Regional Summary of Governance Discussions 2011

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

Vancouver Island

Thank you to all Vancouver Island 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

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 towards 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 were rolled into 5 summary documents – one for each region in BC. The regional reports were provided to each region for review, discussion and further amendment in April 2011; and this report is a revised version which has also been considered through caucus sessions in May 2011. The five regional summary documents once finalized will be merged into a province-wide summary and the draft 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 on 24 – 26 May 2011 and will chart a path forward for the establishment of a new health governance arrangement for First Nations health services in BC.

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

This report begins with a short snapshot profile of the Vancouver Island region. It then provides a detailed accounting of all feedback provided by First Nations in the Vancouver Island region to this health governance process (through regional caucuses and workbooks). The key themes of the feedback provided by Vancouver Island region First Nations are then summarized. Finally, an appendix provides a description of the Health Partnership Workbook process and methodology.

Photo courtesy of Debora Steel, editor of Ha-Shilth-Sa Newspaper

2. VANCOUVER ISLAND REGION SNAPSHOT

The territorial land base of the Vancouver Island region is 55,051 square kilometres – 5.9% of the provincial total. The total population of the Vancouver Island region (2006) is 740,373 and the Aboriginal population is 5.5% at 40,550.

There are 50 First Nations Bands within the Vancouver Island Region:

1. Ahousaht First Nation
2. Beecher Bay First Nation
3. Campbell River Indian Band
4. Cape Mudge Indian Band
5. Chemainus First Nation
6. K'ómoks Band
7. Cowichan Tribes
8. Da'Naxda'xw First Nation
9. Ditidaht Band
10. Ehattesaht Band
11. Esquimalt First Nation
12. Gwa'Sala-Nakwaxda'xw First Nation
13. Gwawaenuk Tribe
14. Halalt Band
15. Hesquiaht First Nation
16. Homalco First Nation
17. Hupacasath First Nation
18. Huu-ay-aht First Nation
19. Ka:'yu:'k't'h'/Che:k:tles7et'h First Nation
20. Klahoose First Nation
21. Kwakiutl Band
22. Kwiakah
23. Kwicksutaineuk-ah-kwah-ah-mish
24. Lake Cowichan First Nation
25. Lyackson First Nation
26. Malahat First Nation
27. Mamalilikulla-Qwe'Qua'Sot-Emox
28. Mowachaht/Muchalaht
29. Namgis First Nation
30. Nanoose First Nation
31. Nuchatlaht Band
32. Pacheedaht First Nation
33. Pauquachin First Nation
34. Penelakut
35. Qualicum First Nation
36. Quatsino
37. Snuneymuxw First Nation (Nanaimo)
38. Songhees First Nation
39. T'Sou-ke First Nation
40. Tla-o-qui-aht First Nations
41. Tlatlasikwala
42. Tlowitsis Tribe

Four Tribal Councils exist within this region:

1. Kwakiutl District Council
2. Musgamagw Tsawataineuk Tribal Council
3. Nuu-Chah-Nulth Tribal Council
4. Naut'sa Mawt Tribal Council

There is one First Nations umbrella health organization within Vancouver Island – the Inter-Tribal Health Authority.

2 VANCOUVER ISLAND REGION SNAPSHOT

87.50% of First Nations in the Vancouver Island region participate in community engagement hubs, as follows:

Cowichan (Hulquminum)

- Cowichan Tribes
- Chemainus
- Lake Cowichan
- Lyackson First Nation
- Malahat First Nation
- Penelakut

Inter-Tribal Health Authority (ITHA)

- Beecher Bay
- Esquimalt
- Gwawaenuk
- Homalco
- Kwicksutaineuk/ Ah-Kwa-mish
- Namgis
- Nanaoose
- Qualicum
- Snuneymuxw
- Songhees
- Tsawataineuk (Kingcome)
- Tseycum
- T'Sou-ke

Kwakiutl District Council (KDC)

- Da'naxda'xw
- K'omoks
- Kwakiutl
- Kwiakah
- Mamalilikula-Que'Qua'Sot'Em
- Wei Wai Kai (Cape Mudge)
- Wei Wai Kum (Campbell River)

Nuu-chah-nulth Tribal Council (NTC)

