'It's a Long Way from Here'—Health Consumer Experiences of Northern Metis

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Manitoba Metis Federation–Health & Wellness Department in collaboration with MMF The Pas Region

Authors:
Julianne Sanguins, RN, PhD
Judith G. Bartlett, MD, MSc, CCFP
Judy Mayer
Sheila Carter
Carol Buchberger
Jennifer Temmer, MSc, RPD
Carrie-Anne Lander, BSc, MNRM

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Disclosure

The results and conclusions in this report are those of the authors and no official endorsement by the University of Manitoba Network Environments for Aboriginal Health Research (NEAHR), or other parties is intended or should be inferred.

For the purposes of this particular study we obtained approvals from the Manitoba Metis Federation to work with Metis in this region and the Faculty of Medicine's Research Ethics Board at the University of Manitoba for approval of our research design and activities.

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Executive Summary

This report resulted from the need to further understand health care consumer experiences in northern and remote Metis communities, in order to help inform Regional Health Authorities of Manitoba and the Manitoba Metis Federation on how they might adapt health programs, services, and policies to better meet the needs of Metis people living in northern Manitoba. This project was a collaborative effort between the Manitoba Metis Federation—Health & Wellness Department, Manitoba Metis Federation The Pas Region, and the University of Manitoba.

In Section 1, an overall introduction to the project and research team is presented. In sections 2 and 3 we offer insight into the Metis, the Manitoba Metis Federation, and the Health & Wellness Department. The Manitoba Metis Federation—Health & Wellness Department (MMF—HWD) conceptual model and approach to ways of knowing are described. In Section 4, a literature review is presented to acquaint readers with challenges that have been identified in the larger literature. These challenges include barriers to accessing existing services as well as a lack of prevention, screening and treatment services. Section 5 offers a synopsis of the methodology and methods used for this study. A description of protocol for entry into the community was given. This community-based participatory research was carried out in three northern remote communities to collect stories and experiences from focus groups and interviews with Metis community members and professional healthcare providers. Data were analyzed by the Collective Consensual Data Analytic Procedure (CCDAP) using coded cards to categorize the data into themes. Ethical considerations, knowledge translation including engagement of Knowledge Networks (locally-based discussion tables between MMF Region staff and the corresponding Regional Health Authority staff), and limitations of the study are all described.

In Section 6 voices of study participants are provided. First, the contributions of Metis citizens regarding their experiences with health services are presented. Later, reflections on the perspectives of health service providers are also introduced to present a parallel understanding of the experiences faced by Metis citizens. Issues of rurality weaved through many of the experiences highlight distance, local availability of health care services, and costs of accessing health care as the main concerns. Program and service needs are discussed in depth. The main challenges are the need for more local physicians and nurses, increased home care access, increased access to health care information, and more support/self-care management groups. Other areas requiring attention include the complicated process to get authorization for medical treatment, the issue of inequity of services or, in some cases, the perception of inequality between Metis and First Nations residents of northern communities. Finally, in Section 7, the key findings of the study are highlighted. A discussion on what this study adds to the larger body of knowledge related to health care service provision in rural and northern Canada is provided.

This research highlighted some of the unique experiences of Metis citizens living in northern Manitoba and the associated influences of this knowledge on policy making and health services delivery, which will ultimately influence the health and wellness of the Metis population. This study is an addition to the growing amount of literature on access to health services for those living in rural and northern areas, while creating a space for information on unique experiences of the Metis citizens.

Section 1: Introduction

1.1 The Manitoba Metis Federation

The Manitoba Metis Federation (MMF), founded in 1967, is the "democratic and self-governing body of the Manitoba Metis community" (Manitoba Metis Federation, 2013). The MMF strives to develop and maintain its capacity to act collectively to successfully promote, protect, and advance the political, social, and economic interests of Metis in Manitoba. The MMF negotiates with provincial and federal Provinces to access funding to provide a wide range of programs and services.

Within the MMF, the Health & Wellness Department (HWD) was established in 2005. The Health & Wellness Department is one of several departments within the Manitoba Metis Federation addressing health, education, and social needs of its members. The Manitoba Metis Federation Health & Wellness Department provides knowledge development and knowledge translation and serves as the Metis Health Authority in Manitoba. Through knowledge development and translation the Manitoba Metis Federation Health & Wellness Department (MMF–HWD) supports knowledge implementation for health planning that is focused on health promotion and wellness. The MMF–HWD is committed to improving the health and well being of Metis people in Manitoba. Using a Metis culture-based holistic health framework, the MMF–HWD builds Metis health planning capacity, develops and implements a Metis health research agenda, and acts as a Metis health 'expert authority' to advise the health system.

1.2 Background of the Research Team

The co-Principal Investigators (co-PIs) on this study were **Dr. Julianne Sanguins and Dr. Judith G. Bartlett. Dr. Julianne Sanguins** is an Assistant Professor in the Department of Community Health Sciences–Faculty of Health Sciences, University of Manitoba. Dr. Sanguins is an RN and holds a PhD in Nursing. Dr. Sanguins is also the Knowledge Development Manager in the MMF–HWD and was a member of the Metis Health Status and Health Services Utilization (*Metis Atlas*) study research team. Dr. Sanguins managed all academic aspects of the study. **Dr. Judith G. Bartlett** is an Associate Professor in the Department of Community Health Sciences in the Faculty of Health Sciences at the University of Manitoba, and an Adjunct Scientist with the Manitoba Centre for Health Policy (MCHP). Dr. Bartlett holds an MD, CCFP, and an MSc in Community Health Sciences. Dr. Bartlett was co-principal investigator on the *Metis Atlas* as well as PI on several projects funded by the Canadian Institutes of Health Research. She is a part-time clinician, an academic physician, and scientific director with a strong understanding of, and experience in, public health administration.

Judy Mayer is the Vice-President of MMF The Pas Region, Minister of the Metis Community Liaison Department, and Minister of Metis Child and Family Services. As part of her active role on the research team, Ms. Mayer participated in study design and analysis and facilitated entry into the communities.

Sheila Carter is Director of the MMF–HWD. Ms. Carter was a member of the *Metis Atlas* research team, the *Cancer in Metis in Manitoba* and the *Diabetes in Metis in Manitoba* studies, providing expertise in health program and policy development. In this project, Ms. Carter

was a member of the team from the project's inception, and participated in study design and analysis.

Carol Buchberger is the Knowledge Network Coordinator for The Pas Knowledge Network and was instrumental in identifying the need for further knowledge in the area, organizing focus groups, and conducting the orientation Wellness Workshops prior to the focus groups.

Jennifer Temmer is the Community-based Research Capacity Developer at the MMF–HWD. Ms. Temmer holds MSc in Rural Planning and Development. Ms. Temmer served as Project Coordinator for the study.

Carrie-Anne Lander is a Research Assistant at the MMF–HWD. Ms. Lander holds a BSc and a Master's degree in Natural Resources Management. She assisted with the writing and editing of this report.

1.3 Justification for Research

Until recently, little was known about access to health care services for Metis residents of Manitoba in northern areas. From the Health Status and Health Services Utilization (*Metis Atlas*) study (Martens, Bartlett, et al., 2010) we know that Metis[1] live diffusely throughout the province of Manitoba. In 2011, there was a gap in knowledge about service provision for Metis living in rural northern communities in the Manitoba Metis Federation (MMF) The Pas Region was identified by The Pas Knowledge Network[2] . In order to support program and policy responses, information on access to health care services for Metis in northern and remote communities in Manitoba is essential. This report provides an initial examination of this important health issue.

Funding was secured from the Manitoba Network Environments for Aboriginal Health Research (NEAHR) program. Two members of the Research Team, Judy Mayer and Carol Buchberger, are from MMF The Pas Region and have been involved in the project design, data collection, analysis, and dissemination.

1.4 Goal and Objectives of this Study

The overall goal of this research is for the MMF and the University of Manitoba to develop an understanding of the experiences of Metis health care consumers living in northern areas of Manitoba. Based on initial discussions held by The Pas Knowledge Network, as well as anecdotal experiences of Metis citizens, the overarching research question guiding this inquiry is "What are the experiences of northern Metis with health care?"

Specific objectives of this study are to:

- Highlight relationships that currently exist for Metis with the health care system;
- Identify networks for Metis within the health care system;
- Recognize the supports for wellness of Metis in The Pas Region;

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[1] The Manitoba Metis Federation does not use the term 'Metis' with the accent (i.e., 'Métis') as is done in some parts of Canada. In this report, 'Métis' is used only when referring to sources that use the accented form.

[2] A Knowledge Network is a locally based discussion table comprised of members from the Manitoba Metis Federation and Regional Health Authorities.

- Identify governance structures that support wellness for Metis in The Pas Region; and
- Demonstrate environments required for wellness of Metis in The Pas Region.

1.5 Overview of Sections

Section 1 provides an introduction to the report.

In Sections 2 and 3, the reader is provided with an overview of the Manitoba Metis Federation as well as the MMF–HWD and its holistic approach to knowledge development.

In Section 4, a comprehensive literature review is given to familiarize the reader with current concepts pertaining to rurality and the issues with rural health care in Canada. In particular, the challenges facing the rural health care system and best practices in the field. Aside from one study examining aging in place for rural Metis seniors in one MMF region, there is no specific literature on Metis health in rural Manitoba. Hence, this study is addressing an existing need to understand the experiences of Metis citizens with the health care system and is filling a gap in knowledge about the determinants of health and wellness in Metis.

The study design is fully described in Section 5, including the Community-Based Participatory Research approach; a description of the study sample (criteria for choosing the study area and how participants were recruited); ethical considerations; data collection methods (environmental scan, focus groups, and key informant interviews using the Metis Life Promotion Framework©); data analysis process (Collective Consensual Data Analytic Procedure); knowledge translation process; and limitations of the study.

Research findings are reported and discussed in Section 6. Several themes were identified from the focus group sessions with Metis health care consumers. These included "Socio-economic Aspects of the Communities", "Individual and Collective Governance Issues", Health Care Consumer Experiences with Programs and Services", "Community Health Needs", "Other Community Needs and Resources", and "Access to Local and Regional Health Services". Themes that emerged from discussions with health care service providers included "Out-of-Pocket Health-Related Expenses", "Sources of Health Information", "Health Program and Service Needs", "Health Workers' Experiences", "Community Dynamics", "Political Issues", "Inequity of Health Programs and Services", and "Provincial and Federal Health Services".

Finally, in Section 7, the objectives are revisited and key findings of the study are highlighted. A discussion on what this study adds to the larger body of knowledge related to health care service provision in rural and northern Canada is provided, while emphasizing the knowledge gained about unique aspects of Metis consumer health experiences in northern Manitoba.

1.6 Summary

Metis citizens from the Manitoba Metis Federation The Pas Region identified a need for further information about health care provision in rural and remote communities in northern Manitoba. They wanted to know what supports and networks for health existed as well as what the barriers for Metis were to be healthy in their communities. Thus far, information in these areas has only been anecdotal; the information derived from this research will fill

this gap, providing information that is current and reliable. This information was collected in a Metis-specific holistic manner to assist Manitoba Health and the MMF in adapting health programs, services, and policies to better meet the needs of Metis people in northern Manitoba. Several recommendations arose from this study and the results will be shared with The Pas Knowledge Network and the communities involved. Working in collaboration, we can improve the health and wellness of Metis in Manitoba.

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Section 2: The Metis People in Manitoba
Adapted from work by Dr. J. G. Bartlett and Ms. S. Carter

2.1 The Metis

The Metis are descendants of early 17th-century relationships between North American Indians and Europeans (Sprague & Frye, 1983). The Metis coalesced into a distinct nation in Manitoba in the late 18th century. After the 1885 fall of Batoche, "Metis were denied a separate identity and ignored for a century" (McMillan, 1995, pp. 312–313). By 1967, with the formation of the Manitoba Metis Federation, the Metis in Manitoba were again asserting their capacity to advocate and function once more in a collective manner. In the 1982 amendment to the Canadian Constitution, Metis were named as one of the three Aboriginal peoples of Canada (Province of Canada, 1982).

The Metis are the fastest growing Aboriginal group in Canada, with an increase in population of 91% between 1996 and 2006 (Statistics Canada, 2008). Increased rates of self-identification related to increased sense of safety (verbal communication, Bartlett, 2011) and pride associated with Metis identity as well as with increased fertility rates are partially responsible for this change in demographics (Adams, Dahl, & Peach, 2013).

2.2 The Distribution of Metis Communities in Manitoba

The Metis constitute 32.3% of Aboriginal peoples in Canada, numbering 451,790 in 2011 (Statistics Canada, 2013a). Between 1996 and 2006 the number of self-identified Metis in Manitoba increased from 40,720 to 71,805, representing an increase of 76% (Martens, Bartlett, et al., 2010). According to the 2011 Census, the number of Metis living in Manitoba was 78,835 with 58.76%, or 46,325 living in Winnipeg (Statistics Canada, 2013b).

In the Metis Atlas, the most recent data available for the northern areas, the total population of Metis in northern Manitoba was 8,177 compared to All Other Manitobans (62,548) (Martens, Bartlett et al., 2010).

According to Statistics Canada data, In addition to being the fastest growing group, in the *Metis Atlas* (Martens, Bartlett, et al., 2010) it was reported the Metis population (2006) was younger than that of all other Manitobans, with 25.4% of the population being less than 15 years of age (compared to 19.1% of all other Manitobans). Only 9.1% of the Metis population was 65 years of age or older compared to a rate of 13.9% for All Other Manitobans.

Metis citizens live in 139 villages, towns, cities, and unorganized territories across Manitoba. In the following figure (2.2.1) we display the distribution of Metis across the province.

Figure 2.2.1: Villages, Towns, Cities, or Unorganized Territories Where Metis Live in Manitoba, 2009

Source: Martens, Bartlett, et al. (2010)
Reprinted with permission.
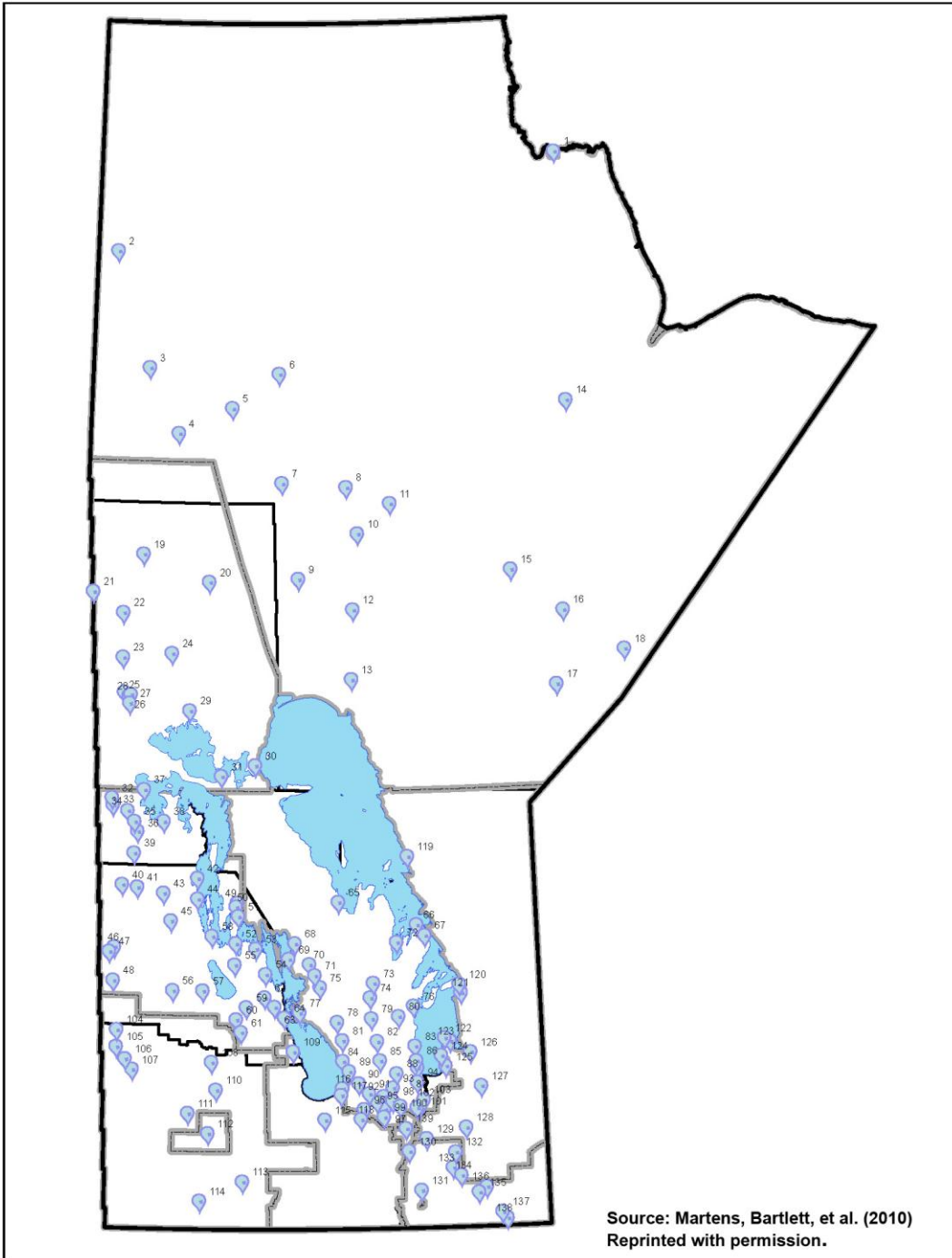
Code Key for Villages, Towns, Cities, or Unorganized Territories (In Regional Order).

Thompson Region		San Clara	47	Warren	95
Churchill	1	Roblin	48	Marquette	96
Brochet	2	Mallard	49	Grosse Isle	97
Lynn Lake	3	Rock Ridge	50	Stonewall	98
Granville Lake	4	Waterhen	51	Rosser	99
Leaf Rapids	5	Spence Lake	52	Stony Mountain	100
South Indian Lake	6	Crane River	53	Lockport	101
Nelson House	7	Cayer	54	St. Andrews	102
Thompson	8	Rorketon	55	Selkirk	103
Wabowden	9	Gilbert Plains	56	**Southwest Region**	
Thicket Portage	10	Dauphin	57	Russell	104
Pikwitonei	11	Winnipegosis	58	Binscarth	105
Cross Lake	12	Ste. Rose	59	St. Lazare	106
Norway House	13	Laurier	60	Birtle	107
Gillam	14	McCreary	61	Erickson	108
Oxford House	15	Eddystone	62	Amaranth	109
Gods Lake Narrows	16	Bacon Ridge	63	Minnedosa	110
Garden Hill	17	Kinosota	64	Rivers	111
Red Sucker Lake	18	**Interlake Region**		Brandon	112
The Pas Region		Dauphin River	65	Belmont	113
Sherridon	19	Matheson Island	66	Boissevain	114
Snow Lake	20	Pine Dock	67	Portage la Prairie	115
Flin Flon	21	Fairford	68	St. Ambroise	116
Cranberry Portage	22	Steep Rock	69	St. Marks	117
Wanless	23	Grahamdale	70	St. Eustache	118
Cormorant	24	Moosehorn	71	**Southeast Region**	
Umpherville	25	Fisher Bay	72	Berens River	119
Big Eddy Settlement	26	Hodgson	73	Seymourville	120
Young Point	27	Fisher Branch	74	Manigotagan	121
The Pas	28	Ashern	75	Victoria Beach	122
Moose Lake	29	Riverton	76	Traverse Bay	123
Grand Rapids	30	Vogar	77	Grand Marais	124
Easterville	31	Eriksdale	78	Beaconia	125
Red Deer Lake	32	Poplarfield	79	Powerview	126
Barrows	33	Arborg	80	Lac du Bonnet	127
Baden	34	Lundar	81	Ste. Rita	128
Mafeking	35	Narcisse	82	Lorette	129
Bellsite	36	Gimli	83	St. Adolphe	130
Dawson Bay	37	Oak Point	84	St. Malo	131
Pelican Rapids	38	Inwood	85	Richer	132
Birch River	39	Winnipeg Beach	86	La Broquerie	133
Northwest Region		Matlock	87	Marchand	134
Swan River	40	Teulon	88	Woodridge	135
Minitonas	41	St. Laurent	89	St. Labre	136
Duck Bay	42	Lake Francis	90	Vassar	137
Cowan	43	Woodlands	91	South Junction	138
Camperville	44	Argyle	92	**Winnipeg Region**	
Pine River	45	Balmoral	93	Winnipeg	139
Boggy Creek	46	Petersfield	94		

2.3 Metis Communities in Northern Manitoba

There is much discrepancy in the ways that the terms "northern", "rural", "remote", and "isolated" are defined in the literature. For the purposes of this study, *northern areas*—sometimes referred to as "the north"—are all areas in Manitoba located north of the 53rd parallel (see Figure 2.3.1). This definition of northern areas is used by other organizations in the province, including Manitoba Health. For example, to be considered a northern resident eligible to receive the benefits of the Northern Patient Transportation Program, the resident must live north of the 53rd parallel (Government of Manitoba, 2011). In this study, we examined three Metis communities—all of which are located north of the 53rd parallel, and while the findings are an expression of the health care experiences of the participants only, these experiences may have some larger resonance for other northern Metis residents.

