this time, based on the depopulated landscape that resulted from these waves of epidemics.

Colonial Period

Following the population collapse, governments and churches sought to actively colonize and control First Nations. Colonial authorities were expanded to facilitate land and resource extraction, and to limit First Nations rights. Indigenous spirituality, political authority, education, health care systems, land and resource access, and cultural practices were all repressed. In some missionary writings there were explicit descriptions of attempts to eradicate traditional healing practices¹⁶. Later on, residential school systems were established to remove children from First Nations with the aim of assimilating them.

The myth of the dying First Nation society was used to justify political action that benefited non-aboriginals at the expense of First Nations. BC was one of the more xenophobic colonies of the British Empire. The nineteenth and twentieth century anti-Chinese and Japanese legislation, union organization, racially-based and segregated work division, and race riots further demonstrate the sustained discrimination and the single race (Caucasian) aspirations of the time.

The 1918-19 Spanish influenza pandemic was the last major epidemic to seriously affect First Nations and marked the end of the epidemic cycles that had begun over 150 years previously. As the 20th century proceeded, First Nations populations reached their low point and then slowly began to rebound. At the same time government and church controls reached their high point.

1874

Petition of Chiefs of the lower Fraser River expressing discontent over land settlement in BC

1876

First Federal Indian Act passed

1882

Tuberculosis bacillus identified by German scientist Robert Koch

1882 – 1883

Measles outbreak – Central Coast

1884 – 1924

Estimated evolution of HIV –from Simian Immunodeficiency Virus (SIV) in Africa - probably from chimpanzees - likely passed to humans through hunting.

1885

Potlatch outlawed

1885

Tsimshian delegation goes to Ottawa to discuss the ‘Indian Land Question’

1885

Completion of the CPR – Montreal to Port Moody. Non-Aboriginal people outnumber First Nations in British Columbia (concentrated in a few urban areas)

1887

CPR reaches Vancouver – spurs immigration

1888

Federal policy creates the Indian Food Fishery – Indians not allowed to fish commercially.

1889

The role of the pancreas in diabetes is discovered in Germany

The Impacts of Church and State

As epidemic diseases declined, endemic disease and other health issues arose. Tuberculosis became a widespread problem and dental health deterioration became an issue. At the same time, diets changed to include more starch and processed sugar. Alcohol use became more widespread in our communities.

The loss of control of traditional health systems, including the repression of cultural practices with shaman and even herbal healing by western doctors, meant that churches and government exerted even greater control over First Nations health during this time. Services were limited and often of low quality, and sometimes western health services were denied to First Nations entirely¹⁷.

Residential schools had high rates of tuberculosis, high mortality rates (especially early in their history), and poor quality food. A high rate of physical and sexual abuse was present in these facilities. Also, there were some cases of children being involved in medical experiments and even incidents of severe punishments inflicted on the children that sometimes resulted in death.

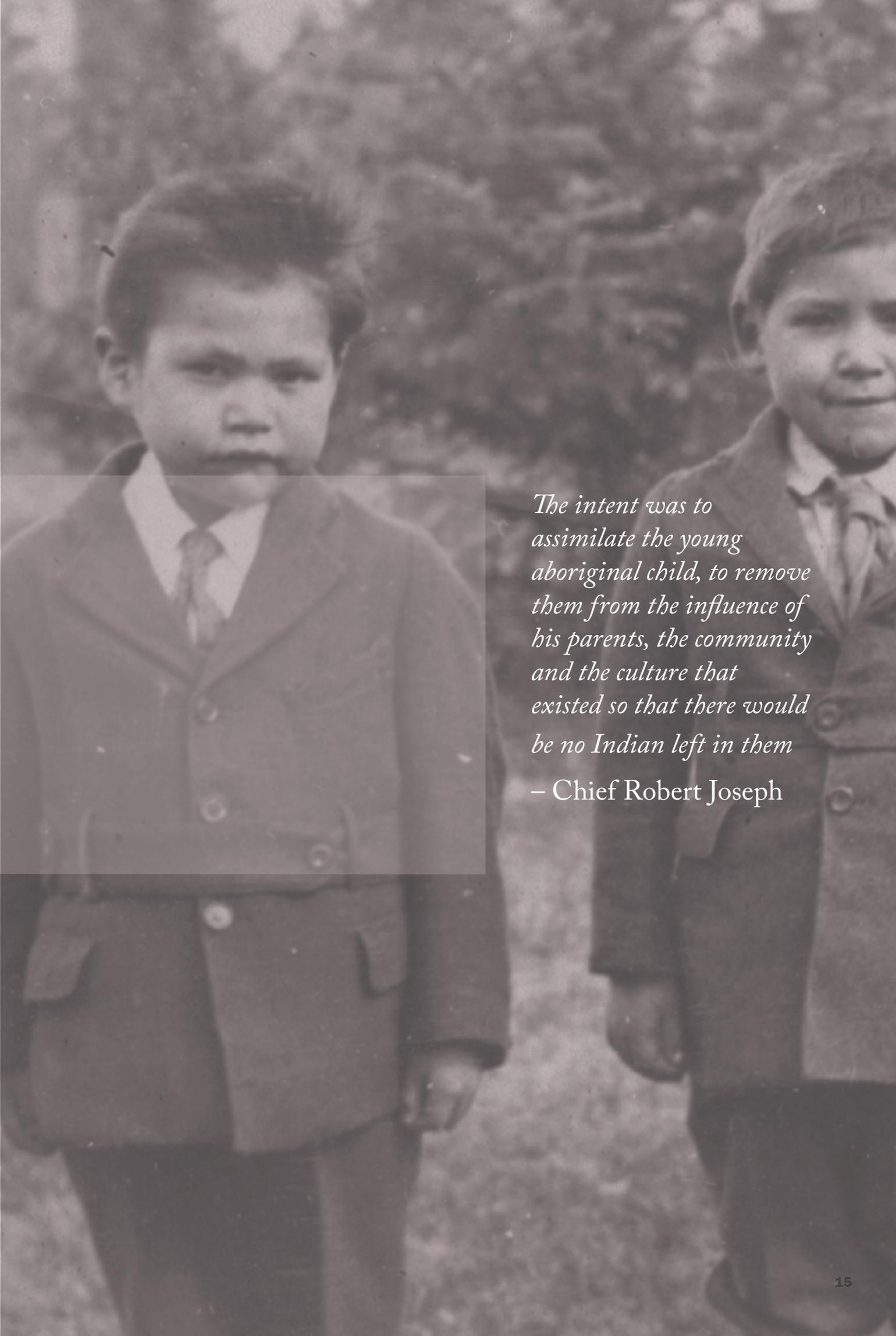
The ongoing residential school assimilation policies repressed First Nations children from speaking their languages, which sought to disconnect the children from their cultural practices. Sick children were kept in the schools in the same facilities as other children, spreading disease both within the schools, and to the communities when children were eventually sent home during their last days¹⁸.

