REVIEW OF CORE COMPETENCIES FOR PUBLIC HEALTH:

An Aboriginal Public Health Perspective

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SETTING THE CONTEXT

 This publication was funded by the NCCAH and made possible through a financial contribution from the Public Health Agency of Canada. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

Acknowledgements

The NCCAH uses an external blind review process for documents that are research based, involve literature reviews or knowledge synthesis, or undertake an assessment of knowledge gaps. We would like to acknowledge our reviewers for their generous contributions of time and expertise to this manuscript.

Citation: Hunt, S. (2015). *Review of Core Competencies for Public Health: An Aboriginal Public Health Perspective.* Prince George, BC: National Collaborating Centre for Aboriginal Health.

Une version française est également publiée sur le site www.nccah-ccnsa.ca, sous le titre *Revue des compétences essentielles pour la santé publique : Une perspective de santé publique Autochtone.*

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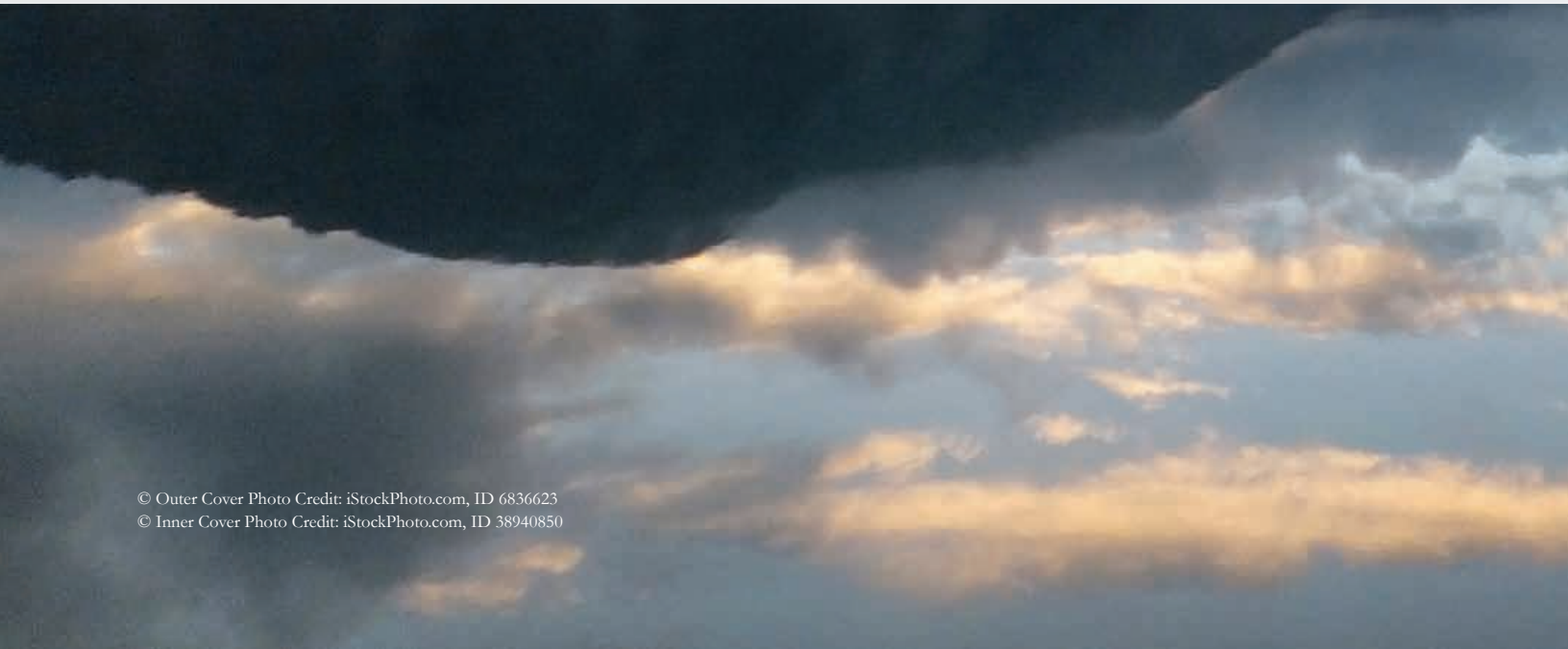
ISBN: 978-0-9952089-0-2



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List of Acronyms

CIPHER	Competencies for Indigenous Public Health, Evaluation and Research
FNHA	First Nations Health Authority of BC
MNBC	Métis Nation British Columbia
NAHO	National Aboriginal Health Organization
PHAC	Public Health Agency of Canada
UN	United Nations

1.0 INTRODUCTION

In 2007, the Public Health Agency of Canada (PHAC) released *Core Competencies for Public Health in Canada 1.0*. The document outlines the knowledge, skills and attitudes necessary for effective public health practice in all health disciplines. The development of the competencies followed the Joint Task Group on Public Health Human Resources' (2005) finding that core competencies for interdisciplinary public health practice was a foundational building block for strengthening the public health workforce. The competencies are intended to provide generic building blocks for a coordinated approach to public health and are designed to guide the development of curricula, training and professional development tools, as well as job descriptions and performance assessment for public health practitioners across Canada. In total, 36 core competency statements are organized under seven categories: public health sciences; assessment and analysis; policy and program planning; implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; and leadership.

This document provides a review of *Core Competencies for Public Health in Canada 1.0.* from an Aboriginal[1] public health perspective[2], building on current international work on the public health of Indigenous peoples.[3]

What is Indigenous public health?

It is estimated that there are between 250-370 million Indigenous people worldwide living on every inhabited continent. Indigenous public health is an emerging field of health research, responding to the health disparities experienced by Indigenous peoples internationally. Research on Indigenous health has been limited by a lack of reliable and accurate data about the health of Indigenous peoples (Greenwood, Lindsay, Halseth, McGregor, de Leeuw, & Keahey, 2014). Inadequate data on Indigenous peoples is due, in part, to poor definition of Indigenous identification, as many countries do not officially recognize their Indigenous peoples and have inaccurate or no statistical data for these groups (Gracey & King, 2009).