Rural areas are very difficult to define and there is no standard definition due to the context specificity; although the most common approach is to define rural as 'anything not urban' (Hanvey, 2005). Health Canada defines *rural* areas as "those composed of less than a threshold population of 10,000, and are away from many urban services and resources" (Health Canada, 2002, n.p.). Considering Health Canada's definition, all of the communities in Manitoba's northern region could be considered rural, except Thompson which surpasses the 10,000 population threshold. Taking all of these factors into account, when referring to "the north" in this report we imply that, for the most part, we are talking about rural areas.

Rural areas can further be classified as being remote or isolated. The Rural Committee of the Canadian Association of Emergency Physicians (1997) defined *rural remote* as "those rural communities about 80–400 km (or 1–4 hours of transport in good weather) away from a major regional hospital" and *rural isolated* as "rural communities greater than 400 km away from a major regional hospital (4 hours or more of transport in good weather)" (12). As per these definitions, the three northern Metis communities involved in this study are rural (by population size and density, as well as distance to an urban center) and remote. Although these communities do have year-round road access, transportation to and from these communities is not always reliable and the roads are often poor, thereby leaving residents isolated during bad weather.

To relate the study population to these areas as defined above, in 2006 there was a total of 8,177 Metis living in the Nor-Man and Burntwood Health Regions north of the 53rd parallel with 5,974 Metis living in the Manitoba Metis Federation The Pas Region in which the study occurred. Approximately 2,750 Metis (approximately 40% of the total Metis population of the north) lived in the small urban centers of Flin Flon, The Pas, and Thompson while the remaining 60% living elsewhere in northern Manitoba (Martens, Bartlett, et al., 2010). Therefore, it can be said that the Metis population in northern Manitoba, for the most part, lives in rural/remote areas.

2.3.1   Communities of Interest

In keeping with the principles of community-based participatory research (described in Section 4.1), the MMF The Pas Region community project collaborators were influential in choosing the study communities and participants. The selected communities were identified by the team to be characteristic of rural/remote communities: they were all 1–4 hours of transport in good weather away from a regional hospital, in this case either in The Pas or Flin Flon. A description of the study region follows—however; no description of the

specific study communities is given, in order to maintain the anonymity of the study participants. The results from the three communities were pooled together to reflect the collective voices of Metis from the three communities, and our analysis does not display the results for each community separately. This study focuses on three northern, rural/remote communities in the MMF The Pas Region a region located largely north of the 53rd parallel (see Figure 2.3.1). The Region is located in west-central Manitoba.

Figure 2.3.1 Map of Manitoba Indicating MMF The Pas Region
(53rd parallel indicated in red)

Source: Manitoba Metis Federation (2013). Reprinted with permission.

According to the *Metis Atlas*, the total population of the Manitoba Metis Federation region is 27,359 people, of whom 5,974 (21.8%) are registered as Metis (Martens, Bartlett et al., 2010). Natural resources are an essential part of the area's economy. Many of the existing communities were established in order to service mines, forestry operations, and hydro-electric projects. Although smaller industries such as tourism, trapping, and agriculture also exist, the majority of the population is dependent on the natural resources extraction sector. Over time, the uncertain nature of this sector has created relatively high levels of unemployment, especially in remote communities.

The Region consists of three distinct types of communities: 1) urban centers, towns, and rural municipalities; 2) First Nations communities; and 3) Aboriginal and Northern Affairs communities (Hynes, Lockhart, Siard, & Elliott, 2010). Aboriginal and Northern Affairs communities are communities that, under the Northern Affairs Act, are "incorporated and form a separate governmental body consisting of a mayor and council in order to sustainably

manage and oversee the interests of the community" (Government of Manitoba, 2012, n.p.). The Metis communities in this region typically fall in the latter category.

The Nor-Man RHA provides the majority of health care services to northern communities in the region. However because of the unique and diverse population in Northern Manitoba, legislation and agreements between the Federal Province, Provincial Province, and First Nations Peoples have shaped the complex nature of health care service provision in the area. Regional, provincial, and federal jurisdictions may be in charge of some or all of the services depending on the demographics of the population in the area.

Federal health service jurisdiction exists due to agreements between First Nations communities and the Canadian government. The First Nations communities include: the Opaskwayak Cree Nation, the Chemawawin Cree Nation, the Mosakahiken Cree Nation, the Msipawistik Cree Nation, and the Mathias Colomb Cree Nation. Each of these communities' respective Health Authority handles the administration of health services for their Treaty members (Nor-Man Regional Health Authority, 2010).

The Nor-Man Regional Health Authority delivers health services to all but the southernmost communities in MMF The Pas Region, which are serviced by the Parkland RHA (Martens, Bartlett et al., 2010). Nor-Man's mandate is "to create an integrated, responsive and accessible health services system that is supportive of individual and community needs" (Nor-Man Regional Health Authority, 2000). The Nor-Man RHA has facilities in seven communities, servicing residents and surrounding communities.

The provincial jurisdiction, administered under the Nor-Man RHA, provides services in the region. The RHA serves a population of approximately 24,199 people of whom 4,073 (16.8%) are Metis (Martens, Bartlett et al., 2010). The borders of the MMF Region are slightly larger than those of the health region thus accounting for the difference in population size. Nor-Man health region is divided into three districts. Within these districts eleven communities are covering approximately 72,000km², from Grand Rapids in the southeast to Flin Flon in the west and Pukatawagan Cree Nation in the north. The three communities in this study are part of Nor-Man RHA District Three located above the 53rd parallel. Under Nor-Man's mandate, all communities are provided with access to ten core services and physician services. These core services include:

- Preventative and community health services
- Health promotion and education
- Health protection
- Mental health services
- Substance abuse/addictions services
- Home-based care services
- Long-term care
- Palliative care
- Development and rehabilitation support services
- Treatment, emergency, and diagnostic services (Hynes, Lockhart, Siard, & Elliott, 2010)

The delivery of these services varies depending on the service provider and accessibility, especially in remote communities. While a variety of health professionals may provide services to the communities access to services may vary depending on a number of factors

including whether one has Treaty membership, registration for social assistance programs, or eligibility for old age pension security benefits. In most First Nations communities, health professionals employed by the local health authority provide community health services, and health professionals from either the Northern Medical Unit or the Nor-Man RHA provide physician services. Typically Metis citizens are not eligible to access services in First Nations communities. In other northern communities, nursing stations are provided by Manitoba Health or the Nor-Man RHA, and other available services are provided by the Nor-Man RHA. Metis people may access services from the provincially-run health centres or anything provided by the RHA, but unlike First Nations people they do not receive any additional health benefits or services from the federal government (Bent, Havelock, & Haworth-Brockman, 2007). Jurisdictional ambiguities and resource limitations have led to gaps in service availability for Metis citizens. Access to services and travel issues are identified in the *Nor-Man Community Health Assessment Report* (2010). Other issues indentified in the RHA Community Health Assessment included economic stress, communication between providers and clients, mental health and wellness, and chronic disease prevention and management (Hynes, Lockhart, Siard, & Elliott, 2010).

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Section 3: Building Metis-Specific Knowledge
Adapted from work by Dr. J. G. Bartlett and Ms. S. Carter

3.1 Introduction

The Manitoba Metis Federation–Health & Wellness Department (MMF–HWD) undertakes Metis-specific health research along with a province-wide process to enhance the use of this research. In this section we provide an overview of the Manitoba Metis Federation (MMF), highlights of the MMF–HWD's use of a Metis-specific lens to build knowledge, and the use of Knowledge Networks to 1) disseminate Metis-specific information; and 2) to engage communities and partners in service and program changes. More complete details can be found in Chapter 2 of the Health Status & Health Services Utilization Study hereafter referred to as the *Metis Atlas* (Martens, Bartlett, et al., 2010).

3.2 The Manitoba Metis Federation

The Manitoba Metis Federation (2010) requires that to be an Individual Member or Child Member [3] of the Manitoba Metis Federation one must:

1) Self-identify as Metis;
2) Show an ancestral connection to the Historic Metis Community; and
3) Be accepted by the contemporary Metis Community.

For 43 years, the MMF has acted collectively to promote, protect, and advance the political, social, and economic interests of Metis citizens in Manitoba. The MMF negotiates with Provinces to access funding for programs and services that are better able to meet Metis citizens' cultural norms.

The MMF has seven regions and a home office, along with a number of associated affiliates. Twenty-one representatives and a president are elected by members of the Manitoba Metis Federation as the MMF governing body every four years. Each region elects a VP and two other Board members; all members are eligible to elect the President. The MMF governing body leads, manages, and guides the strategic direction, objectives, and policies of the Federation and its subsidiaries. The President is the Chief Executive Officer, leader, and MMF spokesperson. The MMF has an Executive Director responsible for overseeing the day-to-day operations of the Federation.

3.3 Manitoba Metis Federation–Health & Wellness Department

The MMF–Health & Wellness Department (MMF–HWD) was created in July 2005 as a Metis-specific 'health knowledge authority.' The Manitoba Metis Federation Health & Wellness Department provides knowledge development through its chronic disease surveillance program and other funded research programs, knowledge translation via Region Knowledge Networks, and serves as the Metis Health Authority in Manitoba. Through knowledge development and translation the Manitoba Metis Federation Health & Wellness Department (MMF HWD) supports knowledge implementation for health planning with Regional Health Authorities that is focused on health promotion and wellness. The MMF HWD is committed to improving the health and well being of Metis people in Manitoba.

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[3] 'Child Member' is a new addition by majority vote on a Resolution at the 2009 MMF Annual Assembly.

Over time the Department has solidified a vision of 'a well Metis community' with its mission of 'creating and facilitating the use of knowledge' to contribute to improving Metis health status. The MMF–HWD is focused on four main strategies intended to move department activity toward its vision. These include:

- Using a Metis culture-based holistic wellness framework;
- Building Metis health planning capacity;
- Implementing a Metis health research agenda; and
- Developing as a Metis 'Health Knowledge Authority' to advise the health system.

For the MMF–HWD, the *Metis Atlas* was the foundational research setting the stage for a range of new research and related activities intended to positively impact the health and well-being of Metis citizens in Manitoba. The Metis Population Database (MPDB) developed for the *Metis Atlas* provided aggregated demographic data for this *'It's a Long Way from Here'* study.

3.4 Culturally Coherent Metis 'Methodology' or Lens for Wellness

3.4.1 Ways of Knowing

The MMF–HWD approaches all departmental activities from a Metis-specific perspective. This Metis lens is rooted in the integration of our historic Indigenous and European ancestries to become a unique Metis 'way of knowing'. Adapted from work by Burton-Jones (1999), the MMF–HWD considers the inclusion of both 'ways of knowing' – Indigenous and Western - as appropriate for Metis. This Metis 'way of knowing' is holistic, including: Narrative (our story, spiritual); Experience (our experience, emotional); Data (our research, physical); and Information (our synthesis of the first three, intellectual) (See Figure 3.4.1). This simple approach is used to demystify research, and to ensure each of our activities is approached holistically (See Figure 3.4.2).

Figure 3.4.1: Holistic Research Model

Holistic Metis Research Model

Quantitative Research

Our Information
intellectual

Our Data
physical

Our
Way of Knowing
(epistemology)

Our Story (narratives)
spiritual

Our Experience
emotional

Qualitative Research
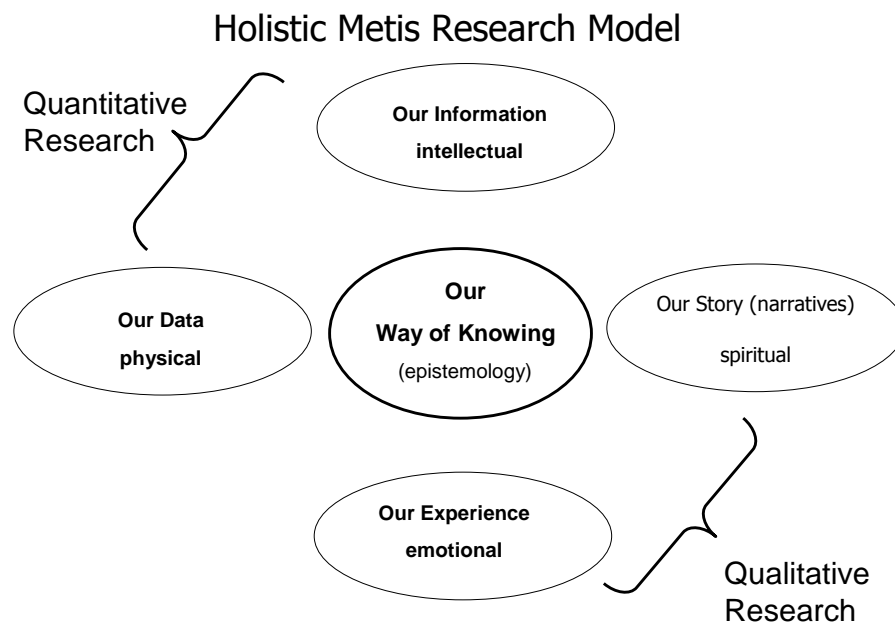
Developed August 18, 2003 by
Judith G. Bartlett MD, CCFP

Figure 3.4.2: MMF–HWD Strategies

The MMF–HWD adapted a holistic framework originally developed for use in an urban Aboriginal community health centre (Bartlett, 1995). The framework was renamed the Metis Life Promotion Framework© (MLPF©) for use with Metis. The MLPF© includes finding balance among 16 important areas that help to determine 'how our life unfolds'. These 16 areas—that is, the 16 'Determinants of Life'—include spiritual, emotional, physical, and intellectual; child, youth, adult, or elder (senior); individual, family, community, and nation; cultural, social, economical, and political (See Figure 3.5.3). It is critical to keep in mind that the MLPF© is a tool for holistically organizing thoughts and information—it does not 'represent' Metis culture.

Figure 3.5.3: Metis Life Promotion Framework© Determinants of Life©

Health can be considered a balance of:

Developed by Judith G. Bartlett, MD, MSc, CCFP, 1995

In 1996, the framework was adapted to consider 'Wellness' (Bartlett, 2004). The 16 'Determinants of Life' were grouped as eight 'Wellness Areas©', which made it easier to think about the determinants for health planning and interpretation of research findings. MLPF© Wellness Areas© naturally flow around the spokes of a Red River cart, representing constant motion and change

Although not explicitly an accepted Metis lens, this tool allows every person engaged in Metis-related health planning to undertake a process whereby they learn 'how to create' Wellness Areas© based on their own life experiences. The Wellness Areas© can be used for individuals, families, or groups as well as distinct diseases. Figure 3.5.4 is used to illustrate the use of the Wellness Model for an individual's health care system experiences. Following this model, Table 3.5.1 demonstrates the types of questions people could be asked about their own experiences.

Figure 3.5.4: Wellness Model for Examining Health Consumer Experiences of Northern Metis

- **Approaching experiences from a wellness perspective**

- **Needs to occur at both policy & program levels**

Adapted from model developed by Judith G. Bartlett, MD, MSc, CCFP, 2004

Table 3.5.1: Wellness Areas© Question Type

WELLNESS AREA©	QUESTION: How experiences with health care services affect my:
Nature	Sense of who I really am as a person?
Identity	Experience of how others see me or how I want others to see me?
Development	Sense of age/ability to express the child, youth, adult, and elder parts of me?
Relationships	Ability to respect and care for others?
Networks	Ability to interact with others?
Supports	Body, and my ability to work and be involved in community?
Environment	Cultural, social, economic, and political influence?
Governance	Ability to choose my destiny and future?

3.5 Knowledge Translation

Knowledge Translation (KT) means using *what we know* from research to influence *what gets done* in health and social programs and services to improve health. Using KT for this study maximizes benefit for Manitoba Metis citizens**.** Combining experiential knowledge with the findings from the *Metis Atlas* has resulted in a more holistic base of information to provide direction to Knowledge Networks to work toward improving the health and wellbeing of Metis in Manitoba.

Knowledge dissemination is an essential part of KT and a critical process enabling translation of evidence into policy and practice (Canadian Institutes for Health Research, n.d.). Such knowledge dissemination places emphasis on 'action', providing decision-makers with tools to create processes that will help to improve the overall health of Metis in Manitoba.

The findings will be examined at The Pas Knowledge Network discussion table in order to identify gaps in services as well as areas in which things are being done well in order to influence program and service delivery by both the Regional Health Authority, and the Manitoba Metis Federation. Knowledge Networks provide an ideal venue for knowledge dissemination by encouraging mutual learning and knowledge exchange (Canadian Health Services Research Foundation, 2005). At this level this study will have the most impact—in influencing health policy and programs in Manitoba to improve services for Metis living in northern areas. For a more detailed description of this process see Chapter 2 in the *Metis Atlas* (Martens, Bartlett, et al., 2010).

The study results are being used to produce this report for the MMF and the funder. We will have opportunity to confirm and build on these ideas as we continue to engage with Metis citizens in Manitoba in future research and in knowledge mobilization with regional Knowledge Networks. Information will be disseminated to the communities in a newsletter, in public sessions, and at the MMF Region and Annual General Assemblies.

The information will also be used by other Knowledge Networks throughout the province to consider access issues within their jurisdiction. This grassroots use of the outcomes enables identification of issues that are locally driven and relevant within the local context. Given that decision makers sit at the Knowledge Network table, this process offers a unique and strategic approach to Knowledge Translation. Any policy issues arising from this study will be taken to the Provincial Metis Health Policy Knowledge Network for discussion.

3.6 Summary

The Manitoba Metis Federation Health & Wellness Department has a well-established partnership with Manitoba Health, and has further developed that partnership through Knowledge Networks with the Regional Health Authorities. These partnerships ensure Metis involvement in decision-making within the health system around health planning, and policy, program, and service delivery. Working within these partnerships, specific needs for knowledge are identified. The Health & Wellness Department is ideally placed to respond and create Metis-specific health knowledge for further use by the Knowledge Networks, as well as for others interested in Metis health. Use of our conceptual model ensures that both Indigenous and Western knowledge are used, marrying our stories and experience with data and facts in order to create as holistic and accurate findings as possible.

In the case of this study *'It's a Long Way from Here'—Health Consumer Experiences of Northern Metis,* the need for the study was identified by the Knowledge Network; two members of the Manitoba Metis Federation from the Region were members of the research team. Results have been shared with the communities and within the larger community of individuals interested in Metis health. This study will form the basis of further work done in The Pas Knowledge Network.

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Section 4: Literature Review

4.1 Health Status in Rural Canada

According to the World Health Organization, health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy human needs and, on the other hand, to change or cope with the environment" (World Health Organization, 2006, p.1). Although Canadians enjoy a high quality of life and relatively good health standards, there exist disparities between urban and rural populations. In general, rural Canadians have higher total mortality rates, higher infant mortality rates, and shorter life expectancies compared to their urban counterparts (Laurent, 2002). The Society of Rural Physicians of Canada who, in a speech given to the Romanow Commission, emphasized disparities in risk factors, morbidity, and mortality rates between those living in rural areas and inhabitants of urban areas. They reported that in rural areas, smoking rates are higher, poverty is more common, mortality rates are higher for most causes of death, and average life expectancy for rural Canadians is three years less than Canadians living in urban settings (Hutten-Czapski, 2002).

The health status of individuals living in northern Manitoba is significantly poorer than the rest of Manitobans. Those living in the north experience higher rates of diabetes and hypertension, shorter life expectancies, and increased premature mortality rates compared to the Manitoba average (Pachkowski, Moss, Racher, & Annis, 2009). In Manitoba, not only is there a rural/urban disparity, but also there are significant differences in rates of some chronic diseases in different populations. In the Nor-Man Health Region, in which the study sites were located, some clear differences between Metis and all other Manitobans have been identified (Martens, Bartlett, et al., 2010). Specifically, Metis had significantly higher rates of ischemic heart disease (11.9% vs. 8.9%), respiratory illness (9.6% vs. 8.1%), and mental disorders (27.8% vs. 23.4%) compared to all other Manitobans in the health region (Martens, Bartlett, et al., 2010).

The Canada Health Act, a legislation that guides health service delivery in Canada, is intended "to protect the physical well-being of all Canadians and to provide all residents with reasonable access to health services without barriers" (Government of Canada, 1985, p.5). Although the Canada Health Act was intended to secure equitable universal health care services to all Canadians, there are many rural and northern regions of the country that are medically and socially underserviced (Jennissen, 1992). In the rural environment, the health care needs of certain groups are often not met, nor are they well understood (Laurent, 2002).

