

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
1. INTRODUCTION	3
Challenges and Change	3
Focusing on Promotion and Prevention	3
Definitions and Concepts	4
The Aboriginal Community	6
Issues and Dilemmas	7
This Paper	8
2. NEEDS AND PRIORITIES FOR PROMOTION AND PREVENTION	8
Recognized Issues	9
Emerging Issues	13
3. CURRENT DELIVERY OF PROMOTION AND PREVENTION PROGRAMS AND SERVICES	14
Overview	14
Aboriginal Control of Programs and Services	14
Inuit, Métis and First Nations Services and Programs	15
Regional and Community Programs	18
Provincial and Territorial Government Programs	20
Federal Government Programs	23
4. KEY ISSUES IN PROMOTION AND PREVENTION PROGRAMMING	26
The Present Reality in Aboriginal Communities	26
Staffing Issues	27
Financing Issues	30
Culture and Tradition	31
Health Information	32
Participation in Decision-Making	33
Capacity Development	34
5. IMPROVING PROGRAMS AND SERVICES	35
NAHO's Role in Population Health, Health Promotion, Prevention and Protection	35
Knowledge-Based Activities	35
Promote Health Issues	37
Research and Research Partnerships	37
Recruitment, Retention, Training and Utilization	38
Traditional Healing Practices	38
6. POSSIBLE LINKAGES WITH OTHER BODIES AND INITIATIVES	39
National Aboriginal Organizations	39
Governments	42
Research Bodies	43
7. CONCLUSION	45
8. BIBLIOGRAPHY	47
9. KEY INFORMANTS	59

EXECUTIVE SUMMARY

Achieving good health is a critical issue facing Aboriginal people. Health is a resource for living and a means to achieving self-determination. Throughout Canada, Aboriginal people are striving to define what wellness is, how it fits into a strategy of renewal and how it can be achieved at the individual, family, community, and Nation level. At the same time, Aboriginal health services, and the public health system in general, are facing formidable challenges and undergoing considerable change.

This paper was developed as a part of the National Aboriginal Health Organization's (NAHO) strategic planning activities in order to identify key issues of concern and recommendations for follow-up to improve population health, health promotion, disease prevention, and health protection services and programs for Aboriginal people. The paper addresses the following questions:

- What is known about the delivery of population health, health promotion, disease/injury prevention and health protection services and programs for Aboriginal people across Canada?
- What issues and concerns have been identified related to the quality and adequacy of these services and programs?
- Is there equitable access to services and programs according to geographic area, on- or off-reserve status, type of community, etc.?
- Who is involved and what is being done to improve these services and programs?
- Given the areas of concern, involvement of other bodies, and NAHO's mandate, what could NAHO do to support the development of better health programs and services?

Information sources for the study included:

- a search of published and unpublished Canadian documents addressing Aboriginal health issues and programs/services. Approximately 190 relevant documents were reviewed;
- an Internet search of Canadian governmental and non-governmental Web sites; and
- telephone or in-person interviews with 28 selected key informants.

Rather than an in-depth study or inventory of programs and services, the paper provides a general overview of the current situation for planning purposes. It drew heavily on existing research and reports as well as the expert opinion of people working at the national, provincial and territorial levels.

Recommendations include engaging in activities and linkages related to knowledge transfer; addressing key promotion/prevention issues; undertaking specific research and developing strategic research partnerships; facilitating the recruitment, retention and training and utilization of Aboriginal health workers; and promoting traditional healing practices.

1. INTRODUCTION

Good health is a balance of physical, mental, emotional, and spiritual elements. All four interact for a strong healthy person. If we neglect one, we get out of balance and our health suffers in all areas.

...Prevention goes hand in hand with a traditionally healthy lifestyle. Good health is achieved when we live in a balanced relationship with the earth and the natural world. Everything we need is provided by our common mother, earth: whole foods, pure water and air, medicines, and the laws and teachings which show us how to use things wisely. Combined with an active lifestyle, a positive attitude, and peaceful and harmonious relations with people and their spiritual world □ good health will be ours.

(Malloch, 1989)

Achieving good health is a critical issue facing Aboriginal people. According to the World Health Organization, health is a resource for living. Without a strong, healthy population, Aboriginal people will not be able to lead full and balanced lives or achieve self-determination. Wellness in the four aspects, strength, resilience, creativity, and energy are required to reclaim what has been lost and build a new relationship with the natural and human worlds.

The National Aboriginal Health Organization (NAHO) reflects this belief in its vision:

(NAHO is) dedicated to improving the physical, social, mental, emotional and spiritual health of Aboriginal Peoples. It is our fundamental belief that the advancement and sharing of knowledge in the field of Aboriginal health is the key to empowering Aboriginal Peoples.

(National Aboriginal Health Organization, 2001a, p. 3)

Challenges and Change

Throughout Canada, Aboriginal people are striving to define what wellness is, how it fits into a strategy of renewal and how it can be achieved at the individual, family, community, and nation level. At the same time, Aboriginal health services and programs, indeed the public health system in general, are facing formidable challenges and undergoing considerable change in every region of Canada. Some of these challenges and changes include:

- the transfer of more responsibility for health services from the federal government to First Nations communities and provincial and territorial governments;
- the growth of culture-based health prevention and promotion programs in Inuit, Métis and First Nations communities;
- greater national attention to infectious and chronic diseases among Aboriginal people;
- increased roles of regional Aboriginal and non-Aboriginal health bodies in allocating resources and delivering health programs;
- government reductions in some program areas and increases in others; and
- continuing (perhaps growing) disparities in access to health services and program funding.

Focusing on Promotion and Prevention

NAHO, as well as the Aboriginal community in general, recognizes that health promotion and disease prevention are cornerstones of wellness. Population health (simply the ability to look at the collective health of a group rather than that of an individual), health promotion (focusing on health rather than illness, disease and injury), prevention (stopping ill-health from occurring), and health protection (taking

measures to safeguard health), are principles and approaches that are compatible with an Aboriginal world view.

In a First Nations world view, healing (getting at the root cause, becoming whole) is synonymous with behaviour change and therefore is central to promotion and prevention. Inuit views of the body offer a holistic vision of the individual and his or her unity with his/her surroundings, a part of a whole that draws its meaning from the relationships that the human being entertains with whatever is living and whatever surrounds him or her (RCAP, 1993b, p. 52). A Métis key informant made this comment in a discussion of Métis health.

Health is the whole person... we don't need to think that we have an addictions problem here, a problem with teens there, Elders who are lonely, women who are depressed. We have to think: People don't feel good. Why is that?

(Kinnon, 1994, p. 2)

An example of a successful health promotion project is provided by Geraldine Dickson in *Aboriginal Grandmothers' Experience with Health Promotion and Participatory Action Research* (Dickson, 2000). Ms. Dickson describes a two-year project involving older Aboriginal women in an ongoing group process that included mutual support, health education, skill development, and political action.

The project and health assessment, in keeping with the true meaning and essence of health promotion, created opportunities and nurtured skills so that the grandmothers healed themselves, supported each other and experienced success in advocating improvement in their personal and collective lives.

(p. 212)

Aboriginal communities are already paying the price of lack of balance, of disrupted connections and treating symptoms. Inadequate prevention efforts will only become more critical as the Aboriginal population grows and ages, more people become ill and there is even greater demand on already stretched health care resources. Based on findings of the first national First Nations and Inuit Regional Health Survey, writers Jeff Reading and Brenda Elias state:

... an epidemic of chronic disease conditions indicates that Elders now require intensive secondary and tertiary prevention programs and improved access to specialized acute and chronic medical care.

(First Nations and Inuit Regional Health Survey National Steering Committee, 1999, p. 51)

Diabetes already is leading to many other health complications. High rates of sexually transmitted diseases will result in higher rates of reproductive health problems, and cancers in the future and poor nutrition will result in a weakened ability to fight disease in the long term.

Definitions and Concepts

Ideas about health, disease and wellness vary considerably from community to community. NAHO is presently in the process of identifying some common elements in an Aboriginal view of wellness that will lead to a framework for the organization's work. This process is a critically important one in future work related to promotion/prevention activities.

As that process is not yet complete, this paper relies on western concepts and ideas related to health. In reality, much of the effort to address Aboriginal health issues at this time is grounded in a western viewpoint.

The following definitions are used in the paper.

Population Health

The population health approach focuses on the entire range of individual and collective factors and conditions, and the interactions among them, that determine the health and well-being of Canadians.

(Working Group on Population Health Strategy, Health Canada, 1996, p. iv)

Population health strategies are designed to improve the health of an entire population rather than focusing on the individual. Usually they address the most relevant determinants of health, or conditions that are known to influence health for a particular group. Major determinants of health include income and social status, education, employment and working conditions, physical environments, personal health practices and coping skills, healthy child development, gender, and culture. Health services play only a small role in creating health.

Health Promotion

A guiding document in the field – the *Ottawa Charter for Health Promotion* – defines health promotion as the process of enabling people to increase control over and improve their health (World Health Organization, Health and Welfare Canada and Canadian Public Health Association, 1986, p. 1). While health promotion has sometimes been overly focused on individual lifestyle change, the theory is one that addresses the context in which people live and the need to make changes on many levels in order to achieve well-being. The five strategies for health promotion are:

- build healthy public policy such as environmental protection legislation, occupational health, violence reduction, etc.;
- create supportive environments through community development and family support;
- strengthen community action so that communities can identify needs and address them;
- develop personal skills that enable individuals and groups to address health issues; and
- reorient health services to be more client-focused and integrated.

Disease and Injury Prevention

Prevention consists of an intervention that has been shown to reduce significantly the likelihood that a disease, injury or disorder will affect an individual or that interrupts or slows the progression of that disease (Canadian Task Force on the Periodic Health Examination, 1980). Primary prevention tries to prevent a disease or condition before it occurs (such as pre-natal care, safe-sex education and injury prevention activities), secondary prevention tries to minimize the effects of a situation (such as diabetes education and mental health counseling).

Health Protection

Health protection refers to actions that protect people against health and safety risks. Science (providing evidence), surveillance (monitoring and forecasting health trends), risk management (assessing and responding to health risks), and program development (taking action) form the basis of health protection activities (Minister of Public Works and Government Services, 1999). These activities might include the development and enforcement of sanitary codes, especially related to food; the protection of drinking water; compliance with clean air standards; animal control; inspection of hygiene and sanitary practices in certain occupations; and testing and certification of drugs, medical devices and consumer goods.

The Aboriginal Community

When considering health promotion, prevention and protection services and programs, it is important to remember the nature and diversity of First Nations, Inuit and Métis people. There are more than one million Aboriginal people in Canada, representing a diversity of cultures, geographic areas and communities. In the 1996 Census, 1,101,960 people reported Aboriginal ancestry (3.9 per cent of the Canadian population), 799,010 (2.8 per cent) identified themselves as Aboriginal people. These figures are generally considered to be underestimates of the total population.¹

As well as sharing many common values and experiences, Aboriginal people embody about 50 culturally distinct groups. First Nations are the largest population grouping, followed by Métis and Inuit.

Aboriginal Group	Number*	%
Identify as First Nations	554,290	69%
Identify as Métis	210,190	26%
<u>Identify as Inuit</u>	<u>41,080</u>	<u>5%</u>
Total		100%

* Some Aboriginal people identify with more than one group.

Aboriginal people live in a variety of communities. Less than one-third now live in rural reserves, a little more than half live in urban areas and one-third live in rural areas other than reserves, often in isolated Northern communities. How many live in primarily Aboriginal communities and use Aboriginal services, rather than being assimilated into the general population, is unknown. The degree of mobility of Aboriginal people between urban and rural communities is high.

The specific demographics of the Aboriginal population have an impact on promotion and prevention issues. It is a population that is;

- young, requiring both greater efforts to promote health and prevent disease among children and youth and to ensure the conditions for health are established early:
 - 38 per cent of population is under the age of 15, compared with 21 per cent of the general Canadian population; and
 - 18 per cent are aged 15 to 24, compared to 13 per cent in the general population.
- rapidly growing, requiring careful planning to ensure that resources will be in place for a considerably larger population and making prevention of future health problems imperative:
 - the birth rate for First Nations people is twice that of the Canadian population in general;
 - projected population growth among First Nations between 1998 and 2010 is 28 per cent, or an additional 180,000 people (Assembly of First Nations, 2000); and
 - projected population growth among Inuit is 48 per cent between 1996 and 2016 (Inuit Tapirisat of Canada, 1999, cited in Archibald and Grey, 2000).
- aging, requiring the development of promotion/prevention programs for older people who likely will carry a large disease burden:
 - while not presently a large proportion of the population, the number of Aboriginal people over

¹ Population and demographic figures in this section are taken from various Statistics Canada sources. In most cases, these figures are considered to be underestimates.

the age of 65 is expected to triple between 1991 and 2016 (Health Canada, 1998).

- increasingly concentrated in urban and inner-city areas, but also living in rural and isolated locales, requiring a variety of promotion/prevention strategies and ones that address cultural plurality, mobility and poverty:
 - about one-fifth of Aboriginal people live in seven of the largest cities in Canada: Winnipeg, Edmonton, Vancouver, Saskatoon, Toronto, Calgary, and Regina;
 - Aboriginal children presently account for one in seven children (13 per cent) under age 15 in the cities of Regina and Saskatoon; and
 - Winnipeg is home to 46,000 Aboriginal people, more than the Northwest Territories and Nunavut combined.
- unevenly distributed across Canada, requiring different approaches and levels of services:
 - 63 per cent live in British Columbia, Alberta, Saskatchewan, and Manitoba;
 - six per cent live in the Yukon, Northwest Territories and Nunavut where they make up 48 per cent of the population; and
 - six per cent live in the Atlantic provinces where they make up 1.6 per cent of the population.

Issues and Dilemmas

All of these factors: the need to reclaim and redefine wellness, the many changes facing Aboriginal communities, the immediate importance of promotion and prevention programs, and the particular characteristics of Aboriginal populations pose particular challenges for Aboriginal and Aboriginal-serving organizations. Some of these are touched on in this paper, all of them deserve careful consideration in the development and improvement of Aboriginal health promotion and prevention. Some of these challenges are:

- How do organizations and communities set priorities:
 - among efforts to improve the determinants of health such as economic development, poverty reduction, environmental protection, and health services?
 - among the many pressing health and social issues?
 - between acute care and emergency response needs, and long-term health promotion and disease prevention?
 - among programs for children, youth, adults, and Elders?
- How can we balance the need to address urgent social and health problems with the need to focus on the future and on health and wellness?
- How can traditional Aboriginal as well as appropriate western knowledge of wellness be used to the best advantage?
- How can promotion/prevention programs reflect the diversity of Aboriginal cultures represented among urban Aboriginal people in particular?
- How can sparsely populated areas and Aboriginal people living and accessing services outside of established Aboriginal communities be served?
- How should organizations cope with rapid change and the need to grow and adapt while continuing to offer services?
- How do we decide how much energy to invest in building Aboriginal organizations (working internally) and improving links with, and responsiveness of, non-Aboriginal organizations?

This Paper

As a part of its strategic planning activities, NAHO requested a study to assist in identifying key issues of concern and recommendations for follow-up activities by NAHO to improve population health, health promotion, disease/injury prevention, and health protection services and programs for Aboriginal people. The questions that this paper addresses are:

- What is known about the delivery of population health, health promotion, disease/injury prevention and health protection services and programs for Aboriginal people across Canada?
- What issues and concerns have been identified related to the quality and adequacy of these services and programs?
- Are there equitable access to services and programs according to geographic area, on- or off-reserve status, type of community, etc.?
- Who is involved and what is being done to improve these services and programs?
- Given the areas of concern, involvement of other bodies, and NAHO's mandate, what could NAHO do to support the development of population health, health promotion, disease/injury prevention and health protection services for Aboriginal people?

Information sources for the study included:

- a search of published and unpublished Canadian documents addressing Aboriginal health issues and programs/services. Approximately 190 relevant documents were reviewed (see bibliography);
- an Internet search of Canadian governmental and non-governmental Web sites; and
- telephone or in-person interviews with 28 selected key informants.

Rather than an in-depth study or inventory of programs and services, the paper provides a general overview of the current situation for planning purposes. It drew heavily on existing research and reports as well as the expert opinion of people working at the national, provincial and territorial levels.

The remainder of the paper will:

- briefly examine critical determinants of health and prevention, promotion and protection issues of concern;
- describe the current delivery of programs and services;
- examine key issues in programming (gaps and challenges);
- recommend selected activities NAHO could undertake to improve prevention/promotion programming; and
- suggest some possible linkages with other organizations also working to improve promotion/prevention.

2. NEEDS AND PRIORITIES FOR PROMOTION AND PREVENTION

Numerous reports have documented the health status and disease/injury burden faced by Aboriginal people. Below are the key, currently-recognized and emerging promotion and prevention issues identified in the study. They are presented briefly below in order to provide a context for consideration of program and service gaps and needs for further action. Issues are not necessarily presented in order of priority.

Recognized Issues

Population Health (Determinants of Health)

Incomes and related social status of Aboriginal people remains low. In 1995, average employment income for Aboriginal people was \$17,382, compared to \$26,474 for Canadians in general. In 1997, the social assistance rate on reserves was 46 per cent, four times the Canadian rate. Almost one-third of Aboriginal children under aged 15 live in single-parent families with resulting low incomes – twice the Canadian rate (Health Canada, 1999b). In urban areas, more than half of Aboriginal children under 15 live in single-parent families (Statistics Canada, 1998). The **employment** rate remains unacceptably low. In 1997-98, the employment rate on reserves was about 71 per cent (29 per cent unemployment).

Poverty has far-reaching impacts on health and well-being.

Poverty affects the ability to eat nutritious food, fill prescriptions, travel to medical appointments, and participate in recreational activities. It is also linked with inadequate housing, which in turn is linked to diseases of the respiratory tract, the spread of infectious diseases, injuries, and violence.

(Smylie, 2001, p. 38)

While there has been some improvement in **education** over the last decade, high school and university graduation rates are lower than for the Canadian population as a whole. Only one-half of the Aboriginal population over aged 15 has a high school diploma, compared to two-thirds of Canadians.

Inadequate and insufficient **housing** are major concerns in Aboriginal communities. Indian and Northern Affairs Canada estimates that one in 10 (11 per cent) houses in First Nations communities is overcrowded, leading to poor health conditions, family tensions and violence. Overcrowding, along with inadequate ventilation and lack of maintenance results in poor indoor air quality and harmful mould growth. (Indian and Northern Affairs Canada, 2001b) About one in four (22 per cent) reserve dwellings had more than one person per room, compared to one per cent in the rest of Canada. Aboriginal people are at greater risk of homelessness (Health Canada, 1999b). The Assembly of First Nations has called for the immediate construction of 22,000 new housing units and considerable investment to bring housing up to the level of Canadians in general (Assembly of First Nations, 2001d).

