Winnipeg Case Study of Health and Social Services: Final Report

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INTRODUCTION

The Aboriginal population of Winnipeg in 1991 was 35,150 which is 35.4% of the total Aboriginal population of Manitoba (99,220) according to the Aboriginal Peoples Survey (Statistics Canada 1991)[1]. By comparison, the Aboriginal population in Toronto is 12.4% of the Ontario Aboriginal population, and the Aboriginal populations of Calgary and Edmonton combined are 41.8% of the Alberta Aboriginal population. Clearly, urban Aboriginal communities are significant in both size and proportion and have a legitimate interest in the development of health and social services relevant to their needs.

Further, 30.6% of the First Nations Aboriginal population in Manitoba lives in Winnipeg while 45.1% of the Métis Aboriginal population lives in Winnipeg[2]. First Nations people make up 57.6% of the urban Aboriginal population in Winnipeg with Métis constituting the remainder. Eleven percent of both First Nations and Métis communities in Winnipeg report poor or fair health status; 38.7% of First Nations people report chronic health problems while 30.5% of Métis report chronic health problems. Thus it would seem that while there are some minor differences in proportional representation of First Nations and Métis people in Winnipeg, both groups are significantly represented and both groups would appear to have similar general health needs.

Winnipeg was the city chosen to officially launch the public hearings of the Royal Commission on Aboriginal Peoples (April 21, 1992) due to the fact of its large Aboriginal population.

In terms of urbanization, although it is usually assumed that the urban Aboriginal population is comprised almost solely of recent migrants from reserve and rural Métis

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1. These figures are based on Statistics Canada tables for "persons reporting Aboriginal identity" from the 1991 Aboriginal Peoples Survey.
2. The "First Nations" designation includes both status and non-status people living on and off- reserve according to the Aboriginal Peoples Survey which only provides statistics for Aboriginal people who indicate "North American Indian" as their Aboriginal identity.

communities, a substantial portion of the population are long-time urban residents due to migration that began in the post-war years. While a significant portion of the population maintains close ties with their " home " communities, and often move back and forth on a regular basis, the majority of the population is stable. Some urban Métis residents are in fact living in their traditional communities since their ancestors have always lived in the area, even as the city developed from their traditional villages (eg. St. Boniface).

These general trends underscore the need for research and policy development in the area of health and social services for Aboriginal people in urban centres. As McClure et al (1992:32) have argued, a bibliographic search yielded "only very limited literature dealing with policy issues in the area of the health of Aboriginal people living in urban areas". Nonetheless, this review and others have documented that urban Aboriginal people have many of the same social, political and health concerns as the non-urban population; they experience a high rate of poverty, poor housing, racism, cultural barriers to accessing services, and a fundamental concern for empowerment and control over the services they require.

It is with these issues in mind that we set out to conduct a social history of Aboriginal health and social services development in Winnipeg, with the objective of documenting the evolution of urban health and social services which reflect Aboriginal priorities and concerns; and which demonstrate some degree of Aboriginal control in their development. This investigation was guided by the following research questions:

* How have urban Aboriginal health services been affected by the historical patterns of North/South referral and development patterns in Manitoba?
* What are the significant events and developments that have triggered development of urban health and social services?
* How has Aboriginal spirituality been accommodated by urban health and social service development? How has traditional Aboriginal medicine been developed in the urban context?
* How have the specific concerns of various constituencies in the urban

population (First Nations, Métis, women) been accommodated in the development of services?

METHODOLOGY

This study was commissioned by the Royal Commission on Aboriginal Peoples in the late spring of 1993 as part of a larger national effort to provide case studies of health and social service initiatives in Aboriginal communities, including urban areas. The Final Report was due in November, 1993, providing a limited time frame in which to assemble a research team, develop a collaborative structure with Aboriginal organizations in Winnipeg, (according to Royal Commission guidelines), collect and analyze data, and prepare a Final Report.

Given the complex nature of an urban environment, this limited time frame meant that we had to be highly selective in our description of service trends. We could not document all Aboriginal health ;and social service initiatives, nor could we provide a comprehensive analysis of the context in which service innovation has occurred. The weaknesses in this document are largely a reflection of the limited time available. However, we hope that our limited and descriptive accounts of a selected sample of Aboriginal initiatives provides some insight into the needs of Aboriginal people living in urban areas for culturally-appropriate health and social services.

The study was largely sociographic in design, with an emphasis on participatory, community-based methodology. Two members of our research team are Aboriginal with strong ties to the Winnipeg Aboriginal community; their exploration of issues relevant to their respective communities proceeded according to guidelines and expectations established by their Aboriginal colleagues in the various agencies they were investigating. However, this study could not be described as thoroughly community-based, given the complexity and heterogeneity of the Winnipeg "community", and the short time frame provided by the Royal Commission for the completion of the study. Full consultation with the Winnipeg Aboriginal community prior to initiating research was simply not possible given the three month period in which the

study was to take place.

The methodology of the study was based on the development of several case studies of innovative Aboriginal health and social services which could be then analyzed to discern general trends and issues in the evolution of urban services. These case studies required an extensive review of all available documentation on these services, combined with in-depth interviews with key personnel and clients (where possible) of these services.

The Research Team conducted over twenty interviews with health and social service providers, policy makers, and administrators in the Winnipeg area. As well, four client interviews have been conducted. A list of representative organizations who agreed for staff to be interviewed is listed below (these interviewees are referred to as "informants" in this report):

Aboriginal Women's Centre
Native Women's Transition Centre
Original Women's Network
St. Boniface Hospital Native Services
Ikwe Widjittiwin (Women's Centre)
Mayfair Boarding Home for Medical Patients
Assembly of Manitoba Chiefs Health Committee
Manitoba Métis Federation Health Committee
Aboriginal Council of Winnipeg
Métis Child and Family Services
Ma Mawi Wi Chi Itata Centre
St. Boniface Hospital Historical Society
Health Sciences Centre Native Services Department
Winnipeg Aboriginal Health Centre Steering Committee
Manitoba Department of Health
University of Manitoba Northern Medical Unit

Given the size and complexity of the Winnipeg area, it was impossible, except through personal contacts, to notify the entire Aboriginal community about the study. Most organizations were aware that the study was proceeding, however, since all of the Co-Investigators are involved in various networks related to health and social services. In general, the level of interest in discussing health and social policy issues was high, since many Aboriginal organizations in Winnipeg were preparing their own Intervenor

Briefs for the RCAP.

Two important issues arose in the context of seeking consent for interviews. Several people agreed to be interviewed on the condition that their identities be kept confidential, and refused to sign a consent form on the premise that this would reveal their identity. There appeared to be some concern that the Royal Commission is not an independent or neutral research organization. Some interviewees indicated they would feel compromised if their consent forms were submitted to the Royal Commission. For this reason, we did not secure a consent form from all interviewees but only proceeded with some interviews where verbal consent was given but no consent form was signed.

The second issue was the high level of concern expressed by some staff working in large health institutions that their programs and jobs might be at stake if they criticized their institutions in any way. Several insisted that their comments be as private citizens rather than as representatives of their institutions; and some were very guarded in comments about current political issues such as health care reform. Fear of provincial government retribution in the form of funding cutbacks seems to be pervasive in the Manitoba community.

A. First Nations Perspectives on Health Service Development (Yngve Georg Lithman)

In order to understand "alternative" approaches to providing health and social services, it is first of all necessary to provide a brief theoretical framework.

There is a general belief in continua which structures much of our understandings of what goes on in society, and what the future will bring. People are given, as it were, a kind of mental template through which we apprehend the world around us, and find the directions for the future. Canadians believe the world progresses, things do get a little bit better, business cycles do cycle, the situation of aboriginal people will improve.

Our mental templates manifest themselves in the conceptualizations we make of the world. Our schemes of conceptualizing become schemes of interpretations of what goes on around us. Our conceptualization of ourselves tell us we can decide to do things. Our templates and conceptualizations provide us with order, and the tools for mentally apprehending the world. The world makes sense, at least most of the time, because we can "see" it working through the particular mode through which we apprehend it. In this world, the common-sense world as it were, we believe such things as that health care systems provide us with the help we need to preserve our health, or at least that doctors and hospitals can take us a long way towards our health.

Those who study how we construct our templates and understandings, those in the field of sociology of knowledge, have shown us several of the features that are important for the generation of our 'knowledge,' our common-sense understandings. They point to the subjects 'social location,' that particular point in society from which the subject views the world. To the rich, it is very easy to believe that their riches are the proper reward of the personal ability of the rich person. Therefore, the rich person is likely to see the world as a pretty fair place, where talent and skill has its rewards. To the poor person, who sees his or her situation as fundamentally generated in the systemic obstacles against improvement of his or her lot, the world is a very unfair place. And the poor and the rich, in some sense, live in the same world.

The sociologists of knowledge also point out how we tend to incorporate knowledges into more comprehensive wholes, we 'bake cakes' of that which meets us; we strive for systematic understandings in our attempts to make sense of the world. In this attempt to create and maintain our mental templates, we dismiss or reshape that which seems contrary to what we 'know.' Our ability to reassess a situation, in the sense of being able to suspend to any significant degree our templates, is often-times very limited.

What does all this have to do with the health care and social services available to aboriginal people in Winnipeg? The short answer could be, that the Winnipeg situation should force a rethinking about basic tenets regarding what the needs are for aboriginal people. It should help us to fundamentally reformulate what health care is, and how it can be provided, what social support structures are needed for aboriginal people and how they can be created. The Winnipeg situation should also show us something perhaps equally important: how the present system has basically been constructed on partly irrelevant premises more related to the way a 'white' middle-class society conceptually apprehends its problems than to the realities at hand. To some extent, and sometimes not an insignificant one, aboriginal people and their leaders have become the adherents of the same ideology; it would have been very surprising if this had not been the case, considering how limited the opportunities have been for aboriginal people to create their own spaces in which to formulate alternative 'knowledge' about the world. The sociologists of knowledge would even suggest that in cases like that of aboriginal peoples in Canada, the 'larger society' tends to have an over-powering influence, an 'hegemonising' effect. It testifies to the resilience of the aboriginal people that, in spite of the socio-economic adversaries they encounter and the massiveness with which the solutions to their problems are presented along white, middle-class ways, there is such a wealth of creative search for alternatives. Here the sociologists of knowledge will help us again to understand why alternatives to the present, those which go beyond merely organizational proliferation or being an aboriginally oriented twin to a service already existing in larger society, will have such a hard time. These alternatives force a kind of conceptual openness, which the very structure of our thought processes will prohibit.

Compounding this situation, and feeding into it, is a politico-bureaucratic structure, which has hierarchies of professionals, procedures developed which are basically geared towards serving the needs of non-aboriginal society, and whose dealings with aboriginal concerns therefore take on features of a colonial kind.

1. The Premises

This part of the presentation of health and welfare issues in Winnipeg will have as a starting point, three propositions:

* The first of these is that the way health care and social services have been structured in Manitoba plays a significant role in maintaining those very conditions that they are set out to remedy. This will be discussed primarily in the context of the rural-urban context.
* The second is that there is virtually no structured political input by First Nations people into the health care and social services in Winnipeg, and this means that there is a lack of 'fit' between First Nations concerns and those services which are available.
* The third proposition, related to the above but more general, is that Winnipeg health and social service delivery is based on conceptual premises concerning what health is and what social services should provide, which are in large measure inappropriate to the realities at hand.

2. Winnipeg

Most First Nations citizens come to Winnipeg for economic needs or as part of a move which has very little to do with turning the back on the First Nation background. The situations in most, almost all, reserve communities are well known - pervasive unemployment, poverty, lack of housing, etc. And, in almost all of them, there is very little access to health care. Sick people, and their families, constitute an obvious part of the Aboriginal community in Winnipeg.

