CIRCUMPOLAR VOICES

Transcending jurisdictions: developing partnerships for health in Manitoba First Nation communities

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ABSTRACT

The article describes national, regional and community-level activities that contributed to the Manitoba First Nation partnership in maternal and child health programming. The activities reveal a potential for health change that is possible through working together across jurisdictional boundaries. Although we are only in the early phases of program implementation, the Manitoba First Nation Strengthening Families Maternal Child Health Program already suggests considerable successes and measurable outcomes. The article encourages development of further partnerships in the promotion of First Nation health and wellness programming.

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Canada laying the foundation for First Nation maternal child health

An overwhelming volume of Canadian research in the past several decades has reported on the massive health and social disparities that see First Nation women and children at the bottom end of the scale on every scientifically conceivable measure of well-being. Whether on- or off-reserve, compared to other Canadians and to First Nation men, First Nation women and children carry the heaviest burden of poverty, illness and disease. The inception of the Manitoba First Nation Strengthening Families Maternal Child Health Project is pivotal in addressing this situation and in doing what needs to be done in order to change the discourse and reality for wellness. The project came to life at a remarkable time in Canadian political history, when governments at every level acknowledged not only that the disparities exist but also that in order to change
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the matter a coordinated effort would be required to address health, underlying governance structures and jurisdictional disputes. Events that transpired between 2004 and 2011 are important to First Nation maternal–child health programming because they indicate commitment to joint-capacity development and health improvement.

Between 2000 and 2005, federal, provincial and territorial governments commenced a flurry of activity towards the development of a Blueprint for Canadian Health. As fundamental as these discussions were to a transformation of health for Canadians, the discussions excluded the First Nations. The Council of the Federation, composed of provincial and territorial premiers, meets annually to discuss reconciling Canada’s fiscal imbalance and addressing population health care issues. Since 2000, the First Ministers Health Accords (involving both the Council of the Federation and the Prime Minister) have been translated into substantial funding commitments. For example, in 2004, the Accord focused on fixing the problems of the health care system. At the meeting, a 10-year plan was presented, focusing on quality, accessibility and sustainability (1).

Across the country, health service governance is rapidly becoming regionalized and there is a policy shift towards enhancement of community-based care. There is a focus on improving efficiency, effectiveness, access, quality and accountability within health delivery. Additionally, there is a growing desire by citizens to participate in decision-making that concerns their health care (2). There is great consensus regarding health care needs within the general Canadian population and, statistics reveal, that these issues and others are even more pressing for First Nations. The criticality for inclusion of First Nations was indicated for several reasons:

- The 2006 Canadian Census enumerated 698,025 people of First Nation descent; that is, the size of the Canadian First Nation population exceeds that of the total population of 4 Canadian provinces;
- Historical relationship and fiduciary responsibility of the Canadian government for the well-being of First Nation peoples;
- Treaty and inherent rights in the Canadian Constitution, section 35;
- First Nation governments have a major responsibility to deliver health services in their communities; and
- First Nations have the power to exercise jurisdiction and authority to make by-laws in public health and safety. (1)

Responsibilities of Canadian and First Nation governments translate into necessary determinants of health and social wellness. Research on population health promotion suggests that the wellness of communities and individuals relies on encouraging them to become involved in education, employment, ecological activities, culture/traditions and lifelong learning. All of these are critical to their health and wellness. These notions move from theory to action in the operations of the Maternal Child Health Project.

Other events were also central to preparing the stage for the Maternal Child Health Project. Both the Royal Commission on Aboriginal Peoples in the mid-1990s and the Romanow Commission of 2001 were significant national initiatives that raised implications for government relations concerning health care. Both recommended greater consolidation of funds targeting First Nations, allowing for greater flexibility in addressing community and regional priorities. Both recommended that partnerships be developed among all parties involved in delivering
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health to First Nations. Ultimately, the recommendations envisioned an improved continuum of care for First Nation communities.

The historic Canada-Aboriginal Peoples Roundtable held in 2004 elevated the profile of First Nation interests. The Roundtable represented an unprecedented opportunity for members of the Federal Cabinet Senate and House of Commons to engage with Aboriginal leaders in a new relationship following the principle of collaboration with an intension towards “real” transformation.