The **residential school experience** is considered to have far-reaching direct and indirect effects on Aboriginal people. More than one-third of elderly respondents to the First Nations and Inuit Regional Health Survey had attended residential school. Jeff Reading and Brenda Elias, in an analysis of the data, proposed that residential schools have negatively affected the following health determinants: income, education, employment, social status, working and living conditions, health practices, coping skills, and childhood development. They recommend research to further examine the link between health status and psycho-social dislocation in areas such as resilience, parenting skill, social factors, family support networks, perceived advantages and disadvantages of old age, health and social services, mental health, and coping with change, poverty and other potential impacts (First Nations and Inuit Regional Health Survey National Steering Committee, 1999, p. 49).

Cultural loss is considered a significant determinant of health and well-being in the Aboriginal community. Positive cultural identity has been linked to resilience and mental health among minorities and community leaders are calling for the preservation of languages and a return to a more traditional way of life. More research is needed to establish direct linkages between cultural loss and poor health outcomes such as mental health problems, drug and alcohol abuse, and sexual risk taking.

It is thought that *environmental damage* affects Aboriginal people to a greater degree because of their close ties to the land, regular consumption of country food (wild game, food plants and medicinal plants) and the amount of time spent outdoors. Environmental contaminants in the air, water and soil pose direct threats to health, reduce the availability of traditional foods and medicines, and erode traditional ways of life. Contaminants have an even greater effect on children for various reasons (Ship, 1998c).

Health Promotion

Nutrition is recognized as a key health promotion issue in Aboriginal communities. An unbalanced diet and food insecurity (hunger), changes in diet from traditional to processed food, environmental contaminants, and nutritional deficiencies are linked to susceptibility to disease, poor pregnancy outcomes and mental health problems. Contributing factors are poverty, high food costs in isolated communities, loss of traditional food knowledge and traditional lifestyle, a move away from breastfeeding, and lack of physical inactivity and recreational opportunities. The related issue of *overweight*, especially the more risky fat centralization in the waist and hips, is emerging as a significant health problem among Aboriginal people (Health Canada, 1999b). Deficiencies in iron, calcium and vitamin D, as well as obesity are significant issues for children (Williams, 1999).

Low levels of *physical activity* are attributed to a more sedentary lifestyle, reliance on store-bought food, loss of traditional ways of life, and depression. Additional research is required in this area to document required levels of activity, preferred activities and interests, and barriers experienced to remaining active.

The prevalence of *smoking* among First Nations and Inuit is 62 per cent, twice the rate for Canadians in general. Rates among Inuit in Nunavut, Labrador, Nunavik, and the Northwest Territories are almost 2.5 times than for Canada as a whole (Archibald and Grey, 2000). Métis smoking rates are also known to be high. Research among First Nations and Inuit show that they started to smoke as early as six to eight years of age (Health Canada, 1999b). Tobacco use and exposure to second-hand smoke are known risk factors for lung cancer, cardiovascular disease, pregnancy complications, and sudden infant death syndrome (First Nations and Inuit Regional Health Survey National Steering Committee, 1999).

Little statistical information is available on *alcohol and drug abuse, and the use of solvents* among Aboriginal people, although there is significant concern about the issue in Aboriginal communities (First Nations and Inuit Regional Health Survey National Steering Committee, 1999; Aboriginal Peoples Survey, 1991). Similarly, fetal alcohol syndrome/fetal alcohol effects (FAS/FAE) is thought to be a significant problem, although research is incomplete. Parental alcohol abuse is a leading risk factor for child neglect and abuse (National Indian and Inuit Community Health Representatives Organization, 1997).

There is little detailed research regarding *mental health and wellness* among Aboriginal people (MacMillan, MacMillan, Orford, et al., 1995). Mental health promotion is an emerging field and Aboriginal communities are experimenting with means of improving mental health and reducing mental health problems. Research is needed on components of mental health for Aboriginal people, including cultural and spiritual aspects, effective approaches to promoting mental health and links to other health issues such as FAS/FAE, violence and unhealthy lifestyle choices.

A national *dental health* survey in the early 1990s showed that only half of Aboriginal children aged six to 12 had healthy gums and 91 per cent suffered from tooth decay. Baby bottle tooth decay was a prevalent condition (Leake, 1992). Dental problems can contribute to chronic infections and affect choice of and the ability to eat healthy food.

Disease/Injury Prevention

Aboriginal people in Canada have one of the highest accidental and violent death rates in the world. In 1992, deaths from *injuries* were higher than for heart disease, cancer or respiratory illnesses. Suicide, motor vehicle accidents, homicides, and drownings were the most common causes of injury deaths. The overall death rate among First Nations and Inuit from injuries and poisonings is up to 6.5 times that of the Canadian population in general (Health Canada, 1999b). Compared to a rate in Canada of deaths due to unintentional injury of 43 per 100,000 people, in Nunavik (Northern Quebec) it is 102, and in the Northwest Territories, it is 128 deaths. Rates for Métis are unknown. For every death from injury, there are an estimated 40 hospital admissions and 1,300 clinic or emergency room visits (McFarlane, 1997a). The contribution of intentional and unintentional injuries to high rates of disability and chronic diseases has not been fully explored.

Suicide in Aboriginal communities is considered by many to be a national crisis, with rates that vary from five to seven times the national average. Large variations in Inuit rates exist, with 94 deaths per 100,000 people in the Qikiqtani region of Nunavut, 82 deaths per 100,000 people in Nunavik in Northern Quebec and 77 deaths per 100,000 people in Nunavut overall (compared to 13 deaths per 100,000 Canadians in general) (Archibald and Grey, 2000). Figures are not available for the Métis. Suicide is the most common cause of fatal injuries among Aboriginal people.

Provide people with proper housing, water, sewage, jobs and the means to provide adequate food and the health status would improve. Suicide is a major problem, in part, related to the high levels of unemployment. We need to intervene before people attempt suicide and to work on prevention.

(Quoted in Archibald and Grey, 2000)

The precise extent of *family violence, child abuse and sexual violence* in Aboriginal communities is unknown, but is thought to be of serious proportions. An analysis by the National Clearinghouse on Family Violence (1997) estimated that at least three-quarters of Aboriginal women have been victims of family violence, and up to 40 per cent of children in some Northern communities have been physically abused by a family member. Family violence has been linked to unemployment, overcrowded housing, and alcohol and drug abuse (National Indian and Inuit Community Health Representatives Organization, 1997) and has a significant long-term impact on health status.

Self-reported prevalence rates for chronic conditions such as *diabetes, cardiovascular disease, cancer, hypertension* and *arthritis/rheumatism* among First Nations and Inuit are all higher than the Canadian average. Chronic health problems are widespread among First Nations and Inuit elderly, are more prevalent among women than men, and increase with age (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). Known risk factors are primarily related to exercise, diet and use/exposure to tobacco smoke.

Diabetes was virtually unknown in Aboriginal communities 50 years ago and is now a leading cause of disability and death. The prevalence rate of diabetes among First Nations and Labrador Inuit is three times that of the Canadian population in general. Currently, one in three Elders over age 65 have diabetes and with no intervention, more than one-quarter of First Nations adults are expected to have diabetes within 20 years. According to a Health Canada source, more than 90 per cent of First Nations adults with diabetes will undergo lower limb amputations and more than half will be hospitalized with heart problems (Health Canada, 1999a; Health Canada 2000b).

The present risk of *cancer* of the breast, colon, lungs, and prostate are lower in Aboriginal people than Canadians in general. However, increases in cancer rates are predicted. Lung cancer incidence already is increasing in some areas. Cervical cancer incidence and death rates among Aboriginal women is high and

screening rates are low (First Nations and Inuit Regional Health Survey National Steering Committee, 1999). Inuit have higher rates of lung and throat cancer than other Aboriginal people. No information is available for Métis.

A number of issues relate to **pre-natal and infant health**. About 15-23 per cent of First Nations babies have high birth weights, which can be associated with birth injuries, developmental problems, gestational diabetes, maternal overweight, and prolonged gestation. Low birth weight is an issue among low income, at-risk and marginalized women. Infant mortality is twice the Canadian rate and sudden infant death syndrome (SIDS) is more common among Aboriginal infants. Aboriginal infants have a lower rate of breastfeeding (Health Canada, 1999b).

The **teen pregnancy** rate is increasing dramatically and is a new concern because personal mobility, family separation and changes in community structures provides far less support to young parents than before. Pregnancies among young Aboriginal teens (under aged 15) are 18 times more common than in the Canadian population.

High prevalence rates of infectious diseases including **hepatitis A, B and C, gastroenteritis, meningitis, gonorrhea** and **chlamydia** have been reported in Aboriginal people. Childhood **vaccination** rates may be considerably lower than for the Canadian population. First Nations children have higher rates of respiratory tract infections (**bronchitis, pneumonia and croup**) as well as **severe otitis media** (ear infection that often leads to hearing loss) (Several authors cited in Smylie, 2001). Suggested increased risk factors include nutritional problems, poverty and crowding, tobacco smoke, and wood fire smoke (MacMillan, MacMillan, Orford, et al., 1996).

Sexually transmitted infections are a particular concern, especially in the North. For example, rates of chlamydia and gonorrhea were 15 and 25 times the national rates between 1989 and 1998 (Nunavut Health Status Report, 2000, cited in Smylie, 2001). Sexually transmitted infections can lead to increased reproductive health problems, including infertility and increased risk of cervical cancer.

HIV/AIDS is a growing problem in the Aboriginal community. Aboriginal cases represented 15 per cent of total cases even though the Aboriginal population was three per cent of the Canadian population in 1999 (Health Canada, 2000a). Aboriginal people represented 26 per cent and 43 per cent of new HIV positive cases in Alberta and Saskatchewan in 1997. Aboriginal people are diagnosed, and therefore likely are contracting the disease, at an earlier age.

The incidence rate for **tuberculosis** among First Nations on reserve declined between 1991 and 1996, but remained more than six times that of the non-Aboriginal population. Rates in 1999 were 18 times higher than the Canadian-born, non-Aboriginal population (Health Canada, 1999b).

Health Protection

Aboriginal people, particularly children, have significantly higher incidence of **water-borne diseases** compared to the general population. The Canada food/water-borne illness rate is 97.8/100,000, in Nunavut it is 291, in Kivalliq region it is 408 (Archibald and Grey, 2000). Rates are not available for Métis. Contaminants in drinking water can include organisms such as giardia, salmonella and E. coli bacteria, dissolved metals, other compounds, pesticides, and industrial chemicals. Sources of contamination include human sewage, agricultural runoff, industry, mining, pulp and paper mills, and flooding (Bethunes, 1998).

Walkerton made the news across Canada, but about one out of eight of our Aboriginal communities are threatened by unsafe water which each year kills our newborn and elderly. These deaths don't make the front pages of Canadian newspapers. But I still remember when eight children died from gastro-enteritis on one season in my communities in James Bay. That was caused by contaminated water.

(Assembly of First Nations, 2001e)

A 1995 Indian and Northern Affairs Canada (INAC) study found that one in four (24 per cent) water systems and one in five (20 per cent) sanitation systems in First Nations communities are substandard (Ship, 1998c). In July, 2001, 47 First Nations communities were under boil water advisories (Hutchinson, 2001). In 1999, 22 per cent of respondents to the First Nations and Inuit Regional Health Survey believed no progress had been made in improving water and sewage systems on reserve (First Nations Regional Health Survey National Steering Committee, 1999).

Some efforts have been undertaken by the Department of Indian Affairs and Northern Development to improve water safety in Aboriginal communities through infrastructure development, upgrading of water treatment facilities and increased training in many communities, as well as efforts in local communities to improve sanitation and decrease contamination. However, more needs to be done to broaden safety efforts and ensure all First Nations communities are protected from water-borne health hazards (Bethunes, 1998; Hutchinson, 2001; Assembly of First Nations, 2001b).

Environmental research in the North, around the Great Lakes in Ontario and on the St. Lawrence Seaway have uncovered **environmental contamination** of many communities, often not identified until the community initiates an investigation. For example, a recent study in Ouje Bougoumou, a Cree community in Northern Quebec, has found high levels of arsenic, cyanide, lead, mercury, and other heavy metals as a result of mining in the area. The lead researcher compared findings to that of the Love Canal in New York State (Dougherty, 2001). Inuit women have the highest levels of polychlorinated biphenyls (PCBs) in breast milk, due to consumption of seal and walrus fat. According to Ship (1998b), the precise implications (of PCBs) for the health of the mother and the infant are unclear, as there is very little research on this

(P. 9). Increased monitoring, advisories on unsafe food and water and further research on long-term effects of environmental contaminants throughout Canada are needed.

Emerging Issues

A number of emerging health issues have arisen in consultations with Aboriginal people, exploratory research studies and interviews with key informants. These are listed briefly below.

- **New cancers** are a concern. Continuing increases in lung cancer are expected as a result of smoking and exposure to second-hand smoke. Reproductive cancers likely will increase as a result of high levels of sexually transmitted diseases.
- **Nutritional status** among Aboriginal people may continue to deteriorate as a result of overall unhealthy lifestyles, poverty and increasingly western diets. Poor nutrition is resulting in vitamin and mineral deficiencies, overall lack of wellness, and lack of resistance to disease. While pre-natal and infant nutrition is being addressed to some extent, adult nutrition has not been a focus in programming.
- With migration to cities, more sedentary lifestyles and an aging population, **growing levels of physical inactivity** will contribute to more health problems.

- If diabetes, accidents/injuries and violence continue unchecked, levels of *disability* will climb.
- Comprehensive approaches to *sexual health* (encompassing sexuality education, healthy sex roles and relationships, acceptance of sexual diversity and disease prevention) have yet to be developed in Aboriginal communities.
- There is a need for renewed, integrated and holistic approaches to *substance abuse*.
- *Occupational health* issues are receiving new and needed attention. Many Northern residents have been exposed to chemicals used in mining. Forestry occupations may involve exposure to pesticides and outdoor occupations in general involve increased exposure to environmental contaminants.
- *Community violence* (child and youth bullying, sexual assault, intimidation, retaliation, etc.) is seen as an issue that has not received as much attention as family violence.
- *Problem gambling* is identified as an addiction affecting some Aboriginal people. Compulsive young gamblers are a particular concern.

3. CURRENT DELIVERY OF PREVENTION PROGRAMS AND SERVICES

Overview

The delivery of promotion and prevention services and programs in Aboriginal communities is characterized by a diversity of approaches. While many innovative programs have been developed, most efforts do not yet reflect a conscious Aboriginal world view. Separate, issue-oriented programs make it difficult to address health in a holistic way. On the other hand, Aboriginal communities often create community-based programs that build on connections among issues and are multi-dimensional.

Virtually all health services (Aboriginal and non-Aboriginal) struggle to maintain a focus on and dedicate resources to promotion and prevention. Competition with acute care needs, shortages of staff and high turnover, community preferences for higher-quality treatment services, and the long-term investment needed for effective promotion and prevention are some of the barriers to success.

Many communities also have questioned whether a balanced enough approach is being taken to changing the conditions in which Aboriginal people live compared to promoting lifestyle changes among individuals.

Aboriginal Control of Programs and Services

Aboriginal communities and organizations are slowly gaining greater control of programs and services. The federal government has been negotiating varying degrees of transfer of responsibility for existing health services with First Nations and Inuit community bodies, and urban Aboriginal organizations are securing funding for health and wellness programs. As of March 2001, 83 per cent of First Nations communities were involved in the federal transfer process: 269 First Nations communities had community-based transfer agreements (responsibility for the planning and administration of health programs), and another 141 had community-based health services contribution agreements (management of specific health programs under one contribution agreement) (First Nations and Inuit Health Branch, Health Canada, 2001). Promotion/prevention programs able to be transferred include community nursing, community health representatives, health education, nutrition, environmental health services, alcohol and

drug abuse prevention, and prenatal nutrition. Communicable disease control, environmental health and medical officer of health services are mandatory.

Transfer has the potential to allow shifts in resources in communities to a more preventive, holistic, culture-based approach, however, the nature of funding agreements, funding levels and the high level of acute care needs in communities are barriers to this evolution.

Land claims agreements have resulted in greater control of health programs for some Nations. The *James Bay and Northern Quebec Agreement* of 1975 was the first such agreement that led to the creation of the first First Nations/Inuit health board. Since then, more than 80 self-government agreements have been signed, with a variety of arrangements for the planning and delivery of health programs. The creation of Nunavut in 1999 is also a significant development as that agreement led to control for Inuit of all health programs and services through the creation of a new territorial government.

Some Métis organizations in the western provinces and Ontario have been successful in negotiating funding agreements for specific services related to family and children's services, long-term care and some preventive health issues. However, Métis organizations have not yet been successful in negotiating land claims and self-government or establishing the authority to deliver comprehensive health services to the Métis population.

First Nations and many Inuit communities are in a time of rapid change in the authority and degree of responsibility for the delivery of health programs, including promotion and prevention programs. There is wide interest in developing programs that are culture-based and appropriate to the communities served. There also is concern that adequate planning and capacity building is not being undertaken to ensure that programs are effective, or that funding arrangements are conducive to effective planning and management. Most Métis and non-Status First Nations communities are in the beginning stages of developing health programs.

Inuit, Métis and First Nations Services and Programs

Inuit Services and Programs

Inuit live primarily in coastal communities in the Northwest Territories, Nunavut, Quebec and Labrador, and in a few southern urban centres. Health services for Inuit fall under the jurisdictions of the Canadian, Quebec, Northwest Territories and Nunavut governments. According to a study by the Inuit Tapiriit Kanatami (formerly Inuit Tapirisat of Canada), and similar to many other isolated or remote Aboriginal communities, a number of factors affect the delivery of health services in the North:

- the population is sparse and widely dispersed, with no health infrastructure comparable to southern areas of Canada;
- a high percentage of the population is Aboriginal, but the reserve system does not exist;
- historically, territorial governments have not had the capacity to provide comprehensive health care services to their residents;
- there has been a gradual devolution of health care services from the federal to the territorial government level;
- land claim and self-government agreements such as the *James Bay and Northern Quebec Agreement* and the *Nunavut Land Claim Agreement*, which include the provision of health care, have been negotiated in several areas; and
- due to the large percentage of young people, and projected large population growth, overcrowded housing and unemployment can be expected to grow dramatically (Archibald and Grey, 2000).

