Manitoba First Nations Public Health Improvement Pilot Project

Year Three (April 1, 2009 – March 31, 2010) Final Report

1. Introduction

This report has been prepared as a requirement of the funding body and as a communication tool to inform the many partners about the main activities of Year 3 as described in the work plan. The partners have been described in previous report and in Manitoba include:

- Four Arrows Regional Health Authority (FARHA)
- Garden Hill First Nation
- Red Sucker Lake First Nation
- St. Theresa Point First Nation
- Wasagamack First Nation
- First Nations and Inuit Health – Health Canada (FNIH)
- Manitoba Health (MH)
- Northern Medical Unit of the University of Manitoba (NMU)
- Assembly of First Nations (AFN).

The report will also be shared with the other two pilot sites of this national project. The abbreviation "MFNPHIPP" in place of "Manitoba First Nations Public Health Improvement Pilot Project" will be used throughout this report

Attached as appendices are the following documents:

- ❖ Year three MFNPHIPP work plan as approved by the Oversight Body at the March 12, 2009 meeting.
- ❖ MFNPHIPP "Report to the Citizens of the four Island Lake First Nations" as distributed widely in November 2009.
- ❖ Report of the MFNPHIPP Island Lake Gathering held in St. Theresa Point First Nation February 8-9, 2010.
- ❖ Chronology of steps taken since the selection of Island Lake First Nations/Four Arrows Regional Health Authority as the MFNPHIPP site in the fall of 2006.
- ❖ April 6, 2010 draft of the MFNPHIPP "Model for Public Health Program and Service Delivery".
- ❖ Legislative review submitted by Krista Yao of Nadjiwan Law Office dates March 26, 2010.

These documents should be referenced to shed further light on the activities, accomplishments, and problems experienced by the MFNPHIPP during year three of its five year span.

The main committees of the MFNPHIPP met as follows during year three:

- MFNPHIPP **Oversight Body (OB) –** 2 meetings as regularly scheduled and budgeted for. In addition members of the OB participated in a meeting called by Jim Wolfe, Regional Director for Manitoba Region, First Nations and Inuit Health in July 2009 to discuss issues FNIH raised concerning MFNPHIPP.
- MFNPHIPP **Technical Working Group (TWG)** – 6 meetings
- MFNPHIPP **Elders and Youth Advisory Council** – 3 meetings

- MFNPHIPP participation in national tri-Pilot Project communications – 2 meetings (one via teleconference; one face to face)

2. **Major factors influencing year three outcomes**

The following factors bear noting:

- Public Health Specialist and MFNPHIPP co-lead Dr. Marcia Anderson DeCoteau found it necessary, for a variety of reasons, to decrease her time commitment to MFNPHIPP for year three.
- FARHA Public Health Coordinator and MFNPHIPP co-lead Grace McDougall also found it necessary to slightly reduce her time spent on MFNPHIPP activities due largely to time demands around her coordinating H1N1 pandemic planning.
- Starting in August and on a half time basis, Hazel Harper began serving MFNPHIPP as the Community Lead working out of St. Theresa Point First Nation. The main role of the Community Lead is intended to be facilitating improved communication and participation by the four Island Lake First Nations and their community health services. In addition, the Community Lead serves as the main support to the Elders and Youth Advisory Council.
- For the third year in a row, funding for MFNPHIPP was significantly delayed (by approximately six months). The cause of this year's delay included an early temporary suspension of funding by FNIH, until a series of communications and summer meetings resolved most issues and re-established a level of trust and communication between MFNPHIPP partners. This funding delay clearly retarded MFNPHIPP activities and goals.
- The resources needed to respond to Pandemic H1N1 also served to hamper progress of MFNPHIPP in Year 3.
- From August 2009 until the end of year three, considerable changes occurred within FARHA governance and management structures and personnel. These changes included the Executive Director going on leave, and restructuring of the FARHA board twice within the year. These events also had an effect on MFNPHIPP progress. The new FARHA Board met in June 2010 for orientation. As the new FARHA Board does not include the health directors of the 4 communities, near the end of Year 3 a decision was made to invite the health directors to participate on the TWG. This was felt to be crucial to maintain their involvement given the knowledge that they hold about community health services and the responsibility they will have to help implement the changes.
- A very positive two day Regional Public Health Team Meeting took place in February in St. Theresa Point First Nation. This included representation from all four communities, members of the TWG, and the active participation of the Chief Executive Officer of NITHA (the Northern Inter-Tribal Health Authority in Saskatchewan) whose model for delivering First Nations Public Health services has served as a base for the MFNPHIPP model. This Gathering offered support to the many changes suggested in the model document.
- After submitting a very questionable evaluation of MFNPHIPP's activities during year two, the national Pilot Projects' evaluator/contractor withdrew from any further evaluation work for any of the Pilots. As the year ended, it appeared that any future evaluation activities will have to be done by FNIH and AFN personnel and will be

based on year end reporting as there will be no separate funds for evaluation. This is unlikely to result in significant benefits or learning to inform future pilot project work, however any more formal or rigorous evaluation would need to be carried out with funding obtained by the MFNPHIPP team or by MFNPHIPP team members themselves with no funding.

3. Work Plan Review

A. Legislative, regulatory and jurisdictional issues

I. *Finalize and sign tripartite agreement to confirm relationships between all parties.* This was not accomplishable in Year 3 for multiple reasons. Prior to proceeding with the Year 3 work plan, the concerns of FNIH MB region had to be addressed. The main mechanism for addressing their concerns was through finalizing a model for public health program and service delivery that would support the function of a provincial Medical Officer of Health and provide more assurance on how all of the core functions of public health would be met. This model is nearing finalization, and must be finalized prior to developing the tripartite agreements. Further, we needed to complete the legislative review prior to the development of these, and select a partner provincial RHA. Multiple meetings were held with officials from the Burntwood Regional Health Authority (BRHA) and the Winnipeg Regional Health Authority where the goals of the project and work to date were discussed, and the potential for building a partnership explored. The RHAs asked for more detail on what such a partnership would involve, and the following are examples of the list of potential items that was discussed:

- **i.** Coverage for the Medical Officer of Health (MOH) when the MOH is unavailable because of vacation, illness, or vacancy;
- **ii.** Coverage for other essential public health functions like the CDC Nurse when the FARHA staff is unavailable;
- **iii.** Service provision to fill shortages on either an in-kind or purchase agreement basis;
- **iv.** Mentorship and knowledge exchange related to public health programs and services and/ or organizational senior management

Both RHAs have expressed their openness to further exploration of a partnership, with pros and cons of either RHA discussed. Key ones include that although the Island Lake communities are geographically within the BRHA, there is currently no transportation between BRHA centers and Island Lake, and the BRHA does not have the same level of resources available that the WRHA has. A main disadvantage of a partnership with the WRHA is that it may not encourage Northern collaboration and increased public health capacity development in the North. A decision about which RHA to partner with for the remainder of the MFNPHIPP is sought for early in Year 4.

II. *Review and implement results of legislative review for provincial MOH services.* The legislative review was completed by Krista Yao, and is included as an appendix. The focus of the legislative review was to look at the proposed public health program and service delivery model and the Manitoba Public Health Act, in effect since April 2009 in its current version. The legislative review has been circulated to all members

of the TWG and OB, and currently sits with the organizational partners to decide if any further review from their perspective is necessary.

III. *Review results of Year 2 scans on EH/ PHI services and develop strategy to improve EH/ PHI services in Island Lake.* Deliberations on this topic led to the inclusion of an Environmental Health Advisor position in the Community Health Surveillance and Support Unit in the new public health program and service delivery model. The Environmental Health Advisor would liaise with the Environmental Health Officers from FNIH, and lead a collaborative environmental health committee to set environmental health priorities for the Island Lake region and propose ways to address them. One of the key priorities is anticipated to be developing mechanisms to supplement the shortage of environmental health services in the region.

IV. *Develop partnerships with stakeholders in order to implement strategy once developed.* This activity will be deferred until the MFNPHIPP progresses to an implementation phase, and the Environmental Health Advisor position can be posted and filled to lead this activity.

B. **Health Information**

I. *Continued participation of the MFNPHIPP co-leads on the National First Nations Client Registry Steering Committee and in development activities.* Given the other challenges with initiating project activities in Year 3 the Client Registry project was difficult to prioritize as it is only one sub-section of the MFNPHIPP. As a result, there were delays in finalizing the contract for the Client Registry project and in initiating those activities. Nonetheless, the co-leads were able to participate in the National First Nations Client Registry and deliverables met for this year. As in Year 2, the work load related to local Client Registry activities is significantly more than the co-leads have time to devote, and this does result in delayed deliverables. Further, there was no community engagement in the Client Registry project this year. There is continued concern about the lack of continuous or sustainable funding for this project that leads to large gaps in time where there is no activity, which also makes it difficult to sustain any momentum. In future years sufficient resources to allow a position dedicated to moving this project forward would be required for success.

C. **Health Human Resources**

I. *Continue to nurture relationships with Indigenous health professional organizations and other Aboriginal HHR initiatives.* Linkages are maintained to the Indigenous Physicians Association of Canada and the Health Careers Access Program and Professional Health Program at the University of Manitoba. With the Aboriginal Health Human Resources Initiative being renewed for two years, a meeting with the FNIH MB lead for AHHRI has been included in the Year 4 work plan.

II. *Support existing Health Authorities in finding solutions to chronic shortages in work space and housing for professional public health staff.* The Regional Public Health Coordinator/ MFNPHIPP co-lead continues to work with the four communities to address recruitment and retention issues, although within the scope of resources available for this project there are limited supportive actions that can be undertaken. However, a discussion was health at the Regional Public Health Team Meeting about FARHA becoming the employer for all of the public health nurses, rather than maintaining the status quo which is that each community is responsible for hiring their public health nurses. This is felt to contribute to increased recruitment and

retention because of the ability to work as a team of regional public health nurses, offering greater personal and professional support. In addition, in the case of vacation, illness, or unfilled position vacancies could be covered by other regionally-employed nurses.

III. *Establish a committee composed of Pilot Team and the 4 First Nation education authorities to encourage completion of high school and pursuit of health careers.* This activity was not undertaken during the project year. At the Regional public Health Team Meeting, a community health staff member presented the idea of gearing all of the curriculum towards health careers, as other schools do when they decide to become a center for excellence for a certain sport or subject (e.g. science). This idea will be further pursued, but possibly not until Year 5 given other priorities for Year 4.

IV. *Participate in career fairs and other events to promote job opportunities in public health at FARHA and the 4 communities.* During the Regional Public Health Team Meeting Dr. Anderson DeCoteau spoke about public health careers to the students during a career fair. The Regional Public Health Coordinator continues to recruit public health nurses for the region, though direct contact, advertisements, and career fairs.

V. *Design and deliver public health education and work shop sessions to current public health staff and health directors.* The Regional Public Health Coordinator did participate in education related to Pandemic H1N1, but further sessions did not occur given the higher priority given to other activities, primarily completing the public health program and service delivery model.

VI. *Explore opportunities for participation in professional development activities, e.g. conferences, for members of the regional and community public health teams.* This activity was deferred because of other higher priority activities.

D. **Communication**

I. *Regular updates on the MFNPHIPP are sent to communities via fax/ newsletter.* A community update was sent in November 2009, approximately 8 weeks after Year 3 funding was received. This is attached in the appendices. A verbal report was given at the Regional Public Health Team Meeting in February 2010 prior to beginning the discussions as summarize in the report attached in the appendices. In addition, communications equipment including video equipment was obtained near the end of the fiscal year, and we anticipate using video messages more to update community members about the project.

II. *A part-time employee is hired by MFNPHIPP in each community to facilitate communication between FARHA/ MFNPHIPP and the communities, and to provide local leadership of MFNPHIPP activities.* Funding was insufficient to accomplish this objective. Instead, with Dr. Anderson DeCoteau decreasing her time to 0.2 FTE salary dollars were freed up that allowed a single Community Lead to be hired. Although this person was physically located in St. Theresa Point she was responsible for leading communications in all four communities. Informal feedback suggests this position was very successful in some regards: planning and facilitating meetings of the Elders and Youth Advisory Council, helping with planning for the Regional Public Health Team Meeting. However, communication about the MFNPHIPP and FARHA has not been perceived to be improved. Potential reasons include a lack of feeling of engagement/ ownership in the other three communities, unreliable

telecommunications infrastructure, and inability to travel at times because of weather.

III. *Executive Director of FARHA continues to update and seek feedback from the Manitoba First Nations Health Technicians Working Group at their regular meetings.* There was significant instability in the Executive Director position at FARHA this year, with the previous ED taking leave and an interim manager appointed, and then the recent hiring of a new ED. In order to fulfill this activity despite the changes in the ED on October 30, 2009 the MFNPHIPP co-leads sent a letter to the Assembly of Manitoba Chiefs giving them information on the status of the Pilot Project and offering to meet with the Manitoba First Nations Health Technicians Network to provide further information and to receive their feedback to the improvement recommendations. There was no response to the letter, or request for a meeting.

IV. *MFNPHIPP leaders invite the Chair from the Chiefs Task Force on Health to attend one of the Oversight Body meetings.* This activity was not accomplished this year.

V. *Regular meetings of the teams from the three pilot sites continue to share experiences and information.* The three pilot sites met during the national meetings during Year 3, including one face-to-face meeting and one teleconference.

VI. *A mechanism is developed with the Assembly of First Nations to disseminate project updates and materials as they are developed to other First Nations in Canada*. This activity was meant to be done in collaboration with the other pilot sites and the AFN, but was not accomplished in Year 3.

E. **Public Health Programming**

I. *Continued modification of strategies to address public health programming priorities identified in Year 2.*

II. *Develop strategies to respond to public health priorities identified by the Oversight Body for Year 3.*

The deliverable related to these planned activities is the Public Health Program and Service Delivery Model, which is nearly finalized. The model proposes an organizational structure which has been modified from that of the Northern Intertribal Health Authority (NITHA). It includes a Community Health Status and Surveillance Unit, a Community Health Support Unit, an e-Health Unit, an Elders and Youth Advisory Council and a Joint Governance Committee which includes representatives from the four Island Lake Communities, FARHA, Manitoba Health, First Nations and Inuit Health, a partner provincial regional health authority, and the Northern Medical Unit at the University of Manitoba.

The model describes how the core functions of public health are currently met within the communities, and proposes how these functions would be met during the implementation phase of this new model. The full paper in its most recent draft is appended. It has been in circulation since the end of Year 2 when the initial draft was developed. It has been reviewed multiple times by both the TWG and the OB, and the Chiefs, Health Councillors, and Health Directors have all been opportunities to review it with a member of the project team. The most recent draft of the model was developed after the Regional Public Health Team Meeting, and includes ideas that were presented and agreed to there (e.g. transferring the nursing positions to FARHA)

as well as ideas that were generated by community health staff at the meeting (e.g. a youth health advisor position to increase relevant programming for youth).

This has been the deliverable that has required the most time and effort during Year 3, and was the key element in providing the clarification that FNIH MB Region required in order to progress in the project. All members of the TWG and OB were surveyed to inquire if there was any disagreement to elements of the model or if further recommends for substantive changes were anticipated. No members emailed a statement that indicated we should expect further substantive changes, and at the most recent meeting of the TWG no significant changes were requested or disagreement stated. This represents a major success of the project this year and leaves us in a good position to draft and make quick progress on having the tripartite agreement signed that will allow us to move to implementation in Year 5.

F. **Evaluation**

I. *At least one co-lead participates on national evaluation steering committee.* Dr. Anderson DeCoteau participated in reviewing the RFP for the consultants last year, though unable to review the applications. Multiple project team members met with the consultants and reviewed the evaluation reports submitted by the consultants. The evaluation steering committee did not have meetings throughout the full year, and plans for evaluation of Year 3 work were developed by representatives of the AFN and FNIH without the opportunity to participate for representatives of the pilot sites.

II. *Regional and community public health staff are informed of importance of evaluation activities and participate willingly.* The consultants who did the Year 2 evaluation contacted different people associated with the project. No further evaluation activities were undertaken at the community level.

