

# ENTITLEMENTS AND HEALTH SERVICES FOR FIRST NATIONS AND MÉTIS WOMEN IN MANITOBA AND SASKATCHEWAN

Kathy Bent  
Joanne Havelock  
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Project #150



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**PRAIRIE WOMEN'S HEALTH**

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**August 2007**

Prairie Women's Health Centre of Excellence (PWHCE) is one of the Centres of Excellence for Women's Health, funded by the Women's Health Contribution Program of Health Canada. The PWHCE supports new knowledge and research on women's health issues; and provides policy advice, analysis and information to governments, health organizations and non-governmental organizations. The views expressed herein do not necessarily represent the official policy of the PWHCE or Health Canada.

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This is project #150 of the Prairie Women's Health Centre of Excellence  
ISBN # 978-1-897250-15-0

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# ACKNOWLEDGEMENTS

This document would not have been made possible without the contribution of a number of people.

We thank PWHCE Board members who conceived of and supported the idea for this project, especially Darlene Beck, Judy Hughes and Linda Otway. Linda Otway provided her expertise in the early conceptual stages. Lisa McCallum assisted in early stages of the work also.

Author Kathy Bent stepped in to undertake a renewed literature review and to conduct the interviews. Thank you, Kathy.

We thank colleagues in the federal government, especially at the Bureau of Women's Health and Gender Analysis, who provided support and made helpful comments and suggestions.

We thank three reviewers for their helpful comments and suggestions on the material.

Miigwech.



# INTRODUCTION

*"It almost seems like the general population doesn't understand that there's specific benefits for each of us and if you are First Nations you can access as long as you have that 10 digit number but First Nation women without Treaty Status, Métis women, and other women are distinctly different and if they do not have that 10 digit number they do not have access to the same kinds of services and programs."*  
– Service Provider

In the *Constitution of Canada* Indian, Métis and Inuit people are all recognized as Aboriginal.<sup>1</sup> However, there are differences in legal status among Aboriginal Peoples that determine what health services they are entitled to receive. Sometimes it is appropriate to use the term "Aboriginal". Many times the term "Aboriginal" and "First Nations" are used interchangeably or casually, without appropriate recognition of who is included under a label; Métis may not be included at all. Frequently it is not clear which group of people is being referred to in research and discussions. According to LaRocque, "stereotypes, politics and government policies have contributed much to the confusion."<sup>2</sup>

However convenient the term "Aboriginal" may be, Aboriginal groups have unique cultures with different languages and traditions that influence self-identify, and should not be thought of as a homogeneous group. Furthermore, this confusion of terms has particular implications in the realm of health care, because terminology, identity and

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<sup>1</sup> Canada, *Canadian Constitution Acts 1867-1982, Constitution of Canada* [s.35.1 (1982)], Department of Justice, Canada. <http://laws.justice.gc.ca/en/const/> and [http://www.solon.org/Constitutions/Canada/English/ca\\_1982.html](http://www.solon.org/Constitutions/Canada/English/ca_1982.html) [Retrieved August 2005]

<sup>2</sup> LaRocque, Emma, "Native Identity and the Métis: Otehpaysuak Peoples", in *A Passion for Identity: Canadian Studies for the 21st Century 4th Edition*, David Taras and Beverly Rasporich (Editors), Nelson Thompson, Toronto, Canada, 2001, page 381.

legal status have direct bearing on who receives what health benefits. More often than not, when looking at health services, it is more suitable to recognize the differences between First Nations, Métis and Inuit women.

This paper was written for both health researchers and policy-makers to examine the legal entitlements for health care services, clarify the terminology, and most importantly to demonstrate how they affect the women seeking health services. This understanding can then be taken into account in new research and policy development.

In keeping with Prairie Women's Health Centre of Excellence's mandate, specific to Manitoba and Saskatchewan, this paper is focused in those two provinces. The discussion in this paper focuses on First Nations and Métis people, who comprise the vast majority of Aboriginal people in the two provinces.

The report is arranged in four parts. Part 1 reviews the history behind the different entitlements to health services in Canada, and outlines current developments. Part 2 provides some information about the health services available. A qualitative research project, described in Part 3, documents the experience of front-line workers who work with Métis and First Nations women and provides their suggestions for reducing barriers to good health. Part 4 provides suggestions for policy-makers and researchers, based on the findings of the preceding sections.

To begin, we give some background about First Nations and Métis women in Manitoba and Saskatchewan.

## Coming to Terms with the Labels

**Aboriginal** – The original people of Canada and their descendants. This term is used in the *Constitution of Canada* [s.35.1 (1982)] and refers to “Indian, Métis and Inuit people”.

**Aboriginal Peoples** – Collective name for all of the original peoples of Canada and their descendants.<sup>3</sup>

**Aboriginal people** – Using people (lower case) refers to more than one Aboriginal person rather than the collective group of Aboriginal Peoples.<sup>3</sup>

**Band** – As defined by the *Indian Act*, a body of Indians for whom lands have been set aside or monies held by the government of Canada or who have been declared by the Governor in Council to be a Band. Today many Bands prefer to be known as First Nations.<sup>4</sup>

**Band membership** – A recognized member of a Band, whose name appears on the approved Band List. Bands that have adopted their own membership codes may define who has a right to membership in the Band, so being a Status Indian may not be synonymous with being a Band member.<sup>4</sup>

**Band Chief** – Leader of a Band and Band Council. The Chief is elected by eligible voters of the Band, or by the councillors, according to the regulations of the *Indian Act*.<sup>4</sup>

**Band Council** – Governing or administrative body of a Band, elected according to procedures laid out in the *Indian Act*. Councillors are elected by eligible members and serve two or three year terms.<sup>4</sup>

**Bill C-31's** – Shorthand reference to people who have regained their Indian Status due to an application under Bill C-31 (passed in 1985). Bill C-31 allowed reinstatement of women and their children who had lost their Indian Status due to marriage with a non- Status Indian or a non-Indian.

**First Nations** – Used in recent years to describe the groups of original inhabitants in what is now Canada, in preference to the word “Indian”. However “First Nations” is not a legally recognized term. It does not include Inuit or Métis people.

**Indian** – First used by Europeans to describe the original inhabitants of North America. Used in the Constitution of Canada and the *Indian Act*.

**Indigenous people** – “Indigenous” means people who are the descendants of the original inhabitants of particular regions or territories.<sup>5</sup>

**Inuit** – Original inhabitants of northern Canada living generally above the tree line. The Inuit are not covered in the *Indian Act* but the federal government makes laws concerning the Inuit. The Inuit are included as Aboriginal people in the Canadian Constitution.

**Inuk** – An individual Inuit person.

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<sup>3</sup>National Aboriginal Health Organization, “Authors Guidelines for Article Submission to the Journal of Aboriginal Health” [http://www.naho.ca/english/journal\\_Guidelines.php](http://www.naho.ca/english/journal_Guidelines.php)

<sup>4</sup> First Nations and Métis Relations Glossary. Saskatchewan Government First Nations and Métis Relations Department <http://www.fnmr.gov.sk.ca/glossary.htm> [Retrieved December 1, 2006]

<sup>5</sup> Indian and Northern Affairs Canada, “The International Decade of the World's Indigenous People” [http://www.ainc-inac.gc.ca/pr/info/info123\\_e.html](http://www.ainc-inac.gc.ca/pr/info/info123_e.html)



**Métis people** – People with mixed Aboriginal and European ancestry who identify themselves as Métis, distinct from Indian people, Inuit, or non-Aboriginal people. They are included as Aboriginal people in the Canadian Constitution.

**Métis National Council Definition:** “Métis means a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation.”<sup>6</sup>

**Mixed blood, Half-breed** – Terms used to refer to persons of mixed ancestry which had negative or racist overtones, but are being reclaimed by some groups or individuals, especially to include persons of mixed blood who do not fit the more formal definitions of Métis.

**Native** – Used in North America to refer to persons of any Aboriginal ancestry. In Canada, this term has acquired some negative overtones, but is still used by some individuals and groups. Commonly used in the United States in the term “Native Americans”.

**Non-Status Indian** – Person who is not registered as a Status Indian under the *Indian Act* either because the person or his/her ancestors were never registered, or because Status was lost through marriage or other provisions of the *Indian Act*, but who identifies as First Nations.

**Reserve** – Lands owned by the Crown, and held in trust for an Indian Band. The legal title to Indian reserve land is vested in the federal government.<sup>4</sup>

**Status Indian** – Legal term for a person who is registered as an Indian under the *Indian Act* of Canada.

**Treaty Indian** – Person who is a Status Indian because he or she is a member of a First Nation that signed a Treaty with the British Crown. A person is sometimes said to have Treaty Status

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<sup>6</sup> Métis National Council. "Who are the Métis? National definition of Métis", <http://www.metisnation.ca/who/definition.html>

## What's in a Name?

This section provides an overview of the important terms used to refer to Aboriginal people in Canada. These terms and several others are defined in brief in the textbox “Coming to Terms with the Labels” (page 2). More information about the history behind these terms will be explained in the following sections.

“Aboriginal” is a term employed in political and policy discussions over the last thirty years to identify descendants of Canada’s original inhabitants. The term has a specific use in the Canadian Constitution of 1982, where Aboriginal people are defined as including “Indian, Métis and Inuit people”.<sup>7</sup>

Prior to colonization, the original inhabitants of Canadian lands identified themselves according to their own names for their people. The word “Indian” was used to describe the original inhabitants of North America by Europeans and is used in historical and legal references. Métis people, settlements and culture arose from the joining of First Nations and Europeans. The people living in the far north were referred to as Eskimo, but are now more correctly called Inuit.

The federal *Indian Act* (1876 and 1958) created a legal definition and requirements for Indian people. “Status Indian” is the legal term for someone who is registered as an Indian under the *Indian Act*; and will be used in this paper. The term “Registered Indian” is also used. Indian people are registered and have Status because of Treaties their ancestors signed, or because of other agreements with the Crown or the Government of Canada. The former group is sometimes referred to as having “Treaty Status”,

more commonly on the Prairies where Treaties covered all of the land.

Most people with Status are of Indian ancestry, however in the past some non-Indian women gained Status when they married an Indian man with Status (and they retain this designation). Some Indian people are legally “non-Status” because they are not registered under the *Indian Act*. This situation can have occurred either because their ancestors were never registered, or because Status was lost through marriage or other provisions of the *Indian Act*. These people are not entitled to additional federal health services.

Some women and their children have regained Status by applying under the provisions of federal Bill C-31. (They may refer to themselves as being a “Bill C-31”.) Bill C-31 was passed in 1985 and allowed reinstatement of Status to women who had lost their Indian Status due to marriage with a man not registered as a Status Indian (a Non-Status Indian man or a non-Aboriginal man)(see page 15). The effects of the reinstatement change as the generations progress. Women registered under Bill C-31 are technically entitled to additional federal health services but may not actually receive some services because they do not have a Band membership, or are not living on a reserve. The clause of Bill C-31 under which women register is also significant, and women may refer to themselves as [section] “6(1)’s”, “6(2)’s” or “half-Status”, as will be seen later in this document.<sup>8</sup>

The term “First Nation” is not legally defined, but it has become the preferred term to refer to Indian people. The plural “First Nations” refers

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<sup>7</sup> Canada, *Canadian Constitution Acts 1867-1982, Constitution of Canada* [s.35.1 (1982)], Department of Justice, Canada. <http://laws.justice.gc.ca/en/const/> and [http://www.solon.org/Constitutions/Canada/English/ca\\_1982.html](http://www.solon.org/Constitutions/Canada/English/ca_1982.html) [Retrieved August 2005]

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<sup>8</sup> See pages 14 – 16. For a full investigation of how Bill C-31 affects Manitoba women’s lives, see Mother of Red Nations Women’s Council. (2005) *Bill C-31 Research Project*, and Mother of Red Nations Women’s Council (2006). *Twenty years and ticking: Aboriginal women, human rights and Bill C-31*.

to the collective of all the nations across Canada. First Nation can be used to describe origins – based on the original societies, such as saying a person is “from the Anishinabe First Nation”. Some individual bands or reserves refer to themselves as a First Nation (for example Muskowekwan First Nation). Other reserves may be more specific, such as Shoal Lake Band of the Cree Nation or Whitecap Dakota/Sioux First Nation. It is worth noting that many communities had a European name assigned for many years and are now returning to their own names, in their own languages.

“First Nation” may be used when referring to individuals with Status, and “non-Status” when referring to individuals without Status; consequently the use of the term First Nation can be confusing. In this paper the term “First Nation” will be used to refer to people with and without Status, with differentiation between Status and non-Status, where appropriate. In this paper the term Indian may be used where necessary to refer to historical or legal matters.

The term “Métis” is commonly used to refer to people with mixed Indian ancestry. Métis people are included as Aboriginal people in the Canadian Constitution, but the Constitution did not define the word “Métis”. Over the years there have been many discussions and definitions of the term. The complexity of the situation created by the history and legal definitions is illustrated in a table by the Congress of Aboriginal Peoples of the groups of people who are in its constituency.<sup>9</sup> Métis people, however they are defined, do not receive any additional health services from the federal government.

Inuit, as recognized in the Canadian Constitution, are a distinct Aboriginal people,

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<sup>9</sup> See the table at: Congress of Aboriginal Peoples, “CAP Constituency Table”, <http://www.abo-peoples.org/about/table.html> [Retrieved May 15, 2006]

many of whom live in the north above the tree line. They receive additional health services from the federal government. The federal government views the provision of extra health services as voluntary, while Inuit (and other Aboriginal) people view federal health programs as an Aboriginal right based on a fiduciary responsibility.<sup>10</sup> Inuit people are not discussed extensively in this paper because their numbers are small in Saskatchewan and Manitoba, but the importance and interconnectedness of their health issues are recognized.

There are, then, many complications and variations in the definitions that have been placed on the original inhabitants, by the rules of government and administration. These lead to differences in access to services. In this paper the primary comparison is made between the First Nations women who are registered as Status Indians, who are eligible to receive certain specific federal health services, and the Non-Status and Métis women who are not entitled to receive these services.

## The Women

Differences between the health status and use of health services for women and men are related not only to biological differences, but also to women’s and men’s social roles. Whether in Aboriginal or non-Aboriginal cultures, women play a primary role in maintaining the health of their families. Aboriginal women also play an increasingly greater role as paid health professionals.

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<sup>10</sup> Inuit Tapiriit Kanatami *Backgrounder on Inuit Health For Discussion at Health Sectoral Meeting, November 4th and 5th, 2004, Ottawa, Ontario* October 20, 2004 Ottawa, Canada, page 3. <http://www.itk.ca/roundtable/pdf/20041105-sectoral-health-backgrounder-en.pdf> [Retrieved May 27, 2007]

In both Saskatchewan and Manitoba Aboriginal people are a significant portion of the population. It is difficult to determine exactly how many women would be directly affected by the issues raised in this paper, but statistics do provide us with some general estimates.

The federal government maintains a register of persons with Status (Registered Indians) and of Inuit people eligible for federal programs. Persons registering for provincial health benefits are asked to give their Indian Status Registry number. This allows the federal and provincial governments to produce statistics on health care utilization and vital statistics. However, these data bases do not identify non-Status or Metis people.

The most recent population data available that identify all groups of Aboriginal people is the come from the 2001 Census.<sup>11</sup> Note, however, that there are complications in defining identity (as we will discuss in this paper) which emerge in the Census data. To start with, people are counted as Aboriginal in the Census if they identify as having a “North American Indian”, Inuit or Métis ancestry, if they report being a Treaty Status or Registered Indian, or if they report membership in a Band.

Then there is a question of who gets counted and asked which questions. The Census of Canada provides a short form to be filled out by 4 out of 5 households and a long form for 1 out of 5 households. Questions related to Aboriginal identity are only on the long form, therefore are based on a 20% sample of the population. As well, the Census does not include reserves that did not participate (one from each of Manitoba and Saskatchewan), and incarcerated persons, homeless people and those in long-term care are

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<sup>11</sup> More recent data regarding Aboriginal Peoples will be available in the Census 2006 Release no. 5 anticipated on Tuesday, January 15, 2008. <http://www12.statcan.ca/english/census06/release/index.cfm>, updated June 20, 2007. [Retrieved July 2007]

not asked about Aboriginal ancestry. See Appendix A for a more full description.

According to the 2001 Census, there were 978,933 people residing in Saskatchewan. The Census question on Aboriginal identity was answered by 963,155 people.<sup>12</sup> For those who responded, an Aboriginal identity was reported by 130,190 people in Saskatchewan: 63,290 males and 66,895 females. Of the 66,895 Aboriginal girls and women, 43,165 reported having a North American Indian identity; 22,260 reported a Métis identity; 105 reported an Inuit identity; 425 reported a multiple Aboriginal identity; and 940 reported other Aboriginal identity<sup>13</sup>. Registered Indian Status was reported by 43,500 girls and women.

In Saskatchewan, in 2001, 52% of the people with a North American Indian identity lived on a reserve, 9 % lived in a rural non-reserve area, and 39% lived in an urban location. Of Métis people, 6 % lived on a reserve, 33 % in a rural non-reserve area and 61% in an urban location. Inuit people mostly lived in urban locations.<sup>14</sup> A

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<sup>12</sup> Statistics Canada, *2001 Census Aboriginal Population Profiles*, Statistics Canada Catalogue no. 93F0043XIE, released June 17, 2003, last modified on November 30, 2005. <http://www12.statcan.ca/english/profil01/AP01/Index.cfm?Lang=E> [Retrieved July 2007] The population base for reporting Aboriginal identity is smaller because it is based on the 20% sample data that excludes institutional residents. Also note that these figures exclude census data for one or more incompletely enumerated Indian reserves or Indian settlements, one from Manitoba and one from Saskatchewan. See <http://www12.statcan.ca/english/Profil01/AP01/Help/Metadata/IndianReservesList.cfm?Lang=E> [Retrieved July 2007]

<sup>13</sup> This category includes those who identified themselves as Registered Indians and/or Band members without Aboriginal identity response.

