1

Health Services Development in an Aboriginal Community: The Case of Peguis First Nation

by Benita Cohen, b.sc.n., m.sc.
Department of Community Health Sciences
University of Manitoba

Paper prepared as part of the
Research Program of the
Royal Commission
on Aboriginal Peoples

December 1994

Contents

Tables

Abbreviations Used

AA	Alcoholics Anonymous
AMC	Assembly of Manitoba Chiefs
BFT	Brighter Futures trainee
CHDP	Community Health Development Program
CHN	Community health nurse
CHNA	Community Health Needs Assessment (Peguis)
CHP	Community Health Plan (Peguis)
CHR	Community health representative
DIA	Department of Indian Affairs
DIAND	Department of Indian Affairs and Northern Development
DNHW	Department of National Health and Welfare
FRH	Fisher River Hospital
FRIH	Fisher River Indian Hospital
HC	Health Committee (Peguis)
LPN	Licensed practical nurse
MHSC	Manitoba Health Services Commission
MIB	Manitoba Indian Brotherhood
MSB	Medical Services Branch (DNHW)
NADAP	Native Alcohol and Drug Abuse Program
NIHB	Non-insured health benefits
NMHOP	Northern Mental Health Outreach Project
NMU	(J.A. Hildes) Northern Medical Unit
PADAP	Peguis Alcohol and Drug Abuse Program
PEM	Percy E. Moore (Hospital)
PHN	Public health nurse
PHS	Peguis Health Services
PMHSC	Peguis Mental Health Steering Committee
RD	Regional director
RN	Registered nurse

Executive Summary

This study describes the development of community health services in Manitoba's largest reserve, Peguis First Nation, located approximately 170 kilometres north of Winnipeg. Using several sources of data ─ documentation (both contemporary and archival), participant observation, and key informant interviews ─ the development of health services in Peguis is explored within the context of the overall development of the community as a whole and within the context of the major stages of federal Aboriginal health policy and health services delivery in Canada over the past century.

Beginning with the circumstances surrounding the relocation of the reserve to its present site, the study traces the shifting locus of control over health care in Peguis from the late 1800s to the summer of 1993. The period before 1980 was characterized by the loss of the traditional medical system in Peguis and increasing government hegemony over medical services ─ coinciding with a period of social and economic underdevelopment of the community as a whole. By contrast, the past 15 years have been characterized by relatively rapid community development in Peguis as a result of increased political organization and a determination to achieve local autonomy in the community's everyday affairs. It is in this context that the locus of control over health care has begun to shift back to the community ─ beginning with local administration of its health centre in 1980 and then, in 1991, the signing of a health transfer agreement with the federal government.

The salient features of the contemporary period of health services development in Peguis can be summarized as follows:

- The period of local administration of the Peguis Health Centre from 1980 to 1991 did build up useful experience and allowed public health providers to respond better to community needs. However, Medical Services Branch still retained significant program leverage and overall fiscal control, limiting the degree of self-determination that Peguis could achieve over the process of health care.
- Peguis entered into the health transfer process with no illusions about its limitations. Transfer was seen as an opportunity to take a small step toward the ultimate goal of

self-government ─ and a logical step, given the band's level of social, economic and political development, and the fact that they had been involved in the local administration of public health services since 1980.

- Certain factors (e.g., more than 10 years' experience with local administration of public health services, a relatively large resource base, both human and material, experience and confidence in negotiating with the federal government, and a thorough knowledge of Medical Services Branch policy) appear to have contributed to successful negotiation of a transfer agreement in July 1991.
- Health transfer is generally viewed as having been beneficial, in the sense that it did result in improved financial resources, more fiscal control during the period of the agreement, more flexibility in programming, an increased ability to respond to community needs, and a greater sense of `ownership' of community health programs.
- Most of the problems that Peguis has encountered since July 1991 have been related to issues that were not part of the transfer agreement. The administration of non-insured health services (nihb), especially related to medical transportation, dental, and optometric services, are areas of particular concern. The band believes that it could run these programs more efficiently if they were transferred to full band control, but a guarantee of an adequate resource base is seen as a prerequisite to such a transfer, and there is considerable concern that the resources available for transfer may be reduced. Late contribution agreement payments for non-transferred programs also continue to place a significant burden on the band's resources, forcing them to borrow from other budgets.
- The major innovations in health services programming have also occurred outside the mandate of the transfer process. The development of the Peguis Mental Health Program is an excellent example of a community-initiated program designed to meet the community's needs (in the absence of a government program) by developing skills within the community to deal with mental health issues.
- During the last decade there has been a renewed interest in traditional healing, and cultural awareness in general, among certain community members. In response to increasing demand from the community, traditional healing services have gradually become integrated into the formal structure of community health services offered in Peguis.

Recommendations

Aside from a number of suggestions for future research, it was not considered appropriate to make any specific policy recommendations based on a single case study of health services development. However, the experience of Peguis First Nation does highlight several issues that merit consideration in any discussion of future Aboriginal health policy.

- As far as the implications for other First Nations considering health transfer are concerned, it must be emphasized that the relatively positive experience in Peguis can in no way be taken as a sign of the `success' of the current transfer policy. Peguis's ability to take advantage of transfer was attributable to specific conditions outlined above (such as 10 years' experience in local management of public health services and a relatively large resource base). In the absence of those conditions, the benefits of health transfer may be questionable.
- Without a commitment on the part of the federal government to ensure an adequate resource base for all potentially transferable health programs and services, the ability of First Nations to achieve real control over the process of health care will be limited.
- The revival of traditional cultural practices (including traditional healing systems), while increasingly popular to many people in the broader society, may in fact be a contentious issue in some First Nations communities. Many key informants emphasized that First Nations communities must be allowed to deal with this phenomenon at their own pace and without outside interference. Furthermore, traditional healing should be offered as one of a variety of options available to consumers of health care in the community. One of the concerns expressed was that Medical Services Branch might increase restrictions on funding for `traditional travel' as the demand for this service continues to grow.
- While there is a desire on the part of those individuals involved in traditional healing at Peguis to have the federal government and dominant medical system recognize the role of traditional medicine, they do not want any government regulation of their services. They explained that traditional healers across the country are already involved in forming a network to share information and to discuss issues such as self-regulation.

Conclusion

In 1987, Peguis First Nation's proposal for health transfer funding stated clearly that transfer was far from the ideal envisioned by that community for control of their health care system ─ the ideal situation being an arrangement enshrined in self-government, involving the establishment of their own institutions and systems independent of government interference. It is likely that, until this vision of self-government is achieved in Peguis, self-determination leading toward health will be limited. Nevertheless, the experience of health services development in Peguis First Nation provides an interesting example of a community that is determined to achieve that goal and that has taken advantage of every opportunity to do so.

Health Services Development in an Aboriginal Community:
The Case of Peguis First Nation

by Benita Cohen

Introduction

Focus of Research

During the past decade there has been an escalation in the struggle of First Nations in Canada for greater control over their destinies ─ including their health.[1] *and* the conditions affecting health as areas of critical concern for their survival and development. (Canada 1983; Fontaine 1991; O'Neil 1993)

In a review of the literature on First Nations health initiatives in Canada, Young and Smith (1992) identified 60 models of community-based health care, including local/regional Aboriginal health authorities (e.g., Blood Tribe Board of Health, Cree Regional Board of Health and Social Services); local transfer-based[2] However, Young and Smith conclude that this literature is quite fragmentary and that there is a need for substantive case studies providing details about specific community-based health program initiatives involving First Nations. They also suggest that more case study research is required to determine the relevance and potential role of traditional medicine in the development of community-based health programs. Peguis Health Centre, in Manitoba, is identified in their review as an example of a local strategy about which there is little or no information in the Canadian health care literature. This study aims to fill that gap.

This case study explores and describes the historical development of health care services in Peguis since the early 1900s (including people's experience of both the traditional Aboriginal and Euro-Canadian medical systems). The transition to local control of community health services, which characterizes the contemporary period in Peguis, is of particular interest, as are current initiatives to establish community-based health programs. It is important to note that this study is *not* an evaluation of health services in the community, but rather a description of the

development of those services, with an emphasis on *process* and the *circumstances* surrounding key events and reflecting the community's (i.e., an Aboriginal) perspective on events.

Methodology

A qualitative design, using a case study approach, was chosen to explore and describe the experience of health services development in Peguis. A qualitative design is indicated for research that delves in depth into complexities and processes and where the importance of context, setting, and the subjects' frame of reference is to be emphasized. (Marshall and Rossman 1989) The principal rationale for using a single-case research strategy is that Peguis qualifies as a `revelatory case', in that it offers an opportunity to document a phenomenon that has not previously been studied. (Yin 1989)

Regarding the potential for generalizing from this study, there are significant differences among First Nations ─ in the history of contact and settlement, geographic location and environmental context, size of population and land base, development of health services, level of political and economic development, and so on ─ not only regionally (e.g., northern compared to southern Manitoba), but also between communities in the same region. Peguis may not be statistically representative of Manitoba's First Nations communities (e.g., size of population and level of economic development), but this is irrelevant in a study of this sort. The purpose of the revelatory case study is *not* to use it as a `sampling unit' in order to draw inferences about other First Nations communities. The primary purpose is simply to document a previously undocumented process. Nevertheless, the experience of health services development in Peguis ─ particularly current initiatives ─ may be useful to other First Nations interested in the issue of local control of health services.

Early in the field work phase, an onsite advisory committee (consisting of two elders and the director of Peguis Health Services) was established to review the progress of the project periodically, deal with any problems that might arise, and review drafts of final reports. As it turned out, this committee met formally on only one occasion, mostly because of difficulty finding a suitable time when committee members were available to meet again. At that time, the committee members indicated approval of the research plan, made suggestions regarding the elders in Peguis who could provide information, and discussed certain sensitive issues in the community that the researchers should be aware of. The second step taken to maintain a

collaborative approach was the hiring of a student from the community to act as a research assistant. The primary function of the individual chosen for the position (following the band protocol for hiring summer students) was to act as a guide and liaison between the researcher and the community.

In keeping with the principle of using multiple sources of evidence to improve the internal validity of the case study, attempts were made to use three sources of data during the period of field work (in Peguis from April to August 1993 and at the National Archives in Ottawa during October 1993): a review of documents (archival and contemporary); observation of key community health development events; and interviews with key informants.

Several types of documents were identified for review, both to frame interview questions and to corroborate and augment information from other sources. It was hoped that federal government documents would provide comprehensive information about the major periods of government-administered health services at Peguis and that records such as annual reports might help to identify major health trends in the community. Unfortunately, finding these documents proved complicated. It was not until early August 1993 that the National Archives was able to determine the probable location of the documents. Research carried out at the Archives in October 1993 did unveil some historical records of the organization and provision of medical services to the people of Peguis. However, the documentation was fragmentary, with large gaps in information, especially relating to the provision of public health nursing services between 1940 and 1980. As a result, certain sections describing health services delivery before 1980 rely heavily on interviews with key informants.

Although there were also large gaps in the administrative records kept by Peguis Health Services (phs) since the band took over administration of its health centre in 1980, a review of available letters, memoranda, minutes of meetings, written reports of events, proposals, progress reports, documents related to the 1991 health transfer agreement, and newspaper clippings did help to reconstruct the major stages and issues involved in the contemporary period of health services development in Peguis.

A second source of data was the observation of, and participation in, key community health development events. These included attendance at a two-day community health workshop on aids, attendance at phs staff and mental health committee meetings, and participation in an annual pow-wow sponsored by the Peguis Health Centre.

Interviews with key informants were the focus of the data collection phase, and they provided the richest source of data. The selection of informants (and documents and events, for that matter) was carried out using a `purposeful' sampling strategy, which involves sampling those people (or documents or events) that will "provide the *greatest opportunity* to gather the *most relevant data* about the phenomenon under investigation". (Strauss and Corbin 1990, p. 181, emphasis in original) The aim of this type of `theoretical' (as opposed to `random') sampling is to sample *events* ─ including the conditions that give rise to them, the consequences, and so on ─ rather than sampling persons per se. (Strauss and Corbin, p. 177)

Since the purpose of the research was to reconstruct the historical development of health care services in Peguis within the context of community development as a whole, interviews began with key elders who were identified (through consultation with several community advisers) as being able to give the broadest history of events in the community. Sampling then branched out from there, in `snowball' fashion. According to Strauss and Corbin (1990), purposive sampling proceeds with a concentration on development and saturation of relevant categories of information, noting variation and process and gradually increasing in depth of focus until no more variation or detail emerges from informants. While every effort was made to do this, both the nature of the subject under investigation and limitations on the time available for carrying out interviews meant concentrating on people who were most likely to provide information about the various stages of health services and community development in Peguis. This fact, combined with the gaps in documentary evidence, means that there are certain periods and events (which are identified in the text) about which we were able to obtain only limited information ─ and, occasionally, no information at all.

It must be also be emphasized that, owing to the need for purposive sampling of key informants who might provide information about the process of health services and community development in Peguis, the perspective presented here is that of those informants only. In this case, it was certain elders and individuals directly involved (either currently or in the past) with the development or provision of health services who were interviewed. The majority of these individuals were female (not surprising, I was told, given that health care has been seen historically as the responsibility of women in this community). While there is always a danger of bias when dealing with information `gatekeepers', every attempt was made to corroborate

information from other sources (individuals and documentary evidence), and, in the case of conflicting view, both perspectives are reported.

In all, 43 interviews were conducted with 38 individuals ─ more than one session was required for several of the informants. Thirty-three of those interviewed were members of Peguis First Nation, with 20 of these individuals being either currently or formerly involved in the development and/or provision of health-related services in the community.[4.] All those interviewed were given the option of rescinding that permission (or permission to use any of their comments) at any time before, during, or after the interview. No one chose that option at the time of the interview. However, one informant approached me several weeks after an interview, requesting to review the written transcript and to delete certain comments. This request was honoured, and the original data were destroyed. All but one of the informants agreed to have their interviews taped. All but one of the interviews were conducted by me (the other one being conducted by the research assistant). Because of the specific historical circumstances of this community (see next section), all Peguis band members speak English fluently, and there was no need for an interpreter to be present during interviews. However, the research assistant set up the interviews and accompanied me to most of the interviews with community members.

The only problem encountered during the interview phase of the field work related to timing. Because this phase of the study (June, July and the beginning of August) coincided with the busiest time of the year in the community (Treaty Days, pow-wows and, generally, a lot of movement in and out of the community), a considerable amount of time was spent trying to track people down. Unfortunately, we were not able to interview several key informants, including Chief Louis Stevenson.

A Brief History of Peguis First Nation

Although the primary focus of this case study is the development of health services at Peguis, it is important to recognize that health-related issues do not occur in a vacuum. They need to be understood within the broader social, cultural, political, and economic context that shapes them. What follows is a brief description of some of the key events in the development of the Peguis reserve as a community.

Origins of Peguis First Nation

Peguis reserve is located about 170 kilometres directly north of Winnipeg in the central Interlake region of Manitoba. The total land base is 76,000 acres (roughly the size of the city of Winnipeg), making it the largest reserve in Manitoba. As of the summer of 1993, some 2300 people lived in Peguis.[5.] Peguis First Nation is a signatory of Treaty 1, signed in 1871. However, the reserve was not always called Peguis, nor was it always located at its present site.

In the 1830s, the British colonial office decided on a policy of assimilation to deal with the Indigenous peoples encountered by European settlers as they moved westward across what is now known as Canada. (Titley 1986) Under the guidance of government agents and missionaries, Aboriginal people were to be settled in permanent villages and educated in English, Christianity and agricultural methods. One of the earliest examples of implementation of this policy took place in the region south of Lake Winnipeg in Manitoba, where the Anglican Church Missionary Society set up a network of parishes, including the parish of St. Peter's. (Czuboka 1960) The difference between this parish and the others was that it was located in an area that had been inhabited in the late 1700s by a group of Aboriginal people and their leader, Chief Peguis. References to Chief Peguis in the literature refer to him as being Saulteaux-speaking, and most of the older informants we spoke to in Peguis referred to Chief Peguis and his descendants as being Saulteaux people. A few of the younger informants used the terms Ojibwa or Anishnabe, but use of the latter term was rare. According to Steinbring, (1981) the term Saulteaux was used widely historically as an exact synonym for Ojibwa ─ especially when referring to the Aboriginal peoples in the area around Lake Winnipeg, who are thought to have migrated to the area at the end of the eighteenth century from the Sault Ste. Marie region of Ontario.

Although there appears to be general agreement that Chief Peguis and his descendants were Saulteaux, certain historical circumstances have led to confusion about the ethnographic composition of the Aboriginal community that developed at St. Peter's during the 1800s. At the same time as the Anglicans were setting up parishes in the 1830s, many Cree people began to move down from the Norway House area of central Manitoba via the boats that transported trade goods between York Factory on Hudson Bay and the Lake Winnipeg lakehead. The Cree settled

with Saulteaux groups living south of Lake Winnipeg. There is evidence that this was the case at St. Peter's, resulting in an intermixture of Saulteaux and Cree peoples. (Czuboka 1960; Steinbring 1981)[6.] The Anglican Church Missionary Society encouraged the Aboriginal peoples of the area to convert to Christianity and to settle permanently in pastoral agricultural communities, such as St. Peter's. Schools were set up to teach the children English and religion. Chief Peguis was one of the first of the area's Indigenous people to convert to Anglicanism in 1838 and to take up agriculture; he was followed by his family, except for one son, who was strongly opposed to the conversion and committed suicide shortly after. (Thompson 1973)

The tendency of the Saulteaux to be more resistant than the Cree in the region to both religious conversion and farming has been noted. (Hallowell 1936) There is evidence that although many of the Cree people in the area followed the lead of Chief Peguis, many of his own Saulteaux people resisted the conversion to both Christianity and agriculture for some time. (Czuboka 1960)

There was apparently some criticism of Chief Peguis for converting to Christianity and accepting agricultural settlement, (noted in Van Der Goes Ladd 1986) but some historians have argued that the chief was motivated by the recognition that only a transition to farming could stave off starvation in the face of the rapid depletion of wild game following the influx of European settlers. (Thompson 1973; Van Der Goes Ladd 1986) In fact, the push to occupy the lands of the North-West in order to claim sovereignty did accelerate greatly after 1867, decimating the buffalo herds and resulting in widespread destitution among the Indigenous people of the prairies. Between 1871 and 1877, the first seven numbered treaties secured for the federal government the Indian title to most of the fertile lands in the southern prairie provinces. (Titley 1986)

The predominantly Aboriginal settlement at St. Peter's was officially set aside as a reserve under Treaty 1 in 1871. The St. Peter's reserve was located on prime agricultural land, and by that time, a significant percentage of its Aboriginal population was engaged in farming, supplemented by small-scale hunting and fishing and occasional contract work. However, the last quarter of the nineteenth century saw a rapid expansion of European settlement as the Canadian Pacific Railway reached the prairies, and St. Peter's would not escape the negative consequences of that colonization drive.

There is evidence that the health of the community suffered considerably from the introduction of alcohol and from epidemics of diseases such as smallpox during this time, but complaints by some of the Aboriginal people of St. Peter's in 1873 about a lack of medical services appear to have gone unheeded. (Czuboka 1960) Not only is this shocking, given that a physician was practising in the nearby town of Selkirk, but it appears to have been in violation of an agreement made with St. Peter's during treaty negotiations in 1871.

While only the terms of Treaty 6 make specific reference to federal responsibility for providing medical care, research into the records of negotiations of other Manitoba treaties suggests that similar agreements *were* concluded. (Manitoba Indian Brotherhood 1979) For example, members of the St. Peter's band who were present at the negotiation of Treaty 1 (signed at Lower Fort Garry, 3 August 1871) swore an affidavit in December 1872 regarding agreements made during the treaty negotiations. An excerpt follows:

> ...That on the day when said Treaty was signed the chiefs did enumerate the articles which they demanded in addition to Treaty money.
>
> That these articles enumerated were agricultural implements for the chiefs and headmen; waggons, horses, harness and suits of clothing; work oxen, bulls, cows, hogs, sheeps, turkeys and fowls; *on each reserve, medical aid* and a school and school master; If they wished to take their treaty money in goods they would be supplied at Canadian prices.
>
> That Governor Archibald and Commissioner Simpson did both promise to the Indians that the things demanded should be given, but said that we will not put all these things in the Treaty paper, but we will promise to make a separate paper which will do as well, and you will be sure of these things.
>
> That these things have not been given, and that when they were demanded by the Chief, Henry Prince, at the payment of this year, he could not get no right answer from the Commissioner... (Canada, Sessional Papers, No. 23A, 1873, p. 9, quoted in Manitoba Indian Brotherhood 1979, emphasis added)

It was not until 1897 that a Dr. J.R. Streep of Winnipeg was appointed medical attendant to the Indians of Clandeboye agency, of which St. Peter's was a part. (Canada 1897) However, this arrangement seems to have been far from adequate. In 1904, a petition was sent from St.

Peter's to the Indian commissioner in Winnipeg, requesting that a doctor be stationed in the nearby town of Selkirk because many people on the reserve were "diseased and suffering" ─ but the request was denied. (Canada 1904) Although no reason was given for turning down the request, it seems safe to assume that the government simply did not wish to spend the money ─ especially since Titley (1986) notes that the government specifically hired only those physicians who could be relied on "*not* to attend to Aboriginal people except in cases of necessity", in order to prevent demands for free treatment. (p. 18)

Although there appeared to be little concern for the physical well-being of the people living on St. Peter's reserve, there was increasing interest in the extremely fertile land on which St. Peter's was situated. During the last quarter of the nineteenth century the *Indian Act*, which contained specific guarantees to protect Aboriginal lands, was gradually amended to accommodate settlers, municipalities, railways and resource companies, which sought cheap land. This trend accelerated after the 1890s when the federal government, disillusioned with the reserve system ─ which had come to be seen as a hindrance to assimilation ─ changed its policy and began actively to encourage the `surrender' and sale of reserve lands across the prairies. (Carter 1990)

In 1907, pressure from land speculators and unscrupulous politicians and government bureaucrats ─ including the deputy superintendent general of Indian affairs, Frank Pedley, who had already participated in no fewer than four fraudulent schemes, personally profiting from Indian land sales ─ culminated in the `surrender' of St. Peter's reserve land.[7] After much protest by many of the people of St. Peter's, a House of Commons debate in 1910 revealed that, after the federal government bought the St. Peter's reserve land (85 per cent of which was considered the best quality land in Manitoba), it sold 35,000 of the 48,000 acres for less than one-third of its actual value to `political friends' in what was to become the thriving city of Selkirk. In 1911, Manitoba's Premier Roblin appointed a provincial royal commission to investigate the surrender and sale of the St. Peter's reserve. The opinion of the majority was that the surrender of the reserve had been completely illegal and should be annulled. The people of St. Peter's were informed that they would be given an opportunity to air their complaints of false representation and fraud at a later date ─ but this promise was never kept.

As for the federal government's response, the department of Indian affairs ignored the conclusions of the royal commission, stepping up their efforts to persuade the people of St. Peter's to relocate to the new site. Finally, in April 1916, the House of Commons (also ignoring the recommendations of the royal commission) passed legislation allowing the sale of St. Peter's land to proceed.

Relocation and the Development of Underdevelopment

The new reserve on the Fisher River ─ named after Chief Peguis ─ was far more isolated than St. Peter's, but it was chosen by band representatives because of the abundance of whitefish in the area and the potential for farming. Several elders in Peguis who were born at St. Peter's still have vivid memories of the move to the new location. Most people appear to have taken the northern route, by boat, to Fisher Bay, and then travelled south along the Fisher River by oxen because the bush was too rough for horses. They had few supplies, and the task of clearing the land and building homes was not an easy one. In addition, one of the conditions of the surrender of St. Peter's reserve had been a promise by the government to provide agricultural implements and seed to people who relocated to the new site. According to a great-grandson of Chief Peguis, Chief Albert Thompson, this never happened. (Thompson 1973)

Nevertheless, despite all the hardships, the elders recall that, at least until the 1940s, most families managed to eke out a living through small-scale farming. Some people raised hogs, chickens, and even cattle. Everyone had gardens and grew their own vegetables, and fish, wild meat and wild berries were plentiful. Most of the houses were built from tamarack and spruce logs. There was no running water or indoor plumbing, but the elders remember that the Fisher River was clean and clear, and everyone would haul water from its springs.

After the railway line came to the nearby town of Hodgson (around 1914), men would cut cordwood and sell it in town, and families also harvested and sold seneca root for extra income. Seneca root and its extracts were once used in as many as fifty types of medicines, including cough remedies and laxatives. Apparently, the Interlake region of Manitoba was the main source of the world supply of seneca root for many years, until the 1950s, when a replacement was found for its original uses and the market for the herb began to decline steadily (*Interlake Spectator* [Arborg, Manitoba] 1986) The elders recall that everyone had to work hard and keep busy in order to survive. Then, things began to change.

Without access to any documented evidence, it is hard to say for sure when ─ or why, exactly ─ conditions began to deteriorate in Peguis. From what the elders told us, the 1940s appear to have been a turning point in the community's history. Many of them recall that, when people began to receive regular social assistance payments, they stopped planting their own gardens and began to buy less nutritious food at the store in Hodgson.

However, there is at least some evidence of a more active form of underdevelopment of the economy in Peguis. Several informants remember that you could not sell or trade livestock or produce without receiving permission from the Indian agent, and they suggested that certain Indian agents may have had an influence on the closing of economic opportunities. Unfortunately, it was not possible to review department of Indian affairs archival records during the time available for this study ─ nor was it within the scope of this study to do so. However, even without documented evidence, the allegation that Indian agents undermined economic development on the reserve is entirely plausible. The fact is that Indian agents continued to have complete authority over all business transactions in Peguis (and other reserves) until the 1950s. This, combined with a lack of financial resources needed to compete with other farmers in the area, likely contributed to the decline in the economy of Peguis.

In 1966, the federal government published the results of a two-year study undertaken to determine the social, economic and educational situation of Aboriginal people in Canada. (Hawthorn 1966) This document became known as the Hawthorn Report. The following information about Peguis is taken directly from that report. Peguis was one of 35 reserves across Canada that were selected for a more detailed study. The results were startling. By 1964, the annual per capita income in Peguis was only 99 dollars ─ the third lowest of the 35 reserves surveyed ─ and one hundred per cent of the households were receiving welfare assistance. Only one per cent of the households had running water or indoor toilets (by this time, according to informants, the Fisher River was seriously polluted, causing frequent outbreaks of diarrhoea), and only 40 per cent of the houses had electricity. Almost 48 per cent of the population of Peguis was under the age of 16, and only 4 per cent of the population was educated past grade 9. Peguis was classified as a depressed, underdeveloped community ─ one of the poorest in Manitoba.