Winnipeg has also recently been dubbed the 'child welfare capital of Canada,' and First Nations and other Aboriginal children are an obvious and large part of the poor children in Winnipeg. Winnipeg is also a city where there is a distinct division into a 'native' part, the north end. If Winnipeg is sometimes described as the most 'american' city in Canada, the ethnic/racial differentiation is certainly present. There is a distinct 'ghetto' feature in Winnipeg.

First Nations and Métis organizations in Winnipeg are few, usually financially strapped, and reaching just a fraction of those who could presumably well use their services. They often have to battle for their legitimacy versus non-aboriginal society. In spite of often impressive work with minuscule resources, the Aboriginal organizations in Winnipeg are often fragile. The downsizing and reductions that both the federal and provincial governments are engaged in have only compounded the problems for Aboriginal situations. These conditions also create an environment where competition is fostered among Aboriginal organizations for increasingly scare resources.

3. Winnipeg and the Depletion of Health Resources for First Nations

Southern and middle Manitoba are virtually littered with hospitals. There are some 70 hospitals outside Winnipeg and an additional 20 facilities with hospital-rated beds in Aboriginal communities. Of these 20, however, only two facilities extend meaningfully beyond 'holding beds' for people waiting to be transported. Transportation away from the community of Aboriginal people who have fallen sick is almost invariably the case for those living outside Winnipeg, The Pas, Sagkeeng (a.k.a. Fort Alexander, with the hospital in neighbouring Pine Falls) and Peguis. Places with several thousand residents, like Cross Lake, Oxford House and Island Lake lack hospital facilities of the kind which would be normal in non-aboriginal communities.

However, hospitals in the small communities of southern Manitoba are under attack. They are said to be expensive and not able to provide the sophisticated diagnostic and treatment facilities that should exist in a modern hospital. There is certainly some truth to this. However, any attempt to close these small hospitals results in massive protests. For one thing, people give great value to the safety they perceive in a hospital facility, even if it cannot provide the sophistication of a modern big-city hospital. For another, and also of very considerable importance, the hospital provides a symbol of the fact that the town in question has a proper infra-structure. If it has a hospital, it probably also has a proper presence of retail activities, a liquor commission store, a proper post office, etc. If the hospital goes, one fears in the small towns, the whole infra-structure of the town may crumble. And, it should not be forgotten that hospitals are invariably significant employers in small towns with limited employment opportunities. So any politician who attempts to revamp the hospital structure in Manitoba is in for a tough ride, and knows it.

By comparison, the First Nations and Aboriginal communities have never been made part of the kind of build-up of community infra-structure which comparatively sized non-Aboriginal communities have experienced. The solution, for a vast majority of the northern communities, has been transportation programs, whereby the patients have been airlifted, primarily to Winnipeg. In 1991-92 alone, the regional office of the

Department of Health and Welfare spent more than $18.000,000 on transportation of First Nations patients. Health care in the northern communities is sparse, and only rarely is there a more permanent presence of physicians (partly as a result of policy - there is a reluctance to establish single or two doctors' offices). So First Nations babies from the north are born in Winnipeg, or Thompson. Sick people are flown out. Medical attention is usually by fly-in, if at all. Apart from nurses and community health representatives, there is virtually no care available on a sustained basis (see discussion of Northern Medical Unit in this context).

The so-called take-over by First Nations will not alter this situation, as these take-overs do not involve insured medical services (i.e. doctor's visits and hospitalization).

So the First Nations were left outside of the build-up of medical services in rural communities. It is unlikely that, with the present trends towards centralization of medical services generally as well as the governmental financial restraints, the First Nations in the north will ever experience the kind of presence of medical expertise that rural communities many times have been able to take for granted.

The real significance of this lies in two related consequences. One is that ill people, often pregnant and elderly, are airlifted out of the communities; the other is that the First Nations communities, far more than non-Aboriginal communities, could have benefitted from the additions to their general economic infrastructure of medical facilities.

The first consequence turns Winnipeg into being the recipient of the ill people from the north, and a whole infra-structure has been created to handle this patient flow. Often times, families will join the patient, especially when the affliction is more long-lasting. The disruptions that this causes in any number of northern families can not be underestimated.

The other consequence ties this situation to the general structural denudement of

First Nations and Aboriginal communities. The northern communities are by and large almost completely lacking in material community resources. Their historical role has more and more drifted to their members being a kind of passive support structure for seasonal or temporary non-aboriginal economic activities often Winnipeg based. Their own structures have never been allowed to develop, with schools, hospitals, services, etc., of the kind that are taken for granted in non-aboriginal communities.

In the First Nations and other Aboriginal communities in the north, the kind of input into their structure that a properly devised medical service would have provided, could have been very important. Without in any way diminishing the importance of other factors, no one would deny the significance that such health facilities could have provided. Whole fields of medicine which are taken for granted in urban areas, such as access to psychiatric and preventative medicine, are in large measure absent in the northern communities, or receive no input from qualified physicians, well familiar with local conditions and the histories of the people living in the communities.

The emphasis on Winnipeg in Manitoba health care matters, exceptionally compounded in the case of First Nations and other Aboriginal communities, is thus not just the provision of good care for specific ailments in Winnipeg. It also represents a structural denudement of northern communities. One aspect of the denudement is the lack of qualified medical input into very significant health-related issues in these communities.

4. Winnipeg Health and Social Services and First Nations

First Nations regard health care as a treaty right. They argue that health care provision was made part of the promises they were given (although the specific 'medicine chest' clause only figures in one treaty). However much this interpretation of the treaties is denied by federal and provincial governments, this treaty right perspective on health care permeates the First Nations stand on health issues. Their position of having been virtually ignored in the organization of health care delivery in the province has a particular bitterness due to this interpretation of history.

The issue of First Nations input into health and social services supply in Winnipeg is becoming increasingly important and contentious. The growth, both in relative and absolute terms of the First Nations presence in Winnipeg has created a variety of discussions and activities through which attempts have been made to create organized First Nations political input into the systems through which there is a delivery of services to First Nations citizens. It must, in this context be remembered that the First Nations are constituted as something else than other rural communities. As a First Nation citizen, you belong to a Band, and the Band has its political leadership. Even if you move away from the reserve community, you still belong to the Band, and you can move back to the community. You can not be a First Nations citizen without belonging to a Band. Your membership ties you to a particular community, and only by ceasing to be a First Nations citizen or by transferring to another Band, can you sever your ties with your Band. It should also be remembered that the Band is a corporation - it has assets, usually and primarily land. The relationship between a Band member and his or her Band and community is thus dramatically different from that of someone who is not a First Nations citizen. If you are not a 'treaty person,' you are supposed to transfer your loyalties to wherever you move. For the First Nations citizens, your Band membership and the home community is something which you can usually give up only with very severe identity and other losses.

The growth of an urban First Nations population has served to focus many First Nations citizens and First Nations leaders attention to how the First Nations should

relate to the urban fact. Their attempts to establish an urban policy are in the beginning stages. Still, there are a number of potential conflicts, some of which have already been in some evidence.

One potential conflict area relates to the issue of how the First Nations political leadership should assert itself. Each Band for itself? Through Tribal Councils? Through an Urban Tribal Council? Through organizations outside the First Nations political leadership? Through 'status blind' organizations, where First Nations and Metis work together?

These are complex issues, and there is no final resolution to them. There has been established a Winnipeg Tribal Council, recognized by the Assembly of Manitoba Chiefs, mandated to be a significant representative of the Winnipeg First Nations citizens. The fate of Band members, in the reserve communities but also in Winnipeg, will always be of interest to the First Nations political leadership. Organizations with specific tasks, some based on the recognition of First Nations status, some status blind, will undoubtedly be with us for all the foreseeable future. The multiplicity of issues, the legal dimensions of First Nations status, the opportunities that present themselves to work together irregardless of status, these are all some of the factors which will continue to provide for a variety of solutions.

However, there is a dire need to point out the negative effects of the lack of an organized First Nations input into the services provided First Nations citizens in Winnipeg. In fact, one may well see how there has been almost something of a continuous propaganda (involving also government and the people in the legal professions) against the creation of a politically responsible First Nations input into urban structures.

The role of politics is, indeed, to ensure a continuous and responsible reshaping of governmental institutions to fit the needs of its users. Hereby, a kind of dual educational process is maintained. The politicians can bring the concerns of their constituents to bear on social change. Those who are mandated by the politicians to

carry out the policies they devise, are sensitized to the concerns of those affected by their work. They are also able, through their interaction with the politicians, to inform the public of the concerns that their organization or they themselves as professionals have.

This in many ways remarkably successful way of conducting the affairs of a society is usually not in evidence when we study how economically disadvantaged minority groups relate to the surrounding society. Their lack of power preempts their democratic prerogatives, to the detriment of both the disadvantaged and the systems and institutions they are supposed to utilize. "Keeping politics out" of something is often an excellent strategy to preserve the status quo and thereby safeguard established interests.

In the Winnipeg situation, the First Nations are struggling with attempts to articulate a First Nations political perspective. The Winnipeg Tribal Council is one step in that process. On the whole, the First Nations are shut out of decision-making in the health and social services area, and organizations like the Ma Mawi Wi Chi Itata (a 'status blind' organization) have, in spite of general admiration, a very difficult time to get appropriate respect in negotiations for the provision of child and family services.

But the work of particular organizations can not replace the political input into the process of developing structures which are responsive to the needs of the people they are to serve. And many times, these organizations will need the support of the First Nations leadership in order to be able to carry out their work over the long haul.

In the area of health care as well as in social services to First Nations citizens off-reserve, the Province is now charged with operational responsibilities. For health care (that is insured health services, i.e. medical care and hospital care), the provinces have assumed that responsibility as a result of various measures, especially during the last 25 years. For social assistance, the federal government will no longer reimburse the province the provincial half of the costs under the Canada Assistance Plan for treaty people living off reserve. There is, as it were, a provincialization of health and social services, especially those provided off-reserve. City authorities have also become

increasingly important, especially in the social services area. This has not manifested itself in any attempts by the Province or the City to involve the First Nations and its leaders in any processes whereby they could provide systematic input into the delivery system. The system spins outside of the checks and balances that should be provided by the political process, and in this void, Aboriginal people, First Nations and Metis, are happy to have those organizations in the city which do attempt to provide them with adequate service.

5. Winnipeg and Perspectives on Health and Social Services

There are realities in the life of a First Nations citizen which may only represent one aspect of their existence, but which are there, are depressing, and which seemingly do not change. The number of unemployed, impoverished First Nations citizens is growing steadily. The abuse in the residential schools left people robbed of pride in their cultures and persons, a horrendous loss. The loss of land, the lack of opportunities to access a means of making a living, have represented losses of that around them. First Nations citizens have to articulate their relationship to health in an historical dimension, which includes these losses. Here, a middle-class, non-Aboriginal attitude to health and well-being can not be put at the foundation of finding a solution to the First Nations health situation. In fact, the issues raised by the situation of First Nations, and certainly to a large degree also for Metis people, must serve to redefine what health care and social services should be all about.

"Standard" health and social services are based on an extremely individualistic premise. Health is an issue to be handled by the individual, and the delivery system has incorporated the philosophy that health care is something which is delivered on an individual basis. This is seen as being sufficiently complemented with a certain control of the physical environment, such as food controls, workplace safety rules, etc. This very minimalistic definition of health care activities in the Canadian context is unusual for a Western society, the US excepted. Community-based health activities, involving all categories of professionals, are far more common in Europe, especially in situations

where disadvantaged minorities are concerned.

Community health clinics, community psychiatric care clinics, community-based preventive maternal and infant care clinics, community-oriented geriatric care - these are all pretty standard fare in many contexts of wealthy countries outside north America. The point is not so much that there is a different organization of health care services, but rather the way that these services are supplied is based upon the premises of the community it serves. The specifics of, say, the First Nations experiences, should be made a part of the health care delivery system.