Despite the statistical gaps, research shows that health inequities are prevalent among Indigenous people worldwide (Gracey & King, 2009; Nettleton, Napolitano, & Stephens, 2007), as they experience poor living conditions and water supplies, restricted access to fresh and nutritious food, and inadequate health services among other conditions. Major health disparities among Indigenous peoples internationally include malnutrition, high rates of infectious disease, shortened life expectancy, illness related to misuse of alcohol and drugs, high rates of violent death, chronic diseases (obesity, diabetes, cardiovascular disease), and illnesses caused by environmental contamination (such as by heavy metals, industrial bases and effluent wastes) (Gracey & King, 2009). Additionally, high infant and maternal mortality rates reflect the specific health disparities experienced by Indigenous women, and the gendered nature of colonial violence and global socio-economic inequality, as do the high rates of violence and disappearances experienced by Indigenous women.

[1] Aboriginal peoples refer collectively to the original inhabitants of Canada and their descendants, including First Nations, Inuit and Métis peoples as defined in Section 35(2) of the Canadian Constitution Act, 1982.

[2] PHAC's *Core Competencies for Public Health in Canada 1.0* has been assessed for determinants of health content by the National Collaborating Centre for Determinants of Health [NCCDH] (2012).

[3] 'Indigenous peoples' refer to the original inhabitants of all continents and countries internationally.

Furthermore, Indigenous groups internationally experience the powerful effects of colonization on their communities and lands by settlers who have introduced new political and governing structures, while alienating Indigenous peoples from their own cultural practices including loss of language, traditional foods and healing methods. Specific circumstances and processes of colonization differ widely among each country, yet most Indigenous people share the common experience of having their traditional ways of life disrupted, as well as experiencing socio-economic and political marginalization and racial prejudice. Land dispossession and the inability to continue living in relationship to local environments have led many Indigenous groups to live on the fringes of society, in urban slums, environmentally degraded areas, or in isolated regions with few natural resources or services. These legacies of colonialism impact the health of Indigenous peoples internationally, including their physical, mental, and spiritual well-being. Colonialism is thus an underlying contributor to health inequities among Indigenous peoples around the globe (Mowbray, 2007). Self-determination is seen as a requirement for restoring Indigenous peoples' control over their lives and revitalizing their land-based traditional economies, which are essential for health and well-being.

The right to health has been established within a number of United Nations (UN) conventions, including the UN Declaration on the Rights of Indigenous Peoples (United Nations General Assembly, 2007), which states that Indigenous peoples have the right to "the enjoyment of the highest attainable standard of physical and mental health" (Article 24). Indigenous health is crucially influenced by structural social determinants of health, which underpin Indigenous peoples' control over resources and access to services, and have a major impact on Indigenous peoples' autonomy (Nettleton, Napolitano, & Stephens, 2007). A social determinants of health framework has been widely used to understand health disparities and to identify possible methods for improving Indigenous health globally, as it allows for an analysis of intersecting systemic, historic and contemporary socio-economic factors that shape the health of individuals and communities. Although there has been an increasing amount of research on Indigenous health disparities and considerable resources have been committed to improving health provision and health promotion for Indigenous peoples, health outcomes in Indigenous communities continue to lag behind those in non-Indigenous communities internationally.

Health, from an Indigenous perspective, is often communal rather than individual. Indigenous peoples have complex socio-cultural and spiritual relationships with lands and ecosystems; thus destruction of, or isolation from, land is a significant factor impacting health. Self and group identity may also be an important determinant of Indigenous health, as the definition of Indigeneity is socio-cultural in nature (Nettleton, Napolitano, & Stephens, 2007).

Following these international trends in Indigenous health, First Nations, Inuit and Métis people in Canada experience a disproportionate rate of disease, mortality and ill-health when compared to non-Aboriginal Canadians. Aboriginal people in Canada experience health inequities across a range of factors such as poverty, housing, physical and sexual violence, and educational attainment, all of which shape disparities in disease as well as Aboriginal peoples' ability to change their circumstances (Adelson, 2005). Rates of illness among Aboriginal people in Canada must therefore "be seen, at least in part, as the direct and indirect present-day symptoms of a history of loss of lands and autonomy and the results of the political, cultural, economic and social disenfranchisement that ensued" (Ibid., p. S59).

Given the continued impact that legacies of colonialism have on the health of Indigenous people and communities, health experts have emphasized the importance of creating culturally relevant models of health care in which Indigenous people themselves take an active role in determining the kinds of services they receive and how their health is measured. A range of health care providers, policy makers and researchers are working internationally across disciplines to improve Indigenous peoples' well-being within a holistic model of health, addressing the impacts of colonialism and the ongoing realities of structural socio-economic inequity, while drawing on the strengths of culturally-rooted teachings and methodologies that Indigenous peoples across the globe continue to practice.

What is culturally relevant health care?

In order to improve Indigenous peoples' health internationally, public health practitioners and systems require a range of knowledge, skills and attitudes that are essential for providing culturally relevant and accessible health services. Within Canada, the development of these core competencies is vital to ensuring the delivery of culturally relevant health care to First Nations, Inuit and Métis people.

Some core competencies which address issues of cultural safety, power, inequity, and incorporation of non-Western knowledge and systems of healing for Aboriginal people are similar to those for working with non-Aboriginal cultural minorities in Canada. Yet within the context of colonialism, some competencies are specific to providing culturally safe health services for Aboriginal people, given both the fiduciary responsibility

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Research has shown that community-based initiatives, cultural pride and the reclamation of traditional approaches to health and healing have helped to improve and promote mental, physical and spiritual health within Aboriginal communities
(Smye & Browne, 2002)

of the federal government to the health needs of Aboriginal people, as well as the specific connections between the lands of Canada and Indigenous health, as rooted in cultural practices and worldviews. Thus, although some of the analysis in this document may be relevant to core competencies of public health for cultural and racial minorities in Canada, many elements will be specific to the historic and current relationship of Aboriginal people to Canadian society.

Research has shown that community-based initiatives, cultural pride and the reclamation of traditional approaches to health and healing have helped to improve and promote mental, physical and spiritual health within Aboriginal communities (Smye & Browne, 2002). Analyses of health must be deeply connected to broad sociopolitical and historic issues, particularly because health care services within Canada are predominantly provided by non-Aboriginal people to whom Aboriginal people have been subordinated. Awareness of the broad sociopolitical and historic issues impacting Aboriginal health disparities is an important component of ensuring health practitioners understand the impact that colonialism and marginalization have on the mental and physical well-being of First Nations, Inuit and Métis people and communities. Additionally, raising awareness among health practitioners of Aboriginal cultural practices, histories and worldviews particular to the region in which they work are key to bridging gaps of misunderstanding among public health practitioners and the Aboriginal people they serve. The recognition and usage of Aboriginal knowledge in improving health and wellness is an important component of restoring Aboriginal peoples' self-determination and their ability to shape their own lives and futures.