The same holds true for residents of northern Manitoba for some measures of health system use. Consistent with the high levels of chronic disease, higher rates of recorded health system utilization are apparent in the Nor-Man health region. For example, Metis in Nor-Man Health Region are seeing physicians at higher rates than all other Manitobans, and are being hospitalized more often than other Metis province-wide (Martens, Bartlett, et al., 2010). However, despite high morbidity rates, Metis living in the Nor-Man health region are significantly less likely to be referred to other physicians, including specialists, compared to other Metis in Manitoba. After adjusting for potentially confounding factors, Metis women in MMF The Pas Region are also less likely to receive mammograms, or to be screened for

cervical cancer, compared to Metis females province-wide (Martens, Bartlett et al., 2010). While these statistics create a partial picture of health care utilization for Metis in the region, it remains unclear if this access is sufficient, efficient, or satisfactory for the consumers.

4.2 Access to Health Care Services

Several barriers make it difficult for rural and northern communities to access health services. Incomes in rural regions are lower than in urban regions, with Manitoba having the largest rural–urban income disparity in Canada (Laurent, 2002). Rural residents are also more likely to have lower educational attainment, which has been shown to negatively impact health behaviours (Vanasse et al., 2010). In addition, geographic remoteness, low population densities, inclement weather conditions, high unemployment, as well as the economic activities on which these rural communities depend (mining, forestry, and farming) can have negative impacts on health (Government of Ontario, 2011; Laurent, 2002; Pachkowski, Moss, Racher, & Annis, 2009).

There are many challenges and barriers in providing adequate health care services to rural populations. As Barer & Stoddart (1999) wrote in their report on access to medical services in rural communities:

> Canadians living in rural and remote areas of the country have always found physician services less accessible than their city-dwelling counterparts. The problem is as old as written commentary on physician resource issues in this country. For the most part, the reasons are no mystery—there is a fundamental mismatch between the needs of rural and remote communities on the one hand, and the needs and choices of physicians on the other hand. There are many communities across this country that are simply too small to support a general practitioner, or that are large enough to support one, but too small to support two or three, let alone the full range of specialists found in large urban centres (6).

Barriers to health care access are: distance to a physician; high physician-to-patient ratios; difficulties with specialist referrals; below-national-standard income of rural residents; insufficient affordable and reliable transportation; inability to provide quick response emergency services; limited access to preventative and community health services; and increased health risks from exposure to the environmental hazards of resource extraction industries. Each of these barriers will be discussed in the following brief review of the literature.

4.2.1   Distance to a Physician

Health inequalities are determined to a large extent by the resources to which individuals have access (Bernard et al., 2007). Health status, health behaviours, and utilization of health care services are associated not only with where people live, but also with important access issues such as transportation and long distances to a physician (Laurent, 2002; Rural Development Institute, 2008). Browne (2010) suggested that northern residents travel great distances to access services that are not available in their local communities. For example, because specialist care is highly centralized in Manitoba, residents of rural and northern Manitoba communities may have to drive for an hour or more for a routine medical checkup or to access a medical specialist (Pachkowski, Moss, Racher, & Annis, 2009).

There is also limited access to both urgent and non-urgent transportation in many remote and northern areas. Many residents in these communities are either unable to travel to receive health care or they have to pay out-of-pocket to travel to health care centers. Some communities have limited or poor road access. Therefore, not only does the distance to health care services pose a barrier, but accessing transportation to reach these health care services further limits access to services. 'Distance decay' is a term used to highlight the decreasing use of health service related to increasing distance that service users reside from the source of these services (Swindlehurst, 2005). In urban centers, nearly 99% of all residents live within five kilometers of a physician. This percentage decreases as the population becomes less dense, and is located farther to the north (Pitblado, & Pong, 2000).

In Manitoba, to redress some of these access issues, the University of Manitoba's Northern Medical Unit (NMU) complements the current health care system in northern remote communities by sending physicians to these communities on a regular basis. The NMU services a total of 12 communities equipped with nursing stations including Grand Rapids and Chemawawin (Easterville) in the MMF The Pas Region (University of Manitoba, 2013). This additional support provides, at least in part, increased access to some medical care.

4.2.2 Physician-to-Patient Ratios

Rural provincial health care systems across the country have long been challenged with inadequate service provision due to insufficient financial and human resources. Despite the many perceived benefits to living in rural communities, and the financial incentives physicians are given to practice in rural areas, a shortfall of professional health care providers to administer necessary services in these areas continues (Rourke, 1993). Physician-to-patient ratios and the ratios of patients to all health care providers is an issue of great concern. In Canada, although 22% of people live in rural areas and small towns with populations of less than 10,000, only 10% of all physicians in Canada live in these areas (Hutten-Czapski, 2002). In 2004, approximately 1,308 family physicians would have been needed in rural areas to bring physician-to-patient ratios up to par with urban areas (Rourke, 2008).

In 1999 the Province established a 'Specialist Recruitment Fund' providing $15,000 to medical specialists recruited from outside the Province (Government of Manitoba, 2006). For each grant a one-year 'return of service' commitment by the recipient is required by the Province. A further $600,000 was committed to this initiative in 2009 (http://news.gov.mb.ca/news/index.html?item=6539). Between 1999 and 2005, more than 150 specialists were recruited from outside of Manitoba. Moreover, the total number of specialists in the Province increased from 993 in 2001 to 1,054 in 2005 (Government of Manitoba, 2009). As of 2010, there were 1,094 specialists in Manitoba, representing a 6.3% increase from 2006 (Canadian Institute for Health Information, 2010). It is hoped that an increase in specialists working in the Province will also increase the access of rural and northern Metis to these specialists, and reduce wait times. However, it is important to consider whether the increase in specialists is keeping up with the increase in Manitoba's population.

4.2.3 Attracting and Retaining Qualified Health Care Professionals

In many instances, rural communities have problems recruiting and retaining health care professionals (Swindlehurst, 2005). In northern communities, long travelling distances, harsh environments, and heavy workloads have been identified as barriers in attracting the necessary numbers of health care workers to such communities (Romanow, 2002). Most physicians who are interested in working in rural settings are from rural backgrounds and are committed to, and comfortable with, working in these demanding environments (Jennissen, 1992). Students with a significant amount (more than 8 years) of rural upbringing are more likely to return to practice medicine in a rural setting (Somers, Strasser, & Jolly, 2007). However, while recruitment incentive programs are in place for rural youth looking to study medicine, only 10.8% of new medical students are of rural origin (Hutten-Czapski, 2002). Most students accepted into medical schools in Canada are from urban settings, and remain in urban settings throughout their medical training. Physicians who practice in urban settings are provided with more support, access to specialists, and have less demanding schedules than those in rural positions (Barer & Stoddart, 1999).

In a 1991 survey of physicians who had recently left their work in rural zones, low morale problems were commonly reported. Low morale was cited as being due to long work hours and insufficient professional support (Ng, Wilkins, Pole, & Adams, 1997). Important factors in a physician's decision to practice in a rural area included flexible work hours, professional backup, availability of specialty services, additional training, access to hospital services, ongoing continuing medical education, and earning potential. Rural communities' limited financial and human resources make many of these factors less appealing for attracting physicians on a long-term basis (Rourke, 1993). Similarly, when it came to retaining 'allied health care professionals' or health care professionals other than physicians or nurses, the positive aspects of the position were often outweighed by the negative aspects of working in rural and remote areas (Campbell, McAllister, & Eley, 2012). Positive aspects of working in the health care field in a rural community for allied health professionals included the rural lifestyle, diverse caseloads, broad experience, family close by, multi-disciplinary team, sound financial reward, cross-cultural environment, and small caseload. The negative aspects cited by allied health professionals included poor access to professional development, professional isolation, insufficient supervision, lack of financial reward, large professional load, lack of promotion options, lack of work resources, long work hours, high cost of living and travel, lack of personal space and time, lack of community knowledge about role, and poor team functioning (Campbell, McAllister, & Eley).

Occupational therapists in Saskatchewan and Alberta felt that working in a rural setting was made easier by hands-on experience in rural practice during training; urban experience prior to undertaking a rural career; having a rural background; personal characteristics, including adaptability and creativity; and having a mentor before entering into a position in a rural area (Wielandt & Taylor, 2010).

Manitoba Health has acknowledged the difficulty with recruitment in rural areas, stating that "there remains an uneven distribution of health care workers between the province's two urban centres and the geographically larger, but less densely populated, rural and northern areas surrounding them" (Government of Manitoba, 2006, p. 22). With the Province's support, the Regional Health Authorities are going to great lengths to attract physicians to their communities. In 2005, the Manitoba Office of Rural and Northern Health (ORNH)

developed the *Manitoba Rural Physician Action Plan,* consisting of five main areas of focus to improve physician-to-patient ratios by creating incentives for medical students:

- Increase the intake of students from a rural background into medical school;

- Increase rural training opportunities for undergraduate medical students;

- Expand rural training opportunities for residents in family medicine and medical specialties;

- Improve the capacity of rural continuing medical education to provide advanced skills-training programs to rural practitioners; and

- Provide infrastructure support to ensure coordination between medical education programs and community needs.

It is uncertain how successful the Rural Physicians Action Plan has been to date; however, Manitoba Health and the ORHN do provide a variety of incentives for health care professionals, primarily nurses and physicians, willing to work in rural areas. Financial incentives include the 'Nurses Recruitment and Retention Fund', 'Family Practice Anesthesia Program' funding, the 'Medical Student/Resident Financial Assistance Program', and 'Return of Service' agreements offered by all Regional RHAs including Nor-Man RHA.

In order to provide long-term solutions in Manitoba, other developmental opportunities including mentorship and 'rural work' experience programs exist. These include the 'Rural Manitoba Health Mentorship Program', the 'Home For The Summer' student rural employment initiative, the 'Rural Week' experience for first year University of Manitoba medical students, 'Job Shadowing' for first year University of Manitoba medical students, and 'Health Quest Career Camp' for senior high school students (ORNH, 2005). Manitoba Health also provides funding for a 'Rural and Northern Community-Based Training Program' for psychology interns and residents, in the attempt to provide more frequent services and limit rural clients' travel to urban centres to receive treatment (McIlwraith et al., 2005).

4.2.4   Specialist Referrals

In 1991, only limited numbers of medical specialists practiced in rural regions of the country (Laurent, 2002). In 2004, only 2.4% of specialists were located in rural areas (Rourke, 2008). Of these specialists, 15% were general surgeons (the highest percentage for any one category). Laboratory specialists, and specialists involved with obstetrics/gynecology, community medicine, and pediatrics each represented less than 4% of specialists located in rural areas (Jennissen, 1992).

Like the rest of Canada, specialist care is highly centralized in Manitoba. Residents of rural and northern Manitoba communities may have to drive for an hour or more to have a routine medical checkup or to access a medical specialist (Pachkowski, Moss, Racher, & Annis, 2009). In many cases residents have to travel to Winnipeg to access specialized care. For those in the study region this may entail an eight-or-more hour bus ride, a six-or-more hour automobile ride, or an expensive airplane ticket. Wait times to see a specialist can be quite lengthy, further compounding the problem. For example, the estimated wait time (as of August, 2012) for MRI scans in Manitoba on average was 12 weeks (Province of Manitoba, n.d.). This situation has not improved since 1996 when the wait time for an MRI

was 9.6 weeks, and the median time from referral to a specialist to treatment was 9.7 weeks (The Fraser Institute, 1997).

Provincially, Metis are referred to another physician or specialist at a statistically significantly higher rate compared to all other Manitobans (Martens, Bartlett et al., 2010). However, in Nor-Man health region where the study sites are located, the ambulatory consultation rate for Metis is similar to all other Manitobans—although it is lower than the Provincial rate for Metis (0.23 visits vs. 0.30 visits per year per resident) (Martens, Bartlett et al.).

4.2.5   Ability to Pay for Additional Costs of Health Care

Some basic services including physician services, surgery/anesthesia, x-ray and laboratory services, hospital services, and some personal care home services are covered for all Manitoba residents through the Provincial health care system (Province of Manitoba, 2012a). Seniors, children, and those receiving social assistance are provided with additional coverage beyond that funded by the public health care system. This coverage includes prescription drugs, dental care, vision care, medical equipment such as prostheses and wheelchairs, independent living assistance, and access to health professionals such as podiatrists and chiropractors. These additional services are not provided free of charge to the general population through the public health insurance plan, but are instead paid for by individuals or their private health insurance plans (Manitoba Health, 2012a). Metis do not receive any additional health benefits from the Federal government (Bent, Havelock, & Haworth-Brockman, 2007); therefore, they must pay for these out-of-pocket expenses or through private health insurance.

In addition to the direct costs of the aforementioned health services, indirect costs must be absorbed by rural people with the potential to create even more barriers to health care for rural residents. Such indirect costs include those associated with personal travel, hotel accommodations, meals, and ambulance use (Hutten-Czapski, 2009). Rural hospitals across Canada are closing on the premise of cost inefficiency, and these indirect costs for residents are not being considered. In some instances, widespread closure of rural hospitals in some provinces has lead to premature deaths (Nagarajan, 2004). These direct and indirect costs associated with health care, combined with high unemployment and lower incomes in rural regions as Manitoba has the largest rural–urban income disparity in the country (Laurent, 2002), and can result in great financial barriers to the already vulnerable rural demographics in accessing the health care services.

4.2.6   Affordable and Reliable Transportation

Two major constraints to effective health care access are transportation and geographical access to services (Swindlehurst, 2005). Public transportation may be unreliable or have inconvenient schedules. Health services may be long distances from client's homes, rendering it impossible for them to attend an appointment with a physician in a single day. While in some cases travel expenses may be claimed retrospectively, this policy may be a barrier to travel related to individuals' financial restrictions (Swindlehurst).

In many provinces in Canada, the burden of increased cost of access to health services experienced by people who live in remote or isolated areas, has been recognized and programs have been put in place to offset the additional costs. These programs vary by province. In Ontario, for example, the Northern Health Travel Grant system (NHTG)

provides eligible northern Ontarians with a stipend of 30.5 cents per kilometer calculated from their home to their nearest referral point. This stipend typically covers less than half the cost of travel, and does not include costs for accommodations (Crump, 2000).

In Manitoba, the Northern Patient Transportation Program provides subsidies for eligible Manitobans; however the list of restrictions is complex. Eligible Manitobans must:

- Live above the 53rd parallel on the West side of Lake Winnipeg, or;
- Live above the 51st parallel on the East side of Lake Winnipeg;
- Be approved for travel by a physician; and
- Not have coverage from an insurer or funder such as an employer, WCB, MPIC, or FNIHB (Government of Manitoba, 2012b).

Public transportation in rural areas in Canada is infrequent and may be inefficient and inconvenient (Litman, 2003). In MMF The Pas Region, the Keewatin Railway Company provides train services to fourteen communities between The Pas and Pukatawagan First Nations community. The communities in which Metis live that are served along this route include Sherridon, Wanless, and Cranberry Portage. This 400-kilometer journey takes a total of eight hours and forty-five minutes depending on weather and track conditions. Delays are common. The VIA Rail Winnipeg–Churchill line serves the Metis community of Cormorant in MMF The Pas Region, leaving The Pas at 1:45 a.m. and arriving in Cormorant at 4:12 a.m. This trip costs $21.00 one way. This line also serves Thicket Portage, Wabowden, Gillam, and Pikwitonei in the MMF Thompson Region (VIA Rail Canada, 2012). Train service from The Pas to Winnipeg is available twice a week, and takes about thirteen and a half hours each way at a cost of ~$260.00 for return tickets (Via Rail Canada, 2013). No bus service is available to directly link the communities in the study to the larger centers of Flin Flon or The Pas. Overnight bus service between The Pas and Winnipeg is available on a daily basis at a cost of ~$190.00 return (Greyhound, 2013).

4.2.7 Emergency Services

The resources to which individuals have access determine, to a large extent, health inequalities (Bernard et al., 2007). Health status, health behaviours, and utilization of health care services are associated with where people live, and with important access issues (Laurent, 2002). A trip in excess of an hour's duration can have health implications to a mother who is in labour, or a stroke victim who is waiting for an ambulance for transport to the nearest medical facility (Spatz, 2000). In the event of a heart attack or a stroke, early intervention maximizes the benefit of intervention and prevention of permanent damage (Canadian Stroke Network, 2011; Lacy, Suh, Bueno, & Kostis, 2001; White, 2011). Delays in intervention will have serious health outcomes.

Two levels of critical care are available in the province. Staff at Level I trauma centres play a central role in the provincial trauma system and service the majority of trauma care in the system. These centres have academic leadership, teaching, and research programs. Level II trauma centres are similar to Level I centres but without the academic component. In Manitoba the Level I and Level II trauma centres are located in the southern cities of Winnipeg and Brandon. These centers serve the Province of Manitoba and Nunavut Territory. In Manitoba, 69% of the population lives within a one-hour radius of these trauma centres travelling by road; approximately 23% live outside the two-hour radius and some 8% live outside a four-hour radius (Hameed et al., 2010).

While the above statistics (Hameed et al., 2010) are used to show that distance to a trauma centre is a serious issue in Manitoba, the problem might be minimized when overly simplified methods are used to determine rural and remote communities' access to emergency health care (McGregor, Hanlon, Voaklander, & Kelly, 2005). The use of straight-line distance measurements by planners provide an efficient way to estimate travel time but also yield an underestimation of rural residents' issues with poor road coverage, climate and topographic barriers, and variable road conditions.

In Manitoba, ambulance services are provided by road and by air. As of February 2012, the Province of Manitoba has contracted with the Alberta-based Shock Trauma Air Rescue Society (STARS) to provide helicopters and emergency care in the Province. Currently 16 Manitoba-based staff members provide services and the organization has hopes of doubling this number in the coming year. The helicopters are currently based in Winnipeg, making travel times to patients 2 or more hours to get to patients in southern and mid-Manitoba. Effectiveness of this service is dependent on weather conditions, availability of resources, location of landing sites, and the condition of the patient (STARS, 2012). The study sites are not located in the catchment for STARS thus this service is not available to the study sites.

Emergency air transportation in northern Manitoba is generally accomplished using fixed wing airplanes. *Lifeflight* is based in Winnipeg and provides on-call service seven days a week with a team of specialized physicians (critical care, emergency ad obstetricians) as well as trained and experienced nurses. "*Lifeflight* provides the primary means of air transport for all seriously ill or injured Manitobans from areas outside the 80 mile radius of Winnipeg in rural and northern Manitoba to urban referral centers in Winnipeg" (n.p.) (Government of Manitoba, n.d.).

4.2.8   Access to Preventative and Community Health Services

Those living in rural communities should also have access to services that promote healthy lifestyles at home, work, and play. Parks, playgrounds, walking/cycling paths, traffic safety, exercise facilities, and organized sports in a physically safe environment can support healthy living (Bernard et al., 2007). With the availability of health services comes the availability of health education for recovery, prevention, and amelioration of chronic disease. Health promotion is a mandate of health services in the Nor-Man health authority (Nor-Man Regional Health Authority, 2000). Health resources such as comprehensive medical centers, as well as services for those who aged, individuals living with disabilities and those affected by family violence are needed. Support groups and palliative services are also health resources that benefit many in the community. Information sources such as public libraries and the internet provide the resources necessary to learn more about self-care and to promote health and wellness (Spatz, 2000). In addition, formal education is directly linked to improved health indicators later on in life for individuals and their children (Haycock, 2010). While schools can be used as direct contacts to educate, provide immunizations, and monitor children's health, formal education can also affect health in three areas: health knowledge and behaviours, income and resources, and social and psychological factors (Haycock).

4.3 Innovations and Best Practices in Rural Health Care

According to Bernard et al. (2007), an equitable society would make health resources universally available to all members of a community according to their needs. Those planning health care systems must take into consideration determinants of health such as gender, occupation, education level, environment, and cultural background. Planners should also acknowledge the utility of non-physician personnel (e.g., specialists, nurses, occupational therapists, physiotherapists, audiologists, and dietitians) to help alleviate physician shortages in rural regions and improve access to health services for individuals living in these regions (Laurent, 2002). In the following subsections we discuss various health resources that might contribute to increasing access to health care.

4.3.1   Telehealth

The use of electronic technologies by providers enables information and communication technology to help eliminate the issue of distance between patients and healthcare professionals. Technologies that are available include a wide variety of mediums such as telephone, fax, e-mail, computer, etc., but interactive video transmissions are typically used today to exchange health related information (Peddle, 2007). It is important to note that telehealth services seem to be most productive when they are used as a complement to traditional health services. This type of service can greatly improve health care service delivery in a variety of fields for clients living in rural and remote areas across the province or the country, helping to reduce the instances and costs of patient travel; however, telehealth is not recommended to be used as the only source for service provision, even in remote communities (Mitton, Dionne, Masucci, Wong, & Law, 2011).