Mary-Ellen Kelm writes *“scores of residential school children were discharged because they were not expected to live. This strategy was intended to achieve humanitarian and practical ends. It allowed the family to spend some time with the child before the child’s death, and it meant one less death to be investigated at the school.”*¹⁹

20th Century Health Care

During the twentieth century, First Nations were in a state of massive change, with populations at all-time low, military strength severely disrupted, and virtually no political power in the face of the repressive Canadian legislation. There was social disruption to the First Nations health care systems, damage to traditional belief systems, a decrease in orally-held knowledge, and new pathogens that all wreaked havoc with First Nations health at this time. The displacement from territory and resources resulted in poverty, reduced food security, and crowded living conditions, all contributing to poor health outcomes.

Some traditional healing continued and even non-Aboriginal people availed themselves of these services, especially in areas with no regular western medicine²⁰. Midwives continued to practice in many areas, partly due to lack of access to western services along with the First Nations resistance to western medicine²¹.



The intent was to assimilate the young aboriginal child, to remove them from the influence of his parents, the community and the culture that existed so that there would be no Indian left in them

– Chief Robert Joseph

Section 3: **Contact**

Doctors argued for western medicine to oversee childbirth, while the federal government opposed paying for western medical care for First Nations women²².

Western medicine was sporadically available; it was seldom of the highest quality and largely segregated. According to Mary-Ellen Kelm, “[i]t is clear that when government and church officials sought to provide medical services to Native people, they did so not just to improve Aboriginal quality of life, but to justify, legitimate, and sustain Canada’s internal colonial relations with First Nations.” Little if any western medical care was available to First Nations to deal with tuberculosis until the 1940s, even though there was an extremely high rate of First Nations people affected by tuberculosis before this time.

Discrimination was overt and widespread. Social segregation, of the kind often associated with the American south, was a common feature in BC during this time²³. During the early 20th century separate “Indian hospitals” were established to treat First Nations peoples with certain diseases, such as tuberculosis. The “fear of interracial pathological contagion” likely provided the greatest motivation for the development of separate services for First Nations.

The Indian Act (1876) provided the following dictates for First Nations Health:

The Governor in Council may make regulations...

- » **to prevent, mitigate and control the spread of infectious diseases on reserves, whether or not the diseases are infectious or communicable;**
- » **to provide medical treatment and health service for Indians;**
- » **to provide compulsory hospitalization and treatment for infectious diseases among Indians.**

By the early-20th century, the spread of tuberculosis, in particular, was causing much anxiety. Between about 1912 and the mid-1930s, government and health officials debated whether to establish separate facilities for Aboriginal people suffering from the disease. In the meantime, a few hospitals opened wards for Aboriginal people with TB, but, overall, treatment facilities were few and far between.

In the mid-1930s, the Cooqualeetza Indian Hospital was established in Sardis, B.C and served as the primary sanatorium for a decade. In the mid-1940s, Indian hospitals also opened in Nanaimo and Prince Rupert. Medical practitioners who worked with Aboriginal peoples had advocated in the 1920s for more facilities closer to where people lived and where their families could be involved in their care.²⁴ The system of hospitals that was established had the opposite effect, however, separating families by large distances, emotionally and physically.

A survivor of Nanaimo Indian hospital Joan Morris says this about her experience “The whole family was in there (Nanaimo Indian Hospital), but we were each individually assigned to different wards, my father in a separate quarter and my mother in a separate quarter and myself. My mom went in in ‘47. I was born in July, so when I was two weeks old, she went in. She was in there 15 years so she was in her 30s by the time she came out. So she lost a good part of her youth and her regular life.”²⁵

Population Rebound

As epidemic diseases became less common, First Nations populations rebounded dramatically. Villages that had been previously been reduced to a mere handful grew quickly as infant mortality fell, life expectancy started to increase again.

Today, First Nations are one of the fastest growing populations in Canada. Birth rates are high, the population is young (estimates are that half the First Nations population is under 25) and it is anticipated that the population will continue to grow into the future at much higher rates than other British Columbians.

A Changing World

World opinion began to change during the 20th century. World War I reduced support of the political status quo, with changes to women's rights, and the role of religion in society. Following World War II, colonial powers were severely weakened and independence movements in Asia and Africa began to gain strength. The Indian (British India) non-violent resistance movement, Cold War activities and propaganda, and the United States civil rights movement strongly influenced the shift of governments away from maintaining overtly repressive systems.

In 1951 the Canadian government quietly dropped some of the more repressive sections of the Indian Act, including bans on cultural expression, political agitation, and segregationist policies. First Nations obtained the right to vote in Canada in 1960, having received the provincial vote in 1949.

In 1969, the federal government produced a white paper, which advanced a policy of formally assimilating Aboriginal people in Canada, removing any 'special rights', dissolving the reserve system, and ending the separate legal identity for Indians. Viewed as a final assault in First Nations identity and culture, the reaction to the 1969 white paper was the birth of modern First Nations political activism.

Following the rise of First Nations political activism, a series of legal cases, social changes, and decreasing direct control ensued. Direct missionary control was reduced or eliminated in most communities, and First Nations began to assert more control over governance and education, culminating in the end of the residential school system, an increase in political authority in limited matters, and, in 1982 the protection of Aboriginal and Treaty Rights in the Canadian Constitution.

1910

BC refuses to submit the Question of Aboriginal Title in BC to the British Privy Council (highest court of the day)

1910

Declaration of the Tahltan Tribe

1910

German scientist discovers insulin - relation to diabetes

1910

Interior Chiefs sign declaration setting out their position on Aboriginal Title & rights.

1911

St'at'imc - Declaration of the Lillooet Tribe

1911

Interior Tribes, Nisga'a Land Committee & the Indian Rights Association meet with BC Premier McBride to protest BC land policies and demand to be heard by Canadian courts. McBride declines.

1913

Nisga'a Land Committee petition presented to the British Privy Council

1914 - 1918

First World War - Resulted in massive losses of life, & changes in economic/political systems.

1918 - 1919

Spanish Flu Pandemic - Worldwide pandemic killed millions. Est. 50,000 deaths in Canada.



Section 4: Where Are We Today?

