

**Regional Summary of  
Governance Discussions**

**2011**

Summary of Feedback from Vancouver Coastal Regional Caucus  
and Health Partnership Workbook



**Vancouver Coastal**

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Thank you to all Vancouver Coastal region Chiefs, leaders, health professionals, and community members who took the time to attend regional caucus sessions and provide feedback through the Health Partnership Workbook.

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## 1. INTRODUCTION

The First Nations Health Council (FNHC) launched a 'Health Partnership Workbook' in January 2011, and made the Workbook available online and as the focus of a series of First Nations regional caucus sessions across the province. The Health Partnership Workbook summarized the discussions about health governance held at more than 100 First Nations regional caucus meetings over the past three years and asked First Nations Chiefs, leaders and senior health professionals in BC to confirm this summary of feedback gathered and share new thoughts and perspectives. The results will inform further discussions, negotiations and relationship-building toward the establishment of a new health governance arrangement for First Nations health services in BC.

The feedback provided by First Nations through the regional caucus sessions and the Health Partnership Workbook has been rolled into 5 summary documents – one for each region in BC. The initial regional reports were provided to each region for review, discussion and further amendment; this revised version of the report was provided again to each region in May 2011. The five regional summary documents will be merged into a province-wide Summary and Consensus document. This Consensus document will be put forward for review and consideration for approval at the 4th Annual Gathering Wisdom Forum to be held in May 2011 and will chart a path forward for the establishment of a new health governance arrangement for First Nations health services in BC.

The summary report collates all of the feedback from the **VANCOUVER COASTAL** region - as provided at Vancouver Coastal regional caucus sessions and through Vancouver Coastal region participation in the Health Partnership Workbook.

This report begins with a the snapshot profile of the Vancouver Coastal region. It then provides a detailed accounting of all feedback provided by First Nations in the Vancouver Coastal region to this health governance process (through regional caucuses and workbooks), followed by a summary of key themes based on feedback provided by Vancouver Coastal region First Nations. The last section informs an appendix which describes the Health Partnership Workbook process and methods.



# VANCOUVER COASTAL REGION PROFILE

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## 2. VANCOUVER COASTAL REGION SNAPSHOT

The territorial land base of the Vancouver Coastal region is 54,484 square kilometres – 5.9% of the provincial total. The total population of the Vancouver Coastal region (2006) is 1,077,572 and the Aboriginal population is 2.3% at 24,270.

There are 14 First Nations Bands within the Vancouver Coastal Region (Samahquam, Skatin Nation, and Douglas First Nations may also be within the Fraser Health Authority region):

- |                           |                                       |
|---------------------------|---------------------------------------|
| 1. Douglas First Nation   | 9. Sechelt Indian Government District |
| 2. Heiltsuk               | 10. Skatin Nation                     |
| 3. Kitasoo                | 11. Sliammon First Nation             |
| 4. Mount Currie Band      | 12. Squamish Nation                   |
| 5. Musqueam First Nation  | 13. Tseil-Waututh Nation              |
| 6. N'Quatqua First Nation | 14. Wuikinuxv Nation                  |
| 7. Nuxalk Nation          |                                       |
| 8. Samahquam              |                                       |

### Five Tribal Councils exist within this region:

1. Naut'sa Mawt Tribal Council
2. Lower St'atl'imx Tribal Council
3. Oweekeno-Kitasoo-Nuxalk Tribal Council
4. Heiltsuk Tribal Council
5. Lillooet Tribal Council

There is one First Nations umbrella health organization within Vancouver Coastal – the Southern St'atl'imx Health Society.

### 92.31% of First Nations in the Vancouver Coastal region participate in Community Engagement Hubs, as follows:

#### TSLEIL-WATUTH NATION )

- o Tseil-Watuth Nation
- o Squamish Nation

#### TLA'AMIN COMMUNITY HEALTH BOARD

- o Sliammon
- o Klahoose

#### LOWER STL'ATL'IMX TRIBAL COUNCIL

- o Douglas
- o Lil'wat
- o N'Quatqua
- o Samagquam
- o Skatin

#### HEILTSUK TRIBAL COUNCIL

- o Heiltsuk Tribal Council
- o Nuxalk
- o Wuikinuxw (Oweekeno)
- o Kitasoo

#### UNREPRESENTED COMMUNITIES

- o Musqueam

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# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

## 3. DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

This section summarizes feedback from the completion of the Health Partnership Workbooks by First Nations from the Vancouver Coastal region and from the minutes of meetings of Vancouver Coastal regional and sub-regional caucus meetings.

This section of the report summarizes feedback about First Nations health governance at a community level, a regional level and a provincial level.

