





First Nations, Inuit and Métis: Respiratory Health Initiatives Environmental Scan

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Under the *Canadian Constitution Act, 1982*, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population. NAHO makes every effort to ensure the term is used appropriately.

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## **Executive Summary**

In Canada, respiratory diseases result in thousands of deaths each year with costly results, and are a significant burden for Aboriginal Peoples. While the National Lung Health Framework (NLHF) was finalized in 2008, the challenge of incorporating the often unique issues relating to First Nations, Inuit and Métis respiratory health remains. The study upon which this report is based provides baseline information to address this gap. This report consists of an environmental scan and associated case studies of respiratory health initiatives for Canada's three Aboriginal populations: First Nations, Inuit, and Métis. The research was conducted by the National Aboriginal Health Organization (NAHO), with support from the Public Health Agency of Canada (PHAC) and the National Lung Health Framework Partnership Secretariat.

Respiratory diseases can be caused by anything inhaled into the lungs that puts people at risk. Acute (short-term) diseases include pneumonia, influenza, and infectious diseases. Chronic (long-term) diseases include lung cancer, Chronic Obstructive Pulmonary Disease (COPD), asthma, tuberculosis, cystic fibrosis, sleep disordered breathing (sleep apnea), occupational lung disease, environmental disease, Respiratory Syncytial Virus (RSV), and allergies. The most common respiratory diseases are related to tobacco use, including lung cancer and COPD. Canada's Aboriginal population suffers similar respiratory health problems to those experienced by populations in many low- and middle-income countries. Multiple social and political factors – often referred to as social determinants of health – influence lung health outcomes for this population.

The environmental scan component involved a search of respiratory health strategies and projects, programs and initiatives that target First Nations, Inuit and Métis. More than 100 strategies, projects, programs and initiatives were identified for addition to the National Lung Health Framework database (available at [www.lunghealthframework.ca/utilities/project-login](http://www.lunghealthframework.ca/utilities/project-login)). An analysis of these is provided in this report, with an emphasis on identifying trends, as well as promising practices and recommendations. The second component includes two to four in-depth case studies of respiratory health initiatives for each of the First Nations, Inuit and Métis populations, using a distinction-based approach and reflecting a range of community sizes and structures. The case studies illustrate how specific contexts and activities lead to successful programming and positive health outcomes, and offer recommendations for further improvement. They also identify successful models to share with other communities that are interested in adapting and enhancing existing programs or building new ones.

The strategies and initiatives examined in this report provide a foundation for creating more effective programming that directly targets Aboriginal respiratory health and addresses the social determinants of health that influence respiratory health outcomes.

### **Environmental Scan**

The analysis of strategies, projects, programs and initiatives is structured according to the National Lung Health Framework action areas: health promotion/awareness and disease prevention; disease detection and management; policy, partnerships and community systems support; and research, surveillance, and

knowledge translation. The majority of projects, programs and initiatives received funding from several primary strategies, including the Aboriginal Health Transition Fund (of Health Canada's First Nations and Inuit Health Branch (FNIHB)), the Federal Tobacco Control Strategy (of Health Canada), the Aboriginal Health Initiative Program (of the Government of British Columbia's Northern Health), the provincial tobacco strategies (including the Aboriginal Tobacco Strategy under Cancer Care Ontario and British Columbia's Aboriginal Tobacco Strategy), and the National Association of Friendship Centres (and provincial components). Many projects, programs and initiatives reviewed for this report received small grants to develop and deliver community-based initiatives.

The majority of relevant strategies, projects, programs and initiatives take a pan-Aboriginal or pan-Canadian approach; however, of those that do target a specific Aboriginal population, most were focused on First Nations (primarily on-reserve) and Inuit. Geographic distribution plays a significant role in the delivery of health care; it is easier to offer services to populations that are grouped in distinct geographic areas. Aboriginal people in urban settings are more often exposed to pan-Canadian programs and services.

Among the Aboriginal strategies that were reviewed, many incorporate a holistic view of health rather than focusing on individual diseases (e.g., the Aboriginal Healing and Wellness Strategy). We were unable to identify Aboriginal strategies, projects, programs and initiatives that target sleep apnea, cystic fibrosis, pneumonia or COPD; these are rather encompassed under pan-Canadian and/or chronic disease initiatives. Our research indicates that projects, programs and initiatives must fit into the local culture, reflect local values, and use appropriate methods; thus, community-based projects, programs and initiatives are the most effective.

Tobacco cessation and tobacco-related diseases are the most targeted respiratory issues for Aboriginal populations, in part due to high Aboriginal smoking rates and the preventable nature of these diseases. Tobacco strategies exist at federal, provincial and territorial levels. The most effective are those that present health impacts in a new way and are targeted towards a specific audience. Research by the Aboriginal Nurses Association of Canada (ANAC) demonstrates that Aboriginal smoking strategies must tailor specific messages about the historical ceremonial usage of tobacco as well as the health risks.

Promising practices regarding tuberculosis also exist. Active case management and screening programs have led to a decrease in the rates of TB in First Nations communities. However, to fully eradicate the disease, more preventive programs and annual screening of individuals, groups, and communities are required for at-risk populations.

There are several broader-scale initiatives that can be used to improve respiratory health. The Blueprint on Aboriginal Health is a national 10-year transformative plan that addresses the gaps in health outcomes between the general Canadian population and Aboriginal Peoples; it offers opportunities for collaboration with respiratory health organizations. At a local level, Aboriginal liaison programs provide direct support to improve the accessibility of health services. TeleHealth – the use of communications

and information technology to deliver health and health care services and information over distances – could be used to provide respiratory health advice for First Nations, Inuit and Métis in remote locations.

One significant gap is the lack of programming and information related to Métis respiratory health. While resources exist for Aboriginal people as a whole, few are targeted towards Métis. At the same time, Métis organizations may be addressing respiratory health indirectly through action on social determinants of health such as housing and education.

### **Case Studies**

In elaborating population-specific case studies for First Nations, Inuit and Métis respiratory health projects, programs and initiatives, we have three goals. First, we highlight, from a community perspective, the positive impact of the project, program or initiative on respiratory health and/or the determinants of health. Second, we highlight the elements of the project, program or initiative that made it successful from the community's perspective. Third, we explore innovations, improvements, ideas, and recommendations to improve success if the initiative is reproduced elsewhere in Canada.

#### ***First Nations***

The majority of initiatives offered to First Nations people in Canada focus primarily on either tobacco abuse cessation or tuberculosis. There are a variety of delivery models for respiratory health initiatives, both on- and off-reserve, offering options to First Nations communities in their selection of models to suit local needs.

A number of other insights emerged from these case studies. First, post-program evaluations were only conducted for a portion of the case study initiatives. When used, they offered important insights. Second, funding arrangements were identified as a major barrier to sustained programming and to long-term success in influencing behavioural change, such as tobacco cessation. Third, only one of the four case studies included a gender-based component, indicating a potential need for a more concerted use of such approaches. Fourth, obsolete First Nations health data may be hindering program planning, indicating a need for improved and updated information. Finally, key informants expressed the desire for governments to “get in better touch” with Aboriginal health issues and needs.

#### ***Inuit***

Respiratory health issues affecting Inuit are often symptoms or by-products of systemic socio-economic challenges and the resulting legacy of societal emotional and mental health problems. It is very difficult to imagine drastically improving (lowering) rates of respiratory disease solely through direct health care initiatives. At the same time, the health system lacks adequate financial resources, indicating the need for a re-prioritization of the health policy agenda. Additionally, experts have indicated that there may be (as yet unstudied) physiological factors that help to explain why respiratory diseases such as TB and RSV have such a significant impact on Inuit.

Tobacco-related initiatives are widespread in Inuit communities, where an adaptive, flexible, community-based approach has significant merit. Community-based projects require a long-term investment of both people and resources, and a commitment to community development.

A number of other insights emerged from these case studies. First, having Inuit champions and/or long-term trusted collaborators at various levels of organizations (especially locally) can significantly enhance success. Second, it is important to look at a broad range of indicators of success and progress to encompass complex and inter-connected issues. Third, public health programs in Inuit regions are making concerted efforts to determine how to achieve greater success in respiratory health, offering an opportunity for increased support. Finally, it is important to note that issues around tobacco addiction and lower respiratory tract infections among Inuit infants (where RSV is dominant, but not the only cause) are serious and persistent problems in all Inuit regions, not just in the case study areas.

### ***Métis***

The limited number of Métis case studies included in this report directly reflects the limited number of existing Métis-specific respiratory health initiatives. Those that do exist tend to focus on tobacco cessation. At the same time, however, there are several Métis housing initiatives (e.g., Métis Nation of Ontario's Residential Rehabilitation Assistance Program, and the Manitoba Metis Federation's Community Housing Managers of Manitoba) that may have indirect impacts on Métis respiratory health. We also identified a number of pan-Aboriginal initiatives which presumably offer access to Métis, although there may be issues around cultural competency in addressing Métis clients.

The case studies offer some important insights for developing or expanding respiratory health initiatives for Métis. First, community-based and community-driven initiatives are deemed particularly effective, especially when championed by committed and engaged staff or volunteers. Second, successful approaches tend to be flexible and adaptable to evolving contexts. They also tend to be holistic in nature, addressing more than just the physical aspects of health and well-being. Third, the consistent availability of funding and other resources is essential. Long-term projects benefit from an improved ability to plan and implement activities in a consistent manner, allowing participants to develop and maintain a sense of connection and stability. The development of mutually beneficial partnerships with other organizations is also facilitated, which tends to improve outcomes.

### ***Conclusions***

The case studies illustrate that few organizations directly target the effects of respiratory disease on Aboriginal health. Rather, many programs are more holistic in nature, focusing on healthy lifestyles. Other interventions also exist. For example, housing programs can have important direct effects (e.g., better ventilation improves respiratory health) as well as other indirect impacts on the social determinants of overall health. Federal initiatives are commonly applied in Inuit communities and on First Nations reserves, but fewer programs are available for off-reserve and Métis populations. Additionally, Métis health data remains limited.



Overarching recommendations for respiratory health projects, programs and initiatives for Aboriginal Peoples include the need for community-based, community-driven, and group-specific services. Separate programs are needed for First Nations, Inuit, and Métis. Program flexibility emerged as important in all case studies, and the need for consistent funding was also highlighted.

Respiratory health issues were certainly recognized as a challenge for First Nations, Inuit and Métis populations, and limitations in services, resources and information relating to these issues were highlighted. There is a need to further address these issues, while recognizing the complexity and impacts of the broader socio-economic context.

## 1.0 Introduction

Stakeholder consultations were held in 2006 across the country to develop a national strategic plan for respiratory health. In 2008, these efforts resulted in the development of the National Lung Health Framework (NLHF). The Government of Canada announced an investment of \$10 million over a period of three years (2009-2012) to the Public Health Agency of Canada (PHAC) and the First Nations and Inuit Health Branch (FNIHB) of Health Canada to address specific information gaps/needs identified in the National Lung Health Framework. This federal investment includes initiatives to increase awareness about prevention, early detection, and self-management of lung diseases, including potential risks from the environment, and with an emphasis on high-risk populations, including children.

While First Nations, Inuit and Métis respiratory health issues have been recognized as important, it remains a challenge to incorporate these issues into the overall Framework while respecting the unique experiences faced by First Nations, Inuit and Métis regarding this aspect of health and well-being. As the National Lung Health Framework nears completion, there is interest in developing an Aboriginal-specific component. This report highlights the respiratory health problems affecting Aboriginal populations and the projects, programs and initiatives that are targeting these diseases.

Canada's Aboriginal population suffers similar respiratory health problems to those experienced by populations in many low- and middle-income countries. Multiple social and political factors (often referred to as social determinants of health) influence lung health outcomes for this population. These include: poverty, lack of education, elevated rates of tobacco use, inadequate housing, unresolved federal-provincial jurisdictional challenges, limited local human resources capacity, and limited funding (AllerGen, 2008).

In Canada, respiratory diseases result in thousands of deaths every year with costly results, and are a significant burden for Aboriginal people, reinforcing the need for timely attention to respiratory health issues. First Nations, Inuit and Métis have their own cultures, practices, and health concerns, and these vary by region and environmental context. As such, there is a need for strategies, projects, programs and initiatives that directly target each of the three Aboriginal populations in Canada.

NAHO was an early and consistent partner in the activities and development of the National Lung Health Framework and assisted in engaging a number of other national First Nations, Inuit and Métis partners. Acknowledging NAHO's commitment to the Framework and its implementation, and recognizing the organization's mandate to engage in knowledge-based activities relating to First Nations, Inuit and Métis health, PHAC and the National Lung Health Framework Partnership Secretariat engaged NAHO to conduct the environmental scan upon which this report is based.

This report has two components. The first is an environmental scan of respiratory health strategies, projects, programs and initiatives targeting First Nations, Inuit and Métis, with an emphasis on identifying promising initiatives and practices, and recommendations for potential replication. More than 100 respiratory health strategies, projects, programs and initiatives for First Nations, Inuit and Métis were identified for addition to the National Lung Health Framework database (available at

[www.lunghealthframework.ca/utilities/project-login](http://www.lunghealthframework.ca/utilities/project-login)), and an analysis of these is provided here. The second component includes up to four in-depth case studies for each of the First Nations, Inuit and Métis populations, using a distinction-based approach and reflecting a range of community sizes and structures. These case studies illustrate how specific contexts and activities lead to successful programming and positive health outcomes, and offer recommendations for further improvement. The case studies also identify successful models to share with other communities that are interested in adapting and enhancing existing programs or building new ones. The environmental scan and associated case studies of First Nations, Inuit and Métis programs will provide the foundation for a meeting of key First Nations, Inuit and Métis stakeholders and National Lung Health Framework Steering Committee members to further develop the Aboriginal-specific component of the National Lung Health Framework Action Plan.

### ***1.1 Aboriginal Population in Canada***

The Government of Canada recognizes three distinct Aboriginal populations, as designated in the *Constitution Act, 1982*: First Nations (Indian), Inuit, and Métis. According to the 2006 Census, over a million people identified themselves as Aboriginal, representing nearly four per cent of Canada's total population (Statistics Canada, 2006).

There are 615 First Nation communities in Canada, which represent more than 50 nations (or cultural groups) and languages. Of the more than one million people in Canada who self-identify as Aboriginal, approximately two thirds are First Nations (Indian and Northern Affairs Canada, 2010). Less than half of First Nations live on-reserve and approximately 81 per cent are Status Indians, meaning they are registered under the *Indian Act* (Statistics Canada, 2008).

Canada is home to over 50,000 Inuit who live primarily in 53 Arctic communities in four geographic regions: Nunatsiavut (Labrador); Nunavik (Quebec); Nunavut; and the Inuvialuit Settlement Region of the Northwest Territories, and increasingly in a number of southern Canadian cities. Inuit make up approximately four per cent of the total Aboriginal population (Inuit Tapiriit Kanatami, 2010).

There are approximately 390,000 Métis living in Canada, representing about one third of the total Aboriginal population. The Métis National Council (2010) considers a person to be Métis if they “self-identify as Métis, are of historic Métis Nation ancestry, are distinct from other Aboriginal Peoples, and are accepted by the Métis Nation.” The historic Métis Nation homeland refers to the area of land in west-central North America used and occupied as the traditional territory of the Métis (or Half-Breeds, as they were previously known). A distinct Métis population initially emerged from the marriages of First Nations women (Cree, Ojibway, Salteaux and others) with French and Scottish fur traders, and eventually Scandinavian, Irish, and English settlers as well. Métis acted as intermediaries between European and Indian cultures, often as guides and interpreters. They developed a unique language called Michif, which has three distinct variations, and have a distinct culture, values and beliefs (Métis National Council, 2010). Métis helped to shape western Canada, and the majority reside in Ontario,

Manitoba, Saskatchewan, Alberta or British Columbia. Approximately two thirds of Métis live in urban areas and one third of the population is less than 14 years old (Métis National Council, 2010).

