HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Indigenous and Northern Affairs

INAN • NUMBER 138 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, February 21, 2019

Chair

The Honourable MaryAnn Mihychuk

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● (1005)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): All right, let's get started. We held up our guests. We're sorry that we are late.

We recognize that the process of reconciliation Canada has begun will take some time, and it's important for us to recognize that here in Ottawa we are on the unceded territory of the Algonquin people.

Many guests are here from Manitoba, so I say a special hello to them.

The way it works is that you'll have up to 10 minutes to present. I'll try to give you signals when you're getting close to the end, and they'll become more frequent as we get there. Then, after everyone has presented, we'll have rounds of questions by MPs of five minutes each, and we'll rotate. I don't know if you have decided on the order of your presentations.

In front of me, we have the First Nations Health and Social Secretariat of Manitoba presenting first. Then we'll have the First Nations Information Governance Centre, and then St.Amant.

If there are no objections, we'll get started. Feel comfortable to start any time you are ready.

Go ahead.

Chief Sheldon Kent (Chairperson, First Nations Health and Social Secretariat of Manitoba): Good morning, everybody.

Certainly, the weather is a lot better here than back home. It's nice and warm here.

Some voices: Oh, oh!

Chief Sheldon Kent: With that, we'll get started because time is running late.

Honourable members of the Standing Committee on Indigenous and Northern Affairs, first of all, I want to acknowledge that I am honoured to be here on unceded Algonquin territory.

My name is Sheldon Kent. I'm the chief of Black River First Nation in Manitoba and the chairperson of the First Nations Health and Social Secretariat of Manitoba. We research policy development and advocate for organizations situated in Winnipeg. Our office is in the Manitoba Treaty No. 1 territory, right in Winnipeg.

I have with me Leona Star, who is a director of research, and Dr. Barry Lavallee, who is a medical adviser. I don't go anywhere without my lawyer, so my lawyer is right here. I'm always protected to make sure I don't violate any laws.

We'll be touching on the following topics: challenges in health and healing services, delivery of essential services, challenges in recruitment and retention, developing and supporting the indigenous workforce, capacity and capacity-building, and self-government.

I just want to say *meegwetch*, and thank you for giving us the opportunity to be heard.

I will turn it over to Louis.

Mr. Louis Harper (Senior Legal Counsel, First Nations Health and Social Secretariat of Manitoba): Good morning. My name is Louis Harper. I work with Chief Kent, Dr. Lavallee and also Leona Star.

Good morning, honourable members of the committee. My presentation this morning, due to time constraints, is in the form of statements—an abridged version that would otherwise have been a detailed presentation on the requirement of self-government as a basis for improved and effective delivery of services in our communities.

In a spirit of reconciliation, we make the following statements and suggestions with respect to capacity-building, funding and retention of professional service providers in our community, in relation to going beyond the Indian Act governance regime.

We believe that new, alternative governance structures, conducive to first nations customary laws and their cultures, values and beliefs, must be put in place as the main feature in providing services in first nations communities.

There are numerous nations in our territories. We believe that first nations must undertake a process of nation rebuilding as collectives to identify culturally appropriate governance structures, systems and service delivery. We believe new governance structures must be designed by first nations to foster a sense of ownership and institutional integrity and sustainability.

As part of the institutional rebuilding, we believe that first nations should build a college of nursing or a college of physicians and surgeons, with the same accreditation as the rest of the country, to recruit people to those professions. In the alternative and in the interim, an aggressive program should be instituted to recruit students to the medical profession.

Depending on the design of the new government structures, we believe an establishment of a civil service of nation-based self-government with a training component will enhance capacity, a pool of expertise and retention of employees.

Again, depending on the design of the new government structures, we believe in establishing aggregated and central management of services delegated by first nations, for example health services, as part of the concept of institutional self-government per se.

Last but not least, we believe that as part of the self-government agreements, a land base should be identified to generate own-source revenue as a supplement to federal transfer funding to sustain first nations government funding.

This is my portion of the presentation.

Thank you.

Dr. Barry Lavallee (Medical Advisor, First Nations Health and Social Secretariat of Manitoba): Thank you and *bonjour*. My name is Barry Lavallee. I'm a physician in Manitoba. I work with the First Nations Health and Social Secretariat of Manitoba. I've been asked to address a specific area here in the context of the indigenous health workforce in community, which I believe attempts to address some of the questions you may have, or information you may want.

