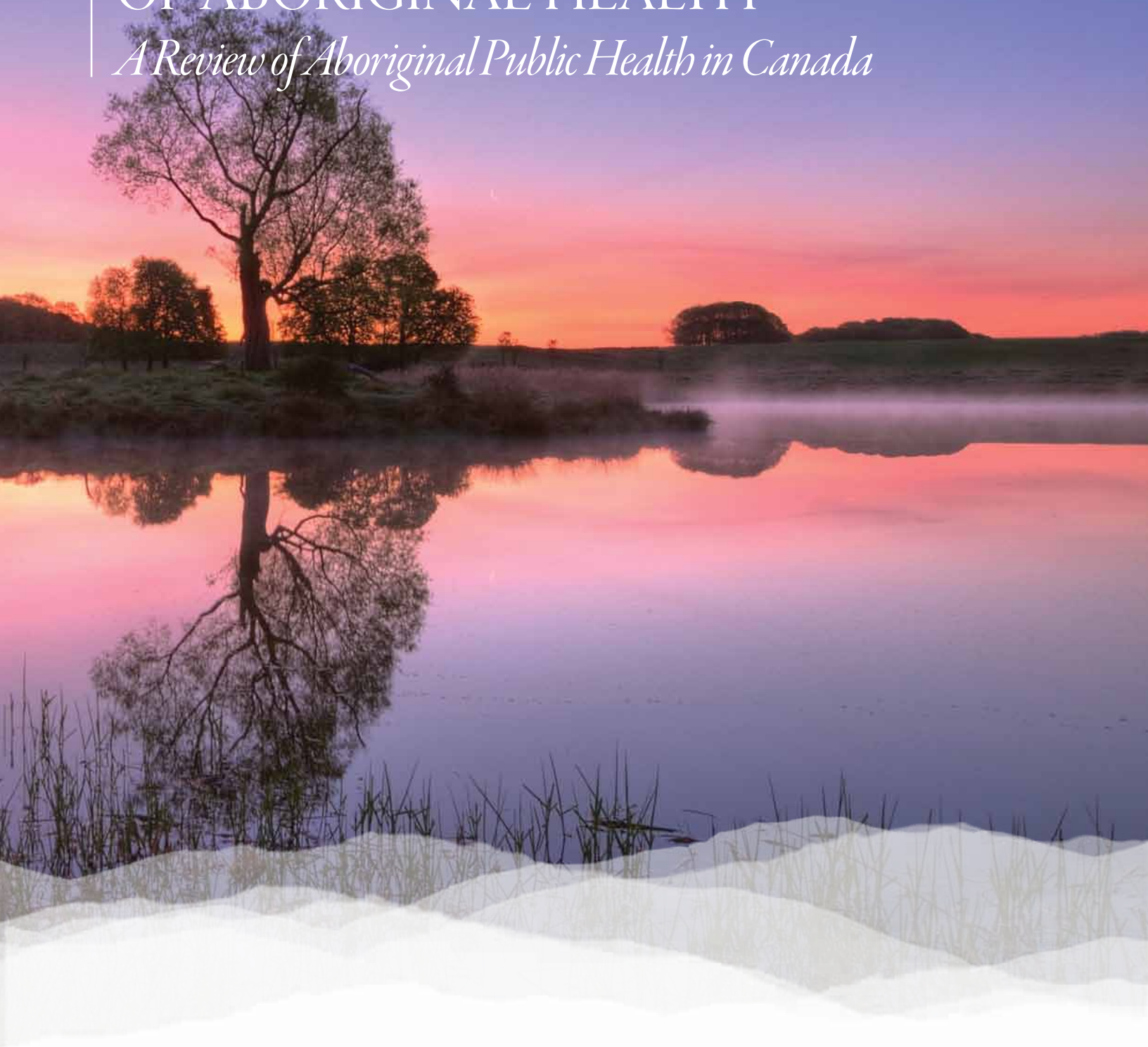


THE STATE OF KNOWLEDGE OF ABORIGINAL HEALTH

A Review of Aboriginal Public Health in Canada



NATIONAL COLLABORATING CENTRE
FOR ABORIGINAL HEALTH



CENTRE DE COLLABORATION NATIONALE
DE LA SANTÉ AUTOCHTONE

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EXECUTIVE SUMMARY

“There is clearly a great need for[...] equity in the types of health-related programs and initiatives offered to Aboriginal peoples across the provinces and territories, in order to improve health and well-being in a culturally appropriate and respectful way.”

In recent decades, there has been considerable improvement in the health status of Aboriginal¹ people in Canada. Nevertheless, Aboriginal people continue to experience a consistently lower level of health than do non-Aboriginal peoples. There are multiple reasons for these health disparities, and many national Aboriginal organizations, as well as federal, provincial and territorial governments, are working to eliminate these disparities.

To further understand the prevalence of health issues among Aboriginal peoples, the underlying causes of these health issues, and what is being done to address them, the National Collaborating Centre for Aboriginal Health formed

a partnership with the Public Health Agency of Canada to compile a report on the current state of knowledge of Aboriginal health, which is intended to inform a Public Health Agency of Canada Aboriginal Public Health Policy Framework. The goal of *The State of the Knowledge of Aboriginal Health*, therefore, is to provide a high-level summary of what is currently known about and being done to improve the health of First Nations, Inuit, and Métis peoples. The report includes an overview of literature and data pertaining to the health issues faced by Aboriginal peoples, an examination of these issues from the perspective of social determinants of health, and summaries of current health programs and initiatives for

Aboriginal populations offered by federal, provincial and territorial governments. (These summaries are based on an Internet search conducted in 2009, and therefore may not be inclusive of all programs and initiatives currently available).

Key Health Issues Facing Aboriginal Peoples

While Canadians, on average, enjoy some of the world's best health care and quality of life, Aboriginal peoples generally have poorer health than the non-Aboriginal population, particularly in terms of maternal, fetal and infant health; child health; certain communicable and non-communicable diseases; mental

¹ The Aboriginal peoples of Canada are defined, by Statistics Canada, as “persons who reported identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit [Eskimo], and/or those who reported being a Treaty Indian or a Registered Indian as defined by the *Indian Act* of Canada, and/or who were members of an Indian Band or First Nation.” For the purposes of this report, “Aboriginal peoples” refers to these three population groups: First Nations, Métis and Inuit, which is inclusive of those who are non-status Indians but who self-identify as First Nations or Inuit.

health and wellness; violence, abuse and injury; and environmental health. This disproportionate burden of ill-health can be largely attributed to adverse socio-economic conditions and historical circumstances which have resulted in a higher prevalence of the risk factors for these conditions, such as alcohol or tobacco use, overcrowded housing conditions and inadequate diet. There are considerable barriers to addressing these health issues, such as geographic, educational and economic barriers, that affect access to health services. The health issues facing Aboriginal peoples, and the barriers encountered in addressing them, are not uniform across First Nations, Inuit and Métis peoples. If they are to be effective, public health interventions must consider the unique contexts in which Aboriginal people live.

Effective implementation of public health interventions requires current and relevant data. However, there are serious limitations in the current health research and data for Aboriginal peoples. At present, much of the available research and data consider Aboriginal peoples as a homogenous group and fail to take into account differences among First Nations, Inuit and Métis; among urban and rural populations; and among on-reserve and off-reserve populations, with respect to the health issues faced, the factors underlying these issues, and the challenges in addressing them. Also lacking is data that is longitudinal, national in scale, and compares the same variables across the same cohort over the same time period. These limitations impede a full understanding of the health of First Nations, Inuit and Métis peoples and the development of strategies to address their unique health concerns and challenges.

Social Determinants of Health

Given that health status is determined by factors that go beyond genetic

determinants and lifestyle decisions, but also by a host of other factors that influence physical, mental and social health and well-being, a more holistic perspective is required to understand the current health disparities between Aboriginal Canadians and the general population. A social determinants of health framework can provide this holistic perspective. Social determinants of health are those factors that focus on the economic and social conditions that govern peoples' lives.

The World Health Organization and the Public Health Agency of Canada have identified some common social determinants that have considerable influence on the health of individuals and communities. These international and national perspectives on social determinants are inadequate for understanding the health inequities faced by Aboriginal peoples in Canada. Indigenous-specific social determinants, such as the impacts of colonialism on Aboriginal languages, culture and identity, underlie some of the most pervasive socio-economic inequities between Aboriginal and non-Aboriginal Canadians. However, Aboriginal peoples do not uniformly experience the same social and economic disparities, nor are they equally affected by colonial policies, and these differences must be taken into consideration in the development of public health interventions.

While attempts can be made to examine each social determinant of health in isolation, the determinants are in fact multifaceted and interactive. This implies that if there are to be meaningful improvements in the health and well-being of Aboriginal Canadians, not only must public health strategies address the socio-economic disparities between Aboriginal and non-Aboriginal Canadians, but they must also adopt an integrated and multi-sectoral approach.

National Aboriginal Health Programs and Initiatives

At the national level, Health Canada has been providing health programs and services to status (registered) Indians living on-reserve and to Inuit living within their traditional territories since 1945. The nature of how these programs and services are being delivered has undergone considerable changes since the 1980s, however, with the federal government moving away from direct service delivery to First Nations and Inuit communities. Most hospital care and primary health services are provided through provincial and territorial governments for all Aboriginal peoples, but there has also been devolution of responsibility towards community-based health services. The federal government's direct role is now primarily through the implementation of limited public health and prevention services and health promotion programs through the First Nations and Inuit Health Branch of Health Canada. Most of the programs and initiatives have been implemented to address the existing health disparities between Aboriginal peoples and other Canadians. However, they are also primarily limited in scope to those Aboriginal peoples which fall under the federal government's direct responsibility as defined under the *Indian Act*. Only a few programs and initiatives have been implemented to assist First Nations that are not registered or live off-reserve, Inuit who live outside their traditional territories, and Métis. The federal government also provides funding to a number of other non-governmental organizations to develop, implement or administer health programs and initiatives.

Several of the health issues facing Aboriginal peoples are well recognized and addressed by the federal government through targeted programs and initiatives. Most notably, the federal government has implemented several programs

and initiatives aimed at the healthy development of infants and children, at improving overall health and reducing diabetes, and at reducing substance use/abuse. Other health issues are less well addressed by the federal government, including those related to cancer, injury, mental health and respiratory illness. There were also few federal programs and initiatives available for Métis and urban Aboriginal populations.

Provincial and Territorial Aboriginal Health Programs and Initiatives

The provinces and territories are responsible for providing health care services for First Nations people living off-reserve, Métis, those not eligible for registration, and Inuit people not living within their traditional territories. They are also responsible for hospital care and most primary health care services for all Aboriginal peoples, including First Nations on-reserve and Inuit. In addition, provincial and territorial governments also implement, either directly or indirectly, health programs and initiatives targeted at addressing current health disparities between Aboriginal peoples and other Canadians. The implementation and administration of programs and initiatives within provinces and territories reflects the complexity of health care provision for Aboriginal peoples in Canada generally. While provincial and territorial governments may develop, implement and administer such health programs and initiatives directly, often this involves multiple levels of government working in partnership with Aboriginal governments and organizations. In addition, most programs and initiatives are not province-wide in scope, but are more local or regional. As a result, there is a lack of

consistency in the types of programs and initiatives that are provided for Aboriginal peoples across the provinces and territories.

As with federal programs and initiatives, some Aboriginal health issues are recognized and addressed more consistently across the provinces and territories than others. While programs and initiatives related to early child development, maternal health and healthy living (physical activity/nutrition) programs are fairly typical across the provinces and territories, programs and initiatives in the areas of suicide prevention, substance abuse, violence against women, cancer and communicable diseases are less common, particularly in provinces with low proportions of Aboriginal people. Programs and initiatives in the territories tend to be available more commonly to the general public than to Aboriginal peoples specifically. And, despite a fairly substantial Aboriginal population, few programs and initiatives that met our search criteria were identified in Manitoba and Saskatchewan.

Given the diversity of Aboriginal peoples across the country – reflected in Aboriginal cultures, socio-economic indicators and differences in health priorities and needs – it is not surprising that diversity and complexity are also reflected in the implementation of health programs and initiatives to serve this population. Nevertheless, in many provinces and territories, too many health needs of Aboriginal peoples are expected to be satisfactorily met through programs and initiatives that are available to the general public, without regard for the unique context in which these health issues have arisen. There is clearly a greater

need for programs and initiatives that reflect the lived-world realities of the population they are intended to serve, and for equity in the types of health-related programs and initiatives offered to Aboriginal peoples across the provinces and territories, in order to improve health and well-being in a culturally appropriate and respectful way. As well, there is a need to enhance access to programs and initiatives for Aboriginal peoples living outside urban centres (where most health programs and services are located) and for non-status First Nations and Métis peoples who are currently excluded from most programs and initiatives and whose health needs are not being adequately addressed.

One limitation of this report is that its focus is on federal and provincial/territorial government programs and initiatives. Aboriginal organizations and governments have been implementing some innovative health programs in particular places that are more culturally appropriate and reflect the specific health needs of those communities. Some of these programs also incorporate Aboriginal approaches to health and healing and are having positive impacts on improving health. The success of such programs draws attention to the need to recognize existing Aboriginal approaches to health and healing.

THE STATE OF KNOWLEDGE OF ABORIGINAL HEALTH

A Review of Aboriginal Public Health in Canada



It should come as no surprise that a person's overall health and well-being are affected by a multitude of factors. To have optimal health, people must have adequate nutrition and housing; they must live free from violence and substance abuse; they must feel like they are contributing to their family, community or environment; and they must have timely access to health care. When people do not have access to these basics of life, they become increasingly vulnerable to serious medical conditions, such as chronic diseases and mental illness. Alarming, this is the state of health in which many Aboriginal peoples in Canada live. In fact, in almost every health-related area, the Aboriginal peoples of Canada experience a consistently lower level of health than do the non-Aboriginal peoples.

There are multiple reasons for the health disparities faced by Canada's Aboriginal populations. Many national Aboriginal organizations, as well as federal, provincial and territorial governments, are working to eliminate these disparities. To further understand the health issues facing Canada's Aboriginal peoples, the underlying causes of these health issues, and what is being done to address them, the National Collaborating Centre for Aboriginal Health formed a partnership

with the Public Health Agency of Canada to compile a report on the current state of knowledge of Aboriginal health, which is intended to inform a Public Health Agency of Canada Aboriginal Public Health Policy Framework. The goal of this document, therefore, is to provide a comprehensive, high-level summary of what is currently known and being done for the health of Canada's Aboriginal peoples.

Definitions

In undertaking a knowledge-gathering exercise like this, and to frame the scope of this report, it is important to define three key terms: Canada's "Aboriginal peoples", "public health" and "public health policy initiative."

The Aboriginal peoples of Canada

Broadly speaking, the Aboriginal peoples of Canada are defined, by Statistics Canada, as "persons who reported identifying with at least one Aboriginal group, that is, North American Indian, Métis or Inuit [Eskimo], and/or those who reported being a Treaty Indian or a Registered Indian as defined by the *Indian Act* of Canada, and/or who were members of an Indian Band or First Nation."² For the purposes of this report, "Aboriginal peoples" refers to these three population

groups: First Nations, Métis and Inuit, which is inclusive of those who are non-status Indians but who self-identify as First Nations or Inuit.

Public health

Public health can be described as "the science and art of promoting health, preventing disease, prolonging life and improving quality of life through the organized efforts of society."³ Through combining sciences, skills and beliefs, public health seeks to improve the health of entire communities and of society as a whole. As such, it emphasizes two areas: "the prevention of disease, and the health needs of the population as a whole."⁴

Public health policy initiative

For the purposes of this report, the term "public health policy initiative" refers to those programs and activities that have been formed in response to federal, provincial or territorial, regional and organizational policies directly related to public health. As such, these initiatives (programs, foundations) focus on community or society-wide health benefits. More specifically, these initiatives are aimed at addressing and eventually eliminating the health disparities faced by particular populations in Canada: First Nations, Inuit and Métis.

² Statistics Canada (2011). Definitions, sources and symbols. Health profile, February 2011. Ottawa, ON: Statistics Canada. Retrieved April 30, 2011 from <http://www12.statcan.ca/health-sante/82-228/help-aide/DQ-QD04.cfm?Lang=E>

³ Committee of Inquiry into the Future Development of the Public Health Function, 1988, as cited in National Advisory Committee on SARS and Public Health (2003). Learning from SARS: Renewal of public health in Canada. Ottawa, ON: Health Canada, p. 46.

⁴ Premier's Advisory Council on Health, 2001, as cited in National Advisory Committee on SARS and Public Health (2003), p. 46.

How This Report is Organized

This report contains four substantive chapters.

Chapter 1 provides an overview of literature and data pertaining to the health issues faced by Canada's Aboriginal population. It summarizes current knowledge of the prevalence and incidence of diseases for Aboriginal peoples generally, and for First Nations, Inuit and Métis peoples, where available. It also highlights some of the current gaps in knowledge of these issues. The chapter draws on published and unpublished literature released since 1995 in the areas of maternal, fetal and infant health; child health; communicable diseases; chronic diseases; childhood abuse/neglect; mental health and wellness; unintentional injuries and disabilities; environmental health; and food security and nutrition.

Chapter 2 outlines an approach to understanding the health issues faced by Canada's Aboriginal population. This approach is rooted in an understanding of health as determined not only by genetics and lifestyle decisions, but also by a host of other factors that influence physical, mental and social health and well-being and that are commonly referred to as "social determinants of health." The chapter begins by providing an overview of what is meant by social determinants of health from international, national and Indigenous perspectives. It then brings these perspectives together to examine the disparities between Aboriginal and non-Aboriginal people on a range of social determinants and the impacts these disparities have had on the health of Aboriginal people in Canada specifically. These social determinants are organized in six categories: socioeconomic status, children and youth, gender, health services, the physical environment, and culture and language. It is important to note that these are not stand-alone

categories, but are instead multifaceted and interactive. The chapter draws on available published and unpublished literature on social determinants, as well as statistical data, to demonstrate the disparities between Canada's Aboriginal and non-Aboriginal population with regards to social determinants of health.

Chapter 3 examines the role of the federal government in providing health programs and initiatives for Aboriginal peoples. It begins with a brief historical overview of the role of the federal government in public health, and then outlines its current roles and responsibilities in the provision of health programs and services. The chapter then summarizes the public health programs and initiatives that have been developed by the federal government for, or have a targeted component for, various Aboriginal populations. This list begins with an overview of programs and initiatives that provide benefits spanning multiple health areas. It is followed by programs and initiatives aimed at improving Aboriginal peoples' health in the areas of children and youth; mental health, suicide and substance use; chronic diseases; communicable diseases; physical activity and nutrition; and environmental health. It concludes with a summary of federal programs and initiatives targeted specifically at the urban Aboriginal population. These programs and initiatives were located through a search of federal government websites and reports in early 2009.

The implementation of health-related programs and initiatives for Aboriginal peoples in Canada is complex. Not only is the federal government involved, but the programs and initiatives are often implemented directly by provincial/territorial governments or through partnerships involving multiple levels of government and/or Aboriginal governments and organizations. Chapter 4 presents profiles of health-related

programs and initiatives implemented at the provincial/territorial level for each province and territory. Each profile begins with some context for the implementation of programs and initiatives in that province or territory. The programs and initiatives are then split into two sections. The first section includes health-related programs and initiatives that are funded and administered directly by the provincial/territorial government for its Aboriginal population across the province or territory. The second section presents examples of other types of health-related programs and initiatives that are available in that province or territory for its Aboriginal population, including regional programs and initiatives that are offered through regional health authorities or municipalities, federal initiatives that are administered by provincial or territorial governments and/or Aboriginal organizations, and programs and initiatives that are administered directly by Aboriginal organizations, such as Aboriginal friendship centre associations. These programs and initiatives were identified through an Internet search in early 2009. Given the challenges associated with Internet-based searches and the different ways programs and initiatives are implemented across Canada, this section is not meant to be inclusive of all programs and initiatives available.

The conclusion summarizes what has been learned about the state of knowledge of Aboriginal public health in Canada. It summarizes the findings from each of the four substantive chapters and uses them to highlight the gaps in knowledge and in programs and initiatives that currently exist in the efforts to meet the health needs of Canada's Aboriginal population.

In addition, an annotated bibliography developed from the literature that was collected for and that formed the basis of Chapter 2 of this report is available as a companion to this report.

Chapter 1:

LITERATURE REVIEW: KEY HEALTH ISSUES



This chapter provides an overview of the literature and data pertaining to health issues faced by Canada's Aboriginal population. It summarizes current knowledge of the prevalence and incidence of diseases, conditions and health-related issues among Aboriginal peoples in Canada generally, and where available, among First Nations (with and without status, living on- and off-reserve), Inuit and Métis populations specifically. It also highlights some of the gaps in knowledge of these health issues.

The literature reviewed for this chapter includes published and unpublished literature⁵ released since 1995 in the areas of maternal, fetal and infant health; child health; communicable diseases; chronic diseases; childhood abuse and neglect; mental health and wellness; unintentional injuries and disability; environmental health; and food security and nutrition. Peer-reviewed literature was identified through the use of scientific databases such as PubMed, MEDLINE and the Applied Social Sciences Index, among others. Non-peer-reviewed literature was identified through a search of the websites of government agencies and departments such as Health Canada and the Public Health Agency of Canada; through national Aboriginal organizations such

as the Aboriginal Healing Foundation and the National Aboriginal Health Organization, among others; and by drawing on our own collection of Aboriginal health resources. This is not a systematic review, nor is there an attempt to critically appraise the literature.

We would like to acknowledge the work of the research team affiliated with the Effective Public Health Practice Project at McMaster University for collecting the data that formed the basis of this chapter. Their annotated bibliography of relevant literature forms a companion document to this report. However, the views and opinions expressed in this chapter remain ours alone.

1.1 Maternal, Fetal and Infant Health

Birthing and midwifery

Birthing and midwifery has been identified in the literature as an important topic among Aboriginal women, whose fertility rate is nearly twice that of non-Aboriginal women (2.6 compared with 1.5, respectively) (Statistics Canada, 2006a). The fertility rate is highest among Inuit (3.3) and lowest among Métis (2.2) women (Statistics Canada, 2006a). Despite this, the literature related to this

topic is relatively sparse and focuses on two key themes: access to health care services generally and more culturally appropriate care specifically.

In remote and rural areas where many Aboriginal communities are located, lack of access to health services can be problematic because of population density too low to support wide-ranging health services, lack of transportation infrastructure, northern climate conditions, and difficulties in communicating health issues and needs as a result of language and cultural barriers (Halseth & Ryser, 2006; Tait, 2008; National Aboriginal Health Organization [NAHO], 2008). Health services in remote and isolated communities are typically characterized by health centres that are staffed primarily by nurses rather than physicians, critical shortages of medical specialists and personnel, high turnover rates for health professionals, limited programs, and lack of medical equipment (NAHO, 2004, 2008; Rohan, 2003; Smith, 2003). This forces the majority of expectant mothers to travel to larger urban centres at 36 weeks, away from the support of their families and communities, in order to give birth (NAHO, 2008; Rohan, 2003). In addition, a lack of culturally relevant

⁵ Unpublished literature is often referred to as grey literature. This literature typically includes technical reports from government agencies or scientific research groups, working papers from research groups or committees, white papers or preprints. These sources of information may be available electronically on the Internet or as hard copies, and since their distribution is not controlled by commercial publishing companies, they may lack basic information such as author, publication date or publishing body. (Wikipedia, "Gray literature," http://en.wikipedia.org/wiki/Gray_literature, accessed January 13, 2011).

services, supports and facilities is a barrier to quality care for Aboriginal mothers (Tait, 2008; NAHO, 2008). It has been recognized by national Aboriginal organizations and practitioners that bringing birthing back to the communities is a means of improving access to culturally appropriate health services for expectant Aboriginal mothers (NAHO, 2008; SOGC, 2007; Epoo & Van Wagner, 2005; Couchie & Sanderson, 2007; Van Wagner, Epoo, Nastapoka & Hardy, 2007).

The birthing process for Aboriginal women is entrenched in culture and tradition. As a result, not only must health services for expectant mothers include modern forms of medical care, but they must also incorporate tradition and cultural beliefs (Skye, 2010; NAHO, 2008). This includes incorporating traditional knowledge, medicine and practices of maternal and child health, as well as Aboriginal conceptions of health and well-being (Skye, 2010). While there is considerable diversity among Aboriginal populations regarding these conceptions of health and well-being, what is shared is a holistic view of health, where balance must be maintained mentally, physically, spiritually and emotionally (Skye, 2010). Increasing the number of Aboriginal midwives to bring birthing back to the communities is seen as one means of improving access to culturally appropriate health services (Smith, 2002, as cited in NAHO, 2008; NAHO, 2004; Healey & Meadows, 2007; Smith, 2003; Couchie & Sanderson, 2007).

Aboriginal midwives typically receive their training either through community-based training programs (as in Ontario and Quebec) or through the passing on of traditional knowledge and skills from one generation of midwives to another (NAHO, 2004). Some midwives, as in the case of Manitoba and British Columbia, prefer to be accredited and work within the College of Midwifery, while others want to be exempt from midwifery

regulations (NAHO, 2004). Aboriginal midwives play an important role in prenatal health promotion, providing primary health services within the scope of their practice, assessing prenatal risk and making appropriate referrals, and assisting with the birth of infants (NAHO, 2008). In addition, they provide expectant mothers with a choice about where they would like to give birth.

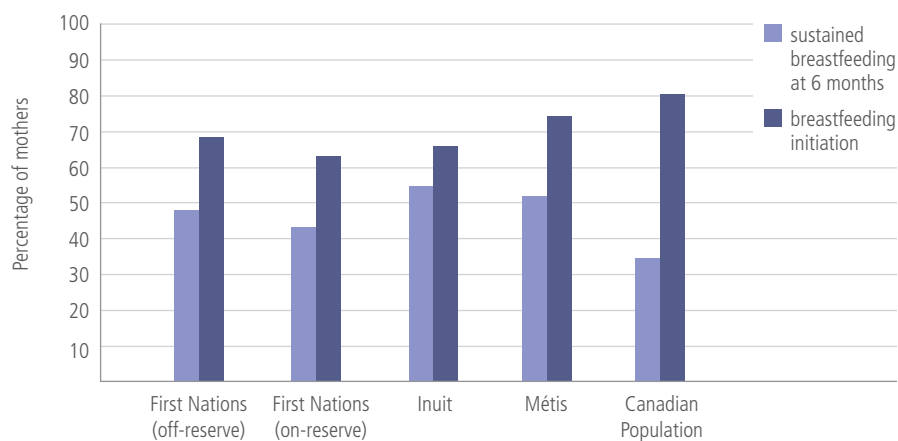
There have been a number of recent initiatives to support Aboriginal midwifery, including the development of Aboriginal midwifery training models and Aboriginal community-based birthing centres such as the Inuulitsivik Health Centre in Puvirnituq, the Rankin Inlet Birth Centre in Nunavut, and the Tsi Non:we Ionakeratstha Ona:grahsta: Six Nations Maternal and Child Centre in southern Ontario (NAHO, 2004, 2008; Skye, 2010). There is some limited evidence demonstrating the success of these birthing centres in improving prenatal care and birth experiences for Aboriginal women (Couchie & Sanderson, 2007). This is reflected in some evaluations that show improvements in perinatal mortality rates, preterm labour, infant birth weight, breastfeeding and the rate of interventions such as C-sections

(Epoo & Van Wagner, 2005). Wider expansion of Aboriginal midwifery is restrained by multiple factors, including increasing regulations regarding midwifery practice, difficulty in recruiting and retaining midwives, lack of public funding for midwifery care, and requirements for midwives to carry professional liability insurance (NAHO, 2004, 2008; Skye, 2010; Smith, 2003).

Breastfeeding and infant nutrition

Very limited epidemiological data on breastfeeding and infant nutrition are available, and what there is tends to focus primarily on breastfeeding initiation and sustained breastfeeding rates. Rates have been found to be generally lower for Aboriginal women than for other Canadians (Black, Godwin & Ponka, 2008). These rates differed among First Nations, Inuit and Métis women. A report edited by McShane, Smylie and Adomako (2009) used data from the 2006 Aboriginal Peoples Survey (APS) for First Nations (off-reserve), Inuit and Métis women and the 2002/03 First Nations Regional Health Survey (RHS) for First Nations women on-reserve to highlight differences in breastfeeding initiation and sustained breastfeeding among these groups of women (Figure 1.1). They

Figure 1.1: Breastfeeding initiation and sustained breastfeeding among mothers, by Aboriginal identity



Sources: ACS 2006, RHS 2002/03 and NLSY 2000/01 (as reported in McShane, Smylie & Adomako, 2009, p. 45)

found that breastfeeding initiation rates were highest among Métis women (74%), followed by First Nations living off-reserve (69%) and Inuit women (66%). They were lowest among First Nations women living on-reserve (63%). Inuit women were more likely to sustain breastfeeding at six months (54%), followed by Métis women (51%), First Nations women living off-reserve (48%), and First Nations women living on-reserve (43%).

Fetal alcohol syndrome and fetal alcohol spectrum disorder

Fetal alcohol spectrum disorder (FASD) encompasses a range of lifelong disabilities resulting from prenatal exposure to alcohol, from the less visible alcohol-related neurodevelopmental disorder to full fetal alcohol syndrome (FAS) (Masotti, Szala-Meneok, Selby, Ranford & Van Koughnett, 2006). This disorder can affect brain function and result in intellectual disability and/or significant alterations in memory, judgment, and cognitive abilities (Masotti et al., 2006). FASD is preventable and is often undiagnosed, with high human and financial costs (Public Health Agency of Canada [PHAC], 2005; Masotti et al., 2006). While FASD is not unique to Aboriginal communities, prevalence has been documented as being higher among Aboriginal children (Robinson, Conry & Conry, 1987; Williams, Odaibo & McGee., 1999). One reason for this is that the risk of FASD is increased by social determinants such as poverty, poor education, untreated mental illness, physical and sexual abuse (Schröter, 2010), conditions which can be more prevalent in Aboriginal communities. This section examines current literature regarding the incidence and prevalence of FAS/FASD among Aboriginal populations. It also summarizes the available literature related to prevention and intervention strategies as they apply to expectant Aboriginal women.

In terms of incidence and prevalence rates, the limited evidence available generally suggests higher rates among Aboriginal populations than among non-Aboriginal populations, but rates can differ substantially between Aboriginal communities. Some researchers describe FAS/FASD as reaching epidemic proportions among Canada's Aboriginal peoples (PHAC, 2005; Premji, Benzies, Serrett & Hayden, 2006; Chudley et al., 2005), while others suggest simply an over-representation of FAS/FASD among Aboriginal populations (Sandor et al., 1981; Williams et al., 1999; Robinson et al., 1987). However, a review of the Aboriginal-specific literature by Pacey (2009) reveals that there is insufficient epidemiological evidence to support higher prevalence of FAS among Aboriginal peoples in Canada. Pacey highlights several issues concerning the published literature on FAS and FASD: the studies are "too methodologically diverse to provide the basis for Aboriginal-specific rates"; the experiential knowledge of Aboriginal communities and clinicians may substantially differ from estimates provided in the literature; "some Canadian Aboriginal-specific published studies focus on higher-risk communities," which may skew perceptions; and most FAS/FASD cases likely fall within the non-Aboriginal population, given the proportion of the total population they constitute (p. ii). Nevertheless, FAS/FASD has been identified as an important public health concern among Aboriginal peoples (Stout, Kipling & Stout, 2001; Pacey, 2009).

There is also a small body of literature on the barriers facing pregnant Aboriginal women in accessing primary, secondary and tertiary FAS/FASD prevention and intervention programs and initiatives, as well as several studies that evaluate current programs and initiatives. A report by the Aboriginal Healing Foundation (2003b) provides a good examination of this body of literature. The authors do this by highlighting the "best practices" for FASD

prevention, identification and intervention reported for the general population by Roberts and Nanson (2000); situating each "best practice" within the larger socio-cultural and historical context of Aboriginal peoples' lives; and assessing each against the various barriers and gaps identified in the literature that prevent successful implementation in an Aboriginal context. The best practices are categorized as primary, secondary and tertiary prevention strategies. The authors conclude that primary prevention strategies, through public health promotion, must be combined with other prevention and intervention strategies if they are to be successful in an Aboriginal context. Secondary prevention strategies can be successful; however, health care professionals must receive training so that trust, communication and respect can be improved between them and their Aboriginal clients (also highlighted by Masotti et al., 2003). Strategies must also be non-judgmental, incorporate traditional Aboriginal knowledge and practices, and be developed in ways that consider the individual and collective experiences of Aboriginal women. The report highlights numerous barriers in addressing tertiary prevention for at-risk Aboriginal women, including psychological, socio-geographic and economic barriers, as well as barriers associated with social networks, stigma and addiction treatment programs. Many of these barriers are directly related to the social context of women's lives – in particular, the role of child welfare services in apprehending children from mothers who are identified as having a substance abuse problem.