From this perspective, the narrowly defined professionalization of health care delivery sees its limits. Health and ill health become defined not as technical applications to a technical problem, but should be seen as reflective of something that is ingrained in the life-style and life-career of the individual. The poor kid with glue in a plastic bag is not one case, his father another, his mother a third, etc. Health becomes, in large measure, a matter of restoring torn ties, mending rifts in the social networks, bringing a person to pride and self-care and a care-giver to others. Physicians and other professionals in this line of work often define their tasks as being a support for assisting people to regain their autonomy. This is a far way from the premises upon which the vast part of the Winnipeg health and social service system work.

But in the cracks of the present system, one also finds the alternatives searching for opportunities to exist. Ma Mawi Wi Chi Itata, fighting for their funding and opportunities to be recognized, works with concepts like "cultural reclamation." "Healing" is working its way into the therapeutic apparatus not only of organizations outside the recognized health care system, but also into the practise of Aboriginal physicians and other health care professionals. To find room for these activities may be the only way through which a worth-while health and social service delivery system can come about.

6. Concluding Comment

This section started with a few statements about how our cultural conceptions

guide the way we interpret the world. This is an unavoidable fact of life. However, there is nothing which restrains us from attempting to overcome the cultural blinds which our social situation bestows upon us. In so doing, it is an unavoidable observation that the Winnipeg health and social service delivery systems have failed Aboriginal people and continues to fail them. These services have tended to denude the northern communities of both culturally and economically needed infra-structural necessities. The power relationships between First Nations (or Aboriginal) leadership and the non-aboriginal society have stifled First Nations (or Aboriginal) input into the delivery systems. The delivery systems, finally, are based upon premises which are very irrelevant to the historical and contemporary dimensions of First Nations (or Aboriginal) existence.

It would only testify to the firmness with which our cultural blinders have been tied around our eyes if we think these faults can be realistically addressed without fundamental rethinking. Into this rethinking must go a greater role for First Nations and Aboriginal organizations, but the larger systems themselves must also change to be more responsive and 'people-close' modes of work.

B. Métis Perspectives on Health Services Development (Yvon Allard)

1. Introduction

Aboriginal health problems in Canada are conceded to be critical in nature. Numerous studies and numerous statistics give evidence to this fact. Mortality and morbidity of Aboriginal peoples in Canada compiled by Statistics Canada and the Medical Services Branch (MSB) of Health and Welfare Canada paint a picture of extreme health problems. While these statistics are alarming, they are nonetheless problematic in that they do not accurately exhibit the true health status of all Aboriginal peoples in Canada, but rather they refer specifically to the health of Status First Nations people living on-reserve and the Inuit of the North. It is ironic that at a time when First Nations peoples and the Inuit consider that they are "studied to death", the health status of Aboriginal peoples living in urban centres is mostly ignored. At the present time, data collection methods, MSB statistics and most health studies, etc. tend to focus on the First Nations on-reserve and Inuit segment of the total Aboriginal population. The inadequacy of relevant data and statistics on Métis and non-status Natives raises many questions.

Estimates vary as to how many Métis and non-status Native people there are in Canada and where they are located. There have been estimates that the number is somewhere around 750,000 to 1,000,000 Métis and non-status Native people in Canada. While arguments exist over the grand totals, there is a consensus that in some cities there are significant numbers of Aboriginal peoples, and that the majority of Aboriginal peoples in Canada are currently living off-reserve. Statistics Canada reports well over half of Canadian families of Aboriginal origin live off reserve, many of those in urban communities. With Western cities having the largest Aboriginal populations: Winnipeg (population 645,000) is home to approximately 15,000 Métis and 20,000 Native people. Edmonton (population 832,000) includes 13,500 Métis and 16,000 Native people. Regina (population 189,000) has an Aboriginal population of 3,700 Métis and 7,300 Native peoples.

There is a large Métis population in the city of Winnipeg, many of whom are the descendants of the original Red River Métis. Many Métis migrants are economic refugees who relocate to urban areas in search of better education and economic opportunities. Regardless of the varied reasons behind the decisions to relocate, Métis migrants usually fail to find more than marginal improvements to their quality of life: employment is scarce and difficult to secure for a number of reasons including racism, lack of adequate education and training, plus the overall weakness of the economy. Where they are able to secure employment, they are usually integrated into the wage labour economy at the lowest level.

The Métis people emerged as a distinct cultural and political entity out of the convergence of cultures of Native peoples and early French and Scottish settlers. A large number of Métis are concentrated in western and northern Canada. The Métis are recognized as an Aboriginal people in the Constitution; although the federal government has not historically recognized legislative responsibility for Métis under section 91(24) of the Constitution Act 1867. Organizations representing Aboriginal people of Métis ancestry continue to face an uphill battle in establishing their legitimacy with provincial governments. Notwithstanding that the Métis have a distinct status as defined in the Manitoba Act 1870 and in Section 35(1) of the Canada Act 1982, and unique needs, as a function of history, cultures, values, beliefs, family structures, linguistic backgrounds and socio-economic conditions, that must be reflected in program and service design and delivery. The Métis have been unable to convince governments to extend the same level of support provided to on-reserve Native and Inuit peoples.

2. Métis Health

A most fundamental question has not been addressed; is the health status of the Métis and non-status Natives person similar to the on-reserve Status Native and Inuit? There can be arguments made on both sides of the issue, but there is little definitive information. Certainly better access to health services is available to the urban Aboriginal person than the Native person living in a remote community. But has this meant an improvement in health? Or, are there other factors such as increased loss of

cultural identity, continued problems with employment, barriers to health care and poor housing which continue to generate poor health statistics for those Aboriginal people living in urban areas? The scarcity of statistics on the Urban Aboriginal population makes it difficult to determine their general health status. To compensate for this lack of available statistics, the health status of the total Aboriginal population is often extrapolated from health statistics for on-reserve Status Natives and backed up by anecdotal and other evidence. More comprehensive information depicting the health status of all Aboriginal peoples in Canada is required. The present lack of health statistics for Urban Aboriginal peoples hampers efforts to identify the extent of the health problems and to find appropriate resources needed to address these problems.

The Métis of Western Canada who are politically represented by the Métis National Council (MNC) and in Winnipeg by the Manitoba Métis Federation (MMF) face many problems in dealing with the health issues of the Métis people. The MNC and MMF organizations tends to be caught between two levels of government of Canada. Under the Constitution, the federal government has a jurisdiction for " Indian " people while the provincial government has jurisdiction for health and as a result neither governments tends to focus much attention on the Métis. There is a clear link between the lack of statistics and health information, and the lack of policy and cultural sensitivity on the part of the provincial and federal governments. While recognizing that health initiatives should be undertaken since the problem is immense and self-evident, the Métis organizations recognize that governments are motivated as much by statistics, research and reports as by the reality they purport to represent. Therefore, Métis health is not deemed as a problem until it has been studied (ie. quantified by health statistics). The volumes of research, and funding of " Native " research by governments has generated only a partial picture of Aboriginal health status in Canada. The challenge to governments is to accept their responsibility in supporting the Métis organizations in dealing with the health problems of Métis people.

There are clearly serious problems in accessing information about the Métis in both rural and urban settings. The MSB of Health and Welfare Canada does not keep

statistics about the Métis since they are concerned for the on-reserve Native and Inuit. The provincial government of Manitoba health care system does not keep health statistics according to Métis utilization rates. Greater funding must be made available in support of researchers who wish to conduct further study on the Métis people. The National Health Research and Development Program (NHRDP) of Health and Welfare Canada spends approximately 5-10 million a year on " Native " health projects; yet no health projects on the Métis are funded. Without the support of programs like NHRDP it is unlikely that any substantial progress will be made in resolving this outstanding research deficiency. The government jurisdictional issue and the inadequacy of present health data collection systems present special problems for the academic researcher, as well as for the Métis political leaders, in developing effective health strategies for the Métis people. There is an important need to Enumerate the Métis population in Canada. This could be done as part of the Tripartite negotiations and would be used to establish a central Métis Registry. Negotiations are underway to establish an Enumeration - Census linkage to the 1996 Canada Census. This would generate data as to number, age, sex, location and most importantly the socio-economic conditions of Métis. This would determine funding levels and program strategies for a Health and Wellness infrastructure for Métis people.

The 1991 Aboriginal Peoples Survey following up on the 1991 Census, conducted by Statistics Canada, provides the most comprehensive information on Métis people in Canada. In June, 1993 the report on " Language, Tradition, Health, Lifestyle and Social Issues " was released by Statistics Canada. The Health Statistics for Métis people residing in the major urban centre of Winnipeg are summarized in Table I. Approximately thirty-one percent of Métis respondents in Winnipeg reported having a chronic health problem, the most common being arthritis/rheumatism (15.4 %), heart problems (8.6 %), and asthma (7.6 %). The incidence of health problems among the Métis was very similar to Aboriginal peoples as a whole, in Winnipeg. An important and significant number of Métis adults (14.2 %) reported special medical needs that are not covered by the Medicare system.

Table I: Chronic Health Problems Among Aboriginal and Métis Adults in Winnipeg

	Total Aboriginal Population	Métis Adults		
	#	%	#	%
Arthritis/Rheumatism	3,150	14.2	1,480	15.4
High Blood Pressure	2,495	11.3	715	7.5
Heart Problems	1,650	7.5	825	8.6
Bronchitis	2,350	10.6	720	7.5
Asthma	1,295	5.8	735	7.6
Emphysema/Shortness of Breath	1,230	5.6	640	6.6
Tuberculosis	475	2.1		
Diabetes	1,335	6.0	530	5.5
Epilepsy/Seizures	430	1.9		
Other Health Problems	2,895	13.1	1,240	12.9

Source: 1991 Aboriginal Peoples Survey, Statistics Canada, Tables 4.2 and 4.6

Health issues are often inseparable from the overall socio-economic and personal circumstances confronting Métis people. Under one style of health delivery system, medical practitioners may function as a counsellor, referral source and support person to the individual simply because of their proximity to the individual. However, the predominant response of the medical profession is to address simply the presenting medical condition rather than these larger issues. Often, this results in the treatment of the symptom rather than addressing some of the root causes of the problem. As a result of this orientation, individuals receiving treatment for health problems usually receive them in isolation. This type of treatment serves as a very short term and repetitive measure. The costs to the individual, and the health care system, continue to grow without substantial progress. There should be an emphasis on developing Métis Community Health Workers; nurses, paramedical staff and community health

representatives (CHRs) play an important role in family support and prevention programs or as an alternative to physicians and health institutions.

A continuum of health care that is accessible and culturally appropriate must be developed for the urban Aboriginal community. The care continuum must provide for a balance between the five essential elements advocated by the World Health Organization (WHO): promotion, prevention, treatment, support, and aftercare. Necessarily, the development strategy must ensure that health services and programs are designed and implemented to give effect to each of these essential components of a balanced health care system. It is essential to develop programs and services that would not only provide treatment for medical conditions, but would more importantly, strive to prevent the development of such conditions through the promotion of healthy lifestyles. Health initiatives should be focused on the entire Métis community (urban and rural) to promote healthy lifestyles. Such health promotion programs could include a health and wellness centre with facilities for health education, physical fitness, sports and recreation activities, and culturally appropriate nutritional awareness programs. Health care must be based upon the traditional holistic perspective that well-being encompasses the entire person - the mental, physical, emotional and spiritual dimensions. The Métis require a health care model that will promote the well-being of individuals and families within the urban Aboriginal community. This can be achieved through the integration of the traditional, holistic approach to medicine with the mainstream medical systems and institutions (eg. St. Boniface Hospital). As well, through the integration of the health component with the range of support services and development programs that will be available through Métis/Urban Aboriginal organizations. Health service delivery should incorporate responsible and efficient use of available resources, both human and financial. An example of such a program would be a " Métis Addiction Counselling " program for Winnipeg to deliver rehabilitation, education and prevention services to Métis people with drug and alcohol related difficulties.