Within a colonial context, culture must be understood as comprised of a complex network of meanings enmeshed within historic, social, economic and political processes that include intersections of race, gender and class, and the impact of structural inequities on life opportunities (Smye & Browne, 2002). Thus, culturally relevant health care is not only about recognizing the distinctness of First Nations, Inuit and Métis peoples as cultural groups, but recognizing the impact of the dominant culture, its

systems and norms, on Aboriginal peoples. Additionally, cultural safety aims to counter tendencies in health care systems to create cultural risk or foster a lack of safety for Aboriginal people who may face misunderstanding, discrimination, racism or disempowerment in their interactions with diverse policies and systems, and representatives of those systems.

To date, core competencies for public health practitioners working with Indigenous communities have not been developed within Canada or internationally. The development of these competencies is challenging, given the cultural and socio-economic diversity of Indigenous groups nationally and globally, as well as the lack of infrastructure and data to support Indigenous health. However, Indigenous representatives from the lands now known as Canada, Australia, New Zealand, the United States and Hawaii have formed *CIPHER: Competencies for Indigenous Public Health, Evaluation and Research*, an international collaboration of Indigenous health experts who have been working on the development of such competencies. An environmental scan was recently completed to support the development of these Indigenous public health core competencies in order to "provide an overview of curriculum and initiatives implemented by governments, universities, and by Aboriginal and non-Aboriginal agencies and organizations to improve the cultural competency and safety of health professionals in their relations with First Nations, Inuit and Métis patients" (Baba, 2013, p. 6).

The core competencies envisioned by CIPHER partners would describe the skills, knowledge and attitudes a public health practitioner could utilize to provide culturally competent and safe health services to Aboriginal individuals and communities. Within Canada, implementation of these competencies could lead to improvements in academic curriculum, training programs, professional certification, health services planning, health policy, and health program evaluation standards. These core competencies in Aboriginal public health could also be used as standardized assessment criteria which could help governments and organizations share best practices more efficiently and promote culturally safe Aboriginal health services across Canada (Baba, 2013). Ultimately, these standards in culturally competent health services could improve the quality of care Aboriginal people receive, and thus contribute to improving their overall health status.

Overview of this document

This document is organized into four sections. The first section following this introduction provides an analysis of the governance and recognition of First Nations, Inuit and Métis people in *Core Competencies for Public Health in Canada 1.0*. This section also provides a discussion

of which public health practitioners are considered to comprise the intended audience of the PHAC competencies. The next section provides an analysis of the attitudes and values which frame the PHAC competencies and each of the seven competency categories. The final section summarizes recommendations for strengthening the alignment of PHAC core competencies with an Aboriginal public health framework.

Methodology

This review focuses on analyzing PHAC's *Core Competencies for Public Health in Canada 1.0* within an Aboriginal public health framework, seeking to address issues of Aboriginal public health including systemic factors related to colonialism, recognition of Indigenous knowledge, and First Nations, Inuit and Métis health governance. As previously discussed, no core competencies have been created to date in the areas of Indigenous or Aboriginal public health, therefore a direct analysis against Aboriginal public health competencies was not possible. However, several core competency documents have been created in recent years, as educational and training institutions, Aboriginal agencies and governments have sought to create models for training and assessing cultural competence in public health practitioners working with Aboriginal people and communities. Cultural competence has been used as an overarching framework in which to develop Aboriginal public health services which can best address the specific needs of First Nations, Inuit and Métis communities in order to effectively remedy existing health disparities. The leadership of Aboriginal people, communities and governments, and their beliefs, values and understandings of health, have been central to creating these competency frameworks in support of the underlying principles of self-determination.

While the focus of this document is on competencies for practitioners of all cultural backgrounds working with Aboriginal people and communities, there are some areas where specific competencies apply to Aboriginal practitioners, as they have emerged in Aboriginal-specific training programs. These Aboriginal health competencies have thus far been created in training for Aboriginal primary health care providers (Hammond & Collins, 2007), Aboriginal nursing (Hart-Wasekeesikaw, 2009), Aboriginal physician training (Lavallee, Neville, Anderson, Shore, & Diffey, 2009), and Aboriginal health care administrators, providers and educators (National Aboriginal Health Organization [NAHO], 2008). The existing core competency frameworks in culturally relevant Aboriginal health have been used in this document as a measure of analysis against which to discuss the relevance of the PHAC competency framework for Aboriginal public health.

2.0 ABORIGINAL HEALTH GOVERNANCE IN PHAC CORE COMPETENCIES

Core Competencies for Public Health in Canada 1.0 states that "all levels of government" were included in the development of the competencies framework and that "governments at the federal, provincial/territorial and local levels" are among those responsible for ensuring proficiency in the competencies (p. 2). Yet the framework does not mention whether or not Aboriginal peoples were recognized as a level of government within Canada in the consultation process for developing the framework. This lack of recognition of First Nations, Inuit and Métis governance bodies is significant given the unique relationship that Aboriginal peoples have with the federal government.

As stated by Michel Roy, Senior Assistant Deputy Minister of First Nations and Inuit Health Branch of Health Canada in the federal department's 2012 *Strategic Plan*:

> Today, First Nations and Inuit health issues intersect with a number of other key government priorities – notably in areas such as social and economic policy, community safety, the environment, and federal-provincial-territorial relations. Moreover, how we choose to address health issues facing First Nations and Inuit is an important consideration in how Canada manages its ongoing relationship with aboriginal peoples. (n.p.)

Arguably, this discussion of the governmental relationship with Aboriginal people signals a duty to recognize and involve First Nations, Inuit and Métis health authorities and governmental bodies in the development of core competencies of public health. Aboriginal peoples have unique relationships with the federal government and to issues of public health in Canada, and thus should be specifically consulted as a level of government and as community partners.