Key themes emerging from the Aboriginal-specific literature on FASD are that in order for interventions to be successful, they must adopt holistic approaches, be non-threatening and culturally appropriate, and have the involvement and support of the community (PHAC, 2005; Aboriginal Healing Foundation

[AHF], 2003b; Masotti et al., 2003). In addition, there must be a coordination of services in order to improve the continuum of care for women struggling with substance abuse problems (AHF, 2003b). Many programs and initiatives focus solely on substance abuse and fail to consider the root causes of FASD, such as poverty and a history of oppression and cultural disruption, which have led in many cases to multi-generational patterns of poor mental health, family violence and substance abuse (George et al., 2007; Stout, Kipling & Stout, 2001; AHF, 2003a). In fact, government funding programs tend to be targeted at specific health issues, such as FASD, rather than at multi-dimensional initiatives that address some of the root causes of FASD (i.e., poverty) that may be considered higher priority by Aboriginal communities (AHF, 2003b). The Aboriginal Healing Foundation (2003b) argues that the emphasis of FASD prevention strategies must shift from pregnancy to the health of women generally, so that life circumstances that are at the root of additional problems can be improved (AHF, 2003b). A key part of improving the health of women generally is improving social conditions in communities with a high prevalence of FASD, which, argues Schröter (2010), should be the most important component of prevention.

While FASD is considered preventable, the Aboriginal Healing Foundation (2003b) emphasizes that most programs and initiatives currently in place in North America have limited success in achieving prevention among women who are considered at highest risk of having children with FASD. Progress has been slow in developing and implementing FASD interventions that address the needs of Aboriginal women and build upon community strengths and cultural characteristics, particularly in urban settings, where at-risk Aboriginal women are more likely to access mainstream services (Masotti et al., 2003).

1.2 Child health

In general, the literature related to child health highlights several key health concerns for Aboriginal children, including otitis media, dental health and respiratory infections. Many of these health concerns stem from poor nutrition, poor housing conditions and a lack of access to adequate health care facilities (UNICEF Canada, 2009).

Otitis media

Otitis media (or middle ear infection) is a common ailment in infants and young children that can lead to hearing loss. It can affect a child's ability to learn and thus have lifelong impacts (First Nations Centre [FNC], 2007). Aboriginal children are more likely to be afflicted with otitis media than non-Aboriginal children; however, prevalence rates vary (Bowd, 2002).

There are no Canada-wide data with which to directly compare prevalence rates of otitis media among First Nations (on- and off-reserve), Métis and Inuit children. Smaller case studies have recorded high prevalence rates, particularly among the Inuit, where rates have been recorded as high as 40 times that of non-Aboriginal children living in urban communities (Bowd, 2005). The two largest studies, the 2006 Aboriginal Peoples Survey (APS) and the 2002/03 First Nations Regional Longitudinal Health Survey (RHS), provide data for Aboriginal peoples across Canada, but they used different age cohorts and phrased the question differently, and therefore cannot provide directly comparable data. The Aboriginal Childrens Survey (ACS) 2006 found ear infection rates among 6-14-year-old children, as diagnosed by a health professional, to be highest among Inuit children (15%), compared with Métis and First Nations off-reserve with status (9%), and First Nations off-reserve without status (8%) (McShane, Smylie & Adomako, 2009). Using 2002/03 RHS

data, McShane et al. (2009) also reported prevalence of otitis media among First Nations children on-reserve at 9%.

While heredity and developmental factors (e.g., immature immune systems) can increase the risk of otitis media, environmental factors also play an important role in the high prevalence of this infection (Bowd, 2002; Reading, 2009b). Environmental factors include living in crowded conditions, household moulds, poor sanitation, inadequate access to medical care, bottle feeding and use of pacifiers, and exposure to smoke (Bowd, 2002).

While otitis media is generally more common in infants and very young children, Aboriginal children appear to remain at risk for developing this infection beyond early childhood and are more likely to develop chronic otitis media (Langen, Sockalingam, Caissie & Corsten, 2007). The RHS also found that most First Nations children suffering from otitis media do not receive treatment, with only 25% reporting that they do (FNC, 2007). Lack of access to health care professionals is one reason why some First Nations children may not receive treatment.

Dental health

Dental health is an important component of overall health and has been identified as a health concern among Aboriginal peoples (McShane et al., 2009; UNICEF Canada, 2009; Peressini, Leake, Mayhall, Maar & Trudeau, 2004a, 2004b; Lawrence et al., 2008; Macnab, Rozmus, Benton & Gagnon, 2008). The First Nations Centre (2007) states that poor dental health is the main source of health disparities among Aboriginal and non-Aboriginal children, particularly in light of associations between poor oral health and infectious disease, obesity and diabetes.

Several studies reveal that Aboriginal children in Canada have much poorer dental health than other non-Aboriginal

children; however, cross-Canada studies that can provide directly comparable data for First Nations (on- and off-reserve), Métis and Inuit children are lacking. A study by Macnab et al. (2008) revealed that Aboriginal children have two to three times poorer dental health than other Canadian children, while a study by Lawrence et al. (2004) reported that approximately 70% of Aboriginal children living on reserve had experienced tooth decay by age 3. Prevalence of dental caries was found to be particularly high among Aboriginal children living in the north (Schroth, Smith, Whalen, Letic & Moffatt, 2005). A contributing factor in the higher prevalence in the north may be that lower incomes combined with high food costs have made it more difficult to obtain nutritionally rich foods (Boult, 2004). The 2006 Aboriginal Children's Survey (ACS), which examined the prevalence of childhood "dental problems," found the highest rates among Inuit (31%), followed by First Nations living off-reserve with status (24%), Métis (15%) and First Nations living off-reserve without status (13%) (as cited in McShane et al., 2009). For First Nations children living on-reserve, the 2002/03 RHS found the prevalence of dental caries among 3-5-year-old children to be 29% (as cited in McShane et al., 2009). However, the usefulness of the ACS and RHS data is limited because of a lack of comparison with non-Aboriginal children, making it difficult to assess the degree to which dental health is a problem among Aboriginal children in Canada.

Respiratory health

There are many types of respiratory problems, ranging from asthma and chronic obstructive pulmonary disease (COPD) to lower respiratory infections, such as bronchitis and pneumonia.

Respiratory problems can afflict all

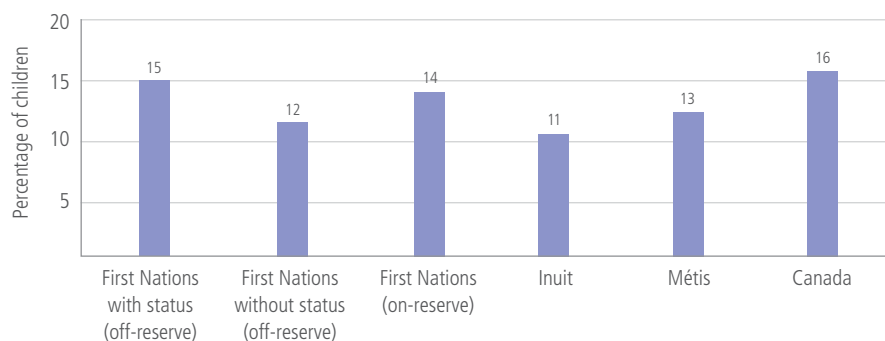
ages but are a greater concern among Aboriginal children than adults (Berghout et al., 2005; Reading, 2009a). For this reason, this section focuses on the prevalence of respiratory health problems as they affect Aboriginal infants and children specifically. It also includes a discussion on some of the risk factors for the increased prevalence and the impacts of respiratory problems on Aboriginal populations.

Literature on the prevalence of asthma among Aboriginal infants and children reveals mixed findings, suggesting there may be risk factors in some locations that are not present in others. A study by McShane et al. (2009), which used data from the 2006 ACS, the 2002/03 RHS and the 2000/01 National Longitudinal Survey of Children and Youth (NLSCY), provides insight into prevalence rates of asthma among Aboriginal infants and children in Canada (Figure 1.2).⁶ The ACS, which examined the prevalence of asthma among children under age 7, found the highest rates among First Nations off-reserve with status (15%), followed by Métis (13%), First Nations off-reserve without status (12%), and Inuit (11%) (McShane et al., 2009). The RHS found

the prevalence of asthma among First Nations children on-reserve under age 12 to be 14% (McShane et al., 2009). When considered with NLSCY data showing that 16% of Canadian children under age 12 suffer from asthma (McShane et al., 2009), the data seem to indicate that asthma is a health concern among Aboriginal and non-Aboriginal children alike; however, it may also suggest a problem with asthma going undiagnosed (Crighton, Wilson & Senécal, 2010). Other studies have found higher rates of asthma and/or COPD among Aboriginal populations in particular settings (Sin, Wells, Svenson, & Man, 2002; Crighton et al., 2010; Berghout et al., 2005).

Geographic location was found to be the most significant factor associated with asthma, with those living in northern territories, on-reserve or rural locations being the least likely to report having asthma (Crighton et al., 2010). Other factors that contribute to higher prevalence of asthma include poor and overcrowded living conditions, low levels of formal education, high rates of unemployment, high rates of tobacco use, and frequent respiratory tract infections

Figure 1.2: Prevalence of asthma among children, by identity and status



Sources: Adapted from McShane et al., 2009, 49, using ACS 2006, RHS 2002/03 and NLSCY 2000/01 data

⁶ Asthma has not traditionally been considered a more major health concern for Aboriginal adults than for other Canadians; however, this appears to be changing (Berghout et al., 2005; Statistics Canada 2008a; Statistics Canada, 2009a; FNC, 2007). Data compiled from Statistics Canada (2008a; 2009a) and the First Nations Centre (2007) show that while 7.8% of the Canadian adult population reported having asthma, prevalence was greater in the Aboriginal population, with 10.6% of First Nations, 9% of Inuit and 14% of Métis adults reporting asthma.

(Jetté, 1992, as cited in Hemmelgarn & Ernst, 1997: 1870; Berghout et al., 2005).

Lower respiratory tract infections among Inuit infants and children have been identified as a serious public health issue and considerable attention has been devoted to this topic in the health literature (Young, Kandola, Mitchell & Leamon, 2008; Kovesi et al., 2007; Orr, 2007; Banerji et al., 2001; Reading, 2009b). Studies have shown that lower respiratory tract infections occur with high frequency and considerable severity, resulting in an extremely high rate of hospital admissions. Orr (2007) reported bronchiolitis attack rates among Inuit infants as high as 57% in some communities in some years, while Banerji et al. (2001) reported hospital admission rates for bronchiolitis in the Baffin Region at 484 per 1000 infants from October 1997 to June 1998. Similarly, Creery et al. (2005) reported high annual hospital admission rates for bronchiolitis and viral pneumonia during the period 1999-2002, with 197 per 1000 infants. Again, environmental concerns such as overcrowding, poor ventilation and exposure to tobacco smoke are key factors in the higher prevalence of these types of respiratory infections (Banerji et al., 2001, 2009; Kovesi et al., 2006, 2007). In addition, lack of breast-feeding (Banerji et al., 2009) and prenatal exposure to polychlorinated biphenyls (PCBs) (Dallaire et al., 2006) have also been identified as possible factors in the alarmingly high rates of respiratory infections among Inuit infants and children.

It is clear from the literature that indoor environmental conditions are a primary cause of respiratory problems among Aboriginal peoples. In colder northern climates, the prevalence of respiratory problems can become even higher because of the increased amount of time spent indoors and exposed to household contaminants such as mould and dust mites (Berghout et al., 2005). Poor indoor environmental air quality is exacerbated

by tobacco smoke; the rate of tobacco smoking among the Inuit has been reported at higher than 70% of adults aged 18-45 (Health Canada, 2007).

1.3 Communicable Diseases

Sexually transmitted infections

Sexually transmitted infections (STIs) are serious health concerns that threaten the general health, well-being and reproductive capacity of many Canadians. If left untreated, STIs may result in serious health consequences, especially for women (Steenbeek, Tyndall, Sheps & Rothenberg, 2009). There are many different types of sexually transmitted infections, the most common of which include chlamydia, gonorrhea, syphilis and HIV/AIDS (which can also be transmitted through injection drugs). The rates of these sexually transmitted infections have continued to rise dramatically, yet little surveillance data are available on STIs and the Aboriginal population (Steenbeek et al., 2009). What data do exist reveal a disproportionate burden of STIs among Aboriginal people, particularly among youth (Devries, Free, Morison & Saewyc, 2009; Steenbeek et al., 2006, 2009).

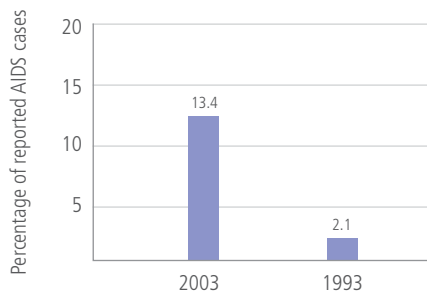
High rates of sexually transmitted infections have been found among certain First Nations and Inuit populations (Devries et al., 2009; Government of Manitoba, 2004; Health Canada, 2004) and in the northern regions (Gesink Law, Rink, Mulvad & Koch, 2008; Steenbeek et al., 2006, 2009). Among the First Nations population, the 2000 reported rate of genital chlamydia was about six times higher than the Canadian rate (1071.5 cases per 100,000 population compared with 178.9) (Health Canada, 2005a). In cases where age and sex were recorded, over half of all First Nations cases occurred in females aged 15-24 (Health Canada, 2005a). The highest chlamydia rates in the country have been recorded in Canada's northern territories. In 2008, Nunavut reported the highest rates of chlamydia

and gonorrhea in Canada, with chlamydia rates 17 times higher and gonorrhea rates 30 times higher than the national average (PHAC, 2010). Common risk factors for STIs include lack of accessible and culturally appropriate health services, lack of anonymity in obtaining condoms and/or clean needles, transience, homelessness, poverty, less than a high school education, prostitution, marginalization of injection drug users and sex-trade workers, and unstable housing arrangements (Government of Manitoba, 2004). Loss of self-esteem and/or a history of substance or child abuse, which are common legacies of colonial policies such as residential school, often underlie these risk factors, leading to the high-risk sexual behaviours that contribute to the spread of STIs (PHAC, 2006b; Young & Katz, 1998). In northern regions, limited access to health care services and confidential treatment may be contributing to the higher prevalence of STIs (Gesink Law et al., 2008).

While most STI prevention strategies focus on common risk behaviours and recommend approaches such as delaying sexual intercourse, limiting partners and using condoms, Devries et al. (2009) also highlight unique factors associated with risky behaviours among Aboriginal youth. These include a higher level of substance use, experiences of sexual abuse, and living on a reserve.

The rapid increase in reported HIV/AIDS cases among Aboriginal populations is another important health concern. The most current epidemiological data on prevalence of HIV/AIDS among Aboriginal populations come from the Public Health Agency of Canada. These data are somewhat problematic, since not all provinces and territories collect ethnicity information as part of their reporting requirements, leaving the possibility of undercounting incidences of HIV/AIDS among Aboriginal populations. Using Canadian Centre for

Figure 1.3: Reported AIDS cases among Canadian Aboriginal populations



Sources: PHAC, 2004, p. 2

Disease Prevention and Control data, the Public Health Agency of Canada (2004) reported 19,344 cases of AIDS over the period 1979-2003. Of the 87.8% of the cases that included information on ethnicity, 3.1% were reported as being Aboriginal people. The Public Health Agency of Canada (2004) also reported an increase in the number of Aboriginal people diagnosed with AIDS, from 1.2% in 1993 to 13.4% in 2003 (Figure 1.3).

Aboriginal people are also overrepresented in the number of cases of HIV infection in Canada, accounting for 5-8% of all cases even though they represent only 3.3% of the total population (PHAC, 2004). In addition, there has been fairly rapid growth in the number of positive HIV tests in Canada among Aboriginal people, from 18.8% of all positive HIV tests in 1998 to 25.3% in 2003 (PHAC, 2004).

Aboriginal women are disproportionately affected by HIV/AIDS when compared with other Canadian women (PHAC, 2004). This difference is most notable in terms of reported HIV cases. When comparing the proportion of women as a total of all reported HIV cases, Aboriginal women accounted for nearly 45% of all Aboriginal cases, while non-Aboriginal women accounted for only 20% of non-Aboriginal cases (PHAC, 2004).

Among youth (under 30 years), more Aboriginal youth tested positive for

both HIV and AIDS than did non-Aboriginal youth, and they did so at a younger age (PHAC, 2004). Nevertheless, the Aboriginal youth proportion of all Aboriginal AIDS cases has been declining. While youth accounted for 40.6% of Aboriginal AIDS cases prior to 1993, during the period 1999-2003 this percentage declined to 13% of Aboriginal AIDS cases (PHAC, 2004).

Injection drug use has become the most common mode of HIV/AIDS transmission within Aboriginal populations. In 1993, 10.9% of AIDS cases were attributed to injection drug use; this increased to 58.3% of cases by 2003 (PHAC, 2004), indicating a shift from HIV as primarily a sexually transmitted disease to one that is transmitted primarily through injection drug use.

Like the transmission of sexually transmitted infections, there is growing evidence that social factors play a pivotal role in susceptibility to HIV/AIDS (Heath et al., 1999). The multi-generational effects of colonization have resulted in many Aboriginal youth participating in high-risk activities (e.g., unprotected sex, injection drug use) that can lead to increased transmission of STIs and HIV/AIDS. Having a history of sexual abuse, mental health issues or involvement in the sex trade are key factors in the high prevalence of HIV/AIDS among Aboriginal peoples (Heath et al., 1999;

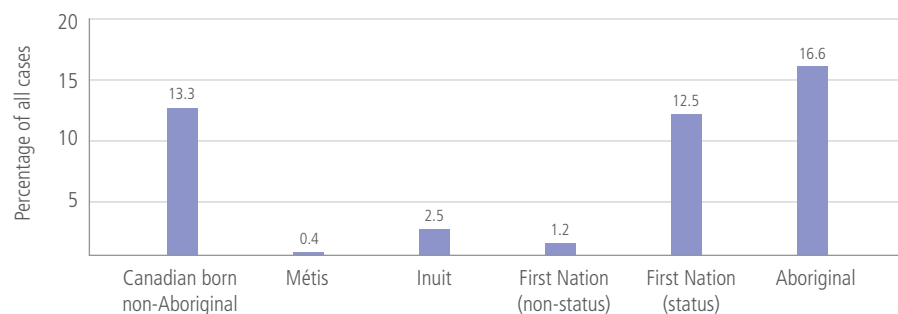
Craib et al., 2003). In addition, individuals who are socially and economically disadvantaged are also at greater risk of becoming HIV infected (NAHO, 2007; Devries et al., 2009; Steenbeek, 2004; Steenbeek et al., 2009; Varcoe & Dick, 2008; Canadian Aboriginal AIDS Network, 2000).

Tuberculosis

Tuberculosis (TB) is a highly infectious disease that begins as a lung infection but can spread to other parts of the body (US Centers for Disease Control and Prevention, 2005). It is transmitted from person to person by breathing infected air during close contact. In the early years of European contact, TB would periodically erupt among Aboriginal populations, resulting in high mortality rates (Grzybowski & Allen, 1999). Over the past century, mortality rates have fallen dramatically as a result of public health interventions, effective drug treatments and improvements in living standards (e.g., housing) (Canadian Tuberculosis Committee, 2002). Tuberculosis has been acknowledged as a major health problem by Canada's Chief Public Health Officer (Butler-Jones, 2008).

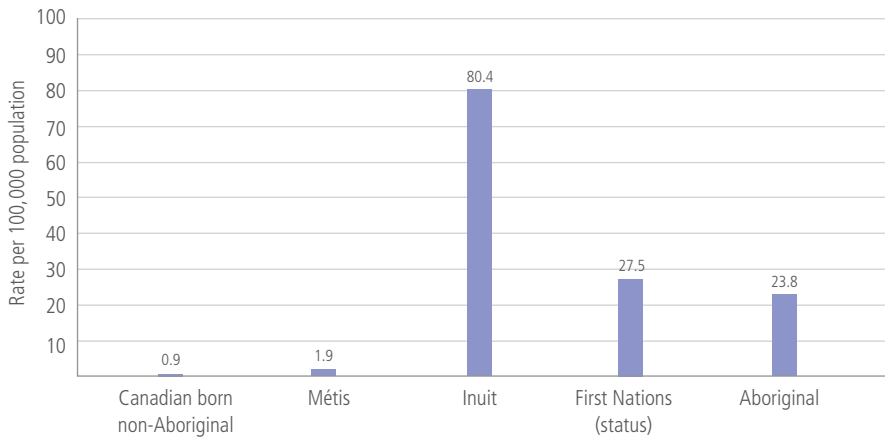
Aboriginal peoples in Canada continue to experience disproportionate rates of TB (Canadian Tuberculosis Committee, 2002; Tait, 2008; Smeja & Brassard, 2000; Butler-Jones, 2008). Despite accounting for only 3.8% of Canada's

Figure 1.4: Proportion of TB cases, by Aboriginal identity and status



Sources: Adapted from PHAC, 2007, p. 4

Figure 1.5: Rate of TB incidence per 100,000 population, by Aboriginal identity



Source: Adapted from PHAC, 2007, p. 4

population (Statistics Canada, 2008a), in 2004 Aboriginal people accounted for 16.6% of all TB cases in the country (Figure 1.4)(PHAC, 2007). In 2004, the incidence rate of TB per 100,000 population was 4.8 times higher for the Aboriginal population than for the general Canadian population (including foreign-born) and 26.4 times higher than for Canadian-born non-Aboriginal people (PHAC, 2007). While TB rates appear to have stabilized among First Nations, and rates are generally low for Métis, periodic outbreaks continue in Inuit settlements, resulting in strikingly high incidence rates of TB (Figure 1.5) (PHAC, 2007). Rates of TB approximately 23 times higher than the total Canadian population have been recorded (Tait, 2008).

1.4 Non-Communicable Diseases

Cancer

Epidemiological data related to cancer among Canadian Aboriginal populations are lacking (Louchini & Beupré, 2008; Circumpolar Inuit Cancer Review Working Group, 2008a, 2008b; Health Canada FNIHB, 2009; Keon & Pepin, 2009). Among the few studies that do examine the prevalence and impacts of cancer on Canada's Aboriginal populations, findings are mixed. This

may be a reflection of the numerous types of cancer and the risk factors associated with each (Earle, 2011), as well as the inconsistent reporting of ethnicity in provincially based cancer registries (First Nations and Inuit Regional Health Survey National Steering Committee, 1999).

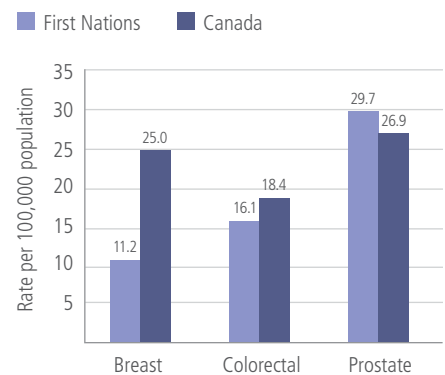
Generally, the impact of cancer among Aboriginal people is less than that among non-Aboriginal populations (Reading, 2009b; Keon & Pepin, 2009). However, some types of cancers may be a greater health concern, while others may be of less concern. For example, in some studies cancer mortality rates have been found to be lower for lung, colorectal and breast cancer among First Nations people than among other Canadians (Health Canada, 2005a). Other sources report higher rates of cervical cancer (Alvi, 2000; FNC, 2006; Young, Kliewer, Blanchard, & Mayer, 2000; Healey, Aronson, Mao & Franco, 2003; Healey, Plaza & Osborne, 2003; Bjerregaard, Young, Dewailly & Ebbesson, 2004) and breast cancer among Aboriginal women (Alvi, 2000; Bjerregaard et al., 2004), prostate cancer among First Nations men (Health Canada, 2005a; Keon & Pepin, 2009; FNC, 2007), and colorectal and lung cancer among First Nations and Inuit (Bjerregaard et al., 2004; Healey, Plaza & Osborne, 2003;

Louchini & Beupré, 2009). Figure 1.6 shows the mortality rates among the First Nations and the Canadian population for three types of cancer as reported in the 2002/03 RHS.

Diabetes

Diabetes has emerged as one of the most important public health concerns for Aboriginal people (Ley et al., 2008; Dyck, Klomp, Tan, Turnell & Boctor, 2002; Oster & Ellen, 2009; Ley et al., 2009). The disease can lead to a wide range of severe health complications, including heart problems, lower limb amputations, diabetic nephropathy and diabetic retinopathy (Health Canada, 2003a). There are three main types of diabetes: type 1 is genetic and results from the pancreas's inability to produce insulin, resulting in patients requiring insulin injections; type 2 is related to lifestyle and generally develops when the body is unable to properly use the insulin produced by the pancreas, resulting in excessive insulin (Campbell, 2002); and gestational diabetes occurs during pregnancy. Type 1 diabetes is fairly rare, even among Aboriginal people, occurring in only about 10% of the general population (Health Canada, 2000b). Type 2 diabetes, which generally occurs later in life and is considered to be largely

Figure 1.6: Mortality rates due to cancer, First Nations compared to the Canadian population, 2007

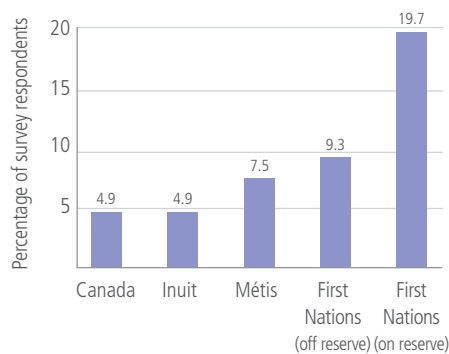


Sources: Adapted from First Nations Centre, 2007, Regional Health Survey, p. 129

preventable (Colagiuri, 2002; Jermendy, 2005), is the most prevalent type of diabetes (Health Canada, 2000b). While limited data exist regarding prevalence of diabetes among Métis and Inuit, type 2 diabetes is considered to be epidemic among First Nations communities, higher than average among Métis, and increasing among Inuit (Health Canada, 2000b). Aside from the high prevalence rates, type 2 diabetes is an important public health issue among Aboriginal people because there is a trend towards increased prevalence of this disease and its risk factors among this population, and Aboriginal people are more likely to be younger at onset, have greater severity of the disease at diagnosis, and have more health complications from the disease compared with non-Aboriginal people (Health Canada, 2000b; Thommasen, Patenaude, Anderson, McArthur & Tildesley, 2004).

The most comprehensive national data on prevalence of diabetes among Aboriginal people can be found in the 2006 APS (for First Nations off-reserve, Inuit and Métis populations) and the 2002/03 RHS (for First Nations on-reserve). Combining the data from these two surveys with 2005 Canadian Community Health Survey (CCHS) data for a Canadian comparison reveals prevalence rates among First

Figure 1.7: Prevalence of diabetes among Aboriginal populations



Sources: Adapted from First Nations Centre, 2007, Regional Health Survey, p. 129

Nations on-reserve that are approximately four times greater than for the Canadian population (Figure 1.7). Métis and First Nations off-reserve also have prevalence rates that are higher than for the rest of Canadians. While the data from these surveys seem to suggest that diabetes is not a major health issue among Inuit, there are some causes for concern. Longitudinal trends suggest that the prevalence rate for diabetes is steadily increasing, with a 2% increase since 2001 (Tait, 2008), as is the prevalence of risk factors such as obesity (Health Canada, 2000b).

Until approximately 20 years ago, type 2 diabetes was typically considered “adult-onset” diabetes (Campbell, 2002). Since then, cases of type 2 diabetes have been diagnosed in First Nations children (Dean, 1998; Dean, Mundy & Moffatt, 1992, 1998; Harris, Perkins & Whalen-Brough, 1996; Fagot-Campagna et al., 2000). While rates vary among First Nations because of inconsistent screening programs and different genetic risks (Dean, 1998), in some First Nations communities, particularly in Manitoba and northwestern Ontario, the prevalence of this disease in children and youth is 1% (Dean et al., 1998). Since type 2 diabetes occurred more often in young females in this study, Dean et al. suggest that the cycle of poor health is likely to be perpetuated because the onset of diabetes before or during pregnancy can affect the health of a developing fetus.

We found few studies that focus on diabetes-related health complications among Aboriginal people. Most studies that examined heart problems and hypertension among Aboriginal diabetics show ratios that are comparable with other Canadians who have diabetes (Health Canada, 2000b). A study by Whiteside (1994) shows higher prevalence of diabetic nephropathy in First Nation diabetics than in non-Aboriginal diabetics. Studies on the extent of lower limb amputations, peripheral neuropathy and

diabetic retinopathy among Aboriginal diabetics are lacking.

The literature also suggests that the prevalence of diabetes among Aboriginal peoples will continue to rise because of the increased prevalence of risk factors such as obesity, hereditary factors and an aging population (Dean, 1998; First Nations and Inuit RHS National Steering Committee, 1999; Health Canada, 2000b; Campbell, 2002; Garriguet, 2008; Health Canada, 2003a). Traditionally, Aboriginal peoples had more active, healthier lifestyles that included hunting and gathering activities, coupled with feast and famine cycles, making inactivity and obesity uncommon (Campbell, 2002). This traditional lifestyle resulted in a genetic predisposition to store energy from the diet more efficiently (Young, Sevenhuysen, Ling & Moffatt, 1990; Thouez, Rannou & Foggin, 1989; Gittelsohn et al., 1998). Over the past 50 years, there has been a rapid shift to a diet of less nutrient-dense market foods, along with the adoption of a more sedentary lifestyle (Thouez et al., 1989, as cited in Health Canada, 2000b; Sharma et al., 2010), which, when coupled with this genetic predisposition, have left Aboriginal peoples more susceptible to obesity and diabetes (Katzmarzyk & Malina, 1998; Young, Dean, Flett, B. & Wood-Steiman, P., 2000; Young, Reading, Elias & O’Neil, 2000; Kuhnlein, Receveur, Soueida & Egeland, 2004; Willows, 2005).

There are numerous barriers in addressing this serious public health issue among Aboriginal peoples. Campbell (2002) highlights a number of social, cultural, economic, geographic, environmental, and financial obstacles to preventing, managing and treating diabetes among this population. Social and cultural barriers include perceptions about weight gain in Aboriginal communities, fears about the side-effects of insulin, the network of family relations that shape children’s health, and a reluctance to accept and implement suggestions from

non-Indigenous health care providers. Economic barriers include poverty, which prevents access to more nutritious but costly foods and may limit a family's ability to relocate to areas where better health care can be obtained. Geographic and environmental barriers include living in isolated, northern regions, which limits access to health care and adequate physical activity. Financial obstacles include the prohibitive costs of screening all Aboriginal children, a strategy proposed by Dean (1998, 1999) and Fagot-Campagna et al. (2000) as necessary in the fight against diabetes among Aboriginal peoples.

Cardiovascular disease

Cardiovascular disease encompasses a range of ailments that affect the heart or blood vessels, including arteriosclerosis, coronary artery disease, heart valve disease, arrhythmia, heart failure, hypertension, orthostatic hypotension, shock, endocarditis, diseases of the aorta and its branches, disorders of the peripheral vascular system, and congenital heart disease (MedicineNet.com, n.d.). Aboriginal Canadians report higher rates of cardiovascular disease (CVD) than other non-Aboriginal Canadians (Anand et al., 2001; Butler-Jones, 2008). This can be attributed, in part, to increased risk factors, including poverty, tobacco use, obesity, hypertension, hyperlipidemia and diabetes (Anand et al., 2001; Keon & Pepin, 2009). This section focuses on the prevalence of CVD among Canada's Aboriginal population.

There are very limited cross-national data regarding prevalence of CVD among Aboriginal peoples. While some hospital admission and mortality data related to CVD may be available in particular regions, cross-national data are generally limited to self-reported survey data through the 2006 APS and the 2002/03 RHS. Most of this information is for the First Nations population only.

The 2002/03 RHS found that heart disease was slightly more prevalent among First Nations adults than among other Canadians (7.6% compared with 5.6%). However, as First Nations adults age, prevalence of heart disease increases, with 11.5% of First Nations adults reporting heart disease compared to 5.5% of other Canadians (FNC, 2007). The acute myocardial infarction rate among First Nations adults is more than 20% higher than among the Canadian population (72.7% compared with 52.1% of the general population, and rates of stroke are nearly twice as high as among other Canadians (71.5% compared with 34.2%) (Health Canada, 2005a).

The main source of information on prevalence of CVD among Métis is the 2006 APS, where 7% of Métis adults self-reported that they had heart problems (Statistics Canada, 2009a). In addition, 16% of Métis self-reported that they had high blood pressure, a risk factor for CVD (Statistics Canada, 2009a). These rates are similar to those reported in the 2001 APS.

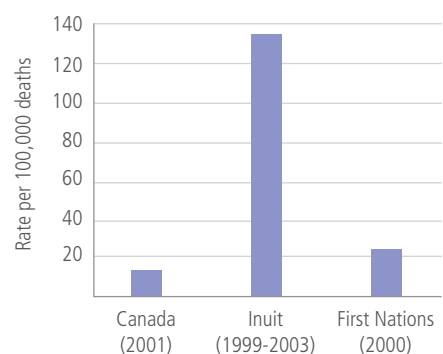
No similar analysis of the APS data is publically available for Inuit adults who self-report heart problems. This may be a reflection of the fact that mortality rates for CVD have, in the past, been lower for Inuit than for other Canadians (Young, 2003a). The Inuit traditional marine-based diet, which is high in omega-3 fatty acids, has been identified as a protective factor against CVD (Pars, Osler & Bjerregard, 2001; O'Keefe & Harris, 2000). However, a shift away from traditional lifestyles and diets towards a more market-foods-based diet has been occurring among Inuit and is increasing the risk factors for CVD, such as high blood pressure, diabetes and obesity (Young, 2003a; Kuhnlein et al., 2004). Recent studies examining prevalence and risk factors for CVD among specific cohorts of Inuit suggest that CVD prevalence is rising and emerging as a health issue for this population (Chateau-

Degat et al. 2010; Egeland & Inuvialuit Settlement Region Steering Committee, 2010; Dewailly, Chateau-Degat, Ékoé & Ladouceur, 2007).