Health-related programs are delivered by a number of different non-Inuit and some Inuit organizations,

such as hamlet councils, women's groups, churches, friendship centres, and government agencies. In the Northwest Territories and Northern Quebec, health and social services are delivered by regional health and social services boards. In Nunavut, services are delivered by regional offices of the Department of Health and Social Services. Health services in Labrador are delivered through the regional Health Labrador Commission, although the Labrador Inuit Health Commission provides public health services in the region.

Most Inuit communities have minimal health services: usually a health centre that may only be staffed by one or two non-Inuit nurses who operate under expanded practice guidelines that allow them to undertake activities usually beyond the role of the nurse. Physicians and regional hospitals can be found only in several larger communities.

Prevention and promotion programs may be sporadic and/or external to the community (e.g. a traveling mental health worker), occasional violence or suicide prevention programs, church-based counseling, etc. Many Inuit communities take advantage of short-term federal promotion/prevention programs such as pre-natal nutrition, tobacco reduction, HIV/AIDS, etc. In general, services are delivered within a western model, even though there is a strong desire for services based on Inuit Qaujimajatuqangit (IQ or Inuit knowledge).

Until Inuit values, approaches and perspectives are incorporated into health and social services, it is difficult to imagine the system enhancing the mental health and well-being of Inuit individuals and communities.

(Quoted in Archibald and Grey, 2000)

Métis Services and Programs

The Métis population in Canada is estimated at 250,000 to 300,000 people (Métis National Council), mostly settled in the western provinces and Northern Ontario. In the 1996 Census, about one-quarter of Aboriginal people identified as Métis. Sixty-five per cent of Métis people live in urban areas (Royal Commission on Aboriginal Peoples, 1996): the cities of Winnipeg, Edmonton and Vancouver have the highest population concentrations. Very little socio-demographic information is available on the Métis, making them the least documented Aboriginal group. (Limited information on demographic characteristics, socio-economic status, family status, culture, education, labour force characteristics, income, housing, and health was collected during the 1991 Aboriginal Peoples Survey.) (Statistics Canada, 1996)

Most Métis access mainstream health services provided by local health organizations and provincial or territorial governments, as well as Aboriginal health centres and programs. It is widely believed that Métis underutilize these services. It is unknown to what extent these services are meeting Métis needs or whether they are being reached by prevention and promotion programs.

Community Métis organizations such as Métis community councils in Ontario, Métis settlement organizations in Alberta, Métis Child and Family Services in Manitoba and Alberta, and the Saskatchewan Métis Addiction Society have become more active in health issues in recent years. A number of Ontario Métis community councils have initiated wellness programs with funding from the Ontario Aboriginal Healing and Wellness Strategy. Provincial Métis and Métis women's organizations, the Métis National Council, and the Métis National Council of Women have been or are becoming more active in the areas of family violence, HIV/AIDS, diabetes prevention, and child, youth and Elder health.

Compared to services and programs for Inuit and First Nations populations, Métis health promotion, prevention and protection services and programs are in the beginning stages of development. Neither the federal nor the provincial or territorial governments has assumed responsibility for providing health

services to Métis people. No level of government has developed a policy or strategy for addressing Métis health needs. National and provincial/territorial Métis organizations lack sustained funding for a health program and there is little progress in the devolution of Métis health funding to Métis organizations.

Métis Nation of Ontario Health Program

The Métis Nation of Ontario has an established health program. Its purpose is to facilitate and co-ordinate effective activities to address the holistic needs of the Métis Nation in Ontario at the provincial, regional and local levels. Activities include a long-term care program operating in 11 communities, a diabetes initiative, a gambling strategy, and a provincial health liaison position that supports healing and wellness activities in local community councils that receive funding from the Ontario Aboriginal Healing and Wellness Strategy. Capacity building in communities, advocacy and policy development also are priorities for the provincial program.

(Métis Nation of Ontario, 2001; personal communication with R. Wraith)

First Nations Services and Programs

First Nations communities benefit from the most comprehensive health programs among Aboriginal People, but one that is based on a complex and multi-faceted funding system, depending on community size and degree of isolation, as well as level of organization/self-direction and identified needs. There is a wide diversity in levels of development of programs and adequacy with which community needs are met. Health-related programs for registered First Nations are funded and, in many cases, administered by Health Canada. Indian and Northern Affairs Canada plays a significant role in addressing health determinants such as education, employment and housing.

Community-based health services usually include community nursing and community health representatives, with traveling or adjacent physician services. Promotion and prevention programs are most often delivered by First Nations organizations such as band or tribal councils, health centres, family and children's services, etc. Off-reserve programs may be delivered through Aboriginal or non-Aboriginal organizations such as Aboriginal and community health centres, friendship centres and youth programs.

The Assembly of First Nations identified seven health priorities for 2001/02, most of which relate to health promotion and prevention:

- building and sustaining health and health care systems, including addressing inequities and gaps;
- human resources, capacity building and training including capacity in basic health administration at the regional level, training funds for emerging health careers, and development of standards of practice;
- a comprehensive health research and infostructure;
- resolution of existing jurisdictional matters;
- establishment of a national mental health program, community-based suicide prevention and training;
- a comprehensive child health policy including nutritional health promotion and related disease prevention, safety and mental health, and children's programming at the community level;
- early screening for cancers;
- smoking prevention and promotion related to second-hand smoke; and
- greater awareness of the state of water systems and recognition of mould as a public health crisis.

(Assembly of First Nations, 2001c)

Regional and Community Programs

With the exception of some national, provincial and territorial education campaigns and co-ordinating efforts, virtually all prevention, promotion and protection programs are delivered at the community level. A particular community will be served by a variety of governmental and non-governmental services and programs that are often funded by different federal, provincial or territorial programs. Promotion/prevention efforts likely are not part of a comprehensive strategy or long-term plan, but responsive to emerging needs and available funding. Promotion/prevention activities are carried out in the course of health care providers' regular contact with clients, through specific projects and outreach activities initiated by an organization or a community-generated, volunteer effort, or through a government service. Aboriginal organizations most likely to deliver programs are band and tribal councils, Métis community councils, Inuit hamlet offices, health centres, friendship centres, and women's and youth organizations. Initiatives may be co-ordinated by or linked to a provincial or regional organization such as a First Nation tribal council, regional Inuit organization or Métis provincial organization.

Targeted federal funding programs related to diabetes, pre-natal nutrition, early childhood development and injury prevention support a substantial proportion of Aboriginal prevention and promotion efforts in the community, through transfer agreements, one-time project grants and longer-term funding. Communities have mixed feelings toward targeted programs and a number of problems in administration of programs have arisen. Many would prefer to have access to block funding, or at least a more seamless, flexible and sustained funding system.

Many different people might deliver health promotion/prevention programs in an Aboriginal community. Providers include community health representatives, community health nurses, health educators, health promoters, community developers, wellness workers, physicians, nutritionists, dieticians, medical health officers, drug and alcohol counsellors, public health inspectors, environmental health officers, traditional health practitioners, family support workers, social workers, and mental health specialists.

Suicide Prevention

An innovative suicide prevention project is the Deana Don't Do It project. The project was developed through a partnership between the Peekiskwetan Let's Talk Society and the community of Desmarais, Alberta. Instead of presenting suicide facts on paper, project staff taped a call-in show whose topic was teen suicide. Aboriginal performers help to identify and explain youth suicide within the talk show format.

(McFarlane, 1997b)

Non-Aboriginal organizations also deliver either targeted or general programs to an unknown number of Aboriginal people. Some key providers are: regional health authorities; government children's, family and social services; municipal public health units; community health clinics; private physicians; family resource centres; and women's centres. A full range of prevention and promotion issues are addressed: pre-natal health, sexual health, diabetes education, tobacco reduction, cancer prevention and screening, mental health, child and family services, and protection programs such as environmental monitoring, drinking water quality, etc.

The methods of delivery, management and accountability, and issues addressed literally are unique to every community and ever changing. The strength of this approach is that programs can be directed to community priorities, growing capacity and changing awareness of needs. Different approaches can be geared to particular groups (e.g. youth, young mothers, isolated Elders, etc.) and therefore be more effective at reaching that group. Weaknesses can include fragmented, short-term efforts; a lack of a holistic, integrated approach; and programs based on available funding rather than community priorities. The program described below is an example of a strong integrated approach to promotion and prevention.

Aboriginal Health and Wellness Centre of Winnipeg

The Aboriginal Health and Wellness Centre is a multi-service urban health centre in Winnipeg, Manitoba. The Centre was launched and in operation by the summer of 1994 after a year of planning and the development of the first federally-funded program. Achieving core provincial health program funding required significant community and provincial health staff effort between 1993 and June of 1997. Presently, it receives funding from Health Canada, Manitoba Health, Healthy Child Manitoba, the Aboriginal Healing Foundation, and the United Way of Winnipeg. Thirty of 32 staff are Aboriginal including nurses, physicians, family support workers, counsellors, and traditional healers.

The Centre utilizes a Medicine Wheel Life Promotion Framework (developed by a founding board member Dr. Judith Bartlett) based on the seven sacred teachings and four directions. Centre programs seek a balance between western medicine and an Aboriginal world view of health and wellness. Because Centre activities are guided by the Medicine Wheel, they are health rather than illness-based and holistic in recognizing the importance of the wholeness of life that encompasses an individual's innate nature (whether spiritual, emotional, physical, or intellectual), their identity, and life stage. Important also for holism is the ability to have a voice (hearing and being heard) in order to access and maintain quality relationships, networks and support systems. Finally, holism encompasses an ability to understand how the cultural, social, economic, and political environment both affects one's life and can be influenced. As a result, all programs are life promotion focused and include the Wellness Program (primary care and clinical services, an onsite traditional healer, a healthy woman and healthy child program, and outreach services, all delivered within a Medicine Wheel framework), a family support program, a men's healing program, HeadStart early childhood education program, a fetal alcohol program and a diabetes outreach project. The Centre has been well received in the community, serving an increasing number of First Nations and Métis people of all ages.

(Aboriginal Health and Wellness Centre, 2000; personal communication with J. Bartlett)

Regional Health Structures

A significant change to the delivery of health services in Canada occurred in the 1990s. Federal, provincial and territorial governments (with the exception of Yukon, Nunavut and New Brunswick in the case of public health services) devolved greater responsibility for planning, allocation of resources and delivery of programs and services to regional governmental and non-governmental structures. In most provinces, these regional bodies are autonomous organizations (health authorities or boards of health) with elected and/or appointed governors. Regional Aboriginal health authorities are also becoming more common (though even less documented) throughout Canada.

There has been concern that prevention and promotion programs in general, as well as Aboriginal health needs, are being overlooked in the competition for scarce resources, and that Aboriginal people are not well represented in the decision-making process in regional authorities. At the least, there is general agreement that attention to Aboriginal health needs within regional structures has been uneven. Some

provinces have allocated one or more Aboriginal positions on the boards, however, positions often have been difficult to fill, Aboriginal members feel isolated and overburdened, cultural differences pose barriers and tensions can arise over allocation of resources and inter-jurisdictional conflict.

There also is concern that resources and decision-making power is not being equitably distributed. For example, in Manitoba, the City of Brandon with a population of 42,000 has a regional health authority, while Winnipeg's Aboriginal population of 46,000 is served by the Winnipeg Regional Health Authority, with minimal Aboriginal representation.

Labrador Inuit Health Commission

A regional Inuit organization has been successful in obtaining funding to provide health promotion and prevention programs to its members. The Labrador Inuit Health Commission (LIHC) was formed in 1985 by the Labrador Inuit Association to address health issues for the 5,000 Inuit residents of Labrador. Its philosophy is based on the belief that health is influenced by a complex array of social, environmental and economic factors, and that better health can only be achieved by health education, and community involvement and consultation.

LIHC receives funding through a transfer agreement with the federal government and through contribution agreements for specific projects. Over the years, it has successfully advocated for and received funding for an alcohol and drug abuse program, interpreters/translators and a community health representative program for Inuit.

Through four local offices and a head office in Nain, it provides a wide range of programs in six core areas: environmental health, mental health, addictions, community and communicable disease, childcare, and home and continuing care. It works closely with the Health Labrador Commission, the regional authority that provides primary and acute care services.

(Archibald and Grey, 2000; Blaikie, 2001)

A growing number of Aboriginal health authorities play a variety of roles: advisory bodies to provincial governments, planning bodies for Aboriginal services in a region, and funding allocation or program delivery organizations. For example, five Aboriginal health-planning authorities in Ontario are responsible for local planning of community health programs and services, although each has taken a unique approach. Some issues that have been identified concerning Aboriginal health authorities in general are: the degree of autonomy from funding bodies, confidentiality in health information, adequacy of resources and gaps in capacity for strategic planning.

Provincial and Territorial Government Programs

The provinces and territories have taken on different levels of responsibility for Aboriginal health promotion and protection programs, which range from comprehensive strategies and dedicated funding mechanisms to limited or no specific programming. Since they are the jurisdictions serving the greatest proportion of Aboriginal people, approaches and programs from the Northwest Territories and Nunavut are of particular interest and are described below. Specific initiatives from British Columbia and Ontario also are highlighted.

Government of the Northwest Territories

Among the provinces and territories, the Northwest Territories has the second largest proportion of Aboriginal people in its population, 48 per cent, or 19,000 people (based on 1996 Census data). The territorial government provides health and social services to First Nations, Inuit and Métis people living primarily in small remote communities.

The territorial government has adopted a broad population health approach with a stated emphasis on health promotion and prevention. *Shaping Our Future: A Strategic Plan for Health and Wellness* in 1998 indicated the importance of dealing with root causes of health and social problems, and the promise of greater emphasis on health promotion, disease prevention and early intervention programs (Northwest Territories Health and Social Services, 1998). A Health Promotion Strategy was created in 1999 to provide a more detailed framework for increased investment in promotion and prevention activities. Three priorities for action were established: active living, healthy pregnancies and tobacco-harm reduction and cessation (injury prevention was added in 2000). Knowledge of tradition and a holistic approach are two of the five principles of the strategy (Northwest Territories Health and Social Services, 1999). However, like most other jurisdictions, the Northwest Territories struggles to make prevention and promotion a priority in a fiscally-restrained environment.

Inter-departmental co-operation is crucial as environmental protection (issues such as rabies control and environmental health risk assessment) is primarily a responsibility of the Department of Resources, Wildlife and Economic Development, and water treatment and waste disposal are under the responsibility of the Department of Public Works and Services.

Using a regionalized structure, the Department of Health and Social Services works with nine health and social services boards, including the Lutsi Ke Dene Band Council, Deh Cho Health and Social Services and the Dogrib Community Services Board. They offer programs and services in family support, child protection, public health, home care, independent living, community wellness, environmental health, and uninsured services. The regional and community boards plan and manage promotion and prevention services, which are delivered primarily by community health representatives, community health nurses, social workers, and increasingly, home support workers as a part of an integrated team. In some cases, partnerships are formed with Aboriginal organizations for the delivery of programs.

Promotion and prevention programs draw heavily on federal-funding sources such as Aboriginal HeadStart, Canada Pre-natal Nutrition Program, Better Beginnings, Brighter Futures, and the Population Health Fund. However, problems have arisen in combining on- and off-reserve funding sources for community-wide programming. Targeted one-time project funding can create problems in building sustained, long-term prevention efforts.

With 30 per cent of the population under 15 years of age (twice the Canadian proportion) and a high birth rate, the Northwest Territories emphasizes programs directed at pregnant women, children and youth. However, multiple federal and territorial-funding sources, most of which are targeted at particular issues and are short-term, make sustained community development difficult.

Staffing issues present challenges in delivering programs.

Shortages and high turnover places the system under a great deal of stress. While some staff are experienced, many are new to the job or community. New staff need time to adjust to their work environment and community to do their best work. Continual turnover means remaining staff must carry a higher work load....

(Northwest Territories Department of Health and Social Services, 2000, p. 5)

British Columbia Aboriginal Health Division

British Columbia is home to 139,655 Aboriginal people (1996 Census figures), the second largest provincial/territorial population after Ontario. The Aboriginal Health Division works to facilitate individual, organizational and community awareness, support and capacity to improve health status and health services for Aboriginal people. It has 10 staff including an Aboriginal Negotiations Manager involved with treaty negotiations and co-ordination with regional health authorities, and three provincial co-ordinators involved with Aboriginal health issues in each of three regions. The Division manages a small budget of \$10 million in dedicated funding for Aboriginal-specific programs such as women's health education, FAS/FAE education/intervention, HIV/AIDS projects, mental health outreach, four urban Aboriginal health centres, and six regional Aboriginal health councils.

Co-ordinated by the Aboriginal Health Division, the province is developing a Provincial Aboriginal Health Services Strategy (PAHSS). Improving health for Aboriginal people was identified as one of six provincial health goals in 1997. There was recognition that program development and objectives must take place with the involvement of Aboriginal health stakeholders and political organizations. PAHSS is being developed over three years (2000/03) by a multi-stakeholder steering committee and involves capacity building and consultation with First Nations and Métis communities, development of resource materials and information sharing. While initially its focus is on access to health services and a meaningful role for Aboriginal people in health care decision-making, the Strategy intends to address prevention and promotion in the future.

The Division has hosted two provincial meetings for Aboriginal governors in regional health authorities to identify issues and make recommendations. An Aboriginal Governors Working Group produced a report containing 50 recommendations to strengthen the involvement of Aboriginal people in regional authorities and improve their ability to address Aboriginal health. The recommendations were accepted by the Ministry of Health (MOH). These resulted in the requirement that health authorities have a minimum of two Aboriginal governors and to develop Aboriginal health plans in collaboration with Aboriginal communities. The MOH is considering ways for Aboriginal people to participate in community-level health delivery organizations.

(British Columbia Ministry of Health, Aboriginal Health Division, 2001)

Government of Nunavut

Nunavut is home to an estimated 28,000 people, 85 per cent of whom are Inuit. Nunavut had the highest provincial/territorial population growth rate in Canada in 2000/01, mainly driven by high fertility rates as well as some migration of people from other provinces and territories (Statistics Canada, 2001), with an estimated 13 per cent increase in population since the 1996 Census.

Nunavut is Canada's newest territory, formed in 1999 as a result of the 1993 Nunavut Land Claims Agreement. While the agreement gave Inuit the right to self-government, residents chose a public rather than self-government structure for the territory's Inuit and non-Inuit residents. Nunavut embodies a new vision of government:

... Nunavut incorporates Inuit values and beliefs into a contemporary system of government. Its working language is Inuktitut, but other languages used in government are Inuinnaqtun, English and French. Inuit culture is promoted through the Department of Culture, Language, Elders, and Youth which plays a key role in helping all departments develop and implement policy reflective of Inuit values.