The Board of Directors of the Manitoba Métis Federation have established a Health Committee to examine health issues of Métis people in Manitoba. The Health Committee was established in March, 1992, and consists of elected Board Members

from different regions of Manitoba. The MMF Health Committee has put forward several recommendations to the MMF, the most important of which is that due to the critical issues in Health, that the MMF move Health Care delivery and management on to the tripartite negotiations agenda as an area of self-government, and that federal funds be made available to begin primary research. It further recommended that the MMF conduct a Provincial Research Forum on Health Issues effecting the Métis of Manitoba. As well, that the Métis Nation concerns on Health Care should be dealt with through the participation of the MMF Health Committee in the Manitoba Health Care Reform process.

The terms of reference for the MMF Health committee are:

* Increase the participation of Métis on Health Service Boards and commissions.
* To be able to respond to Health care issues on an ongoing basis.
* To work with communities in identifying issues in Health Care.
* To assist communities in gaining control of health care resources in a manner determined by the community.
* To provide education on Health issues that most effect the Métis Nation.
* To ensure that Métis specific research take place on Health issues.
* To assist in the promotion of Wellness for the individual and the community as determined appropriate by the individual and the community.

The Manitoba Provincial Health Care Reforms have a major impact on Métis people, in that historically, Métis have not received any federal health programs. Although Metis are entitled to the same provincial health services as any other resident of Manitoba, in practice, rural Manitoba Metis communities are usually ignored. Manitoba Health however, has no special programs for Métis or the Aboriginal population in Winnipeg. The current Manitoba Health Care Reforms must address the health care needs of the Métis people of Winnipeg. Within the overall process of provincial health reform, hospital resources are being converted to other methods of

health care. The MMF and the provincial government are in the early stage of negotiation for some form of Métis-specific services such as outpatient clinics. Health is being added as an issue to the agenda of Tripartite negotiations. It is essential to negotiate a level of health services that is at least equal to that received by Native and Inuit peoples and that these health services be appropriate to Métis peoples needs. There is an urgency to develop Métis-specific health and social programs as part of a Health and Wellness infrastructure for Métis People.

3. Métis Child and Family Services

Aboriginal people are inordinately over-represented in the child welfare system, the justice system, and the adult welfare system. A system of culturally appropriate services must be established to provide services for the Métis people who are frequently overlooked by the present social support systems.

Provincial and local Child and Family service agencies have been reluctant to enter into arrangements with Métis communities and organizations(Metis Nation of Alberta 1990). As a result, the services provided to Métis children and families tend to be culturally inappropriate and ineffective. At the present time the Aboriginal Council of Winnipeg (ACW) have established the Ma Mawi Wi Chi Itata Centre to provide support to child and family services for Winnipeg Aboriginal peoples on a status-blind basis (refer to earlier section in report). The Manitoba Métis Federation (MMF) has established the Métis Child and Family Support Program (MCFSP), whose core mission is to support and strengthen Métis families in the province of Manitoba. The MMF is working with the Province of Manitoba toward the development of a mandated Métis Child and Family Services Agency (MICHIF). The major goals of MCFSP are as follows:

* To establish and maintain a child and family service agency in the Province of Manitoba which supports Métis families by providing culturally appropriate programs and services which are designed to encourage and promote maintenance of the family unit within the Métis communities.
* To promote Métis culture as a basis for developing and providing

programs and services as well as providing opportunities for developing Métis cultural awareness within the Métis communities.

* To promote and facilitate Métis community involvement in the development and provision of programs and services to Métis families.
* To develop and maintain preventive services for Métis children and families.
* To act as advocate on behalf of Métis children and families involved with or receiving services from provincial or local child and family service agencies.
* To develop the human resource potential of the Métis community.
* To work co-operatively with all family service agencies in Manitoba in the development of programs and services and the delivery of said supports that are in keeping with stated goals and objectives.
* To develop a standard of service that protects the right of the individual to self-determination.

Some initiatives under consideration for children would attempt to prevent the early development of behavioral patterns that increase the risks in adulthood for illness and premature death. These programs would address such lifestyle risks as unhealthy diets, a lack of physical activity, the use of tobacco, alcohol and other drugs, as well as unsafe sexual practices. Other programs would focus on women to prevent low birth weight, fetal alcohol syndrome, nutritional deficiencies and childhood accidents.

The Federal Governments " Brighter Futures Initiative " identifies Aboriginal children as a group of children most at risk for injuries, illness, abuse and neglect. It suggests that Aboriginal and poor children face a complex environment and, as a result, are likely to experience a " higher than normal incidence of poor health and nutrition, mental health problems, disability and injury, or abuse and neglect ". In particular, the Brighter Futures report notes that the Aboriginal infant mortality rate is more than double the average national rate; the death rate due to injuries, poisoning and violence among First Nation pre-school children is six times the national rate; and the rate of suicide

among First Nations adolescents is up to seven times the national rate. It refers to other measurements of hospitalizations, low birth weight, fetal alcohol syndrome, mortality and social disruption which reflect the poorer health and well-being of Aboriginal children. It is also noted that Aboriginal youth are at risk of becoming involved in street life, and therefore, at risk for poverty, criminal involvement, sexual exploitation, chemical abuse, sexually transmitted diseases and AIDS. The Brighter Future Initiative is currently developing co-funding strategies with the provincial governments. This should provide an opportunity for the MMF to receive at least partial federal funding for Métis-specific projects and programs for Métis children in Winnipeg.

C. Women's Perspectives on Health Service Development (Moneca Sinclaire)

1. Introduction

Aboriginal women have migrated to urban areas from either Indian reserves or Métis settlements, and others are born and raised in the urban setting. At least thirty five percent of Native families were headed by females. Aboriginal women are more likely than Aboriginal men to live in an urbanized area. Statistics show that many Aboriginal women are caught in a vicious cycle of poverty, violence, alcoholism and suicide. Aboriginal women and their children who live in urban Canadian society are victims of racism, sexism, classis, and domestic violence(Hamilton and Sinclair 1991).

The people who are in the health and social services field have cited domestic violence as the primary reason why Aboriginal women will relocate to an urban setting. In many cases the women want to relocate to the urban area where anonymity is possible. Although shelters and counselling services do exist in some rural towns that may be close to reserves, these services are described as ineffective because family and community have access to the women. The community or family often pressure the women to resolve their domestic problems and return to their homes(Sopp-Gilson, 1980).

The political, economic and cultural factors that have constrained or enhanced the development of Aboriginal women's health and social services in Winnipeg, Manitoba will be discussed. Since it has been noted that domestic abuse against women is the predominant reason why Aboriginal women will relocate to an urban area, concerns raised by agencies about this issue will be presented first. This discussion is based on interviews with care providers and clients in women's shelters and services in Winnipeg.

2. Accessing the Services

When an Aboriginal women makes the decision to leave her community she

generally will ask the local authorities to place her in a shelter or she will phone a national crisis line and they will make arrangements for accommodations at a crisis centre. In other cases an Aboriginal woman will make the decision to enter a centre because it is the only alternative she has if she wants to regain custody of her children or she will call from the airport and ask for assistance. Some times the centres that are culturally appropriate will be filled and she will then be placed in another shelter or crisis centre. There is a preference to use the centres in Winnipeg because the women become invisible. In a smaller setting the women may not be anonymous and they may become persuaded to return to their home communities. Some women will leave their children in their communities because the council members will not allow her to leave the community with the children since it is a way to keep the women on the reserves. The women who leave their children may eventually return to the community and may not get another opportunity to leave.

In the present situation the agencies that are mandated to look after Aboriginal women do find there is a revolving door syndrome that occurs because the women do not have the skills to leave their abusive situation. It has been noted that this syndrome is not particular to just Aboriginal women but to any woman who has been in an abusive situation. Women will return to their partners on average eight and up to twenty times before they will actually break the ties. For the centres, their policy is to always keep the door open and not to judge the women's behaviour since many of the women suffer from low self-esteem from the constant psychological abuse in their relationships. The mental abuse they suffered as children in turn means the women will have unhealthy coping mechanisms. Many women are heavy smokers, abuse alcohol, drugs, and are sexually active at a early age. As one informant described the problem:

> I think it is hard to sell the idea of health until the other problems are looked after. Mental health is the big issue her. If mental health is not looked after then the physical cannot be cured.

The women continue to use the same coping methods they learned when they were young and they find their situation does not improve. The women that do enter the shelters or centres will eventually remain in the city. One of the issues the centres

face is the fact that their centres are perceived as a urban centre that will only cater to urban Aboriginal women and that women must relocate to the city in order to use the facilities.

Some of the centres would like to be able to do presentations in smaller communities and present their service to the women. They find they have a harder time getting into the communities because of funding and because they do not have contacts in those communities, and the Council will not let them go into the communities since the counsellors may be perceived as home wreckers.

Most of the programs do not have funding to have a follow-up program and they have observed that the women may continue the same pattern in the city. Eventually a few of the women will enter some form of educational institution to get out of the poverty cycle. The majority will live in the urban area continuing the same pattern of poverty and eventually return to alcohol and drugs to cope with their living conditions.

3. Political Factors

Aboriginal women have historically been discriminated against on the basis of sex by the governments of Canada. When the Indian Act was introduced it imposed a patriarchal system and patriarchal laws which favoured men, giving them the right to confer status and band membership, and at one time allowed only men the right to vote in band elections. Today the patriarchal system has continued to be part of the political system of Aboriginal governments. One informant stated:

> One issue that I think Aboriginal self-government has not adequately raised or talked about effectively is male domination, sexism, oppression of women and children and male violence..the leaders in power have to acknowledge male domination...in urban areas...metis and reserve areas women do not even have a voice.

The continuation of Aboriginal women being viewed as a second-class citizen is due partly to the fact that with patriarchal government, Aboriginal women have not had the same socio-economic opportunities as their male counterparts. It is also due partly

to the women not being able to voice their rights in their own communities or in any political situation. So far, Aboriginal men and male organizations have not adequately represented women's interests, and they are not taking the initiative to ensure that women are given a say in any political process(Native Women's Association of Canada 1989).

Even when Aboriginal women try to voice their concerns in their own communities they are called "trouble makers". It is most evident that women are not being heard when you hear stories about women trying to leave their abusive situations and the chief and council, mostly male, will try and convince her to stay with her spouse. Since the women do not have any economic means or support of the community more often than not they will return to their abusive situation. In some cases the women will leave the community without their children. One informant stated:

> Sometimes the women will leave the community on their own and they will be in a total mess. They have left their children and their families trying to get out of an abusive situation....most know if they return their chances of coming back to the city are very low.

Historically women in many Aboriginal societies had a central role within family, government and spiritual ceremonies.

> ...Mohawk society had women elected chief and council members. The women played an important role in the council level and decision making level. Council could not make decision unless everyone was in agreement and this included the women who voted them in. Traditional models of power equality were practised. What kind of power do we have now?

Aboriginal women know they need to have a stronger voice in the Aboriginal self-government movement. All the women interviewed felt that the self-government was being run by aboriginal men. They felt there would continue to be a gender issue entrenched into the self-government movement because the men have been indoctrinated into the patriarchal politics where men are the decision makers and women are the supporters. Another informant stated:

> ...with Christianity and boarding schools the focus has changed from

> matriarchal to patriarch. You know Aboriginal women are not really being heard look at the constitutional talks the women were not even allowed into the chambers. Our people still need a lot of healing before they can become a self governing people... change from a male dominated to more co-operative.

The second political issue that is of concern to the health and social services for Aboriginal women is that of health reform. Many of the centres that have aboriginal women as their clients are very busy trying to keep their centres running and they find that they cannot become involved in other political issues. They know that it is important to have a voice in the health reform but at the same instance "time is a commodity". If attending one meeting on health reform means cancelling a women's sharing circle then the women's sharing circle has higher priority.

The centres are aware of the impact health reform will have on their agencies. They know that with health reform it may mean that their funding may decrease and they will be forced to work with fewer staff. They also express fear that with health reform that community based agencies may not get the support they want. They ask; "How can government talk about increasing community health and at the same time delete the home care program and get rid of positions in other community health centres?" The agencies are afraid of the new policies yet they do not have the people power to advocate in the health reform movement.