1.5 Mental Health and Wellness

Like childhood abuse/neglect and violence against women, the mental health issues experienced by many Aboriginal people are often rooted in the erosion of Aboriginal culture and values that has resulted in socio-economic marginalization and loss of self-esteem (Browne, McDonald & Elliott, 2009). There is considerable literature about mental health issues among Aboriginal populations in Canada that sets these issues within the context of the impact of colonial policies (PHAC, 2006a; Mignon, O'Neil & Wilkie, 2003). However, current epidemiological data on specific mental health issues and suicide are lacking, particularly disaggregated data that show prevalence rates for specific Aboriginal populations (First Nations, Métis, Inuit, on-reserve versus off-reserve, young versus old, etc.). This section focuses on the available literature on the prevalence of two specific mental health issues: suicide and substance abuse.

Figure 1.8: Number of suicides per 100,000 deaths, First Nations and Inuit compared with Canadian population



Note: First Nations data derived from unpublished Health Canada data, Canadian data derived from Statistics Canada, and Inuit data derived from Nunavut Bureau of Statistics. Source: Government of Canada, 2006, p. 167

Suicide

While there are some epidemiological data on suicide among Canada's First Nations and Inuit populations, these data are lacking for non-status First Nations and Métis (Kirmayer et al., 2007; Moniruzzaman et al., 2009; Advisory Group on Suicide Prevention, 2003). The literature shows that Aboriginal suicide rates have consistently been higher than those of other Canadians (Figure 1.8) (Kirmayer et al., 2007). In 2000, for example, suicide rates were reported at 24/100,000 for First Nations, which was approximately double the rate among the general Canadian population (Kirmayer et al., 2007). The Inuit suicide rate is considered to be among the highest in the world (Health Canada, 2006). Between 1999 and 2003, it was reported to be more than 10 times the national rate, at 135/100,000 (Government of Canada, 2006, as cited in Kirmayer et al., 2007). Suicide tends to be more common among the young; over a third of all deaths among Aboriginal youth are attributable to suicide (Health Canada, 2003b). The 2002/03 RHS also found that alcohol use was implicated in 80% of suicide attempts (FNC, 2007). As in the general population, males were more likely to die as a result of suicide than females (Advisory Group on Suicide Prevention, 2003); however, Kirmayer et al. (2007) also found that Aboriginal females were more likely to attempt suicide than their male counterparts.

Despite these alarming statistics, there are considerable variations in suicide rates among communities. A study of suicide in First Nations communities in British Columbia found that some communities had rates nearly 800 times the national average, while in others suicide was virtually unknown (Chandler & Lalonde, 1998). Another study showed that all cases of suicide among Aboriginal people in Newfoundland were found within a few communities in northern Labrador, comprising only 25% of that province's

Aboriginal population (Aldridge & St. John, 1991). There is a tendency for suicides to occur in clusters, which may be because of the ripple effect of trauma within small, close-knit communities (Advisory Group on Suicide Prevention, 2003). Chandler and Lalonde (1998) found that communities that had taken active steps to preserve and rehabilitate their culture had dramatically lower rates of suicide.

The high rates of suicide among youth in many Aboriginal communities indicate that the problem is not just an individual one but stems from community-wide issues (Kirmayer et al., 2007). Many Aboriginal youth experience isolation, marginalization and unsupportive family relationships, which, when coupled with uncertainty about their identity (brought about by colonization and rapid cultural change), leaves them feeling that suicide is the only solution to their problems (Advisory Group on Suicide Prevention, 2003). Given these wide-ranging risk factors, community-based programs would be most appropriate, particularly those that target multiple levels (from general programs to promote mental health among individuals, families and communities to programs that target at-risk individuals and programs that respond to crises) (Advisory Group on Suicide Prevention, 2003). There are, however, few evaluation-based studies to assist communities with selecting suicide prevention strategies that will be effective within their communities (Advisory Group on Suicide Prevention, 2003).

Substance use

Use and abuse of alcohol, drugs, solvents and tobacco have been well-documented in many Aboriginal communities. A report from Health Canada (2003b) revealed that 73% of respondents considered alcohol and 59% considered drug abuse as problems in First Nations communities. The same report also noted that 1 in 5 Aboriginal youth reported

using solvents, with over half starting before age 11. Despite this, current cross-national data about the prevalence of substance abuse among specific groups of Aboriginal people are often lacking (Korhonen, 2004; Kirmayer et al., 2007). Much of the literature on this topic is qualitative and focuses primarily on the need for community-based strategies to reduce substance use and abuse. The most detailed quantitative data on substance abuse are available for First Nations populations only and can be found in the 2002/03 RHS.

In terms of alcohol abuse, the 2002/03 RHS found that First Nations people consumed alcohol less frequently than the general Canadian population; however, when they drank, they were more likely to consume five or more drinks on a single occasion (16% for First Nations compared with 6.2% for other Canadians) (FNC, 2007). This finding was supported by the 2000/01 CCHS for off-reserve Aboriginal people (as reported in Tjepkema, 2002) and for Inuit peoples (as reported in Kinnon, 2007). Tjepkema reported that 27.2% of off-reserve Aboriginal people drank weekly, compared with 38.4% of the general Canadian population; however, 22.6% of off-reserve Aboriginal people were heavier drinkers, compared with 16.1% of the general population. Similarly, Kinnon reported that 37% of Inuit adults did not drink alcohol, and among those who did, 70% drank less than three times per month; however, 30% drank heavily, compared with only 20% of other Canadians.

Data on the prevalence of drug use among Aboriginal peoples are very limited. The 2002/03 RHS provides some data regarding marijuana and general illicit drug use among First Nations. Marijuana is the most widely used illicit drug in Canada (Chansonneuve, 2007). This is reflected in the RHS, with 26.7% of First Nations survey respondents self-reporting marijuana use over the past year compared



with 14.1% of the general Canadian population (FNC, 2007). The RHS also found that overall illicit drug use was generally low among First Nations survey respondents; however, it was still more than double that of the general Canadian population (7.3% compared with 3%) (FNC, 2007). In terms of type of illicit drug use, a study by the National Native Addictions Partnership Foundation (2000, as cited in Chansonneuve, 2007) reported that 20% of the organization's clients used illicit drugs, and of these, 12.2% reported narcotics use and 8.6% reported hallucinogen use.

There is an extreme lack of data on the misuse of prescription drugs among Aboriginal populations, with no national-level data available and only a handful of isolated studies published. The available evidence suggests that Aboriginal people are at elevated risk for abusing prescription drugs (Rehm & Weekes, 2005). While the 2002/03 RHS did ask First Nations respondents about prescription drug use, including codeine, morphine and opiates, the survey did not ask about whether there was misuse of prescription drugs. A study by Wardman, Kahn & el-Guebaly (2002) found that 48% of Aboriginal people who sought addiction treatment services

did so as a result of prescription drug abuse. Prescription drug misuse has been identified as a health concern in some First Nations communities. For example, the Sioux Lookout First Nations Health Authority identified prescription drug misuse as a health concern within their communities and devoted a workshop to finding a solution to this problem (Sioux Lookout First Nations Health Authority, 2009). In addition, a survey of National Native Alcohol and Drug Abuse Program health service workers reported that 40% of workers felt that prescription drug misuse was a problem in their community (Health Canada, 2005b).

Very little information about solvent abuse is available. There have been isolated studies in some First Nations and Inuit communities (and most of them quite dated), but none in Métis communities (Baydala, 2010). What studies have been done seem to indicate that solvent abuse is most prevalent among First Nations and Inuit youth aged 12-19 living in places with limited economic opportunities (Coleman, Grant & Collins, 2001; Weir, 2001; Baydala, 2010; Collin, 2006). For example, a large study of Aboriginal children and youth in Manitoba and Quebec found that that 20% of Manitoba

youth and 15% of Quebec youth tried solvent sniffing, with regular use being reported by 3% and 2% of adolescents respectively (Layne, 1987, as cited in Health Canada, 1998). Similarly, a 1996 survey in the Northwest Territories revealed high use of solvents among Aboriginal people (19%, compared with 1.7% among non-Aboriginal people) (Northwest Territories Bureau of Statistics, 1996, as cited in Health Canada, 1998). More recently, 50% of Manitoba's Pauingassi First Nation children and youth living on-reserve were reported to be abusing solvents (Collin, 2006), while other communities have stated that up to 60% of youth report use of inhalants (Dell, 2005). A National Native Alcohol and Drug Abuse Program survey of health service workers reported that 24.3% of workers felt that solvent or inhalant abuse was a problem in their community (Health Canada, 2005b).

In discussing the prevalence of tobacco-smoking among Aboriginal people, it is important to distinguish between traditional and non-traditional tobacco use. For many First Nations people, tobacco is considered sacred and is used for a variety of medicinal and ceremonial purposes, including giving

thanks to the Creator and Mother Earth, communicating with the spirits, and purifying the mind and healing the body (Assembly of First Nations, 2002.). A sacred pipe is used for these purposes. However, non-traditional tobacco use, or recreational use, is highly addictive and harmful to health and is considered a serious and growing public health concern among First Nations, Inuit and Métis populations (Reading & Allard, 1999; FNC, 2007). This section reports on the prevalence of non-traditional smoking among Aboriginal people.

There is a strong association between tobacco-smoking and increased risk for cardiovascular disease, respiratory illnesses and certain cancers, and evidence to suggest that non-traditional use of tobacco may also lead to drug and alcohol experimentation, gambling and other unhealthy behaviours (Reading & Allard, 1999). Among First Nations adults living on-reserve, the 2002/03 First Nations Regional Health Survey reported a smoking rate of 58.8%, with the majority smoking on a daily basis (FNC, 2007). The highest rates of daily smoking were found among younger adults, with 53.9% of adults aged 18-29 reporting that they smoked daily, compared with 23.5% of those aged 60 or more (FNC, 2007). The smoking rate among First Nations youth was reported at 37.8%, with 12-year-olds at 10.9% and 17-year-olds at 60.7% (FNC, 2007). Rates of smoking were higher for female youth than for male youth. The smoking rate for pregnant First Nations women was the same as that of the general First Nations population.

The 2006 APS reveals that smoking rates are highest among Inuit (Tait, 2008). Smoking rates among Inuit varied by age and by region. Among Inuit adults, 64% reported being smokers, with 58.8% smoking on a daily basis. The rate has remained relatively unchanged since 2001 and is still over three times that reported in the 2005 CCHS for all adults in

Canada (17%)(Tait, 2008). The highest rates of smoking were found among young Inuit adults aged 25-34, while the lowest were found among adults over age 55 (38%). Among Inuit youth, 56% of those aged 15-19 reported smoking daily. Inuit adults living inside Inuit Nunat were more likely to report smoking daily than those living outside this region (73% compared with 40%).

Smoking prevalence data are much more limited for Métis adults and youth. This may be a reflection of the lower prevalence rates that have been reported to date compared with Inuit and First Nations populations, and/or the fact that a number of Métis adults have reported that they have already reduced their smoking (Statistics Canada, 2009a). The 2006 APS reported that 31% of Métis adults smoked on a daily basis, a decline of 6% from the 2001 APS. (Statistics Canada, 2009a). The percentage of Métis adults who did not smoke at all had also increased 7% since 2001 (61% in 2006 compared with 54% in 2001) (Janz, Seto & Turner, 2009).

Substance abuse is a common method of dealing with the daily challenges of marginalization, poor self-esteem and intergenerational trauma experienced by many Aboriginal peoples (Chansonneuve, 2007). Substance abuse, which can lead to high rates of incarceration, injury, accidental deaths, suicide, violence, child abuse and neglect, and sexual promiscuity (Chansonneuve, 2007; Aucoin, 2005), has had tremendous social and psychological impacts on individuals, families and communities. Nevertheless, Aboriginal communities have made significant progress over the past 30 years in addressing this widespread and long-standing social and health issue. There are numerous examples of best practices in prevention and recovery programs that encompass a holistic health-promoting world view and Aboriginal approaches (Chansonneuve, 2007).

1.6 Violence, Abuse, Injury and Disability

Abuse and family violence

This section examines available literature related to abuse and family violence. Specifically, it focuses on two topics that are recognized as having considerable impact on Aboriginal families and communities: violence against women and childhood abuse and neglect (Tait, 2008; Aboriginal Healing Foundation, 2003a; Keon & Pepin, 2009; PHAC, 2003). Violence and abuse among Aboriginal individuals, families and communities must be considered within the complex social, political and historical factors that have shaped Aboriginal peoples' lives (Reading, 2009a). Colonial policies such as the establishment of reserves and the residential school system eroded Aboriginal culture and values, resulting in widespread socio-economic marginalization and loss of self-esteem (Reading, 2009a; Aboriginal Justice Implementation Commission [AJIC], 1999; Browne, McDonald & Elliott, 2009; Native Women's Association of Canada [NWAC], 2009). These policies produced conditions in which violence and abuse have become the norm in many Aboriginal communities (AJIC, 1999).

Much of the literature on childhood abuse and neglect is informed by the results of the Canadian Incidence Study of Reported Child Abuse and Neglect 1998 and/or 2003, which revealed an overrepresentation of Aboriginal children in the child welfare system (PHAC, 2003). While Aboriginal people constituted approximately 3.8% of the population of Canada (Statistics Canada, 2008a), they accounted for approximately 15% of the total cases of substantiated maltreatment (Trocmé et al., 2005). Among these cases, 10% were First Nations children with status, 2% were Métis or First Nations children without status, and 1% were Inuit children. The 2003 data suggest that these cases were more likely to involve neglect

and lack of supervision than physical or sexual abuse (Trocmé et al., 2005). In interpreting these data, it is important to consider not only the context of Aboriginal peoples' lives but also some unique social and cultural factors: Aboriginal families are more likely to be headed by a female single parent than are non-Aboriginal families (PHAC, 2003), which can create additional stresses in the household, leading to abuse or neglect; and interpretations of what constitutes "neglect" can vary among cultures. Irvine (2009), for example, describes how traditional Aboriginal child-rearing practices that include the ethic of non-interference can be misinterpreted by non-Aboriginal child welfare authorities as being indicative of "neglect."

For many Aboriginal women, violence is a very real threat that they must live with. The literature on this topic focuses on prevalence, severity, the root causes of this violence, and the barriers faced by Aboriginal women in putting an end to it. Violence against women is considered in some Aboriginal communities to have reached epidemic proportions (AJIC, 1999). It has been reported that approximately three-quarters of Aboriginal women are the victims of family violence at least once in their lives (Health Canada, 1999), and that they are 3.5 times more likely to experience violence than are other Canadian women (NWAC, 2009). While there are limited prevalence data on violence against women among Canadian Aboriginal populations, the alarmingly high rate of violence experienced by Aboriginal women in their homes, communities and Canadian society at large is recognized by government departments and agencies and Aboriginal organizations as being one of the most important health concerns Aboriginal women face (NWAC, 2009; AJIC, 1999; AuCoin, 2005; Health Canada, 2000a).

Aboriginal women are more likely to be the victims of severe forms of spousal violence (e.g., being choked, threatened with a deadly weapon, or sexually assaulted) than are non-Aboriginal women (NWAC, 2009). They are also more likely to live in an environment where spousal violence is triggered by substance abuse (RCAP, 1996; Aucoin, 2005). Further, Aboriginal women are three times more likely than non-Aboriginal women to die as a result of violence (Health Canada, 2000a).

In addition to the literature on the socio-economic roots of violence,⁷ there is literature on the systemic and discriminatory barriers Aboriginal women face when they are victims of violence. Systemic barriers include a lack of safe housing, shelters and services for victims of abuse, particularly those that can address the unique cultural and social issues Aboriginal women face (Ipsos-Reid Corporation, 2006; National Aboriginal Circle Against Violence, n.d.; Harper, 2005). Discriminatory barriers include sexism and racism. Sexist beliefs typically place women in a position inferior to men, resulting in violence (AJIC, 1999). Sexism is often manifested in a lack of support for female victims of abuse on reserve when the chief and council members are male and seem unwilling to address abuse issues (Ipsos-Reid Corporation, 2006). Racism can take the form of unsympathetic treatment by police and judicial authorities (AJIC, 1999; Ipsos-Reid Corporation, 2006). Given these barriers, many Aboriginal women are forced to move from their reserves into urban centres to escape the violence, where, instead of finding a better life, they may become vulnerable to sexual exploitation and further violence (Lévesque, 2003, and Culane, 2003, as cited in Browne et al., 2009).

The literature on childhood abuse and neglect and family violence tends to address Aboriginal people generally, with no real disaggregation by First Nations, Inuit or Métis populations, or by urban compared with on-reserve populations. To provide a better understanding of the impacts of childhood abuse and neglect and family violence on specific populations so that meaningful solutions can be found, further research is needed.

Injury and disability

Injuries have tremendous impact on Canadian society in terms of direct and indirect economic costs (costs of health care, loss of employment income) and diminished quality of life (Tjepkema, 2005). They can also contribute to other health problems, including depression, substance abuse, eating and sleeping disorders, and sexually transmitted infections (FNC, 2007). Injuries are considered to be the leading cause of death for Aboriginal people under age 45 and a major cause of disability (Health Canada, 1996, as cited in Health Canada, 2001; Tjepkema, 2005).

Unintentional injuries

Injuries can be both unintentional, where there is no intent to harm, and intentional, where injuries are either self-inflicted or inflicted by someone else (Health Canada, 2001). Since suicide and family violence are covered earlier in this chapter, this section focuses specifically on unintentional injuries, the causes of which can include motor vehicle accidents, drowning, accidental poisonings or drug overdoses, accidental falls and fire (Health Canada, 2001).

It is widely accepted that Aboriginal people are at greater risk for injury than are other Canadians, due to social, psychological and environmental factors. For example, northern climates and road conditions and access can lead to higher

⁷ Literature on socio-economic roots of violence will be discussed in further detail in chapter two.

rates of motor vehicle accidents; a hunting lifestyle can result in higher numbers of suicides and injuries due to firearms; overcrowded and dilapidated housing can lead to increased stress, resulting in family violence and accidental injuries; and poor social conditions can lead to increased risk of violence and suicide (Health Canada, 2001). High-risk lifestyle factors also increase the risk of injury among Aboriginal peoples. For example, alcohol is believed to contribute to motor vehicle crashes, suicide and violence (FNC, 2007), while tobacco use has increased the risk of injury resulting from fires (Health Canada, 2001). Despite the fact that injuries account for one third of deaths among Aboriginal people (Young, 2003b), very little data are available on this health issue beyond some First Nations-specific and/or total Aboriginal population data (Health Canada, 2001). Most of the existing data are based on mortality statistics rather than non-fatal injuries (Tjepkema, 2005).

The available data on unintentional injuries among Aboriginal people show patterns similar to those of the general Canadian population, but with significantly higher rates (Health Canada, 2001; FNC, 2007). For example, Aboriginal people are more likely than their non-Aboriginal counterparts to be injured as a result of motor vehicle accidents (including ATVs and snowmobiles), drowning, accidental poisoning and accidental falls (Health Canada, 2001; FNC, 2007; Karmali et al., 2005). There are disparities in injury rates between Aboriginal and non-Aboriginal people in terms of gender, age, Aboriginal identity and geographic location. Injury rates are generally higher for Aboriginal males than for females, which may reflect their participation in higher-risk activities (Tjepkema, 2005; Karmali et al., 2005; FNC, 2007). Aboriginal people living in more northern and remote regions are at higher risk for motor vehicle accidents, and drowning rates for Aboriginal people are particularly high in the Northwest

Territories, Yukon and Atlantic provinces (Health Canada, 2001). Injury rates are lower for Aboriginal children than they are for higher age groups (FNC, 2007). First Nations youth living on-reserve have extremely high injury rates compared with other Canadian youth in general or First Nations youth living off-reserve (FNC, 2007). Injury rates are fairly similar for Aboriginal children and youth living off-reserve and other Canadian children (Statistics Canada, 2004; Tjepkema, 2005).

Unintentional injury rates among Aboriginal people have improved considerably over time, but remain higher than for the general Canadian population and can lead to premature mortality (Health Canada, 2001). For the First Nations population, the potential years of life lost (PYLL) for unintentional injuries is 2,571.7 per 100,000 population, which is almost 4.5 times the 2001 Canadian rate (Health Canada, 2005a). First Nations men are more likely to die prematurely than women, with 3,376.2 PYLL compared with 1,688.7 PYLL for women (Health Canada, 2005a)

The lack of non-fatal injury data represents a significant barrier to injury prevention programs targeted at Aboriginal peoples (Tjepkema, 2005). Identifying the most common causes of injuries would help communities plan programs that reduce injury (FNC, 2007). Injury prevention strategies require action at multiple levels, including attacking the root causes (e.g., reducing socio-economic disparities, strengthening families and communities), modifying the environment in which injuries take place (e.g., enforcing seatbelt laws, reducing access to firearms), and implementing programs that modify lifestyles, such as public safety education programs or treatment for substance abuse (FNC, 2007).

Disabilities

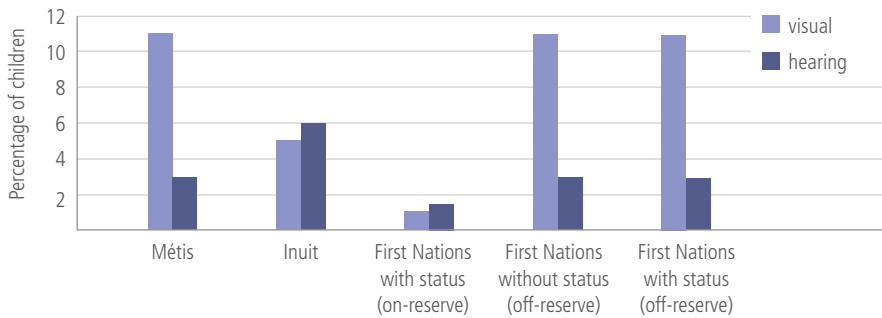
Disability has been defined in several ways but generally refers to a reduction of

activity levels due to a health (cognitive or physical) condition (Health Canada, 2009). With the exception of the 2002/03 RHS, which provides some discussion on the prevalence of disabilities among Canada's First Nation population, few data exist for other groups of Aboriginal people.

Disabilities are more prevalent among First Nations adults, children and youth than in the general population, and as with the general population, disabilities become more common as individuals age (FNC, 2007). When the age-standardized prevalence is calculated to provide a more accurate picture of prevalence, 28.5% of First Nations adults living on-reserve self-report having a disability, compared with 25.8% of the general Canadian population (FNC, 2007). The most common disabilities identified among First Nations adults are arthritis/rheumatism and chronic back pain.

Among First Nations children living on-reserve, attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD), learning disability, fetal alcohol syndrome (FAS), and fetal alcohol effects (FAE) are recognized in First Nations communities as having potentially harmful or challenging implications for school learning and lifelong trajectories (FNC, 2007). The 2002/03 RHS found that 2.4% of First Nations youth and 2.6% of First Nations children have ADD/ADHD, with only 34.2% and 37.6% respectively receiving treatment for it. In terms of a learning disability, fewer on-reserve First Nations youth than Canadian youth generally reported prevalence of a learning disability (3.5% compared with 6.3%), while 2.9% of on-reserve First Nations children also reported having a learning disability (FNC, 2007). In terms of FAS/FAE, 1.8% of First Nations children have been diagnosed as having this condition (FNC, 2007). The low reported prevalence rates may represent a lack of access to diagnosis by educational psychologists and other professionals.

Figure 1.9: Visual and hearing impairments among Aboriginal children, by identity and status



Sources: Adapted from ACS 2006, RHS 2002/3 and NLSCY 2000/1 data, as cited in McShane, Smylie, & Adamako, 2009

There are few gender-based differences in prevalence of disability between on-reserve First Nations boys and girls generally (FNC, 2007).

For First Nations children living off-reserve, the 2006 APS asked questions regarding learning disability and attention deficit disorder. Unlike the RHS, the APS found a greater prevalence of learning disabilities and ADHD among First Nations children living off-reserve than among other Canadian children, and among First Nations boys compared to girls. First Nations boys were twice as likely as girls to have been diagnosed with a learning disability (18% compared with 9%) and more than twice as likely to have been diagnosed with ADHD (13% compared with 5%) (Statistics Canada, 2009b). No similar data from the 2006 APS have been analyzed or are publically available for Inuit or Métis children.

The 2002/03 RHS also reported low prevalence of blindness or vision problems among First Nations children on-reserve (less than 2% of First Nations children), while the 2006 APS reported 11% of First Nations (off-reserve), Métis and Inuit children had visual impairments (Statistics Canada, 2009b) (Figure 1.9). The differences in prevalence identified by the RHS and APS may again reflect a lack of access to diagnostic services.

While the percentages of Aboriginal adults, youth and children living with a disability are in most cases either similar to or slightly higher than the general Canadian population, living with a disability can be more challenging for Aboriginal people because of lower levels of health, income and employment. Aboriginal people also face more barriers in accessing health-related services (Elias, Demas & Assembly of Manitoba Chiefs, 2001; FNC, 2007).

1.7 Environmental Health

Two environmental health issues important to Canada's Aboriginal population are environmental contamination and climate change. Both of these environmental health issues have significant implications for the safety and overall health and well-being of Aboriginal people.

Environmental contamination

This section explores two environmental contamination topics: the presence of pollutants in the food chain and drinking water quality.

To a large extent, there has been a transition in Aboriginal peoples' diet away from country foods – foods that are predominantly harvested from the environment – towards a market-based diet. Nevertheless, country foods such as

seal, caribou, whale, ducks, fish and berries continue to be important from both a nutritional and cultural perspective, and compose a large proportion of Aboriginal peoples' diet (Kirmayer et al., 2000; Van Oostdam et al., 2005; Tait, 2008; Batal, Gray-Donald, Receveur & Gray-Donald, 2005; Lawn et al., 2002; Simpson, 2003). Over the past 20 years, environmental contamination of the food chain has been well documented (Dewailly et al., 2000). Human industrial and urban activities have resulted in the emission of toxic heavy metals, particularly mercury and lead, that are transported through the atmosphere to northern regions and accumulate in traditional food sources (Hermanson & Brozowski, 2005; Dallaire, Dewailly, Muckle & Ayotte, 2003). Aboriginal populations thus have a greater risk of exposure to contaminants than do non-Aboriginal populations, particularly the Inuit, who consume considerable quantities of sea mammals that are highly contaminated by methylmercury and other potentially pro-oxidant contaminants (Bélanger, Mirault, Dewailly, Berthiaume & Julien, 2008; F. Dallaire et al., 2003; F. Dallaire et al., 2004; R. Dallaire et al., 2009; Nickels, Furgal, Buell & Moquin, 2005).

A number of studies have been undertaken investigating the association between organochlorine (OC) exposure, either through direct consumption of contaminants or through prenatal exposure, and a number of health-related illnesses. Prenatal exposure to polychlorinated biphenyls (PCBs) has been associated with neurodevelopmental, cognitive and motor functions. (A good discussion of the health impacts of consuming environmental contaminants can be found in El-Hayek, 2007.) Given that the Inuit consume greater quantities of country foods and are therefore more likely to be exposed to environmental contaminants, most Aboriginal-specific studies have focused on this population. A study by F. Dallaire et al. (2004)

highlighted a possible association between prenatal exposure to OC with acute infections early in life in this subset of the Inuit population, while another study by Dewailly et al. (2000) found an association between OC exposure with the incidence of infectious diseases and immune dysfunction in Inuit infants. However, another study by R. Dallaire et al. (2009) on the relationship between exposure to potential thyroid-disrupting toxicants and thyroid hormone status in pregnant Inuit women and their infants within the first year of life found little evidence that the environmental contaminants examined in the study had any effect on thyroid hormone status. Among Nunavik adults, a study by Valera, Dewailly and Poirier (2008) suggested that mercury has a harmful effect on blood pressure and heart rate variability.

Over recent decades, there has been a decline in exposure to persistent organic pollutants (POPs) through food contamination, both as a result of restrictions and regulations on the use and disposal of POPs and as a result of dietary changes (F. Dallaire et al., 2003; Fontaine et al., 2008). Nevertheless, higher mean concentrations of POPs and heavy metals have still been found in adult blood, cord blood and breast milk of Inuit (Ayotte, Dewailly, Fyan, Bruneau & Lebel, 1997; Dewailly et al., 1993, 1998; Rhainds, Levallois, Dewailly & Ayotte, 1999; El-Hayek, 2008; Fontaine et al., 2008). Concentrations of contaminants were directly correlated with age, level of education, marital status and household size, with higher levels being found among older Inuit, those with less formal education completed, and those living in couples and among households with more than six individuals (Van Oostdam et al., 2005).

The decline in the consumption of traditional foods among Aboriginal peoples, particularly in the Arctic, has placed these people in a dilemma

(Dewailly, 2006). On the one hand is concern over the health implications of consuming environmental contaminants, which has, in part, played a role in the decline of traditional food consumption (Furgal et al., 2005). On the other hand, traditional country foods, in particular marine products, are important sources of protein and essential nutrients and some individuals may lack access to healthy alternatives to these food sources. They have also been linked to positive health outcomes; for example, increases in birth weight and visual acuity of newborns, lower incidence of thrombotic disease, and lower mortality rates from cardiovascular diseases (Dewailly et al., 2001). Dewailly (2006) argues that while there is a need to reduce the exposure of Inuit to POPs and heavy metals, there must be preventive action to ensure that levels of protective factors in this traditional diet are not diminished. F. Dallaire et al. (2004) posit that, given the association of prenatal exposure to environmental contaminants with the health of infants, the focus should be on reducing prenatal exposure by focusing on preventive action on expectant mothers.

The issue of quality and delivery of safe drinking water has been a long-standing concern for many First Nations communities (Standing Senate Committee on Aboriginal Peoples [SSCAP], 2007). Poor-quality drinking water and wastewater systems can pose the risk of water-borne diseases. The most public manifestation of this was the case of Kashechewan in northern Ontario where community members were evacuated because of a contaminated water crisis (SSCAP, 2007). Despite investments made in recent decades to improve drinking water systems, an assessment by the Department of Indian and Northern Affairs and Health Canada in 2001 revealed that almost three-quarters of on-reserve drinking water systems posed significant health risks, with a 2007 progress report indicating

that 97 First Nations communities were considered at high risk (SSCAP, 2007). As of January 31, 2011, 116 First Nations communities were under long-term boil water advisories (Health Canada, 2011a). In many communities, water is contaminated not only as a result of poor treatment facilities (design and location), but also as a result of economic development and other human activities that have polluted the source water surrounding them (SSCAP, 2007). Despite the importance of this health issue for First Nations people, very little literature is available beyond what is found in government reports focusing on challenges and barriers.

In rural and remote locations, wells, cisterns and septic systems are very common. They are often poorly constructed, with wells often located poorly, allowing for surface run-off and contamination by animals (Expert Panel on Safe Drinking Water for First Nations [EPSDW], 2006). In First Nations communities, there are numerous challenges in establishing safe and efficient water regimes, including “high costs of equipment, construction and maintenance of facilities in remote locations; limited local capacity and ability to retain qualified operators; and lack of resources to properly fund system operation and maintenance” (Cram, 2007, as cited in SSCAP, 2007, p. 3). In addition to these challenges, there is a lack of consistency in the way small water systems are legislated and managed, and multiple federal and provincial or territorial government authorities are involved in First Nations water and wastewater matters, creating confusion over roles.

First Nations communities have been advocating for a comprehensive framework for safe drinking water in their communities. The Expert Panel on Safe Drinking Water for First Nations was created as part of a federal action plan to address their concerns. The panel

recommended that a framework include source water protection; treatment of drinking water and wastewater; secure distribution of water; monitoring; training and certification of small water system operators; good operations, management and governance; cautious decision-making; research and technology; and a suitable policy and regulatory framework, particularly for water and wastewater systems that do not fall under provincial or territorial jurisdiction, such as wells and cisterns (EPSDW, 2006). The Standing Senate Committee on Aboriginal Peoples concluded that before a regulatory regime is put in place, the resource gap must be addressed. Small water system operators cannot be expected to comply with new regulations on the provision of safe drinking water, with heavy fines for failure to comply, without significant investment in both human resources (training and certification of water system operators) and physical assets (improved water system infrastructure)(SSCAP, 2007).

Climate change

Climate change and its impacts are expected to be experienced first, and most dramatically, in Arctic regions (Intergovernmental Panel on Climate Change [IPCC], 2001; Berkes & Jolly, 2001). In these regions reside large groups of Aboriginal people who are “still inextricably tied to their local environments through culture and tradition,” and who rely “on the natural environment for many aspects of livelihoods, health and well-being” (Furgal et al., 2008, p. 308). They are thus vulnerable to the impacts of climate change. Research on climate change and health impacts on Canada’s Aboriginal population is in its infancy (Berner, 2005; Hassie, Rytkonen, Kotaniemi & Rintamaki, 2005; Furgal & Séguin, 2006). This research is based on scientific evidence as well as on indigenous knowledge and local observations.

The available evidence suggests that significant changes in climate are occurring in Canada’s north and that they are having impacts, some positive and some negative, on the Aboriginal people living in these regions (Furgal & Séguin, 2006; Van Oostdam et al., 2003, 2005; Nickels et al., 2005). Over the past several decades, average temperatures in the western and central Arctic have warmed by approximately 2-3^o C (Weller et al., 2005). This has resulted in a thinning of sea- and freshwater ice; shorter winter season; reduction of permafrost; changes in fish, bird and mammal distribution and migration patterns; and increased erosion of some shorelines, among other effects (Huntingdon & Fox, 2005; Ouranos Climate Change Consortium, 2004; Weller et al., 2005; Cohen, 1997). The impacts of these environmental changes on the health and well-being of Aboriginal peoples living in these regions can be characterized under four main categories: access to resources, safety, predictability and species availability (Berkes & Jolly, 2001).