I broke this down into two particular areas based on the assumptions behind the work that was done by the Royal Commission on Aboriginal Peoples and the various pieces of great literature that attempted to explore the needs of first nations people and their health in community and what the vision was for first nations people.

In that particular context, per volume 3 of the RCAP report, first nations people want to see physicians, nurses and health care systems in not only biomedicine systems, but also want to see themselves. They want to see their own culture and their own values within those health care systems. Therefore, increasing the number of first nations health care providers in community becomes a paramount area that we should target.

There are two phases. One is renewed government and institutional actions targeting pre-professional supports and enhancements for community people to enter colleges and universities and to be successful in admissions to nursing, medical, dental and other professional schools across Canada. This is in the form of really basic outcomes, such as having adequate sciences and mathematics support for first nations schools across Manitoba and Canada, no matter the size of those particular schools.

Another is increased educational funds for communities, because the ratio certainly describes inequity in the distribution of monies to support first nations children in schools when compared with provincial standards. Also needed is equitable, plus restructured, funding for all first nations schools in a holistic way. That is quite necessary.

Also important in the interim period when they're looking at pre-professional support enhancements is really targeting the mature adult population of first nations people who can gain access to health institutions. For those of you who are not from Manitoba, that is something that was called the access program or, in the terminology before that, the special pre-medical studies program. The terminology changes depending on the politics. You would consider these bridging programs. They support people to increase their skills to be competitive in applications to schools such as medical schools.

The other thing is to look at increasing the number of first nation health care professionals. Again, this is about the government and organizations supporting indigenous-specific organizations, such as the Canadian Indigenous Nurses Association and the Indigenous Physicians Association of Canada as voluntary organizations that do exceptional work across Canada, and, with regard to the universities that have medical schools, supporting mentorship programs for self-identified indigenous students to enter medicine.

The other issue, which is paramount to addressing the indigenous health workforce, is to really look at ground zero and examine how indigenous-specific racism is manifested—and not only for indigenous people seeking access to health care systems. Indeed, we have a lot of literature available to date that testifies to that. The elimination of racism both in health care systems and in organizations is in itself a way to increase the number of those in the self-identified first nations health care workforce. That's really important.

Thank you. That is it. I think I'm at my one-minute mark.

● (1010)

The Chair: Thank you very much.

You have one minute left, Leona, if you want to take it.

Ms. Leona Star (Director of Research, First Nations Health and Social Secretariat of Manitoba): Last, we need to support culturally based initiatives that are meaningful and measure our own indicators of success and well-being according to our own priorities, to ensure that we are celebrated as our own indigenous nations and not necessarily celebrated as Canadians, because I know we'll never be Canadians. Nor do we want to be Canadians. We want to be celebrated for who we are as Anishinaabe, as Nehiyawak.

The Chair: On that point, let's go to the First Nations Information Governance Centre.

Ms. Bonnie Healy (Chair of Board of Directors, First Nations Information Governance Centre): [*Witness speaks in Blackfoot*]

I am happy to be here today. I am Bonnie Healy from the First Nations Information Governance Centre. I am currently the chair of the centre. I am here with my co-executive Mindy Denny, and I will let her introduce herself when it comes time.

The FNIGC is a fairly young organization. We incorporated in 2010 but since before that we have been working as a committee and have been quite responsible for the development of the regional health survey and for ensuring that a data system is developed for first nations by first nations. We have a special mandate from the Assembly of First Nations chiefs. FNIGC envisions that every first nation will achieve data sovereignty in alignment with their distinct world view. We work in close collaboration with the 10 regions. We have a board of directors from each one. A lot of our work involves the development of capacity-building around research and the implementation of the ownership, control, access and possession of first nations information.

We are responsible for rolling out three national surveys: the First Nations Regional Health Survey; the First Nations Education and Employment Survey; and, a survey that would be of interest to this group for this study, the First Nations Labour and Employment Survey, which we're ready to deploy in the next few months.

AFNIGC, the Alberta centre, is the only regional centre in Canada that is a satellite incorporated entity and partner of this national centre. I am the executive director of the AFNIGC. A big part of the importance of gathering data is that communities do not have data available to them to make evidence-based decisions to set their priorities.