Responsibility for Aboriginal public health care in Canada

Health care for Aboriginal people is delivered in the context of an inter-jurisdictional health system administered by federal, provincial, territorial, First Nations, Inuit and Métis governing bodies. Health care is managed differently for First Nations, Inuit and Métis peoples, within the context of their distinct historic and ongoing relationships with the federal government.

Aboriginal people have argued that the federal government is required to provide health programs and services based upon existing treaty rights and fiduciary responsibility rather than as a matter of policy (Royal Commission on Aboriginal Peoples, 1996). However, the federal government provides certain health programs and services to on-reserve First Nations and Inuit as a matter of policy rather than enacting legislation in relation to the provision of Indigenous health care. The mandate for First Nations and Inuit health is derived from the 1979 *Indian Health Policy*, which gives the federal government a specific governmental responsibility for First Nations and Inuit health that is distinct from other parts of the Canadian population (Health Canada, 2014a). Significantly, although the federal government does have a specific fiduciary duty to Métis peoples, Métis health is not included in this policy.

According to Health Canada (2014b), provincial governments deliver hospital, physician, and public health programs to all Canadians but generally do not operate directly on-reserve. Health Canada funds primary care in 85 remote/isolated First Nations communities, and public health nursing, health promotion/disease prevention, environmental health services, and home and community care in well over 600 communities. First Nations and Inuit communities have taken on various levels of responsibility to manage federally funded health services, as Aboriginal people have long expressed a desire to have greater control over their own health care in order to better integrate Aboriginal health and wellness models. As Aboriginal people increasingly claim responsibility for the governance of their education, safety and other aspects

...community health representatives often serve as a bridge between Aboriginal people and the health care system, in rural and remote areas in which hospitals, clinics and other formal health care facilities do not exist. Further, home care workers and outreach workers conduct follow up care with Elders or others who may not be able to travel to urban centers for health services...

of their communities, new models are emerging for First Nations, Inuit and Métis systems of health governance.

Most recently, the collective management of First Nations health care in British Columbia (BC) by the BC First Nations Health Authority (FNHA) provides a model where a regional First Nations health authority has assumed responsibility for public health in First Nations communities across the province. Through the *British Columbia Tripartite Framework Agreement on First Nations Health Governance*, Health Canada transferred its role in the design, management and delivery of First Nations health programming in BC to the new FNHA on October 1st, 2013, along with the resources of the First Nations and Inuit Health branch of Health Canada in BC. The collective goal of the Tripartite First Nations Health Plan is:

> …to ensure First Nations are involved as equal partners in the planning and management of health services for our people. The work that BC First Nations are doing today will help us achieve that goal, and to ensure future generations have authority to enact policies, measure success, allocate resources, and establish service standards that are accountable to our communities. We need to work together to create healthy, strong, more vibrant communities now and in the future (First Nations Health Council, 2011, p. 1).

Through this historic agreement, the FNHA now administers federal health programs and services to First Nations people in BC using both First Nations traditional healing knowledge and an understanding of the impact of contact and colonization on the health of First Nations people, with a vision to restoring wellness for all First Nations people and communities. The FNHA has the ability to deliver services that are tailored to meet the

diverse needs of rural and urban First Nations communities across the diverse geographic regions of BC, which are rooted in incredible linguistic and cultural diversity, including 32 different languages.

Within Canada's territories, insured health services and programs are delivered to all citizens through the territorial governments. However, Health Canada provides additional funding for some services for First Nations and Inuit peoples (including those who are self-governing) in the territories.

Health services for more than 400,000 Métis people across Canada are governed differently than for First Nations and Inuit peoples. The Métis Nation is represented through elected provincial governing bodies from Ontario westward, namely the Métis Nation of Ontario, the Manitoba Métis Federation, the Métis Nation – Saskatchewan, the Métis Nation of Alberta and the Métis Nation British Columbia. These Métis governance structures are the contemporary expression of the centuries-old struggle of the Métis Nation to be self-determining within the Canadian federation and are the Governing Members of the Métis National Council (Métis National Council [MNC], 2014). The Métis Nation's governance structures and institutions continue to shift, through changing governance agreements and court cases which determine Métis peoples' relationship to other levels of government.

Recent Federal and Supreme Court cases could change the federal government's responsibilities over health of Métis people. In 2008, federal representatives and the Métis National Council signed the *Métis Nation Protocol* allowing Métis representatives to pursue greater legal authority and guaranteed financing that will enable them to deliver programs and services to Métis people. In 2013, a historic ruling in the Supreme Court of Canada found that Métis people and non-status Indians should be considered "Indians" within s.91(24) of the *1867 Canadian Constitution Act's* treatment of their right to land and status, meaning that the federal government has the same obligation to Métis people as it does to status Indians (Daniels v. Canada, 2013). An additional 2013 Supreme Court ruling for the Manitoba Métis Federation found that the federal government has an obligation to implement land grant provisions for the Métis, but has thus far failed to do so (Manitoba Métis Federation Inc. v. Canada, 2013). Further, in April 2014, the Federal Court of Appeal ruled non-status Indians should not be considered 'Indians' but preserved the designation for the Métis. The case was appealed to the Supreme Court to reinstate the Indian designation for non-status Indians, and the government's Department of Aboriginal Affairs cross-appealed, asking the court to deny Indian status to the Métis as well as non-status Indians. This case is still before the courts. If the decision to grant Indian status to Métis people is upheld, the federal government would have to accept responsibilities for creating policies and programs for Métis people, including in the area of health (Paradis, 2013).

In 2006, the Métis Nation British Columbia (MNBC) signed a historic *Métis Nation Relationship Accord* with the Province of British Columbia, which included a focus on closing the gaps in health disparities among Métis peoples at the levels of community, family and individual health (Province of BC & MNBC, 2006). Since that time, MNBC Ministry of Health conducted a provincial survey to gauge Métis health priorities within the province, and has worked to ensure Métis people living in BC have equitable access to existing programs and services, as well as enhance current services to become culturally appropriate (MNBC, 2014). Through a 2011 partnership with the provincial government, MNBC has also been working to gather statistical data on the health of Métis citizens in order to strengthen their program development, monitoring and reporting on the prevalence of chronic diseases and overall health and wellness (MNBC, 2011).

Who comprises public health practitioners?