4. Cultural Factors

Historically Aboriginal women were never considered inferior to men until Europeans arrived. In European society men were considered the legal and political masters of women. European contact along with residential school systems were economically and culturally destructive for Aboriginal women. Aboriginal women used to be part of the council and they would elect the men to be on council and decisions could not be made until everyone in the community agreed.

Today the separation of men and women is still evident. Many of the boards for

Aboriginal women's groups in Winnipeg, Manitoba are comprised of women only. The women interviewed felt that men could not understand the issues they spoke about until the men realize how entrenched they are in the European system of thinking. The women see some mens' groups beginning but many of the mens' groups are not looking at the root causes of why they are abusive and suffer from alcoholism. Men must understand that the cycle of abuse of women and children began with residential schools.

The shelters that are culturally appropriate focus on the history of colonialism and sexism to help the women understand the root causes. They also have sweats and have cultural teachings from elders in the community. Many of the elders are female speakers and they volunteer their time. They have sharing circles in the centres and before each circle they have sweet-grass and sage burnt. They are burnt to cleanse the women's spirits and to protect them from any mental or psychological harm that may occur when the women speaks in the sharing circle.

For women that do not want to participate in the sweet grass and sage burning they can decline and still share in the circle. Some of the women choose to share a passage from the bible before they participate in the circle which is respected by the group as long as respect is given for the sweet-grass and sage burning ceremony.

5. Economic Factors

Health reform is the main economic factor that is putting constraints on many social services agencies. Agencies do not know from one day to the next whether or not they will receive reduced funding or no funding. One agency had to reduce their staff members and others work long hours with little economic compensation. With economic constraints, agencies worry about staff burnout and future resources. They question the purpose of health reform and what will happen to services. One interviewee stated:

I don't know if the health reform will actually do what it is set out to do. I

> don't think that community centres will be increasing or get more funding...I think people will always have bad health and reducing the services are not going to ensure good health.

The one resource that agencies are lacking in is follow-up services. If there is no follow-up there is a greater chance that the women will return back to the same lifestyle that coerced them into the shelters in the first place.

If health reform does take away services it will not just impact the agency but the clients will be affected. Health reform does not seem to be considering the other costs that will be associated with services cutback. The province is not consulting with community members or groups. Instead, the health reform movement is making changes and deciding who should get what. One informant stated:

> Health reform will take away services that most poor people use and it will emphasize the powerlessness of people even more. There will be shorter stays for acute care of people and they will be sent home but in many Aboriginal homes in the city the homes are not adequate enough to support adequate care.

There will be a greater gap between people who have economic stability and people who do not have funds. The people with funds will be able to afford services that may no longer covered under provincial health.

6. Conclusion

The overall conditions facing Aboriginal women in urban areas are appalling, particulary when one compares them to non-Aboriginal women and to Aboriginal men. Aboriginal women who live in urban communities face deplorable social, economic and educational conditions. They also face sexism and racism from non-Aboriginal as well as sexism and negative treatment from Aboriginal men. The economic conditions according to Statistics Canada clearly demonstrate that in many cases, the social conditions facing Aboriginal women are worse than those facing Aboriginal men(White

1985).

Canadian Native women's organizations will probably continue to receive little or inadequate funding to implement and develop programming that would better meet the needs of Native women and their families. If Aboriginal men and women do not learn to work together as a team there will always be a clear division of who obtains what funding for what purpose.

In the present situation of health reform agencies are unsure whether or not they will receive funding to continue in the operation of their centres. With the uncertainty of funding many of the agencies interviewed were cautious in their answers and many would conduct the interview as individuals, not representatives of their place of employment.

D. Urban Aboriginal Health and Social Services: Case Studies

In this section of the report, we provide descriptive summaries of health and social services in Winnipeg with a specific orientation to Aboriginal people.

1. St. Boniface General Hospital: Case Study of a Métis Health Institution

The history of one of Winnipeg's major tertiary hospitals is firmly embedded in Metis culture. Recent work by several historians working with the archives of the Grey Nuns Society provide interesting insight into this relationship (Festival du Voyageurs Society 1991).

St. Boniface General Hospital (SBGH) is a major Tertiary Hospital situated in Winnipeg, Manitoba. The SBGH developed at an historic spot, the Forks of the Assiniboine and Red Rivers; it is situated at the very heart of the Red River Métis historic territory. The Red River Métis settlement was established in 1734 when the French-Canadian explorer Pierre Gaultier de Varennes et de La Verendrye mapped the area, and subsequently in 1737 constructed a fort, Fort Maurepas. The Red River settlement slowly grew around this trading post and by the early 1800s was at the centre of the Red River Métis Nation of southern Manitoba. The major health problems among the Métis people were mainly injuries and ailments brought on by their rugged occupations and lifestyles; and infectious communicable diseases such as tuberculosis, influenza, dysentery, measles and smallpox. Infectious disease epidemics were rampant among the Métis and Native peoples of the Red River.

The tale of the St. Boniface Hospital starts in Montreal in 1737, Mme d'Youville was a widow who spent her time and substance on social work among the poor and unfortunate, and founded an order devoted to their care - the Sisters of Charity or Grey Nuns. The Catholic mission in St. Boniface was founded in 1818 and in the early 1840's approached the Grey Nuns of Montreal to come to St. Boniface to administer social and health care services to the Métis people. In 1844, four nuns arrived at the St. Boniface cathedral and a new building was constructed which was both the Grey Nun's place of residence and an

infirmary. During the first ten years (1844-1854) 6,000 home visits were made by the Grey Nuns to care for the sick and invalid. The Grey nuns spoke french but also learned the local Métis (Michif) language and several Native languages (Saulteaux, Cree). The need for health care was dramatic because of recurrent disease. All over Ruperts Land, the interaction between the European and the Indigenous population led to the spread of whooping cough, scarlet fever, chickenpox, smallpox, typhoid, measles and tuberculosis. For instance, in 1846 epidemic measles was followed by dysentery and famine. The Grey Nuns were involved in health care during that terrible epidemic.

The health care given by the Grey Nuns was a mixture of European, Native and Métis approaches and medicines. The Grey Nuns believed in the healing abilities of simple medicinal plants and used them extensively in the preparation of prescriptions. These included balm, cane, pumpkin seed, flax seed, quack-grass, bark of cherry tree, golden rod, plantain, mint, etc. They prepared herb teas, ointments, poultices and other remedies. The Grey Nuns offered spiritual help and guidance to the Métis people of the Red River who were for the most part Catholic. The Grey Nuns were involved in social works of charity in providing food, clothing and shelter to the poor, aged and destitute. Around 1882, the Sisters were incorporated as the Sisters of Charity of the North West Territories (ie Western Canada).

The first official St. Boniface Hospital was established in 1871, the first institutional hospital in Western Canada. In 1870 there were two events that made this possible. The first was that Manitoba entered the Canadian Confederation as a Province under the Métis leadership of Louis Riel (recently acknowledged as the founder of Manitoba and a Father of Confederation). The second was that the smallpox epidemic of 1870 had stimulated a mass vaccination campaign, in which the Grey nuns vaccinated 3,323 people, and the Provincial government had to open a large temporary hospital in Winnipeg. In 1871, there were some scanty funds to found a hospital. The first St. Boniface Hospital (1871) was four beds on the second floor of the wooden building used to store garden tools and as a repair shop and laundry. In 1871, 177 patients were treated and received medication, 886 wounds were dressed; there were

631 home visits and board, clothing and education costs were provided for 29 orphans and 25 elderly ladies. The SBGH was established as a community-based hospital to serve the Métis people of Winnipeg in a holistic approach.

A consideration of the history of the St. Boniface Hospital inevitably raises the question of the place of religious institutions in a health care system. Are the virtues claimed by religious institutions of care for the whole patient capable of being assessed by controlled comparative trials? Is it better for the community to spend its health care dollars partly on health services controlled by religious bodies, which may be more holistic but whose range of services may be affected by religious policies? The early history of the St. Boniface hospital is an illustration that the health care system of a community must be an integral part of the community, and more importantly must take its direction from the needs of the community. The current Provincial Health Care Reforms in Manitoba is dismantling the medical services provided by the St. Boniface General Hospital to the Métis community in Winnipeg and Manitoba at large. There is great concern that language and spiritual services will be cut due to financial constraints. It is interesting to wonder whether something of the humanity and spirituality of the founders of the SBGH has been lost, or not. And if so whether it matters for the medical care of the sick patient. The Métis people will not allow the St. Boniface Hospital to exist only to cure the Métis patient, rather it must work with the Métis community to heal the Métis person. The healing process, however, should serve not only the present medical problem, but should provide ongoing support for Métis people to continue the improvement of their lifestyle.

2. (J.A. Hildes) Northern Medical Unit, Faculty of Medicine, University of Manitoba (John O'Neil):

The Northern Medical Unit based in the Faculty of Medicine at the University of Manitoba, began activities in 1969 in Churchill, Manitoba, at the request of both federal and provincial governments who were unable to provide physician services to either Churchill or the Keewatin District of the Northwest Territories. Although technically not an "urban" service in the sense that it does not provide services to urban Aboriginal residents, the Unit is the primary coordinator for referral of Inuit and First Nations and

Inuit patients from the Keewatin Region, NWT., and northern Manitoba into Winnipeg doctors and hospitals. It is also a key player in the general development of urban Aboriginal health services through its outreach, education, research and consultancy services.

In its twenty-five year history, the Unit has been the subject of two intensive reviews and indirectly a component of one author's (O'Neil) ongoing research into health care delivery in the region. This summary is based largely on these reviews.

The first systematic inquiry into the role and function of the Northern Medical Unit was in 1971 by Professor David Fish, Ph.D., formerly the Head of the Department of Social and Preventive Medicine at University of Manitoba and now Dean of Health Sciences at University of Northern British Columbia. Fish is critical of the early years of the Unit, claiming the Unit was intended to provide an exemplary model of a community health clinic but has instead provided little else than traditional doctor's services, albeit for salary rather than fee-for-service. He further claims the Unit was developed without any prior consultation with the communities to be served, but was an idea developed by senior government and university representatives(Fish 1970).

Fish describes the initial objectives of the Unit to provide four physicians in a community health clinic in Churchill, with fly-in physician services to the Keewatin, and a roster of visiting consultant visits to Churchill. Other services envisaged were a social worker, community health workers, and a dentist with assistants, but these plans were slow to develop. Although Fish is critical of the "medical dominance" implicit in the Unit's focus, he does acknowledge that an Inuit liaison worker was added to the Winnipeg administrative office in 1972 to contact Inuit patients in hospital, and two Native community health workers were added to the Churchill clinic. In general, Fish argues that the Unit failed in its responsibility to serve as a model for the first community health centre in the province of Manitoba, a responsibility he argues should have been the *raison d'etre* of a university-based initiative. He cites the refusal of both general practitioners and consultants to adopt a "community" approach in their work, and the failure of the Unit's Director to instill this philosophy, as the primary reasons for this(Moison and Fish 1976).

Despite these apparently inauspicious beginnings, the Unit thrived and was subsequently asked by the provincial government to provide physician services in Norway House (1975), Hodgson (1976), Fly-in communities (1978), Island Lake (1979), and Rankin Inlet, NWT (1981). Although the philosophy of the Unit continued to be based on a community health model - with exemplary medical services complemented by outreach and social services, preventive health measures, health education, and the involvement of local people - this model has rarely been achieved.

In 1976, the Unit was reviewed by the first director of the Unit, Dr. J. A. Hildes. In this review, Hildes identifies the important role that university-based medical services play in monitoring health conditions in remote communities. However, he also describes the problematic context of contractual relations with the federal and provincial authorities, citing resistance to the inclusion of local Aboriginal input and a refusal to institute an independent audit of services as major problems. His paper also however, clearly describes the hierarchal and centralized nature of the medical care system for Aboriginal people in rural and remote areas, where not only medical care but the bureaucratic apparatus that manages the system are " remote" to the communities which require service(Hildes 1976).