### Community Level

'Community level' refers to the 203 First Nations in BC and the 130 First Nations community health centers in BC. At this level, First Nations and their health technicians deliver health programs and services to their local populations.

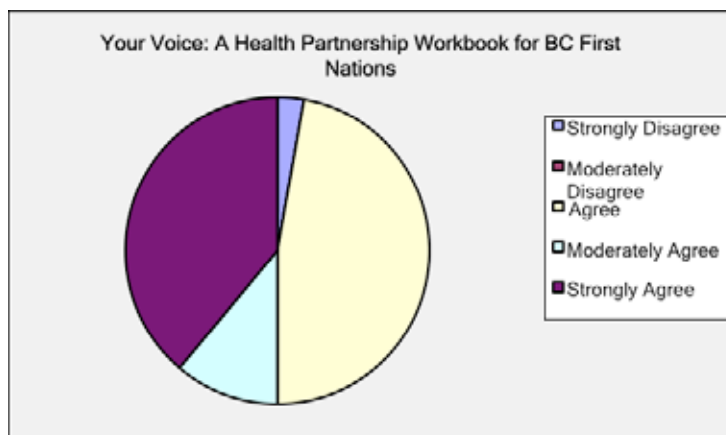
The workbook summarized the principles and requirements for First Nations health governance at a community level, as stated by First Nations at regional caucus sessions over the past several years. Specifically First Nations have stated that a regional health transfer process must:

- Increase and support First Nations decision-making over the health of their peoples;
- Ensure the transfer results in opportunities to leverage more funding for community-level programs and the reinvestment of current resources to improve health at the community level; and
- Enable collaboration with other First Nations and local and regional health program and service providers.

First Nations in the Vancouver Coastal Region responded to these principles as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	2.8%	1
Disagree	0.0%	0
Agree	47.2%	17
Moderately Agree	11.1%	4
Strongly Agree	38.9%	14
<b><i>answered question</i></b>		<b>36</b>
<b><i>skipped question</i></b>		<b>4</b>

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION



Through participant feedback on the workbooks, and through the small group sessions at the Regional Caucus meeting, the following principles and requirements were also identified as a priority:

- **Trained Professions** – need for First Nations trained professionals to work in communities at management / administration level as well as health service level;
- **Community-driven and Nation-based** – focus on communities (especially rural and remote communities) and work on a Nation to Nation basis; focus should be on Nation-building, not continuing to work on a small scale in communities as this often prevents comprehensive planning and health services being put into place; empowering grass-roots communities to participate and create less dependence on the system and more dependence on self-care and fostering wellness; Elders, children and youth need to be a part of the community picture; strong communication is needed at community and Nation level; and,
- **Evaluation** – develop evaluation skills and to use the learning for the community’s benefit in the future.

The workbook asked participants to indicate their level of support for the following statement:

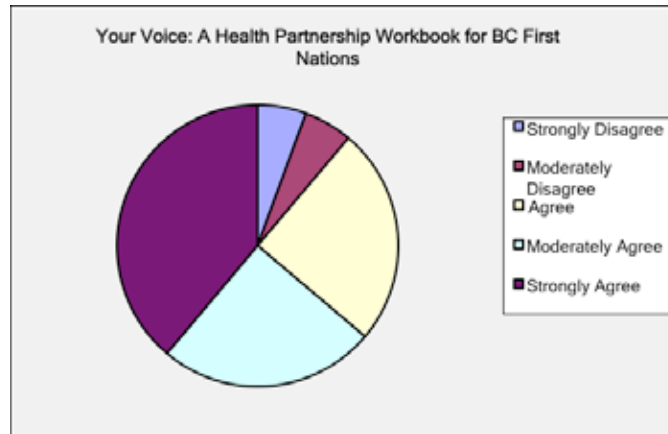
*“A Regional Health Transfer process would support the greater local control over health services and the development of local health program and service delivery models”*

The following table indicates their response to this statement:

Answer Options	Response Percent	Response Count
Strongly Disagree	5.6%	2
Disagree	5.6%	2
Agree	25.0%	9
Moderately Agree	25.0%	9
Strongly Agree	38.9%	14
<b><i>answered question</i></b>		<b>36</b>
<b><i>skipped question</i></b>		<b>4</b>

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## DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION



Participants were asked to add other comments regarding local control of health services or add general comments. The following is a summary of the comments provided by participants on this section:

- **Collaboration and Recognition** – regional transfer processes needs to be inclusive to all Nations; Vancouver Coastal Health needs to work with all Nations, regardless of population size; remoteness must be factored in; ‘the less we focus on political issues amongst one another, the more we can reach consensus to strongly support each other’; Health Directors need to be engaged as well as Chief and Council;
- **Capacity** – Capacity is very important, especially with a focus on community plans and individual health plans; important to have ‘proper qualified employees with sincere interest in their position of employment’; need to be pro-active and innovative in managing change and growth for these services, and an administration well versed and trained in managing this process;
- **Funding** – need for increased funding for administration to be negotiated as part of the health transfer in addition to the funding offered for services; funding must be used for what it is intended for.
- **Capital Development** –need for funding to upgrade the infrastructure especially in most small isolated communities;
- **Community Engagement on health needs and perspectives** – one said that ‘more community engagement is needed in the process; communities should be facilitated to identify real needs – not just what people think they are entitled to or wish lists; needs and wants are different;
- **Self-Care** – First Nations have been negatively impacted to the point of dependency and need to regain the unique ancestry & traditional ways of wellness’;
- **Service Gaps** – transportation to health facilities, clinics, hospitals and ambulances; health workforce; prescriptions; and,
- **Evaluation and Learning** - Being open to making adjustments knowing trial and error are valuable learning opportunities; owning up to mistakes/miscalculations and taking responsibility to readjust by being flexible.

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

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## Regional Level

'Regional level' refers to the five regions in BC – Fraser, Interior, North, Vancouver Island and Vancouver Coastal. Within regions, First Nations collaborate on shared health issues of relevance and develop regional perspectives on First Nations health and wellness amongst themselves. They also collaborate with the Regional Health Authority (RHA) on regional First Nations health issues.

Through regional caucus sessions over the past several years, First Nations have formed key principles and requirements for health governance as it relates to the regional level, as follows:

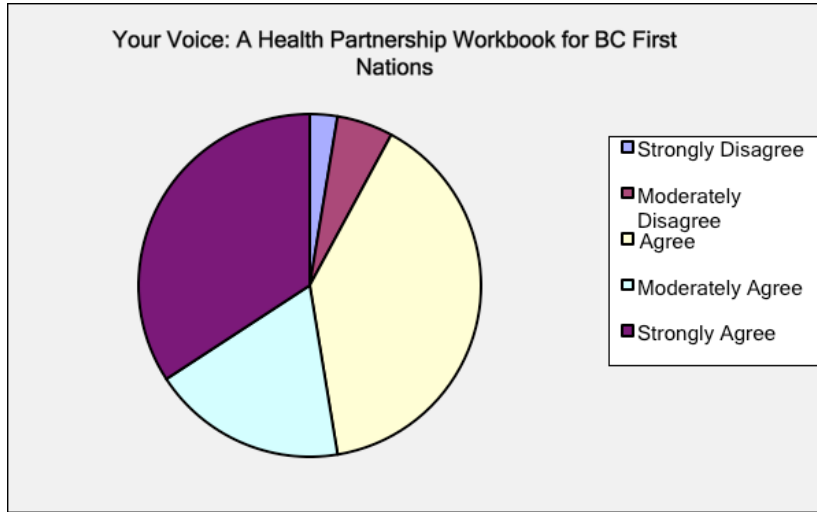
- Maintenance of Regional Caucuses to reflect collective authority and the high importance of partnerships and agreements with Health Authorities;
- Continuing to support collaborations and relationship building among First Nations;
- Supporting the development of First Nation health programs, services and initiatives, which can be delivered by and serve the needs of the region;
- Supporting the development of regional perspectives on health and wellness;
- Increasing collaborations with RHAs to leverage provincial resources;
- Enabling First Nations to have a greater influence over services provided by RHAs to First Nations;
- Supporting regional and sub-regional planning; and,
- Improving communication based on regional expectations, including accountability and reporting.

First Nations completing the workbook were asked how they felt about these principles– the results for the Vancouver Coastal region participants provided the following responses:

Answer Options	Response Percent	Response Count
Strongly Disagree	2.6%	1
Disagree	5.3%	2
Agree	39.5%	15
Moderately Agree	18.4%	7
Strongly Agree	34.2%	13
<b><i>answered question</i></b>		<b>38</b>
<b><i>skipped question</i></b>		<b>2</b>

# 3

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION



Respondents also identified the following principles and requirements:

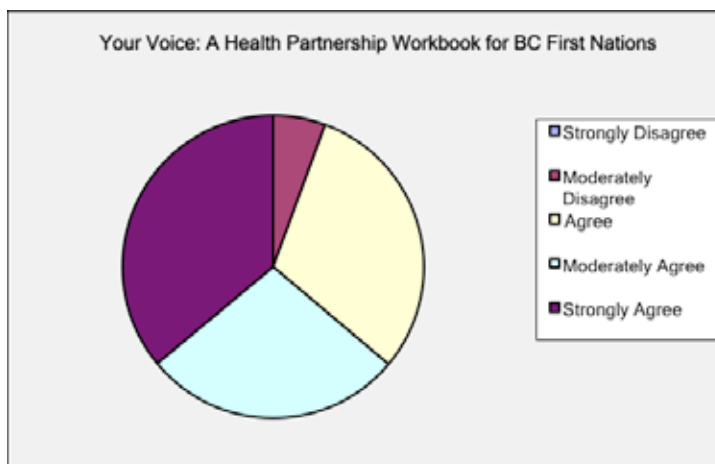
- **Aboriginal Title and Rights** - need to be recognized throughout all levels; ‘the business of this new health authority needs to respect the territories of Nations - we sit as family at the regional tables; and,
- **Gaps** - Elder Care needs to be included as well as discussion of our urban families at the Regional level.

The workbook also asked participants to indicate their level of support for the following statement:  
*“First Nations have stated that they would like to see the regional caucus structure continue as part of the new regional health transfer process with the purpose described above”*

The following encapsulates their response to this statement:

Answer Options	Response Percent	Response Count
Strongly Disagree	0.0%	0
Disagree	5.6%	2
Agree	30.6%	11
Moderately Agree	27.8%	10
Strongly Agree	36.1%	13
<b>answered question</b>		<b>36</b>
<b>skipped question</b>		<b>4</b>

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION



Participants were asked to state what they believed Caucuses were doing well and what additional things they thought the Caucuses could improve on . The results from the Vancouver Coastal region are as follows:

WHAT CAUCUSES ARE DOING WELL	WHAT CAUCUSES NEED TO IMPROVE
<ul style="list-style-type: none"> <li>• <b>Representation:</b> Southern St’atl’imx communities are well represented but need to gather more at community level; seem to have a good mandate; I am sure they will be doing well because they will be working on our communities’ behalf; Caucuses need to include people with wide range of skills so they represent a diversity of experience and backgrounds.</li> <li>• <b>Networking and Communication:</b> It is a good place for communities to focus on the needs of the entire regions; It is a good forum to work with each Nation to work on Health &amp; Wellness; looking to the communities for determining needs.</li> <li>• <b>Information Dissemination:</b> the information is very in depth and caucuses are doing well; they bring the grass roots issues and concerns to management.</li> <li>• <b>Health Authority relationship:</b> Engaging with the existing Health Authorities while at the same time representing the needs of individual First Nations communities.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Communications:</b> Common reporting structure needs to be developed; agree collectively of what needs to be reported so the people sign off before they take the information somewhere else; ensure we can see the needs of individual communities or areas; communicate more with health technicians; use webcasts and make notes available online.</li> <li>• <b>Cost factor/benefit:</b> does the caucus cost generate value or is there a better way? The analysis of achievements and benefits of their work should be produced; meetings and caucuses carry a cost and are part of effective service delivery when they are focused, effective, responsive and accountable.</li> <li>• <b>Reporting:</b> Report regularly to individual communities; make short, easy-to-read and understand memos that can be easily distributed to all community members &amp; staff.</li> </ul>

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# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

Participants were asked if they had any other general comments on regional level priorities:

- **Separating politics and business** - Be consistent and do not focus on political issues or let politics take priority; and,
- **Caucus Member Knowledge** - Educate regional caucuses on the geography of the First Nations in the region such as geography, remoteness, populations, needs, etc. and ensure they continually update themselves to represent the communities accurately. One respondent recommended a bio of each Caucus / FNHC member be produced so regions know what skills and background each representative has to represent them.



## Provincial Level

'Provincial level' refers to the full geography of the Province of BC. At this level, health programs and services that serve all First Nations and First Nations individuals in BC are designed and delivered, and other population health issues are addressed. First Nations engage at a senior level with federal and provincial governments on strategic-level health issues.

### Principles of the Structure

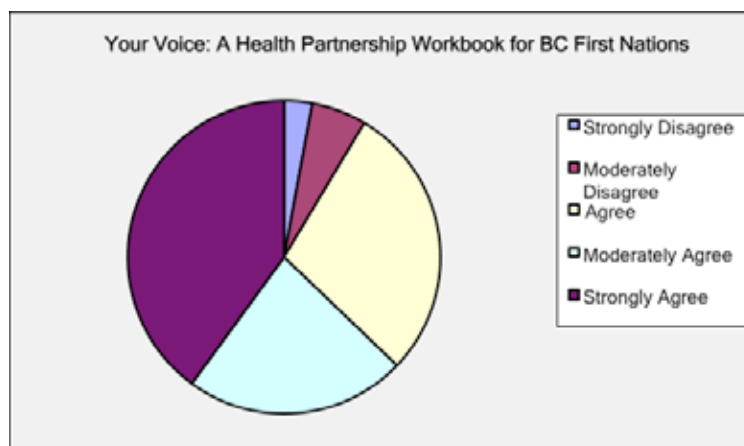
The workbook outlined a number of key principles and requirements for the structure that needs to be in place to support the regional health transfer process at the provincial level. First Nations have stated that the regional health transfer process must:

- Increase First Nations decision-making, control and flexibility in health program and service philosophy, design and delivery;
- Foster collaborations and partnerships;
- Function at a high operational standard;
- Not impact on Aboriginal title and rights or the Treaty rights of Nations; and,
- Not impact on the Crown's fiduciary duty – including the ability of First Nations to transfer responsibility back to the federal government if the arrangement does not work for First Nations.

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

First Nations completing the workbook were asked how they felt about these principles – the results for Vancouver Coastal are as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	2.9%	1
Disagree	5.7%	2
Agree	28.6%	10
Moderately Agree	22.9%	8
Strongly Agree	40%	14
<b>answered question</b>		<b>35</b>
<b>skipped question</b>		<b>5</b>



Respondents were asked if any principles were missing – the following summarizes the themes from the responses:

- **First Nations and Inuit Health (FNIH) Policy changes** - Change the requirements for the Home and Community Care policies and requirements to allow other adult members in the home a break and temporary respite care for Elderly Clients who cannot take care of themselves fully;
- **Off-Reserve Inclusion** - need to include our families living in urban settings; and,
- **Social Determinants of Health** – Buy-in has to come from other Ministries that are going to play a role in improving First Nation health, not just the Ministry of Health Services - Buy-in needs to come from Children and Families, Social Development, Environment, etc.

At one of the Caucus sessions, queries were asked about the role of the First Nations provincial organizations, the costs of maintaining these and who was ‘in charge’. It was confirmed that communities drive the mandate and focus of the First Nations organizations. This discussion also covered the need for clarity of the Terms of Reference for the FNHC and Caucuses and more clearly defined roles of the First Nations Health Directors Association (FNHDA) and First Nations Health Authority (FNHA).

# 3

# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

## Future Mandate for the First Nations Health Council (FNHC)

The workbook summarized that, based on feedback from Regional Caucus sessions, the mandate for the First Nations Health Council from 2012 and beyond should include:

- Continued leadership for implementation of the Transformative Change Accord: First Nations Health Plan and Tripartite First Nations Health Plan;
- Providing support to First Nations in achieving their health priorities and building relationships at local and regional levels;
- Health advocacy with government partners and others at the highest levels;
- Overseeing and advocating for service improvements for First Nations; and,
- Overseeing the transition of First Nations and Inuit Health (FNIH) to a new First Nations Health Authority (FNHA).

Participants were asked if any key principles for this mandate were missing. The Vancouver Coastal region participants responded as follows:

- **Relationships between the First Nations health governance partners** - Principles need to emphasize the relationship between FNHC & First Nations Health Directors Association (FNHDA); doesn't state relationship between FNHC, FNHDA & FNHA; and,
- **First Nations Decision-Making** - Ensure decisions are made with First Nation practices, medicines, traditional teachings as part of the considerations; add a role for international advocacy for indigenous health rights.

## Future Structure and Composition of the First Nations Health Council

Some participants recommended that since the regional health transfer process will strive to devolve services to the local and regional levels as much as possible, and include representation of First Nations in regional caucuses and the new First Nations Health Authority, – the future FNHC should be a smaller group, with perhaps 1-2 representatives appointed per region.

Participants were asked if they had any comments about the future structure and composition of the FNHC and the responses were as follows:

- **Diversity of FNHC Structure** – Representation should include people who represent a diversity of communities - elder reps, youth reps, and community and social work people;
- **Need for Continuity** - Representation should not be changed considering all the work done on implementation and the length of time it takes to get up to speed on health. Further along into process it may be an option if everyone agrees it should be;
- **Advocacy** – Ensure representatives are held accountable for having a voice on behalf of communities and not just showing up saying nothing; be sure they are speaking at the meetings. If they are not vocal enough; not advocating enough for us then they should not be present; and,
- **Transparency** – Even when the FNHC and Caucuses are selected, their Terms of Reference, appointment processes and accountabilities must be made transparent to everyone.