Core Competencies for Public Health in Canada 1.0. states that "administrative staff and some other public health workers (such as community health representatives, out-reach workers and home visitors) are not expected to have all of the core competencies listed in this document. They will have an appropriate sub-set of the competencies, depending on their role" (p. 2). Yet it is often these public health workers who are at the heart of service provision for Aboriginal communities in rural, remote and isolated areas, as well as urban communities with a concentration of Aboriginal residents. These community health representatives often serve as a bridge between Aboriginal people and the health care system, in rural and remote areas in which hospitals, clinics and other formal health care facilities do not exist. Further, home care workers and outreach workers conduct follow up care with Elders or others who may not be able to travel to urban centers for health services, due to lack of transportation or other mobility constraints. Thus, although Aboriginal people do access care from physicians, nurses and other public health practitioners covered by these competencies, it is clear that the omission of outreach workers, community health representatives and home visitors from proficiency in the competencies could have a significant impact on the level of health services received by remote, isolated and urban Aboriginal communities.

3.0 REVIEW OF PHAC CORE COMPETENCIES BY CATEGORY

A review was conducted of content pertinent to Aboriginal public health throughout PHAC's *Core Competencies for Public Health in Canada 1.0*. This section provides a summary of this review's findings within the competency framework, first discussing attitudes and values, then reviewing each of the seven competency categories, and finally analyzing the appendices.

No reference is made to Aboriginal peoples throughout the competencies document, with the exception of two references in the appendices. However, as explored in the remainder of this document, some of the competencies respond to core issues that have been identified in research on Aboriginal public health or intersect with the available Aboriginal health competency frameworks.

Additionally, colonialism is not mentioned as a specific factor impacting public health in Canada in *Core Competencies for Public Health in Canada 1.0*. As discussed in the introduction, Canada's history of colonization continues to impact the health of Aboriginal communities as well as their relationships to health care systems. Colonialism should thus be mentioned as a specific factor impacting public health in Canada.

Competency Statements: Attitudes and Values

Core Competencies for Public Health in Canada 1.0 states that "all public health professionals share a core set of attitudes and values" (p. 3), yet these values and attitudes are not listed as core competencies because they are difficult to teach and assess. This provides a challenge to the development of core competencies that fit within an Aboriginal public health framework. The assumption that all health professionals share a set of values overlooks the differences in identity, social location and cultural background among health practitioners. Within a cross-cultural approach to health care provision, it would be more suitable for practitioners to have a self-reflexive practice in which they understand their own attitudes and values in order to be able to develop culturally relevant services as they work across cultural difference (see Category 5 below for more discussion of cultural relevance as a core competency of public health).

However, despite this underlying incongruence, some of the stated attitudes and values have great significance to Aboriginal public health. *Core Competencies for Public Health in Canada 1.0* outlines important values such as "commitment to equity, social justice and sustainable development, recognition of the importance of the health of the community as well as the individual, and respect for diversity, self-determination, empowerment and community participation" (p. 3). The document states that these values emerge from a social determinants of health framework. These competencies could be further strengthened if the historic and ongoing impacts of colonialism, discussed in the introduction section of this document, were understood as a core determinant of Aboriginal peoples' health.

Self-determination, mentioned here as a core value guiding public health in Canada, is clearly a loaded term when applied to First Nations, Inuit and Métis people and communities. Again, a self-reflexive practice that allows health care practitioners to understand systemic power dynamics, their specific role within health care systems, as well as their broader social positioning would facilitate a greater ability to foster self-determination among Aboriginal people and communities. Clarifying these levels of self-determination would strengthen the link between this value and Aboriginal public health competencies. For example, self-determination for Aboriginal people could include competencies such as "support and build the capacity of individuals and families to take greater responsibility for their own health and wellness" (Hammond & Collins, 2007).

Category 1: Public Health Sciences

Category 1 on public health sciences includes knowledge and skills related to "behavioral and social sciences, biostatistics, epidemiology, environmental public health, demography, workplace health, and the prevention of chronic diseases and injuries" (p. 3). The competencies listed in 1.1 include demonstrated knowledge in "the health status of populations, inequities in health, the determinants of health and illness…", as well as "the factors that influence the delivery and use of health services" (Ibid). These competencies have particular relevance to Aboriginal public health, given the systemic inequities which impact Aboriginal peoples' health, as well as the recognition that the health of First Nations, Inuit and Métis people is impacted by lower quality of life due to intersecting determinants of health. However these should be expanded to indicate that competence is required in knowledge of health disparities faced by First Nations, Inuit and Métis peoples, and the socio-economic inequities they face that contribute to these disparities. Additionally, practitioners should be required to have knowledge of the role that family, social and community relations play in seeking health care for Aboriginal people, within extended kinship networks.

Competency 1.2 goes on to list knowledge about the "history, structure and interaction of public health and health care services at local, provincial/territorial, national and international levels" (p. 4). This should be amended to explicitly include First Nations, Inuit and Métis peoples as being uniquely impacted by the structural and historic factors which shape national health services.

Overall, these competencies in public health sciences reflect Western conceptualizations of health – or conceptualizations of health that have roots in European socio-cultural norms, beliefs and worldviews – without a recognition of non-Western and Aboriginal views of health which are based in holistic models. For example, there is no mention of the knowledge of Aboriginal healers or Elders. The addition of language from international Indigenous public health literature such as being "open to learning from Elders, medicine people and traditional healers" (Hammond & Collins, 2007, p. 43) could be added to make this competency more inclusive of Aboriginal health knowledge and science. Without the inclusion of this knowledge, "public health sciences" is being conceptualized explicitly within a Western paradigm.

Integrating a "two-eyed seeing" approach to health sciences is one way to acknowledge the strengths of both Western and Aboriginal knowledge. *Etuaptmumk*, or two-eyed seeing, is a Mi'kmaw concept introduced by Elder Albert Marshall in 2004 in the context of integrative science. Two-eyed seeing refers to seeing from one eye with the strengths of Indigenous ways of knowing and from the other eye with the strengths of Western ways of knowing, and learning to use both eyes together within integrative or transcultural work (Institute for Integrative Science and Health, n.d.). This approach has been put into practice in health research and policy (Institute of Health Economics, 2011) as a way of transcending the conflicts between Western and Indigenous approaches to health, in order to draw on the strengths of both. In the context of Indigenous health research, two-eyed seeing calls for Indigenous worldviews to be upheld in the identification, definition and solutions to health issues in order to ensure Indigenous peoples' knowledge and experience are central to the creation of knowledge about Aboriginal health (Martin, 2012). This framework emerges out of a recognition of the potential harms of health research which is imposed on Indigenous peoples or which frames them as a 'problem population', potentially ignoring the wisdom of Indigenous health knowledge which sustained communities for millennia prior to colonization. The integration of two-eyed seeing in the competencies on public health sciences would strengthen this section's applicability to Aboriginal peoples' health.