Recognition of this fact in part stimulated a request by the Unit for an External Review of the role of Medical Consultants in 1984, a review that became more comprehensive in addressing the overall role played by the Unit in the provision of urban-based health services to Aboriginal people in remote areas. O'Neil participated in that review as an observer.

In 1984, grants from provincial and federal governments to the Unit totalled $2,035,601.00. For this amount, the Unit provided the services of 15 salaried general practitioners in the areas identified above, and a total of 416 fly-in consultant days (serving a total population of approximately 19,200 Cree, Inuit, and Caucasians). Consultants represented nearly all medical specialties including pediatrics, cardiology, psychiatry, orthopaedics, internal medicine, opthamology, surgery, E.N.T., obstetrics,

radiology, anaesthesia, and urology. In practical terms, these numbers meant that the Island Lake area in northern Manitoba had a pediatrician, psychiatrist, and obstetrician available in their community for approximately nine days respectively per year, and had to travel to the Norway House hospital to see the other specialists.

Briefing notes presented to the External Review Committee indicate that the visiting consultant program was originally intended to reinforce the general objective of the Unit which was to bring medical services to people in their communities rather than transport them to Winnipeg hospitals for medical care. However, the impact of the Unit's programs have produced the opposite effect, with a steadily increasing number of referrals being made over the last two decades for specialist medical care in Winnipeg. This has been particularly true in the area of obstetrics where policy changes in the late 1970's required all women to be transported to Winnipeg for childbirth, irrespective of their health status, and in spite of the fact that obstetricians were seeing most women pre-natally during visits to northern regional centres.

Also of concern was the apparent failure by visiting consultants to understand or contribute to the needs of local primary health care workers. Psychiatry was identified as particularly problematic. In presentations to the Review Committee, nursing representatives indicated that visits by psychiatric consultants to northern communities were often more destructive than helpful, with little attempt made to develop multidisciplinary, community-based approaches to the mental health needs of the community. Although other specialties were not criticized as harshly, the Review Committee noted a general lack of coordination between the Consultant Program and primary care activities in northern communities(Northern Medical Unit, 1984 1985).

In a recent presentation to the International Congress on Circumpolar Health in Iceland in 1992, Whitmore claims the Northern Medical Unit has been reasonably successful in meeting the medical needs of remote communities; the changes required are at the level of political involvement in the governance of the system. Aboriginal representation is requiredon hospital Boards and "other health decision bodies", which one presumes would include the University and Medical Faculty including the Northern

Medical Unit(Whitmore 1993).

The presence of the Northern Medical Unit in Manitoba has had a significant impact on the development of health and social services in Manitoba and Winnipeg. In general, providing sickness services to Aboriginal people in remote communities has not been community-based or contextualized, despite an elaborate system of fly-in doctors, but has resulted in a system where "sick" people and their families relocate to Winnipeg. The social and cultural implications of such a massive relocation should be obvious, and should also be a critical factor when considering changes in the Aboriginal health care system.

The significance of these problems to this study of urban health services is complex. First of all, the Northern Medical Unit is a powerful presence in the general field of Aboriginal health in the province. Senior representatives of the Unit are influential advisors to both provincial and federal governments and play an important role in ensuring that Aboriginal health and social issues remain on the political agenda. However, due to the fiscal structure of the Unit, it remains almost exclusively a provider of physicians' services and thereby medically dominated. As a consequence, Aboriginal health in the province and the city, has been defined largely in terms of medically-treatable diseases, with a systemic emphasis on transporting northern Aboriginal patients into Winnipeg hospitals for routine care.

3. Interpreting Services in Winnipeg Hospitals (John O'Neil):

The first dedicated interpreting service for Aboriginal patients in a Canadian urban hospital was initiated in Winnipeg in 1971. Stories conflict as to how the "Interpreter Service" was conceived. Aboriginal activists in Winnipeg describe the lobbying efforts of several people at the Manitoba Indian Brotherhood (MIB). These individuals recognized the important role that community health workers were serving on reserves, and proposed to the Children's Hospital that a similar "liaison" worker would improve communication problems at the hospital. Communication problems had become an issue when the niece of one of the MIB staff from a northern reserve was

admitted to Children's Hospital and was afraid to use the toilet. Her experience of extreme discomfort resulted in a meeting of MIB and Children's Hospital staff to discuss a MIB proposal to introduce medical interpreters into Children's Hospital. Children's Hospital staff do not remember the incident of the little girl who refused to go to the toilet, but cited growing concerns in the Hospital that Aboriginal paediatric patients (who formed approximately 60% of the patient population) had mortality rates much higher than other children. Hospital staff had concerns that communication problems were inhibiting the quality of care they could provide and saw medical interpreters as a possible solution.

With funding from employment and training grants from both the federal and provincial governments, four interpreters were hired in 1971 to work in Children's Hospital (speaking the different dialects represented in Manitoba and Northwestern Ontario). After three years, Health Sciences Centre applied to the Manitoba Health Services Commission (MHSC)for permanent funding to continue this program on an expanded basis into all the Health Sciences Centre Hospitals. Program developers remember that their proposal was in competition with another MHSC proposal for an expensive piece of new technology for the Paediatric Intensive Care Unit, but the Hospital Board supported the Native Services proposal and funding was awarded. In 1976, three more positions were added to the funding bringing the total staff complement to seven including a full-time Coordinator.

The first Coordinator of Native Services at the Health Sciences Centre, Mr. Larry Starr, initiated discussions with senior officials at the other large teaching hospital in Winnipeg, St. Boniface, which also had a large proportion of Aboriginal patients referred from northern communities(see later discussion of Metis perspectives on hospitals). With assistance from medical staff at the Northern Medical Unit in the Medical Faculty at the University of Manitoba, a proposal was developed and funded in 1978 by the Donner Foundation for two interpreter positions at St. Boniface(Starr and Ross 1977). These workers were to be "coordinated" by Mr. Larry Starr from the Health Sciences Centre. However, Mr. Starr left his position in 1976 and a new Coordinator was not hired

until 1979 (Mrs. Margaret Lavallee). Mrs. Lavallee recalls the period as very hectic with communication needs outstripping the resources available at Health Sciences Centre and does not recall having much opportunity to meet with St. Boniface staff.

On November 24, 1980, a St. Boniface surgeon inserted two glass beads (description of the number of beads inserted varies from media reports of "dozens", to the Hall Inquiry Report of "two") into the ends of a suture after a lung biopsy on a 52 year old Cree woman from Shamattawa in northern Manitoba(Pona 1980; Read 1980). The surgeon claimed he had joked with the patient about inserting these beads prior to the surgery, and indicated to a subsequent inquiry that he had meant to communicate his respect for the patient's beadwork abilities. He claimed to have used another Cree male patient in the hospital as an interpreter, although this individual denied any knowledge of a discussion about beads. The patient, who did not speak English, claimed no such consent was obtained and was embarrassed and angry after wondering why hospital staff were looking at her surgical area and laughing (the sutures were located below her right armpit in an area she could not see without the aid of a mirror). The patient and her husband sought the assistance of the Four Nations Confederacy (previously the Manitoba Indian Brotherhood) and Justice Emmett Hall was commissioned by St. Boniface Hospital to conduct an inquiry(Winnipeg Free Press, 1980; Lowery and McKenzie 1980).

Although Justice Hall exonerated the surgeon of any racist intent, he warned the medical community that a clear breach of informed consent had occurred and recommended strongly that services be developed to ensure non-English speaking patients had access to well-trained interpreters to prevent further breaches from occurring. The brief from the Four Nations Confederacy also focused on systemic problems rather than individual actions and recommended improved Native Liaison Services. They further warned that further incidents of this nature would not be tolerated, and cited court action as a future prospect(Hall, 1981).

St. Boniface Hospital subsequently provided expanded funding to the Native Services Department on a permanent basis and began an intensive search for a

Director, who was to report directly to the Hospital President. This position was well-funded (relative to salaries for Aboriginal workers at the Health Sciences Centre) and was contracted with much attention to maintaining confidentiality within the hospital and instilling loyalty among Aboriginal staff to the institution. Our informants report that there was much concern that further media attention to racist incidents would be harmful and contrary to the spirit of the Grey Nuns Mission Statement which characterizes the St. Boniface Hospital. This attitude of stressing institutional over community loyalty has, until quite recently, continued to characterize Native Services at St. Boniface hospital, according to informants.

In contrast, the Native Services Department at the Health Sciences Centre has developed in a somewhat different direction. In the early 1980's, an increasing number of Native patients began to request access to elders and\or traditional healers while resident in the hospital. At the same time, faculty in the Department of Social and Preventive Medicine at the University of Manitoba began a five year study to document the role of Native medical interpreters in the two teaching hospitals, although the majority of the work occurred in the Health Sciences Centre (Kaufert and O'Neil 1989). As Native patients began to assert their culturally-defined needs, incidents of conflict and misunderstanding with hospital staff occurred, requiring mediation by Native Services interpreters. These mediation\advocacy activities of Native Services staff became the focus of the University of Manitoba study, and faculty researchers became involved in a process of institutional education in an effort to both legitimate and expand the important functions of Native Services staff in the hospital(Kaufert and O'Neil 1991; O'Neil 1989).

In 1986, the Hospital and provincial government recognized the value of these broader functions (beyond strictly language interpretation) through the development of a so-called "New Careers Program". This initiative, funded by the provincial department of employment and training, provided almost two years of on-the-job training for the interpreting staff at the two teaching hospitals. The curriculum focused on developing assertiveness and communication skills, understanding medical terminology, family

violence and crisis counselling, inter-cultural mediation, and health education. At the end of the program, the interpreters were certified as "Native Liaison Workers".

Interviews conducted with participants in the "New Careers Program" reveal that while the interpreters generally viewed this opportunity positively, some of the training modules - particularly counselling skills - were specifically oriented to a Western professional model of service provision, which the interpreters found difficult to adapt to work with Native families. Typical to their work was the situation of a Native elder with a terminal illness where the entire extended family would attempt to maintain a vigil at the bedside; in the process breaking most of the hospital regulations related to visiting behaviour. Interpreters were required to first of all understand the cultural principles behind Native attitudes towards death and dying while at the same time attempt to enforce hospital regulations. These types of conflicts were not easily resolved by the "New Careers" training.

In response to these conditions, the Director of the Native Services Department, Mrs. Margaret Lavallee, also began a process of "retraditionalizing" her department. Initially, a woman elder from the Winnipeg community, Mrs. Vera Martin, began to meet with the interpreter staff on a regular basis to discuss problems and work-related stress. Mrs. Martin also provided traditional counselling to patients in the hospital. Other healers in Manitoba and occasional visitors from out of province also met with interpreter staff and began to provide an increasing level of traditional services to patients on request. The increase in these services continued to require interpreter advocacy as hospital procedures and regulations, and medical and nursing staff attitudes, were challenged. Examples of conflicts range from the simple need to disconnect fire alarm systems for "smudging" ceremonies in the patients' rooms, to traditional healer's requests that patients refrain from taking western medications for a period of four days prior to traditional treatment.

Interpreter response to the retraditionalizing process ranged from resistance, in situations where staff had strong Christian religious backgrounds, to total immersion, as in the situation of the Director who is now a pipe-carrier and conducts her own sweat

lodges. Some staff turnover occurred due to these differences in approach, but the Health Sciences Centre Staff are now a united and positive force in the urban retraditionalization process beyond the hospital walls. Members of the Native Services Department (now called E Nway Ta Ma Ka Wak - "people speaking for people") serve on various Aboriginal and mainstream Boards and Committees throughout Winnipeg, contributing to the development of culturally-sensitive health and social services for Aboriginal people(Fedun 1993).