All three Aboriginal populations have high birth rates, which will continue to put pressure on available health care services into the future. The Métis population has grown by 91 per cent over the last 10 years, both as a result of higher fertility rates and an increasing tendency to self-identify as Métis. The population distribution of these three groups factors into their ability to access health care services.

This report recognizes that social determinants of health play a vital role in how Aboriginal people develop and are treated for respiratory diseases. Compared to the rest of the Canadian population, Aboriginal people are at a disadvantage in terms of income, education, and employment (National Lung Health Framework Partnership Secretariat, 2008), resulting in barriers with regards to how they receive health care and how their diseases are treated. These factors can ultimately lead to a higher risk of infection and poor health outcomes. Other issues include acculturation, social exclusion, colonialism, trauma from residential schools, and other experiences linked to colonial history. The systemic stress placed on Aboriginal communities as a result of urbanization and social exclusion has limited their opportunities – as individuals and groups – to participate fully and equally in society, including the realm of health services (National Lung Health Framework Partnership Secretariat, 2008).

## ***1.2 Respiratory Health***

Respiratory diseases can be caused by anything inhaled into the lungs that puts people at risk. Respiratory diseases cost Canadians an estimated \$154 billion per year in direct and indirect costs (National Lung Health Framework Partnership Secretariat, 2008, pg 2). There are a range of respiratory diseases which vary by type: acute (short-term) and chronic (long-term). Acute diseases include pneumonia, influenza, and infectious diseases. Chronic diseases include lung cancer, Chronic Obstructive Pulmonary Disease (COPD), asthma, tuberculosis, cystic fibrosis, sleep disordered breathing (sleep apnea), occupational lung disease, environmental disease, Respiratory Syncytial Virus (RSV), and allergies.

The most common respiratory diseases are related to tobacco use, including lung cancer and COPD. Lung cancer will soon be the third leading cause of death in the world (World Health Organization, 2009). Asthma, tuberculosis, sleep-disordered breathing (sleep apnea), and influenza – both seasonal and pandemic – are all common respiratory diseases unrelated to tobacco. These common respiratory diseases are the primary focus of this paper.

### **1.2.1 Lung Cancer**

Due to high smoking rates among Aboriginal people in Canada, lung cancer is a primary concern. It occurs when cancer – a “disease where cancerous cells grow out of control and start taking over normal cells and organs in the body” (Canadian Lung Association, 2010) – begins in the lungs. Lung cancer is most frequently caused by smoking or by inhaling second-hand smoke, although it can also be caused by radon, asbestos, and other toxic products.

### **1.2.2 Chronic Obstructive Pulmonary Disease**

Chronic Obstructive Pulmonary Disease (COPD) is a chronic lung disease usually caused by smoking. COPD also includes other lung diseases, such as chronic bronchitis and emphysema. COPD cannot be cured; however, with proper treatment it can be managed. Chronic bronchitis occurs when airways are irritated, red, swollen, and partially block air from passing through. Emphysema occurs when there is damage to the air sacs at the tips of the airways, making it difficult to take in oxygen.

### **1.2.3 Asthma**

Asthma is a chronic disease where breathing passages (airways) are extra sensitive, making breathing difficult. The causes of asthma include family history and allergies to indoor and outdoor pollutants. Although asthma is considered a chronic disease, with proper treatment it can be effectively managed. Treatment and medication allow people to live relatively normal lives.

### **1.2.4 Tuberculosis**

Tuberculosis (TB) is an infectious and contagious disease. TB enters the body through inhalation, and settles in the lungs. It can spread through the central nervous system, affecting the bones and joints. Unlike COPD and asthma, tuberculosis can be cured with treatment. During the 1950s and 60s, tuberculosis rates fell dramatically across Canada with the introduction of antibiotics. Despite this drastic drop in rates, tuberculosis still persists in Aboriginal communities (Canadian Public Health Association, 2010).

### **1.2.5 Sleep Disordered Breathing – Sleep Apnea**

Another common respiratory disease is sleep-disordered breathing, or sleep apnea, which is a breathing problem that interrupts sleep. Short pauses between breaths occur while sleeping. These pauses (apneas) may last for 10 to 30 seconds and people can stop breathing dozens or hundreds of times each night. Factors that influence sleep apnea include obesity, gender, age, and family history.

### **1.2.6 Influenza – Seasonal and Pandemic**

There are two different types of influenza: the regular seasonal flu and the pandemic flu. The regular seasonal flu is a common infection of the nose, throat and lungs caused by the influenza virus. The virus causes an infection in the respiratory tract, including nose, nasal passages, throat, lungs, and bronchial tubes. It is contagious and kills thousands of Canadians every year. The regular seasonal influenza falls into three categories: A, B, and C. Only type A causes pandemics in humans. An influenza pandemic is defined as “a global epidemic of influenza and it occurs when a new influenza virus emerges and starts spreading in a similar way to normal influenza” (World Health Organization, 2009). Since the pandemic strain of the virus is considered new, human immune systems have limited immunity and those who become infected are at a greater risk of experiencing more serious health outcomes.

They often cause symptoms similar to those of the regular seasonal flu, and spread in much the same way through contact with people who are coughing and sneezing. Examples of pandemic influenzas include H1N1, Severe Acute Respiratory Syndrome (SARS) and the Spanish influenza.

## **2.0 Analysis of Existing Strategies**

This section provides a review and analysis of existing respiratory health strategies, projects, programs and initiatives that target First Nations, Inuit and Métis populations. It describes the methods used in this study component, discusses the results and their importance, and identifies promising practices and recommendations.

### ***2.1 Methods***

The information in this report was gathered through extensive Internet searches and email contact with approximately 100 individuals and organizations that work in the respiratory health field and/or in Aboriginal health. Initially we targeted the departments (or branches) of health and social services at federal, provincial, and territorial governments in a website search, focusing on Aboriginal programming (e.g., the First Nations and Inuit Health Branch (Health Canada), the Urban Aboriginal Strategy (Health Canada), and the Institute of Aboriginal People's Health (Canadian Institutes of Health Research – CIHR)). After thoroughly examining available online information to identify any strategies, projects, programs or initiatives that addressed First Nations, Inuit and Métis respiratory health, we undertook email follow-up as required. A range of national, regional, and local Aboriginal organizations was also contacted, including: the Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), the Métis National Council (MNC), the Congress of Aboriginal Peoples (CAP), the five provincial Métis organizations, the Métis Settlements General Council, and others. Representatives of relevant networks such as the Aboriginal Nurses Association of Canada (ANAC), the National Association of Friendship Centres, the Centre for Aboriginal Health Research (University of Victoria), and the Arctic Health Research Network-Yukon were also contacted, as were respiratory health organizations including the Canadian Thoracic Society, the provincial lung associations, and others. Emails were also sent to all participants of the Yukon and Northwest Territories National Lung Health Framework Stakeholder Engagement Sessions (held in March 2008) and participants of the National Lung Health Framework Aboriginal Meeting (August 2008). Initial contact was made via email or telephone to encourage feedback and ensure a broad sampling of relevant stakeholders.

### ***2.2 Strategies and Action Areas***

The majority of projects, programs and initiatives identified for addition to the National Lung Health Framework database received funding from several primary strategies. These include: the Aboriginal Health Transition Fund (of FNIHB), the Federal Tobacco Control Strategy (of Health Canada), the Aboriginal Health Initiative Program (of British Columbia's Northern Health), the provincial tobacco strategies (including the Aboriginal Tobacco Strategy under Cancer Care Ontario and British Columbia's Aboriginal Tobacco Strategy), and the National Association of Friendship Centres (and provincial

components). Many projects, programs and initiatives reviewed for this report received smaller grants (\$5,000 and upwards) to develop and deliver community-based initiatives.

A number of the overarching strategies that we reviewed are administered by Health Canada's FNIHB, which provides funding for programs and services for health promotion and illness prevention for on-reserve First Nations and Inuit communities (Health Canada, 2010c). These FNIHB strategies are structured to address the primary goal of decreasing health inequalities between Aboriginal and non-Aboriginal people.

This section provides an analysis of the different strategies, projects, programs and initiatives that address First Nations, Inuit and Métis respiratory health. We have structured this analysis based on the National Lung Health Framework action areas, including: health promotion/awareness and disease prevention; disease detection and management; policy, partnerships and community systems support; and research, surveillance, and knowledge translation. It is important to note the limitation of categorizing the strategies, projects, programs and initiatives under specific action areas, as some overlap may occur. For example, one strategy may focus in part on policy, partnerships and community/systems support, while another component focuses on disease management.

### **2.2.1 Health Promotion/Awareness/Disease Prevention**

The central objective of this action area is to “prevent, and moderate the impact of, respiratory illnesses through the development and implementation of effective, co-ordinated: health promotion, awareness, exposure reduction, and smoking prevention/cessation activities” (National Lung Health Framework Partnership Secretariat, 2010). The strategies, projects, programs and initiatives that fall in this action area are primarily related to tobacco cessation.

#### ***2.2.1.1 Tobacco***

Statistics show that one in five Canadians currently smokes (National Lung Health Framework Partnership Secretariat, 2008). Smoking rates in First Nations communities are double those of the rest of Canada, and rates in Inuit communities are more than double those of the rest of Canada. Smoking is considered a major public health issue that affects both smokers and non-smokers. Tobacco is associated with several respiratory health issues of concern, including lung cancer and COPD. Smoking causes 85 per cent of lung cancer cases (Health Canada, 2010b), a disease that affects Aboriginal people – particularly Inuit – at an alarming rate.

A significant number of respiratory health strategies, projects, programs and initiatives focus on tobacco cessation and prevention. At the national level, Health Canada has a Federal Tobacco Control Strategy that aims to reduce overall smoking prevalence, with an emphasis on First Nations, Inuit and other Aboriginal groups, as well as youth and young adults (Health Canada, 2010b). The Strategy provides tools such as self-help guides and support groups to encourage people to quit smoking, as well as resources for health care professionals (e.g., facilitator's guides to teach them how to help people quit smoking).

Most provinces (e.g., British Columbia, Alberta, and Ontario) have a government branch or a non-government/non-profit organization that focuses on tobacco control and cessation. Cancer Care Ontario has an Aboriginal Tobacco Strategy (ATS) which focuses on disease prevention, knowledge translation, and the creation of tobacco-wise communities. This strategy encourages health promotion and awareness about tobacco use and misuse. The Aboriginal Tobacco Strategy stresses the differences between traditional (ceremonial and ritual use) and commercial uses of tobacco, and raises awareness about tobacco health related issues and diseases. This strategy serves Ontario's rural/urban on-reserve Aboriginal communities. In 2007 and 2008, the ATS funded 11 projects focused on protection, prevention and cessation, and most projects were targeted towards Aboriginal youth. In creating tobacco-wise communities, ATS is improving awareness about the risk factors associated with using tobacco.

Targeting Aboriginal youth is a common approach for tobacco cessation programs. In 2009, the Government of Canada funded two such programs in Nunavut: the Quit to Win Challenge and the For Youth by Youth Trainer Training program. The former is being implemented by the National Indian and Inuit Community Health Representatives Organization (NIICHO), and the latter by the Government of Nunavut over a two-year period. The Quit to Win Challenge is a six-week contest that encourages Inuit youth (from eight to 17 years old) to quit smoking and remain tobacco-free. Prizes are randomly distributed to those who complete the objectives. This project includes an educational component on tobacco use for implementation in schools, as education is considered to play a key role in the prevention of smoking. The For Youth by Youth Trainer Training Program offers Inuit youth the opportunity to learn the necessary skills to educate and influence their peers in a positive way about the damaging effects of smoking.

Another initiative of interest is ActNow BC (launched in 2005), which has an Aboriginal-specific component (Aboriginal ActNow BC) that is being implemented by the National Collaborating Centre for Aboriginal Health. This active living health promotion strategy aims to address risk factors and reduce the chances of developing a chronic disease. Reducing tobacco use is one of the four target areas of this initiative. Currently more than 40 community-based healthy eating and active living projects are supported by Aboriginal ActNow BC. Additional foci involve: a) evaluating research on Aboriginal health and chronic disease prevention, b) identifying research gaps, and c) working towards more relevant, meaningful and useful evidence-based health research for diverse BC communities.

### ***2.2.1.2 H1N1 Virus***

The H1N1 influenza virus outbreak, officially declared a pandemic in June 2009, raised a worldwide response. Found in over 200 countries, H1N1 led to the death of approximately 16,000 people across the globe (World Health Organization, 2009). H1N1 spreads in a similar way to the seasonal influenza and is easily transmitted by exposure to infected droplets through coughing or sneezing. Most of the deaths caused by this outbreak occurred in younger, seemingly healthy individuals, which was one of the reasons why it caused such widespread panic. Pregnant women, children, and people with an



already present chronic lung condition are considered more vulnerable to serious and severe illness from this virus.

People living in remote areas, such as many First Nations, Inuit and Métis, are at a higher risk of H1N1 infection. Many Aboriginal communities face challenges such as overcrowding, lack of running water and poor nutrition, all of which increase the likelihood of infection. Also, accessibility to health care services plays another vital role; those who become infected and live in remote/isolated areas may have difficulties in reaching health care services in enough time to be properly treated. Many First Nations, Inuit and Métis individuals also have underlying chronic medical conditions, which place them at a higher risk for H1N1.

The initial response to the H1N1 outbreak in Canada was carefully planned and efficient. PHAC provided information on its website about efforts to protect and treat First Nations, Inuit and Métis (Public Health Agency of Canada, 2010). However, most available information and planning tools target First Nations and Inuit populations. In response, the Métis National Council indicated concern about the lack of H1N1 flu pandemic planning for Métis, despite similar health risks as First Nations and Inuit populations. While the federal government has acknowledged the vulnerability of First Nations and Inuit populations and is working collaboratively to meet the needs of each group, the Métis do not seem to have garnered significant and equal attention.

Health Canada provided a comprehensive response to First Nations living on-reserve in regards to the H1N1 Flu Virus, including access to care, personal protective equipment, preposition of antiviral medication, epidemiological research, and support for developing and implementing pandemic plans (Public Health Agency of Canada, 2010). The Assembly of First Nations (AFN) is the national representative organization of the First Nations in Canada. When a pandemic like H1N1 occurs, AFN seeks to enhance direct engagement of First Nations governments through information, communication, facilitation, and advocacy. For the Inuit population, PHAC has worked with the provinces and territories to monitor outbreaks, and to distribute vaccines, antiviral medication and other supplies. Although Health Canada and PHAC provide general information for all Aboriginal populations, there does not appear to be any national services/programs specifically targeted towards Métis. However, the provincial Métis organizations do provide online information (e.g., Métis Nation-Saskatchewan has online resources to provide Métis with an enhanced understanding of prevention methods).

The Native Women's Association of Canada (NWAC) recognizes the relationship between the H1N1 pandemic and Aboriginal women in Canada. This virus has the potential to devastate the Aboriginal population for various reasons, including reduced immunity, complex health needs, lack of access to health services, and higher sensitivity to infectious disease. NWAC (2009) claims that women are the key determinants of health in a community since they are usually the primary caregivers. Education for women may be vital in minimizing the threat of this and similar viruses.

### **2.2.1.3 Other**

Respiratory diseases are garnering attention in the Aboriginal health research community, and some recent initiatives aim to engage community members to both build awareness and contribute community knowledge to better understand the social and environmental factors that put people at risk. One such initiative was a May 2010 *CIHR Café Scientifique* held at the First Nations Longhouse at the University of British Columbia in Vancouver, which focused on Aboriginal health and risk factors for cardiovascular and respiratory disease. Discussion focused on current knowledge of chronic disease in First Nations, Inuit and Métis populations, key factors to reducing chronic disease, future trends, lifestyle changes, and other mechanisms for improving Aboriginal health.