In terms of access to resources, earlier melting of ice has meant changes to the frequency and timing of fishing and hunting (Furgal & Séguin, 2006). For example, early melting of ice may prevent transportation to hunting and fishing areas. This has also meant higher financial costs for those who are gathering traditional foods through hunting and fishing activities, and increased risk of injury, as methods of marine and land transportation must be changed in order to travel greater distances to procure these foods (Guyot, Dickson, Paci, Furgal & Chan, 2006; Furgal et al., 2002).

“Significant warming, increased precipitation, and changes in climatic variability and the occurrence of extremes” have been recorded in Arctic regions (Ford & Smit, 2004, p. 390). Climate change has also resulted in unpredictability of weather conditions, which has

implications for Inuit access to resources, safety and health. The unpredictability of weather has meant fluctuations in water levels, with flooding noted at times, while at other times, lower rainfall levels have meant fewer berries, less water for wildlife, and warmer waters, which affects fish spawning (Guyot et al., 2006). Furgal and Séguin (2006) also reported increases in respiratory stress resulting from summer temperature extremes.

In terms of safety, early melting of ice has resulted in increased injuries and drowning (Furgal & Séguin, 2006). Sound knowledge of sea ice is critical to hunting success and safety (Berkes & Jolly, 2001). Inuit are also more likely to live in coastal communities, and in these communities, climate change has resulted in shore erosion and reduced permafrost melting, which threatens housing and infrastructure (Furgal & Séguin, 2006; Furgal et al., 2008).

Warmer seasonal temperatures have meant the arrival of new species, increases in the number of existing species, declines in other species, and changes in migratory patterns (Guyot et al., 2006; Berkes & Jolly, 2001; Furgal & Séguin, 2006). For example, cougars have expanded into more northern areas (Guyot et al., 2006), increasing risks to safety. The presence of more biting flies and insects has been noticed (Furgal & Séguin, 2006). There have also been changes in the range and intensity of infectious diseases, food and water-borne diseases, and diseases associated with air pollutants and aeroallergens (Ebi, Sari Kovats & Menne, 2006; Furgal et al., 2008). Changes in the availability of forage and water and increased intensity of parasitic infections have affected the size of wildlife stocks, migration patterns and the size of a community’s harvest (Berkes & Jolly, 2001).

Inuit are more vulnerable to the impacts of climate change because of the critical health challenges they face, lower socio-economic status, a limited natural and

economic resource base (Furgal & Séguin, 2006), and their intimate connection to the natural environment (Furgal et al., 2008). The impacts of climate change have implications for their cultural, social and mental health. For the Inuit in particular, hunting and gathering activities are “an important source of physical activity, [bring] individuals together and [are] an important part of reconnecting with Inuit identity, transmitting language and knowledge, and relieving physical and mental stress associated with community-based jobs” (Furgal et al., 2008, p. 337). Further, restricted access to traditional food sources has potential implications for food security and nutritional health, and may further shift Inuit towards a more sedentary lifestyle (Furgal et al., 2008).

Aboriginal communities in the Arctic have shown tremendous capacity to adapt to environmental changes brought about through climate change (Furgal & Seguin, 2006; Berkes & Jolly, 2001; Ford & Smit, 2004; Ford, Smit & Wandel, 2006). Short-term responses to land-based activities such as switching species and adjusting

when, where and how hunting takes place are more immediate coping mechanisms. Longer-term locally appropriate strategies are also being developed in many communities to address climate-related impacts. For example, community hunting and sharing programs have been developed in some places to ensure equitable access to traditional food sources (Berkes & Jolly, 2001; Furgal et al., 2002), and community freezers have been established in some places to increase access to safe and healthy foods in the face of environmental changes (Furgal & Seguin, 2006).

1.8 Food Security and Nutrition

Food security was defined by the World Food Summit of 1996 as having “access to sufficient, safe, nutritious food to maintain a healthy and active life” (World Health Organization, 2011, Para. 1). This definition includes dimensions of food availability (sufficient quantities of appropriate quality), food access (having sufficient resources to obtain appropriate nutritious food), utilization (adequate diet, clean water, sanitation and health

care such that all physiological needs are met), and stability (access to adequate foods at all times) (FAO Agricultural and Development Economics Division, 2006). Generally, lack of food has not been considered a problem for Canada (Che & Chen, 2001). However, food security and nutrition have been identified as important issues for Aboriginal people, particularly in rural and remote regions where access to low-cost nutritious food can be lacking (UNICEF Canada, 2009; Tait, 2008; FNC, 2007; Willows, Veugelers, Raine & Kuhle, 2009; Batal et al., 2005).

Information on Aboriginal food security and insecurity rates is generally lacking. What exists focuses mainly on First Nations and Inuit populations and suggests that they are more likely to experience food insecurity than is the general Canadian population. Among on-reserve First Nations households, rates of food security on reserves have ranged from 21% to 83% (McShane, Smylie & Adomako, 2009). For Aboriginal households living off-reserve, the 2007/08 CCHS reported rates of food insecurity



that were three times higher than for non-Aboriginal households (Health Canada, 2011b). The survey reported that approximately 20.9% of Aboriginal off-reserve households were food insecure (compared with 7.2% of non-Aboriginal households), with 8.4% having severe food insecurity (compared with 2.5% of non-Aboriginal households) (Health Canada, 2011b). Among Inuit, the 2006 APS reported that 30% of Inuit children aged 6-14 experienced being hungry because of a lack of food in the household or lack of money to buy food (Tait, 2008). Of these children, 24% experienced it on a monthly basis, while 21% experienced it more frequently (Tait, 2008).

There is a strong association between food security, income and employment (McShane, Smylie & Adomako, 2009; Willows et al., 2009; Batal et al., 2005; Reading, 2009b). The inability to afford or access nutritious food can result in inadequate nutrition, which has significant health implications, particularly early in life, including hampered intellectual, social and emotional development; growth retardation and impaired psychomotor development; decreased ability to concentrate and poor school performance; greater risk of chronic diseases; and compromised immune systems and

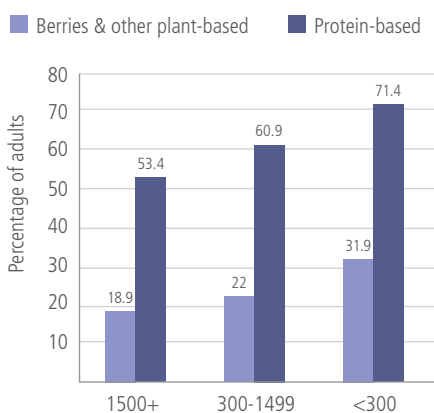
increased susceptibility to infections (Che & Chen, 2001). In rural and remote regions, the ability to afford nutritious food is hampered further by the high costs and poor selection of these foods (Che & Chen, 2001; Boulton, 2004). Junk food is generally lighter and less costly to ship to remote locations than are nutritious foods (Haas, 2002), making them the more affordable options for low-income families living in these regions. For example, in places like Paulatuk, Northwest Territories, food prices can be 470% higher than in Ottawa (Haas, 2002). Cost and availability of nutritious food is an important factor in the increased reliance of Aboriginal people on processed “Western” foods, increased overall sodium consumption, and higher calorie intakes (Willows et al., 2009). The significant health risks associated with these dietary practices have been noted elsewhere in this chapter.

Traditional (country) food sources are a nutritious and less expensive alternative to high cost store-bought foods (Statistics Canada, 2001). Country foods are rich in iron, calcium and vitamins A and C, and are considered to be higher in protein and lower in fat than most meats from southern Canada (Statistics Canada, 2001). In addition, seal and whale are excellent sources of omega-3 fatty acids, which have been found to reduce the risk of cardiovascular diseases (Pars et al., 2001; O’Keefe & Harris, 2000). Along with the nutritional benefits of country foods, acquiring them is physically demanding and therefore contributes to improved fitness levels. For the Inuit, acquiring country foods also offers economic benefits, with an estimated \$40 million of country food being harvested in Nunavut annually (Canadian Arctic Resources Committee, 1989). It is an important component of Inuit culture, the “...embodiment of the connection Inuit have to the land and its bounty” (NAHO, 2004, as cited in Statistics Canada, 2001, p. 12), and thus contributes to Inuit health and well-being (Statistics Canada, 2001).

The consumption of country foods has been declining among Aboriginal people in Canada (Kuhnlein, 1992; Kuhnlein et al., 2004; Sharma et al., 2010). Many factors have been attributed to this decline, including the introduction of wage labour (Kuhnlein, 1992), concern about the level of contaminants found in these foods (Furgal et al., 2005), the high cost of harvesting traditional foods, the effects of global change on access to these foods (Furgal & Séguin, 2006; Berkes & Jolly, 2001), and a decline in farming skills and knowledge about traditional foods (Brown, Isaak, Lengyel, Hanning & Friel, 2008; Guyot et al., 2006; Furgal et al., 2002). Nevertheless, country foods are still an important food source for many Aboriginal people, particularly among Inuit, where they still account for the majority of fish and meat consumed (Tait, 2008). Among Inuit, the consumption of country foods is highest among those living in Inuit Nunavut (Tait, 2008), with 68% of the adult population harvesting country foods and 65% of its residents living in homes where at least half of the meat and fish consumed is country food (65%) (Statistics Canada, 2008b). Among First Nations populations, the 2002/03 RHS investigated consumption of protein-based and plant-based traditional foods and found a correlation between traditional food consumption and community size. While the majority of First Nations adults living on-reserve consumed protein-based country foods, those who lived in larger communities were less likely to consume traditional foods than those living in smaller communities (Figure 1.10).

Older Aboriginal people are more likely to consume country foods, while youth are consuming more processed, store-bought foods (Brown et al., 2008; Kuhnlein et al., 2004; Willows et al., 2009; Statistics Canada, 2001). This trend does not bode well for the health of future generations of Aboriginal people.

Figure 1.10: Percentage of First Nations adults consuming traditional foods, by community size



Sources: FNC, 2007, pp. 99, 169, 258

1.9 Summary

It is clear from these findings that Aboriginal people generally have poorer health than the general Canadian population has. This can be attributed largely to the social, cultural and political factors that have shaped, and continue to shape, their lives. Many of the health conditions facing Aboriginal peoples are the result of a higher prevalence of the risk factors that underlie these conditions, such as alcohol or tobacco use, overcrowded housing conditions and inadequate diet. They also face considerable barriers in addressing their health issues, such as geographic, educational and economic barriers that can affect access to health services. Public health interventions targeted at addressing these health conditions must consider the unique contexts in which First Nations, Inuit and Métis live.

It is also evident from this literature review that there are serious limitations in the data available, which impedes our understanding of the health of First Nations, Inuit and Métis. A great deal of the literature available on the health topics reviewed in this chapter treats Aboriginal people as a homogenous group. Literature and data that compare First Nations, Inuit and Métis, or urban and rural, or on-reserve and off-reserve Aboriginal people are often lacking. Likewise, data that are cross-national and longitudinal and that compare the same variables across the same cohort, over the same time period, are also lacking. This makes it difficult to assess the true picture of the health status of the Aboriginal population, and to make meaningful comparisons between different groups. Without such data, developing strategies to address key public health concerns facing specific groups of Aboriginal people will be challenging.

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Chapter 2:

SOCIAL DETERMINANTS OF HEALTH



The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, and political beliefs, economic or social condition.

– World Health Organization, on its inception July 22, 1946 (as cited in Anderson, Baum & Bentley, 2004: 58).

It is well accepted that health is determined not only by genetics and lifestyle decisions, but by a host of other factors that influence physical, mental and social health and well-being. Social determinants of health are those factors that focus on the economic and social conditions that govern peoples' lives (National Collaborating Centres for Public Health [NCCPH], 2008). For Canada's Aboriginal population, social determinants are often at the root of the many health disparities. This chapter summarizes current knowledge of the social determinants of health for Canada's Aboriginal peoples. It begins by providing an overview of what is meant by "social determinants of health" from international, national and Indigenous⁸ perspectives. It then brings these perspectives together to examine the disparities between Aboriginal and non-Aboriginal people on a range of social

determinants, and the impact of these disparities on the health of Aboriginal people in Canada specifically. These social determinants are presented in six sections: socioeconomic status, children and youth, gender, health services, the physical environment, and culture and language. It is important to note that these are not stand-alone categories of determinants, but are multifaceted and interactive.

2.1 Perspectives on the Social Determinants of Health

Before we can understand the impact of social determinants on the health of Canada's Aboriginal population, we must understand what is meant by social determinants of health. The World Health Organization [WHO] (2011) defines social determinants of health as

...the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. [para. 1]

Several frameworks have been presented, both internationally and in Canada, that identify the factors that constitute social determinants of health. These frameworks have some commonalities, yet also have differences to suit the socio-economic circumstances in particular places. However, the factors identified in these frameworks as important influences on health tend not to adequately address the unique context of Aboriginal peoples' lives. This section begins by providing an overview of those social determinants that are considered important influences on health and that have been identified by the World Health Organization (the international perspective) and the Public Health Agency of Canada (the national perspective). This is followed by a discussion of some of the unique socially determined factors that affect the health of Aboriginal people in Canada specifically.

The international perspective

The sensitivity and relationship of health to our social environment is multifaceted and complex. For example, many major diseases (e.g., type 2 diabetes, cardiovascular disease) are believed to be determined by networks of interacting exposures that have the ability to affect an individual's health either positively or negatively. In general, disease and health

⁸ The term "Indigenous" is commonly used in an international context to refer to those peoples who originated from or are native to a particular place. In Canada, Indigenous people are often referred to as "Aboriginal." For the purposes of this chapter, the term "Indigenous" will be used whenever referring to international perspectives on social determinants, while the term "Aboriginal" will be used when referring specifically to the Canadian context and will include First Nations (on-reserve and off-reserve, status or non-status), Inuit and Métis collectively.

conditions are thought to be a result of social, economic and even political forces, which are referred to as social determinants of health. In 2003, the World Health Organization identified 10 main social determinants in *Social determinants of health: The solid facts* (Wilkinson & Marmot, 2003):

Social gradient or status

Low socio-economic status is strongly correlated with poor education, a lack of amenities, unemployment and job insecurity, poor working conditions and unsafe neighbourhoods (Commission on the Social Determinants of Health [CSDH], 2008). Individuals with low socio-economic status are generally twice as likely to develop serious illnesses and experience premature death as those with higher socio-economic status (Donkin, Goldblatt & Lynch, 2002). WHO also notes gender as a particularly important factor in social status; gender inequalities affect health through violence against women, lack of decision-making power, and unfair divisions of work and leisure, and the empowerment of women is recognized as a “key to achieving fair distribution of health” (CSDH, 2008, p. 16).

Stress

Stressful circumstances, such as lack of control over work, home or social situations, have the potential to damage health, leading to premature death. Stress is caused both by social circumstances and the psychological ability to cope with those circumstances. Individuals who report frequently feeling stress are vulnerable to a variety of conditions, including infections, diabetes, high blood pressure, cardiovascular disease, depression and aggression (Brunner, 1997; Brunner et al., 2002; Wilkinson & Marmot, 2003).

Early life

The World Health Organization emphasizes early life, including fetal development, as an important determinant for healthy adult development (Wilkinson

& Marmot, 2003). Healthy fetal development is compromised by factors such as exposure to teratogenic substances (e.g., alcohol, tobacco), maternal stress, nutritional deficiencies and insufficient exercise. Investment in early childhood development results in positive health outcomes (Early Child Development Knowledge Network [ECDKN], 2007, as cited in CSDH, 2008). A continuum of care for mothers and children is crucial, from pre-pregnancy through pregnancy and childbirth to the early days and years of life (WHO, 2005).

Social inclusion and control

Poverty, deprivation and social exclusion have all been shown to have major impacts on health and to play a role in premature death (Shaw, Dorling & Brimblecombe, 1999). Both absolute poverty (a lack of basic material necessities to sustain life) and relative poverty (defined as living on less than 60% of the national median income) deny individuals access to decent housing and education (Walter, 2007). The stress resulting from living in poverty has particular consequences for pregnant mothers, babies, children and elderly people. Social exclusion can be a result of racism, discrimination, stigmatization and hostility (Wilkinson & Marmot, 2003).

The nature of employment

Financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards are linked to good employment and working conditions (Marmot & Wilkinson, 2006, as cited in CSDH, 2008). The nature of employment also plays an important role in health and longevity. Having less control in one’s work environment is strongly related to health problems like back pain and cardiovascular disease (Bosma, Peter, Siegrist & Marmot, 1998).

Unemployment

Generally, employed people experience better health than those who are

unemployed (Wilkinson & Marmot, 2003). Unemployment can provide unique barriers to both physical and psychological health for individuals and their families. This includes direct barriers to health imposed by financial strain, as well as indirect barriers resulting from anxiety and depression associated with unemployment and basic financial insecurity.

Social support

Support works on two levels: individual and societal. Feelings of belonging and being cared for, loved, respected and valued help to protect people against poor mental and physical health. Research on the physiological effects of positive social support (Cohen & Herbert, 1996; Heffner, Kiecolt-Glaser, Loving, Glaser & Malarkey, 2004; Uchino, Uno & Holt-Lunstad, 1999) has identified disparities in rates of depression (Oxman, Berkman, Kasi, Freeman & Barrett, 1992), pregnancy outcomes (Nuckolls, Cassel & Kaplan, 1972) and various chronic diseases between individuals who feel socially included and those who feel excluded or isolated (Kaplan, Salonen, Cohen, Brand, Syme & Puska, 1988). Social support can improve recovery rates and improve pregnancy outcomes in vulnerable groups of women (Wilkinson & Marmot, 2003).

Addiction

The World Health Organization has identified addiction to alcohol, tobacco and other drugs as an important social determinant that is commonly linked to socially and economically disadvantaged populations (Wardle et al., 1999, as cited in Wilkinson & Marmot, 2003). Substance use and misuse are directly linked to numerous detrimental physical and mental health outcomes such as injury, suicide, poisoning, cancers, depression and premature death. Addictions are also associated with increases in violence and crime rates (Health Canada, 1998).

Food: Access to affordable, nutritious food is vital to health and well-being. Shortages,



poor-quality foods and lack of variation of foods contribute to malnutrition and deficiency-based diseases, including cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental problems. Excessive processing of foods, resulting in high levels of fats, starch, sugar and salt in foods is also a concern, especially among low-income populations. Wilkinson and Marmot (2003) note that access to good, affordable food makes more difference to what people eat than does health education.

Transport

The World Health Organization identifies “healthy” transport – cycling, walking, and the use of public transport rather than the use of automobiles – as a social determinant of health, arguing that these alternative means of transportation promote health because they provide exercise, reduce fatal accidents, increase social contact and reduce air pollution (Wilkinson & Marmot, 2003).

The World Health Organization’s overarching recommendations for action

to address inequities focus on improving daily living conditions and tackling inequitable distribution of power, money and resources, as well as measuring inequality, evaluating actions taken, expanding the knowledge base, training, and raising public awareness about the social determinants of health (CSDH, 2008).

The national perspective

The population health approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one’s goals, to acquire skills and education, and to grow. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health. The best articulation of this concept of health is

...the capacity of people to adapt to, respond to, or control life’s challenges and changes (Frankish, Green, Ratner, Chomic & Larsen, 1996, as cited in PHAC, 2001, para. 3).

The Public Health Agency of Canada (PHAC) recognizes that major health disparities persist among various groups in Canada (Public Health Agency of Canada [PHAC], 2006). Factors such as socio-economic status, Aboriginal heritage, gender and geographic location are closely linked to key health inequalities.

PHAC (2003) identifies 12 categories of determinants of health. Of these, healthy child development is a determinant shared with the World Health Organization’s (WHO) (2003) early life determinant, and several other PHAC determinants are embodied within the WHO framework. For example, PHAC’s education and literacy, and gender determinants are somewhat embodied in WHO’s social gradient or status determinant; PHAC’s income determinant is embodied in both the WHO social gradient and social inclusion and control determinants; and PHAC’s social environment and social support networks determinants are embodied in WHO’s social support determinant. Differences between the two frameworks include four determinants

identified by WHO that are not found in PHAC's framework (stress, addiction, food and transport) and five determinants not found in WHO's framework (physical environment, personal health practices and coping skills, biology and genetic endowment, health services and culture). The differences in these two frameworks largely reflect different expectations of what conditions are essential for healthy living for individuals living in Third World conditions (which the WHO framework targets) compared with the expectations of individuals living in more developed nations like Canada.

In order to avoid repetition with the WHO framework, brief summaries are provided below for only those determinants identified by PHAC that are either not addressed or not adequately addressed in the WHO framework:

Education and literacy

The attainment of education is linked with lifelong developmental trajectories and is thought to positively contribute to learning, problem-solving skills and a sense of mastery or control over a multitude of life circumstances (Ross & Wu, 1995). Education levels are closely linked with socio-economic status, income security and subsequent material security for individuals and their families.

Physical environment

Whether man-made (e.g., housing quality) or natural (e.g., air quality), the environment plays a key role in physical and psychological well-being (PHAC, 2003). Environmental factors, such as contaminants in the air, water, food and soil, contribute to negative health outcomes, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

Personal health practices and coping skills

These are defined as "actions by which individuals can prevent diseases and

promote self-care, cope with challenges, develop self-reliance, solve problems and make choices that enhance health" (PHAC, 2003, p. 7). Personal health practices can include smoking, alcohol and drug use, unsafe sex and high consumption of fats. Research has shown that personal life "choices," or practices, are greatly influenced by socio-economic environments (Bobak, Jha, Nguyen & Jarvis, 2000; Canadian Public Health Association, 1997; Makela, Valkonen & Martelin, 1997; Marsh & McKay, 1994).

Biology and genetic endowment

The organic makeup of the body affects health and well-being. Genetic endowment can predispose individuals to particular diseases and health issues. For example, a genetic predisposition may be a factor in the significantly higher prevalence of type 2 diabetes among Aboriginal populations in Canada (Toth, Cardinal, Moyah & Ralph-Campbell, 2005; Robert, Henian, Anthony, Zinman, Harris & Anderson, 2000).

Health services

Access to health services, including both treatment and secondary prevention, are important factors in health promotion, prevention and restoration. Access to particular types of health care, such as dentistry, mental health counselling and prescription drugs, is directly related to income levels, with Canadians who have low and moderate incomes having limited access to these types of health services (PHAC, 2003).

Culture

Some individuals and groups face cumulative health risks associated with being "outside" of dominant cultural values. Stigmatization, marginalization and/or racism based on cultural preferences by mainstream society can have detrimental and irreversible effects on health and longevity.

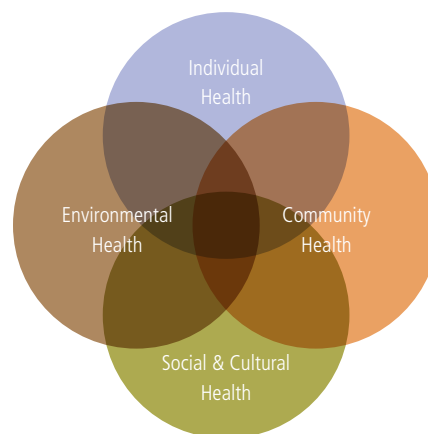
The indigenous perspective

Indigenous people's concept of health and survival is both a collective and an inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, the physical, and emotional. Linking these four fundamental dimensions, health and survival, manifests itself on multiple levels where the past, present, and future co-exist simultaneously. (Durie, 2004, p. 1139)

In the Assembly of First Nations' 2006 First Nations Health Reporting Framework, health determinants are organized in four overlapping areas (see Figure 2.1). The unique First Nations measures included in the "social and cultural health" category are related to effects of colonization (e.g., residential schools), self-determination, language, cultural practices and traditional land.

Current models of health and the social determinants that inform them do not comprehensively target Aboriginal peoples' needs, nor do they properly address the health disparities that exist in Aboriginal communities (Anderson,

Figure 2.1: First Nations determinants of health



Sources: Assembly of First Nations (AFN), 2006

⁹ For example, see the work of the National Collaborating Centre on Aboriginal Health (at <http://www.nccah-ccnsa.ca/>), First Nations Centre (2007) and RCAP (1996b).

2001; Anderson, Baum & Bentley, 2004; FNC, 2007b). While the current models address “surface” causes, such as health practices, stress, psychosocial resources and medical care, they do not address the underlying “structural” causes, such as economic, political, legal, cultural and social factors (e.g., racism) (Anderson, 2001). De Leeuw, Greenwood and Cameron point out that the literature on social determinants tends not to account for the ways that “colonial institutions, ideas, and practices combine to undermine Indigenous peoples’ access to and control over a range of social determinants such as culture, physical environment, and healthy child development” (2009, p. 2).

A vital starting point in addressing the long-standing economic, political and social disparities that Aboriginal peoples face is an understanding of the history of their oppression and marginalization and how it has affected their health and well-being (Anderson, Baum & Bentley, 2004; Browne, Smye & Varcoe, 2005; Loppie Reading & Wien, 2009; Pan American Health Organization [PAHO], 2008). Also required is an understanding of Indigenous peoples’ concepts of health, which often embrace an eco-social and communal perspective rather than simply a perspective that places importance on the health of the individual (Nettleton, Napolitano & Stephens, 2007). Tynan and colleagues (2004) believe that understanding social determinants of health is about understanding the stories, experiences and daily lives of the individuals, families and communities that negotiate the many coexisting determinants on a routine basis.

If the health of Indigenous peoples, both in Canada and internationally, is to be markedly improved, a wider range of Indigenous-specific social determinants needs to be addressed. Recent literature

identifies Indigenous-specific social determinants of health that include colonialism, globalization, migration, cultural continuity, territory, access, poverty, racism, social exclusion, self-determination, land/environment and environmental stewardship.⁹ Although these determinants are listed as discrete categories, there is a complex and interconnected relationship between them. De Leeuw, Greenwood and Cameron (2009) note that Indigenous peoples and organizations agree with and utilize a social determinants framework in attempting to conceptualize Indigenous peoples’ health disparities (see Loppie Reading & Wien, 2008). Indeed, it is this fundamental interconnectedness between the various social determinants of health that appeals to Indigenous peoples, as it conforms to their shared world view, which emphasizes the interconnectedness of life. The focus of the discussion of Indigenous-specific determinants and their impacts on health that follows is on the four inter-related determinants: colonization, culture, racism and self-determination.

Colonization has been defined as “a process that includes geographic incursion, socio-cultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services and ultimately, the creation of ideological formulations around race and skin colour that position the colonizer at a higher evolution level than the colonized” (Kelm, 1998, as cited in Loppie Reading & Wien, 2009, p. 21). Colonization has long been recognized in the literature as being an Indigenous social determinant with direct impacts on the health status of Indigenous peoples (Anderson, 1988, as cited in Anderson et al., 2004). Colonization affects the health of Indigenous peoples by producing social, political and economic inequalities, and by eroding cultural identity.

The World Health Organization suggests that “a toxic combination of policies” resulted in irrevocable loss of land, language, culture and livelihoods (CSDH, 2008, p. 36). Colonization has:

...de-territorialized and ... imposed social, political, and economic structures upon Indigenous peoples without their consultation, consent, or choice. Indigenous peoples’ lives continue to be governed by specific and particular laws and regulations that apply to no other members of civil states. Indigenous people continue to live on bounded or segregated lands and are often at the heart of jurisdictional divides between levels of government, particularly in areas concerning access to financial allocations, programmes, and services.
(CSDH, 2008, p. 36)

For Indigenous peoples, who generally view health as encompassing the individual, the community and the ecosystem in which they live (PAHO, 2008), and whose cultures have been intimately connected to traditional lands and environments, the loss and degradation of the lands and resources on which they have depended for their livelihoods have weakened or destroyed associated economic, social and cultural practices considered essential for health and well-being (Nettleton, Napolitano & Stephens, 2007). Research has shown that the health of the land and the health of the community are synonymous, and that relationships to the physical environment nurture the spiritual, economic, political and social roots of culture (US Department of Health and Human Services, 1999). Bartlett (2003) states that “land loss is among the most significant factors contributing to cultural stress within Aboriginal communities” (as cited in Richmond & Ross, 2009, p. 404).

¹⁰ The term “Indian” has historically been used by the federal government to refer to the Indigenous population. While this term has more commonly been replaced by “First Nations,” it is still reflected in historical documents such as the *Indian Act*.

Colonialism has also had irrevocable consequences for cultural continuity – the degree of social and cultural cohesion within a community (Loppie Reading & Wien, 2009). Maintenance of language and cultural traditions are important here in fostering a sense of individual and community identity. Cultural continuity has been identified as important for the mental health and well-being of Aboriginal populations. For example, Chandler and Lalonde (1998) demonstrated the link between cultural continuity and rates of suicide among British Columbia’s First Nations population.

Another social determinant closely linked to colonialism, with its embedded notions of the inferiority of those being colonized, is “racism.” Racism has been defined as “a belief that race is the primary determinant of human traits and capacities and that racial difference produces an inherent superiority of a particular race” (Merriam-Webster online). Research suggests that individuals who are subject to racism and other forms of discrimination often have more negative health outcomes than those who are not (Wortley, 2003). Racism results in an inequitable distribution of

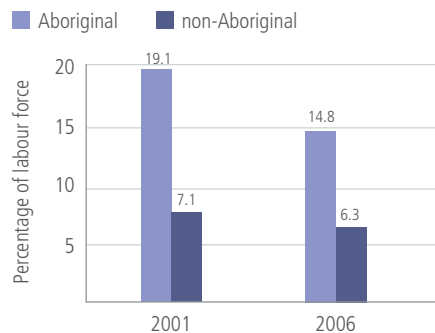
resources, power, freedom and control, which ultimately influences Indigenous peoples’ socio-economic and health status (Adelson, 2005).

A final social determinant identified as important to Indigenous peoples’ health is that of self-determination. Self-determination is broadly defined as the right of all peoples to “freely determine their own political status and freely pursue their economic, social and cultural development” (Office of the United Nations High Commissioner for Human Rights, 1996-2001). Self-determination has important implications for Aboriginal health because it fosters empowerment and allows individuals to take control of their lives and health development (Cornell, 2006; Marmot, 2005). Loss of autonomy has been a prominent feature of colonial processes (Royal Commission on Aboriginal Peoples [RCAP], 1996b). Research has shown that self-determination can improve mental well-being (Chandler & Lalonde, 1998) and generate economic development that can serve as a tool for alleviating poverty and other social conditions that lead to ill health (RCAP, 1996a).

2.2 Current Health Realities

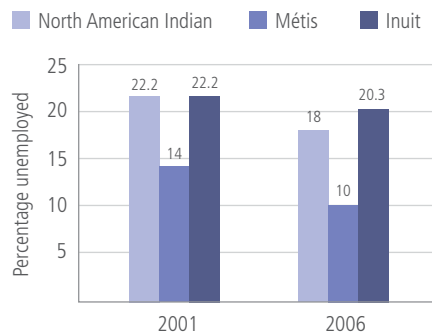
This section integrates Indigenous, international and national perspectives on social determinants with available socio-economic data to highlight the environment in which First Nations, Inuit, Métis and non-status Indian¹⁰ health is currently determined. The first part focuses on the socio-economic status of Aboriginal people across Canada, including employment, type of work, income, educational attainment and economic development. The second part focuses on children and youth, emphasizing healthy early development and family structures. The third part focuses on health concerns specific to and particularly prevalent for Aboriginal women, and discusses violence and criminalization not only as a result of social status but also as a mitigating factor in Aboriginal women’s wellness. The fourth part discusses access to health services in terms of early detection and prevention, while the fifth part looks at loss of language and culture as important social determinants of health for Aboriginal Canadians.

Figure 2.2: Percentage of Aboriginal and non-Aboriginal labour force unemployed, 2001 and 2006



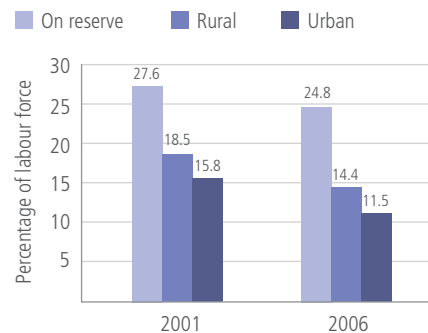
Sources: Statistics Canada (2001), Census 2001, Topic-based tabulations, Cat. No. 97F0011XCB01044; Statistics Canada (2006), Census 2006, Data Products, Topic-based tabulations, Cat. No. 97-559-XCB2006019

Figure 2.3: Percentage of North American Indian, Métis, and Inuit unemployed, 2001 and 2006



Sources: Statistics Canada (2001), Census 2001, Topic-based tabulations, Cat. No. 97F0011XCB01044; Statistics Canada (2006), Census 2006, Data Products, Topic-based tabulations, Cat. No. 97-559-XCB2006019

Figure 2.4: Percentage of Aboriginal force unemployed, by location, 2001 and 2006



Sources: Statistics Canada (2001), Census 2001, Topic-based tabulations, Cat. No. 97F0011XCB01044; Statistics Canada (2006), Census 2006, Data Products, Topic-based tabulations, Cat. No. 97-559-XCB2006019

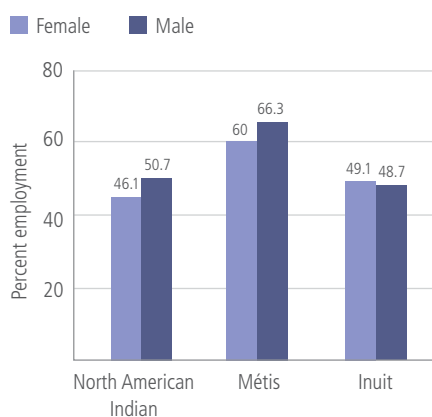
¹¹ The quality and coverage of data related to Aboriginal peoples has long been a source of concern (Smylie, 2009)

In this section, the term “Aboriginal” is used to refer to all groups of Aboriginal peoples collectively, and wherever possible the terms “Inuit,” “Métis” or “First Nations” are used to denote specific groups of Aboriginal peoples. However, source data may use and employ terms differently than is done in this chapter. For example, data derived from Statistics Canada may use the term “North American Indian” to refer to the First Nations population, or may further define First Nations people by whether they are registered status Indian (that is, they are registered under the *Indian Act* and are thus entitled to the rights and benefits articulated in the act). Further, some sources may use the term “Aboriginal” in a way that is not as inclusive as it is used here. Please note that when highlighting the differences among Aboriginal peoples, the discussion that follows uses the same terms as those employed by the source data.