III. *Evaluation framework reviewed by project team, TWG, and additional local items suggested.* The project team and TWG did review both the evaluation framework and draft reports from the consultants, providing substantive feedback. However, given both the delay in receiving funding and the lack of additional resources for local evaluation, no further work was done locally.

IV. *Local evaluation undertaken, as necessary, to supplement national evaluation.* While local evaluation would be very helpful in planning for future years of the project, and in identifying both successes and challenges, without resourcing this activity is not possible.

4. Conclusion and Future Considerations:

Year three was a very different year than the two preceding years given its concentration on developing a complete First Nations Public Health model that would find acceptance with all stakeholders. However, similar challenges existed as with preceding years given the significant delay in Pilot Project funding, which once again pushed back the time for moving into full implementation. Further, feedback at the Regional Public Health Team Meeting suggested that communication about the project and the role of FARHA had not improved as much as we hoped, highlighting that as a priority for Year 4.

Despite the many challenges noted close to the beginning of this report, Year 3 had at least one major success. The near finalized public health program and service delivery model has

been thoroughly vetted with all stakeholders, and with no further substantive feedback anticipated it provides a strong foundation on which to build the tripartite agreements and implementation plan.

Year 4 will not be without its challenges. During this year all of the partner organizations will be asked to commit to significant changes, and we will need them to review and sign agreements in a timely fashion if we hope to move to implementation in Year 5. As this project year begins all partners are being asked to give firm approvals to the public health program and service delivery model and the changes it will mean for their respective organizations. This will be a real test of the commitment of many individuals in both governmental and First Nation regional and community health agencies to embrace real change. For some it will mean a change in the financial and human resources they control or grant to support First Nation Public Health Services. It will be necessary for the senior officials and politicians to demonstrate their commitment to resolving longstanding jurisdictional issues

An additional recent concern came to light during the May 2010 tri-Pilot Project national teleconference as expressed by First Nations & Inuit Health headquarters officials. During this teleconference it became clear that sustainability of improvements made during the PHIPP is not guaranteed after the March 31, 2012 end of the project. If this is actually reflective of the senior government's policy or direction, then this presents enormous challenges to all MFNPHIPP partners. The question in their minds will probably be: "should we say yes to the good changes proposed by the Model and test them out during year five, only to have to go back to where services now are on April 1, 2012?"

The main positive hopes that the drafters of this Final Report conclude with are:

- Many individual have spent much time working on this project over the past three plus years in the belief that real improvements could be made to First Nations Public Health services. They are good and committed people and will not easily give up on the possibility of such improvements actually happening and being sustained.
- Significant resources of money and manpower have already been used to get to this critical point and senior officials and politicians will surely not easily allow these past expenditures to have no tangible results.

Appendix A: Year 3 Work Plan

Manitoba First Nations Public Health Improvement Pilot Project
April 1, 2009- March 31, 2010 Work Plan (Year 3)

Given the delay in funding in Year 2 it is anticipated that some of the activities from Year 2 will need to be carried over to Year 3, as it was not possible to accomplish the full years work in the 6 months that funding was available for.

Key Result Area	Objectives	Activities	Timeline	Anticipated Outcomes
A. Legislative, regulatory, and/ or jurisdictional issues	1. Ensure that a provincial MOH can lead the FARHA public health programs and services beginning in Year 4.	1. Finalise and sign tripartite agreement to confirm relationships between all parties. 2. *Review and implement results of legislative review for provincial MOH services.*	September 2009 *September 2009- March 2010*	Tripartite agreement is signed by all parties, with detailed responsibilities of all parties. *Supporting legislation is in place for new MOH service model.*
	2. Establish effective Environmental Health/ Public Health Inspection (EH/PHI) service for the Island Lake communities.	1. Review results of Year 2 scans on EH/PHI services and develop strategy to improve EH/ PHI services in Island Lake. 2. *Develop partnerships with stakeholders in order to implement strategy once developed.*	June 2009 *March 2010 and ongoing*	Strategy to improve EH/ PHI services approved by Oversight Body. *Improved communication and collaboration between different partners involved in Environmental Health*
B. Health Information	1. Participate in First Nations Client Registry project.	Continued participation of the MFNPHIPP co-leads on the National First Nations Client	April 2009- March 2010	Next phase of Client Registry project completed.

		Registry Steering Committee and in development activities.		
	2. Develop local capacity for data collection, analysis and response.	1. Regional MIMS clerk does more inputting into MIMS and is available for queries from communities. *2. Education and planning sessions on defining local health indicators, and how to collect and use them.* 3. Limited local data collection and analysis for the purpose of program evaluation.	April 2009-ongoing *May 2009* March 2010	Enhanced regional MIMS reporting and use. *More local capacity to use public health information.* Completed program evaluation (program to be determined).
C. Health Human Resources	1. Implement actions of the completed Year 2 HHR Action Plan.	1. Continue to nurture relationships with Indigenous health professional organizations and other Aboriginal HHR initiatives. *2. Support existing Health Authorities in finding solutions to chronic shortages in work space and housing for professional public health staff.* 3. Establish a committee composed of Pilot Team and the 4 FN education authorities to encourage	April 2009-March 2010	Successful recruitment and retention of public health nurses.

		completion of high school and pursuit of health careers. *4. Participate in career fairs and other events to promote job opportunities in public health at FARHA and the 4 communities.*		
	2. Provide opportunities for Public Health Professional Development of existing staff.	1. Design and deliver public health education and work shop sessions to current public health staff and health directors. *2. Explore opportunities for participation in professional development activities, e.g. conferences, for members of the regional and community public health teams.*	April 2009-March 2010	Increased capacity and skills of regional and community public health staff.
D. Communication	1. Assure all parties are aware of and supportive of overall pilot project goals, objectives, and activities.	1. Regular updates on the MFNPHIPP are sent to communities via fax/ newsletter. *2. A part-time employee*[1] *is hired by MFNPHIPP in each community to facilitate communication between FARHA/ MFNPHIPP and the communities,*	April 2009 and ongoing *April 2009-March 2010*	Communication has improved at every level (national, regional and community), and all parties are aware of and supportive of project activities.

[1] Ideally this would be a full-time person in each community, however for purposes of budget considerations only a part-time employee is included.

		and to provide local leadership of MFNPHIPP activities. 3. Executive Director of FARHA continues to update and seek feedback from the Manitoba First Nations Health Technicians Working Group (MFNHTWG) at their regular meetings. *4. MFNPHIPP leaders invite the Chair from the Chiefs Task Force on Health to attend on of the Oversight Body meetings.* 5. Regular meetings of the teams from the 3 pilot sites continue to share experiences and information. *6. A mechanism is developed with AFN to disseminate project updates and materials as they are developed to other First Nations in Canada.*	April 2009 and ongoing *Date TBD* April 2009 and ongoing *April 2009 and ongoing*	
E. Public Health Programming	1. Continued modification of strategies to address public health programming	1. Further modification of Island Lake Immunization Strategy (appended).	April 2009 and ongoing *April 2009 and*	A strategy to improve coordination and efficiency of the immunization program has been

	priorities identified in Year 2.	*2. Elders and Youth Public Health Advisory Council continues to meet.* 3. Sexual health education continues. *4. Other elements of sexual health strategy developed.*	*ongoing* April 2009 and ongoing *June 2009 and ongoing*	agreed to by all parties and is ready for implementation. *Enhanced community ownership of and input into MFNPHIPP.* Increased knowledge about sexual health. *More coordinated sexual health program.*
	2. Develop strategies to respond to public health priorities identified by Oversight Body for Year 3.	1. Develop relationship with WRHA, who is now providing TB case management for First Nations people with TB. *2. Develop strategy to respond to elevated rates of TB in the communities.* 3. Develop strategy for chronic disease prevention and prevention of impacts from chronic disease. *4. Form partnerships with other projects on chronic disease (e.g. Diabetes Integration Project, Manitoba Renal Program).* 5. Assist with Pandemic Planning in the	May 2009 and ongoing *September 2009- March 2010* June 2009- March 2010 *May 2009 and ongoing* September 2009 and ongoing	More coordinated and effective response to elevated TB rates. A community-driven strategy to prevent chronic diseases and their impacts. *All chronic disease prevention programs are identified and ways to collaborate agreed to.* More progress made on Pandemic Plans, and more communication between the involved service providers.

		communities, and coordinating with the regional and provincial plans.		
F. Evaluation	1. Participate in national formative evaluations.	1. At least one co-lead participates on national evaluation steering committee. *2. Regional and community public health staff are informed of importance of evaluation activities and participate willingly.*	January 2010-March 2010	Formative Evaluation of Year 3 completed.
	2. National evaluation supplemented with local formative evaluation to ensure relevance.	1. Evaluation framework reviewed by project team, TWG, and additional local items suggested. *2. Local evaluation undertaken, as necessary, to supplement national evaluation.*	September 2009- March 2010	Local evaluation completed to meet local needs.

Appendix B: November 2009 “MFNPHIPP Report to the Citizens of the four Island Lake First Nations”

Manitoba First Nations Public Health Improvement Pilot Project

A Report to the Citizens of the four Island Lake First Nations

1. Introduction:

In 2007 at the initiative of the Assembly of First Nations, three Public Health Pilot Projects began across Canada. One was in Saskatchewan (File Hills Qu'Appelle Tribal Council); one was in Ontario (Kenora Chiefs Advisory); and our Island Lake region was selected as the Manitoba site. All three Pilot Projects were asked to test out different ways the Public Health Services in First Nation Communities could be improved. The common definition of "Public Health" is those services that seek to prevent diseases and promote healthy living for individuals, families and communities. These include a wide range of activities such as immunization of our children, education aimed at how to prevent us getting diseases such as diabetes, measures to make sure our community water supply is safe etc. The three pilot projects were designed to last for five years and all are currently at the half way point.

2. Who are the major players in our Pilot Project?

Overseeing and approving the Pilot Project work in Island Lake is a thirteen person group called the Pilot Project **Oversight Body.** Its members are:

- The eight person Four Arrows Regional Health Authority's Board (the Chiefs and Health Portfolio Councillors from Garden Hill, St. Theresa Point, Wasagamack and Red Sucker Lake First Nations).
- The Four Arrows Regional Health Authority's Executive Director (Jonathan Flett).
- Manitoba Health's Chief Provincial Public Health Officer (Dr. Joel Kettner).
- First Nations & Inuit Health's Senior Advisor of Policy and Strategic Planning (Peter Rogers).
- Assembly of First Nations' National Pilot Projects Director (Dr. Kim Barker).
- University of Manitoba, Northern Medical Unit's Director (Dr. Bruce Martin).

Doing the major Pilot Project planning and testing work are members of the **Technical Working Group.** This is a group of individuals from the partner organizations who all have a particular expertise in the Public Health field. The three main players of this group are:

- Grace McDougall, Pilot Project Co-Lead: Grace is a member of the Garden Hill First Nation, a Registered Nurse, and the Public Health Coordinator at Four Arrows R.H.A.. Grace has also recently been assigned specific H1N1 pandemic planning responsibilities by the Four Arrows R.H.A. Board.
- Dr. Marcia Anderson, Pilot Project Co-Lead: Marcia is a Medical Doctor, with a specialty in Public Health and Internal Medicine. She is a member of the U. of M. Faculty of Medicine and a Manitoba Health, Medical Officer of Health. Marcia is also President of the Indigenous Physicians of Canada Association.
- Hazel Harper, Pilot Project Community Lead: Hazel lives in, and is a member of, the St. Theresa Point First Nation. She is a former Health Director and Band Administrator, with a wealth of experience in First Nation health services.

Elders and Youth Advisory Council. This group has met twice already, and plans are underway for a third meeting in November. There is an elder and a youth representative from each community. Their role is to help us design programs and services that will best meet the health priorities of the communities.

Finally, the real Public Health work at the community level is done by staff such as Public Health Nurses, Community Health Representatives, Health Directors and others in the four First Nation Health Services.

3. What Pilot Project work has been done and what is planned?

The first two years (April 2007 – March 2009) were mainly spent on building relationships, collecting background information, identifying ways to get the communities involved, and in planning the new approaches to be tested in the next three years. The following are just a few of the many positive Public Health improvements which will hopefully be approved and started this year for full implementation in the final two years (April 2010 – March 2012):

- A clear, written description of the new model of Public Health programs and services available to the citizens and communities of Island Lake.
- An electronic system (called a Client Registry) designed so that when the province's electronic medical records are also working we can provide better care to each person, and also learn more about the health of the community as a whole through population health assessments.
- A clearly identified Medical Officer of Health, designated under the Manitoba Public Health Act, to work half time on Island Lake Public Health issues and to provide leadership to resident Public Health practitioners, Island Lake citizens, and Chiefs and Councils.
- Improved access to an electronic immunization system to assure children, and all our population, are as protected as possible against preventable diseases.
- New initiatives to encourage our young people to enter health professions.
- New public education initiatives to help us all avoid, wherever possible, chronic health conditions such as diabetes, fetal alcohol spectrum disorder etc.

4. Conclusion:

If you have any questions about this Pilot Project, or have any suggestions about how it could work better, please contact Hazel Harper by phone: (204) **462-2692** (leave a message if there is no answer); in person (at a place of your choosing in any community – please phone to make arrangements); or by e-mail---Hazelharper@mts.net . Although living in St. Theresa Point, Hazel will be travelling regularly to all communities.

Appendix C: Report of the MFNPHIPP Island Lake Gathering held in St. Theresa Point First Nation February 8-9, 2010

REPORT

Manitoba First Nations Public Health Improvement Pilot Project (MFNPHIPP)

Island Lake Gathering – February 8-9, 2010

Held at the St. Theresa Point First Nation High School

1. Introduction:

The Gathering was planned as the MFNPHIPP neared the end of its third year. The objectives hoped to be achieved through the Gathering were stated as follows:

- **To participate in, understand, and endorse the final two year initiatives of the Manitoba First Nation Public Health Improvement Pilot Project (MFNPHIPP).**
- **To explore and develop public health service improvements within and between all organizations.**
- **To develop and strengthen a spirit of teamwork and cooperation as all players work toward excellence in Public Health services in Island Lake.**

Over the two days, sixty two individuals participated in some or all of the sessions. This included members from the following MFNPHIPP mechanisms:

- MFNPHIPP Oversight Body
- MFNPHIPP Technical Working Group
- MFNPHIPP Elders and Youth Advisory Council

Participants also came from the following organizations or bodies:

- Garden Hill First Nation Council
- St. Theresa Point First Nation Chief and Council
- Wasagamack First Nation Council
- Assembly of First Nations
- Health Canada – First Nations & Inuit Health - Regional Office
- Manitoba Health
- University of Manitoba - Northern Medical Unit
- Four Arrows Regional Health Authority
- Red Sucker Lake Health Authority
- Red Sucker Lake Nursing Station
- Wasagamack Health Authority
- Wasagamack Nursing Station
- St. Theresa Point First Nation Health Authority
- St. Theresa Point High School
- St. Theresa Point Nursing Station
- Garden Hill Health Directorate
- Garden Hill Nursing Station

- Neewin Health Care
- Island Lake Tribal Council
- Northern Inter-Tribal Health Authority (NITHA)

All participants were given a folder of information when they registered with background documentation including the following:

- Gathering Agenda
- February 5/10 draft of the MFNPHIPP Model for Public health Program and Service Delivery
- A MFNPHIPP Report to the Citizens of the four Island Lake First Nations

If readers of this report who were not at the Gathering, would like to access any of this material please contact MFNPHIPP Administrative Assistant, Phyllis Wood at Four Arrows R.H.A. (ph: (204)-947-2397 or e-mail Phylliswood@mts.net).

The following sections of this report will not attempt to capture all the comments made during the two days of the Gathering, but rather will seek to summarize the main content, conclusions and observations as recorded and heard by the several members of the Gathering planning team.

2. Presentations:

Three major power point presentations, followed by questions and comments from the floor, served as the main content around which the Gathering flowed. Copies of all three are attached to this report and were:

I. The opening presentation on the history and development of the Northern Inter-Tribal Health Authority (NITHA). It was presented by Dennis Moore, the Chief Executive Officer of that northern Saskatchewan organization. A NITHA representative was invited to present at the Gathering as much of their experience in developing First Nation Public Health services has served as an inspiration in developing the MFNPHIPP model of services.