(Government of Nunavut, 2001b)

The mission of Nunavut Health and Social Services is to promote, protect and enhance the health and well-being of all Nunavummiut incorporating Inuit Qaujimajatuqangit (Inuit knowledge) at all levels of service delivery and design. One of the goals is to deliver flexible, culturally-sensitive programs (Government of Nunavut, 2001a). The department provides a broad range of services including primary and acute health care, child protection, family services, mental health, health promotion and protection, and injury prevention. Services are provided by the territorial government through community health centres, social services offices, and drug and alcohol treatment centres. Since the dissolution of regional health boards after Nunavut was formed, local government councils provide advice and guidance to the Department regarding local health issues and planning for their own wellness activities. The Government of Nunavut also administers a number of Health Canada programs for First Nations and Inuit. Health protection programs and services address threats to health presented by communicable diseases, including sexually transmitted diseases, tuberculosis, hepatitis B, trichinosis and environmental concerns such as air, soil and water contamination.

Ontario Aboriginal Healing and Wellness Strategy

The Ontario Aboriginal Healing and Wellness Strategy is unique in Canada due to its breadth of programming and joint management with Aboriginal organizations. Implementation began in 1994/95 as a partnership between 15 First Nations and Aboriginal organizations, the Ministry of Health, Ministry of Community and Social Services, Ontario Native Affairs Secretariat and the Ontario Women's Directorate. Funding in 2000/01 was \$33 million, directed toward on- and off-reserve health programming and family violence prevention and intervention. The Strategy also funds the operation of 10 community health access centers that offer culturally sensitive and appropriate primary health care and a wide range of prevention and promotion programs. Other allocations support 125 community prevention and health promotion workers in 105 communities, crisis intervention teams in 47 First Nation communities and 30 urban communities, and 14 health outreach workers in areas without an Aboriginal health center. As well, nine health liaison positions in provincial Aboriginal organizations and five Aboriginal Health Planning Authorities are supported. In addition to these permanent allocations, a Community Support Funding Program contributes to specific programs and proposals that support healing and wellness and increase capacity.

While the program is not without controversy in its ability to fairly allocate resources and address needs across the province and across Nations, it is supporting culture-based health programming with a significant prevention/promotion component. Traditional healing, inclusion of Elders and community participation are strongly encouraged. Strengths include joint management between government and Aboriginal organizations, the transfer of skills to Aboriginal communities and truly community-based initiatives.

(Aboriginal Healing and Wellness Strategy, 2001; personal communication with M. Harding)

Federal Government Programs

Two branches of Health Canada are involved in health promotion, prevention and protection programs for Aboriginal people in Canada. As well, Indian and Northern Affairs Canada (INAC) and Canada Mortgage and Housing Corporation (CMHC) address health determinants such as economic development, education and housing.

Health Canada

The vast majority of health programming is directed toward registered First Nations and Inuit through the First Nations and Inuit Health Branch (FNIHB), formerly Medical Services Branch. More limited targeted programs for off-reserve and Métis communities are provided through the Population and Public Health Branch (PPHB).

FNIHB has as one of three designated activities the provision of community-based health promotion and prevention programs on-reserve and in Inuit communities. The other activities are the provision of non-insured benefits (such as dental care and mental health services) and the provision of primary care and emergency services, as well as support for the transition to increased control and management of these health services by First Nations and Inuit communities themselves.

The federal government introduced new funding initiatives for First Nations and Inuit health in 1999 (\$190 million over three years) to be developed with First Nations and Inuit participation: a home and community care program (with some prevention content, although this is not the main focus), a First Nations Health Information System, expansion of the Canada Pre-natal Nutrition Program and an Aboriginal Diabetes Strategy. As well, the federal government's response to the Royal Commission on Aboriginal Peoples, Gathering Strength Canada's Aboriginal Action Plan, included \$350 million in funding for the Aboriginal Healing Foundation (responding to the legacy of abuse in residential schools), an expanded Headstart Program (preschool education centres), a Housing Innovation Fund, additional water and sewer projects, and support for NAHO.

Some of the main Health Canada programs that contribute to community promotion/prevention programs include:

- Community Health Representatives Program which supports over 900 Aboriginal health workers employed by 577 bands and Inuit organizations;
- National Native Alcohol and Drug Abuse Program (NAADAP) which supports community addictions workers and the National Addictions Awareness Week, as well as projects to improve administration and support for addictions workers;
- Aboriginal Diabetes Initiative (\$58 million over five years, a component of the National Diabetes Strategy) which funds culturally appropriate prevention, education, treatment and care, and lifestyle supports and surveillance. There is an on- and off-reserve component;
- A Healthy Start □ Prenatal Nutrition (a component of Canada Prenatal Nutrition Program) intended to improve health outcomes for on- and off-reserve pregnant women, mothers and infants. The programs were expanded in 1999, and over 400 community projects have been funded. Fetal alcohol syndrome/fetal alcohol effects is a new priority;
- Indian and Inuit Childhood Injury Prevention Program which encourages the development of community action projects likely to reduce the number of injuries in Native communities;
- Aboriginal HeadStart, an early intervention program for pre-school Aboriginal children. In 1999/2000, 156 off-reserve communities received operational funding and another 47 had funding for needs assessments. The program was recently expanded to include First Nations children living on-reserve. There is an emphasis on health promotion, nutrition, social support, and parental and family involvement; and
- Building Healthy Communities, which is available to First Nations and Inuit communities and aims to

increase community services for First Nations and Inuit in such areas as mental health, home nursing care and solvent abuse.

FNIHB also initiated a National Tuberculosis Strategy in 1992 with the goal to eliminate tuberculosis by 2010. Regional programs were enhanced to improve detection and treatment of cases and contacts, and improved surveillance, research and education activities.

In health protection, FNIHB has a mandate to reduce the effects of environmental health hazards by enhanced monitoring and testing of the quality of drinking water, and air in houses and schools, as well as addressing general environmental health issues such as waste disposal, workplace safety and contaminated sites. Through its Environmental Health Program and Drinking Water Safety Program, FNIHB monitors water quality and supply, and sewage treatment in First Nations and Inuit communities, and recommends improvements to INAC. It also conducts epidemiological research on traditional food to reduce the impacts of food-borne contaminants.

Other Health Canada initiatives are in the developmental stages. Comprehensive mental health programming, especially suicide prevention, has been identified as a significant gap in promotion/prevention initiatives. A Mental Health Strategy is now in the draft stages, and Health Canada and the Assembly of First Nations recently formed an advisory group on suicide prevention to address the high rate of suicide among First Nations youth. The group is expected to make recommendations in the fall of 2001. A National First Nations and Inuit Injury Prevention Working Group is providing guidance for the development of a national framework for injury prevention and control that is culturally relevant. A pilot project involving five telehealth projects which have the potential to offer health education and prevention information by means of telecommunications has recently been completed.

In addition to targeted programs, Aboriginal communities access general federal funds such as:

- Canadian Strategy on HIV/AIDS;
- Brighter Futures, Community Action Program for Children; and
- Population Health Fund.

Health Canada both undertakes and supports external Aboriginal health research through funding of NAHO and the Institute of Aboriginal Peoples' Health at the Canadian Institutes for Health Research.

Indian and Northern Affairs Canada (INAC) and Canada Mortgage and Housing Corporation

Indian and Inuit Affairs at INAC is responsible for supporting First Nations and Inuit in developing healthy, sustainable communities and in achieving their economic and social aspirations (Indian and Northern Affairs Canada, 2001c). In addition to activities related to economic and community development, self-government, infrastructure development, education, and housing, INAC has been involved in water quality issues and household mould. The Family Violence Prevention Program for First Nations encourages communities to address family violence and provides funds for shelters and family violence prevention projects. Canada Mortgage and Housing Corporation (CMHC) administers a number of housing improvement programs for First Nations and Inuit.

Northern Secretariat, Health Canada

Improvements in the administration of federal prevention/promotion programming for all Aboriginal Peoples in the territories is expected as a result of the formation of the Northern Secretariat at Health Canada. The Secretariat was created in 1998 with responsibilities to manage Health Canada's community-based health promotion and illness prevention programs for First Nations and Inuit in the territories, and integrate and streamline these programs.

Across the North, we share the dilemma of providing effective health promotion programs in very small communities... (that) need the ability to invest their energies in improving health, rather than meeting the separate administrative requirements of three orders of government and a multitude of stove-pipe programs (Northern Secretariat, Health Canada, 2000, preface).

The federal and three territorial deputy ministers of health have drafted a Territorial Wellness Framework that will guide implementation. The role of the Secretariat has been expanded to become a single window for Northern communities to access federal promotion/prevention funding. This development will reduce the administrative burden on communities and enable them to address the needs of Métis, First Nations and Inuit members in a more integrated way.

The stated expected outcomes of the Framework are:

- the development of a single, integrated process through which to achieve good health promotion and wellness activities;
- improvement of health status of territorial residents over time;
- the harmonization of wellness resources to effect positive change in health; and
- better access to funds for community-based activities.

(Northern Secretariat, Health Canada, 2000, 2001)

4. KEY ISSUES IN PROMOTION AND PREVENTION PROGRAMMING

Key issues for the improvement of Aboriginal promotion/prevention programs and services are presented in this section, grouped in the following categories:

- The Present Reality in Aboriginal Communities;
- Staffing Issues;
- Financing Issues;
- Culture and Tradition;
- Health Information;
- Participation in Decision-Making; and
- Capacity Development.

The Present Reality in Aboriginal Communities

First Nations, Inuit and Métis communities are at many stages of development and face different levels of social and economic problems that affect their ability to address promotion and prevention issues. Some communities have achieved a degree of community involvement, have a capable workforce and a future-thinking leadership, are proactively planning and implementing programs, including culture-based approaches, and have developed sound administration. Others are struggling with overwhelming social problems, lack of infrastructure, competing visions and interests, and a crisis-driven approach.

Some other factors that impede the ability of Aboriginal communities to proceed smoothly on a collective healing journey are:

- high levels of poverty that affect all aspects of community development, the ability to participate in programs, to make healthy personal choices and to create a healthy environment;
- high levels of death by suicide, injury and violence, family breakdown and cultural isolation that have created an acute experience of grief and loss in many communities that makes action difficult;
- a high level of child sexual and physical abuse and neglect so that a significant number of adults in the community have difficulty building healthy family and community relationships;
- reliance on, and an attachment to, the land that creates different perceptions of environmental risk;
- a significant loss of trust and loss of self-direction as a result of colonialism;
- the loss of connection to family, community and Nation; poor education and living conditions; cultural and language suppression; and sexual, physical and emotional abuse that has had a profound effect on residential school survivors and their descendants; and
- pressing immediate concerns (the need for acute medical care, crisis intervention, staff turnover, and financial problems) that detract from long-term planning and investment in promotion/prevention.

The health system is dealing with crisis all the time. It is not equipped to deal with prevention, so the crisis will be repeated. ... the system is treatment driven, disease driven. This is a worldwide problem. The idea of prevention and promotion still needs to be worked on by health care providers.

(Quoted in Archibald and Grey, 2000)

To be effective, community programs must be based on community reality. For example, clinical practice guidelines for diabetes in Aboriginal communities emphasize the need to view diabetes in the context of the profound social changes experienced by Aboriginal communities (and) recognize the importance of community involvement in developing and implementing treatment and education programs, programs which are compatible with and indeed incorporate traditional values and customs (First Nations and Inuit Regional Health Survey National Steering Committee, 1999, p. 70).

It is important to remember that following either a traditional Aboriginal or a health promotion approach means that problems in communities will not be solved quickly or in isolation from each other. Balance and integration in different aspects of health and involvement/healing of individuals, families, communities and Nations is required. However, progress is being made and there are many success stories to share and models to explore.

Staffing Issues

Four main issues in staffing of promotion/prevention programs are apparent:

- the acute shortage of health professionals, especially nurses, in Aboriginal communities;
- the need for more Aboriginal health care providers and promotion/prevention workers;
- the need for skill and knowledge development among health workers; and
- the need for trained health program managers and administrators.

Staff Shortages

The chronic scarcity of health professionals, particularly nurses, is causing alarm in Aboriginal communities across Canada and is a common theme among promotion/prevention experts. Vacant positions, high turnover and lowered expectations in hiring due to the lack of qualified candidates is affecting the ability to deliver safe, effective services.

Further, the scarcity of key professional resources is forcing a re-thinking of what is realistic in terms of service delivery to the more remote and very small settlements. ... the day of one-person stations or delivery units is neither sustainable nor acceptable.

(George B. Cuff and Associates Ltd., 2001, p. 8)

Northern key informants repeated the now-common phrase that we must develop a Northern workforce, but acknowledged it will take at least 20 years to equal gains seen in the education sector. The reality is that technical and professional skills will have to be imported into northern and southern Aboriginal communities for many years to come.

FNIHB has initiated a National Nurse Retention and Recruitment Strategy to address the severe shortage of nurses working in First Nations communities. The Strategy addresses both creating a work and living environment to encourage nurses to stay in First Nations communities, and recruiting the best possible nurses for those communities. Follow-up activities include promoting better clinical support and supervision, addressing housing and community safety concerns, more active recruitment efforts in the regions, and a focus on attracting First Nations nurses. FNIHB also is looking at funding processes in transferred communities that take into account the rising cost of nursing services. Nevertheless, turnover, understaffing and vacant positions remain critical problems.

Aboriginal Health Workers

Developing Aboriginal human resources is essential to ensure the success of the new approaches to health and healing we recommend. Without the necessary Aboriginal administrators and service providers, it will not be possible to improve Aboriginal health and social conditions. There must be a substantial and continuing commitment to develop capacity of Aboriginal people to provide health and social services. This capacity building should be an important part of the relationship between Canadian governments, mainstream service agencies and Aboriginal governments and organizations.

(Royal Commission on Aboriginal Peoples, 1996, Vol 3, p. 60)

In spite of increased educational opportunities and active recruitment, there still are very few Aboriginal health care providers in Canada. As a result, the vast majority of Aboriginal people receive promotion/prevention services from non-Aboriginal people. There is wide recognition that to be most effective, to ensure that Aboriginal service approaches reflect the culture and reality of the community, that values and philosophies are respected and that community members are receptive to promotion/prevention messages, more Aboriginal people need to be employed in these programs. One key informant stated that the health promotion message has to come from Inuit, otherwise it is seen as coming from white outsiders.

Skill and Knowledge Development Among Health Workers

Increased skills and knowledge are acknowledged as necessary for the improvement of health promotion/prevention efforts at the national, provincial/territorial, regional and community levels. Both Aboriginal and non-Aboriginal nurses, physicians, community health representatives, addictions workers, counsellors, and others would benefit from a better understanding of:

- cultural knowledge of health and wellness;
- the strengths and current challenges facing Aboriginal communities;
- key issues and the connections among them;
- population health, health promotion and disease prevention theory and practice;
- community development, client participation and empowerment practices; and
- best practices in program planning, delivery and evaluation.

Priorities for skill development include the ability to:

- use plain language and clear communication;
- be culturally sensitive (attitudes and values) and culturally competent (practical ability to respect cultures);
- integrate a promotion/prevention focus in all aspects of health services;
- be proactive in identifying issues and threats to health; and
- practice the full range of health promotion activities (build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services).

Community Health Representatives

Community health representatives (CHRs) were the first Aboriginal health workers to provide formal health education and prevention activities in First Nations and Inuit communities, through funding from the federal government. They have grown to more than 900 workers employed by 577 bands and Inuit organizations in Labrador. Their role in the health system has evolved over the years and includes promotion, prevention and protection functions related to environmental health, immunization, screening, pre- and post-natal care, health education, community development and mental health. CHRs may be the only source of stability and reliability in health services that experience high staff turnover among nurses and physicians. The Royal Commission on Aboriginal Peoples, among other bodies, identified the CHR program as one of the most successful programs involving Aboriginal people in promoting health. However, a number of challenges exist in making full use of this resource. The National Indian and Inuit Community Health Representatives Organization (NIICHRO) has identified continuing regional disparities in salary levels, and availability and access to training certificate/diploma programs for CHRs as ongoing problems. Also, most training is not accredited or transferable to other health career programs. Issues related to working conditions for CHRs include: lack of funding for training and for community programs, misunderstanding/underestimating the CHR role, lack of career opportunities, unrealistic workloads, fluctuating salaries and benefits, and job insecurity.

(Royal Commission on Aboriginal Peoples, 1996; Ship, 1998a)

Program Managers and Administrators

The focus on the recruitment and training of Aboriginal health care professionals has perhaps overshadowed the concurrent need for trained health administrators. Health management careers is one area where there is a severe shortage of trained Aboriginal professionals: a need which becomes particularly acute in many communities working toward transfer of health services.

(Smylie, 2001, p. 49)

There is a great need among regional co-ordinators, program managers and supervisors for knowledge and skill development to better conceive and manage promotion/prevention programs. The view in the field is that program providers may be promoted to management positions without proper preparation and that health administrators are not well versed enough in the realities and values of Aboriginal communities to be effective.

Some specific needs for improvement include the ability to:

- ensure the collection and use of health data in program decision-making;
- create an integrated long-term health plan based on community needs;
- effectively implement a health plan involving multiple programs, funders, service providers, and agencies;
- determine human resources needs and effectively staff programs within existing constraints; and

- negotiate with and be accountable to funders, making best use of available resources.

Financing Issues

A number of financing issues affect the ability of communities to address promotion/prevention issues.

Short-term Targeted Funding

A considerable portion of funding for Aboriginal promotion/prevention efforts is provided by the federal government through targeted funds. While targeted funds may enable a community to focus on a particular issue, raise awareness of certain health issues and, in some cases, overcome resistance to change (e.g. tobacco reduction and family violence prevention), problems with targeted funding include:

- activities may be fund-driven rather than the community's priority (chasing money);
- projects are short-term and usually involve a grants competition, requiring repeated investment of time and resources;
- programs must deal with multiple funders that have different requirements and expectations; and
- there are restrictions on how money is spent that may not fit with the community's vision.

A Northern key informant reported that one community has accessed 19 different territorial and federal funds for various programs. Rather than developing a community wellness plan that is holistic and integrated, efforts are project-driven, short-term and focused on the funding organizations' priorities. Urban Aboriginal health programs may have one or more federal sources of funding combined with one or more provincial sources of funding, all with different spending restrictions and reporting mechanisms. They may require separate evaluations.