Living conditions do not appear to have improved significantly during the 1970s. One informant, age 20, recalls that in 1979 her family lived in a small rat-infested house with no

indoor plumbing. She and her sister used to carry five-gallon pails of water to the house at least three times each day from the well that provided water for the cows.

Community Development in the Contemporary Period

By contrast, the 1980s and early 1990s have been a period of dramatic community development in Peguis. Some of the accomplishments that have been achieved include[8.] Many new permanent jobs have been created during this period, and the unemployment rate appears to have dropped to an estimated 50 to 55 per cent (official figures were not available, and there are still seasonal fluctuations). While this level of unemployment is excessive compared to Manitoba's non-Aboriginal communities, it does compare favourably to other Manitoba First Nations. However, according to the band's economic development officer, Larry Amos, Peguis still receives approximately four million dollars in welfare payments each year.

This contemporary period of economic development in Peguis is a fascinating one. Unfortunately, it is beyond the scope of this study to deal with the subject in detail. Suffice it to say here that the leadership of Chief Louis Stevenson and his administration since 1981 has been a key factor in much of the economic progress that has been made in Peguis.[9.]

Development of Government Health Services

As we have seen, the period before relocation to the new reserve was characterized by neglect of the health of the Aboriginal people of St. Peter's, during a time when health status was deteriorating significantly in the face of rapid European settlement of the Red River region. The St. Peter's experience was not an anomaly, but rather a typical example of the low priority given to the provision of medical services to Aboriginal people by the federal government in the late nineteenth and early twentieth centuries. (Graham-Cumming 1967; Young 1984)

Subjugation of the Traditional Medical System

Before exploring the development of formal[10.] For the Lake Winnipeg Saulteaux (as for the southern Ojibwa people in general) there is evidence that the Midewiwin Lodge, or Grand Medicine Society, was a major institution in their society at the time that European settlers

arrived in the Lake Winnipeg-Red River region. (Hallowell 1936; Steinbring 1981) The central focus of the Grand Medicine Society was on maintaining good health through training in the traditional medical arts. However, numerous non-medical activities were associated with annual gatherings, and there was a strong spiritual emphasis in many of the Midewiwin rituals and ceremonies. (Steinbring 1981)

There is no doubt that many of the Saulteaux people in St. Peter's were active members of the Midewiwin Society ─ including Chief Peguis before his conversion to Christianity ─ and there is evidence that many of the Mide healers put up the greatest resistance to both religious conversion by the Anglicans and agricultural settlement at St. Peter's. (Czuboka 1960; Hallowell 1936) Unfortunately there is no evidence of Midewiwin ceremonies being conducted at St. Peter's after the 1870s, and it is not clear what happened to those who were members of the Society.

It was during the last quarter of the nineteenth century that efforts to assimilate Aboriginal people accelerated, and it is possible that many of the remaining hold-outs resisting conversion at St. Peter's eventually bowed to the pressure or else died out naturally. However, the fact that the son of one of the Mide leaders from St. Peter's later became headman of the Midewiwin near the Bloodvein reserve (Hallowell 1936) suggests that at least some of the Mide leaders who resisted assimilationist efforts may have left St. Peter's during this period and gone to reserves in the region where Midewiwin ceremonies and resistance to Christian conversion persisted through the first quarter of this century.

According to both written sources (Thompson 1973; Van Der Goes Ladd 1986) and interviews with elders, the people who relocated to the new reserve on the Fisher River were those who had already converted to Christianity, and there is no evidence that a Midewiwin ceremony was ever held on the Peguis reserve in the years following relocation. However, as we will see, this does not mean that traditional medical knowledge had been entirely lost (see the section beginning on page for a discussion of contemporary events).

Early Medical Services: Before 1940

Before 1924, medical services provided by the federal government were limited. Many of the elders interviewed for this study remember that a doctor would travel occasionally to Peguis on horseback from either Arborg or Selkirk and provide medical services out of a local dwelling, or

sometimes go from home to home visiting the sick (identified to him through word of mouth). They also recall that some medicines were kept at the Anglican mission house on the reserve. However, they suggested that, more often than not, no doctor was available ─ a perception that is supported by a series of department of Indian affairs (dia) memos. (Canada 1917; Canada 1920; Canada n.d.a) The fact that it was up to the Indian agent to decide who should see a physician and to send for one may account in part for the fact that visits from physicians seem to have been limited. However, it is likely that the emphasis of Duncan Campbell Scott, deputy superintendent of Indian affairs, on restraint in spending on Indians in 1913 (Titley 1986) was also a factor.

Many of the elders recall that when there was no doctor visiting the reserve, people would make a four- to six-day round trip on horseback through the bush to the town of Arborg in order to see the nearest physician. Once the train reached the nearby town of Hodgson, the Indian agent might authorize a trip to Winnipeg in the case of very serious illness. The first references ─ both written and oral ─ to serious disease in Peguis relate to the outbreak of Spanish influenza that swept many parts of the world during 1918 and 1919. Unfortunately, it was in 1918 that the position of chief medical officer for the department of Indian affairs was officially abolished "for reasons of economy", so there was no one to co-ordinate a medical response to the epidemic, which killed more than 4000 Aboriginal people in Canada. (Titley 1986, p. 87) As of April 1919, a total of 44 people had died in Peguis as a result of Spanish influenza.

Increased funding under the Mackenzie King administration during the 1920s may partly explain why Indian affairs agreed to hire a permanent medical officer for the Fisher River agency. In 1924, Dr. James Bird became the first physician to reside (at least part-time) in the `Resident Halfway House' ─ The Halfway being the popular name for the Fisher River Indian agency buildings located in the middle of the Peguis reserve. A nurse was sent to the agency during that year as well, although it appears that she may have been employed by the Anglican Mission rather than Indian affairs. (Canada 1925)

The major health concern during the 1920s and 1930s was tuberculosis (tb). The official tb death rate among First Nations peoples of the Prairies in 1930 was approximately 560 per 100,000 population. (Graham-Cumming 1967) According to the medical officer who worked in the Interlake region during the 1930s, the area was seriously affected by the disease, and he estimated that the death rate was actually 700:100,000 during the early 1930s. (*Interlake Spectator* n.d.) Unfortunately, Dr. Bird's concerns that people with active tb were being sent

home to die and infecting others, and his requests that these people be removed to sanitoriums (Bird 1929) appear to have been ignored. In 1931, Indian agents were advised that no tubercular Indians would be admitted to sanitoriums. The cost of one year of treatment in a sanitorium was $1000 per person ─ the annual expenditure in 1931 for Aboriginal people with tb was less than ten dollars per person.

While it is true that the Canadian economy was hit hard by the Depression in the 1930s ─ with widespread poverty and unemployment on the prairies ─ the slashing of appropriations for Aboriginal health services during that time cannot be explained entirely by the recession. The fact that per capita health expenditures for Aboriginal people in 1934 were less than one-third of that spent on the non-Aboriginal population (Graham-Cumming 1967) suggests that the chronic underfunding of Indian health services had less to do with a real lack of funds than with a lack of will ─ which could be explained only by a general attitude that did not place the same value on the lives of Aboriginal people and non-Aboriginal people.

The emphasis placed on reducing expenditures did have an effect on the provision of medical services to the people of Peguis. In 1930, the government had opened a nursing station on the Peguis reserve. It was referred to as the Fisher River Nursing Station because it was located on the banks of the Fisher River, which runs through Peguis from south to north. The Fisher River Nursing Station served all three reserves in the Fisher River Indian agency (Peguis, Fisher River, and Jackhead), as well as other First Nations communities in the region, and there is evidence that this was the first such facility to be built on a reserve by the federal government. It contained two adult beds and two or three cribs, but only a limited amount of medications were kept there.

Although no written documentation of this information could be found, several of the elders remember that Miss Brandon was the first ─ perhaps only ─ nurse to work out of the nursing station, and that she was often assisted by an aide from the community. According to Rita Dozois (who worked for Medical Services Branch (msb)-Manitoba Region for many years), a nurse who was hired by Indian affairs to work as a community health nurse (chn) in Manitoba during the 1930s told her that there was only one policy ever written down at that time regarding a chn's duties ─ she had to enter every Indian household in her area once a month and report that she had done so. (What she did while in the home seems to have been irrelevant!) If this was the case, given the vast area that the Fisher River agency covered, it is likely that Nurse Brandon

was not present in the nursing station very often. In fact, several of the elders have strong memories of seeing Miss Brandon travelling around the area on horseback or by horse and buggy in the summer and by horse-drawn sleigh in the winter. Sometimes she would be by herself, while at other times she would accompany the physician on home visits.

Unfortunately ─ whether because of the depression, a lack of political will, or a combination of the two ─ it seems that these efforts were often hampered by a lack of funds. For example, Nurse Brandon's request for a dentist to visit the area in 1931 (because she had been doing all the dental work herself since 1924) was rejected by Indian Commissioner Graham as a "large and unnecessary expenditure". (Canada 1931) In addition, from early 1931 until late 1934, Nurse Brandon had less assistance from a physician. Early in 1931, Dr. Bird was forced to resign as the medical officer for Fisher River agency because of poor health. The position was left unfilled until the summer of 1931, at which time it was downgraded to part-time status, so that the doctor could generate his own income from serving the non-Aboriginal population of the area and "decrease expenditures". (Canada 1931)

The new, part-time medical officer of Fisher River agency was Dr. Percy E. Moore. Seven months after Dr. Moore took up his position, he was informed that his $2100 annual salary would be subject to a 10-per cent reduction, and he was advised to "exercise economy in every direction". (Canada 1932) It was not until November 1934 that Dr. Moore's part-time position was upgraded to a full-time position.[11.]

Dual Medical Systems: 1909-1930s

It seems reasonable to assume that, despite there being a regional nurse and medical officer based in Peguis from 1924 onward, the combination of several factors ─ a lack of resources from the federal government, restrictions on access to and provision of services for Aboriginal people, and the size of the area these two medical care providers had to cover ─ resulted in only limited use of formal medical services in Peguis during this period. This hypothesis was, in fact, confirmed by several elders. However, it appears that an alternative medical system did exist in the area and continued to function well into the 1930s.

From what the elders say, virtually all the people who came to Peguis from St. Peter's were Anglicans, and there is no evidence of traditional spiritual ceremonies or activities being carried out on the new reserve after the relocation. However, the curing aspect of traditional

medicine did remain intact. Two of the elders describe the traditional medicines that were widely used:

> We used `Indian medicine'...Indian roots... One kind was *weh'kes* [pronounced wee-kays], that's Indian ginger in English.[12] *weh'kes* and rub it on there and it would come out like powder...you put that in hot water, and you could sweeten it if you liked...and that was our medicine. (Edith Thickfoot, age 92)

> I remember that there was medicine for the heart, we called it [pronounced `namaypin']...that grows down the back here... I don't know what you call it in English...and there was medicine for fever and for if you couldn't stop the bleeding... There was also something from the spruce trees I used to use on my kids when they had a sore that wouldn't heal... There was medicine for everything...even for venereal disease... There was medicine too for women after they had their babies, to clean your system out and make you strong...it was black current root. You go in the muskeg and there's little...we used to call them `tea pots'. You got five of them and boiled it in a kettle and that's what we used to drink after we had our babies. (Aurelia Thickfoot, age 77)

While many of the common herbal remedies were used in every household, there were also two types of traditional practitioners who provided specialized care ─ the `Indian doctors' and the midwives:

> There were certain people who were the Indian doctors... There was [name]. She was one of them. And there was a woman from Fisher River that knew heart medicine... People from Peguis would travel all over for what they were looking for... The men knew the same kind of medicines too...like my dad...and my father-in-law. I helped him one time make this man sweat. Now they use the sweatlodge. Then they used medicine to make people sweat out...plus they used something in water, they called it juniper. (Aurelia Thickfoot)

> I remember we never ever went to a [white] doctor. My grandmother was an Indian doctor... My grandfather was the same. They used to work together, but he used to look after the men... I remember I used to follow her around and go

> different places where they would ask her to go if someone was sick. But I couldn't tell you what was wrong with them because that was confidential to them...she didn't tell me... I used to ask her, "Granny, why don't you show us what you're doing?" She answered, "No, my girl, by the time you grow up there won't be any of this around".

One of the elders remembers that her grandmother practised her medicine until shortly before her death ─ in fact, she remembers accompanying her grandmother to see her last patient in 1935. The female elders remember that women continued to have their babies at home with the help of a midwife, even after the nursing station opened. Sometimes the Indian doctors would assist them, and sometimes the nurse was in attendance as well. It seems that some women did deliver in the nursing station if they were at higher risk, or stayed there after giving birth if there were any problems. While the use of midwives during the 1920s and '30s may have occurred in part by necessity, because the nurse and physician had to travel widely during that time, some of the female elders suggested that most women preferred the services of a midwife:

> [Pregnant women] were more comfortable at home with their own kind of people.
>
> •
>
> I had twelve children, and I stayed home with most of them. I preferred it because there was a way that the midwives did it to help you and there wasn't too much suffering... If there was a little bit of trouble...then the healer would work with the midwife. (Aurelia Thickfoot)

Hegemony of Government Medical System

It was not until the end of the 1930s that an improved operating budget was introduced for Aboriginal health services, and it seems likely that this development was not unrelated to the fact that Dr. Percy E. Moore had become the acting superintendent for medical services in 1939. Dr. Moore, after all, had worked as a medical officer in the field for several years and had experienced the lack of resources at first hand ─ unlike his predecessor, Dr. Stone. In any case, the number of federally run `Indian hospitals'[13].

The Fisher River Indian Hospital: 1940-1973

Even though construction of the Fisher River Hospital (frh) was begun the same year that Dr. Moore left his job as the medical officer for the Fisher River agency, it is likely that he had a lot

of influence on the decision to build the hospital on the Peguis reserve. One of the elders recalled that he spoke enthusiastically about the possibility of such a facility being built when he was still working out of the nursing station. One of the unique (and apparently unusual) features of the frh was that it was constructed almost entirely using Aboriginal labour from the area (except for the plumbing). Construction was halted for some time at the outbreak of the war in 1939. Finally, during the summer of 1940, the old nursing station was closed and the new Fisher River Hospital was officially opened by Dr. Moore.

The facility ─ referred to by most people in Peguis now as `the old Indian hospital' ─ was intended to serve all the Interlake reserves. According to notes prepared by Dr. E.L. Ross of the Sanitorium Board of Manitoba for the official opening, the primary purpose of the hospital was the eradication of tuberculosis from the Interlake region. (Ross 1940) However, the frh was to provide general medical services as well. The beds for tubercular patients were located on the ground floor, while the rest of the beds were on the second floor. The frh was initially staffed by a resident doctor, a director of nursing (referred to as `Matron'), two additional registered nurses (rns), and trained auxiliary nurses and ward aides from the community (see following pages for further discussion).

There are considerable discrepancies in the figures given regarding the patient capacity of the frh. The notes prepared for the official opening (as well as other government documents) indicate that the facility initially had a 24-bed capacity and that 12 beds were for tubercular patients. Yet the descriptions provided by elders who worked there, including one person who helped to build the facility, are remarkably similar and suggest that there were more than 30 beds (the figures given ranging from 32 to 38). Perhaps the discrepancy can be explained by the frequent references made by former employees to overcrowding and the need to put extra beds and/or cribs in the wards ─ 24 beds may have been the official number only. The beds were divided between pediatric, maternity, nursery, adult men, adult women, isolation, and the terminally ill. There was a combined delivery and operating room, but only minor surgery was conducted there.

The physical design of the hospital was odd, to say the least. The public entrance to the building was on the second floor, accessible only by climbing ─ or being carried ─ up a steep flight of stairs outdoors. There was no elevator in the building, and all supplies and patients had to be carried or hoisted between floors. However, none of the former employees complained

about these things. The facility was one of the first buildings in the community to have both electricity and a telephone, and there was one feature that the female employees considered a luxury. As one former employee explained,

> [There was] one bathroom with a tub and toilet for the females. The men just had a sink and toilet. Nobody had running water at home. We used to have our baths at the hospital. We used to have to go to work early, say, an hour and forty-five minutes early, so you could have a bath before you went to work.

During the early years, especially before roads improved, the only way to get mail or supplies was to pick them up from Hodgson, where the train arrived from Winnipeg three times a week. It appears that as many supplies as possible ─ including linen and hospital gowns ─ were made by the hospital staff themselves, and each morning someone milked the four cows kept by the hospital.

Several important features about the Fisher River Hospital's operation from 1940 to 1973 are worth highlighting. One is related to community response to the new hospital and to the increase in formal medical services. According to one of the elders who worked at the frh, at first there was some resistance among some community members about going to the hospital for treatment:

> When they first opened up the hospital, even though they were sick, you had a hard time to get them to come to the hospital... I don't know. It seemed like they thought once they were in the hospital the doctors would start chopping them up. A lot of them were afraid of that 'cause I can remember a young man dying not too far from here and there was no reason for him to die, but he wouldn't even allow the doctor to come and see him... The trouble we had most was getting the maternity cases into the hospital at that time. They didn't seem to want to come.

For the most part, however, people turned increasingly to the hospital for medical care. At least three factors might explain this phenomenon.

First, and perhaps most important, during the period when the hospital was developing its services in the early 1940s, the option of using traditional midwives and Indian doctors was disappearing as these old people died and their skills died with them. A second factor relates to general health conditions in the community. Monthly reports from the Indian agent in 1942 state that all patients with active tuberculosis were hospitalized and that many were making good

recoveries. (National Archives, rg 29, vol. 2930) However, while the incidence of tb may have been declining, the reports throughout 1942 and 1943 indicate that general health conditions in Peguis were below normal, and there are frequent references to the large number of children with bad colds and to continued outbreaks of whooping cough, measles and ─ occasionally ─ encephalitis and polio. From the stories the elders tell about how Peguis has changed over the years, it appears that the period when the old hospital functioned (1940-1973) was characterized by a declining local economy and an increase in certain social and health problems ─ e.g., problems related to a gradual switch to store-bought foods lacking nutrients, overcrowded housing lacking proper sanitation facilities, and an increased use of alcohol. As a result, it is possible that the demand for medical services may have increased during this period.

Another interesting feature of this period that may account for the community's acceptance of the hospital is that the frh provided employment to many residents of Peguis, some of whom were involved in its construction, others in its maintenance, kitchen and laundry services. As the following informant describes, some people worked in a variety of jobs over the years on an ad hoc basis:

> Myself, I first washed the walls of the whole hospital, and then they asked me to do the sewing so I had to make gowns, sheets. Then I got into the Matron's quarters to look after their rooms. Then one day the cook didn't show up for two days so they asked me to go and help in the kitchen. That's how I never left there for fifteen years.

The experience of the ward or nurse's aides, who were almost all residents of Peguis (with a few from the nearby Fisher River reserve), is particularly important. Many of the ward aides started out working in the kitchen or laundry, then eventually were given the opportunity to train as aides, while others remained aides throughout their employment. The following informant's experience appears to have been typical:

> I was a nurse's aide. I started from the laundry...then they asked me if I'd go up in the wards. I was scared to go in the wards because I thought there was too many sick people, so they put me cleaning floors. Then after that they told me I was there long enough, I should go to be a nurse's aide. So I went, and there I stayed.

Although at least one of the ward aides took a nursing assistant course in Winnipeg, most of the aides received their training on the job from the nurses. According to former aides who

were interviewed, aside from the Matron, there often weren't many rns on staff. There were some auxiliary nurses, but it is not clear how many of the auxiliary nurses were actually licensed practical nurses (lpns). It seems that during the first 10 to 15 years of the hospital's operation, certain ward aides actually were trained on the job to become auxiliary nurses. However, there were also nurses who had taken an lpn course in Winnipeg. At least two lpns were Aboriginal women who lived in Peguis, but the majority of rns and lpns were non-Aboriginal.

Both the ward aides and the auxiliary nurses or lpns were given tremendous responsibility for the care of patients, and they did tasks that they might not have done in another setting. Several of the former aides and lpns describe their jobs:

> It was exciting. It was challenging to work in the old hospital. There we were allowed to do everything. Give out medications, injections, start ivs [intravenous lines], suture... Most women were having babies almost every year or so [in the early 1960s]. I remember we had four babies delivered in one night. It seemed the nursery was always full. At times, we had to deliver the babies ourselves because the doctor wouldn't get there in time. I was young and I didn't have too much experience in obstetrics. We sure had to learn fast out here though because there were so many deliveries. (Ann Bird, former lpn at the frh)

•

> I gained a lot of experience there because at that time...we did everything, assisted the doctor in deliveries, give needles, even used to take x-rays and develop them. We did all that... I remember this one time I assisted with this lady who was in labour all night... I was supposed to be in charge so I called the doctor... By the time he got there this woman was really sick, so...he did a Caesarian and I assisted... He said to me, "This is the only sterile one [needle] we got here. I better not drop this." (Verna Spence, former aide at the frh)

•

> There weren't many lpns, maybe three. But there were quite a few ward aides, and there was an rn to cover every shift. Sometimes two rns during the day...one rn and a ward aide or mostly an lpn and a ward aide worked the evening and night

> shift. So the lpns had to deliver a lot of the babies that were born there. They didn't send them into Winnipeg then... My first day on the job, my first duty was to go in the delivery room and deliver a baby. I said, "What? Me?" ...me and one ward aide, we delivered the baby. We called the doctor but by the time he got there the baby was already born and the cord was cut. You had to be a nurse in those days. You couldn't say no, leave the mother laying there. So we did the best we could. (Eleanor Olson, former lpn at the frh)

Eleanor Olson kept a little notebook with information about deliveries at the hospital, and the last time she counted before leaving the old Fisher River Hospital she had delivered 125 babies. One former auxiliary nurse from the community described the old hospital as being more like a nursing station. The doctor wasn't always there because of the frequent need to travel to other reserves in the area, and often there were not many rns on staff, and so the rest of the staff simply did what they had to do to care for the patients. Virtually all the informants who had worked at the frh as either a nurse's aide or lpn stated that they remember the work being exciting and challenging, and that the working relationship with the non-Aboriginal nurses and physicians was a fairly good one. As one former ward aide described,

> We were equal. They [white nurses] weren't snotty. We got along. ...an rn or an lpn didn't care if they had to wash diapers or linen. They never complained. They'd do it...give us a hand if they knew we were overloaded...and if we saw them needing our help then we'd go help them too.

In addition, almost every informant who had been a patient in the frh remembered receiving very good care. When former aides and lpns were asked to comment about this, several people suggested that, because they were aware that they weren't formally qualified to do a lot of their work, they always tried to do their very best. There was also the fact that the ward aides and some of the lpns often knew the patients or their families. A report sent by the assistant superintendent of medical services after a visit to the frh in 1942, which emphasized the "efficiency and spirit of co-operation shown by the staff", provides some external confirmation of the informants' perceptions about the quality of care and working relationships among the staff. (Canada 1942) In 1967, however, a different point of view was expressed in a report submitted by an msb official. (Canada 1967) This person noted that the turnover of nurses at the frh had been tremendous. The hospital should have had a staff of nine rns and nine ward aides,

but the average number of rns had been only two. Acknowledging that the population of ward aides had been more stable, the official went on to state:

> This latter fact also presents problems for the continually shifting rn staff. The aides, having been exposed to numerous nurses throughout the years, tend to go their own merry way, paying little or short-lived attention to directions from the nurse-in-charge... Good and safe patient care is the goal of any hospital. This goal is indeed far off as conditions now are at the Fisher River Hospital. (p. 1)

The closing of the Fisher River Hospital

In 1973, a major change occurred in Peguis, both for the community as a whole and for the employees of the frh. During that year, the old hospital was closed and a new facility ─ the Percy E. Moore Hospital ─ was opened at the southern border of the Peguis reserve on land ceded to the federal government.

The new Percy E. Moore Hospital (pem) came into being for several reasons. First, the old frh had been condemned for a number of years as obsolete and unsafe. (Canada 1964a; Canada n.d.b) Second, it was hoped that a new modern facility might attract physicians who would stay for longer periods. It was also anticipated that the new hospital would serve First Nations communities on the east side of Lake Winnipeg as well as the Interlake region. The major consideration, however, appears to have been the desire on the part of the federal government to build an integrated hospital to serve the needs of both Aboriginal and non-Aboriginal populations in the area. The rationale offered for an integrated facility was that the size of the integrated hospital would allow more economical operation than a solely Indian health facility, and the population in the catchment area would provide a comfortable workload for two physicians, thus raising the level of service to the Aboriginal as well as non-Aboriginal population. (Canada 1964a)

However, there is some evidence that this initiative was more than a matter of improving cost-effectiveness.

In 1964, the Royal Commission on Health Services had recommended that the administration of health services for Aboriginal people be entrusted to the provinces and that health services be provided for them in the same manner as for other Canadians. (Canada 1964b)

In a memo to the director of medical services in Ottawa that same year, the regional superintendent of medical services, central region, proposed that the operation of the new hospital would eventually be transferred to provincial control. (Canada 1964c)[14]. Regardless of the motivation behind the decision, interviews with informants from Peguis suggest that the closing of the old hospital was perceived as a major loss by the people of the community for several reasons. The fact that the hospital was no longer centrally located was definitely an inconvenience, but this does not appear to have been a major objection. Almost every informant referred to the old frh as "their" hospital, a "community" hospital, a "real Indian hospital". One person stated that the doctors at the frh were "more like family doctors" and that there was a "closeness" because they would come and visit you in your home. The new hospital was different.

For the ward aides and lpns (who all moved over to the new hospital initially), the new standards of practice that were brought into effect meant that they could no longer perform duties that they had carried out for years at the old hospital ─ making their jobs less challenging. New rns (some from the old hospital in the nearby non-Aboriginal community of Fisher Branch) took over many of the aides' and lpns' former tasks. Several former employees from Peguis stated that the working relationship between the rns and the aides/lpns at the new hospital was strained. As for the nursing care at the pem, most of the informants who had either worked or been a patient in both the old and the new hospital expressed the belief that the quality of care was not as good as it had been at the frh.