<sup>14</sup> Statistics Canada, *2001 Census, Aboriginal Peoples of Canada*, Topic-based tabulations, Table 23 (Aboriginal Identity (8), Age Groups (11B), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census – 20% Sample), Cat. No. 97F0011XCB2001001, <http://www12.statcan.ca/english/census01/Products/standard/themes/DataProducts.cfm?S=1&T=45&ALEVEL=2&FREE+0> [Retrieved July 2007]

In 2001, 50% of the girls and women with North American Identity lived on-reserve, while 54% of boys and men lived on-reserve. This was similar to patterns found in a study of 1996 data for Saskatchewan Aboriginal women.<sup>15</sup>

The total population in Manitoba in 2001 was 1,119, 583. Of the 1,103,695 Manitobans answering the Aboriginal identity question, 150,040 reported having an Aboriginal identity: 73,030 males and 77, 010 females. Of the Aboriginal girls and women, 46,925 reported having a North American Indian identity; 28,610 reported a Métis identity; 175 reported an Inuit identity; 250 reported a multiple Aboriginal identity; and 1,040 reported other Aboriginal identity. Registered Indian Status was reported by 47,170 girls and women.<sup>16</sup>

*"Of the approximately 90,000 Status Indians counted during the 2001 Census, 56% lived on-reserve, 24% in Winnipeg and 20% elsewhere – mostly in urban settings. Of the approximately 52,000 Métis, 50% lived in Winnipeg, and 50% in other urban centres and smaller communities – many in predominantly Métis communities, some adjacent to First Nations and some not."*

*"Fully 48,995 or 85.3% of northern Aboriginal people are Status Indians, of whom 40,090 or 82% live on-reserve. Manitoba has a higher*

*proportion of its on-reserve citizens living in isolated, fly-in communities than any other province except Quebec — 32% according to Indian and Northern Affairs Canada data."<sup>17</sup>*

So we can see that the issues discussed in this paper affect a large number of women throughout Manitoba and Saskatchewan.

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<sup>15</sup> Saskatchewan Women's Secretariat, *Profile Of Aboriginal Women In Saskatchewan*, Regina, Saskatchewan, November 1999, pages 13-15, <http://www.swo.gov.sk.ca/pub.html#ProfAbWomenv> [Retrieved July 2007]

<sup>16</sup> Statistics Canada, *2001 Census Aboriginal Population Profiles*, Statistics Canada Catalogue no. 93F0043XIE, released June 17, 2003, last modified on November 30, 2005. <http://www12.statcan.ca/english/profil01/AP01/Index.cfm?Lang=E> [Retrieved July 2007] The population base for reporting Aboriginal identity is smaller because it is based on the 20% sample data that excludes institutional residents. Also note that these figures exclude census data for one or more incompletely enumerated Indian reserves or Indian settlements, one from Manitoba and one from Saskatchewan. See <http://www12.statcan.ca/english/Profil01/AP01/Help/Metadata/IndianReservesList.cfm?Lang=E> [Retrieved July 2007]

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<sup>17</sup> Manitoba Aboriginal Affairs Secretariat and Services Canada, *Aboriginal People in Manitoba*, Winnipeg, Manitoba, 2006, page 15. <http://www1.servicecanada.gc.ca/en/mb/aboriginals.shtml> [Retrieved July 2007]



# PART 1: SETTING THE SCENE

In Canada, stemming from the *British North America Act* of 1867 (see page 11), the primary responsibility for health care services rests with the provincial governments, but the federal government also provides some health-related services to all Canadians.

The *Canada Health Act*, originally passed in 1985, outlines the provisions that guide the federal, provincial, municipal and territorial governments in the delivery of health care services including cash disbursements for declared services.<sup>18</sup> These provisions include universal access to insured hospital care and primary health care provided by doctors and other health care professionals, although there is a variation in services by province, health region, and geographic location. Health Canada reports that all Aboriginal people have access to these services as any other resident of Canada.<sup>19</sup>

However Inuit people and First Nations people who are registered as Status Indians are entitled to receive some other specific federal services, while Métis people and First Nation individuals without Status are not eligible.

Several key events in Canadian history have led to the current situation in which not all Aboriginal people are entitled to the same health services.

## Key Events Regarding Entitlements to Health Services for Aboriginal peoples

1763 -1906: Royal Proclamation and First Nations Treaties

1870 to c. 1906: Métis Scrip

1867: British North America Act

1876 and 1958: Indian Act

1982: Canadian Constitution and Charter of Rights and Freedoms

1982: Women's Equality Provisions

1985: Canada Health Act

1985: Bill C-31

1996: Royal Commission on Aboriginal People

2002: Métis Nation Council Definition

2004-2005: Federal Roundtables on Health

2005: Kelowna Accord

## First Nations

When colonized by the Europeans, Canada's original inhabitants lived in many First Nations, with a number of different languages and considerable cultural variation. Fur trade, white settlement, and ensuing government restrictions pushed First Nations into different territories.

## First Nations Treaties

The Royal Proclamation of 1763, by King George III, stated that any lands within the territorial confines of the new governments (present day Quebec, Florida, West Florida and Granada) that had not been ceded by the Indian people were reserved for the Indian people. It

<sup>18</sup> Canada, *Canada Health Act* (R.S., 1985, c. C-6) <http://laws.justice.gc.ca/en/C-6/text.html> [Last retrieved February 27, 2007]

<sup>19</sup> First Nations and Inuit Health Branch, Health Canada, "Non-Insured Health Benefits", [http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html) [Retrieved November 13, 2006]

implied that all lands that had not been surrendered to the King (the Crown) belonged to the Indian people and provided that lands required for a settlement had to be bought from the Indian people and could only be bought by the Crown (representing government) at a public meeting. Questions remain concerning whether this provided title to the land or simply recognized the pre-existing reality that the lands belonged to the Indian people, and whether the proclamation applies to all the lands of Canada or just the territory that had been discovered by the British at that time. Nevertheless, the Royal Proclamation set the stage for treaties to be signed between the First Nations people and the Crown.<sup>20</sup>

The treaties were signed agreements between First Nations and the Crown in which the First Nations agreed to share land or granted access to the land, and in exchange the Crown agreed to provide certain protections and rights to the First Nations and their descendants.<sup>21, 22</sup> Although it is not the case in all parts of Canada, all of the land in what are now the provinces of Manitoba and Saskatchewan were covered by treaties. The treaties provided for parcels of land to be reserved for the Indian people who signed, but the federal government retains the title to the land. These designated lands are referred to as “Reserves”.

Pre-Confederation treaties were signed between First Nations and representatives of the British Crown in several parts of what is now Canada.

<sup>20</sup> John L. Steckley and Bryan D. Cummins, *Full Circle: Canada's First Nations*, Prentice-Hall, Toronto, 2001, pages 119-120.

<sup>21</sup> Wayne E. Daugherty, *Treaty Research Report, Treaty One and Treaty Two: Summary*, Indian and Northern Affairs Canada 1983, [http://www.ainc-inac.gc.ca/pr/trts/hti/t1-2/index\\_e.html](http://www.ainc-inac.gc.ca/pr/trts/hti/t1-2/index_e.html) [Retrieved May 11, 2006]

<sup>22</sup> Mercredi, Ovide and Mary Ellen Turpel, *In the rapids: navigating the future of First Nations*, New York: Viking, 1993, pages 60-61.

Eleven numbered treaties were subsequently signed between 1871 and 1906. There were also treaties related to specific regions. For the most part, the treaties cross provincial boundaries. The lands that became Manitoba were affected by Treaties 1 through 6 and 10<sup>23</sup>, while in Saskatchewan lands Treaties 2, 4, 5, 6, 8 and 10 were signed.<sup>24</sup>

Of particular importance to health is Treaty 6 that was signed in 1876 by the Cree Nation in relation to land in Saskatchewan and Alberta. Treaty 6 includes a clause that states a “medicine chest” will be kept in the house of each Indian Agent for the benefit of the Indian people.<sup>25</sup> There was considerable debate in the following years about the meaning of this clause but the “medicine chest” clause was eventually interpreted to mean free medical care to the Indian people. (Other usual benefits were the provision of reserve land, annual payment of five dollars per year per person, farming and agricultural assistance, schools, educational assistance, fishing twine, uniforms, medals and flags for the principal chiefs, and a promise that hunting and fishing could go on as usual.)<sup>26</sup>

<sup>23</sup> Assembly of Manitoba Chiefs, “First Nations Treaties with the British Crown”, <http://www.manitobachiefs.com/treaty/retracing.html> [Retrieved February 2006]

<sup>24</sup> Saskatchewan Indian Cultural Centre, <http://www.sicc.sk.ca/bands/> [Retrieved May 2006]

<sup>25</sup> Ray, Arthur J., Jim Miller, Frank Tough, *Bounty and Benevolence: A History of Saskatchewan Treaties*, McGill-Queen's University Press, Montreal & Kingston, 2000, page 143.

<sup>26</sup> Native Law Center and the National Aboriginal Health Organization, “Native Law Centre Discussion Paper Series in Aboriginal Health: Legal Issues Treaty No. 6 "medicine chest clause"”, University of Saskatchewan, Saskatoon <http://www.usask.ca/nativelaw/medicine.html> [Retrieved February 2006]



## The B.N.A. Act and Health

The *British North America Act* (BNA Act) established the country of Canada in 1867. The BNA Act granted some of the responsibility for health care to the provinces and the federal government retained responsibility for certain aspects of health for all Canadians.

*"At Confederation, the Constitution Act, 1867 made few specific references to health responsibilities. The federal government was allocated jurisdiction over marine hospitals and quarantine while the provinces were to establish, maintain and manage hospitals, asylums, charities and charitable institutions. From 1867 to 1919, the Department of Agriculture covered any related health concerns.*

*In the 74 years between the establishment of the first federal health department and the emergence of a reconstituted health department in 1993, federal government responsibility grew to include health services for Indian and Inuit people, federal government employees, immigrants and civil aviation personnel. It also included investigations into public health, the regulation of food and drugs, inspection of medical devices, the administration of health care insurance, and general information services related to health conditions and practices."*<sup>27</sup>

The division of responsibilities has created confusion for First Nations people over who provides and covers the cost of health services since it was the British Crown that had signed the original treaties and the medicine chest clause, (making them the responsibility of the federal government), but the provinces are responsible for health care delivery.

Not only is entitlement fragmented but the issues are further complicated by discussions, tensions, wrangling and haggling between the federal government and the provinces. Robert Allec writes,

*"Ample documentation attests to the fact that the long standing conflict between the provincial and federal governments has negatively impacted First Nations peoples and has resulted in the patchwork of fragmented services which exists today..."*<sup>28</sup>

He goes on to say:

*"To a large degree, jurisdictional issues which impact on accessibility and comprehensiveness stem from the decades of a 'tug of war' over which level of government is responsible for services. Although the Manitoba government is required to provide equal access to health care services under the Canada Health Act for all residents of Manitoba including First Nations living on reserves, it takes the position that the federal government is responsible for certain health services to First Nations people who are Status Indians under the Indian Act. As a result, some health services not covered by the Canada Health Act but otherwise provided by the provinces through the regional health authorities may or may not be provided to First Nations communities ... This fundamental disagreement translates in a very real way into program fragmentation, problems with coordinating programs underfunding, inconsistencies, service gaps and lack of integration ..."*<sup>29</sup>

## Section 91(24)

Particular to Aboriginal people in Canada is Section 91(24) of the British North America Act, that states that legislative authority for "Indians,

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<sup>27</sup> Chenier, Nancy Miller, *Health Policy in Canada*, Political and Social Affairs Division, Depository Services Program, revised December 4, 2002, <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/CIR/934-e.htm> [Retrieved December 5, 2006]

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<sup>28</sup> Allec, R, *First Nations health and wellness in Manitoba: Overview of gaps in service and issues associated with jurisdictions*. Prepared for Inter-governmental committee on First Nations health, 2005.

<sup>29</sup> Ibid.

and Lands Reserved for the Indians” rests with the federal government of Canada.<sup>30</sup>

## The Indian Act

The *Indian Act* is administered by the federal Department of Indian and Northern Affairs (or Indian and Northern Affairs Canada – INAC). The *Indian Act* (1876 and 1958) defines the term “Indian” and spells out rights and entitlements under the law. According to the *Indian Act*, the term Indian “...means a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian.” Under the *Indian Act*, people who were registered were referred to as Status Indians and they had the right to live on a reserve, vote for a Band Chief and Council, share in Band money and own and inherit property on a reserve. Status was handed down along the male line of the family. The *Indian Act* also prescribed the conditions under which an Indian person became enfranchised. That is, the *Indian Act* outlined the process in which an Indian person gave up treaty rights in exchange for full Canadian citizenship.

One author comments on the intent of the *Indian Act*:

*“The Act spelled out a process of enfranchisement whereby Indians could acquire full Canadian citizenship by relinquishing [their] ties to their community. This involved giving up [one’s] culture and traditions, and any rights to land. The cost of Canadian citizenship for an Aboriginal person ... surpassed the cost for an immigrant from another country. The government of Canada saw the Indian Act as a temporary measure to control Aboriginal Peoples until they were fully assimilated through enfranchisement. [This] clearly failed in Canada, as the rate of enfranchisement was extremely low. [It] was not until the 1960s that this policy changed*

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<sup>30</sup> Canada, *British North America Act, 1867*, VI “Distribution of Powers” Section 91 “Powers of the Parliament”, Article 24. <http://www.justice.gc.ca/en/ps/const/loireg/pl11-3.html> [Last retrieved February 23, 2007]

*and Indians were granted the right to vote in federal elections. This was the first time that the government acknowledged citizenship for Aboriginal Peoples without the condition of the assimilation into the Canadian white society.”<sup>31</sup>*

Under its patriarchal rules, an Indian woman lost her Status if she married a man who did not have Status. On the other hand a non-Indian woman who married an Indian man with Status became a Status Indian.

*“The definition of Indian in the 1876 Act emphasized male lineage. An Indian was defined as any male person of Indian blood reputed to belong to a particular band; any child of such a person; and any woman lawfully married to such a person. If an Indian woman married a non-Indian, she lost her status. The Act and subsequent amendments also continued and furthered the policy of enfranchisement. Various incentives to enfranchise existed, including access to voting rights. Enfranchisement became compulsory in a number of circumstances; for example, it was automatic if an Indian became a doctor, lawyer, Christian minister, or earned a university degree.”<sup>32</sup>*

## Governance of Reserves

Prior to colonization, First Nations and Inuit Peoples had their own systems of government, with distinct and powerful roles of decision-making and influence for women, which varied among the cultures, many of which were matriarchal. Colonization imposed new forms of governance. The patriarchal European system, combined with the imposition of Christian

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<sup>31</sup> Hick, Steven, *Canada’s Unique Social History*, Carleton University School of Social Work, <http://www.socialpolicy.ca/cush/m8/m8-t7.stm#defindenfranchisement> [Retrieved May 11, 2006]

<sup>32</sup> Furi, Megan, Jill Wherrett, *Indian Status and Band Membership Issues*, Library of Parliament, February 1996, revised February 2003, <http://www.parl.gc.ca/information/library/PRBpubs/bp410-e.htm> [Retrieved May 11, 2006]

religion and the suppression of traditional spiritual practices, sometimes through legal means, led to a further demolition of Aboriginal culture and decision-making processes. Specifically, the roles played by women were considerably diminished.

Life on the reserves was overseen by an Indian Agent hired by the federal government, with an excess of imposed rules and regulations often administered in an arbitrary fashion. Part of the governance imposed was the election of Chiefs and Band Councils, replacing traditional methods of choosing leadership. There is ongoing discussion today, including with the federal government, concerning what methods of leadership selection are most appropriate.<sup>33</sup> Important traditional roles women held, that varied among cultures, were not recognized in the new decision-making systems. Only in recent years are women running for Chief and Council positions; although women may have continued to have influence over decisions, men were in the seat of formal decision-making. The Indian agents and the federal department senior administrators were also men.

There are many important decisions made on reserves that influence personal and community health over which women have had little formal authority.

## The Constitution and Charter of Rights

In 1982 the Canadian Constitution was repatriated from England to Canada and some revisions made. As stated earlier, the new Canadian Constitution included Section 35 defining Aboriginal peoples as including Indians, Inuit and Métis people.