II. Immediately following the NITHA presentation was one on the MFNPHIPP journey to date and its plans and hopes for the final two years of the Pilot Project and beyond. It was entitled “Planning for a Healthier Future” and was presented by MFNPHIPP Co-Leads Dr. Marcia Anderson & Grace McDougall and MFNPHIPP Community Lead, Hazel Harper.

III. On the second day of the gathering, Alex McDougall, Executive Director of Neewin Health Care presented on the history and development of that organization as it plans and oversees the development of primary health care services (including hospital and 24/7 medical care) actually located in the Island Lake region. A Neewin representative was invited to present at the Gathering as the future plans for Island Lake First Nation health services from both perspectives involve significant integration between primary health care and public health in some form at both governance and service levels.

Following each presentation many questions, answers and statements were exchanged between Gathering participants and the presenters which provided both clarification and, in general terms, support for the directions being pursued by each of the three.

3. Observations by MFNPHIPP Oversight Body representatives:

Because the Oversight Body oversees and approves the overall direction of MFNPHIPP, each member or a delegated representative present at the Gathering was asked to give a brief (three minutes or less) observation on what they can see be accomplished through the Pilot Project. The following represents a summary of these observations as recorded and understood by members of the Gathering planning team:

- Dr. Joel Kettner - Manitoba Health:

  Expressed the hope the Pilot Project accomplishes 3 things: 1. better health and services in the four communities; 2. better health and services for all First Nations in Manitoba; 3. better health and services for all Manitobans. When it comes to public health if we can work better together and draw on the strengths of all levels of government and recognize First Nation self-government principles and goals, we can accomplish many public health goals. Public Health is both a shared responsibility and a shared opportunity for all from the top levels of government to each individual in each home.

- Dr. Kim Barker - Assembly of First Nations:

  By the creation of the Public Health Agency of Canada in 2004, AFN was concerned that the transfer of public health expertise out of FNIH and into PHAC was going to negatively impact First Nation communities since PHAC was not focused on public health on reserves. So the need to build public health services and capacity in First Nation communities, coupled with the stated goal of FNIH getting out of service delivery into funding alone, underscored the importance of the Pilot Projects. Thus it is very important that First Nations build capacity to provide services themselves and build partnerships with the province and its regions. The more this succeeds, the less we need to worry about strategic changes by the federal government.

- Mark Sagan and Jim Wolfe - First Nations & Inuit Health, Manitoba Region:

  Mark Sagan on day # 1 acknowledged both how challenging public health can be but also how effective it can be when the communities, FNIH and Manitoba Health all work together. He used the recent response to H1N1 as one example. Public Health is not a project, it's a system. Thus the Pilot Project, by trying to find ways to involve all who are working in public health, is about demonstrating how we can meet our shared public health goals.

Jim Wolfe on day # 2 expressed gratitude that progress has been made. Through some tough discussions, we all now have a much better understanding of what we're dealing with. There is a need for greater involvement of the communities in the Pilot Project. More involvement with both FNIH Nursing Stations and Regional office staff in the work of the project team would be helpful. Continued work to clarify the role of a Medical Officer of Health prior to implementation of new model is important. Stressed was FNIH's responsibility to fund public health services and along with this their responsibility for ensuring that services are provided properly, whether this be by communities or other providers. The urgency of the Pilot Project work and the importance of seeing that the services are constructed and delivered well, was underscored. Thus continued efforts at working together through all issues, no matter how difficult, will produce good results.

- Andy Wood (management) and Councillor Nora Whiteway (board member from Wasagamack First Nation) - Four Arrows Regional Health Authority:

  Any Wood, on day # 1 noted that this is one of the first gatherings ever held focused only on public health. Treatment should not be the only focus and it seems there is never enough staff. In order to lessen the need for ever more treatment we must focus on public health and prevention and this is what the Pilot Project is doing.

- Councillor Norah Whiteway, also on day # 1 noted that when we went to other meetings such as OCAP we were told how sick indigenous people were, for example: in Island Lake we used to drink water from the lake. Now our water is treated and we don't know if the chemicals are making us sick. We lost most of our traditional ways and our youth are lost and aren't taught our culture, most of it because of technology. We need to reconnect to the earth. I hope we can see how we can do improvements by the end of this Pilot Project. We won't get well just by using drugs and pills.

- Dr. Bruce Martin – University of Manitoba, Northern Medical Unit

  On day #2, echoed the sense of profound urgency behind the work of the Pilot Project ie. given the very heavy burden of disease, scarce resources and an expanding population. Even if more human resources are pored in, without leadership in the public health realm we will have limited success. The Northern Medical Unit continues to be strongly behind the Pilot Project initiative, which will only be successful when done by collaboration and accountability to communities.

- Chief David McDougall - St. Theresa Point First Nation

  As First Nation leaders, we try to work with the entities that are out there, but we're in a very disadvantaged position. Every time we try to suggest a new model we are told that has already been tried and failed in a different region. For example, in response to a proposal we had to bring different pharmacy and physician services to our community, we were told by Jim Wolfe that it would simply mirror puppy mills where you line up

the people and cash in on the prescription drugs. But we haven't had a proper physician service in years, and right now we have only 1.5 physician days/week for a community of 3000 people. Our men are dying faster than our women. We go in the waiting room and see women, children and elders. We have to look after them first, but what about the men. We need to get our act together. We have to come to the table with meaningful emphasis. When we talk about the hospital concept we have to start a business case and a full business plan, so we can have the statistics that are relevant to that. Statistics are not being provided to us in a meaningful way. I don't go running to the press every time I have a disagreement with Jim Wolfe, but its getting really frustrating and I told the Minister of Health that the only recourse we have is to tell our people to start taking legal action. We have treaty agreement based on our inherent rights. Minister Oswald said they don't negotiate with terrorists, and then they went to the press themselves before anyone came to talk to me about it. I don't confront in that way and we all need talk about this in a way that will have meaningful impact for our people. This goes for public health also. We have 3rd world conditions here. Our school is sorely underfunded and does not have science courses to accommodate university entrance especially in leading to health careers. The students can't get the 28 credits they need here to move on to advanced health education, because we don't have enough financial resources to hire more specialized teachers, so they have to go out of the community if they want to succeed in this way. And then people say we don't have enough graduates! We need to look at the best way to serve our people and we shouldn't shy away from creating a paradigm shift that might better serve our people. I will be working hard to build better relationships with politicians and officials at both federal and provincial levels, so that together we can work with toward the betterment of Island Lake people.

(**Note**: During a different portion of the Gathering, Chief David McDougall, offered these thoughts to the Gathering. Although his comments were not focused only on his hopes for the Pilot Project and were made without the time limits noted above, as a Four Arrows R.H.A. Board member Chief McDougall is also on the Oversight Body, and thus it seemed appropriate to include a summary of his observations here.)

4. Day # 1 Small Group reports:

Through a "scientific" random process, four groups were formed with membership in each representing the very diverse make up of the Gathering. At the end of the two periods of small group discussion, spokespeople from each of the four groups ("spades, hearts, diamonds and clubs") gave reports of their discussions. The two questions serving as a focus to these deliberations were: A. "What are some things that aren't working well in Public Health now and how would the changes at the regional level as explained in the presentation on the MFNPHIPP model affect our public health service delivery?"; and B. "What supports or systems changes do we need from Four Arrows R.H.A. or others that can improve our public health services locally?"

As expected, the reports from the groups were extensive and contained both many common themes, but also some differences of emphasis and opinions. Rather than attempt to summarize such diversity, the reports, taken from the notes of the presenters and our team's recording of their presentations, have been included as an appendix to this report.

5. Community reports:

Each community health service was given the opportunity to make a brief presentation on public health activities they delivered. Red Sucker Lake Health Authority unfortunately did not have representatives present at this point in the agenda. The following represents a summary of what each group presented as recorded and understood by the Gathering team:

- Garden Hill Health Directorate Team: (Oberon Munroe, Paula Monias, Gloria Munroe, Larry Monias, Arlene Kennedy, Marilyn Wood, Erna Talylor):
  Community activities noted were: diabetes awareness; exercise program by physical activity research team in high school; and youth awareness of active lifestyles. Child worker and nutrition worker present "Kids in the Kitchen" at the school. Prenatal classes by child development worker and parenting skills are held weekly. Cultural activities like fishing and hunting for the health program are also undertaken.

- St. Theresa Point First Nation Health Authority Team: (Thelma Mason, Victoria Flett, Esther Mason):
  Noted and especially proud of: walking trail (but can't use it in winter); and gardening project (first time only 11 people interested but last year there were 38 people with gardens - go on local radio weekly to encourage people to garden). Noted also was a start doing parenting skills classes (but it's been a slow process – tried phone calling but still response was not strong). One of the CHRs is personally promoting active living by walking to work every day both to be a role model for active living and to improve her own health.

- Wasagamack Health Authority Team: (Councillor Nora Whiteway, John James Harper, Virginia Harper):
  Most noted with pride was H1N1 preparedness (they only had a couple of cases, but prepared well by gathering up information and identifying lead people in different areas of their community). They noted the need and their efforts to encourage the youth to have good self-esteem and to be proud of who they are.

6. Day # 2 Small Group Reports:

In the Gathering folder material, there were seven focus questions listed. There were also seven members of the MFNPHIPP Technical Working Group (TWG) at the Gathering and each one became the facilitator of one of the small groups, and the participants then selected which particular group/question most interested them and proceeded to that particular group. After the time limit for the small group discussion was reached, participants reassembled as a plenary and a spokesperson of each group presented their group's conclusions. The following summary of each group's conclusions was taken from the notes of the presenters and our team's recording of their presentations:

- **Question:** Discuss what change, if any, government departments (Manitoba Health, FNIH) and provincial regional health authorities should consider to support the improvement of First Nations public health services.

TWG facilitator – John Robson; Presenter – Rose Neufeld

- Position of the Chiefs and other leadership is that they are not part of BRHA. Island Lake wants its own provincial RHA and has tried in past but told that the number of RHAs in province won't increase. Points for why there should be an RHA are: that Churchill is smaller and has their own RHA; residents access care from WRHA and don't have a relationship with BRHA, due largely to travel difficulties to get to and from Thompson. Citizens from Island Lake have been part of the BRHA board but this hasn't resulted in visible results. If Island Lake region had its own RHA, it would have more input into policies and procedures.
- If Island Lake had an RHA. it would then have a Medical Officer of Health to service this region, like other RHA's.
- Governments need to be willing to share their resources to support autonomy for Island Lake
- If Island Lake had its own RHA, the role of senior governments would be: funding; assisting in development of processes to deliver services; and honouring treaty and fiduciary responsibilities.
- NIHB should also be governed locally so that there could be more flexibility
- Costs associated with returning dead bodies to community- could be cut if there were a hospital in Island Lake. This would save substantial money (for federal government, First Nations and families) and although savings to personal pain can't be measured, this factor needs to be noted

- **Question:** <u>Discuss the pros and cons of having a single regional health promotion budget with regional administration and support rather than small disease and injury prevention/ health promotion budgets given directly to the communities (as currently happens).</u>

  TWG facilitator – Dr. Marcia Anderson; Presenter – Robert Flett

  - One would first need to know how much money is currently going into each community for health promotion and how it is calculated (how much money each community gets)
  - Pooling resources available would be better because each community only gets small amounts
  - Need to redirect a portion of the dollars that go to acute care into prevention
  - Community perception of the regional entity (Four Arrows RHA) is a barrier: the regional entity needs to work better with the communities- need to know what communities want, communicate better
  - Region could take on role of advocating for funds and attract professionals to lend expertise
  - Could lead to improved youth representation (eg. a regional youth health worker)
  - The role of the CHR could be maximized as the frontline, community based health promotion workers- it is FNIH's responsibility to find a way to replace the work they do in Nursing Station; and they should have some accountability to regional coordinators of health promotion programs
  - Can have community level workers work as regional coordinators (e.g. a CHR with an interest in youth could be the regional youth health lead, and region could pay part of their salary to do this)

- ❖ Any structure that's developed has to have community involvement, not the status quo where its dictated to communities what they have to do, because it often doesn't fit into community's plan
- ❖ Finally, when the presenter asked the assembled if everyone agreed that resources should be pooled, nobody disagreed

- **Question:** As the development of the Island Lake Primary Care Center continues, discuss the best governance of regional public health and primary care; and how do we ensure there is a mechanism to hear and respond to community health needs?

  TWG facilitator – Grace McDougall; Presenter – Jim Wolfe
  - ❖ Options would be to be: A. part of an existing a provincial regional health authority; B. its own provincial RHA; or C. an independent RHA.
  - ❖ All transportation goes to Winnipeg supports it being part of WRHA; but since we are geographically in the north should it be part of BRHA?
  - ❖ Board would need to report to the Chiefs, and have representatives from all communities
  - ❖ Or Board could be a combination of local health leadership and leadership from province and federal government.
  - ❖ Currently primary care in the nursing station is referred to as a band aid solution and need more resources.
  - ❖ Best governance would be one board for both primary care and public health
  - ❖ Important to have good and transparent communications so all communities know what is going on and there is a greater discussion and awareness of what the needs are
  - ❖ One idea was raised to have community events when something new is happening to get everyone's opinion
  - ❖ Responding to a question, Dennis Moore reported that in NITHA they've used community focus groups, using skilled facilitators and with a cross-section of the community (including health workers, youth, elders, etc); he also cautioned that it's easy to drift away from community input. NITHA also recently made commitment to pull all health directors annually to report on what NITHA is doing
  - ❖ Having our own primary health care center will make us better able to respond to community health needs because it will be in our control
  - ❖ Having a communication and statistics team to provide information that will help overcome cultural and language barriers- but important to use simpler terms so people can understand more of what's being told to them

- **Question:** Discuss what contributions a regional Environmental Health Advisor could make to improve environmental health in the communities.

  TWG facilitator and presenter – Dr. Linda Poffenroth
  - ❖ The advantage would be a regional employee can spend more time in the communities than is available through FNIH program

- Preference would be to have someone who has lived in the communities who understands what the day-to-day realities are, and even speaks the language
- Could spend more time with communities on developing solutions to problems like dust, waste management, water quality in the lake
- Want someone to do more than just water testing
- Can work on housing issues- both solving problems once develop but also supervising building so that problems don't develop
- Can help with food security to look at issues like outdated food in the Northern store and not just for emergencies or outbreaks
- It would be good to have people in the communities who had training in environmental health- could work with the regional environmental health advisor; look for training programs for community based workers
- Someone from the south doesn't have time to go around the communities- they might arrive on the morning flight than go back on the afternoon flight, so what can they do in a couple hours? If it was someone from the region they would have time to go around and spend time to meet real environmental health needs.
- A question was asked about a new bio-monitoring initiative from FNIH - how does it fit in? Answer: if there were a regional environmental health advisor, it would be that person who would talk to the communities about things like bio-monitoring, not FNIH employees
- Regional advisor could also follow up on things like exposure to mines, advice on new developments , how to deal with dogs
- Question was asked about just transferring the FNIH EHOs to the communities and Jim Wolfe says that happened in other areas, for example Swampy Cree Tribal Council, but you need to make sure that transfer is viable.

- **Question:** Discuss what leadership, knowledge, skills or other contributions a medical officer of health could make to improve public health programs and services in the communities.

  TWG facilitator – Dr. Kim Barker; Presenter – Erna Taylor
  - The Island Lake communities are unique and isolated, so MOH needs to understand language and culture by spending time within them
  - MOH needs to help build capacity
  - MOH should provide leadership to public health nurses and CHRs
  - MOH would work closely with leadership to prioritize public health issues and develop solutions to problems like housing and mould
  - Right now it seems like things are left undone, e.g. people working in mouldy education building - EHO comes and writes report, but then there is no money to deal with it, and no one pushes it. MOH could help communities tell the government about what the real needs are

- **Question:** Discuss what practical steps could be taken by community health services and other community groups to encourage more young people to enter health professions/jobs and return to work and live in the communities.