- Ahousaht First Nation
- Ditidaht First Nation
- Ehattesaht
- Hesquiaht First Nation
- Hupacasath First Nation
- Huu-ay-aht First Nation
- Ka:'yu:'k't'h'/ Che:k'tles7et'h'
- Mowachaht/Muchalaht
- Nuchatlaht
- Tla-o-qui-aht First Nation
- Toquaht
- Tseshaht First Nation
- Uchucklesaht First Nation
- Ucluelet First Nation

South Island

- Tsartlip
- Tsawout

Independent communities

- Halalt
- Pacheedaht
- Paquachin
- Gwa'Sala'Nakwaxda'xw
- Quatsino
- Tlatlasiwala
- Tlowitsis

3. DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

This section summarizes feedback from the completion of Health Partnership Workbooks by First Nations from the Vancouver Island Region.

Further feedback provided by First Nations in the Vancouver Island region through the Health Partnership Workbook, and at Vancouver Island regional caucus meetings, has also been incorporated into this report.

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

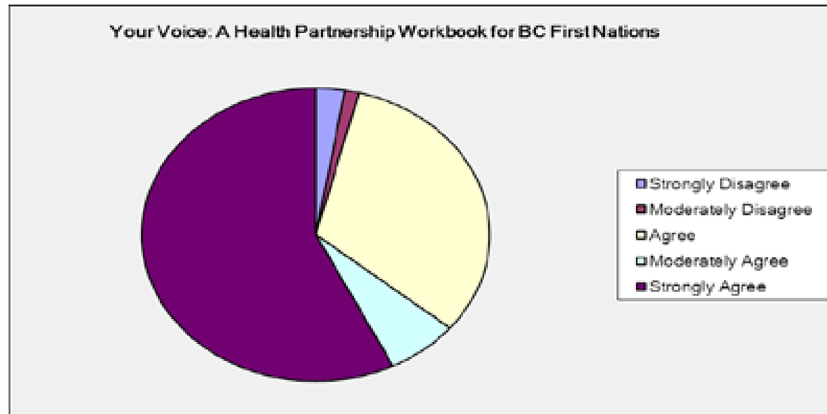
— Ensure the transfer results in opportunities to leverage more funding for community-level programs and the reinvestment of current resources to improve health at the community level; and

— Enable collaboration with other First Nations and local and regional health program and service providers.

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

Answer Options	Response Percent	Response Count
Strongly Disagree	2.7%	2
Disagree	1.3%	1
Agree	32%	24
Moderately Agree	6.7%	5
Strongly Agree	57.3%	43
	answered question	**75**
	skipped question	**6**

3 DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION



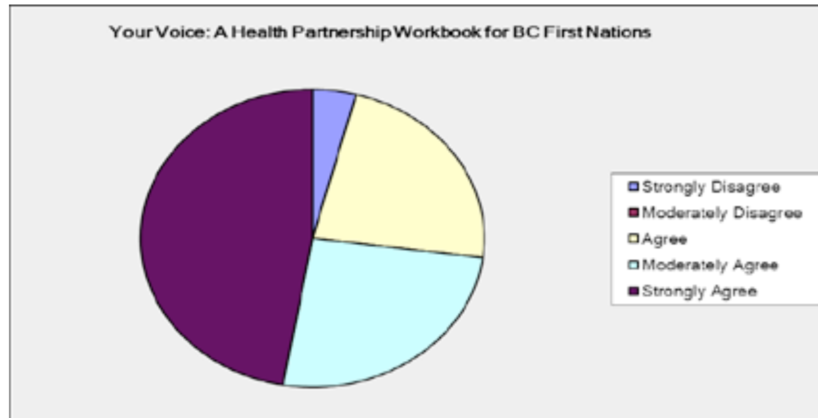
Participants in the workbooks, and through the small group sessions at the Regional Caucus meeting, also identified the following principles and requirements:

- **Supporting communities** – providing training and support; promoting traditional foods, practices and knowledge transfer; increasing communications; helping to encourage communities to organize so they do not have to affiliate with too many health bodies; putting authority to determine health service priorities in the hands of communities; providing opportunities for communities at grass roots level to have input to decision-making;
- **Incorporate off-reserve need** – involve off-reserve First Nations in considerations;
- **Service gaps** – fill service gaps especially with dialysis, alcohol and drug, mental health, and emergency services; ensuring services for isolated and remote communities regardless of location and size of population; address social determinants of health (e.g. housing, education, transportation)
- **Addressing small and isolated/remote community issues** – ensure ongoing engagement with smaller and isolated communities that are challenged to participate in centralized meetings; ensuring small and isolated communities do not 'fall through the cracks"
- **Supporting health human resource development** – facilitate on-going educational support for those interested in the health care field at any level as well as continued education for those in the field; assess existing expertise that is in place and help to sustain it for communities.