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<sup>33</sup> Indian and Native Affairs Canada, "Communities First: First Nations Governance, Saskatchewan Region, November 29, 2001", [http://www.ainc-inac.gc.ca/ps/lts/fng/prev/EA\\_GDG\\_SaskN29\\_e.html](http://www.ainc-inac.gc.ca/ps/lts/fng/prev/EA_GDG_SaskN29_e.html) [Retrieved April 17, 2007]

The *Canadian Constitution Acts 1867-1982* also included the *Canadian Charter of Rights and Freedoms*. Article 25 of the Charter outlines Aboriginal rights:

*"The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including*

*a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and*

*b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired."*<sup>34</sup>

The Charter also provides for the equality of women and men. Article 15 on Equality Rights states:

*"15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."*<sup>35</sup>

Article 28 was also a key article for women:

*"28. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons."*<sup>36</sup>

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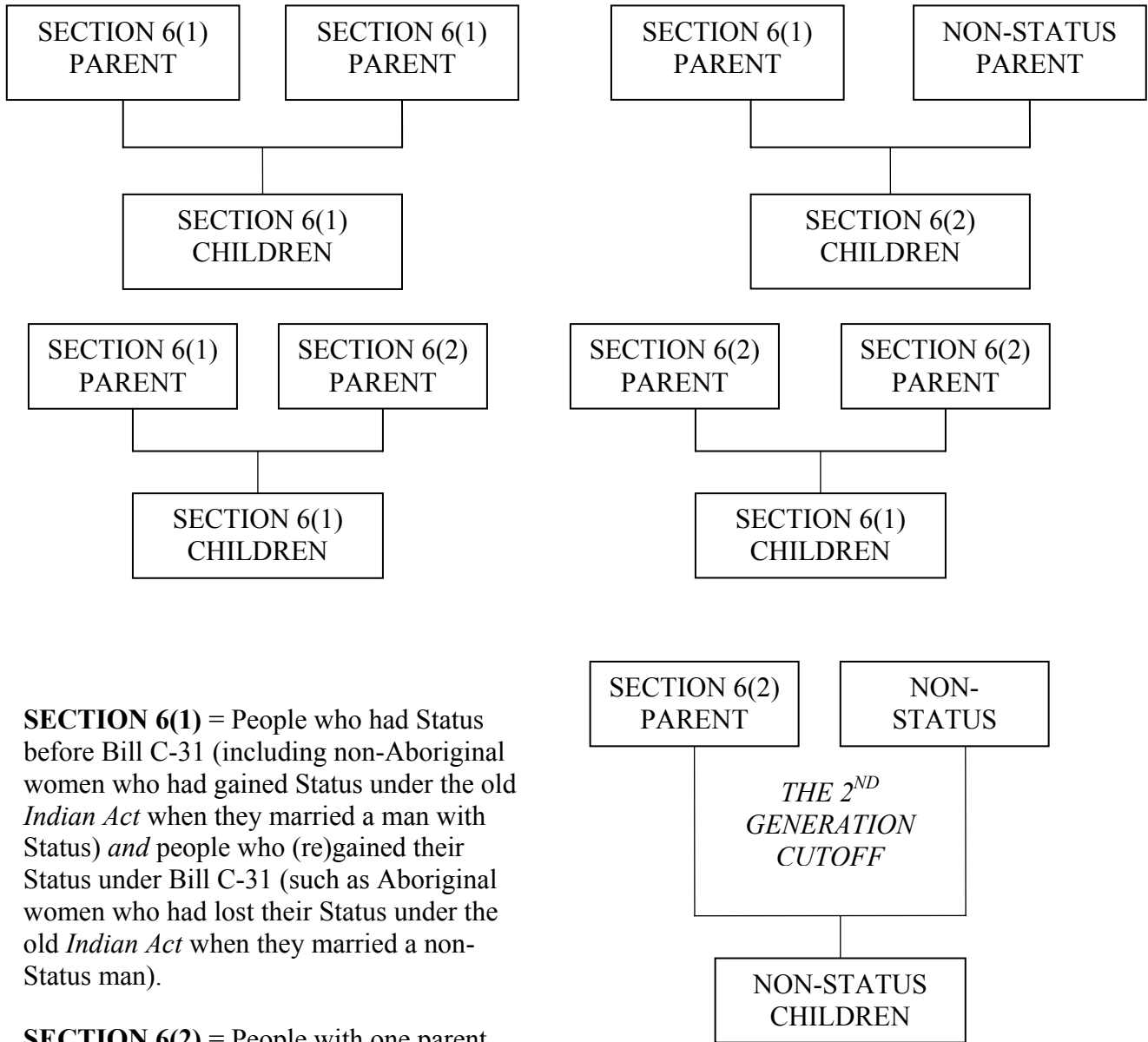
<sup>34</sup> Canada, *Canadian Charter of Rights and Freedoms*, Schedule B, Constitution Act, 1982, Article 25, <http://laws.justice.gc.ca/en/charter/index.html> [Retrieved May 11, 2006]

<sup>35</sup> Canada, *Canadian Charter of Rights and Freedoms*, Schedule B, Constitution Act, 1982, Article 15, <http://laws.justice.gc.ca/en/charter/index.html> [Retrieved May 11, 2006]

<sup>36</sup> Canada, *Canadian Charter of Rights and Freedoms*, Schedule B, Constitution Act, 1982, Article 28, <http://laws.justice.gc.ca/en/charter/index.html> [Retrieved May 11, 2006]

**Figure 1.**

Entitlement to Indian Status under Section 6 of the Bill C-31 amendments to the *Indian Act*, for children born of various parenting combinations (adapted from Clatworthy, and MORN 2005)



**SECTION 6(1)** = People who had Status before Bill C-31 (including non-Aboriginal women who had gained Status under the old *Indian Act* when they married a man with Status) and people who (re)gained their Status under Bill C-31 (such as Aboriginal women who had lost their Status under the old *Indian Act* when they married a non-Status man).

**SECTION 6(2)** = People with one parent entitled to registration under Section 6(1) and one parent not entitled to registration. This includes most of the children of women who had lost their Status for “marrying out” under the old *Indian Act* (notably, it does not include the children of women who gained Status by “marrying in” under the old *Indian Act*).

**Only the children of Section 6(2) parents can be denied Status, on the basis of the 2<sup>nd</sup> generation cutoff.**

## Bill C-31

Bill C-31, “An Act to amend the *Indian Act*”, was passed in 1985. It was intended to comply with the *Canadian Charter of Rights and Freedoms* and correct the sex discrimination in the *Indian Act* that until then stripped women of their Status if they married a man who did not have Status.

According to Section 6(1) of Bill C-31, the following groups are now entitled to registration as Status:

- People who already had Status before Bill C-31 (including women who had acquired Status under the *Indian Act* when they married a Status man)
- People who had been removed from the Indian Register because they or their mother had married a non-Indian
- People who had been removed from the Indian Register through “voluntary” enfranchisement
- People who had been removed from the Indian Register through other forms of involuntary enfranchisement (e.g. for joining a profession or receiving a university degree)
- People whose parents were both entitled to registration under Bill C-31.

It is important to note that Bill C-31 allows people to register for Status, but non-Aboriginal women who gained Status through marriage keep their Status, even after divorce.

Section 6(2) further provides that those people who have one parent who can register under Section 6(1) and one parent who is not entitled to register, are still entitled to register. However, the *children* of people who register under Section 6(2) have different rights and entitlements than do the children of people registered under Section 6(1). This is called the

“second-generation cut-off” (Figure 1, Page 14).<sup>37</sup>

Since its introduction, Bill C-31 has been criticized repeatedly because it has not reduced discrimination against women, but instead has created a new class of half-Status people:

*“The Bill has created new divisions in Aboriginal communities and deepened some old ones - between Aboriginal people who have Status and those who do not, between people living on-Reserve and off, and between people who have band membership and those who do not.”<sup>38</sup>*

*“Bill C-31 was intended to address this sex discrimination and bring the Act into accord with human rights legislation, complying with the Canadian Charter of Rights and Freedoms. However, in the 21 years since it was passed, the Bill has created new problems and issues for Aboriginal women. MORN finds that in fact Bill C-31 has had – and continues to have – devastating effects on the lives of women. Many families and communities have been divided by the Status and membership issues generated by Bill C-31.”<sup>39</sup>*

Although a person may be a Status Indian, it is up to a Band whether she or he is considered a Band member. Entitlements reinstated under Bill C-31 do not necessarily translate into Band membership. This can be problematic for women and their families who have had their Status reinstated through Bill C-31. Women may not have many connections to a Band, or there may be a shortage of resources for such things as housing, education programs or health care on the reserve, so that Bands can be reluctant to accept new members.

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<sup>37</sup> Mother of Red Nations Women’s Council of Manitoba, *Aboriginal Women, Human Rights and Bill C-31 Position Paper* 2006, page 67.

<sup>38</sup> Mother of Red Nations Women’s Council of Manitoba *Bill C-31 Research Project*. 2005.

<sup>39</sup> Mother of Red Nations, August 2006, page 1.

Mother of Red Nations Women's Council of Manitoba notes that women with Status who do not have Band membership cannot and do not always receive the rights, privileges and services to which they are entitled. Therefore a woman who is registered under Bill C-31 may not be able to use on-reserve services, because she is not a Band member and not living on-reserve. A woman who had her Status reinstated through Bill C-31 would still be eligible for the Non-Insured Health Benefits Program. The federal government has been criticized for not providing sufficient funds and resources to accommodate the increased populations and new Band memberships. Band Councils have also been critiqued when Bill C-31 members are treated as second-class citizens.<sup>40</sup>

## Human Rights Act

Section 67 of the *Canadian Human Rights Act* states:

*"Nothing in this Act affects any provision of the Indian Act or any provision made under or pursuant to that Act."*

According to a review in the Library of Parliament Legislative Summaries,

*The sole exception of this nature in the CHRA, section 67 has affected primarily First Nations people governed by the Indian Act, explicitly shielding the federal government and First Nations community governments from complaints of discrimination relating to actions arising from or pursuant to the Indian Act. According to then Minister of Justice Ron Basford, section 67 was a necessary measure in 1977 in light of the government's undertaking not to revise the Indian Act pending the conclusion of ongoing consultations with the National Indian*

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<sup>40</sup> See, for example, the literature review in Mother of Red Nations Women's Council of Manitoba *Twenty-years and ticking: Aboriginal women, human rights, and Bill C-31*. 2006.

*Brotherhood (4) and others on broad Indian Act reform. (5)*<sup>41</sup>

Because of Section 67, it has not been possible to make complaints about discrimination related to matters such as: registration or non-registration of someone as a Band member; use of reserve lands; occupation of reserve lands; wills and estates; education; housing; ministerial decisions with regard to incompetent individuals and guardianship; and the enactment of bylaws.<sup>42</sup>

Thus, First Nations women have not been able to file human rights complaints for the issues listed above, based on sex or gender discrimination. While many of these matters are not part of health services, they are determinants of health. Moreover, the effect on support for education also can affect women in their potential roles as health professionals.

Bill C-44, "An Act to amend the Canadian Human Rights Act", will ensure that the *Canadian Human Rights Act* is fully applicable on-reserve.

*Bill C-44, an Act to amend the Canadian Human Rights Act, received first reading in the House of Commons on 13 December 2006. The bill repeals section 67 of the federal human rights statute, which has restricted access to its redress mechanisms with respect to "any provision of the Indian Act or any provision made under or pursuant to that Act."*<sup>43</sup>

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<sup>41</sup> Mary C. Hurley, *Bill C-44: An Act to amend the Canadian Human Rights Act*, Library of Parliament, Legislative Summaries: LS-546E Section B-1 [http://www.parl.gc.ca/common/bills\\_ls.asp?lang=E&ls=c44&source=library\\_prb&Parl=39&Ses=1](http://www.parl.gc.ca/common/bills_ls.asp?lang=E&ls=c44&source=library_prb&Parl=39&Ses=1) [Retrieved April 25, 2007]

<sup>42</sup> Canadian Human Rights Commission, *A Matter of Rights: A Special Report of the Canadian Human Rights Commission on the Repeal of Section 67 of the Canadian Human Rights Act*, Ottawa, October 2005, pages 2-3, [http://www.chrc-ccdp.ca/proactive\\_initiatives/section\\_67/toc\\_tdm-en.asp](http://www.chrc-ccdp.ca/proactive_initiatives/section_67/toc_tdm-en.asp) [Retrieved April 17, 2007]

<sup>43</sup> Mary C. Hurley, 2007.

Some work is also currently being done to address the additional issues related to Matrimonial and Real Property on reserves.<sup>44</sup> This is especially pertinent to the rights of spouses to housing and to continue to live on a reserve after a divorce.

often relocate to pursue educational or work opportunities, due to domestic difficulties, for better housing or to access health or social services. But the attachment and vested interest in their home reserve remains, and they are still affected by some reserve decisions.

## Voting in Band Elections

Originally, only Band members residing on-reserve could vote in Band elections. The 1999 Corbiere decision by the Supreme Court of Canada declared that Section 77(1) of the *Indian Act* was unconstitutional because it discriminated against the equality rights of Band members who did not reside on a reserve by preventing them from voting. Following the decision the Department of Indian Affairs and Northern Development held a two-stage consultation process. The federal Bill C-7 was intended to address the issues that were raised, but died on the federal Parliament's Order Paper in November 2003.<sup>45</sup>

The extent that changes due to the Corbiere decision are implemented is important, as many First Nations individuals and their families live away from their home reserve. For example, in Saskatchewan, about half of the women who are members of First Nations live off-reserve.<sup>46</sup> They

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<sup>44</sup> Congress of Aboriginal People, "CAP – Corbiere Compliance" [http://www.abo-peoples.org/policy/corbiere\\_compliance.html](http://www.abo-peoples.org/policy/corbiere_compliance.html) [Retrieved April 24, 2007]

<sup>45</sup> Congress of Aboriginal People, "CAP – Corbiere Compliance" [http://www.abo-peoples.org/policy/corbiere\\_compliance.html](http://www.abo-peoples.org/policy/corbiere_compliance.html) [Retrieved April 24, 2007]

<sup>46</sup> Miriam McNab, "First Nations Women in Saskatchewan", *The Encyclopedia of Saskatchewan*, [http://esask.uregina.ca/entry/first\\_nations\\_women\\_in\\_saskatchewan.html](http://esask.uregina.ca/entry/first_nations_women_in_saskatchewan.html) [Retrieved May 24, 2007] "Of 114,248 members of seventy-four First Nations in Saskatchewan in 2003, women comprised 50.7% (57,887). While 28,168 women lived on reserves in the province, 29,719 lived off reserve, according to Department of Indian Affairs records."

## The Métis

In September 2002 the Métis National Council adopted a specific definition that Métis people are people with Indian ancestry and ancestry from the initial European settlers (English, Scottish, Irish and French), who self-identify as Métis, are of historic Métis Nation ancestry, are distinct from other Aboriginal Peoples and are accepted by the Métis Nation.<sup>47</sup> This definition confines the use of “Métis” to descendants of the peoples from the historical settlements in the Prairies, and also includes some Métis from Ontario and British Columbia. Not all people who identify as Métis agree with this definition.<sup>48</sup> Some groups that do have a history dating back to early settlement and who consider themselves as Métis may not have documented links to the historical Métis settlements. People who are of First Nations and other European or Slavic ancestry, Asian or African heritage, who are groups not part of the original historical settlement, may have Status, but if not, would also not be included as Métis.

## Métis Scrip

The federal government does not accept that it has any additional responsibilities for Métis health other than those it holds for the general population of Canada.

*While Treaties were entered into with the Indian nations within Western Canada, the federal government attempted to extinguish the Aboriginal title of the Métis by issuing scrip to the Métis individually. By that action, the government of Canada maintains that the*

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<sup>47</sup> Métis National Council, “Who are the Métis? National definition of Métis”, <http://www.metisnation.ca/who/definition.html> [Retrieved February 23, 2007]

<sup>48</sup> Goulet, George and Terry, *The Metis: Memorable Events and Memorable Personalities*, FabJob Inc, Calgary, 2006, page 159.

*rights of the Métis have been dealt with, and that such rights have been extinguished.*<sup>49</sup>

Scrip was a government-issued certificate entitling the bearer to a specific amount of land or money, but not a specific piece of land. Once the recipient chose the land, it was registered. In some cases, scrip could entitle the bearer of the scrip to obtain the equivalent of the land value in cash from a Land Registry Office.<sup>50</sup>

The *Manitoba Act* of 1870 provided for land grants to the children of Métis families and the *Dominion Lands Act* of 1874 provided for scrip certificates to the heads of Métis families<sup>51 52</sup>

Scrip was offered in those areas where a treaty had already been signed with Indian people, or in areas where a treaty was being negotiated. Métis who were already part of treaties could withdraw and take scrip. There were 12 “Half-Breed Commissions” that enumerated the Métis and issued scrip over the years from 1885 to 1921 in lands that are now parts of Manitoba, Saskatchewan, Alberta and the Northwest Territories. There were variations between the Commissions about who was eligible, as well as challenges in communicating about scrip with Métis people who were living in remote locations and in them attending the Commission hearings to apply for scrip. About two-thirds of the scrip issued was for money scrip.<sup>53</sup> Of those Métis

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<sup>49</sup> Métis Nation of Saskatchewan, “Métis Rights”, <http://www.metisnation-sask.com/rights/index.html> [Retrieved February 2007]

<sup>50</sup> The Other Métis, “Frequently Asked Questions”, <http://www.othermetis.net/MetisFAQ.html> [Retrieved February 2007]

<sup>51</sup> Goulet, George and Terry, *The Metis: Memorable Events and Memorable Personalities*, FabJob Inc, Calgary, 2006, page 147.

<sup>52</sup> Purich, Donald, *The Metis*, James Lorimer & Company, Toronto, 1988, pages 57-74.

<sup>53</sup> *Ibid.* pages 107-116.



who took land, much was sold at discount to land speculators. This left most Métis without a land base.<sup>54</sup> In addition to language and literacy barriers, there were many cases where advantage was taken and Métis people were wrongly persuaded due to poverty or other pressures to exchange their land for money. Also at that time males were considered the head of the family, likely resulting in a lack of control by the women over the fate of the scrip.

Over the years, the inherent value of scrip has changed. Despite no longer having any value for land registry, scrip did generate records of the people who applied, and the records are now a way of identifying Métis families. The Métis National Council had insisted for a time that only Métis whose ancestors were eligible for scrip or land grants could identify as Métis, but later modified this to refer to a Métis “Homeland”. As noted earlier, and as discussed in the next section, the debate over this matter is still ongoing among Métis people. Nevertheless, land grants and scrip processes have become a basis for claims for many western Métis people.<sup>55</sup>

## Métis Definitions

The Native Council of Canada (NCC) was founded in 1971 to represent the interests nationally, of Métis and non-Status Indians, a population that out-numbers all other Aboriginal people combined. The principle of NCC, at that time, was to address their lack of recognition as Aboriginal peoples and to challenge the exclusion of their constituency from federal responsibility.<sup>56</sup>

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<sup>54</sup> Ray, Arthur J., *I Have Lived Here Since the World Began: An Illustrated History of Canada's Native People*, Lester Publishing, Toronto, 1996, pages 262-267.

<sup>55</sup> Dunn, Martin “The Other Métis, Frequently Asked Questions”, <http://www.othermetis.net/MetisFAQ.html> [Last retrieved February 27, 2007]

<sup>56</sup> Congress of Aboriginal Peoples, “Background Information – Political Structure” <http://www.abo-peoples.org/background/background.html> [Retrieved May 15, 2006]

In 1982 the Canadian Constitution included Métis as Aboriginal people, but provided no definition of Métis. In 1983, the Métis National Council (MNC) broke off from the Native Council of Canada and focused on the concept of the “Métis Nation” as a definition of “Métis” in order to help reinforce political and legal claims for support from the federal government and transfer of jurisdictional control similar to that developing with Status Indians.

MNC’s direction comes from the elected leadership of the Métis Nation’s governments from Ontario westward (Métis Nation of Ontario, Manitoba Métis Federation, Métis Nation-Saskatchewan, Métis Nation of Alberta, Métis Provincial Council of British Columbia).<sup>57</sup>

*“Overall, the Métis National Council’s central goal is to secure a healthy space for the Métis Nation’s on-going existence within the Canadian federation.”<sup>58</sup>*

After the MNC left, the NCC reformed into the Congress of Aboriginal Peoples (CAP). CAP’s current mandate is “... to represent off-reserve Indian and Métis peoples regardless of status under the Indian Act.”<sup>59</sup> This includes people living in urban, rural and remote areas of Canada. CAP’s members are provincial or territorial affiliate organizations: Labrador Métis Nation, Federation of Newfoundland Indians, Native Council of Prince Edward Island, Native Council of Nova Scotia, New Brunswick Aboriginal Peoples Council, Native Alliance of Quebec, Ontario Métis Aboriginal Association,

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<sup>57</sup> Métis National Council, “Who is the MNC?” <http://www.metisnation.ca/mnc/index.html> [Retrieved May 15, 2006]

<sup>58</sup> Métis National Council, “Who Are the Métis? FAQ’s”, <http://www.metisnation.ca/who/faq.html> [Retrieved May 15, 2006]

<sup>59</sup> Congress of Aboriginal Peoples, “Background Information – Political Structure”, <http://www.abo-peoples.org/background/background.html> [Retrieved May 15, 2006]

Aboriginal Council of Manitoba, United Native Nations (B.C.), and the C.A.P. National Youth Committee.<sup>60</sup>

During the last several years, Métis organizations across Canada have been consulting with their members, legal experts and historians, to develop a nationally-accepted definition of Métis, agreed to by the Métis people.