Socio-economic status

This section examines socio-economic status among Canada’s Aboriginal populations using data pertaining to employment, unemployment and labour participation rates; levels of educational

Figure 2.5: Percentage of Aboriginal labour force employed, by gender, 2006



Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based tabulations, Cat. No. 97-559-XCB2006019

attainment; type of occupation; and income. The data reveal notable socio-economic disparities among Aboriginal and non-Aboriginal Canadians, and among various groups of Aboriginal peoples, that can result in health disparities.

Employment

According to Statistics Canada,¹¹ in 2001 the unemployment rate for Aboriginal people as a whole was well over twice the rate for non-Aboriginal people (19.1% and 7.1%). The pattern was the same in 2006 (14.8% and 6.3%), although both groups showed reduced unemployment rates between 2001 and 2006 (Figure 2.2).

Among Aboriginal people, Inuit people have the highest unemployment rates in Canada. They are followed closely by North American Indians (Figure 2.3).

Statistics Canada census data for 2001 and 2006 show notable differences in unemployment rates for Aboriginal people living on-reserve and those living in urban and rural areas (Figure 2.4). In 2001, Aboriginal people living on-reserve were almost twice as likely to be unemployed as those living in urban areas, and in 2006 they were more than twice as likely to be unemployed. Over the five-year period between the Statistics Canada censuses, unemployment rates decreased for all three groups; however, those living on-reserve experienced significantly smaller decreases in their unemployment rate (2.8%) than those in rural (4.1%) and urban (4.3%) areas.

Unemployment rates also vary by province and territory. In 2001, Newfoundland and Labrador had the highest unemployment rates for Aboriginal people across Canada (33.5%), followed closely by New Brunswick (28.1%) and Yukon (26.8%)(Statistics Canada, 2001a). The unemployment rate improved in 2006 for

Aboriginal peoples in all provinces, with rates declining by an average of 4.8%, with the exception of the Northwest Territories, which declined by only 1.9% over the five-year period.

There have been improvements in the labour force participation of Aboriginal peoples since the 2001 census. According to Statistics Canada’s 2006 census data, the employment rate of Aboriginal peoples was 53.7%, up from 49.7% in 2001 (Statistics Canada, 2006). The participation rate of Aboriginal peoples had similarly increased to 63%, up from 61.4% in the previous census (Ibid.). Nevertheless, significant disparities remain between the labour force participation of Aboriginal peoples compared to non-Aboriginal people, with significantly lower rates of employment and participation.

There are also gender differences in Aboriginal peoples’ participation in the labour force. In 2006, male North American Indians had an unemployment rate of 19.8%, compared with females at 16.2%. Similarly, Inuit men’s unemployment rate was 23.8%, compared with 16.7% for Inuit women. Gender differences in unemployment rates were largely insignificant for Métis people: 10.5% for males and 9.5% for females (Statistics Canada, 2006).

Aboriginal women are also less likely to be employed than both Aboriginal men and non-Aboriginal women. In 2006, both Métis men and women had the highest employment rates of all Aboriginal groups. With the exception of Inuit women, men were more likely to be employed than their female counterparts. Of all Aboriginal men, Inuit men were the least likely to be employed (Figure 2.5).

Among registered Indians,¹² employment rates were higher for males than for

¹² “Registered Indians,” or “Status Indians,” refers to those individuals who are registered under the *Indian Act* and are thus entitled to the rights and benefits articulated in that act (Statistics Canada, Registered or Treaty Indian status of person, <http://www.statcan.gc.ca/concepts/definitions/aboriginal-autochtone4-eng.html>).

females both on-reserve (39.6% and 38.5%, respectively) and off-reserve (57.6% and 49.3%, respectively) (Figure 2.6) (Statistics Canada, 2006).

Type of work

According to Statistics Canada, Aboriginal people are less likely to be employed in higher-paying positions that require higher levels of education. While the non-Aboriginal population worked more in management, health, natural and applied sciences, and financial or business

positions, Aboriginal people were more likely to be employed in sales and services, trades and primary industry positions. There was little change to this pattern between the 2001 and 2006 censuses (Figures 2.7 and 2.8).

Aboriginal occupation varies by location, in on-reserve, urban and rural areas (Statistics Canada, 2001a; 2006a). In 2001, the urban Aboriginal (14.9%) population worked more often in business, finance and administrative positions than did individuals living in rural areas (10.7%) or on-reserve (10.5%). The urban population also worked more often in sales and service industry positions (28.9%) than did rural (24.8%) and on-reserve (23.9%) individuals. There were significantly more primary industry positions on-reserve (9.5%) and in rural areas (10.7%) than in urban areas (3.7%) (Figure 2.9).

In 2006 (Figure 2.10), these trends continued, with urban Aboriginal people working in business, financial and administrative positions (16.2%) and sales (30.3%) more often, while on-reserve and rural populations were more often employed in primary industry positions (10.1% compared with 3.3% in urban areas)(Statistics Canada, 2006).

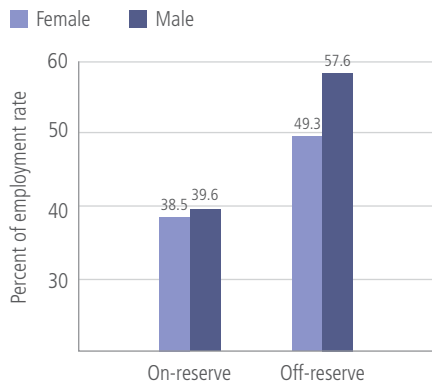
Aboriginal women are also more likely to work in lower-paying occupations, such as sales or administration (Hull, 2001), and the 2002/03 First Nations Regional Longitudinal Health Survey (RHS) indicated that First Nations women are also more likely to work in part-time positions than men (9.4% and 5.7%, respectively) (First Nations Centre [FNC], 2007).

There were no other reportable differences in either the 2001 or the 2006 census between North American Indians, Inuit and Métis or between registered and non-registered Indian status in terms of the types of occupation held.

Income

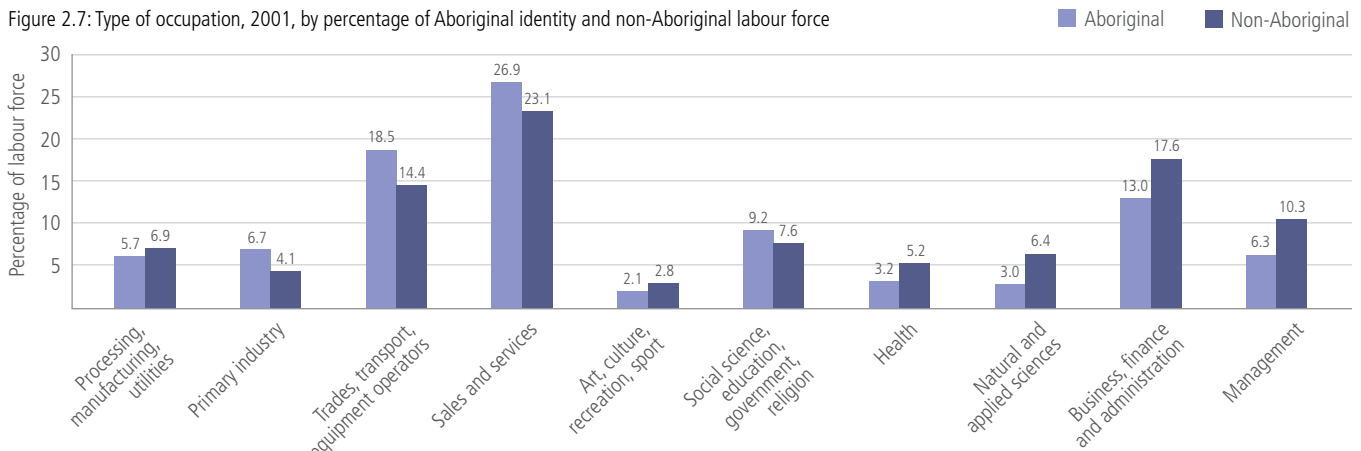
The association between household income and health is illustrated by Loppie Reading and Wien (2009) using data adapted from Tjepkema (2002). They report that Aboriginal Canadians living in low-income situations have significantly higher levels of fair or poor health (34%) than do middle- (26%) or high-income (14%) Aboriginal Canadians. Low-, medium- and high-income Aboriginal Canadians report fair or poor health significantly more often than do non-Aboriginal Canadians in all three income categories (Figure 2.11).

Figure 2.6: Percentage of labour force employed, registered Indians on-reserve¹³ and off-reserve,¹⁴ by gender, 2006



Source: Statistics Canada (2006), 2006 Census of Population, Cat. No. 97-559-XCB2006013

Figure 2.7: Type of occupation, 2001, by percentage of Aboriginal identity and non-Aboriginal labour force

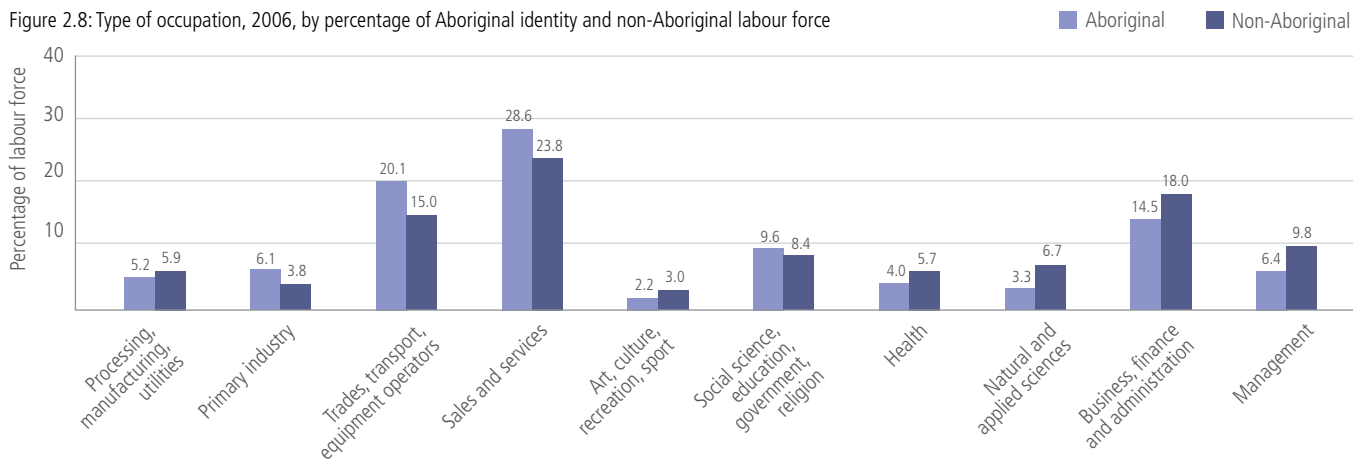


Sources: Statistics Canada (2001), Census 2001, Topic-based tabulations, Cat. No. 97F0011XCB01044; Statistics Canada (2006), Census 2006, Data Products, Topic-based tabulations, Cat. No. 97-559-XCB2006019

¹³ Registered Indian status is based on self-reporting of the respondent.

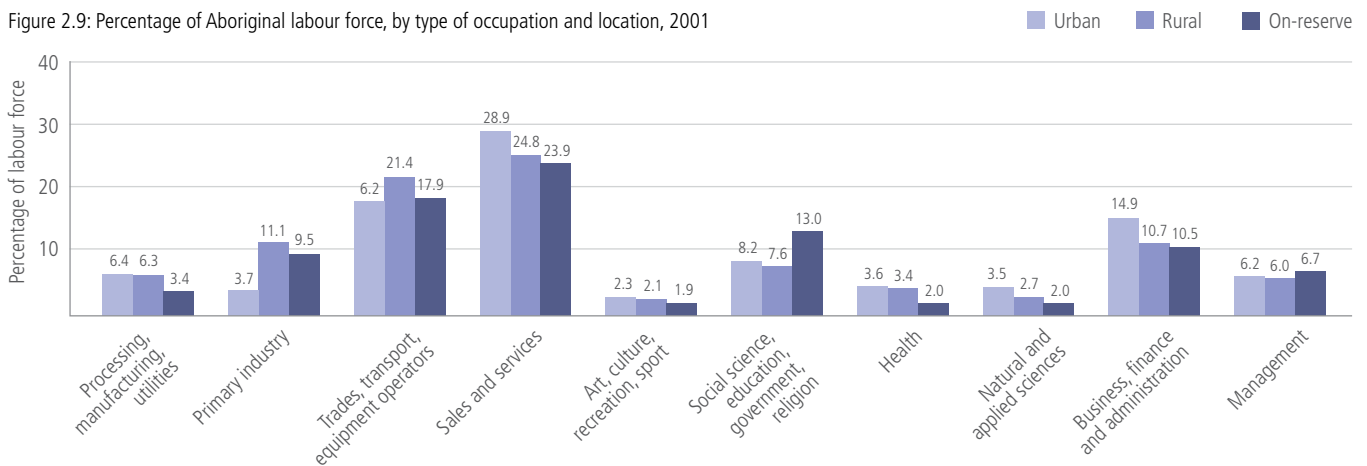
¹⁴ Total registered Indian Canadian population living off-reserve.

Figure 2.8: Type of occupation, 2006, by percentage of Aboriginal identity and non-Aboriginal labour force



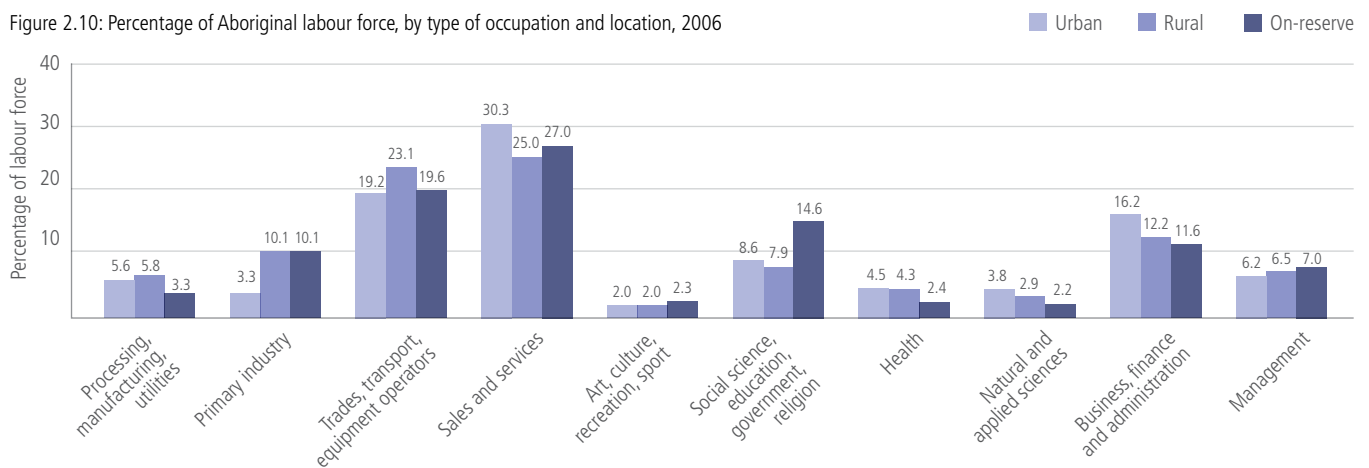
Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-XCB200604

Figure 2.9: Percentage of Aboriginal labour force, by type of occupation and location, 2001



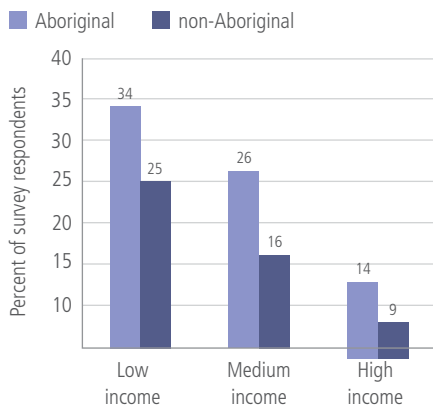
Source: Statistics Canada (2001), Census 2001, Topic-based tabulations, Cat. No. 97F001XCB01045

Figure 2.10: Percentage of Aboriginal labour force, by type of occupation and location, 2006



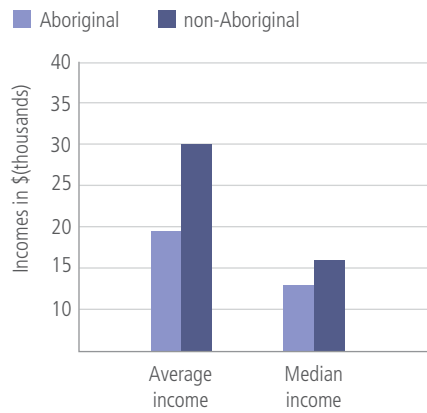
Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-564-XCB2006002

Figure 2.11: Percentage off-reserve Aboriginal and non-Aboriginal populations who self-reported fair or poor health, by level of household income, 2000/01



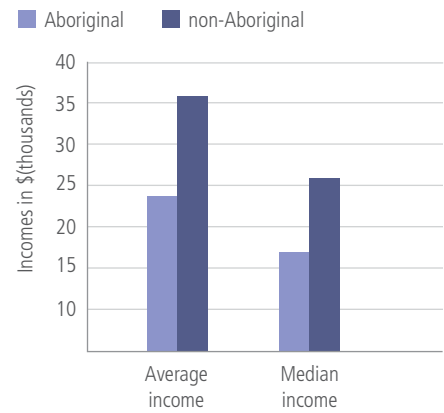
Source: Adapted from Tjepkema (2002)

Figure 2.12: Comparison of annual average and median incomes between Aboriginal and non-Aboriginal populations, 2001



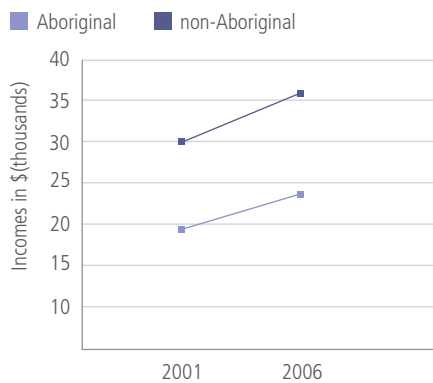
Source: Statistics Canada (2001), Census 2001, Topic-based Tabulations, Cat. No. 97F0011XCBO1047

Figure 2.13: Comparison of annual average and median incomes between Aboriginal and non-Aboriginal populations, 2006



Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-563-XCB2006061

Figure 2.14: Comparison of differences in annual income between Aboriginal and non-Aboriginal populations over the period 2001-2006



Source: Adapted from Tjepkema (2002)

While income levels have been rising for Aboriginal peoples, they are still significantly lower than for non-Aboriginal peoples. According to the 2001 census, the average annual income was \$19,132 for Aboriginal people compared with \$30,062 for non-Aboriginal people, while the median annual income was \$13,525 for Aboriginal people compared with \$16,167 for non-Aboriginal people (Figure 2.12). The 2006 census showed increases in both average income (\$23,888 for Aboriginal people, compared with \$35,872 for non-Aboriginal people) and median income (\$16,752 for Aboriginal

people compared with \$25,955 for non-Aboriginal people) (Figure 2.13).

Despite the rising income levels, the income gap between Aboriginal and non-Aboriginal people has, in fact, been increasing, with a difference in average income of \$11,868 between the two groups (Figure 2.14).

Differences in total average income between Aboriginal and non-Aboriginal people also vary across provinces and territories. The largest income gaps are found in Nunavut, Northwest Territories, Alberta, and the Yukon (Figure 2.15).

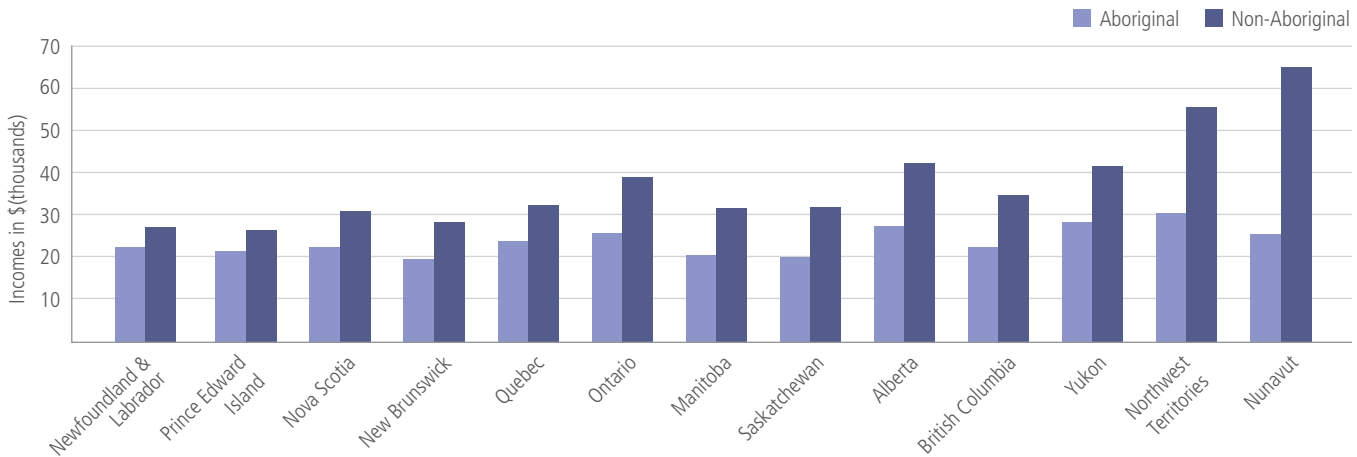
Notable disparities exist among North American Indians, Inuit, and Métis in terms of average employment income, with rates lowest for North American Indians and highest for Métis. In 2001, average employment income for North American Indians was \$17,376, \$4,837 lower than for Métis (Statistics Canada, 2001a). While the 2006 census shows increased average annual employment income for all three identities, the disparity between identities continues, with Métis people earning approximately 5.6% more than North American Indians over this census period (Figure 2.16).

Educational attainment

For Indigenous peoples, education is “a lifelong learning process that requires both formal and informal learning opportunities” for all ages (Battiste, 2005, p. 4). Mainstream skills such as literacy and numeracy are important in ensuring that Aboriginal peoples are able to compete in the labour market and thus improve their socio-economic circumstances. Equally important in the learning and education process for Aboriginal peoples is their intimate connection to the land, the knowledge and skill in and from place, and their language and culture (Battiste, 2005). The incorporation of these values into education has been clearly linked with “being and becoming a healthy person, family member, community member, and member of society” (Smylie, Williams & Cooper, 2006, p. S22).

Educational attainment is an issue of particular importance to Aboriginal peoples, given the youthfulness of the population. The average age of Aboriginal people is 27 years, with 30% of the Aboriginal population under the age of 15 compared with 17% of the non-Aboriginal population (Statistics Canada, 2006).

Figure 2.15: Average employment income of Aboriginal identity and non-Aboriginal Canadians (15 years of age and older) in constant (2005) dollars by province and territory



Source: Statistics Canada (2006), Census 2006, Topic-based Tabulations, Cat. No. 97-563-XCB2006008

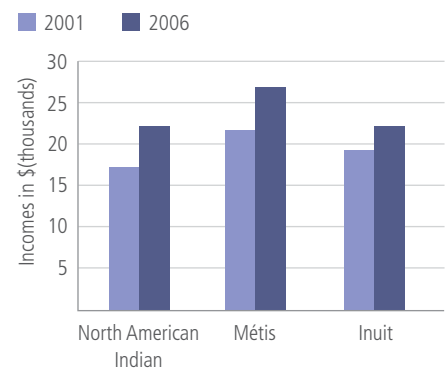
Lower levels of education for Aboriginal peoples than for their non-Aboriginal counterparts have been reported. According to the 2006 census, nearly twice as many Aboriginal people (43.7%) as non-Aboriginal people (23.1%) had not completed high school or received a certificate or diploma for any kind of educational training (Statistics Canada, 2006). In addition, non-Aboriginal people were 2.8 times more likely than Aboriginal people to have completed a bachelor's degree at a post-secondary institution (11.9% compared with 4.2%). By extension, a smaller proportion of Aboriginal people had attained a graduate degree at either a master's or doctorate level (0.8% and 0.2%, respectively) than had non-Aboriginal people (3.5% and 0.7%, respectively). However, a higher percentage of Aboriginal people had completed apprenticeships and trades (11.4%) than had non-Aboriginal people (10.8%) (Statistics Canada, 2006).

Among the different Aboriginal populations, educational attainment levels were lowest among Inuit, with 60.7% not having completed high school, compared to 48.4% of North American Indians and 34.6% of Métis (Statistics Canada, 2006).

Geography is also a factor in levels of educational attainment among Aboriginal populations. Individuals living on-reserve had the lowest levels of education across all categories. They also had the highest percentage of people with no certification, diploma or degree (59.5%), compared with Aboriginal people living in urban (36.3%) and rural (44.1%) areas (Statistics Canada, 2006). Figure 2.17 shows education levels by location.

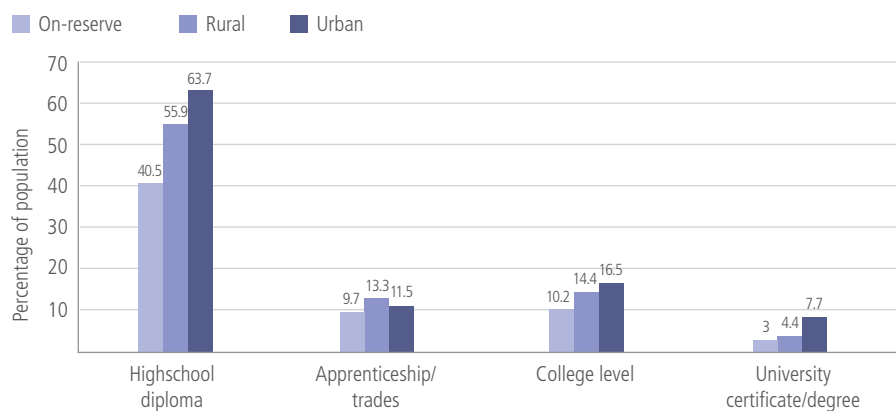
Statistics Canada (2001, 2006) census data indicate that educational attainment of Aboriginal people varied across

Figure 2.16: Average employment income by Aboriginal identity, 2001 and 2006



Source: Statistics Canada (2001), Census 2001, Topic-based Tabulations, Cat. No. 97F0011XCB01047; Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-563-XCB2006061

Figure 2.17: Highest level of education among Aboriginal identity population by location, 2006



Source: Statistics Canada (2006), Census 2006, Topic-based Tabulations, Cat. No. 97-560-X2006028

provinces and territories as well. Figure 2.18 shows percentages of individuals possessing less than high school education, with no certificates, diplomas or degrees, across Canada in 2001 and 2006. Over this period, while the percentage of Aboriginal people with less than high school education decreased in most of the provinces and territories, it increased by 3.9% in Yukon Territory and by 8.3% in Nunavut.

The eastern provinces had the highest percentage of Aboriginal people with completed university certificates and/or degrees. This was particularly evident in Nova Scotia (10.5% of the Aboriginal population), followed by Newfoundland (8.8%), New Brunswick (6.4%) and Quebec (6.1%). The lowest rates of post-secondary completion were in Nunavut (2%), Northwest Territories (3.2%), Yukon (5.3%) and British Columbia (5.3%) (Figure 2.19).

Aboriginal people experience multiple barriers in completing post-secondary education. Aboriginal men and women

give different reasons for not completing a post-secondary program. A study that examined post-secondary education among First Nations men and women using Aboriginal Peoples Survey 2006 data (Milligan & Bougie, 2009) found that the main reasons given by women for not completing post-secondary education included financial reasons (14%), obtaining or wanting to work (14%), pregnancy (12%) and other family responsibilities (11%); while for men, obtaining a job or wanting to work was the main reason given. Despite these financial and familial barriers, Aboriginal women were nearly twice as likely as Aboriginal men to have a university certificate, diploma or degree (7.1% compared with 4.5%) (Statistics Canada, 2006). However, 36% of Aboriginal women completed post-secondary levels of education, compared with 50% of the general population of Canadian women. In 2006, 6.3% of Aboriginal women had obtained a university degree, compared with 16% of non-Aboriginal women (Milligan & Bougie, 2009).

Economic development

Economic development generates employment opportunities and leads to improved education and skills acquisition. It is an important tool in alleviating poverty and other social conditions that lead to ill health (RCAP, 1996a). In turn, good health is essential to economic development, as “ill health reduces an individual’s probability of participating in the labour force” (Suhrcke, McKee & Rocco, 2007, p. 1467).

Economic development encompasses a range of practices aimed at promoting more intensive and advanced economic activity, including macro-economic development, local economic development and community economic development (Dauncey, 1996). When economic development is undertaken with community values and aspirations in mind, the resulting revenues can be used to improve local services and the health and well-being of communities as a whole (e.g., Ketilson & MacPherson, 2001). It can also foster empowerment, build capacity and enhance individual



and community resilience. For Aboriginal Canadians, who experience a disproportionate burden of ill-health compared with the rest of the population, economic development is of critical importance to improved health outcomes.

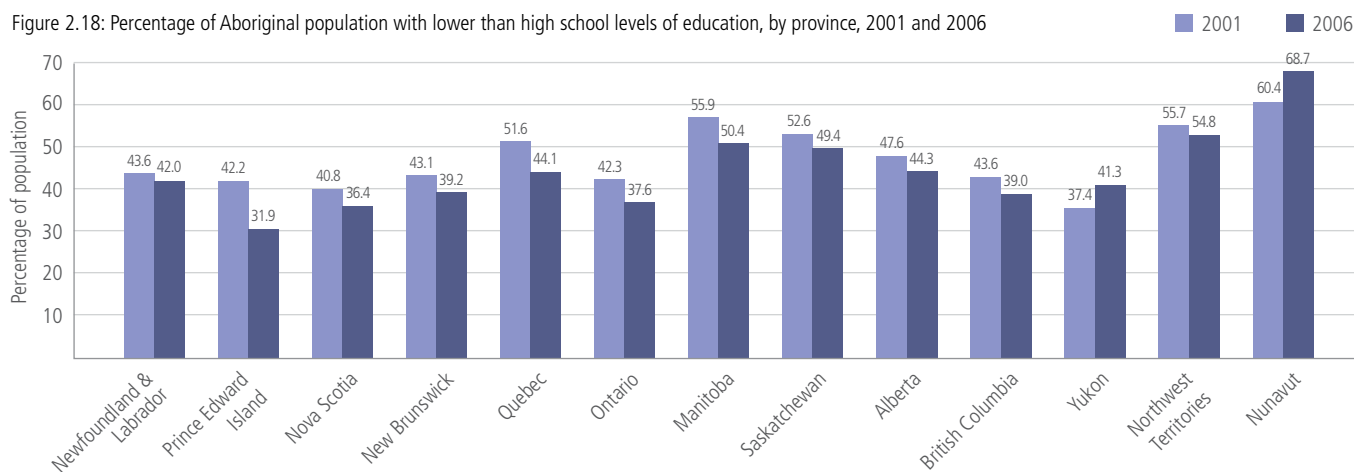
Economic development in an Aboriginal context must take into consideration some unique circumstances. Aboriginal people have an intimate connection to the land and view the health of the land and the health of the community as synonymous, “nurtured through relationships to the physical environment and the cultural,

spiritual, economic, political and social roots it provides” (RCAP, 1996c, as cited in Richmond & Ross, 2009, p. 404). Consequently, Aboriginal people are “more likely to experience the adverse health effects of government and industrial decisions that can dispossess them of their environments” (RCAP, 1996c, as cited in Richmond & Ross, 2009, p. 404). Resource development projects can threaten traditional economies and result in loss of habitat, environmental contamination and depletion of resources, affecting Aboriginal peoples’ physical and spiritual

health, and the availability of traditional foods (Richmond & Ross, 2009).

