KEEWATINOHK INNINIW MINOAYAWIN INC.

A First Nations-Led Response to the HIV Public Health Emergency

Addressing Structural Inequities Through Public Health Transformation, Equitable Investment and First Nations Self-Determination

Brief to the House of Commons Standing Committee on Health (HESA)
Study: Rising Rates of HIV Infections in Canada
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The HIV Public Health Emergency in Manitoba

Manitoba declared an HIV public health emergency in May 2026. Disproportionately high rates among Indigenous peoples and in rural and northern regions are compounded by barriers to prevention and care. [1–2]

Geographic isolation, limited healthcare infrastructure, workforce shortages and fragmented federal and provincial responsibilities create barriers to HIV prevention, testing, treatment and continuity of care in northern First Nations. These intersect with inadequate housing, homelessness, poverty, food insecurity and the ongoing effects of colonialism, intergenerational trauma and systemic racism. Unmet mental health needs, substance use and limited access to culturally safe mental health, addictions and harm reduction services further affect prevention, testing and continued treatment. [3–4]

> **The federal response to HIV must invest not only in specific HIV interventions, but also in First Nations-led public health systems to deliver and sustain them.**

Experiences of racism, stigma and concerns about confidentiality in small First Nations may further discourage people from seeking care. Compounding these are limited access to healthcare providers, diagnostics, authorized prescribers, pharmacy services and local medication supplies, as well as inconsistent clinical guidance, training and referral pathways in nursing stations and health centres. [5]

Post-exposure prophylaxis (PEP) must begin as soon as possible and within 72 hours of potential HIV exposure. In remote or fly-in Nations, delays in accessing a prescriber, medication or transportation can undermine timely prevention. Pre-exposure prophylaxis (PrEP) similarly requires more than medication coverage: culturally safe and confidential assessment, counselling, laboratory testing, prescribing and follow-up are essential. [5]

The HIV emergency requires an integrated public health response that includes mental health and addictions services, harm reduction, culturally safe prevention and treatment, and action on the underlying social and structural conditions affecting First Nations health and wellness. Manitoba supports HIV care and treatment through the Manitoba HIV Program; Nation-based prevention and testing must connect with this provincial network. [6]

Lessons from Tuberculosis and First Nations-Led Public Health

Northern Manitoba's tuberculosis (TB) experience provides an important lesson for HIV. For approximately 15 years, the Winnipeg Regional Health Authority has coordinated TB services for the majority of First Nations in Manitoba. TB rates in northern Manitoba have worsened during this period: the Northern Health Region recorded an age-standardized incidence rate of 113.8 per 100,000 in 2024, compared with 74.0 in 2010. These are regional rates; Indigenous Manitobans have consistently represented the largest proportion of active TB cases since 2015. [3, 7–8]

> **The HIV emergency presents an opportunity to respond in a new way. First Nations must be central to developing the public health response from the outset, rather than being asked to address the consequences of systems and policies developed without their meaningful involvement.**

KIM is redesigning public health services through a First Nations-led Public Health Unit, integrating communicable disease surveillance, prevention, screening, clinical services and follow-up within northern First Nations, with connections to mental health, addictions and harm reduction services. [9] Cultural safety will be measured through First Nations-defined key performance indicators (KPIs), including patient-reported experiences, institutional accountability and impacts on access and outcomes.

Like HIV, TB is shaped by social and structural determinants of health. A change in service administration alone cannot resolve these conditions. However, First Nations-led public health systems can strengthen health system accountability to First Nations, identify local barriers, coordinate services and advocate for investments to address these determinants.