In Alberta, the use of teleophthalmology services by service providers has helped many rural residents with diabetes cut travel costs and time for essential retina screening appointments. As of 2009, through this service more than 5,500 patients were assessed, 930 were referred for additional testing, and 2% of assessments have required referrals for an in-person examination due to poor image quality of retina scans (Ng, Nathoo, Rudnisky, & Tennant, 2009). Additionally, such services can be combined with mobile health clinics with professionals who assist with retinopathy, glaucoma screening, and other exams related to diabetes maintenance (such as foot examinations, blood testing, blood pressure checks, and height and weight measurements). Mobile medical staff can work in conjunction with specialists in urban centres to provide quality care (Jin, Martin, Maberley, Dawson, Seccombe, & Beattle, 2004).

In Manitoba, telehealth sites are located in all 11 RHAs. In Nor-Man health region, in which MMF The Pas Region is located, there are six sites: Easterville Nursing Station, Grand Rapids Nursing Station, Flin Flon General Hospital, Snow Lake Health Centre, The Pas Primary Health Care Centre, and The Pas Health Complex (MBTelehealth, 2012). The provincial telehealth program provides services for specialist appointments, discharge planning, and case conferencing. The use of the telehealth program by service providers allows for support for regional administration, is a resource for creating support groups and televisitation, and provides monthly educational topics for both patients and practitioners. During the month of June 2012 for example, several educational opportunities were given through telehealth services including: diabetes education; cardiology; internal medicine; anesthesia; pediatrics; cancer; Telehealth 101; obstetrics; nutrition and oral health; clinical nutrition; Alcoholics Anonymous support group; palliative care; autism; maternal health;

women's health; occupational therapy; and issues in communication, language, and confidentiality (MB Telehealth). Not all of the communities in this study had in-house access to telehealth services; some residents would have had to travel to access the service.

4.3.2 Community-based Health Services

The argument has been made that an active strategy in providing health care services is more effective than the passive alternative (Mikkonen & Raphael, 2010). As Gupta, Roos, Walld, Traverse, and Dahl (2003) suggested that by actively bringing health services to clients, instead of expecting individuals to come to the health services, practitioners can reach a larger percentage of the population. Programs that are based in the community, rather than in the hospital, are exemplars of this active strategy.

One example of a community-based health service is the Manitoba Breast Screening Program. Since this program began in 1995, mammography screening services in rural and remote Manitoba communities have become more accessible through the use of mobile vans, which travel to about 50 communities each year. In Manitoba, bringing the services to women in rural communities dramatically increased the amount of breast screenings in these areas, thus decreasing the longstanding disparities between the rural and urban demographics and people from different socio-economic classes. Between 1991 and 1999, rural coverage for breast screening rates rose from 12.6% to 52.7% (Gupta et al., 2003). By providing other itinerant services like the Breast Screening Program, access to health care could be improved for rural communities.

4.3.3 Nurse Practitioners

The employment of nurse practitioners (NPs) is a potential solution to the problem of recruiting and retaining physicians in rural, northern, and remote communities. NPs involve patients in decisions related to care, help to improve access to primary health care, reduce pressures in the health care system, and build trusting relationships that are valued by patients (Canadian Nurses' Association, 2011). Studies on patient satisfaction have found that often patients are more satisfied with NPs than with physician services because NPs spent more time with their patients and provided them with more information (Horrocks, Anderson, & Salisbury, 2002; Kinnersley, et al., 2000; Mitton, Dionne, Masucci, Wong, & Law, 2011; Thrasher & Purc-Stephenson, 2008).

Despite positive results in working with patients, the role of the NP has been slow to develop in Canada. Lack of legislation and regulatory authority for the role, unclear descriptions about role definition, lack of established funding mechanisms, opposition from the medical profession, and inconsistent educational requirements are barriers to implementing the NP role nationwide (Sangster-Gormley, Martin-Misener, Bowne-Wamboldt, & DiCenso, 2010).

In Manitoba, professionals in these positions have undergone graduate-level training allowing them to work autonomously to diagnose and treat clients. NPs prescribe medications, order and interpret screening and diagnostic tests, as well as perform minor surgical and invasive procedures within their particular scope of practice (College of Registered Nurses of Manitoba, 2011). NPs seem to be a limited resource in rural Canada. In 2009, the majority of NPs worked in urban centres (78.8%) while the remainder worked in rural (9.5%) or remote communities (10.6%) (Canadian Institute of Health Information,

2010). On a national scale, trends between 2005 and 2009 showed that NP positions more than doubled from 943 NPs in 2005 to 1,990 NPs in 2009. The majority of these positions were full-time employment.

In Manitoba, legislation for NPs was implemented in 2005 (Canadian Institute of Health Information, 2010). As of December 31, 2013, 131 nurses were reported as practicing in an 'extended practice' role in Manitoba (College of Registered Nurses of Manitoba, 2014).

4.3.4   Midwives

According to the Midwifery Act of 1997, "the practice of midwifery means the assessment and monitoring of women during pregnancy, labour, and the post-partum period; and of their newborn babies, the provision of care during normal pregnancy, labour, and post-partum period; and the conducting of spontaneous vaginal deliveries" (Province of Manitoba, 2010, n.p.). In Manitoba, midwives are employed by the RHAs and are funded by the Province. Their services are covered through Manitoba public health insurance. In Manitoba, standards guide their practice (College of Midwives of Manitoba, 2005).

There are many benefits of midwives working with women in remote areas. In addition to eliminating travel time for appointments and associated expenses for women, midwives are also able to support and share knowledge in a culturally appropriate manner, supporting that empowerment of women and communities (Kreiner, 2008).   Historically, midwives historically played an important cultural role in Metis maternal and child health (National Aboriginal Health Organization, 2010). Today, the delivery of maternity care in Manitoba is generally centralized in hospitals that are located in urban centres (Carroll & Benoit, 2004). In rural and remote communities, women at risk for complications are temporarily relocated to reside near a hospital for up to six weeks before their due dates (Kreiner, 2008). Even women, who are at low risk for complications during childbirth, may be asked to leave home before their due dates. Having trained and certified midwives permanently located in these communities would reduce the need for relocation of women who are at low risk for complications during delivery, in turn reducing the financial and emotional strain on these women and their families.

Chamberlain, Barclay, Kariminia, & Moyer (2001), in their evaluation of a birthing centre in the Northwest Territories, reported stress as a major outcome associated with mothers having to leave their home communities to give birth. Women reported homesickness, depression, lack of support, boredom, and difficulties with being surrounded by strangers and a strange environment, culture, language, and food. In addition to this emotional stress, the women incurred financial hardship related to the cost of babysitters for children left at home, airfare and absence from work for the partner, and long distance phone calls. The birthing centre where this evaluation took place, 1000 km by air from Winnipeg on Hudson Bay, was opened in 1993. The Centre and the presence of midwives had a positive influence on expectant mothers—since they were able to give birth closer to home and receive care from in keeping with their culture and language, much stress was reduced. The midwives continued to provide care to these mothers in the study by visiting them in their homes after the births (Chamberlain et al., 2001). Couchie & Sanderson (2007) also reported that First Nations, Metis, and Inuit populations want local women to be educated to deliver midwifery services within their communities. They stated that First Nations, Metis, and Inuit women want to choose where they give birth and who provides maternal care to them. They

recommend midwifery as an integral part of the changes to maternity care for rural and remote First Nations, Metis, and Inuit communities.

4.4 Summary

In Canada, health disparities are substantive between urban and rural communities, and Manitoba is no different. The province's centralized health system and geography create immense challenges for providing quality health care to rural and remote communities. While much research has been done regarding the state of rural Canadian health care, little is known about health care in rural Metis communities. Studies have identified many of the barriers to rural health care provision including: recruitment and retention of health care professionals, transportation, access to emergency services, excessive physician-to-patient ratios, and additional out-of-pocket costs for services users. Innovations such as telehealth, community-based health programs, midwives, and nurse practitioners are new ways to provide affordable, accessible, culturally appropriate, quality health care to Metis citizens in rural and remote communities across Manitoba.

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Section 5: Research Design

5.1 Methodology

A community-based participatory research (CBPR) approach was used in this study. CBPR is a collaborative approach to research that equitably involves all partners in the research and process and recognizes the unique strengths that each brings (Israel, Schulz, & Parker, 1998). CBPR is used to engage with community partners—in this case the MMF community—in the research process, and to benefit the community by translating the knowledge gained in the research into intervention and policy change (Cargo & Mercer, 2008). This process in turn is used to create social change, build relationships based on trust, improve the quality of life for community partners, and give them a voice (Israel et al., 1998). A guiding principle of CBPR is that the community is seen as a unit of identity. CBPR has a co-operative focus—to engage community members and researchers in a joint process in which they contribute equally. Other guiding principles ensure that CBPR is:

- Conducive to co-learning and a capacity building process;
- Empowering to community partners (builds on strengths and resources of community);
- Mutually beneficial with a balance between research and action; and
- Recognizant of the long-term, cyclical, and iterative nature of the CBPR process.

In keeping with the principles of CBPR, this research was conducted in collaboration with members of the MMF community, who assisted in every phase of the project—from selecting the study sites, through recruiting participants, to analyzing the data, and to interpreting the data. Community members on the research team also reviewed the preliminary report and assisted in dissemination of report results in the community. Building on the research relationships that were developed during the process of this study, a subsequent study examining access to maternity care for Metis women has been undertaken in this region.

5.2 Methods

5.2.1 Protocol for Entry into Communities

In recognition of, and in commitment to CBPR principles and to strengthen bonds of trust with the Metis community, researchers in this study followed a specific process to obtain permission and gain access to Metis communities to collect data. This process engaged community collaborators at each step. A letter of support was secured from the Vice-President of MMF The Pas region. The Region's Knowledge Network Coordinator assisted in recruiting participants by contacting the Chairs of the Metis Locals in regional communities and informed them of the research to garner interest among local Metis citizens. The Knowledge Network Coordinator arranged meeting spaces, provided refreshments for the focus groups, and attended all focus groups and interviews to introduce the researcher and assist with note taking as well as data analysis.

A letter of support was also obtained from the Nor-Man Regional Health Authority to gain permission to approach professional health care workers employed with the Nor-Man Regional Health Authority.

5.2.2 Data Collection

The Metis communities in this study were identified by The Pas Knowledge Network based on their status as rural/remote communities, and anecdotal experiences of the community research team that MMF members in these communities had experienced challenges with health service delivery access. The identity of the participating communities has not been disclosed throughout the entire project in order to protect the anonymity and confidentiality of the research participants. Participants were chosen through snowball sampling (Miles & Huberman, 1994), with key people providing the community collaborators with the contact information of those who had indicated an interest in participating in the project. In order to inform community members about the study, posters were also displayed in the local post offices, Friendship Centres, MMF Regional Office, and Metis local offices. The poster was also printed in the MMF regional newsletter. Radio advertisements were also broadcasted on local community radio stations.

Once participants were recruited, the Project Coordinator, with guidance from the Co-Principal Investigators, obtained informed consent from each participant. Individuals who were interested in participating had the study explained to them, were provided with an opportunity to ask questions of the researcher, and were asked to read and sign the consent forms. The consent form was explained in detail as required.

Focus groups and key informant interviews were carried out in three communities. Throughout the data collection period, two visits were made to each of the communities. Two focus groups were conducted in one community and one was conducted in each of the other two communities. On two occasions when the team arrived in the community no one was available to participate. Each focus group involved 5–12 participants with a total of 26 individuals participating in the focus groups. Basic demographic information was collected from the participants—this information was anonymized, aggregated, and used for descriptive purposes only.

Each of the four focus groups lasted approximately 1.5 hours. Prior to the focus groups, participants were given an orientation to the Metis Life Promotion Framework© and the Wellness Areas© in order to build familiarity and comfort with this holistic approach. During the focus groups, participants were asked a series of questions based on the Wellness Areas© (See Figure 3.4.1) (Bartlett, 2004).

Seven key informant interviews were undertaken with health service providers using a semi-structured interview tool in order to create a holistic picture of the northern health care system, including its strengths and challenges. The key informants were individuals who provided health services in one, or more, of the study communities. They were health providers employed with the Regional Health Authority, or physicians practicing in the region. Each person who volunteered to participate was interviewed. The key informant interviews which lasted approximately 1.5 hours followed a structured format using an interview tool. Respondents were asked questions pertaining to community strengths and weaknesses, existing health-related services and programs in the community, barriers to care, and their own personal experiences.

5.2.3 Analysis

The data analysis was conducted by all members of the research team using the Collective Consensual Data Analytic Process (CCDAP) (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell,

2007). Key informant interviews and focus group discussions were transcribed by the Project Coordinator. Each transcript was reviewed and coded separately by two people— the Project Coordinator and one of the principal investigators. In this coding process, each narrative was broken down into ideas, and key phrases were identified. These phrases were then printed onto cards. The two coders then compared their coding to ensure consistency in coding or inter-rater reliability. After all of the transcripts were coded, the entire research team met in a facilitated analysis session. The team worked collectively to cluster the cards under random symbols. Once all the cards were placed on the wall, the clusters were themed according to the information they contained. For each community, two groups of analysis occurred: one for Metis health service consumers and the other for service providers. After this process was completed, analysis across communities was undertaken to identify common areas of needs and strengths, and to answer the research questions. Results of the analysis are presented and discussed in Section 6. To protect the anonymity of participants, names are not attached to quotes used in the analysis and results.

5.3 Ethics

The fundamental tenet of the project is that it was founded within an 'ethical space' whereby representatives of the Manitoba Metis community could meet together with researchers through all stages of the research project in order to engage in a constructive dialogue about the intentions, values, and assumptions of each project partner. Constant engagement in this 'ethical space' allowed for a deeper understanding of the unique perspectives of Metis community representatives and researchers, the development of common interests for both partners, and the promotion of mutual respect and trust which has continued even after the completion of the research project (Castellano & Reading, 2010; Ermine, 2007). Indeed, the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (2010) advise "taking time to establish a relationship can promote mutual trust and communication, identify mutually beneficial research goals, define appropriate research collaborations or partnerships, and ensure that the conduct of research adheres to the core principles of respect for persons, concern for welfare—which in this context includes welfare of the collective, as understood by all parties involved—and Justice" (p. 110). Principles of Metis-focused research (ownership, control, access, and stewardship) were negotiated and respected throughout the research process.

Ethical approval for the project was secured through the University of Manitoba Human Research Ethics Board (Bannatyne Campus).

5.4 Rigour and Trustworthiness of Data

In any qualitative study it is essential to discuss the topic of trustworthiness as it relates to the study findings. There are a variety of methods by which a qualitative study can be evaluated to establish its trustworthiness. One of these methods is to apply Guba & Lincoln's (1989) set of four evaluative criteria to the study. These four criteria include credibility, transferability, dependability, and confirmability. To achieve the first criterion, Shenton (2004) listed a number of measures that can be taken by researchers, some of which include adopting well established research methods; developing an early familiarity with the subjects' culture; triangulating (the use of different methods such as focus groups and personal interviews); using tactics to encourage honesty in informants; peer scrutinizing of

the project; and examining past research findings to assess congruence with the current research. We believe these steps have been taken in this study—a testament to the credibility of this research. Shenton discussed the difficulty in applying the research findings to other situations and populations but indicated that to allow transferability, the second criterion, researchers must provide enough detail on their study to allow others to replicate the study. In order to meet the second criterion, we have carefully documented the methods used in this study. In order to establish confirmability we have taken steps to ensure the findings accurately represent the data, by ensuring that the original coding was completed independently by two individuals and that our analysis process was done collectively. We believe that we created knowledge in a systematic manner that builds on previous literature and extends the understanding of the experience of Metis living in northern Manitoba in accessing health services. Understanding of these experiences may ultimately lead to better support for those seeking services.

5.5 Knowledge Translation

Knowledge Translation (KT) is an important aspect of successful community-based research (Masching, 2006) used to focus on the interactions or partnerships between the research team and end users to facilitate the use of research findings in decision making (Shea et al., 2005). KT is accomplished by generating and mobilizing research findings into a structured knowledge-sharing platform, ensuring appropriate engagement amongst researchers, policy developers, program deliverers, and communities of interest.

The results of the study are being used to produce this report for the Manitoba Metis Federation. Data will be reported in an aggregate form, and no participant-identifiable data will be presented. All publications are subject to prior review by the Manitoba Metis Federation. Community members on the research team will review the draft report and data synthesis, and will participate in the dissemination of report results in the community. Additionally, information will be disseminated to the communities in the more established mechanisms of newsletters, face-to-face sessions, and at their annual general meeting. Participants have also been offered the option of having the report mailed directly to their homes. Abstracts will be submitted to relevant academic conferences.

5.6 Limitations

Throughout the study, the researchers encountered several limitations. In the original study protocol, four communities were identified as meeting the selection criteria and were confirmed as study sites. During the data collection period, remoteness and isolation of the communities as well as their small populations often resulted in inability to recruit sufficient Metis participants for a focus group. In one site, physical access was limited to heavily travelled logging roads. In collaboration with local representatives, the research team decided that data collection would not occur in one community due to safety concerns with logging truck traffic as well as inconsistent road conditions. It is notable that our inability to access the community to conduct data collection speaks to the further reduced access to health services for residents of this community. In another community, despite securing commitment in advance and prior advertising using posters and radio, researchers were unable to garner interest to participate after two visits to the community. Thus, there arose a need to change study communities mid-study. Given the timeline for the project, the team decided to amend the research protocol from four communities to three and to identify

another community to engage in the research. Even with the change to protocol we were not able to meet our target of two focus groups in each site.

The objective of the focus groups was to better understand Metis health issues using the Life Promotion Framework©, and a Wellness Workshop was used to explain how the framework could be interpreted. However, participants had difficulties with the abstract nature of the questions and at times felt unable to answer them. With prompting, and further clarification of the questions, this issue was addressed within the sessions. This experience will shape the process used in developing the questions for subsequent research endeavours. The conceptual model will continue to be used in subsequent studies; based on this experience the questions we use in the focus groups will use clearer language.

Despite these limitations, the team felt that data saturation had been reached in the focus groups and key informant interviews, as ideas began reappearing in the separate sessions.

As with any qualitative study, the data are comprised of the experiences of a few individuals and are not generalizable to the larger population. Nonetheless, given the lack of Metis-specific information regarding access to health services for rural/remote Metis, outcomes will be of interest to other MMF Regions in the province as well as in other provinces. As the responses were not ranked by participants in order of their importance to them, further research is needed to provide policy makers with substantive evidence for program direction. The ideas in this report, however, offer an important and useful starting point for discussion.

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Section 6: Findings

In this Section, the results of the study will be presented and discussed. As described in Section 5, focus group discussions with Metis health care consumers and key informant interviews with health service providers were recorded, transcribed, and analyzed using the CCDAP method. The voices of Metis health care consumers will be presented and discussed in Section 6.2 and those of health service providers will be discussed in Section 6.3. Interestingly much overlap is apparent between some sections, as many of the issues are intertwined. Therefore, issues may be presented more often if they were discussed in focus groups and in key informant interviews.

6.1   Study Sample

Study participants from the three study communities were chosen using the methods outlined in previous sections. Throughout the data collection process, a total of 26 Metis people from three rural/remote communities north of the 53rd parallel in Manitoba took part in four focus groups. In the original study design two focus groups were planned in each community to maximize the opportunity for community input. Two trips were made to each community however despite extensive advertising including word of mouth, radio ads, and posters in the community, individuals did not come to focus groups in two instances. As a result only four focus groups were held instead of the six that were originally planned. We believe sufficient data were obtained from the four focus groups to provide direction to the Knowledge Network.

All participants submitted the demographic information sheets: participants were about equally divided between males and females (46.2% vs. 53.8%, respectively). About one-third of the participants (30.8%) lie in the 31-40 years age group. Participants whose age at the time of interview was 60 years or younger constituted 69.2% of the study sample, while those older than 60 years composed roughly one-third of the sample (30.8%). Over half of the participants in the study earned less than $15,000 annually (57.7%) and a small number of participants (7.6%) reported earnings above $45,000. Most participants achieved an educational level between grades 5 and 10. Employment status was divided into three categories: paid (53.8%), family (15.4%), and volunteer (3.8%); seven people chose not to respond to this question. Participants were not asked the exact nature of their employment (i.e., what did they did). The demographics may reflect the relatively high level of unemployment in the community as well as those participants over the age of 60. Only two participants had lived in their communities for less than ten years (7.7%); the majority had lived in their community between 11 and 40 years (57.8%), and the remainder had lived in their communities for more than 40 years. While most participants reported that they had access to transportation (73.0%), seven individuals (27.0%) had no access to transportation in the community. Twenty-three participants (88.5%) had used health services in the past year. A wide variety of health services were accessed by participants, including health centres (50%), physicians (73%), public health nurses (81%), dentists (50%), pharmacists (58%), nutritionists (12%), and other services (8%). The other services accessed were a respirologist and emergency medical services such as ambulance. The following table (6.1) illustrates the demographic information that was collected from the study sample.