For community members at large, there were several reasons for disappointment with the new hospital. First, there is documented evidence that the three local reserve communities were led to believe that the new facility would be a real community hospital run by a local board consisting of two-thirds Aboriginal representatives.[15]pem opened, local Aboriginal involvement on the hospital board had been reduced to a mere token presence.

Second, within only a few years of the new hospital opening, no surgical services were being offered, only a few low-risk deliveries were being done, and the number of beds had been cut by more than half ─ leaving many people feeling that they were being poorly served. In its first full year of operation in 1974, pem reached the peak of its utilization, with more than 250 per cent of the admissions logged in the last full year of operation of the old Fisher River Hospital. However, community participation and use declined dramatically in 1975. By the

middle of 1976, the average occupancy rate was only 39 per cent, and serious consideration was being given to closing the state-of-the-art hospital. (Manitoba 1976)

Several factors appear to have contributed to this phenomenon. Until early in 1975, patients admitted to the pem came not only from the local district, but also from reserves on the east side of Lake Winnipeg (Berens River, Little Grand Rapids, Pauingassi and Poplar River). However, because of the lack of a satisfactory airstrip nearby, which made the journey difficult and uncomfortable for patients, and because air services between those reserves and Winnipeg improved and was less expensive, patients from those reserves were increasingly routed to Winnipeg. (Copping 1976) While this factor accounts for some of the decline in utilization, there is evidence that this was not the primary factor.

In 1975, the contract with a group of physicians from Arborg to provide medical services to the Percy E. Moore Hospital was terminated amidst considerable controversy,[16]·nmu)for provision of physician services. It was at this time that surgical services were suspended (owing to the lack of a surgeon and a shortage of nursing staff). The Arborg group, who continued to operate a satellite clinic in the town of Fisher Branch, began to refer their patients (i.e., the non-Aboriginal population) to the hospital in Arborg.

In 1983, an independent consultant's report on the Percy E. Moore Hospital concluded that it was "one of the finest, most inefficient medical complexes in all of Canada". (ceso 1983, p. 3) The report noted widespread dissatisfaction with the hospital and recommended that the pem be converted to a community hospital, providing both acute and long-term care, with total control in the hands of a community hospital board. None of the study's recommendations was ever implemented.

Finally, the most common complaint voiced by informants was the perception that, with the occasional exception, there has been a high turnover of medical staff at the pem. Although several physicians over the years appear to have gained the trust of Peguis residents, many informants described negative experiences that made them lose faith in the Percy E. Moore Hospital, and it was suggested that a substantial number of Peguis residents prefer to see a family physician in Arborg or even Winnipeg for continuity of care. A community health worker confirmed that, because of the frequent physician turnover, many women prefer to deliver their babies in Winnipeg.

Another opinion expressed frequently was a belief that, since the University of Manitoba took over provision of medical services, they were dealing with young, inexperienced doctors. One elder expressed resentment that "these young greenhorns only come here to practise on us, and then when they get enough practice they go somewhere else".

According to Dr. Sharon MacDonald, medical director of the nmu, at least four major factors contribute to the difficulty of retaining physicians at this rural hospital. First, the multi-jurisdictional nature of the hospital ─ with physicians employed by the Northern Medical Unit, the province paying the per diem for patients, and overall administration of the hospital in the hands of the federal Medical Services Branch (msb) ─ makes problem solving difficult, and physicians may feel that they are caught in the middle at times. Second, because the msb-run hospital is not part of the overall health care system in the surrounding Interlake region, physicians are professionally isolated ─ for example, they are salaried (as opposed to the fee-for-service payments received by their counterparts in other Interlake hospitals) ─ and there is no shared on-call system. Third, with funding for only four physicians (one of those being responsible primarily for providing services in Fisher Branch), physicians are on first call one night in four and on back-up every second night. The rigorous call system, combined with a high level of demand for service, may lead to burn-out. Finally, physicians have experienced both physical and social isolation in the area. The lack of available housing off the grounds of the hospital has contributed to a difficulty integrating into the local Aboriginal community.[17.] In summary, for the people of Peguis, even though the old Fisher River Hospital was run by the federal government, there was a sense of it being `their' hospital, a place where they felt at home. By contrast, the modern new Percy E. Moore Hospital was run in a more bureaucratic manner, and it was no longer seen as part of the community. Current issues related to pem are discussed in the section beginning on page .

Public health services: 1940-1980

Unfortunately, only a very sketchy history of public health services during the period from 1940 to the 1970s could be obtained from informants. A search of government archival material also failed to turn up more than a few isolated references to public health services at Peguis before 1980.

It appears that in 1940, when the old nursing station closed, community health services operated largely out of the Fisher River Hospital ─ at least until the mid- to late 1950s. However, public health programs do not appear to have been offered in any organized fashion during that time. In fact, former staff at the frh recall that, during those years, the director of nursing was also responsible for public health in the community. Eleanor Olson, who began working as an lpn in the out-patient clinic at the frh around 1957, stated that she often went out with the physicians to conduct immunization clinics in the schools at Peguis, Fisher River and Jackhead reserves. Eleanor also remembers that, around 1959, she went every morning (before she started work at the hospital at 8:00 a.m.) to give an insulin injection to the first known diabetic person in Peguis.

Aside from the public health work carried out by nursing staff based at the Fisher River Hospital, several informants remember that, as early as 1940, a nurse came to the community on Treaty Day each year to assist the physician in taking x-rays for tb control purposes. There are also memories of a nurse coming into the school and giving pills to the children in the 1950s. One informant remembered that the pills looked like dog biscuits (probably a vitamin pill) and that many children thought they were being punished. However, it is not clear where these nurses came from. Rita Dozois, a former msb nursing officer, believes that a provincial public health nurse may have served the area at some time during the 1950s ─ but this could not be confirmed.

It does not appear to have been until the late 1950s that the federal government began to provide organized public health services on a regular basis to Peguis and the surrounding reserves. However, these services were very limited, with one public health nurse serving all the reserves in the surrounding Interlake region. The nurse worked out of an old house next to the frh (one informant believed that this was actually where the original nursing station had been located), and this public health office was known officially as the Fisher River Health Centre.

In 1962, public health services in the area developed further when Dorothy Stranger, who was born and raised in Peguis, was hired as the first community health worker at the Fisher River Health Centre. The community health worker training program was the largest of a number of government-initiated training programs for Aboriginal health auxiliary workers and para-professionals. (Whitmore et al. 1988) Begun in 1960 in Norway House, Manitoba, the purpose was to teach basic concepts about health and sanitation to auxiliary health workers, who would then go back to their communities and teach their people. Dorothy Stranger was one of three Aboriginal people in Manitoba to be trained in the first year of the program in 1961.

Soon after Dorothy began working, Anna Pothorin, a former matron at the frh, became the community health nurse (chn)[18]. At some point in 1970 or 1971, formal public health services were expanded in the Interlake region, with more nurses being hired, so that there was one chn for each of the Interlake reserves. Anna Pothorin became nurse-in-charge of the Fisher River Health Centre and dealt primarily with Peguis after that time. In 1977, more auxiliary health workers were hired for the Interlake region. They were now known as community health representatives, or chrs. Verna Spence, who had worked as a nurse's aide in the old hospital, joined Dorothy Stranger, and the two chrs then worked primarily in Peguis.

Both the chrs and many other informants have fond memories of Anna Pothorin, who continued to work as nurse-in-charge at the Fisher River Health Centre until 1980, when the band took over administration of the health centre and hired its own nurses (see next section). As one woman recalled,

> I remember Miss Pothorin travelled back and forth to Jackhead now and then and she would stop by...just to see how I was doing and how the kids were. She was very well liked. And Dorothy Stranger too. They were very kind people. I remember one time when [my daughter] was sick...[Anna] left her car at the road and she walked in, snow blowing, cold and everything... We very seldom took our children to the hospital. She would come to the house. Miss Pothorin was like family. She fit right in.

This same informant recalled that she was brought up using red willow for a medicine, and she would give it to her kids if they had colds. When she told Anna Pothorin and Dorothy Stranger about this, both Anna and Dorothy said that this was good, and Anna never discouraged

her from using her traditional medicines. According to Rita Dozois, the former msb nursing officer, Anna Pothorin had certain personal qualities that contributed to her being a good community health nurse:

> ...somebody who had an even temperament and who was accepting of other people...who was more than willing to sit and listen and who was not a pushy character. And that certainly was Anna. ...in the long run, Anna was more effective in doing things than a lot of other nurses were, who were always demanding. Anna was liked everywhere she went because she was so understanding.

Unfortunately, Anna Pothorin died in 1989 and with her, a wealth of information about this period of health services development in Peguis. What can be said is that, under her guidance and with the assistance of the chrs, the foundation was laid for the provision of public health services in the community. The health needs of Peguis during the 1960s and 1970s reflected the state of community development ─ many of the problems related to the high level of unemployment and poor living conditions on the reserve ─ and the public health staff did their best to respond to those needs. However, by the late 1970s, and escalating into the 1980s, the community began to undergo a transition, and the resulting changes in the provision of health-related services would reflect this.

Summary

The period from 1940 to 1979 in Peguis was one of dramatic economic decline. During this time, the community's transformation from self-sufficiency to dependency and underdevelopment was completed, resulting in the loss of community control over conditions affecting health. The development of health services during this period reflected a similar trend and was characterized by the gradual development of the hegemony of a bureaucratic government medical system and loss of community control and a sense of ownership over the process of health care. See Tables 1 and 2 for a summary of major developments during this period.

Local Administration of Community Health Services: 1979-1991

During the 1970s, the federal government began to transfer the administration of a number of health-related services ─ such as local medical transportation, chrs, and some nursing services ─

to individual bands or tribal councils through contribution agreements. While the motivation behind this initiative can be debated, there is no doubt that it coincided with the growing calls by First Nations for more control over their lives.

In its 1971 document, *Wahbung — Our Tomorrows*, the Manitoba Indian Brotherhood (mib) concluded their discussion of the dismal state of health among Manitoba's Aboriginal peoples with the following statement regarding health services delivery:

> The effectiveness of the health services programs has historically been hampered by both the lack of understanding and the lack of involvement of Indian people. Externally controlled hospitals and nursing stations, externally developed programs of curative or preventive medicine have left little room for local participation. ...It is essential...that we have a more direct role in defining our needs, in establishing programs and priorities and in the implementation of programs and services. (mib 1971, p. 172)

Table 1
Summary of Peguis Community/Health Services Development:
Before 1940

Community Development	Relocation and economic subsistence
Aboriginal Health Policy/ Services	● Lack of comprehensive Aboriginal health care system [*BNA Act*, *Indian Act*, Treaties] ● Government's position: provision of services based on `humanitarian' policy rather than fiduciary or legal responsibility ● period of fiscal restraint/chronic underfunding of Aboriginal health services
Peguis Health Services	`Dual Medical Systems' ● **→1923**: intermittent physician services to Fisher River Agency ● **1924→**: permanent medical officer for Fisher River Agency ● **1924→**: nurse working out of Fisher River Agency (hired by Anglican Church?) ● **1930-1940**: Fisher River Nursing Station (resident nurse) ● **→mid-1930s**: `Indian doctors' and mid-wives active

Table 2
Summary of Peguis Community/Health Services Development: 1940-1979

Community Development	`Underdevelopment' ● economic decline ● social problems rising
Aboriginal Health Policy/ Services	`Organized Aboriginal Health Services' ● **1945**: responsibility for Aboriginal health services transferred to newly created dnhw ● **1962**: MSB created ● **1970s** First Nations demand greater involvement in health services delivery; msb transfers some community health services to band, tribal council administration (local medical transport, chrs, etc.) ● **1979**: new `Indian Health Policy'
Peguis Health Services	`Government Control of Medical Care System' ● **1940**: Fisher River Indian Hospital opens (nursing station closed) ● **1950s**: public health services for region operate from Fisher River Health Centre ● **1962**: first chr at Health Centre ● **1972**: contract for local medical transportation transferred to band administration ● **1973**: Percy E. Moore Hospital opens (old hospital closed) ● **1979**: chr, nursing positions transferred to local band management

The mib proposed that a regional health services board be established, with equal representation from Manitoba First Nations and the federal government. This board would be responsible for evaluating and assessing existing health care services; recommending policy with respect to program adaptation, new program development, and methods of delivery; and facilitating the establishment of hospital boards and health committees at the community level. (mib 1971) The mib's proposal appears to have been overlooked.

However, in 1978, msb-Manitoba's regional director reported that there had been considerable activity in Manitoba in the areas of Indian involvement and transfer of control of health services. He listed several examples:

> - For the first time representatives of the Indian people throughout Manitoba, the Manitoba Indian Brotherhood and Medical Services staff took part in a Health Planning meeting at the Norway House Reserve, 7 and 8 September 1977, to discuss present and future health programs for Manitoba Indians. Meetings of this nature will be on-going.
> - The majority of bands in Manitoba are contracted to provide chr and transportation services.
> - The Pas Band, Fort Alexander Band, Sandy Bay Band are contracted to provide nursing services, and The Pas Band is anticipated to assume complete control over their health program in the next fiscal year.
> - It is also anticipated that Peguis Band would be requesting contracting to provide nursing services in the upcoming fiscal year. (Canada 1978a)

Whitmore et al. (1988) have suggested that, although the transfer of administrative responsibility for certain health-related services built useful experience in program management and local administration, it did not constitute a transfer of control, since msb retained overall fiscal control and significant program leverage. In the following section we explore what happened in Peguis, to determine the relevance of this criticism.

Public Health Services Under Local Administration

As we have seen, Peguis's experience with government-administered public health services from the mid-1960s to 1979 had not been a bad one, largely because the public health nurse seemed to have gained acceptance by the community. However, beginning with the takeover of education

services in 1977, a desire to take over management of community services appears to have gained momentum steadily in Peguis. Msb had already contracted with Peguis in 1972 to allow the band to arrange and pay for local medical transportation in their area and to the nearest medical centre. By early 1978, the Peguis chief and council had initiated discussions with msb regarding taking over the administration of further health services. A document outlining msb-Manitoba's interpretation of the new 1979 Indian health policy stated that "the focus of the future will be in supporting the role of Indian bands and organizations in providing services directly". (msb n.d.) In that same year, public health nursing and chr services were transferred to Peguis band administration. Then, early in 1980, Peguis took over management of its health centre, which was renamed the Peguis Health Centre.

Anna Pothorin and the nurses for the Jackhead, Fisher River and Lake Manitoba reserves were moved into a small office in the Percy E. Moore Hospital, where they continued to provide public health services for the other Interlake communities. When the band took over administration of the health centre early in 1980, Kathy Bird (originally from Norway House, but a resident of Peguis since 1970 after she married a Peguis band member) had been working as an rn at the Percy E. Moore Hospital for about a year after graduating from the Brandon General Hospital School of Nursing in 1978. Her dream had always been to work as a public health nurse. In April 1980, Kathy was hired as the first band-employed community health nurse at Peguis Health Centre. When the second, senior nurse hired by the band retired in June 1981, Kathy became nurse-in-charge of Peguis's public health services ─ a position she holds to this day.

The initial reaction of community members to the new band-operated health centre is difficult to gauge. It appears that there may have been some initial disappointment about band-operated public health services, especially from people who had become accustomed to Anna Pothorin over the years. As one woman (who remembered Anna giving needles and conducting baby clinics in living rooms) put it,

> It was hard at first... It was nice that our own people ran it [the Health Centre], but it was very small, and you had to sit and wait... It wasn't the same atmosphere as at home...

However, the mandate of public health programs was changing. Anna Pothorin had functioned during a period when control of infectious diseases was still the major focus, and

when a lack of personal automobiles and poor roads in Peguis meant that she did a lot of her work in people's homes. When the band took over the health centre, the focus of public health had shifted to prevention of disease and health education, with an emphasis on taking responsibility for one's health. Despite the few criticisms that were expressed, there was consensus among those interviewed that having `our own people' operating the health centre was an important development. The following comments made by two community members were typical:

> It's our people, which is very good... The only disadvantage was when you had to travel back and forth yourself. But now that they have a vehicle to pick up people who don't have cars, that's excellent...

•

> Well at least you always know that they are there... You feel more at home with them [nurses from Peguis] when you talk to them... When they ask you something you feel free to tell them... You can relate to them more than some of the outsiders...

What difference did the administrative transfer make to the delivery of public health programs in Peguis? An important point to note is that, when msb transferred the chr and community health nurse (chn) programs to band administration, it was a person-year *with msb program content* that was transferred. The following comment from a former msb nursing officer who was familiar with Peguis summarizes msb's position:

> The only concerns that people would have had at that time were that if they [Peguis] were going to take over the program, then they had to take over the entire program, and not be selective... Maternal/child health was our number one priority... Our second priority was control of communicable diseases, which really meant immunizations...and then we had school health, care to the elderly and chronic disease... Those were our five priorities at the time...so they were the programs that really were not negotiable when they took over... If they had another way of providing the care that was fine.

In theory, then, the Peguis Health Centre staff were now free to provide public health services in their own way. However, they were still required to deliver programs designed by

msb according to the government's priorities and to report regularly to msb. As Verna Spence, the chr, comments,

> I just continued doing what I always did...no difference after 1980... We still had to give monthly reports to msb...

Kathy Bird describes the shift to local administration of public health programs this way:

> ...the only control there was, the bands hired their own [staff] and they paid us. They got a lump sum from Medical Services to pay us...everything else, they [msb] still wanted to control...

Despite the lack of control that characterized local management of public health services, there were some advantages to the new arrangement. The local orientation of the health service, with the health workers reporting directly to the chief and band council, meant that Peguis Health Centre could respond more quickly and effectively to community needs. Kathy Bird states:

> ...if we saw a need in the community...if there was nothing in the guidelines about Medical Services being able to cover the health needs, we made sure we went out and went after it... We had a good working relationship with the chief and council, and they supported us in whatever we needed to do.

The local orientation also resulted in increasing involvement in community activities to promote public health programs and public health awareness. Nurses' narrative reports and the chrs' monthly reports[19.] From a review of health services development between 1979 and 1991, it is clear that several obstacles placed significant constraints on the Peguis Health Centre's ability to deliver a public health program that would totally satisfy both the consumers and the providers of these services. They are summarized in the next few pages.

Inadequate physical space

When Peguis took over the administration of their health centre it was located in an old building that had originally been the Indian affairs office for the Fisher River agency. The space was very small, which prevented staff from holding health education classes for groups such as prenatal clients and diabetics. A more serious problem was the poor condition of the building. Repeated flooding had caused serious damage to the structure. One employee who worked in the building recalls that "we got rained on together and we got cold together in the winter". By early 1984, the

building had been condemned. There are repeated references, in memos and monthly reports from Kathy Bird to msb, expressing serious concerns about the environmental health hazards at the old health centre, including holes in the chimney causing a carbon monoxide leak, cracks in concrete walls, and non-functioning electrical outlets. Unfortunately, the problem was not resolved until July 1987, when the Peguis Health Centre moved into the new facility where it is located today.

Administrative bind

Along with the discomforts caused by the physical environment, local administration of the health centre produced an added headache. On 12 November 1981, a letter was sent from the Peguis Health Centre staff and the chief and council to msb-Manitoba's south zone director. It was a request for a co-ordinator or administrator for the health centre, to be a direct liaison with the chief and council and msb. The following excerpt makes Peguis's dilemma clear:

> ...As it is now, no one has any *direct* responsibility for the Peguis Health Program. Chief and Council are the employers, yet Medical Services guidelines are followed. The Health staff, it seems, are floundering with two indirect bosses and with *no direct* guidance or control. This guidance and control...must come from their own office, and should be someone who is aware of what must be done and will be an advocate for their needs and the needs they see in the community. Nurses are caught in the bind of attempting to administer the Health Office as well as carry out the necessary community health programs... An Administrator, as we see it, would be a positive step towards native control of their own health needs and programs... [emphasis in original]

For Kathy Bird, the nurse-in-charge of Peguis Health Centre, the double role of administrator and health care provider meant lots of paper work and meetings with msb in addition to her nursing responsibilities. She recalls what it was like:

> What I found would happen was, I would really get into the administrative part, and my fieldwork would fall. Then I would get involved in the fieldwork and my administrative stuff would all pile up... It was a good thing that there was enough of us. There was the other nurse, there were two chrs, so I could do a lot of delegating... It was heavy, but I was able to do it.

Kathy recalls that several attempts were made to obtain funding for an administrator, but she is not sure what happened with these requests. Correspondence from a band official to Keith Cale, acting regional director of msb-Manitoba, in July 1982 indicates Peguis's intention to apply for a health administrator position and part-time clerk for the health centre under the Community Health Demonstration Program (chdp, which was established to allow First Nations to develop pilot projects in community-based health planning and program delivery and to prepare for the transfer of existing services. (Young and Smith 1992) Unfortunately, no further documentation was found on the subject. When asked to comment on the issue, a former msb south zone director stated that, although she could not remember seeing a formal proposal from Peguis, it is unlikely that it would have been accepted, since chdp funds were supposed to be used in developing broader community-based program initiatives, not to create new administrative positions. It was not until 1990 that the problem was resolved (see section beginning on page).

Relationship with msb

The added administrative responsibility was not the only problem facing Peguis Health Centre staff. Unfortunately, an incident early in 1980 set the tone for the new relationship between health centre staff and msb. As Kathy explains:

> ...just before I went there, Medical Services pulled out everything, all their equipment...furniture... If one of the chrs hadn't literally locked the door and not allowed them to take anything else, they would have taken everything... Starting from that, and trying to build it up again to the things that we needed, that was a struggle.

According to a former msb official, the items removed from Peguis Health Centre were required for the new clinic in Hodgson, where Anna Pothorin and the other msb nurses continued to provide public health services to residents of the other Interlake communities for several years. However, at least two health centre employees maintain that many of the items taken were put in storage, while some of the furniture was auctioned. Whatever the circumstances, this incident appears to have been perceived as a form of punishment by the health centre employees, and it created some tension between the staff and msb for some time.

From Peguis's point of view, the constant questioning of their administrative decisions and the endless red tape required before changes could be implemented was sometimes

perceived as an infringement on their desire for local autonomy. One incident that illustrates the struggle for control that characterized the relationship between Peguis and msb during this period occurred in 1986, when the second community health nurse (chn) position became vacant. The band hired Eleanor Olson, who had lived and worked in the community as an lpn (first at frh and then at pem) since the mid-1950s. From msb's point of view, this was not acceptable, since the contribution agreement called for employment of two chns, both minimally qualified at the rn level. According to a former msb nursing officer:

> At that time, lpns were not allowed to give injections and Eleanor had never worked out in the field before as a public health nurse...and we just felt that she didn't have enough background to work in public health...

However, from Peguis's point of view, Eleanor Olson's employment as a chn made sense. Kathy Bird explains:

> Eleanor had already been a nurse for 20 years and more. She lived through, she saw the epidemics...she delivered babies, she sutured... being a member of the community, being a Native woman, her experience is invaluable... I don't think that her getting the title of rn behind her name could even cover all the experience she has. I don't have any problem with her being hired. Sure there was the legalities, according to public health law...as to what she can do, but she went out and got her certifications that she needed for ims [intramuscular injections] and stuff like that. She always upgraded herself through workshops...

For Peguis this was not simply a matter of a logical choice, but a matter of self-determination. In a letter dated 1 August 1986, Chief Louis Stevenson responded to msb's concerns:

> ...we are exercising our right to self-government and self-determination...we are deciding what is best to suit our needs and the needs of our people... I consider this arrangement as being conclusive for as long as Eleanor is available and willing to serve our community.

Eleanor Olson continues to work as a chn at Peguis Health Centre today.

Funding

The monthly nursing reports and minutes of meetings for this period indicate that inadequate funding and large deficits were a constant source of concern. Kathy Bird recalls that the band had very little control over the funding process:

> ...usually there wasn't any consultation with us before things were done. The contribution agreement was pretty well decided by Medical Services, as to what we were going to get... Most times it was sent out at such a late date, that in order to get the funding for the next fiscal year, it didn't leave any time for negotiation.

Charlotte Johnson, who was the msb-Manitoba south zone director from 1982 to 1987, agrees that contribution agreements were often sent out very late, leaving little time for negotiation. However, she states that zone administrators had to wait for an allocation of funds from the regional office, which in turn had to wait for an allocation of funds from Ottawa ─ a process that took some time.

In November 1988, staff of Peguis Health Services[20] msb officials to review the band's health-related programs. Concerns about inadequate funding dominated the discussion. The workload was increasing as the number of programs run from the health centre increased, but there had been no increase in funding for support staff, leaving the band to bear the cost of these positions. For example, when the new Peguis Health Services facility opened in 1987, dental services also moved into the new facility from their previous location in an old trailer near the school. This placed an additional strain on the receptionist and clerk positions. Another concern expressed by the band at the November 1988 meeting was the 0% increase for operations and maintenance in the contribution agreement for that fiscal year.

Workers from Peguis's Native Alcohol and Drug Addiction Program (nadap) attended the meeting and pointed out that they were unable to do the necessary preventive programs or workshops because they were so underfunded. An msb representative explained that the base was maintained from year to year and increased a little bit for salaries, but acknowledged that the budget had been designed five years earlier. When a Peguis band councillor asked whether the budget could be re-prioritized at the end of that fiscal year, an msb official responded that the band could "re-prioritize within the budget", while another suggested looking for funds from the family violence program. The minutes indicate that the two nadap workers left the meeting at

this point. It was this sort of interaction that produced a feeling of frustration among peguis's community health workers and the chief and council and contributed to the perception that they were constantly having to fight with an inflexible bureaucracy that did not meet the needs of their community.

At a meeting of the Peguis Health Committee (see page) held in early 1989, the discussion centred around the "meagre budget" provided by msb to the health centre, which was placing severe limitations on the staff's ability to do anything beyond regular tasks. At this meeting, one of the participants expressed the hope that the upcoming health transfer negotiations would produce "at least a slightly better financial status".

To summarize, while local administration of the health centre and public health services after 1979 did increase the band's level of involvement in the health care delivery process, lack of overall control over finances and programming restricted Peguis's ability to control that process in a meaningful way. According to msb-Manitoba's interpretation of the 1979 Indian health policy, the appropriate role of msb would be to enhance the ability of Indian people to develop and manage the full range of direct and supportive services that were necessary to maximize health potential. (msb n.d.) It would seem, from Peguis's perspective, that this goal had not been achieved as a result of local administration of its public health services after 1979.

