3.5: Leadership Structures

Over the years since the health transfer system was introduced, there have been key lessons learned and identified by First Nations and Inuit people who continue today to address the gaps by advocating for equitable, seamless health care that honours treaty rights. First Nations communities work with organizations that support communities in carrying out policy and protect treaty rights. The Federation of Sovereign Indigenous Nations (FSIN) represents 74 First Nations in Saskatchewan, and the Assembly of First Nations (AFN) is the national representative organization of 630 First Nations in Canada. These organizations work with First Nations through their leaders to promote, protect, and implement the treaty promises in areas such as Indigenous and treaty rights, economic development, education, languages and literacy, health, housing, social development, justice, taxation, land claims, and environment, as well as an array of issues that are of common concern. First Nations communities fall under 50 culturally and linguistically distinct groups dispersed across Canada. There are a number of other political entities that also represent the different First Nations populations at different levels, including local Band Councils, Tribal Councils, and provincial organizations.

The following table sets out the levels of leadership within the First Nations leadership structure and the responsibilities that fall under each level. As a nurse leader, it is important to understand First Nations leadership structures in order to know who has responsibility for areas that nurses may want to address.

Table 3.4.1 Levels of Leadership within the First Nations Leadership Structure

<table>
<thead>
<tr>
<th>Responsible for the following to manage, maintain, and provide health care services:</th>
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<tbody>
<tr>
<td><strong>First and second levels</strong> (First level – First Nations)</td>
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<tr>
<td>• Record management (including staff activity records)</td>
</tr>
<tr>
<td>• Administration system to hire and supervise staff</td>
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</tbody>
</table>
| Community; Second level – Tribal Council or organization of multiple communities | • Professional support  
• Program design and delivery  
• Program direction  
• Program support  
• Program evaluation  
• Purchasing of educational materials  
• Supervision of educators and professionals  
• Advocacy  
• Data collection and report preparation  
• Development of program linkages and coordination to facilitate single source access to social programs for children and families  
• Capacity building including training, education, community development, peer support, and networking  
• Community-based research |
|---|---|
| Third level (Regional or provincial) | • Maintenance of a working relationship with Health Canada, Service Canada, Indigenous and Northern Affairs Canada (INAC), and the Assembly of First Nations (AFN)  
• Representation on regional, provincial, and national working and advisory groups  
• Northern regional strategic planning for the North  
• Data stewardship for partners as mandated  
• Data collection and coordination with partners  
• Development of program linkages and coordination to facilitate single source access to programs and services  
• Capacity building including training, education, community development, peer support, and networking  
• Program support, such as the distribution of relevant documents and information  
• Program and clinical expertise  
• Coordination of training  
• Program evaluation and monitoring  
• Research and evaluation |
| Fourth level (National) | • Facilitation of research  
• Maintenance of a working relationship among Health Canada, MSB (Medical
As a nurse leader working with Indigenous leaders and communities, it is important to refer to the First Nations Wholistic Policy and Planning Model (Reading, Kmetic, & Gideon, 2007), which was created to better understand the policy structure, planning, and interventions associated with performance indicators that are realistic for communities. This model attempts to capture the complexity of working with Indigenous communities from an Indigenous perspective. This model has the following key characteristics (p. 30):

- community at its core;
- four components of the Medicine Wheel (spiritual, physical, emotional, and mental);
- four cycles of the lifespan (child, youth, adult, and Elder);
- four key dimensions of First Nations self-government (self-government/jurisdiction, fiscal relationships/accountability, collective and individual rights, and capacity/negotiations);
- social determinants of health; and
- three components of social capital (bonding, bridging, and linkage).

**Essential Learning Activity 3.4.1**

For more information on the First Nations Wholistic Policy and Planning Model, refer to p. 5 of *First Nations’ Wholistic Approach to Indicators*, a document submitted by the Assembly of First Nations (Canada) at the Aboriginal Policy Research Conference held in Ottawa, Ontario, March 22–23, 2006. The report was prepared for the Meeting on Indigenous Peoples and Indicators of Well-Being at the conference.

Once you’ve reviewed the document provided in the link above, describe how the medicine wheel is related to the full diagram on p. 7 of *First Nations’ Wholistic Approach to Indicators.*