Governments are making improvements in the design and dissemination of project funds, and communities are developing the capacity to make better use of project funding within their overall goals. However, continued changes are needed to streamline this process and develop community capacity. Aboriginal organizations would benefit from more flexibility in government funding to spend in ways that make sense in the community, while maintaining accountability.

Time Delays and Administrative Burden

Many Aboriginal organizations, both in and outside the federal government health transfer process, have been frustrated by the amount of time required to prepare for and negotiate funding agreements for promotion/prevention programs, accompanied by what is seen as inadequate capacity development and support for communities. Also noted is that government program staff themselves require additional capacity to be effective in assisting Aboriginal communities while streamlining the process.

Funding Levels for Promotion/Prevention

Funding levels are not considered adequate to address the high rate of health and social problems in Aboriginal communities, especially Northern and remote communities. In a recent presentation to the Senate Social Affairs Committee, the Nunavut Health Minister said that federal programs in Nunavut are too underfunded and fragmented to make a dent in the staggering health and social challenges the territory faces. Lung diseases, smoking, substance abuse and suicide are all high, and the health care infrastructure is poorly equipped to handle the burden. It is extremely difficult to recruit and retain nurses who provide 90 per cent of primary care. Health-related travel (virtually all acute care treatment is provided in the south) consumes 20 per cent of the health budget (Health Edition, 2001).

Transportation to programs and health services is a major issue in many Aboriginal communities. Métis and non-Status First Nations are particularly disadvantaged in this area. The need for improved transportation extends beyond reimbursement for travel to medical appointments, to assistance that removes barriers to participation in prevention and support programs, builds community participation and supports healthy lifestyle choices. Innovative methods of providing support and delivering programs in remote and rural areas are needed, as well as recognition that transportation is both a significant need and a high-cost item.

Culture and Tradition

Many Aboriginal communities, and individuals, are engaged in a process of cultural renewal. Eighty per cent of respondents to the First Nations and Inuit Regional Health Survey thought that a return to traditional ways is a good idea for promoting community wellness. More than 70 per cent believed there has been recent progress in traditional ceremonial activity, renewal of Native spirituality and traditional approaches to healing; and more than 50 per cent reported a revival of men's and women's traditional roles. In general, survey respondents favour a wellness model that is more holistic; based on the family; places a greater emphasis on personal, family and community responsibility; and is very diverse (community-specific) (First Nations and Inuit Regional Health Survey National Steering Committee, 1999).

In spite of this, at the present time, the majority of promotion/prevention programs and services are based on Western approaches that have been adopted with few modifications. An unknown (and likely increasing) number of Aboriginal people are accessing mainstream services as they concentrate in urban centres. There is increasing awareness, among Aboriginal and non-Aboriginal service providers, of the need for more cultural content in programs.

As ownership of family-related services has increasingly passed to Aboriginal control, it has become evident that simply staffing those services with Aboriginal people is only part of the answer. The services themselves need to be designed by Aboriginal people to make them work as a reflection of the culture of the host community and the belief system found there.

(Minister of Public Works and Government Services Canada, 1997, p 12)

More needs to be done in establishing what constitutes a culture-based program or one that is culturally appropriate. There are many different expressions of nationhood and culture, with community-specific differences, as well as commonalities. For example, an analysis of family violence projects funded by the federal government identified the following distinct characteristics of an Aboriginal program:

- values Aboriginal tradition and culture;
- recognizes the importance of ritual and ceremony;
- values the wisdom and role of Elders;
- emphasizes connectedness;
- works to restore balance;
- supports nurturing and mutually-respectful relationships;
- honours the central place of women;
- accepts the client as a whole person;
- assumes equality between service provider and service user;
- has a central attitude of caring; and
- prefers to forgive rather than judge or punish.

(Minister of Public Works and Government Services Canada, 1997)

Guidelines developed by the Society of Obstetricians and Gynaecologists of Canada (Smylie, 2001) identify a number of recommendations for health care professionals working with Aboriginal people, including:

- develop a basic understanding of various groups, demographics, geographic territories and language groups of Aboriginal Peoples in Canada;
- understand the disruptive impact of colonization on health and well-being;
- appreciate the holistic definition of health;
- work proactively with Aboriginal individuals and communities to address gaps and barriers; and
- respect traditional medicines and work with Aboriginal healers.

There is a need to further explore and develop the role of different traditional healing systems in prevention and promotion and find ways to integrate these with other approaches and philosophies. Consultations undertaken by the Aboriginal Nurses Association of Canada concluded that integration of traditional and biomedical approaches was possible, if not easy.

It was evident (from discussions) that the traditional health-illness beliefs of Aboriginal people could be used within a primary health care framework to encourage self-care, illness prevention and health promotion. What remained a question was how to integrate traditional practitioners into this framework, given the opposing world views of traditional and biomedical practitioners.

(Aboriginal Nurses Association of Canada, 1993, p. 8)

Diabetes and the Traditional Medicine, Alternative Healing Program

The Traditional Medicine, Alternative Healing Program began at the Kanonhkwashteri:io Health Facility in Akwesasne, Quebec, in 1997. The healers work with people at the emotional, physical and spiritual levels and the well-being of the person. The program works with a biochemist, an iridologist, seers, and different healers and medicine people from across Canada and the United States. Friends, family and the community at large are included as well. The program has a networking system that includes the community health representatives, community health nurses, nutritionists, traditional family support workers, and others. A Council of Elders has been working on the issue of diabetes to restore some of the old teachings and pass along knowledge to children and youth.

(Mitchell, 1998)

Health Information

The availability of accurate, timely and cost-effective health information is a recognized concern in the public health system in general. The development of health information systems for Aboriginal people also involves issues related to ownership of information; confidentiality in small communities; identification of the population through ethnic identifiers; jurisdictional differences among governments that collect information on Aboriginal people; the need for new relationships among researchers, Aboriginal organizations and federal and provincial/territorial governments; and needs for human capacity and infrastructure development to collect and use information. These issues are particularly pertinent as more Aboriginal organizations gain control over health programs and require health information to respond to community health needs.

Priority information needs include:

- development of health information systems for Métis comparable to First Nations and Inuit;
- current and projected demographic changes;
- ongoing incidence and prevalence of the full range of identified diseases and conditions (surveillance has tended to be focused on communicable and some chronic diseases);
- investigation of new trends and emerging issues; and
- monitoring of environmental quality (water, air, land, and food/medicine sources).

A paper on Métis health for the Royal Commission on Aboriginal Peoples, completed in co-operation with the Métis National Council had these research-related recommendations:

- that national research be undertaken to determine the nature and incidence of chronic health conditions and the prevalence of social problems in Métis communities;
- that provincial and territorial governments be encouraged to work with Métis organizations to identify the health needs and gaps in services for the Métis;
- that research on Aboriginal people include separate analysis of the Métis; and
- that a means be developed to ensure that all information on Métis health that is generated in Canada is available to those working on Métis health issues.

(Kinnon, 1994)

Health information needs are being better addressed through initiatives such as the first and second First Nations and Inuit Regional Health Survey, First Nations and Inuit Health Information System, a second Aboriginal Peoples Survey, increased research funding and support to the Institute of Aboriginal Peoples' Health and NAHO, attempts to establish Métis registries in the provinces and territories, and many regional and local data collection and capacity-building initiatives. Pauktuutit Inuit Women's Association and Inuit Tapiriit Kanatami have undertaken a consultation and development process to ensure that the Inuit component of the Health Information System reflects Inuit knowledge and values, and serves Inuit needs (Mailloux and Gillies, 2001). New partnerships, such as that between the Northern Health Research Unit at the University of Manitoba and the Assembly of Manitoba Chiefs in Manitoba (O'Neil, Reading and Leader, 1998) and Ontario First Nations and the Ontario Region, Medical Services Branch, Health Canada (Johnson, 1997) are being formed.

The First Nation Health Information System being developed by First Nations and Inuit Health Branch, Health Canada, is a comprehensive health information system, including training and capacity building for more than 600 First Nations communities. While still in the developmental stages (it is 60 per cent implemented), it is expected to result in improved surveillance indicators, including communicable diseases, vaccinations and population indicators. Problems identified in the First Nations and Inuit Health Information System project relate to the need for better technical support for computer systems and better training in use of technology for data collection, analysis and use.

Participation in Decision-Making

Little research has been done to examine the common issues related to the regionalization of government health services and Aboriginal health needs. The HEALNet Regionalization Research Centre has completed one study, *Exploring Health Care Regionalization and Community Capacity* (Kouri and Hansen, 2001) that included a case study of a Saskatchewan health district with a high First Nations and Métis population. The report concluded:

Racial boundaries are the most significant barrier to regional identity in the northwest. Aboriginal interviewees were more critical of decision processes, feeling more excluded from issue definition

and decision-making... The board also was characterized as not fully understanding Aboriginal health issues. (P. 26)

At the provincial level, an Aboriginal Governors Working Group was formed in 1999 in British Columbia to examine the issues related to regionalization and Aboriginal health. The group made 100 recommendations grouped under the following goals:

- ensure adequate Aboriginal representation (on health boards);
- ensure accountability to the Aboriginal community;
- all governors, Aboriginal and non-Aboriginal, need an appropriate orientation to be effective;
- health authorities to provide the necessary resources to support Aboriginal involvement;
- provide meaningful support to Aboriginal governors to reduce isolation and increase sharing of ideas;
- require all health authorities to develop Aboriginal health plans, or at least an Aboriginal component to the health plan;
- address information gaps and needs to ensure all governors have the same information to make informed decisions; and
- provide education and training opportunities for all governors.

(Aboriginal Governors Working Group, 1999)

The BC Aboriginal Health Division subsequently funded the development of a Health Authorities Handbook on Aboriginal Health and an Aboriginal Health Resource Directory.

In an analysis of governance and accountability structures in delivering health and social services in the Northwest Territories, George B. Cuff and Associates Ltd. (2001) identified problems with the capacity of community health board members to fulfill the role expected of them.

Concerted efforts are required to ensure that Aboriginal people are more actively involved in health program decision-making and that the supports are in place to sustain their participation in non-Aboriginal bodies.

Little is known about Aboriginal health authorities and additional research should be undertaken to document and examine their development. Efforts to provide resources and share information among members of Aboriginal health authorities also would enhance promotion/prevention programs and services.

Capacity Development

Capacity development is a commonly-heard phrase in the Aboriginal promotion/prevention field these days. Capacity development is a primary tenet of the federal health transfer process and the economic and community development initiatives of INAC. Capacity development in this context usually means the ability of Aboriginal communities and their health authorities to develop and administer health programs. Capacity can include adequate knowledge and skills among decision-makers, managers and service providers; staffing; resources; physical infrastructure; and computer and telecommunications technology.

... (C)apacity building is more than just developing technical abilities such as computer training and use of the Internet. It is building capacity in self-determination in health care, building upon an individual and community development process. It is developing and applying abilities to govern and manage, make informed evidence-based decisions, plan strategically, identify and set priorities, evaluate, manage human and fiscal resources effectively and efficiently, and take responsibility for the successes and failures of health interventions. Capacity building also implies the capacity for

working with external agencies, organizations, institutions, and departments to share knowledge and experiences.

(Mailloux and Gillies, 2001, p. 24)

Some capacity development needs have been explored in other sections such as Staffing Issues, Financing Issues and Health Information. Aboriginal capacity development is an area that should be further explored and defined by Aboriginal people. Some important questions to consider are as follows:

- What is capacity in the Aboriginal health context and how can it be achieved?
- What are the priorities/strategies for knowledge and skill development (content, process, and management)?
- How and by whom should knowledge and skill development be undertaken (increased college and university training, ongoing professional education, access to ongoing technical expertise, face-to-face training, tele- and computer-education, through partnerships among which Aboriginal organizations, professional associations, professional schools, governments)?
- How can capacity development be better conceived and co-ordinated among Health Canada regions and headquarters, Aboriginal health authorities, band councils, tribal councils, Métis organizations, Inuit organizations, etc.?
- Would the development of standards and certification of a wider range of health program workers contribute to capacity?
- How can efforts to recruit and retain Aboriginal and non-Aboriginal workers be improved?
- What are the minimum requirements for management and administrative systems, physical infrastructure and computer and telecommunications technology and how can they be met?
- What are the basic needs for health information in the short and long term and how can they be met?

5. IMPROVING PROGRAMS AND SERVICES

NAHO's Role in Population Health, Health Promotion, Prevention and Protection

NAHO clearly has a key role to play in the development of promotion/prevention programming for Aboriginal people. It is impossible to conceive of improving the health of Aboriginal people (NAHO's mission) without placing promotion and prevention at the forefront.

This section presents specific recommendations for NAHO activities, grouped according to the organization's objectives. The next section makes some suggestions for possible linkages to other organizations in pursuing these activities.

Knowledge-Based Activities

- Identify and disseminate **best practices** in all aspects of the design and delivery of community promotion/prevention programs: community development and accountability, needs assessments, program planning and financing, integrated program delivery, collaboration, etc.
- Develop an **Aboriginal framework** for health and wellness that includes common values and perspectives from different regions and Nations to assist in developing culture-based programming.
- Develop a discussion paper that examines the **relevance of common population health, health promotion and disease/injury prevention models and approaches** to Aboriginal communities, starting with an Aboriginal world view.
- Develop and distribute **tools for priority setting** among the many pressing issues in promotion and

prevention facing communities that is based on research knowledge, an analysis of costs versus benefits, community resources and short- and long-term benefits.

- Promote **plain language and clear communication** in all programs and services for Aboriginal people through a plain writing policy for NAHO, a plain writing campaign directed at service providers and skill-building workshops for those in the field.
- Identify and highlight **good health promotion practice** (e.g. directed by Aboriginal people, empowering of individuals and communities, and addressing individual and collective change).
- Consider a regular **theme-based publication** or Internet/e-mail bulletin for service providers on key promotion/prevention issues, providing up-to-date information on the issue and its context, traditional teachings and values, and innovative models representing different population groups, settings and Nations. (NIICHO's *In Touch* magazine is an excellent resource that could serve as a model or the organization could be contracted to expand the magazine's scope and distribution.)
- Collect and promote access to a limited number of high quality plain language, culturally-appropriate **client information resources** (pamphlets, videos, posters, workshop plans, etc.) on key health promotion, prevention and protection issues (drawing on materials available from existing clearinghouses and other organizations, and contracting with experts to write/adapt new material if needed).
- Analyze information relevant to community health promotion/prevention programs from **population-based Aboriginal surveys** such as the First Nations and Inuit Regional Health Survey, Aboriginal Peoples Survey and other provincial/territorial surveys and make it available in an accessible format to those in the field.
- Consider supporting a **network of urban Aboriginal health centres** to share information and knowledge on healing and wellness issues, strategies to address cultural diversity, barriers to service, models of collaboration, etc.
- Link and promote knowledge sharing among **Aboriginal health authorities** (including tribal council health committees, urban and rural Aboriginal health planning bodies, regional Inuit associations and provincial/territorial Métis organizations) across Canada.
- Develop ways to support and educate Aboriginal board and staff members of **regional health structures** and planning bodies (e.g. hold a national meeting or teaching conference, develop an Internet-based communication system, magazine, etc.).
- Undertake a process to better understand and define capacity-building needs and develop a **national strategy for capacity development** for Aboriginal communities to plan and manage health programs.
- Based on identified gaps and working with appropriate partners (e.g. FNIHB, provincial/territorial governments, colleges and universities, Aboriginal health organizations, etc.), facilitate or deliver **capacity-building activities** (e.g. conferences, skills workshops, certificate programs, distance education) for service providers, health planners, managers, governors and administrators. High priority areas are:
 - strategic health planning (moving from needs assessment to program design and implementation);
 - collection and use of health data;
 - human resources planning and management (identifying staffing needs, knowledge and skills

- and ensuring adequate monitoring and supervision);
 - program management of multi-dimensional programs; and
 - use of technology.
- Compile and distribute **best practices** resources on topics such as:
 - community-based capacity-building strategies and activities;
 - incorporating traditional knowledge and healing practices into promotion/prevention efforts;
 - operating culturally-diverse programs within the Aboriginal community;
 - planning, designing and implementing community wellness strategies; and
 - co-development and co-management of programs by governments and First Nations, Métis and Inuit organizations.
- Collect and disseminate **international indigenous knowledge** related to self-determination in health programming, capacity building, building healthy communities, and addressing specific promotion/prevention issues.

Promote Health Issues

- Provide research knowledge and national data to policy makers at the federal, provincial, territorial and regional levels to encourage the development of **comprehensive policies on Aboriginal health** that includes First Nations, Inuit and Métis people.
- Co-ordinate a knowledge-based consultation and planning process to **set priorities among existing and emerging promotion/prevention issues** and circulate among Aboriginal health organizations, policy makers, researchers, etc. Some important issues that arose in this investigation included poverty, environmental contaminants, water quality, nutrition through all the life stages, injuries, and sexual health.
- Conduct or facilitate exploratory research on **emerging health issues** and promote further research and action on these issues among relevant stakeholders.
- Explore ways to **inspire Aboriginal community leaders** to become more proactive and forward-thinking in addressing health, including healthy economic and social development, and healthy public and private sector workplaces.
- Monitor progress and share information on new and innovative **provincial and territorial government policies and programs** for Aboriginal health promotion and prevention.

Research and Research Partnerships

- Advocate for and advise on the collection of comprehensive and meaningful health information on **Métis populations**.
- Work with other initiatives (e.g. Institute of Aboriginal Peoples' Health, Consortium of Health Promotion Research Centres) to document the **value of prevention** in increasing health and reducing health care costs.
- Continue to monitor new research findings and community knowledge of emerging issues and connections related to promotion and prevention and **recommend research topics** to the Canadian health research community. Possible research topics that arose from this investigation include:
 - environmental health: long-term effects of exposure to environmental contaminants, effects

- of exposure to multiple contaminants, continuing investigation of the benefits and risks of country food, effects of environmental contamination and traditional healing materials, effects of climate change
 - violence: effects of community violence on individuals, families, communities and Nations, effective violence prevention strategies, effects of sexual abuse and sexual assault on sexual decision-making and sexual health
 - mental health: short- and long-term effects of trauma and grief/loss, specific mental health conditions, determinants of mental health.
- Study the strengths and weaknesses of **telehealth** as a means of providing health education, advocacy and support. Can this technology be used in a culturally-appropriate way? Is video and computer-based communication compatible with cultural knowledge and values? Is it effective for promotion/prevention?
- Partner with other bodies (e.g. Canadian Consortium for Health Promotion Research and its member research centres, Population and Public Health Branch and First Nations and Inuit Health Branch, Health Canada) to promote the **evaluation and dissemination of results** of Aboriginal promotion/prevention/protection initiatives.
- Study the effects of **regionalization of health service delivery** on Aboriginal health and ways to strengthen Aboriginal involvement and influence (possible partners: HEALNet Regionalization Research Centre and provincial governments with high Aboriginal populations).
- Document the strengths and weaknesses of different funding mechanisms and ways to **consolidate, streamline and sustain funding** used by Aboriginal organizations for health promotion, prevention and protection programming.