TWG facilitator – Hazel Harper; Presenter – Barry Flett

- Need to make sure students know what the jobs are that are available in health in the communities
- Have professionals talk to the youth about their careers
- Have resources for training needs
- Encourage our kids to stay in school
- Better communication between health and educational authority to prepare students for careers in health
- Programs to cost share for training programs between the levels of government
- Need to have plan to hire graduates from here
- Attitudes to our own graduates need to change
- Work experience programs for youth/ internship programs
- Involve the parents
- Know what is going to be needed in the community in the future, and plan for it
- Role models program
- Design a training program based on current job inventories and future need
- Visits to schools more often to encourage students to go into health field (e.g. nurse every couple months)
- Return of service for students who are sponsored by the community
- Set up information booths where young people hang out
- Profiles of job description and salaries of different positions in the health care field
- Newsletter and web pages for young people to raise student awareness
- Provide constant encouragement to young people by health professionals
- Have a high school course that can be integrated into the curriculum that can focus on health care
- Youth center to link all these ideas- where all of this information will be available
- Bulletin board at the high school
- Have someone decipher public health information into simpler terms for the youth
- Have a film or documentary of different career opportunities available
- Rose Neufeld commented that in BRHA they have a high school course that is first step towards getting a paramedic license, had 3 or 4 partners that helped to pay for it. Every person who graduated went into a health profession of some kind.
- Jonathon Flett commented on the influence education authority, e.g. Winkler and Carman decided they were going to produce more hockey players so taught more about hockey in school. So if we want people to staff a regional primary health care center we should focus more on health and science teaching in the schools and have a goal of producing more health care workers. Takes a long time- like a 10 year plan to produce health workers, not just occasional career days.
- Byron Beardy commented that we took on our own education to train our teachers so we should do the same thing now in the health field
- Alex McDougall commented that when they started working on the Master Service Plan for the Primary Health Care Centre they took an inventory of the positions. We saw the need to train our own people. FARHA tried to get together with the Island Lake education authorities to sponsor a health specific training

program. Invitations went out to the education authorities and their people to start a strategic plan and nobody showed up. Tried a second time, and had only one phone call. But, we know they have their own resource limitations, so we need to look at other resources because its hard to get education resources shifted to health training.

- **Question:** Discuss the pros/ cons of a suggestion that public health nurses become Four Arrows R.H.A. employees.

  TWG facilitator – Mark Sagan; Presenter – Dr. Bruce Martin
  - ❖ If a regional health entity were to employ PHN they should:
    - Recruit PHNs
    - Set work plans and accountabilities
    - Determine what the adequate number of nurses would be to meet all functions
    - They could work as a pool across the communities so if someone is sick they can be covered
    - Expertise in supervising PHNs
    - Create good communication between PHN and nursing station staff
    - Share records between PHN and nursing station staff
    - Create equity/ equivalent salary and benefits as FNIH and other recruitment agencies
    - Work well with FNIH
  - ❖ Important to have more FN nurses who are familiar with surroundings and people
  - ❖ More hardworking people who get lots done
  - ❖ Lots of concern about STIs not being adequately dealt with now, so need more resources
  - ❖ Would be hard for the NIC to supervise PHNs too
  - ❖ Preference to have 1 regional entity hiring the PHNs
  - ❖ What/ who FARHA is and their role wasn't clear to all participants in the group
  - ❖ Jonathon Flett commented that a central body recruiting and governing nurses might help stop nurses getting BCR'd out of the communities. It can also help to develop support systems between communities so if too much work in one you can add resources from somewhere the demand isn't as great. A central body would also have greater capacity to go out and recruit nurses in Canada, the US or internationally. Might also be able to negotiate comparable salaries.

7. Conclusion:

At the end of two full days of work, the Gathering planning team felt that all of the objectives stated for the Gathering had been at least been partially met. The Gathering featured a good turn out from all partner groups and discussion featured an honest exchange of information and opinions. The final two years of the Pilot Project five year term commence April 1, 2010, and the Gathering was seen by most as an appropriate launch for this period of testing First Nations Public Health improvements planned by the many partner groups over the first three years.

Appendices:

1. Northern Inter-Tribal Health Authority (NITHA) – ("Northern Saskatchewan First Nations Working Together")
2. Manitoba First Nations Public Health Improvement Pilot Project (MFNPHIPP – "Planning for a Healthier Future")
3. Neewin Health Care
4. February 8, 2010 MFNPHIPP Gathering Small Group Work Reports

Note: This report submitted by Gathering planning team:

- Grace McDougall
- Dr. Marcia Anderson
- Hazel Harper
- Phyllis Wood
- John Robson

Appendix 4 – February 8, 2010 MFNPHIPP Gathering Small Group Work Reports

What are some things that aren't working well in public health…?	**What supports or system changes do we need in FARHA or others to improve public health services locally?**
• Need to focus on preventive aspects of oral health (fluoride in water, improve diet, teach kids how to brush teeth, etc.) • PHNs only have time to do immunizations and not time for other public health activities • CHRs too busy acting as Nurses Aides and not focusing on community • Resources have to be adequate for community size (not enough public health nurses in the community) • No operational budget included for public health program/ nursing • Better environmental health services (including water) also inadequate response when issues identified, e.g. mold in houses • Need to integrate traditional medicine and knowledge into	• Communities need to know what supports might be available; look at what province might have to offer e.g. environmental health, nursing support • Help in environmental health (EHOs or PHIs, advocacy) • Community education in environmental health • Improved communication between departments (e.g. nursing station and public health) • Advocacy for more resources • More trained people in the community • Elder advice to workers • Clear roles and responsibilities for workers, so have job descriptions for all programs • Adequate money and people to resolve housing issues

public health system • People on lots of pills but don't always know what they're on or what it's for; public health intervention could be to improve health literacy • Healthy public policy: e.g. policy on exercise for 15 minutes twice a day at their workplace • More public health education: schools, tv, radio • Not enough resources to fix environmental health issues • Need health advisors so can help manage transitions when chief and council change quickly • Some workers get overtired, can't finish paperwork in work hours because they are overworked • Inadequate diabetes education • Sometimes inaccurate health information is given to patients • Always in crisis mode, so can't focus on prevention • In 1976 in STP there were 6 nurses including 1 PHN, now even though community bigger still only 6 nurses • Language and cultural barriers, isolation hamper public education • Need more suicide prevention for youth • Sexual health education (STIs and teen pregnancy) not promoting sexual activity but teaching how to be safe • In order to raise healthy babies and lower costs promote breastfeeding • More community education on prevention topics • Need to hire a team/ work as a team not just one individual to do all of the work • Need more injury prevention (lifejackets, seatbelts, bike helmets) • Too much nepotism	• Add traditional medicine approaches • More nurses hired for public health positions and for nurses in the communities so CHRs can go out of the nursing station into communities • CHRs need to advise community on hygiene and health issues • Need to work with educational authorities to do career path mapping so community members can be recognized for their skills and become part of the health workforce • There is a 4 year teaching program locally, why can't we do the same for RNs? • Respect community input and collaborating with the communities for all health professionals; encouraging communities to do what they can do • Find ways to break down language and cultural barriers • Have person from outside live here for 6 months so they can understand community realities • In community 1 nurse to do just immunizations, 1 or more to do other public health functions • More water technicians to have safer drinking water • Improved health literacy • Mandatory training for all public health employees to build capacity • Have 1 entity to oversee public health so don't get run around on public health issues • Research- e.g. effects of superjuice on the community and individuals • Keep kids in science past grade 9 so they can enter health careers • Make community education presentations right before bingo starts; ensure notice goes out to

• Focus too much on negativity instead of positive aspects • Not enough interest from public when information/ presentations are happening e.g. pamphlets or tv presentations; need to increase community engagement • People aren't independent enough, don't take enough responsibility to look after themselves, their homes, the environment • Need to get people to stop focusing just on crises, but to a more preventive approach • Ensure everyone is giving a common message (leadership, public health) • Not enough information exchanged between the 4 communities, so miss opportunities to learn from each other's best approaches/ practices	public for days- a week before presentation happens • Positive outlook on presentations, don't put people down for what they are doing, have encouraging messages so people will participate in their wellbeing rather than tune out • 4 communities should recognize FARHA and work with them • Clarify role of BRHA • FARHA should be more visible in the communities • Clarify mandate of FARHA and why they are there • Consider board membership: should be mixture of technicians and leadership • Be able to offer competitive hiring packages for nurses (salaries and benefits) as compared to FNIH and other nursing jobs • Identify way to retain nurses once they are in the communities • Create mechanisms to enable communities to share information with each other

Appendix D: Chronology of steps taken since the selection of Island Lake First Nations/Four Arrows Regional Health Authority as the MFNPHIPP site in the fall of 2006

Manitoba First Nations Public Health Improvement Pilot Project

Island Lake First Nations/Four Arrows R.H.A. Site

Chronology of steps taken since site selection (fall 2006)

- **November 27, 2006:** Meeting of Four Arrows R.H.A. personnel with Dr. Joel Kettner, Dr. Linda Poffenroth, Dr. Bruce Martin as part of a continuing process to secure half-time Medical Officer of Health (M.O.H.) services for Island Lake. This meeting acknowledges the reality of Four Arrows R.H.A. being the Manitoba public health improvement pilot site and these same representatives pledge to be an integral part of the process and to continue the M.O.H. initiative as part of the pilot project. (Note: This will be named **MFNPHIPP meeting #1).**
- **January 23, 2007:** National pilot projects meeting (Ottawa) called by First Nations & Inuit Health Branch. Attendees: all three pilot site representatives; Dr. Kim Barker, A.F.N.; F.N.&.I.H. regional and H.Q. staff; and Public Health provincial Manitoba, Saskatchewan and Ontario staff. Manitoba attendees: Andy Wood, Grace McDougall, Laurie Wood Ducharme (Four Arrows R.H.A.); Alex McDougall (Neewin Health Care); Dr. Joel Kettner (Manitoba Health); Dr. Linda Poffenroth (First Nations & Inuit Health – Manitoba Region).
- **February 2, 2007:** Part-time services of consultants Debbie Grimes and John Robson secured to participate in preparation of Manitoba First Nations Pilot Proposal by March 31, 2006 deadline.
- **February 5, 2007:** Letter from Andy Wood to extensive list of provincial, federal, university and First Nation governments and organizations advising them of pilot project and drafting of proposal.
- **March 2, 2007:** First draft of proposal circulated to a number of First Nations, University and governmental health personnel requesting feedback.
- **March 20, 2007**: Second draft of proposal circulated to same personnel as for first draft for additional feedback.
- **March 30, 2007**: Letter and final proposal ("Manitoba First Nations Public Health Improvement Pilot Project") submitted to Dr. Kim Barker, A.F.N..

- **April 23, 2007**: Meeting with representatives from Manitoba Health, F.N.&I.H. – Manitoba Region, Dr. Kim Barker to receive feedback on Proposal and begin outline of year #1 actions planned. (Note: **MFNPHIPP meeting #2**).
- **April 26, 2007:** Continuation of April 23rd meeting to work on draft year #1 work plan. (Note: **MFNPHIPP meeting #3**).

- **May 10, 2007:** Meeting with Dr. Kim Barker and other partners concludes year #1 work plan ("Manitoba First Nations Public Health Improvement Demonstration Project: Summary of Year One Initiatives"). Potential of a qualified Medical Public Health person to join pilot project team and act as Island Lake M.O.H. is stated at this meeting. (Note: **MFNPHIPP meeting #4**)
- **May 28, 2007:** Participation in national pilot projects information sharing meeting via videoconferencing, followed by brief **MFNPHIPP meeting #5).**
- **June 25, 2007: MFNPHIPP meeting #6** held with a focus on staffing options of pilot project for year one and beyond, with a recommitment to have significant involvement of medical public health expertise.
- **July 23, 2007: MFNPHIPP meeting #7** held. Announcement made that Dr. Marcia Anderson has joined Manitoba Health and will have specific responsibilities working with the Pilot Project.
- **August 30-31, 2007:** Dr. Kim Barker and Brock Rowlands visit communities with Grace McDougall.
- **September 7, 2007: MFNPHIPP meeting #8** held with Marcia Anderson participating. Terms of Reference for Technical Working Group approved.
- **October 19, 2007: MFNPHIPP meeting #9** held. Plans finalized for October 25th inaugural meeting of Oversight Body. Oversight Body draft Terms of Reference approved for presentation at October 25th meeting.
- **October 25, 2007:** Inaugural **Oversight Body meeting** held. Terms of Reference for both Oversight Body and Technical Working Group approved.
- **November 13, 2007:** Draft Memorandum of Understanding (MOU) circulated.
- **November 23, 2007: MFNPHIPP (Technical Working Group) meeting #10** held. Decision taken to have three jurisdictions' (Heath Canada, Manitoba Health and Island Lake First Nations) officials review draft MOU for approval or amendments prior to signatures by political leaders.
- **November 30, 2007:** Draft MOU sent to jurisdictional authorities along with letter from TWG Chair requesting review and clearance.
- **January 17-18, 2008:** Community visits to Red Sucker Lake and Garden Hill by Dr. Marcia Anderson, Grace McDougall, Debbie Grimes and Kimberly Hodgson to dialogue on future plans and activities of Pilot Project.
- **January 23, 2008:** participation in national Pilot Projects video conference by members of TWG.
- **January 25, 2008: Technical Working Group meeting # 11** held.
- **February 15, 2008**: U. of M**. C**ommunity Health Sciences Colloquium - Pilot Project presentation by Dr. Marcia Anderson and Grace McDougall.
- **February 15, 2008**: Initial draft of 2008-2009 Work Plan and Budget circulated to TWG for review.

- **February 26, 2008**: Community visit to Wasagamack by Pilot Project team members.
- **February 27, 2008: Oversight Body meeting #2** held in St. Theresa Point.
- **February 28, 2008:** Community visit to St. Theresa Point by Pilot Project team members.
- **March 20 & 28, 2008: Technical Work Group meeting # 12** held.
- **March 25, 2008:** MOU was signed by all 4 chiefs.
- **March 28, 2008:** Final MOU presented as well as the Year One Final Report (DRAFT Edition) to the TWG.
- **June 6, 2008: Technical Working Group meeting # 13** held.
- **June 24, 2008:** Participation in conference call between other Regions and AMC to discuss the Client Registry.
- **September 8, 2008: Technical Working Group meeting #14** held.
- **September 23, 2008:** Meeting held with FNIHB regarding data management aspect of Immunizations.
- **October 10, 2008: Technical Working Group meeting #15** and **Oversight Body meeting # 5** held. Immunization Team meeting held.
- **October 30-31, 2008:** Tri-Regional (Sask., Mb., Ont.) Pilot Projects meeting held in Winnipeg.
- **December 4, 2008:** All Partners meeting held in Winnipeg.
- **January 12, 2009:** Meeting with Sierra Systems regarding Client Registry contract for Phase 0; Meeting with Sierra will continue on tentatively for every Wednesday till the end of the contracted term.
- **January 23, 2009: Technical Working Group Meeting # 16** held.
- **January 26-27, 2009:** Community Visits to Wasagamack and St. Theresa Point.
- **February 5, 2009: Oversight Body Meeting # 4** held in Garden Hill.
- **February 23-24, 2009:** Community Visits to Wasagamck and St. Theresa Point.
- **February 26, 2009:** Meeting held with the Chiefs of Island Lake to update them on the current progress and deliverables of the Public Health Pilot Project.
- **March 2-5, 2009:** MFNPHIPP took part in a Regional Health Conference in Garden Hill First Nation.
- **March 9-10, 2009:** Community Visits to Garden Hill and Red Sucker Lake.
- **March 12, 2009: Oversight Body meeting #5 held**. First meeting of the Elders and Youth Advisory Counsel (**EYAC**) held.
- **March 16-27, 2009:** MFNPHIPP co-leads & Alex McDougall (Neewin) took part in the International Indigenous Peoples Primary Health Care Training Conference in Australia.