## **2.2.2 Disease Detection/Management**

The disease detection and management action area focuses on “improving the health outcomes and quality of life for everyone in Canada through early detection and better management of respiratory diseases” (National Lung Health Framework Partnership Secretariat, 2010). The chances of surviving and managing a disease both increase with earlier detection. Aboriginal-focused strategies, projects, programs and initiatives for both asthma and tuberculosis are relevant to this action area.

### **2.2.2.1 Asthma**

Asthma is a “chronic inflammatory condition of the airways characterized by recurrent symptoms of variable airflow limitation” (Asthma Society of Canada, 2010a). In First Nations populations, 15 per cent of children and youth suffer from asthma, compared to 12 per cent of the total Canadian population of children and youth. There is a slightly higher prevalence among First Nation adults compared with the general Canadian adult population (National Lung Health Framework Partnership Secretariat, 2008). Due to issues of isolation and access to care, it can be difficult to get an accurate perception of asthma prevalence rates in Aboriginal communities. Disease detection and management are key action areas as asthma can be effectively managed once the contributing factors have been identified.

Some recent initiatives focus specifically on Aboriginal health and asthma. The Asthma Society of Canada (ASC) published a report in January 2009, entitled *A Shared Vision: Ensuring the quality of life for adults and children with asthma and allergies in First Nations and Inuit communities in Canada*. This study examined the perceptions and experiences of asthma and related allergies in First Nations and Inuit communities (Asthma Society of Canada, 2009). Results indicated that less than one third of First Nations children with allergies are receiving treatment, which may be reflective of limitations in access to health care. At the same time, there is a lack of data for Inuit communities, making it difficult to determine precise prevalence rates and analyze the extent of impacts on community health.

Building on its 2009 report, the ASC published *A shared voice: Engaging First Nations and Inuit communities in the development of culturally appropriate asthma and allergy education materials and resources for youth and their families*. This report offers an overview of existing asthma education materials and resources and recommends possible adaptations to these materials to improve cultural

appropriateness and better address the needs of First Nations and Inuit (Asthma Society of Canada, 2010b).

### **2.2.2.2 Tuberculosis**

Tuberculosis is a disease that affects a greater number of Aboriginal people than non-Aboriginal people, resulting in specific projects, programs and initiatives to reduce its impacts. Inuit have a tuberculosis rate 185 times higher than that of non-Aboriginal Canadians, and First Nations have a rate 31 times higher. Contributing factors include crowded housing and inadequate sewage control on some reserves and in remote communities, as well as malnutrition and lack of education (AllerGen, 2008). It has also been suggested that Aboriginal people have historically had high tuberculosis rates and, as such, older people can still carry the bacteria in their body, therefore having the potential to re-infect, especially if not treated immediately (Canadian Lung Association, 2010).

The Tuberculosis Elimination Strategy was created in 1992 to address the rising rates of tuberculosis in Aboriginal communities. This strategy functions at a national level but responsibilities – including community health education, case management, drug supply, and outbreak management – filter through the regional level, and are implemented through primary health services at a community level (Health Canada, 2010c). The program is supported by FNIHB of Health Canada at the national level, and targets on-reserve First Nations populations, as well as Inuit communities in Labrador. In keeping with the national goal, the TB program aims to reduce the incidence of the disease in First Nations, Inuit and Métis communities to 3.6 cases per 100,000 by 2015, ultimately leading to the elimination of TB by 2050. Focal strategies include detection and diagnosis, prevention, and support for health care workers and communities.

One program of possible interest for application in the Canadian setting is the Practical Approach to Lung Health (PAL), developed by the World Health Organization. It uses a pragmatic approach to health services management, targeting multi-purpose health workers in primary health care settings with successful TB control programs in place. PAL training supports earlier identification of patients with TB and increases clinical efficiency of the quality of services provided. This program has already been successfully implemented in low- and middle- income countries, leading to improvements in early detection of TB, and diagnosis and treatment of those with respiratory illnesses who use primary health care services (World Health Organization, 2010). PAL could be implemented in First Nations, Inuit and Métis communities to complement existing TB programs and services.

### **2.2.3 Policy/Partnerships/Community/Systems Support**

The policy, partnerships, community/systems support action area aims to “develop, implement and strengthen the support structures essential to an effective respiratory health management strategy for all sectors, including policy and legislation, partnerships, community supports, and health care system design and delivery” (National Lung Health Framework Partnership Secretariat, 2010). This section focuses on TB initiatives and the Aboriginal Health Transition Fund.

### ***2.2.3.1 Tuberculosis***

The National Tuberculosis Elimination Strategy was released in 1992 and is undergoing renewal, with a late 2011 target date for completion. The goal is to reduce the incidence of TB in on-reserve First Nations and Inuit communities. As part of the national strategy, Strategic Community Risk Assessment and Planning for Enhanced Tuberculosis Programming (SCRAP-TB) was created to address the identified need for community-specific risk assessment. It offers a community capacity-building platform for First Nations and Inuit to access and share information, to assess local risks for TB, to design and implement community-specific plans, to foster partnerships, and to strengthen community capacity to address such issues (First Nations and Inuit Health Branch – Health Canada, 2007; Government of Canada, 2010). SCRAP-TB functions in the action areas of health promotion/prevention, as well as disease detection and management.

An example of an Aboriginal component within a provincial organization is British Columbia's Centre for Disease Control – Tuberculosis Control. This centre has a designated Aboriginal component referred to as Tuberculosis Services to Aboriginals (TBSA). The main purpose of TBSA is to provide consultative services to health professionals who provide health services to First Nations living on-reserve. In their Communicable Disease Control Manual there is also a section with information on program policies and standards of tuberculosis that are specific to First Nations communities in BC (British Columbia Centre for Disease Control, 2010).

### ***2.2.3.2 Aboriginal Health Transition Fund***

While not specifically focused on respiratory health, Health Canada's Aboriginal Health Transition Fund (AHTF) is an example of policy/partnerships/community/systems support. This initiative (to run until the end of March 2011) supports First Nations and Inuit communities in implementing more integrated health systems, and provincial and territorial health systems in adapting their services to better meet the needs of all First Nations, Inuit and Métis, including those living off reserve and in urban areas. Over the long term, the AHTF aims to improve the integration of federal, provincial, and territorial funded health care systems; improve access to health services; achieve health programs and services that are better suited to Aboriginal peoples; and increase the participation of Aboriginal peoples in the design, delivery, and evaluation of health programs and services (Health Canada, 2010a).

## **2.2.4 Research/Surveillance/Knowledge Translation**

The action area of research, surveillance and knowledge translation has the goal of driving "effective prevention and management of respiratory disease and its risk factors, through enhanced, co-ordinated research and surveillance efforts that are then translated into both improved health outcomes and economic benefits" (National Lung Health Framework Partnership Secretariat, 2010).

### **2.2.4.1 AllerGen**

AllerGen (Allergy, Genes and Environment Network) is a research network involving partners from a variety of academic disciplines. They work to understand the physiological and psychological aspects of allergic and related immune diseases such as asthma. AllerGen is conducting an Aboriginal study, *Engaging Aboriginal families affected by allergies and asthma in support-education program development* through the University of Alberta. Among other things, this network is improving respiratory research capacity and improving understandings of the relationship between respiratory health and the needs of at-risk populations (AllerGen, 2010).

## **2.3 Social Determinants of Health**

Social determinants can influence the health of individuals, families, communities, and nations in both direct and indirect ways. Social determinants include: education, access to health services, income, economic development, employment, poverty, and housing. These social determinants influence health and well-being, and play a significant role in health outcomes. Aboriginal people who face a number of social barriers can be at higher risk for both infection and improper diagnosis and treatment of diseases. As such, we recognize and examine strategies that may affect respiratory health through effects on relevant social determinants.

### **2.3.1 Housing**

Housing is an important social determinant of health, as unsafe housing can influence the occurrence of respiratory diseases. In Inuit communities, there is a prevalence of overcrowding, making ventilation a critical issue. Ventilation is the process by which fresh air is introduced and stale air removed from an occupied space (Kovesi et al., 2009). According to Statistics Canada, Inuit live in the most crowded living conditions in Canada. Crowding is defined as more than one person per room in a dwelling. In Inuit Nunangat (Inuit homelands) – the Inuvialuit Settlement Region (NWT), Nunavut, Nunavik (Quebec), and Nunatsiavut (Labrador) – 38 per cent live in crowded conditions (Statistics Canada, 2008). The younger Inuit populations are vulnerable to respiratory disease due to weaker immune systems and exposure to second-hand smoke from indoor smoking. The Nunavut Housing Corporation has therefore conducted studies to determine the negative effects of poor ventilation for Inuit communities, but programs or projects have yet to be established (Kovesi et al., 2007; Kovesi et al., 2009). Furthermore, the Government of Nunavut's Department of Health and Social Services has taken steps to encourage people to smoke outside rather than inside in an effort to prevent tobacco-related diseases.

Another program that addresses health outcomes is the First Nations Environmental Public Health Program. It offers a variety of activities, training, and education for First Nations populations. The program is funded through Health Canada and supports the delivery of public health and health promotion services for First Nations on-reserve and Inuit communities. Program services include inspections, evaluations, advice, guidelines, and recommendations to further encourage healthier and safer housing. A detailed environmental public health guide for First Nations is available, providing information about environmental health issues and tips on how to make changes in the home (Health

Canada, 2010e). These services are essential for healthy housing, particularly when we consider that almost 50 per cent of First Nations living in Band housing reported mold or mildew in their home (National Lung Health Framework Partnership Secretariat, 2008).

Several Métis housing corporations/organizations exist, although benefits are not necessarily Métis-specific. The Métis Urban Housing Corporation, funded by the Métis Nation of Alberta, provides repair or replacement assistance to homeowners for capital items that are considered health or safety related (Métis Urban Housing Corporation, 2010). Recently, the Community Housing Managers of Manitoba (part of the Manitoba Metis Federation (MMF)) were provided with \$4.3 million to renovate 645 public housing units. This will provide Métis and other tenants living in urban, rural, and remote areas of Manitoba with safer, healthier, longer-lasting structures. Although this financial initiative is led by the MMF, the repairs are not specifically targeted towards Métis populations. In Saskatchewan, the Provincial Métis Housing Corporation and Métis Nation-Saskatchewan have a Home Repair Program which supports Métis in upgrading their properties to meet health and safety standards, extending the life of the home by 15 to 20 years. As well, the Métis Nation of Ontario runs a Residential Rehabilitation Program that provides low-income house owners with financial assistance to repair or rehabilitate sub-standard housing to meet the standard minimum level of safety. These housing programs may indirectly impact the respiratory health of Aboriginal people.

### **2.3.2 Education**

Education is another important social determinant of health. Education for health professionals was identified as an important activity among many of the strategies examined. For instance, the National Lung Association offers regular teaching/education programs for this target group. Most organizations support the idea that education will provide opportunities for health professionals and individuals to become more knowledgeable about diseases and, in turn, teach others how to effectively prevent and treat diseases.

The Aboriginal Nurses Association of Canada (ANAC) was created specifically to improve the health of Aboriginal people. ANAC supports Aboriginal nurses, promotes the development and practice of Aboriginal health nursing, and aims to increase the number of First Nations, Inuit and Métis nurses. ANAC argues that it is essential to have a curriculum that prepares both Aboriginal and non-Aboriginal graduates to respect the knowledge of First Nations, Inuit and Métis, and develop awareness of both historical and contemporary contexts (ANAC, 2005). By modifying health education programs, more targeted services can be offered to address the health concerns of First Nations, Inuit and Métis populations. The British Columbia Lung Association (BCLA) is working on a project titled: *Establishing Need for Awareness Initiatives about Risk Factors for Respiratory Diseases among Health Professionals Working with First Nations, Inuit, and Métis Communities*. This project is funded by PHAC and is focused on assessing the needs of health professionals. The approach taken by the BCLA is focused on health promotion, awareness, and prevention, and they are targeting all types of chronic disease.

## ***2.4 Results and Discussion***

### **2.4.1 Trends**

Of the many strategies, projects, programs and initiatives examined during our research, the majority take a pan-Aboriginal approach rather than specifically targeting First Nations, Inuit, or Métis populations. However, of the strategies, projects, programs and initiatives that did directly target a population, most were focused on First Nations (mostly living on-reserve) and Inuit. Geographic distribution plays a major role in the delivery of health care services; it is easier to offer treatment to populations on-reserve or in remote communities because they are grouped in distinct geographic areas. Aboriginal people who live in urban settings are more often exposed to programs that provide services and support for the general public.

Among the Aboriginal strategies that were reviewed, many incorporate a holistic view of health rather than simply focusing on individual diseases. They have a more encompassing view of health that includes mental, spiritual, emotional, and physical elements. An example of an initiative that uses this holistic view is the Aboriginal Healing and Wellness Strategy. This program is located in Ontario and its mandate reflects a wide set of values, including family healing, communication with Aboriginal communities, and the reflection of Aboriginal culture in its activities. The strategy currently funds three different types of initiatives through 18 programs. Their initiatives vary between specific allocations, specialized projects and an Aboriginal healthy babies/healthy children program. The intent is to provide programs that are community-based and delivered through Aboriginal organizations.

Throughout our review, we were unable to identify Aboriginal strategies, projects, programs and initiatives that targeted sleep apnea, cystic fibrosis or pneumonia. The programs available for these diseases are for the general public, and focus on disease detection and management. We were unable to identify any Aboriginal programs specifically dealing with COPD; most relevant programs focus on chronic diseases in general. For example, the Saskatoon Indian and Métis Friendship Centre has a chronic disease prevention initiative that targets First Nations and Métis individuals. This initiative provides classes to teach people how to manage their chronic diseases, including asthma and COPD. BreathWorks, run by the Canadian Lung Association, is the most widely used program for COPD, although there is no Aboriginal component. The National Lung Association also has general online resources for COPD including guides, fact sheets, and information about a telephone hotline.

### **2.4.2 Promising Practices and Recommendations**

Our research indicates that community-based projects, programs and initiatives are the most effective (Aboriginal Nurses Association of Canada, 2005; Health Canada, 2010c). Projects, programs and initiatives must fit into the local culture, reflect local values, and use appropriate methods.

Tobacco-related respiratory disease garners the most attention in the First Nations, Inuit and Métis context. Lung cancer is the leading cause of death for Canadian Inuit, even though cigarettes in the Arctic are the most expensive in Canada. Although the Federal Tobacco Control Strategy reports a

decline in smoking-related deaths, cigarette sales and the number of youth using tobacco (Health Canada, 2010b), there is a recognized need for an Inuit-specific tobacco reduction strategy that reflects Inuit culture and values. Inuit Tapiriit Kanatami has developed such a strategy, although only some components have been funded by Health Canada to date. The Inuit Tobacco-Free Network is one such component that provides a range of online resources for Inuit smokers and other Inuit organizations that are interested in learning more about the health risks. In 2010, the Inuit Tobacco-Free Network provided three-month distance education courses to Inuit health and wellness workers to share promising practices in tobacco reduction. The courses aimed to provide health and wellness professionals with the necessary tools to encourage community members to quit or reduce smoking. For a reduction in smoking to occur, it is important that projects, programs and initiatives be community-based, and focus on the needs and resources of Aboriginal people. Higher levels of control and support at the community level make it more likely that projects, programs and initiatives will achieve success.

For Inuit especially, accessing health care is a major concern, especially for those who have cancer. Often, the cancer is not identified until it is in severe stages. Early detection programs and preventive strategies, as well as improved disease management and treatment, are needed. Overall, the continued need for improved services to more effectively treat Inuit was noted.