The Royal Commission on Aboriginal Peoples recommended:

*"Every person who*

- a. identifies himself or herself as Métis, and*
- b. is accepted as such by the nation of Métis people with which that person wishes to be associated, on the basis of criteria and procedures determined by that nation, be recognized as a member of that nation for purposes of nation-to-nation negotiations and as Métis for that purpose."<sup>61</sup>*

The National Assembly of the Métis National Council passed a motion made on September 27, 2002 with the following definition.<sup>62</sup>

*"Métis means a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal Peoples and is accepted by the Métis Nation."*

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<sup>60</sup> Congress of Aboriginal Peoples, "Affiliates", <http://www.abo-peoples.org/affiliates/index.html> [Retrieved May 15, 2006]

<sup>61</sup> Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples, Volume 5, Renewal: A Twenty-Year Commitment*, Ottawa, 1996, page 241, section 4.5.2 "Métis Identity".

<sup>62</sup> Métis National Council, "Who are the Métis?", National definition of Métis", <http://www.metisnation.ca/who/definition.html> [Retrieved February 23, 2007]

A second motion was passed with the following definitions:

*"Historic Métis Nation" means the Aboriginal people then known as Métis or Half-Breeds who resided in Historic Métis Nation Homeland;*

*"Historic Métis Nation Homeland" means the area of land in west central North America used and occupied as the traditional territory of the Métis or Half-Breeds as they were then known;*

*Métis Nation" means the Aboriginal people descended from the Historic Métis Nation, which is now comprised of all Métis Nation citizens and is one of the "aboriginal peoples of Canada" within s.35 of the Constitution Act of 1982;*

*"Distinct from other Aboriginal Peoples" means distinct for cultural and nationhood purposes.*

The definition confines the Métis people to the descendants of the people from the historical settlements on the Prairies and also includes some people from Ontario and British Columbia. The definition excludes many people who are descendants of Indian and European ancestors, and is not accepted by all Métis.<sup>63</sup> Critics point out that the Constitution refers to Métis people, not the "Métis Nation". There will likely continue to be debate and discussion around these definitions in the future. If the Métis National Council definition is accepted by the federal government as the basis for providing additional health services in the future, there will be people who consider themselves Métis who will be excluded.

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<sup>63</sup> Goulet, George and Terry, *The Metis: Memorable Events and Memorable Personalities*, FabJob Inc, Calgary, 2006, page 159.

## Health Entitlements for Non-Status and Métis People

Despite not being signatories to treaties, for many years, Métis people have been stating that as one of the founding peoples of Canada they should be receiving additional consideration in health and other areas. The Royal Commission on Aboriginal People supported the rights of Métis people based on legal, moral and political reasoning.<sup>64</sup>

Yvonne Boyer, writing for the National Aboriginal Health Organization, states “Since 1982, Aboriginal and Treaty rights have been recognized and affirmed as constitutionally protected rights under Section 35 of Canada’s *Constitution Act, 1982*”.<sup>65</sup> She also notes that although this Act clearly states that the term “Aboriginal” refers collectively to the Indian, Inuit and Métis peoples of Canada, the health policies, services and entitlements differ significantly for these groups. She argues that from a legal standpoint, since non-Status (Indian) and Métis people are included as Aboriginal peoples, they should be entitled to all the health benefits that their First Nations Status counterparts are entitled to, as a result of signed treaties between First Nations communities and the Government of Canada.

According to Boyer, despite the legal recognition and affirmation of both Aboriginal and treaty rights, the federal government of Canada still has not, in good faith, acknowledged what these rights mean in terms of health services to all

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<sup>64</sup> Canada. Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples, Appendix 5A: General Sources of Métis Rights*, Ottawa, 1996. [http://www.ainc-inac.gc.ca/ch/rcap/sg/cj5a\\_e.pdf](http://www.ainc-inac.gc.ca/ch/rcap/sg/cj5a_e.pdf) [Retrieved May 27, 2007]

<sup>65</sup> Boyer, Yvonne, *No. 1 Aboriginal Health: A Constitutional Analysis*. Discussion Paper Series in Aboriginal Health: Legal Issues. National Aboriginal Health Organization and the Native Law Centre, University of Saskatchewan. 2003, page 5.

Aboriginal people. Boyer asserts, “that the provision of health services to First Nations and Inuit Peoples is done as a matter of policy only and not because of any fiduciary obligation, or Aboriginal or treaty right”.<sup>66</sup> Boyer takes her discussions one step further when she argues, within an international human rights context and from the perspective that health is a basic human right, that Canada’s international and domestic obligations are not being met in providing Aboriginal people access to adequate health-related services, given their poor health status.<sup>67</sup>

While governments may work to ensure that non-Status Indian and Métis people have adequate access to health services and work to create better health outcomes for them, this approach based on social policy considerations will not be the same as one based on an acknowledgement that they have an entitlement to health services as founding peoples of Canada.

A recent positive development was the inclusion of Métis representatives in the health policy meetings for the *Blueprint on Aboriginal Health* where First Ministers and leaders of national Aboriginal organizations, including Métis, met to discuss the pressing health issues of First Nations, Inuit and Métis people. The Congress of Aboriginal Peoples, which includes in its mandate non-Status Indians, was also a part of these discussions.<sup>68</sup>

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<sup>66</sup> Boyer, Yvonne, *No. 2 First Nations, Métis and Inuit Health Care: The Crown’s Fiduciary Obligation*. Discussion Paper Series in Aboriginal Health: Legal Issues. National Aboriginal Health Organization and the Native Law Centre, University of Saskatchewan. 2003, page 5.

<sup>67</sup> Boyer, Yvonne, *No. 3 The International Right to Health for Indigenous People in Canada*. Discussion Paper Series in Aboriginal Health: Legal Issues. National Aboriginal Health Organization and the Native Law Centre, University of Saskatchewan. 2004.

<sup>68</sup> Canada, *Blueprint on Aboriginal Health: A 10-Year Transformation Plan*, prepared for the meeting of First Ministers and leaders of National Aboriginal organizations November 24-25, 2005.

## Transfer of Jurisdictional Control

As noted earlier, originally, under the *Indian Act*, all activities on reserves were under the authority of the Indian Agent – appointed by and representing the federal government. Following rules set out by the federal government, Band Councils were formed of elected representatives with an elected Chief. Treaty Councils have been formed among Bands on lands covered by a Treaty and Grand Councils formed of Bands within a geographic area. These larger organizations have an enhanced ability to hire administrative and program delivery staff and administer programs. In recent years some Band Councils, Treaty Councils and Grand Councils have negotiated with the federal government to deliver some health and social services. This is part of a larger movement towards self-governance desired by First Nations.

Locally controlled services have the potential to be more responsive to local needs. Band Councils, Tribal Councils, or Grand Councils will set priorities for services they control, thus the importance as discussed earlier, of further discussions about appropriate decision-making processes suiting First Nations traditions and current situations.

Service delivery may differ between services administered by First Nations organizations and those managed through the federal or provincial governments. In Saskatchewan and Manitoba this is coupled with the variation in services due to differential priority-setting among provincial health regions. The differences can create confusion for women and their families in comparing service availability.

The Native Women's Association of Canada (NWAC) has raised another issue:

*"As jurisdictional control over health is transferred to First Nations, Métis and Inuit communities, measures will be required to*

*ensure that health and social conditions that perpetuate Aboriginal women's inequalities will be eradicated rather than exacerbated. These measures must ensure the unique health needs and rights of Aboriginal women are respected, protected and fulfilled.*

It will be imperative that health models for increased control over the administration, funding and delivery of health services for First Nations, Métis and Inuit peoples all involve participation of independent First Nations, Métis and Inuit women's groups to ensure adequate attention is paid to the particular health needs and rights of Aboriginal women. Policies and protocols based on non-discrimination on the basis of gender should be established, along with adequate representation of Aboriginal women at all levels from service delivery to management of health services."<sup>69</sup>

## Canada-Aboriginal Peoples Roundtable

The Canada-Aboriginal Peoples Roundtable of 2004 "was an unprecedented gathering of Ministers, Parliamentarians and Aboriginal leaders."<sup>70</sup> At the meeting, agreement was reached to hold First Nation, Inuit and Métis consultations on life-long learning, housing, health, negotiations, economic opportunities and accountability, between September and November 2005.<sup>71</sup> The involvement of Métis

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<sup>69</sup> Native Women's Association of Canada, *Background Document on Aboriginal Women's Health For the Health Sectoral Session, Following up to the Canada-Aboriginal Peoples Roundtable*, October 2004, page 7.

<sup>70</sup> Canada-Aboriginal Peoples Roundtable, *Strengthening the Relationship: Report on the Canada-Aboriginal Peoples Roundtable April 19th, 2004*. Ottawa, Canada. [http://www.aboriginalroundtable.ca/rtbl/strenght\\_rpt\\_e.pdf](http://www.aboriginalroundtable.ca/rtbl/strenght_rpt_e.pdf) page 4 [Retrieved August, 2005]

<sup>71</sup> Patterson, Lisa L. *Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005*, Parliamentary Information and Research Service, May 4, 2006, <http://www.parl.gc.ca/information/library/PRBpubs/prb0604-e.pdf> [Retrieved Dec 18, 2006]

people at the Roundtables marks the more recent development of opportunities for pressure and interest in expanding federal responsibilities regarding Métis health. However, to date, few, if any, initiatives have been developed in relation to Métis and non-Status women's health when it comes to access to health care.

The Native Women's Association of Canada has a representative organization in each of the thirteen provinces and territories across Canada. While the Roundtable process was being developed, NWAC requested a roundtable specific to women, but later agreed that it would make each roundtable consider women's concerns more effectively if women's representatives were at each session, mainstreaming women's concerns rather than having them separate.<sup>72</sup> NWAC was an active participant in the Canada-Aboriginal Peoples Roundtable process.

*"NWAC nominated experts as well as hired consultants to research and present on each sectoral meeting topics and, naturally, push for gender specific issues to be brought to the table."<sup>73</sup>*

Details of the progression of the Roundtables are included in Appendix C.

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<sup>72</sup> Conversation with participant Judy Hughes, December 2006.

<sup>73</sup> Native Women's Association of Canada, "Canada-Aboriginal Peoples Roundtable" <http://www.nwac-hq.org/roundtable.htm> [Retrieved May 14, 2006]



## PART 2: ENTITLEMENTS AND HEALTH SERVICES

The *Canada Health Act* outlines the provisions that guide federal, provincial, municipal and territorial governments in the delivery of health care services. Primary responsibility for health care services rests with the provincial governments.

Saskatchewan and Manitoba provincial governments provide full coverage or some cost coverage for a wide range of health services including medical, hospital, surgical, x-ray and other diagnostic, physiotherapy, occupational therapy, chiropractic services, optometry, home care, long term care, mental health, public health, services for persons with disabilities, addictions treatment, health information services, some dental services, prescription drug costs, and some ambulance services. Both provinces also provide some extra coverage for low-income families and individuals.<sup>74 75 76</sup>

Despite the wide range of funded services, the costs for services not covered can pose significant difficulties for women. There is a presumption that employee benefits for private health insurance coverage are widely available and that “most” citizens have such benefits. Women report, however, that part time and low-

paying jobs keep them from buying drugs or health care that they need.<sup>77</sup>

Provinces also administer social welfare systems. First Nation people with Status living on a reserve in Manitoba or Saskatchewan can receive social assistance from the Department of Indian and Northern Affairs under the same terms and conditions as offered by the provincial governments. If First Nations people establish residence off-reserve, they are subject to the same eligibility criteria as other residents for provincial social assistance. Manitoba and Saskatchewan do provide dental care, eyeglasses and other services for people receiving social assistance. In Saskatchewan the social services department, Community Resources, nominates clients to the Department of Health for the supplementary health benefits program. However, a client already covered by NIHB would not be eligible for provincial supplementary health benefits. This may be problematic if the drugs covered under NIHB are inconsistent with those covered by the province of residence.

### The Non-Insured Health Benefits Program

*"Provinces and territories are responsible for delivering health care services, guided by the provisions of the Canada Health Act. Health care services include insured hospital care and primary health care, such as physicians and other health professional services. First Nations people and Inuit access these insured services through provincial and territorial governments, like any other resident.*

*There are a number of health-related goods and services, however, that are not insured by provinces and territories or other private*

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<sup>74</sup> Saskatchewan Health, *It's For Your Benefit: A Guide to Health Coverage in Saskatchewan* November 2003 [http://www.health.gov.sk.ca/mc\\_dp\\_skhealthbooklet.pdf](http://www.health.gov.sk.ca/mc_dp_skhealthbooklet.pdf) "Emergency Transportation" [http://www.health.gov.sk.ca/ph\\_br\\_ae\\_emer\\_transp.html](http://www.health.gov.sk.ca/ph_br_ae_emer_transp.html) [Retrieved December 5, 2006]

<sup>75</sup> Manitoba Health, "Are You Covered?" <http://www.gov.mb.ca/health/mhsip/#insuredmedicalbenefits> [Retrieved November 2006]

<sup>76</sup> Manitoba Family Services and Housing, "Employment and Income Assistance Program" <http://www.gov.mb.ca/fs/assistance/eia.html>, "infohealth Guide to health services in Manitoba" [Retrieved November 2006]

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<sup>77</sup> See for example: Savarese, Josephine, *Exploring the Intersections Between Women's Health and Poverty*, Prairie Women's Health Centre of Excellence, Winnipeg, Manitoba 2004.

*insurance plans. To support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians, Health Canada's Non-Insured Health Benefits (NIHB) Program provides coverage for a limited range of these goods and services when they are not insured elsewhere.”<sup>78</sup>*

The Non-Insured Health Benefits (NIHB) program administered by the First Nations and Inuit Health Branch of Health Canada is the key program available to First Nations people with Status and Inuit people that is not available to Métis people and First Nation people who do not have Status.

### Non-Insured Health Benefits

NIHB benefits are considered for coverage if and when:

- the item or service is on a NIHB Program benefit list or schedule;
- it is intended for use in a home or other ambulatory care settings;
- prior approval or predetermination is obtained (if required);
- it is not available through any other federal, provincial, territorial, or private health or social program;
- the item is prescribed by a physician, dental care provider, or other health professional licensed to prescribe; and
- the item is provided by a recognized provider.

The NIHB covers First Nations people with Status and Inuit people for:

- short-term crisis intervention,
- mental health counseling,
- certain medical supplies and equipment,
- drugs,
- dental care,
- vision care, and
- medical transportation.<sup>79</sup>

A person is eligible for NIHB if she or he is a resident of Canada and meets one of the following criteria: “A registered Indian according to the Indian Act; an Inuk recognized by one of the Inuit Land Claim organizations; or an infant less than one year of age, whose parent is an eligible recipient.”<sup>80</sup>

NIHB requirements include a clause that states,

*“when recipients are eligible for benefits under a private health care plan, or public health or social program, claims must be submitted to these plans and programs first before submitting them to the Non-Insured Health Benefits Program”<sup>81</sup>*

For the most part, the NIHB program is billed directly by the health care service providers. If recipients do pay directly for their goods or services, however, they can apply for reimbursement. Requests for reimbursement must be received on a NIHB Recipient Reimbursement Request Form within one year from the date of service or date of purchase. There is an appeal process for recipients denied a benefit, but it is considered tedious, lengthy and unattractive to women who would rather suffer the outcomes of going without a service than be subjected to government bureaucracy that coincides with the appeal process.

<sup>78</sup> First Nations and Inuit Health Branch, Health Canada, “First Nations and Inuit Health: Benefits”, [http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index\\_e.html](http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html) [Retrieved September 12, 2006]

<sup>79</sup> Ibid.

<sup>80</sup> Ibid.

<sup>81</sup> Ibid.



Eligibility distinctions must also be made between and among First Nation women residing on-reserve, off-reserve, rurally and in cities

when it comes to entitlements and access to health programs and services.

<b>TABLE 1 - Entitlements to Health Services for First Nations and Métis Women</b>				
<b>Group</b>	<b>Location</b>	<b>Entitlements to Services &amp; Programs</b>		<b>Major Issues</b>
		<b>Federal and Provincial Governments</b>	<b>NIHB</b>	
All groups		All services		Services that are not culturally appropriate prevent women from wanting to access these services.
First Nation with Status	On-reserve	All services	All services	All services are not available on-reserve. Women must travel off-reserve to access health services or go without services.
First Nation with Status	Off-reserve in rural or urban setting	All services	All services	Not as many services available in rural setting.
First Nation non-Status	On-reserve	All services	None	Often unable to pay for services that others have covered by NIHB. Not all services are available on-reserve.
First Nation non-Status	Off-reserve in a rural or urban setting.	All services	None	Often unable to pay for services that others have covered by NIHB. Not as many services available in rural setting.
Métis	On-reserve, off-reserve or in a rural or urban setting	All services	None	Often unable to pay for service that others have covered by NIHB. Not as many services available in rural setting.

## Key Issues

For First Nations people with Status, there are many services covered by the provincial health departments and the Non-Insured Health Benefits Program, but there are some costs that are not covered by either the provincial health program or NIHB. Women and men without Status and Métis receive provincial health services, but cannot access the NIHB; people with low income are only eligible for additional health cost coverage if they receive social assistance.

For people entitled to NIHB, the complexity of the program is a problem. The lists of services, health care, equipment and drugs change frequently as there are advances in medicine or new research. And finally, as the budget available changes, certain drugs, equipment or procedures may be added or removed from the lists.

The Assembly of First Nations has produced an in-depth report and a strategy for addressing concerns with NIHB to ensure First Nations people have access to health care services, based on their needs and as their Treaty and inherent rights to health.<sup>82</sup>

Women living off-reserve have different access to care, as a report on the effects of Bill-C-31 reports:

*"For the most part, health care provisions such as eye glasses and prescription medication are covered by Non-Insured Health Benefits equally for those who live on and off reserve.... Access to health services becomes more difficult when someone requires specialized care or medication and resides off First Nations territory. Many specialized services require an individual to live on reserve to get the service or care, or to receive the funding for access. In addition, many of the policies related to criteria or eligibility are further defined by individual band policies and procedures and therefore can be further discriminating about who has access to specialized services."<sup>83</sup>*

A study of Aboriginal people with disabilities in Regina and Saskatoon also found that jurisdictional issues affected service access.