- **May 8, 2009:** The DRAFT YEAR 2 FINAL REPORT and Year 2 deliverables submitted.
- **May 12, 2009:** Client Registry Meeting in Toronto; Sierra will be presenting an updated status report for the Steering Committee.
- **June 11, 2009: Technical Working Group meeting #17** held. All Partners Meeting via teleconference held.
- **July 8, 2009:** Meeting of Oversight Body with FNIH-Mb. Regional Director Jim Wolfe held.
- **July 24, 2009:** MFNPHIPP co-leads reply to FNIH concerns coming out of July 8th meeting submitted to all relevant parties prior to the August 6, 2009 meeting.
- **August 6, 2009: Technical Working Group meeting #18** held. New team member, Hazel Harper as MFNPHIPP Community Lead participated.
- **September 10, 2009: EYAC meeting** held.
- **September 11, 2009: Oversight Body meeting #6** held, including participation of EYAC.
- **September 28, 2009: Technical Working Group meeting # 19** held.
- **November 2, 2009: EYAC meeting** held.
- **November 4, 2009:** MFNPHIPP "Report to the Citizens of the four Island Lake First Nations" widely distributed.
- **December 2-3, 2009:** National Pilot Project meeting held in Regina.
- **December 7, 2009: Technical Working Group meeting #20** held. Decision made to hold Public Health Pilot Gathering in one of the Island Lake communities on February 8-9, 2010. Notice re: this sent to all potential participants.
- **January 7, 2010:** Meeting of co-leads with representatives from WRHA, BRHA and Mb. Health re: R.H.A. partnership with Island Lake Public Health.
- **January 18, 2010: Technical Working Group meeting # 21** held.
- **February 8-9, 2010:** MFNPHIPP **Gathering** held in St. Theresa Point First Nation.
- **March 16, 2010: Technical Working Group meeting #22** held.
- **March 19, 2010: M**eeting of co-leads with Dr. Catherine Cook of WRHA re: potential partnership. BRHA unable to attend.
- **March 23, 2010: Oversight Body meeting #7** held.
- **March 29, 2010: EYAC meeting** held
- **April 13, 2010: Technical Working Group meeting #23** held.
- **May 13, 2010:** National PHIPP Video Conference held.
- **June 22, 2010: Technical Working Group meeting # 24** scheduled.

Appendix E: April 6, 2010 draft of the MFNPHIPP "Model for Public Health Program and Service Delivery"

Manitoba First Nations Public Health Improvement Pilot Project Future Model for Public Health Program and Service Delivery

Part 1: Overview

Vision: Four Arrows Regional Health Authority (FARHA) will work as a second and third level structure[2] in a partnership agreement with Garden Hill First Nation, Red Sucker Lake First Nation, St. Theresa Point First Nation, Wasagamack First Nation, Manitoba Health, one or more partner provincial Regional Health Authorities (RHA), and First Nations Inuit Health Manitoba Region to support and enhance public health program and service delivery in the First Nations communities in Island Lake. Through this agreement FARHA, governmental and regional health authority partners will support and enhance public health programs and service delivery in the four First Nations communities and seek to provide advice, coordination of activities, education, data support and management, planning and research, and policy development.

In order to operate effectively as a second and third level structure, there must be a clear understanding of the roles, responsibilities and authority of FARHA and commitment to accept these roles, responsibilities and authority by the first level structures, which are the communities. The communities will need to be able to see the value in agreeing to act under the broader authority, and FARHA must be able to provide expertise, enabled by the pooling of resources, to the communities that they would not otherwise have available by acting independently.

Values / Principles

Teamwork: we all have skills and knowledge that are valuable to improving the health of the individuals, families and communities in the Island Lake region and will contribute our own knowledge and skills and respect the contribution of others.
Shared responsibility: public health is all of our responsibility- we all have a role to play and we should put our common goal for the increased health of the Island Lake people first in how we act and work together.
Shared opportunities: by working together we increase the knowledge, skills and resources available to all, thus increasing our opportunity for good health.

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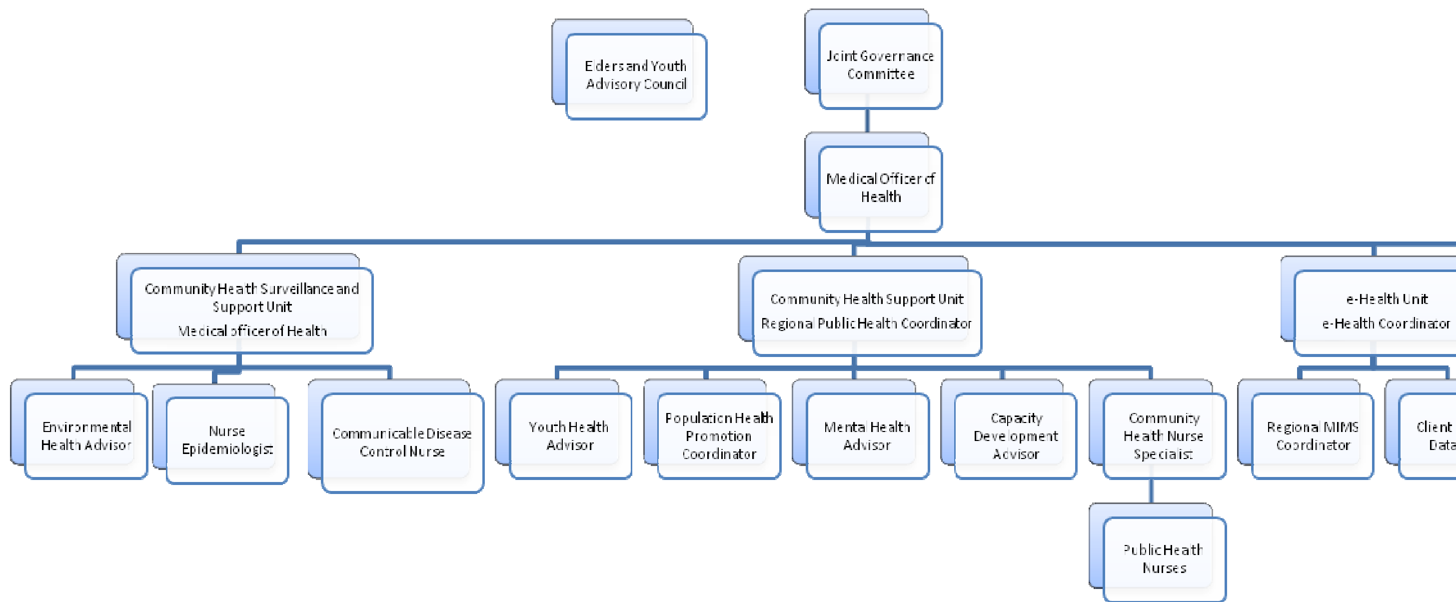
[2] *Note: In this context “first, second and third levels” are used as follows:

- Third level service: Performs best out of an organization with province-wide scope.
- Second level service: Performs best out of an organization with regional or tribal council scope.
- First level: Performs best out of an organization with closest attachment to communities and its citizens.

Proposed Public Health Improvement Pilot Project Model[3]:



Template: This proposed structure has been modeled after the Northern Inter-Tribal Health Authority in Saskatchewan, noting that NITHA has been operating since 1996, and serves more people in 33 communities, so the scope of what they are able to do is much greater. There are three main areas that this model would focus on in the MFNPHIPP project: the Community Health Status and Surveillance Unit, the Community Health Support Unit, and e-Health.

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[3] This model refers only to the PHIPP and is not intended to replace the FARHA organizational structure or governance for non-public health programs and services.

The proposed model is one that could become an important service element of a future provincial First Nation Health Council, First Nations Health and Social Commission or a provincial RHA serving Northern First Nations.[4] Regardless of when this occurs, the Manitoba First Nations Public Health Improvement Pilot Project aims to demonstrate a working public health program and service delivery model with increased First Nations leadership in the Island Lake area. The positions listed in the model do not necessarily require a full time worker for each one, but one individual may fulfill multiple functions, and some community-based workers may additionally fulfill a regional function.

It is expected that although these are shown as separate units for the sake of clarity that all people would work in a collaborative fashion. For example, the community health nurse specialist could seek advice from the medical officer of health whenever needed, the nurse epidemiologist would work very closely with the e-Health Unit, and the Regional MIMS Clerk would also respond to the needs of the Regional Public Health Coordinator and Community Health Nurse Specialist in supporting the immunization programs.

Community Health Status and Surveillance Unit: in collaboration with FNIH Health Surveillance and Analysis Unit, MHHL Health Information Branch and possibly a partner provincial RHA Health Information Division, provide regional public health surveillance, and support the communities in responding to public health issues under surveillance.

- *Medical Officer of Health (MOH):* provide leadership to all aspects of Community Health Surveillance and Support Unit; work in collaboration with Regional Public Health Coordinator to support Community Health programs; be an active participant in provincial MOH activities and call-schedule; maintain partnerships with other Northern MOHs, the Chief Provincial Public Health Officer, FNIH RMO, and the partner provincial RHA. In addition to these functions within the Community Health Status and Surveillance Unit, the MOH can provide senior leadership of all public health functions, has legal powers under the Public Health Act of Manitoba, and will build important relationships with primary care physicians and nurses.
- *Communicable Disease Control Nurse:* receive reports of notifiable communicable diseases and coordinate control activities; provide direct support to frontline workers including responding to inquiries, offer possible interventions when concerns are identified, and be available as a resource to CDC programs in communities.
- *Environmental Health Advisor:* serve as main communication link between FNIH Environmental Health Office, FARHA and the four Island Lake communities; explore potential service options with PHIs from partner provincial RHA; provide advice to CHSSU and the communities on environmental health issues.
- *Nurse Epidemiologist:* coordinate the flow of information between jurisdictions, including MHHL, partner provincial RHA, and FNIH; pursue potential areas of collaboration with partner provincial RHA including Community Health Assessment cycles; lead collection, synthesis, and analysis of public health information. This is one role that if unable to fill in the PHIPP years due to budgetary constraints or difficulty hiring could be filled through a partnership with MHHL or a partner provincial RHA.

[4] Assembly of Manitoba Chiefs. Manitoba First Nations Health & Wellness Strategy: a 10 Year Plan for Action. August 2006.

Community Health Support Unit: in collaboration with other jurisdictional partners provide support to all elements of public health practice in the communities.

- *Regional Public Health Coordinator:* provide leadership to the Community Health Support Unit; recruit Community Public Health Nurses for the Island Lake communities; provide support and promote communication between community public health programs (e.g. ADI, injury prevention, CPNP); represent FARHA on committees/ working groups relevant to the areas of community health practice
- *Community Health Nurse Specialist:* provide orientation and skills training development for nurses working in the Community Public Health Nurse role; be available as a resource to Community Public Health Nurses; support Community Public Health Nurses to play leadership roles in local public health activities; liaise with other jurisdictional partners to identify training opportunities (e.g. immunization workshops) to support role of community health nurses.
- *Public Health Nurses:* at the February 8-9, 2010 Regional Public Health Team Meeting there was overall support for centralizing the hiring and supervising of public health nurses to FARHA. Thus, funding for public health nursing positions and the responsibility for recruitment would go to FARHA. The nurses would report to the Community Health Nurse Specialist, and each would be assigned to one community, primarily. However, the nurses would be able to work as a pool to allow for coverage of other communities in the event of vacation, illness, or a position vacancy.
- *Capacity Development Advisor:* lead role in identifying areas for capacity development in community public health teams; plan capacity development workshops to build skilled public health workforce; implement and evaluate capacity development activities; identify other professional development opportunities including conferences and courses and support participation by regional and community public health team members.
- *Mental Health Advisor:* promote teamwork amongst the mental health workers in the four communities and advise on the inclusion of mental health considerations in health promotion activities.
- *Population Health Promotion Coordinator:* in collaboration with the health directors and frontline community health promotion workers develop a regional plan and budget for health promotion each year; coordinate health promotion activities across the region; promote teamwork amongst the four communities; lead skill development in health promotion.
- *Youth Health Advisor:* in cooperation with the Health Promotion Coordinator develop youth-specific health promotion programs; work with Elders and Youth Advisory Council to identify and develop ways to respond to youth health needs; participate in health careers promotion for youth.

e-Health Unit: participate in current and planned e-health initiatives and support implementation of e-Health solutions that will enhance public health program and service delivery in the Island Lake communities and allow maximum interoperability with necessary provincial and federal systems.

- *e-Health Coordinator:* participate in Steering Committee of First Nations Client Registry Project; lead all aspects of First Nations Client Registry Project; liaise with e-Health departments of other organizations including FNIH, Assembly of Manitoba

Chiefs, and Manitoba e-Health; provide leadership in the implementation of any planned e-Health initiatives including Panorama. This position will have both an operational and policy function as they will both participate in committees and strategic development, but also provide support to the communities as initiatives are rolled out.

- *Regional MIMS Clerk:* receive manual MIMS reports from the communities and input them into MIMS; be available for immunization inquiries from the front line staff. This person would be expected to maintain contact with the MIMS data entry clerk at FNIH in Winnipeg to ensure ongoing coverage during vacations or illness, or if there is a backlog of records that need to be inputted.
- *Client Registry Data Clerk:* perform tasks associated with initial development of First Nations Client Registry; maintain First Nations Client Registry.

Elders and Youth Advisory Council: provide input and advice from community members as to the impact of various public health programs/ services on the elders and youth in the community. The Elders and Youth Advisory Council does not have a governance role, but may be asked to provide input and/ or advice by the Joint Governance Committee, and staff of any of the units or programs at the regional or community level. The council is comprised of one elder and one youth representative from each of the four communities.

External Links: (these may be informal, in the form of working relationships, and in some instances may include written agreements, e.g. data sharing agreements):

CEO: reports to the Joint Governance Committee as it pertains to implementation of this new Public Health Program and Service Delivery Model. The make-up of this Joint Governance Committee is described in the next section. The CEO will also maintain link with CEO of partner provincial RHA and relevant leaders in FNIH.

MOH: part of provincial network of MOHs, including a proposed Northern MOH Practice Group. Maintain solid communication and working relationship with FNIH RMO.

Environmental Health Advisor: with Environmental Health Office of FNIH and develop relationship with Public Health Inspectors (PHIs) of partner provincial RHA.

Nurse Epidemiologist: as described above.

Regional Public Health Coordinator: develop and maintain relationships with Immunization Coordinators and Public Health Managers from FNIH and partner provincial RHA.

e-Health Coordinator: as described above.

This is not an exhaustive list, as it is anticipated that more concrete links would be developed in response to operationalization of public health activities, e.g. a strategy to improve immunization rates or contact tracing for communicable diseases.

Also, as noted earlier, should a province-wide First Nations Health Council or organization be created a number of the positions and functions could potentially operate as part of this new third level structure (e.g. MOH, Nurse Epidemiologist), whereas others could remain as second level FARHA

positions (e.g. Regional Public Health Coordinator). Somewhat similar arrangements exist in the NITHA context where tribal council-level health organizations work in conjunction both with NITHA and community public health staff. Prior to any future First Nations Health Council changes however, all the remaining second level functions noted in the model would become the responsibility of specific public health staff members at either the FARHA or community levels.

Governance of Proposed Public Health Program and Service Delivery Model

This model is proposed with the understanding that all partners agree that First Nations self-determination is a key operating principle. The Chiefs of the four communities have freely chosen to pursue this project as the means of piloting a relationship with a provincial MOH, and by extension the provincial public health system which is organized at the levels of provincial and regional roles and responsibilities. As this involves multiple jurisdictions, this will mean the need for shared leadership and shared responsibility in a *Joint Governance Committee.*

The Joint Governance Committee will include:

1. Board of the FARHA[5].
2. Executive Director, FARHA.
3. Senior Public Health Lead, Manitoba Health and relevant Manitoba Health regional health authority(ies).
4. Senior Public Health Lead, First Nations Inuit Health-Health Canada, Manitoba Region
5. Senior Public Health Lead, partner provincial Regional Health Authority
6. Director of the Northern Medical Unit, University of Manitoba

Participating as non-voting members:

1. Regional Public Health Coordinator, FARHA
2. Public Health Specialist, Manitoba First Nations Public Health Improvement Pilot Project
3. National PHIPP Lead, Assembly of First Nations

The functions of the Governance Committee would be:

- to oversee implementation of the proposed model;
- lead implementation of changes required within their respective organizations;
- ensure that while transitioning models that all of core functions of public health continue to be provided in the communities;
- approve any agreements necessary to fulfill specific functions of public health, for example surveillance, which would then be taken to each relevant organization for signing.