Section 4: First Nations People and Social Determinants of Health

Although First Nations in BC are varied and diverse, they also have significant similarities, particularly in social and economic circumstances. Many of these situations stem from historic factors such as colonization, assimilation policies (including Residential Schools) and discrimination.

First Nations' views of health tend to be holistic, seeing connections between health, food, work, culture, family and community. The Ancestors taught that understanding the land, leadership, sustainable use of resources and the ability to provide for family and community were essential to survival. These values and skills, when put together, addressed what academics now call the social determinants of health. This holistic approach continues to be held by many First Nations and is becoming widely accepted among non-Aboriginal peoples as well.

First Nations balanced ways of life was disrupted and there was a serious decline in their social and economic wellbeing due to the changes associated with contact and colonization. These changes and the effects of residential schools are still being felt by First Nations families and communities today. Despite these issues, BC First Nations have shown incredible resiliency and continue to embrace ancient cultural principles that strengthen the wellness of the people.

Communal values including respecting elders, caring for the people and coming together in times of crisis continue to be strong cultural convictions. Social support networks remain solid among many First Nations through family and community. Family and community problems, the intergenerational effects of residential schools, and the continuing high rate of child apprehensions have eroded these connections to varying degrees for some families and communities. First Nation communities continue to work to maintain and strengthen these connections and to offer support and assistance to those in need.

“We need to return to many of the ways that sustained us for so long”.

– Dr. Evan Adams

Increasing fuel costs, reductions in boat ownership (associated with the decline of commercial fishing), pollution, habitat loss and loss of access have all had negative impacts on food security of First Nations people in BC. An increased reliance on ‘market foods’ and the rise in food costs generally create situations where diets often include unhealthy foods. Decreasing economic opportunities with the associated poverty and

1920

Compulsory attendance for all First Nations children aged 7-15 at Indian Residential Schools.

1921

Sir Frederick Banting & Charles Herbert Best found a way to reverse induced diabetes in dogs.

1922

Canadian researchers Dr.s Banting and Best develop first treatment of diabetes in humans – make patent available without cost – treatment spread around the world.

1923

F.G. Banting and J.J.R. Macleod – win the Nobel Prize for Physiology or Medicine - for the discovery of insulin

1929

First Nations population in BC reaches its lowest point (22,605). Population rebound begins

1929

New York Stock Exchange - market crash begins the Great Depression

1936

Health Insurance legislation in BC – was never implemented due to opposition from doctors.

Section 4: **Where Are We Today?**

unemployment and the high cost of shipping food to remote communities also affects food security. In some places, lack of safe, reliable drinking water has also affected health and has influenced the trend to drinking unhealthy drinks such as pop.

Currently, food security varies by region and the availability of local healthy food. Cultural practices of reciprocity and sharing food continue to be practiced and many people who are not themselves food gatherers obtain traditional food through family or community connections, both at home and away. These cultural practices and the persistence of the traditional food gathering economy offset some of the negative effects of poverty and food insecurity for people who are connected to their community and family harvesters.

The lack of opportunities, employment and options for many people in First Nations communities causes a wide range of problems for both individuals and communities. Many communities have high unemployment and lack opportunities for their people. Prior to the imposition of non-Aboriginal governments, First Nations used resources in their territories to meet the needs of the communities and people. Over the past century these resources have been alienated and First Nations have suffered economic and social dislocation which has had an adverse effect on health. Poverty, lack of opportunity and the related lack of social status and purpose is having devastating effects on First Nations people and communities. Economic development and recent policy changes that allow greater access to resources are beginning to have some positive outcomes but there remain significant.

Canada's universal health care system (Medicare) is among the best in the world, with high quality services theoretically available to all citizens. Health care services are an important factor in health outcomes, yet access for First Nations is an issue, particularly for people living far from urban centres. The division of powers between the federal and provincial governments has caused a distinction between general health care and health care for First Nations during the development of health services in Canada. Until recently there has been reluctance on the part of provincially administered health services to include First Nations fully in the health system.

First Nations communities and individuals lack of access and to some extent a degree of alienation from health services effect health outcomes and reduce the likelihood of early detection, treatment of disease and reduce the likelihood of surviving serious injuries.

Housing is a problem for nearly all First Nations communities, with crowding, poor housing and associated problems that create social stresses, environmental and health concerns. Lack of economic opportunity, backlogged social housing programs, and problems with maintenance, and a unique land management system all conspire to hinder development of safe and affordable housing for First Nations communities. In urban areas many First Nations are forced by economic circumstances to reside in poor housing and they share many of the issues with their counterparts who reside in home communities.

Aboriginal Health Issues Today

Although First Nations health has improved in some areas in the past few decades, there are still serious health issues within First Nation communities. The health gap between First Nations and other British Columbians that continues to exist can only be addressed through strategies that consider the overall social determinants of health and improved information on performance indicators to measure success of these strategies.

Some of the prevalent health concerns within First Nations communities include mental health, diabetes, obesity, cancer, respiratory disease, dental health, HIV/AIDS, addictions and children’s health. Many of these problems can be attributed to adverse effects to the social determinants of health that accompanied colonization. In addition, First Nations are subject to world-wide trends such as urbanization, lower levels of physical activity and increased reliance on processed foods. For example, diabetes is partially caused by a considerable change in diet and an increased dependence on market foods.

It is clear that there needs to be a multi-faceted approach to combat health issues and challenges.

Through collaboration, First Nations people are creating opportunities for positive change to help strengthen health outcomes. First Nations are in the process of assuming a role in managing First Nations health, in partnership with government. In the following sections, the measures First Nations and the government are taking to close the gap in health between First Nations people and the rest of Canada will be discussed.

Social Determinants of Health
 All societies are affected by social and economic factors in complex and inter-related ways. These factors affect health and wellness, determining in part whether people remain healthy or become sick, and determine resilience when people are unwell. These socio-economic factors are called ‘social determinants of health’ by

policy makers and health care professionals.
Social Determinants of Health - can be understood as the social and economic conditions in which people live and which influence the health of the individual and their community.
 Though there is no hard and fast agreed upon list of social determinants of health they are generally agreed to include:

- » **Social Status and income**
- » **Education**
- » **Employment and working conditions**
- » **Food security**
- » **Gender**
- » **Health care services**
- » **Housing**
- » **Social exclusion**
- » **Social support networks**
- » **Early (childhood) life**

1939 – 1945

Second World War – Global conflict with tremendous losses. Changed the economic and political landscape of the world –instrumental in humbling Britain & beginning of decolonisation. Also had impacts on the roles of women, and reconfigured the world into two spheres of influence (Superpowers – the Soviet Union & United States)

1944

The antibiotic Streptomycin developed – first effective treatment for TB

1946

Saskatchewan – Introduces Universal hospital care - served as a foundation for the development of Canadian Medicare.