Later in 2004 and for the first time, Aboriginal leaders participated in a special meeting with the First Ministers to discuss health priorities. While the notion of transformative change remained abstract, it referred to a change in the Canadian political system generally, and the health system particularly, at its core, so that the root causes of health disparities are corrected. This contrasted the previous policy of affirmative action, which was essentially a Band-Aid solution that left underlying problems unaddressed.

A 2005 meeting of the Special Chiefs Assembly held in British Columbia was also noteworthy. An important development in the transformation of healthcare services and wellness of women and children through programming came from the statement of the Assembly of First Nations Women’s Council on the responsibility of both governments and community to women’s governance. The statement highlighted a need for equity and the building of strong partnerships at every level that included women and their responsibilities to cultural sustainability and revival, family and community health (3).

Prime Minister Paul Martin summarized the core of the issues at the events of 2004–2005 when he said, “No longer will we in Ottawa develop policies first and discuss them with you later. This principle of collaboration will be the cornerstone of our new partnership” (4). A distinct voice for First Nation women in government is essential to health transformation. The relationship between governance, active participation in daily living and transformative health is foundational to the ongoing work of the Maternal Child Health Project in Manitoba.

**Funding maternal child health programming on-reserve**

National Chief Fontaine tabled a First Nations Health Action Plan at the First Ministers Meeting that included a vision with 6 pillars. The goal of the plan is a sustainable First Nation control of health care that encompasses a culturally informed approach with elements concerning sustainable financing, integrated care, health human resources, public health infrastructure, healing, information and research capacity (5). At the meeting, Prime Minister Martin committed $700 million as initial investment for improvement of health services for Aboriginal people. Follow-up funding to the regions in 2005 emphasized integration, linkage and consolidation of relationships and partnerships within and between organizations, governments and communities.

The events described above are vital to understanding the co-responsibilities for the establishment of health equity in First Nation communities through the Maternal Child Health Program in Manitoba. For example, the Blueprint for Canadian Health aligns with First Nation history and rights-based relationship to Canada. Sustainable programming is dependent on political commitment. The Blueprint for Canadian Health is an action-plan agenda: the Manitoba First Nation Strengthening Families Maternal Child Health Program is the realization of that plan.
Developing the national maternal child health project

In 2006, Health Canada released funds for the Maternal Child Health Pilot Project. Original documents describe a comprehensive approach to the delivery of community-based health services that would build on community strengths, priorities and existing programming. Services would include reproductive health, screening and assessment of pregnant women and new parents, and home visiting by nurses and paraprofessional staff who would provide education, support, follow-up and referral services. Families in need would receive targeted services, i.e., pre- and postnatal health services, case management, intensive home visitation, infant development programming, and access to rehabilitation services for children with special needs. The broad mandate to improve health and social outcomes for childbearing women and young families would necessitate linkages and supports between programs and services, across jurisdictions (6).

Manitoba First Nation Strengthening Families Maternal Child Health Project

In Manitoba, the Maternal Child Health project was housed in the Nutrition and Diabetes Unit of the Community Programs Directorate at FNIH, allowing for the unit partners, the Canadian Prenatal Nutrition Program and Aboriginal Diabetes Initiative to connect with the pilot activities. Linkages and collaboration were promoted with support from the Community Programs Directorate Integration Committee. Early in the process of project development, FNIH contacted the Assembly of Manitoba Chiefs (AMC) to co-manage and implement the project; invitations were also extended to the Southern Chiefs Organization and to the Manitoba Keewatinook Ininew Okinowin. The gesture recognized the necessity of a self-governing model to meeting health goals.

An immediate action that followed was the formation of the Manitoba First Nation Maternal Child Health Advisory Committee, which appointed First Nation experts in maternal and child health and social services representing families and programs from all 64 Manitoba First Nation communities. The Committee’s mandate was not easy. Finite resources meant that not all First Nations would receive the program. In order to succeed in proving the potential for the project to improve health, the Committee would have to plan wisely. It had 5 years to prove that the project, if executed universally, would result in measurable community health improvements. As such, the joint responsibility of the region, in cooperation with the funded communities was substantial. Criteria was set by the Committee and included documentation of successfully implemented programs, support through band council resolution or equivalent, evidence of successful recruitment and retention of qualified staff, relevant required infrastructure, resources and support for sustainability.