Table 6.1 – Demographics and Characteristics of the Study Sample

Sample criteria	No.	%
Age:		
≤ 20	1	3.8
21-30	4	15.4
31-40	8	30.8
41-50	2	7.7
51-60	3	11.5
61-75	4	15.4
>75	4	15.4
Sex:		
Male	12	46.2
Female	14	53.8
Annual Household Income:		
0 – $15,000	15	57.7
$15,001 – $30,000	5	19.3
$30,001 – $45,000	3	11.6
$45,001 – $60,000	1	3.8
> $60,000	1	3.8
No Response	1	3.8
Education Level Obtained:		
< Grade 5	1	3.8
Grade 5 – 10	16	61.5
Grade 11 – 12	6	23.2
Some university or college	2	7.7
University or college	1	3.8
Employment Status/ Type of work:		
Paid	14	53.8
Volunteer	1	3.8
Family	4	15.4
No response	7	27.0
How long have you resided in your community?		
< 10 years	2	7.7
11 – 20 years	5	19.3
21-40 years	10	38.5
41-50 years	2	7.7
>50 years	6	23.2
No Response	1	3.8
Do you have access to transportation?		
Yes	19	73.0
No	7	27.0
Have you used health services in the past year?		
Yes	23	88.5
No	3	11.5
If yes, what services have you used?		
Health Centre	13	50.0
Doctor	19	73.1
Public Health Nurse	21	80.8
Dentist	13	50.0
Nutritionist	3	11.5
Pharmacist	15	57.7
Respirologist	1	3.8
EMS	1	3.8

6.2 Metis Health Consumer Voices

While each of the three communities in this study is unique, their residents share many of the same challenges and barriers to health services. The information presented in the four focus groups is an aggregation of the Metis voices from the participants in all communities involved in this study. We have used this approach to assure, to as great an extent as possible, the anonymity of participants in the report.

In order to gain an understanding of the experiences of the Metis community members as health care consumers, participants were asked to respond to a series of open-ended questions based on the Wellness Areas© posed to them during the focus groups. The following topics emerged as important themes related to Metis consumer health care experiences: 1) socio-economic situation of their communities; 2) individual and collective governance issues; 3) Metis consumer experiences with health programs and services; 4) community health needs; and 5) other community needs and resources.

6.2.1   Socio-Economic Situation of the Communities

Community Memories

Participants shared their favourite memories of growing up in their communities. Many of these memories reflected times past and different lifestyles. Some participants talked about sharing time with friends and family, and of communal events like dancing, hockey, and bingo. Others talked about fishing, trapping, and hunting. Still others reminisced about spending time outside working the land and cutting wood.

> *"When we were young it was straight bush. We cleared the land. Me and my husband used to clear the land. We used to go in the bush overnight, and take our children out there and cut wood".*

Participants also talked about 'Metis Days', but reported that the celebration no longer occurs in their community due to insufficient funds.

Economic Opportunities

While participants emphasized that little opportunity for full-time employment is available in any of the study communities, some job opportunities do exist in the natural resource industries in all three communities, either on a seasonal or casual basis. In one community, University College of the North (UCN) has been training people in the plumbing, welding, and carpentry trades in order to start a local housing project. There are also 'odd jobs' to help make extra money; however, there seemed to be a general sense that it was "mostly the same people doing the jobs" and therefore not a lot of opportunity for others to do this kind of work.

In several communities, the Province of Manitoba supports summer jobs for youth through the 'Green Team' summer program. Despite these opportunities, participants were outspoken about the current unemployment situation.

> *"I don't think we're as bad off as some places like those fly-in communities. But there are some things. Like you know a lot of us here, over half this town is on social assistance or unemployment…".*

Family and Community Supports

Formal and informal supports for people to become and to stay healthy exist in all the communities. While formal supports, such as a recreation facility or a disease-related support group, were less commonly reported by participants, examples of the informal support offered by family and friends were abundant. One person told us:

> *"I go to the [local hangout] every night at 8 p.m. and us old farts sit around and talk for an hour, an hour and a half, or whatever. It's just, then we drink our three coffees...it is networking".*

Among participants, genuine concern was shown for the health of their family members and friends. They related stories about advocating and helping friends and family. In one instance a family member left the community to receive training so she could take care of her ailing grandmother. Another participant looked after her siblings when her father went to Winnipeg for physician's appointments.

Community Involvement

Moving beyond the role people played in their immediate families, participants talked about playing a role in the functioning of the greater community. In one of the study communities, participants explained that regardless of whether one is Metis or First Nations, "people help each other". In some cases, participants had moved back to their communities after having been away, in order to get involved and support local initiatives.

> *"I lived in the city and then I've been back for 4 years…the reason I came back was for my family and just getting involved with things…hoping to get other things done for the younger kids around here. Maybe getting a youth centre going".*

In another community there were mixed opinions about supporting community and, specifically, about having children around. One participant liked having kids around to help her whereas another participant worried about children visiting.

6.2.2   Individual and Collective Governance Issues

Community Leadership

As individuals living in rural communities, participants contributed different ideas around their experiences with 'voice' and the ability to make themselves heard or have someone speak on their behalf. Reports on experiences with local governance varied. In one community it was noted that the mayor and councillors represent them well. Changes such as minor infrastructure projects have been attributed to current leadership at the local level.

That was not a universal experience, however. In other communities, members felt "they were not listened to" by the local municipal council and that they had to adapt to their situations because "nothing was going to change".

One participant shared this observation:

> *"I just have to accept it the way they [the local council] say it is because no one is going to change anything for us. We have to go with the flow".*

In another community, participants felt that the local council should consult with the entire community and bring in programming to meet the needs of everyone not just one group.

Community and Metis Voices

While many participants indicated that they felt they have little influence with the municipal officials, there did seem to be confidence in the Metis Locals[4] to help improve community life and to provide Metis with a voice. Participants in one community credited the MMF Local with the successes they have had:

> *"The only thing we got is because we're on this MMF Local in the community so we can out-number the council sometimes".*

It was suggested that MMF Locals also help bring more coherence and community spirit to the communities by organizing social events and bringing Metis together. However, while the MMF helped to support their voice in the community at times, participants reported that there were scheduling issues between the MMF Regional staff and their MMF Local, particularly when coordinating visits to the community.

Self-Advocacy—Individual Voice

Individual voice refers to the ability to speak for oneself and manage the course of one's own affairs. In view of this definition, several participants voiced the hope that other community members could mobilize themselves to implement change rather than merely talking about it. While we heard that participants did not always advocate for change in the community, some did. One participant reported advocating for change for themselves with the store manager, by discussing the possibility of making appropriate food available for purchase for those living with diabetes.

> *"Yes I know [there is little fruit in the store] because I went and complained because they didn't have any rye bread to…Nothing for a diabetic here. They don't have any food. I got them to order some food for a diabetic…".*

When it comes to communicating with a health care professional about their health, for the most part, participants did not report having a problem talking to their physicians. *"I can't talk for others, but I don't have a problem expressing issues with the doctor".* Other participants were very clear about having a need for someone to speak for them when they were ill. We heard from a few participants *"Well you need someone to talk for you if you're sick".* Furthermore, some found asking for information about health to be intimidating and reported *"feeling stupid"* and *"embarrassed"* when asking questions of their doctor. *"It's scary; you have to go ask for it [health information]".* Thus there may be a dissonance between asking for services when you are healthy and requesting medical assistance when you are ill.

Perceptions of Inequality

Participants described ongoing tensions that exist between Metis and First Nations Peoples. Often these tensions are politically charged and augmented by perceptions of inequality felt by Metis community members. Perceived inequalities include the awareness that First Nations communities receive more funding for programs and services than the Metis communities do. Many of these tensions are of a political nature based on entitlement, funds, and access to services. Some participants also suggested that politicians only come to

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[4] According to the Manitoba Metis Federation Constitution (2008), "The Federation shall be organized on the basis of regional associations ("Regions") which shall comprise the total of local associations ("Locals") within the boundaries of each Region". Each of the communities in this study was a separate MMF local.

the community to garner votes and bring benefits to the neighbouring First Nations community, and that the Metis community rarely benefits from these negotiations.

One participant gave his/her reason as to why health and social services provided to Metis in northern and isolated Metis communities should be equivalent to those offered to First Nations counterparts:

> *"…the Metis are as local as they [First Nations] are or were, so I think health services should be the same; there should be no distinguishing in a health profession manner. This community should get defined as an <u>isolated</u> community and everyone gets treated equally…".*

Participants also felt that all Manitobans should be treated fairly. However, they felt that they are seen as being racist when they expose injustice or unfair treatment. Despite this claim, and the price one participant feels the Metis have paid for voicing their opinions, it was felt that it is important to have their voices heard.

> *"Well we are almost a forgotten entity and I know they've started now for years and years and we're just starting to be heard, but there is a hell of a price to be paid for getting heard".*

Impact of Bill C-31

The consequences of Bill C-31 on Metis were discussed at length. Under Bill C-31, some Metis citizens—specifically, some children and women who had previously been refused treaty status—were given the opportunity to qualify for treaty status (Furi & Wherrett, 2003). The benefits associated with treaty status—such as coverage for medications, housing, and access to many programs and services that have not historically been available to Metis— were believed to be an incentive for some Metis to renounce their Metis identity and "become treaty". In some circumstances, this move was strategic and based on a need to access health services and medications that they were unable to access as Metis citizens.

In one community, a number of participants related that the amount of people signing up for treaty rights under the bill and moving into the First Nations community has dramatically changed the face of the Metis community.

> *"We've lost about 90% of the Metis members that were [here]. This used to be a pretty strong Metis group in the 70's and 80's but now they're all C-31 so the issues are just, it's a non-issue for them".*

> *"It's [Bill C-31] changed the structure totally. Like half the town has moved across to the reserve for obvious reasons—free housing".*

While we did not hear about the impact of Bill C-31 on individual families, experiential knowledge gained from the community members of our research team created the awareness that Metis communities have been affected, and individual family units have been impacted. Clearly, for the participants in this study, the repercussions of Bill C-31 extend far beyond access to health care and housing, into issues of identity and equality, and community cohesion.

6.2.3   Metis Consumer Experiences with Health Programs and Services

This study was undertaken to allow Metis citizens living in remote northern communities to share their consumer health care experiences. In all three communities, participants were vocal, sharing positive and negative experiences. All experiences were individually-based and a reflection of the participants' interpretations of their real life experiences. Experiences

ranged on a spectrum from good quality care to feelings of neglect and inattention from health care providers.

Some participants felt they had not been treated differently and that they had good experiences with the local health care system. We heard positive stories about visiting the local health centre or nursing station, especially for management of chronic health issues.

> *"Well I've had a pretty good experience with the health [services] in town there. Like I've been treated really good by the staff and the nurses. Any emergencies that I've gone through they've treated me pretty good and my family".*

> *"...they seem to be fair with everybody".*

However, while instances of positive experiences were reported, some participants expressed distrust of local health professionals and the quality of care provided locally:

> *"We are more concerned about what's going to happen because you don't get that—it's like you're in and out and you don't get checked as thoroughly as you should and then you're sent home with Tylenol or something, and you have to come back when you're really sick".*

> *"It's like they don't care".*

> *"Sometimes the health services are cruel, mean".*

After two bad experiences, when they felt "dumb" and "embarrassed", one participant said:

> *"It made me feel alone, kind of mad you know…right now I got no faith in the town hospital…I have one good doctor…and I go to Winnipeg to see the doctors".*

Another participant suggested that to get good care, one needed to be "rushed" out of the community in the ambulance. In some circumstances, participants opted to pay or drive themselves or family members into town or to Winnipeg to seek medical attention.

However, others suggested that medical attention in the city is not much better than in their own community, or that urban physicians were unaware of the services and resources that exist in rural and northern communities.

> *"There is a sense of isolation we get here. Like when you go to the city like you're from the community so they kind of dispense with you and they patch you up and they send you back to that community and that's the end of your health care".*

While some participants reported that physicians in Winnipeg may not be aware of the resources that exist in their community, others commented that physicians in Winnipeg also do not understand the challenges of getting to an appointment outside of their communities. Another participant reiterated this point, expressing frustration about an appointment with a physician:

> *"I went to a medical in town to the doctor's clinic…I came back here, I got a message a week later at the nursing station that 'doctor so-and-so wants to see you right away'. So I drove to town, I got there; he looked at me for about 5 seconds, and said 'You're okay, I see nothing to worry about'. $80 worth of gas and 7 hours of my time, so now what's the encouragement for me to go back and ask for another medical to get the same silly reply?…I think he wanted to get his fee to see me personally, as opposed to giving the message to the nursing station. They could have told me all your tests look good. He knows where I live, he knows how far away I am, but for him he wants his $58.50".*

Health Programs and Services

Differing levels of availability of health programs and services exist in each community. Within the communities, some itinerant health services are provided by the RHA. A mental health worker visits each community twice a month to counsel people on an individual basis; although, some participants reported that was not enough to meet their needs. A diabetes education worker comes to communities intermittently. As identified in the first section, the delivery of these services varies depending on the service provider and the accessibility of the community, especially in the more remote communities.

All of the communities had Home Care service "on paper", but it was often seen as insufficient or unstaffed and therefore non-existent. In one site, no Home Care workers were available to provide services at the time in the Metis community.

Another health issue in all three communities is the wait time for medical supplies such as oxygen. It was noted that this access was very different for individuals living in larger centres such as Winnipeg.

> "Like this man here waited for how long to get oxygen? Three months? And in Winnipeg he waited two days and it showed up at his house, and here he waited three months, because it's isolated here".

Access to Physician Services

In northern and remote communities, access to physician services is quite different from access to health services in urban areas. Most participants said they have had positive experiences with their physicians and they were comfortable with them. They made comments such as:

> "I think my doctor cares".

> "I like my doctor…well he's very nice to me; he talks to me very kindly. Some doctors are very grouchy in town like they just want to know what's wrong with you and shove you out the door. My doctor sits and talks to me, he explains things to me. So that's what I like".

As all three communities are remote and have small populations, none have resident physicians. Two of the communities have physicians who visit semi-regularly. While some participants felt that physicians *were* accessible when they needed to see them, others reported that they needed to manage their own health without the assistance of physicians, as getting an appointment in a timely manner was difficult.

> "But you can't see a doctor whenever you want to. You got to make an appointment before…at least a month. Otherwise you have to go to the out-patient hospital and sit there for hours and hours".

Similarly, participants said that the scarcity of physicians also made having follow-ups very difficult, and this worried some of them.

> "It's like say if my daughter…she's been having stomach trouble, it's not only when she eats, it's just whenever. So she went and got an ultrasound done. And they haven't gotten back to her. It's like a couple months have gone by and she's working so she can't really phone during the day to say like 'what's my results, have you found anything out?' and then I'm after her…like a couple weeks I could see, but a couple of months later it's like 'okay, there is nothing wrong with you'. You know are you all of the sudden going to find out that there's something really wrong with you later, you know what's going on?"

Scarcity of physicians has left some participants unsure about ways to proceed with medications and treatments for their health.

> *"I was supposed to go back a week or so ago, they changed it to next month well. Last month I was supposed to go on the 17th or something and what I've been doing, I was on high blood pressure pills, he's trying me without them and I started feeling whatever, getting my blood pressure checked here and it's been up so like he is trying to make me get off it. I guess he ended moving my appointment up another month so further back so I didn't know if I should start taking them again or not".*

One participant joked that they would start sending the health system a bill for providing their own self-management practices!

Participants also raised the issue of the familiarity of caregivers in small communities. Some felt that personal relationships made it difficult to share personal health information with practitioners.

Continuity of Care

Community members in all three communities brought up issues with continuity of care including physicians, nurses, and other health care professionals. Continuity of care infers an ongoing relationship between one or several care providers and the patient (Encyclopedia, 2012). Continuity of care has been identified as a significant factor in better standards of care and improved health outcomes (Sudhakar-Krishnan & Rudolf, 2007). We were told:

> *"Well it would be nice if you can have a doctor for a little instead of having five for a year…I've had five doctors in the past year and they're all gone. I've had to make appointments with new doctors".*

Often participants experienced long wait periods between physician visits to the community nursing stations and, as such, personal health histories—instead of direct visits with patients—are being used between doctors and nurses to help diagnose patients. The reliability of this method of information exchange has some participants concerned.

> *"And there was no doctor here for December. The nurses told the doctor and it's just what the nurse tells him".*

One participant stated this issue very succinctly:

> *"And then where do you have the time to say, 'Oh maybe I should check on him?' It's out of his [the physician's] mind right because we're not his patients, he is [not] our doctor".*

Sources of Health Information

Participants were asked about the sources of their health information. In two of the three communities participants said that in order to be informed about health information sessions, they listened to the radio or read posters in central areas such as the post office, store, nursing station, and council office.

> *"[We get our health information] from the community, like from the council office or the Band office they have some little things on the wall".*

However, in one community no formal pamphlet or poster system is in place to inform them about activities. Most participants do not have access to the internet in their homes; however those who do use it to look up health information. Others used medical reference books to gain information on health-related topics.

One participant found the Province's regional medical help line which offers health information and assistance in emergency situations to be a helpful resource—although mentioned that few people use the service.

> *"I think it's better than calling the nursing station because the nurses just say, take some Tylenol and they [the help line] explain everything".*

> *"And they care. Like they say 'if you're not doing any better you can always call us back' and they'll give you their name so you can talk to the same person".*

When this resource was presented in the focus group, its existence was clearly a surprise to the other focus group members. This circumstance may represent a missed opportunity by the health care system to increase awareness of a reliable, 24/7 source of health information.

Finally, we were told that when participants feel they need information and there none is available, people talk to each other to discuss their medical issues.

> *"Well, look at what we [know]. Look at her she'll complain about something, that's 'oh well I had that before or whatever'. There were a couple other ones [of symptoms] like, my husband's... The symptoms they were describing that's how I felt awhile ago and it must have been blood pressure. We talk to each other".*

Access to Local Home Health Services

In one community, only elders are visited by nursing station staff in their homes; all other community members must find their own way to the nursing station. This concern was not identified in the other sites.

Some participants voiced concerns with the Home Care Program. These concerns were not experienced by everyone. For some, Home Care services are seen as a good resource in the communities, especially for the elderly and those with disabilities.

> *"Oh they [Home Care] come and clean the kitchen and bathroom, and they help with your cooking but I didn't have to. Some of them do it, prepare meals. But my husband used to, he was handicapped. He had Home Care. They'd come in and help him with the bath when he needed it".*

Access through the Home Care Program helps Metis get assistive and adult continence devices; however, one participant was unsure if Home Care still provided these services. Another participant liked the Home Care Program because she could continue to work instead of staying at home to take care of her family member.

It was suggested that, unfortunately, high demand created the need for Home Care services to reduce their hours with clients in the community.

> *"Yes, but there's a lot of people who need that [Home Care] so they cut down the hours. My sister gets bathed three times a week; Monday, Wednesday and Friday. She had a stroke".*

6.2.4 Community Health Needs

A. Transportation and Related Challenges

Access to Outside Community Health Services

Health services in the communities were described as limited. As a result, transportation to hospitals and specialists was an important topic of discussion. Participants observed that while

they were able to get their blood pressure checked at the nursing station, they needed to travel outside the community for most medical appointments or to get medications changed. In one community, the nurses are only able to do limited blood work, and in another community, access to getting blood drawn is only available in town.

This issue was indicated by one participant to be a challenge:

> *"[It is only available] in town. You have to do [blood] tests all over and starve myself. It's pretty hard to drive all the way to town just to go for blood work. Not eat all day".*

For some medical services, such as mammograms, participants said they needed to travel to town for access.

Transportation for Health Services

Transportation for appointments or to pick-up prescriptions was a topic of discussion in all of the study sites. A local community taxi service is available in only one of the communities, while in the other two communities Metis citizens are dependent on friends or family for rides. According to one participant, this situation makes getting to the nursing station a challenge, especially with multiple children in tow. Another participant also discussed the difficulties of walking to the local nursing station:

> *"Well the nurse's station here is at the other side of the river and you have to cross the train bridge to the other side of the river, unless you want to walk all the way around, which would take forever".*

We were told by participants that over time, a few community members have had to move away because of illness and there is often a lot of travel associated with chronic illness. In particular, we heard issues with kidney failure and the ensuing need for dialysis. Individuals requiring dialysis in the Nor-Man Health Region may access services in the in-hospital dialysis unit or perform home dialysis. Individuals may be considered eligible for home dialysis by their physician (Manitoba Renal Program, n.d.). This eligibility is not related to Metis status but is related to a complex set of factors including overall health status, willingness to engage in home dialysis, and availability/ability of friends or family to be trained to assist in the home dialysis procedure. However, Metis in need of in-hospital dialysis must travel great distances to access services and costly transportation is needed several times a week. Transportation for dialysis is provided and paid for neighbouring First Nations communities. This disparity was evident to participants.