Recruitment, Retention, Training and Utilization

- Participate in national efforts to **recruit and retain both Aboriginal and non-Aboriginal health workers**.
- Explore the value of and support efforts to **set standards** for different promotion/prevention occupations.
- Take a leadership role in developing **better health human resources planning** for Aboriginal health services.
- Explore **new occupations and new ways of providing services** in remote and isolated communities.
- Evaluate and transfer knowledge of **effective cultural training** for non-Aboriginal and Aboriginal service providers, with an emphasis on culturally competent practice (skills) in addition to awareness and sensitivity.
- Document the strengths, weaknesses and gaps in **professional school curricula** in addressing Aboriginal health issues and recommend improvements.

Traditional Healing Practices

- Study the **role of traditional and cultural knowledge** in promotion, prevention and protection programs. How can traditional healing be integrated into prevention and promotion? What universal

principles form the basis for an Aboriginal approach?

- **Create resource materials** that pass on traditional teachings by different Nations (First Nations, Métis and Inuit) on a variety of issues (e.g. Cree teachings related to sexuality, Métis teachings on nutrition, Inuit teachings on healthy pregnancies, etc.).
- Document existing **promotion/prevention programs that are based on traditional knowledge** and disseminate widely.
- Ensure that resource materials for clients and service providers stress the **importance of traditional teachings and cultural knowledge**.

6. POSSIBLE LINKAGES WITH OTHER BODIES AND INITIATIVES

National Aboriginal Organizations

Aboriginal Healing Foundation

www.ahf.ca

The Aboriginal Healing Foundation (AHF) is a national non-profit foundation established in 1998. It will distribute \$350 million in federal government funding to community healing projects over 10 years. Its mission is to encourage and support Aboriginal people in building and reinforcing sustainable healing processes that address the legacy of physical and sexual abuse in the residential school system, including intergenerational impacts.

Possible linkages: facilitate linkages between AHF and research bodies to explore residential school experiences as a determinant of health, establish effects of childhood trauma on health including inter-generational effects, as well as evaluate effective healing approaches.

Aboriginal Nurses Association of Canada

www.anac.on.ca

The Aboriginal Nurses Association of Canada (A.N.A.C.) is a member-based organization concerned with Aboriginal health issues and community nursing. A.N.A.C. has been active in prevention issues related to family violence, HIV/AIDS, and sexual and reproductive health. It has produced educational materials and resources and holds annual teaching conferences. It recently completed a nursing survey that examines factors related to nurses staying in or leaving Aboriginal communities, including recommendations for better recruitment. Follow-up activities are underway.

Possible linkages: explore community nurses' needs for promotion/prevention education and resources and look at ways to work with this network to strengthen capacity and address recruitment and retention issues.

Assembly of First Nations

www.afn.ca

Through its First Nations Health Secretariat, the Assembly of First Nations (AFN) works to protect treaty, Aboriginal, constitutional, and inherent and human rights to health and health care services for First Nations. Activities include advocacy and support for First Nations health, policy analysis and development, research and communications, health promotion on child health (prenatal nutrition, SIDS, FAS/FAE), oral health, traditional use of tobacco, effects of residential schools, HIV/AIDS, mental health, and diabetes. In the area of environment, AFN manages the First Nations Environmental Contaminants Program, a small program that provides project funding for environmental health research, and is investigating drinking water safety. AFN held a national housing conference in 2001 that raised many issues related to healthy housing.

Possible linkages: work with the organization to advance environmental, water quality and housing issues, and to explore information dissemination partnerships.

Congress of Aboriginal Peoples

www.abo-peoples.org

The Congress of Aboriginal Peoples (CAP) represents the interests nationally of off-reserve Indian and Métis Peoples regardless of status under the *Indian Act*. It has been active in areas related to determinants of health such as employment, education, housing, and the environment, as well as women's, youth and urban Aboriginal issues. CAP has addressed health issues such as diabetes and HIV/AIDS.

Possible linkages: explore possible partnerships related to environment and health, urban Aboriginal promotion/prevention programs, capacity building, and information sharing among its constituency.

Inuit Tapiriit Kanatami

www.tapirisat.ca

Since it was established in 1971, Inuit Tapiriit Kanatami (ITK), formerly Inuit Tapirisat of Canada, has acted as the national voice for Inuit of Canada. Along with its four regional associations and Pauktuutit Inuit Women's Association, ITK has addressed health and environmental issues such as the development of a health action plan, cancer among Inuit, diabetes, HIV/AIDS, mental health, home and community care, Northern contaminants, and health information needs. Pauktuutit has been active in the areas of family violence, child sexual abuse, residential schools, and women's health needs.

Possible linkages: look at ways to support the development of innovative Inuit-based approaches to promotion/prevention in Northern communities and document Inuit health knowledge and world view. Explore information dissemination partnerships.

Métis National Council

www.metisnation.ca

The Métis National Council (MNC) is the national representative of the Métis in Canada. MNC has been active in the areas of economic development, youth, housing, homelessness, and health issues such as HIV/AIDS, diabetes, and child and youth health. It also is advocating for more federal responsibility for Métis health, more equitable access to Aboriginal health funding, and collection of Métis health information.

Possible linkages: work with MNC to increase federal involvement in Métis health promotion/prevention

efforts and to increase Métis data collection. Explore information dissemination partnerships.

National Indian and Inuit Community Health Representatives Organization

www.niichro.com

The National Indian and Inuit Community Health Representatives Organization (NIICHRO) is active in supporting community health representatives (CHRs) who in turn are key health promoters in many First Nations and Inuit communities. Its activities include the development of training tools, advocacy on health issues, and publication of *In Touch* magazine. Over the last several years, *In Touch* has provided information for service providers on issues such as HIV/AIDS, environmental health, healthy pregnancies, diabetes, Elder health, etc. NIICHRO also has called for development of national occupational standards for CHRs, and better training opportunities and working conditions.

Possible linkages: NIICHRO training tools could be more widely disseminated and/or adapted to other audiences. In Touch magazine is a valuable source of information on current issues. NAHO could work with NIICHRO to respond to specific training needs related to key promotion/prevention issues

Métis National Council of Women, Native Women's Association of Canada and Pauktuutit Inuit Women's Association of Canada

www.nwac-hq.org

www.pauktuutit.on.ca

These three national Aboriginal women's organizations have been actively involved in promoting women's wellness issues, providing tools and resources to Aboriginal women, and advocating on health issues such as violence, HIV/AIDS, reproductive health, culture and gender, and access to health services.

Possible linkages: involve the associations in expert working groups, consultations and policy circles. Support networking among them and other Aboriginal associations. Explore information dissemination partnerships.

Issue-Specific Associations such as the Canadian Aboriginal AIDS Network, National Aboriginal Diabetes Association and the Native Mental Health Association

These organizations address specific health issues and are good sources of expertise and networks of health care providers concerned with the issues.

Possible linkages: maintain contact with these and other issue-specific organizations to share information and resources, identify emerging issues and build networks.

Aboriginal Clearinghouses and Education/Training Organizations such as Nechi Training, Research and Health Promotions Institute; Zah-Geh-Do-Win; and the Vancouver Native Health Society

www.nechi.com

www.anishinabek.ca

www.vnhs.net

These organizations provide education/training and/or distribute resource materials on different health promotion/prevention issues of concern to Aboriginal people.

Possible linkages: monitor training/education and available resource materials and promote their availability. Consider partnering on particular knowledge development and information dissemination projects.

Governments

First Nations and Inuit Health Branch, Health Canada

www.hc-sc.gc.ca/fnihb-dgspni/fnihb/

The First Nations and Inuit Health Branch (FNIHB) is actively involved in a diverse range of promotion, prevention and protection issues, as well as capacity building leading to transfer of health authority, research, monitoring of trends, production of resources and development of health information systems for First Nations and Inuit.

Possible linkages: monitor FNIHB activities and knowledge development in relevant areas, consider joint knowledge dissemination/best practices activities, and consult and advise on research priorities.

Population and Public Health Branch, Health Canada

www.hc-sc.gc.ca/pphb-dgspsp/new_e.html

The Population and Public Health Branch promotes a population health approach to improve the health of Canadians, and houses most of the federal promotion/prevention and many of the health protection programs. It is a major source of funds for Métis, non-Status First Nations and urban Aboriginal projects related to childhood development, diabetes, pre-natal nutrition, HIV/AIDS, etc. All of the funding programs generate considerable knowledge related to programming approaches, best practices and factors in success. Funds engage in varying levels of knowledge dissemination. For this inquiry, a search of the Health Canada Grants and Contributions database for Aboriginal projects between 1995 and the present yielded numerous project descriptions.

Possible linkages: review and monitor funded Aboriginal projects from the various programs and work with the sponsors to more-widely disseminate knowledge generated, possibly through a theme magazine, Internet or e-mail bulletin, or best practices publications that are widely disseminated.

Provincial and Territorial Governments

Some provinces and all three territories have well-established Aboriginal health programs and policies on particular issues, undertake research and consultations, and support Aboriginal health organizations. Many of them are generating useful resources on promotion/prevention issues such as Aboriginal women's health, cancer prevention, HIV/AIDS and pre-natal health. Other provinces are at the beginning stages of addressing Aboriginal health issues.

Possible linkages: develop relationships with Aboriginal health initiatives in each of the provinces and territories in order to build networks, share information and resources, promote action on Aboriginal promotion/prevention issues and more widely disseminate research findings and community resources. Pay particular attention to advances in the territories.

Research Bodies

Institute of Aboriginal Peoples' Health

www.cihr.ca/institutes/iaph

The Institute of Aboriginal Peoples' Health (IAPH) is a newly formed research institute that will provide a significant contribution to Aboriginal health research in Canada, much of which will be relevant to population health, promotion, prevention and protection efforts. The goal of the IAPH is to lead a national advanced research agenda in the area of Aboriginal health, and promote innovative research in the field. Four priorities have been identified: a survey research centre; child and youth health promotion and risk reduction, community wellness and addictions; stress and its relation to diabetes; and prevention of accidents and injury. Community-academic partnerships and capacity building are stressed. IAPH recently announced spending of \$74 million, including support for eight projects designed to develop capacity for Aboriginal research in Canada.

Possible linkages: maintain close linkages with the Institute and explore ways in which the respective roles of NAHO and IAPH can be complimentary. Explore ways to facilitate applied research that is both practical and relevant, empowering of communities and capacity enhancing.

Other Institutes of the Canadian Institutes for Health Research

www.cihr.ca

In addition to the Institute of Aboriginal People's Health, 12 other institutes address a range of health issues and population groups such as cancer, respiratory health, infection and immunity, gender, healthy aging, and childhood and youth health. Knowledge development in these areas will be of interest to Aboriginal practitioners. For example, research results from a recent call for proposal co-sponsored by three institutes entitled "Improving Access to Appropriate Health Services for Marginalized Groups" will be of use to service providers in the Aboriginal community. Much of the research knowledge produced will not be readily accessible to community members.

Possible linkages: Monitor calls for proposals, research awards and completed projects for their applicability and usefulness to Aboriginal communities and explore ways to disseminate results in plain language and non-print formats. Encourage support for research that advances promotion/prevention efforts and addresses newly emerging health issues.

Canadian Institute for Health Information and its Canadian Population Health Initiative

www.cihi.ca

The Canadian Institute for Health Information (CIHI) is a federally-funded national organization dedicated to improving the health of Canadians and the health system through better collection of health information.

Its Canadian Population Health Initiative (CPHI) is a new initiative aimed at generating and disseminating new knowledge on the determinants of health that contributes to population health policy.

Possible linkages: explore with CIHI methods of generating more health information on Métis and non-Status First Nations through joint initiatives with the provinces and territories. Monitor new knowledge on determinants of health and population health approaches relevant to Aboriginal communities generated by CPHI and collaborate on dissemination. Encourage CPHI to address issues of particular relevance to Aboriginal promotion/prevention programs.

HEALNet Regionalization Research Centre

www.regionalization.org

The goal of the Regionalization Research Centre is to provide an avenue for regional health authorities to meet their research needs and to promote the study of regionalization as an innovation. The Centre has done limited work in the area of Aboriginal participation in health authorities to date, or investigated the strengths and challenges facing Aboriginal health authorities that might create a cross-cultural learning environment.

Possible linkages: discuss possible joint research, networking and knowledge transfer opportunities on topics such as governance, equitable participation, funding priority setting, multi-cultural service delivery, needs in remote areas, etc.

Canadian Consortium for Health Promotion Research and its 14 Member Centres

www.utoronto.ca/chp/consort/index.htm

The Canadian Consortium for Health Promotion Research works to enhance health promotion research, policy and practice in Canada through linking research, capacity development and information dissemination. The 14 health promotion research centres work as multi-disciplinary, academic-community partnerships to conduct research, develop capacity and share knowledge. Some of the centres may have done limited work in areas related to community capacity and partnership building with Aboriginal organizations, but all of them are concerned with community development, equity issues and Aboriginal participation.

Possible linkages: discuss opportunities for working together to advance health promotion research that is relevant to Aboriginal communities, explore and promote Aboriginal models and culture-based programs, encourage/broker partnerships between researchers and Aboriginal community bodies, explore knowledge dissemination possibilities.

The Northern Contaminants Program, Department of Indian Affairs and Northern Development, Centre for Indigenous Peoples' Nutrition and Environment and Arctic Institute of North America

www.ainc-inac.gc.ca/NCP/abt/des_e.html

www.cine.mcgill.ca

www.ucalgary.ca/UofC/Others/AINA

The Northern Contaminants Program, Department of Indian Affairs and Northern Development is a multi-year initiative to identify and monitor contaminants in the Arctic ecosystem, educate Northerners about contaminants, and work on international agreements to control them. New research is funded each year. The program also supports the Centre for Indigenous Peoples' Nutrition and Environment (CINE) in Montreal. CINE is a university-based research and education centre for Indigenous Peoples. It employs a participatory research model to address concerns about nutrition and food contamination. It also undertakes specific research projects each year. The Arctic Institute of North America (AINA) conducts research, often in partnership with other organizations related to earth sciences, biological sciences, social sciences, etc.

Possible linkages: monitor research findings and examine their application to other Aboriginal communities. Work with CINE to find ways to promote nutrition as an important issue and to support further research and education.

Centres of Excellence on Women's Health Research, Violence Against Women and Children, and Children's Health

These centres of excellence are funded by the federal government, but operate autonomously to generate knowledge in their area of specialization. All of them are involved in population health, health promotion, prevention or protection research or knowledge dissemination to some extent, and operate as academic-community partnerships. Some collaboration with Aboriginal organizations has occurred.

Possible linkages: linkages could be made with the centres to reinforce the importance of Aboriginal health issues and to encourage further partnerships with Aboriginal organizations.

National Health Research and Development Program, Canadian Health Services Research Foundation, Primary Health Care Transition Fund, and the Health Transition Fund

www.chsrf.ca

www.hc-sc.gc.ca/htf-fass/

The National Health Research and Development Program (NHRDP) is a long-standing federal government program that supported health research and is now winding down. A search of its grants database between 1990-2004 revealed 91 research projects with Aboriginal content, 57 of which (63 per cent) were directly related to promotion and prevention issues. The newer Canadian Health Services Research Foundation (CHSRF) funds policy research that is health-services oriented, so it is less involved in promotion/prevention issues, but concerned with access to health services, service utilization and health program management. It also is committed to knowledge transfer. The Primary Health Care Transition Fund (PHCTF) is an \$800 million research fund announced in 2000 that will support large-scale primary health care initiatives in the provinces and territories. One priority is low-population jurisdictions. The Health Transition Fund (HTF) is a \$150 million fund supporting 141 projects across Canada to test and evaluate innovative ways to deliver health care services. It also might generate research that is relevant to the delivery of Aboriginal health programming.

Possible linkages: existing and new research projects should be reviewed for content that would be useful in the field of Aboriginal promotion/prevention. CHSRF, PHCTF and HTF could be encouraged to fund community-relevant research in which promotion/prevention activities are integrated with health services.

7. CONCLUSION

Aboriginal communities have created a rich body of practice in the areas of population health, promotion, prevention and protection. Some examples include:

- communities that have assumed transfer of responsibility for various health services and programs, are participating in health services agreements to manage specific programs, and others that are engaged in community needs assessments and service planning processes toward greater responsibility for programs;
- Aboriginal organizations and agencies that have created culture-based program models and are delivering services in integrated and holistic ways;
- provincial, territorial and regional organizations that have undertaken a leadership role in advocating for better promotion/prevention services and that act as conduits of information for regional and community programs; and
- national and professional organizations that have created networks and resources on a wide variety of issues.

As well, the federal and territorial governments, and several provincial governments, have developed some new and expanded programs to address particular issues, have increased research funding related to Aboriginal health, and are beginning to examine capacity issues and the recruitment and retention of Aboriginal health workers.

However, programs and services are at different levels of development. Aboriginal communities continue to face many challenges:

- the wide range of immediate health and healing issues facing Aboriginal communities;
- critical staffing shortages, staff turnover and lack of cultural training among non-Aboriginal health care providers;
- financing issues such as short-term project funding, time delays and inadequate levels of funding for promotion/prevention;
- the need to support and promote increased culture-based and traditional healing approaches;
- gaps in comprehensive, accurate, timely, and cost-effective health information;
- barriers to participation in decision-making related to population health programs and health services; and
- the need for a better understanding of gaps in capacity and how to address them.

NAHO has an important role to play in supporting successful initiatives and addressing needs and challenges. It can make an important contribution in disseminating knowledge created both in community practice and in formal research; promoting knowledge-based action on currently recognized and emerging health issues; facilitating research and research partnerships that advance promotion/prevention efforts; increasing the recruitment, retention, training, and utilization of Aboriginal service providers who are skilled in these areas; and promoting increased inclusion of traditional healing practices and cultural knowledge in promotion/prevention programs and services.

NAHO also has a role in posing challenging questions and supporting open discussion of the issues faced by Aboriginal communities in providing programs, needed improvements in programs and conflicting views related to approaches, priorities, etc. NAHO's key challenge is in acting as an effective bridge between community realities and needs, and national mandates, as well as ensuring that new knowledge is made truly accessible to a wide range of people while addressing the needs of a diverse and rapidly-changing population.