Before proceeding to a discussion of Peguis's experience with the health transfer program, which began in the late 1980s, it is essential to explore several related health services initiatives that developed in the community during the 1980s. The following examples indicate that the evolution of community-based public health services did not occur in a vacuum but were part of a broader phenomenon occurring in Peguis at the time.

Meeting the Needs of the Elderly

One issue that continued to be a serious problem for both the community at large and health centre staff in the early 1980s was the inability to meet the needs of the chronically ill in Peguis. The provincial home care program did not include treaty Indians, nor did the federal government provide funding for home care nursing services. This put a lot of pressure on the public health staff to provide these services, even though their mandate was to focus on public health programs. With only fifteen beds in operation at the nearby Percy E. Moore Hospital, many

chronically ill elders were being sent to facilities far away from the community. By 1983, residents of Peguis decided that the situation was no longer acceptable.

In November 1983 a seniors' residence (level 1) opened in two donated houses on the reserve. Elva McCorrister, who was born and raised in Peguis and who is now the director of the Peguis Personal Care Home, describes how the original seniors' residence (or seniors' centre, as it was also known) developed:

> ...there were elders that were living alone in the community at that time who were unable to look after themselves...or they were staying home with no one to care for them...with no proper meals cooked for them... They really needed the supervision. So...we decided that we would use a couple of houses... We just took them in and hired some health care aides...ladies from the community to come in and provide the basics for them, like meals, and cleaning and bathing. Just sort of a safe place for them...

Elva recalls that the community's initiative was met with less than enthusiastic support from either the provincial or the federal government:

> We were told by different government officials, government agencies, that we were not supposed to be doing this thing because we weren't licensed and we didn't have proper staff, and the facility was not built to code...and you name it. This is when we started approaching Indian affairs and Canada Mortgage and Housing for a personal care home.

Indian affairs did agree to provide a $50 per diem for the eight initial residents through its Social Services-Adult Care budget. However, the fact was that the seniors' residence only partially met the need in the community. By March 1984 there were 20 people on the waiting list. Moreover, the greatest need at Peguis was for care at levels 3 and 4, which could not be provided by the seniors' residence. The people of Peguis found themselves caught in a jurisdictional grey area. Personal care homes are usually licensed by the provincial government. However, in the case of a reserve, provincial governments will not license a facility, since health-related services are considered a federal responsibility. Unfortunately, the problem is more complicated than a jurisdictional dispute between provincial and federal governments. It extends into the federal bureaucracy itself. Elva McCorrister explains:

> There is still that grey area. There is still argument between Medical Services Branch and the department of Indian affairs about whose responsibility it is to provide adult care/long-term care [on reserves]. Indian affairs says it's not really their mandate, and msb says it's not their area and they are only into hospitals and that sort of thing.

A good example of the problem faced by the community occurred at a meeting held between representatives of Peguis, msb and dia on 30 November 30 1983. According to the minutes, when a Peguis band councillor indicated that a licensed practical nurse was needed for the seniors' centre, the dia official stated that they were not in a position to respond to this need in the short term. The Peguis councillor proceeded to ask whether msb could address the interim need until dia funding came through, to which the msb officials responded that they did not have the jurisdictional authority to do so.

At this meeting, Peguis made an alternative proposal to msb. At that time there was talk of turning a vacant wing of the hospital into offices. Peguis requested that six (unused) acute care beds be converted to level 3 and 4 care, and that 14 staff residence units be converted to level 1-2 (semi-ambulatory) care. This was not a new idea. In May 1983, a consultant's report had recommended that pem be converted to the delivery of both acute and level 4 (possibly level 3) nursing care. (ceso 1983) The report also recommended that a study be done to determine the feasibility of converting some part or all of the staff residence to level 1 and level 2 nursing care beds.

The result, according to Elva McCorrister, was the following:

> We had meetings and meetings, and nothing ever came of it either... I can't remember there even being a letter or response. There was nothing done... They turned it [the vacant wing] into offices.

What happened next is characteristic of how Peguis responded to perceived needs in the community during this period. The went ahead and built an extension to the existing seniors' residence in the fall of 1984, expanding the capacity to 15 beds. Although part of the cost of the expansion was paid by Indian affairs, in April 1985 dia suddenly cut all funding to the centre, claiming that it failed to meet Manitoba Health Services Commission standards for health and safety and that the expansion had never been approved in the first place. (*Interlake Spectator*, 3 July 1985) However, in an interview with a local newspaper, the federal mp for

Selkirk-Interlake, Felix Holtmann, suggested that the real problem was that Indian affairs was reluctant to set a precedent by continuing to fund the Peguis seniors' centre:

> They may fear that other bands may just go ahead [and build similar centres] and ask for funding afterwards. (*Interlake Spectator*, 3 July 1985, p. 3)

Once again, Peguis went on the offensive. The band could not afford to keep the centre running on its own. To protest the withdrawal of funding, Chief Louis Stevenson applied for a permit to hold a demonstration in front of dia offices in Winnipeg. A few days before the protest was scheduled to take place, Indian affairs approved more than $350,000 for the operation of a personal care home at Peguis. Elva McCorrister comments:

> It [the threat of political protest] had a lot to do with them approving our proposals...ultimately, it was up to Indian affairs to give their final stamp of approval... I definitely depended on them [the band leadership]...for that final shove with Indian affairs... We were always able to depend on the leaders to help us.

The band continued to push for improved personal care services and, in 1988, the Peguis Personal Care Home moved into a new 22-bed facility subsidized by Canada Mortgage and Housing. At the moment, funding from Indian affairs allows them to operate 20 of the available beds. Msb covers the cost of drugs and specialized services provided at a physician's request.

Having this facility in Peguis has several benefits. The obvious one is that elders requiring a high level of care can now remain in the community rather than being sent to an institution far away. Another major benefit is that it creates employment. With the exception of a couple of casual workers, all the staff are from Peguis. A third, perhaps unexpected, benefit has been that the personal care home has become a focus for community involvement. Elva McCorrister explains:

> We have a senior citizens' club. They meet here every week...Thursdays for bingo...and we have an exercise program... Also we have services, church services, where the community is invited to attend... So it is sort of a drop-in... We do deal with all the seniors in the community. I am also an advocate for a lot of them in dealing with their pensions...and stuff like that. So they are always in and out of here for various reasons.

Elva made a point of emphasizing that, ideally, Peguis would like to have as many of its elders maintained at home as possible. The fact that neither Medical Services Branch nor the provincial government provides funding for a home care nursing program for Aboriginal people living on reserves poses a problem, in terms of maintaining chronically ill elders in their homes. However, a lot of effort has been made to improve services for the well elderly and maintain them in their homes. The personal care home took over operation of (non-nursing) home care services, which were formerly administered by the band's social services workers. A co-ordinator does the assessments, and homemakers are hired from the community to provide basic cleaning and cooking services to an average of 20 homes in the community. This, according to Elva McCorrister, helps a lot of people stay at home.

In addition, Peguis has taken steps to meet the housing needs of its elders by building a ten-unit apartment block for people who can still live alone. Located next to the personal care home and a five-minute walk from the mall, the apartment building is convenient to all the services residents need. Elva McCorrister is very pleased with the outcome:

> This just works beautiful here... There is a waiting list for that place. They really like living in that apartment... They sort of work together and help each other and socialize with each other. We sure need another unit like that.

After ten years, Peguis has made tremendous progress in meeting the needs of its elders (as well as elders from other First Nations communities). This involved the dedication and persistence of people like Elva McCorrister and the commitment of the band's political leadership to obtaining the needed services one way or another.

Confronting Alcoholism in the '80s

When key informants were asked to identify the motivating factor for their personal involvement in community health-related services or to identify a major turning point in community development as a whole, a recurring theme in many of the interviews were the frequent references to the early 1980s. "It was when people started sobering up" was a frequent comment.

Informants offered several reasons why alcohol abuse had become such a widespread problem in Peguis. Loss of economic self-sufficiency was an important factor. Cutting and selling wood and grain farming were two important sources of income for community members in the early years. The loss of these economic opportunities ─ at least in part because of an

inability to compete with non-Aboriginal people in the region who had more resources, such as bigger trucks ─ was identified as having a major impact on the people of Peguis. The introduction of social assistance in the mid-1940s appears to have exacerbated the problem. As one informant described it,

> I remember around the early '50s. I can remember when my parents started to get welfare, or rations, as we knew it at that time... They were able to go up to the agency [local Indian affairs office] up here with their teams of horses and wagons and load up with tomatoes, milk, bacon, tea, lard...and they would come back home. I would always wonder how could they afford these things? Times before, we always went out in the bush and got deer and moose...rabbits...and that's where I started to see people sit back, not taking any initiative... As time went on and people started to get welfare cheques...they just continued to not do anything... When people start sitting back with nothing to do then that's when they start getting into something else to occupy their time. That's where they started getting into alcohol.

Low self-esteem, resulting from bad experiences in residential schools and negative stereotyping of Aboriginal people, was also emphasized by a number of informants. Until the 1960s, only primary school education was available on the reserve. Beyond grade 7, children had to go away to residential schools ─ Brandon, Birtle and Portage la Prairie were the ones named most frequently by informants. One man, who has been sober since the early 1980s, described how his childhood experience affected his self-esteem:

> When I was in school here in Peguis, we couldn't speak our own language... I learned a few words of Cree because another guy that I knew spoke it... One day [the teacher] comes over and says: "What did you say?" I repeated the word in Cree...and she never asked me what it meant. I tried to tell her that it meant `hello'. She said: "You go in there and wash your mouth out with soap"... Yes, that's all we were taught ─ `you dirty Indian'...you didn't want to be that because you were treated so miserable... I think that a person has to establish an identity, and if they're going to establish an identity, it might as well be their own. For a long time, I wanted to be a white man. That's crazy.

Another key informant described how the experience of residential school led to alcoholism later in life:

> I was in one of those residential schools, and what I went through there is something that I'll never forget. It will always be within me, with all the abuse that happened. When I left that system, I buried that deep inside, hoping it would never surface again... They used to say, "You're just a bunch of lazy Indians, you'll never amount to anything." I grew up believing that, and I started acting it out.

Regardless of the root cause, alcoholism was certainly taking its toll in the community. As one young man recalls,

> I can still drive along the roads and remember all the accidents...alcohol-related...where a lot of my friends, my peers, died.

In the early 1970s, several community members formed an Alcoholics Anonymous (aa) group in Peguis, but it was not until the early 1980s that a movement toward sobriety gained momentum in the community. For most of the people we interviewed, there is no question about when the turning point occurred. The following comments were typical:

> I found a big difference in the early '80s. A lot of other people were sobering up at that time. One of the biggest things that happened at that time was, Chief Stevenson got in as chief...and I think that it was about three months after he got in as chief that he announced he was joining aa...that he was stopping drinking. I think that had a big impact on the whole community when he publicly said that at a band meeting... At that time there was a big enthusiastic group of aa members that kept doing sober socials and dances...and he was a big part of those activities...always got up there and reinforced sobriety.

•

> I think that the changes started when Louis got in as chief, for the main reason that Louis don't drink...and most of the council don't... That was a big thing in my life as well. I quit drinking in the early '80s. He [the chief] set a precedent... That is the difference here. The leaders on the reserve who have respect for themselves gain respect. The ones who don't drink have one hundred per cent more respect.

One key informant credits the progress made in Peguis over the past twelve years to the movement toward sobriety among community leaders:

> I've seen our community move ahead so fast in the past twelve years that it is almost unbelievable. When I was with [names community program] I'd go out to other communities and do workshops and tell them how we overcame certain problems. I went as far as Fredericton, New Brunswick, and they had heard about Peguis, about our leadership being sober... I believe we need leaders who are straight and sober in their lives to set that example for their people.

In 1982, a resident of Peguis was hired by msb to work as a Native Alcohol and Drug Abuse Program counsellor in the community. Over the next few years, the nadap worker, a very active group of aa members, and the band's political leadership worked to deal with the alcohol problem in the community. One of the steps taken was to remove the liquor licence from the community hall. Although the reserve was not `dry', and alcohol could be obtained easily in surrounding communities, many informants felt that this was a positive step. Several of the respondents who were involved in the sobriety movement during that time recall that it was not always easy, especially if people remembered them from their earlier alcoholic years. They realize that it took a while to earn respect back and to become trusted.

Despite the positive developments that had occurred, there was still a great need for treatment services for people with addictions ─ not just in Peguis, but in many of the surrounding Interlake communities as well. Members of the local aa group had started writing letters requesting a treatment facility for the area in the early 1970s. There was only one treatment centre on a reserve in Manitoba by the late 1970s (Sagkeeng Alcohol Rehabilitation Centre in Fort Alexander), which was operated through msb's nadap program. As Jean Buck, the current executive director of the Peguis Al-Care Treatment Centre, recalls,

> A group of people ─ sober people ─ got together, some with the chief and council, some with the school board, and we just sort of wrote up proposals and got the idea across that we wanted a treatment centre for Peguis. We submitted those to Medical Services...through our nadap program at the time. It wasn't until we got the economic development officer involved that he was able to get a more formalized feasibility study done on it...how we could serve...not only this community, but the surrounding communities... Through that, we were able to

establish one. The council put a lot of work into that as well, and they did a lot of pushing to get one put here.

It is interesting to note that the federal government's approval of funding for an alcohol and drug treatment centre for Peguis came during a period of intense political protest during 1986 ─ including demonstrations and occupation of Indian affairs offices in Winnipeg ─ by Peguis and other Manitoba First Nations. They were protesting the department's failure to correct wrong-doing outlined in a report by an independent auditor, which confirmed that the Manitoba office of Indian affairs had mismanaged its financial affairs, leaving First Nations in debt and facing further program reductions. (*Winnipeg Free Press*, 15 August 1986; *Interlake Spectator*, 20 August 1986)

In September 1987, a new 20-bed facility for the treatment of alcohol and other addictions opened in Peguis. While intended mainly to serve the local Interlake reserves, the Peguis Al-Care Treatment Centre can take clients from surrounding non-Aboriginal communities if the need is there. However, the focus of the program is definitely on meeting the needs of Aboriginal clients. The centre's executive director, Jean Buck, describes the program:

> The program is six weeks long, and it's for residential as well as non-residential clients... We may have about three or four from the community who come in during the day, or sometimes it's more than that, it varies... [At the moment] about thirty per cent of the residents are from Peguis... The program is based on the 12 steps of Alcoholics Anonymous [but] there are options for those that are into the traditional ways of life, as well as the Christian way of life... We have six counsellors in all. They have gone through a two-year training program and they are certified counsellors... We have nine support staff, including myself, so we have 15 permanent staff altogether, and we have about seven part-time staff. All are Native people and all are from the community.

One of the counsellors, Dave McPherson, believes that the program is effective in meeting its clients' needs because of the different orientation or approaches used by the various workers:

> We're all from different backgrounds. There's a Pentecostal minister, another's an atheist, one's Anglican, one's Catholic, and a traditional person. We need all these things to help people because each person that comes to treatment will probably

be looking for something. So, if I can't offer it, then we'll make the referral. As time went on, it became natural. We all know a little about each other's ways [of counselling].

According to Jean Buck, the Al-Care centre's staff serves as role models for the community:

Our staff are all sober... It is important that we portray a sober life, and not only portray it, but live it. People do watch you. You are a role model whether you like it or not... Our policy is to wait a year, have persons sober for a year before they can work here... Our part-time staff is growing... we have people coming in here that want to work in the treatment centre.

Another advantage for the Al-Care centre is that it can use the large number of locally run resources in the community, including social services, ambulance and emergency services, the health centre, and cultural speakers. (See the section beginning on page for a discussion of the role of Peguis's mental health and cultural programs in the Al-Care centre.)

As in the case of the personal care home, community involvement and the support of community leaders are important factors in the Al-Care centre's successful operation. Although funding comes from msb through annual contribution agreements, the centre is incorporated and has its own board of directors, currently made up of seven community members. Jean Buck explains:

We have full support of the chief and council, in terms of running this place... What we do is, we evaluate our program every year... We have our clients do an evaluation on us, when the program is complete. Like, what did they like best about it, what did they like least? ...some of the program content, was it any use to them? ... We sit down, the whole staff and board and we look at it and see where we could improve in areas.

She thinks that it is a combination of the program, the atmosphere, and the location that makes the Peguis Al-Care centre popular with clients:

Our pr [public relations] is through the clients... They like it here...and tell [others] what the program is about and how it helped them. Other people want to come and find out for themselves...and it just sort of goes on like that.

Problems with addictions still exist in Peguis ─ just as they do in other communities (See section beginning on page for a discussion of other community-based programs that are currently dealing with this problem.) However, Jean Buck believes that sheer determination has helped Peguis at least begin to address the needs of its community (and others):

> It took us a long time to get a treatment centre here. ...you have to fight for it...get together and give each other encouragement. Just don't give up.

Control of Ambulance and Emergency Services

A third example of a community health-related initiative during the 1980s ─ this one involving the takeover of a previously existing service ─ is worth mentioning briefly. In July 1985, Peguis took over operation of the regional ambulance service serving the Peguis, Fisher River and Jackhead reserves, as well as the surrounding non-Aboriginal communities of Fisher Branch, Harwill and Red Rose. According to Larry Amos, the band's economic development officer, Peguis believed that it could run a service that could better meet the needs of those it served.

The new Fisher Ambulance Service was set up in the Peguis emergency services building, along with both the police and fire departments for the reserve, and the three services shared a 24-hour emergency telephone system. In addition to vehicles and dispatchers for the three services now being in the same building, the service was now in a location that was more central to the majority of the population served. According to an official at Fisher Ambulance Service, this has resulted in quicker response times.

Another obvious benefit of band-controlled ambulance services has been the creation of jobs for Peguis residents (four full-time and four part-time dispatchers and 10 drivers and attendants). Less obvious, perhaps, is the fact that the ambulance service has become another source of community involvement and community pride. As Larry Amos explains,

> As a community project, I think that the ambulance service deals a lot with the community. ...[it] became a focus for those individuals who were involved in it. It was a job...very demanding...but it gave the people that were involved gratification, and acceptance in the community. They've done great!

Unfortunately, the initiative has not been without its problems. According to Cecilia Stevenson, director of Peguis Health Services, msb has never fully recognized the operation of

the ambulance service as being part of their mandate, and the band has therefore had to absorb a large part of the cost of its operation.

Summary

To summarize this period of health services development, by the late 1980s, several conditions existed in Peguis that help to explain the context in which health transfer and the subsequent health program initiatives developed. First, the 1980s had been a period of dramatic economic development, fuelled by a political leadership that was fiercely committed to the principle of self-determination and that took every opportunity to exercise that option. Second, a cadre of active community members and workers had developed who took the initiative to meet the health needs of the community in the absence of government services. Finally, while responsibility for operating the community's health centre did build up useful experience in local administration and program management, there is no doubt that msb still retained significant program leverage and overall fiscal control. The question to be answered now is whether the health transfer initiative shifted the balance of power to Peguis's advantage.

The Health Transfer Experience

The 1979 Indian health policy supported the goal of Aboriginal people to be self-determining and called for increased participation of Aboriginal people in the planning, budgeting, and delivery of health services in Canada. (Canada 1979) In line with this new policy direction, Medical Services Branch initiated a three-year demonstration program in 1982, which was intended to encourage First Nations communities to gain experience in the operation of their own community health programs. Two of the 31 projects funded under the Community Health Demonstration Program (chdp) were in Manitoba ─ at Sandy Bay and the Northeast Indian Health Council. While Sandy Bay's demonstration project paved the way for the eventual full transfer of its health programs to band control, the authors of a study of the Sandy Bay project concluded that the chdp did not allow adequate time, training resources, or flexibility to develop a community-planned and -operated health program. (Garro et al. 1986)

In 1986, msb announced a new Indian health transfer policy, (Canada 1986a) which was presented as a positive response to demands by First Nations for more control of their health services. The three-stage transfer process was presented as an optional initiative for all First

Nations communities within provincial boundaries that would permit health program control to be assumed at a pace determined by a community's individual circumstances and health management capabilities.

The main features of the 1986 health transfer policy are discussed in relation to Peguis's experience in the next few pages. Before doing so, however, it is interesting to note some of the major criticisms of the transfer policy expressed by First Nations in response to the initiative. In November 1987, the Assembly of First Nations organized the National Indian Health Transfer Conference to examine issues related to the transfer of health services from federal government to First Nations. Although some First Nations saw transfer as a positive development that would give them more input into their health services, numerous delegates at the conference expressed suspicions about the government's motivation in pursuing transfer at that time, suggesting that the government's primary intent was to rid itself of its fiduciary obligations to First Nations while implementing cost-cutting measures. (afn 1988) These representatives cautioned other delegates about pursuing transfer without clear federal recognition of health as an Aboriginal and treaty right and without a guarantee of future health care funding.

Specific concerns about the health transfer policy expressed at the conference included the following: the `no enrichment' clause, meaning that health services and budgets would be frozen at the time of transfer; the ineligibility of several programs for transfer ─ especially non-insured services; insufficient time (two years) and funds to complete the required pre-transfer activities of conducting needs assessments and designing a community health plan; the exclusion of training for health care workers; the calculation of funding based on the number of registered band members living on-reserve at the time of transfer only; and a lack of funding to support the integration of traditional healers into First Nations health care systems. (afn 1988)

Commenting on the `no enrichment' clause, Culhane Speck (1989) points out that existing services are inadequate and underfunded and that there are major differences between First Nations in the number and quality of services available. Thus, the `no enrichment' clause amounts to freezing inequality between communities. (p. 200) In addition, Culhane Speck argues that, no matter what the real needs identified by needs assessments carried out as part of the transfer process, the `no enrichment' clause ultimately determines whether and how these needs can be met. (p. 202) As for the exclusion of non-insured benefits as a transferrable program,

Culhane Speck warns that this leaves open the possibility that these benefits might be withdrawn and the certainty that they would be administered by msb criteria. (p. 200)[21.] Let us turn now to an examination of Peguis's involvement in the health transfer process to determine the relevance of these criticisms to this community's experience.

Motivation for Undertaking Health Transfer [22.]

Cecilia Stevenson, director of Peguis Health Services, grew up in the Cree community of Norway House in central Manitoba and later married a member of Peguis First Nation. She was working at msb in Winnipeg in 1987 when she was approached by the Peguis chief and council and asked whether she would be interested in coming to work for the band as their transfer co-ordinator. Peguis was interested in submitting a proposal for pre-transfer funding, and they had heard that Cecilia and her husband were planning to move back to the community that summer after living in Winnipeg for several years. Cecilia's background as a community development adviser with msb, working in the pre-transfer area, made her an ideal candidate for the job.

Peguis chief and council were eager to get the project started as soon as possible. The first task was to submit a proposal for funding the research and development, or pre-transfer, phase of the transfer process (discussed in greater detail later in this section). Although she continued to work for msb until October 1987, and did not officially become a band employee until funding was received in January 1988, Cecilia Stevenson began to work with the band on a voluntary basis in the summer of 1987. Her experience meant that she was able to assist them in developing their proposal fairly quickly, and this was submitted to msb in September 1987.

In the introduction to the proposal the following statement indicates that Peguis had no illusions about the process they were becoming involved in:

> We are acutely aware of the limitations under which the transfer process exists. It is not the mode under which we would prefer to deal, the ideal that is envisioned would be an arrangement enshrined in the Self-Government concept. The concept would see us establishing our own institutions and systems independent of government interference save fiscal appropriations by virtue of entitlement under our treaty, aboriginal and inherent rights as found in the Treaties, Royal Proclamation of 1763, Canadian Constitution, International Law and other

> foundations. In spite of the shortcomings of the transfer process, however, we value the opportunity it presents and we recognize it as a tangible step towards Self-Government and Self-Determination. (Peguis 1987, p. 2)

Cecilia suggests that participation in the transfer initiative was a matter of taking advantage of an opportunity that made sense, given the stage of social and political development Peguis had reached:

> It was a whole series of...developmental experiences over the years that got them [Peguis leadership] to that point where...they had all the tools and so that's what they went with... We all knew that our eggs were not in that one basket. We knew enough to recognize it for what it was, and we were going to take advantage of that, and in business that's what you do. You look at whatever initiative there is, and you analyze it and if you come out with more positives or if it looks like a good risk, you go with it.

Funding for Peguis's proposal was approved swiftly, and the first phase of the pre-transfer period began in January 1988, with Cecilia Stevenson working full-time as a transfer adviser for the band.

Research and Development Phase: January 1988-September 1990

During the pre-transfer period (which, at the time Peguis was involved in this phase, was limited to 24 months), communities have the opportunity to conduct the research needed to prepare their community health plan (chp). This might include research of existing services and resources, a community health needs assessment, and community health status assessment. The overall objective of this phase, according to msb guidelines, was development of a community health plan outlining the health status, needs, priorities and resources required for delivery of health programs. The other major task required during this phase was the development of a new management structure at the community level. (Canada 1987) These two processes are discussed separately.

Determining the community's health needs

Although very time-consuming, in some ways this was the easiest part of the pre-transfer process for Peguis. With the assistance of consultants in the University of Manitoba's Department of

Community Health Sciences, a community health needs assessment (chna) was designed and conducted in 1988. The actual development of the chna questionnaire involved the input of all phs staff, pem medical and administrative personnel, and other health-related band employees (e.g., staff of the personal care home). Five community members were then hired and trained as interviewers to work for a 20-week period.

According to Cecilia Stevenson, the chna did not necessarily tell them anything new. She sums up the experience this way:

> We viewed this as an exercise... The major positive outcome of the community health needs assessment, in my mind, was that it documented what we already knew... The data that we gathered has given us sort of like a synoptic view of our needs, and it helps us to plan ahead... It gave us some statistical data upon which we can base our arguments for hopefully gaining more resources later on...in fact, it helped us already, in our negotiations...

Aside from the chna being a useful exercise that helped to highlight problem areas, Peguis was also fortunate that, during this same period, Medical Services Branch invited participation in an assessment of the health status of all residents in the Percy E. Moore Hospital catchment area. This was intended to assist in the planning and delivery of services within the msb's mandate. The results of the assessment were made available to Peguis early in 1989, allowing them to compare and combine results with the chna.