The workbook also 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"*

Answer Options	Response Percent	Response Count
Strongly Disagree	4.1%	3
Disagree	0.0%	0
Agree	23%	17
Moderately Agree	25.77%	19
Strongly Agree	47.3%	35
	answered question	**74**
	skipped question	**7**

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION 3



Additional comments provided on this statement included:

- **Service Gaps** - need more doctors and medical services for smaller and isolated communities and ability to sustain them for longer terms;
- **Efficient Use of Funding** – ensure additional layers of bureaucracy/cost/administration are not absorbing funds that could go to services;
- **Cultural Competency** – provide cross-cultural training for non-native staff; encourage input from Elders in designing better services and programs; and,
- **Advocacy** – ensure provincial level bodies 'will actually "speak" for the people.

Other general comments that were offered about community health services are summarized below:

- **Services** – maintain and increase current service levels; recognize traditional healers, community care service providers and community champions; do not simply adopt Western practices but blend the best of both worlds;
- **Business and Politics** - ensure that politics do not interfere in the workplace;
- **Unity** – support everyone moving forward together and with the same information; create opportunities for people to work together to solve common issues;
- **Accountability** - ensuring accountability of the committees, hub groups and other sub-regional bodies for the funds they get and the way they work including information they provide; and,
- **Fiduciary and Constitutional Rights** – First Nations have special status and it must be upheld.

3 DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

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 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 including:

- Maintenance of Regional Caucuses to reflect collective authority and to enter into 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 Island region participants are as follows:

Answer Options	Response Percent	Response Count
Strongly Disagree	2.8%	2
Disagree	0.0%	0
Agree	11.1%	8
Moderately Agree	29.2%	21
Strongly Agree	56.9%	41
	answered question	**74**
	skipped question	**9**

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

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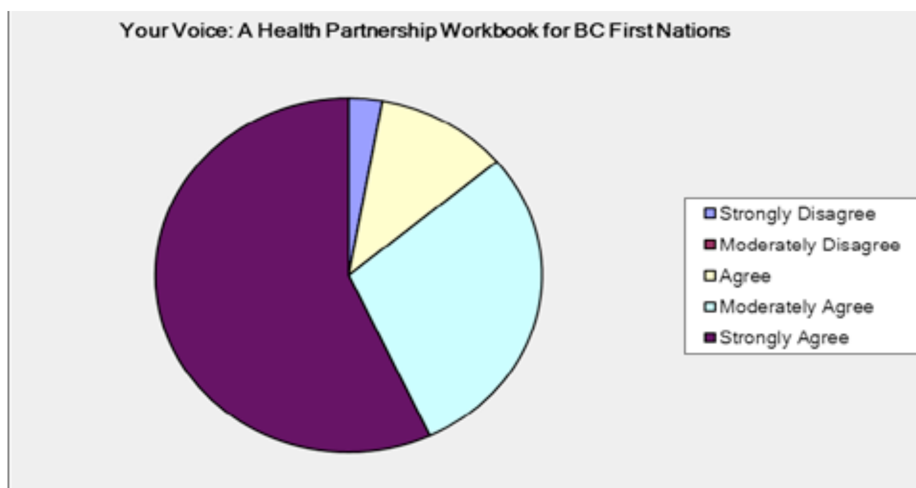