Getting an early start on the project, Manitoba region began implementing activities even before an actual flow of resources was received from Health Canada national office. By the time the funds flowed, the program had obtained momentum and was operating from 16 communities. Funding and central co-management comes from FNIH Manitoba region. AMC delivers detailed programming across the province through the office of the Regional Nurse Program and Practice Advisor. The responsibilities of this key position rested on a single person’s shoulders, Wanda Phillips-Beck, BN, MSc, for 3 years until an additional position at that office
was created for a peer support specialist with the responsibility to travel from the region into the communities to connect program philosophy, standards, procedures, ongoing training and assessments (7).

Unique to Manitoba is the role of the University of Manitoba’s Indigenous Health and Social Justice Working Group. Under the Direction of Dr. Rachel Eni, it will deliver a program of research and evaluation to support ongoing improvements of the project as it is being delivered in the communities. Wanda and Rachel work together regularly and in a daily fashion in the design and delivery of an empirically derived – action-oriented program/research/evaluation approach.

A final link to the partnership is the active engagement of the community program staff and family participants in the day-to-day operations of the project. Communities are engaged in all aspects of programming. The project reflects unique community as well as regional priorities, cultures, values and ways of life.

**Manitoba First Nation Strengthening Families Maternal Child Health Project objectives and ongoing activities**

Objectives of the SF-MCH project are as follows:

- Promote wellness of the mind, body and spirit of individuals and families.
- Facilitate trust and supportive relationships.
- Increase community capacity through education, healthy environments and provision of health services.
- Provide the tools for engagement.

The following are ongoing activities that are being developed and implemented in the communities. Each of the activities is currently undergoing evaluation. It is our intention to report on each of these activities in terms of outcomes and impacts in the next phase of Manitoba First Nation Strengthening Families Maternal Child Health Project (2011–2012).

1. **Maternal Child Health Information Management System**: Both authors, in coordination with the partners, developed a sophisticated regional health information database that connects with other health and social services databases. Additional partners involved in the database project are Manitoba Centre for Health Policy and Departments of Pediatrics and Child Health, University of Manitoba. The system is accessible at community and regional levels. Privacy, confidentiality and ethical protocols (i.e., University of Manitoba Ethics Department and First Nation Ownership Control Access and Possession) guide system management.

2. **Education and Training**: Programs are accessible to community staff on topics applicable to culturally informed program implementation and management.

3. **Quality Assurance through the Regional Peer Support Program**: This program focuses on enhancing Manitoba First Nation Strengthening Families Maternal Child Health Project development and delivery. Already, resulting from delivery of the peer support program, we see measurable improvements in program administration, increased support to community staff, higher rates of program participation, improved comprehensiveness of home visits, high-quality data, greater investment to programs and capacity development by the paraprofessionals.
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4. **Research and Evaluation:** Research attends to the needs of communities as they are indicated according to our action-oriented approach. Research topics reflect community priorities: healthy pregnancies and childbirth, traditional Aboriginal midwifery, infant health and mortality, adolescent pregnancy and parenthood, grandparenting and foetal alcohol spectrum disorder.

5. **Provincial Healthy Child Manitoba, Families First Program Partnership:** Partnership with HCM has allowed us to work through many gaps in First Nation programming. Brainstorming and resources for programming are shared. Standards for Manitoba First Nation Strengthening Families Maternal Child Health Project are measured according to provincial inputs/outcomes. Maternal mental health and the peer support programs are two examples of ongoing collaborative engagement.

**Conclusion**

This article described the work involved in the design and implementation of collaborative maternal child health programming in Manitoba First Nations. Partnership requires commitment, communication and flexible daily management from many different teams at different levels and from multiple jurisdictions. So far, it is believed within the Manitoba First Nation Strengthening Families Maternal Child Health Project that such work is not only possible but also desirable if we are to reach the goal of health equity.

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