Research by the Aboriginal Nurses Association of Canada (ANAC) demonstrates that Aboriginal smoking strategies must tailor specific messages about the historical ceremonial usage of tobacco as well as the health risks. For example, tobacco is not considered a sacred plant for Inuit. It is too cold to grow tobacco in the Arctic, however, tobacco was introduced to Inuit through trade. With this understanding, the programs designed for Inuit have to take into account their history and culture. Initiatives that focus on the use/misuse of tobacco in both traditional and commercial settings may not be as relevant for Inuit as for First Nations who have historically used tobacco in traditional contexts. The most effective strategies are those that present health impacts in a new way and are targeted towards a specific audience. A “comprehensive, collaborative, strategic approach that integrates and supports community-based initiatives” (ANAC, 2005) is needed.

The BC Aboriginal Tobacco Control Strategy has been quite successful in encouraging smoking cessation. The strategy incorporates cultural teachings, involves communities in creating and implementing processes, builds partnerships, and draws on the energy and interest of youth. As such, it is a program that truly integrates Aboriginal culture and values. The Honour Your Health Challenge promotes a healthy, active lifestyle, free from tobacco misuse. As British Columbia has the lowest smoking rate of any province, it is an example to follow.

There are also promising practices regarding tuberculosis. Active case management and screening programs have led to a decrease in the rates of TB in First Nations communities. However, to fully eradicate the disease, more preventive programs and annual screening of individuals, groups, and communities are required for at-risk populations (BC Centre for Disease Control, 2004). Both education and training positively affect nutrition and housing conditions, which in turn affects the number of people who become infected with tuberculosis. As such, a focus on education and nutrition



programming would result in multiple benefits for Aboriginal people. PHAC continues to develop and publish a range of reports and supporting documentation on tuberculosis prevention and control.

From a broader perspective, the Blueprint on Aboriginal Health is a national 10-year transformative plan that addresses the gaps in health outcomes between the general Canadian population and Aboriginal Peoples, including First Nations, Inuit, and Métis populations. The Aboriginal Health Blueprint is a combined effort of the federal, provincial, and territorial governments in collaboration with Aboriginal leaders and organizations. This plan exists in the context of the Canadian health care system and aims to decrease health outcome gaps by 2015. A separate framework exists for First Nations, Inuit, and Métis populations respectively, to address the distinct needs of each group. Potential collaboration with Aboriginal respiratory health organizations could be initiated to address health outcomes.

One way of providing direct support for Aboriginal people accessing health services is to have an Aboriginal liaison program. In some locations, where the same services are provided to both Aboriginal and non-Aboriginal people, Aboriginal liaisons act as mediators between Aboriginal clients and the health care system. Alberta has such a program, with its primary goals being: to improve access to existing health services, increase levels of knowledge, develop programs/services that address Aboriginal health needs, adopt an Aboriginal health model of wellness, and increase cultural awareness/understanding for health care professionals. Aboriginal liaisons may help Aboriginal people feel more comfortable with the health care system, resulting in more accessible treatment.

Another potential opportunity for providing health care services in remote communities is TeleHealth. TeleHealth refers to the use of communications and information technology to deliver health and health care services and information over distances. Through video and telephone conferencing, medical imagery and hi-speed technology, doctors and nurses provide medical advice and diagnosis for patients living in remote areas. Further initiatives could be established to help ensure the efficacy of this system for those suffering from respiratory diseases in remote locations.

## ***2.5 Conclusions***

The projects, programs and initiatives led by the social services and health departments in the 10 provinces and three territories were thoroughly examined in this review. In the territories, tobacco cessation programs were common, reflecting higher smoking rates among the Aboriginal population. Each department delegated a section of their health website to discuss current programs/initiatives. While almost every province/territory had an Aboriginal section, very few had respiratory health initiatives relating to Aboriginal populations.

The majority of respiratory health projects, programs and initiatives focus primarily on the area of health promotion and prevention. Most Aboriginal health-related organizations focus to some degree on tobacco cessation. Youth-oriented tobacco projects that focus on awareness and disease prevention are particularly prevalent. Accordingly, the respiratory health issues that attract the most attention and support appear to be those associated with tobacco, especially lung cancer. While projects, programs and initiatives targeting diseases such as COPD, asthma, and sleep apnea do exist, we were unable to

identify specific Aboriginal initiatives addressing these illnesses. Most Aboriginal organizations appear to incorporate a holistic view of health, focusing on all aspects of health and well-being, rather than singularly focusing on specific facets.

Most of the provincial governments have a department of Aboriginal Affairs/Relations, yet the provinces have generally only recently begun to specifically recognize Aboriginal respiratory health. The chronic disease strategies, projects, programs and initiatives that do exist are more often targeted towards diabetes, which is prevalent among Aboriginal people. To date, research on other health issues, such as COPD and asthma, for specific Aboriginal populations has been limited. Overall, existing programs may target aspects of respiratory health, but often tend to be more general in nature.

One significant gap is the dearth of programming and information related to Métis respiratory health. While there are resources such as toolkits, models and booklets available for Aboriginal people as a group, few are targeted towards the Métis population. At the same time, Métis organizations may be addressing respiratory health indirectly through action on social determinants of health such as housing and education.

In order for any health program to be truly all-encompassing, we must take into serious consideration the different needs of First Nations, Inuit, and Métis people. Each group may have different respiratory concerns and health risks, requiring programs that are population-specific and even gender-specific. While addressing lifestyle choices and behavior is important, it is also imperative to identify and address the root causes (e.g., social determinants) of respiratory health ailments.

## 3.0 Case Studies

This section describes and discusses a number of case studies for each of the three Aboriginal populations. In elaborating population-specific case studies for First Nations, Inuit and Métis respiratory health projects, programs and initiatives, we aim to do three things. First, we highlight, from a community perspective, the positive impact of the project, program or initiative on respiratory health and/or the determinants of health in the community. Second, we highlight the elements of the project, program or initiative that made it successful from the community's perspective. Third, we explore innovations, improvements, ideas and recommendations that the community believes would make the project, program or initiative more successful if it were to be reproduced elsewhere in Canada.

A standard list of questions was developed to guide the semi-structured interviews undertaken for each case study (Appendix 1).

### 3.1 Case Studies – First Nations

Using the master list of cross-Canada Aboriginal respiratory health initiatives developed through the environmental scan component of this research project, potential target initiatives were initially investigated through Internet searches to identify five suitable organizations to interview. A conscious attempt was made to select cases that reflected a variety of different settings, scopes, and respiratory health matters. However, because only two parties followed through with their initial agreement to be interviewed, an *ad hoc* personal networking approach was later used to seek out several more key informant interview subjects.

Ultimately, four organizations/initiatives participated in key informant interviews to provide concrete case study examples of respiratory health services for First Nations people in Canada:

1. Sliammon Smokers' Clinic is based in and serves the rural Sliammon First Nation in British Columbia.
2. The "Taking the Lead for Change" Tobacco Cessation Strategies initiative is offered in Aboriginal communities across Canada – the majority of which are First Nations – through presentation and implementation of a training manual, community empowerment guide, and other visual aids by members of the National Indian and Inuit Community Health Representatives Organization (NIICHO) to assist community members in quitting smoking.
3. Cancer Care Ontario's Tobacco Program engages and assists Aboriginal communities in Ontario in creating tobacco abuse cessation and prevention strategies that build capacity, foster collaborative partnerships, and promote knowledge exchange.
4. Peterborough County-City Health Unit's "Choose to be Smoke-Free" Tobacco Cessation Program offers tobacco cessation services to residents of nearby Curve Lake First Nation.

A reasonable range of program types is represented in the case studies, including:

- A national program ("Taking the Lead for Change") that primarily serves First Nations people by generating awareness about the perils of smoking.

- A provincial program (Cancer Care Ontario’s Tobacco Program) that serves Aboriginal people, including First Nations on and off-reserve, by helping communities to deliver their own health promotion initiatives, including treatment options.
- A West Coast, on-reserve clinic (the Sliammon Smokers’ Clinic) that offers both treatment and health awareness promotion services to local residents.
- A mid-country program (“Choose to be Smoke-Free”) which may not be tailored, administered, or controlled by Aboriginal people, but which deliberately takes in clients from a nearby First Nation to treat smoking addiction.

While all four initiatives serve First Nations people, only the Sliammon Smokers’ Clinic serves this population exclusively. Moreover, Peterborough County-City Health’s Program has only a limited First Nations-specific component, where it deliberately reaches out to this population through a referral arrangement.

The Sliammon Smokers’ Clinic and Peterborough County-City Health’s Program offer treatment services for tobacco addiction/cessation to individual clients, while Cancer Care Ontario funds such endeavors but does not itself directly provide treatment. All three organizations also promote awareness. “Taking the Lead for Change” focuses solely on the promotion of tobacco control, in general, as a matter of public education.

Ideally, programs that address other respiratory health issues, such as asthma or tuberculosis, should also have been included. Unfortunately, interview uptake proved difficult. Regardless, the majority of existing programs across the country relating to respiratory health seem to focus on tobacco cessation and prevention.

### **3.1.1 Case Study 1: The Sliammon Smokers’ Clinic**

#### ***3.1.1.1 Overview***

The 1,000-strong Sliammon First Nation is located on the “Sunshine Coast” of British Columbia in a relatively rural setting about 133 kilometres north of Vancouver. The Sliammon Smokers’ Clinic is presently non-operational because new funding must be sought out and secured. The three-year pilot-project, however, has reportedly been of great assistance to many Sliammon residents.

Opened as a part of a self-created Tla’Amin Tobacco Control Strategy, the clinic was the first nicotine intervention centre in a First Nations community in Canada. The impetus was an observation among Sliammon’s health care and medical personnel - supported by statistics pertaining to all First Nations people - that the smoking rate among teens and adults in the community was unacceptably high.

Through the co-operative efforts of a nurse and doctor, a variety of confidential services were offered to Sliammon Band members at no charge. Initially, these included:

- Nicotine gum, the “patch,” or Zyban.
- Traditional Sliammon healing ceremonies (such as brushings, sweats, or healing circles).
- Information and resources about quitting smoking and second-hand smoke.
- Monitoring with a carbon monoxide breathalyzer.
- Free Internet access for tobacco education and smoking cessation websites.
- Free and confidential telephone access to the BC Smokers Helpline.

As the program evolved, other service components were added:

- A community support group (e.g., celebrations for individuals who achieved set amounts of time without smoking).
- Public support for individuals who refrained from smoking. This came in the form of acknowledgement in newspapers/newsletters, and included both recent and long-term “quitters”.
- Program awareness materials, such as Sliammon Smokers’ Clinic vests.

### ***3.1.1.2 Benefits***

The Sliammon Smokers’ Clinic targeted teen and adult members of the Sliammon First Nation who smoked. There were no gender-based distinctions in terms of service provision or service content.

While services were extended to both adults and teens, adults reportedly benefited the most because they were, as a group, more likely than teens to fear the negative health effects of tobacco. It is thought that the adults in Sliammon likely had a greater sense of their own mortality than did their teen counterparts. Although no statistics were quoted, the key informant interview respondent did conclude that the Sliammon Smokers’ Clinic was quite successful, as evidenced, in part, by the fact that funding renewal was currently being sought out.

### ***3.1.1.3 Success Factors***

Project success was attributed to several factors, including:

- Extensive use of a community support group to help clients refrain from smoking (through recognition and praise of group members reaching milestone time-spans for smoking restraint).
- Provision of support to both short- and long-term “quitters” through methods mentioned above and publically highlighting their successes in local newspaper articles and newsletter pieces.
- The overall effort to educate smokers and potential smokers about the harmful effects of smoking.
- The hiring of a nursing assistant from within the Sliammon community who was herself an ex-smoker.

More generally, success was thought to be due to:

- Positive community focus and attention on local individuals' successes.
- Development and distribution of promotion and awareness materials, such as posters and other materials featuring local smoking cessation success stories, and items of clothing printed with the clinic logo.
- Pursuit of a process that made clients "think about where they were and where they wanted to be."

#### ***3.1.1.4 Suggestions for Improvement***

While the Sliammon Smokers' Clinic is deemed by Tla'Amin Community Health – its parent organization – to have been a highly successful anti-smoking project, several lessons have been learned throughout its establishment, operation and current suspension of activity. These have led to the following recommendations:

- The smoking clinic's nurses should have the authorization and training to carry out "designated duty" actions, such as prescribing tobacco replacement resources and medications.
- Sufficient time should initially be allotted to building the anti-smoking clinic's programming component foundations, starting with a thorough needs assessment.
- Longer-term funding should be secured in advance so that project operation does not need to be interrupted while new funding is secured (short-term "sunset" provisions should be avoided entirely, if possible).
- First Nations should be given more say and control in regards to health care funding matters in general, and over their smokers' clinics in particular.

#### ***3.1.1.5 Contact Information***

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## **3.1.2 Case Study 2: The National Indian and Inuit Community Health Representatives Organization’s “Taking the Lead for Change” Tobacco Cessation Strategies**

### ***3.1.2.1 Overview***

The National Indian and Inuit Community Health Representatives Organization (NIICHRO) is a national, not-for-profit charitable organization which represents First Nation and Inuit Community Health Representatives (CHRs). Its goals are to:

- Upgrade the quality of health care of First Nations and Inuit people to the standard of health enjoyed by the rest of the population of Canada.
- Provide a forum for CHRs to communicate and exchange information with each other about various community health initiatives and how to improve the CHR program at the national level.
- Create and promote awareness and understanding about the CHR Program in Canada.
- Provide a mechanism and a means for advising First Nations and Inuit communities, First Nations and Inuit Health Branch (FNIHB), Health Canada, and others on all matters pertaining to CHRs.

In order to achieve its first goal, NIICHRO established “Taking the Lead for Change” Tobacco Cessation Strategies, which were delivered nationally in all First Nations (and Inuit) communities that employ CHRs. Funding for this initiative came from Health Canada’s First Nations and Inuit Tobacco Control Strategy (FNITCS). Specifically, NIICHRO’s own “strategies” were to present and promote adherence to its own health information and promotion products, including:

- A nicotine addiction training manual.
- A flip chart and activity book.
- A fact sheet for a related Smoke-Free Homes sub-initiative.
- Various posters.
- A survey tool and guide for researchers (for gathering baseline data on local community nicotine addiction).

NIICHRO sells these resources to generate funding to continue providing public presentations on nicotine addiction in the absence of government funding.

### ***3.1.2.2 Benefits***

Most materials for the nicotine addiction cessation strategies were targeted towards youth, adults and Elders. The Smoke-Free Homes sub-initiative, however, was aimed primarily at children and youth. In addition, a gender-specific cessation component was designed for and offered to pregnant women.

Because no post-initiative evaluation was funded by Health Canada, it is difficult to say with certainty whether or not “Taking the Lead for Change” has been successful in reducing smoking on-reserve. The situation is exacerbated by the fact that NIICHRO is not physically located in the communities that its

members serve, and therefore cannot accurately gauge the perspectives of First Nations communities about the success of its strategies.

NIICHR0 is confident that its materials are sound, even if they are admittedly becoming slightly dated as time goes on. Indeed, the various strategy materials are still being requested, which does indicate a level of success in terms of its uptake in First Nations communities. Generally speaking, it is felt that some overall progress is being made in First Nations communities in the area of tobacco cessation. However, NIICHR0 recognizes that related initiatives of other organizations share credit for this improvement.

### ***3.1.2.3 Success Factors***

While NICHRO believes that all of its nicotine addiction cessation resources are effective, its flip chart seems to be especially popular with consumers. This may be due to the fact that it is a simple and pictorial product easily understood by a range of audiences. It has been noted that this format would likely be equally effective in educating people about other health issues, such as mental or gender-related issues, for example.