*"This study found that First Nations persons with disabilities usually left their reserves in order to access health and social services. If their disability came as a result of an accident or deteriorating condition, they found that a "temporary" move to the city was necessary to access rehabilitation or treatment. The days evolved into months and the months into years. Without consciously thinking about it, they had developed a new life off reserve. The dream of returning to the reserve gradually faded from memory. Leaving behind*

*their families, First Nation people found loneliness and isolation. They now live in a "foreign" and hostile urban culture where they feel socially excluded. The primary reason for moving into the city was to access services. Interestingly, the federal government directs its health funding through the [then] Medical Services Branch of Health Canada or Indian Affairs. Therefore, in order to access funds for support programs, physical aids and services, First Nations individuals must apply to their Bands for approval for payment, then apply or go to the provincial departments or non-profit organizations for the service or aid. Since they are no longer located on the reserve, these individuals with disabilities get the "ping pong" treatment, shuffled from one agency to another. Provincial government programs are reluctant to become involved and refer these patients to the federal agency: Medical Services refer to the Band government. The Band administrators hold an "out of sight, out of mind" attitude and refer to provincial programs. The situation is extremely frustrating for both clients/consumers of service and professional service providers. The research participants repeatedly and emphatically complained about accessing services and in frustration, they simply "gave up asking". Many reported managing "on my own" without supports and services to which they were fully entitled.*

*The research has indicated some serious issues regarding self-government. In this research, it was determined that the right to self-government by First Nations superseded the rights of the First Nations persons with a disability. This means that the Band and Tribal Councils determine how resources are allocated and can deny individuals access to buildings, employment, training opportunities, and services, if they choose to apply for resources elsewhere."<sup>84</sup>*

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<sup>82</sup> Assembly of First Nations, *First Nations Action Plan for Non-Insured Health Benefits*, April 25, 2005, [http://www.afn.ca/cmslib/general/NIHB%20Action%20Plan\\_Fe.pdf](http://www.afn.ca/cmslib/general/NIHB%20Action%20Plan_Fe.pdf) [Retrieved August 2005]

<sup>83</sup> Mother of Red Nations Women's Council of Manitoba, 2006, page 35.

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<sup>84</sup> Durst, Doug and Mary Bluehardt, *Aboriginal People with Disabilities Vacuum in Public Policy*, Saskatchewan Institute for Public Policy Briefing Note, Issue 6, January 2004, Regina, pages 4-5.

Métis women and First Nations women without Status face a different situation – they are not eligible at all for NIHB. They must pay for extra health services such as eye care or dental services, unless they are receiving social assistance or have some of the costs covered by a health benefits program. This imposes a greater hardship on Métis and non-Status women who experience, as a group, higher rates of unemployment, under-employment and poverty compared with the non-Aboriginal population. As seen in Part 2, there is much discussion about federal fiduciary responsibilities and women’s entitlements not being met.

For women living on-reserve or off-reserve, services may not be culturally appropriate. Women living on-reserve must travel long distances to access many services, and the same is true for other women living in rural areas. Some of the specialized services available on-reserve are not available off-reserve.

For women who carry much of the responsibility for health care in families, there is the difficulty of trying to arrange health care for neighbours or family members who happen to have different Status under the *Indian Act*. This is a source of confusion and tension, as we will see in Part 3.

The fact that jurisdictional difficulties create problems in addressing health issues is also a concern for health professionals. For example, in his presentation, *Aboriginal Health in Canada: In pursuit of equity*, Dr. Michael Green discussed health status, health indicators and how the lack of clear jurisdiction on health issues creates a lack of accountability as well as gaps and grey zones in funding and delivery of services, thus interfering with attempts to improve equity in health status and access to health services.<sup>85</sup>

The interviews with service providers in Part 3 illustrate how the jurisdictional lines are blurred and difficult to navigate, and subsequently affect Aboriginal women and their communities.

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<sup>85</sup> Green, Michael “Aboriginal Health in Canada: In pursuit of equity”, Centre for Health Services and Policy Research, Queen’s University, Kingston  
<http://chspr.queensu.ca/downloads/epid803/2006/November%208%20--%20Aboriginal%20Health%20and%20Equity.ppt> [Retrieved February 27, 2007]



## PART 3: INTERVIEWS WITH SERVICE PROVIDERS

To begin to explore how jurisdictional differences and entitlements affect Métis and First Nations women (with and without Treaty Status) qualitative interviews were conducted with service providers in Manitoba and Saskatchewan,<sup>86</sup> because their positions allow them to observe and comment on how the rules and regulations affect women seeking care.

### Research Process

The interviews used Aboriginal methodologies wherever possible. For example, a reliance on the spoken response is in keeping with oral traditions. Therefore, in the following description of the study results, direct quotes from the women who took part in this study are used as much as possible. As well, the researcher conducting the interviews situated herself within the study as is common when using and integrating an Indigenous methodological narrative approach in research.<sup>87</sup> The study followed both standard and Aboriginal ethical procedural guidelines and received ethical approval from PWHCE.

### Participants

Interviews were conducted with 10 Métis and First Nations female health care workers residing in Manitoba and Saskatchewan. The women were recruited via the use of a non-random, snowball technique. The principal researcher contacted possible participants either by telephone or email and invited them to participate in the study. The potential participants

were asked to fax a signed consent form to the PWHCE office in Winnipeg if they agreed to participate. The interviews were tape-recorded and lasted forty-five to ninety minutes long. The participants were asked to provide demographic information about themselves. They were asked a series of questions related to their experiences in helping Aboriginal women seeking health services and their understanding of the women's rights to health care. If needed, a debriefing period followed each interview to ensure that recalling problematic events did not overly distress the participants.

The participants were told that reports and presentations on the final results might contain direct quotes from the interviews, but that their identity would be kept confidential and no individual names or personal information would be disclosed to anyone outside of the research team.

Six of the women interviewed were from Saskatchewan, and three were from Manitoba. At the time of the interviews five of the women lived in a large centre, three lived on a reserve (two northern), and two lived in non-reserve rural communities (one northern). Five of the women self-identified as having Status, and five were Métis or non-Status. Note that First Nations women referred to in this section include First Nation women who are registered and have Status, and women who do not have Status, that is non-Status women. Also note that in Manitoba and Saskatchewan, First Nations signed Treaties that are the basis for having Status, so that people may be referred to as having Treaty Status or as being Treaty. Métis participants self-identified themselves. The term "other Aboriginal" was used to include consideration of any Aboriginal women who might not fit into the definitions of First Nations or Métis.

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<sup>86</sup> This project is specific to women residing in Manitoba and Saskatchewan but it is recognized that there may be major differences for Aboriginal women living in other parts of Canada due to the diversity of Canadian Aboriginal cultures.

<sup>87</sup> Smith, L, *Decolonizing methodologies: Research and Indigenous Peoples*, Zed Books, London and New York, 1999.

## Questions

A semi-structured interview protocol consisting of nine questions was developed. The interview questions were designed to allow those who work with First Nations and Métis women to speak of women's life experiences in relation to access to health services. An example of one of the questions is, "Do you deal with policies that limit or exclude First Nations, Métis or other Aboriginal women from health services and programs? Please explain." The interview transcripts were analyzed for relevant themes, in relation to current services and traditional knowledge.

## Results – Barriers to Services

All the women interviewed were involved either directly as front line workers or indirectly as managers with helping First Nations, Métis or other Aboriginal women access health services and programs. All the women interviewed stated that they either experienced themselves or witnessed problems related to getting health services and programs as a result of entitlement and jurisdictional issues. They all knew women who had difficulty accessing health programs and services in their areas, no matter if they lived on-reserve, rural off-reserve, off- but near a reserve, or in urban areas. The responses did not differentiate in detail the particulars of access to health services by First Nations and Métis women, but did outline major differences. A number of the barriers to health services were seen to be experienced by all Aboriginal women.

The interviews revealed three significant points:

1. There are a number of significant barriers to health care affecting all Aboriginal women, including issues related to transportation, language, age, health, lack of empowerment, lack of education, and a history of abuse and discrimination.
2. For First Nations women with Status, a lack of awareness of what their entitlements are and what programs and services are available to them as part of the entitlements, keeps women from getting the care they need.
3. Métis and non-Status women lack any additional entitlements beyond what is provided by the provinces, resulting in inadequate coverage of health needs and a sense of lack of rights compared to those with Status.

## Eligibility for Services

As discussed earlier in this paper, eligibility for services and programs covered under the NIHB Program requires that a person must be a Registered Indian according to the *Indian Act*, a narrow and outdated definition. Benefits, however, are also available to an infant under the age of one year, as long as a parent is an eligible recipient; final approval comes from NIHB.

Participants expressed concern that recent cutbacks to the benefits covered by the NIHB program have restricted access to proper medical treatment for some women. For example, as one woman stated,

*"A couple of years ago there was a medication that was quite costly, and the client could not afford it, and they wanted the client to write a letter, but they denied it. It was a prescription for dementia. They wanted the client to write a letter explaining why it was needed, we wrote the letter back, asking how a client with dementia could be expected to write a letter."*

On the other hand, non-Status and Métis women, living on-reserve or in rural or urban settings fare the worst because they have no entitlements and therefore have to rely on other federally and provincially funded health benefit programs that are limited in scope and may not provide adequate coverage. Many people do not have private or employment-related health insurance to cover the extra costs of dental and eye care,

extra prescriptions not covered in the drug formularies or ambulance transport.

*"If you are Métis and you don't have money how are you going to access medicine?"*

As noted in Part 1, Bill C-31 provided for the reinstatement of persons who had lost their Status due to clauses of the *Indian Act*. (For example, Aboriginal women lost their Status if they married a man who did not have Status.) There are many cases of women who have different Status from their children. The fact that only Status women have entitlement to the NIHB creates havoc for Status women whose children do not have Status and for Status women who are married to Métis men who also are not entitled to the NIHB program.

When complaints are voiced, Ottawa officials state that Bands get money for Bill C-31 individuals, and therefore complaints should be addressed to Band leaders. When complaints are taken to the Band officials, they deny that funds are received in this manner. One woman stated,

*"We try to phone people to state our concerns but we get the blind eye you could say from government people because basically the decision making is done through there, so it affects the grass root people. Not really thinking that it is expensive to live up North, not to mention your medical expenses, when you are being flown out of Winnipeg. Or you could be flown to Thompson and then Winnipeg and even all the ambulance bills. You don't have to pay for the air transportation to get you to the nearest care facility, but you have to pay for all those ambulances. It's a burden."*

However, in most cases, if Métis people and people who do not have Status live on a reserve, they will be assisted as much as possible within the constraints of the guidelines set by the NIHB program. One woman stated,

*"It doesn't matter if they are Métis, Status or Non-Status. For Non-Status peoples we do our best here at the clinic to get their*

*equipment or whatever they need provided that they stay on the Reserve, but once they leave the Reserve ... I guess that is when the province or whoever takes over. We are not able to access drugs for them. Basically if they are Non-Status they are on their own. We had a little fund here at the clinic where people who cannot purchase the drugs on their own, we help them out ..."*

The same woman provided another example of the limitations. She stated,

*"We had a client denied a walker, she got a prescription, taken it to wherever, and it was not covered. So (she) came, and we wrote the letter, and they wrote the letter back stating that (she was) not covered unless (she was) oxygen dependent, overly obese, so we purchased a wheeled walker, and lent it to (her)."*

Provincial welfare systems can contribute more stress to the complexity of these health entitlement and jurisdiction issues. One provider gave the following example,

*"I had a person come up to me who lives in the community, but I think that she's Métis, and I don't know if it would make a difference or not that she's on Provincial Welfare, because if you're on Provincial Welfare, and live in the community, that is who gives you your welfare whether you're Treaty or not. I understand that the Mother had a child that was medi-vacc'd to [place], so the Mom obviously went with the child because the child was under age. Three days into whatever was wrong with this child, the Mom was still in [place], and I don't know how this system works, but Income Security got a hold of her, and they were going to start deducting from her welfare check because she was in [place], and they were going to pay the YWCA in [place], and reduce the amount of her monthly check because she was in Thompson."*

Another Manitoba First Nation woman living and working in Winnipeg stated,

*"I think that maybe sometimes there may be some covert exclusion, stemming from a lack of understanding about some of the issues or*

*ability to empower Aboriginal people as well as other cultures as well."*

For the on- and near-reserve health care providers however, there was little difficulty defining and discussing the problems associated with access to programs and services. The providers spoke of difficulties concerning women's lack of awareness of what programs and services are available, what will be covered by their First Nation or other funding sources, discrimination, and the complexity of FNIHB program policies and provincial health policies related to access to medications, services and programs.

In addition to these over-arching concerns, the women interviewed for this project identified 10 barriers related to entitlements and accessing services:

- Transportation
- Inadequate or Insufficient Programs
- Insufficient Knowledge of Programs, Services, and Funding
- Language Barriers
- Discrimination
- Self-esteem
- Poverty and Age
- Child Care
- Lack of Education
- Fear of Abuse and Disclosure

## Transportation

Given the geography of Saskatchewan and Manitoba, community isolation and the vast distances that must be traveled, transportation for medical purposes is a prime issue for all Aboriginal women. Participants spoke of how the mode of transport is determined by Status.

*"We all go to the same health centre but another example would be if I had an appointment in Winnipeg, made by the doctors here. If I had to go I would get a warrant from the nursing station and I would go on the bus. If my daughter, who is Status, went to the nursing station with me, she*

*would fly to Winnipeg, so that's a big thing we see. My brother had an angioplasty done and the next day they wanted to send him home on the bus, and he couldn't even walk. That's through Northern Transportation, so that is government policy. It's mainly because he wasn't Treaty at the time, but now he's Treaty, so now he gets to fly. In Winnipeg if you had to go to Toronto if you were Status you would fly, but if you're not you'd have to take the bus."*

As one interviewee stated, "...if a Métis person is medi-vacc'd out of the community, and if you're not on welfare, you are basically on your own." Non-Status and Métis women who do not have coverage with insurance companies such as Blue Cross and who need medical transportation have to provide their own means to cover the costs. This adds to the stress caused by whatever health issue with which they are dealing.

These kinds of situations are disheartening and most women interviewed for this study commented that these discrepancies in health care entitlements lead to conflicts and discrimination within Aboriginal communities that are not easily addressed. For women who live in the North and who have to deal with both government policy and the policies of organizations such as the Northern Transportation Company that hold government contracts to transport for medical reasons, the problem is further exacerbated. For example, as one woman questioned,

*"Why is Northern Transport covering the cost of the plane but not the cost of the ambulance to get there? The health facility is not at the airport, so the cost of the ambulance should be covered."*

Other transportation issues relate more to the medical taxi service than to government policy. If the medical taxi cannot pick up a patient, the patient will end up not being able to keep her appointment. And in some communities medical taxis have a hard time keeping on schedule. There are not always enough taxis available. One woman stated,



*"If I need a medical taxi at 10 o'clock Friday evening, I may have a hard time finding somebody, or Sunday morning at 7 o'clock."*

These examples must surely contribute to the reasons that underlie the poor health status of Aboriginal women.

### **Inadequate or Insufficient Programs**

There are some programs and health services offered on-reserve, or in near-reserve communities and in rural settings which local people are able to use because they are offered right in the community. However, some of the health care providers are not in the community five days per week. For example, specialists such as dieticians may only go to a community twice a month. Generally most communities, whether they are on or off-reserve, or in a rural or urban setting, do not have enough funding to adequately provide the amount and kinds of health services that are needed by a population whose health status falls well below the average of the general population. One woman stated,

*"We do not offer services in the community such as podiatry, or psychotherapy. We do not provide in-patient, addictions or mental health treatment, so those are services not available in the community. Women ... then would have to travel to (the nearest large town) if they wanted to see, let's say a physician."*

Another woman who lives in urban Saskatchewan recalled,

*"There was a pregnant woman, an i.v. drug user, who came into our clinic for help, but there was no detox available to take her, her baby died...women with addiction...we don't have detox beds available, Moose Jaw and Regina couldn't take her because she was over the first 12 weeks of pregnancy."*

A woman in Manitoba voiced the same concern with some of the services and programs offered through the local health authority. She said,

*"We always believe that a healthy family leads to a healthy community... A lot of the programs that they offer, for example, Baby Best Start, just stuff to benefit the Mom and child and family - we're not getting those services, and we're trying to find out why. We don't have enough exposure to what programs that are out there for us as a community."*

These concerns are examples of how in writing entitlements appear to be honoured. However, the capacity to which the entitlements are honoured also should be considered. The government may say that First Nation people with Status are entitled to all these services or that First Nation, non-Status and Métis women are entitled to the same health services and programs as other Canadian women through the provincial and federal programs. However, if the services are not available and not culturally relevant, the entitlement is not really honoured.

### **Insufficient Knowledge of Programs, Services and Funding**

Aboriginal women suffer the effects of ill health at rates that are alarming. The lack of awareness about what health programs and services are available to them contributes to their plight. An interviewee stated that,

*"The number one reason is because they don't really know what kind of programs that are available for them out there. A lot of the information is available to them, but I think we have to start providing more awareness to First Nations communities in terms of what kind of funding is available to assist them in doing more research projects and also to assist with the Elders."*

On a Manitoba First Nation reserve the situation is even worse.

*"I wouldn't be afraid to say that the service is not what it should be at the First Nations level. For anybody that is really concerned about health, the information is very limited. There are no workshops. There's CHR (Community Health Representatives) but they don't do*

*community visits, like home visits. When it first became available they use to hold monthly meetings to provide this kind of information but this is not happening anymore...because ...the older CHR's died or quit the programs."*

Another respondent pointed to a lack of awareness as a main barrier:

*"I don't believe most of the First Nations do [have an awareness of programs and services] because they still depend on their Chief and Council to [organize] that for them which I see is not right. The Métis women have a good understanding of where they can go for help and what their access or their entitlements for programs but the First Nations don't."*

There was confusion concerning how their community adjacent to a reserve would be included in a regional health authority's needs assessments:

*"Speaking for off Reserve we don't really know what is all out there. For example the Regional Health Authority, which we're supposed to be under, but because we're adjacent to [a] Reserve I understand that when the Health Authority was first starting out, they asked ...if they could do the health assessment needs that had to happen in the community, like a survey, and said no, yet they didn't send the information and ask us, and we're a totally different government body."*

*"The other one I think is the lack of awareness of services. I think that even occurs in the city where you'd think that women should know what services are available. Many women still don't know what the Health Region offers or if they go to self-help groups, so it is a definite lack of awareness of services."*

Understanding what services and programs are available is not much better in an urban setting. A Saskatchewan woman stated,

*"The biggest problem is living in poverty ...those ones will seek out help...they have come to seek out [our Centre]...through word*

*of month...prior to coming they do know they will get free milk, most of them are completely unaware of the programs and services that are available for them because most don't get the paper and watch television."*

There are a high number of transient people who come from a reserve or the North to the cities, and they experience a culture shock of sorts that prevents them, in most cases, from developing an adequate understanding of the health services and programs to which they are entitled. Printed health information, the internet, or a single consultation with a practitioner, are not, in isolation, sufficient to ensure women understand new information.