Category 2: Assessment and Analysis

This category outlines six competencies in the area of assessment and analysis. These competencies are based in rational decision-making processes and bio-medical models of health, citing the use of "data, facts, concepts and theories" to "make evidence-based decisions" (p. 4). Although assessment and analysis skills and knowledge can be applied in a culturally relevant manner, the category does not reflect any awareness of Aboriginal conceptualizations of health which include non-rational factors such as spiritual and metaphysical knowledge which might indeed be considered to create culturally appropriate "recommendations for policy and program development" (Ibid) in diverse First Nations, Inuit and Métis community contexts. Given that health is conceptualized holistically within many Aboriginal cultures, this Western analytical approach to assessing health does not align with culturally relevant approaches.

The competency area could be made more relevant to Aboriginal public health concerns by adding a specific competency in assessing knowledge and practices related to the improvement of First Nations, Inuit and Métis health in Canada. This is a core cultural safety competency from the Association of the Faculties of Medicine Canada's competencies for physicians (Lavallee et al., 2009). Additionally, the ability

to undertake open-minded inquiry and assessment across cultural differences could be added (Council on Education for Public Health, 2011), in recognition that specific analytical skills are necessary in working within diverse First Nations, Inuit and Métis community contexts.

Category 3: Policies and Program Planning, Implementation and Evaluation

This category outlines eight competencies for effectively planning, implementing, and evaluating policies and/or programs in public health. This includes the management of public health incidents such as disease outbreaks and other health emergencies. The competencies in this area include demonstrated knowledge of policy and program options within a range of public health areas, the implementation of these policies and programs, the ability to develop a plan based in available procedures and regulations, and the ability to use available resources to achieve maximum outcomes. While a social determinants of health framework is used in this category, few other elements are listed which would allow for these competencies to be made relevant to Aboriginal communities. Within the context of Aboriginal public health, it is important to recognize the previously discussed inequity of resources which impact some communities' ability to respond to public health incidents. Specific policies and programs which are in place to address Aboriginal health nationally, provincially and regionally should also be specifically mentioned as required knowledge. In particular, this section should include a discussion of the jurisdictional conflicts that can occur in relation to federal/provincial responsibility for responding to health epidemics and other emergencies on-reserve vs. off-reserve.

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The emphasis in this category is on developing plans, policies and guidelines to address specific health issues, yet culturally-relevant policies and programs require the recognition that some policies may indeed require the ability *not* to follow the rules in order to allow for cultural difference. Indeed, Aboriginal peoples' health may be negatively impacted if health practitioners are more concerned with following policies or protocols than with serving individual First Nations, Inuit and Métis clients according to their specific needs and cultural norms.

Category 4: Partnership, Collaboration, Advocacy

This category outlines four competencies required to work with others to improve the health and well-being of the public "through the pursuit of a common goal." The competencies include collaborating with partners, which could include First Nations, Inuit and Métis stakeholders (though they are not explicitly named), and mediating between differing interests which could also arise within cross-cultural Aboriginal community contexts.

Advocacy, or "speaking, writing or acting in favor of a particular cause, policy or group of people" is described as important for reducing health inequities. This competency is particularly relevant for health practitioners working in support of Aboriginal peoples' health needs and realities. However, the competency does not recognize that Aboriginal people often themselves advocate *to* health practitioners for changes in the services they are receiving. Thus, this competency should not only call for the advocacy of health practitioners but should call for practitioners *to hear and respond to* the advocacy of Aboriginal people themselves. This is indeed important as health care is one of many systems impacting First Nations, Inuit and Métis peoples' lives in complex ways, and is one site in which Aboriginal people call for change to promote their own health and well-being. Thus, the competencies under Category 4 would better respond to Aboriginal public health realities if they included supporting others to advocate for themselves and hearing advocacy from First Nations, Inuit and Métis people and communities.

CULTURAL SAFETY INSTITUTIONAL POLICIES COLONIZATION POWER IMBALANCES DISCRIMINATION

Category 5: Diversity and Inclusiveness

This fifth category of competency is the area where Aboriginal health concerns are best accounted for, as it emphasizes a determinants of health perspective, acknowledges the need to consider diverse populations in health policy and programs, and requires competence in culturally relevant approaches to health.

Competence 5.1 asks that practitioners "[r]ecognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific populations." As previously mentioned, a determinants of health framework has increasingly been used to understand and improve the health of specific Aboriginal communities. Access to resources and services have a significant impact on health, and a growing body of research confirms that lower socioeconomic status is related to lower health and wellness outcomes (Greenwood et al., 2014). Thus, this competence aligns with an Aboriginal public health framework.

Competence 5.2 requires that practitioners "[a]ddress population diversity when planning, implementing, adapting and evaluating public health programs and policies." This requirement to consider population diversity also aligns with an Aboriginal public health approach, as each individual First Nation, Métis and Inuit community faces differing determinants of health, histories, and health governance structures. The ability to consider and work effectively across these diverse circumstances is essential to effectively serving Aboriginal populations.

Finally, competency 5.3 calls for practitioners to: "[a]pply culturally relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities." This language of cultural relevance and appropriateness goes beyond cultural awareness (knowledge of difference) and sensitivity (respecting cultural difference), yet the meaning of these terms is not clearly defined in the competencies document. A clearer definition of these terms reveals how this competency is relevant within an Aboriginal public health context, as distinguished from cultural minorities more broadly.