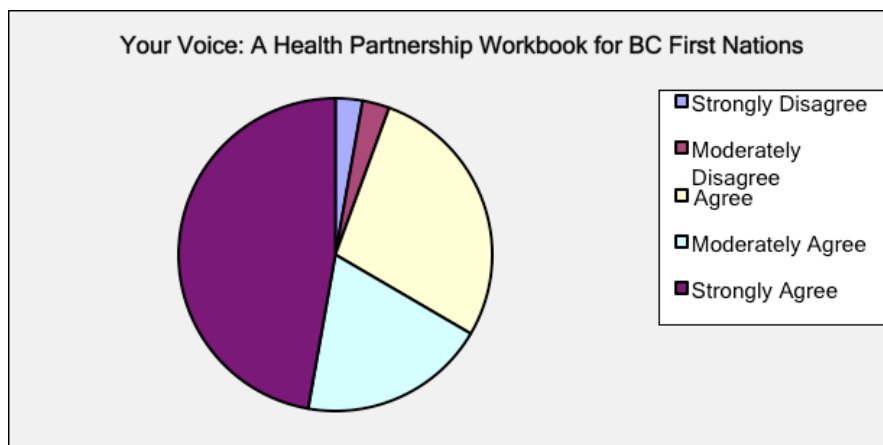
# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

One respondent questioned what would happen to the FNHC once the FNHA comes into effect, asking 'Will the FNHC remain the same? Will their staff transfer over to the FNHA? Will the FNHA work at the senior level discussions with Government with the FNHC or alone? Another asked if the FNHC would continue to serve just British Columbia, or whether it would one day become a national-level organization.

## First Nations Health Directors Association (FNHDA)

Based on the feedback provided in the workbooks, there was general consensus that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority. Participants responded as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	2.8%	1
Disagree	2.8%	1
Agree	27.8%	10
Moderately Agree	19.4%	7
Strongly Agree	47.2%	17
<b>answered question</b>		<b>36</b>
<b>skipped question</b>		<b>4</b>



# 3

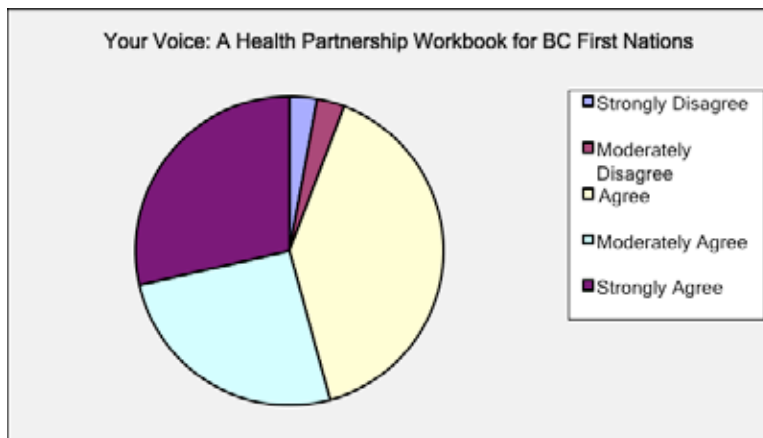
# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

## First Nations Health Authority (FNHA)

The following provides a summary of the principles that First Nations believe are fundamental to the activities and operations of the First Nations Health Authority:

- Recognize the authority of individual BC Nations in their governance of health services in their communities;
- Protect, incorporate and promote First Nations knowledge, beliefs, values, practices, medicines and models of health and healing into the health programs and services in BC First Nations;
- Enhance collaborations and relationships that impact on First Nations health;
- Uphold reciprocal accountability particularly in their relationship with First Nations;
- Uphold professional standards and ethics;
- Uphold the highest standards in order to avoid conflict of interest;
- Have a transparent and manageable appointment process; and,
- Have a Board of Directors with relevant experience and expertise with respect to First Nations health programs and services and successfully running a large organization.

Answer Options	Response Percent	Response Count
Strongly Disagree	2.9%	1
Disagree	2.9%	1
Agree	40%	14
Moderately Agree	25.7%	9
Strongly Agree	28.6%	10
<b>answered question</b>		<b>35</b>
<b>skipped question</b>		<b>5</b>



Participants were asked if they supported these principles – the results are as follows:

Respondents were asked if any key principles for the FNHA were missing. Many of the comments focused on accountable and the need for assurance that the principles they develop would say for reciprocal accountability between the FNHA, FNHC, and FNHDA for timely completion.

## Reciprocal Accountability

Reciprocal accountability is a key part of the regional health transfer process. Reciprocal accountability means shared responsibility – amongst the Federal Government, Provincial Government, the Health Authorities, the First Nations Health Council, the First Nations Health Directors Association and in future the First Nations Health Authority. It also includes First Nations themselves who have primary responsibility to look after themselves first and foremost and to work with partners to improve health outcomes for First Nations populations.