What we have done in our region is to really work on fixing the data sources, because the Indian registry doesn't have timely updates of deaths and births. Reporting inaccurate data is something we've done in collaboration and partnership with the province. Part of the management and governance of our own data and information is based on our free, prior and informed consent. We are the fastest growing demographic, but our numbers grow and so do our concerns about our socio-economic conditions, our traditions and our health. There is a growing disparity between indigenous peoples and the rest of Canada, through a variety of historical sources, including Canada's legislation and policies. When it comes to our treaty rights to self-determination, as data drives policy, we must assert our right to govern our data. The only thing that separates our people from anyone else is opportunity.

Through increased communications, collaboration and participation in data management, we must move forward on the fundamentals of OCAP so that we can continue to build partnerships and relationships and are able to act and have a sense of being involved in a true management process as nations in partnership. Driving policy and legislation means gaining capacity, resources and infrastructure while respecting the indigenous world views passed on to the generations, which are just as valid today.

A big part of it is making sure that we have the data available to first nations so that they can set their priorities, and measure and evaluate their successes. A lot of the funding they receive does not include evaluation dollars and components. We have worked with first nations to apply for research grant money so that they can evaluate how they are actually succeeding. One of the examples I can share is from the Blood Tribe in the opioid crisis. They have been in a declared crisis since 2014 and they have done a lot of harm-reduction work. The first year they had 34 deaths. They have worked collaboratively as a collective to really try to address this issue and have had great success. When they declared their second crisis last February, they had 78 overdoses and they had timely access to the overdoses that presented in the ED departments and only two deaths. Four years ago they would have had more deaths, if the harm-reduction work didn't happen. But they didn't have dollars available to do the evaluation to see exactly how they were doing with harm reduction and really addressing the issue. So, having data available to them has really helped in that regard.

● (1015)

Ms. Mindy Denny (Treasurer, First Nations Information Governance Centre): Thank you, everybody, for welcoming me here today. My name is Mindy Denny. I'm from Eskasoni First Nation. I work in Membertou with the Union of Nova Scotia Indians. I'm their director for information, governance and data projects. As Bonnie mentioned, I'm also her colleague on the executive of the First Nations Information Governance Centre.

On the topic of community capacity-building and retention of talent in the delivery of essential services on reserve, our work provides some insight. Data from these national survey processes help to construct a holistic portrait of life in first nation communities, including ready and able talent and capacity on reserve. By assessing education level, skills, training needs and employment readiness in the first nations labour markets more generally, first nations are able to identify strengths and gaps with respect to the on-reserve workforce as it pertains to essential services.

First and foremost, this data is used by first nations leadership to help inform community planning and decision-making in communities. All of FNIGC's published national data is available at no cost on FNIGC's data online tool. Our free online data tool is accessed by first nations communities and is also available just generally to the public. In addition, unpublished and record-level data can be accessed on a pay-per-use basis to individuals pursuing academic research, policy development, and program planning and evaluation through the First Nations Information Governance Centre's data centre. Our data helps inform decisions around strategic investments by federal and provincial governments with respect to health, well-being, education and training in first nations communities across Canada.

I have some notes here about some specific data that talks about the labour market in the first nations communities, but I think I'm going to move away from that to discuss what I think is really an important part of community capacity-building and retention of talent in delivery of services on reserve. I think what's really important is that the individuals we're recruiting to the first nation to work with us, people with expertise...or even to build the capacity in the communities of our own. It's important to have the essential tools to help individuals perform their duty. We don't have the right connectivity, the right hardware, the right software or the right training available. We're unable to measure gaps from a perspective that it's a quality of life defined and self-determined by first nations. We need an opportunity to develop human development indices as well as well-being indices that are respective of first nations and their idea of their place in this world.

We're talking about connectivity, about hardware and software, and about support. What's most important is support, statistical and analytical support, at the first nation and community level. We're working really hard at the First Nations Information Governance Centre and with their partner regions to develop statistical capacity. We really feel that in order for first nations to take control of their own affairs and contribute to enhancing the quality of life of their members, this is necessary.

I have two more minutes left, so I'll pop it back to Bonnie in case she'd like to add something that I might have missed.

● (1020)

The Chair: You're not obligated to take the whole time.

Voices: Oh, oh!

Ms. Bonnie Healy: No, that's fine.