The Peguis community health plan contains a summary of the major findings of both assessments. Several important features are worth mentioning here. Msb's health statistics show that Peguis's crude mortality rate was much greater than that expected if Peguis band members had the same age- and cause-specific death rate of all Manitobans, with the excess appearing to stem largely from diseases of the circulatory system, neoplasms (cancer) and endocrine/metabolic/nutritional disease (diabetes). The crude rates for these three causes of death in Peguis were also greater than for the two Aboriginal comparison groups. The fourth most common cause of death was injury and poisoning. This rate was also greater than that of Manitoba residents in general, but less than that of the two Aboriginal comparison groups. (Peguis 1990, Table 4)

From a subjective point of view, people interviewed for the chna identified alcohol and drug abuse as the major health concern in the community, especially among younger people.

Informants generally indicated that substance abuse was both the cause and the effect of a multiplicity of other problems, including lack of knowledge and motivation to seek help, unemployment, depression, physical abuse and teenage pregnancies. (Peguis 1990, p. 14)

Finally, the general survey of community members suggested that significant numbers of people in Peguis were experiencing a high level of stress in their lives. In fact, a check with Percy E. Moore Hospital revealed that 29 suicide attempts (all unsuccessful) were treated in the 21-month period between July 1987 and April 1989. (Peguis 1990, p. 7) Those interviewed for the assessment emphasized an urgent need for community mental health workers and the development of community mental health services.

It should be noted here that the Peguis community health plan identifies two major priorities that emerged from the needs assessments. The number one priority was to improve existing health programs and services. Many of the recommendations listed in the chp are aimed at achieving this goal by improving the co-ordination and administration of existing services and use of innovative approaches. In other words, they would not necessarily involve extra resources. However, the second priority identified was the need to develop a comprehensive community mental health program. Since there was no formal mental health program being delivered by msb during the pre-transfer period, this goal would require new resources ─ and therefore, by definition, would be beyond the scope of the health transfer initiative. (See section beginning on page for a detailed discussion of this issue.)

Developing a community-based management structure

The second major task during the pre-transfer phase was to develop a management structure at the community level to deliver health programs following transfer. According to msb guidelines, the structure designed would depend on the size of the operation and how the band envisaged integrating the program with existing operations. The health authority could take a variety of forms. This might involve the training of a health committee or board of directors and might also involve the training of a health administrator to provide continuing direction to health staff. Ultimately, the powers of the health authority would be those delegated by the chief and council and could include the power to propose local by-laws; the powers assigned to health providers (for example, to require action to be taken to correct an environmental hazard); and the authority to commit funds or pay accounts. (Canada 1986b, p. 4; Canada 1987, p. 7)

As it turned out, the training of a health administrator did not pose a problem, since Cecilia's experience as the Peguis transfer co-ordinator allowed her to make the transition easily to the new administrative position. In addition, since taking over management of the health centre in 1980, the chief and council had been functioning as the health authority in Peguis, with the health centre staff reporting directly to them. However, the band did enter into the transfer initiative with the long-term intention of developing an autonomous health board. One of the first steps taken during the first year of the pre-transfer period was an attempt to establish a health committee (hc). It was hoped that this structure would become a permanent health authority, or health board, after transfer.

Early in 1988, chief and council were approached for direction regarding the selection of hc members. The method chosen was to call for volunteers at a public band meeting (nine signed up), then to invite those people to another meeting to measure the real interest and to provide more information. Four of the original volunteers responded to the invitation. Along with the band councillor who held the health portfolio, this constituted the five-member hc as planned. It was intended that the health portfolio councillor would chair the health committee, acting as a liaison between chief and council and the hc members. Initially, it appears that the chief himself held the health portfolio, but another member of the band council assumed the portfolio in the fall of 1988. Unfortunately, one of the four community members could not continue, and a decision was made to have a seven-member committee in order to avoid having to retrain as often if someone withdrew. Potential candidates for the remaining vacant positions were sought by approaching phs staff and hc members for recommendations, with ratification obtained later from the chief and council. It is significant that most of the hc members were people who were working in one of the community's human service organizations.

Progress reports and hc meeting minutes throughout 1988 indicate that a tremendous amount of time and effort was expended by Cecilia Stevenson and several phs employees to develop the committee. Training sessions included detailed presentations on the historical organization and provision of health services to Aboriginal people in Manitoba, explanation of the transfer initiative and the overall plan of activities for the pre-transfer period, and familiarization with terminology used in the health care field.

The hc met regularly during 1988, and a progress report submitted to msb in March 1989 indicates that the growing confidence and involvement of members had resulted in their acting

on several issues to encourage healthy practices in the community, especially in relation to garbage disposal and sanitation. However, it is also clear that development of the hc was being hindered by constant turnover in its membership. It appears that, in almost all cases, people could not continue to participate because of increased or new work commitments locally or elsewhere. Each time someone resigned, a replacement had to be sought and trained to bring them up to the level of knowledge of the other members.

Some time after April 1989, the decision was made not to pursue formal hc activity at that time. Cecilia recalls that this decision was not taken lightly:

> I'm a strong believer in community development principles...community involvement being one of the main principles of community development...involving people in decision making... The people who had the opportunity to be on the committee contributed to our overall development...[but] we couldn't keep on with it. Helping people to develop takes a lot of effort and commitment and time, and that could have been a whole job in itself. It was taking up a lot of my time. Because of the demands of the pre-transfer process...the fact that we had to get the work done in a short timeframe...and so a choice had to be made...in essence, we had to put aside those honourable principles...

After the spring of 1989, Cecilia and the phs staff continued ― and still continue to this day ― to consult directly with chief and council regarding major decisions involving the transfer process. The formation of an autonomous health board remains a goal of both Peguis Health Services and the chief and council. Unfortunately, most of the time since the transfer agreement was signed has been spent on developing the administrative infrastructure required to operate Peguis's community health programs effectively (see section beginning on page). However, it is anticipated that the issue of developing a health board will be addressed in the near future. To avoid the problem that occurred with the former health committee, Cecilia Stevenson would like to see more lay people from the community become involved in the process this time.

While the establishment of a health committee did not work out as planned, Cecilia was able to complete the other tasks involved in laying the groundwork for the new management structure of Peguis Health Services. Most of these tasks involved the development of policies and procedures related to the administration of programs and services. Perhaps the easiest one

for Peguis was the development of an emergency response plan ─ one of the four mandatory programs that must be continued following transfer (the others being communicable disease control, environmental/occupational health and safety, and treatment services). This simply involved revising the plan that was already in place in the community. The development of job descriptions was also straightforward. With input from the employees, all existing job descriptions were revised to reflect the specific activities required to meet the needs of the community.

During this time, Cecilia also developed a new health personnel policy manual. Although this was not an absolute requirement of pre-transfer planning, it was felt that it would be more beneficial to seize the opportunity to address and enhance this area before transfer, so that phs would be in a better position to meet the challenges of implementing new programs. Cecilia acknowledges that, although she attempted to involve the staff in this process by circulating drafts and requesting feedback, there was some resistance to this initiative at first. Perhaps policies, procedures, rules and regulations were associated with the non-Aboriginal, bureaucratic services that had ruled people's lives in the past. However, the initial resistance appears to have dissipated over time as the value of certain policies and procedures has been demonstrated. As Cecilia explains,

> An example of a policy that we have is the flexible hour policy...you put in your eight hours or whatever...you give it your best, and take a little break now and then... If you need to take off from the office for two hours...let's say it's personal...you just take it. It's what we call `comp time'. You just pay it back. So it is much fairer. It gives people a better feeling inside.

Several phs employees mentioned the `flexible hour' policy as a positive feature of the work environment. One individual, who had worked at the hospital at one time, noted a big difference in the two workplaces:

> When you're employed by the government you have to sign in by the clock, sign out by the clock. If you were a few minutes late everybody would know about it. They would say, "You get paid for eight hours of work and that's how long you have to work." ...This is home... We know that we're getting paid to do the work, but nobody stands there watching you. By feeling good about where you work, you do your work better.

Although there were definitely some growing pains involved in the establishment of a new management structure at Peguis Health Services, all the employees interviewed who were involved in the process acknowledged that they were consulted throughout the pre-transfer phase. Verna Spence, who has worked as a chr in Peguis since 1977, made the following comment:

> Cecilia really got us involved in that [process]. Anything she did she'd have a meeting and discuss with us and she'd ask for our opinions, because she felt that we had been here longer than her, and she really used us that way. She'd get ideas and suggestions from us. I found that good because it was something that Medical Services would never do. They would just go ahead and do something.

Cecilia Stevenson believes that the management structure that ultimately evolved reflects the dynamics of the community:

> [Peguis] is a mixture of traditional structures, still very much present in the way things are done in an Indian community...with it is the modern way of doing things... According to traditional custom...it's a hierarchical system. The way that an Indian person looks at that hierarchical system, or the way that the chain of command works is that the chief got there because he earned the right to be there, by the wisdom he shows, by his actions, his respect for his people... People trust that this person, and the councillors, have taken on the commitment of taking care of their people... There are many communities where nothing happens unless the chief says so. In this community and many others, the chiefs have modified that a bit... In our case, they have given over some of that decision-making power to organizations such as ours. That can be summarized by one line that the chief told me several years ago: "I trust your judgement." ...It is never a relinquishing of authority. It's like a sharing, a delegating of responsibility.

When asked to summarize the major obstacles during the pre-transfer process, Cecilia Stevenson suggested that the very limited timeframe given to do all the pre-transfer work was a big problem. Trying to develop a transfer budget was also a difficult task in the absence of a breakdown of the actual dollars that would be available for transfer (In fact, the band received a detailed breakdown of the budget only *after* the transfer agreement was signed in 1991.) In addition, Cecilia believes that there was a lack of guidance in developing the evaluative

component of the proposed health programs. However, she went on to state that at least some of the problems arose from the fact that msb staff were learning as they went along, and she acknowledges that msb now provides better evaluation guidelines and financial information than they did earlier. In fact, there is evidence that, at the time that Peguis was developing its community health plan, msb was asking Peguis (and other communities involved in the pre-transfer phase) to do something that they themselves had not been able to do very well. In a document outlining msb's strategic plan for the 1988-1993 period, it was acknowledged that "current Branch Information Systems...are inadequate for measuring accurately the effectiveness of Medical Services Branch programs". (msb 1988, p. 1)

Transition Period and Negotiations: September 1990-July 1991

In September 1990, a three-month interim agreement came into effect that was intended as a bridge from the pre-transfer research and development phase to the negotiation phase. At this time, Cecilia Stevenson became the acting health director of Peguis Health Services, responsible for implementing the new health management structure and preparing for the transfer negotiations. In a report to msb in October 1990, Cecilia stated bluntly that the "temporary or fragmented approach" to the management funding process was making it difficult to implement long-term initiatives. Nevertheless, a gradual transition to the new management structure had been implemented, with the chp and general plans having been reviewed by all phs staff. In conclusion, Cecilia stated that, in the time remaining under the interim agreement, attention will focus on "deciphering the barrage of requests and requirements from msb and determining how we will or if we can meet them".

The actual health transfer negotiations took place in 17 meetings held between January and July 1991. Cecilia Stevenson suggests that several factors facilitated the negotiation process:

> We [the Peguis negotiating team] agreed that we would use a diplomatic approach ─ actually I would prefer to call it a nation-to-nation approach ─ even though the process didn't warrant it... We were prepared to spell things out to them if necessary and this is what we did several times. That diplomatic approach helped us a lot. Also, good organization in terms of the material that we presented, preparation of the material, research... The other thing that helped [was] the fact that we have our own legal adviser, and myself as health adviser, both from the

> community, working with the main negotiators, the chief and council...who have a lot of experience in negotiating and dealing with governments, and they are very progressive... The fact that I had all this prior experience with the government and working in the area of transfer really helped ─ not just within the negotiation process, but all throughout the pre-transfer process ─ I was at ease.

While it is true that the starting point for negotiations was set at the band's existing resource level, with no allowance for major program enrichment, it appears that the factors enumerated by Cecilia did give Peguis some leverage during negotiations. The phs operating budget (before transfer) was just under $298,000. In the first full year following transfer this amount more than doubled to $678,000. A large part of this increase involved new funds for portions of msb regional and zone positions (discussed further later in this section), administration, and training (short-term workshops, skills upgrading, etc.). However, Cecilia gives one example of where Peguis was able to negotiate better funding for pre-existing programs:

> We wrote pages and pages of substantiation, of arguments showing that our health education budget was only $66 a year. That was what our budget was ─ five bucks a month, yes... What it boiled down to was to put it right in front of them and say, "Look, this what you are giving us for health education, and yet your `three pillars' of the Indian health policy and your mission statement says that you are going to go for quality assurance." ...I wanted to make them look at themselves and show them what was really happening... And that's what it took.

In other areas, it was a question of negotiating for the best possible conditions within the limits of existing resources. For example, Peguis demanded, and received, funding for the highest-level nursing position (in terms of the salary range), thus avoiding having to renegotiate this at a later date. Cecilia states that they consciously negotiated for "little edges here and there, which all built up".

On 23 July 1991, Peguis signed a five-year health transfer agreement ─ the third such agreement in Manitoba.[23]

Perceived Benefits of the Transfer Agreement

Interviews with key informants suggest that the perceived benefits of the transfer agreement can be classified into two, often overlapping, categories ─ technical/administrative improvements and an increased sense of ownership among health care providers.

Perhaps the major benefit of transfer was the provision of new management funding, allowing the band to hire Cecilia Stevenson as the permanent director of health services to oversee the public health program, the alcohol and drug abuse prevention program (formerly nadap), patient services and ambulance services. In addition, a co-ordinator of patient services was hired to oversee medical transportation services and patient information. This has been especially beneficial to Kathy Bird, nurse-in-charge at the health centre, who previously had to carry a lot of the administrative responsibility and deal with problems related to patient services in addition to her clinical responsibilities. As we will see later, the presence of an administrator also allowed Peguis to take advantage of additional opportunities for health services development that arose following transfer.

Several aspects of the new financial arrangements were also cited as being beneficial and increasing local control. The shift from monthly to annual reporting to msb was a welcome change. One informant described monthly reporting as "degrading ─ that's all you spend your time doing". The switch from rigid to flexible budget lines allows phs to shift resources to concentrate on program priorities as they see fit. As for the switch from surplus-reversion to surplus-retention, one informant summed it up this way:

> It's such a big relief to know that you don't have to say, "Well, I got this much, and I have to spend it on this, and if I don't spend it they'll take it away.

All the phs staff interviewed indicated that the transfer process had given them an increased sense of ownership of their community health programs. The comments from informants in two separate programs convey this feeling:

> I think that we have more freedom locally to do what we have to do to design or develop programs to meet our needs. We don't necessarily have to take them from Medical Services. We work together on that with the chief and council and come

up with plans that better suit our own community. I think that's one of the best changes that have taken place since the transfer.

•

Having our own administration...running our own programs, making our own guidelines... not having Medical Services hand you this great big list of things telling you to do this and that. We're free to do the things that we want to do the best way that we know how and the way that we think is best for our clients.

Several informants made positive references to the collective nature of the program planning and review process at phs. One of the chrs stated:

We don't plan programs by ourselves...we kind of sit down and brainstorm...we're like one big family, we do it together.

The author had the opportunity to observe two such program review and planning sessions. On both occasions the phs staff met for two days, using the brainstorming technique, and systematically reviewed every aspect of their programs. When asked to comment on this, Cecilia Stevenson states that a bureaucratic management approach would not work well in a setting such as phs. Instead, they use the `people approach':

Being small really helps a lot. You are able to say, "Let's huddle." ...It's so much easier to say, "Do this, do that" [and] "don't ask any questions". But then you risk negative results... This makes people feel better about themselves, it makes them feel part of the decision-making process... It just makes sense, even though it takes a long time.

Finally, another feature of the transfer agreement that should be mentioned was the transfer of extra dollars for training. This came at an opportune time for Peguis ─ just as momentum was building to develop a new program (see next section for details).

Some examples of health program developments since transfer are discussed in the next section, but first we will look at the perceived limitations of the transfer experience.

Limitations of Transfer Agreement and Future Initiatives

One feature of the transfer agreement highlights the disadvantage for Peguis (and other First Nations) resulting from diseconomies of scale. Msb calculated and transferred what amounted to

Peguis's portion of regional and zone support programs and positions. The full list of portions of positions transferred includes regional and zone program and medical officers, regional and zone nursing services, regional and zone environmental health services, regional and zone nutrition program, regional and zone health education program, nadap regional consultant, chr regional consultant, and zone maintenance services.

With only a portion of the resources or salary available for each position, this makes it very difficult to retain the necessary experts, and training dollars for these transferred positions are not included. One example of the problem this poses relates to environmental health. Although this area has seen dramatic improvements in Peguis, largely related to economic development over the past decade, it remains one of the mandatory programs required by msb. Before transfer, a regional environmental health officer (eho) provided consultative and support services to Peguis, along with the other Interlake First Nations. After transfer, Peguis would have to make arrangements for its own eho. With the money they received from msb, they would be able to hire someone for only six days a year. At the time of writing, Peguis was expecting to work out an arrangement for assistance from the Swampy Cree Tribal Council, which was able to transfer a full-time eho because it represents a group of First Nations.

Another example of this problem relates to the medical officer position. Peguis received enough money to hire a medical officer for 12 days a year (half of what Peguis had requested). Phs staff had hoped that a medical officer of health would work with them in developing certain aspects of their community health programs ─ especially the evaluation component and monitoring of health status. It was only in the spring of 1993 that a contract was finalized with the University of Manitoba's Northern Medical Unit to provide such services. Cecilia Stevenson says that a tremendous amount of time and energy was involved in developing contracts for both the positions described here, and she realizes now that, ideally, it would be much better if those positions had been transferred to a regional or district Aboriginal organization.

It appears that most of the problems Peguis has experienced following transfer involve the administration and/or delivery of health services that have not been transferred. For example, an official in the band office confirmed that contribution agreement payments involving non-transferred services continue to arrive late (including advances), forcing the band to dip into other budgets.

Under the terms of the transfer agreement, msb agreed in principle that the transfer of several identified services could be negotiated in the future at the request of Peguis and as mutually agreed to. The full list includes contract dental services, contract optometric services, drugs and medical supplies, contract lease agreement, the Percy E. Moore Hospital, non-insured health benefits, and the nadap treatment program (the Al-Care Treatment Centre). The two major problem areas related to these future considerations for transfer are discussed in the following sections.

Non-insured health benefits

Before looking at the issue of non-insured health benefits as it relates to Peguis, some background information may be helpful. Non-insured health benefits (nihb) are extended health services that have been provided by the federal government to Aboriginal people for many years. The benefits package includes vision and dental care (excluding contracts for professional services), prescription drugs, medical supplies, medical equipment and transportation for medical care. These non-insured services are considered to be a Treaty right by Aboriginal people, and there has been considerable concern that the federal government intends to limit or withdraw these services. This concern is not unfounded.

In late 1978, Medical Services Branch issued a policy directive to its regional and zone officials that effectively eliminated payment of non-insured services for all Aboriginal people who were not indigent. According to the minister of national health and welfare, Monique Bégin, this directive did not in fact represent a change in federal policy, but was merely delineating the federal government's long-standing policy in a more specific manner ─ that is, that Aboriginal people who are in a position to pay for their own health or health-related services should do so, and that indigent people residing on reserves would be assisted. (Canada 1978b) The Manitoba Indian Brotherhood's response was blunt:

> The Manitoba Indian Brotherhood, representing the 44,081 status Indians of the province, has rejected the federal government's recent "Uninsured Health Services to Registered and Treaty Indians" guidelines... The mib maintains that protestations of "fiscal restraint", the alleged rationale of the cutbacks, cannot justify a breach of faith or the denial of federal trustee responsibility to the Indian people. The mib believes that these cut-backs are a thinly-veiled disguise to

> implement the 1969 White Paper on Indian Policy; by shirking its constitutional responsibility, the federal government will no doubt look to the province to fill the gap which will be created by the cut-backs... The recent guidelines will fall heaviest on the marginally or seasonally employed, who can barely make ends meet. The mib considers the cut-backs in transportation and drugs as particularly irresponsible... (Manitoba Indian Brotherhood 1979)

The widespread protest from Aboriginal groups across the country led the minister to officially suspend the guidelines officially early in 1979. However, it is important to understand that the regional offices of msb have considerable autonomy in setting specific nihb guidelines in their jurisdictions. It is most interesting to note that, in November 1978, the regional director of msb-Manitoba sent a memo to the acting director general of msb program management in Ottawa "in order to clarify that, in fact, the Policy is being and has been applied in Manitoba quite substantially and perhaps to a greater extent than in other Regions". (Canada 1978a, p. 2) G.B. Campbell, the regional director, explained that Manitoba region had recently begun to tighten up the supply of free prescription drugs to Indian people in the city of Winnipeg and in rural areas. After being informed by the mib that, in rural areas, people were suffering hardship as the result of the initiative, he had agreed to suspend the guidelines in respect of prescription drugs only and in rural areas only. All other guidelines in the policy on uninsured services were already being applied. (Canada 1978a, p. 1)

In 1989, msb once again unveiled new nihb guidelines that further limited coverage, and once again there was considerable opposition to many of the proposed changes by First Nations. One of the major concerns appears to have been msb's intention to continue transferring administration of uninsured services to the Blue Cross. Msb had contracted with Blue Cross in 1989 to administer dental services, and this privatization process was seen as further removing First Nations from self-government, with the financial benefits of administering health services going to a non-Aboriginal corporation.

Medical Services Branch responded by establishing a working group with First Nations representatives to review the whole nihb program. By early 1991, organizations such as the Assembly of Manitoba Chiefs (amc) felt that the government was trying to push through the changes without seriously considering many of the working group's recommendations, and they demanded that msb postpone implementation of the new guidelines until adequate revisions and

recommendations had been made by the nihb working group and the amc's health committee had sanctioned the proposed nihb procedures. (amc 1991) While these protests appear to have been successful in postponing implementation of the new guidelines for more than a year, in the end it appears that msb did not accept the working group's advice. In September 1992, the new nihb package came into effect, and prescription drugs were transferred to Blue Cross in early 1993.

That is the background. It is interesting to note that several key informants at phs stated that they were not opposed to many of the changes in the guidelines per se, but rather the manner in which the changes were implemented by msb. At the moment, services included in the nihb package are not available for transfer.

The largest portion of nihb in Peguis consists of the medical transportation budget (this budget is equal to approximately half the entire transfer budget), and it seems this is the area that has caused the biggest headaches for phs staff (and probably msb as well) in the past. Nurses' narrative reports and other phs documents contain numerous references to msb's constant questioning of the staff's requests for patient medical travel, and Kathy Bird recalls that a lot of her time was taken up dealing with the paperwork involved.

Before the spring of 1990, Peguis had to cover the cost of medical travel and then submit a monthly bill to msb for reimbursement. In April of that year, the band entered into a contribution agreement for local administration of the medical travel program, which means that the band now receives the funds according to a payment schedule, then submits monthly statements to account for the money spent. As a result, phs had greater responsibility for making decisions related to patient travel, but they still had to follow msb guidelines, and they had to manage the huge deficit that the program had always entailed. In addition, msb was starting to limit funding for this program, leaving Peguis with greater responsibilities and a shrinking budget.

It is interesting to see how phs has dealt with this dilemma. Cecilia Stevenson explains that their philosophy was simple. Peguis considers non-insured health benefits to be a treaty right. Therefore, phs has a responsibility to respect that treaty right. First, they took some steps (such as refining their record-keeping methods) in order to make the operation of the program as efficient as possible. Following transfer in July 1991, a patient services co-ordinator was hired to manage the program. At the same time as phs was streamlining the operation of the program, they conducted their own review to demonstrate to msb that funding was not adequate to meet

their medical transportation needs and that their use of the funds had been legitimate. According to Cecilia Stevenson, this took a tremendous amount of time, including writing letters to doctors to obtain proof that patients had been seen by them in the past, but the effort was worth it:

> Now that they [msb] have finally seen the proof, they are coming through — they've restored our base. What I mean by restoring the base is that...msb has said it will cover for all those deficits in the last three or four or five years...they have agreed that these [deficits] were actually part of program costs...so now the budget is up to what it should have been all along.

Unfortunately, even after all this, phs is still running a deficit each month. However, Cecilia feels that they have now proven to msb that phs can run the medical travel program efficiently, and that this program should be considered for transfer. She believes that, by having full control over the use of funds, Peguis could find more economical ways of providing this service. Cecilia would like to see the band have an opportunity to run a pilot project to simulate a transfer. In the meantime, phs plans to conduct a survey of community members to determine whether the various options they are considering regarding future operation of a transferred program are practical.

The other major problem areas related to nihb concern dental and optometric services. In both cases, msb has agreed in principle to transfer the contract for these professional services to Peguis.

From the mid-1970s until 1987, dental services for residents of the Peguis, Fisher River and Jackhead reserves were provided from a trailer situated in Peguis. Originally, the contract for professional services was with the University of Manitoba, with dental students doing most of the work under a dentist's supervision. In 1987, dental services moved into the new phs facility. The arrangement with the university ended, and msb then contracted with a dentist directly, leaving the dentist and an assistant from the community to provide the services. While the new dental services facility was an improvement over the trailer, the staff were unable to keep up with the demand for dental care. In 1991, phs put their case before msb, requesting additional funds to hire a dental hygienist. Their statistics showed that Peguis dental services' dentist/patient ratio was double the provincial average. In December 1992, a reply came in writing from msb. It stated, in part,

> ...Your request has been accepted as being logical and appropriate for the dental health needs of your community. However, unfortunately it constitutes a major restructuring and redirection of dental health care funds within the current nihb system. At present, the system is not structured such that your request can be addressed. (msb 1992)

Although an interim arrangement has now been made to ease some of the overload in service demand, it is clear that a long-term resolution of the problem is required. Cecilia Stevenson states that they are eager to take over the dental services contract from msb, but that it would be irresponsible to do so unless the resource base is improved.

As for optometric services, Peguis believes that under a transfer arrangement they could offer a much better service than the existing one. At present, a team of two optometrists and two assistants holds two- or three-day clinics in Peguis twice a year. Msb pays for the non-insured services (including travel expenses), while the Manitoba Health Services Commission (mhsc) covers professional fees. Since it is virtually impossible for the optometry team to see everyone who needs service during the regular eye clinics, the band ends up sending people to optometrists in Winnipeg. According to Cecilia, if the (roughly) $36,000 now being spent annually on travel to Winnipeg for optometric services were transferred to phs, they could provide monthly eye clinics and avoid sending residents off the reserve (which adds to medical travel costs). The problem is that msb cannot transfer the $36,000 to Peguis under current Treasury Board regulations. As a result, this is another situation where Peguis feels that they could run a better service under a transfer arrangement, but they see no point in proceeding unless they are guaranteed an adequate resource base.