Federal and Provincial Investment, Policy and First Nations Authority

KIM's Public Health Unit is currently funded to deliver TB services; additional investment is needed for broader HIV and sexually transmitted and blood-borne infection (STBBI) services. In November 2026, the Public Health Agency of Canada (PHAC) confirmed its $5 million HIV self-testing and peer-support investment limits eligibility to existing funding recipients and activities to non-reserve settings. These restrictions raise concerns about equitable access and structural racism, particularly for northern and remote First Nations. [10–11] Canada's STBBI Action Plan 2024–2030 prioritizes Indigenous leadership, remote testing and long-term funding. [12]

> **First Nations must be involved not only in responding to public health emergencies, but in determining the policies, investments and service models intended to prevent them.**

First Nations health transformation must extend beyond service delivery to meaningful authority over governance, policy, resource allocation and accountability, recognizing First Nations laws, knowledge, governance and Nation-specific priorities. Canada and Manitoba retain responsibilities for equitable healthcare; Manitoba's public health mandate includes surveillance, disease prevention and emergency response. Both governments must address jurisdictional gaps with First Nations. [13]

KIM's March 17, 2025 Agreement in Principle (AIP) with Canada recognizes First Nations participation in policy development and the principle "***Change Must Be for the Good***." Section 6.1 recognizes citizens of the 23 Nations who elect to receive KIM services, regardless of residence. These commitments should inform public health policy. [14] UNDRIP Articles 21, 23 and 24 and the Truth and Reconciliation Commission's health Calls to Action reinforce these commitments. [15–16] The Auditor General reported in 2025 that Indigenous Services Canada (ISC) had not reassessed comparable access to essential healthcare in remote First Nations since 2016. [17]

Recommendations to the Standing Committee on Health

KIM respectfully recommends that the Committee call upon the Government of Canada to undertake the following actions:

1. **Improve access to comprehensive HIV prevention and treatment.** Support First Nations-led models of care that strengthen access to HIV testing (including point-of-care and self-testing on and off reserve), PrEP, PEP, treatment, mental health and addictions care, harm reduction, pharmacy services, provider training and ongoing clinical care, including Nation-based and virtual services where appropriate.

2. **Adopt cultural safety and humility standards and HIV guidance for care in First Nations.** Implement CAN/HSO 75001:2026 (E), Cultural Safety and Humility, in practitioner orientation and training. Develop Manitoba-specific PrEP and PEP guidance for nursing stations and health centres, including initiation, monitoring, referral and confidentiality. Establish First Nations-defined cultural safety KPIs measuring respect and freedom from discrimination, responses to racism and complaints, and delayed or missed care associated with cultural unsafety. [18]

3. **Establish a coordinated federal, provincial and First Nations-led HIV response.** Direct PHAC, ISC and Health Canada to work with First Nations, First Nations-led health organizations on and off reserve, Manitoba and the Manitoba HIV Program to address HIV prevention, testing, treatment, harm reduction and continuity of care, with defined responsibilities and shared accountability. Assess federal HIV and STBBI funding eligibility, geographic restrictions and allocations, including PHAC's self-testing investment, for inequitable effects. Reflect the distinct experiences of First Nations women, youth, Two-Spirit and LGBTQIA+ people, people who use substances, and people living with HIV.

4. **Invest in First Nations-led public health systems and align federal public health policy with health transformation commitments.** Establish predictable, flexible, multi-year funding supporting Nation-based workforces, diagnostics, surveillance, clinical support, integrated mental health and addictions services, harm reduction, prevention and follow-up, reflecting the actual costs of northern and remote delivery. Work with First Nations health transformation partners and Manitoba to resolve jurisdictional and policy barriers and implement integrated services.

5. **Establish meaningful mechanisms for First Nations participation in federal policy development.** Create formal opportunities for First Nations governments and First Nations-led health organizations to influence federal public health priorities, HIV program design, funding criteria and evaluation before decisions are finalized. Require substantive responses to First Nations recommendations, including reasons and timelines, and assess investments against equitable health outcomes and First Nations-defined indicators, respecting First Nations data sovereignty.

Conclusion

Manitoba's HIV public health emergency requires urgent action on structural barriers within public health institutions. Northern Manitoba's TB experience demonstrates the consequences of leaving systemic causes of inequity unaddressed.