### Principles for Reciprocal Accountability

The workbook set out the following principles based on First Nations input and dialogue over the past several years:

- Clear roles and responsibilities;
- Clear performance expectations;
- Balanced expectations and capacities;
- Credible reporting; and,
- Reasonable review and adjustment.

Vancouver Coastal First Nations who responded to the workbook added the following principles:

- **Evaluations and cost effectiveness:** annual performance reviews of the First Nation governing entities; and,
- **Ethics:** based on cultural teachings with Elders overseeing ethics guidelines or establishing an Elder's Ethics Committee.

### Processes for Reciprocal Accountability

The workbook outlined a number of suggestions from First Nations to achieve a high level of reciprocal accountability:

- Regional Caucus sessions including all BC First Nations and their health organizations;
- Regular meetings of the Provincial [now Tripartite] Committee on First Nations Health;
- Regular reciprocal accountability and health partnership meetings between the partners to measure progress and discuss potential changes to roles, powers or funding that may be required; and,
- Regular senior political and technical meetings with key decision-makers at national and provincial levels to focus on BC First Nations health priorities and plans.

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# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

## ADDITIONAL FEEDBACK

### Questions and Concerns

Several other issues were raised:

- **Government readiness** – whether the government (provincial particularly) is ready to engage with First Nations as First Nations develop their own traditional health and wellness plans and whether they would provide or support these plans with sustainable resources;
- **Traditional Healers and Practices** - spiritual ‘healers’ in the front-line work need to be included in any models of health and there should be standards set;
- **Off-Reserve People** – must be included in these processes but do not appear to be reached by the FNHC processes;
- **Continuity** – communities who have visiting doctors or on call doctors do not have continuity of care;
- **Funding tracking** – concerns about whether funding will be clawed back by the FNHA; and,
- **Infrastructure** – for on-reserve health centers, or regionally-based clinics that serve aboriginal clientele.

One comment seemed to highlight a theme from the engagement in this region related to cost-benefit and community-driven focus of the First Nation governing bodies:

*“After reading the workbook and watching the video, I notice that the FNHC has done a lot of good work. There is, however, A LOT of mention about committees, caucuses, boards, etc. I am curious to know what we are going to see happening on the ground as a result of the work you are doing, and how soon will we see those changes implemented?”*



# DETAILED FEEDBACK FROM VANCOUVER COASTAL REGION

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## Framework Agreement for the proposed Transfer of First Nations Inuit Health

The FNHC presented the draft Tripartite Framework Agreement on First Nation Health Governance to some of the Regional Caucus sessions and several queries were raised relating to:

- Legal Review – currently underway and to be disseminated to communities
- Support for communities in regard to the transition – to be addressed with support of the FNHDA for technical advice, training and accreditation
- Coverage for on and off reserve members
- Non-Insured Health Benefits (NIHB) funding issues
- Generating revenue as the new FNHA - so there isn't a long term reliance on Government funding
- Assurance that Health Transfer agreements would not be affected

It was noted at one Caucus session that BC was the front-runner in terms of forming a FNHA to assume management of a FNIH regional operation, and so there were few precedents to follow in terms of forming a FNHA in Canada.



# 4

# KEY THEMES & SUMMARY OF FEEDBACK

## 4. KEY THEMES & SUMMARY OF FEEDBACK

### Community Principles

Of the responses received, over 97% of participants agreed with the community level principles that were expressed in the Health Partnership Workbook. Almost 89% of the participants agreed that a Regional Health Transfer process would support greater local control over health services and the development of local health program and service delivery models. Some further considerations put forward included the need to develop trained professionals for communities; ensure a community-driven nation-based approach; conduct an evaluation and address problems with Non-Insured Health Benefits (NIHB). Participants also noted the need for greater collaboration and recognition; capacity building for health planning; ensuring politics from business; addressing capacity development needs; and supporting people to maintain wellness and reduce dependency on services.

### Regional Principles and Regional Caucuses

From the workbook feedback, 94.5% agreed with the regional level principles that were expressed in the Health Partnership Workbook. Further, 91.5% of responses agreed that they would like to see the regional caucus structure continue as part of the new regional health transfer process. Additional comments were made about the need to separate politics from business and to ensure Caucus members developed and made themselves aware of their region in all respects so that they could advocate effectively.

Participants were asked to identify what the Regional Caucuses were doing well – many believe that the caucuses play an important role and carry out their responsibilities effectively; networking and communication; information dissemination and building a health authority relationship. Areas that felt the Caucuses need to improve upon are communications, cost/benefit consideration of their own value to communities and reporting to communities.