1948

United Nations Declaration of Human Rights – non-binding but very influential – stipulated a number of rights – for all people regardless of race, gender etc. Includes freedom of religion, universal right to vote, all people are free and equal.

1949

BC First Nations get the provincial vote.

1951

Indian Act amended – potlatch ban lifted.

1954

Brown vs. Board of Education – US Court decision – rules segregated schools illegal – a powerful ruling that influenced the US Civil Rights Movement.

Section 4: **Where Are We Today?**

Who is Responsible for First Nations Health Care in BC?

Canada has a system of government with a national (federal) government and regional (provincial) governments, each with its own jurisdiction and responsibilities. In Canada, the division of power (jurisdictions) between the federal and provincial governments is largely derived from the British North America (BNA) Act (1867) and the Constitution Act (1982) which form, along with precedents and new and amended legislation, the Constitution of Canada.

The provinces have jurisdiction over regulating hospitals²⁶ from the BNA Act. There were several decades of disputes that ended in the 1930's in a decision of the Judicial Committee of the Privy Council finding that the administration of health care would be a provincial concern, but that the federal government would have responsibility to protect the health and well-being of the population.

The division of powers in Canada, according to the Constitution, stipulates that “Indians and lands reserved for Indians” are a matter of federal jurisdiction. This has caused significant jurisdictional issues over the years with health jurisdiction and program delivery as it pertains to First Nations people.

The provinces are responsible for providing and administering the bulk of health care in Canada. Universal health care in Canada evolved during the 20th century and involves federal funding, as well as provincial funding to support what is generally agreed is a world-class health system. Federal health care is provided for inmates of federal penitentiaries, the military, First Nations, and some services are provided to veterans and members of the RCMP. The federal government inherited a fiduciary duty to First Nations from the British Crown upon confederation which was reflected in the BNA Act. In addition, the federal government provides large amounts of funding to the provinces to help fund universal health care²⁷.

Jurisdictional responsibilities and fiscal struggles between the federal and provincial governments have shaped the creation of the health system in Canada for First Nations. The federal government aims to provide comparable services to First Nations that the individual provinces provide to non-First Nations within their jurisdiction, including health.

In most First Nations communities the federal government has come to provide some health services, which are commonly limited in scope and function. First Nations generally use provincially-provided health services for all serious health issues. In order to do this, Health Canada (First Nations and Inuit Health) provides funding to cover costs associated with First Nations access to the provincial health care system in an attempt to provide services that are generally comparable to those received by non-First Nations through the provincial system.

In addition, Health Canada provides funding to First Nations for specific programs, such as pandemic planning, diabetes, HIV, patient transportation²⁸ (to travel to health care appointments), environmental health, and many other programs. During the 1980s, Canada began offering First Nations the option of transferring (delegating) some of the health care administration to First Nations through the Health Transfer process. Currently, over 80%



Hon. Leona Aglukkaq, Minister of Health, Government of Canada

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of the 203 BC First Nations communities are involved in some form of transfer. BC has the highest percentage of First Nations communities involved in health transfer in Canada.

When the Health Transfer was originally introduced, there were critics and opposition. However today, most people believe that the transfer of health responsibility to First Nations was a “step in the right direction” and has been considered by some First Nations as a great success. As many First Nations demonstrated their ability to administer programs within their communities, it created a new debate of whether an increased amount of control was needed to better address our unique health issues.

First Nations Steps towards Change

In 2005, BC First Nations political leadership came together and agreed to work cooperatively, signing the Leadership Accord. This Accord formalized a working relationship among the three main First Nations political organizations in BC (the BC Assembly of First Nations, First Nations Summit, and Union of BC Indian Chiefs). This working relationship between the three organizations is referred to as the First Nations Leadership Council (the Leadership Council).

The Leadership Council entered into the New Relationship (2005) with the Province of British Columbia, which committed the signatories to “...*restore, revitalize and strengthen First Nations and their communities and families to eliminate the gap in standards of living with other British Columbians, and substantially improve the circumstances of First Nations people in areas which include: education, children and families, and health...*”.

At the 2005 First Ministers meeting in Kelowna, the Leadership Council, Government of Canada, and the Province of BC signed the Transformative Change Accord. The Accord committed the signatories to establish a new relationship based on mutual respect and recognition and to close the social and economic gaps between First Nations and other British Columbians in several areas including: relationships, education, health, housing & infrastructure, and economic opportunities. There was agreement among the parties that the approach to closing these gaps must take into account the Social Determinants of Health.

The Leadership Council and the Province of BC then entered into a bilateral agreement in November 2006 to address the health area of the Accord. The Transformative Change Accord: First Nations Health Plan (TCA: FNHP) includes 29 action items, including health promotion/disease and injury prevention, health services, and performance tracking. The creation of the First Nations Health Council is identified as the first action item in the Transformative Change Accord: First Nations Health Plan.

The federal government joined BC and the Leadership Council in signing an MOU in November 2006 that committed the parties to develop a Tripartite First Nations Health Plan (the Plan). Agreed to in June of 2007, the Tripartite First Nations Health Plan included the original 29 action items from the TCA: FNHP as well a commitment to explore a new administrative arrangement for the delivery of health

services to First Nations in BC, with the aim of increasing First Nations control over health services to their own peoples.

A New Governance Partnership and Administrative Arrangement

The Tripartite First Nations Health Plan calls for the development of a new First Nations health governing structure to increase First Nations decision-making in matters of health.

This new structure includes four components:

- » **First Nations Health Council (FNHC): Advocates and supports BC First Nations and oversees the negotiations of the development of a First Nations Health Authority.**
- » **First Nations Health Authority (FNHA): Will assume responsibility for federal health services currently delivered by First Nations and Inuit Health and agreed upon provincial services.**
- » **First Nations Health Directors Association (FNHDA): Provides voice for the collective experience of BC First Nations Health Directors and Managers and will advise the new FNHA on policy direction and service delivery models.**
- » **The Tripartite Committee on First Nations Health (TCFNH) is comprised of the Deputy Ministers of Provincial Health Ministries, Deputy Minister of First Nations and Inuit Health, BC Region, and the CEO's of BC's 6 Health Authorities. The TCFNH is responsible for enacting system change and developing a reciprocal accountability framework to ensure that health services better meet the needs of BC First Nations.**

Between 2007 and 2010 a great deal of progress has been made in development of each these areas.