In summary, the current administration of non-insured health benefits, and the federal government's perceived reluctance to transfer these services, are viewed as obstacles to greater self-determination with respect to community health programs in Peguis. Several key informants at Peguis Health Services expressed confidence in the band's ability to manage nihb programs more effectively than the government. One person stated bluntly that "we are being forced to stay back because of msb's archaic policies." The frustration surrounding this issue appears to be intensified by a sense that they are caught between a rock and a hard place. On one hand, there is a recognition that the government is cutting costs, and there is a desire to transfer nihb while the dollars are still there. However, the impatience to take over is tempered by the realization that, if

the existing resource base is not enough, then the transferred programs could cause even more problems.

Percy E. Moore Hospital

By far the most complex unresolved issue facing Peguis is the future of the Percy E. Moore Hospital (pem), which is eligible for transfer under the terms of the 1991 agreement. This is a complicated issue, for several reasons.

First, there is the multi-jurisdictional nature of the facility. The external consideration here is that, although the hospital is situated on Peguis land, it serves all three local reserves, as well as surrounding non-Aboriginal communities. Internally, although the facility is administered by Medical Services Branch, the Manitoba Health Services Commission (mhsc) continues to pay the per diem and, since the late 1980s, it also pays the salaries of the physicians hired by the University of Manitoba's J.A. Hildes Northern Medical Unit (nmu). While most of the hospital's nursing staff are payed by msb, nurses in the out-patient clinic are paid by the nmu. Although the multi-jurisdictional factor is not considered an absolute deterrent to taking over operation of the hospital, it seems safe to conclude that any negotiation process will be a complex one, involving a number of parties.

A much more serious problem concerns the resource base that would exist should a transfer occur. Although pem was designed as a 38-bed facility, as discussed earlier, the capacity was reduced to 16 beds by the early 1980s. There are no surgical services available, and only a few low-risk deliveries are done each year. Also as discussed earlier, several informants stated that, owing to the lack of services and frequent physician turnover, they prefer to go elsewhere for elective medical care. Considering that the operating budget for pem is slightly over half a million dollars, the question that arises is whether it makes sense to transfer control of a facility that is seen as inadequate. Key informants acknowledged that this is a serious problem. At the very least, Peguis wants a guarantee that the current operating budget is maintained as the existing base for transfer negotiations and that the person-year level not be any less at negotiation time.

Just before the signing of Peguis's health transfer agreement in 1991, msb-Manitoba reduced the operations and maintenance base of the pem by 5.7 per cent. In a letter to the federal finance minister at the time of transfer, Chief Louis Stevenson made the following comments:

> We are planning on taking over the control of the Percy E. Moore Hospital within the next few years but already we are experiencing the counter-effects of the government restraint policy on our plan... If anything deters Peguis from even contemplating a takeover of the magnitude of the Hospital with its already inadequate resource base, it is this [budget cut]. (phs Archives)

Chief Stevenson went on to urge the government to restore the pem's resource base to its original budget with the original person-years remaining as the existing base for transfer. The letter concludes with a request:

> We propose that you establish a moratorium on further cutbacks and person-year reductions on all transferable resources. To do otherwise will surely discourage other First Nations from accepting your offer of Health Transfer.

Apparently, Chief Stevenson never received a reply to this letter. However, even with a guarantee to restore the original resource base, Cecilia Stevenson doubts that the people of Peguis (and others) would be satisfied with the status quo:

> When we do the pre-transfer work, it will be with a plan, with that same conviction that we had two years ago...that we have to take over that hospital because it's part of our progress as Indian people, that we have to take control of our own affairs... We could make it into the hospital that it used to be a long time ago, that people talked about...a much-improved hospital because, it would be at that point, a community hospital where there would be input from community members...and there would be a sense of real ownership. I'm convinced that could work, but only with agreement from the provincial and federal governments. Otherwise, we would have to settle for the mediocre, which is to carry on existing [services], and whether we want that or not is something that we are going to have to decide at the time when we finish the pre-transfer work... There's no way that we will let ourselves take on a white elephant and just...perpetuate it.

Summary

In summary, health transfer is perceived as a generally positive experience by key informants in Peguis, who see it as a limited, but nevertheless useful, opportunity to increase control over the development of community health programs. Most of the problems experienced by the band

relate to resources that have not been transferred. As far as future transfer of nihb and the Percy E. Moore Hospital are concerned, there is concern about inheriting an already inadequate resource base. In the next section we explore developments in Peguis's community health programs in more detail.

Health Program Development Beyond Transfer

Shifting Focus

In the two years since the health transfer agreement was signed, a lot of effort has been focused on developing the administrative infrastructure required to operate Peguis's community health services effectively. The review and streamlining of the medical travel program have already been discussed. Phs staff have also begun developing a health information management system. At this point, statistics are being collected on all public health activities to build a data base that will help in program evaluation at a later date. One of the staff is completing computer training so that phs doesn't have to depend entirely on outside expertise in these efforts.

Cecilia Stevenson acknowledges readily that they are just now getting to the point where they are ready to sit down, sort out the health priorities identified in the community health plan, and do the necessary program planning. In fact, she says that it may be another year before they are at the point where they would have liked to be at the time of transfer ─ a situation she blames on the very limited pre-transfer timeframe under which they had to work. Despite the slow pace of progress, several health service initiatives indicate a shift in focus to meet the needs of the community better. One example is the changing role of the chr.

Verna Spence explains that when she first started as a chr in the late 1970s, her role could be described as "jack of all trades, master of none". The chr's duties included assisting the nurse with basic health teaching (especially regarding infant care and sanitation), dealing with mental health and substance-abuse problems, and carrying out tests (such as water sampling) under the mandatory environmental health regulations. However, both the community and its health services have developed to the point where many of the tasks previously done by chrs are no longer required. Among the factors that have combined to change the role of the chr are improved housing conditions and sanitation (e.g., indoor plumbing, garbage pick-up), a lower incidence of infectious diseases, increased prevalence of breastfeeding, a very high

immunization rate, high attendance at well baby clinics, and the development of substance abuse and mental health services.

Over the last couple of years, chrs have moved toward greater specialization. Each chr is teamed with one of the nurses, with one team focusing on diabetes and other chronic diseases, while the second team focuses more on child and maternal health. Both the chrs stated that they find this arrangement more satisfying than doing a little bit of everything.

Diabetes is becoming a growing concern in Peguis, with about 100 diagnosed cases so far. One of the projects the chronic diseases team has been working on in the past couple of years is development of a diabetes education program. As Eleanor Olson, one of the chns, explains,

> The reason why we're doing that is, the government diabetic education program is not made for Native people. They don't understand all those big words. So what we're trying to do is to use plain language...we're trying to meet the needs of this community, not necessarily others.

According to Eleanor, they have been quite successful in promoting self-care, with the majority of diabetics now being non-insulin-dependent, and about two-thirds of the known diabetics attend clinics for monitoring. However, Kathy Bird acknowledges that the phs diabetic clinic is still a long way from functioning as they had hoped. She would like to see a regular clinic where people come in, have their blood checked, feet checked, and get some teaching. Part of the problem is that, because of frequent turnover and the shortage of physicians at the pem, there is not always a doctor available to attend the clinic at phs, which means that people may have to make an extra trip to the hospital if there is a problem. In addition, since patients have to go to the hospital to have their bloodwork done and to receive their medication in any case, many of them simply decide to go through the out-patient clinic at the hospital for their care. While these problems remain to be worked out, phs staff are concentrating on increasing the community's awareness about diabetes.

As for the prenatal program, this is another high-priority area. According to Kathy Bird, there are 25 to 30 pregnant women at any given time in Peguis. There is concern about the number of pregnancies among single teenagers, and this is an issue that remains to be dealt with. In the meantime, phs has taken steps to make existing prenatal education more appropriate for the needs of the community. Prenatal classes have been held in the health centre periodically since it moved into the new facility in 1987. However, it was found that the format ─ once a

week for several weeks ─ was not working. In the past few years, the format has been changed to two-day workshops, with an interesting twist. As the chr explains:

> Kathy came up with that idea. It has been terrific. We bring in a couple of grandmothers from the community to talk about their experiences, and the things that we have now that they didn't have. They encourage the parents to come to the health centre and get the babies' needles. Our moms and dads will sit and ask questions and the grandmothers will answer...everybody's involved.

Both the nurse and the chr responsible for the maternal/child programs agree that something very interesting has happened in Peguis in the past few years. They have noticed a definite increase in the involvement and interest shown by fathers in their partners' prenatal health and in their children's health care. The chr is quite pleased with this development:

> Our dads are getting quite good...they even bring their babies to baby clinic. They ask what the needles are for and whether there will be a reaction... I'm hoping that they're passing it on to their friends.

Although neither of the public health providers could offer an explanation for this phenomenon, they both agreed that a general increase in awareness about health in the community may have played a part.

Another area that has seen a shift in focus is the Peguis Alcohol and Drug Awareness Program (padap, formerly nadap). While the staff still do assessments and referrals for treatment, as well as counselling, they are attempting to put more emphasis now on education and prevention. One of the workers describes the changes:

> ...[before transfer nadap] used to be more geared to adults... After the transfer [Cecilia Stevenson] said this is our program now, we can do what we want with it. So, I took the initiative...to change it around a little bit and focus more on youth... Why work with adults, when the problem is there? Why don't I go a little bit further and work on the youth, and prevent...

The prevention orientation has involved doing a lot more work in the school, giving presentations, working with the local pride (People Resisting Impaired Driving Everywhere) group, and promoting a variety of recreational activities as alternatives to alcohol and drugs.

In addition to a change in focus, one of the padap workers stated that another positive change since transfer has been the integration of their program into the overall community health program:

> Before that, I was working across the road, in the old band office. Being away from the health office...we were apart...they didn't know what we were doing, and we didn't know what they were doing. But now that we are working here...we feel more connection, more supervision... We are feeling more like a team.

Although both padap workers stated that they feel they have made some progress, they both acknowledged that there is much more work to be done, such as developing a more structured alcohol and drug education program for all target groups.

Finally, a good example of phs's effort to increase community awareness about and involvement in health issues was the two-day aids conference held on the reserve in April 1993. While the phs staff had done a number of smaller workshops on aids in the school and for other community organizations over the years, they weren't really sure just how much the community as a whole knew about the issue. It was one of the padap workers who initiated the idea of having a major community workshop. In January 1993 a committee was formed to organize the event, consisting of representatives from the various health services programs, social services and the Al-Care Treatment Centre. In addition, a community member was invited to participate on the planning committee. One of the phs workers explains the reasoning for this initiative:

> I guess in past workshops, we more or less did it on our own, with our resource people. This time, we wanted a community aspect...the community to be involved as much as possible... When [the community member] came in, he hadn't worked in the field...no training or anything like that, but he brought into our committee, enthusiasm... It kind of gave us the extra push to get together and do something exciting, something new. I think it helped everybody to have a community member involved, and I'm sure it's something we will do again.

However, the community involvement did not stop with one person on the planning committee. An effort was made to involve a number of different sectors of the population in the actual event. The chief was invited to give the opening address. Respected elders were invited to speak at the beginning and the end of the conference. The school was approached for permission to invite all students in grades 6 to 12 to attend both days of the conference, and grade 12

students were asked to create and perform a play about aids. Residents of the Al-Care Treatment Centre were invited to attend. Daycare services were offered to any parent who might not be able to attend otherwise. In the end, more than 300 community members attended each day of the conference. Key informants stated that they believe the conference succeeded in raising not only the level of awareness about aids, but also the level of tolerance and understanding.

In summary, the discussion so far has concentrated on examples of some new ways of organizing and delivering health information and services in Peguis that had previously (at one point or another) been provided by msb. Perhaps the most interesting developments, however, involve innovative programs that were not provided historically by msb. In the following sections, two examples are highlighted.

Case #1 - Traditional Program

Throughout the 1980s, a period of dramatic social and economic development in Peguis, a second phenomenon was occurring, as some community members began to explore traditional cultural values and practices that had been lost. This phenomenon was not unique to Peguis but was part of a widespread resurgence of traditional Aboriginal health care practices throughout Canada over the past decade. In Manitoba it is evident that, despite a long period of active suppression of the traditional Aboriginal medical system, these practices have persisted and/or are now being revitalized in certain areas. For example, Garro's (1988) study of one First Nation community in southern Manitoba revealed active use of traditional healers, while Gregory (1989) suggests that traditional Aboriginal healers in northern Manitoba are at the centre of the cultural renaissance in health care. Moreover, it appears that the increasing demand for and active use of traditional medicine is putting pressure on the western medical system to form a new relationship with traditional healers. (Gregory 1989; Gagnon 1989)

In Peguis, owing to a variety of factors ─ some of them discussed earlier in this paper ─ the loss of traditional Aboriginal language and culture has been quite extensive over the past century. As a result, the process of rediscovering traditional cultural roots has been a very slow and, occasionally, painful one in the community ─ so painful, that I was advised to use discretion in dealing with the topic. Suffice it to say that there was serious opposition to the traditionalists in certain sectors of the community. The conflict between the two groups appears to have reached its peak in the late 1980s. In fact, it is for this reason that the community health plan

made no mention of the role traditional healing might play in post-transfer community health program planning. However, it is clear that the demand for traditional healing services not only existed, but was growing.

During the 1980s, there was a slow but steady increase in the number of people who approached health centre staff requesting access to traditional healers. Kathy Bird, nurse-in-charge at phs, explains what happened:

> We approached msb to see if they would support us in helping these people to get to see a traditional healer, because there was none here in our community... We used their mission statement [1979 Indian Health Policy]...to justify why our people should go to see traditional healers or why traditional healers should come here. So we had quite a number of meetings with msb and we were finally able to get that established.

In effect, the travel costs and expenses involved in visiting a traditional healer became a special category within the non-insured health benefits program. In May 1985, Kathy Bird received a written policy statement from msb-Manitoba's south zone director (who was relaying the directive she had received from the regional director), clarifying the department's three criteria for dealing with requests for `traditional travel' reimbursement. (msb 1985) These were

1. Msb should attempt to facilitate referral to traditional healers in the same manner in which we would to any other health professional...when appropriate.

2. Prior approval for arrangements is required if msb is to be financially involved. If no approval sought, we would consider visits as self-referrals with appropriate reimbursement.

3. Payment can only be made on submission of all receipts.

Charlotte Johnson, a former msb south zone director, acknowledged in a recent interview that Peguis did play a role in shaping msb-Manitoba's policy regarding traditional healers, in the sense that the high volume of requests from Peguis highlighted the need for more formal guidelines to deal with the issue. However, she pointed out that Peguis was not the only community making such requests but was part of a broader emerging phenomenon.

Essentially, from that point in the mid-1980s, referral to traditional healers became a service offered to clients of Peguis Health Services on request. According to Kathy Bird, this development was simply a matter of meeting an expressed need in the community:

> It was only a few to begin with, but it has been growing steadily... The people should have the opportunity to choose whatever method of healing they want to go through. ...if they want to know I explain to them what is available... I do it [referral to healer] on request only, with the exception of, if I know that person follows traditional ways already, then I might suggest seeing a traditional healer for a certain thing.

The demand for these services has grown to the point where a traditional healer now travels to Peguis at least every three months, and sometimes more often, to hold `clinics' at the traditional grounds on Matootoo Lake ─ a site that has become known as a traditional healing centre in Manitoba. Clients, healers, and even non-Aboriginal health care providers travel to Matootoo from all over to use the services offered there.

These grounds were established by Carl Bird, who recently changed his Christian name to the Anishnabe name, Mide Megwun ─ `Mide' meaning life, and `Megwun' meaning feather. Mide Megwun Bird, a former child and family services worker and band councillor in Peguis, is a traditional teacher and one of seven traditional chiefs appointed by the female elders of the Three Fires Society, a large North American spiritual organization based on the teachings of the traditional Midewiwin Grand Medicine Society. Mide Megwun is one of a group of people in Peguis who are currently undertaking the lengthy process of becoming healers themselves. The site at Matootoo Lake was chosen because traditional teachers and elders tell stories of this being an area where healers came to pick medicinal plants and build sweatlodges in the past. In fact, the word `matootoo' means `sweatlodge' in the Ojibwa language.

Kathy Bird states that there are always at least 30 to 40 requests to see visiting healers at these clinics, and the demand is sufficient that people continue to be sent out of the community for treatment between these visits. Statistics kept by the nurses at phs indicate that, between July 1991 and March 1993, there were 325 client contacts related to traditional healing.

While many Aboriginal people from outside the community continue to request services at Matootoo Lake, key informants stated that there is increasing interest from within Peguis. This has been especially true for people suffering from emotional problems (see Case #2, page , for a more detailed discussion), and several key informants involved in alcohol and drug counselling indicated that more clients, especially youth, are beginning to request information about the traditional healing approach. None of the key informants could identify precisely why this has

happened, but all agreed that there has been a definite easing of tensions in the community over the past year or so, with a noticeable increase in tolerance for those choosing the traditional approach. Several informants suggested that the extensive positive coverage of Aboriginal culture in the mass media recently may have resulted in more people feeling comfortable with the idea. Others suggested that it was simply a matter of time before community members turned to explore their cultural roots and practices. However, they all agreed that the issue is still a sensitive one in Peguis and that community members who would identify themselves as traditionalists are still in the minority.

It should also be noted here that members of the advisory committee (and others) were consulted regarding informants who would be open to questions about traditional healing and those who might be upset by this line of questioning. In Peguis, I was informed, the greatest resistance has been among the elders of the community. However, it was interesting to discover in interviews with elders that there was more concern about the spiritual side of traditional healing than with the use of traditional medicines. In fact, almost all the elders interviewed spoke about the use of traditional medicines when they were young and indicated that they still use plants for a variety of ailments. Only one elder acknowledged that traditional healing in all its forms might be useful, while only one person disagreed categorically with all forms of traditional healing.

When asked to define the term `traditional healing', all the traditionalist informants emphasized its holistic nature. Among the comments were these:

> ...the traditional healer will look at the whole person. That means the physical, emotional, spiritual, and mental components of the person...

•

> ...if I'm feeling stressed out, then I go to see a traditional healer for whatever it is. Like, if I need to ask for a physical healing, it may be addressed in many different ways. It might be through herbs. It might be through the sweatlodge. It might be through the ceremonies. But the ritual of the ceremony is also for the mind, and I know that my spiritual self is also being looked after.

•

> There's always a follow-up that's given to any person seeking traditional help, whether it be to continue to make the medicine until it's all done, or to bless yourself with sweetgrass, or to go to the sweatlodge, or a referral is made to see another person. So there is always that continued support.

•

> Traditional healing is also the getting together of people to discuss our needs, or to go back and remind us of some of the things that have passed, to rejuvenate a feeling that we once had that was good, and to share it with one another. That's traditional healing. With our people there was always some sort of gathering, whether it was a sun dance, a Midewiwin Lodge, a pow-wow, where we celebrated life. That was mental health.

In addition to dealing with existing health problems in a holistic way, traditionalist informants suggested that traditional cultural teachings can play an important role in health promotion. For example, `Young Women's Teachings' are offered at Matootoo, to prepare girls for the emotional, physical and spiritual transition to womanhood. The program is described as promoting self-respect and increased self-esteem in young women, which may result in the prevention of early pregnancy. Mide Megwun Bird described ceremonies and teachings to mark boys' transition to manhood and emphasized that, aside from promoting self-esteem among young men, they can play an important role in decreasing abuse of women in Aboriginal society:

> A lot of people think in our culture that it's a man's world, that we control everything, but that's totally wrong. In our culture, women are the backbone of our community, and the women are the backbone of the Three Fires Society today. It is the women who make the major decisions in our lodge, and half of our sweatlodge, our teaching lodge, half of everything belongs to the women... One of the things that happens to a lot of women, and especially Indian women, is abuse... We as men are responsible for a lot of the abuse of our own women, and that has to stop, so that we can come together, we can work, then you know that cycle of abuse will be broken and we will build strong good circles again.

Several of the traditionalist informants spoke of how people have come to Matootoo Lake with very little understanding of either traditional culture or healing, but then something happens to them. According to Mide Megwun Bird, this phenomenon is easily explainable:

> A lot of times Indian people say, "I lost my culture, I lost my tradition, I lost my identity as an Indian person." I don't believe that... The traditional elders say you don't really lose it. It's right here inside of you. And sometimes, when you smell the sweetgrass or the sage, or if you go to the sweatlodge, or if you hear the drums, you feel something go right through you, and sometimes you feel something stirring inside of you, like it wants to come out. The old people call that `blood memory'...that's what it is...it runs in the blood. We've never lost it.

Finally, traditionalist informants emphasized that the return to traditional values and teachings should not frighten people. As one person explained,

> We don't say you have to give up your car, your microwave and go out and live in the bush in a teepee, not that at all. We believe that you take the good things from western society, but you also take the good things from your own culture, and you can put them together and you can make them work for you.

Another informant suggested that returning to traditional cultural values and practices does not mean regressing, as far as community development is concerned, but rather moving ahead by looking at alternatives.

When asked about the implications of growing interest in traditional healing for Peguis Health Services, both Kathy Bird and Cecilia Stevenson acknowledged that, in the past two or three years, msb has become more supportive of their requests for traditional travel assistance. However, they both admitted that they are worried that msb might try to impose more restrictions on the program as the number of people wanting to use the traditional program increases.

It appears that concern about the possibility of increased restrictions on funding for traditional travel is well founded. In a memo sent to all msb regional directors in April 1991, the assistant deputy minister (msb) outlined a new policy regarding this non-insured service. This directive contained several new restrictions, including the following: to see a traditional healer, an individual would need a physician's referral; individuals who were granted approval to see a traditional healer would not be allowed to travel outside Manitoba, if they wanted their travel costs to be covered by nihb; and no travel costs could be applied for retroactively. (msb 1991)

These conditions were rejected by the Assembly of Manitoba Chiefs health committee, which recommended that the policy not be recognized by First Nations people. When the new nihb guidelines came into effect in September 1992, the proposed restrictions had been removed.

Commenting on the possibility of restrictions on traditional travel, Kathy Bird pointed out:

> In Alberta, one of their restrictions is that you cannot go and see a traditional healer outside your province. We are fortunate enough to still have access to Canada and the United States for traditional healers. It probably has to do with that increase in demand. It's not going to stop, it's just going to grow because our people are starting to look at their own healing holistically.

In addition, more non-Aboriginal health care providers are showing an interest in traditional approaches to healing. For example, some 20 msb nurses from one region of Manitoba recently attended a workshop on cultural awareness and traditional healing at Matootoo Lake. Apparently, some of the nurses were not even aware of the forms that are required by msb for traditional travel assistance. Cecilia Stevenson is certain that the nurses' increased awareness will result in a greater number of referrals to traditional healers.

When asked about the relationship between traditional healers and the dominant medical system, key informants stated that there has been a definite increase in the number of health professionals coming to Matootoo Lake for their own personal interest. According to Mide Megwun Bird, the University of Manitoba's Northern Medical Unit and the Health Sciences Centre in Winnipeg have sent staff to Matootoo Lake recently to learn more about traditional healing, and workshops have also been done with the Manitoba Medical Association. Apparently, the Health Sciences Centre has, on several occasions, requested assistance from Matootoo Lake in dealing with certain patients. Even the hospital in Gimli, Manitoba, recently requested that a traditional person from Peguis bring sweetgrass, a pipe and a drum to an Aboriginal patient who was dying of cancer. However, all the key informants involved in traditional healing stated that they had never received any requests for workshops or patient services from the local Percy E. Moore Hospital, and that only a few individual physicians at the hospital had ventured to Matootoo Lake out of personal interest. Mide Megwun Bird, traditional teacher at Matootoo Lake, made the following comment about this situation:

> Well, you know, the ideal working relationship between us and the Percy Moore Hospital ─ first of all, it has to start with education. I think the doctors and the nurses and the people who run it have to be educated first. There has to be cross-cultural workshops being done there... I guess the ideal thing that could happen would be Percy Moore working more in a holistic way of helping our people...there should also be a referral system.

While key informants all agreed that the ideal situation would be formal recognition of the role of traditional healers, and the development of a referral system between the traditional and western health care providers, they were adamant that the government should not have any involvement in regulating their services. One person said: "Traditional healers don't want to be signing forms." Another explained:

> There is a network across Canada and into the States. Our people who are involved in a traditional healing program here know the medicine men, the traditional healers who are out there. They know which ones are credible and which ones are not, which ones have integrity, and so on. They have their own policing system...a surveillance and monitoring system of their own.

Mide Megwun Bird stated that he has frequently gone to check out traditional healers first, before referring anybody to them. He concluded:

> I think that we have to regulate ourselves... We talk about local control and self-government... We can't let the government decide any more for us ─ they decided before... We have to get together as traditional healers, we have to start networking across the country, and we do need the support of our leadership.

Mide Megwun acknowledged that this networking process has already started to happen. The Assembly of First Nations has been sponsoring a series of workshops for traditional healers across Canada, for the purpose of networking and sharing information. The most recent gathering occurred at Matootoo Lake in August 1993.

In the next section, we explore another innovative program initiated to meet a need in Peguis that was not being met by existing government services. In this case, unlike that of the traditional program, the gap in services was seen as an example of a failure by the federal government to meet its responsibility to provide a specific type of health care.

Case #2 - Peguis Mental Health Program

As we have seen, the Peguis community health plan submitted in 1990 identified the need for a comprehensive mental health program. Before examining what happened in Peguis, it is worth discussing briefly the history of mental health services for Aboriginal peoples in Canada, since it provides a classic example of federal/provincial jurisdictional wrangling in which the Indigenous population falls through the cracks.

The federal government has never provided organized mental health services to Aboriginal Canadians and has attempted overtly to offload this responsibility to the provinces at every opportunity. For example, a regulation in the *Indian Act* makes First Nations people subject to the mental health laws and services that exist in the provinces. Then, in 1968, the federal government announced that it was ceasing payment for the treatment of Aboriginal people in provincial mental institutions. (Canada 1968b)

The provinces, on the other hand, have always maintained that it is not their responsibility to provide these services to Aboriginal people and have reacted strongly to federal attempts to offload financial responsibility for health and social services. (Manitoba 1975) The Manitoba Mental Health Act, for instance, states that an Indian or Inuit patient may be refused admission to a psychiatric facility unless payment is guaranteed by the federal government ─ a stipulation that apparently has never been enforced. In the absence of either federally run mental health treatment services msb has contracted for itinerant psychiatric services to various First Nations communities across Canada, but the day-to-day management of mental health problems has been left largely with local nurses and community workers.