### ***3.1.2.4 Suggestions for Improvement***

NIICHR0 does not feel that sufficient statistical data exists to discuss program success(es) in detail, but has offered recommendations as to how similar programs should be funded and operated in the future:

- The term “nicotine addiction” should replace the term “tobacco cessation”, not only to put the crux of this health issue into its proper perspective, but also to avoid an implicitly derogatory, and therefore culturally inappropriate, reference to a plant that many First Nations consider to be a divinely given medicine (when used with restraint in a proper spiritual manner).
- Building awareness of nicotine addiction programs and products as a first step is crucial to ongoing success, in part because “smokers don’t always [readily] step forward” and since the “numbers” aspect of addiction can be focused on later in the program.
- Initiatives that experience limited success are better than no programming in the area of tobacco cessation; therefore it is unwise to cease their funding entirely when no other alternatives are in place.
- It is a good idea to periodically evaluate the appropriateness and effectiveness of project resources and “tweak” them as necessary.
- Pictorial flip charts are useful for health promotion because most types of audiences find them to be easy to comprehend and they tend to spark good conversations about the issue(s) at hand. Moreover, they can be used to address a number of different health issues.
- The Indigenous Physicians’ Association of Canada, Aboriginal Nurses Association of Canada, Assembly of First Nations’ Tobacco Action Circle, Canadian Paediatric Society Indian and Inuit Health Committee (CPS Committee), and National Aboriginal Friendship Centres should all be involved in the development of a national-level Aboriginal Respiratory Health Framework.



### **3.1.2.5 Contact Information**

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### **3.1.3 Case Study 3: Cancer Care Ontario's Tobacco Program**

#### **3.1.3.1 Overview**

Cancer Care Ontario is the provincial agency in Ontario charged with continually improving cancer services and advising the provincial government on matters pertaining to cancer. Governed by the *Cancer Act* and responsible to the Minister of Health, Cancer Care Ontario:

- Directs and oversees public health care dollars to hospitals and other cancer care providers.
- Implements provincial cancer prevention and screening programs designed to reduce cancer risks and raise screening participation rates.
- Works with cancer care professionals and organizations to develop and implement quality improvements and standards.
- Uses electronic information and technology to support health professionals and patient self-care through improvement to cancer service safety, quality, efficiency, accessibility, and accountability.
- Plans cancer services to meet current and future patient needs and works with health care providers to continually improve cancer care.
- Transfers new research into improvements and innovations in clinical practice and cancer service delivery.

Cancer Care Ontario has three programs that serve Aboriginal people, including the Aboriginal Tobacco Program. Broadly speaking, this health promotion initiative falls under the "Smoke-Free Ontario" strategy, as it urges and assists Aboriginal communities in Ontario in creating tobacco abuse cessation and prevention strategies. Secondary program goals include building capacity, fostering collaborative partnerships, and promoting knowledge exchange.

The Aboriginal Tobacco Program was created for two reasons. First, high rates of smoking exist in Ontario's Aboriginal communities, and these are linked to negative health outcomes. Secondly, the province's *Smoke-Free Ontario Act* does not directly address the needs of Aboriginal people. In

combination, these factors compelled the creation of an initiative that would find effective smoking control solutions for Aboriginal communities.

The Aboriginal Tobacco Program does the following:

- Provides funding and support to implement short-term tobacco cessation programming targeted at youth and/or pregnant and post-partum women.
- Funds and administers a Youth Tobacco Working Group which develops and implements a Tobacco-Wise Sports and Recreation campaign for the Little Native Hockey League (Little NHL) and Aboriginal communities.
- Collaborates with other organizations to use current resources and inform the development of future resources to better meet Aboriginal needs (e.g., it hosts a website promoting tobacco-wise communities and lifestyles).
- Provides materials such as posters, wristbands and pamphlets to raise awareness in Aboriginal communities.
- Connects front-line health staff to training programs on commercial tobacco prevention, cessation, and protection.
- Provides evidence-based information to community leaders that demonstrates how to build a tobacco-wise community.

### ***3.1.3.2 Benefits***

The Aboriginal Tobacco Program is creating awareness about tobacco abuse cessation and prevention in Ontario's Aboriginal communities. The overall program focuses on reaching Aboriginal youth; there is no gender-specific component at this time.

On-reserve First Nations seem to be particularly receptive to this message, which may be in part due to the involvement of committed and knowledgeable health centre directors at the local level.

### ***3.1.3.3 Success Factors***

As indicated above, health centre directors' knowledge of their own communities is thought to be assisting in the uptake and success of Aboriginal Tobacco Program-sponsored initiatives in Ontario Aboriginal communities. Overall success is also attributed to the array and range of program components available to planners, including, but not limited to, access to project assistance and expertise, and partnership facilitation (e.g., "piggy-backing" local Aboriginal initiatives on mainstream ones).

### ***3.1.3.4 Suggestions for Improvement***

The key informant interviewee informing this case study suggested the following useful advice for parties who may wish to adopt the program for their own use in the future:

- Information sharing between the provincial government and Aboriginal organizations is crucial in preventing the duplication of services, and it is especially important that governments help Aboriginal organizations share best practices with one another.
- Existing smoking intervention options and measures can and should be adopted and adapted for Aboriginal people; it is not always necessary to re-invent the wheel.
- Innovative programming that incorporates various Aboriginal cultures should be adopted whenever possible.
- Sufficient amounts of time should be allotted to communities to deliver smoking control programs that are truly effective.
- Careful attention must be paid to on-reserve/off-reserve differences.
- Attainment of program sustainability is crucial, not just where funding matters are concerned, but also regarding project knowledge retention in the face of high staff turnover rates.
- Health centres should highlight to clients that Non-Insured Health Benefits (NIHB) include smoking cessation measures.

### ***3.1.3.5 Contact Information***

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## **3.1.4 Case Study 4: Peterborough County-City Health’s “Choose to be Smoke-Free” Tobacco Cessation Program**

### ***3.1.4.1 Overview***

For the past two years, the Curve Lake First Nations Health Centre has participated in a mainstream tobacco cessation program that is mostly delivered off-reserve. The First Nations-specific component of the “Choose to be Smoke-Free” Tobacco Cessation Program involves the referral of First Nations residents to the program by the Curve Lake Health Centre staff. Nonetheless, it seems to have a reasonably high rate of success where First Nations clients are concerned.

### ***3.1.4.2 Benefits***

The “Choose to be Smoke-Free” Tobacco Cessation Program is not designed specifically for First Nations, but it nonetheless seems to be working in terms of service uptake, as Curve Lake community members

are choosing to use the service. While a valid argument can be made that this is due to the fact that it is “the only game in town,” it is important to recognize that any program success in attracting First Nations clients is better than none at all.

Quarterly reports issued to the program’s working group indicate that the number of persons who seek to enter the program is quite satisfactory. It is also anecdotally reported that 63 per cent of clients from the Curve Lake First Nation were found to have refrained from smoking for at least an eight-week period once cessation was initiated.

It should be noted that the program focuses solely on the adult population, and it does not have a gender-specific component.

### ***3.1.4.3 Success Factors***

As noted above, part of the program’s success in service uptake could be due to the fact that no other options are available to the residents of Curve Lake First Nation. However, the success rate for smoking cessation through this program can be attributed to the fact that the “Choose to be Smoke-Free” Tobacco Cessation Program employs Nicotine Replacement Therapy (NRT) in conjunction with supportive personal counselling. In combination, these two methods are thought to be much more effective than if only one or the other of them were to be administered.

### ***3.1.4.4 Suggestions for Improvement***

The most obvious recommendation is to create a separate First Nations designed and administered tobacco abuse cessation and prevention program. While this may not be possible at this time, it is important to note that First Nations individuals can gain some benefit from accessing mainstream programs like Peterborough County’s when alternatives are not available. Accordingly, the following recommendations are put forward for any First Nation that may consider forming a referral partnership with a mainstream initiative:

- Use a treatment program which employs Nicotine Replacement Therapy (NRT) in conjunction with supportive personal counselling.
- Involve trained front-line workers on-reserve, if possible.
- Foster holistic connections with other health initiatives, if possible.
- Maintain close connection with local municipal health units that extend tobacco cessation programming specifically to First Nations residents. Highlight to them that it is advantageous, in terms of proposal and program success, to be able to show good uptake by First Nations.

### ***3.1.4.5 Contact Information***

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## ***3.2 Case Studies – Inuit***

To initiate the Inuit case studies, emails were sent out to Inuit health contacts requesting information on Inuit-specific respiratory health projects, programs and initiatives. Follow-up emails and telephone calls were used to determine a long list of potential Inuit case studies. From these, a list of four case studies was selected:

1. Tuberculosis (TB) treatment and management by the Nunatsiavut Government and Labrador-Grenfell Regional Health Authority in the Nunatsiavut Region.
2. Initial research and a subsequent territorial government program to reduce lower respiratory tract infections (LRTI) caused by RSV among Inuit infants in Nunavut.
3. A community-based participatory research project called “Changing the Culture of Smoking” (the CCS Project), a tobacco control program running in Ulukhaktok and Aklavik in the Inuvialuit region of the Northwest Territories.
4. The “Stay Quit to Win” tobacco control program run by the public health department of the Nunavik Regional Board of Health and Social Services (NRBHSS) in the Nunavik region of Quebec.

### **3.2.1 Case Study 1: Tuberculosis Management and Treatment Program, Nunatsiavut**

#### ***3.2.1.1 Introduction***

This case study examines the unique approaches taken by the Nunatsiavut Government and Labrador-Grenfell Regional Health Authority in the treatment and management of tuberculosis (TB) in the Nunatsiavut Region.

#### ***3.2.1.2 Background***

The Nunatsiavut settlement area of Labrador encompasses 72,520 square kilometres of land and water and includes the communities of Hopedale, Makkovik, Nain, Postville, and Rigolet. Approximately 2,400 people live in these coastal communities, the largest of which is Nain (population 1,034), according to 2006 Census data. The five Nunatsiavut communities are isolated, without roads to connect them to each other or to other communities in Labrador.

Through their land claims process, Labrador Inuit have negotiated the creation of the first Inuit ethnic regional government in Canada. The Nunatsiavut Government (NG) came into being on December 1,

2005. It is currently assuming legislative authority over aspects of governance of Labrador Inuit territory in stages, according to their transitional plans.

The delivery of health services in Nunatsiavut is shared between the NG Department of Health and Social Development and the Labrador-Grenfell Regional Health Authority (LGH), one of four regional boards operating under provincial authority.

LGH provides clinical health services through community health facilities and a regional hospital in Happy-Valley Goose Bay, while NG provides a range of public health, mental health and addictions services, as well as wellness and healthy children services.

Tuberculosis (TB) rates among Inuit in Canada are significantly higher than for any other population group in Canada. Public Health Agency of Canada data indicates that the average rate of TB among Canadian Inuit is 185 times higher than for the non-Aboriginal Canadian-born population. Among Labrador Inuit for the period from 1997 to 2008, the average rate was 89.7 per 100,000, approximately 81.5 times higher than the rate for the Canadian-born non-Aboriginal population. Consequently, in Nunatsiavut, TB management and control remains a critically important and challenging public health issue.

TB management and control at the provincial level falls under the authority of the Chief Medical Officer of Health within the Newfoundland and Labrador Department of Health and Community Services. At the regional level, reporting and surveillance are the responsibility of the Medical Officer of Health and the Health Protection Services branch of LGH. Management, prevention and education activities fall under the purview of NG Public Health division of the Department of Health and Social Development.

### **3.2.1.3 Overview**

The TB Management and Treatment Program was initiated as part of the newly formed Nunatsiavut Government's responsibilities for public health services in 2005. TB management is delivered through a collaborative partnership between LGH and NG where roles and responsibilities are shared.

The program is run by NG and LGH and involves a core team consisting of the NG director of health services; the NG community health nursing co-ordinator; the LGH regional medical officer of health; the LGH communicable disease control nurse; two assigned physicians, and all community-based NG public health nurses, community health aides, and LGH clinical health care staff.

Based on *Canadian Tuberculosis Standards – 5th Edition (2000)*, NG developed a TB control manual that outlines the roles of participating professionals (community and hospital) in the management and treatment of TB, and defines specific communications processes among the parties. The manual ensures consistent, standardized practice over time and in the face of staff turnover.

A second key aspect of the TB Program is the NG community health aides. These are NG positions at the community level that (among other duties) fulfill critical responsibilities for direct observation therapy, direct observation prophylaxis, contact identification, and contact tracing.

Thirdly, the Nunatsiavut TB Program benefits from access to a unique set of information resources, called “TB Bibles,” that are kept in each community. These are alphabetical ledgers containing TB-related histories by family, which date back to the 1950s.

The program evolves continuously in response to changing circumstances and opportunities for improvement. For instance, the designation of two responsible physicians at the hospital in Goose Bay and regular bi-weekly TB clinics at the hospital has created more consistency than having community-assigned doctors managing TB cases from “their” communities.

#### ***3.2.1.4 Benefits***

The TB Program has been very effective at improving the reaction time from identification of suspected cases to treatment of the individual and initiation of TB management.

However, the program has been unable to effectively reduce TB rates. It is challenged by resource issues (human and financial) and the fact that TB is closely tied to socio-economic determinants beyond the control of public health staff.

#### ***3.2.1.5 Success Factors***

Several factors were identified as contributing to the success of the TB Program. These include:

- Strong collaboration between NG and LGH, and a shared practical approach to TB management.
- A core set of professionals with deep experience with TB in Nunatsiavut.
- Meticulous record-keeping in the TB Bibles.
- Community Health Aides (CHAs), who are critical to community-level TB management. CHAs tend to be long-term employees, some of whom are bilingual and have deep knowledge about their communities (e.g., how and where to find individuals).

Program staff still face challenges regarding client compliance for TB treatment, lack of human resources, lack of equipment (e.g., having to fly clients to hospital for diagnostic X-rays), long turn-around time for laboratory analyses, and a general lack of TB education among hospital staff.

#### ***3.2.1.6 Suggestions for Improvement***

Information is crucial to successful TB management; a robust database should be created at the beginning of any TB program and rigorously maintained. Further, staff training and orientation is very important. In terms of other good models for TB management among Inuit, a suggestion was made to review the TB management model of the Northwest Territories.

#### ***3.2.1.7 Contact Information***

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## **3.2.2 Case Study 2: Respiratory Syncytial Virus Research and Program, Nunavut**

### ***3.2.2.1 Introduction***

This case study examines initial research and the subsequent territorial government program related to lower respiratory tract infections (LRTI) caused by RSV among Inuit infants in Nunavut.

### ***3.2.2.2 Background***

#### ***3.2.2.2.1 Nunavut***

Created on April 1, 1999, Nunavut is a vast territory, spanning three time zones and comprising one-fifth of Canada's total land mass. It includes 1.9 million square kilometres of land, including most of the Arctic Archipelago and all of the islands of Hudson's Bay, James Bay and Ungava Bay. Nunavut's population of nearly 29,500 people (based on 2006 Census data) live in 25 municipalities spread throughout the territory. Approximately 83.6 per cent of residents are Inuit. Iqaluit, the capital city, is the largest community, with a population of approximately 6,200 (in 2006). There is no road access to any of the communities in Nunavut.

Health care in Nunavut is delivered directly by the Government of Nunavut, Department of Health and Social Services (HSS). Organized into three administrative regions (Qikiqtaaluk, Kivalliq and Kitikmeot), HSS manages all health facilities within the territory and provides health care services to all residents.

Primary health care is provided through community health centres located in every community. There is one acute care facility in Iqaluit – the Qikiqtani General Hospital (QGH) – and two regional health centres: the Kivalliq Health Centre in Rankin Inlet and the Kitikmeot Health Centre in Cambridge Bay. A significant amount of care, including most secondary and tertiary care and specialist services, is provided outside the territory in referral centres located in Ottawa, Montreal, Winnipeg, Edmonton, and Yellowknife.