As with other committees within FARHA all attempts would be made for consensus to be reached. Options for program and service delivery may be: community-led programs/ services, FARHA-led programs/ services, services purchased by FARHA from either a provincial RHA or MHHL, or services provided by FNIH. The last option has been retained, recognizing that FNIH-MB Region currently provides a range of services but has the long term strategy of getting out of service provision.

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[5] Includes representatives from each of the four communities.

Part 2: Core Functions of Public Health

One of the stated goals of the MFNPHIPP is to clarify what the core functions of public health are, and how they will be provided in the participating First Nations communities. The following list of public health functions is taken from the First Nations Inuit Health Public Health Placemat January 2008.

- Health surveillance
  - Public health surveillance strategy
- Population health assessment
  - Factors underlying good health and health risks
- Disease and injury prevention
  - Chronic diseases
  - Diabetes prevention
  - Suicide prevention
  - Infectious disease/ communicable disease control (CDC)
    - TB
    - Immunization
    - Blood-borne pathogens
- Population Health promotion[6]
  - Active living
  - ECD/ AHS
  - Maternal and child health
- Health protection[7]
  - Environmental health
    - Drinking water
    - Wastewater
    - Housing
    - Food safety
    - Facilities inspections
    - Solid waste disposal
  - Communicable Disease Control (certain functions as listed in the Public Health Act)
- Emergency preparedness
  - Pandemic
  - All hazards emergency planning

Part 2 of this report will focus on describing how each of the functions is currently delivered, and how the services could be delivered under the proposed Public Health Program and Service Delivery Model, including both community level and regional considerations.

Health Surveillance

[6] Population Health Promotion can be defined as creating the conditions that support the best possibly health for everyone. (Saskatchewan Health *A Population Health Promotion Framework for Saskatchewan Regional Health Authorities.*) This extends beyond healthy behaviors to addressing the underlying determinants of health.

[7] For the sake of clarity Health Protection will be limited to regulated public health standards. In the remainder of the paper though CDC will be discussed under disease and injury prevention even though some CDC functions are regulated under the Public Health Act.

Current Status

FNIH maintains a significant role in health surveillance for the four communities. In the case of notifiable diseases, the reports go from MHHL to FNIH for appropriate follow-up. These may then be referred on to the public health nurses for further action as appropriate, such as for contact tracing. None of the four communities describe a formal public health surveillance strategy. The Regional Public Health Coordinator at FARHA does not routinely get reports of notifiable diseases, and one reason for this may be privacy legislation and the perception that FARHA is not part of the circle of care. FNIH does compile summary reports of diseases under surveillance and shares them as appropriate, with the appropriate permissions from the community leadership when needed.

In Wasagamack the CHRs play a role in responding to raised community health issues, for example when many students were complaining about headaches during school hours the CHRs were asked to go and investigate. This was mainly under the direction of the Band Council, but the CHR asked the EHO to come as well. An oil spill was found in the crawl space and the school had to be closed.

Proposed Health Surveillance in New Model

The Community Health Status and Surveillance Unit would become the lead for public health surveillance in the region, in collaboration with FNIH Health Information Division, Manitoba Health (MH) Health Information Branch and possibly a partner provincial RHA. The goal of this surveillance, broadly speaking, would be to inform disease prevention and control measures. A secondary goal will be to increase the capacity at the regional and community level to recognize and respond to public health issues. Access to health information will depend on an individual's role and what they will use the information for, so that processes respect both privacy legislation and the need for efficient and reliable access to information. As a second level body, FARHA will need signed agreements of the communities in order to access the relevant information to carry out the actions described below.

There are three main positions at the regional level who will implement the health surveillance strategy, as will be illustrated by discussion the flow of information (notification of a reportable disease) through the system. The CDC Nurse will receive the report of the notifiable disease from MH and refer it to the public health nurse in the appropriate region for follow-up which may include treatment and/ or contact tracing. The public health nurse will involve community level employees such as the CHRs as appropriate for the follow-up, for example if it's an enteric pathogen that requires further investigation as to the source of the infection. The CDC Nurse will be responsible for maintaining a secure record of the infection, recording when the appropriate follow-up has occurred and reporting the relevant information back to the province through the appropriate channels (e.g. case investigation forms, or Panorama once implemented). The CDC Nurse will advise the Public Health Nurse as needed should difficulties arise with the follow-up needed and involve the MOH when needed.

The CDC Nurse will send de-anonymized data to be entered into a database for the purpose of population surveillance to the nurse epidemiologist. This will allow following rates of notifiable diseases across time periods. The CDC Nurse will also send the data to FNIH to assist with the compilation of provincial rates over time.

The Nurse Epidemiologist, MOH and CDC Nurse will meet regularly with relevant public health nurses and public health program staff to review the surveillance results and plan appropriate action. The MOH and Nurse Epidemiologist particularly will need to have solid communication with FNIH and MH to identify trends across the province that may affect the health of the people in the Island Lake region. The mechanisms for data sharing and surveillance will evolve over time with the implementation of the First Nations Client Registry, Panorama and possibly electronic medical records.

In the event that the FNIH nurses are the first to become aware of a potential problem, for example an increased number of people presenting to the health center for care for diarrheal illnesses, the FNIH nurse would notify the public health nurse, or in their absence the FARHA CDC nurse. The public health nurse would collect the appropriate information to date to discuss with the CDC nurse and the MOH, who would direct further investigation and follow-up. The MOH would call Cadham Provincial Laboratory, if needed, to obtain an outbreak code, and provide written directions to the public health staff and the nurses about what tests are needed and the outbreak code to be included on all laboratory requisitions. The MOH, based on reports from the health center about the number of people still becoming ill and seeking care as well as the laboratory reports, will determine appropriate actions and also determine when the outbreak is over. The need for additional support will be determined by the MOH in discussion with the public health team and may be available through the partner provincial RHA or the MH Public Health Division.

Population Health Assessment

Current Status

This is an identified gap in the four communities. There have been community health assessments when community health plans are revised every 5 years according to the Transfer Agreements. This is not considered sufficient to identify and respond to community health priorities. The other identified ways to currently identify community health priorities is by determining the reasons that people come to the clinic, which gives a general idea of the most common illnesses, or by using the results of independent research projects that are done in the community.

Proposed Population Health Assessment in Future Model

The goal of Population Health Assessment will be to describe the burden of illness (incidence, prevalence, mortality of diseases and injuries, including mental health) and to understand the health of the population of the Island Lake communities in the context of key factors that influence health and health risks so that community and regional level health planners have the information they need to respond to the health needs of the communities.

This will be a key area to develop partnerships and build on existing mechanisms for population health assessment in the Island Lake Region. Certainly there is expertise in Community Health Assessments (CHA) at the Regional Health Authorities, and opportunities for partnership may be through a joint community health assessment or a mentoring relationship between the partner provincial RHA and FARHA. Within FARHA this would be led by the Community Health Surveillance and Support Unit, with leadership from the MOH and the Nurse Epidemiologist. Although many of the national surveys will not sample in the Island Lake region, information for

population health assessment can also be drawn from the First Nations Regional Longitudinal Health Survey, through partnerships with the Center for Aboriginal Health Research (CAHR) and/ or Manitoba Center for Health Policy (MCHP) at the University of Manitoba, and as it evolves through development of two separate activities: the First Nations Client Registry and the provincial electronic health record. In addition, FNIH remains a valuable resource for both the information that they hold as well as their expertise, and so there would be strong communication and collaboration with FNIH-MB Region.

It will be important to have a regional report, and as much as possible community level reports on a regular basis (perhaps each 5 years for a full report as with the CHA cycle). Appropriate attention will need to be paid to maintaining general privacy guidelines particularly for community level reports. In order to ensure that the reports are relevant to community health planning needs, a regional committee that includes representation from each of the four communities will be formed to inform the development of the population health assessment and implement the collection, analysis and response to the data collected. The committee will be chaired by the MOH and include representatives from FNIH, the partner provincial RHA and others as relevant (e.g. MHHL Health Information Branch or CAHR).

When health priority issues are identified where data is not available, the Community Health Surveillance and Support Unit will determine, in partnership with others, how to best obtain the data. This may include original data collection such as local surveys, from time to time. This will require additional funding as well as training, the latter of which is available through courses offered by the Statistics Canada Aboriginal Unit.

The population health assessment will be seen as an excellent opportunity to build the capacity of the communities to identify their own health information needs, and to collect, analyze and respond to health information.

As with the health surveillance plan, it is vital to being able to carry out population health assessment that the OCAP and privacy legislation issues are resolved in a way that is satisfactory to everyone. It is noted that in March 2010 there will be a national OCAP forum, and it is planned to have representatives from the MFN PHIPP attend and apply the lessons learned at the national forum in this work locally.

At this point, the ideal goal would be to do the first population health assessment in the final year of the PHIPP. As such, work would begin in Year 4 which would include:

- Forming the Population Health Assessment Committee;
- Doing preliminary education for the public health teams about what population health assessment is and why it is important and useful;
- Developing a framework for the Population Health Assessment and populating it with key indicators;
- Determining which of the key indicators are available and where, and which would require original data collection;
- Developing an implementation plan for Year 5 to obtain the data and write the reports.

Disease, Injury and Suicide Prevention And Population Health Promotion

Current Status

This is an area of identified weakness in the communities. These programs are often funded separately from the global health budget of the community, and there are often significant delays to receiving funding. As an example in the Year 1 Gap Analysis it was noted that Aboriginal Diabetes Initiative (ADI) funding was received for one year in February, so they were in a rush to post and fill the position. Positions lapse because of the fragmented approach to this funding. In addition prevention programs have funding variously distributed, that is some goes directly to the communities and some goes to FARHA who will then flow the money to the communities. There is a lack of teamwork across the Island Lake region, leading to isolated initiatives and workers in each community.

Current programs operating in Wasagamack include ADI (diabetes prevention and care), Canada Prenatal Nutrition Program (CPNP), and suicide prevention. All of these programs have 1 worker. They offer healthy cooking classes, diabetes counseling, teaching about nutrition, and suicide prevention.

In addition to a CPNP worker who does parenting classes, and sewing and cooking classes Garden Hill also has a Mental Health Therapist that visits 8 days a month, who sees patients on referral from the suicide prevention worker, and a suicide prevention team. There is a research based exercise team that develops a calendar of activities and occasional visits from a nutritionist.

St. Theresa has limited programming in these areas, with underlying concerns including resources, knowledge, and community concerns. There are independently operating Aboriginal Head Start and Early Childhood programs.

Red Sucker Lake has a suicide prevention worker and a CPNP worker who monitors prenatal patients. They also have independently operating Aboriginal Head Start and a daycare.

At the time the Year 1 gap analysis was written there were also HIV/AIDS prevention programs and community gardening projects operating in some of the communities.

Proposed Population Health Promotion in New Model

The goals of population health promotion and disease, injury and suicide prevention in the Island Lake Region are to reduce the incidence and/ or impacts of injuries, suicide and chronic diseases such as diabetes through public education, programs, and advocacy, and to increase the health and quality of life of the people.

At the February 8-9, 2010 Regional Public Health Team Meeting in St. Theresa Point there was agreement that the benefits to regionalizing the approach to population health promotion outweigh the downsides. Thus, a regional Population Health Promotion Coordinator position would be created, with the responsibility to lead health promotion activities in the region. The coordinator would work in collaboration with the health directors and frontline health promotion workers to develop a regional plan and budget for population health promotion each year. A balance between a shared regional approach to maximize teamwork and expertise and the need for flexibility to meet individual

community needs will be a key goal of this work plan. The frontline population health promotion workers would be the Community Health Representatives (CHRs).

In order to achieve this, a number of issues would need to be resolved, including:

- An adjustment from program based, individual community disease and injury prevention budgets to a regional health promotion budget. Note that the CHRs would remain as part of the community health budgets.
- A written and agreed to job description for CHRs that focused on population health promotion as their primary responsibility. The American Indian Health Service defines health promotion as “the provision of information and/ or education to individuals, families and communities that encourage family unity, community commitment, and traditional spirituality, that make positive contributions to their health status.” The World Health Organization defines health promotion as “the process of enabling people to increase control over their health and its determinants, and thereby improve their health.” These definitions highlight aspects of education, social marketing of healthy lifestyles, and advocating for changes in the environment that facilitate health and healthy living.
- FNIH developing ways to replace the functions currently played by CHRs in the nursing station.
- Enhanced visibility of FARHA in the communities, and perceived increase in regional support for community activities.

The Population Health Promotion Coordinator would work in partnership with the Capacity Development Advisor to increase skills of the CHRs for leading community-based health promotion; identify priority areas for action in the communities; develop or modify existing health promotion materials so they are locally and culturally relevant; and, evaluate health promotion and disease prevention activities.

Each program area would have an identified regional team lead from amongst the community workers in that area, for example a CHR from Garden Hill with a particular interest in diabetes and nutrition may lead diabetes prevention, whereas a CHR in Wasagamack with an interest in youth and sports may lead the injury prevention programs. This team leader, in collaboration with the Population Health Promotion Coordinator could plan regular regional meetings by teleconference or face-to-face when appropriate to further develop programs, plan regional events, discuss challenges and strategies in implementation, and assist with the program evaluations.

Youth health is an area that has been mentioned by the Elders and Youth Advisory Council as requiring more focused attention and approaches. A Youth Health Advisor could ensure that the appropriate focus is being given to youth health needs, in order to develop a healthy and productive population that is ready to participate in community life, parent, work, or play other important roles. The Youth Health Advisor would thus work closely with EYAC and the Population Health Promotion Coordinator to ensure that health promotion activities are appropriate to reach the youth, and where necessary targeted youth programs are developed and implemented.

The Mental Health Advisor would play a lead role in ensuring that health promotion activities include consideration of mental health needs, particularly given the high prevalence of mental health issues

including substance abuse amongst First Nations people. This is anticipated to increase the relevance of health promotion to the holistic understandings of health that many First Nations people have.

The MOH will provide strategic advice on programs but also play a significant role in developing and advocating for healthy public policies that support the goals of disease and injury prevention.

We would encourage and seek to enhance the existing programs like CPNP and Brighter Futures that encourage health pregnancies and early childhood development.

Infectious Disease/ Communicable Disease Control: Immunizations

Current Status

Raising immunization rates to above the national standard is one of the local project goals, and remains a priority concern for each of the four communities. The following excerpt is taken from the Year 1 deliverable "Manitoba First Nations Public Health Improvement Pilot Project Gap Analysis."

> *In three of the four communities the lack of consistent and adequate public health nursing staff hampers the immunization programs. Issues related to the recruitment and retention of nursing personnel have varied over the 4 years since transfer; however, inadequate resourcing is currently cited most frequently. Immunization rates in two of the four communities have fallen significantly behind due to insufficient nursing staff. Compounding the human resource issue is the addition of new vaccines e.g. the addition of varicella and meningococcus since the time of public health transfer and the anticipated roll out of HPV later this year. Workload increases such as these significantly impact the communities' ability to successfully deliver mandated programming. The lack of direct access to MIMS in the communities results in an inability to obtain accurate and timely vaccine information; yet another impediment in the process of delivering efficient, effective public health programming in the region.*

Since the time the Gap Analysis was written in Year One (2007-8) of this project, improved access to MIMS through the internet improves the potential ability of communities to directly access MIMS. However, the lack of the ability to identify all First Nations patients within the MIMS database continues to hamper the accuracy of First Nations immunization rates. An operating First Nations Client Registry would improve this. In the interim updating MIMS is done on an annual basis by Field Surveillance Officers on placement with FNIH from PHAC using manual reports from nursing stations and health centers, as well as the data that is available using MHSC Registered First Nations (generally estimated to be about 65% of all First Nations).