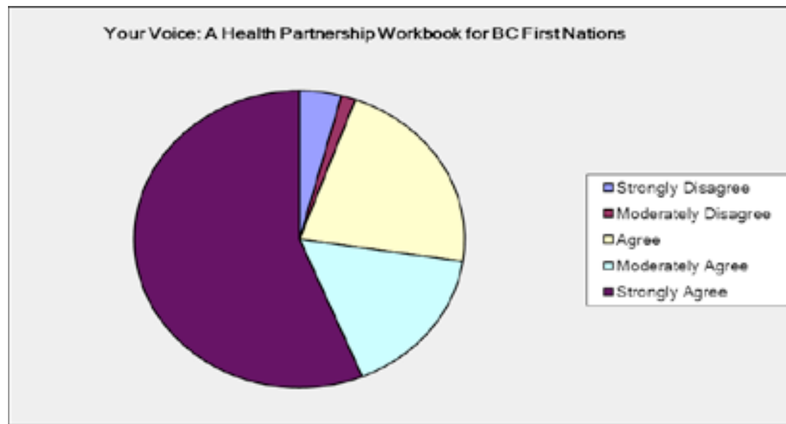
Participants also identified the following principles and requirements:

- **Information and Communications** – Caucus leaders need to report and provide information to First Nations; Caucuses need to summarize information directly after sessions and provide early feedback to help representatives report back as soon as possible while information is current; ensuring report summaries and information go directly to communities and not just to representatives who are busy and cannot always get the information out;
- **Caucus Representation** – More members from remote and isolated communities; representation from people who actually live on-reserve; staggering terms of representatives to ensure continuity of 'work in motion'; ensuring involvement of health administration and technicians and not just political people; and
- **Ensuring smaller and isolated communities are recognized** - capacity and resources for smaller and isolated bands needs to be addressed as they face different issues to larger communities or those closer to cities.

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"*

Answer Options	Response Percent	Response Count
Strongly Disagree	4.1%	3
Disagree	1.4%	1
Agree	21.9%	16
Moderately Agree	16.4%	12
Strongly Agree	56.2%	41
	answered question	**73**
	skipped question	**8**

3 DETAILED FEEDBACK FROM VANCOUVER ISLAND 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 Island region are as follows:

WHAT CAUCUSES ARE DOING WELL	WHAT CAUCUSES NEED TO IMPROVE
• Networking and Information - Connecting communities and informing leadership of what's going on; providing updates and convening meetings; communication / engagement between health frontline and political bodies; bringing the regional nations together 'and giving us a collective voice'	• Information Dissemination and Communication - Get information out to the communities; consider taking meetings to smaller and isolated communities; improve communications; connect with communities that aren't attending to see why; provide information out to community members.

Participants were asked if they had any other general comments on regional level priorities; these responses largely focused on the need to address the interaction of politics and administration:

- 'As a worker I have a different policy than Chief and Council'
- 'We have much work to do and many of our Chiefs were not present'
- 'Our leaders need to make health a priority as it is central to everything'

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION 3

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.

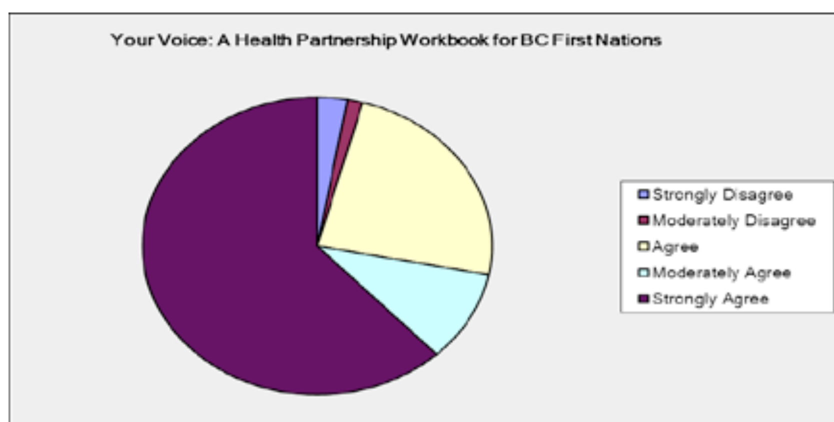
Principles

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 ability for First Nations to transfer responsibility back to the federal government if the arrangement does not work for First Nations.