As I think maybe Mindy has said at other meetings, as we look at really trying to create parallel world views to look at indicators on how we measure wellness or how we achieve wellness, our focus is really trying to work with our language groups to develop indicators that are important to them to really get back to the life the Creator intended us to live. That's the gap we're interested in closing.

With that, we do understand that we need to have parallels and look at the UN sustainable development goals and indicators to measure things like life expectancy and infant mortality, and to really monitor. But really, on what those measurements are, it's just measuring how well we assimilate, and we don't assimilate well. We do need to keep an eye on that, because a lot of the jurisdiction and legislation underpinnings have not been focused on preventative care or establishing things like primary care networks, which are really focusing on keeping us healthier longer.

Ms. Mindy Denny: Can I take that last minute to mention something else?

The Chair: You have much less time: 10 seconds.

Ms. Mindy Denny: Okay.

Statistical capacity for first nations really supports self-government and the development of formulas to support first nations in the negotiation of self-government and taking on the fiduciary responsibility of providing adequate programs and services.

Thank you.

The Chair: We will now move to the St.Amant centre—an old institution with a new mission.

Ben, please, go ahead.

● (1025)

Mr. Ben Adaman (Senior Manager, Clinical Services, St. Amant): Yes, it's an old institution. There's a lot happening at St. Amant. I'd be happy to tell you all about it.

Good morning to everyone, to members of the committee, to Chief Kent, Mr. Harper, Dr. Lavallee, Ms. Healy, Ms. Denny, and Ms. Star. Thank you very much for the invitation to appear before you this morning.

I'd like to begin by recognizing that we are on the unceded territory of the Algonquin Anishinaabe nation. I would also like to acknowledge the memory of Jordan River Anderson. Jordan has left us a powerful legacy, and what happened to him must never happen to another child.

I'd like to especially thank and celebrate our many partners in Manitoba's first nations communities and tribal councils. They guide our work, and we are honoured to walk this path with them.

Finally, I'd be remiss if I didn't also acknowledge our friends and partners from other service providers, including Eagle Urban Transition Centre, Manitoba Adolescent Treatment Centre, and the Rehabilitation Centre for Children.

Norm and I will be sharing a little bit with you today about some of the important capacity-building initiatives taking place in Manitoba, through the Jordan's principle child first initiative. I'd like to be very clear, though, that this is not our story. This is the story of first nations community members who are absolutely determined to create better futures for their children.

That said, allow me to provide just a little bit of context and a little bit of information about St.Amant. We are a not-for-profit organization that offers a very wide range of services and programs to children and adults with developmental disabilities, autism and acquired brain injury. We operate a health and transition centre for complex health and stabilization needs in over 100 community sites and homes. We offer specialized services for children with autism, and a wide range of clinical supports for children and adults living in the community at large.

Two years ago we were approached by the first nations and Inuit health branch to deliver services to children in their home communities, through Jordan's principle. Before accepting this offer, we thought carefully about whether it was appropriate for us, as a non-indigenous organization, to accept this responsibility. In the end we agreed, only because this is an unmet need. We fully embrace the vision of ultimately transferring these services to an indigenous organization. In the interim, though, we are honoured to contribute according to the wishes of communities.

Our mandate is to deliver services in an equitable fashion to first nations children and youth throughout Manitoba. Community-based teams in any of those 63 communities can refer directly to our services and don't require any sort of pre-authorization from government. Our services through Jordan's principle include behavioural psychology, counselling, social work, nurse consultation, and dietician services, all with a focus on children with developmental disabilities, autism and complex health needs. We commit to service that is respectful, culturally safe, holistic, and person- and family-centred.

Since we first started receiving referrals in the summer of 2017, we've grown from supporting one child in one community to now over 300 children in over 40 communities across Manitoba, all at no cost to families or communities themselves.

But as I said, this story is not about us. Jordan's principle has resulted in significant employment and resource development in Manitoba. Each of Manitoba's 63 first nations and each of the seven tribal councils has received funding to develop programs tailored to their community. In total, right now there are over 1,100 first nations people employed in Manitoba, through Jordan's principle; and over 90% of those people are living within first nations communities.