> *"So you know, it's the options over there [on a First Nations community]; that funding allows for a driver, a van. They can wait for four or five hours to go through the process and bring them home but we don't have that ability. It would be on your own buck".*

In certain circumstances, participants noted that taxi services would be paid for by the health system.

> *"If it's an emergency, like even if you're in town in the hospital they'll come and pick you up…then they'll [the health system] pay for the taxi. It's some medical…she'll take you there and she'll come and get you".*

Those who are able to, often prefer to drive themselves, as sometimes taxi services are unavailable (reserved by someone else) or late. In those communities that did not have taxi service, the taxi would come from The Pas, over an hour away. Participants suggested that a medical van would be helpful to get people to their appointments.

"It would be nice to have a handi-van here for trips to town. Sometimes the taxi's not here right away…or it's full and you can't get to town…It's worrying to go there because the taxi lady will drop you off at the Dairy Queen or at the clinic and after that you roam around waiting for her…she just drops you off and you have to see the doctor, you have to walk to the Dairy Queen there and wait sometimes for five hours!"

When participants were asked why they did not carpool, they responded:

"It's cheaper to go in the taxi than to hire someone".

Participants also said they had to travel all the way to Winnipeg to see specialists because either not enough specialists were available or they were not located in town.

"…because they have to go all the way to Winnipeg. And it sucks because the doctors [specialists] they're not in town".

"I go once a month to Winnipeg…cancer…check-up. A check-up every month".

The long distance to the city was seen as a problem, and those with jobs emphasized this problem.

"Like if you're working and you need to take time off to go to the doctor in Winnipeg. It probably affects everyone who's working because you have to leave your job to go to a fifteen-minute appointment hours away".

Participants explained that, in special circumstances, patients are able to travel to Winnipeg by plane, but typically the Northern Patient Transportation Program (NPTP) only pays for bus travel. However, the bus is seen as a less reliable source of transportation.

"You could be two hours on the side of the road…2.5 hours it [the bus] was broken down by Riding Mountain. We wanted to get out, it was too hot in the bus…a lot of people complain about that…about the bus".

Medical Travel Policy

Travel for health care services is one of the largest expenses that Metis must cover for themselves. As no public transportation exists, those who do not have cars must pay out-of-pocket for private taxis to take them to town—sometimes this cost exceeds one hundred dollars per trip. The Northern Patient Transportation Program (NPTP) is a Provincial Province program that provides subsidies for authorized travel for physician appointments and emergency care for all people living in Northern Manitoba above the 53rd parallel. The Northern Patient Transportation Program (NPTP) was designed to help to alleviate the cost of travel; however, participants said the amounts provided are often insufficient.

"We have people on this side that I speak of for instance, like my son and grand daughter have to go for a doctor's appointment in Winnipeg. She had meningitis last year, she is just coming back from it…They're on provincial welfare so they got a whopping big cheque for $37 to go to Winnipeg for travelling money…The appointment is at ten a.m. so you have to take the bus the day before to get there for tomorrow. So now there are hotel rooms and all that sort of thing".

However, many participants commented that this funding is not sufficient to get to the nearest hospital and back; this problem can be particularly burdensome for seniors on a pension. If deemed necessary, NPTP will also cover the additional cost of an escort for minors and those too sick to travel alone. However, NPTP does not pay for hotels when participants have medical specialist appointments in Winnipeg.

"Oh I have to go to Winnipeg. They [NPTP] pay my bus fare there. I have to stay overnight because my appointment was at 10:30am but I have to pay for my own room. I'm not going to get reimbursed for that".

Many participants did not understand the policies related to medical travel and the rules related to compensation for this travel. We were told:

"I don't know. I don't have a clue. Well there's some different people who have been working in there and it seems like they come up with a few different rules all the time".

Metis who are currently on social assistance have some of their medical transportation covered by the program.

"You have to pay the taxi here; you have to pay the nurses. Metis have to pay their own. But there is some sort of paper for Metis on welfare and they only have to get a pink slip at the provincial building in town and they get their teeth and their medical [paid for]. We have a program, we 'keep' people on welfare but if you're working, no. But if you're on welfare they [the Province] pay for it".

Different funding models for First Nations and Metis make the logistics of travelling for medical reasons difficult and frustrating for those attempting to navigate the system.

"The only problem I had was last year, my wife had to go to Winnipeg to see a specialist, so they provided her with an escort and she's First Nations. So I was the escort. So they, the health services in town, they provided you with one night's room for the escort but not the patient. So we went to Winnipeg, I helped her, we stayed in a hotel room, come back, submitted the invoice and they told my wife that she wasn't qualified [to stay in the hotel] because she was First Nations and because they have a place to stay, a group place on Riverside Street".

Emergency Medical Transportation

The availability and use of ambulances was a concern as well. In one community in particular, participants commented on the high quality of emergency transportation services in their community.

"We have good ambulance service. I've used it three times… I worked [volunteered] for the ambulance for three or four years and the level now is considerably higher. Now they are paramedics; we were just sort of cab drivers fifteen years ago. There is a much better system now. When they come they are very thorough. That part has changed, it is much better".

In contrast, one of the communities had no ambulance services at all and participants suggested that training for paramedics and access to an ambulance in the community would be a good idea. We heard that if a community member needs emergency transportation, an ambulance must be dispatched to come from a town that is located an hour away.

In another group a participant explained that two communities currently share one ambulance service. Participants believe that because First Nations clients in the other community are completely covered for using ambulance services they can call to get paramedics to bring them to the nursing station even in non-emergency situations. This approach holds up the services for others who need the ambulance and is especially problematic because the two communities are more than 60 kilometres away from each other.

"[The ambulance costs] about $300 and… plus $3.50/km—that's on top of the things for First Nations people that are covered. So they call the ambulance whenever they want even if they don't need the ambulance; [if] they just want a ride to the nursing station. They just give the nurse an excuse…it can be held up for people who actually need it".

Compounding the issue, the cost of services, for those who need ambulance services, some participants felt discouraged to go to the nursing station in an emergency because they could not pay for the services they needed, such as medication and ambulances.

"Well if you go to the nursing station now and if I got really hurt and they go to go around, who's going to pay for the ambulance? Who's going to pay for the medication? So most of the time I don't bother going, I'll heal on my own… [I feel] unwanted because I have to pay everything myself. But Treaty people they have they go in style with the red lights and everything".

Participants in the focus groups did not mention emergency air travel.

B. Other Personal Health-Related Costs

Lack of financial support for transportation may create a barrier to chronic disease management for some individuals. NPTP does not cover travel for picking up medications, optometrist visits, or dental appointments. The Canadian Diabetes Association's *Clinical Practice Guidelines* (2013) recommends that individuals with diabetes see an optometrist for an annual specialized eye exam. If people with diabetes cannot afford to make the trip to see the eye doctor on their own, this may have serious consequences in the management of their disease.

Not being able to reach an optometrist is an issue for those who need glasses. Not being able to pay for the glasses compounds the problem.

"…I know two people who need glasses they won't go for them because they aren't free. One of them is a friend. I found two pairs of glasses over the past five years and she kept them both times because she doesn't want to go pay for her own".

Other large out-of-pocket expenses for Metis are medications and assistive devices. While some people have Pharmacare insurance, it was explained that this is based on income, and that there is a ceiling or maximum amount that can be reimbursed. Medication is expensive for many participants and is difficult for some people to afford.

"You're allowed a max through Pharmacare…$3400 a year, so that's like $290 a month before Pharmacare coverage kicks in so that's about 11 months. I only get like two or three weeks. But that's based on income and I get my pension so that's how they gauge it. Money doesn't go as far as it used to but the policies stay the same".

Aside from paying for the medication, participants told us about the cost of transporting the medication to the communities. One of the communities used to have a service where prescriptions were handled through the nursing station, but this program had ended. In all the communities, residents must go into The Pas to collect their medications either by private car or taxi.

In order to offset the cost of prescription medications, some participants said that they used traditional medicine such as willow branches and roots before they went to the nursing station for prescription medicine. This was the sole reference made to traditional healing in any of our focus groups.

C. Community-Based Health and Social Services

Participants suggested that the programs provided by the community health workers were good, but believed that few people were interested in them unless they were directly affected by a certain disease. Despite this, other participants said they would like to see more programs and activities to support a healthy lifestyle—especially for those with diabetes.

One participant noted that while occasionally Alcoholics Anonymous meetings were held in their community, a great need for more support with drug and alcohol addiction was apparent. Participants thought that such programs would also help the community be a safer place to live.

> *"What I'm really interested in, like if I call…are you having a problem right now are you an alcoholic and...You want people to be honest with themselves to get rid of that drink or that…whatever. I think we need more help with that in our community".*

For each of the study communities, the nearest woman's shelter is in The Pas; in some cases this is up to a two-hour drive. In most communities, only the RCMP is present to deal with domestic violence issues.

Historically, Metis placed high importance on the value of family. Metis families were once large and family members were bound to each other by loyalty and obligation to represent and advocate for relatives, and support each other materially and emotionally (Macdougall, 2008). Today, Metis families still live by these familial traditions thus care of seniors was seen as an issue of concern in the communities. Participants discussed a need for more health services for those who are aging as these types of services are not available in their communities.

> *"I think the older you get, the more level of services you need. I find…like arthritis...Like the nurse is here but there's a lot of things they can't help you with either".*

> *"[We need] Home Care workers working for the elders".*

Metis seniors may have to leave their communities when they are no longer able to care for themselves. While this practice did not seem to happen frequently, participants expressed sadness about having to see their seniors leave the community when they could no longer care for themselves. They believed that if appropriate supports for seniors were available in the community, then they would not be forced to leave the community, and would potentially have a better quality of life.

> *"Yes maybe every senior, just about every senior has died outside the community. They have to go to nursing homes or in care in the hospital".*

> *"Every time they send an elder to an old folks' home they go and die over there. I think they're too lonely and cooped up".*

6.2.5 Other Community Needs and Resources

In the focus group discussions, participants listed a variety of needs as well as resources that influenced their ability to be healthy. Participants articulated needs including support groups, food security, housing, personal safety, and opportunities for children and youth. These needs were common across the groups. Several resources, unique to each community, were identified.

Support Groups

While informal supports are important, participants acknowledged that more formal supports for health management would be welcomed. Currently, the only organized group in one community is the monthly church service. Some participants identified a distinct need for formal supports, such as walking and exercise groups, in order to stay healthy and lose weight.

> *"…I guess it would help to lose weight but it's kind of hard. We were walking …I guess it would be better to have groups of people [to walk with]".*

In addition to support to increase activity level, participants also felt they needed more health programs or workshops to inform people about obesity or other health issues.

Food Security

While in all three communities the issue of access to healthy food was discussed, in one community this issue was particularly concerning. For one participant, this issue was the most important topic the group discussed:

> *"Oh maybe the part about the access I think for the, for trying to live healthy and that [is the most important thing]. There is no grocery store here. We need to have stuff like that".*

Many participants commented on their experiences with trying to access healthy food and live in a healthier way. As some communities have no store, residents have to do their grocery shopping in the closest town—but not everyone can afford to travel to town on a regular basis for fresh food. Some participants said they planted gardens and raised chickens in order to help offset the cost of food; however, this is a temporary project for them. Another community has a local store, but the quality of the food is poor and the store is rarely open.

While participants seemed aware of strategies to cope with the issue of food security, one participant criticized a family member for using money to buy unhealthy food, and another was concerned about what they saw as "wasting food".

> *"We give her [problems] sometimes for the way she buys groceries—buying junk food".*

Health and Housing

Housing is an important determinant of health. Overall, participants commented that feeling safe and warm in their homes was important to them. In one community, participants explained that approximately thirty houses in the community were rented from Manitoba Housing. The local council had made an agreement to build three additional houses, but they were unsure who would live in them.

In another community, the situation was similar—many of the community's houses were rented from Manitoba Housing. Some of the participants experienced mould in their houses, which they knew had an adverse affect on their health.

> *"I've been living in that house now for 11 years and the mould is just black. You wash it, once, twice every few months and it keeps coming back. We had the chief come in and two of the councillors and they said just wash it, paint it".*

Participants spoke about the need for assurance that they could be comfortable in their homes; however, frequent power outages (especially in winter) were problematic, especially for those who rely on it for medical purposes such as dialysis.

> *"See what happens if the power goes out and it's out for two days and you know if her machine shuts down and she needs to get this fluid in her body and…how long do you figure they'd [power outages] last? Maybe six hours at the longest? ...They are usually year round. Like if we have a big thunderstorm in the summer, then in the winter you'll have a big wind storm or something or whatever".*

Physical access to one's home is a concern for some residents. Participants who live in Manitoba Housing can have ramps installed in their housing unit with a physician's order. Participants were unaware of any program for those who did not live in Manitoba Housing[5]. Even with support of physicians for the retrofitting of their home, the ability to get skilled labourers to complete the work posed a problem in at least one community.

Community Safety

Community safety was of particular concern in one community. Vandalism and theft were identified as security issues with much of this problem being blamed on youth.

> *"Yes, some kid came in to my house and just grabbed some pills off the table and I never thought so I just keep things locked up in my room when I'm not home".*

A participant explained that a community patrol had existed, but had been disbanded and as a result believed problems in the community had increased. One participant noted that firefighters had to put out fires at abandoned houses in the community. Some participants raised the issue of dogs running free in the community. Although many of the dogs were used to protect property, they have been allowed to run loose. Another individual summed up the issue of safety by saying:

> *"Well I have lots of memories because there have been so much drastic changes in 40 years that I associate with the community. When I came here, there wasn't as much violence like today. Dishonesty and crime was virtually non-existent. There's been a deterioration of social awareness, social conscience, in the last 40 years...But 40 years ago, the fishing boats are all pulled up on the shore; they had all their equipment in the boats, they had guns, nobody locked their doors…that way of life is gone now, or virtually gone. You can't leave anything outside; it's gone you know, like the fishermen have to haul everything out of their boats every night or it won't be there in the morning".*

Opportunities for Children and Youth

While participants discussed issues of safety, they also suggested that a solution would be to provide more opportunities and activities for children and youth to "stay out of trouble".

> *"That's why our young people, you see them lots in court…they don't have nothing better to do".*

Schools in the communities provide education up to grade 12, and daycares to help working parents. A dilemma that participants faced was no school buses to bring their children to school. Many parents do not have vehicles, so children are forced to walk, sometimes up to half an hour often in extremes of weather.

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[5] The Province of Manitoba offers a forgivable loan up to $3000 for those who qualify to make changes to their homes to increase access: http://www.gov.mb.ca/housing/pubs/hasi.pdf

"If kids don't go to school then the parents won't get allowance [social assistance]…but there are no buses, and parents don't have vehicles to take them…the buses [are important] even though I don't have kids, but they're important".

According to older participants in one community, after-school activities have stopped as the drop-in centre had been burned down. This statement perhaps exemplifies a lack of awareness about services that do exist in the community. A younger participant in the same focus group explained that a facility does exist and that programming is offered for youth after school and on weekends.

"There is too [a drop-in centre]…it is right behind the health centre by the school…there's that old store. They put a trailer in the back of the health office and they brought in a trailer… [it is open] six until eleven pm…they have pool, ping pong…they play man tracker [a game] at night…with flashlights you are running around in the bush".

Another participant also noted that free gym nights are available on a weekly basis, for people to play sports. Finally, one participant shared that an information line is available for youth to call if they want more information or if they are being abused.

"Not all of us want to call, but some people call for information like to ask about Herpes and STDs and they phone that line. Or if they get a beating from their old man, abuse or whatever, they phone that number and the counsellor can call a taxi and take her to the nearest women's centre".

Community Resources

Participants shared their knowledge of the resources that exist in their communities to meet many of their needs with other members in the focus groups. In one community, participants listed the following resources as currently available: fire services with firefighters who are trained in First Aid and CPR; community clean-up projects; hunting and fishing opportunities; churches; two basic stores; an RCMP station; a health centre; and a drop-in centre. All of the communities have access to a health centre where, at a minimum, emergency and preventive health services are delivered.

6.2.6   Summary of Metis Health Consumer Voices

Participants in the focus groups willingly shared their stories and experiences in the hope that the experiences of others would be enhanced. Throughout the one-and-a-half-to-two hour focus group sessions, individuals talked, laughed, and at times questioned each other about ideas that were presented. The experiential knowledge offered by participants broadened understandings about access to, and experiences with, health services for Metis citizens in these communities.

6.3 Perspectives of Health Care Service Providers

The perspectives of the health care service providers involved in this study were recorded using a semi-structured interview format. The purpose of these interviews was to provide another perspective of health care service provision in rural northern Metis communities—possibly for use in triangulating the data. Although exceptions were noted, the majority of service providers were not community members. In their discussions, providers typically divided the community by "treaty patients" (First Nations patients) and "non-treaty patients", including the Metis population in the latter grouping. The themes that emerged from these discussions with health care service providers were 1) out-of-pocket health-

related expenses; 2) sources of health information; 3) health program and service needs; 4) health workers' experiences; 5) community dynamics; 6) political issues; 7) inequity of health programs and services; and 8) provincial and federal health services.

6.3.1   Health Workers' Experiences

In sharing their experiences, these health workers helped shape a better understanding of the health care system in rural and northern Metis communities. Many of the health care professionals currently working in the nursing stations had been in their respective communities for between two and five years though they were not originally from these communities. They live in the community full time, typically in housing provided by the health system.

> *"…I work here in the community; I've been here for two years. But I've been here before in the past ten years".*

> *"We have housing provided through the Province of Manitoba Department of Health and I have my own residence which is provided. The other full time nurse has her residence. We have a trailer, a three bedroom teacherage and an on-site trailer that we have for the itinerant staff that come in. They are adequate".*

Because the staff members lived on-site, they typically did not travel great distances to arrive at their workplace. Some did travel occasionally for meetings and workshops. In one community, a health care worker often worked full time with few opportunities for vacation. While relief is available for vacation if scheduled in advance, sickness often is difficult to cover.

> *"We have a pool of agency nurses that we can use for short term, but most times if we're sick we're working still. You'd have to be pretty sick to call in sick. You can call in sick and stay home, but there is always work to do".*

Health care professionals at nursing stations in the three communities revealed that they were often unable to meet the work demands placed upon them, due to time constraints and low staff numbers. This staffing issue was described by one service provider as a hindrance to quality care.

> *"Because there are only two full-time nurses here it's kind of hard. We try to have a nurse that is contracted out that comes every month which we have already so it's continuous with the same person instead of having somebody else who you don't know. It's difficult when we have different people who come and go. Things are missed and things are not, it just isn't".*

While nurses are able to receive most clients on a daily basis, they are understaffed and, at times, it is a challenge to meet the demand.

> *"That's what we need—more time and more people. And sometimes it seems like the same people are always coming. It gets discouraging but we have to do with what we have".*

Inflexibility of work hours was a challenge for service providers and work schedules often conflicted with community members' preferences to attend workshops in the evenings.

> *"And a lot of people prefer night time stuff but for us, we can't do the night time stuff. We have to do stuff during working hours".*

Furthermore, if community workers plan programming outside of their stipulated hours, they are not paid for their work.

> *"... we don't get paid for it. We're not going to. I did a prenatal class just because I went out of my way to do them after hours and there were a few women who were interested…I did those on my own time".*

In addition to resident service providers, those who provided services on an itinerant basis in the communities also were interviewed. Visiting physicians to the communities typically drive to the nursing stations on a weekly basis and are reimbursed for their mileage. One health service provider talked about the myths of incomes and living standards in the North.

> *"[E]ven though they're working, the hydro is God awful expensive, transportation, gas, Auto-Pac. They all need ski pants, they all need boots, and they all need to be fed. The list goes on and on. A pay cheque only stretches so much. And while people in the south think people in the north make billions of dollars, they don't. That's a myth".*

One participant stated she sees much strength in the community where she works:

> *"It's a good community. One of the strengths I see is that people are not demanding. They are good people. I've been around where people can be very demanding and rude and that's something I can say about the community here, they are respectful and they say 'thank you'. We do the best we can and they appreciate it".*

Health service providers recognized that community members were grateful to them for their hard work.

> *"They knew that I was working last year straight through at Christmas. Early in the morning the next day they were banging on the door bringing me plates of food because they knew I had not gone home to eat".*

One health service provider suggested that those who are making policies for the health care system in remote communities need to have a better idea of the reality of where, and how, people live.

> *"One wish isn't going to cut it. There are too many things that need to be changed…It's very difficult for people to have someone in an urban setting in a corporate office thinking, hmm, how can you make life better? Until you have been here, lived here…you come up here when it's -55°C and the power is crapped out on you and you've got no wood stove to back you up…So you figure out what our problems are by living here…so I want multiple wishes".*

6.3.2   Community Dynamics

Community Challenges

In all of the three communities general infrastructure needs were identified. Road conditions in particular need improvement.

> *"And that's the most frustrating thing is our roads, it's just terrible".*

In one community safety of the children related to the cisterns was a concern because cisterns create hills close to the roads and children like to play on them.