There are also differences between younger and older women in getting the information they need:

*"Maybe the younger women know what is available and how they can access it. The older women, say around 60 or so, if you don't tell them they don't know. They are so old school that they don't go out and find the information that is needed, they wait for someone to come out and tell them this and that and whatever, and only then they realize what is available."*

The lack of awareness also extends to searching for funding.

*"Not knowing what's out there would be one of the barriers facing Aboriginal women. Under the province, Aboriginal and Northern Affairs have a program called "Recreation and Wellness". I'm asking them to explain what do you mean by wellness? We should know that if we have to apply for funding for something ... so we need to understand what does Aboriginal and Northern Affairs mean by "Recreation and Wellness.""*

Clearly, information is a major issue according to the women interviewed for this study. In many cases, First Nations women with Status, non-Status and Métis women are not aware of their entitlements nor which health services are offered. Indeed, the program that governs their

entitlements is failing to adequately inform them of their entitlements and hence, it indirectly denies them full entitlement.

## Language Barriers

Inappropriate use of language was raised by the participants as one of the reasons women do not know about or receive health services and programs.

*"The barriers would be the awareness of the programming. We need to bring more awareness ... to up-date of what kind of programming is available. And also speaking like when we are doing presentations to communities, we should be speaking in their language, Cree or Saulteaux. This way we're capturing the people that are elderly".*

As one Manitoba First Nation woman stated, "because of the language barrier ... they are afraid to express themselves where their health is concerned." Therefore, the limited entitlements that First Nation women have are greatly hindered by the fact that, in many cases, they are not willing to express themselves when it comes to accessing the service or to speak up if they are not receiving their full entitlements.

## Discrimination

Despite continued improvements aimed at eliminating discrimination based on race, gender, age and stereotypes, there are still many incidences of racism and discrimination reported by Aboriginal women. Racism and discrimination prevent many women from seeking out and obtaining health care services.

A woman interviewed gave this example:

*"We have a lot of complaints about how our people are treated in the hospital, and a lot of it is based on their appearance. You know if they have say for example a real bad earache and you go in there and you seem like you're sort of half cut and right away they assume that you're drunk. So, as you go in there, and because of the color of your skin, they don't treat you the same as everyone else."*

A Manitoba health care worker provided evidence about the situation in her province:

*"Any people they contact, say even some professionals in the health care field, are very domineering like "I know better than you do and you listen to what I say", that kind of attitude."*

It is these kinds of discriminatory practices that prevent First Nation women obtaining their legitimate entitlements. Discrimination also affects Métis and non-Status women, especially if they look "more Aboriginal" and have darker skin. This exacerbates the fact that they first have to suffer the effects of the lack of health entitlements and are then discriminated against when they try to make use of mainstream health services and programs.

A Saskatchewan health care worker explained that she has regularly witnessed bad attitudes towards hard-core street women and addicts:

*"Hard core street women – they feel they can't, they feel shame and guilt, they feel like they failed. They isolate to a place where they can continue using. They don't access any services at all. Addicted women that are on the streets won't go to the doctor. If they develop cysts from using, they will try to take care of it themselves. They don't go because of the attitude society has about these women."*

*"It is really attitudes that prevent people from coming. If they are using at night they sleep at day and nothing is available at night when they are out and about. Downtown area is our world, everyone is there for the same reason and then there is the other world that we don't belong. Most of them have had a negative experience, they over explain themselves at hospitals."*

*"Addicts will not walk into a place with moms holding their babies; they will not feel comfortable walking into that place because of the way it is set up... [saying] "I really need help and there [are] families therewith healthy babies and families." A lot of these women have lost their babies or children to*

*foster care long term, so they will not come in and feel comfortable waiting to see if someone is available to see them, they won't do that."*

## Self-esteem

Some providers noted that a lack of self-esteem or confidence prevents some women from accessing health services and programs and prevents them from speaking out if their entitlements are jeopardized by bureaucratic red tape and discriminatory practices. Comments in this regard include the following:

*"We are sub human...we are less than because we have never been included."*

*"A huge barrier is the Aboriginal people's inability to empower themselves. It is a limitation that has been carved in stone through residential schooling, through stigma discrimination, prejudice. It's something that's been there, carried from one generation to the next."*

*I also think services that are not meeting the unique needs of First Nations women and their families for instance if someone needs an interpreter, and there isn't any available. I think that women who look after their own families tend to be more likely not to look after themselves, and that would create it's own barrier in itself. As women I think that we should think of ourselves as number 1, so that we're there for our grandchildren."*

## Poverty and Age

Poverty is a major issue that affects all areas of Aboriginal women's lives, and difficulties with entitlements to health services add to the problem. This was clearly reflected in the interview data, as was a concern for age and health issues.

*"I think it is their age, and or health, whether they are able to get around on their own, or whether they need an escort with them. Sometimes the independent ones are accessing the services, while the ones who need to rely on others to bring them or care for them, are not coming out. We do provide outreach, but there are still a few elderly women that won't go*

*anywhere without their daughters or whomever."*

The elderly, the most poor and most sick are the individuals suffering the most because of the entitlements issues discussed thus far. Regardless of Status, the lack of entitlements and inadequate services and programs affects the lives of the most vulnerable women.

## Child Care

The Aboriginal population is one of the fastest growing segments of the Canadian population. It is, however, important to note that the majority of the Aboriginal population is very young, so special considerations need to be taken to address this changing demographic. The lack of adequate daycare and babysitting services has been identified as another barrier, as indicated by the following comment:

*"...a lack of reliable babysitting services, if you want to go back to training or school, or even go for in-patient addiction treatment. Especially a lot of women say no because they say 'who is going to look after my children?'"*

## Lack of Education

Although education levels of Aboriginal people are increasing rapidly, there is still a large proportion of the Aboriginal population who lack an adequate level of education. Consequently this further hinders women's ability to access proper health services and programs.

## Fear of Abuse and Disclosure

One service provider remarked that, due to residential school effects and also due to poverty conditions that predispose Aboriginal women to accessing work in the sex trade industry, a fear of sexual assault presents a major barrier for a lot of Aboriginal women in accessing health services. She stated,

*"Fear of sexual abuse is another barrier facing women thinking of accessing health services, for perhaps at some time in their lives they*

*have been abused sexually, and may carry a shame of themselves, and don't want to open up to anyone about their experiences, or fear of that person's perception of them."*

## **Service Providers' Recommendations for Change**

Providers who were interviewed were asked for their ideas and recommendations about what needs to change. The women provided numerous suggestions that are compiled here:

### **Policy Changes**

1. Status women living off-reserve, but near their reserve community should have access to the same services and sources as their on-reserve counterparts.
2. Women who registered under Bill C-31 should have some access to the same services and sources of funding that are given to other women with Status. First Nation communities are receiving funding on their behalf but oftentimes women who were reinstated under Bill C-31 do not receive the benefits.
3. Métis women living in rural areas, on-reserve, near a reserve or in towns and cities should be entitled to the same services as their First Nation counterparts.
4. An Aboriginal ombudsman should be appointed to oversee matters related to entitlement issues under Bill C-31.
5. Women need to be informed and take part in any policy discussions relating to cutbacks or the frequent changes to the NIHB. Presently, most Aboriginal women are not made aware of these changes until they try to access the service and then have to go without because of the cutbacks.

6. Aboriginal people need to be in control and need to make their own decisions when it comes to policies related to their health. One Aboriginal woman stated, "We do not want to be taken care of anymore; we need to be included and not excluded. We need to be 100% responsible for ourselves and our health care."
7. There needs to be more Aboriginal women in positions of power so that Aboriginal women's health needs and concerns do not take a backseat.
8. Health care must be thought of in a holistic manner where everything is interconnected and the social, economic, psychological and political dimensions all intertwine to affect the whole individual. Child-care, education opportunities, employment and training for Aboriginal women should be a priority for all levels of government.
9. More community involvement on all levels is recommended (i.e., health care access, services, programs, research and policy). One woman stated "we have people making decisions about us that do not have a clue of what the needs of the people are."

### **Services and Programs**

10. Federal health organizations have to enhance and give priority to programs that meet the needs of First Nation women and children including increased funding for treatment and healing programs for women because, currently, most Aboriginal women have to leave their community to get help in these and other pertinent health care areas.
11. Provincial Health Government officials need to explore options on how to better meet the needs of First Nation women with Status, non-Status women and Métis women. Health services and programs funded at the provincial level need to be improved in terms

of making them more accessible and culturally relevant.

12. More services and programs that deal with preventative measures and interventions for First Nation women with Status, non-Status, Métis, and other Aboriginal women must be developed.
13. Prevention should be done at the community level. For example, a lot of First Nation women living on-reserve or near-reserve are diabetic and they usually are moved to Winnipeg or put in a personal care home, "...but by the time they get into those homes it is too late already, you know, their health has progressed so badly that there is no cure for anything."
14. More health education programs starting at an elementary level are needed.
15. Northern and other non-reserve communities with high Aboriginal population need to have funds to deal with health issues specific to Aboriginal women who do not have access to NIHB. There is a strong desire to improve Aboriginal women's health status, but resources are needed to do so. More funding resources are needed, regardless of the locale.

## **Elders and Traditions**

16. Elders must be respected. A lot of Elders on the reserves live in shacks, and some of them have no running water. Most of them live in third world conditions with very poor housing, unsanitary conditions and so forth.
17. A sense of community and cultural traditions has to be brought back in all Aboriginal communities, regardless of location.

## **Communication**

18. Produce a newsletter that specifically targets Aboriginal women. The newsletter should contain information on how to access health services, what programs are available for women (i.e., sexual assault centre, women's shelters, specific counseling for women and physical screening for breast cancer), and eligibility for NIHB benefits.
19. Because literacy is a challenge for some women, the newsletter should be produced in plain English. We need to have avenues that bring more awareness to women with a lower formal education level because they, in particular, do not know what the funding is for services or how to access information such as diabetes information.
20. A comprehensive list of funding resources for each community is needed.
21. Community members and advocates need to be trained and employed to go door-knocking so that Aboriginal people can be approached directly, at the grassroots and community level, in order to acquire adequate information on the health care needs of Aboriginal women.
22. All health care field workers who work with Aboriginal women in the Northern communities, on-reserve or in an urban setting, should be fluent in the language of the people they are serving. Aboriginal people have to understand information about the medication they are taking, and they should be fully aware of the side effects of the medication.
23. Aboriginal women and advocates have to be more vocal and attend more workshops that strengthen their resolve to improve health conditions.

24. Province-wide mailing lists should be created in order to increase awareness of all health care programs and services available to Aboriginal women. Currently, in some cases, women find out mostly through just word of mouth, which is a useful but not very efficient system.
25. Partnerships have to be developed because there is an awareness of the benefits of working on Aboriginal women's health issues together.
26. Low health status can be linked to residential school issues that have not been dealt with. Efforts have to be made to increase awareness of residential school issues.

## Jurisdictions

27. Governments and the general population must be educated on the fact that First Nation and Métis peoples are not homogenous groups. As one woman stated, "It almost seems like the general population doesn't understand that there's specific benefits for each of us, and if you are First Nations, you can access as long as you have that 10 digit number but First Nation women without Treaty Status, Métis women, and other women are distinctly different and if they do not have that 10 digit number they do not have access to the same kinds of services and programs."

## Research

28. Research projects must include the youth, the middle aged women and the elderly, because the Elders are the ones that provide their guidance and their wisdom.
29. Innovative ideas have to be developed on how to connect with First Nation, non-Status and Métis women. Aboriginal cultures are traditional oral cultures, so these ideas must encompass those traditions such as research information sessions that include an

invitation to have bannock and tea while participating in the study or distributing health information packages.

30. It was also recommended that there were too many research studies and not enough action taking place when it comes to Aboriginal women's health issues. As one woman stated "we have to quit with all the studies forever, and I don't think we will be writing anything new. Now let's take action." If studies are being conducted, a close examination of what the needs really are should occur only with direct involvement of the community.
31. However, more research is one main recommendation. One woman stated that health research is needed "not only for women, but for First Nations communities as a whole, because also there are different types of health issues that are occurring in our community."
32. More preventative measures and interventions must take place, but first these measures and interventions must be identified through solid community-based research.





## PART 4: DISCUSSION AND CONCLUSIONS

There is no shortage of documentation about the poor health status of Aboriginal peoples in Canada, including women. Despite the many materials written and the promises of programs and funds, the situation persists.

However the ambiguity about who is being discussed in research and policy remains. As we have seen, the term “Aboriginal” serves as an over-arching term for the original people of Canada. But more specific concepts are needed when discussing health care services and access to care. Every new report or manuscript should include a precise description of the Aboriginal women or men involved.

Entitlements to health care services are complicated by over 400 years of colonization and more than 150 years of legislation. In Manitoba and Saskatchewan the early land treaties set principles of federal fiduciary oversight for many services, including the responsibilities for providing health care, thus making a distinction between those with Status and those without Status. Métis peoples were not included in the treaties and only some were even eligible for scrip. The segregation was perpetuated in ensuing legislation, including through the *Indian Act*, its revisions and the more recent amendment, *Bill-C31*.

Complicated as the NIHB system is for First Nations, the system is non-existent for Métis residents in Manitoba and Saskatchewan. As explained, Métis residents are entitled to only those health care services available to all provincial residents. Settlement patterns, family ties, and geography have contributed to having some people receiving health care on one side of the road (or lake) and others not.

### Health Research that Recognizes Health Entitlements

There has been limited research done on the health and factors that influence the health of Aboriginal women (see Bennett, for example).<sup>88</sup> While the poor health status of First Nation women has been documented, there are less data available about Métis women. And there has been limited research done on the positive health practices women are taking.<sup>89</sup> Aboriginal organizations are now taking more of a lead in guiding new research that is culturally appropriate. Note as well that there are important protocols and ethics standards that have been developed for doing research with, for and by Aboriginal women.<sup>90</sup>

All health researchers must be very clear about whom, and with whom, they are conducting their studies as it will affect results and subsequent recommendations. Any research or new study examining determinants of health, healthy living, health care access, wait times, or service provision must be very clear about the population to be studied or involved in the study and their entitlements to health care services. Researchers must bear in mind that even members of the

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<sup>88</sup> Bennett, Marlyn, *Annotated bibliography of Aboriginal women's health and healing research*, Aboriginal Women's Health and Healing Research Group, Vancouver, British Columbia, 2005.

<sup>89</sup> Ibid. page 44.

<sup>90</sup> See for example, Saskatoon Aboriginal Women's Health Research Committee, *Ethical guidelines for Aboriginal women's health research*, Prairie Women's Health Centre of Excellence, Saskatoon, Saskatchewan, 2004. <http://www.pwhce.ca>

same family may be technically entitled to different health care.

Researchers must become familiar with the study community's history and then learn how women of the community can or cannot make use of the project, program or service examined. A research study of health care access requires this historical and entitlement account to set the context fully.

There are numerous communities in Manitoba and Saskatchewan (Cross Lake and The Pas, for example) where reserve and non-reserve lands are adjacent to each other and the residents daily move from one side to the other, but cannot necessarily seek or receive the same health care services.

Research based on existing administrative, survey, population and other data sets is limited by how populations were included. For example Statistics Canada uses several methods for identifying Aboriginal ancestry, most often using a broad definition, allowing survey and census respondents to self-identify as having Aboriginal ancestry. However some First Nation reserves refused to take part in some national surveys (Census Canada, for instance), and in other cases survey design did not include residents of the northern territories, most of whom are Aboriginal (e.g. Canadian Community Health Surveys).

Manitoba Health, in contrast, collects health utilization data about all Manitobans and data can be retrieved about those persons who voluntarily declare their First Nations status to Manitoba Health.<sup>91</sup> The Manitoba Vital Statistics registry of deaths, however, includes as "First Nations" all those, and only those, whose place of residence at the time of their death was a First Nations Reserve, thus excluding all Aboriginal Manitobans who live off-reserve and making no distinction about Métis or Status.<sup>92</sup>

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<sup>91</sup> The process is similar in Saskatchewan.

<sup>92</sup> Donner, L., H. Isfeld and M. Haworth-Brockman. 2006. *Manitoba field testing of gender-sensitive core set of*

Smylie and Anderson summarize the numerous limitations in the existing data sets.<sup>93</sup> The authors also note that the population health measures used were by and large set by non-Aboriginal people and do not yet include health measures that reflect Aboriginal health concepts. The authors state "...data coverage and quality, data jurisdiction and utility, data governance and relevance and infrastructure and human resource capacity"<sup>94</sup> are challenges to any measure of Aboriginal health in the existing health measurement systems. That is, *using or interpreting these data without the context of health entitlements can lead to erroneous information* about the health of a population.

## Health Policy that Recognizes Health Entitlements

The terminology we have explored in this paper also needs to be understood by all policy-makers in health and other sectors. As in research, the term "Aboriginal" is a useful term, enshrined in the Canadian Constitution. However, it is essential that policy work differentiate among people with regard to their entitlements. Those writing, or indeed, interpreting policy relating to health care services must be specific with who is being served.

Information gathering for policy purposes should include news items, reports, and consultations that draw in and recognize the views of people with differing health care entitlements. And naturally, they also need to recognize the differences between determinants of health,

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*leading health indicators*, World Health Organization and Prairie Women's Health Centre of Excellence. Available from [pwhce@uwinnipeg.ca](mailto:pwhce@uwinnipeg.ca)

<sup>93</sup> Smylie, J., and M. Anderson. 2006. "Understanding the health of Indigenous peoples in Canada: key methodological and conceptual challenges", *Canadian Medical Association Journal* 175(6): 602-605.

<sup>94</sup> Ibid.

health status, and health services accessed for men and women. Protocols and suitable consultation methods will vary among the different groups.