First Nations Health Council

The First Nations Health Council (FNHC) was created in 2007 to support BC First Nations in the implementation of the Tripartite First Nations Health Plan. The original FNHC was comprised of representatives from the First Nations Summit (FNS), Union of BC Indian Chiefs (UBCIC), and BC Assembly of First Nations (BCAFN). In March 2010 resolutions from the UBCIC and FNS called for a reorganization of the First Nations Health Council. The purpose of this reorganization was to ensure that the FNHC was directly accountable to the communities that they served. Over the course of 2010, 15 regional representatives were appointed 3 from each region, including North, Vancouver Coastal, Interior, Vancouver Island, and Fraser. The new regionally appointed FNHC has a two year mandate and is charged with overseeing discussions with Canada and BC on a new governance partnership and administrative arrangement for the delivery of health services to First Nations in BC.

1955

Early case of HIV identified
– Englishman David Carr

1959

HIV – in Congo – early case identified later through analysis of stored tissue samples

1950 – 1960s

BC racial segregation ends

1960

First Nations – right to vote in federal elections

1961

National Indian Council formed

1964

US enacts the Civil Rights Act – bans discrimination based on race, colour, religion or national origin

1966

Medical Care Act (enacted 1968) – Federal legislation – to allow provinces to establish Universal Health Care Plan

1968

National Indian Council divided into – the National Indian Brotherhood (Status Indians) & the Native Council of Canada (Non-status & Metis)

1968

National Indian Health Care Plan

1969

Early cases of HIV in Norway & Detroit – identified later – analysis of stored tissue samples

First Nations Health Council Transitional Timeline, As of April 21, 2010

2012

IMPLEMENTATION of New First Nations Health Administrative Arrangement

2011

Finalize Agreements for New First Nations Health Administrative Arrangement

2010

February 2010, Basis of Framework Agreement reached as “Political Agreement”

March 2010, First Nations pass resolutions to rescind existing First Nations Health Council replacing it with 15 member regionally appointed Council

Regions inform communities of the Health Council shift to regional representation

Communities are informed of resolutions passed at political assemblies

April 2010, New First Nations Health Council works with First Nations Interim Health Governance Committee co-chairs to develop transition plan

Regions determine processes and criteria for decision making and appointment of members to new First Nations Health Council

Communities have opportunity to attend regional meetings, receive information on changes to Health Council Structure, discuss regional structure and nominate representatives

2009

Health Directors Forum, and Community discussions held on structure and roles of new governing body

2008

BC Assembly of First Nations, First Nations Summit and Union of BC Indian Chiefs develop First Nations Interim Health Governance Committee and Regional Caucuses to steer health governance work

2007

Tripartite First Nations Health Plan is signed (June)

Communities participate in Health Council through assemblies and through Regional Caucuses on Health Governance

2006

Bi-lateral Transformative Change Accord: First Nations Health Plan signed

First Nations achieve Memorandum of Understanding with BC and Canada

2005

First Nations Leadership Accord established, and Transformative Change Accord signed

March 16, 2011, the First Nations Health Council adopted a motion to initial the British Columbia Tripartite Framework Agreement on First Nations Health Governance (Framework Agreement)

May 2010, New First Nations Health Council works with First Nations Interim Health Governance Committee co-chairs to develop Terms of Reference for new First Nations Health Council blending the roles of the current Health Council and the First Nations Interim Health Governance Committee

All Chiefs Assembly May 18-20th Vancouver

Regional appointments to Health Council

June 2010, New First Nations Health Council appointed for 2 year term, and Framework Agreement reached for “Legal Agreement”

Each region develops its own Terms of Reference

Regional Terms of Reference outline the communities role in new structure

Month 2010, Tripartite Agreement on Structure and roles of new governing body

First Nations Health Directors Association Incorporates

First Nations Health Authority

The 2007 Tripartite First Nations Health Plan prescribed a three-year timeframe for BC, Canada, and BC First Nations to develop a new First Nations governing body (now being referred to as a First Nations Health Authority). In 2010, the tripartite partners achieved the Tripartite First Nations Health Plan: Basis for a Framework Agreement on First Nations Health Governance. The Basis Agreement sets out an incremental approach for the development of a new administrative arrangement for First Nations Health services. The Basis Agreement describes the creation of First Nations Health Authority (FNHA) that will operate similar to other health authorities with a unique focus on First Nations health. The proposed FNHA will administer current federal programs and services, including contribution agreements and other agreed-upon provincial programs and services.

First Nations Health Directors Association

Over the past two years, and led by a steering committee of Health Directors, the First Nations Health Directors Association was developed. In 2010 the FNHDA was incorporated under the Societies Act. The FNHDA will advance health planning and service delivery on behalf of First Nations in British Columbia, including but not limited to the following key roles:

- » **providing advice and assistance respecting First Nations governance with the aim of assisting in shaping health policy and legislation;**
- » **supporting First Nations Health Directors in the development and implementation of health programs;**
- » **creating a foundation for networking, knowledge, information sharing and communication;**
- » **providing opportunities for First Nations Health Directors to engage in professional development and mutual support initiatives;**
- » **supporting the implementation of the “Transformative Change Accord: First Nations Health Plan” and the “Tripartite First Nations Health Plan”**

The Tripartite Committee on First Nations Health

The Tripartite Committee on First Nations Health (TCFNH) is comprised of the Deputy Ministers of Provincial Health Ministries, Deputy Minister of First Nations and Inuit Health, BC Region, and the CEO's of BC's 6 Health Authorities. The TCFNH was originally deemed as an advisory committee in the Transformative Change Accord: First Nations Health Plan. The mandate of the committee was to:



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- » **Review and monitor the Aboriginal Health Plans of British Columbia's health authorities**
- » **Take an active role in monitoring health outcomes in First Nations communities; and**
- » **Recommend actions that the province, First Nations or Health Canada should undertake to close the health gaps.**

In 2010, the committee met and further refined its mandate to include:

- » **Coordinate planning, programming and service delivery of the FNHA with Health Authorities in support of First Nations Community Health and Wellness Plans;**
- » **Establish reciprocal accountabilities between BC First Nations and the HA's to ensure HA's work with and collaborate with BC First Nations in their respective regions to develop and review their plans and strategies for Aboriginal and First Nations people**
- » **Facilitate discussions and coordinate planning and programming between BC First Nations, the Province, and the Federal Government on all matters relating to First Nations health and wellness, including the determinants of health;**
- » **Provide a forum for discussion on the measures of reciprocal accountability for the parties with respect to all agreements**
- » **Prepare an annual report for the Ministers of Health and the First Nations Health Council**

The Basis Agreement and other Future Agreements

The Tripartite First Nations Health Plan commits the Parties to develop a new governance partnership and administrative arrangement for the delivery of health services to First Nations in BC.