Although immunization is a recognized public health function and public health has been transferred to the communities, FNIH primary care nurses remain integral to the immunization programs. Particularly when there is the absence of public health nurses, or when there just aren't enough, FNIH nurses perform immunizations, fill out the MIMS paperwork and submit to the FNIH regional office for inputting into the MIMS database. This regional employee can also take inquiries on a case-by-case basis regarding an individual's immunization status. These FNIH nurses report to nursing supervisors at the regional office, and have no connection to the public health nurses or the Regional Public Health Coordinator. In two of the four communities the FNIH nurses run well baby clinics which are a key opportunity for immunizations to be given. MIMS information is used to send

reminder letters are sent by the province to parents directly at key age milestones if their children are behind in their immunization coverage.

When present in Garden Hill, the public health nurse has the primary responsibility for doing immunizations, and will go with a CHR to the school to do the school based programs including Hepatitis B in Grade 4 and HPV for Grade 6 girls.

In Wasagamack the public health nurse does immunizations of babies, school age children and adults at the clinic. FNIH also has well baby clinics once a week where immunizations are given, and FNIH also does the BCG vaccinations. The CHRs assist the immunization program by calling people when they are due for immunizations and Medical Transportation will pick them up if transportation is needed.

In Red Sucker Lake immunizations are done primarily by the FNIH nurse except when they have a visiting public health nurse, which happens three times a year. FNIH also has a well baby clinic, and tracks when people are due for immunizations. The CHRs will contact the patients that are due for immunizations.

In St. Theresa Point immunizations are coordinated by the public health nurse, with a public health assessment doing the MIMS reporting. FNIH also has a weekly well baby clinic. The CHRs review immunization cards and notifies the public health nurse of people who are due for immunizations. The public health nurse does school based programs like Hepatitis B, and FNIH nurses will occasionally do special clinics such as for influenza vaccination.

Proposed Immunization Program in New Model

The goals of the Immunization Program are:

- Develop a more coordinated approach to the immunization program, as a core component of public health;
- Enhance regional and community capacity to run the immunization program;
- Ensure appropriate “info-structure” (i.e. the mechanism to record, aggregate, and analyze immunization related data) is in place at the regional and community level through the existing planned initiative Panorama; and,
- Increase immunization rates across the region to above national standards (coverage over 95%).

Multiple people from more than one jurisdiction will continue to be involved in the delivery of the immunization program, but hopefully enhanced coordination at the regional level and across jurisdictions will address the concerns regarding low immunization rates.

The Community Health Nurse Specialist will function as the Regional Immunization Coordinator, leading implementation of the immunization program, sharing resources and information from the provincial network of immunization coordinators, convening and communicating with all others involved in the delivery of immunizations, liaising with the Regional MIMS Clerk (whether at FNIH or in the future at FARHA) and, when available, the Nurse Epidemiologist to monitor the success of the immunization program, and providing support to the frontline staff as needed. By having a

Regional Immunization Coordinator with close relationships to the provincial network, the Immunization Coordinator of the partner provincial RHA and the Public Health Division of MH, there will be a more direct line of timely information flowing through the Island Lake Region to the communities. It will also increase the networking opportunities and allow for sharing of strategies to boost immunizations in resource-challenged settings.

The Nurse Epidemiologist will be responsible, with the assistance of the Medical Officer of Health, and linking to Health Information Analysis and eHealth First Nations and Inuit Program from FNIH-MB Region and from Manitoba Health to provide an annual update on immunization rates. The Medical Officer of Health will be available as a resource to the Regional Immunization Coordinator as needed to answer questions, and also to communicate from MOH teleconferences and other sources new information about immunizations and the provincial immunization standards. The MOH, in serving only these 4 communities, will be more available to respond to these requests and provide leadership, than the current arrangements allow.

The Regional Immunization Coordinator will convene regular immunization team meetings to monitor the program and provide a forum to raise and address issues. Other members of the immunization team to be included are:

- Regional Public Health Coordinator
- Medical Officer of Health
- FNIH-MB Region Nurse Managers or Nurse-in-Charge at the Nursing Stations
- Public Health Nurses from the 4 communities
- FNIH Immunization Coordinator

The role of the Regional MIMS Clerk would be to:

- Perform regional and community level inquiries under the direction of the Immunization Team or request reports from MHHL (e.g. missing MMR+ Varicella immunizations for all children in each community born between January 1, 2003 and December 31, 2003);
- Perform MIMS inquiries as needed for public health nurses (PHNs) or primary care nurses (PCNs) (e.g. a 7 year old child who recently moved to the community presents with a dog bite and the PCN needs to know when the last tetanus was); and,
- Update MIMS records as community level workers supply the MIMS recording sheets.

Although the role of MIMS Clerk is currently fulfilled by someone at FNIH-MB Region, it is seen as a necessary step in transferring public health program and service delivery to the communities, increasing the visibility and importance of e-health and health information at the community and regional level, and increasing capacity at the regional level to participate in e-health and health information activities. The FNIH immunization data clerk would remain available to support immunization data reporting in the Island Lake region, so careful thought needs to be given when implementation begins if the Regional MIMS clerk could take this over completely aside from vacation and/or sick time or if the workload related to MIMS is too great and needs to be shared.

At the community level, the following employees and their roles are listed.

- *Public Health Nurses*: work in concert with public health staff and primary care nurses to immunize children as needed and document in charts and on MIMS records, submit MIMS records to health clerk.

- *Primary Care Nurses*: work in concert with public health staff to immunize children as needed and document in charts and on MIMS records, submit MIMS records to health clerk.
- *CHRs*: assist with identifying children who are missing immunizations under the guidance of the immunization coordinator or supervisor; assist with improving public awareness of need for immunization and immunization campaigns; assist as directed in getting people into the health centers for their immunizations.
- *Health Clerks*: assist with identifying children who are missing immunizations under the guidance of the immunization coordinator or supervisor; schedule appointments for immunization; and, collect MIMS records from the public health nurses and primary care nurses and submit the records to the Regional MIMS Clerk.

Anticipated Challenges

The sharing of health information at the regional level with FARHA has been raised as a current barrier to implementing some of these recommended changes, because of the interpretation of the Personal Health Information Act (PHIA) and consideration of FARHA as outside of the circle of care. This will be a common challenge for many of the public health activities, and is a priority to discuss and resolve.

Health Protection: Infectious Diseases (Tuberculosis and Communicable Disease Control)

Current Status

TB and other communicable diseases are handled differently. The reports of notifiable communicable diseases go from Manitoba Health to FNIH-MB Region and then to the FNIH primary care nurses who arrange appropriate treatment. If needed, the case is then referred to public health for follow-up, for example contact tracing. This has been described above in the health surveillance section.

For tuberculosis the Winnipeg Regional Health Authority has a significant role to play with respect to case and outbreak management under the provincial policy and standard setting of the Manitoba Health Public Health Division Tuberculosis Unit which is part of the provincial Communicable Disease Control Branch. At the community level treatment and Mantoux testing is done by the FNIH nurses, with assistance from CHRs and Directly Observed Therapy (DOT) workers).

Proposed Communicable Disease Control in New Model

This has been described as follows in the section on health surveillance, given the close relationship between the two activities. There are three main positions at the FARHA level who will implement the health surveillance strategy, as will be illustrated by discussion the flow of information (notification of a reportable disease) through the system. The CDC Nurse will receive the report of the notifiable disease from MH and refer it to the public health nurse in the appropriate community for follow-up which may include treatment and/ or contact tracing. The public health nurse will involve community level employees, such as the CHRs, as appropriate for follow-up (for example if it's an enteric pathogen that requires further investigation as to the source of the infection). The CDC Nurse will be responsible for maintaining a secure record of the infection, recording after the appropriate follow-up has occurred, and the relevant reporting back to MH. The CDC Nurse will

advise the Public Health Nurse as needed should difficulties arise with the follow-up needed and involve the MOH when needed.

Proposed Tuberculosis Control in the New Model

There have been recent changes in tuberculosis control in the Island Lake Region, so at this point it does not seem wise to try to again change the TB control program. This is something that could be re-evaluated as the five year cycle of the pilot project closes, based on successes and lessons learned in other areas of public health.

Health Protection: Environmental Health

Current Status

At present two Environmental Health Officers (EHO) stationed in FNIH regional office in Winnipeg provide the equivalent of .75 staff years of services to the four Island Lake communities. The main community level employees working in concert with them are Water Technicians, although other staff such as CHRs and Public Health Nurses do attend to environmental health issues in their normal work days. For example, in Red Sucker Lake referrals for housing assessments are sent to the CHR and the Health Authority who do the initial assessment, and then refer the cases on to the EHO.

The booklet "Your Environmental Health Program" provides specific information on First Nations Environmental Health Activities that are carried out by Environmental Health Officers in the following areas:

- Community Water Quality
- Private Water Quality
- Community Sewage Disposal
- Private Sewage Disposal
- Solid Waste Disposal
- Food Quality
- Institutions
- Special Events
- Recreational Facilities
- Communicable Disease Control (water, food and vector-borne diseases)
- Pest Control
- Housing
- Environmental Contaminants
- Occupational Health and Safety

The activities described are varied and include sampling and analysis, inspections, staff training, corrective recommendations etc. The EHO visits Wasagamack four times a year to do housing and facility inspections and well as food quality inspection at the Northern Store. In between visits if a concern is brought forth a CHR will investigate the complaint. The water technician is employed half time, and samples public places, homes and water wells. The housing and waste disposal are under the band's supervision.

The EHO visits Garden Hill at least once a month to follow up on referrals from the community for issues such as mold infestation or to perform facility inspections. The Water Quality Monitor works half time and collects four samples each day from Monday to Friday. Most of the community homes use portable cisterns that are maintained/ inspected by the First Nations Band Water and Sewage program.

In St. Theresa Point there is a water monitor, and the band is responsible for housing, facilities and waste disposal. The housing authority does attend to housing issues related to health such as mold by sending referrals to the CHR or EHO.

In Red Sucker Lake environmental health referrals are made to the health authority, who address the issues (CHRs do this) and then report to the Chief and Council. The Water Quality Monitor works closely with the EHO, and does random tests at homes and public places. The band is responsible for waste disposal and facilities inspections, except when the facility inspection is related to a person with disabilities, which would then go to the health authority to do the initial assessment.

There is no environmental health focused position at the FARHA level.

To date the main pilot project activity has been gathering basic information on what environmental resources exist and clearly stating a desired outcome to improve environmental services and outcomes within the four communities.

Proposed Environmental Health Program in New Model

In order to enhance environmental health and build capacity both at the community and regional levels, an environmental health advisor will be hired. This individual would lead a collaborative environmental health committee which might include the project's Public Health specialist, a Board member, a community Health Director, one or more community level employees working in or interested in environmental health, and FNIH's Regional Environmental Health Manager. The Environmental Health Advisor's main objective would be to recommend to the Technical Working Group practical steps to be pursued within the project's remaining time frame to improve the level of environmental health services and their integration within the existing First Nation public health services. This would also include the exploration of potential ways to collaborate with the partner provincial RHA, the provincial Public Health Division, and Manitoba Conservation and Water Stewardship. In addition they would recommend potential actions to increase community engagement in environmental health. Finally, it would be expected that the Environmental Health Advisor and the committee, would lead advocacy efforts on issues like housing and water supply. The Elders and Youth Council has mentioned multiple environmental health issues that a regional level employee in Environmental Health could help address and advocate for resolution, including concerns about contamination of sites in the community. Building expertise in tools such as Health Impact Assessments would assist in these advocacy efforts.

Emergency Preparedness

Current Status

With the events of the past year, mainly the effects of pandemic H1N1 influenza significant attention has been paid to emergency preparedness in the Island Lake regions, with advances made on planning and response at both the community and regional levels. Support has been given to this through FNIH, as well as through training workshops held by Provincial/ Territorial First Nations organizations (PTOs). During H1N1 each community identified a pandemic coordinator, and the Regional Public Health Coordinator had her work re-scoped to focus on supporting the community pandemic planning and responses. Thus, the experience of pandemic H1N1 influenza has taught valuable lessons in emergency preparedness in the Island Lake region.

With the pandemic response, financial support and technical support was provided by FNIH-MB region. Guidelines for public health measures, immunizations, and clinical care were set by Manitoba Health and applied in the First Nations communities. Concerns of the First Nations were represented to the province by the involvement of PTOs and FNIH-MB region on various provincial incident command structures.

In addition to the pandemic response Garden Hill and Wasagamack have Emergency Response Teams and plans for other hazards such as forest fires. Red Sucker Lake and St. Theresa Point both identified the need to update their Emergency Preparedness plans.

Proposed Emergency Preparedness in Future Model

In the new model of program and service delivery the communities would still need to have community response plans and a community response coordinator. However, the role of the regional staff would be enhanced. The Regional Public Health Coordinator would be responsible for ensuring both the regional and community plans are up to date, and will work well together. The MOH will provide technical advice on the plans as needed, and also be the main liaison between provincial level planning and response and the regional/ community plans. The MOH will communicate the most up to date information, and lead discussions as to any necessary changes to community/ regional plans and responses. As with other notifiable communicable diseases, reports of cases in the region will be received by the CDC nurse, and referred on as appropriate and described in the health surveillance section.

Appendix F: Legislative review submitted by Krista Yao of Nadjiwan Law Office dates March 26, 2010

Nadjiwan Law Office Barristers & Solicitors 915 Jocko Point Road, RR4 Nipissing First Nation North Bay, Ontario P1B 8G5 Ph: (705) 753-9815 Fax: 1-866-280-9174 e-mail: mail@nadjiwanlaw.ca Patrick M. Nadjiwan, H.B.S.W., LL.B. Krista M. Yao, B.A. (Econ.), LL.B.
March 26, 2010
By E-mail
Dr. Kim Barker
Assembly of First Nations
Health and Social Secretariat
Dear Dr. Barker:
RE: FIRST NATIONS PUBLIC HEALTH PILOTS –MANITOBA'S *PUBLIC HEALTH ACT*
I was asked to review Manitoba's new *Public Health Act* with a view to identifying potential opportunities and barriers that may exist in relation to the Manitoba First Nations Public Health Improvement Pilot Project model for public health program and service delivery. In this opinion I will first describe how the provincial *Public Health Act* can apply within First Nation communities (on-reserve), and then proceed to three areas of potential impact upon the pilot project model.
Application of *The Public Health Act On-reserve*
Prior to considering potential impacts of the new *Public Health Act* on the public health pilots, it is important to consider how the Act applies in First Nation communities, and what limitations may exist.
By virtue of the *Constitution Act, 1867* and section 88 of the *Indian Act,* provincial laws of general application apply "to and in respect of Indians" except in the following circumstances:
• If any provision of the law conflicts with an existing federal law, the *Indian Act*, *Indian Act* regulations, and band by-laws, that provision will not apply. To the best of my knowledge, the new *Public Health Act* has no such conflict. However, individual First Nations would have to be queried to see if they have any conflicting laws or band by-laws. As well, if Parliament were to ever enact a law or regulations (such as the repealed Indian Health Regulations), then there could be a conflict and the federal enactments would supersede the provincial.

• If a provision attempts to regulate Indians as Indians, or attempts to regulate the use of Indian (reserve) land, it will not apply. For example, the province cannot pass legislation that directly regulates traditional healers. The new *Public Health Act* gives the Lieutenant Governor in Council authority to make regulations "respecting the location, construction, maintenance, sanitation and operation of public accommodations, camps, resorts, and public attractions involving animals" (s.112(1)(u). Those regulations may not apply on-reserve.

It is worth noting that several other provisions of *The Public Health Act* could potentially affect the use of property (on-reserve) and thereby not apply. For example, s.26(1)(g) allows public health officials to issue a health hazard order requiring a person to "construct, excavate, install, modify, replace, remove, reconstruct or do any other work in relation to a place or premises, or a thing." It is possible that such a provision would not apply on reserve because it could be characterized as controlling the use of Indian land.
Accordingly, public health officials and First Nations should be aware of the potential conflict, and understand that they will have to deal with them according to the facts, on a case by case basis.
• Provisions of *The Public Health Act* also will not apply if they unreasonably infringe upon any existing Aboriginal and/or treaty rights. I can see no obvious infringement in the legislation, but it is possible that in applying certain sections, there could be a potential infringement. For example, if a quarantine or isolation order prevented someone from accessing traditional medicines, there could be an infringement. Again, this would have to be considered on a case-by-case basis, according to the fact situation presented.