8. BIBLIOGRAPHY

- Aboriginal Diabetes Initiative, Health Canada (2000). *Diabetes Among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence*. Ottawa.
- Aboriginal Governors Working Group, British Columbia Aboriginal Health Division (1999). *Achieving a Balance of Wellness for all British Columbians: Aboriginal People and Regionalization*. Victoria.
- Aboriginal Healing and Wellness Strategy (2001). Strategy Description and Programs and Services. 09/09/01.
- Aboriginal Health and Wellness Centre (2000). *Directions for the Future*. Winnipeg.
- Aboriginal Nurses Association of Canada (1993). *Traditional Aboriginal Medicine and Primary Health Care* (submission to the Royal Commission on Aboriginal Peoples). Ottawa.
- Aboriginal Nurses Association of Canada (1999). *Report of the Aboriginal Roundtable on Sexual and Reproductive Health*. Ottawa.
- Aboriginal Nurses Association of Canada (2000). *Survey of Nurses in Isolated First Nations Communities: Recruitment and Retention Issues*. Ottawa.
- Aboriginal Nurses Association of Canada and Planned Parenthood Federation of Canada (in press). *Sourcebook on Sexual and Reproductive Health for Aboriginal Communities*. Ottawa.
- AIDS Weekly* (July 10, 2000). "HIV/AIDS: An Epidemic Among Aboriginal Communities in Canada."
- Amagoalik and Associates (1999). *The Nunavut Land Claim Agreement: For Whom?* Rankin Inlet: Inter-Organizational Workshop with NTI, DIOs and IPGs.
- Anand, Sonia and Vincent Tookenay (1999). "Cardiovascular Diseases and Aboriginal Peoples." *Canadian Journal of Cardiology*, 15(Suppl G): 44G-46G.
- Archibald, Linda and Roda Grey (2000). *Evaluation of Models of Health Care Delivery in Inuit Regions*. Ottawa: Inuit Tapirisat of Canada.
- Armstrong, Robin P. (1994). "Developing Social Indicators for Registered Indians Living On-Reserve: The DIAND Experience." *Social Indicators Research*, 32: 235-49.
- Assembly of First Nations (1999). Assembly of First Nations Plan of Action for Health. *New Relationships and Partnerships in Health: Summary Report*. Ottawa: Assembly of First Nations and Medical Services Branch Joint Health Policy Forum, March 29-30, 1999.
- Assembly of First Nations (2000). *First Nations Populations in Canada* (fact sheet, May 2000). Ottawa.
- Assembly of First Nations (2001a). Availability of Diabetes Programs and Services, *Analysis of Existing Programs and Services in First Nations Communities*. 09/09/01.

- Assembly of First Nations (2001b). Drinking Water. www.afn.ca/Programs/Environment/drinking_water.htm 10/30/01.
- Assembly of First Nations (2001c). First Nations Health Priorities, 2001-2002. 06/18/01.
- Assembly of First Nations (2001d). First Nation Vision for Housing. www.afn.ca/Programs/Housing/HS/housing.htm 10/04/01.
- Assembly of First Nations (2001e). National Conference on First Nations Health: Our Voice, Our Decisions, Our Responsibility (press release). www.afn.ca/Press%20Releases%20&%20Speeches/national_health_conference_first.htm 06/18/01.
- Assembly of First Nations, First Nations Health Secretariat (1999). *Aboriginal Health Institute Consultation Report*. Ottawa.
- Assembly of First Nations and Medical Services Branch Joint Health Policy Forum (1999). *New Relationships and Partnerships in Health: Summary Report*. Ottawa.
- Barker-Collo, Suzanne L. (1999). "Reported Symptomatology of Native Canadian and Caucasian Females Sexually Abused in Childhood." *Journal of Interpersonal Violence*, 14(7): 747.
- Benoit, Cecilia and Dena Carroll (2001). "Marginalized Voices from Vancouver's Downtown Eastside: Aboriginal Women Speak About Their Health Care Experiences." *Centres of Excellence for Women's Health Research Bulletin*, 1(2): 6-7.
- Bergman, Brian (1996). "Dark Days for the Inuit: Tuberculosis Outbreaks Revive Memories of an Earlier Epidemic." *Maclean's*, 109(10): 66-9.
- Bethunes, David N. (1998). "Contamination of Aboriginal Water Resources." *In Touch*, 8(2): 11-15.
- Blue Moon Consulting (2001). *Understanding HIV/AIDS Epidemiology: HIV/AIDS Surveillance Among Canada's Aboriginal Peoples*. Ottawa: Health Canada.
- Blythe, Jennifer, Michael Ladouceur, Wendy Goodine, et al. (1995). *Maternal-Child Health Care Programs for Aboriginal People: A Review of the Literature*. Ottawa: Health Canada.
- British Columbia Ministry of Health (2001). Aboriginal Health. www.hlth.gov.bc.ca/aboriginal/ 09/10/01.
- Browne, Annette J., and Jo-Anne Fiske (2001). "First Nations Women's Encounters with Mainstream Health Care Services." *Western Journal of Nursing Research*, 23(2): 126-47.
- Buchigani, Norman and Christopher Armstrong-Esther (1999). "Informal Care and Older Native Canadians." *Ageing and Society*, 19(1999): 3-32.
- Burd, Larry and Michael E.K. Moffatt (1994). "Epidemiology of Fetal Alcohol Syndrome in American Indians, Alaskan Natives, and Canadian Aboriginal Peoples." *Public Health Reports*, 109(5): 688-94.
- Canadian Institute of Child Health (2001). Aboriginal Children and Youth. www.cich.ca/aboriginal.htm 09/10/01.

Canadian Medical Association (1994). *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada*. Ottawa.

Canadian Nurses Association (1995). *Health in Canada: Perspectives of Urban Aboriginal People*. Ottawa.

Canadian Public Health Association (1993). *The Preliminary Study on the Training and Recruitment of Aboriginal Public Health Workers: Issues Identification Paper*. Ottawa.

Canadian Task Force on the Periodic Health Examination (1980). *Report on the Canadian Task Force on the Periodic Health Examination*. Ottawa.

Cannon, Martin (1998). "The Regulation of First Nations Sexuality." *The Canadian Journal of Native Studies*, 1(1998): 1-18.

Chockalingam A., N. Campbell, T. Ruddy, et al. (2000). "Canadian National High Blood Pressure Prevention and Control Strategy." *Canadian Journal of Cardiology*, 16(9): 1087-93.

Clarke, Heather F., Rhea Joseph, Michèle Deschamps, et al. (1998). "Reducing Cervical Cancer Among First Nations Women." *The Canadian Nurse*, March, 1998: 36-41.

Cultural Diversity Challenges and Changes (2000). *Nursing Now: Issues and Trends in Canadian Nursing*, 7(February). Ottawa: Canadian Nurses Association.
www.cna-nurses.ca/_frames/welcome/frameindex.html 11/27/01.

Daniel, M., K.G. Rowley, C.P. Herbert, et al. (2001). "Lipids and Psychosocial Status in Aboriginal Persons With and At Risk for Type 2 Diabetes: Implications for Tertiary Prevention." *Patient Education and Counseling*, 43(1): 85-95.

Daniel, M., S.A. Marion, S.B. Sheps et al. (1999). "Variation by Body Mass Index and Age in Waist-to-Hip Ratio Associations with Glycemic Status in an Aboriginal Population at Risk for Type 2 Diabetes in British Columbia, Canada." *American Journal of Clinical Nutrition*, 69(3): 455-60.

Daniel, Mark and Diane Gamble (1995). "Diabetes and Canada's Aboriginal Peoples: The Need for Primary Prevention." *Social Science and Medicine*, 32(3): 243-59.

Daniel, Mark, Lawrence W. Green, Stephen A. Marion, et al. (1999). "Effectiveness of Community-Directed Diabetes Prevention and Control in a Rural Aboriginal Population in British Columbia, Canada." *Social Science and Medicine*, 48(1999): 815-32.

Diabetes and Change (1998). *In Touch*, 9(1).

Dickson, Geraldine (2000). "Aboriginal Grandmothers' Experience with Health Promotion and Participatory Action Research." *Qualitative Health Research*, 10(2): 188-213.

Dion Stout, Madeleine and Gregory D. Kipling (1999). *Report of the Aboriginal Roundtable on Sexual and Reproductive Health*. Ottawa: Aboriginal Nurses Association of Canada.

Dion Stout, Madeleine, Gregory D. Kipling and Roberta Stout (2001). *Aboriginal Women's Health Research Synthesis Project Final Report*. Ottawa: Centres of Excellence for Women's Health Research Synthesis Group, Health Canada.

- Dougherty, Kevin (2000). "Cree Community More Polluted than Love Canal." *Ottawa Citizen*, Oct. 23, 2001.
- Downey, Michael (1999). "Canada's Genocide: Thousands Taken from Their Homes Need Help." *Maclean's*, April 26, 1999: 56.
- Enarson, D.A. (1998). "Tuberculosis in Aboriginals in Canada." *International Journal of Tuberculosis and Lung Disease*, 2(9): S16-S22.
- Eyles, John, Steven Birch and Shelley Chambers (1994). "Fair Shares for the Zone: Allocating Health Care Resources for the Native Populations of the Sioux Lookout Zone, Northern Ontario." *The Canadian Geographer*, 38(2): 134-50.
- First Nations and Inuit Health Branch, Health Canada (2001). Transfer Status as of March 2001. www.hc-sc.gc.ca/fnihb/bpm/hfa/transfer_status/ 10/01/01
- First Nations and Inuit Regional Health Survey National Steering Committee (1999). *First Nations and Inuit Regional Health Survey National Report 1999*. St. Regis, Quebec.
- FitzGerald, J. Mark, Lei Wang and R. Kevin Elwood (2000). "Tuberculosis: Control of the Disease Among Aboriginal People in Canada." *Canadian Medical Association Journal*, 162(3): 351-5.
- Flores, G., D. Gee and B. Kastner (2000). "The Teaching of Cultural Issues in U.S. and Canadian Medical Schools." *Academic Medicine*, 75(5): 451-5.
- Garro, Linda C. (1995). "Individual or Societal Responsibility? Explanations of Diabetes in an Anishinaabe (Ojibway) Community." *Social Science and Medicine*, 40(1): 37-46.
- George B. Cuff and Associates (2001). *It's Time to Act: A Report on the Health and Social Services System of the Northwest Territories*. Yellowknife.
- Gittelsohn, Joel, Stewart B. Harris, Andrew L. Thorne-Lyman, et al. (1996). "Body Image Concepts Differ by Age and Sex in an Ojibway-Cree Community in Canada." *Journal of Nutrition*, 126(12): 2990-3000.
- Goertzen, James (1999). "Teaching Activities for Aboriginal Health Issues." *Canadian Family Physician*, 45(June): 1442-4.
- Government of Nunavut (2001a). *Health and Social Services*. Iqaluit.
- Government of Nunavut (2001b). Nunavut: A New Vision. www.gov.nu.ca/flag.htm 9/18/01.
- Gregory, David, Wendy Whalley, Judith Olson, et al. (1999). "Exploring the Experience of Type 2 Diabetes in Urban Aboriginal People." *Canadian Journal of Nursing Research*, 31(1): 101-15.
- Hanley, A.J.G., S.B. Harris, J. Gittelsohn, et al. (2000). "Overweight Among Children and Adolescents in a Native Canadian Community: Prevalence and Associated Factors." *American Journal of Clinical Nutrition*, 71(3): 693-700.
- Harner, T. (1997). "Organochlorine Contamination of the Canadian Arctic and Speculation on Future Trends." *International Journal on Environment and Pollution*, 8(1-2): 51-73.

Hay, J. and R.J. Shephard (1998). "Perceptions and Patterns of Physical Activity: A Comparison of Mohawk/Cayuga and Non-Native Adolescents." *American Journal of Human Biology*, 10(5): 629-35.

Health Canada (1994). *Meeting of National Aboriginal Organizations and Health Canada: Meeting Report*. Ottawa.

Health Canada (1998). *Reaching Out: A Guide to Communicating with Aboriginal Seniors*. Ottawa. Catalogue no. H88-3/20-1998E.

Health Canada (1999a). *Budget 1999: Action on First Nations and Inuit Health Agenda*. Ottawa.

Health Canada (1999b). *A Second Diagnostic on the Health of First Nations and Inuit People in Canada*. Ottawa.

Health Canada (2000a). HIV and AIDS Among Aboriginal People in Canada. 10/10/01.

Health Canada (2000b). *Health Canada Performance Report For the Period Ending March 31, 2000*. Ottawa.

Health Canada and Aboriginal Nurses Association of Canada (1997). *It Takes A Community: A Resource Manual for Community-Based Prevention of Fetal Alcohol Syndrome and Fetal Alcohol Effects*. Ottawa.

Health Edition (October 26, 2001). "A Call for Help from Nunavut," 5(42). www.healthedition.com 26/10/01.

Hefferman, C., C. Herbert, Grams G.D., et al. (1999). "The Haida Gwaii Diabetes Project: Planned Response Activity Outcomes." *Health and Social Care in the Community*, 7(6): 379-86.

Hegele, R.A. (1999). "Genetic Prediction of Coronary Heart Disease: Lessons from Canada." *Scandinavian Journal of Clinical and Laboratory Investigation*, 59(Suppl 230): 153-67.

Henriksson, Lennart E. and Richard G. Lipsey (1999). "Should Provinces Expand Gambling?" *Canadian Public Policy*, 15(2): 259-73.

Hoepfner, Vernon H. and Darcy D. Marciniuk (2000). "Tuberculosis in Aboriginal Canadians." *Canadian Respiratory Journal*, 7(2): 141-6.

Hunter, Jennifer (1998). "Haunted by the Past: Cancer Stalks a Remote Community." *Maclean's*, 111(31):20.

Hutchinson, Michael (2001). "Boil Alert: Drink at Your Own Risk." *aboriginaltimes*, August-September 2001.

Indian and Northern Affairs Canada (2001a). First National Survey Finds First Nations People on Reserve are Optimistic About their Future (news release). 10/31/01.

Indian and Northern Affairs Canada (2001b). First Nations Housing. www.ainc-inac.gc.ca/pr/info/info104_e.thml 10/31/01.

Indian and Northern Affairs Canada (2001c). Mandate, Roles and Responsibilities: Indian and Northern Affairs Canada.

www.ainc-inac.gc.ca/ai/mand_e.html 11/02/01.

Indian and Northern Affairs Canada and Health Canada (no date). *First Nations Occupants Guide to Mould* (pamphlet). Ottawa.

Johnson, Jeff (1996). "Mohawk Environmental Health Project Integrates Research into the Community." *Environmental Science and Technology*, 30(1): 20A-21A.

Johnson, Roger J. (1997). "The Development of a Computerized Health Information System to Facilitate Program Planning/Evaluation and Enhanced First Nations Control of Community Health Services." *Canadian Journal of Public Health*, 88(3): 207-9.

Kahana, Leo M. (2000). "TB Among Aboriginal Canadians." *Canadian Medical Association Journal*, 162(10): 1404.

Kinnon, Dianne (1994) *Health is the Whole Person: A Background Paper on Health and the Métis People*. Ottawa: Royal Commission on Aboriginal Peoples.

Kirmayer, Laurence J., Gregory M. Brass and Caroline L. Tait (2000). "The Mental Health of Aboriginal Peoples: Transformations of Identity and Community." *Canadian Journal of Psychiatry*, 45(September): 607-16.

Kouri, Denise and Lori Hanson (2001). *Exploring Health Care Regionalization and Community Capacity*. Saskatoon: Regionalization Research Centre.

Kuran, Heidi (1999). "Women, Environment and Breast Cancer." *In Touch*, 13(Winter), 1999.

Lambert Colomeda, Lorelei Anne (1996). *Through the Northern Looking Glass: Breast Cancer Stories Told by Northern Native Women*. New York: NLN Press.

LaRocque, Emma (1994). *Violence in Aboriginal Communities* (reprinted from *The Path to Healing*, Royal Commission on Aboriginal Peoples). Ottawa: Health Canada.

Leake, J.L. (1992). *Report on the Oral Health Survey of Canada's Aboriginal Children Aged Six to Twelve*. Toronto: Department of Community Dentistry, University of Toronto.

Leenaars, A.A. (2000). "Suicide Prevention in Canada: A History of a Community Approach." *Canadian Journal of Community Mental Health*, 19(2): 57-73.

Leenaars, Antoon, Chris Cantor, John Connolly, et al. (2000). "Controlling the Environment to Prevent Suicide: International Perspectives." *Canadian Journal of Psychiatry*, 45(September): 639-44.

Lemchuk-Favel, Laurel (1999). "Effective Partnerships and Health Reform." *New Relationships and Partnerships in Health: Summary Report*. Ottawa: Assembly of First Nations and Medical Services Branch Joint Health Policy Forum, March 29-30, 1999.

Leskiw and Associates (2001). *Review of Aboriginal Services at Health Sciences Centre and St. Boniface General Hospital*. Winnipeg: Winnipeg Regional Health Authority.

- Little, Lois M. and Michael J. Prince (1993). *Community Control of Health and Social Services in Northern and Aboriginal Communities: A Literature Review and Analysis of Canadian Experiences*. Yellowknife: Special Committee on Health and Social Services, Legislative Assembly of the Northwest Territories.
- Macaulay, A.C., G. Paradis, L. Potvin, et al. (1997). "The Kahnawake Schools Diabetes Prevention Project: Intervention, Evaluation, and Baseline Results of a Diabetes Primary Prevention Program with a Native Community in Canada." *Preventive Medicine*, 26(6): 779-90.
- MacDonald, W.A. (1998). "Medical Teaching Program in a Rural Northern Hospital." *International Journal of Circumpolar Health*, 57(Suppl 1): 83-6.
- MacMillan, H.L., A.B. MacMillan, D.R. Orford, et al. (1995). "Aboriginal Health." *Canadian Medical Association Journal*, 155(11): 1569-78.
- Maclean's (1998). "Historic Hot Zone." 111(13): 31.
- Malchy, B., M.W. Enns, T.K. Young, et al. (1997). "Suicide Among Manitoba's Aboriginal People, 1988 to 1994." *Canadian Medical Association Journal*, 156(8): 1133-8.
- Manitoba Health (2001). Manitoba Health Annual Report. www.gov.mb.ca/health/ann/199697/3a-m4.html 9/19/01.
- McCormick, Rod (1995). "The Facilitation of Healing for the First Nations People of British Columbia." *Canadian Journal of Native Education*, 21(2): 251-322.
- McCormick, Rod (1997). "Healing Through Interdependence: The Role of Connecting in First Nations Healing Practice." *Canadian Journal of Counselling*, 31(3):172-84.
- McFarlane, Peter (1997a). "New Approaches to Injury Prevention." *In Touch*, 7(3): 1-3.
- McFarlane, Peter (1997b). "Suicide: Intentional Injury." *In Touch*, 7(3): 7-10.
- McGowan, Patrick and Lawrence W. Green (1995). "Arthritis Self-management in Native Populations of British Columbia: An Application of Health Promotion and Participatory Research Principles in Chronic Disease Control." *Canadian Journal on Aging*, 14(Suppl 1): 201-13.
- Mailloux, Louise and Peter Gillies (2001). *Inuit Health Information Initiative: Discussion Paper*. Ottawa: Pauktuutit Inuit Women's Association and Inuit Tapirisat of Canada.
- Malloch, Leslie (1989). "Indian Medicine, Indian Health: Study Between Red and White Medicine." *Canadian Women's Studies*, 10(2.3): 105-112.
- Métis Nation of Ontario (2001). Métis Nation of Ontario Health. www.metisnation.org/MNO/HEALTH.html 10/03/01.
- Mill, Judy E. (1997). HIV Risk Behaviours Become Survival Techniques for Aboriginal Women. *Western Journal of Nursing Research*, 19(4): 466-90.
- Mill, Judy E. and David A. Desjardins (1996). "The Feather of Hope Aboriginal AIDS Prevention Society: A Community Approach to HIV/AIDS Prevention." *Canadian Journal of Public Health*, 87(4): 268-71.