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

Answer Options	Response Percent	Response Count
Strongly Disagree	2.8%	2
Disagree	0.0%	0
Agree	8.5%	6
Moderately Agree	50.7%	36
Strongly Agree	38%	27
	answered question	**71**
	skipped question	**10**



3 DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

Participants were asked if any principles were missing – the following summarizes key themes of the responses:

- "I agree with everything however my experience has been that First Nations tend to live in a box, and what we are saying in the above gets push aside, we need to "Walk our Talk"
- "Sometimes our district councils don't communicate well, don't listen to our needs. The bands' definition of programs may be different from theirs. They need to be more accommodating to move forward & make changes"
- "We need to ensure connectivity between the First Nations Health Directors Association, First Nations Health Council, Community Engagement Hubs, etc - they should become more uniform and lines of communication between these entities as well as with community should also become clearer"

Future Mandate for the First Nations Health Council

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 (TCA:FNHP) and Tripartite First Nations Health Plan (TFNHP);

— 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 FNIH to a new First Nations Health Authority.

Participants were asked if any key principles for this mandate were missing – the results from the Vancouver Island region are as follows:

- **Communication** – ensure information goes to all First Nations on Vancouver Island, not just to regional bodies;
- **Risk Management** – deficit protection like the Provincial & Federal Governments have; and,
- **Accountability** – maintaining accountability and consulting regularly with First Nations to 'keep everyone in the loop'.

Areas that participants felt could be improved with the First Nations Health Council were:

- Being more transparent with the Terms of Reference and meeting minutes;
- Being adaptable and prepared for change;
- Sharing a Strategic Plan aligned with the FNHDA Strategic Plan; and,

- Ensuring someone in the field is available to respond to community questions.

Future Structure and Composition of the First Nations Health Council (FNHC)

The workbook summarized 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 – some First Nations have stated that 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:

- "I would like to see this process done in a respectful manner that speaks to the grass roots people, and addresses all communities, not just the ones you can work on because someone in your staff is from that community"
- "They have to have transparency to the people - not hide anything"
- "I would hope that, with strong communication, respectful ongoing input we could move to smaller, not increased - regional representation"
- "Make sure we don't get too top heavy and ensure the money goes to communities to meet their health needs"

First Nations Health Directors Association (FNHDA)

The workbook summarizes previous feedback from First Nations that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority.

Answer Options	Response Percent	Response Count
Strongly Disagree	2.9%	2
Disagree	0.0%	0
Agree	7.1%	5
Moderately Agree	15.7%	11
Strongly Agree	74.3%	52
	answered question	**70**
	skipped question	**11**

3 DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

Participants were asked if they supported this statement and the results are as follows:

Representatives from the First Nations Health Directors Association (FNHDA) board attended the regional caucus session and presented. Several questions were asked of the FNHDA representatives including how they connected with hubs; how membership was acknowledged; who the Health Directors were on the Committees that FNHDA had set up and how to fill vacancies on the FNHDA. These were all addressed by the FNHDA presenter. The work of the community engagement hubs and health directors were supported.

First Nations Health Authority (FNHA)

The workbook summarized the principles that First Nations have clearly stated to date for 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	2.8%	2
Disagree	0.0%	0
Agree	8.5%	6
Moderately Agree	50.7%	36
Strongly Agree	38%	27
	answered question	**71**
	skipped question	**10**

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

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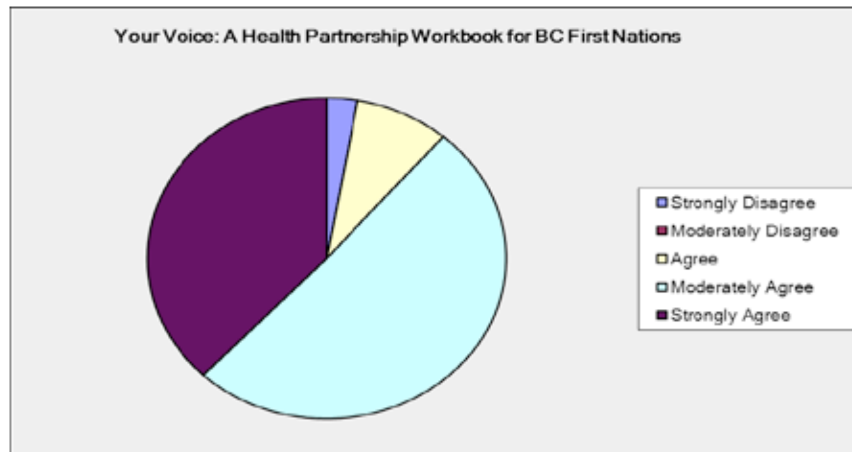