### 3.2.2.2 Respiratory Syncytial Virus (RSV)

According to the World Health Organization, Respiratory Syncytial Virus (RSV) infection is the most significant cause of severe respiratory illness in infants and young children worldwide, and the most frequent cause for hospitalization of infants and children in industrialized nations. It is estimated that the global RSV disease burden is 64 million cases and 160,000 deaths every year.

RSV, which infects the lungs and airways, is a very common virus – so common that, according to the Canadian Lung Association, almost all children have been infected with RSV by the age of three. RSV outbreaks tend to occur between late fall and early spring. In the North, it is usually later – often the RSV season is in spring and early summer. It is usually a mild disease with symptoms similar to a common cold, but can sometimes be severe and lead to other serious lower respiratory tract infections (LRTI) like pneumonia or bronchiolitis.

Generally, premature infants, those with underlying cardio-pulmonary conditions and newborns are at higher risk for developing severe respiratory illness as a result of RSV infection. Nunavut is challenged by extremely high rates of hospitalization of infants for RSV.

### ***3.2.2.3 Part I – Research project: A case-control study of risk factors and viruses associated with hospitalization due to lower respiratory tract infections (LRTI) in Canadian Inuit children***

#### 3.2.2.3.1 Overview

Early in 2000, the then Nunavut Chief Medical Officer of Health (CMOH), Dr. Ann Roberts, expressed concern about extremely high rates of hospitalization of children for lower respiratory tract infections (LRTIs) in the Baffin region. The CMOH became aware of preliminary work by Dr. Anna Banerji and initiated a request for her to design and implement a case control study.

In 2000-2001, Dr. Banerji wrote a proposal for a case control study, the main focus of which was to understand why Inuit children were getting so sick with LRTIs, but also to explore possible risk factors and identify what kinds of viruses and bacteria were infecting these children (at that time, they hadn't determined it was RSV definitively), with the ultimate goal of ascertaining what could be done to address the problem. It should be noted that not all cases of bronchiolitis are due to RSV – other viruses also cause LRTIs.

Dr. Banerji applied for funding for the study from several Canadian research funding agencies, including the Canadian Institutes of Health Research and the First Nations and Inuit Health Branch of Health Canada. She was declined. Believing the research to be important and necessary, the Nunavut Department of Health and Social Services found monies from their own budget to commission Dr. Banerji directly to undertake the research.

Over a 14-month period in 2002-2003 (covering two bronchiolitis seasons), the study compared infants and children less than two years of age who had been hospitalized for LRTIs at the Baffin Regional

Hospital to a matched-age cohort of children who had never been hospitalized. All of the children were from Qikiqtaaluk (Baffin Region) communities.

The research included:

- A questionnaire examining risk issues (prematurity, race, gender, and environmental factors such as exposure to smoking and housing circumstances).
- Swabs of both sick and healthy children to determine which viruses and bacteria were present in their nasal passages. (All samples were sent to a lab in Israel to check for *Simkania negevensis* bacteria.)

Dr. Banerji was responsible for running the project, which involved approximately 12 physicians and nurses at the hospital and, later, several specialists involved in laboratory and data analysis.

The project evolved as information emerged confirming RSV as the predominant virus affecting the children. Coincidentally, a new monoclonal antibody (vaccine) Palivizumab (trade name: Synagis) became available in 2002; previously there was no treatment for RSV other than providing support for the symptoms and mitigating the risk of secondary infections. In response to the emergence of a possible preventive treatment, an additional study parameter was added to compare the costs of hospitalizations for RSV versus the costs of preventive treatment with Palivizumab.

#### 3.2.2.3.2 Benefits

The research project was successful at revealing previously unknown information about the high rates of LRTIs among Inuit children, including:

- Identification of RSV as the dominant virus affecting children hospitalized for LRTIs.
- Identification of a series of risk factors associated with increased risk of hospitalization.
- Evidence that RSV infection (alone, and in combination with other viruses) is impacting Inuit infants and children much more severely than other population groups.
- An analysis of the costs for hospitalization versus preventive use of Palivizumab for the area involved in the study, although this activity was outside of the scope of the original proposal.

These findings provided evidence to guide public health management initiatives and advocacy for Nunavut, as well as providing more direction for future research. The project results have been published. Further, the Canadian Paediatric Society has recently undertaken a review of the cost analysis study.

#### 3.2.2.3.3 Success Factors

Project success was attributed to:

- Significant communication efforts throughout the project. Using the media (radio and print), the team maintained a high level of public communication before, during and after the study.
- Very high enrolment levels (half of the birth cohort of 2002). The willingness of families to enroll their children in the study speaks to the importance of the issue and the community's desire to

find solutions. (There were challenges in obtaining enough children for the control sample of the study; as a result, the study required an extension.)

- High levels of active participation by physicians and nurses at the Baffin Regional Hospital; they were critical to the enrollment of children and their families in the study. A nurse was also employed specifically for this study.

#### 3.2.2.3.4 Suggestions for Improvement

The project findings stimulated interest among the scientific and medical community. Dr. Banerji is now working with other researchers on an RSV surveillance project involving other hospitals and communities in the Arctic, and participating in the development of another similar project for First Nations infants and children in Canada.

### ***3.2.2.4 Part II – Territorial RSV program***

#### 3.2.2.4.1 Overview

By 2004, the CMOH had implemented an RSV vaccination program for high-risk infants, identified by medical assessments and CMOH approval, based on an examination of the efficacy of Synagis (Palivizumab). The objective of the program is to reduce rates of hospitalizations for bronchiolitis among infants.

The program runs system-wide. Medical personnel in all health facilities, as well as consulting pediatricians in referral hospitals, assess infants and notify the CMOH. Local health facility nurses administer the vaccination program in the community where the infant resides. Decision-making occurs at the CMOH level of Health and Social Services. Because Synagis is very expensive, the program requires active support from the executive level.

The department has developed a surveillance tool for RSV, a reporting mechanism for front-line health care providers. All confirmed positive cases of RSV are documented and reported to the CMOH, including associated issues, current/prior eligibility for Synagis, medical treatments given, whether the infant has required medivac and hospitalization, and outcomes.

This is an evolving program. Those involved are seeking to validate outcomes while collecting evidence upon which to base decisions about enhancement of the RSV program. The CMOH and GN health promotion programs and primary care services continue to work on reducing the risk factors for hospitalization, such as reducing smoking, promoting breastfeeding, etc.

The Department of Health and Social Services is responding to patient needs as part of their responsibility. There are no additional funding opportunities outside of the departmental budget.

#### 3.2.2.4.2 Benefits

Based on a recent evaluation of the RSV program since 2004, it appears that the rate of infant hospitalization has been reduced. The severity of cases has also been reduced.

#### 3.2.2.4.3 Success Factors

Factors influencing the program's success include:

- The willingness of the Department of Health and Social Services to invest in the original exploratory research.
- Adoption of the Synagis vaccine as a preventive measure.
- The development of an active surveillance program to improve the RSV program's efficacy going forward.
- A very high level of support from families, which maintain the participation of their children in monthly vaccinations.

#### 3.2.2.4.4 Suggestions for Improvement

It is important to institute and closely monitor a surveillance program at the outset of a vaccine program. Furthermore, when commissioning independent research, it is important for all parties to establish clear agreements regarding information exchange (raw data and analysis).

#### 3.2.2.4.5 Contact Information

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### **3.2.3 Case Study 3: “Changing the Culture of Smoking” – A Community-Based Participatory Research (CBPR) Project, Inuvialuit Region**

#### ***3.2.3.1 Introduction***

This case study examines the community-based participatory research project called “Changing the Culture of Smoking: Community-Based Participatory Research to Empower Inuvialuit Communities” (the CCS Project). This is a tobacco control program led by the National Indian and Inuit Community Health Representatives Organization (NIICHRO) and their partner, Consultancy for Alternative Education (CAE Canada). It runs in Ulukhaktok and Aklavik in the Inuvialuit region of the Northwest Territories.

#### ***3.2.3.2 Background***

Aklavik and Ulukhaktok are two communities in the Inuvialuit settlement area of the Northwest Territories (NWT), which also includes the communities of Inuvik, Paulatuk, Sachs Harbour, and Tuktoyaktuk. The populations of Aklavik and Ulukhaktok are approximately 594 and 398 respectively (based on 2006 Census data).

Health services in these communities are delivered by the Beaufort Delta Health and Social Services Authority, one of eight regional health authorities under the jurisdiction of the Government of the Northwest Territories Department of Health and Social Services.

Smoking rates in the Inuvialuit region are estimated at 61 per cent of the population (based on 2006 Statistics Canada data). Consequently, tobacco control is a priority for health care providers and community residents alike.

#### ***3.2.3.3 Overview***

The CCS Project is a five-year community-based participatory research (CBPR) tobacco reduction project running in Aklavik and Ulukhaktok.

The CCS Project arose when a community worker in Aklavik responded to a call for proposals for CBPR projects from the Canadian Tobacco Control Research Initiative (CTCRI), now subsumed under the Canadian Cancer Society Research Institute (CCSRI). Working with colleagues from CAE Canada, they formed a team, including other community development workers and researchers, and identified NIICHRO to act as the host organization. The proposal was successful and they received funding to undertake the CCS Project.

A national team of seven people (including NIICHRO staff, since NIICHRO has administrative responsibility) oversees the project. There are two co-ordinators in each community who work directly with residents to develop and run the initiatives within the CCS Project. As a community-based

participatory research project, the communities “run” the project, both developing and directing all activities with their respective co-ordinators.

The CCS Project focuses on developing individual capacity and critical thinking skills, developing community cohesion, and providing education about tobacco use.

The CCS Project is continuously evolving as co-ordinators work with communities and the national team to undertake tobacco reduction activities in each community. They have completed a variety of initiatives so far, including an initial baseline survey concerning smoking history and attitudes of adults and youth, a four-week “Quit Smoking Challenge” in the two communities, a competition for students to produce video public service announcements, organizing tobacco-free outdoor activities, delivering training sessions with youth, offering counselling and support to individuals in the process of quitting, and providing a consistent flow of educational material and information within the communities. Plans for future activities are being drawn up by the local teams in consultation with their communities.

The CCS Project is jointly funded by the Canadian Institutes of Health Research (CIHR) and the Canadian Cancer Society Research Institute. In this case, the project team was responding to a government priority (opportunity) in the form of the call for proposals. The model used was developed by the Canadian Tobacco Control Research Initiative, and accepted by CIHR as an outstanding example of an effort to align institutional priorities and community needs. By enabling the development and implementation of a CBPR model, the funders ensured that the CCS Project will not just respond to community needs, but also be determined by community priorities. The funding format is flexible, offering funds in advance and allowing unspent balances to be carried forward into the next fiscal year.

#### ***3.2.3.4 Benefits***

As a result of the CCS Project, these communities are actively engaging in tobacco reduction activities at much higher rates than are seen for similar activities in non-CCS communities, maintaining regular communication, and building continuity of resources and information within their communities.

There are several indicators of benefits to the participating communities, including:

- Anecdotal evidence from nurses that more people are asking for nicotine replacement therapies to support efforts to quit smoking.
- Anecdotal evidence from teachers that the program is helping youth.
- Anecdotal evidence of behavior changes; several people have reportedly quit smoking while others are actively reducing their smoking, and some individuals indicate that they no longer smoke indoors.

#### ***3.2.3.5 Success Factors***

The CBPR model is believed to be a critical element of the CCS Project’s success. This model, combined with a stable and flexible five-year funding commitment, enables the project teams (particularly the

community co-ordinators and teams) to provide continuity and develop relationships in the communities over time.

Some other factors contributing to success include:

- Team structure; community co-ordinators and teams have constant support for problem resolution, training or resource needs from other members of the national team.
- Extensive consultation; within each community, consultation over time (years) enabled identification of the informal “permission givers” and leaders, and allowed relationship-building between teams and communities.
- Support from community organizations such as hamlet offices, health centres, retail outlets, schools, and youth councils.

### ***3.2.3.6 Suggestions for Improvement***

There is a need to ensure continuity of funding for CBPR programs. This is a critical element for success, where smaller amounts of funds over a longer period are preferable.

It is important to recognize that the process of building relationships and momentum in a community-based participatory research project takes time. This cannot be rushed and requires flexibility on the part of co-ordinators and team members.

### ***3.2.3.7 Contact Information***

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## **3.2.4 Case Study 4: “Stay Quit to Win Challenge” – Tobacco Control, Nunavik**

### **3.2.4.1 Introduction**

This case study examines the “Stay Quit to Win” tobacco control program run by the Public Health Department of the Nunavik Regional Board of Health and Social Services (NRBHSS) in the Nunavik region of Quebec.

### **3.2.4.2 Background**

#### **3.2.4.2.1 Nunavik**

The Nunavik settlement area spans approximately 660,000 square kilometres of northern Quebec. Fourteen communities along the coasts of Hudson’s Bay and Ungava Bay are home to approximately 11,000 residents (based on 2006 Census data). The largest community in Nunavik is Kuujjuaq, the regional headquarters, with a population of 2,132 (in 2006). There are no roads connecting any of the 14 communities to neighbouring communities or to other regions of Quebec.

The NRBHSS, headquartered in Kuujjuaq, is the regional agency responsible for the management and delivery of health services to the residents of Nunavik, operating under the provincial authority of Quebec’s Ministère de la Santé et des Services sociaux. Health care services are provided to communities through two regional hospitals: the Hudson Coast’s Inuulitsivik Health Centre and the Ungava Coast’s Tulattavik Health Centre. In addition, each operates a network of points of service facilities – equivalent to community health centres – in each municipality.

The reduction of tobacco use and addiction among Nunavik residents has long been a priority for the Public Health Department of NRBHSS, where up to 70 per cent of adults and youth in Inuit communities are smokers.

#### **3.2.4.2.2 Quit to Win Initiatives**

The Nunavik program is an incentive-based intervention program initiated in 2003 when the NRBHSS decided to adapt a provincial program called the Quit to Win! Challenge. The Quit to Win! Challenge is an initiative of ACTI-MENU, a company affiliated with the Montreal Heart Institute’s Prevention Division (see website: [www.defitabac.qc.ca/defi/en](http://www.defitabac.qc.ca/defi/en)). The Quebec initiative was, in turn, inspired by the World Health Organization’s international “Quit & Win” challenge, originally developed in Finland and subsequently administered in various countries since 1994.

These are voluntary initiatives wherein participants commit to quit smoking for a fixed period of time, usually six weeks. Participants are supported throughout the process and receive prizes based on their degree of success.



### 3.2.4.3 Overview

The main focus of the Nunavik Stay Quit to Win! Challenge is to motivate Nunavik residents to quit smoking. The challenge has been held annually since 2003, from March 1 to April 11, with the exception of 2008. Initially, Nunavik adapted the program to include four categories for participants: youth, adults, community, and schools. The contest was open to non-smokers as well, both to recognize the value of not smoking as being potentially prize-worthy and to encourage youth to remain smoke-free. In response to ongoing evaluation and participant feedback, further program adaptations have been made, such as replacing the community category with a youth centre category. The program was amended again in 2009 to focus the competition on smokers only (i.e., non-smokers were no longer eligible) and further refine the categories. The program will continue to evolve to reflect changing circumstances and maintain its appeal to potential participants.

The program is managed and co-ordinated by the health promotion agent and two colleagues from the Public Health Department of NRBHSS. During the annual challenge period, staff from health facilities in each of the 14 communities support both initial enrolment and testing of participants at the end of the contest to confirm smoke-free status.

Funding for administrative and management costs is provided through NRBHSS as part of the Public Health Department's tobacco control agenda. Originally, federal and additional Quebec-based funds were available, but these monies have been steadily reduced in recent years. It is becoming increasingly difficult for NRBHSS to support costs associated with the program.