Wrangling between federal and provincial governments appears to have had a particularly detrimental effect in Manitoba, with its large Aboriginal population. A provincial mental health task force reported in 1982 that rural mental health services in Manitoba were grossly underfunded and that certain groups had suffered disproportionately through neglect ─ including the Aboriginal population. (Mental Health Working Group 1983) In 1985, a survey of 57 First Nations communities in Manitoba (sponsored jointly by three tribal councils) revealed that mental health services to First Nations communities in Manitoba were hit and miss. (First Nations Confederacy et al. 1985)

As for the provision of mental health services in Peguis, a few independent therapists were offering counselling services to community members, and the Northern Medical Unit was providing a psychiatric visit to the Percy E. Moore Hospital for one half-day every two weeks. However, according to key informants, these arrangements were hardly adequate to meet the needs of the community. People with major mental disorders ended up in institutions in Selkirk or Winnipeg, and when they came out, there wasn't enough follow-up for them in the community, so they ended up either back in the institution or, occasionally, in jail. Community health workers recall that they did their best to provide support to these people, but they often felt helpless because they couldn't provide the special care required.

The problem was not limited, however, to a lack of local services for the mentally ill. Although Peguis saw significant progress during the 1980s, in terms of economic development and improved living conditions, this did not necessarily result in improved mental health among community members. As Kathy Bird explains:

> We are a lot more comfortable in our nice homes... But our community, like any other Native community, has been through a lot of negative things in the past... In spite of all the things we have here, there are still many people out there who are hurting... Thirteen years ago, people more or less looked at mental health as only mental illness. In the last ten years, people have become more open about what happened to them in the residential schools...about abuse. People have become aware of all these other things that are causing them unhappiness in their life and affecting their mental health. People have started to realize that there is something missing in their lives, and they want to know who they are, where they come from, and it's all affecting them mentally and spiritually... It has changed with the increase of people's awareness and people willing to talk about these things. So there is a bigger demand for mental health workers.

In early 1991, some community members decided that if government was not going to provide organized mental health services in the community, they would have to do it themselves. A key person in this initiative was Elva McCorrister, director of the personal care home. She recalls:

> I was going through a difficult time myself, because I had a son that had a mental health problem... I was sort of dealing with Selkirk [provincial mental health

> institution] and not getting anywhere with them... There was nothing in the community... I started approaching [Cecilia Stevenson] on the subject and she said, "Well, let's have a meeting". We talked about who should be involved... We figured that we had these people in the community with mental health problems... They were going to the Al-Care, they are coming here [personal care home], they are going to social services, to nadap workers, they are going to public health... These are the organizations that the people are making the rounds to...so we invited all the key people [from these organizations]... We set up the committee that way so that we could deal with it together.

This is how the Peguis Mental Health Steering Committee (pmhsc) was formed. Another pmhsc member describes how the committee functioned:

> It started off as ─ we sort of took on the role as mental health workers. I took on...the more severe cases in the community. So we took on a supervision role, to watch them and to keep an eye out for them. If we had to intervene, we would, even if it was by visits or talking with other members of the family... Then, if we needed help, we would call another member... We would always network together, keep in contact.

In September 1991, Cecilia Stevenson received approval from the chief and council to start developing a proposal for a formal community mental health program. When asked whether transfer gave the pmhsc confidence to pursue the mental health initiative, Cecilia responded this way:

> ...Transfer was incidental, but not so incidental that it didn't help at all. Sure, it gave a bit of a boost. I think that the extra resources we received...enabled us to respond earlier... For one thing, the management structure or funding gave us that extra edge or ability for us to look at areas such as mental health... It gave us that extra manpower that was needed for someone to oversee and do the strategic planning that could not be done in the old setting.

Although the steering committee provided support and continued monitoring of people with serious mental health problems, it was clear that pmhsc members by themselves could not provide the necessary counselling services. Early in 1992, the pmhsc took advantage of another

opportunity that allowed them to move a step closer to their goal of establishing a comprehensive mental health program in the community. Peguis (along with the other two Interlake Tribal Council First Nations) was invited to take part in a community mental health project developed by the Northern Medical Unit, which had received funding from Medical Services Branch to carry out a three-year demonstration project.

The Northern Mental Health Outreach Project (nmhop) was designed as an alternative to the itinerant psychiatric model, which involved occasional visits by psychiatrists to First Nations communities. The nmhop was based on a public health, or community mental health, approach. One feature of this initiative was the establishment of a provincial nmhop steering committee, through which participating communities had direct input to the development and direction of the program. The other major feature of this model was that nurse practitioners with extensive psychiatric and mental health experience would provide direct clinical services in the community about two days a month (with psychiatrists providing back-up only). However, Gwen Armstrong, the nurse hired as the Peguis mental health counsellor after being approved by the pmhsc, explains that the purpose of nmhop was not simply to substitute nurses for the lack of available psychiatric services:

> The nmhop program is designed as an enabling program. There are three things that we do. One is to provide a measure of direct clinical work to the people of the community. That's probably the least important component of the program. The other two aspects of the program are teaching, finding strong, interested, capable people in the community ─ either who are officially workers in the community, or unofficial lay counsellors ─ and transferring some of the skills that we have learned in our careers as nurse practitioners. And the third aspect is probably the most difficult to define, but the most important, and that is to, in a general sense, support the efforts of the Indian people themselves to improve the mental health of their communities...to support and, when asked, to give guidance or counsel on all sorts of initiatives that can make their community a happier and healthier place to live.

It was a commitment to these fundamental principles of the nmhop, rather than specific experience in either a community or an Aboriginal setting, that made Gwen Armstrong (who is non-Aboriginal and had previously worked in a hospital setting) an ideal candidate for this

position. In addition, Gwen believes that she was fortunate to have worked with mentors who used a management model that encourages people to develop their own skills and abilities.

According to Cecilia Stevenson, the nmhop initiative came along at just the right time and fit in well with Peguis's own vision of a community mental health program:

> We told nmhop from day one when they came into our community... "This is the way we have planned it, this is the way we are going to do it, this is the way it will be. We are glad to have you on board.

Gwen Armstrong describes how she took direction from the steering committee:

> Originally when I first came out here I viewed my role as getting more involved in the preventive side. However, when there were people in such immediate need for counselling, you have to see them first and gain your acceptance, then you can carry on... The steering committee have a very good sense of what is happening in their community and who the people in need are...they identified the people who they considered were the most acute cases... We worked it out so that when the steering committee members referred somebody, they maintained the role of case manager. So I would be a consultant to them in doing the assessment initially, then they [pmhsc members] would either provide the counselling or keep in touch with the person until I got out there every four weeks or so.

Although the first few months of 1992 were spent dealing mainly with the people most in need of support, the pmhsc decided to take the first step in building community awareness about mental health issues by organizing a workshop aimed specifically at workers in all the community organizations. This was in response to an expressed need on the part of the community's resource workers for workshops that would help them serve community members better. The May 1992 event was very successful, with more than 80 people participating.

An important feature of the event was that it was endorsed personally by the chief, who opened the workshop on a very personal note by sharing his own life story; this gesture was viewed positively by the group. In addition, the afternoon speaker enthralled the audience so much, provoking in them a strong desire to share their own stories, that the steering committee decided to abandon the rest of the agenda and to carry on with what was happening spontaneously.

One participant at the May 1992 workshop remembers that it became a "healing circle rather than a workshop". It was then that the pmhsc realized how much work needed to be done with the community resource people before they could turn to the general community awareness workshops. As Gwen explains,

> ...The traditional way when looking at the Medicine Wheel is what I'm taught again and again. One must look after one's own Medicine Wheel, and then next, one can help one's family, and then next, one's community, and then finally, help the Indian Nation. ...There are many strong people here...and they have used their own internal resources to get into the position that they are in. However, they are undertaking very difficult work, and that requires growth and change for themselves individually. These are often people who feel that, because resources for counselling and therapy are so limited, they have been reluctant to use a counsellor's time for themselves when they feel that there are others that are more in need. So there is a great need for healers and helpers themselves to have help to balance and strengthen their own Medicine Wheels.

In addition to recognizing the need to work with the community's resource people, the pmhsc made the decision to move on to the next logical step in the development of a community-based mental health program ─ training people from the community to be mental health workers. Once the availability of counselling had become known in the community, the demand for services had grown rapidly, to the point that neither pmhsc members nor Gwen Armstrong could carry the load by themselves. In many cases, it was not a matter of needing someone with extensive mental health experience, but rather, someone with the time to listen and provide support. It was at that point that the pmhsc selected three community members to be mental health worker trainees ─ without the structure of a training program to put them into, and without any assurance of funding.

In April 1992, Peguis had submitted a formal proposal for a mental health program to msb. In October of that year, at the same time the three community members were chosen to be mental health worker trainees, Cecilia Stevenson was informed that there were no funds available to support the proposed program, but that some money would be available through the federal government's forthcoming Brighter Futures initiative.

The selection of the trainees was an interesting process. After the positions were advertised, applicants were interviewed by the pmhsc in September 1992. The qualities the committee was looking for in prospective trainees included respect for both traditional and contemporary ways of healing; basic counselling skills, through education or experience or, ideally, both; and some personal life experience that qualified them to be helping others. Perhaps the most important qualification was that the applicant be a person community members respected and felt comfortable with and could trust to respect confidentiality.

When asked to describe why they thought they had been chosen for the position, two of the trainees commented:

> I worked with alcoholics for two and a half years as a part-time counsellor at the Al-Care. One of the counsellors told me that there was an opening for three mental health workers. I didn't have the faintest idea what mental health was, but I applied. ...I think that the qualities were that I'm a caring person...and I'm a sharing person. I share my own life story with other people. I care what happens to our people. ...In order to work with people you have to understand where they're coming from. To do that you have to get your own life in order. I started that, healing, working on myself about three years ago. Ever since I started working on myself, doors have been opened.

•

> I didn't really know too much about mental health, but I knew that there was a difference between mental health and mental illness. I said that I didn't have any certificates or high education to impress them [the pmhsc] with. What I had to offer them was the teachings that I received from the [traditional] elders through the last twelve years, like caring, sharing, love and kindness, honesty and respect. ...I remember that they asked [in the interview]: "What is your definition of mental health?" I said that it had to do with a balance...of the mind, body and spirit.

During the fall of 1992, using the training dollars received under the transfer agreement, the first phase of training began on an intermittent basis, usually during Gwen's visits to the community. The steering committee had looked into existing mental health worker training

programs but did not find one suited to the needs of Peguis. Moreover, there was still no guarantee of continuing funding for the program. Nevertheless, as Gwen explains,

> The circumstances were such that...the need was so acute in the community, that we felt we were going to go ahead and set up some sort of program, with just very sporadic training provided by myself, and supervision provided by the professionals on the Peguis Mental Health Steering Committee. I felt that this was actually desirable, not to go into a program with a set curriculum. It's unexplored territory. We didn't know at the onset what their learning needs would be, so we didn't want to fit them into an existing program. We think that their role is pretty unique.

Although all the trainees indicated that they felt quite comfortable with traditional approaches to healing, they expressed the need for basic training in the western approach to dealing with mental health problems. Gwen began by teaching what she calls the basic "safety items", such as conducting a mental health assessment (including how to assess for symptoms of major mental illnesses and for risk of suicide) and basic principles of crisis management. Over the past year, they have addressed a variety of topics, including dealing with unresolved grief; sexual abuse; medications used to manage major mental illnesses; basic therapy issues, such as attachment and separation, confidentiality, structuring interviews; and time management.

In January 1993, funding from the Brighter Futures program did come through, and the Peguis mental health program moved on to the next stage of its development. Before looking at how this unfolded, it may be worthwhile to describe Brighter Futures and how it has fit into Peguis's community health programs. Brighter Futures is based on six program elements: community mental health, child development, healthy babies, injury prevention, parenting skills, and solvent abuse (the staff refer to the latter five elements by the acronym chips). The fact that Peguis had already developed a proposal for its mental health program and had made recommendations in its community health plan related to the other program areas made it fairly easy to draw up a proposal for Brighter Futures funding.

According to Cecilia Stevenson, program objectives that they have identified in the chips areas should be attainable using existing resources, as well as the extra nurse and/or health educator they plan to hire in the near future. For this reason, the bulk of the Brighter Futures monies is being used for the mental health program. When asked whether this funding is

adequate, Cecilia replied that although the funding is very much appreciated, it is still not what is needed. In Peguis's case, their first-year Brighter Futures budget was $55,000 in total, or $9000 for each program element. In addition, there still appeared to be a problem with late payments from msb. Brighter Futures monies for the period beginning 1 April 1993 were not received until the beginning of September 1993, leaving the band to carry the costs for five months.

Once Brighter Futures funding was assured, the three trainees were hired as full-time employees of phs. Gradually, the Brighter Futures trainees (or bfts, as they came to be known) started to take over the follow-up of people in the community between Gwen's visits. A steering committee member describes how this development has changed her role:

> Now that there are trainees and people to work with the clients, that leaves me free to do other things with my own workload. ...I am assigned one mental health worker trainee who reports to me once a week. She tells me what's happening, what she's doing. It's a way for her to unload and for me to give feedback about what I see her doing good, and what I think she could do better.
>
> The arrangement works well, as far as the trainees are concerned. As one person stated,
>
> It's good because a lot of times you get a real tough case, and you don't know where to go, but these people [pmhsc members] have been here for quite awhile. Being the professionals that they are in their field, they can always help us understand more about our clients.
>
> Gwen's role has also evolved. As she explains,
>
> I'm the second line of support for them [trainees]. Each of the Brighter Futures workers has two supervisors identified from the steering committee, and the plan is to meet weekly with each of their supervisors to discuss their cases. Then, if there is a concern that their supervisor doesn't feel competent handling or needs another opinion, then they phone me. ...Each month when I go out, I discuss with each of the workers each of their cases, the dynamics of the case. We talk about counselling being a planned process, so we make treatment plans for the sessions that will take place before we meet again.

The speed at which the process has evolved is quite remarkable. According to Gwen, by May 1993, the steering committee began to make referrals directly to the Brighter Futures workers. In fact, when Gwen arrived for her June visit to the community, for the first time there

were no new referrals for her because the bfts had already done their own assessments and felt that they could handle the cases themselves. Gwen feels that this experience has shown that Peguis does have the capacity to deal with most of the issues that come up.

The trainees also expressed surprise at how quickly the program has developed and how their confidence has grown in such a short period. All three trainees stated that the acceptance from the community has been a major factor in their development as mental health workers, and that being community members themselves has not been a disadvantage. As the bfts explain,

> I think that a lot of that [confidence] comes from the people accepting us now. When we first started, we were afraid that people wouldn't come in and talk to us. ...A lot of people are scared that if they talk about their personal problems, it's going to get out. ...One of our biggest things is confidentiality. ...We haven't had a problem.

•

> I usually talk to the person first, and ask them if they feel comfortable. I have one client who is related to me. I asked her if she would rather work with my partner, but she said that she'd feel more comfortable with me. There are times when we do have to give the client to a different worker. It's the person's choice.

•

> I think that once we explain that we're training our own people to work with our people they would agree. The advantage is that Indian people are talking to Indian people or helping Indian people or listening to Indian people...knowing them...I think they feel more relaxed at the first contact.

•

> I would say that a lot of people have greeted me or talked to me that have never talked to me before. I've met people, just anywhere in the hallway, in the mall...and they ask if they could come and see me.

One of the trainees stated that there may have been concern among community members at first about the trainees' ability to handle the work, because of past reliance on non-Aboriginal

people for these specialized services. Gwen Armstrong acknowledges that, at first, there was some reluctance to see the bfts, particularly among those who had started to see Gwen. Lately, however, an increasing number of people, given the choice between seeing Gwen or seeing the bfts, have chosen the latter option.

As far as the approach used with clients of the mental health program is concerned, all the key informants emphasized that offering people as many options as possible in their own community is the main priority. Gwen Armstrong summarized their overall goal as follows:

> We want to be able to offer a variety of resources to people who are in need. If they want to see one of the therapists in the community who was operating here previously, that's great and we'll support that. If they want to see me, that's great and we'll support that. If they want traditional healing, then we'll make sure that they have access to that. If they want to see the religious counsellors, that's great. If they want to see the Brighter Futures workers, that's the best! We want people to be able to meet their mental health needs in an unrestricted sort of way. We're also aware that seeing multiple counsellors can be detrimental to a person's progress, so we try to have one primary person being identified as the primary counsellor.

One of the trainees describes the approach taken with clients:

> We don't make up our clients' minds. We are not here to do that. Each individual has a responsibility to make up his or her own mind which way they would like to be treated. ...There's the European way and the cultural way, and whichever way they feel comfortable with, we respect that way. ...There are some who have to be on medication, and you try and explain how important it is to take the medication. Then there is the cultural way. There are a lot of clients who do not need the European medicine. They can go to the traditional healer.

Two of the three bfts stated that more than half their clients are using traditional healing services available at Matootoo Lake. Statistics kept by the mental health program indicate that, although in many cases people are using more than one type of service, an increasing number of clients are choosing traditional healing as a primary approach. The mental health workers are not surprised by this development. The fact that the majority of their clients are under 40 years of age appears to be an important factor. As one bft explains,

> ...our culture is coming back now, and a lot of our young people are aware of it. ...People who are young want to experience new things. This, to them, is something new...the culture... If you take the elders, a lot of them were brought up with the churches, and to practise our culture was a no-no.

Gwen Armstrong agrees that younger people tend to be more open to the traditional approach to healing, and she feels that people in older age groups may more often be using the counselling services offered by religious organizations:

> It seems that there's a generation or two...who, in order to protect themselves, in order to survive, they were required to reject their tradition. Many of them did it with a great deal of strength, so it's very difficult for them to do this about-face.

Gwen and the bfts described an interesting event that suggested that many people simply are not aware of the availability of traditional healing services or how to gain access to them. In May 1993, a visiting traditional healer held a special workshop on mental health issues at Matootoo Lake. An invitation to attend was extended to all clients of the mental health program. Several clients who hadn't previously used traditional healing took part in the workshop, which included a sweatlodge ceremony and traditional teachings. Gwen saw three of these people for counselling the following day, all of whom were tremendously positive about their experience at Matootoo.

In addition to counselling, the mental health team has begun to do more community education and prevention. The bfts now do a workshop with each new group of clients at the Al-Care Treatment Centre, where they talk in general about mental health. Aside from providing information, the trainees state that each time they go to Al-Care, two or three of the clients approach them and request counselling.

After a second workshop for community workers in November 1992 at Matootoo Lake, the bfts decided to design and carry out a needs assessment survey of all the community's resource people, to determine what types of workshops are required in the future. They plan to conduct a series of specialized workshops to meet the specific needs of different groups, beginning with the teachers in the fall of 1993. The next step will be to organize workshops for the community at large. Gwen Armstrong states that, in terms of prevention, the team also has taken a different kind of step recently. Whereas previously the mental health workers saw only clients who had been referred or who had approached them directly, this time the bfts (with the

endorsement of the pmhsc) went out immediately to provide support to people in a crisis situation.

When asked to describe the major achievements of the mental health program so far, every worker gave examples of clients who had been stabilized as a result of their intervention. One trainee stated that the greatest success has been with the newly referred clients, as opposed to those with long-standing mental health problems who continue to receive treatment from outside sources. Gwen believes that, in a number of cases, people would have had major breakdowns without the care they have been receiving, and that many people would have had to go elsewhere to get help. For Gwen, an extremely important achievement has been the process whereby, through the Peguis Mental Health Steering Committee, an awareness of an overwhelming need in the community has been translated into action.

Despite the successes, there was general acknowledgement that they have probably dealt only with the tip of the iceberg, in terms of meeting all the needs of the community, and there are concerns that they are still not reaching all the people in need. When asked what the implications are for the future of the program, Gwen acknowledged that the number of workers is going to have to grow. However, funding restraints have been a major concern. At the end of March 1993, funding for nmhop was cut. Peguis Health Services made the decision to keep paying Gwen out of their program funds, but they were forced to lay off one of the mental health worker trainees during the summer of 1993. Although it was felt that the two remaining bfts could handle the workload for the time being, this will obviously become a serious problem as the demand for services grows.

In July 1993, the federal government agreed to reinstate funding of nmhop ─ but only at 75 per cent of the original allocation. Gwen describes the impact of uncertain funding on the development of the mental health program:

It's a very awkward situation to be in. The clients that I see, in order to be planning my therapy with them, in order for them to be planning their lives, they need to have some expectation about how long I'm going to be coming here. Because of the uncertain status of nmhop, and the inadequate Brighter Futures funding for Peguis for this year, I would be unable to give any commitments to my clients, as well as commitments to the Brighter Futures workers, in terms of their training. ...For the Steering Committee as well, it's difficult, in terms of preventive

programs and things that need to be planned ahead. ...I don't know how they [phs] have been accessing the funds to pay me, but I do know that this is a hardship and that it should not have to come out of other sources.[24.] One of the problems with Brighter Futures funding is that it is increased in increments over five years, with the first-year budget being limited to monies for research and development. Gwen Armstrong and Cecilia Stevenson agree that by January 1993 Peguis was already at a stage where they could have used the year 3 or 4 funding level for programming. However, Cecilia Stevenson tries to be optimistic about the future of the mental health program:

> My understanding is that msb has made the commitment that they will continue funding the mental health program in the Indian reserves. Whether they will keep funding the other components of the Brighter Futures initiatives program or not, I don't know.

In the meantime, the Peguis mental health program is considered so important that both phs and the steering committee are committed to keeping it going ─ one way or another. According to Cecilia Stevenson, phs will continue to use the bulk of the Brighter Futures monies in the mental health area, and they are currently exploring the options available regarding payment for Gwen's services, including the option of billing for professional services through the nihb program.

Summary

In conclusion, both the traditional program and the mental health program developed through a resolve to meet expressed needs in Peguis that were not being met (for whatever reason) by the government's formal health services. In both cases, the initiatives were undertaken despite a lack of policies to provide direction, or funding, or both. In both cases, the motivation appears to have come out of a natural momentum in the community, quite independent of the transfer initiative. In the case of the mental health program, however, the extra administrative resources and general increased feeling of ownership of community health programs appears to have given Peguis a definite edge in terms of program development. See Table 3 for a summary of the major developments during the period from 1980 to 1993.

Conclusion

Summary of Major Themes

The development of formal health services in Peguis occurred in the context of historical circumstances unique to that community; we cannot therefore draw specific inferences from this experience for other First Nations. Nevertheless, several major themes and issues emerge from Peguis's experience, some of which may have relevance to other First Nations involved in community-based health initiatives.

Development of formal health services (before 1980)

1. There was a period ─ before government-funded medical services were provided in an organized way ─ when a dual medical system existed in Peguis, when traditional `Indian doctors' and midwives continued to provide the most consistent care to people in the community. Owing to a variety of factors, the western medical system became dominant in the 1940s. It is only in the last decade that the traditional Aboriginal approach to health care has begun to emerge again in the community, once again creating a situation of a dual system of care. This time, however, some initial steps have been taken to integrate the traditional approach with the mainstream community health services.
2. From 1940, as a result of construction of a federal hospital on the reserve, treatment services and public health services in Peguis have developed separately (although there appears to have been some overlap during the 1950s and 1960s). The major issue related to the provision of treatment services was the loss of what was considered a `community hospital' when the old Fisher River Hospital was closed down in 1973. The Percy E. Moore Hospital is perceived by the community as bureaucratic, not providing adequate services, and not being responsive to the needs of the community.

Table 3
Summary of Peguis Community/Health Services Development: 1980-1993

Community Development	**Toward Self-Determination** ● **early 1980s**: sobriety movement among community leaders ● **1981→**: rapid community development during administration of Chief Louis Stevenson
Aboriginal Health Policy/ Services	**Transfer of Administrative Responsibility** ● **1986**: Health Transfer Policy
Peguis Health Services	**Local Administration of Community Health Services** ● **1980**: Band administration of Peguis Health Centre ● **1985**: Band takes over operation of ambulance services ● **1987**: 20-bed Alcohol & Drug Treatment Centre opens ● **1987**: Peguis applies for pre-transfer funding (Peguis Health Services moves into new facility) ● **1988**: 22-bed Personal Care Home opens ● **January 1988**: pre-transfer phase begins ● **1988-1990**: preparation of community health plan; new management structure ● **January-July 1991**: transfer negotiations ● **July 23, 1991**: Peguis Health Transfer Agreement signed ● **1991**: Peguis Mental Health Steering Committee formed ● **February 1992**: nmhop nurse begins working with pmhsc ● **October 1992**: pmhsc chooses mental health worker trainees ● **January 1993**: `Brighter Futures' funding ● **1993**: training of community health workers continues (during this period, traditional program integrated into public health services)

Community health-related services since 1980: general themes

1. The major developments in health-related community services since 1980 have occurred during a period of dramatic economic and social development in Peguis, which has been fuelled by a strong political leadership committed to the principle of self-determination. It appears that a general movement toward sobriety among community leaders in the early 1980s was also an important factor in this contemporary phase of community development. During this period, support from the political leadership was cited a crucial factor in the success of many community-based initiatives.
2. The development of the personal care home, the Al-Care centre, and the Peguis mental health program are examples of health-related services developing as a result of

community members taking the initiative to meet the community's needs in the absence of formal government services. In the case of chronic care and mental health services, there was the added problem of being caught in jurisdictional grey areas, where neither the federal nor the provincial government accepted responsibility for providing services. The lack of funding for home care nursing on reserves by either level of government is another example of this phenomenon, which continues to pose a problem for the public health staff in Peguis today.

3. While the period of local administration of public health services in Peguis did build up useful experience and allowed public health providers to respond better to community needs, msb still retained significant program leverage and overall fiscal control, limiting the degree of self-determination that Peguis could exercise over health care. However, there are examples (such as hiring an lpn rather than an rn as a community health nurse) that illustrate the band's efforts to achieve a degree of self-determination ─ especially where government policies or standards were considered incompatible with community needs.