In 1991, the Health Sciences Centre struck an Aboriginal Services Review Committee, which included representation from HSC's Board of Directors and various departments, as well as from six different Aboriginal organizations in Manitoba, to examine hospital policy regarding Aboriginal patients (who continue to be significantly over-represented in the hospital population). The HSC Board has accepted the nine recommendations of this Committee, summarized as follows:

* Providing Aboriginal people with a greater voice in the affairs of the Centre through establishment of a standing committee of the Board on Aboriginal Affairs;
* Enhancing cultural awareness and promoting dialogue with Aboriginal people;
* Committing resources to ensure the services of traditional healers are available;
* The promotion of employment equity for Aboriginal people at HSC;
* Increasing cultural awareness of staff through education programs;
* Increasing educational opportunities for Aboriginal staff at HSC;
* Enhancing outreach educational activities;
* Establishing links to Aboriginal organizations and leaders; and
* Increasing the autonomy, authority and capacity of Native Services.

In summary, the Native Services Department at Health Sciences Centre has come a long way from its humble beginnings in 1971. Aside from being the first and model program of its kind that has since been adopted at other urban and rural hospitals

in Manitoba, Saskatchewan and Ontario, the Department continues to play a key role in both the retraditionalization of Aboriginal health care in the city, as well as contribute to the development of new and innovative health and social services designed to serve Aboriginal people in a culturally appropriate manner.

4. Ma Mawi Wi Chi Itata Centre (John O'Neil):

The Ma Mawi Wi Chi Itata Centre ("We all work together to help one another") was established in September, 1984 with the election of a twelve member community board. The Centre is Native-controlled and provides support services and resources to Native children and families in Winnipeg. The Centre provides support services to the Indian Child and Family Services agencies, Métis child and family support committees, the Winnipeg child and family service agencies and other community organizations. The Centre is founded on a vision of the Aboriginal community in Winnipeg to provide a supportive living environment for Native children and families. The major goals of the Centre are to maintain a resource centre to support Native families in Winnipeg, to promote Aboriginal culture as a basis for providing services, to facilitate Aboriginal community involvement in family service provision, to provide preventative and advocacy services to the Aboriginal community, to contribute to community development and to protect the rights of the individual for self-determination(Ma Mawi Wi Chi Itata, 1984).

The initiative for the Centre arose from the tragic death of a Native child in the care of the Children's Aid Society in 1982. This event led to the formation of the Winnipeg Coalition on Native Child Welfare, which together with the Indian and Métis Friendship Centre, facilitated the election of the Board and development of the Centre. The goals and objectives of the Centre are as follows:

* To establish and maintain a resource centre in the city of Winnipeg which provides support programs to Native families that are designed to encourage and promote the maintenance of the family unit in the community.

* To promote Native culture as a basis for developing and providing programs and services as well as providing opportunities for developing Native cultural awareness within the community as a whole.
* To promote and facilitate Native community involvement in the development and provision of services to families.
* To develop and maintain preventive services for Native children and families.
* To act as an advocate on behalf of Native children and families involved with or receiving services from child welfare agencies.
* To work cooperatively with all Family Service Agencies in Manitoba in the development of programs and the delivery of services that are in keeping with these goals and objectives.
* To develop and maintain a standard of service that protects the rights of the individual to self-determination.

According to their mission statement, the Ma Mawi Wi Chi Itata Centre is based on the rights of Native people to self-determination. The Centre considers child welfare problems in the Native community to be grounded in the colonial nature of relations between Aboriginal people and the Euro-Canadian majority; to this end, Centre programs and practice flow from a process of decolonization based on a critical analysis of history, society, culture and self(BEMA Consulting Group 1991).

In their brief to the Royal Commission on Aboriginal Peoples, the Centre describes the history of Aboriginal child welfare initiatives in Manitoba(Ma Mawi Wi Chi Itata Centre, 1993). The Winnipeg Coalition on Native Child Welfare, with the full support of the Manitoba Métis Federation, other urban Aboriginal organizations, and the Faculty of Social Work at the University of Manitoba, petitioned the Minister of Community Services to fund a fully-mandated Native Family Services (modelled on the existing Jewish Child and Family Services agency) to deliver a full range of child welfare services to the urban Aboriginal community. At the time, on-reserve child and family services were being transferred from the federal government to First Nations control,

beginning with the creation of the Dakota Ojibway Child and Family Services in 1981. The province was also in the process of de-centralizing the Children's Aid Society into six new regional child and family services in Winnipeg.

Although the Coalition lobbied for the creation of a mandated Aboriginal agency responsible for all Aboriginal people in the city, the province offered control over the core area agency and resource functions for Aboriginal people covered by other agencies. The Coalition rejected this offer, partially because it was geographically limited and partially because of a fear that an agency with limited child protection functions would be perceived by the Aboriginal community as an arm of the colonial system. Eventually, the Coalition reached an agreement to establish a non-mandated resource centre - Mamawi - intended to serve all regional child and family services with Aboriginal clients. This decision had significant costs as the Manitoba Métis Federation rejected the decision, withdrew from the coalition and have initiated independent proposals for urban Métis people.

Nearly a decade later, the experience of Mamawi has been often characterized as frustration and disagreement with the various regional provincial child and family services in the city. Mamawi's perspective is that they have achieved no real influence over the actions of the mandated agencies, and despite recognition by independent reviews such as the Aboriginal Justice Inquiry, their work has largely been ignored by mainstream agencies.

However, and perhaps ironically, the regionalization plan of the previous NDP government has been reversed by the current PC government and city child and family services have been recentralized. Perhaps because they only deal with one agency, the recent experience of Mamawi has been better. Reports are that dealing directly with one agency is easier, rather than trying to convince several agencies to consult when dealing with Aboriginal families.

From the perspective of Mamawi, the most distressing problem in the current political environment is their relationship with First Nation and Métis political authorities.

Until recently, First Nation Tribal Councils have not addressed the needs of urban Treaty people and status-blind organizations like Mamawi have provided services where needed. However, Tribal organizations are now attempting to develop a continuum of services from the reserve to the city and appear to view the activities of status-blind organizations as either a threat to the development of their own services, or as culturally inappropriate to the needs of people from a reserve culture. As stated in the Mamawi submission to the RCAP:

> "Reserve-based child and family services rarely use the culturally appropriate resources that the Mamawi Centre has developed, choosing instead to use placement and treatment resources developed and managed by mainstream institutions. The irony of this situation is that these same non-Aboriginal institutions tend to refer First Nations children and youth to the Mamawi Centre to meet the requirements of culturally appropriate services"[3].

Similarly, the Manitoba Métis Federation is insistent on developing Métis-specific services under their own jurisdiction and do not consider Mamawi to be meeting the specific cultural needs of Métis families. These conflicts over jurisdiction related to legal designations are regarded by Mamawi as perpetuating the colonial and genocidal effects of the Indian Act and as counterproductive to the timely development of effective and efficient health and social services for Aboriginal people in Winnipeg.

Citing the wealth of experience developed by status-blind organizations in meeting the needs of urban Aboriginal people, Mamawi, together with the Aboriginal Council of Winnipeg (created in 1990 as the amalgamation of the Winnipeg Council of Treaty and Status Indians, and the urban Indian Association) and other status-blind Aboriginal economic and social organizations are now proposing to develop an Aboriginal Health and Wellness Centre in Winnipeg. In 1990, these organizations took possession of the old Canadian Pacific Railway Station, located in the heart of the urban Aboriginal community and have since leased space to a variety of political, economic

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3. The Ma Mawi Wi Chi Itata Centre Inc., (Wayne Hegalson), Presentation to the Royal Commission on Aboriginal Peoples National Roundtable on Health and Social Issues, March 10, 1993, Vancouver, pp. 33.

and social Aboriginal organizations. The Health and Wellness Centre is proposed as the centrepiece to this project, symbolizing a holistic approach to promoting wellness among urban Aboriginal people. The Steering Committee for this effort is negotiating directly with the provincial government for funding; and have indicated they see little role for federal participation. Although the Aboriginal Council of Winnipeg includes Treaty, non-status, and Métis people among its membership, and certainly clients of their services come from all three groups, the Centre cites lack of support from First Nation and Métis organizations as a primary reason for slow development. Indeed, the recent creation of the Winnipeg Tribal Council, and its recognition by the Assembly of Manitoba Chiefs, is regarded by the Centre as a counterproductive development which "perpetuates the inappropriate, unresponsive and unaccountable political structures and processes that was established on reserves through the Indian Act (sic)"[4].

Finally, the Centre recognizes that health and wellness for urban Aboriginal people is essentially a women's issue. Citing the perception that the majority of urban Aboriginal families are single-parent and headed by women, the Centre intends to focus their efforts on the needs of these families. Further discussion of women's needs and perspectives will be addressed in subsequent sections of this report.

5. Native Women's Transition Centre Case Study (Moneca Sinclaire)

The Native Women's Transition Centre is a home for Aboriginal women and children in need of full-time and long term support. The original building was located in Selkirk avenue for over ten years and then moved to Aikens Street with new facilities and resources. There is accommodation for eighteen residents and the length of stay is six months to one year but varies depending on individuals needs. The Centre constantly has a waiting list of at least six to eight months. They have a exercise room with a whirlpool and a counselling room for one on one counselling. The Centre has maintained their clients confidentiality and protection by ensuring that the front door is locked at all times. The Centre will ask the women who they want visiting and phoning

4. Ibid, pp. 42.

them and names and photographs, if available, are given to the front desk clerk. The Centre is open to women in the process of changing their life situations, women in transition.

The Centres' philosophy is to begin the process of self-identity and they encourage Native self-awareness through ceremonies and elders coming to the Centre to speak to the women. The Centre believes that women and children have the right to self-sufficiency, self-determination, dignity, respect, caring, and the right to share in the decisions that affect their daily lives.

They promote their philosophy by having the women learn to share in decision making processes and having the common experience of living and working together. They provide long term accommodations, child-care and supportive counselling and advocacy services. The women listen to culturally appropriate role-models and are given the opportunities to improve their self-esteem. The women begin to learn how to live in a community environment by doing volunteer work with groups in the community. Some women will join a sewing club or do volunteer work at the Friendship Centre.

The women are admitted into the Centre if they are of Aboriginal descent (Status, Non-Status, Métis) and if there exists a history of abuse and/or victimization by partners or other people or by a institutional system. There also exists a need for preventive education, modelling and skill-building in the areas of child-care and parenting skills; there exists a history of substance abuse and finally there is a need for post-institutional care.

Some of the women will admit themselves into the Centre because another agency, such as Child and Family Services will recommend the transition Centre as one of processes to obtain custody of their children who may be in the agency's care. One informant stated:

> I learned it from children's aid and child and family services. They said you get into the native centre and you would have a better chance of getting your children back...I put in an application and it took six months.

Some women may not be admitted into the Centre if they are suffering from the effects of chronic alcohol or drug abuse withdrawal symptoms which may be life threatening. Also exempted from admission are women suffering from mental health problems where immediate treatment or intervention is needed. If the women are willing to receive help the Centre will provide referrals and advocacy service on behalf of these individuals. Once the individuals have achieved some measure of stability they are encourage to re-apply for admission.

Of the four women interviewed at this Centre all were in institutional care since they were five to seven years old. They were either in foster care or wards of child and family services for adoption purposes. Two of the four interviewees were in Linden Woods (a home for unwed mothers) when they were fourteen and fifteen. Three of the four women interviewed applied to the Centre to secure their chance of return of their children from child and family services.

Three of the women expressed their discomfort at staying at a Centre that did not encourage the "native heritage". One interviewee felt that some shelters were harder to stay in because the women that stayed in the shelters were racist against "Indian women". All four interviewees liked the transition Centres atmosphere and really felt they were learning a lot about being a "Indian" person. Three of the four interviewees did not know anything about the ceremonies or teachings and it was their first time in a sweat lodge. They felt that this cultural component made the Centre a more comfortable place than the other locations.

The Centre also tries to teach the women how colonization, patriarchal leadership, and class structures have contributed to their life today. They use teaching circles and films of historical events to discuss these issues. The Centre feels that it is important for the women to understand what they learned from their mothers and what their mothers learned from their mothers and so on. That history has an important impact on who they are today and without understanding this, it is harder to move forward.