KIM's First Nations-led Public Health Unit demonstrates that northern First Nations are advancing solutions grounded in their priorities, knowledge and governance. However, First Nations cannot transform public health systems independently of the federal and provincial policies, funding arrangements and jurisdictional responsibilities that shape healthcare access. Both governments must remain accountable for their respective responsibilities.

> **First Nations-led public health is not simply an alternative way to deliver existing programs. It is an opportunity to transform the systems that have failed to adequately meet the needs of First Nations for generations.**

Canada and Manitoba must change how decisions are made, resources are allocated and First Nations influence policy. The HIV response must not repeat approaches that leave jurisdictional gaps and direct resources to services rural and remote First Nations struggle to access.

KIM welcomes the opportunity to contribute to this study and work with both governments toward an equitable, First Nations-led public health response.

Appendix A — About Keewatinohk Inniniw Minoayawin Inc.

Established in December 2019, KIM advances health and wellness transformation under the direction of 23 northern Manitoba First Nations. Our mandate is a comprehensive, integrated health system designed, delivered and managed by First Nations, grounded in sovereignty, self-determination and Nation-specific health priorities.

This work is anti-racist in its foundation: dismantling colonial structures, policies and practices that perpetuate anti-First Nations racism and health inequities by returning health system authority to First Nations.

KIM's work includes public health and communicable disease services, clinical care, health transformation, medical transportation, mental wellness and Nation-driven health innovation, with cultural safety and anti-racism as cross-cutting priorities.

Appendix B — References and Supporting Materials

1. Government of Manitoba. (2026, May 7). Province declares a public health emergency to combat the spread of HIV.
2. Manitoba Health. (2025). HIV in Manitoba 2024: Annual Surveillance Update.
3. Manitoba Chief Provincial Public Health Officer. (2025). A Healthier Manitoba for All: 2025 Health Status of Manitobans Report.
4. Manitoba HIV Program. (2022). Manitoba HIV Program Report 2018-2021.
5. Keewatinohk Inniniw Minoayawin Inc. (2026, June 2). Increasing Access to PrEP for Northern Remote First Nations Citizens. Internal briefing note.
6. Manitoba HIV Program. (2025). 2025 Manitoba HIV Program Update.
7. Manitoba Health. (2014). Tuberculosis Surveillance Report: Manitoba, 2000–2012.
8. Government of Manitoba. (2014). Manitoba Tuberculosis Program: Roles and Responsibilities Matrix.
9. Keewatinohk Inniniw Minoayawin Inc. (2026). Public Health Unit Strategy and Model of Care. Internal organizational materials.
10. Public Health Agency of Canada. (2026, November 4). Correspondence with KIM regarding HIV self-testing and peer-based support funding. Organizational correspondence.
11. Keewatinohk Inniniw Minoayawin Inc. (2026, November 6). Structural Racism, Human Rights and Federal Public Health Funding for Northern First Nations. Correspondence prepared for the federal Ministers of Health and Indigenous Services.
12. Public Health Agency of Canada. (2024). Government of Canada's Sexually Transmitted and Blood-Borne Infections Action Plan 2024–2030.
13. Government of Manitoba. The Public Health Act.
14. Keewatinohk Inniniw Minoayawin Inc. and Government of Canada. (2025, March 17). Agreement in Principle for Health Transformation. KIM organizational agreement; relevant sections include 6.1 and 8.
15. United Nations. (2007). United Nations Declaration on the Rights of Indigenous Peoples. Articles 21, 23 and 24.
16. Truth and Reconciliation Commission of Canada. (2015). Calls to Action. Calls 18–24.
17. Office of the Auditor General of Canada. (2025). Follow-up on Programs for First Nations.
18. Health Standards Organization. (2026). Cultural Safety and Humility (CAN/HSO 75001:2026).