Cultural competence and cultural safety are terms used to talk about culturally relevant practices in cross-cultural work in a range of fields. Although definitions for these terms differ across various usages, there are several elements that are common across these definitions in their usage in Aboriginal health. Both cultural competence and cultural safety require that practitioners have a level of *self-awareness* (Hart-Wasekeesikaw,

2009; Lavallee et al., 2009) from which to build their capacity to work with diverse groups of people whose background differs from theirs. Cultural competence and safety also require that practitioners have a set of *attitudes and behaviors*, as well as *institutional policies* that facilitate the delivery of effective health services according to the specific cultural beliefs, behaviors and needs of diverse communities (Office of Minority Health, 2001). Cultural safety also requires that health practitioners have an understanding of *power imbalances*, *institutional discrimination*, *colonization* and *colonial relationships* and their impact on health and health care (NAHO, 2008). In the context of working with Aboriginal peoples – as opposed to other cultural minorities – cultural competence and cultural safety must be rooted in an awareness of the impacts of colonialism on Aboriginal peoples generally, as well as specific knowledge of the history and culture in the traditional territories in which a practitioner is working.

This awareness of systemic and historic factors of colonialism are connected to self-reflective practices that foster a practitioner's understanding of their own positionality in relation to these colonial power dynamics (Hart-Wasekeesikaw, 2009). Cultural competence and safety further require an intersectional analysis of power and identity, as culturally safe services will be defined and experienced differently by all individuals depending on their particular socio-cultural position and the impact of factors such as racism, sexism, heteronormativity, and so on. These expanded definitions of culturally relevant and appropriate approaches to health care provision provide important insights into how competency 5.3 aligns with frameworks for Aboriginal public health.

It is worth noting that although *Core Competencies for Public Health in Canada 1.0* includes cultural relevance as a core competency, the education program associated with these competencies, *Skills Online*, does not address cultural competency or safety, nor does it specifically mention Aboriginal health. It would be beneficial for these competencies to be integrated into the *Skills Online* program, perhaps drawing on or linking to existing online programs such as the BC Provincial Health Services Authority's *Indigenous Cultural Competency Training Program*.[4]

[4] The Provincial Health Services Authority in BC's *Indigenous Cultural Competency Training Program* can be accessed at http://www.culturalcompetency.ca/.

Category 6: Communication

Communication is the focus of the sixth category of competencies, with emphasis on various forms of verbal and non-verbal communication, use of technology and multi-media, and the ability to interpret information for a diversity of audiences. Communication is also an important component of the Aboriginal public health competencies that were reviewed. Working with Aboriginal people requires competency in communication that is culturally-safe and relationship-centered (Hart-Wasekeesikaw, 2009; Lavallee et al., 2009; NAHO, 2008; Hammond & Collins, 2007). Indeed, the interrelatedness of cultural safety and communication is emphasized in all of the Aboriginal public health competencies that were reviewed.

Further to the communication competencies listed in *Core Competencies for Public Health in Canada 1.0*, communication within Aboriginal community contexts requires the ability to "be open to learning from Elders, medicine people and traditional healers", as well as the ability to interpret cultural practices and beliefs of the local community to non-Aboriginal practitioners (Hammond & Collins, 2007, p. 43). Additionally, the impact of language barriers should be acknowledged as many First Nations, Inuit and Métis Elders and those living in remote communities may have English as their second language. The ability to work effectively across language barriers is key to culturally appropriate communication with Aboriginal communities.

Category 7: Leadership

This final section of *Core Competencies for Public Health in Canada 1.0* outlines competencies in the area of leadership. These competencies are focused on enabling "organizations and communities to create, communicate and apply shared visions, missions and values." Leadership is also an important element of the Aboriginal public health competencies that were reviewed, including the shared concern with ethics as a core aspect of effective leadership. Hammond and Collins (2007) define leadership within Aboriginal public health as linked to integrity, confidentiality, rights and responsibilities – elements which could supplement the existing leadership competencies. Additionally, the PHAC competencies could be strengthened by

...communication within Aboriginal community contexts requires the ability to "be open to learning from Elders, medicine people and traditional healers", as well as the ability to interpret cultural practices and beliefs of the local community to non-Aboriginal practitioners
(Hammond & Collins, 2007, p. 43)

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Within an Aboriginal public health context, leadership competencies should be adapted within cross-cultural environments to allow for Aboriginal models of leadership to be recognized.

considering how leadership styles are shaped by cultural norms, as knowledge of culturally specific forms of leadership may be important for non-Aboriginal practitioners working within First Nations, Inuit and Métis communities. Within an Aboriginal public health context, leadership competencies should be adapted within cross-cultural environments to allow for Aboriginal models of leadership to be recognized. Given the development of new models of health governance led by Aboriginal peoples, such as the BC First Nations Health Authority, this section on leadership should acknowledge the ways emergent forms of Aboriginal health governance challenge conventional models of leadership, requiring practitioners to find new ways of relating.

Appendices

The appendices in *Core Competencies for Public Health in Canada 1.0* are comprised of a glossary of terms and practice examples of the core competencies. The glossary and practice examples include two references to 'Aboriginal' and 'First Nations' people; Inuit and Métis people are not specifically mentioned.

The definition for 'advocacy' states: "Advocacy often aims to enhance the health of disadvantaged groups such as First Nations communities, people living in poverty or persons with HIV/AIDS" (p. 9). Aside from this mention as a "disadvantaged group", Aboriginal people, communities, knowledge and health are not referred to in any other aspect of the glossary. However, terms such as 'culturally-relevant', 'diversity', 'empowerment', 'equity', 'social justice' and 'values' are defined, which have relevance to Aboriginal peoples' treatment in public health systems.

Additionally, the practice examples include a reference to Aboriginal people in competency statement 1.1: "Discuss the need for a pre-natal nutrition program in an Aboriginal community as well as contributing factors such as income, education, culture and traditional foods" (p. 16).

4.0 SUMMARY OF RECOMMENDATIONS

The health of Aboriginal Canadians is a pressing social and political issue that continues to call for dedicated resources, policies and public health frameworks. In recognition of the ongoing disparities between Aboriginal and non-Aboriginal peoples' health, guidelines have been created by numerous professional health organizations to create competencies in culturally relevant care for Aboriginal people and communities. Additionally, new governance agreements are being formed between Aboriginal nations and federal and provincial governments which shift the responsibility and leadership for health care into the hands of Aboriginal people themselves. In light of these recent initiatives in Aboriginal public health, it is timely to update the 2007 *Core Competencies for Public Health in Canada 1.0* in order to make them relevant to health care provision for First Nations, Inuit and Métis people.