Housing is an important infrastructure need. Many of the houses in the community were described as "decrepit" and "poorly insulated". While new management for subsidized

housing has helped to moderately improve conditions, much work remains to be done. Many of the houses in one community were rental houses, with high rental rates. Poor insulation in the houses also can lead to high costs of hydro each month, notably because rental housing does not have wood fire stoves, a more cost-efficient heat source for families (as well as an important back-up source of heat).

> "It's harder to get CMHC [Canadian Mortgage and Housing Commission] to go with wood stoves simply because of the fire hazard you know and most of the new housing coming up with CMHC or whatever they call it. But it's more straight electric heat and that's costly, very costly".

Access to affordable food was seen as a problem by Metis community members and health care professionals. The quality of merchandise in stores is lacking in all three communities and the prices prohibit most people from shopping in them.

> "The one [store]… is not too bad, but the other one is outrageous. I'm talking like $5 for a loaf of bread, $8 for a jug of milk. I'm not sure what our plans are for getting a grocery store".

In one community, the retailer orders a few vegetables but they sell out quickly. Currently, in order to purchase food, people must travel "on their own" to the nearest town, which is 2.5 hours away. Service providers indentified that not everyone can afford to travel so far for nutritious food.

Community Habits

One health worker stated that the community was tight-knit, and that this was a great strength.

> "Everybody comes together if somebody needs [support]".

> "The strengths are, it's a close knit community and everybody helps each other out so anything that does go on like any sort of information sessions there are always a lot of participation and a lot of help, volunteers and stuff like that".

One of the advantages to living in a small community, according to one health worker, is the familiarity of people with other members of the community.

> "It's kind of nice to be from a smaller place where you know every single person; you know their dogs by their names, you know what I mean? So it's kind of good that way so that when there is some sort of, like everybody knows if the family is going through some kind of hardship or tragedy, everybody pulls together and I think that's one of the strengths here".

Despite being tightly-knit another health professional thought that members of the community needed to show more leadership and take charge of change of their own communities.

> "I think both communities need, it's kind of a tired word but they need to find their voices and be empowered themselves to make the changes that are most appropriate for them".

Participants suggested that the younger generation in the community were not as 'helpful' as generations before them.

> "…I'm finding the younger generation is a little different today. They're not as helpful as the generation before them".

While the communities are considered by most standards to be small, health workers emphasized that it is not the number of people that is important, but the individuals themselves.

> *"We're not a 7000-person [community name] or a huge community, but we have our share of aches and pains and our share of on-going medical problems".*

When asked if the small population of the community had to do with the community being underserviced, staff indicated that although their communities were small their needs also needed to be taken into consideration in health planning. They indicated that although their numbers were few, they counted too.

For communities with First Nations communities adjacent to them, the populations have mixed over the years, making it difficult to determine exactly how many Metis live there.

> *"I can't think off hand, but I know there are about 85 [Metis] on the community side, but there are more that live on the reserve side with their spouses. We don't really have that list, which we should, but we only have the list of people who live on the community side and we do have some treaty people living on our side too. It has to do with housing I think".*

The social dynamics in remote communities, especially those based beside First Nations communities, have a distinct flavour. In many cases, health care workers talked about "rivalries" between Treaty and Metis community members; however, in general, they said that people were treated fairly by health professionals and community members, and help is given to those in need regardless of their status.

When asked about barriers for Metis in accessing health services in the community, service provider replied:

> *"…Everyone is treated the same. There are no barriers, I don't see them".*

> *"I think that people are treated fairly. They are treated the same when they come here. I've worked in other places where treaty and non-treaty are treated differently but not here".*

> *"There are people who, another thing I find, when something happens everybody gets together, there's a lot of support that way…yes a death or an illness or if there's been an accident or something you know that's where people are supportive".*

6.3.3 Political Issues

While there was awareness of differences in funding between Metis and neighbouring First Nations peoples, there seemed to be a lack of insight about on-reserve access to health services for Metis and the implications of that. This lack of awareness is exemplified by this comment by one health service provider who commented about the local political efforts of one First Nations community adjacent to a study community.

> *"…of the Band. They are obviously fighting for whatever they have. I know that from the community, they have been fighting for a long time to get a new nursing station built. I believe this has come to fruition. There could be much more…training and…"*

From the service provider's perspective having a new nursing station built would be of benefit to anyone who lived in the area. However there could be complexities associated with access for Metis to a Provincial nursing station that is situated within a First Nations community that the provider was not aware of.

6.3.4   Out-of-Pocket Health-Related Expenses

Although all Canadians are technically provided with universal health care, a variety of costs are incurred by individuals. These 'out-of-pocket' costs in many cases decrease the ability of Metis living in remote and rural communities to access and benefit from quality health services. The primary cost for many Metis, as mentioned previously, is transportation to and from medical appointments that are not covered or sanctioned by the local nursing station. The distance and cost of getting to the nearest dentist or optometrist, on top of the fees charged for service, often are prohibitive for many Metis living in remote communities.

The cost of appointments that are covered by the Northern Patient Transportation Program (NPTP) is only partially subsidized. Speaking to her own personal experience, one service provider reported:

> *"…I got my husband to take my receipts and everything back, and those papers that they get you to fill out so, I can't believe that my trip to Winnipeg and my trip to town they reimbursed me back the same amount. And it's further to Winnipeg".*

Local service providers were aware that if a Metis citizen must travel to Winnipeg or town for an appointment, NPTP subsidized their travel; however, the patients are still responsible for incurring the costs of hotels and food while in transit to and from their destinations. Also, dentist and optometrist services are paid for by Metis. This issue is a particular concern with respect to oral health.

> *"Dental is not covered. A minor portion of their basic needs are met in many circumstances. It's okay, we've got 16 year-olds here that need dentures because they've never gone to the dentist. What is the basic diet of most children these days? Sugar, carbs and acids. How long do you think the teeth are going to survive up here? Toothpaste at the store is close to $6.00".*

Service providers were keenly aware that medication is another cost borne by Metis citizens. While those who receive social assistance are covered by the Provincial Province for their medication needs, self-employed people or those not receiving social assistance must pay the costs themselves. We heard that this policy can have a large impact on health.

> *"We have one gentleman who is on EI [employment insurance] who has been prescribed [medication] for one year and he can't afford it. So how do you say to the person, 'give up your benefits and your rights at work, go on welfare and your meds are covered?' That's what you should be saying to them because that's the only way you can get this medication covered. Here we are encouraging people to be independent, to be productive, contributing members of society".*

In addition, because Metis are unable to get medication on credit, the process of getting their prescriptions filled is much more lengthy and complicated.

> *"That's another problem we have for Metis people. Unfortunately the pharmacy was owned by a private owner before. I was able to get credits where they could send me my pills right away, but there are other Metis here that when the doctor writes the prescription for them and it's faxed out, but they don't send medication right away, not until people send out their money to pay for them…"*

Service providers were aware that for those who do not drive, coordinating payment and delivery of their medication is very complicated.

6.3.5   Sources of Health Information

Health care service providers explained that when they run health promotion and disease prevention workshops and information sessions, they typically advertise throughout the communities letting people know that all residents are welcome and that the sessions are free of charge. To advertise, service providers largely depend upon word of mouth; they also put up posters in high-traffic areas; they submit write-ups to local newsletters; and they hold public meetings in order to inform people about events. As radio stations are available in two of the communities, information is shared using that medium. We were told that the nursing stations also provide patients with free information pamphlets that they can take home.

Some of the workshops offered include prenatal information sessions and information sessions at the local schools. The annual health fair always has a good turnout (including children) according to one service provider. The health fairs are typically held in the community centres and many of the workshops are held in the nursing station conference rooms.

In one larger community health information workshops are run occasionally for both Treaty and non-Treaty community members. Diabetes information sessions and nutrition classes are hosted by the nursing station and presented by speakers travelling in from outside the community. Funding is limited for workshops at this station and attendance is sparse for those that are held.

One health worker observed that people do not come to events unless they are affected by the diseases that are the topic of the sessions. Another believed that many people are missing out on important information about their health by not attending. Health professionals in one community were unsure if everyone was aware of the services they provided that despite their best efforts to advertise their events. Health professionals in all three communities stated that few people attend information sessions regardless of the efforts to advertise them. A fall-out effect is apparent as others may learn from those who do attend.

> *"But sometimes, especially with mine, I don't have funding to have people to come to our workshops, there are always a few people who come, but a lot of people are losing out on all the information we have to give them. But the saying goes, 'if you have two, then people will learn from them' ".*

6.3.6   Health Program and Service Needs

Health Promotion and Prevention – Mandate and Challenge

Health promotion was seen as a mandate at all of the local nursing stations; however, in each of the three communities enough staff was rarely available to implement as many programs as the health care providers would like. One service provider explained that the nursing stations were "putting out fires" instead of helping to create healthy communities. Other service providers described the circumstances further:

> *"And it's hard on us the people who live here because I have to do a lot and I don't get a chance. There are three of us working on the floor and I have a lot to do and I do them whenever. Like tomorrow afternoon when the nursing station is closed, sometimes people come here even though it's closed. I could do more prevention and teaching but we're too busy treating".*

"And it's a great mixture between acute and chronic with very little on prevention. Very little focus on that. There is not enough hands, time, or money for that. So we are running around with band-aids literally".

Participants suggested that bringing in two physicians to visit the nursing stations each week would enable patients to benefit and see improvements in overall health.

While health professionals in all of the communities explained that services provided at the nursing stations were available to *all* community members, they emphasized that no programs or services are delivered specifically for Metis citizens. In one community, a health professional shared that chronic disease prevention programs do exist for Treaty community members, but that they are not accessible to Metis community members. In another community, access to health information was also an issue as health care workers were unaware of where to get current pamphlets and information.

"Another thing like pamphlets like this, I was going through a lot of my old pamphlets and I have no idea where to get new ones from, they don't have them in town. Because they used to have a library before but now they don't. They do send us some stuff when they get it from town but there is certain stuff we need".

Transportation

The largest barrier for Metis in accessing health programs and services, according to health professionals, is the distance they need to travel to reach services not provided in the local nursing stations. People must travel hundreds of kilometres.

"For Winnipeg it will be four hours - 400km - and to town is over 200km, 2.5 hours".

For those without vehicles, reaching the nursing station within the communities can also be a problem. In emergencies, ambulance services can also take hours to respond as often they have to travel from other communities, or from town, to pick up a patient.

"When we phone sometimes we get the other community and that's 2.4 hours or in a different community and that's about two hours away".

In some instances air transfers are possible, but poor conditions for air strips in the communities mean this option is only used when optimal conditions are available. In an emergency that happens at night or in the winter, the problem may be serious.

"Well I think it would be beneficial for both communities and help safety over all. It certainly would be helpful to have air flight at night in [community two]. It's not that common that we need to do this, but it would be beneficial to have that services and a lot of these medical evacuations are handled by the nurses in communication with a physician".

We were told that in order to lower out-of-pocket costs in one community, many people try to book dentist and optometrist appointments in Winnipeg so they can take the bus instead of paying for a taxi to seek more local treatment. In another community, unless medically sanctioned, no private taxi services operate outside the community. Community members must find their own means to get to town for non-NPTP eligible appointments such as dentists and optometrists.

"There is no transportation available here. They have to find their own way there. To me I think that it's not a good thing. If only it was available. There are people I know that you have to have a family— you have to have a family who can drive you. It's hard to find a ride. You have to call

around and people are reluctant to give rides and there is no taxi available. Or they can't pay for a ride".

Service providers told us that in one community participants must travel at inconvenient times to get to town. This option could be difficult for the elderly, those travelling with multiple (or small) children, or those with physical disabilities.

For those who do have coverage through social assistance, approval for coverage for travel is required from the appropriate Province bodies in town or in Winnipeg. This permission can be difficult to obtain if an emergency occurs outside office hours.

> *"It is very difficult and it is a great source of stress. A great source of stress because you know there is nothing you can do. You can call in favours and you can get on your knees and cry your little heart out but if it's not between 9-5 then you're done".*

Transportation options within the community were identified as a barrier for people to get to health services.

> *"That's what they need, services to pick up people. They have that in another community. The taxi service brings people to the nursing stations".*

In another community, a health care professional noted that although houses are relatively close to the nursing station, the need for in-community transportation services existed for those who can't walk or need assistance. A lack of in-community transportation to the nursing station was especially a challenge for elders and young parents with children. In an emergency, the lack of transportation could be a very serious issue.

> *"There is no taxi service here so when there is no ambulance they have to look for a ride. And that's a very difficult thing to have to look for a ride in the middle of the night when you are sick".*

In an emergency, health care providers use either ambulance or plane services to transport patients to Winnipeg or to the hospital in town.

> *"If there is an emergency situation, that's where our doctor will call to have them sent to but if town isn't accepting because they are a small facility themselves then…the next place is Winnipeg".*

Service providers explained that, until the beginning of 2011, ambulances were available in two of the study communities. However, one ambulance was recently decommissioned, so both of these communities—60 km away from each other—now share ambulance services. In one of the communities, no ambulance service was available on weekends.

> *"With the ambulance part, it can get really dangerous because there is no ambulance here usually and they cut us off on the weekend. We have to anticipate when there is not going to be an ambulance. There is a pattern. So on a weekend if there is no ambulance until Sunday we have to utilize the ambulance from another community, and if there's an emergency then it has to come one hour from there and pick up the person and it takes two hours for the plane to land there and that's an hour to Winnipeg. Or if it's by ground they have to travel one hour here then two hours to town so that's three hours".*

Another method of emergency travel was by airplane. Of the three communities involved in this study, two had airstrips. While transporting critical patients by air was a great advantage, unpredictable weather conditions and issues with maintenance of the landing strip and the lights can limit accessibility for Medevac planes.

Emergency transportation may be required for victims of domestic abuse to reach a safe place, as none of the three communities that participated in this study have women's shelters. The closest safe house was located between 150 and 200 kilometers outside of the communities. One service provider identified that no safe place is available for these women in or outside the community.

Pharmacies and Medication

Service providers reported that no pharmacies were available in the communities. Medications were not covered for self-employed and uninsured Metis, and as a result Metis citizens paid for their prescriptions out-of-pocket—sometimes the result is not getting the drugs one needs. Insufficient funding was available to purchase even a limited supply of basic medications for those in need. In one nursing station, a limited supply of basic medications was maintained, but appropriate medications may not always be available when required and drugs were they were shipped by bus from a community 2.5 hours away.

Service Gaps in the Community

The service providers identified several service gaps in the communities in which they worked including physiotherapy, occupational therapy, Home Care, and mental health services.

> *"I think there is a lot of room for improvement. There is no physical therapy or occupational therapy in the communities. Mental health is woefully lacking in both communities. I would say that medical services barely keep their head above water. There is a physician going in on a weekly basis but it's really just keeping its head above water that way. It's not a lot of time for programming…can be more putting out fires…"*

Health care providers stated that no dental or optometric services were available in their community and patients requiring those services needed to travel to The Pas or Winnipeg for these appointments. One health care worker suggested that having an itinerant dental therapist would assist those who are unable to afford to travel to town.

> *"And if we had a dental therapist that would look at Metis people - they do have a dental therapist on the reserve at the school - but she only works with the Treaty people. If you're Metis you have to make your own arrangements and go to town…"*

Communities serviced by the Northern Medical Unit (NMU) of the University of Manitoba have access to retinal screening and foot care for people with diabetes. These services come infrequently, however, as they were—in the participants' opinions—saturated with clients.

In one community, foot care services had recently become available—but availability of the service was insufficient, with the provider coming to the community only every 3 months. A nurse from a similar program, Diabetic Education Resources, visited two of the communities—however, the distance between their main office and the communities is great and therefore much of their time was spent commuting instead of seeing patients.

According to health care professionals, mental health services were available in all three communities. These services were considered to be a priority issue. We were told services needed to be increased to meet the demand. At least one service provider believed that mental health services were not very well organized.

> *"Mental health services, the same thing though, they are very sporadic. They usually phone us the Monday before they come up".*

In one community, patients had not seen a mental health worker over the entire summer.

> *"Right now we lack mental health [services]. That's a big problem".*

We also heard that there are insufficient Home Care services for Metis due to a lack of Home Care aides employed in the community. As a result relatives and friends filled this service gap, and sometimes people had to move out of their community to acquire the help they needed.

One health service provider thought that having midwifery services in these communities would help with prenatal support—such services were currently only available on a limited basis.

Health service providers suggested that diagnostic machines would be helpful in their clinic in order to provide more timely results on blood tests, particularly for acutely ill patients.

> *"We don't have a lab, so our blood work that we have to do or urine tests that we have to do goes out on Monday, Wednesday and Friday before 11am and that can get complicated because if you have an acute patient that needs blood work right then like you can't say 'Oh well you can't be sick. Come Monday before 11am. Right.' Then they are going out to town just for lab work which is unfortunate".*

> *"I think those things [deaths] can be prevented with simple x-rays and blood work. What we have is, you can get your throat checked, but we don't have much. Basic things, I mean basic".*

In one community the health service provider reported that every two years a mobile mammography service came to the nursing station, Metis women in the other study communities still had to travel to town for the service.

Telehealth systems were currently located in two of the three study communities. In both communities, however, health care professionals believed that insufficient numbers of trained people were available to effectively operate the program. For example, in one of the communities, the telehealth system was in place and the equipment was unused until practitioners were trained to use it in 2009.

> *"…We have a telehealth system that's available to everyone so…the only thing is that we don't have enough trained people to do it so there is only myself and one other person so we have to be there for it. So we have to get more people trained on that".*

6.3.7 Inequity of Health Programs and Services

According to one health worker, Metis have the same access to services as First Nations, but they incur extra transportation costs for travel to town for dental and eye appointments.

> *"Metis have the same as status people except transportation is hard. Metis get covered; the bus is covered for them if they go to Winnipeg and a taxi service if they go to town for a doctor appointment. The only thing that isn't covered for them is dental and eyes so they have to provide their own".*

Transportation for Metis patients was an issue in other communities as well. This issue is particularly problematic for pregnant Metis women as they have no access to transportation unless they are in labour, whereas First Nations women get evacuated sometimes several weeks before they are due to give birth.

"…For prenatal, if you're a Metis you have to kind of wait until you're in labour and then you get rushed out to town but if you're treaty, you can go and stay in town, they usually stay at a hotel, they usually stay there for two weeks before the baby is due. If a Metis wanted to do that they would have to pay for it themselves".

In the same community, Metis did not typically have access to ambulance services as they were owned and run by the local First Nations band.

"There are ambulance services from the band sometimes there [that] Metis community...can use but the band has issues giving rides… [the priority is] for band members or they're full. I don't think they're covered the same way as the First Nations…"

"The band, the [band name] ambulance services absorbs that cost. They have never refused but everybody has a budget. Everybody has limited funds.

Furthermore, extra services are provided only—although Metis will not necessarily be turned away when seeking treatment.

"…But the reserve has a worker called a CPNP worker who does programs for diabetes and prenatal programs...Like I know if there is someone who is pregnant on this side [Metis community], she won't turn them away but her focus is mainly on the reserve because she's funded by them".

In another community, Home Care is only provided in the First Nations community for Treaty members.

"Not here [the community] but the band does [have Home Care]. There is no one who can give them [Metis] Home Care".

Since Bill C-31 was put into effect, many eligible Metis have signed up to get their treaty numbers in order to have access to additional health and housing services. This policy has changed the face of many Metis communities, especially those living beside First Nations communities particularly with respect to Metis identity and culture. Reflecting on her own personal experience, one service provider mused:

"It's kind of hard because a lot of people have gotten their Treaty through C-31. Like I grew up Metis but I'm Treaty now".

6.3.8 Provincial and Federal Health Services

Within-Community Health Services

Our Key Informants were able to provide a wealth of information about the programs and services that existed within their worksites. Nursing stations were located in all three of the study communities. Each of the resources and contexts of the nursing stations is specific to their community. The stations were each equipped with capable and competent nursing staff that brought health care to the communities. Depending on the size of the community, one to three Registered Nurses and a community health worker were available. Two of the communities also had on-call workers for first response to after-hour emergencies. For example, the Provincial nursing station in one community currently has two nurses and an on-call worker. Therefore, this nursing station is able to keep regular hours during the week and provide 24-hour on-call emergency care. Also at this nursing station, a basic stock of medications was available to be provided free-of-charge to patients.

"…I guess that's one of the biggest things, people come for their medications especially if they are on income security like and they don't, they have like these minimum wage jobs and they don't want to really pay for medications".

The nursing station in this community also holds health fairs on a yearly basis for all members of the community including youth. However, that level of service was not reported in the other communities.

In another community, the nursing station was administered by Federal funding. While the services provided at this station were generally similar to those at Provincial stations, some differences were apparent. The Federal station was very large with seven employees at the health centre, five of whom were full-time employees and two were agency-employed Registered Nurses. With this staff, primary and community health services were run on regular week-day hours and emergency services were available 24 hours a day. Two physicians from the Northern Medical Unit (NMU) visited the community on a monthly basis. Special services, such as flu clinics, occasionally came to the nursing station.