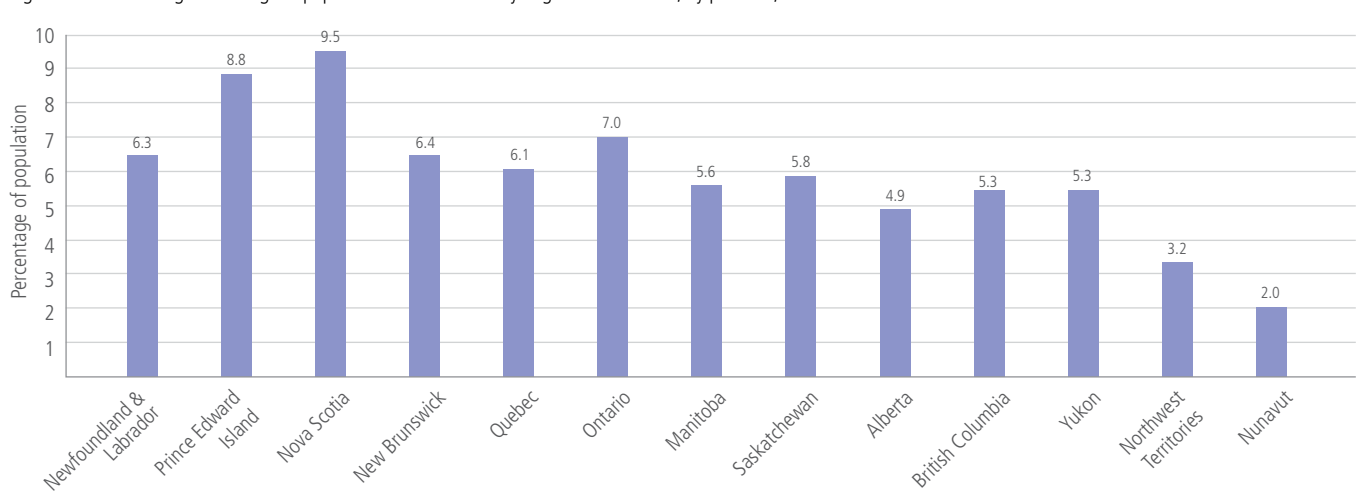
The impacts of economic development on Aboriginal health can be both direct and indirect. Direct health outcomes are more readily apparent in cases where economic development initiatives have resulted in environmental degradation and contamination. For example, in Northwestern Ontario, the spilling of methyl mercury into a local river by a nearby chemical plant poisoned the food supply of the Ojibway people in the Grassy Narrows First Nation

Figure 2.18: Percentage of Aboriginal population with lower than high school levels of education, by province, 2001 and 2006



Source: Statistics Canada (2001), Census 2001, Topic-based Tabulations, Cat. No. 97F0011XCB01043; Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-560-X2006028

Figure 2.19: Percentage of Aboriginal population with a university degree or certificate, by province, 2006



Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-560-X2006028

and drastically altered their cultural and economic ways of life (which are dependent on the fishing industry) (Wheatley, 1998, as cited in National Collaborating Centre for Aboriginal Health, 2009). Similarly, a number of Dene Nation employees who worked at the Port Radium uranium mine in the Northwest Territories between 1942 and 1960 were uninformed about the risks of working with uranium and subsequently experienced high rates of death from cancer (Nikiforuk, 1998).

While negative health outcomes like these may seem to be a convincing argument to avoid economic development initiatives, most Aboriginal communities recognize the need for economic development to facilitate increased Aboriginal participation in the economy and enhance community well-being. Though less tangible, the indirect health benefits of economic development are numerous and cumulative. For example, Arctic Co-Operatives Limited not only created employment for a substantial number of Aboriginal people, but it also contributed to the physical, social and personal infrastructure of Aboriginal communities, improving access to services that the community needs and improving quality of life (Ketilson & MacPherson, 2001). Similarly, the Diavik Diamond Mine in the Northwest Territories formalized an agreement in 1999 with the Government of Northwest Territories and with the Tlicho Government, Yellowknife Dene First Nation, Kitikmeot Inuit Association and Lutsel K'e Dene First Nations that included provisions for training, employment and business opportunities specifically for Aboriginal northerners; cultural and community well-being components that integrate cultural values and respect for the community into its operations; and committed the company to providing a number of health and wellness-related services for its employees (Diamik Diamonds Project, 1999).

While the potential benefits of economic development can be numerous, they can also be harmful for Aboriginal health. In order to ensure that economic development provides more benefits than harm, meaningful involvement by Aboriginal peoples is required so that initiatives reflect community aspirations and needs. For Aboriginal peoples, generating revenue is not the only reason for undertaking economic development initiatives, and it is important that there be a genuine effort to balance social and economic benefits and to include consideration for market and traditional economies in these initiatives.

Children and youth

Early development

A child's early development is dependent on healthy maternal care, as well as the environment in which infants grow and develop. This section focuses on maternal behaviours during pregnancy, infant birth outcomes, and rates of breastfeeding among Aboriginal mothers.

Maternal smoking during pregnancy can negatively affect the fetus in a variety of ways, including suppressing the mother's appetite, reducing oxygenation and flow of nutrients to the fetus in vitro, and altering cellular growth and activity of the nervous system (Slotkin, 1998). First Nations mothers living on-reserve have higher rates of smoking during pregnancy (36.6%) than do other Canadian mothers (23.7%) (Connor & McIntyre, 2002; FNC, 2007a). According to both the National Longitudinal Survey of Children and Youth (Statistics Canada & HRSDC, 1999) and the RHS (FNC, 2007a), pregnant Aboriginal women living on-reserve are three times as likely to smoke more than 10 cigarettes per day as are other pregnant Canadian women (5.3%), and to smoke more often into the third trimester (32.2% and 17.2%, respectively). Using results from a 1997 Heart and Stroke Foundation survey, the Provincial Health Officer of British

Columbia (1998) stated that in addition to prenatal exposure to tobacco smoke, 27% of Aboriginal children aged 11 years and under are exposed to environmental tobacco smoke on a daily basis.

The impacts of alcohol consumption during pregnancy on the health of infants are well documented. In many Aboriginal communities, fetal alcohol spectrum disorder (FASD) has been identified as a public health concern, yet given the ambiguities associated with diagnoses, documentation and biased data collection, the true prevalence of the disorder is unknown (Pacey, 2009; May, 1994). Currently available studies have tended to involve communities where alcohol use was known to be high (Poole, 2007). Prevalence rates vary across Canada, with the majority of diagnoses being made in western regions (Tait, 2003). (Please see Chapter 1 for more information about FASD prevalence.)

Despite the lack of research on FASD, alcohol abuse has been consistently reported as a major problem in Aboriginal women's health (Grace, 2003; Stout, Kipling & Stout, 2001). Tait (2003) argues that the high prevalence rates of FASD/alcohol-related birth effects and alcohol abuse in Aboriginal women are more importantly connected with chronic poverty and social marginalization than with the ethnic identity of the women at risk. Similarly, Bray and Anderson (1989) argue that research that examines demographic, socio-economic and socio-cultural factors in relation to FASD among Aboriginal populations would help to determine which Aboriginal populations are at increased risk.

Inadequate maternal health can also be reflected in birth outcomes such as unhealthy birth weights and infant mortality. Birth weight is an important measure of infant health. Infants with lower than average birth weights are thought to be at higher risk for infection,

illness and death (Health Canada, 2002). In 2001, 8% of Aboriginal infants living off-reserve had low birth weights, compared with 5.6% for infants in the general population (Statistics Canada, 2005; Statistics Canada, 2004a). Conversely, the proportion of high birth weight infants is also more prevalent and significant in Aboriginal communities. For example, the 2002/03 RHS found that that 21% of First Nations infants were in a high birth weight range (> 4.0 kg.) compared with 13.1% of non-Aboriginal infants (FNC, 2007a). Evidence suggests that changes in utero can be linked to poorer health later in childhood and adulthood (e.g., type 2 diabetes [Barker, Hales, Fall, Osmond, Phipps & Clark, 1993]). High birth weight among Aboriginal infants has been attributed to factors such as diet, lifestyle and genetics (Schwartz & Taramo, 1999; Boyd, Usher & McLean, 1983).

Aboriginal infants have substantially higher rates of infant illness and death (17.9%) than those in the general population (7.9%) (Luo et al., 2004). In British Columbia, infant mortality rates between 1981 and 2000 were more than twice as high in the Aboriginal population as in the non-Aboriginal population, and post-neonatal mortality rates were 3.6

times higher (Statistics Canada, 2004b). Post-neonatal mortality is commonly attributed to socio-economic and living conditions (e.g., preventable infections). During the same period, however, infant mortality rates for Aboriginal infants born in rural areas declined by 64% and by 47% for those living in urban areas, suggesting a need for greater attention to Aboriginal maternal and infant health in urban areas (Luo et al., 2004).

Breast-feeding has been shown to provide infants with optimal nutrition, protect against gastrointestinal and respiratory infection (Canadian Pediatric Society, Dietitians of Canada, and Health Canada, 1998), and build maternal bonds between mother and infant (Else-Quest, Hyde & Clark, 2003). Despite these benefits, Aboriginal children are less likely to be breast-fed than other children in Canada.¹⁵ The prevalence of breast-feeding among Aboriginal women has been associated with some social determinants. For example, an analysis of 2002/03 RHS data has suggested that breast-feeding was more common among First Nations mothers with university education (83.5%) than among those with less than high school (57.8%), high school (60.0%) and college (69.7%) education (FNC,

2007a). Breast-feeding was also found to be associated with higher family income (>\$50,000); First Nations mothers living in lower-income households (<\$15,000) reported being less likely to breast-feed their infants (FNC, 2007a) (Figure 2.20).

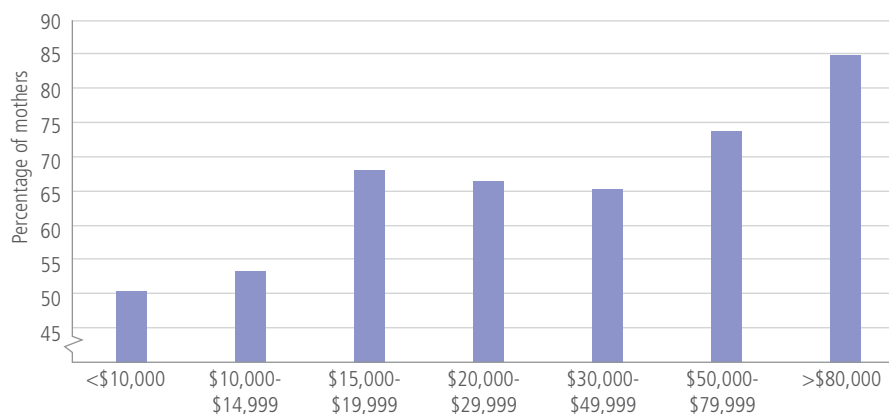
Family

The physical and social environments in which children live are vital to healthy individual development. Family size and structure, and the age and education levels of parents, are factors in providing infants and children with an optimal environment for healthy development. Aboriginal families in Canada are faced with more challenges and stresses than are non-Aboriginal families.

Aboriginal families are larger than non-Aboriginal families. For example, approximately 17% of young First Nations children living off-reserve, 28% of Inuit children and 11% of Métis children live in families with four or more children, compared with 8% of their non-Aboriginal counterparts (Statistics Canada, 2006). First Nations children living off-reserve with registered Indian status also live in larger families than do children with non-registered Indian status (Statistics Canada, 2006). The 2002/03 RHS found that a large proportion of children living in First Nations communities lived in homes in which five or more people resided (66.3%) (FNC, 2007a). The survey also found that approximately 83% of First Nations families included two or more adults, and 38% had three or more children and/or youth.

Among Aboriginal households, it is quite common for adults other than parents to be living in the household. For example, the 2002/03 RHS found that 37.9% of First Nations households on-reserve included adults other than parents, with approximately 16.5% of households including grandparents and 15.5% including aunts, uncles or cousins

Figure 2.20: Percentage of First Nations mothers who breastfed their infants, by family income, 2002/03



Source: FNC, 2007a

¹⁵ For more details on the prevalence of breast-feeding among Aboriginal populations, please see Chapter 1.

(FNC, 2007a). Nine percent of First Nations children living off-reserve lived with their grandparents, compared with 5% of non-Aboriginal children (Statistics Canada, 2008b). Among the Inuit, the number of people living in households is presenting serious health challenges,¹⁶ as Inuit are nearly five times more likely to live in households containing more than one family than are non-Aboriginal people (18% compared with 4%) (Statistics Canada, 2008a). While larger household size can be attributed in part to the fact that Inuit have traditionally lived in family groupings, a serious shortage of housing in most Inuit communities has also been identified as a contributing factor (Pauktuutit Inuit Women of Canada, 2006).

Aboriginal children are also less likely to live in two-parent households than are non-Aboriginal children. Approximately 50% of First Nations children living off-reserve, 59% of First Nations children living on reserve, 67% of Métis children and 70% of Inuit children live with two parents, compared with 86% of non-Aboriginal children (Statistics Canada, 2008a). Aboriginal children are more than twice as likely to live in lone-parent households compared to non-Aboriginal children (35% compared with 17%) (Statistics Canada, 2008a). Of Aboriginal children, First Nations children living off-reserve are most likely to live in lone-parent households (41%), followed by First Nations children living on reserve (33%), Métis children (31%) and Inuit children (26%) (Statistics Canada, 2008a). Living in lone-parent households can place additional financial, emotional and mental strains on individuals.

There have been only slight variations in the percentages of Aboriginal lone parent

families since 2001. For First Nations children living on-reserve, there has been only a one percent increase in lone parent households since 2001 (Statistics Canada, 2001b; 2009). Unfortunately, no direct comparisons can be made in terms of lone parent family status for First Nations families living off-reserve using publically available sources of census data from 2001 and 2006.¹⁷ Among Métis households, the percentage of lone-parent families has declined slightly (approx. 3%) since 2001, while it has increased slightly (approx. 3%) among Inuit households (Statistics Canada, 2001b; 2008a). The percentage of lone parent households among non-Aboriginal people has remained virtually unchanged at 17% (Statistics Canada, 2001b; 2008a).

Family living situation (lone-parent versus two-parent households) has been found to be linked with level of education and household income. The 2002/03 RHS, for example, found that First Nations parents with higher levels of education (bachelor's degree or greater) had significantly higher incomes and were also more likely to be living in a household with the second parent rather than being single parents (FNC, 2007a).¹⁸ Figure 2.21 shows the percentage of First Nations children in Canada, by mother's education level, living in two-parent homes.

In addition to lone-parent family status, the age of parents can be a factor that hinders or contributes to a child's healthy development. Younger parents may have lower education levels or incomes, which can affect their ability to support their children. Aboriginal children are being raised by younger parents than non-Aboriginal children are, with 27% of off-reserve First Nations, 22% of Métis and 26% of Inuit children under age 6 living

with mothers between the ages of 15 and 24, compared with 8% of non-Aboriginal children (Statistics Canada, 2008b).

Gender

Gender is a powerful social determinant of health (PHAC, 1999, 2003).

Epidemiological data show that males tend to die earlier than females, while females experience more mental health issues (e.g., depression, anxiety) and a wider range of cancers than men (PHAC, 1999). For Aboriginal women, the health inequities that can result from gender are exacerbated by issues stemming from such factors as colonialism, social exclusion and racism. These issues include lower socio-economic status, lower educational levels, fewer employment opportunities, lower-quality housing and physical environment, and weaker community infrastructure (Society of Obstetricians and Gynecologists of Canada, 2001). Social determinants of health are cyclical and repetitive in nature – one stemming from another – which in turn perpetuates the inequalities that a multitude of Aboriginal women in Canada face on a daily basis.

Health concerns

In Canada, diabetes is the seventh leading cause of death. Type 2 diabetes prevalence rates are currently five times higher for Aboriginal women than non-Aboriginal women, whereas Aboriginal men are three times more likely than non-Aboriginal men to suffer from this disease (Health Canada, 1999a). According to Health Canada (1999b), Aboriginal people in Saskatchewan, Manitoba and Ontario have the highest rates of diabetes, whereas those in British Columbia have the lowest rate. In 1996/97, Aboriginal women in Saskatchewan were 24 times more likely to be hospitalized as a result of this

¹⁶ For example, see the discussion on respiratory illnesses among Inuit in Chapter 1.

¹⁷ Statistics Canada 2001b breaks down lone parent family status among First Nations families by whether they are on-reserve or living in Census Metropolitan areas (thus omitting other off-reserve First Nations persons), while 2008b provides lone parent family status for First Nations families off-reserve only (including those living in rural areas and in Census Metropolitan areas).

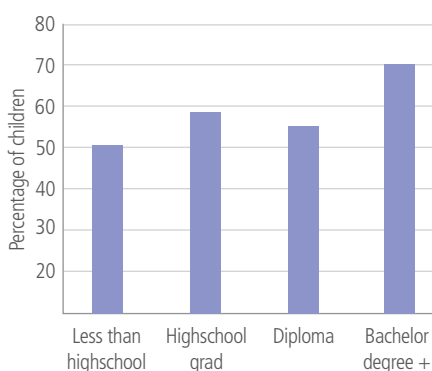
¹⁸ Caution should be used in interpreting these statistics, as they do not necessarily mean that parents with higher education levels stay in relationships longer or more often.

disease than Aboriginal women in any other province or territory (Saskatchewan Women's Secretariat, 1999).

Cancer mortality rates have also been found to be higher in the female Aboriginal population than in the non-Aboriginal population. For example, cervical cancer death rates for First Nations women in British Columbia are close to six times the national average (Band, Gallagher, Threlfall, Hislop, Deschamps & Smith, 1992). Over a 30-year period, the average rate of death from cervical cancer for Aboriginal women in British Columbia was 33.9 per 100,000, whereas for non-Aboriginal women the rate was 8.1 (Centres of Excellence for Women's Health Research, 2001).

Canadian Aboriginal women are also close to three times more likely to contract AIDS than non-Aboriginal women (23.1% compared with 8.2%) (Barlow, 2004). Aboriginal women, in particular younger populations (15-29 years), have accounted for approximately 50% of new HIV cases over the past 20 years, while non-Aboriginal females across Canada make up only 16% of the population diagnosed with HIV (Prentice, 2004).

Figure 2.21: Percentage of First Nations children living in two-parent home, by mother's education level, 2002/03



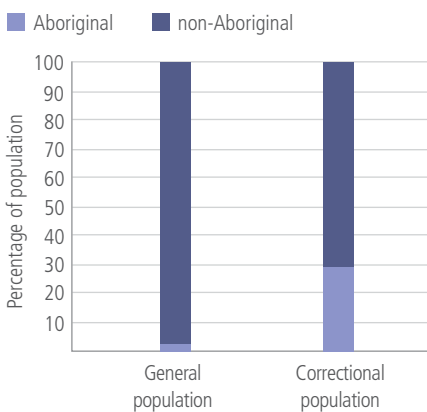
Source: FNC, 2007a, p.231

Violence

One of the most serious threats to the well-being of Aboriginal women is the alarmingly high rate of violence they experience in their homes, communities, and Canadian society at large. (Native Women's Association of Canada, 2009, p.1)

It has been estimated that three-quarters of Aboriginal women are the victims of family violence at some point in their lives (Health Canada, 1999c). Aboriginal women are 3.5 times more likely to experience violence than their non-Aboriginal counterparts (Native Women's Association of Canada [NWAC], 2009). The Native Women's Association of Canada (2009) reports that Aboriginal women are more likely to suffer from severe forms of spousal violence (e.g., to be choked, threatened with gun or knife, or sexually assaulted) compared with non-Aboriginal women. Aboriginal women are also much more likely to live in an environment with substance abuse-related spousal violence (RCAP, 1996a). Alcohol-related hospital admissions are three times more prevalent among Aboriginal women than among non-Aboriginal women

Figure 2.22: Percentage of Aboriginal and non-Aboriginal women in the general and correctional facility population, 2003



Source: Canadian Human Rights Commission, 2003

(NWAC, 2002). The overall mortality rate as a result of violence is three times higher for Aboriginal women than for non-Aboriginal women, with approximately five times more Aboriginal women aged 25-44 dying from violence-related injuries than other Canadian women (Health Canada, 2000).

Criminalization

The over representation of Aboriginal people within the Canadian criminal justice system is euro-centric and indisputably the most egregious example of the racist legacy of colonialism. (Canadian Association of Elizabeth Fry Societies, 2004)

In 2003, Aboriginal women accounted for 29% of women in federal correctional facilities (Canadian Human Rights Commission, 2003) yet represented only 3% of the female population in Canada (Figure 2.22). During the period 1996/97-2001/02, the number of Aboriginal women in the correctional system increased by 36.7%, compared with an increase of 5.5% for Aboriginal men (Canadian Human Rights Commission, 2003). During the same period, of the Aboriginal women within the federal prison system, 66% were between the ages of 20 and 34, compared with 56% for other Canadian women.

Research has shown that women who have been incarcerated are more often unemployed, have significantly lower education levels (Trevethan, 1999), and more commonly experience drug and alcohol addiction issues (Serin & Cousineau, 2001). In addition, incarcerated Aboriginal women are more likely to report a history of physical abuse than are their non-Aboriginal counterparts (90% compared with 67%)(Canadian Human Rights Commission, 2003).

Health services: access and utilization

Access to health services is an important determinant of health that can be limited by challenges associated with socio-economic status, geographic location, lack of infrastructure and staff, jurisdictional ambiguities, language and climate. Some of these challenges apply to all groups of Aboriginal peoples, while others may be unique to specific groups.

Individuals with lower income and education levels may not seek treatment at the early stages of an illness or may not be able to afford prescription medication or additional services that are currently extra-billed by physicians. The challenge to access is a particular issue among homeless populations. Homeless people encounter additional barriers in accessing health services, including an inability to provide proof of insurance coverage, and mental illness or substance abuse problems (Hwang, 2001).

Aboriginal people living in rural and remote locations face unique barriers to health care access, including lack of transportation infrastructure, speaking only Indigenous languages, long wait times, northern climate conditions and low population density (Halseth & Ryser, 2006; Tait, 2008). For example, of 52 Inuit communities in the North, none have year-round road access and only a few have hospitals (Tait, 2008). Large distances and low population density mean higher service delivery costs per capita, resulting in reduced access to health services and health professionals (Halseth & Ryser, 2007, 2006). Halseth and Ryser (2006, 2007) also note that urban service delivery models (e.g., rigid delineation of job responsibilities between physicians and nurses) are not well suited to rural settings.

Aboriginal people are more likely to access the services of a nurse than those of a doctor, and are less likely to access more specialized health care professionals, such as dentists and family physicians. This is particularly true in Canada's northern regions. A key reason for this is a lack of access to permanent physicians and medical specialists, and greater reliance on the provision of health services through health centres that are staffed with nurses (Tait, 2008). Patients are usually sent to urban areas in the south for medical emergencies, hospitalization, appointments with medical specialists, diagnosis and treatment (Guèvremont & Kohen, 2001). Many Aboriginal people must therefore leave their communities and their support networks to access more specialized medical care. For those who speak only their Native language, a lack of translation services can add additional stress for patients.

Results from the 2006 Aboriginal Peoples Survey highlight the reduced access to health care experienced by Inuit. Inuit were less likely to have seen or talked on the phone with a medical doctor over the past year than the general Canadian population (56% compared with 79%) (Tait, 2008). The first point of contact with the medical system for 70% of Inuit was a nurse. Ten percent of Inuit adults indicated that they did not receive health care at a time when they required it, and 5% indicated that over the past year, they have had to be away from their home for a month or more due to illness.

In order to have positive health outcomes, individuals must not only have access to health services but also have timely access (Loppie Reading & Wien, 2009). Loppie Reading and Wien state that the most common type of barrier to health service

access faced by First Nations adults living on-reserve are systemic barriers, including long wait-lists, needed services not being covered or approved by the federal Non-Insured Health Benefit plan, and doctors or nurses not being available in their area.¹⁹

Jurisdictional issues also hamper access to health care services. The federal government has primary responsibility for the provision of health services for Inuit living within traditional territories and registered/status Indians²⁰ living on-reserve. Only the Non-Insured Health Benefits program applies to all status Indians and Inuit regardless of where they live (NCCAH, 2011). All other Aboriginal people who do not qualify for registration under the *Indian Act* receive their health services from provincial and territorial governments.

While this delineation appears precise, the fragmented and complex nature of the health care system for Aboriginal peoples is generally acknowledged (Lavoie & Gervais, 2011; Assembly of First Nations, 2006; Canada, 2005; Inuit Tapiriit Kanatami, 2004). Provincial and territorial governments provide a number of health services, and in some places there has been a regionalization of provincial health services through the development of health boards or authorities. In addition, federal and provincial/territorial ministries and departments have entered into agreements to provide some services, including agreements related to the Health Transfer Policy whereby the planning, management and delivery of health services has devolved to the communities (National Health and Welfare, 1989). This has resulted in unequal provision of health services among provinces and territories (NCCAH, 2011).

¹⁹ Data adapted by Loppie Reading and Wien from the First Nations Regional Longitudinal Health Survey (RHS) 2002/03: Results for Adults, Youth and Children Living in First Nations Communities (Ottawa, ON: First Nations Centre, 2005), p. 130, Table 3.

²⁰ "Registered, status or treaty Indian" refers to those who reported that they were registered under the Indian Act. Treaty Indians are persons who are registered under the Indian Act and can prove descent from a band that signed a treaty. The term "treaty Indian" is more widely used in the Prairie provinces (Statistics Canada, <http://www12.statcan.ca/english/census01/products/analytic/companion/abor/definitions.cfm>).

Jurisdictional issues like these, with the various levels of government disputing responsibility for payment of health services, have led to inequitable access to health services for Aboriginal peoples. The death of a young Cree boy, Jordan River Anderson, while waiting for federal and provincial governments to resolve jurisdictional issues, underscores the inequity of health service provision for Aboriginal peoples (Blackstock, 2009). Blackstock, Prakash, Loxley and Wien (2005) identified 393 First Nations children (from 12 of the 105 First Nations child welfare agencies) affected by jurisdictional disputes. Extending these findings to all First Nations child welfare agencies resulted in an estimate of thousands of First Nations children being denied access to government services each year (Blackstock, 2009).

Similarly, the jurisdictional limitations that fail to recognize Métis identity and rights (Lamouche, 2002) have resulted in health disparities among the Métis (Tait, 2009). The Métis lack access to services that status First Nations and Inuit receive through Health Canada's Non-Insured Health Benefits Program and other federal programs. While Métis have access to mainstream services, little or no attention is paid to their specific cultural or geographical needs (Tait, 2009). While the federal government has recently included the Métis in Aboriginal initiatives, funding has not been comparable to First Nations and Inuit funding (National Aboriginal Health Organization, 2004).

Early detection and prevention

Lack of access to health care services can prevent early diagnosis of illness and disease. Individuals who are unable to access health care regularly will be less likely to seek help when they experience irregular symptoms, and diseases that are treatable when detected early are often not found until treatment or total recovery is no longer possible. With the rates of cancers,

diabetes and communicable diseases rising, early screening is of particular importance for Aboriginal people in Canada. Cancer – including cervical, breast, lung, prostate and colorectal cancer – is the fastest-growing health concern currently among Aboriginal populations (Cancer Care Ontario, 2004; Morrisseau, 2009). Higher mortality rates among Aboriginal people than among non-Aboriginal people have been attributed to diagnosis at later stages of the disease, limited access to screening and treatment services, and lack of awareness of early detection and prevention (Morrisseau, 2009).

Health Canada (2009) examined the utilization of diagnostic services, specifically mammograms, the papanicolaou (Pap) test, and the digital rectal exam, among Aboriginal and non-Aboriginal individuals from 1999 to 2003. They found that non-Aboriginal women aged 50-59 had mammograms more often than Aboriginal women in the same age cohort (88.3% compared with 73.3%), and older Aboriginal men were more likely to have a digital rectal exam than younger men (16.9% compared with 13.8% for men younger than 60 years of age). Conversely, young Aboriginal women reported having Pap tests (89.4%) more often than did females in the general Canadian population (87.7%).

Despite the rates of utilization of such diagnostic services, the latent timing of the diagnosis remains largely problematic for Aboriginal peoples' health outcomes. Health Canada (2009) reported that in the case of diseases such as cervical cancer, which is approximately three times more prevalent among Aboriginal females, access to screening services, vaccination and education programs could generously assist in prevention and early detection. Diabetes and communicable diseases (e.g., pneumonia and influenza) are also disproportionately prevalent in Aboriginal communities. Lack of accessible services and education pertaining to prevention is suggested as a plausible explanation as to why these diseases, which are thought to be largely preventable, are disproportionately represented in Aboriginal communities (Health Canada, 2009).

The physical environment

The physical environment, whether man-made (e.g., housing quality) or natural (e.g., air quality), also has a direct impact on health outcomes. For Canada's Aboriginal peoples, environmental dispossession, or the "processes through which Aboriginal peoples' access to the resources of their traditional environments is reduced," is also a unique physical environment feature that has been shown



to have a direct impact on health and well-being (Richmond & Ross, 2009, p. 404). The disruption of traditional food supplies caused by dislocation from traditional territories and the establishment of “reserve lands” has resulted in dietary and lifestyle changes that have led to higher rates of diabetes and obesity, and the prevalence of other major chronic diseases such as arthritis/rheumatism, hypertension and asthma (Smylie, 2008). Further details about the prevalence of such diseases can be found in Chapter 1. This section focuses primarily on Aboriginal peoples’ housing conditions.

Housing conditions

Housing quality and accessibility are important determinants of health. Poor housing conditions, such as the presence of mould, lack of safe drinking water, and overcrowding, have been associated with increased risk of morbidity from infectious disease, chronic illness, injuries, poor nutrition and mental disorders (Krieger & Higgins, 2002). Similarly, housing, homelessness and use of temporary shelters contribute to poor health outcomes and an increased risk of premature death (Centre for Housing Policy and Enterprise Community Partners, 2007; Hwang, 2001).

Disparities in housing reflect a range of other determinants, including low socio-economic status, unemployment, poverty, social exclusion and low levels of educational attainment. In Canada, Aboriginal peoples are disproportionately affected by poor housing and living conditions (RCAP, 1996a).

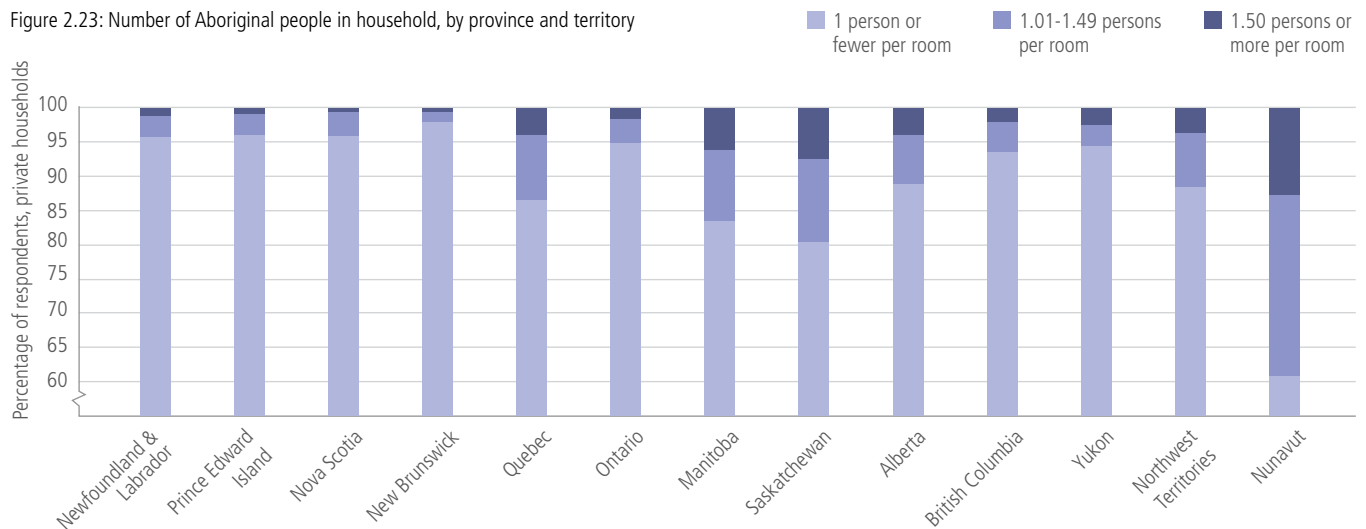
A home encompasses not just a physical structure, but the social and natural environment in which it is situated. The physical condition of a home includes its state of repair; the presence and quality of plumbing, electricity, safe drinking water, insulation, fire prevention, heating, flooring and furnishings; and the presence of physical, biological or chemical contaminants such as pests, allergens, mould or radon (Krieger & Higgins, 2002). Social dimensions of housing range from a sense of belonging and control over one’s home (i.e., housing security, social status, prestige) to the domestic environment in the home (i.e., personal sense of safety, overcrowding) (Bryant, 2003). The environment surrounding a home is equally important. Proximity of services, such as schools, recreation areas, health care, support services, grocery stores and shopping centres, and water and sewage facilities, has a direct impact on

health, as does the proximity of industrial waste and other ecological contaminants (Krieger & Higgins, 2002).

Housing for Aboriginal people must be considered within the context of demographic pressures. The Aboriginal population in Canada is young, increasingly urban, and growing at a rate nearly six times faster than the non-Aboriginal population (Statistics Canada, 2008a). In 2006, the Aboriginal population surpassed the one million mark, reaching 1,172,790, which is 4% of the total population of Canada (Statistics Canada, 2008a). Approximately 54% of Aboriginal people resided in urban areas in 2006. Almost half of the Aboriginal population (48%) consists of children and youth under the age of 24 (Statistics Canada, 2008a). While there have been improvements over the past decade in the availability and quality of housing for Aboriginal people, they have so far failed to keep pace with these demographic pressures.