Involving groups in decision-making processes is another area in which it is critical to have men and women representing the groups with differing health entitlements and access to services. This includes considering Status as well as geographic location, in particular.

Communication about consultations and policy recommendations also needs to take into account the communication approaches that will work successfully with the different groups of Aboriginal men and women.

## **Remembering Women**

Lost in the confusion often are the women themselves. As we've seen in Part 3, Aboriginal women and the people who wish to assist are equally enmeshed in the words and regulations.

Although they are directly affected, the women may not have the time or thorough explanations to fully comprehend the complex details of evolving policies and regulations, which is a source of confusion.

But the women recognize the inconsistency between the treatment of First Nation people with Status, those who do not have Status, and Métis people.

The women health care providers interviewed for this study and the women they work with see access to services as linked with a number of factors affecting their lives, and state that these factors need to be taken into consideration and addressed. They also emphasize that work needs to be done to ensure a more sensible and equitable way to provide health services to all Aboriginal people, whether First Nations, Métis, Inuit.



# APPENDIX A

## An overview of the First Nations and Métis population in Manitoba and Saskatchewan (Census Canada 2001)<sup>95</sup>

Living Location of North American Indian and Métis People in Saskatchewan and Manitoba, 2001 Census <sup>96</sup>										
		Total	Girls and Women				Boys and Men			
			Total	On-reserve	Rural non-reserve	Urban	Total	On-reserve	Rural non-reserve	Urban
Numbers										
Manitoba	North American Indian	90,345	46,930	24,870	4,230	17,830	43,415	26,100	3,580	13,735
	Métis	56,795	28,615	320	8,035	20,260	28,185	350	8,530	19,305
Saskatchewan	North American Indian	83,745	43,165	21,560	4,000	17,605	40,580	22,135	3,500	14,940
	Métis	43,695	22,260	1,400	6,985	13,870	21,435	1,405	7,370	12,660
Percentages										
Manitoba	North American Indian		100 %	53 %	9 %	38 %	100 %	60 %	8 %	32 %
	Métis		100 %	1 %	28 %	71 %	100 %	1 %	30 %	69 %
Saskatchewan	North American Indian		100 %	50 %	9 %	41 %	100 %	54 %	8 %	36 %
	Métis		100 %	6 %	31 %	62 %	100 %	6 %	43 %	59 %

<sup>95</sup> Adapted from Statistics Canada, *2001 Census, Aboriginal Peoples of Canada*, Topic-based tabulations, Table 23 (Aboriginal Identity (8), Age Groups (11B), Sex (3) and Area of Residence (7) for Population, for Canada, Provinces and Territories, 2001 Census – 20% Sample), Cat. No. 97F0011XCB2001001, <http://www12.statcan.ca/English/census01/Products/standard/themes/DataProducts.cfm?S=1&T=45&ALEVEL=2&FREE=0> [Retrieved July 2007]

<sup>96</sup> This table includes people for whom a single identity was reported. There were also some Inuit people, some who reported multiple backgrounds and some who were members of a band who did not report an Aboriginal identity – there groups are not included in this table. Percentage totals may not add to 100% due to rounding.

Of the Saskatchewan girls and women who stated in the Census that they had a North American Identity, 50% lived on a reserve while 9% lived in a rural non-reserve area and 41% in an urban area. Boys and men with a North American Identity were slightly more likely than the girls and women to live on a reserve – 54% lived on a reserve. Métis people were more likely to live in an urban setting. Of the Saskatchewan Métis girls and women, 6% lived on a reserve, 31% in a rural non-reserve location and 62% in an urban location. At 34%, Métis men were slightly more likely to be living in a rural non-reserve area.

Of the Manitoba girls and women who stated in the Census that they had a North American Identity, 53% lived on a reserve while 9% lived in a rural non-reserve area and 38% in an urban area. At 60%, Manitoba North American Indian Identity boys and men were the most likely to be living on a reserve.

Métis women and men were much more frequently living in an urban location. Of the Manitoba Métis girls and women, 1% lived on a reserve, 28% in a rural non-reserve location and 71% in an urban location. Métis boys and men were very slightly more likely to be living in a rural non-reserve area.

Comparing the two provinces, the Manitoba boys and men of North American Indian Identity were most likely to be living on a reserve. Manitoba Métis people were most likely to live in an urban location. And Saskatchewan Métis people were more likely to be living on a reserve than those in Manitoba – 6% compared to only 1%.

# APPENDIX B

## Relevant Organizations

First Nations, Métis, Inuit and other organizations are playing a strong role in national and regional leadership and policy-making around health, among many other issues and organizations also may have a measure of control over the management of health services. These same organizations and conduct their own research and policy-analysis that should be reviewed in doing research and policy analysis related to the health of Aboriginal women.

The role of women is receiving increased formal recognition, through the creation of Women's Councils or other committees within Aboriginal organizations.

Other women's organizations not directly affiliated with governing bodies have played an important role regarding Aboriginal health. These groups typically include women of any Aboriginal background – providing a perspective that cuts across the lines drawn by other organizations and jurisdictions.

Organizations representing Aboriginal women have also played an important role in health care – whether through identifying and providing public education or self-help processes, organizing and supporting health services on a volunteer basis or through formal organizations, or by contributing to policy discussions around health within Aboriginal political organizations and at the local, provincial and national levels.

## National Level Organizations

### Aboriginal Nurses Association

The Aboriginal Nurses Association of Canada (ANAC) is a non-governmental, non-profit organization established out of the recognition that Aboriginal people's health needs can best be met and understood by health professionals of a similar cultural background. As an affiliate group of the Canadian Nurses Association, it is the only Aboriginal professional nursing organization in Canada. ANAC has completed various reports outlining how Aboriginal women face a number of barriers that prevent them from getting adequate health care.<sup>97</sup>

### Aboriginal Women's Health and Healing Research Group

The Aboriginal Women's Health and Healing Research Group is a national network of First Nations, Métis and Inuit women researchers interested in community-based research focused on the health of Aboriginal women, their families and communities.<sup>98</sup>

### Assembly of First Nations

The Assembly of First Nations (AFN) is the national organization representing First Nations citizens in Canada. AFN has completed a number of policy reports related to health issues.<sup>99</sup>

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<sup>97</sup> Aboriginal Nurses Association of Canada, <http://www.anac.on.ca/publications.html> [Retrieved August 2005]

<sup>98</sup> Aboriginal Women's Health and Healing Research Group, <http://www.awhhr.ca> [Retrieved December 15, 2006]

<sup>99</sup> Assembly of First Nations, "Policy Reports", <http://www.afn.ca/article.asp?id=103> [Retrieved August 2005]; First Nations Action Plan For Non-Insured Health Benefits April 25, 2005 <http://www.afn.ca/cmslib/general/>

AFN points out federal fiduciary obligations in relation to the fact that “the Crown has consistently disputed recognition of Treaty rights to health or health care, except for certain specific treaties, and the scope and content of the fiduciary duty”.<sup>100</sup>

In 2004 AFN held the “National Policy Summit on Developing and Implementing a First Nations Health Action Plan”. AFN’s primary goal was to develop a First Nations Health Action Plan that is First Nations controlled and sustainable and that adopts a holistic, culturally appropriate approach.<sup>101</sup> The results from a session on First Nations’ jurisdiction in health and mechanisms for engaging with Federal, Provincial and Territorial Health Care Systems indicate that much work is still needed in this area despite all the promises of rectifying the problem. This summit was a first step in gathering information for the *Blueprint on Aboriginal Health*.

In 2005, the AFN and the federal government made a joint commitment to bring the health status of First Nations people up to the Canadian

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[NIHB%20Action%20Plan\\_Fe.pdf](#) [Retrieved August 2005]; and, “Update on the Canada-Aboriginal Peoples Roundtable follow-up September 2004.” <http://www.afn.ca/article.asp?id=417> [Retrieved August 2005]

<sup>100</sup> Assembly of First Nations, *First Nations Action Plan For Non-Insured Health Benefits, April 2005*. [http://www.afn.ca/cmslib/general/NIHB%20Action%20Plan\\_Fe.pdf](http://www.afn.ca/cmslib/general/NIHB%20Action%20Plan_Fe.pdf), page 1. [Retrieved August 2005]

<sup>101</sup> Assembly of First Nations, *National Policy Summit On Developing and Implementing A First Nations Health Action Plan held October 28–29, 2004 at the Winnipeg Conference Centre*, <http://www.afn.ca/cmslib/general/National-Policy-Summit200546142311.pdf> [Retrieved August 2005]; *First Nations Health Action Plan: First Ministers Meeting September 2004. Part I*. <http://www.afn.ca/cmslib/general/Action-Plan-1.pdf> [Retrieved August 2005]; *First Nations Health Action Plan: First Ministers Meeting September 2004. Part II*, <http://www.afn.ca/cmslib/general/Action-Plan-2.pdf> [Retrieved August 2005].

average by 2015.<sup>102</sup> The AFN was a full participant in the Canada-Aboriginal Peoples Roundtable Process.

## AFN Women’s Council

The AFN Women’s Council is dedicated to ensuring “that First Nations women’s perspectives are included in all policy directives and activities, in addition to ensuring that the AFN is an effective advocate on behalf of first Nations women.”<sup>103</sup>

The AFN Women’s Council has been active at a number of national meetings including meetings on issues such as health and healing, corrections, family violence, youth and gender-based analysis.

## Congress of Aboriginal Peoples

*The Congress of Aboriginal Peoples (CAP) was founded in 1971 as the Native Council of Canada (NCC). It was established to represent the interests nationally of Métis and non-status Indians, a population that outnumbered all other native people combined ...to address the lack of recognition of themselves as Aboriginal peoples and to challenge the exclusion of our constituency from federal responsibility.*<sup>104</sup>

The Native Council of Canada (NCC) re-formed into CAP after the Métis National Council broke from the NCC in 1983.

The current mandate of CAP is “... to represent off-reserve Indian and Métis peoples regardless

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<sup>102</sup> Karen Howlett, “Fontaine to seek premiers' support for overhaul of native health care”, *Globe and Mail*, Tuesday, August 9, 2005, page A4.

<sup>103</sup> Assembly of First Nations – “AFN Women’s Council” <http://www.afn.ca/article.asp?id=133> [Retrieved July 2007]

<sup>104</sup> Congress of Aboriginal Peoples, “Background Information – Political Structure”, <http://www.abo-peoples.org/background/background.html> [Retrieved May 15, 2006]



of status under the Indian Act.”<sup>105</sup> This includes people living in urban, rural and remote areas of Canada. CAP’s members include provincial and territorial affiliate organizations: Labrador Métis Nation, Federation of Newfoundland Indians, Native Council of Prince Edward Island, Native Council of Nova Scotia, New Brunswick Aboriginal Peoples Council, Native Alliance of Quebec, Ontario Métis Aboriginal Association, Aboriginal Council of Manitoba, United Native Nations (B.C.), C.A.P. National Youth Committee.<sup>106</sup>

CAP has also conducted work related to health access and entitlements and outlined key issues for the Aboriginal Peoples Roundtable relating primarily to jurisdictional issues as they affect Aboriginal people who do not live on a reserve. CAP restate the federal government’s fiduciary obligation to *all* Aboriginal people, regardless of Status or residence on-reserve or off-reserve, and contends that the provincial governments’ constitutional responsibility for the delivery of health care within their jurisdictions also must be upheld.<sup>107</sup>

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<sup>105</sup> Congress of Aboriginal Peoples, “Background Information – Political Structure”, <http://www.abo-peoples.org/background/background.html> [Retrieved May 15, 2006] See the table “Types of CAP Constituents Created by Federal Legislation” for the people that CAP includes in its mandate. <http://www.abo-peoples.org/background/ConsituencyTable.htm>

<sup>106</sup> Congress of Aboriginal Peoples, “Affiliates”, <http://www.abo-peoples.org/affiliates/index.html> [Retrieved May 15, 2006]

<sup>107</sup> Congress of Aboriginal Peoples: *Health Care in Crisis for Off-Reserve Aboriginal People. Congress of Aboriginal Peoples Background Paper for the Aboriginal Health Round Table, November 4 & 5, 2004*, <http://www.abo-peoples.org/RoundTable/Backgrounders/HealthBkgnd.pdf> [Retrieved August 2005]; *Accord on Cooperative Policy Development between the Congress of Aboriginal Peoples and the Government of Canada*, <http://www.abo-peoples.org/RoundTable/PolicyAccord.pdf> [Retrieved August 2005]; “Notes for Remarks by Dwight A. Dorey, M.A. National Chief Congress of Aboriginal Peoples To the Canada/Aboriginal Policy Retreat, Ottawa, Ontario Tuesday, May 31, 2005”. <http://www.abo-peoples.org/RoundTable/05-05-31-Retreat%20Speech%20final.pdf>

## Inuit Tapiriit Kanatami

Formed 30 years ago, the Inuit Tapiriit Kanatami (ITK) is the national Inuit organization in Canada, representing four Inuit regions – Nunatsiavut (Labrador), Nunavik (northern Quebec), Nunavut, and the Inuvialuit Settlement Region in the Northwest Territories. ITK has worked on the settlement of comprehensive land claim agreements in the four Inuit regions.

ITK worked to protect Inuit rights and ensure their inclusion in the Canadian Constitution. ITK continues its efforts to improve living conditions for Inuit economically and socially, including health, working in a holistic way to address all factors. ITK has a Health Department that identifies health priorities and represents national Inuit health interests. The Department is advised by the National Inuit Committee on Health. ITK was a participant in the Canada Aboriginal Peoples Roundtable.<sup>108</sup>

## Métis National Council

The Métis National Council (MNC) was formed from a group that had moved away from the Native Council of Canada in 1983.<sup>109</sup> MNC receives its direction from

*“...the Métis Nation's governments from Ontario Westward (Métis Nation of Ontario, Manitoba Métis Federation, Métis Nation-Saskatchewan, Métis Nation of Alberta, Métis Provincial Council of British Columbia)... Overall, the Métis National Council's central*

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[Retrieved August 2005]; “Indian Act / Bill C-31”, <http://www.abo-peoples.org/programs/C-31/c-31.html> [Retrieved August 2005]; “RCAP Report Supports Resource Rights for All Métis”, <http://www.abo-peoples.org/Communications/Backgrounders/RCAPmetis.html> [Retrieved August 2005]

<sup>108</sup> Inuit Tapiriit Kanatami, “Inuit Tapiriit Kanatami” <http://www.itk.ca/> [Retrieved May 27, 2007]

<sup>109</sup> Métis National Council, “Who is the MNC?” <http://www.Métisnation.ca/mnc/index.html> [Retrieved May 15, 2006]

*goal is to secure a healthy space for the Métis Nation's on-going existence within the Canadian federation.*<sup>110</sup>

As discussed earlier in this paper, MNC has created a definition of Métis.

MNC was an active participant in the Federal Roundtable process and continues to play an active role in consultations with the federal government regarding health.<sup>111</sup>

## MNC - Women of the Métis Nation

The Métis National Council structure includes the Women of the Métis Nation committee and the Métis Women's Secretariat. The Secretariat

*"...seeks input from Métis women and facilitates their full and equal participation within the Métis Nation. Through its participation at the national level, the Métis Women's Secretariat ensures that the unique concerns and issues of Métis women are brought forward".*<sup>112</sup>

## National Aboriginal Health Organization

The National Aboriginal Health Organization (NAHO) is "...an Aboriginal-designed and controlled body committed to influencing and advancing the health and well-being of Aboriginal Peoples through carrying out knowledge-based strategies." NAHO's objectives are to:

- *Improve and promote Aboriginal health through knowledge-based activities.*

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<sup>110</sup> Métis National Council, "Who Are the Métis? FAQ's", <http://www.Métisnation.ca/who/faq.html> [Retrieved May 15, 2006]

<sup>111</sup> Métis National Council, "Métis Nation Cabinet – Health" <http://www.metisnation.ca/cabinet/health.html> [Retrieved May 25, 2007]

<sup>112</sup> Métis National Council, "Métis Women", <http://www.Métisnation.ca/women/index.html> [Retrieved May 15, 2006]

- *Promote an understanding of the health issues affecting Aboriginal Peoples.*
- *Facilitate and promote research on Aboriginal health and develop research partnerships.*
- *Foster the participation of Aboriginal Peoples in delivery of health care.*
- *Affirm and protect Aboriginal traditional healing practices.*<sup>113</sup>

## Native Women's Association of Canada

Native women's organizations from across Canada formed the Native Women's Association of Canada (NWAC) in 1974. Thirteen Provincial and Territorial Member Associations provide connections to Aboriginal communities, and input to the NWAC Board and Annual General Assembly.

*"The Native Women's Association of Canada (NWAC) is founded on the collective goal to enhance, promote, and foster the social, economic, cultural and political well-being of First Nations and Métis women within First Nation and Canadian societies.... Much like a "Grandmother's Lodge", we as aunts, mothers, sisters, brothers and relatives collectively recognize, respect, promote, defend and enhance our Native ancestral laws, spiritual beliefs, language and traditions given to us by the Creator."*<sup>114</sup>

NWAC's mission is

*"To help empower women by being involved in developing and changing legislation which affects them, and by involving them in the development and delivery of programs"*

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<sup>113</sup> National Aboriginal Health Organization, About NAHO", [http://www.naho.ca/english/about\\_naho.php](http://www.naho.ca/english/about_naho.php) [Retrieved December 15, 2006]

<sup>114</sup> Native Women's Association of Canada, "PTMA's", <http://www.nwac-hq.org/ptma.php>. [Retrieved December 5, 2006]

*promoting equal opportunity for Aboriginal women.*"<sup>115</sup>

A key development has been, after a long struggle for recognition, the formal inclusion of the Native Women's Association of Canada in federal/provincial/territorial/Aboriginal discussions about health and other issues.<sup>116</sup>

### **Pauktuutit - Inuit Women of Canada**

Pauktuutit represents Inuit women of Canada for the betterment of Inuit women, their families and communities.

*"Pauktuutit fosters greater awareness of the needs of Inuit women, advocates for equity and social improvements, and encourages their participation in the community, regional and national life of Canada."*<sup>117</sup>

The organization works in policy development and community projects. Pauktuutit strives to promote self-confidence and self-reliance; motivate Inuit women to realize their potential as individuals and as a group; provide Inuit women with a united voice; and, encourage them to take their rightful place in society and be involved in all levels of Canadian society. Another goal is to promote equity for the independent view of Inuit women in all levels of Canadian governmental and non-governmental structures and facilitate collaboration between Inuit women and other Aboriginal people.