Participants were asked if they supported these principles – the results are as follows:

Participants were asked if any key principles for the FNHA were missing – the results from this region are as follows:

- **Board of the FNHA** – needs to have relevant experience and expertise with respect to First Nation health programs and services and successfully running a large operation; there needs to be criteria for selecting good leaders; Board of Directors cannot have a direct connection to other health organization or tribal councils to make sure that there is no conflict of interest; Board members should have staggered terms to promote continuity;
- **Philosophy** - Incorporate teachings from our hereditary system; Incorporate a traditional language perspective; accountability to First Nations in a timely and accurate manner for contracts and financial management; ensuring policy priorities came from communities and not 'from the center'; and,
- **Priorities** – Review of the Non-Insured Health Benefits (NIHB) program; addressing population growth and C3 impacts on funding; protecting existing transfer agreements; arranging for retention of surpluses by First Nations.

Photo courtesy of Hul'quimi'num' Health Hub

There were also some concerns raised about the costs of maintaining the FNHC as well as an FNHA Board – duplicating administration. Participants wanted to see efficiencies and not multiple structures all

utilizing funds that should be used for community services.

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 that have been shaped by 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 Island First Nations who responded to the workbook added the following principles:

- **Reporting** – streamlining reporting so that duplicate reports do not have to go to multiple agencies; and,

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION

3

Processes for Reciprocal Accountability

The workbook outlined a number of processes for reciprocal accountability that First Nations have developed including:

- — 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.

First Nations from Vancouver Island also identified the following processes:

- **Capacity, training and development** – inclusion of culture and tradition in policy; supporting community capacity; providing training to support individuals to be their own health advocates;
- **Funding security** – must be maintained at local levels, not just at district or provincial levels;
- **Unity** – including the strength of our Youth and the wisdom of our Elders; build Nation-to-Nation unity and strength;
- **Conflict of interest** – must be clearly defined and easy to understand; and,
- **Clarifying roles** – ensuring communities know who is accountable and responsible for what e.g. RHAs, FNHC, communities, FNHA, hubs etc.

Photo courtesy of Hul'quimi'num' Health Hub

- **Focus** – ensuring First Nations community health needs are always at the forefront.

OTHER FEEDBACK

Challenges with Change and Engagement

Some concerns were expressed at the regional caucus session about the extent of change “coming at communities all at once” including initiatives being undertaken by other Ministries and government agencies. There were concerns that this was difficult for some communities to respond to and participate in. This was associated with another issue related to some Chiefs and Council not coming to the meetings to hear what is going on to report back. Participants discussed ways to address this. One participant said the ideal would be to meet them all over a meal and talk. Another said that it was necessary to keep things moving forward and to continue to make progress because then Chiefs will come - when they stagnate and go nowhere then Chiefs disengage. It was considered that this would be an ongoing challenge but one that always needed to be addressed through using different methods of communication and information sharing.

Relationship with the Vancouver Island Health Authority

The regional caucus session involved a discussion on the relationship of First Nations in the Vancouver Island region with the local regional health authority (RHA) – Vancouver Island Health Authority (VIHA). One participant suggested that the three (3) families on the Island come together and engage with VIHA and “breathe life into the relationship”.

There were several questions at multiple meetings on how to get First Nations on the board of VIHA and they were directed to the Ministry of Health which processes appointments.

Participants wanted to know how many First Nations people were using VIHA services but were advised that there were problems with data and information collection that needed to be addressed.

It was also stated that there was a need for culturally competent services across the board at VIHA including all their separate sites. Some also raised an issue of VIHA beginning to centralize services (e.g. hospital planning) and how this would affect planned Wellness Centers. It was considered important for First Nations to develop their relationships with their Health Authorities and it was noted that a working group from the Caucus is already investigating this with VIHA.

VIHA presenters stated that they were tracking their own progress against the action items in the TFNHP and that VIHA was open to a relationship (e.g. MOU) with the Island families. In response one speaker said it was important the families go with a united voice and have a government to government relationship with VIHA.