"There is the nursing station which you get like regular nursing services, community health, they can have home care, they can see the doctor, there is mental health, and there are all the resources. That's what we have here".

At the Federal nursing station, Metis were referred to specialists outside of the community and, like the Provincial stations, travel costs are covered by NPTP. The Federal nursing station had access to telehealth services, which were used on a regular basis. This system had helped to improve the quality of care available for patients in the community; people had medical appointments, and nurses took part in workshops and updated their training through the use of telehealth services.

"But whenever stuff comes up like tomorrow, one of the nurses is going to sit in on the conference 'baby friendly'; they haven't had one of those for awhile. It involves all the stations and we get to see what everybody is doing on their stations".

The nursing stations provide health promotion programs and emergency care for community members, but as explained by a participant, providing programs was difficult to accomplish due to understaffing. Another participant described the frustration of not being able to help everyone who needs help:

"…It would be good to have another registered nurse because like when she's gone for three weeks and people are like phoning well maybe this one needs her needles and we need blood work done in fasting and I can't wait until I get to town and that's where you are like well sorry but there is nothing I can do…"

Health workers also feel their nursing stations could use updates in some areas.

"I know [name] said herself it feels like we are being left behind sometimes, like we have to go to these meetings and then you hear these new things going on and you are like well where were we?"

Nursing station services were provided for Metis and other non-Treaty community members as well as First Nations members. Physicians travelled in to two of the three study communities. They worked for and were funded through the Northern Medical Unit at the University of Manitoba. This program helped Manitobans living in the north see a physician closer to their homes. Telehealth systems in two of the three study communities were used to enable patients to set up appointments with their physicians without having to incur the

costs of travel, and to have the ability to see certain specialists, such as dermatologists, who they would be unable to see otherwise.

"It's [telehealth] good to cut down on travel costs".

"Yes you can see a dermatologist; they even have a stethoscope where the doctor can listen to the person's chest".

In one community that did not have physicians travelling in on a regular basis, Metis had access to physicians in The Pas, an hour-and-a-half away. All the Metis citizens in the study communities had to access specialist services in The Pas.

We were told by a service provider that in one community a Tuberculosis program was in place for several individuals in the community who need that service.

"…It could be an epidemic. It's mostly just the transients who come and stay here for awhile and have some form of TB".

Within-Community Health Programs

Health programming offered in one community also included prenatal classes and reproductive health education.

"We have a lot of prenatals [in the school] so we try to do lots of stuff with birth control and that sort of thing".

"…One of our nurses works closely with the prenatals. Actually we have prenatal days on Wednesdays. They come in on Wednesdays and this nurse does their routine checkups and stuff like that. And she makes the appointments for them when they go to see the doctor in town and stuff like that".

In another community, the telehealth system was funded, in part, by the adjoining First Nations community and was used frequently by various groups for different meetings and events. This opportunity has not been available in Metis communities.

"From my understanding, that [telehealth system] was half funded by the reserve though. They sort of set up their own things too and come to the nursing station and have it done, but as far as I know the town [Metis] doesn't do that. I don't know if they know about it…"

In some circumstances specialized services were brought in to the communities. According to the experience of the service providers, mental health services were periodically available in two of the communities. These services were available for both adults and youth. On a periodic basis, diabetes education and attention were provided.

" …But there are from the primary education resource in town they will come out and talk on a monthly basis and they come out with a … and a nutritionist and so people might have the ability to try out different cooking and …and other diabetes information".

A diabetes education resource (DER) team travelled into the community to do retinal screening and foot care.

"…They [DER] come in once a month and you know we call around the community and book appointments and see whose behind on retinal screening and who hasn't been screened and you know we've had like if somebody is newly diagnosed we bring them in with the dietician and that who will go over everything with them".

In one community, health care workers said that every two years a mobile mammography service came to the nursing station. One health professional managed this program and ensured that women were registered for the service. Often they were often unable to see all of the women requiring mammograms so these women still had to travel to town for the service.

In some circumstances other specialized services were brought in to the communities. According to the experience of the service providers, mental health services were periodically available in two of the communities. These services were available for both adults and youth. On a periodic basis, diabetes education was also provided.

Systemic Barriers to Health

Although the health care providers within the study communities strived to meet the basic needs of all patients, systemic barriers were apparent within this process. The two largest barriers identified were insufficient staff and inadequate funds to run the stations.

> *"…It's never enough [the budget]. There is never enough staff. We need more hours in the day, we need more hands but I think that for the most part we meet the patients' basic needs".*

A third major systemic barrier (especially for emergency situations) was the complicated and time-consuming processes currently in place to attain authorization for transportation for treatment.

> *"…But if you have a five year old child who just got mauled by a dog and who requires not just surgery but plastic surgery, how do we get them out because it's Sunday at 2pm and not Monday to Friday 9-5pm. Because you also have to go through dealing with provincial social assistance, you have the financial worker then you have the social worker to both of them and get their authorization. To inform and get authorization. Now it's complicated, it's complex, it is, the system needs improvement…there is going to be a great tragedy one of these days and how do you tell the parents of a youngster or the child of a mom or a dad that the system just failed…there is no mechanism to allow, ensuring us to provide consistent, safe transportation when we need it and when we need it, we need it quickly".*

The final systemic barrier noted was the lack of availability of medication to give patients in rural communities.

> *"We use to do that, that they could bring their money here and we'd send their money out, but there have been changes at the nursing station and we don't do that now…yes [that system worked] because they could get their medication faster [and without the added expense of having to go in to town]".*

6.3.9   Summary of Perspectives of Service Providers

Key informants in this study were individuals who provided health care services to Metis consumers in the study communities. They willingly and graciously shared their work experiences. The experiential knowledge offered by the key informants further developed our understanding of the benefits and challenges of providing services to Metis citizens in northern settings.

6.4 Summary

The voices of Metis health consumers living in northern Manitoba clearly identified issues consistent with many other rural, remote, and northern residents seeking health services. Metis participants recounted their experiences in response to community resources, access to health, and other services. Additionally, their insights into Metis culture and their identification of the importance of having a voice, both personally and politically, contributed another dimension to our understanding of the experience of Metis in this region. The impact of Bill C-31 on community and family structure was identified as an important factor affecting the complexity of this issue.

Caregivers identified issues that reflected the available literature on health care provision in rural, remote and northern areas and paralleled many of the issues Metis participants identified including: access to services, financial impact, and transportation.

In the next section the key findings arising from this study will be reviewed.

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Section 7: Discussion

7.1 Revisiting the Objectives

The overall goal of this research was to better understand the experiences of Metis health consumers living in northern areas of Manitoba. The specific objectives were to 1) articulate relationships that currently exist for Metis within the health care system; 2) identify networks for Metis within the health care system; 3) identify supports for wellness for Metis in the MMF The Pas Region; 4) identify governance structures that support wellness for Metis in MMF The Pas Region; and 5) articulate environments required for wellness for Metis in MMF The Pas Region. Each of these objectives will be discussed to address with specific examples provided.

The research was successful at articulating relationships that currently exist for northern Metis—at least those within the 3 study communities—within the health care system. We learned a great deal about the experiences of northern Manitoba Metis through focus groups with Metis health care consumers and through interviews with their formal health care service providers. We learned about the programs and services available to northern Metis locally (within their communities), regionally (the nearest town), and provincially. We also learned about the struggles northern Metis face in accessing these programs and services, whether financially, logistically (long distances and cost of travel), or as a consequence of jurisdictional ambiguity (inequity of programs and services). We also learned about programs and services that northern Metis believe are required to further meet their health care needs. Importantly, we also learned of some of the perceptions that northern Metis have about available programs and services, their access to them, and the inequities between themselves and their First Nations neighbours.

The research did not identify many specific formal networks for Metis within the health care system—although the importance of informal networks (i.e., family, friends, and the community) for Metis health and wellness was highlighted. The formal supports that were identified included Home Care services, health information phone services, health and wellness workshops, and youth drop-in centres. However, we learned that these services were either not known about by many, were not used by many, or were inadequate relative to the needs of the community residents. For example, Home Care services were in high demand but a shortage of workers to care for the clients limited the ability to provide these services. Aside from the youth drop-in centre in one community, the lack of recreational activities and formal networks/support for youth was made apparent. Moreover, although some opportunity to learn about health and wellness was provided through workshops and health fairs, participants expressed a desire for more of these learning opportunities. Participants expressed the desire to have some formal support groups put in place for mental and physical health and wellness. In particular, exercise groups were identified as a good way to motivate people to get healthy and active and lose weight. Additionally, participants would like to see groups such as Alcoholics Anonymous offered in their area— they felt that this would not only help those suffering with addictions to get the help they need to recover, but that these resources also might contribute to making the communities safer. Continuity of care was an issue for northern Metis residents. Participants believed that adequate follow-up to their medical appointments and tests was needed.

Governance structures that support wellness for Metis are needed in MMF The Pas Region. We learned that, aside from the support of MMF Locals, self-governance is lacking for Metis with respect to health and wellness in The Pas Region. The Provincial and Federal Government's administered health care programs and services to Metis, such as the Northern Patient Transportation Program (provincial), the Northern Medical Unit (university/provincial), Telehealth (provincial), nursing stations (federal and provincial), and a variety of services provided by the RHA (provincial). While not a direct support for health and wellness, the MMF Locals indirectly acted to improve the well-being of Metis in these northern communities by giving a voice to the Metis residents and through fostering coherence and community spirit. In identifying the governance structures that existed to support health and wellness of Metis in the north, jurisdictional ambiguities and different funding models for First Nations and Metis are seen as issues that need to be addressed. Actual and perceived inequities of programs and services between Metis and their First Nations neighbours has lead to confusion as to what is and is not available or accessible for Metis.

After we have identified programs, services, supports, networks, and governance structures that currently exist or that are required to support health and wellness of Metis, we can begin to articulate what the environment surrounding health care provision in Manitoba's northern communities should look like. We have attempted to do that by discussing the implications of this research on policy and actions to build a health care environment conducive to Metis health and wellness. This discussion follows in Section 7.3.

7.2 Summary of the Key Findings

The following list of the research findings from this study is not exhaustive, but rather the key findings are stated as they relate to health care consumer experiences of Metis residing in northern Manitoba.

- Metis receive more informal rather than formal support with respect to health care networks. Often, friends and family are the primary ones to help Metis with self-care and in travelling to access health care. Formal supports are an identified need for the study communities.

- Metis Locals improve community life by giving Metis a voice and contributing to cultural coherence and community spirit.

- Metis have varied opinions on Local Government—some believe that the Mayor and Council are doing positive things for the community, others believe they need to be consulted more or that they have no voice.

- Some participants reported feeling intimidated to speak for themselves with health care service providers, and preferred to have others speak for them, while others did voice their own concerns.

- Ongoing tensions between Metis and First Nations Peoples are due to perceptions of inequality as well as inequity in provision of health programs and services.

- Bill C-31 has had an impact on the face of northern Metis communities as many Metis renounced their Metis status, applied for treaty status, and moved into local First

Nations communities to obtain medical coverage, housing, and other benefits that were not available to them without Treaty status.

- Mixed feelings were shared about treatment by health care providers, with some participants reporting that they were treated well and treated fairly, and others reporting unequal treatment or distrust in their physicians.

- Issues of health disparities and perceived racism were identified.

- Some participants believed that access to health care was sufficient while many others reported having a difficult time accessing the services they need.

- More variety in health programs and services are needed locally, and more support groups are required for issues such as addictions, weight loss, or diseases management, especially chronic diseases such as diabetes. The few programs that do exist were delivered by itinerant service providers on an occasional basis and not everyone was aware of them.

- Home Care services were reported to be a major need, especially for those wanting to age in place. In one community, no Home Care service was provided, and in the other communities, Home Care was in high demand, leaving little time for the Home Care workers to provide care to everyone in need.

- Medical transportation was a major concern reported by participants due to the rurality and distance of the study communities to health service providers. Not only was transportation described as costly, but the distance required for travel was seen as difficult to manage, especially for those with health problems, the elderly residents, or parents with small children. Furthermore, long distances to access health care caused problems for those with jobs who could not take the time off from work for travel.

- Although the Northern Patient Transportation Program assists with travel to medical appointments, the program does not provide insufficient funds to cover costs that are incurred. Metis living in the north reported a lack of understanding of the policies and rules associated with travel under this program.

- Local public transportation is lacking in these Metis communities and residents may not have access to a motor vehicle. Often medical transportation coverage was for out-of-town travel only. An affordable medical van within the communities would help resolve this problem.

- Some communities have emergency transportation ambulance services and paramedics, however, others lack this service or the service is available at limited times. One of the communities in this study shared an ambulance with another community, but the communities were 60 kilometres apart which was very problematic in an emergency. Airplane transportation was available for critical patients, but bad weather, poor runway maintenance, and lack of runway lighting at night could limit service provision.

- Inequity of services between First Nations and Metis was reported with respect to medical and emergency transportation; for example, First Nations have access to transportation to dialysis units, but Metis do not.

- Other health-related costs were identified as barriers to accessing health care for residents of these northern communities. The cost of medications or assistive devices and the cost of travel to pick up medications from the nearest pharmacy could be prohibitive.

- Aside from the difficulty and costs associated with accessing physician services outside of the community, participants also voiced their concerns about the difficulties in getting an appointment with local (itinerant) physician services. Wait times were reported to be lengthy, and follow-ups were not timely—leaving some to manage their own health or seek health advice from other community members. Participants believed that some of their important health information might be "missed" when the same doctor did not see them at subsequent visits.

- Participants in all three communities raised the issue of food security. Residents of one community were particularly concerned as their community had no store and travel to town to purchase groceries was costly. In another community, the store had poor-quality food and was rarely open. The cost of food and the transportation required to access healthy food was a major barrier to healthy living for many northern Metis communities.

- Community safety was a concern raised by participants due to an increase in crimes such as vandalism, theft, and arson in the communities. Participants suggested that more local recreational opportunities for youth would help to "keep them out of trouble". Power outages were another community safety issue that was addressed—this identified as an occasional problem in some communities, with serious consequences for those who rely on power for medical purposes such as home dialysis.

- Health care service providers shared many of the same concerns as the Metis health care consumers, particularly with respect to the issues of transportation and the lack of locally provided health programs and services or availability of healthy foods. Health care providers indicated a significant need to bring in more staff to promote health and well-being and to be able to provide good-quality health care to meet the needs of the community.

- Mental health services were a priority identified by some health care service providers, as some consumers have had to wait for months in order to receive care. Participants identified other services that were lacking in their communities such as physiotherapy, occupational therapy, Home Care, dental therapy, and midwifery.

- Health care service providers reported a need for diagnostic machines and a better supply of medications at the local nursing stations.

- The telehealth system is currently available in two of the study communities, but not enough people have been trained to administer the service.

- Service providers raised concerns about community and housing safety by reporting the poor conditions of rental and subsidized housing units and the high cost associated with heating these units.

- Health care service providers, in general, believed that Metis and First Nations community members were treated fairly and equally even though they recognized the

discord that existed. Service providers were able to identify programs that were available only to those with First Nations status. Often they referred to members of the community as either "treaty" or "non-treaty", stressing the importance of this distinction in the health care arena.

- Health care service providers stated that the two largest barriers to health were insufficient staff and inadequate resources to run the nursing stations. A third major systemic barrier was the complicated and time-consuming process to attain authorization for treatment, particularly for emergency situations. The fourth major systemic barrier was the system for getting medications to patients in rural communities as nursing stations can no longer bring in medications for people—instead residents must travel long distances to pick up their medications.

- Policy makers for the health system in northern communities need to have a better understanding of the needs of Metis in these communities in order to design policies that address their needs and meet their expectations. The issues of rurality, remoteness, and isolation need to be considered at the forefront. Participation of residents and health providers from these Metis communities in setting policy can help to insure that programs and services are designed to effectively meet the needs of those who live in these communities.

7.3 Direction of Future Research

The researchers in this qualitative study gathered input from Metis health care consumers and their formal health care service providers regarding programs, services, and supports that were available to Metis living in northern areas of Manitoba. Future research should involve talking to the provincial authorities responsible for administering health care for northern Metis, as well as health policy analysts/planners, in order to document details on programs and services that currently exist. While the Metis health care consumers and their health care providers were able to paint a picture of what is available, and share their experiences with accessing these programs/services, some were unsure about what services are and are not available, and for whom. Metis people need more information about programs to ensure that they are making full use of the programs and services available to them.

While the three communities involved in this research are thought to be representative of Manitoba's northern Metis communities, future research could be conducted in other locations in the north to further capture the experiences of northern Metis health care consumers. Some communities have access to programs and services that are not available in other northern communities. Gathering information from other northern and remote communities would illustrate a clear picture of the needs and expectation of Metis living in these communities in a way that will greatly aid health planning and funding processes. These findings will also help to inform policy and guide action for those communities and the health regions in which they are located.

7.4 Conclusions

The MMF and the researchers sought to better understand the experiences of Metis health care consumers living in north Manitoba, a topic that was, and continues to be, ambiguous for many. The Manitoba Metis Federation The Pas Region identified a need to know more about the programs, services, supports, and networks that exist or are needed for northern Metis citizens to be healthy in their communities. In a Metis-specific holistic manner, the experiences of Metis health care consumers from three representative rural and isolated northern communities were documented, supported by information from their formal health care providers. The key findings were presented in this section and were discussed relative to their implications for policy and action. Obstacles related to rurality, remoteness, and lack of local health care services, were woven through many of the experiences, and were the main concerns that place Metis at a distance from health and wellness in spite of the efforts made to provide them with quality health care services. Program and service needs were discussed, with some essential services being identified beyond the need for more local physicians and nurses. Increased access to Home Care services, better access to health care information, and more support and self-care management groups can lead to healthier people and prosperous communities.

The issue of inequity of services or, in some cases, the perception of inequality between First Nations and Metis residents of northern communities creates tension and ongoing distress. This area of concern has been affected by, and will continue to evolve with changes to the legal rights of Metis (Government of Canada, 2013). As laws and policies change to reflect Metis rights, health care provision to Metis living in northern communities will evolve.

Although further research into the experiences of Metis health care consumers living in northern areas of Manitoba is recommended, we feel this research has helped to fill the gap in understanding of the programs, services, supports, and networks available at this time. The information we gained from this study will be shared with MMF The Pas Knowledge Network and the communities involved in the research, and will assist Manitoba Health and the MMF to adapt health programs, services, and policies to better meet the needs of Metis people living in northern and rural Manitoba. This collaborative effort will help to improve the health and well-being of Metis in Manitoba.

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Glossary

Manitoba Metis Federation (MMF) Membership

At the MMF, Metis identity is verified by self-identification, Metis ancestry, and community acceptance through membership application and a confirmation process. Through a genealogy with supporting evidentiary documents, an individual and his or her family are able to determine whether or not a Metis ancestral connection can be established. Supporting evidentiary documents many include Federal Census records, sacramental records, Manitoba and Northwest scrip affidavits, post records and journals. All individuals seeking membership in the MMF are required to have a genealogy completed by a recognized institution in order to objectively verify the applicant's historic Metis nation ancestry. Application for membership begins at the receiving Local in the area in which an individual resides (Manitoba Metis Federation, 2010).

Metis

The Metis are descendents of early 17th-century relationships between North American Indians and Europeans (Sprague & Frye, 1993). The Metis coalesced into a distinct nation in Manitoba in the late 18th century. After the 1885 fall of Batoche "Metis were denied a separate identity and ignored for a century" (McMillan, 1995, pp.312-313). By 1967, with the formation of the Manitoba Metis Federation, the Metis in Manitoba were again asserting their capacity to advocate and function once more in a collective manner. In the 1982 amendment to the Canadian Constitution Metis were named as one of the three Aboriginal peoples of Canada (Government of Canada, 1982).

Northern Patient Transportation Program

The program subsidizes "the cost of transportation required for residents of Manitoba located in the north to obtain medical or hospital care at the nearest location available for health conditions either on an elective or emergency basis. Subsidy may include costs for an essential escort (as required for an infant or disabled person).Eligibility for the program is limited to Manitoba residents north of the 53rd parallel on the west of Lake Winnipeg, and on the east of that lake to the Ontario boundary coverage is extended south to the 51st parallel, where travel is approved by a physician, and where the patient does not have coverage from an insurer or funder (the employer, WCB, MPIC, FNIHB, etc.)" (Province of Manitoba, 2011).

Nursing Station

Provincial Nursing Stations "provide cost-effective and quality healthcare, develop relationships with community leadership for joint decision-making on innovation and service delivery issues within the community" (Province of Manitoba, n.d.). Two of the study sites had Provincial Nursing Stations as their primary source of health service; the other had a Federally-funded Nursing Station.

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