We can probably all agree that supporting children and youth with disabilities and their families to achieve their own life goals is inherently meaningful and fulfilling work. I can tell you that the Jordan's principle community staff and leadership are deeply committed to that work and to making positive change. Service providers like St.Amant have been called upon to support the community-driven capacity-building efforts of those leaders. Providing welcoming and accessible education to front-line staff is critical to building skills and confidence, and it's also one way that we can contribute to reconciliation.

Since February 2018 we've received over 350 workshop requests from nearly 40 communities, and to date our clinicians have delivered about 120 workshops in 23 communities around Manitoba. Some of the topics we've provided training on include supporting children who have challenging behaviour, coping strategies for care providers who are working with those kids who have challenging behaviour, introduction to autism, and many more. We've counted over 1,500 participants in our workshops in the past 12 months.

Everyone is welcome at our workshops. Participants have included family members of children with disabilities and staff from Jordan's principle programs, schools and health centres. An incidental benefit of all of this training in the communities has been the opportunity for relationship building among the staff of different service providers within those communities.

● (1030)

One thing that I find interesting here is that the training and workshops for community members occur in a context. That context is a long-term relationship characterized by trust and mutual respect between the community members and the staff from St.Amant who are providing the training.

The clinicians who are delivering those workshops and the participants are also partners in delivering services to individual children and youth, so they have a dual relationship. That ongoing relationship creates opportunities for the clinicians to better understand the learning needs in the community and the learning styles of their partners. It also creates opportunities for reinforcing learning through in-the-moment coaching over an extended period of time.

Those opportunities increase the likelihood of information being retained and consistently applied. In that way, we hope that the need for support from outside service providers like us will decrease over time.

Capacity-building efforts targeting front-line staff have the potential to result in an enduring impact in the communities. Community members who receive training are often rooted in their communities, and many may choose to stay there over the long term. The approach that we've taken is consistent with a multi-tiered strategy that includes both credential-focused academic training—such as what Dr. Lavallee has advocated for—and high-quality professional development for an existing workforce.

St.Amant has also collaborated on the development and delivery of a structured training curriculum for community Jordan's principle program staff.

I'd like to invite Norm to speak to that.

Mr. Norm Martin (Clinical Educator, St.Amant): Thank you, Ben.

My name is Norm Martin. I'm a clinical educator with St.Amant. I am new to this initiative. I joined the the St.Amant team in August 2018. I'm not really an expert, but I do provide core training to communities through the tribal council partnerships.

The training extends over six days and is co-facilitated by two other organizations, the Rehabilitation Centre for Children and the Manitoba Adolescent Treatment Centre, in conjunction with St. Amant. The topics are chosen by the tribal councils, and they are designed and delivered by our working group. Currently, we have had a dozen training dates where we went into the communities—organized by the tribal councils. Three hundred and nineteen people were trained, and 68% have been employed under 3 years in their jobs through the initiative. Seventy per cent are childhood development workers and respite staff; that's our main training demographic. The rest are tribal council service coordinators, administrative assistants, case managers, drivers, and educational staff, volunteers and students.

The topics I deliver include patient confidentiality, person- and family-centred care, social role valorization, challenging behaviours, interpersonal conflict resolution, and stress reduction. My post-evaluation results show that my training participants have identified other training that they would like to receive: training on mental health-related topics, on reaching full potential or helping participants reach their full potentials, on reducing stigmas around disabilities, on how to support older children and youth outside the age parameters of Jordan's principle, on how to address the cultural view and the community's view with regard to disabilities, and on supporting people with complex needs and/or multiple disabilities.

I've received great support from St.Amant in learning and delivering the training materials, and I've made some observations in carrying out my role in this job. Training is both needed and appreciated. The staff receiving the training are new to Jordan's principle, but they are not new to understanding the needs and the limitations within the communities. They're eager to learn the skills and to deliver valued services to their communities. There really is no shortage of dedicated and devoted people in the communities who are carrying out this line of work.

Our work in this initiative has already changed the lives of many of those we support, and we're creating trusting partnerships with communities. Although trust takes time, we've developed solid relationships with many of the communities that we provide services for. I know that I'm not just speaking for myself when I say that I've learned as much as I have taught.