DETAILED FEEDBACK FROM VANCOUVER ISLAND REGION 3

Tripartite Framework Agreement on First Nation Health Governance

A number of themes and comments emerged from the discussion on a new First Nations Health Authority which would be established to assume control of the current Health Canada – First Nations and Inuit Health (FNIH) operation. One participant stated that Band Councils had a lot of fear about the process because everything was 'evolving so fast'. Another said that the FNHC and the new FNHA would have funding challenges because FNIH was already faced with dealing with this issue with communities. They felt it was important that a funding and risk analysis for communities is conducted which assesses their funding arrangements - especially those having trouble now managing with small resources.

At regional and sub-regional caucus meetings in April and May 2011, the draft Tripartite Framework Agreement on First Nation Health Governance was reviewed and discussed in detail, including:

- Legal Review: It was confirmed that an independent legal review of the Framework Agreement is underway and will be circulated to all First Nations in May 2011;
- Interim FNHA: It was noted that the First Nations Health Society has the ability to become an interim FNHA to allow space and time for First Nations to decide how to structure the new legal entity which would become the FNHA;
- Funding Issues:
    - CAPITAL: Capital funding continues to be a problem and has been cut back in recent years – this must be a priority for the new FNHA;
    - Non-Insured Health Benefits (NIHB): NIHB must be a key priority from the FNHA and requires a large number of policy changes informed through extensive engagement with experts and First Nations;
    - ESCALATOR CLAUSES: The Agreement includes escalator clauses for annual increases to the budget of the First Nations Health Authority;
    - OWN SOURCE REVENUE: It was confirmed that the federal Own Source Revenue policy does not apply to the funding under the new health governance arrangement – the First Nations Health Authority will be able to generate additional revenues and invest 100% of those revenues back into First Nations health programs;
    - RESIDENTIAL SCHOOL FUNDING IMPACT: It was confirmed that funding will continue for the Indian Residential Schools program in BC although the program will likely be cut for the rest of Canada;
    - COVERAGE FOR NON-STATUS: Section 2.1 (2) of the Framework Agreement states"... and potentially, the non-aboriginal population..." – it was stated that this is to do with issues and access to health services, and that the Framework Agreement would include ability for First Nations to provide services to others within their catchment area if desired;
    - SUNSETTING PROGRAMS: It was confirmed that regional sun-setting programs will continue, and this includes programs such as HIV/AIDS, Diabetes and Residential Schools;
    - BILL C-3: It was confirmed that the Framework Agreement ensures that additional

funding will be provided to cover the "C3's" that are coming back into definition as status First Nations;

- o TARGETED FUNDS: Questions were asked as to whether the FNHA will operate a proposal driven process – it was clarified that existing funding agreements will continue to exist as-is unless First Nations and the FNHA agree to changes, and that the FNHA will be able to design different types of funding mechanisms once new programs are designed;

- NATURE OF THE FRAMEWORK AGREEMENT: Clarification was provided with respect to the Framework Agreement as an 'administrative arrangement' – this is to make it clear that we are not talking about self-government, jurisdiction or law making, this is talking about the administration and planning of health programs and services;
- OPT-OUT: It was clarified that this is "all or nothing" – if the majority agree then the transfer of health services will apply to all First Nations – also, if the arrangement doesn't work, it can be terminated for everyone; and,
- DEFINITIONS OF BANDS / NATIONS: It was confirmed that this applies to all First Nations in BC, and in particular those that have funding arrangements directly with FNIH BC Region.

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4. KEY THEMES & SUMMARY OF FEEDBACK

Community Principles and Involvement

Of the responses received, over 96% of participants agreed with the community level principles that were expressed in the Health Partnership Workbook. In total over 96% of the participants agreed that 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. Some further considerations put forward included the need to address service gaps; support individual communities with training, capacity development and advocacy; incorporate off-reserve needs; ensure efficient use of funding and to address cultural competency of non-native health workers.

Regional Caucuses

From the workbook feedback, 97.2% agreed with the regional level principles that were expressed in the Health Partnership Workbook. Further, 94.5% of responses agreed that they would like to see the regional caucus structure continue as part of the new regional health transfer process, while 5.5% disagreed that the caucus structure should continue.