### Provincial Principles

In total 93.5% of the respondents agreed or strongly agreed with the Provincial level principles expressed in the Health Partnership Workbook. Other principles that respondents felt should be considered are the need to focus on changing FNHI policies to benefit communities; ensuring off-reserve inclusion and addressing the social determinants of health.

### First Nations Health Council (FNHC)

In terms of the mandate of the Council, respondents agreed with the principles proposed including the need for enhanced relationships between the First Nation health governance partners and ensuring First Nations decision-making was done in a traditional way. Respondents also commented on the FNHC structure and composition and noted the need for diversity with respect to membership (to include elders, youth etc.); and the need for continuity of existing members; advocacy and transparency.

### First Nations Health Directors Association (FNHDA)

Nearly 94.4% of respondents agreed that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority.

# KEY THEMES & SUMMARY OF FEEDBACK

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## First Nations Health Authority

Nearly 94.3% of the responses were agreeable to the principles relating to the FNHA expressed in the Health Partnership Workbook. Respondents also stated that it is important that there is a process to ensure these principles are upheld; to ensure there is reciprocal accountability between the FNHC, FNHDA and FNHA and that the three governing bodies remain 'tied together'.

## Reciprocal Accountability

No participants disagreed with the principles outlined for reciprocal accountability; However, some added other ideas such as evaluating for cost-effectiveness of the First Nation governing structures and addressing ethics (with one idea of forming an Elders Ethics Committee).

## Other General Issues

A number of other issues were important to the participants at the Vancouver Coastal regional caucus sessions and through the workbooks. These related to:

- Government readiness (to support First Nations with implementing their Health and Wellness Plans);
- The draft Framework Agreement for the transfer of FNIH;
- Including Traditional Healers and Practices;
- Concerns about service continuity;
- The need for infrastructure funding; and,
- Including off-reserve people in all of the FNHC processes.



## 5. METHODOLOGY

The Health Partnership Workbook was developed by the FNHC in late 2010, and rolled out to First Nations across BC in January 2011. The Workbook summarized the feedback from more than 90 regional caucus sessions held over the past three years, and posed key questions to confirm this summary, and solicit further wisdom and advice.

There were two main methods of collecting feedback from First Nations communities, Chiefs, leaders and health professionals, into the Health Partnership Workbook:

- 1) Conducting Regional Caucus meetings in each of the five regions in BC and inviting all Chiefs, leaders and health workers to attend Regional Caucus meetings and during these meetings:
  - a. asking participants to complete workbooks at the sessions (or to send them in after the session) so that the FNHC had completed hard copy workbooks to contribute to these regional summary reports; and
  - b. taking notes at regional and Vancouver Coastal Regional Caucus of discussions and questions which could also add additional value to the information contained in the workbooks or complement the workbook information; and
- 2) Making the workbook document available on-line through [surveymonkey.com](http://surveymonkey.com) which is an on-line survey tool, and encouraging community representatives to respond using this method if they could not attend the engagement sessions.



# APPENDIX - METHODOLOGY

# A

The regional sessions were organized in accordance with the needs and priorities of each region. Therefore, the regional sessions included a variety of approaches, such as: convening sub-regional sessions in some of the larger areas; conducting one to one sessions with some Nations who wanted their Tribal Council to hear the information at a Council meeting; conducting presentations at other gatherings and holding sessions over two days instead of one where there were a larger regional attendance requiring significant travel time. This report includes Health Partnership Workbook feedback and input from Vancouver Coastal First Nations received in the period from January 2011 through to May 2011, and from a number of regional and sub-regional caucus sessions and community meetings, including (but not limited to):

- January 7: Vancouver Coastal Regional Caucus
- January 17: Mt. Currie
- January 28: Vancouver Coastal North Sub-Regional Caucus
- February 10: Lilwat Nation
- March 8: Tsleil-Waututh Nation
- March 10: Lower Sta'alt'imc
- March 21-22: Vancouver Coastal Regional Caucus
- March 25: Sliammon Nation
- March 28: Musqueam
- April 17: Nuxalk Nation
- May 2: Vancouver Coastal Regional Caucus
- May 3-4: Heiltsuk Nation

Facilitators, presenters and note-takers attended every meeting to present prepared information such as PowerPoints and hand-outs; hear questions and issues; and record the proceedings. Hard copy workbooks were handed out at the sessions and some participants completed these at the meetings while others agreed to complete them later and send them in. On some occasions, smaller work groups convened at the sessions and notes on flipcharts were also incorporated into the notes of the session to be included in the regional summary reports. Information gathered from these sessions and methods (notes, completed workbooks, flipcharts, on-line workbooks) has been incorporated into this report.