Minister of Indian Affairs and Northern Development (1998). *Gathering Strength: Canada's Aboriginal Action Plan, A Progress Report, Year 1*. Ottawa.

Minister of Public Works and Government Services Canada (1997). *Beginning a Long Journey: A Review of Projects Funded by the Family Violence Prevention Division, Health Canada, Regarding Violence in Aboriginal Communities*. Ottawa.

Minister of Public Works and Government Services (1999). *National Consultations Summary Report: Renewal of the Federal Health Protection Legislation*. Ottawa.

Mitchell, Emmy (1998). Traditional Health and Diabetes. *In Touch*, 9(2): 12.

Mitchell, Sonia, Caroline Tait, Laverne Contois, et al. (1998). *Wisdom of Native Women: Wellness Conference for Urban Aboriginal Women*. Montréal: Centre d'excellence pour la santé des femmes Consortium Université de Montréal.

Moffat, T. and A. Herring (1999). "The Historical Roots of High Rates of Infant Death in Aboriginal Communities in Canada in the Early Twentieth Century: The Case of Fisher River, Manitoba." *Social Science and Medicine*, 48(12): 1821-32.

Moore, Jan Allison (1999). "Comparison of Risk of Conductive Hearing Loss Among Three Groups of Arctic Audiology Patients." *Journal of Speech, Language and Hearing Research*, 42: 1311-23.

Morrison, N. and J. Dooley (1998). "The Sioux Lookout Diabetes Program: Diabetes Prevention and Management in Northwestern Ontario." *International Journal of Circumpolar Health*, 57 Suppl (1): 364-9.

Muhajarine, N. and C. Darcy (1999). "Physical Abuse During Pregnancy: Prevalence and Risk Factors." *Canadian Medical Association Journal*, 160(7): 1007-11.

Muhajarine, N., C. Darcy and L. Edouard (1997). "Prevalence and Predictors of Health Risk Behaviours During Early Pregnancy Saskatoon Pregnancy and Health Study." *Canadian Journal of Public Health*, 88(6): 375-9.

Myers, Ted, Sandra L. Bullock, Liviana M. Calzavara, et al. (1997). "Differences in Sexual Risk-Taking Behaviour with State of Inebriation in an Aboriginal Population in Ontario, Canada." *Journal of Studies on Alcohol*, 58(3): 312-23.

National Aboriginal Health Organization (2001a). *Annual Report 2000-2001*. Ottawa.

National Aboriginal Health Organization (2001b). *Management Plan*. Ottawa.

National Clearinghouse on Family Violence (1997). *Family Violence in Aboriginal Communities: An Aboriginal Perspective*. Ottawa.

National Forum on Health (1997). "The Need for an Aboriginal Health Institute in Canada." *Canada Health Action: Building on the Legacy, Final Report, Volume II*. 18/10/01.

National Indian and Inuit Community Health Representatives Organization (1997). "Intentional Injuries: Family Violence." *In Touch*, 7(3): 11-13.

National Indian and Inuit Community Health Representatives Organization (2000). "HIV/AIDS

Conference Recommendations.” *In Touch*, 15(Summer).

National Indian and Inuit Community Health Representatives Organization (2001). What is NIICHRO? www.niichro.com 20/09/01

Native Social Work Journal, Special Edition: HIV/AIDS: Issues Within Aboriginal Populations, 3(September, 2000).

Northern Secretariat, Health Canada (2000). *Deputy Ministers' Territorial Wellness Framework Document*. Ottawa.

Northern Secretariat, Health Canada (2001). The Northern Secretariat. 09/24/01.

Northwest Territories Department of Health and Social Services (1998). *Shaping Our Future: A Strategic Plan for Health and Wellness: Summary*. 9/21/01.

Northwest Territories Department of Health and Social Services (1999). *Health Promotion Strategy: Executive Summary*. 9/21/01.

Northwest Territories Department of Health and Social Services (2000). *Business Plan 2000 to 2003*. Yellowknife.

O'Neil, John D. (1995). “Issues in Health Policy for Indigenous People in Canada.” *Australian Journal of Public Health*, 19: 559-66.

O'Neil, John D., Jeffrey R. Reading and Audrey Leader (1998). “Changing the Relations of Surveillance: The Development of a Discourse of Resistance in Aboriginal Epidemiology.” *Human Organization*, 57(2): 2307.

O'Neil, John D., Jeffrey Reading, Judith Bartlett, et al. (1999). *Integrating a Focus on Aboriginal Health Research in the Development of the Canadian Institutes of Health Research: A Concept Paper*. Winnipeg: Department of Community Health Sciences, University of Manitoba.

Peters, Ron and Lou Demerais (1997). “Improving Mental Health Services for Urban First Nations: Policy Issues Relevant to Health Care Reform.” *Canadian Journal of Community Mental Health*, 16(2): 29-36.

Poland, G.A., R.M. Jacobsen, S.A. Colbourne, et al. (1999). “Measles Antibody Seroprevalence Rates Among Immunized Inuit, Innu and Caucasian Subjects.” *Vaccine*, 17(11-12): 1525-31.

Poonwassie, Anne and Ann Charter (2001). “An Aboriginal Worldview of Helping: Empowering Approaches.” *Canadian Journal of Counselling*, 35(1): 63-73.

Potvin, Louise, Serge Desrosiers, Mary Trifonopoulos, et al. (1999). “Anthropometric Characteristics of Mohawk Children Aged 6 to 11 years: A Population Perspective.” *Journal of the American Dietetic Association*, 99(8): 955-62.

Receveur, O., M. Boulay and H.V. Kuhnlein (1997). “Decreasing Traditional Food Use Affects Diet Quality for Adult Dene/Métis in 16 Communities of the Canadian Northwest Territories.” *American Society for Nutritional Sciences*, July 18, 1997.

Redwood-Campbell, L., W.A. MacDonald and K. Moore (1999). Residents' Exposure to Aboriginal Health Issues: Survey of Family Medicine Programs in Canada.” *Canadian Family Physician*, 45: 325-30.

Restoule, Brenda Marilyn Marie (2000). "Healing in Ojibwa First Nation Communities: Investigating the Relationship Among Acculturation, Health and Identity." *Dissertation Abstracts International Section B: the Sciences and Engineering*, 60(10B).

Rosenburg, Ted, Ora Kendall, Jamie Blanchard, et al. (1997). "Shigellosis on Indian Reserves in Manitoba, Canada: Its Relationship to Crowded Housing, Lack of Running Water, and Inadequate Sewage Disposal." *American Journal of Public Health*, 87(9): 1547-51.

Royal Commission on Aboriginal Peoples (1993a). *The Path to Healing*. Ottawa: Minister of Supply and Services Canada.

Royal Commission on Aboriginal Peoples (1993b). *Public Hearing Discussion Paper 2: Focusing the Dialogue*. Ottawa: Minister of Supply and Services Canada.

Royal Commission on Aboriginal Peoples (1996). *People to People; Nation to Nation: Report of the Royal Commission on Aboriginal Peoples, Volume 3: Gathering Strength*. Ottawa: Minister of Supply and Services Canada.

Sawchuk, P., M. Rauliuk, A. Kotaska, et al. (1998). "Infant Nutrition Program Effectively Prevents Iron-Deficiency Anemia in a First Nations Community." *International Journal of Circumpolar Health*, 57 Suppl (1): 189-93.

Schuller, P.D., G.W. Thompson and T. Taerum (1998). Awareness of Periodontal Disease in a Group of Northern Canadian Children. *International Journal of Circumpolar Health*, 57 (Suppl 1): 163-8.

Schwartz, Sandra (2000). "Environment: A Key Determinant of Children's Health." *Health Promotion in Canada*, 34(1): 10-3.

Shah, Baiju R., Janet E. Hux and Bernard Zinman (2000). "Increasing Rates of Ischemic Heart Disease in the Native Population of Ontario, Canada." *Archives of Internal Medicine*, 160 (June 26): 1862-6.

Shah, C.P., T. Svoboda and S. Goel (1996). "The Visiting Lectureship on Aboriginal Health: An Educational Initiative at the University of Toronto." *Canadian Journal of Public Health*, 87(4): 272-4.

Ship, Susan Judith (1998a). *The Development of National Occupational Standards for Community Health Perspectives: Issues Identification Paper*. Kahnawake, Quebec: National Indian and Inuit Community Health Representatives Organization.

Ship, Susan J. (1998b). "Environmental Contaminants and Traditional Food." *In Touch*, 8(2): 7-10.

Ship, Susan J. (1998c). "Environmental Damage and Aboriginal Health." *In Touch*, 8(2): 2-6.

Ship, Susan Judith and Judi Jacobs (1998). First Nations Diabetes Programs.
www.niichro.com/Diabetes/Dia6.html 03/08/01.

Silverman, Barbara E., Wendy M. Goodine, Michael G. Ladouceur, et al. (2001). "Learning Needs of Nurses Working in Canada's First Nations Communities and Hospitals." *The Journal of Continuing Education in Nursing*, 32(1): 38-45.

Smylie, Janet (2001). *A Guide for Health Care Professionals Working with Aboriginal Peoples* (SOGC Policy Statement No.100). Ottawa: Society of Obstetricians and Gynaecologists of Canada.

- Sokoloski, Elizabeth H. (1997). "Canadian First Nations Women's Beliefs About Pregnancy and Prenatal Care." *Canadian Journal of Nursing Research*, 27(1): 89-100.
- Statistics Canada (1996). *A Profile of the Métis*. Ottawa. Catalogue no. 89-547-XPE.
- Statistics Canada (1998). "1996 Census: Aboriginal Data." *The Daily*, Jan. 13, 1998.
- Statistics Canada (2001). "Population Estimates, July 1, 2001." *The Daily*, Sept. 25, 2001.
- The Senate Standing Committee on Social Affairs, Science and Technology (2001). *The Health of Canadians: The Federal Role: Volume Four: Issues and Options*. Ottawa.
- Stephenson, Peter H. (1997). "Environmental Health Perspectives on the Consequences of an Ideology of Control in Natural Systems." *The Canadian Review of Sociology and Anthropology*, 34(3): 350-68.
- Sunday, Julie and John Eyles (2001). "Managing and Treating Risk and Uncertainty for Health: A Case Study of Diabetes Among First Nations People in Ontario, Canada." *Social Science and Medicine*, 52(2001): 635-50.
- Svenson, Kenneth A. and Christopher Lafontaine (1999). "The Search for Wellness." *First Nations and Inuit Regional Health Survey National Report*. St. Regis, Quebec: First Nations and Inuit Regional Health Survey National Steering Committee.
- Tarrant, Marie and David Gregory (2001). "Mothers' Perceptions of Childhood Immunizations in First Nations Communities of the Sioux Lookout Zone." *Canadian Journal of Public Health*, 92(1): 42-5.
- Tookenay, Vincent F. (1996). "Improving the Health Status of Aboriginal People in Canada: New Directions, New Responsibilities." *Canadian Medical Association Journal*, 155(11): 1581-3.
- Tripartite Working Group on Aboriginal Health (1993). *The Federal/Provincial/Territorial/National Aboriginal Health Report to the Ministers of Health and National Aboriginal Organizations*. Ottawa: Minister of Supply and Services Canada.
- Vaccine Weekly* (1999). "Immunization in a First Nations Community During a Hepatitis A Outbreak." Feb. 15, 1999.
- Van Oostdam, J., A. Gilman, E. Dewailly, et al. (1999). "Human Health Implications of Environmental Contaminants in Arctic Canada: A Review." *Science of the Total Environment*, 230(1-3): 1-82.
- Van Uchelen, Collin P., Sara Florence Davidson, Seanna V.A. Quressette, et al. (1997). "What Makes Us Strong: Urban Aboriginal Perspectives on Wellness and Strength." *Canadian Journal of Community Mental Health*, 16(2): 37-50.
- Waldram, James B., D. Ann Herring and T. Kue Young (1995). *Aboriginal Health in Canada*. Toronto: University of Toronto Press.
- Wein, E.E. (1995). "Evaluating Food Use by Canadian Aboriginal Peoples." *Canadian Journal of Physiology and Pharmacology*, 73(6): 759-64.
- Wein, E.E., M.M.R. Freeman and J.C. Makus (1996). "Use of and Preference for Traditional Foods Among the Belcher Island Inuit." *Arctic*, 49(3): 256-64.

Wheatley, B. and S. Paradis (1996). "Balancing Human Exposure, Risk and Reality: Questions Raised by the Canadian Aboriginal Methylmercury Program." *Neurotoxicology*, 17(1): 241-9.

Wheatley, B., S. Paradis, M. Lassonde, et al. (1997). "Exposure Patterns and Long Term Sequelae on Adults and Children in Two Canadian Indigenous Communities Exposed to Methylmercury." *Water, Air and Soil Pollution*, 97(1-2): 63-73.

Williams, Lylee (1999). "Our Most Precious Gift: Child Health in Aboriginal Communities." *In Touch*, 12(Summer 1999): 3-8.

Wilson, C.E. (1999). "Sudden Infant Death Syndrome and Canadian Aboriginals: Bacteria and Infections." *FEMS Immunology and Medical Microbiology*, 25(1-2): 221-6.

Working Group on Population Health Strategy, Health Canada (1996). *Toward a Common Understanding: Clarifying the Core Concepts of Population Health, Discussion Paper*. Ottawa.

World Health Organization, Health and Welfare Canada and the Canadian Public Health Association (1986). *The Ottawa Charter for Health Promotion*. Ottawa.

Young, T. Kue (1998). "Aboriginal Health: Not Just Tuberculosis." *International Journal of Tuberculosis and Lung Disease*. 2(9): S23-S25.

Young, T. Kue, Michael E. K. Moffat, and John D. O'Neil (1993). "Cardiovascular Diseases in a Canadian Arctic Population." *American Journal of Public Health*, 83(6): 881-7.

Young, T.K., E. Kliewer, J. Blanchard, et al. (2000). "Monitoring Disease Burden and Preventive Behaviour with Data Linkage: Cervical Cancer Among Aboriginal People in Manitoba, Canada." *American Journal of Public Health*, 90(9): 1466-8.

Young, T.K., H.J. Dean, B. Flett, et al. (2000). "Childhood Obesity in a Population at High Risk for Type 2 Diabetes." *Journal of Pediatrics*, 136(3): 365-9.

Young, T.K., P. McNicol and J. Beauvais (1998). "Factors Associated with Human Papillomavirus Infection Detected by Polymerase Chain Reaction Among Urban Canadian Aboriginal and Non-Aboriginal Women." *Sexually Transmitted Diseases*, 24(5): 293-8.

9. KEY INFORMANTS

Loretta Bayer
Director
Manitoba Aboriginal Health Strategy

Tom Bradfield
Manager, Aboriginal Negotiations
Aboriginal Health Division
British Columbia Ministry of Health Services

Bernice Downey
Executive Director
Aboriginal Nurses Association of Canada

Don Fiddler
Director of Health
Métis National Council

Debra Gillis
Director
Health Programs Support Division
First Nations and Inuit Health Branch
Health Canada

Fjola Hart-Wasekeesikaw
Chairperson, Health Research and Health
Information Priority Advisory Committee
National Aboriginal Health Organization

Richard Jock
Executive Director
National Aboriginal Health Organization

Denise Kouri
Director
HEALNet Regionalization Research Centre

Bill Lyall
Chairperson, Inuit Centre Governing Committee
National Aboriginal Health Organization

Michael Martin
Senior Policy Analyst
National Aboriginal Health Organization

Judith Bartlett
Chairperson, Board of Directors
National Aboriginal Health Organization

Keith Conn
Director General
Community Health Program Directorate
First Nations and Inuit Health Branch
Health Canada

Joan Feather
Director
Prairie Region Health Promotion Resource
Centre

Tracy Gibbons
Policy Advisor
Northern Secretariat
Health Canada

Michelle Harding
Director
Aboriginal Healing and Wellness Strategy
Ontario Ministry of Health

Margaret Horn
Executive Director
National Indian and Inuit Community Health
Representatives Organization

Elaine Johnston
Director
Health Secretariat
Assembly of First Nations

Nathalie Lachance
Director, Métis Centre
National Aboriginal Health Organization

Miriam Lyall
Inuit Centre Governing Committee
National Aboriginal Health Organization

Gail McDonald
Director, First Nations Centre
National Aboriginal Health Organization

Heather McNeill
Chairperson, Health Policy, Capacity Building
and Public Education Priority Advisory
Committee
National Aboriginal Health Organization

Richard O'Brien
Assistant Deputy Minister
Nunavut Health and Social Services

Cathy Praamsma
Assistant Deputy Minister
Northwest Territories Department of Health and
Social Services

Robert Watt
Director, Inuit Centre
National Aboriginal Health Organization

John O'Neil
Director
Manitoba First Nations Centre for Aboriginal
Health Research

France Picotte
Chairperson, Métis Centre Governing
Committee
National Aboriginal Health Organization

Eric Shirt
Chairperson, Traditional Health and Healing
Priority Advisory Committee
National Aboriginal Health Organization

Roberta Wraith
Health Manager
Métis Nation of Ontario