Participants were asked to identity what the Regional Caucus was doing well – the main theme of the feedback was the Caucus was doing good work in trying to provide a mechanism for networking and informing communities. Areas that participants felt the Caucus needed to improve upon were information dissemination and communication (especially to reach rural and isolated communities).

First Nations Health Council

In total 94.9% of the participants agreed or strongly agreed with the Provincial level principles expressed in the Health Partnership Workbook while 4.2% disagreed. While additional principles were not offered, some participants did comment on the need for First Nations to think innovatively and to ensure that community perspectives were taken into account.

For the mandate of the Council, participants agreed with the principles proposed and added communication, risk management, managing conflict of interest, transparency and respect for community voice.

First Nations Health Directors Association

A total of 97.1% of participants agreed that the FNHDA should play a key role in providing technical advice and guidance to the FNHC and the First Nations Health Authority. Several questions were asked of the FNHDA representatives including how they connected with hubs; how membership was acknowledged; who the Health Directors were on the Committees that FNHDA had set up and how to fill vacancies on the FNHDA.

First Nations Health Authority

A total of 97.2% of the responses were agreeable to the principles relating to the FNHA expressed in the Health Partnership Workbook. Principles that participants thought should be added included statements relating to philosophy (use of traditional language) and Board skills and expertise for the new FNHA.

4 KEY THEMES & SUMMARY OF FEEDBACK

Reciprocal Accountability

No participants disagreed with the principles outlined for reciprocal accountability however some added other ideas such as ensuring better reporting practices; ensuring First Nations health needs remained the focus; training and development; and, unity.

Relationship with Vancouver Island Health Authority

The regional caucus session involved a discussion on the relationship of First Nations in the Vancouver Island region with the local regional health authority (RHA) – Vancouver Island Health Authority (VIHA). One participant suggested that the three (3) families on the Island come together and engage with VIHA and "breathe life into the relationship". There were several questions on how to get First Nations on the board of VIHA and they were directed to the Ministry of Health which processes appointments. Participants wanted to know how many First Nations people were using VIHA services but were advised that there were problems with data and information collection that needed to be addressed. It was also stated that there was a need for culturally competent services across the board at VIHA including all their separate sites.

VIHA presenters stated that they were tracking their own progress against the action items in the TFNHP and that VIHA was open to a relationship (e.g. MOU) with the Island families. In response one speaker said it was important the families go with a united voice and have a government to government relationship with VIHA.

Other General Issues

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

- Challenges of constant change and engaging with communities to maintain information and knowledge sharing;
- Questions related to the transfer of FNIH process; and,
- Sustaining information sharing with and inclusion of small and remote/isolated communities.

There were also questions raised related to the Framework Agreement to clarify:

- That an independent legal review is underway;
- Funding issues relating to capital, sun-setting programs, Bill C-3, coverage for non-status and non-insured health benefits;
- That the Agreement will not impact on First Nation self-governance;
- There is no "opt-out" for individual communities – only for all communities; and,
- There is no impact on existing health contribution agreements.

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, and:
   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 sub-regional Caucus meetings 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 which is an on-line survey tool and encouraging community representatives to respond using this method if they could not attend the engagement sessions.

Photo courtesy of Debora Steel, editor of Ha-Shilth-Sa Newspaper

A APPENDIX - METHODOLOGY

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 on 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 workbook feedback and input from Vancouver Island families received in the period from January 2011 through to May 2011 from a number of sessions including:

- Nuu-Chah-Nulth, 31 January 2011
- Campbell River, 11 February 2011
- Port Hardy, 15 February 2011
- Duncan, 16 February 2011
- Tsartlip, 18 February 2011
- Port Alberni, 23 February 2011
- Port Alberni, 25 February 2011
- Nanaimo, 27 February 2011
- February 28 and March 1 – Nanaimo (collective Regional Health Caucus Session)
- Port Hardy, 15 April 2011
- Chemainus (Coast Salish), 19 April 2011
- Port Alberni – Tsehaht FN (Nuu-Chah-Nulth), 21 April 2011
- Nanaimo, 26 April 2011
- Coast Salish, 16 May 2011
- Port Hardy, 17 May 2011
- Nuu-Chah-Nulth, 18 May 2011

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. All information gathered from all sessions and methods (notes, completed workbooks, flipcharts, on-line workbooks) has been incorporated into this report.