Although recent census data show that overcrowding in Aboriginal homes has declined in the last decade, housing and living conditions across Canada remain a critical health issue for Aboriginal people, particularly with respect to the spread of

Figure 2.23: Number of Aboriginal people in household, by province and territory



Source: Statistics Canada (2006), Census 2006, Data Products, Topic-based Tabulations, Cat. No. 97-558-XCB2006025

communicable diseases like tuberculosis (Clark, Riben & Nowgesic, 2002). In 2006, 11% of Aboriginal people lived in homes with more than one person per room, a decline of 6% since 1996 (Statistics Canada, 2008a). Overcrowding is particularly acute for First Nations people on-reserve, where approximately 26% live in crowded homes, and for Inuit, where 36% of the population report living in crowded homes. Almost half (49%) of Inuit in Nunavik reported living in crowded dwellings (Statistics Canada, 2008a).

Overcrowded housing conditions among Aboriginal people vary across the provinces and territories (Figure 2.23). Nunavut had the highest percentage of its Aboriginal population living in overcrowded conditions, followed by Saskatchewan and Manitoba (Statistics Canada, 2006). Overcrowded living conditions were less of a concern for Aboriginal people living in the Maritime provinces. The overcrowded housing conditions among Inuit have been linked, in part, to the forced relocation of Inuit to permanent settlements, and have contributed to high rates of severe respiratory tract infections (Kovesi et al., 2007, as cited in Smylie, 2008).

In the 10-year period between the 1996 and 2006 censuses, there was also no marked improvement in the number of Aboriginal people living in homes that require major repairs (Statistics Canada, 2008a). Statistics Canada 2006 census data indicate that nearly one in four Aboriginal people reported living in such homes. Twenty-eight percent of First Nations people reported living in a home requiring major repairs. On-reserve, housing disparities were greater, with approximately 44% of First Nations people

residing in homes in need of major repairs. For Inuit people, approximately 28% reported living in homes requiring major repairs; this number increased to 31% in Inuit Nunaat²¹ (Statistics Canada, 2008a).

The problems with on-reserve housing have been recognized widely (Office of the Auditor General of Canada [OAGC], 2003). On-reserve housing tends to deteriorate more rapidly because of poor construction, lack of maintenance and overcrowding (OAGC, 2003). There are backlogs in social housing construction and limited funding for basic on-reserve services such as sanitation, education and primary health care (Webster, 2007). These housing deficiencies can lead to increased social, physical and medical stresses. Improvement of on-reserve housing is impeded by several factors, including ambiguous legal rules for on-reserve housing, uncertain band council regulation powers, socio-economic and demographic factors (Aboriginal growth rate, levels of income and unemployment, societal problems on-reserve), and increasing band debt (OAGC, 2003).

On-reserve housing conditions, coupled with better opportunities for education and employment, access to services, and home ownership off-reserve, have contributed to the increasing urbanization of Aboriginal people. The latest Statistics Canada census data reveal that of the substantial off-reserve First Nation population,²² three out of four live in urban areas (Statistics Canada, 2008a). However, instead of finding a better life in the cities, many Aboriginal people encounter homelessness. While estimates vary, a study by Hwang (2001) reveals that Aboriginal people are overrepresented by a factor of 10 in Canada's overall homeless population – that is, they

constitute a percentage of the homeless population that is 10 times greater than their percentage of that city's population. Homeless individuals are at risk of dying prematurely and suffer from a wide range of health problems stemming from the physical and social conditions under which they live (Hwang, 2001). For example, homeless people are admitted to hospital up to five times more than the general population.

Culture and language

From an Aboriginal perspective, health is not “merely the absence of illness or disease, nor is it a set of statistics or measurements. Health is understood to be the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family, and community” (British Columbia Ministry of Health, 2002, p. 10). Illness can be understood as a failure to maintain harmony or balance in all aspects of life.

While there are cultural and linguistic differences among Aboriginal peoples in Canada, they “share a common social, economic, and political predicament that is the legacy of colonization” (Kirmayer, Brass & Tait, 2000, p. 607). Colonization has led to the disruption of languages and cultures that are central to perceptions and experiences of health and illness. For Aboriginal Canadians, who bear a disproportionate burden of illness, culture and language are essential to improving health outcomes.

Culture is a dynamic and adaptive system of meaning that is learned, shared and transmitted from one generation to the next and is reflected in the values, norms, practices, symbols, ways of life

²¹ The term “Inuit Nunaat” means Inuit homeland and refers to all Inuit living within one of four regions extending from Labrador to the Yukon and Northwest Territories: Nunatsiavut, Nunavut, Nunavik and Inuvialuit. They share a common culture and many traditions (Atlas of Canada, 2010). Recently, the Board of Directors of the Inuit Tapiriit Kanatami voted to change this term to “Inuit Nunangat” so that it includes not only the land but the water and ice surrounding the land (Inuit Tapiriit Kanatami, 2009).

²² According to 2006 Statistics Canada census data, only 40% of First Nations people are estimated to be living on-reserve, while the remaining 60% live off-reserve.

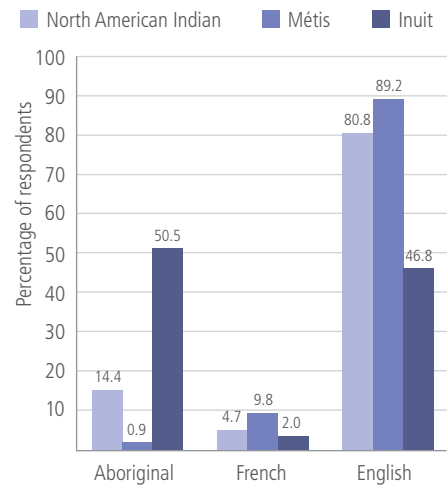
and other social interactions of a given culture (Kreuter & McClure, 2004). It is the foundation of both individual and collective identity, and its erosion can adversely affect mental health and well-being, leading to depression, anxiety, substance abuse and even suicide (Kirmayer, Brass & Tait, 2000). Culture can affect our perceptions of illness, including how patients “express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment” (Brightman, 1993, as cited in Richmond & Ross, 2009, p. 404). Inuit perceptions of mental health, for example, focus on an individual’s “state” at any particular time. A person may exhibit unusual behaviour one day and be perfectly normal the next. Consequently, that individual may not be identified as mentally ill and in need of treatment (RCAP, 1996c, as cited in Richmond & Ross, 2009).

Similarly, the cultures of health practitioners and health service providers can influence diagnosis, treatment and service delivery (Bartlett, 2003). Cultural differences between patients and health service providers may lead to providers ignoring symptoms that are important to patients, and patients not following through with prescribed treatments (US Department of Health and Human Services, 1999). As a result, patients can be at risk of not having their health care needs recognized and met.

The disruption of culture is acutely felt in the loss of traditional language among Indigenous peoples. Language is “a conveyor of culture” (Kirmayer, Brass & Tait, 2000, p. 613) and the means by which knowledge, skills and cultural values are expressed and maintained. Language suppression, particularly for Indigenous peoples, is “a form of disempowerment and oppression” that affects self-identity, well-being, self-esteem and empowerment, all of which are key factors in individual and community healing (Cohen, 2001, p. 143). Language maintenance and continuity are critical to revitalizing culture and to the survival of any Indigenous people (Battiste & Henderson, 2000).

Figure 2.24 shows the percentage of languages spoken most often in Aboriginal peoples’ homes across Canada, by Aboriginal identity (Statistics Canada, 2006). Approximately 14% of North American Indian people report speaking Aboriginal languages most often in their homes, while 49.9% of Inuit people report speaking their Aboriginal language most often in the home. Approximately 10% of Métis people identify French as the main language in their home. Conversely, 79.6% of North American Indian, 88.7% of Métis and 46.9% of Inuit peoples across Canada report English as the language spoken within the home.

Figure 2.24: Language spoken most often in the home by Aboriginal identity, 2006



Source: Statistics Canada (2006), Census 2006, Topic-based Tabulations, Cat. No. 97-564-XCB2006002

Language spoken most often at home varies across the provinces and territories. Nunavut and Quebec have the highest percentages of individuals speaking an Aboriginal language most often within the home, at 62.3% and 31.6%, respectively. Prince Edward Island (0.6%), British Columbia (1.7%) and Yukon (1.9%) have the lowest rates.

Figure 2.25 shows the language most often spoken at home by location of residence – on-reserve, rural and urban. Aboriginal people living on-reserve speak Aboriginal languages at home more often (28.9%)



than Aboriginal people living in both rural (11.4%) and urban locales (1.8%).

The legacy of colonization and poor health continues to be felt by young Aboriginal people in Canada today. The Canadian government enacted a range of colonial policies designed to assimilate Aboriginal peoples, which involved cultural and linguistic suppression, forced relocation onto reserve lands, alienation from traditional territories and ways of life, and, perhaps most devastatingly, the creation of residential schools. The goal of residential schools was to assimilate Aboriginal peoples into European society through the separation of children from the cultural influences of families and communities (Bennett, Blackstock & de La Ronde, 2005). The first of these schools were established as part of early missionary activities, but they proliferated after the endorsement of the 1879 Davin Report, peaking in 1931 with over 80 schools across Canada (Bennett et al., 2005). The schools alienated children from their culture by forbidding them to speak their traditional languages or learn the skills they needed to thrive in their communities (Tait, 2003). Residential schools relied heavily on discipline, punishment and public humiliation, leading to intergenerational impacts:

It is clear the residential school system contributed to the central risk factor for FASD, substance abuse, but also to factors shown to be linked with alcohol abuse, such as child and adult physical, emotional and sexual abuse, mental health problems and family dysfunction. The impact of residential schools can be linked to risk factors for poor pregnancy outcomes among women who abuse alcohol, such as poor overall health, poor education, and chronic poverty. (Tait, 2003, p. 75)

Aboriginal people continued to experience trauma, loss and grief as a result of the rapid expansion of the child welfare system in the 1960s. During this period, commonly known as the “Sixties Scoop” (Sinclair, 2007), disproportionate numbers of Aboriginal children were placed in foster care. For example, by the end of the 1960s, “30% to 40% of the children who were legal wards of the state were Aboriginal children – in stark contrast to the rate of 1% in 1959” (Fournier & Crey, 1997, as cited in Kirmayer et al., 2000, p. 609). Children were apprehended under circumstances that were deemed to be “child neglect” but that were instead related to issues of poverty (Bennett et al., 2005). Many of these children were placed in foster homes and adoptive care with non-Aboriginal families (Kimelman, 1985).

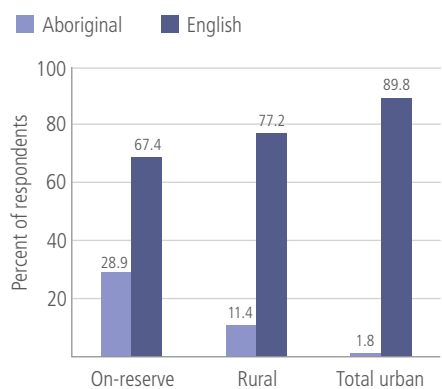
Like the residential schools, the “Sixties Scoop” represented another assault on the ability of Aboriginal peoples to maintain and transmit their culture, fracturing families and communities, and affecting both individual and community health. Health consequences associated with residential schools and the “Sixties Scoop” have included elevated rates of suicide, alcoholism, violence and “pervasive demoralization” (Shkilnyk, 1985; LaFromboise, 1988; Richardson, 1991; Waldram, 1997, as cited in Kirmayer et al., 2000).



2.3 Summary

This chapter has sought to conceptualize Aboriginal health broadly within a social determinants of health framework. Such a framework is consistent with a more holistic perspective of health. However, it is also clear that international and national perspectives on social determinants are inadequate for understanding the health inequities faced by Canada’s Aboriginal population. While there are pervasive inequities between Aboriginal and non-Aboriginal Canadians in determinants such as income, education, employment, social inclusion and gender, among others, Indigenous-specific social determinants such as environmental dispossession and colonialism, which resulted in the disruption of Aboriginal languages, culture and loss of self-determination, underlie many of the socio-economic inequities that have led to increased prevalence of a host of physical illnesses, as well as poorer mental health and well-being. Only by addressing these broader social determinants will there be any meaningful improvements in the health and well-being of Aboriginal Canadians.

Figure 2.25: Language spoken most often at home by Aboriginal identity population, by location of residence, 2006



Source: Statistics Canada (2006), Census 2006, Topic-based Tabulations, Cat. No. 97-558-XCB2006015

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Chapter 3:

NATIONAL ABORIGINAL HEALTH PROGRAMS AND INITIATIVES



First Nations, Inuit and Métis peoples have a unique and special status in Canada that is constitutionally recognized. This is reflected in a complex policy framework for providing health programs and initiatives to Aboriginal²³ peoples, involving multiple levels of government (i.e., federal, provincial/territorial, Aboriginal) and multiple stakeholders (NCCA, 2011). While public health practices and policies in Canada have continued to improve the life of Canadians as a whole, Aboriginal peoples continue to experience health inequities and poorer quality of life than other Canadians.

This chapter examines the role of the federal government in providing health programs and initiatives to Aboriginal people. It begins with an examination of the emergence of the federal government in public health, and current roles and responsibilities in the provision of health programs and services. The chapter then summarizes the federal public health programs and initiatives that have been developed for, or have a targeted component for, various Aboriginal populations. Many of these programs and initiatives have been implemented to address the health disparities that these populations face.

3.1 Historical Overview

In Canada, a governmental role in public health began in the early 1830s, when both Upper and Lower Canada established boards of health. With the creation of Canada in 1867, the provinces began to pass provincial public health acts, public health boards were established to ensure that health hazards were remedied, and medical officers of health were appointed to ensure health and welfare within various regions (Health Canada, 2003b). As medical science evolved, so did the activities and programs covered by these public health boards. They began to inspect livestock for disease, implement control practices for sexually transmitted infections, implement and oversee facilities aimed at preventing the spread of communicable disease (such as TB sanatoria), and regulate the pasteurization of milk (Health Canada, 2003b).

In the 20th century, Canadians saw much improved public health, resulting in reduced mortality rates and increased life expectancies. Vaccination and immunization programs reduced the spread of communicable diseases such as mumps, measles and diphtheria, while improved sanitation and health promotion activities also reduced the

spread of infectious diseases. Public health practitioners recommended measures to reduce inequalities in health across the various levels of education and income (Health Canada, 2003b). Dependence on health information garnered through surveillance programs and data collection to inform public health practice has grown.

3.2 The Current Context

This section outlines the role of the federal government in developing health programs and initiatives for Aboriginal peoples. It also summarizes the role of three national Aboriginal organizations in health and health policy.

Given the unique and special status of First Nations, Inuit and Métis peoples, there are multiple authorities responsible for providing health programs and services to this population. At the national level, since 1945 the federal government has been providing health programs and services to status (registered) Indians²⁴ living on-reserve and to Inuit living within their traditional territories (Wigmore & Conn, 2003b). Primarily, these programs and services include limited public health and prevention services, and health promotion programs provided by the First Nations and Inuit

²³ Throughout this report, the term “Aboriginal” is used to refer to First Nations, Inuit, and Métis peoples inclusively. In the literature and descriptions of various organizations, First Nations will sometimes be subdivided by Indian Act status (status or non-status) or by residence on- or off-reserve.

²⁴ “Registered” or “status” refers to those who reported they were registered under the Indian Act. (Statistics Canada, Definitions, <http://www12.statcan.ca/english/census01/products/analytic/companion/abor/definitions.cfm>)

Health Branch (FNIHB) of Health Canada. Most hospital care and primary health care services are provided through provincial and territorial governments (Health Canada, 2009b). FNIHB does play a role in this, however, through its Health Facilities and Capital Program which provides efficient and effective health programs and services to its clients, even those living in remote and isolated regions, by “supporting the construction, acquisition, leasing, operation and maintenance of nursing stations, health centres, health stations, health offices, treatment centres, staff residences, and operational support buildings” (Government of Canada, 2010). For First Nations people who do not live on-reserve, or for urban Inuit or Métis, the federal government plays only a limited role. The health of these population groups is considered the responsibility of the province or territory of residence.

Two major policies guide the implementation and administration of health services for First Nations and Inuit: the Indian Health Policy (1979) and the Health Transfer Policy (1989). The Indian Health Policy emerged from the federal government’s recognition that First Nations and Inuit could assume responsibility for administering any or all of their community health programs (NCCAH, 2011). The policy’s goal is to increase the “level of health in Indian communities, generated and maintained by the Indian communities themselves” (Health Canada, 2004, p. 39). The policy is built on the “three pillars of community development, the traditional relationship of the Indian people to the Federal government, and the interrelated Canadian health system” as a means to address the health inequities faced by many Aboriginal people (Health Canada, 2007c, p. 2). Yet despite this recognition of the need for more community control over health, the policy is limited. It does not specify whether both registered and non-registered Indians are included in

the coverage, and it has not led to the implementation of short-, medium- or long-term strategic health objectives (Lavoie & Gervais, forthcoming).

The Health Transfer Policy was enacted in 1989 as a means of providing direct community control over health programs. The policy is implemented through the negotiation of Health Transfer Agreements between the federal government, represented by FNIHB, and First Nations communities to gradually transfer control over health programs and resources to these communities. When the policy was initially enacted, it provided opportunities for single Aboriginal communities and tribal councils south of the 60th parallel to assume responsibility for the planning and delivery of community-based health programs and services, as well as some regionally based programs (Wigmore & Conn, 2003b). With the establishment of integrated agreements in 1994, opportunities for community control over health broadened to also include communities in the Yukon and the Northwest Territories (Wigmore & Conn, 2003b).

Health Canada also works with provinces, territories and First Nations communities to support an on-reserve public health system. This system includes infectious disease control and surveillance, prenatal education and immunization, and environmental health services (such as drinking water testing and health inspections). In order to address public health concerns, the three levels of government (federal, provincial and territorial, and regional/community) work together to address regulatory issues and concerns.

A key concern in the context of Aboriginal health is the lack of continuity between federal and provincial and territorial policy and coverage, particularly in terms of payment for services. Provincial and federal governments do not always

agree on which level of government is responsible for paying for health services for First Nations people living on-reserve. This ambiguity over jurisdictional responsibilities has on occasion compromised health, as in the case of Jordan River Anderson, a young child who died while waiting for governments to determine fiscal responsibility for his health care (Blackstock, 2009).

The Health Council of Canada, a federal organization that assesses health care in Canada, has made several recommendations to address inter-jurisdictional and infrastructural disparities, including the following:

- Aboriginal peoples (First Nations, Métis and Inuit) must be enabled to be, and respected as, full partners with federal, provincial and territorial, and regional jurisdictions in developing and implementing an Aboriginal Health Reporting Framework. To achieve this, the various levels of government must work in collaboration with Aboriginal organizations to ensure that the determinants of health that affect a given Aboriginal population are addressed.
- Communities must be supported in adopting a population health model that will reflect the unique health needs of Aboriginal peoples.
- The specific socio-economic and geographic needs of some Aboriginal populations, especially in isolated or northern regions, must be addressed (Health Council of Canada, 2005).

In addition to working with provincial and territorial governments to provide health programs and services to Aboriginal people, the federal government also provides funding to a number of other non-governmental organizations to administer programs and initiatives on their behalf. For example, the federal government (through Canadian Heritage’s Aboriginal Peoples’ Program) has

provided funding to national and affiliated provincial and territorial associations and Aboriginal friendship centres for a wide range of culturally appropriate programs and services that aim to improve the health and well-being of urban Aboriginal people and strengthen their cultural identity (Canadian Heritage, 2010a).

The blueprint on Aboriginal health

Over the past 20 years, there has been increasing recognition of the need to close the gap in health outcomes between Aboriginal peoples and the general Canadian population by addressing issues related to the complexity of health service provision for Aboriginal peoples, and through concerted efforts on determinants of health (Health Canada, 2005a, p. 1). In response to this recognition, First Ministers and national Aboriginal leaders met in 2005 to develop concrete initiatives to improve the health status of Aboriginal peoples. These efforts resulted in the development of a 10-year Transformative Plan that is intended to guide future decision-making by federal, provincial and territorial governments and Aboriginal leaders in achieving their stated vision of “closing the gaps in health outcomes through comprehensive, holistic, and coordinated services” (Health Canada, 2005a, p. 4).

The Blueprint on Aboriginal Health is not legally binding; its goals are articulated desires for change and co-operation. They include:

- closing the gap that currently exists between the general Canadian population and Aboriginal peoples by improving access to and quality of health services through comprehensive, holistic and coordinated service provision by all levels of government (federal, provincial, territorial, regional and local)
- establishing quality health programs and services in all regions and communities, regardless of location or of their relationship in the *Indian Act*

- responding to the specific and varying needs of women, youth and elders through the use of culturally relevant, gender-based analysis in research, policy and program development (Health Canada, 2005a).

In order to achieve the stated goals, the blueprint sought to build upon and broaden existing relationships between federal, provincial and territorial governments and between First Nations, Inuit and Métis organizations, governments and service providers. The funding procedure for this plan is a prime example of this approach: while the source of funding is through the federal government, provincial and territorial governments will assume the responsibility for allocating and managing the funding in order to ensure sustainability of the Aboriginal health care systems. The blueprint is considered a living document, to be reviewed periodically so that accountability can be maintained and goal attainment can be evaluated (First Ministers and Leaders of National Aboriginal Organizations, 2005).

National Aboriginal organizations

A number of First Nations, Inuit and Métis organizations are involved in helping to shape the public health policy agenda at the national level. These organizations are directed by and for Aboriginal peoples and their scopes transcend provincial and territorial boundaries (please see National Collaborating Centre for Aboriginal Health [NCCA], 2010, for further details about these organizations). Nearly all of these national organizations have a broad mandate, and undertake advocacy, representation or lobbying work. A brief summary of the three main national organizations – the Assembly of First Nations, the Inuit Tapiriit Kanatami and the Métis National Council – is provided below. Each of these organizations plays a key role in the development of health policy on the national scale.

The Assembly of First Nations is the national representative organization of the First Nations of Canada. The Assembly of First Nations Secretariat presents the views of the various First Nations through their leaders in such areas as Aboriginal and treaty rights, economic development, education, languages and literacy, health, housing, social development, justice, taxation, land claims and environment. With regard to public health, the Assembly of First Nations works to ensure that all First Nations people and communities have access to and experience the same quality of life and public health care as are enjoyed by all Canadians (see, for example, Assembly of First Nations [AFN], 2006).

The Inuit Tapiriit Kanatami is the national Inuit organization in Canada. It represents Canada’s four Inuit regions: Nunatsiavut (Labrador), Nunavik (northern Quebec), Nunavut, and the Inuvialuit Settlement Region in the Northwest Territories. Since its creation in 1971, the Inuit Tapiriit Kanatami has represented and promoted the interests of the Inuit. In terms of health care and public health, the Inuit Tapiriit Kanatami has research and initiatives in the areas of suicide prevention, mental health, cancer, diabetes, environmental/nutritional health and health transfer (Inuit Tapiriit Kanatami, 2009).

The Métis National Council represents the Métis people of Canada. In particular, the council is responsible for acting on and enhancing the desires and aspirations of Métis governments at the national and international levels. In terms of public health policy and care, the Métis National Council has developed specific health target areas in all provinces from Ontario westward. Initiatives include diabetes programs, family services, HIV/AIDS awareness and prevention, health programs, long-term care, and child and youth care (Métis National Council, n.d.).

3.3 Federal Health Programs and Initiatives

This section identifies federal programs and initiatives directed at improving Aboriginal health and wellness. Programs and initiatives were identified through a search of federal government websites and reports using a range of search terms related to specific Aboriginal health issues. The search was limited to programs and initiatives that are implemented, funded and administered by a branch or department of the federal government for Aboriginal peoples or that have a specific component of the program targeted at Aboriginal peoples.

The programs and initiatives listed here represent those available at the time this Internet search was conducted, early in 2009.²⁵ Therefore, this chapter may not be inclusive of all federal programs and initiatives, particularly given the limitations of using publicly available information on the Internet, where information is forever shifting and where it is often difficult to ascertain whether the information provided is complete or accurate.

This section begins by briefly summarizing three programs or initiatives that provide benefits spanning multiple health areas: the Non-Insured Health Benefits Program, the Aboriginal Health Human Resources Initiative, and the Aboriginal Health Transition Fund. This is followed by a summary of programs and initiatives categorized by specific area of health, including children and youth, mental health/suicide/substance use, chronic diseases, communicable diseases, physical activity and nutrition, and environmental health. The section concludes with a summary of programs

and initiatives targeted specifically at the urban Aboriginal population. For each program or initiative, information regarding its objectives, scope, budget and start and end dates is summarized where this information is readily available from the program website. This chapter focuses only on the application of these programs at the national level. Details about how they are delivered within specific provinces and territories can be found in Chapter 4, Provincial and Territorial Aboriginal Health Programs and Initiatives.

Non-Insured Health Benefits Program

At the federal level, equitable access to health care resources and other health benefits is currently addressed by the Non-Insured Health Benefits Program (NIHB). The objective of this program is to “support First Nations and Inuit in reaching an overall health status that is comparable with other Canadians...” through the provision of health services and treatments that are not covered by provincial or territorial insurance or other private insurance plans (Health Canada, 2005c, p. 5).²⁶ This includes coverage for a specified range of drugs, dental care, eye and vision services, medical supplies and equipment, short-term crisis intervention mental health counselling, and medical transportation. It also covers health care premiums in British Columbia.²⁷

To be eligible for the NIHB program, an individual:

- must be a registered Indian according to the *Indian Act* or an Inuk recognized by one of the Inuit Land Claim organizations or an infant less than one year of age whose parent is an eligible client

- must be currently registered or eligible for registration under a provincial or territorial health insurance plan
- cannot be otherwise covered under a separate agreement (e.g., self-government agreement) with federal, provincial or territorial governments (Health Canada, 2010a, p. 7).

In addition, claims must be submitted first to any private health care plan or public health or social program that clients are also eligible for before they can be submitted to the NIHB program.

This program has no termination date and funding fluctuates based on the number of claims made. In 2008/09, total NIHB expenditures were \$934.6 million, with pharmacy costs comprising 44.8%, medical transportation comprising 29.4%, and dental costs comprising 18.9% of total expenditures (Health Canada, 2010a, p. 17).

Aboriginal Health Human Resources Initiative

The shortage of health care workers, particularly in First Nations communities, has been recognized as a national issue (AFN, 2008). In addition, Aboriginal people are under-represented in all health care fields (AFN, 2008; Congress of Aboriginal Peoples, 2007). To address the human health resources crisis, in 2005 the federal government implemented the Aboriginal Health Human Resources Initiative (AHHRI). The AHHRI received a funding allocation of \$100 million over a five-year period to support regional and national projects that met the goals of increasing the number of Aboriginal people working in health careers, adapting health care educational curricula to support the development of

²⁵ The initial search for programs was undertaken in 2009 and the programs listed herein were in place in that year. However, subsequent revisions to this document and the need to verify information, sometimes through updated Internet web pages, means that citation dates may be after 2009.

²⁶ The services are intended to enable the eligible Aboriginal populations to adopt a community health approach and develop a reciprocal accountability relationship with various government organizations (Health Canada, 2005b).

²⁷ This was covered in Alberta until January 1, 2009 as well when the Government of Alberta eliminated health care insurance premiums for all Albertans (Government of Alberta, 2011).

cultural competencies, and improving the retention of health care workers in Aboriginal communities (Health Canada, 2007d).²⁸ The AHHRI is intended to complement and integrate with, wherever possible, work underway in the provinces and territories as part of the Pan-Canadian Health Human Resources Strategy (2003).

The AHHRI is funded by Health Canada's FNIHB and is governed through a national First Nations and Inuit advisory committee that includes community and national representation, as well as a Métis and off-reserve advisory committee (AFN, 2008). To implement the goals of the initiative, funds are provided to national and regional organizations through contribution agreements and contracts. Regional projects are developed and funded through a collaborative work planning process that involves regional FNIHB and provincial or territorial officials in articulating spending priorities, and approval of the work plan by the national office. Program clients include all First Nations, Inuit and Métis regardless of status or where they reside; health care providers providing services to First Nations, Inuit and Métis; universities and colleges that deliver health care programs; Aboriginal and non-Aboriginal health professional and para-professional organizations; and associations representing colleges and universities (AFN, 2008).

Information on the initiative's success in recruiting, training and retaining Aboriginal health care workers is not readily available on the Internet.

Aboriginal Health Transition Fund

The Aboriginal Health Transition Fund (AHTF) was announced in 2005 as a mechanism for addressing the gap in health status between Aboriginal and non-Aboriginal Canadians through improving the quality of, and access to, existing health

services (Health Canada, 2010g). The fund supports projects under three funding envelopes: Integration, Adaptation and Pan-Canadian (Health Canada, 2009c). Projects under the Integration funding envelope support improved coordination and integration between federally funded and provincially and territorially-funded health services in First Nations and Inuit communities. Projects under the Adaptation funding envelope support provincial and territorial governments in adapting their health programs so they are better suited to meet the needs of First Nations (both on- and off-reserve), Inuit and Métis. Projects under the Pan-Canadian funding envelope "contribute to the knowledge and resources on integration and adaptation of health systems for Aboriginal peoples; address integration or adaptation issues on regional or national levels; and build tools, research and resources to support the individual projects funded through the Aboriginal Health Transition Fund" (Health Canada, 2009c, Pan-Canadian, para. 2).

A total of \$200 million was allocated over a five-year period for the AHTF, with \$80 million for each of the Adaptation and Integration envelopes and \$40 million for the Pan-Canadian envelope (Health Canada, 2006d). Since the fund's initiation, over 311 health-related projects have received funding (Health Canada, 2010g). These projects have piloted different approaches to coordinating and adapting health services in areas such as e-health, substance abuse, child and youth care, mental health, chronic disease, public health, home care and governance (Health Canada, 2010g).

Children and youth

Over the past decade, there has been much discussion and research on improving Aboriginal child and youth health care. Working with the federal government, FNIHB and PHAC are

identifying strategic opportunities that will contribute to improving the health and well-being of First Nations and Inuit children and youth. The following programs and initiatives are funded by the federal government and its agencies and departments and are targeted at Aboriginal children and youth so that they have the opportunity to achieve the same health outcomes as other Canadian children and youth.

Canada Prenatal Nutrition Program

The Canada Prenatal Nutrition Program is a community-based program targeted at improving the health and well-being of pregnant women, new mothers and their infants facing challenging circumstances. It is offered through two streams. The first is funded and administered by the Public Health Agency of Canada for all Canadian women and their infants. While the program does not specifically target Aboriginal peoples, participation rates among off-reserve Aboriginal people are high in some jurisdictions (particularly in the Prairie Provinces). The program, in operation since 1995, currently receives funding at approximately \$27.2 million annually (Public Health Agency of Canada [PHAC], 2007a).

The second stream – First Nations and Inuit Component – is funded and administered by Health Canada for pregnant women and new mothers with infants up to 12 months of age who live on-reserve or in Inuit communities. The program funds local community projects delivered by community health and social service providers, as well as dietitians, nutritionists, lactation consultants and others. It is aimed at improving the overall nutritional health of expectant and new mothers and their children. The objectives of the program are to:

- improve the adequacy of the diet of prenatal and breast feeding First Nations and Inuit women

²⁸ This program has been extended to March 2013.

- increase access to nutrition information, resources and services, particularly to those women who are at high risk
- increase breast-feeding rates, initiation and support
- increase knowledge- and skill-building opportunities in maternal and infant nutritional health
- increase the number of infants who are fed age-appropriate foods within the first 12 months (Health Canada, 2007b).

More than 9,000 women take part in the FNIHB's Canada Prenatal Nutrition Program each year (PHAC, 2007a). While no recent budget information could be found for the First Nations and Inuit Component of the program using Internet-based sources, one federal government report revealed \$9,328,012 in federal funding in the 2005/2006 fiscal year to support 450 projects in this stream (Government of Canada, 2007).

Aboriginal Head Start on Reserve and Aboriginal Head Start in Urban and Northern Communities

The Aboriginal Head Start (AHS) programs are designed to prepare young Aboriginal children for their school years by meeting their emotional, social, health, nutritional, spiritual and psychological needs in a holistic and nurturing environment. The programs provide early childhood intervention targeting the needs of Aboriginal children up to six years of age. Each program includes six elements: promotion and protection of Aboriginal language and culture, nutrition, education, health promotion, social support, and parental and family involvement. The overall goals of the AHS programs are to help parents contribute to their child's healthy development, encourage children to enjoy lifelong learning and support them in doing so, and reduce the negative health effects experienced by some Aboriginal children as a result of high rates of poverty and

lack of social supports in many Aboriginal communities (Health Canada, 2003a).

The Aboriginal Head Start in Urban and Northern Communities Program has been in operation since 1995. Funded and administered by the Public Health Agency of Canada, the program provides for the establishment of early childhood development programs for First Nations, Métis and Inuit children living in urban centres and large northern communities across Canada (Williams, n.d.). It operates with an annual budget of approximately \$35 million (Indian and Northern Affairs Canada [INAC], 2008c). As of 2008, approximately 140 AHS sites received funding for programs across Canada, reaching approximately 4,500 children aged 0-6 years (INAC, 2008c).

In 1998, AHS was expanded to include First Nations children living on-reserve. The Aboriginal Head Start on Reserve Program is funded and administered by the First Nations and Inuit Health Branch of Health Canada. Currently, the program operates with an annual budget of approximately \$59 million (Health Canada, 2010b). As of 2008, over 354 sites, providing services to a total of 383 First Nations communities, have received funding for early child development programs (INAC, 2008d).

The First Nations and Inuit FAS/FAE Initiative

Fetal alcohol syndrome and fetal alcohol effect (FAS/FAE) are preventable birth defects resulting from the consumption of alcohol during pregnancy. While the prevalence of FAS/FAE is generally unknown (Pacey, 2009), research suggests that it affects approximately 1 to 3 of every 1,000 live births in Canada, with higher rates among Canada's Aboriginal populations (Health Canada, 2005d). Fetal alcohol spectrum disorder (FASD) is the term used to designate the wide range of effects attributed to FAS/FAE.