Finally, it is possible that some provisions of *The Public Health Act* will not apply to First Nations or in relation to reserve land simply because the legislation deals with specific geographic areas, or where powers are given to certain bodies (i.e. municipalities) only. For example, regulations under *The Public Health Act* gave the City of Winnipeg authority to appoint public health inspectors. That provision would have no impact on First Nations. As well, under the new legislation regional health authorities or the Minister can enter into agreements with municipalities for public health officials to enforce municipal by-laws. There is no equivalent mechanism in the statute to enforce First Nation by-laws. Therefore, those provisions would have no impact (either positive or negative) for First Nations.
In summary, it would be fair to say that *The Public Health Act* will apply on-reserve for First Nation communities. Public health officials appointed under the Act generally have authority on-reserve. However, in some cases it is possible that there may be a conflict, and *The Public Health Act* provision will not apply. Those cases will typically be: where there is a conflicting

federal law or band by-law, where there is an impact on Aboriginal and/or treaty rights, or where the result is to regulate the use of land on-reserve.

The *Public Health Act*: Impact on Public Health Officials

There were a number of limitations in the old *Public Health Act* (PHA) that resulted in gaps for First Nations. Many of those limitations have been resolved in the new legislation, including:

• Under the previous PHA, the province (or regional health authority or municipality) was required to pay remuneration to all medical officers of health, inspectors, and public health nurses. With limited budgets, resources were not prioritized to on-reserve needs. As well, this remuneration requirement prevented appointment of existing First Nation (or FNIH/FNIHB) employee as public health officials.

The new *Public Health Act* says nothing about remuneration. Removing this requirement should open the door to provincial appointment of existing First Nation/federal public health professionals that can be fully integrated within the provincial public health system, and to other arrangements where funding comes from an alternative source.

• The old PHA gave responsibility for appointment of public health officials (medical officers, public health nurses, inspectors) to regional health authorities and/or municipalities. By linking public health officials to a particular region, it created limitations on possible First Nation public health officials, where First Nations across regions could share resources; and it lead to 'natural' preferences for non-First Nation communities in the region.

The new *Public Health Act* gives the Minister authority to "appoint or designate" medical officers, inspectors, public health nurses, and investigators. By removing mandatory linkages to regional health authorities, it should provide much greater flexibility for First Nations to create their own relationships with other First Nations, other regional health authorities, and directly with the province. It should also allow First Nations to prioritize the delivery of public health services by public health officials to their own communities.

Removal of the mandatory provincial payroll and increased flexibility to move away from regional linkages into a more centralized approach should fit the Manitoba First Nations Public Health Improvement Pilot well. It will permit public health officials to operate within First Nation communities in a dual role: with necessary provincial jurisdiction under the PHA, as well as with federal jurisdiction through authority of FNIHB and/or the First Nation. This should facilitate the integration of public health administration and services as contemplated by the pilot, and permit a governance structure based upon the First Nations' model.

For example, a communicable disease control nurse or a nurse epidemiologist as contemplated within the Community Health Status and Surveillance Unit could also be designated by the province as a public health nurse - resulting in greater potential authority and jurisdiction, as well as potentially easier exchanges of provincial public health information.

Moreover, the new legislation creates additional designations for public health officials which carry some functions of medical officers of health, but which do not require that the individual be a physician. For example "health officers" have many of the same authorities as medical officers - but do not need to be physicians. "Investigators" are also described and given certain administration and enforcement functions within the legislation. This increased flexibility in the roles of public health officials could present more options for First Nations to deal with public health human resourcing challenges.

There is one additional factor that should be noted that arises from appointing or designating FNIHB or First Nation staff as provincial public health officials, and that is found in sections78 and 79 of *The Public Health Act*.

Information about public health threat

78(1) The chief public health officer may require any person to provide information that the chief public health officer reasonably considers necessary to assess the threat that a disease presents to public health, and to plan for and deal with the threat.

78(2) The chief public health officer may, in writing, authorize a director, medical officer, inspector, health officer, public health nurse or regional health authority to collect the information required under subsection (1) on his or her behalf.

79 A person required to provide information under section 78 must do so.

According to the above sections, any public health official appointed under the Act must collect and disclose information for the chief public health officer if the chief public health officer considers it necessary. This would be a mandatory disclosure, even if the First Nation community (or FNIHB) did not want the information disclosed; or if there was some other interest in withholding the information, that the community thought should prevail. This probably would not be a significant issue in the future as it is already an existing conflict with FNIHB collection of First Nation data, but First Nations should be aware of the mandatory requirement, and the inability of the First Nation to limit or control disclosure or a community's public health information in this particular circumstance.

***The Public Health Act*: Information Sharing**
A concern has been expressed that the Regional Public Health Coordinator at FARHA does not routinely receive reports of notifiable diseases. While this type of communication was permitted under the old *Public Health Act* (although perhaps not recognized) the new legislation also explicitly authorizes the communication, under sections 80 and 81:
Information sharing: minister and chief public health officer
80 For the purpose of assessing the impact of, and planning for and dealing with, a threat to public health, the minister or the chief public health officer may disclose information to each other and to any of the following:
(a) a director, medical officer, inspector, public health nurse or health officer;
(b) a government department or government agency;
(c) an educational body, health care body or local government body as defined under The Freedom of Information and Protection of Privacy Act;
(d) a department or agency of the Government of Canada or of another province or territory of Canada;
(e) a person or entity designated by the Government of Canada or by the government of another province or territory of Canada as being responsible for public health services;
(f) a band as defined in the Indian Act (Canada);
(g) the government of a foreign country, or of a state, province or territory of a foreign country;
(h) an organization representing one or more governments, or an international organization of states.
Information sharing: medical officers, etc.
81 Subject to the regulations, for the purpose of administering or determining compliance with this Act, a director, medical officer, inspector, health officer or public health nurse may disclose information to any person described in the regulations.
The relevant regulations are found within The Public Health Act, Information Sharing Regulations (30/2009):
Information sharing: director, medical officer, inspector, public health nurse
2(1) For the purpose of administering or determining compliance with the Act, or a municipal by-law pursuant to an agreement under

subsection 21(1) of the Act, a director, medical officer, public health inspector or public health nurse may disclose information to any of the following persons:
(a) the chief public health officer;
(b) a director, medical officer, public health inspector, public health nurse or health officer;
(c) a health professional;
(d) a health care body as defined under *The Freedom of Information and Protection of Privacy Act*;
(e) a person who carries out responsibilities or functions similar to those carried out by any of the persons described in clause (b) for or on behalf of
(i) an Indian band,
(ii) the Government of Canada or an agency of the Government of Canada,
(iii) the government of a province or territory of Canada, or an agency of such a government,
...

We can see that the minister, the chief public health officer, a director, medical officer, inspector or public health nurse are all authorized to release information to health professionals, on behalf of a First Nation. There is no rationale for preventing the flow of information from public health officials for the province, to either First Nations or their health staff (which may also include provincially-designated public health officials) provided it is for purposes of administering the Act – which purposes are sufficiently broad. Given that there are no legal obstacles to sharing public health information, any ongoing difficulties could be addressed through communication protocols or other policies. Certainly, in all of the documentation and promotion of the new legislation, Manitoba stresses that it is now able to react more quickly and appropriately to public health concerns. One of the elements of quick reaction is to information the proper people. The new Act could be used to facilitate to more open information sharing, and inclusion of First Nation health authorities.

The Public Health Act: Health Surveillance

The Manitoba First Nation public health improvement pilot draft describes a new model with collaborations between the Community Health Status and Surveillance Unit, federal and provincial partners, and possibly a regional health authority partner. The new *Public Health Act* may facilitate the linkages and authorities that are contemplated under the draft model. However, the legislation may also contain some limitations on future roles for First Nations.

Subsections 82(3) and (4) state:

Trustee may be designated to maintain a registry
82(3) Subject to the regulations, a registry forming part of the provincial health surveillance system may be established, maintained, or both, by a person who is a trustee under *The Personal Health Information Act* and who is designated in the regulations for this purpose.
Collecting, etc. information for system
82(4) For the purposes of the provincial health surveillance system, the minister, and any person authorized by the minister, may
(a) obtain or collect information from any source;
(b) use, analyze and interpret information in the system;
(c) link information in the system with other information, whether the information is in the system or outside of it; and
(d) disclose information in the system.
Neither First Nations nor First Nation health authorities (including FARHA) are included as "trustees" under *The Personal Health Information Act*. As a result, according to subsection 82(3) they would never be able to "establish or maintain" a provincial health surveillance system. This may limit future aspirations of a First Nations information system that is integrated into a provincial system.
On the other hand, the role of First Nations can be expanded within a provincial surveillance system, through subsection 82(4) wherein the minister may authorize any person collect, use, analyze, interpret, link and disclose information in the system. Since there are no limitations on what type of "person" may be authorized by the minister, it could include First Nations and First Nation health authorities. There is no requirement similar to subsection 82(3) that the person be a trustee or be somehow designated in regulations. This provision could potentially be used to allow First Nations to participate in and take advantage of provincial health surveillance tools and systems for their own surveillance needs. For example, it could allow First Nations, Tribal Councils or FN organizations to access and analyze data within future applications such as Panorama.
On the other hand, while subsection 82(4) can facilitate the participation of First Nations within a provincial health surveillance system or registry, we cannot neglect the fact that it could be used by the province and others to access First Nations data. The concern would be that if First Nation identifiers are attached to individual information contained within a health surveillance system, that the minister would have full authority to use, link, interpret and disclose First Nation-specific information, without First Nation consent. This would be inconsistent with OCAP principles. It is important to note that the provision in 82(4) is optional; the minister "may" authorize any person, etc. Therefore, it is still open to First Nations to assert their rights and governance over information with First Nation identifiers.

In summary the new *Public Health Act* addresses some significant gaps, particularly related to appointment of public health officials. The changes provide more flexibility in relation to roles and employment, which fit well within the draft MFNPHIPP Model, and should also assist First Nations in meeting some of their resourcing challenges. These changes, and other described above should facilitate development of partnerships and sharing of information that form part of the draft model. They will allow for integration of First Nations into the provincial public health system, including provincial public health surveillance systems.

At the same time, it is important to be aware that with increased integration and partnership, there may be impacts upon the ability of First Nations to control and limit use and disclosure of First Nation information. Those limitations can be addressed in many ways, such as through data sharing agreements and communication protocols. For other limitations, for example, in instances where disclosure is mandatory, First Nations will have to balance for themselves whether the overall public health and community benefits of the partnerships and integration, offset some loss of control.

I would be pleased to respond to any questions or comments.

Sincerely,

Nadjiwan Law Office
Digital Signature
Per: Krista M. Yao
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Appendix G: Follow-up communication with Krista Yao with questions arising from TWG about legislative review

We went through the legislative review at the last TWG and there were a number of questions raised. I said I would communicate those questions to you, and ask if hopefully you could provide both a written response and attend our next meeting to go over them and answer any further questions that arise. Our next meeting is scheduled for May 18th. The questions included:

1. Are there any by-laws in the 4 communities regarding public health that may interfere with the public health act? (Hazel will also be asking the chiefs this).

   - I doubt it. All Indian Act by-laws are registered with the Department of Indian Affairs (INAC), since INAC has the authority under the Act to reject them. I contacted INAC about 1 year ago and they advised that they have never had any public health by-laws filed by any First Nation. However, the best way to be sure would be to ask the Chiefs, as Hazel is doing.

2. Do BCRs have a different legal status than by-laws in this review?

   - BCR's are simply an expression of the will or direction of Council. If it's a tribal council, they are often referred to as TCR's. They signify that a decision has been made or a direction been ordered. BCR's are necessary for Band Councils to enter into contracts, amongst other things. On the other hand, by-laws have the force of law, and can be enforced in court. Band by-laws can be enforced with quasi-criminal sanctions – including fines and even imprisonment. If provincial laws are inconsistent with Band by-laws, the by-law will prevail. This has happened, for example, in Ontario in relation to provincial non-smoking laws. If a First Nation enacts its own non-smoking by-law that is inconsistent with the provincial law, the provincial law has no effect, to the extent of the inconsistency.

3. On page 5 in describing information sharing you have underlined "a band as defined in the Indian Act" as a party that the minister or CPHO could disclose information to. However, FARHA is not an Indian band, so we weren't sure if that applied. On the other hand, we think it meets the definition in criterion e "a person or entity designated by the Government of Canada or by the government of another province or territory of Canada as being responsible for public health services."

   - Correct, FARHA is not an Indian band. However, there may a way to format information sharing so that an agreement includes the individual First Nations as parties (together with FARHA), which could trigger the section. The second definition regarding a "designated entity" is possible. However, that would require the Government of Canada, or the province to actually "designate" FARHA – which may be a difficult and bureaucratic process.

4. What information is included in what can be disclosed? Does this include nominal, individual health reports; only non-nominal-summary data, etc?

   - For the purposes of the Public Health Act (and regulations) "Information" includes personal information, personal health information, proprietary information and confidential information. Basically, this means the type of information that is protected by existing privacy laws. So it includes nominal, individual health reports. There are no restrictions under the Act on sharing non-nominal summary or aggregate data – provided that it is not possible to identify any individual (for example, where cell sizes are very small, in a small community).

5. we all found page 7 confusing, and weren't sure what the overall messages were as it pertains to a First Nations body participating in health surveillance and/ or developing a client registry that will interact with the provincial client registry.

   - Sorry about the confusion. I'll try to explain it in another way, and provide more details on implications.

   Because First Nations or First Nation health authorities are not defined as "trustees" under PHIA, they would not be able to be the custodian or administrator of any part of a provincial health surveillance system. This would preclude arrangements that may otherwise allow a First Nation health authority, like FARHA, to own and manage its own database, that is linked to a provincial surveillance registry. In other words, it would limit FARHA from aspirations that it may have, to own and control its own health surveillance system, that is linked or part of provincial surveillance registries. FARHA can only be 'participants' in a provincial health surveillance system, and will not be able to be custodian or administrator of any part of the system.

   I'm not sure how this will impact upon a FARHA client registry with intended links to the provincial client registry, for a few reasons: (a) I'm not sure if the provincial client registry would be considered a "health surveillance system". It would depend upon what information is contained within the provincial registry, and what is the purpose of the registry; (b) The limitation would only apply if the First Nation client registry was considered to be "part" of the provincial registry. The Act does not provide details on what conditions would make a registry "part". The Ministry of Health should be able to provide its own interpretation.

   I can't answer your questions definitively, because much depends upon the Ministry of Health's interpretation. However, it is important to recognize that s.82(3) of the new Act may impact upon the ability of FARHA to be a custodian of an integrated or linked client registry. The exact impact will depend upon Manitoba's position, given the actual data flow and linkages for a registry.

   The previous discussion addressed limitations on FARHA's ability to be a "custodian" of a registry or database. On the other hand, s.82(4) of the new Public Health Act says that the Minister may authorize "anyone" to *collect, use, link and disclose information contained in a provincial health surveillance system*. So although FARHA may not be able to be the custodian of the data, it would still be able to collect, use, link and disclose information – provided that the information is held somewhere else.

   From a practical perspective, this may mean that FARHA cannot be the custodian of its own data (if you want it to be "part" of a provincial health surveillance system). But this does not seem to prevent FARHA from entering into a service agreement with a designated custodian (under s.82(3)) – for the same purpose. This type of option would still allow FARHA to access and use the data for its own purposes (provided authorization is obtained under s.82(4)). And it would still allow FARHA to control third party access, use and disclosure of the data – through terms of the service agreement. Basically, it just limits who may be the custodian. If you recall from the OCAP Forum in

March, this service-agreement model is used by the Tui'kn Partnership in Nova Scotia, for their First Nation client registry.

Thanks.