In closing, I'd just like to share a story from a woman I met while delivering this training. This woman grew up in a remote first nations community and was part of a large, tight-knit family. One of her brothers was born with a developmental disability and lived in the family until her mother's health was compromised. They could no longer provide the care necessary for this young man, and this young man was placed in an institution. The family would visit him in the institution, which led to some challenging behaviours. Upon the end of these visits, he would often act out as he didn't want these visits to end; he wanted to leave with the rest of his family. A decision was made by his mother to reduce these disruptions by no longer visiting him anymore. The family avoided these visits for 20 years. For 20 years, this man lived in an institution without any contact with his family. This woman shared her story and wished that Jordan's principle had happened sooner, as it would have greatly helped her brother stay connected with his family and remain in the community—which I believe to be true.

This story had a huge impact on the significance of this initiative. Since joining St.Amant, I've learned of many other situations where children live in seclusion. Without adequate resources, many parents feel the need to protect their children and keep them at home, away from school and other community activities. This initiative has allowed children to experience inclusion and independence. This is so meaningful to the entire community. I have never experienced such meaningful and rewarding work.

Thank you.

● (1035)

The Chair: I'm going to ask members to consider reducing the time of questioning to three minutes each so that each party has the ability to ask at least one or two questions.

If that's all right with members, MP Dan Vandal will lead us off.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you very much.

Thank you for being here, all of you. I'm very impressed by your presentations. Three minutes is not long.

Back in September, the Government of Canada invested nearly $68 million to transform first nations health, in partnership with MKO, to arrive at better health outcomes.

Chief Kent, Louis, or Dr. Lavallee, can you offer some perspective on that? Have you been involved in this transformation? If you have, how's it going? If not, why not?

Chief Sheldon Kent: I can't really speak to that because I'm not part of MKO. I'm more southern. MKO represents 26 northern communities, so I have no contact other than when we run into one another.

Mr. Dan Vandal: Do you have any perspective on that?

Dr. Barry Lavallee: No, I do not either.

Mr. Dan Vandal: Okay.

To Ben or Norm—we don't have a lot of time—what sort of advice would you give us as elected officials on how we can support the fine work you're doing?

Mr. Ben Adaman: First of all, thank you very much for that kind feedback.

My suggestion would be, recognizing there's a little bit of self-interest here, to continue to support the Jordan's principle child-first initiative and to continue to support the opportunities for building capacity of a workforce that is in place and has a thirst for knowledge like nothing I've ever experienced before.

From sitting down with case managers from communities or spending time with front-line staff from communities I've had the pleasure of visiting—probably almost 50 of the communities now—I can tell you that they're an inspiring group of people. They want to do the best they can, and they need training that is accessible to them in the sense of being tailored to the nature of the work they're doing and positioning them for success. They come in with different levels of education and experience, so the training is proportional to their starting place, recognizing that they can go as far as they can go.

Mr. Dan Vandal: You mentioned a number of children who have been helped through Jordan's principle in Manitoba. I think you did. Can you repeat that number?

Mr. Ben Adaman: Yes. St. Amant alone has supported about 300, but there are thousands of children who have received support—

Mr. Dan Vandal: That's in Manitoba.

Mr. Ben Adaman: —in Manitoba, yes.

Mr. Dan Vandal: I can tell you that in Canada there were well over 200,000 children who have received support from Jordan's principle.

Mindy or Bonnie, what advice do you have for us as elected officials on how we can help you better do your job?

The Chair: You have 15 seconds.

Ms. Bonnie Healy: No pressure.

We really need to be resourced to be able to address the data gaps. The fact is that first nations are living essentially in information poverty. First nations don't have privacy laws that cross over to their jurisdiction that protect their community. They're mimicking and mirroring what government does, and government ministries don't share data very well together. If you're really going to approach it from an inherent way of what we call *aakaakstimaan*, a collective way of addressing problems, we have to be able to share our information systems so we can help solve problems and address issues, and close those gaps and achieve better health outcomes for our people.

Also, we really need to use the data and the evidence that's in front of us, as well as develop our own indicators and our own world views, to really try to develop our own culturally relevant and respectful ways of service delivery to help us achieve a better life for our members.

● (1040)

The Chair: All right, MP Arnold Viersen has given up a minute of his time.

So you've got two minutes left.

Mr. Arnold Viersen (Peace River—Westlock, CPC): I have two minutes, all right. Thank you, Madam Chair.

Thank you to our guests for being here.

Dr. Lavallee, you mentioned the Indigenous Physicians Association of Canada. Are you a member of that?

Dr. Barry Lavallee: Yes.