In its concern for culture, Pauktuutit provides resources to ensure that children are raised with Inuit values, heritage, culture and language. Pauktuutit promotes the rights and interests of

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<sup>115</sup> Native Women's Association of Canada, "About Us", <http://www.nwac-hq.org/about.htm> [Retrieved May 14, 2006]

<sup>116</sup> Native Women's Association of Canada, <http://www.nwac-hq.org/home.htm> [Retrieved May 12, 2006]

<sup>117</sup> Pauktuutit- Inuit Women of Canada, "About Us" <http://www.pauktuutit.ca/> [Retrieved May 27, 2007]

Inuit women and children; works towards better social, economic and political conditions for Inuit women; and strives for better individual, family and community health conditions.

## **Provincial Level Organizations**

### **Assembly of Manitoba Chiefs**

In Manitoba the Assembly of Manitoba Chiefs (AMC) represents 64 First Nations in the province.<sup>118</sup> AMC has a Health Secretariat with a Health Committee composed of Chiefs and supporting staff. AMC prepared the *Manitoba First Nations Health and Wellness Strategy – a 10-year Plan* for input into the federal and provincial process for the *Blueprint on Aboriginal Health* process and worked to establish a blueprint specific to First Nations.

*"With regard to government policy and programming, AMC continues to challenge the limitations and barriers First Nations people face when accessing health care both on- and off-reserve. Formal recognition of the Treaty Right to Health remains as AMC's primary objective when addressing health concerns and some progress has been made to ease the access to and delivery of health care services in Manitoba. While progress has been made, the challenge remains to ensure First Nations have a full seat at the government table when designing policy and programs for First Nations."*<sup>119</sup>

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<sup>118</sup> Assembly of Manitoba Chiefs, "Manitoba First Nation Chiefs", <http://www.manitobachiefs.com/chiefs/chiefs.htm> [Retrieved May 12, 2006]

<sup>119</sup> Assembly of Manitoba Chiefs, "Health Secretariat", <http://www.manitobachiefs.com/health/health.html#sectHealth> [Retrieved May 12, 2006]

## AMC-First Nations Women's Council

The AMC First Nations Women's Council is deeply concerned with women's health and rights.<sup>120</sup>

*The poor health status, as well as the legal, political, economic and social marginalization Manitoba First Nations women experience—especially those living on-reserve—are well documented. The FNWC recognizes that this situation is a result of colonization and can only be addressed through recognizing, implementing and protecting the unique bundle of rights that First Nations women have, including basic human rights as well as treaty, aboriginal and inherent rights.*<sup>121</sup>

## Federation of Saskatchewan Indian Nations

The Federation of Saskatchewan Indian Nations (FSIN) represents 74 First Nations in Saskatchewan.<sup>122</sup> Their structure includes a Vice-Chief in charge of health issues, a Health and Social Secretariat and a Women's Council.<sup>123</sup> Their vision for health encompasses,

*"the fulfillment of treaty obligations and to achieve holistic health for First Nation individuals, families and communities."*

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<sup>120</sup> Assembly of Manitoba Chiefs, "Women's Issues Updates", <http://www.manitobachiefs.com/women/women.html> [Retrieved May 12, 2006]

<sup>121</sup> Keely Ten Fingers, "A 10-Year Challenge to Improve the Lives of Manitoba First Nations Women," <http://www.manitobachiefs.com/women/women.html> [Retrieved May 12, 2006]

<sup>122</sup> Federation of Saskatchewan Indian Nations, "About FSIN", <http://www.fsin.com/aboutfsin/index.html> [Retrieved August 2005]

<sup>123</sup> Federation of Saskatchewan Indian Nations, "Secretariats", <http://www.fsin.com/secretariats.html> [Retrieved May 15, 2006]

As well,

*"the Federation is committed to honouring the Spirit and Intent of the Treaties as well as the promotion, protection and implementation of Treaties that were made with the First Nations more than a century ago"*

including giving control of health services to First Nation's people.

## FSIN - Saskatchewan First Nations Women's Council

The FSIN Women's Council works on policy issues that impact First Nations women and youth, most recently focusing on exploited children in the sex trade, and First Nations women and violence.<sup>124</sup>

## Manitoba Métis Federation

The Manitoba Métis Federation (MMF) promotes the history and culture of the Métis people, educates its membership respecting their legal, political, social and other rights, promotes the participation of its members in community, municipal, provincial, federal, Aboriginal, and other organizations, and promotes the political, social and economic interests of its members.<sup>125</sup>

## MMF - Métis Women of Manitoba

Métis Women of Manitoba committee members work to "...improve the social and economic situation of Métis peoples, with a particular focus on Métis women and children."<sup>126</sup>

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<sup>124</sup> Federation of Saskatchewan Indians, "Women's Council", <http://www.fsin.com/womenscouncil/index.html> [Retrieved May 15, 2006]

<sup>125</sup> Manitoba Métis Federation, "Objectives", <http://www.mmf.mb.ca/pages/objectives.php> [Retrieved May 12, 2006]

<sup>126</sup> Manitoba Métis Federation, "Métis Women of Manitoba", <http://www.mmf.mb.ca/pages/departments/mwm/> [Retrieved May 12, 2006]

## Métis Nation – Saskatchewan

The Métis Nation – Saskatchewan (MNS) is a province-wide political organization that has been existence for almost 50 years and “represents the interests of approximately 80,000 Métis people in Saskatchewan”, including interests and issues relating to health. MNS has done extensive work on the definition of a Métis person and assuring Métis rights.<sup>127</sup>

## MNS - Métis Women of Saskatchewan

The Métis Women of Saskatchewan is a provincial organization with locals throughout the province. MWS is

*“...mandated to provide a voice to Métis Women across the province. The organization has evolved over the years to an increased emphasis on governance and Métis Women’s perspectives on Métis governance matters.”*<sup>128</sup>

## Mother of Red Nations

Mother of Red Nations Women's Council of Manitoba (MORN) formed in 1999 “to promote, protect and support the spiritual, emotional, physical and intellectual wellbeing of Aboriginal women and children in Manitoba.” MORN has a council with representatives from four regions of the province, and is affiliated with NWAC. MORN acts in political and advocacy work, and recently produced reports and a policy statement regarding Bill C-31.<sup>129</sup>

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<sup>127</sup> Métis Nation – Saskatchewan, “Métis Rights”, <http://www.Métisnation-sask.com/rights/index.html> [Retrieved May 12, 2006]

<sup>128</sup> Métis Nation – Saskatchewan, “Métis Women of Saskatchewan”, <http://www.Métisnation-sask.com/women/index.html> [Retrieved May 12, 2006]

<sup>129</sup> Mother of Red Nations, “Mother of Red Nations Council”, [http://morn.cimnet.ca/cim/92C270\\_397T25016.dhtm](http://morn.cimnet.ca/cim/92C270_397T25016.dhtm) [Retrieved December 15, 2006]

## Saskatchewan Aboriginal Women’s Circle Corporation

Saskatchewan Aboriginal Women’s Circle Corporation (SAWCC) is a provincial organization with the goal of promoting and enhancing the status of Aboriginal women.

*SAWCC works to unite and involve women by addressing issues of concern through resource sharing, education, advocacy and research ... We are mandated to address issues regarding employment, family violence, child welfare, education, justice, health, AIDS, the Indian Act, the Constitution, Aboriginal rights and other pressing issues brought forward by our membership.*<sup>130</sup>

SAWCC members were active participants in the federal Roundtable process. SAWC is affiliated with NWAC.

## Provincial Involvement

Provincial governments play a central role in policy related to health services delivery and Aboriginal issues.

## Manitoba Government

The Government of Manitoba has a Department of Aboriginal and Northern Affairs.<sup>131</sup> In addition the Health Department has an Aboriginal Health Branch.<sup>132</sup> Of particular interest related to health jurisdictions, in 2005 community consultations were conducted by the Mother of Red Nations Women’s Council of Manitoba and the Aboriginal Council of

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<sup>130</sup> Saskatchewan Aboriginal Women’s Circle Corporation, <http://www.sawcc.net/> [Retrieved December 15, 2006]

<sup>131</sup> Government of Manitoba, “Manitoba Aboriginal and Northern Affairs”, <http://www.gov.mb.ca/ana> [Retrieved December 15, 2006]

<sup>132</sup> Government of Manitoba, “Manitoba Health – Aboriginal Health Branch”, <http://www.gov.mb.ca/health/ahb/index.html> [Retrieved December 15, 2006]

Manitoba, in cooperation with Manitoba Health Aboriginal Health Branch “to develop a regional work plan on Aboriginal health for Aboriginal women and urban/rural and off-reserve Aboriginal people throughout the province of Manitoba”. These consultations were used to inform the national *Blueprint on Aboriginal Health*.<sup>133</sup> The Intergovernmental Committee on First Nations Health produced the report, *First Nations Health and Wellness in Manitoba: Overview of Gaps in Service and Issues Associated with Jurisdictions*, in 2005.<sup>134</sup>

## Saskatchewan Government

The Saskatchewan Government has a First Nations and Métis Relations department and a focal point for Aboriginal health in the Policy and Planning Branch of Saskatchewan Health. In addition, Health Regions have staff or units with a focus on Aboriginal health. In consultation with the communities involved, the province developed the *Framework for Cooperation – Métis and Off-Reserve Strategy – 1999, 2001*.<sup>135</sup> The Saskatchewan Health report, *A Healthy Province: The Action Plan for Saskatchewan Health Care*, refers to off-reserve health care.<sup>136</sup> A key element of the Action Plan is the Northern Health Strategy that will address both on-reserve

and off-reserve health care, the Aboriginal health workforce, and more coordinated and effective service delivery. The “Saskatchewan Approach Document” outlines an action plan intended to be implemented by the Province of Saskatchewan and the federal First Nations and Inuit Health Branch - Saskatchewan Region and Aboriginal peoples, including First Nations, Inuit and Métis.<sup>137</sup> The *Saskatchewan Engagement, The Final Report on Aboriginal Health Blueprint* summarizes meetings across the province, as input to the federal *Blueprint on Aboriginal Health*.<sup>138</sup>

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<sup>133</sup> Aboriginal Blueprint, “Community Consultations on the National Blueprint on Aboriginal Health”, [http://www.aboriginalblueprint.org/cms/index.php?option=com\\_frontpage&Itemid=1](http://www.aboriginalblueprint.org/cms/index.php?option=com_frontpage&Itemid=1) [Retrieved February 2006]

<sup>134</sup> Assembly of Manitoba Chiefs, “Intergovernmental Committee on First Nations Health (ICFNH)”, <http://www.manitobachiefs.com/icfnh/icfnh.html> [Retrieved December 2, 2006]

<sup>135</sup> Saskatchewan First Nations and Métis Relations, “Urban Strategy for Métis & Off-Reserve First Nations People (MOR): Framework for Cooperation, 1999 and 2001”, [http://www.fnmr.gov.sk.ca/html/relations/mor\\_intro.htm](http://www.fnmr.gov.sk.ca/html/relations/mor_intro.htm) [Retrieved December 2, 2006]

<sup>136</sup> Saskatchewan Health, “Saskatchewan. Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care”, [http://www.health.gov.sk.ca/hplan/health\\_care\\_plan.pdf](http://www.health.gov.sk.ca/hplan/health_care_plan.pdf) [Retrieved December 5, 2006]

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<sup>137</sup> Saskatchewan Health, *The Saskatchewan Approach Document*, [http://www.health.gov.sk.ca/ps\\_aboriginal\\_health.htm](http://www.health.gov.sk.ca/ps_aboriginal_health.htm) [Retrieved February 2006]

<sup>138</sup> Saskatchewan Health, *Final Report on Aboriginal Health Blueprint Engagement Process*, prepared for Saskatchewan Health by the Saskatchewan Institute of Public Policy. [http://www.health.gov.sk.ca/mc\\_dp\\_aboriginal\\_health\\_blueprint.pdf](http://www.health.gov.sk.ca/mc_dp_aboriginal_health_blueprint.pdf) [Retrieved February, 2006]

# APPENDIX C

## The Aboriginal Health Roundtables

On April 19, 2004, former Prime Minister Paul Martin convened the Canada-Aboriginal Peoples Roundtable. At this meeting agreement was reached to hold consultations specific to First Nations, Inuit and Métis people. Topics were: lifelong learning, housing, health, negotiations, economic opportunities and accountability.<sup>139 140</sup>

On September 13th, 2004 at a Special Meeting between First Ministers and National Aboriginal Leaders on Aboriginal Health, First Ministers and National Aboriginal Leaders also committed to developing an Aboriginal Health Blueprint with the goal of making real progress to close the gap between Aboriginal peoples and other Canadians. The Aboriginal Health Transition Fund was intended to "...enable Federal-Provincial-Territorial governments, First Nations governments who deliver health care services, and Aboriginal communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal peoples, including First Nations, Inuit and Métis."<sup>141</sup>

In addition, at a policy retreat between federal Cabinet and Aboriginal Peoples on May 31, 2005

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<sup>139</sup> Patterson, Lisa L, "Aboriginal Roundtable to Kelowna Accord: Aboriginal Policy Negotiations, 2004-2005", Library of Parliament, Parliamentary Information and Research Service, Ottawa, Publication # PRB 06-04E [Accessed May 2007 at <http://www.parl.gc.ca/information/library/PRBpubs/prb0604-e.htm> ]

<sup>140</sup> Canada-Aboriginal Peoples Roundtables [Accessed May 2007 at [http://www.aboriginalroundtable.ca/index\\_e.html](http://www.aboriginalroundtable.ca/index_e.html)]

<sup>141</sup> Canadian Intergovernmental Conference Secretariat, "News Release - Special Meeting of First Ministers and Aboriginal Leaders, Ottawa, Ontario - September 13, 2004 - Improving Aboriginal Health: First Ministers' and Aboriginal Leaders' Meeting", [http://www.scics.gc.ca/cinfo04/800041005\\_e.html](http://www.scics.gc.ca/cinfo04/800041005_e.html) [Retrieved Dec 6, 2006]

the federal government and the three constitutionally-recognized Aboriginal Peoples signed bilateral agreements to guide their renewed relationships.

The activities culminated in Kelowna, British Columbia at the meeting of First Ministers and Aboriginal leaders held November 24th and 25th, 2005. The *Blueprint on Aboriginal Health: A 10-year Transformative Plan* was presented at the gathering.

At this meeting, the Kelowna Accord, *First Ministers and National Aboriginal Leaders: Strengthening Relationships and Closing the Gaps*, was signed. The intent was to set goals and measure progress over ten years to obtain improvements in relationships, education, health, housing and economic opportunities and raise the standard of living for Aboriginal Peoples. Resources were allocated to support the involvement of Aboriginal people in developing policies, programs and services.

The election of a new Conservative government in January 2006 led to some uncertainty about whether the federal government would honour the agreements made by the previous government.

### Métis People at the Roundtables

The Roundtables included discussions relating specifically to Métis people and centered on issues related to jurisdiction and control that are affecting the delivery of, and access to, health services for Métis people. The meeting group proposed a plan of action that would coincide with the group's definition of success in improving health conditions.<sup>142</sup>

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<sup>142</sup> Canada-Aboriginal Peoples Roundtable, "Health Sectoral Follow-Up Session Flip Chart Notes: Métis

The *Blueprint on Aboriginal Health* included a three-page report on the development of a Métis health framework. This meeting was the first time that Métis people were included in self-governing meetings of this sort.

Various other legal agreements such as a Framework Agreement between the Government of Canada and the Métis National Council that was signed on May 31, 2005, offer hope for Métis people whose inherent Aboriginal rights are currently not fully defined or recognized. Objective Five of the Framework Agreement is to develop “initiatives that will help to improve the quality of life of Métis people within Canada”.<sup>143</sup> At the minimum, Métis organizations such as the Métis National Council, the Manitoba Métis Federation, and other supporters of Métis rights have been arguing that this segment of the Aboriginal population should at least have entitlement to the same health services and programs offered to First Nations people who have Status.

## Women at the Roundtables

NWAC analyzed the Roundtable reports concerning how they reflected Aboriginal women’s issues and perspectives and made recommendations on how to move toward more equitable resolutions for all involved. NWAC made the following summary comment about the Canada - Aboriginal Peoples Roundtables:

*“Fundamental to the exercise of self-determination is the right of peoples to construct knowledge in accordance with self-determined definitions of what is real and what is valuable. Just as colonial policies have denied Aboriginal peoples access to their lands, so also have colonial definitions of*

*truth and value denied Aboriginal people the tools to assert and implement their knowledge. Colonial policies are also one of the significant sources of discrimination and disadvantage Aboriginal women face in society today.*

*The CAPR process can be viewed as the first step in changing this destructive historical pattern of interaction. However, it will only be successful if the structural inequalities facing all Aboriginal women in Canada are eradicated. The voices of Aboriginal women cannot continue to be marginalized but must be integrated at every step of the way.*

*Now is the time to work in collaboration with one another for the full participation of First Nations, Métis and Inuit women in all issues fundamental to the collective as well as the individual well being of Aboriginal peoples in Canada.”<sup>144</sup>*

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Breakout Group.” Ottawa, Canada.”  
[http://www.aboriginalroundtable.ca/sect/hlth/rprt/Flpcht\\_m\\_etis\\_e.pdf](http://www.aboriginalroundtable.ca/sect/hlth/rprt/Flpcht_m_etis_e.pdf) [Retrieved August, 2005]

<sup>143</sup> Canada, Métis Nation Framework Agreement  
<http://www.ainc-inac.gc.ca/nr/prs/m-a2005/02665mnc.pdf> , page 4. [Retrieved August 2005]

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<sup>144</sup> Native Women’s Association of Canada, *Alternative Report: Follow Up to the Sectoral Sessions, Canada Aboriginal People’s Roundtable, (CAPR), May 2005*, page 39.



## **How the Roundtables Can Improve Jurisdictional Issues**

At this time, it seems that the new Conservative federal government is not committed to implementing the *Kelowna Accord*, signed by the previous Liberal government. However, there are some indications that while the Accord itself may be put aside, the new government will undertake initiatives related to Aboriginal people.

The recommendations of the Accord were based on consultations that took place across the country. But there is still need for additional gender analysis of the recommendations and how they should be implemented. NWAC has made good inroads into representation of women at the national policy-making level. More work needs to be done to support the recognition of the diversity among Aboriginal women and to support the work of gender analysis by NWAC and within other Aboriginal organizations.

Work must be done to ensure the federal government also upholds international and national commitments to gender analysis and gender equality.