The Tripartite First Nations Health Plan: Basis for a Framework Agreement on First Nations Health Governance (Basis Agreement) is a step forward in fulfilling that commitment. This process has been supported by BC First Nations through resolutions and through a new partnership with the federal and provincial governments.



“through this process we can put a plan together that really reflects the realities of First Nations communities... and have better outcomes with less use of resources”.

– Gwen Philips

The Basis Agreement was initialled in July 2010. It is a political document that sets out understandings amongst Canada, BC and First Nations relating to establishing a new governance partnership and a reciprocal accountability framework amongst the Parties, and the administrative transfer of the BC FNIH Regional Office to a new First Nations Health Authority (FNHA). The Basis Agreement is one step in the process – it sets out general commitments and scope of work moving forward in establishing a new governance partnership and administrative arrangement.

In follow-up to the Basis Agreement, on March 16, 2011, the First Nations Health Council adopted a motion to initial the British Columbia Tripartite Framework Agreement on First Nations Health Governance (Framework Agreement). The Framework Agreement is a legal document that ties down commitments to funding and sets the general legal responsibilities and commitments for the federal and provincial governments and First Nations in support of the new health governance arrangement. The initialling of this draft does not mean it is approved but signifies that the negotiators for Canada, BC and the First Nations Health Council have completed substantive discussions and the document is ready to be provided to First Nations for consideration.

Final approval to sign and execute the British Columbia Tripartite Framework Agreement on First Nation Health Governance will be subject to a resolution adopted by First Nations Chiefs and delegates at the Gathering Wisdom forum scheduled for May 2011. This resolution will consider the adoption of a consensus paper which outlines the key elements of the draft Framework Agreement and other key documents in this process to establish a new health governance structure for First Nations in BC.

Canada, BC and First Nations are now discussing a number of subsequent agreements to be developed in the coming years, which will each bring us a step forward in realizing our commitments in the Tripartite First Nations Health Plan. **The Basis Agreement, the Framework Agreement and any future agreements do not affect Aboriginal title and rights or the Crown’s fiduciary duty to First Nations.** These agreements will also not displace the role of individual First Nations in delivering health services. Through the transfer in administration to First Nations control, these agreements will give First Nations the ability to shape health services to better meet their needs, and shift the focus from a sickness system to a wellness system. Furthermore, the new governance partnership established through these agreements will support better

coordination and collaboration between First Nations and provincial health authorities, particularly with respect to First Nations community health and wellness plans.

Overall, these agreements represent the next step along the path to improving First Nations health and access to quality care by increasing First Nations control over decisions relating to health policies, programs and services, and increasing First Nations influence in addressing key health issues with federal and provincial partners.

Grand Chief Ed John's vision is that our people are the ones who *“find and develop the solutions that make sense for our people”*.

First Nations are engaged in this ongoing dialogue to establish these new agreements through five regional caucuses established throughout the province. These caucuses are essential to providing direction and support to the tripartite discussions to establish a new governance partnership and administrative arrangement for the delivery of health services to First Nations in BC.

International Context

BC First Nations are breaking new ground in Canada with the Tripartite First Nations Health Plan and the initiative to develop a new First Nations Health Authority. However, Indigenous people around the world have made great progress in taking control of their health systems. These Indigenous people from other countries have informed our work and provided us with valuable lessons as we move forward with discussions and deliberations.

In both Aotearoa (New Zealand) and the United States, Indigenous people have begun to assume more control in health to improve the well-being of their people. In both cases there are substantial legal protections of rights and roles related to health governance. As a result, the institutions and governing models that have been created have a reasonable degree of stability. Both groups have negotiated a role in health care governance and control over the health care systems for their people.

A key lesson learned from Aotearoa and the US is the necessary distinction between political governance in health and governance in front-line service delivery. Governance in health operates at two levels:

- » **At a national or state/provincial level: To govern matters of policy, appropriations, legislation, priority-setting and standards (for example, the broad role/status of traditional medicine vis-a-vis the western medical model),**

1969

White Paper – sparks modern First Nations political activism

1973

Calder (Nisga'a) Case – triggers changes in Federal Indian Policy

1979

Smallpox eradicated – World Health Organization

1980s

Rise of drug resistant TB – dashes hopes of eradicating the disease.

1981

AIDS first recognised by the American Centre for Disease Control.

1982

Canada Act – Constitution patriated – Charter of Rights and Freedoms protects Aboriginal and Treaty Rights

1984

Last Indian Residential School in BC closes

1984

Canada Health Act – Set national standards for health care and prohibited user fees and extra billing.

1985

Bill C-31 – Reverses Indian Act discrimination based on gender – many FN regain status

1990

Regina v. Sparrow – landmark court decision – recognizing Aboriginal right to fish for 'food, social & ceremonial' purposes.



Alaska

Canada

United States

Lessons from the Alaska Tribal Health Compact

- » Establish a consensus process that is agreed to by all participants.
- » Include principles of participation (behaviour, language, spokespersons, etc.).
- » Hold people accountable for upholding the consensus process – act when people diverge from the agreed process.
- » Maintain the ‘opt in/opt out’ provision so that Tribes always have a choice.
- » Commit people in writing to upholding the consensus process and principles before they can ‘join’.
- » Clarify who are the approved negotiators or spokespersons, clarify roles of other participants who are not negotiators and roles of observers (allow full Tribal participation, but clarify roles).
- » Collective negotiations can be done for ‘common issues’, while allowing Tribes to negotiate their own issues separately and independently as schedules to a common agreement.
- » Provide a process for regular review of the agreement with the government in a structured formal way.

- » **Front-line health service delivery level: Including prioritizing how local resources will be spent, local service design and delivery and the ongoing self-determination of individual Tribes or Nations.**

In both cases these issues were kept separate so the Tribes could politically advocate directly with government, while mandated service providers could focus on the business of managing day-to-day health service delivery. In each system Tribes maintain their autonomy and the right to enter into negotiations with government.

United States

In the US, health self-governance has been mandated by the federal government. The process is voluntary and is protected by legislation, as are the trust responsibilities of the United States government (akin to the Fiduciary Duty in Canada). Through the Indian Self-Determination and Education Assistance Act (Public Law 93-638) of 1975 [ISDEAA], Tribes can opt into one of two different options for health self-governance: remain within the federal health system, or take a combination of delivery systems depending on their needs and ability. If the Tribes wish, they can retrocede – or return responsibilities for specific program areas back to the federal government. The Obama administration recently oversaw the reauthorization of the Indian Health Care Improvement Act, which removes the annual votes to allocate funds and makes a number of other improvements to Indian health governance.