By its nature, the program also relies on partnerships with local and regional sponsors to provide prizes (e.g., airlines, local retailers, etc.). In terms of non-financial support, individuals from schools, retail outlets and municipal offices in all communities support the program by assisting with promotion and/or distribution of contest materials. The media (local community radio and CBC North) also promote the contest in every community.

#### 3.2.4.4 Benefits

The program has been successful at engaging almost 5,000 Nunavimmiut in a focused effort to reduce and/or quit smoking.

<b>Nunavik Stay Quit to Win Challenge Numbers of Participants 2003 - 2010</b>									
	<b>Year</b>								<b>Total</b>
	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008*</b>	<b>2009</b>	<b>2010</b>	
Youth Age 8 – 17	336	507	498	863	563		197	86	<b>2,924</b>
Adults Age 18+	291	354	352	358	266		76	85	<b>1,965</b>
<b>Total Participants</b>	<b>627</b>	<b>861</b>	<b>850</b>	<b>1,221</b>	<b>789</b>		<b>273</b>	<b>171</b>	<b>4,792</b>
	<b>2003–2007: participants were smokers &amp; non-smokers</b>						<b>2009–2010: participants were smokers only</b>		

\*No data

Successful “quitters” include:

- 2007 – Five youth, four adults (nine total)
- 2009 – 11 youth, six adults (17 total)
- 2010 – Eight youth, 13 adults (21 total)

While the numbers of actual “quitters” may seem low, the additional value of incentive-based intervention programs rests in their contribution to: a) de-normalizing tobacco use within communities, and b) shifting people’s attitudes about quitting, such as depicted in Prochaska and Velicer’s (1997) stages of change model – from pre-contemplation (not thinking about it), to contemplation (considering it), to preparation, to action.

The NRBHSS has observed evidence of these value-added behavioural shift impacts over the past several years. Many houses have become smoke-free; people realize smoking is not good for their children, so they go outside – an impressive commitment when temperatures can be as low as -40°C. They have also noted an increase in requests for and use of pharmacological aids to quit smoking, indicating a shift from pre-contemplation to attempts at quitting.

Tobacco use and addiction is a health issue that is significantly affected by social and economic factors. It relates to personal levels of security and stability – when one is faced with significant socio-economic problems every day, unfortunately a common situation in Nunavik, it is difficult to give priority to the stressful task of quitting smoking. However, maintaining a sustained annual focus on the importance of quitting and encouragement to do so *in and of itself* may be the more important element of the program when so many other critical issues can take precedence in family and community life.

The benefits of the Nunavik program are revealed in the participants’ feedback comments, which are predominantly positive. For example: “it’s helped me a lot and now I’ve stopped smoking and I’m much healthier” and “keep promoting what you are doing to Nunavimmiut.” Participants report beneficial health effects, including breathing more easily, coughing less, feeling more energetic, and getting sick less often.

Evaluation of the program is done annually in early fall, several months after the challenge. The health promotion agent contacts all participants who were smokers and administers a questionnaire to examine how many remain “quit” after the challenges, for how long, and the reasons for any relapses.

It is difficult to assess whether smoking rates in Nunavik have been reduced since the program began in 2003 because there is no comparative data available. The most recent data is from 2004.

#### ***3.2.4.5 Success Factors***

Interviewees cited several factors contributing to the value of the program, including:

- Very high rates of promotion and participation by schools – this is encouraging since it means they are engaging and educating young people before smoking habits become entrenched.

- Active support from community contacts such as local organizers and staff from schools, as well as retail outlets and municipalities.
- High levels of publicity – promotional and educational material is well distributed in the communities, and media promotion is very helpful.

Program challenges include effectively offering support or counselling for participants who have relapsed (started smoking again) or withdrew from the challenge because they could not quit. NRBHSS attempted to establish a network of trained, local smoking counsellors in each community, but unfortunately, the activity level of the counsellors remained very low in spite of additional incentives such as stipends for counselling sessions. NRBHSS is considering an alternative approach to smoking counselling, where it would be incorporated into a new community-based health representative/health and social worker position.

#### ***3.2.4.6 Suggestions for Improvement***

It is important to engage the whole community as a partner in the process (i.e., families, schools, etc.), not just individuals. It is important to engage a “champion” at the local school level. When there is someone in a school who is highly supportive of the program, the participation rate among this critical target group is higher.

#### ***3.2.4.7 Contact Information***

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### ***3.3 Case Studies – Métis***

To date, Métis health research has been limited. A report produced by the Government of Manitoba, entitled *Aboriginal People of Manitoba*, suggests two reasons for this phenomenon. The first is the absence of a Métis registry. While several provincial Métis organizations have initiated their own registration process, these are still in the early phases, and a national registry is completely lacking. The second is the absence of any bureaucracy/organization with a mandate of delivering, overseeing, and funding directly targeted health care services for Métis. In contrast, there is extensive data for First Nations and Inuit populations that is continuously being compiled and made available for researchers (Hallett et al., 2005).

In 2006, 54 per cent of Métis aged 15 and over had reportedly been diagnosed with a chronic condition (Statistics Canada, 2006). The most common conditions included arthritis, asthma, and high blood pressure. Fifty eight per cent of Métis adults self-rated their health as excellent/very good. Also, of the parents/guardians with children aged six to 14, 84 per cent reported their children to be in excellent/very good health. Métis have a slightly lower rate of access to a family doctor compared to the total Canadian population; in 2006 about 81 per cent had access to a doctor.

Not only are there health differences between Métis and the general Canadian population, there are differences within the Métis population, including between genders. A higher proportion of Métis women reported having a chronic health condition: 57 per cent versus 50 per cent for Métis men. Women were also more likely to report arthritis and rheumatism, asthma, and bronchitis (Statistics Canada, 2006). These statistics demonstrate the necessity for group-specific and gender-specific programming.

The research conducted for our case studies was an extension of the environmental scan that forms the foundation of this report. Included in the 100-plus emails sent to Aboriginal and respiratory health related organizations were requests for information on Métis-specific projects, programs and initiatives. Reminder emails were sent where responses were not forthcoming. Further, telephone contact was initiated with the Métis organizations (Métis National Council, the five provincial Métis organizations, and the Métis Settlements General Council) and other targeted organizations with programs of potential interest. If deemed suitable for a case study, arrangements were made for follow-up telephone interviews with the program co-ordinator(s) (Appendix 1).

Although there are very few existing Métis-specific initiatives, we were able to complete the following two Métis-specific case studies:

1. The Saskatoon Indian and Métis Friendship Centre's Chronic Disease Prevention Initiative involves healthy living classes and activities, with a focus on managing chronic diseases such as asthma and COPD (among others). The clientele is approximately 25-30 per cent Métis.
2. The Métis Nation British Columbia engaged 33 of the 36 Métis Chartered Communities through the Aboriginal ActNow BC Program. Métis youth representatives focused on tobacco cessation

and undertook a range of activities. Eighteen per cent of leaders and participants who originally smoked reported having quit as a result of the program.

### **3.3.1 Case Study 1: The Saskatoon Indian and Métis Friendship Centre's Chronic Disease Prevention Initiative**

#### ***3.3.1.1 Introduction***

This case study examines the Saskatoon Indian and Métis Friendship Centre's Chronic Disease Prevention Initiative. It involves healthy living classes and activities, with a focus on managing chronic diseases such as asthma and COPD (among others).

#### ***3.3.1.2 Overview***

The Saskatoon Indian and Métis Friendship Centre (SIMFC) is a non-profit organization incorporated in 1968. The Centre's primary vision is to improve the quality of life of Aboriginal people in Saskatoon. Since its inception, the Centre has developed and delivered numerous social, recreational, cultural, and educational programs.

The SIMFC identified the need for chronic disease programming through a case study and needs assessment conducted by a family violence worker on staff. These needs were consistent with the Aboriginal health statistics released by Statistics Canada, indicating that Aboriginal populations experience high levels of chronic diseases such as obesity, diabetes, etc. As a result, funding became available from the Government of Canada to address these concerns.

The SIMFC staff recognized the challenges of their clients, many of whom struggle with addictions as well as chronic diseases. Based on client interest, the SIMFC initiated the Chronic Disease Prevention Initiative as a pilot project in February 2009, and received two years of funding from the Urban Aboriginal Strategy: \$30,000 in 2008-09 and \$61,400 in 2009-10. Once funding was received, a program co-ordinator was hired and background research was conducted. SIMFC is applying for additional funding to maintain the initiative.

This initiative involves reaching out to people in the community through the development of print materials and engaging with people in their homes. The initial sessions at the SIMFC began with a series of monthly workshops, focused primarily on information-sharing and awareness-building about chronic disease and healthy living. Additionally, gatherings of Elders and youth were held to jointly discuss concerns around health and to tackle the issues collaboratively.

The SIMFC offers a counselling service through a local worker, who guides participants in the area of living well, including questions around sexual health and chronic disease. Funds from the Chronic Disease Prevention Initiative also went towards the purchase of fitness equipment, including several machines, weights, and skipping ropes. This extends the services provided by the SIMFC and attracts a greater diversity of individuals. The initiative has also allowed for the development of new and fruitful

partnerships. One example is the food box program, where the Centre is able to distribute food boxes for a cheaper price, and have access to extra fruits and vegetables for distribution to members in need. It also provides an opportunity for members to gain volunteer experience with the food box program.

As part of this initiative, the SIMFC runs a LiveWell with Chronic Conditions program, consisting of a series of classes (approximately 2.5 hours in length) over a six-week period. Two SIMFC staff members, including one Métis, were trained by LiveWell trainers at the Saskatoon Health Region, and now deliver the program to primarily Aboriginal participants. The program provides a wide range of information, activities and support for people living with chronic diseases, and helps young people build a healthy lifestyle to protect themselves against the development of such illnesses.

LiveWell classes generally attract between six and nine participants. The recent series of classes attracted five participants, two of whom are Métis and three of whom are Status Indians. Two participants are seeking help in managing their asthma, while the others are managing other (non-respiratory health related) chronic conditions. Métis are particularly well served by this program, as they are often limited in their ability to obtain necessary medication due to high costs and the lack of support for Métis under the Non-Insured Health Benefits Program.

The SIMFC runs other programs, such as the New Steps Program, which integrates teachings from dietitians, health educators, personal trainers, and Elders. Overall, staff members estimate that the SIMFC serves approximately 1,500 people per year, of which approximately 25 to 30 per cent are Métis.

### ***3.3.1.3 Benefits***

The LiveWell classes primarily tend to attract female adults, whereas males are more interested in fitness programs. The practitioners indicated that this may be due to gendered activity preferences, as well as the increased likelihood of females recognizing that they have a long-term disease that needs to be managed.

The practitioners use evaluation forms at the end of a series of classes to better understand what is working and identify opportunities for improvement. The practitioners deem the program to be working if they are helping at least one person to become healthier. They note tangible changes in participants' health. For example, one dedicated female program participant has undergone a noticeable change in attitude, and her eating habits have changed, leading to significant weight loss and an increased ability to manage her chronic condition. SIMFC staff also indicated that transient clients will take the opportunity to try out a fitness machine at the Centre. Youth numbers have also started to increase with more equipment and resources.

### ***3.3.1.4 Success Factors***

The practitioners of this program indicated multiple reasons for its success. The SIMFC has been in operation for over 20 years, offering important social, recreational, cultural, and educational programs to bring the community together and support people in need. Located in a central area accessible to

downtown Saskatoon, it has developed into an important community space, and is especially vital for homeless people in the area. For example, the supper program attracts a significant number of people. The SIMFC has a dedicated staff and a good, multi-purpose space in which to run their programs. The range of complementary programming attracts and serves a mixed demographic, with some offerings during the day and others in the evening. The Centre also provides information (e.g., pamphlets, contact information) to link people to resources from other organizations. The practitioners also noted a higher level of participation for programs that are offered with some consistency, rather than one-off events. In sum, a combination of resources, partnerships and consistency offer a supportive context in which to run a successful Chronic Disease Prevention Initiative.

### ***3.3.1.5 Suggestions for Improvement***

The practitioners noted a need to attract more male participants for the LiveWell program. They are contemplating combining the classes with a fitness program afterwards. As well, they are obtaining participant feedback through the use of evaluation forms at the end of each series of classes.

The practitioners recommend the following steps to encourage consistent participation in programming:

- Start with a vision and a plan of how you want things to happen on a weekly basis.
- Lay out in detail what the program will look like, down to the snacks, chairs, and pieces of equipment.
- Make sure to set up programming in a consistent way so that people learn what is available and become accustomed to it.
- Provide incentives such as food, vouchers and giveaways. This is important, as is the presentation of information in a 'cool' and relevant form.

To date, community needs are being met by the Chronic Disease Prevention Initiative funds, however, this type of funding is generally allocated for a limited timeframe (one to two years). There is a need for longer term funding to enable ongoing programming. The SIMFC would benefit from a full-time chronic disease worker on staff, as this type of service is integral to the health of the community and to improving the cycle of violence. The SIMFC plays a vital role in the community, as many members feel more comfortable going to the Centre than to a health clinic. As a non-profit organization, the staff is well-versed in being creative with available resources and working with what they have.

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Saskatoon Health Region's LiveWell with Chronic Conditions Program:  
[www.saskatoonhealthregion.ca/about\\_us/strategic/transforming\\_live\\_well.htm](http://www.saskatoonhealthregion.ca/about_us/strategic/transforming_live_well.htm)

## **3.3.2 Case Study 2: Métis Nation British Columbia's Aboriginal ActNow BC Program**

### ***3.3.2.1 Introduction***

This case study examines Métis Nation British Columbia's tobacco cessation initiative within the context of the Aboriginal ActNow BC Program.

### ***3.3.2.2 Overview***

Métis Nation British Columbia (MNBC) was created in 1996 and was formally incorporated as the Métis Provincial Council of British Columbia (MPCBC). MNBC represents 36 Métis Chartered Communities in BC and is mandated to develop and enhance opportunities for these communities through the implementation of culturally relevant social and economic programs and services.

MNBC took the opportunity offered by Aboriginal ActNow BC to act as the lead organization in guiding the development of community-based projects that contribute to achieving health goals in BC's Métis communities. Aboriginal ActNow BC, a stream of ActNow BC, was implemented by the National Collaborating Centre for Aboriginal Health (NCCAH) to address risk factors and reduce the incidence of chronic disease by supporting healthy choices relating to four pillars of health: healthy eating, physical activity, healthy choices during pregnancy, and reducing tobacco use.

After receiving funds in 2007, MNBC was initially able to engage 12 of the 36 MNBC Chartered Communities. It was recognized that some of the messaging to communities acted as a barrier to participation, as the wording in the applications made it seem too onerous to apply for and receive funding. Furthermore, some community volunteers were concerned about the pressure of taking responsibility for the funds. In 2008, after working with community leaders and addressing perceived barriers, 33 of the 36 MNBC Chartered Communities developed programs. Most activities focused on nutrition and physical activity, and a few on maternal health, while tobacco use did not initially receive significant attention. It was later noted, however, that many who participated in physical activity-based programs reduced or quit smoking as it interfered with their participation (e.g., Learn to Run programs); thus these programs resulted in indirect impacts on respiratory health.



In response to the low uptake on tobacco use activities, the MNBC Director of Health approached the MNBC Youth Committee (which had funding left over from a provincial youth forum) and suggested that members spearhead a program on healthy living without the harmful use of tobacco. A call for submissions was shared through the distribution network and a social media page (Facebook). Grant applications were received, focusing on personal stories about Métis youth experiences, and resulted in the development of a calendar, posters, Frisbees, water bottles, and other products showcasing healthy Métis youth and highlighting the benefits of living without smoking. These Métis youth are now role models for their peers.