General Recommendations

A summary of recommendations is provided below for making *Core Competencies for Public Health in Canada 1.0* more consistent with an Aboriginal public health framework:

1. Recognize and name First Nations, Inuit and Métis governing bodies along with federal, provincial and territorial governments, and engage them as partners in the development of the revised competencies.
2. Extend the relevance of the competencies to public health workers such as community health representatives, outreach workers and home visitors who often work with remote and rural Aboriginal communities.
3. Mention colonialism as a specific factor impacting public health in Canada.
4. Integrate a self-reflexive practice in which public health practitioners are aware of their own values within the context of cross-cultural work, rather than assuming all public health practitioners have the same values.
5. Clarify the meaning of self-governance within First Nations, Inuit and Métis community contexts.

CATEGORY RECOMMENDATIONS

Category 1

Public Health Sciences

Amend "public health sciences" to require knowledge of health disparities faced by First Nations, Inuit and Métis peoples, and the inequities that contribute to these disparities. Require knowledge of the role that family, social and community relations play in seeking health care for Aboriginal people, within extended kinship networks. Also recognize Aboriginal and Indigenous knowledge (IK) and holistic Aboriginal health paradigms through an integration of "two-eyed seeing" in health sciences. Recognize Elders and other Aboriginal knowledge keepers as health practitioners.

Category 2

Assessment and Analysis

Amend to recognize non-rational factors such as spiritual and metaphysical knowledge which account for Aboriginal models of health. Add a competency in assessing knowledge and practices related to the improvement of First Nations, Inuit and Métis health in Canada and the ability to undertake open-minded inquiry and assessment across cultural differences.

Category 3

Policies and Program Planning, Implementation and Evaluation

Recognize the inequity of resources which may impact a community's ability to respond to public health incidents. Specific policies and programs to address Aboriginal health nationally, provincially and regionally, should be specifically mentioned as required knowledge. Recognize the need to adapt or bend policies in order to avoid creating harm for Aboriginal peoples, for whom certain rules may not fit.

Category 4

Partnership, Collaboration, and Advocacy

Recognize the need for competency in hearing advocacy from Aboriginal peoples, among other underrepresented groups, who may advocate for specific services or treatment from health care practitioners and systems. Also add the need to support others to advocate for themselves.

Category 5

Diversity and Inclusiveness

Clarify the definition of culturally relevant and appropriate services and integrate this competency throughout the *Skills Online* education program.

Category 6

Communication

Better recognize the interrelatedness of cultural safety, communication and relationship-building. Include a competency on the ability to work effectively across language barriers.

Category 7

Leadership

Consider the culturally-specific nature of leadership styles and new forms of leadership required within emergent models of Aboriginal health governance.

Appendices

Integrate First Nations, Inuit and Métis peoples and knowledge into the glossary of terms to ensure Aboriginal public health frameworks are recognized within the core competencies. Add 'colonization' to the glossary on its own or within the definition of 'determinants of health.' Create practice examples which speak directly to the public health realities of Aboriginal people and communities in both urban and rural areas.

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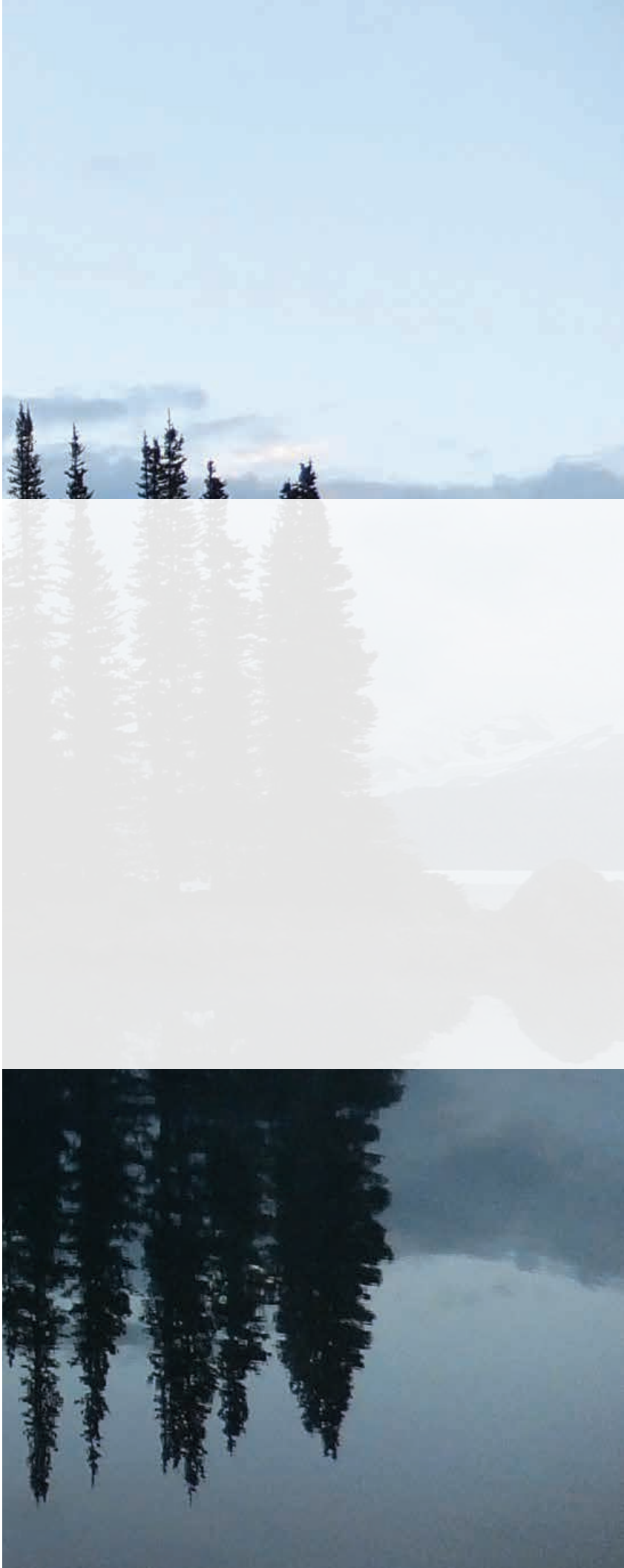

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