Alaska Model

In Alaska an agreement was negotiated among many of the Tribes, as well as with government to create a system of health governance. This system includes a state-wide organization of Tribes (Alaska Native Health Board), which conducts advocacy and policy work. Individual Tribes and regional groups operate in service delivery and maintain autonomy for their own affairs outside of collective actions.

Alaska is similar to BC, with 231 Tribes (BC has 203), a large geographic area, and diversity of First Nations cultures. The Tribes decided to work together to take advantage of the opportunity to improve health care delivery. Since the creation of this system the Tribes have established a workable system that provides significant flexibility and control over how health care is delivered to the Tribes in the State.

The unity and strength from collective advocacy in Alaska is worth noting. From this arrangement space is created for Alaska Natives to do things they want to do, without interference from the state government.

1990

Oka Standoff – between Mohawks and the Town of Oka/Quebec/Canada – over land dispute

1993

The World Health Organization (WHO) declared Tuberculosis a global health emergency

1996

Last Residential School closed in Canada

1997

First First Nations Grad from UBC Medical School – Dr. Nadine Caron

2005

BC First Nations Leadership Council created

2005

New Relationship – BC & First Nations sign agreement - new relationship on Aboriginal Issues

2006

Bi-lateral Transformative Change Accord: First Nations Health Plan signed

2007

Tripartite First Nations Health Plan signed

2007

First Nations Health Council established

2010

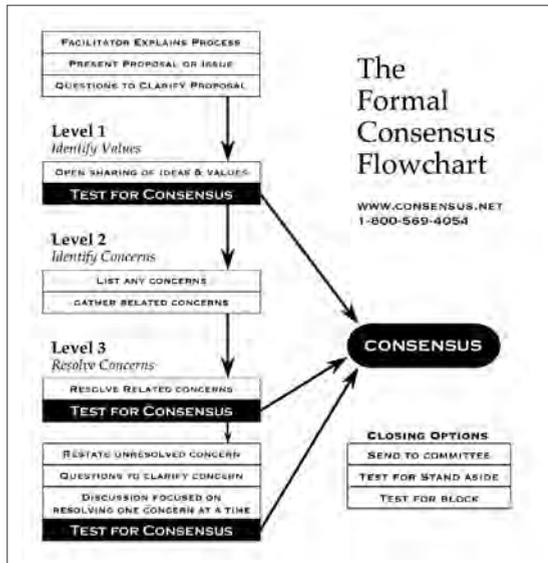
Basis for a Framework Agreement on Health Governance initialled

2010

BC First Nations Health Directors Association created

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Consensus model Extracted from: *On Conflict and Consensus* by C.T. Lawrence Butler and Amy Rothstein, Food Not Bombs Publishing, 1987-2007.



Formal consensus-based decision making model

In Alaska, the Tribes have developed a formal consensus-based decision making model for collective action. The creation of the formal process allows everyone to understand the process which otherwise could be a source of contention. Training is provided to Alaskan leaders to ensure they are aware of how the process works. The model includes broad open discussion on issues from all tribes & areas at a regional level, then, from this discussion, the Tribes reach consensus on key issues to take forward that are common across the state.

The Tribes then reach consensus on how issues should be resolved. There is an array of agreed principles for negotiation in place regarding the behaviour of parties towards one another.

Aotearoa

In Aotearoa, the relationship between Maoris and the New Zealand government is guided by the Treaty of Waitangi. This treaty stipulates a relationship and status for the Maori where their wishes must be considered. Government engages with Maori Tribes regarding health policy, and health care delivery. There is an annual national Maori Forum managed by the Ministry of Health and individual Tribes may advocate directly with the Crown as well.

District level health boards are required by law to develop treaty-based relationships with Tribes within their area. As a result, the district-level health service delivery system has been altered to be bi-cultural in order to meet the needs of both Maori and non-Maori.

Internationally, there is a movement for Indigenous people to become involved in health care for their own people, including involvement in the health governance for their people and delivery of health care services. There is a definite advantage to health care governance when Tribes collectively work together on common issues, while ensuring that individual Tribes/Nations maintain self-determination on local or individual issues.

The work that is being done in BC is part of a worldwide movement of Indigenous people taking control over their health and wellness, and doing so, in partnership with government. The exact nature of the change varies depending on the legislative context, but the movement towards Indigenous people taking more control over their own health care is clearly apparent. BC First Nations are now in a position to create changes to assert more control over their own health through the Tripartite First Nations Health Plan, including a new form of health governance. BC First Nations are the first in Canada to undertake this important change.



Equator

Australia

Aotearoa
(New Zealand)

International Date Line

Endnotes

¹Diets were high in protein (fish, meat, and fish eggs), fat (Ooligan and other oils eaten with dried foods), some fruit (berries), and limited vegetables (seaweeds, root vegetables such as camas lily and rice root, and inner bark of the pine and hemlock, and shoots of a variety of plants).

²Boyd, Robert T. Demographic History, 1774-1874. In *Handbook of North American Indians: Volume 7 Northwest Coast*. Ed. Wayne Suttles. Smithsonian Institution. Washington. 1990. P.136

³Hopkinson, J., Stephenson, P., & Turner, N. (1995). *Changing traditional diet and nutrition in aboriginal peoples of coastal British Columbia*. In P. Stephenson, S. Elliott, L. Foster, & J. Harris (Eds.), *A persistent spirit: Towards understanding aboriginal health in British Columbia* (pp. 129-166). Victoria, BC: University of Victoria.

⁴Cybulski, Jerome S. *Human Biology in Handbook of North American Indians: Volume 7 Northwest Coast*. Ed. Wayne Suttles. Smithsonian Institution. Washington. 1990.p.p.58, 59. Nearly 50% of adults were affected by abscesses in the pre-contact period. Cybulski attributes the very high incidence of abscesses to cultural practices of using the teeth as tools, particularly of women, leading to increased wear of teeth. A high level of head and facial fractures in men that suggest a high incidence of trauma to teeth and upper jaws. Both tooth wear and fractures can lead to abscesses in teeth and Cybulski views a probable link between the high rates of abscesses and these factors.

⁵Many infectious diseases are the result of agricultural societies living in crowded conditions with animals where diseases cross from an animal species to humans- e.g. Swine flu, Avian flu, Small pox. First Nations, lacking widespread exposure to domesticated animals developed few such diseases prior to contact.

⁶Boyd, Robert T. Demographic History, 1774-1874. In *Handbook of North American Indians: Volume 7 Northwest Coast*. Ed. Wayne Suttles. Smithsonian Institution. Washington. 1990.