6. Special Pre-Medical Studies Program, University of Manitoba (John O'Neil):

Developed in 1979 as an "affirmative action" type program to prepare Aboriginal students to be competitive for admission into medicine, dentistry, medical rehabilitation or pharmacy, this program has struggled to maintain its funding base, despite unparalleled success in producing Aboriginal medical professionals. The program is only one component of the more generic "Access" program in the Department of Continuing Education at the University of Manitoba which provides support services to Aboriginal students and preparatory assistance for those interested in admission to professional schools. Jointly developed by Aboriginal leaders, the provincial Department of Education, and partially funded by the Federal government, this program has now produced eight physicians (5 currently in training), 3 dentists (1 in training), one pharmacist (1 in training), and 2 medical rehabilitation professionals (4 in training). Nursing is not included within the program (Stephens 1991).

Federal funding which amounted to 60% of the costs of program administration and financial support for students, was discontinued in 1990 when the Northlands Agreement expired. Since then, the province has contributed some additional money to keep the program alive, but most of the costs have been off-loaded onto Band and Tribal Councils (for status Indian students), or other provincial programs including social assistance. A recent confidential review of the Program by Peat, Marwick and Associates has been submitted to the provincial Minister of Education and it is hoped this review may provide some stability to the Program.

The impact of this Program on the medical community in Manitoba is nothing less than profound and these impacts are as yet in their infancy. Since all Aboriginal students must apply to medical school under the same conditions as other students, there are no stigmatizing characteristics to admission that would impact negatively on Aboriginal medical students. Graduates report that they were forced to cope with some discriminatory attitudes on the part of other students, but in general have been accepted as equal members of the medical community. As practising medical professionals, Aboriginal doctors are having a very large impact on the development of Aboriginal

health services. Some have embraced traditional teachings which they have incorporated into their family practice settings, serving both to legitimate these interests for non-Aboriginal medical practitioners as well as with older reserve residents who sometimes retain negative feelings engendered by the churches and the Indian Act. Others have taken on issues of ethical responsibility and racism within the profession and have initiated disciplinary measures from the provincial College of Physicians when non-Aboriginal physicians have acted inappropriately with Aboriginal patients. Others are now in senior positions within federal, provincial and university health departments and agencies and, although constrained by bureaucratic practice, are promoting Aboriginal interests in setting health policy and developing programs. Perhaps most significantly, for the theme of this report, several are fundamentally involved in the development of the Aboriginal Health and Wellness Centre described above and are intent on developing the first joint Aboriginal family practice in an urban setting.

E. Conclusions

Although the research plan outlined a broad range of questions to be addressed in this case study, three issues have emerged in our interviews as central to policy and planning for Aboriginal health and social services in urban areas; 1) Women's health concerns, 2) Jurisdictional Issues, and, 3) Development of Aboriginal Healing in the City:

1. Women's Health Concerns

It seems clear that women's concerns about domestic violence in particular are the foremost priority for many people in the urban Aboriginal health and social services field. Increasingly, Aboriginal women from reserves and rural communities are only able to escape abusive situations for themselves or their children in their home community by accessing women's services such as shelters and counselling services in Winnipeg, and eventually by relocating to Winnipeg with the assistance of these services. Although shelters and counselling services do exist in some rural towns that may be close to reserves, these services are described as ineffective because family and community have access to the women and often pressure women to resolve domestic problems and remain in their homes.

Aboriginal women's services in Winnipeg report that empowerment of women is a primary concern. Often women in abusive situations feel alienated from their reserve cultures, or extended family in the city, due to a perception that these "communities" are male dominated and resistant to change. Creating a new cultural community for Aboriginal women in the city becomes a component of the empowerment and healing process. Spirituality may be central to this process for some women and is emphasized in some services more than others. Also important are teaching circles where the colonial history of Aboriginal relationships with the wider society are emphasized. As one client explained " I never realized how my own history of abuse was linked to abuse of the Native culture. For me, my own healing is part of a return to Native spirituality".

However, Aboriginal identity may also have problematic aspects in an urban context where some women are Treaty and escaping reserve conditions while others are Métis or non-status from urban backgrounds. One Métis women explained that while mainstream services for women in the city are "too white", there are also sometimes problems in relating to the experiences of reserve women. From the perspective of providing effective services, most of our informants argued that a variety of options are necessary, to allow clients to find the right environment in which to pursue personal healing in an appropriate "community" context.

Most of our informants indicated that the provision of urban services for Aboriginal women in abusive home situations has been the source of some difficulty for Aboriginal political organizations. Women's organizations report that they experience some animosity from the largely male-dominated Aboriginal organizations over the issue of providing status blind services which sometimes appear to challenge the Chiefs' concern for preserving First Nations cultural traditions.

2. Development of Aboriginal Healing in the City:

In spite of the problems and concerns outlined above, most of our informants cited a high level of cooperation and cross-referral at the level of day-to-day client service. Our impression to date is that independent of "status" and other distinctions, Aboriginal health workers consult freely with their counterparts in other Aboriginal agencies as the need arises. For example the SUGAR group is a voluntary group consisting of representatives from all Aboriginal constituencies in the city with an interest in preventing the rising incidence of Diabetes in the urban Aboriginal population. Typically, the SUGAR group has been promised funding from federal and provincial governments as well as the Canadian Diabetes Association, but has received nothing as each funding partner waits for the other to commit first. The "status" rhetoric seems to be confined largely to political forums particularly when federal and\or provincial representatives are present, and does not seem to interfere with client service.

Urban Aboriginal people with an interest in traditional spirituality and healing were

described to us as the "smallest but fastest growing sector of the urban community". Every Aboriginal health initiative in the city includes an emphasis on ensuring that traditional spirituality is part of the healing process and that traditional healers are available to even the most disabled hospital patient, in spite of the absence of a sweat lodge in the city. However, our informants also emphasized that other spiritual values must also be respected since many Aboriginal people are devout Christians. St. Boniface Hospital describes their Native Services Department as providing spiritual services in the same tradition as the founding Grey Nuns, some of whom in Manitoba were Métis women.

3. Jurisdictional Issues

Central to our informants' concerns for the provision of urban Aboriginal health services are different perceptions regarding who should be responsible for providing services. There are essentially four representative types of organizations in Winnipeg who provide health and social services to various degrees; 1) Mainstream service departments (i.e., Native Services in the major hospitals) who are provincially funded and provide a status blind service to all Aboriginal people who require mainstream services such as hospitalization, 2) Aboriginal service organizations (e.g., Ma Mawi Chi Itata Centre, Native Women's Transition Centre) that provide either direct health and social services or operate as resources to mainstream service organizations, 3) Aboriginal political and cultural organizations that have developed to represent urban Aboriginal people and are usually status-blind (e.g., Aboriginal Council of Winnipeg, Indigenous Women's Collective), and 4) First Nations and Métis representative organizations with responsibilities only to their respective constituencies.

To date, almost all ethnospecific[5] urban health and social services for Aboriginal people have been developed in the first three types of services, albeit sometimes with the support of First Nations or Métis organizations. For example, the Native Services

5. Ethnospecific is a term used to describe a health or social service which is intended solely for members of a particular ethnocultural community and where services are designed to be culturally appropriate and linguistically accessible.

departments in the two Winnipeg tertiary hospitals were initiated at least partially in response to concerns raised by the First Nations Confederacy regarding an elderly woman who had been allegedly mistreated by a surgeon in one of the hospitals. Almost without exception, these services have been provincially funded.

Currently, both the First Nations and Métis organizations in Winnipeg are developing policy initiatives which would situate health and social services for their respective memberships within (or at least attached to) the primary political bodies. The central issue for these organizations is to develop services which reflect the continuum of experience of their memberships from rural\reserve communities to the urban environment. Of foremost concern to these organizations is the establishment of "tripartite framework agreements" with the federal and provincial governments (Assembly of Manitoba Chiefs 1993). These agreements are being negotiated bilaterally with each level of government and are intended to both guarantee a federal obligation to fund urban (as well as reserve and rural) health and social services, and to formalize provincial responsibilities and relationships with self-governing Aboriginal communities. Both First Nations and Métis representatives have expressed concern that too much development with a status blind orientation may undermine their negotiating position with the federal government (First Nations on the basis of Treaties and the Indian Act, and Métis on the basis of the 1982 Constitution Act). First Nations representatives are particularly concerned about the erosion of federal responsibility. Until bilateral negotiations between First Nations and federal representatives resolve Treaty obligations, First Nations leaders are understandably worried that further status blind development will be detrimental to their position.

Despite some development of urban Aboriginal health and social services from the provincial government, several informants expressed considerable disappointment with provincial efforts, from both the current Conservative government as well as the former NDP government. Previous governments have been resistant to the idea of Aboriginal control over service administration; current health care reforms, while promoted as community-based development, are perceived as merely a cost-cutting

exercise where those with the greatest needs are the first to lose.

In terms of identity, several of our consultants referred to the importance of recognizing and respecting different Aboriginal identities and traditions, most obviously those related to traditional tribal cultures such as Cree and Ojibway, and to the legislated differences described above. Another less obvious difference is in relation to long-term residents versus recent migrant urban people. In Winnipeg there is a significant second and indeed third generation Aboriginal community whose socialization experiences and sense of identity are quite different from people who have either recently migrated from a reserve or rural community (country), or travel back and forth between the city and the country. Health and social service provision is effected by these distinctions when a particular service is described as for a particular group by clients.

F. Recommendations

1) Research is urgently required in order to clearly identify the nature of the health problems of urban Aboriginal people. These research initiatives must be developed with the full participation of all urban Aboriginal organizations.

2) In order to ensure that mainstream health and social institutions provide culturally appropriate services to Aboriginal clients who often constitute a significant proportion of the health care consumers for hospitals, community health clinics, district health centres, etc., Aboriginal representation on governing bodies (such as Hospital Boards) should be increased. This increased participation should complement an increased focus on the education of Aboriginal people in the health professions. Racism in mainstream health care institutions must be eliminated.

3) Development of urban Aboriginal health services must respect the diverse historical and cultural realities of urban Aboriginal peoples. Programs or funding initiatives should not perpetuate competition among Aboriginal organizations for scarce resources . Two approaches are necessary:

* Recognition of a stable urban Aboriginal culture where "status" distinctions are blurred requires the development of urban-based health and social services.
* Equally, recognition of an urban Aboriginal population that live in a social reality that embraces both rural and remote communities and reserves, and urban centres, require the development of a continuum of services by appropriate First Nations and Métis organizations.

4) Further development of urban Aboriginal health and social services must not perpetuate the historical tradition of developing urban medical services at the expense of service development in rural and remote communities. Development of Aboriginal health care expertise in the city should be structurally linked to enhanced, community-based service development in northern and rural communities through the auspices of appropriate First Nation and Métis organizations. For example, shelters and other services for women who are survivors of domestic violence need to develop outreach services and a network of facilitities which provide appropriate services closer to women's home communities.

5) The development of a demographically representative cadre of Aboriginal health workers must remain a priority for urban as well as rural and remote areas. In addition to understanding the patient's culture, Aboriginal doctors, nurses, social workers, interpreters, and other community health workers provide very important advocacy services to Aboriginal families who constitute a disproportionate sector of the client population for most urban health and social services.

6) Aboriginal control over urban health and social services is essential if these services are to develop in a flexible, innovative and community-responsive way to urban needs. Integrating traditional healing or simply developing a holistic approach to health and social well-being requires an ability to integrate funding at the community or service level which is currently beyond most urban Aboriginal agencies, who generally remain accountable to various mainstream institutions or provincial government departments.

7) Against many barriers and constraints, urban Aboriginal people have nonetheless managed to develop important health and social services which provide essential services to their community. Further development of urban Aboriginal services must recognize these contributions and build upon these efforts in future work.

Appendix A - References

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