Mr. Arnold Viersen: How do you bring to bear the expertise that's built within that organization on this particular organization that you're here representing today?

Dr. Barry Lavallee: The intention of the Indigenous Physicians Association of Canada is to mentor indigenous people who wish to enter health care fields. It's really based on an attempt to address health inequities and health outcomes, as well as health parameters for first nations, Métis and Inuit. Statistically, when we look at the data, we see that the impact of colonization bears most of the brunt of disease and unwellness patterns in first nations communities. Really, the intention of that organization is to work with universities across Canada to ensure that those universities work with the local communities to address some of those health workforce gaps where first nations people are not represented. It's a volunteer organization, basically.

Mr. Arnold Viersen: Yes. Are you seeing any trend lines at all? Are we starting to see more and more first nation people taking up the task of being a doctor or—

Dr. Barry Lavallee: Well, I wouldn't orient it in that way. I would say that when we look, as an example, at the University of Manitoba, we see that people who apply to medical school are predominantly—80%, or maybe 90%—self-identified Métis, with very few first nations. So the parameter and the proxy of what changes in colonial society is really indicated, in my professional opinion, by the number of first nations people who apply and apply successfully to enter medical school.

We're far behind. We see very little change. The change occurs because communities are reorienting their schools and telling the kids that it's time to go to university, to finish grade 12, and to really point to the health care systems to address our own health care needs. That is a function of the strength of communities.

Mr. Arnold Viersen: Thank you so much.

The Chair: We are now moving to MP Georgina Jolibois.

Ms. Georgina Jolibois (Desnethé—Missinippi—Churchill River, NDP): Good morning, and thank you for coming. I appreciate the presentations by all organizations.

I'm from Saskatchewan. In Saskatchewan we're having similar conversations among Northern Medical Services, Saskatchewan Health, FNUC, as well as INAC and other groups. We are having similar experiences and similar thought processes on the idea behind increasing indigenous participation to be professionals in various fields, including physicians and nursing, and the list goes on.

That's really great work that you're doing, but there's the question of statistics. The presentation you provided is really important. I'm sorry if I missed it, but how can the federal government continue the support that you're seeking from various levels, including federal? That would be helpful.

Ms. Mindy Denny: I think that if Canada made significant investments in info systems for first nations the way that it does in its own governance, it would be supportive of good governance practices for first nations.

When statistical capacity is developed in first nations and they have an opportunity to have jurisdiction over the information and mitigate further harm from misuse or misinterpretation of data, I believe that first nations can support Canada in achieving the UN sustainable development goals, as well as arrive at sustainable and predictable funding for first nations at the community level. I think that data is important for first nations to plan appropriately. It's essential. No good government would make investments or plan for their population without information that gives them a clear understanding of what they need to do. The investment in statistical capacity serves first nations much more than just for planning. I think it will help us to evaluate how well we're doing.

● (1045)

Ms. Bonnie Healy: I will wrap it up quickly. One of the committees to which I've newly been appointed is the AFN-Indigenous Services Canada committee of former Minister Jane Philpott. The 10-year grant funding is based on outcomes—to measure that they've closed the gap, so to speak. The data sources they've used include things like Stats Canada's Indian registry. We discovered in Alberta how flawed those data sets are and that using bad data has gotten us into the problems we're now facing because of inadequate funding and improper policy. For example, the first nations health policy is really meant only to contain disease on reserve; it was never meant to prevent disease from happening. In the Indian registry, the flaws we discovered were that 10% of the population in Alberta on the Indian registry were 106 years old and half the children were not accounted for. The Indian registry doesn't have a natural relationship with vital stats and thus does not include timely updates of births and deaths. If nations and the funding formulas are dependent on that, first nations are always going to be underfunded.

We're in a real catch-up mode. We do need to look at possibly funding the first nations statistical institute in the FNIGC, which really addresses free, prior and informed consent, and implements the ownership, control, access and possession of information. With that, we can have a respectful relationship to clean the data in the way that it needs to be done.

The Chair: Thank you so much. *Meegwetch*.

I think you really articulated the value of data very well in your final comments. We took note of that previously, but I just think you really succinctly described how it impacts every family. If we don't have the right numbers, then people will be the losers.

Thank you to everybody who travelled so far. We appreciate it.

That closes our meeting. *Meegwetch*.