⁷Contact – refers to the first contact a society has with foreign peoples. In the case of British Columbia First Nations it generally refers to contact with Europeans (whites) as First Nations had wide contacts with each other for a centuries, often over long distances.

⁸Elsewhere in the Americas, Vikings visited eastern and northern Canada and briefly settled in Newfoundland until driven out by First Nations around a thousand years ago. Sustained European contact elsewhere in the Western Hemisphere, the Spanish in Central and South America, the Portuguese in Brazil and English, French, and Dutch in eastern North America, began several hundred years prior to recorded contact on the Northwest Coast. Basque and French fishers and whalers were known to travel to the east coast without leaving written records prior to the advent of explorers who mapped and recorded their travels.

⁹Sir Francis Drake may have passed through British Columbia while on secret voyages for England (1577-1580) and certainly landed north of the Spanish colonies on the Pacific coast, Spanish trade between Mexico and the Philippines may have resulted in either accidental or purposeful presence of Spaniards. Some early traders, especially Americans (known as Boston-men by coastal First Nations) were more interested in trade than exploration and may not have recorded their travels.

¹⁰Diseases had developed in the Eastern Hemisphere or “Old World” differently than in the Western Hemisphere, largely due to developments in agriculture and settlement patterns. Diamond, Jared *Guns, Germs, and Steel: the Fates of Human Societies*. W.W. Norton & Company. New York & London. 1999. Pp. 196, 197. “The major killers of humanity throughout our recent history – smallpox, flu, tuberculosis, malaria, plague, measles, and cholera – are infectious diseases that evolved from diseases of animals, even though most of the microbes responsible for our own epidemic illnesses are paradoxically now almost confined to humans.” The domestication of a wide range of species, coupled with the proximity of animals to people in the Eastern Hemisphere, caused quite a few diseases that originated in animals to spread to humans. The Western Hemisphere, lacking many species suitable for domestication (the dog, llama, alpaca and guinea pig), did not experience this phenomenon to the same degree. Diseases that originated in the Eastern Hemisphere (Europe, Asia and Africa) were not present in the Western Hemisphere so First Nations had neither biological immunity nor cultural adaptations to them when they first came into contact with them.

¹¹Warfare, previously a rather limited occurrence in severity, increased dramatically as the social disruptions from population decline destabilized the traditional political environment. The introduction of firearms made warfare much more deadly. In some cases warfare decimated or even annihilated populations already heavily affected by loss from disease.

¹²Boyd, Robert. *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*. P.14.

¹³Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-1950*. UBC Press. Vancouver. 1998. P.4.

¹⁴Boyd, Robert. *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*. UBC Press/University of Washington Press. Vancouver & Toronto, Seattle & London. 1999. p. 45-46.

¹⁵ Boyd, Robert. *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*. UBC Press/University of Washington Press. Vancouver & Toronto, Seattle & London. 1999. p. 160

¹⁶ R. Geddes Large. *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast*. Mitchell Press Limited. Vancouver. 1968. P.p. 65, 66.

¹⁷ In some cases health care was denied to people who refused to convert to Christianity, who practiced traditional health and spiritual practices, who were considered likely to die anyways, or out of simple racism.

¹⁸ Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*. UBC Press. Vancouver. 1998. P.p. 68, 69.

¹⁹ Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*. UBC Press. 1998. P. 74.

²⁰ Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*. UBC Press. 1998. P. 153.

²¹ Pers. Comm.. – with Philip Hogan – the late Lillian Gladstone 1996 – Heiltsuk elder – talked about how Heiltsuk women refused to be seen by missionary doctors, preferring Heiltsuk midwives for giving birth during the early part of the twentieth century.

²² Kelm, Mary-Ellen. *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*. UBC Press. 1998. P.p. 166-172.

²³ Trains and steamships were segregated, in some places whites-only bathrooms and drinking fountains were in place. “Indians” were barred from pubs, pool halls, advanced education, and denied the right to vote.

²⁴ Kelm, M. (Ed.). (1998). *Colonizing bodies: Aboriginal health and healing in British Columbia 1900-50* (p. 125). Vancouver, BC: UBC Press.

²⁵ <http://web2.uvic.ca/courses/safety/mod1/notes4.htm> Downloaded January 31/11.

²⁶ This clause has been interpreted as health care delivery through ongoing development of the roles of the governments.

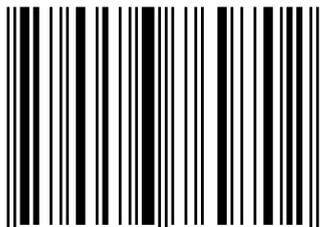
²⁷ The federal government transfers billions of dollars annually to provide partial support for the Canadian health care system which supplements provincial funding.

²⁸ Also available to non-Aboriginals living in remote communities.

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- Front Cover** Background Image
Hazelton Indian Village Medicine Man.
Image A-06031 courtesy of Royal BC Museums, BC Archives
- INSET COLOUR IMAGES
- Kids in Parade
courtesy Carrier Sekani Family Services
- Mom Walking
courtesy First Nations Health Society
- Drying Fish
courtesy First Nations Health Society
- Young Woman
courtesy Carrier Sekani Family Services
- Young Family
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- Little Graduate
courtesy Carrier Sekani Family Services
- Young Man Regalia
courtesy Carrier Sekani Family Services
- Page vi** Two Women
Image 394 courtesy of the Sto:lo Research and Resource Management Centre
- Page 2** Woman Shaman from Clayoquot Sound – copied from Edward S. Curtis – “The North American Indian”
Image E-00873 courtesy of Royal BC Museums, BC Archives
- Page 6** Hazelton Indian Village Medicine Man.
Image A-06031 courtesy of Royal BC Museums, BC Archives
- Page 10** Isreal Sgat’iin, Nisga’a Chief from the Nass River
Image E-07668 courtesy of Royal BC Museums, BC Archives
- Page 11** Nurse with child suffering from smallpox - 1901-03 Smallpox outbreak in Boston.
The Boston Medical Library in the Francis A. Countway Library of Medicine.
- Page 15** “The young boys of the Alberni Residential School” (detail)
Image E-07668 courtesy of Royal BC Museums, BC Archives
- Page 18** Image of Man and Girl
courtesy Carrier Sekani Family Services
- Page 23** Federal Health Minister, Leona Aglukkaq
courtesy of First Nations Health Society
- Page 29** Image of Children Children Around Drum
courtesy of Seabird Community Hub
- Page 31** Image of a Young Boy
courtesy of First Nations Health Society

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