MNBC's Aboriginal ActNow program was initiated in 2007 and ran until March 2009. Leaders and participants were surveyed in 2009, with all data being received by August 2009. As of March 2010, final reports were still being finalized. The partnership with NCCAH allowed for the transfer of supplementary funds to complete the reporting process.

### ***3.3.2.3 Benefits***

MNBC's Aboriginal ActNow initiative resulted in a range of community-based and community-driven projects, many of which addressed multiple ActNow target areas. There were several gender-specific projects initiated in areas other than tobacco cessation, including a maternal health network (e.g., women's yoga classes), and other women-specific fitness activities such as group kayaking. Women had a higher tendency to get active than their male counterparts; however, this may have been influenced by the leadership taken by women's representatives from each MNBC region.

MNBC has Chartered Community Youth leaders that elect a regional youth representative in each of the seven regions, as well as a provincially elected Youth Chairperson, who has a seat on the Board of Directors. These leaders took on the challenge of generating tobacco cessation initiatives in Métis Chartered Communities across the province. While the province of BC targeted a 10 per cent reduction in tobacco use through ActNow; MNBC managed to achieve an 18 per cent reduction among participants. The program focused on physical activity, based on the idea that the more someone is physically active, the less they will smoke.

At the end of the MNBC ActNow initiative, an evaluation of the program was completed using Survey Monkey, an online survey tool. The evaluation garnered responses from 46 of 72 leaders and 140 of approximately 3,100 participants. Each individual answered questions about quitting smoking as a result of the program, and the results were impressive. MNBC achieved an 89.9 per cent success rate for Métis Chartered Community involvement. Three of 18 smoking leaders responded in the survey that they had quit as result of the ActNow program, and of the participants who responded to the question (31 out of 122 total respondents), 16 still smoked, while 15 had quit. Overall, the MNBC Aboriginal ActNow initiative resulted in decreased rates of smoking, improved nutrition and increased rates of physical activity. The MNBC Director of Health noted a net benefit to the province of BC, where health improvements stemming from this project will more than re-pay Aboriginal ActNow funds by way of future savings in healthcare.

### ***3.3.2.4 Success Factors***

ActNow was very beneficial for the province of BC, both for Aboriginal and non-Aboriginal communities. It promoted simple and reasonable targets that make a difference for overall health and well-being, where individuals, households and communities could play an active role in achieving them. ActNow

programming was community-driven; a lot of flexibility was built in so that communities had choices as to which target(s) to address and how to proceed. This generally resulted in a range of activities that engaged and benefited all community members. The lack of imposed restrictions helped to make this program work, as community members engaged from the beginning and took on responsibility for the outcomes.

With many community initiatives, success depends on the engagement of volunteers. Aboriginal ActNow enabled payment for community co-ordinators, which encouraged participation; however, many communities were reluctant to charge this administration fee. The availability of funding helps build capacity in communities, as they are able to hire a co-ordinator, and offer incentives such as snacks and water, running shoes, boots, socks, pedometers and track jackets. Having access to necessary materials enables participation and generates cohesiveness within the community activity group (e.g., walking or hiking group). Aboriginal ActNow stimulated multiple partnerships. For example, the Sport Check partnership resulted in reduced prices on shoes, and partnerships with gyms, community halls and city facilities enabled participants to use fitness resources at reduced rates.

Overall, the Aboriginal ActNow initiative benefited from financial power, clout, and available tools and resources. This also enabled important partnerships that further facilitated and encouraged participation.

### **3.3.2.5 Suggestions for Improvement**

Several recommendations emerged from this project. First, care must be taken at the onset of the initiative to communicate objectives and requirements in accessible language. The idea of being accountable for large sums of money can be intimidating for potential volunteer community leaders, and if they are not well informed about what is required of them, they may choose not to engage. It is also important at the onset to provide ideas to communities about how they may wish to design their programming and how they may best network with regional parks, recreation districts, etc., to develop and implement project activities.

It is important to designate some administrative funds to pay for things like hall rental, refreshments and community co-ordinators. Take the time to ask communities what they need to overcome barriers and ensure project success. For example, some participants may require travel support (e.g., taxi vouchers) or daycare.

The importance and increased effectiveness of a community-driven process is clearly reflected in the following statement by MNBC's Minister responsible for Health/President, Bruce Dumont:

*"The community-driven process empowers Métis people to take ownership of their health...With support, we have increased our community capacity and seen many 'champions' rise to the challenge, positively impacting their own health, that of their families and of their Métis community."* (National Collaborating Centre for Aboriginal Health, 2010)

### **3.3.2.6 Contact Information**

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### ***3.4 Case Studies – Discussion and Conclusions***

This section offers some final reflections on the above population-specific case studies.

#### **3.4.1 First Nations**

The majority of initiatives offered to First Nations people in Canada seem to focus primarily on either tobacco abuse cessation or tuberculosis. Admittedly, these are important respiratory health initiatives; however, there are a range of others that may not receive adequate attention.

Post-program evaluations were only conducted for a portion of the case study initiatives. When used, evaluations offered important insights, allowing managers to better assess the effectiveness of their programs and make changes for future programming. In the cases where evaluations were not conducted, interviewees generally indicated that this would have been useful.

The short-term nature of many funding arrangements is considered a major barrier to sustained programming and to long-term success in influencing behavioural change, such as tobacco cessation.

In the small sample of case studies presented here, only one had a gender-based component. This may indicate a need for increased focus on a gender-based approach to First Nations and Aboriginal tobacco abuse cessation and prevention programming, although a wider range of programs would have to be sampled to confirm this.

One key informant also expressed an opinion that the obsolescence of data from the First Nations Regional Longitudinal Health Survey (RHS) may be hindering program planning; complete and up-to-date information is needed to support the design and implementation of initiatives in order for them to have the maximum benefit for First Nations people who live on-reserve. More generally, most informants also expressed a desire for various levels of government to “get in better touch” with First Nations and Aboriginal health needs.

As noted above, there is significant variety in the types of respiratory health initiatives available to First Nations people, both on- and off-reserve across Canada. This offers diverse choices for First Nations communities in their selection of particular models to suit their needs.

### 3.4.2 Inuit

The Inuit case studies reflect the reality that social and economic determinants play an important role in influencing respiratory health outcomes, an issue already acknowledged during the development of the National Lung Health Framework. Respiratory health issues affecting Inuit are often symptoms or by-products of systemic socio-economic challenges and the resulting legacy of societal emotional and mental health problems. It is very difficult to imagine drastically improving (lowering) rates of respiratory disease solely through direct health care initiatives in the face of these challenges. For example, even though TB management is achieving positive results in Nunatsiavut, it is difficult to reduce the number of cases because of other health and well-being issues that result from the existing socio-economic context. At the same time, the health system lacks adequate financial resources, indicating the need for a re-prioritization of the health policy agenda. Additionally, experts have indicated that there may be (as yet unstudied) physiological factors that help to explain why respiratory diseases such as TB and RSV have such a significant impact on Inuit, an area that would benefit from more targeted research.

As previously mentioned, tobacco-related initiatives are widespread in Inuit and other Aboriginal communities. While socio-economic context is known to be related to smoking rates on a global scale, while challenging, there are positive actions that can be taken within these contexts. Our case studies indicate that the community-based approach has significant merit. Local programs may have more impact as they have more of a 'personal touch,' although they tend to require significant financial inputs. Community-based projects require a long-term investment of both people and resources, and a commitment to community development. It is essential to have continuity among key champions/leaders, and in the amount and availability of funding (even if not in large amounts). It is also important to engage local people at the beginning of the project and maintain high levels of engagement throughout. An adaptive and flexible approach works well, including regular evaluation, tweaking, and the willingness to try new things. At the same time, other challenges must be overcome, such as the fact that quitting smoking may be a low priority when people are facing significant stress as a result of their socio-economic context.

Several other insights emerged from the Inuit case studies. First, having Inuit champions and/or long-term trusted collaborators at various levels of organization (especially locally) can make a big difference to the success of any initiative. Second, it is important to look broadly at indicators of success and progress. By only considering the fluctuation of health status or rates of disease earlier on in the intervention cycle (especially for smoking), one misses out on the bigger picture, which encompasses complex and inter-connected issues. Third, public health programs in Inuit regions are making concerted efforts to determine how to achieve greater success in respiratory health, offering an opportunity for increased support. Developing an Aboriginal component of the National Lung Health Framework may help in mobilizing such efforts.

Finally, it is important to note that issues around tobacco addiction and lower respiratory tract infections among Inuit infants (where RSV is dominant, but not the only cause) are serious and

persistent problems in all Inuit regions. The locations of the above case studies should not be taken as an indicator of isolated incidence.

### **3.4.3 Métis**

The limited number of Métis case studies included in this report directly reflects the limited number of existing Métis-specific respiratory health initiatives. Those that do exist tend to focus on tobacco cessation. At the same time, however, there are several Métis housing initiatives (e.g., Métis Nation of Ontario's Residential Rehabilitation Assistance Program, and the Manitoba Metis Federation's Community Housing Managers of Manitoba) that may impact Métis respiratory health. We also identified a number of pan-Aboriginal initiatives which presumably offer access to Métis, although there may be issues around cultural competency when addressing Métis clients.

The above case studies offer some important insights for developing or expanding respiratory health initiatives for Métis, many of which may also be applicable to other Aboriginal populations. Community-based and community-driven initiatives are deemed particularly effective, especially when championed by committed and engaged staff or volunteers. Successful approaches tend to be flexible and adaptable to evolving contexts. They also tend to be holistic in nature, addressing more than just the physical aspects of health and well-being. Long-term projects benefit from an improved ability to plan and implement activities in a consistent manner, allowing participants to develop a sense of connection and comfort in knowing that they have continued support. As such, the consistent availability of funding and other resources is essential. It also allows the development of mutually beneficial partnerships with other organizations, which tends to improve outcomes.

### **3.4.4 Final Thoughts**

The First Nations, Inuit and Métis case studies illustrate that few organizations directly target Aboriginal respiratory health. Rather, many programs are more holistic in nature, focusing on healthy lifestyles. Other interventions also exist. For example, housing programs can have important direct effects (e.g., better ventilation improves respiratory health) as well as other indirect impacts on the social determinants of overall health. Federal initiatives are common for Inuit communities and First Nations living on-reserve, but fewer programs are available for off-reserve and Métis populations. Additionally, Métis health data remains limited.

Overarching recommendations for respiratory health projects, programs and initiatives for Aboriginal Peoples include the need for community-based, community-driven, and group-specific services. Separate programs are needed for First Nations, Inuit and Métis. Program flexibility emerged as important in all case studies, and the need for consistent funding was also highlighted.

Respiratory health issues were certainly recognized as a challenge in all three of the First Nations, Inuit and Métis populations, and limitations in services, resources and information around these issues were highlighted. There is a need to further address these issues, while recognizing the complexity and impacts of the broader socio-economic context.

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# Appendix 1: Case Study Interview Template

## *Case Study Overview*

Together, up to five in-depth, local-level case studies are to be undertaken for each of the First Nations, Inuit and Métis populations. Each series should reflect a range of community sizes and structures within Canada (e.g., on-/off-reserve, urban, rural, remote) and reflect a range of respiratory health issues (e.g., asthma, chronic obstructive pulmonary disease (COPD), influenza, tuberculosis (TB), lung cancer, respiratory syncytial virus (RSV), etc.). The program or strategy may focus specifically on respiratory health (including smoking reduction/protection), or may address social determinants of health (e.g., culture, housing) that impact respiratory health. The goals are to: (a) illustrate how specific contexts and activities lead to successful programming and positive health outcomes, and provide recommendations for further improvement; and (b) document successful models for sharing and promotion with other communities interested in adapting or enhancing existing programs, or building new programs.

## **Target Interviewees**

1. Project/program leaders/planners/implementers/managers.
2. Participants/clients/community members.
3. Funders.

## **Before the Interview (Interviewees: 1,2,3)**

- Welcome and thank the participant for their willingness to answer questions. Set up a mutually agreeable time, if inconvenient now.
- Explain the general purpose of the interview discussion, how the information will be used, and why the participant was chosen.
- Explain how information will be recorded.
- Address the issue of confidentiality.

*We are doing these interviews as part of a series of case studies to document successful respiratory health projects, programs and initiatives for First Nations, Inuit and Métis. We are interested in learning why these are successful, and how lessons learned can be communicated to other communities that are interested in setting up projects, programs or initiatives to address respiratory health.*

*We would like to be able to include your name in our report. Are you comfortable with that?*

## **Interview Questions**

### **Introductory Questions (1,2,3)**

- What is the name of your organization/community?
- What is your position in the organization/community?
- Contact information:
  - Telephone number.
  - Email.
  - Mailing address.

### **Overview of project/program (1,3)**

- What is the name of the project/program?
- How was the project/program initiated?
  - How has it evolved?
  - Who/which organization(s) is/are responsible for running the project?
  - How many people are involved in running the project?
- What is the main focus?
  - Please describe the different aspects or components.
- Which strategy/organization provided funding and/or support for the project/program?
  - How much funding was provided? For which lengths of time?
  - Beyond funding, was there any other type of non-financial support provided? If yes, please explain.

### **Determine whether funding opportunities/government support are in line with community needs (1)**

- Were you responding to government priorities, or vice versa?
- Was the project constrained at all by government-imposed priorities?
  - If so, in what ways?
- Is there a way to better align government priorities and community needs?

**(3)**

- Were you responding to community priorities, or vice versa?
- Is the funding strategy flexible or constraining for communities?
  - If so, in what ways?
- Is there a way to better align government priorities and community needs?

**From the community’s perspective, how has the project/program benefited health/determinants of health in the community? (1,2,3)**

- Is this project/program working?
- Is there an evaluation available?
- What are the indicators that it is working?
- How is it benefitting people’s health and well-being?
  - What are the outcomes for respiratory health?
- Approximately how many clients/residents were affected by the project/program?
- Which populations are most affected by the project/program? (*e.g., age groups, gender, health status, etc.*)
  - Why were these populations particularly affected?
- Was there a gender-specific component or any gender-specific considerations during project/program planning and/or implementation?

**From the community’s perspective, what are the project/program elements that made it successful? (1,2)**

- What are the reasons that this project is successful/effective?
  - *Context-related* – community strengths/assets, leadership, public awareness/interest, access to services, size and location, etc.
  - *Operations-related* – logistics, order of activities, types of tools used, selection of target group, existence of steering/implementation committee, etc.
  - *Good fortune/chance* – coincidence with available expertise/support, ability to dove-tail with other programs/activities, etc.).
  - *Other*

- Describe some of the innovative ways that your community has made this project successful (based on answers in section 2).
  - How did you use your community's strengths?
  - How did you overcome challenges?
- What are some of the things that might need improvement/tweaking/changing to improve the project/program?
  - How could the project/program be made more effective?
- What are some of the things that might need improvement/tweaking/changing to improve the funding strategy?
  - How could the strategy be made more effective?

**Explore other innovations, improvements, ideas, and recommendations that the community believes would make the project/program even more successful, if it were to be reproduced elsewhere in Canada (1,2)**

- What recommendations or advice would you offer to another community wishing to implement a similar project?
- Is there a report or evaluation component from this project that could provide guidance for other groups?
  - If so, please send it to First Nations Centre/Métis Centre/Inuit Tuttarvingat of NAHO by email or mail (*circle centre name and mailing method*).
- Are there tools/documents that emerged from this project/program that could be used or adapted in other contexts/communities?
  - If so, please send it to First Nations Centre/Métis Centre/Inuit Tuttarvingat of NAHO by email or mail (*circle centre name and mailing method*).

**Other (1,2,3)**

- Do you know of any other successful projects or programs in Aboriginal respiratory health?
- Do you have suggestions about particular organizations that should be involved in developing a national Aboriginal respiratory health framework?
- Is there anything else that you care to add that you feel we should know?