The health transfer experience

The federal health transfer policy has been viewed with some scepticism in the literature. Some have criticized the initiative for its limitations ─ such as the ineligibility of certain programs for transfer ─ while others have argued more vehemently against transfer as merely one more example of the federal government trying to offload responsibility for providing services to First Nations. There is no doubt that the history of federal Aboriginal health policy since the 1960s ─ with a trend toward devolving responsibility for Aboriginal health services to the provinces and several attempts to cut non-insured health benefits to status Indians ─ and the introduction of the transfer initiative without meaningful input from First Nations lend credence to the argument that transfer represents a "revenge of the hidden agenda". (Culhane Speck 1989)

The findings of this study do not allow the author to draw definitive conclusions about the *intent* of the health transfer policy. However, based on Peguis's experience with the transfer initiative, it is possible to state the following:

1. Peguis entered into the transfer process with no illusions about its limitations. Rather, it was viewed as an opportunity to take a small step toward the ultimate goal of

self-government ─ and a logical step, given the band's level of social, economic and political development and the fact that they had been involved in the local administration of public health services since 1979-1980.

2. Certain factors (e.g., more than ten years' experience with local administration of public health services, a relatively large resource base, both human and material, experience and confidence in negotiating with the federal government, and a thorough knowledge of msb policy) appear to have contributed to successful negotiation of a transfer agreement in July 1991.

3. Transfer is seen generally as having been beneficial, in the sense that it did result in improved financial resources, more fiscal control during the period of the agreement, more flexibility in programming and an increased ability to respond to community needs, and a greater sense of `ownership' of community health programs among community health workers.

4. Most of the problems Peguis has encountered have been related to issues that were not part of the transfer agreement. The administration of non-insured health services (nihb), especially related to medical transportation, dental and optometric services, are areas of particular concern. The band believes that it could run these programs more efficiently if they were transferred to full band control, but a guarantee of an adequate resource base is seen as a prerequisite for such a transfer, and there is considerable concern that the resources available for transfer may be decreased. Late contribution agreement payments for non-transferred programs also continue to place a significant burden on the band's resources, forcing them to borrow from other budgets.

   Another complex issue relates to control of the Percy E. Moore Hospital. Peguis has expressed its intention of eventually assuming control of the hospital from msb. However, the inadequate resource base, the multi-jurisdictional nature of the hospital's funding and administration, and the number of communities served by the hospital make this a daunting task that will require considerable discussion and planning.

5. The major innovations in health services programming have also occurred outside the mandate of the transfer process. The development of the Peguis mental health program is an excellent example of a community-initiated program designed to meet the

community's needs (in the absence of a government program) by developing skills within the community to deal with mental health issues.

6. As far as the implications for other First Nations considering health transfer are concerned, it must be emphasized that the relatively positive experience in Peguis can in no way be taken as a sign of the `success' of the transfer policy. What I have tried to emphasize is that Peguis's ability to take advantage of the initiative resulted from the specific conditions outlined above. In the absence of those conditions, First Nations would want to weigh carefully the risks and benefits of health transfer before initiating the process.

7. This case study suggests a number of issues related to health transfer that would be appropriate areas for future research. First, a comparative case study of First Nations that have signed transfer agreements (preferably after the completion of their first five-year plan) would be worthwhile to determine that factors have contributed to the perceived success or failure of these initiatives. It would also be useful to compare the experience of First Nations with locally administered community health services that are transfer-based to those initiatives that have occurred outside transfer. Certainly, it would be interesting to reassess the situation at Peguis in the future to determine whether concerns about achieving or maintaining an adequate resource base for various services have been addressed satisfactorily. It would also be appropriate, after an appropriate period has elapsed, to carry out both a qualitative and a quantitative evaluation of phs programs, including a survey of community residents, to determine their perceptions of the transfer process. While an evaluation is scheduled for 1995 (as set out in the terms of the agreement), this may be too soon to assess accurately the success or failure of the transfer initiative at Peguis, given that the health information system is only now being developed and that new programs, such as the mental health program, are only in the early stages of development. In addition, changes in health status related to public health initiatives are likely to take longer than five years to become apparent and measurable. Finally, in Manitoba, there is some discussion of transferring all health programs to First Nations in the context of a pilot project involving self-government over all programs previously administered by the federal government. The implications and potential impact of such an initiative would be an extremely useful focus for future research.

Issues related to traditional healing

1. During the last decade there has been renewed interest in traditional healing and cultural awareness in general among certain community members. In response to increasing demand from the community, traditional healing services have gradually become integrated into the structure of community health services offered in Peguis.
2. The revival of traditional cultural practices has been a very contentious issue in the community and, although tensions have eased recently, this issue is still a very sensitive one. Many key informants emphasized that although traditional Aboriginal culture (including `Indian medicine') is becoming increasingly popular in the broader society, First Nations communities must be allowed to deal with this phenomenon at their own pace and without outside interference. Furthermore, traditional healing should be offered as one of a range of options available to consumers of health care in the community.
3. A small but active group of people is involved in traditional healing in Peguis. These individuals made it clear that although they would like to see the federal government and dominant medical system recognize the role of traditional medicine, they do not want government regulation of their services. They argue that traditional healers across the country are already involved in forming a network to share information and to discuss issues such as self-regulation. Several traditionalist informants expressed concern about msb increasing restrictions on funding for traditional travel as the demand continues to grow.
4. In terms of implications for future research in this area, the literature on community health programs incorporating traditional medicine in First Nations settings is fragmentary, so that more in-depth case studies of these initiatives would be useful in determining the potential role of Aboriginal medicine and healing methods in community health care models. It would be particularly interesting to compare how traditional healing is used in different First Nations communities (e.g., functioning completely separately from other community health programs; autonomous, but with some informal interaction; or fully integrated with other community health programs). Where possible, it would be useful to understand the contextual factors that have led to the development of these initiatives, the opinions of traditional healers regarding the optimal relationship

with the biomedical system, and their perspective on regulation of traditional Aboriginal medicine and healing. The relevance of traditional Aboriginal medicine and healing to health transfer is controversial (since it is, by definition, not eligible for transfer), so the experiences of First Nations that have entered into transfer agreements would be particularly interesting. Having said this, the extremely sensitive nature of this issue in some communities, and the desire for anonymity, may prohibit research in this area, and it should be undertaken only with the full approval and guidance of community advisers.

Issues for Consideration

Beyond the recommendations for further research mentioned above, it would not be appropriate to make specific policy recommendations based on this single case study. However, the experience of health services development in Peguis does raise a number of issues that merit further consideration.

1. The health transfer initiative has resulted in Peguis First Nation having increased control over the process of health care delivery (i.e., greater program leverage and fiscal flexibility and a sense of ownership of community health programs). However, it is clear that until non-insured services are available for transfer, and as long as the federal government continues to control medical treatment services for Peguis and retains overall fiscal control of health services, one must conclude that Peguis has achieved increased ─ but far from complete ─ control over health care. If the federal government is serious about transferring real control of health care to First Nations, there must be a commitment to ensuring an adequate resource base for all potentially transferable services.
2. The fact that many of the problems experienced by Peguis Health Services have been associated with services that are not part of the transfer agreement (in particular non-insured health services) supports the criticism that the transfer policy is extremely limited in its ability to offer real control over health services delivery. Non-insured health services must be available for transfer, and First Nations such as Peguis should be given the opportunity to administer these programs (with an adequate resource base assured) if they choose to do so.

3. In addition to ensuring an adequate resource base for all potentially transferrable programs, there must be a commitment to continue and expand funding to programs not included in the transfer initiative ─ such as mental health and traditional travel.
4. Late contribution agreement payments further undermine the ability of First Nations to control health care if they are constantly having to borrow from other budgets, and the federal government should make every attempt to rectify this problem.
5. The experience at Peguis suggests that the potential role, if any, of traditional healing must evolve at the community level and at a pace determined by individual First Nations. Issues such as regulation and funding of traditional medicine must be worked out within and between those communities as well. In the meantime, the federal government can support these initiatives by recognizing the value of traditional Aboriginal medicine and continuing to fund traditional travel.
6. Economic and social development of Peguis First Nation over the past decade or so have certainly increased the level of control over conditions affecting the physical and social health of the community. However, it is important to keep in mind that unemployment and social service transfer payments in this community remain higher than would be acceptable in any non-Aboriginal community and that both the physical and the emotional health of the community remain less than optimal. Peguis's proposal for health transfer funding in 1987 stated clearly that transfer was far from the ideal envisioned for control of their health care system, and it is worth repeating here:

   ...the ideal that is envisioned would be an arrangement enshrined in the self-government concept. The concept would see us establishing our own institutions and systems independent of government interference save fiscal appropriations by virtue of entitlement under our treaty, Aboriginal and inherent rights...(Peguis First Nation 1987)

It is likely that, until this vision of self-government is achieved in Peguis ─ as in all First Nations ─ then self-determination leading toward health will be limited. Nevertheless, the experience with health services development in Peguis First Nation provides an interesting example of a community that is determined to achieve that goal and that has taken advantage of every opportunity to regain control over both the process of health care and the conditions that affect health in the community.

Notes

This study would not have been possible without the co-operation of a number of people in Peguis. I would like to thank Chief Louis Stevenson for permission to carry out this study, and to the elders who advised me in the early stages of the field work. Special thanks to all the staff of Peguis Health Services who put up with my presence and a million questions for over four months ─ especially Cecilia Stevenson, the Director of phs, who encouraged me to carry out the study and spent many hours of her time answering questions. Christine Cochrane, who worked as my community research assistant, was an invaluable source of information and provided much insight into the workings of the community. Finally; I would like to thank Nora Cochrane for her hospitality, and for making my stay in the community a very memorable one.

References

Unpublished Documents

National Archives of Canada, Record Group 29, Health and Welfare ─ Manitoba Region Files

Bird, Dr. J. 1929. Letter to Dr. E.L. Stone, Department of Indian Affairs, Ottawa. 1 February 1929. rg 29, vol. 2930, 851-1-X200, pt. 1a.

Canada. 1897. Memo, H. Reed, Deputy Superintendent General Indian Affairs, to the Superintendent General of Department of Indian Affairs, Ottawa. 29 March 1897. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1904. Report, Assistant Indian Commissioner, Winnipeg, to Department of Indian Affairs, Ottawa. 23 July 1904. rg 29, vol. 2775, 822-X200, pt. 1a.

_____. 1917. Miscellaneous memos, Department of Indian Affairs-Manitoba Region files. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1919. Letter, T.H. Carter, Indian Agent for Fisher River Agency, to the Secretary of Indian Affairs, Ottawa. 29 April 1919. rg 29, vol. 2930, 851-1-X200, pt. 1a.

_____. 1920. Letter, W. Graham, Department of Indian Affairs Commissioner, to J.D. McLean, Assistant Deputy Minister and Secretary, Department of Indian Affairs, Ottawa. 6 April 1920. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1925. Letter, Reverend Stevens, Fisher River Indian Mission, to Duncan Scott, Deputy Minister of Indian Affairs, Ottawa. 2 July 1925. vol. 2775, 822-1-X200, pt. 1a.

_____. 1931. Memo, Duncan Scott, Department of Indian Affairs, Ottawa, to Hon. Thomas G. Murphy. 30 July 1931. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1932. Letter, Duncan Scott, Department of Indian Affairs, Ottawa, to Dr. Percy E. Moore. 18 February 1932. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1942. Memo, W.L. Falconer, Assistant Deputy Superintendent Medical Service, Ottawa, to [name illegible]. 2 July 1942. rg 29, vol. 2775, 822-1-X200, pt. 1a.

_____. 1964a. "Memorandum to Cabinet. Reconstruction of Fisher River Indian Hospital". Submitted by Hon. J. LaMarsh, Minister of National Health and Welfare. 10 August 1964. rg 29, int. #127, vol. 2607, 800-1-X298, pt. 1.

_____. 1964c. Memo, O.J. Rath, Regional Superintendent Medical Services, Central Region, to Director Medical Services, Ottawa. 14 April 1964. rg 29, vol. 2606, 800-1-X200.

_____. n.d.b "Report on Fisher River Indian Hospital (Fire Trap)". Submitted by E. Appleton, Maintenance Supervisor, Manitoba Zone. rg 29, int. #127, vol. 2607, 800-1-X298, pt. 1.

_____. 1967. "Report on the Fisher River Indian Hospital". [Author's name illegible]. 31 October 1967. rg 29, int. #127, vol. 2607, 800-1-X298, pt. 1.

_____. 1968. Letter, Dr. M.J. DeKoven, Manitoba Zone Director, msb, to Dr. J.B. Morrison, Deputy Minister of Health, Province of Manitoba. 7 March 1968. rg 29, int. #111, vol. 2776, 822-1-X200, pt. 4.

_____. 1978a. Memo, G.B. Campbell, Regional Director, msb-Manitoba Region, to Director General, Program Management, msb Ottawa. 16 February 1978. rg 29, vol. 2933, 851-1-X200, pt. 10.

_____. 1978b. Memo, G.B. Campbell, Regional Director, msb-Manitoba Region, to Acting Director General, Program Management, msb Ottawa. 17 November 1978. rg 29, vol. 2933, 851-1-X200, pt. 10.

Copping, Dr. J.D. 1976. "Notes on Historical Development ─ Percy E. Moore Hospital". Memo to file. 30 August 1976. rg 29, int. #127, vol. 2621, 800-2-X298, pt. 2.

Manitoba. 1975. "Government of Manitoba Urges Federal Commitment to Native Health Programs". News Release. 17 January 1975. rg 29, int. #133, vol. 2932, 851-1-X200, pt. 7a.

Manitoba. 1976. Letter, Premier Edward Schreyer to Rt. Hon. Pierre E. Trudeau, Prime Minister of Canada. 15 March 1976. rg 29, int. #133, vol. 2932, 851-1-X200, pt. 8a.

Manitoba Indian Brotherhood. 1979. "Press Release". 23 January 1979. rg 29, int. #64, vol. 2933, 851-1-X200, pt. 10.

Ross, Dr. E.L. 1940. "Notes relative to the Official Opening of the Indian Hospital at the Fisher River Agency, Saturday July 6, 1940". Prepared by Dr. E.L. Ross, Sanitorium Board of Manitoba. rg 29, int. #127, vol. 2607, 800-1-X298, pt. 1.

Peguis Health Services Archives

Assembly of Manitoba Chiefs (amc). 1991. "Certified Resolution. Non-Insured Health Benefits". amc Indian Act Review and Health Conference. Winnipeg. 14 February 1991.

Canada. 1986a. "A Discussion Paper on the Transfer of Indian Health Programs for Consultation with the Indian People". 26 March 1986. Ottawa: Health and Welfare Canada, Medical Services Branch.

Canadian Executive Services Overseas (ceso). 1983. "Report of the c.e.s.o. Study of Alternative Uses for Percy E. Moore Hospital Complex". Prepared by C.W. Miller. Winnipeg. May 1983.

MSB. N.D. "1979 INDIAN HEALTH POLICY INTERPRETATION". MEDICAL SERVICES BRANCH, MANITOBA REGION. DEPT. FILE I.A.1.

_____. 1985. Letter, C. Johnson, South Zone Director, msb-Manitoba Region, to Kathy Bird, phs. 22 May 1985.

_____. 1988. "Medical Services Branch Strategic Plan, 1988". Prepared by Planning and Review, msb. Winnipeg.

_____. 1991. Memo, G.N. Faulkner, Assistant Deputy Minister, msb, Ottawa, to all Regional Directors, msb. 5 April 1991.

_____. 1992. Letter, Keith Cale, Acting Regional Director, msb-Manitoba Region, to Cecilia Stevenson, phs. 9 December 1992.

Peguis First Nation. 1987. "Proposal for research and development funding on the transfer of health resources to the control of Peguis First Nation". September 1987.

_____. 1988-89. Peguis health transfer program ─ quarterly reports.

_____. 1990. Peguis community health plan and reports.

_____. 1991. "Peguis First Nation ─ Health Services Transfer Agreement". 26 July 1991.

_____. 1992. "Peguis mental health proposal".

_____. 1980-1993. Minutes of phs staff meetings; chrs' and nurses' monthly reports.

Provincial Archives of Manitoba, Winnipeg

Canada. n.d.a "List of doctors, by location, authorized to serve Indians, 1912-1924". Department of Indian and Northern Affairs. vol. 2.

Other Sources

Assembly of First Nations (afn). 1988. *Special Report: The National Health Transfer Conference*. Ottawa, March 1988.

Canada. 1964b. Royal Commission on Health Services. *Report*. Ottawa: Minister of Supply and Services.

_____. 1979. *Indian Health Discussion Paper*. Ottawa: National Health and Welfare, Medical Services Branch.

_____. 1983. *Minutes of Proceedings and Evidence of the Special Committee on Indian Self-Government in Canada*. Ottawa: Minister of Supply and Services.

_____. 1986b. *Health Program Transfer Newsletter*. Ottawa: National Health and Welfare, Medical Services Branch.

_____. 1987. *Health Program Transfer Handbook*. Ottawa: National Health and Welfare, Program Transfer and Policy Development Directorate, msb.

_____. 1991. *Health Status of Canadian Indians and Inuit ─ 1990*. Ottawa: Minister of Supply and Services.

Carter, S. 1990. *Lost Harvests: Prairie Indian Reserve Farmers and Government Policy*. Montreal and Kingston: McGill-Queen's University Press.

Cohen, Benita. 1994. "The Development of Health Services in Peguis First Nation: A Descriptive Case Study". Masters thesis. University of Manitoba.

Culhane Speck, D. 1989. "The Indian health transfer policy: A step in the right direction or revenge of the hidden agenda?" *Native Studies Review* 5/1: 187-213.

Czuboka, M.P. 1960. "St. Peter's: A historical study with anthropological observations on the Christian aborigines of Red River (1811-1876)". M.A. Thesis. University of Manitoba.

First Nations Confederacy, Brotherhood of Indian Nations, and Manitoba Keewatinowi Okimakanak. 1985. *Indian Mental Health Research: Final Report*. August 1985.

Fontaine, P. 1991. "Health for First Nations in the 1990s". *Manitoba Medicine* 61: 21-22.

Gagnon, Y. 1989. "Physicians' attitudes toward collaboration with traditional healers". *Native Studies Review* 5/1: 175-186.

Garro, L.C. 1988. "Resort to folk healers in a Manitoba Ojibwa community". *Arctic Medical Research* 47 (suppl. 1): 317-320.

Garro, L., J. Roulette, and R.G. Whitmore. 1986. "Community control of health care delivery: The Sandy Bay experience". *Canadian Journal of Public Health* 77 (July/August): 281-284.

GraGraham-Cumming, G. 1967. "Health of the original Canadians, 1867-1967". *Medical Services Journal* 23/2: 115-166.

Gregory, D. 1989. "Traditional Indian healers in northern Manitoba: An emerging relationship with the health care system". *Native Studies Review* 5/1: 163-173.

Hallowell, A.I. 1936. "The Passing of the Midewiwin in the Lake Winnipeg Region". *American Anthropologist* 38/1: 32-51.

Hawthorn, H.B., ed. 1966. *A Survey of the Contemporary Indians of Canada: Economic, Political, Educational Needs and Policies*. Ottawa: Indian Affairs Branch.

Manitoba Indian Brotherhood. 1971. *Wahbung: Our Tomorrows*.

Marshall, C. and G. Rossman. 1989. *Designing Qualitative Research*. Newbury Park: Sage Publications.

Mental Health Working Group. 1983. "Mental health services, Manitoba: A review and recommendations." September 1983.

O'Neil, J. 1986. "The politics of health in the fourth world: A northern Canadian example". *Human Organization* 45/2: 119-128.

_____. 1993. "Report from the Round Table Rapporteur". In *The Path to Healing, Report of the National Round Table on Aboriginal Health and Social Issues.* Ottawa: Royal Commission on Aboriginal Peoples.

Steinbring, J.H. 1981. "Saulteaux of Lake Winnipeg". In *Handbook of North American Indians*. Volume 6: Subarctic. Ed. June Helm. Washington, D.C.: Smithsonian Institution.

Strauss, A. and J. Corbin. 1990. *Basics of Qualitative Research*. Newbury Park: Sage Publications.

Thompson, A.E. 1973. *Chief Peguis and His Descendants*. Winnipeg: Peguis Publishers Limited.

Thompson, G. 1993. *Mental Health, the Essential Thread*. Edmonton: Alberta Department of Health.

Titley, E.B. 1986. *A Narrow Vision*. Vancouver: University of British Columbia Press.

Tyler, Wright and Daniel Ltd. 1983. *The Illegal Surrender of St. Peter's Reserve*. Winnipeg: Treaty and Aboriginal Rights Research Centre of Manitoba.

Van Der Goes Ladd, G. 1986. *Shall We Gather at the River?* Toronto: United Church of Canada.

Whitmore, R., B. Postl and L. Garro. 1988. "Strategies for involving native people in the operation and control of health services". *Arctic Medical Research* 47 (suppl. 1): 350-353.

Yin, R. 1989. Case *Study Research: Design and Methods*. Applied Social Research Methods Series, Volume 5. Newbury Park: Sage Publications.

York, G. 1990. *The Dispossessed: Life and Death in Native Canada*. London: Vintage U.K.

Young, D. and L. Smith. 1992. *The Involvement of Canadian Native Communities in their Health Care Programs: A Review of the Literature since the 1970s*. Edmonton: Canadian Circumpolar Institute and the Centre for the Cross-Cultural Study of Health and Healing.

Young, T.K. 1984. "Indian health services in Canada: A sociohistorical perspective". *Social Science and Medicine* 18/3: 257-264.

1. Throughout this paper the terms Aboriginal, First Nation, and Indigenous people are used interchangeably as identifiers. Use of the terms Indian and Native has been criticized by some people as being derogatory. However, many Aboriginal people do use these terms, and there has been no attempt to change direct quotations where they have been used. In addition the terms Indian and Native may be used when making a direct reference to an item in the literature that uses those terms or to organizations or policies that use the terms in their titles.

2. This refers to the federal government's current health transfer policy, discussed later in this study.

4. Direct quotations in the text may or may not be followed by the individual's name in parentheses. Where no name appears, it should be assumed that either the individual did not give permission for comments to be attributed to her/him, or that identification of that person would have indirectly revealed the identity of others who had requested anonymity. There are also several instances where, even though the informant agreed to be identified, it was decided not to use a name ─ usually because of the potential sensitivity of the issue being discussed or in cases that may have made the person vulnerable in some way. Where two or more informants are quoted, their words are separated by a ●.

5. Figures provided by the Peguis band office.

6. Steinbring notes that "at times the degree of intermixture makes it difficult to classify a band as either Cree or Saulteaux, the people themselves not being completely sure which English label is appropriate". (p. 245) This appears to be the case at Peguis today. One person we talked to was adamant that the people who moved to the present site of Peguis were Saulteaux. However, several of the elders who were born at St. Peter's and moved to the new reserve told us that their parents and grandparents spoke Cree. Sorting out this issue of cultural identity will ultimately be up to the people of Peguis. In the meantime, the large signs at the southern entrances to the reserve welcome visitors to the "home of the Ojibway and Cree peoples".

7. The circumstances surrounding this historical event are discussed in detail in a 500-page document. (Tyler et al. 1983) Most of the information that follows on the surrender and its aftermath is taken from this source.

8. Information provided by Peguis band office.

9. For a detailed account of Louis Stevenson and his (often controversial) administration, see York 1990, pp. 235-246, and a biographical article in the *Winnipeg Free Press*, 19 October 1986, p. 9.

10. The word `formal' is used here to describe medical services provided by non-Aboriginal practitioners as part of the bureaucratic western (or biomedical) system. Use of the term is not intended to suggest the superiority of the biomedical system over the traditional

Aboriginal medical system, which was well organized and equally `formal' in traditional Aboriginal societies.

11. There is evidence that Dr. Percy E. Moore was the only regional medical officer working for the federal government during this time (*Interlake Spectator* n.d.) and, according to informants, he was well liked by the people he served. Dr. Moore continued to work as the medical officer for the Interlake region until 1938, when he was appointed assistant to the federal government's medical superintendent, Dr. E.L. Stone. When Dr. Stone resumed his military duties in 1939, Dr. Moore became the acting superintendent for the duration of the war and was finally appointed medical superintendent of Indian Health Services in 1945 under the newly created Department of National Health and Welfare. He remained in that position until his retirement in 1965. Dr. Moore is credited with having set up a chain of some 16 hospitals and nursing stations throughout northern Canada. (Graham-Cumming 1967)

12. It is interesting to note that all the elders used the term *weh'kes*, which is a Cree word for ginger root. This lends credence to the theory that there was considerable intermixing of Saulteaux and Cree people at St. Peter's and that many people who came to Peguis from the former reserve were of Cree descent.

13. This is the term used widely in the literature and by those interviewed in Peguis.

14. The Manitoba Hospital Commission did, in fact, agree to pay one-third of capital cost of the new facility because it would provide hospital care to a segment of the non-Aboriginal population that was not large enough to operate their own community hospital. (Canada 1964a)

15. The Fisher River Lay Advisory Committee, set up by msb to discuss phasing out the old frh and opening the new hospital, met regularly between 1969 and 1973. Details of this period, based on minutes of these meetings (National Archives, rg 29, vols. 2607-08, 800-1-X298), can be found in Cohen (1994).

16. The details surrounding termination of the contract with the Interlake Medical Clinic group are discussed more fully in Cohen 1994.

17. Dr. MacDonald acknowledges that there is room for improvement in the orientation provided to new physicians. One possibility that she has suggested is that each doctor be assigned to a community sponsor, or family, in order to learn more about the reserve communities they serve. However, Dr. MacDonald also suggests that the communities themselves have some responsibility for creating a welcoming atmosphere for new physicians who are entering a new environment.

18. The terms community health nurse (chn) and public health nurse (phn) are used synonymously in the remainder of the text.

19. Unless otherwise indicated, references to miscellaneous health centre documents (nurses' notes, monthly reports, etc.) are based on material in the Peguis Health Services archives.

20. When the health centre moved into its new quarters in 1987, it became known officially as Peguis Health Services (phs). The two names are used interchangeably in the remainder of the text.

21. See more detailed discussion of non-insured health benefits later in this section.

22. The terms `health transfer' and `transfer' are used interchangeably in the remainder of the text.

23. Peguis's health transfer agreement was among the first four to be signed in Manitoba ─ the first one being at Pukatawagan (formerly Mathias Colomb), followed by Sandy Bay. Swampy Cree Tribal Council signed their agreement at roughly the same time as Peguis did.

24. Postscript: Funding for the nmhop ended in March 1994.