In 1999 the federal government began to allocate additional funding through the Canada Prenatal Nutrition Program specifically for programs that address FAS/FAE issues in Aboriginal communities. The First Nations and Inuit FAS/FAE Initiative, delivered through the First Nations and Inuit Health Branch, is targeted at "FAS/FAE affected individuals, persons at risk, families, community members, health and social service providers, community leaders, teachers and other educators, and corrections and justice system workers" (FAS/FAE Technical Working Group, 2001, p. 17). It was established to "create conditions in which maternal and infant health will flourish" by aiming to prevent FAS/FAE births, and by increasing the "knowledge, skills, and quality of life of FAS/FAE affected children, mothers, fathers, and families" (FAS/FAE Technical Working Group, 2001, p. 11). Its objectives are to:

- raise awareness about FAS/FAE and the dangers of drinking during pregnancy;
- identify and work with persons at risk and their partners in order to reduce the risk of FAS/FAE
- identify and work with FAS/FAE affected individuals in order to lessen the educational, social and behavioural impacts of FAS/FAE by supporting them
- create connections between related programs and initiatives (FAS/FAE Technical Working Group, 2001, p. 12-13).

Through this initiative, funding is made available for projects, services and activities that fall into one of three categories:

- health promotion and awareness regarding FAS/FAE issues;
- education and training for anyone falling within the target group for the initiative; and
- identification of diagnostic tools and intervention supports and strategies designed to increase the quality of life

of individuals and families affected by FAS/FAE (FAS/FAE Technical Working Group, 2001, p. 17-18).

Funding for FASD projects, activities and services is directed towards on-reserve First Nations, First Nations north of the 60th parallel, and Inuit communities. Projects may be initiated by First Nations bands, tribal councils, First Nations and Inuit organizations, or by community-based organizations or agencies that are supported by First Nations or Inuit governments.

The initiative received an initial allocation of \$750,000 for its first year of operation, but since its third year has been operating with a budget of approximately \$1.7 million annually (FAS/FAE Technical Working Group, 2001). While the program as administered through the Public Health Agency of Canada for Canadians generally has undergone an evaluation, no similar evaluation is readily available for the Aboriginal-specific component of the program as administered by Health Canada. There is therefore no available information regarding the number of programs that have been funded.

Maternal Child Health Program

The Maternal Child Health Program (MCH), announced in September 2004, is aimed at supporting pregnant First Nations women and families with infants and young children who live on-reserve. The primary goal of the program is to encourage and support women, children and families in realizing their full developmental potential, through an integrated and community-centred approach to resources, support and

programs (Health Canada, 2007b). Through support from community Elders, the Canada Prenatal Nutrition Program and nursing services, mothers and families have access to a broad range of programs and services, such as FASD information, home and community care, oral health access, and other community-based programs. In northern communities (the territories, Nunavik and Labrador), MCH is focused on expanding and enhancing those services already provided by the province or territory and Health Canada, including the Canadian Prenatal Nutrition Program and FASD programs, in order to increase the number of communities that have programs and provide more intensive activities. Elements of the program include home visits by community health nurses and family visitors; integrating culture into care; screening and assessment; case management, including early intervention, coordination of services for families, and provision of culturally competent care; and health promotion (Health Canada, 2007b).

The original budget for this program allocated \$110 million over a five-year period (AFN, 2004). Since this funding was deemed insufficient to provide every First Nations community with a MCH program, funding was initially provided only to those communities with the capacity to provide such a program, with a view to funding other communities once they had acquired this capacity. The intent of the program was to continue and expand its operations (AFN, 2004), and further funding was allocated for this program to at least 2012 (INAC, 2010a).²⁹ No information about numbers

of clients helped through the program is readily available.

Brighter Futures

The Brighter Futures program was introduced in 1992 to assist First Nations and Inuit communities in developing community-based approaches to improve health through health promotion and ill-health prevention. The program provides funding for programs, services or activities that strive to increase awareness, change attitudes, build knowledge and enhance skills in any one of five areas: mental health, child development, parenting, healthy babies or injury prevention (Health Canada, 2007a).

The Brighter Futures program is directed at all members of eligible First Nations and Inuit communities, and is delivered by a variety of service providers, including mental health workers, wellness workers, youth workers and community Elders. Each community corporation or band council must request its own funding through a grant application process. Funds are determined on the basis of the current community population and the cost of living index. Currently, the majority of First Nations and Inuit communities receive Brighter Futures and/or Building Healthy Communities³⁰ funding. Information on the number of proposals funded under this program is not readily available; however, an evaluation undertaken in 2006 found that activities funded under the Brighter Futures Program are relevant and address First Nations and Inuit community health and wellness needs and priorities (Health Canada, 2006a). Information on an overall budget for this program is not readily available.

²⁹ Budget 2010 highlights indicated that \$285 million has been set aside for renewing investments in the Aboriginal Diabetes Initiative, Youth Suicide Prevention Initiative, maternal and child health programs, Aboriginal Health Human Resource Initiative, and the Aboriginal Health Transition Fund collectively (INAC, 2010a).

³⁰ Health Canada is currently considering consolidating the Brighter Futures program and the Building Healthy Communities initiative, since both programs focus on mental health at the community level. This would create a single funding program that would allow each community to address mental health, child development, parenting, healthy babies and/or injury prevention, based on what the community deems necessary. The consolidated program would ideally deliver a seamless, community-based continuum of services that would address the needs and development of the entire community – from child to Elder. Details about the Building Healthy Communities program can be found later in this chapter, under “Mental health, suicide, and substance abuse.”

Mental health, suicide, and substance abuse
 Many Aboriginal communities have documented high levels of mental health problems, manifested in depression and demoralization, family violence, substance abuse and suicide (Kirmayer, Brass & Tait., 2000; Canadian Mental Health Association Ontario [CMHAO], n.d.; Health Canada, 2006b, 2007b; Cheechoo, Spence & members of the Nishnawbe Aski Nation Decade youth Council, 2006; Chansonneuve, 2007). Many of these mental health problems are rooted in “a long history of colonization, residential school trauma, discrimination and oppression, and losses of land, language and livelihood” (CMHAO, n.d., para. 6).

The following programs and initiatives are funded by the federal government and its agencies or departments to target mental health issues, suicide and substance abuse among Aboriginal peoples.

Building Healthy Communities

Building Healthy Communities is a federal program designed to aid First Nations and Inuit communities and their respective provincial or territorial government in developing community-based approaches for mental health crisis management. The program was established in 1994 and is funded and administered by Health Canada. It provides eligible First Nations and Inuit communities with funding for community-based programs, services and activities in the areas of solvent abuse and mental health crisis management. The primary goals of the program are to:

- develop and provide the necessary tools for communities to deal with mental health and addictions
- focus on communities in crisis and high-priority cases, such as suicide
- provide crisis intervention, after-

care and training for caregivers and community members

- support intervention to decrease the number of suicide attempts and other violent crisis situations (Health Canada, 2007b, p. 16).

The Mental Health and Crisis Intervention component of the program provides assessment and counselling programs, referrals for treatment and follow-up, after-care and rehabilitation for individuals and communities in crisis, culturally sensitive training for community members and caregivers, and community education about mental health and suicide (Health Canada, 2007b).

Funding is allocated through a grant proposal process. Each community corporation or band council must request its own funding, which is given on the basis of the current community population and the cost of living index. Currently, the majority of First Nations and Inuit communities receive Brighter Futures and/or Building Healthy Communities funding.³¹ Information on the number of proposals that have received funding through this program is not readily available; however, an evaluation undertaken in 2006 found that activities funded under the Healthy Communities Program are relevant and address First Nations and Inuit community health and wellness needs and priorities (Health Canada, 2006a).

With the exception of the Mental Health and Crisis Intervention Component of the program, which operates with an annual budget of \$30 million (Health Canada, 2007b), budget information for the Building Healthy Communities initiative is not readily available.

National Aboriginal Youth Suicide Prevention Strategy

The National Aboriginal Youth Suicide Prevention Strategy was implemented in 2005 to address the urgent need to reduce the rate of suicide among Aboriginal people. The overall goal of the strategy is to decrease the incidence and increase the awareness of youth suicide (Health Canada, 2007b). To achieve this, the program aims to help Aboriginal youth and communities establish a sense of identity, meaning, resilience and purpose, all of which are integral protective factors. The strategy also seeks to develop and use culturally relevant tools and resources to foster resiliency, spiritual and emotional health, coping skills and leadership development. Communities are encouraged to develop crisis response and stabilization protocols, and to increase emergency response capacity in order to cope in the aftermath of a suicide and to prevent suicide clusters from forming (Health Canada, 2007b).

Aboriginal youth living on-reserve, Inuit youth and off-reserve Aboriginal youth are able to access services under the strategy. Services are delivered by a variety of mental health and health care providers and professionals (Health Canada, 2007b).

A budget of \$65 million was allocated over a five-year period for the strategy (Congress of Aboriginal Peoples, n.d.), and funding for the strategy has recently been extended to 2012 (INAC, 2010a).³²

National Native Alcohol and Drug Abuse Program

The National Native Alcohol and Drug Abuse Program (NNADAP) is a Health Canada initiative designed to help First Nations and Inuit communities develop

³¹ Health Canada is currently considering consolidating the Building Healthy Communities initiative and the Brighter Futures program, since both programs focus on mental health at the community level. This would create a single funding program that would allow each community to address mental health, child development, parenting, healthy babies and/or injury prevention, based on what the community deems necessary. The consolidated program would ideally deliver a seamless, community-based continuum of services that would address the needs and development of the entire community – from child to Elder.

³² Budget 2010 highlights indicated that \$285 million has been set aside for renewing investments in the Aboriginal Diabetes Initiative, the Youth Suicide Prevention Strategy, maternal and child health programs, the Aboriginal Health Human Resource Initiative, and the Aboriginal Health Transition Fund collectively (INAC, 2010a).

local programs aimed at preventing the abuse of alcohol, drugs and solvents and restoring the well-being of both individuals and communities. The program was established during a 1970s pilot project and made permanent in 1982 as part of a comprehensive federal strategy aimed at providing treatment, prevention, research and training (National Native Addictions Partnership Foundation, n.d.). The program is now largely controlled by First Nations communities and organizations (Health Canada, 2006c).

In order to provide prevention, treatment and after-care resources to over 500 Aboriginal communities, NNADAP currently:

- supports First Nations in reducing the incidence of substance abuse in their communities
- builds capacity and develops culturally appropriate community-based addictions programs and services
- increases awareness and understanding of alcohol and substance abuse and alternative healthier lifestyles
- strengthens relationships between community-based programs and services and residential treatment
- provides post-treatment support for individuals and families (Health Canada, 2007b).

NNADAP provides over 550 programs that include prevention activities aimed at preventing alcohol and drug abuse problems, intervention activities aimed at dealing with existing abuse problems at the earliest stage, and after-care activities to prevent a reoccurrence of alcohol and drug abuse problems (Health Canada, 2006c). These programs are located on First Nations reserves and in Inuit settlements.

NNADAP was originally developed as a five-year \$154 million program (Hodgson, Hanki, Paul, Toulouse & Jock, 1998). It has been undergoing a renewal process since 2007, made

possible by the federal government's announcement of the National Anti-Drug Strategy. The announcement came with a funding commitment of \$30.5 million over five years, and \$9.1 million ongoing, to enhance addiction services for First Nations and Inuit populations (NNADAP, n.d.).

NNADAP Residential Treatment

The Residential Treatment component of NNADAP has created 52 treatment centres, with approximately 700 beds, across Canada to directly address substance abuse and treatment for First Nations on-reserve and eligible Inuit (Health Canada, 2006c). The treatment centres are operated by First Nations organizations and communities. They provide in- and out-patient support and treatment, education on addictions issues and information on treatment services. Treatment centres also offer information and assistance to community-based NNADAP workers who provide follow-up or after-care support services. The main objectives of the program are to:

- provide culturally appropriate in-patient treatment
- provide equitable access to treatment in all First Nations communities across Canada
- promote mental wellness and build awareness of addictions-free lifestyles;
- strengthen links between residential treatment and community-based prevention programs
- develop a cohesive treatment delivery system to improve access to and quality of services
- enhance service delivery and support to communities in addressing addiction priorities (Health Canada, 2007b).

Information on program budget and start dates could not be readily obtained.

Youth Solvent Abuse Program

The Youth Solvent Abuse Program, developed by FNIHB, is another of Health Canada's initiatives designed to help First

Nations and Inuit communities develop local programs aimed at preventing the abuse of alcohol, drugs and solvents and restoring the well-being of both individuals and communities. This community-based prevention, intervention, after-care and in-patient treatment program is specifically targeted at First Nations and Inuit youth who are addicted to or at risk of inhaling solvents (Health Canada, 2007b). The program involves youth, parents and communities as youth attempt to deal with issues such as family violence, suicide and depression that are often at the root of, or result from, solvent use. Treatment is based on Aboriginal values and beliefs, focuses on personal growth and wellness, and offers a continuum of care, beginning at the pre-treatment stage and following through to post-treatment care (Health Canada, 2007b).

The primary objectives of the Youth Solvent Abuse Program are to:

- provide specialized treatment and recovery programs for persons with chronic solvent abuse problems in a manner that is sensitive to and respectful of their unique cultural heritage
- provide in-community supports to individuals and families pre- and post-treatment
- increase the awareness and understanding of solvent abuse and alternative healthier lifestyles
- network and work collaboratively with other community-based programs and resources, including NNADAP workers and other workers, to ensure that client needs are met (Health Canada, 2007b).

The program is run through 10 Youth Solvent Addictions Centres, accommodating 120 treatment beds in total, located across the country (Health Canada, 2005b). Some of these centres provide programs for youths aged 12-19 years, while others target youth aged 16-25 years. The centres also provide solvent abuse training and information centres for

community workers. Each year, a minimum of 212 clients are treated through the program (Health Canada, 2005b).

The program was established in 1993, and currently operates with an annual budget of approximately \$13 million (Health Canada, 2005b).

Indian Residential Schools Resolution Health Support Program

Residential schools have had a tremendous intergenerational impact on the health of many Aboriginal individuals, families and communities. To assist with the healing process, the federal government announced the Indian Residential Schools Resolution Health Support Program in 2007 (Fletcher, 2007). The program is administered by Health Canada in partnership with Indian and Northern Affairs Canada, and provides professional mental health counselling and emotional support services (Fletcher, 2007). In addition, clients can receive assistance with transportation services to appropriate service providers (Fletcher, 2007). Individuals eligible for the program include former students of residential schools (and their families) who are in the process of resolving claims through the Independent Assessment Process, receiving Common Experience Payments, or participating in Truth and Reconciliation and Commemoration events (Health Canada, 2010f).

Funding for the program has grown to meet a growing demand for services, from an original allocation of \$94.5 million over a six-year period in the 2006 budget, to \$24.5 million for the 2009 budget, to \$65.9 million over two years in the 2010 budget, for a total of \$184.9 million over the past six years (AFN, 2010). Since the program's inception in 2006, the number of client interactions for services has grown from less than 10,000 in its first year to almost 60,000 client interactions in 2009/10 (AFN, 2010).

Labrador Innu Comprehensive Healing Strategy

In 2001, the federal government, through Indian and Northern Affairs Canada, initiated the Labrador Innu Comprehensive Healing Strategy (LICHS) to help resolve serious health, social and safety issues in the communities of Davis Inlet and Sheshatshiu (INAC, 2005b; 2007b). The strategy seeks to move beyond dealing with symptoms to addressing root causes, and its primary goals are to "restore health and hope, create strong communities and focus on building a future for the Innu communities" (INAC, 2005b, para. 1). The vision of the strategy is for the federal and provincial governments to work in partnership with the Innu to advance Innu community healing; build increased Innu capacity for the management and delivery of some government programs; conclude a land claim Agreement-in-Principle; address issues arising from sexual, physical and emotional abuse; achieve improvements in health, education, family and social well-being, economic development, community development, public safety and First Nation governance; and manage the LICHS in an integrated and effective fashion (INAC, 2008c).

The strategy received an original allocation of \$81 million over three years, including \$59 million from INAC, \$20 million from Health Canada, and \$2 million from the Solicitor General (INAC, 2005b). The strategy has continued to be extended since it was implemented, receiving \$20.5 million for 2004/05 and a further \$102.5 million for 2005/06 to 2009/10 (INAC, 2008e). Progress to date has been wide-ranging, including the construction of a new community in Natuashish and the relocation of the Mushuau Innu to this community; band creation and registration for both the Mushuau Innu and Sheshatshiu Innu First Nations; additional reserve creation; new social and community-based health programs;

the development and implementation of country treatment and after-care programs in both Innu communities; delivery of crime prevention projects; and new infrastructure, such as an RCMP detachment, health facility, school, safe houses, housing, church, cultural centre and wellness centre (INAC, 2007b).

Family Violence Prevention Program

The Family Violence Prevention Program, administered by Indian and Northern Affairs Canada, provides funding for family violence prevention projects in most First Nations communities (INAC, 2010e). Projects funded through this program are culturally appropriate and aim to decrease family violence and create a more secure family environment for children on-reserve by providing abuse prevention and protective services for children and their families (INAC, 2010e).

The program is intended for the benefit of those who ordinarily reside on-reserve (INAC, 2005a). However, certain individuals who are living off-reserve will qualify if they are: accessing health or social services not available on-reserve; are students who maintain a residence on reserve, are members of families that maintain a residence on-reserve, or individuals who return to live on-reserve with family; are children who are in joint custody who live more than 50% of the time on-reserve; or are children in care under a mandated child welfare authority (INAC, 2005a).

Funding for programs is through a variety of mechanisms. INAC provides operational funding for on-reserve shelters and reimburses costs for off-reserve shelter services used by First Nations people who are ordinarily resident on-reserve (INAC, 2010e). Communities can also apply for grant funding for specific projects aimed at reducing the incidents of violence on reserve. Prevention, treatment and research projects either receive funding that is regionally distributed and

determined on a per capita basis or are funded on a project basis (INAC, 2010e).

The program was approved in 2005 and approximately \$29.6 million has been invested annually by the federal government for family violence prevention programs and services on-reserve (Department of Justice, 2010). Operational funding is provided for a network of 41 shelters and approximately 350 community-based prevention projects on-reserve (Department of Justice, 2010).

Chronic illnesses

Chronic illnesses are influenced by a range of factors, both environmental and individual, and develop over a long period of time (Earle, 2011). Chronic illnesses can include diabetes, cardiovascular diseases, chronic respiratory diseases and cancer, among others. Aboriginal peoples in Canada disproportionately experience chronic illnesses (Earle, 2011; Ralph-Campbell et al., 2009; AFN, 2007). However, only one federally funded and administered program, the Aboriginal Diabetes Initiative, was identified through a search for programs and initiatives that addressed chronic illnesses. An additional program, the First Nations and Inuit Home and Community Care Program, is included in this section because it targets individuals who are living with chronic illnesses or disabilities generally.

Aboriginal Diabetes Initiative

The Aboriginal Diabetes Initiative (ADI) is a national program run by Health Canada and aimed at reducing the incidence and prevalence of diabetes among Aboriginal peoples and improving the health status of First Nations and Inuit individuals, families and communities (Health Canada, 2007b). The initiative emerged as part of the Canadian Diabetes Strategy in 2004. The purpose of the strategy was to provide a framework

that would aid in the development of an integrated and coordinated approach to reducing the social, human and economic impacts of diabetes in Canada (Health Canada, 2007b). The ADI provides community-based and culturally appropriate health promotion activities, including prevention, screening and care for First Nations and Inuit individuals who live with diabetes or are at risk of acquiring it. At the national level, it also seeks to:

- increase individual and community capacity (to build knowledge of the disease)
- improve surveillance (to decrease the rate of people who contract diabetes)
- increase research, evaluation and monitoring (to help develop treatment procedures, preventative measures, and eventually a cure)
- focus on national co-operation between provinces/territories, their health units, and the federal programs (Health Canada, 2007b).

The ADI operates under two funding streams: First Nations On-reserve and Inuit in Inuit Communities (FNOIIC) and Métis, Off-reserve Aboriginal and Urban Inuit Prevention and Promotion (MOAUIPP). The FNOIIC stream provides funding to First Nations and Inuit communities for diabetes programming, while the MOAUIPP stream supports community health promotion and prevention projects based on a national call for proposals process, with between 30 and 40 projects supported annually (Health Canada, 2007b). Overall, the ADI aims to ensure that diabetes programming is as equitably delivered as possible across the country, including to Métis, off-reserve and non-status Aboriginal peoples, and urban Inuit.

Prevention, screening and treatment programs are delivered in partnership

with tribal councils, First Nations organizations, Inuit community groups and provincial and territorial governments through contribution agreements established by FNIHB (Health Canada, 2008a). The ADI began operations with a budget of \$190 million over a five-year period to 2009. Additional funding has been secured for the program until at least 2012 (INAC, 2010a).³³

First Nations and Inuit Home and Community Care Program

The First Nations and Inuit Home and Community Care Program (FNIHCCP) was established through FNIHB in 1999 to enable First Nations and Inuit communities to meet the growing need for home care services for community members living with chronic diseases and disabilities. The overall goal of the program is to build the capacity within First Nations and Inuit communities to deliver comprehensive, culturally sensitive, accessible and effective home care services so that those living with chronic and acute illness can be assisted in maintaining optimum health, well-being and independence within their homes and communities (AFN, 2005). The target population of the program is First Nations and Inuit who reside on a First Nations reserve (south of the 60th parallel), Inuit settlement (north or south of the 60th parallel), or First Nations community north of the 60th parallel (Health Canada, 2010d).

The program was phased in over the first three years with a total budget of \$152 million. Since that time, \$90 million has been budgeted annually, though actual spending for the program has been higher than this, to nearly \$100 million, for the past few years (Health Canada, 2010d). As of 2007, 633 of a possible 645 eligible First Nations and all 53 eligible Inuit communities have received

³³ Budget 2010 highlights indicated that \$285 million has been set aside for renewing investments in the Aboriginal Diabetes Initiative, Youth Suicide Prevention Initiative, maternal and child health programs, Aboriginal Health Human Resource Initiative, and the Aboriginal Health Transition Fund collectively (INAC, 2010a).

funding through this program (Health Canada, 2010d)

Physical activity and nutrition

The prevalence of obesity is significantly higher among Aboriginal Canadians than among non-Aboriginal Canadians (Katzmarzyk, 2008; PHAC, 2009; Bruce, Riediger, Zacharias & Young, 2011). Being overweight or obese has a negative effect on a person's overall health, and has been found to be a factor in health issues such as diabetes, cancer, heart disease and mental health problems. The following programs and initiatives are funded by the federal government and its agencies and departments to target physical activity and nutrition among Aboriginal people.

North American Indigenous Games

The federal government, with provincial and territorial governments, has committed to supporting the North American Indigenous Games as a means of providing opportunities for Aboriginal youth to participate in sport and recreation. The North American Indigenous Games are two-week friendly sport and cultural competitions held across North America every six years (Canadian Heritage, 2003). The commitment to support these games dates back to 1995, when federal, provincial and territorial governments met with national Aboriginal sport representatives and agreed to develop joint strategies to eliminate barriers to Aboriginal participation in sport and recreation. In the 2008 Games held in Cowichan, British Columbia, the federal government and host provincial government each contributed 35% of the total budget, to a maximum of \$3,500,000, with the host society and municipal/regional government being responsible for the balance of the budget (Canadian Heritage, 2003).

In addition, at an August 2009 meeting of federal, provincial and territorial ministers

who are responsible for sport, physical activity and recreation, there was agreement to provide funding for Aboriginal athletes to "travel to future North American Indigenous games," wherever these might be (Nation Talk, 2009a).

Integrated Pan-Canadian Healthy Living Strategy

The Public Health Agency of Canada's Integrated Pan-Canadian Healthy Living Strategy is an "intersectoral initiative designed to improve health outcomes and reduce disparities in health status in Canada" (PHAC, 2003, What is the Integrated Pan-Canadian Healthy Living Strategy? para. 1). It commits the federal, provincial and territorial governments to work together in a collaborative and coordinated way to reduce non-communicable diseases by addressing their common risk factors and the underlying societal conditions that contribute to them (Secretariat for the Intersectoral Healthy Living Network et al., 2005). The strategy aims to obtain a 20% increase in the proportion of Canadians who are physically active, eat healthy, and have healthy body weights.

While the strategy targets the population of Canada as a whole, particular emphasis is placed on children and youth, and on certain population groups such as Aboriginal peoples. The Aboriginal component of the Healthy Living Strategy included input from Aboriginal people. A great many initiatives have been undertaken by the federal, provincial and territorial governments in support of the strategy, including many that specifically target Aboriginal populations (for example, see those listed in PHAC, 2010).

The strategy was endorsed by federal, provincial and territorial health ministers in 2005 (PHAC, 2008). Information on budgets could not be readily obtained from Internet sources.

Food Mail Program

In northern and remote communities, lack of local food availability and the high costs of transporting nutritious foods are significant barriers to a nutritious diet. In response, the federal government works to promote food security, reduce retail costs and ensure access to safe, quality, affordable food in northern communities through its Food Mail Program.³⁴ This program is a collective effort between INAC, the federal government and Canada Post to provide nutritious, perishable food and other essential items to isolated northern Aboriginal communities at reduced postage rates. More than 18 million kilograms of food are shipped annually to more than 70,000 people across the North, and the program is growing every year. INAC provides approximately \$45 million per year in subsidies for the program. The Food Mail Program also conducts surveys to measure nutrition and food costs in the parts of Canada that are primarily serviced by air (INAC, 2008b).

Communicable diseases

Two communicable diseases that have a tremendous impact on Aboriginal individuals, families and communities are HIV/AIDS and tuberculosis (TB). While incidence rates of HIV have decreased among the Canadian population generally, they have been steadily increasing among First Nations and Inuit populations, in part due to increased risk factors such as poverty, substance use, injection drug use, sexually transmitted infections and limited access to health services (Health Canada, 2010c). Likewise, TB rates have fallen dramatically among the Canadian population generally, yet Aboriginal Canadians continue to be overrepresented among TB cases at a rate of almost four times that of the Canada-wide rate (Canadian Tuberculosis Committee, 2002).

³⁴ This program was replaced in April 2011 by the Nutrition North Canada Program.

To address these communicable diseases, the federal government has committed funding through both Health Canada and the Public Health Agency of Canada for HIV/AIDS and TB prevention and control across Canada. In recognition of the impact both of these diseases are having among Aboriginal populations, Health Canada, through FNIHB, works to reduce incidence rates among First Nations on-reserve and Inuit communities. The following programs and initiatives are funded by the federal government and its agencies and departments to target HIV/AIDS and TB.

Federal Initiative to Address HIV/AIDS in Canada – FNIHB Component

The Federal Initiative to Address HIV/AIDS in Canada was launched in January 2005 and replaced the Canadian Strategy on HIV/AIDS. The initiative is a key element of the federal government’s comprehensive approach to HIV/AIDS and provides funding for “prevention and support programs reaching vulnerable populations, as well as research, surveillance, public awareness, and evaluation” (PHAC 2007b). The Public Health Agency of Canada is responsible for overall coordination of the initiative across Canada, while Health Canada’s FNIHB is responsible for community-based HIV/AIDS education, prevention and related services for First Nations on-reserve and some Inuit communities. The objectives of the FNIHB component of the initiative are to:

- increase knowledge of the HIV/AIDS epidemic within First Nations on-reserve through improved community-based knowledge development, improved analysis of surveillance data, and improved translation of knowledge into practice
- increase the availability of evidence-based HIV/AIDS interventions based on analysis of regional project results, trends in epidemiological data, and research findings generated through

other Aboriginal-specific funding streams under the Federal Initiative to Address HIV/AIDS in Canada

- increase awareness and reduce the stigma within communities to promote testing, access to prevention, education and support, and supportive social environments for those vulnerable to and living with HIV
- strengthen partnerships within FNIHB and provincial governments in order to increase access to care and support for First Nations living with HIV/AIDS
- increase effective collaboration of current and new partners towards the achievement of a coordinated and integrated response to HIV/AIDS at regional, national and international levels (Health Canada, 2007b).

At start-up in 1998, \$2.4 million was allocated by the federal government in support of HIV/AIDS programs for First Nations, Inuit and/or Métis with HIV/AIDS (Native Management Services & PHAC, 2005). This amount has been steadily increasing. While no current budget information is readily available, FNIHB reportedly spent \$2.5 million on the First Nations and Inuit component of the initiative in 2006/07 (PHAC, 2007c).

Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project Fund

The Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project Fund (the Non-Reserve Fund) is one of eight current grants and contributions programs under the Federal Initiative to Address HIV/AIDS in Canada aimed at strengthening Canada’s response to the HIV/AIDS epidemic. The Non-Reserve Fund has three main priorities: to build on existing work being done in the community, to enhance partnerships and sustainability, and to make HIV/AIDS a part of the work done by existing Aboriginal services and agencies that may not currently do this type of work (Native Management Services & PHAC, 2005). All projects funded by the Non-Reserve

Fund benefit non-reserve Aboriginal communities.

The Non-Reserve Fund focuses on sexual health and/or injection drug use harm reduction initiatives in vulnerable populations, with an emphasis on holistic and culturally appropriate program delivery and participation of Aboriginal peoples living with HIV/AIDS in programs and education (Health Canada, 2007b). The fund is administered by the Public Health Agency of Canada. Funding for projects is allocated through a competitive request for proposals, which has been issued every two years since the initial call for proposals in 2000 (Native Management Services & PHAC, 2005). The initial budget for projects under this fund was \$1.2 million (half of the amount originally allocated to support the Aboriginal component of the Canadian Strategy on HIV/AIDS). This amount has been increasing over the years and was \$1.68 million annually from 2006 to 2008 (Health Canada, 2007b).

Tuberculosis (TB) Prevention and Control Program – First Nations and Inuit component

Tuberculosis affects a greater percentage of Aboriginal Canadians than of other Canadians, in part due to the lower socio-economic levels of many Aboriginal people in Canada (Health Canada, 2009a). The TB Prevention and Control Program is one element of Canada’s National Tuberculosis Elimination Strategy, introduced in 1992. While the Public Health Agency of Canada assumes overall responsibility for the TB Prevention and Control Program, the FNIHB oversees the component of the program targeted at First Nations living on-reserve and Inuit living in Labrador (Nunatsiavut). The program is delivered through primary health services at the community (on-reserve) level (Health Canada, 2010e).

The primary objectives of the program are to:

- reduce the incidence of TB infections in First Nations and Inuit communities to 3.6 cases per 100,000 by 2015
- detect and diagnose TB infections among those exposed to infectious cases and prevent the spread of the disease to other people in the community
- provide treatment to those with active and latent disease, prevent the emergence of drug resistance and achieve life-time control of the individual's TB infections
- support health care workers and communities in the prevention and control of TB infections at the community level by supporting awareness activities and promoting understanding of TB (Health Canada, 2007b).

Budget information for this program is not readily available from Internet sources.

Targeted Immunization Strategy

The Targeted Immunization Strategy was developed and implemented by the FNIHB to improve coverage rates for routine immunizations. The strategy was specifically targeted at First Nations children who live on-reserve or in Inuit communities who are under the age of 6. Objectives of the strategy were to improve coverage rates for routine immunizations, moving them towards the international target of 95%; reduce vaccine-preventable disease incidence, outbreaks and deaths; and develop an integrated immunization surveillance system (Health Canada, 2007b). Additional goals were to implement newly recommended vaccines programs (varicella, conjugate pneumococcal, conjugate meningococcal C) for these populations, improve the data on and understanding of immunization coverage rates, reduce the incidence of vaccine-preventable diseases, reduce barriers to immunization, and increase use of best practices in implementation (Health Canada, 2007b).

The strategy was announced in 2003 with a budget of \$32 million allocated over a five-year period (Stout & Harp, 2009). Despite a completion date of March 2008, the strategy continued for at least one more fiscal year (2008/09), though no further information beyond this date is readily available.

Environmental health

Indian and Northern Affairs Canada (INAC) is responsible for ensuring that environmental health standards are met in Aboriginal communities throughout Canada, including a safe water supply (INAC, 2009a). The following programs and initiatives are funded by the federal government, through INAC, to target environmental health.

First Nations Water Management Strategy

The First Nations Water Management Strategy is a collaborative effort of First Nations communities, Health Canada and INAC. The seven-part strategy aims to address urgent waste water and drinking water issues in First Nations communities, focusing on:

- upgrading and building water and waste-water facilities to meet established design, construction and water quality standards, with a priority on identified facilities
- creating an effective water quality monitoring program combined with a comprehensive and coordinated compliance and reporting regime that will improve the detection of drinking water problems in a timely manner
- establishing an effective and sustainable operation and maintenance program
- planning for the continued expansion and enhancement of training programs
- developing integrated water quality management protocols with clearly defined roles and responsibilities
- outlining a comprehensive set of clearly defined standards, protocols and policies, using a multi-barrier approach (INAC, 2008a).

The strategy operated on a five-year plan from 2003 to 2008, with a budget of \$1.6 billion (INAC, 2008a). There is currently no information readily available on the Internet to indicate whether the strategy is still in place.

Northern Contaminated Site Program and Northern Contaminants Program

INAC funds and administers two programs targeted at improving the Arctic ecosystem and helping Aboriginal communities make informed decisions about their food choices (INAC, 2009b, 2006). The first of these, the Northern Contaminated Sites Program, was launched during the late 1990s as a means of cleaning up the Arctic environment after mining and military operations. The objective of the program is "to reduce and eliminate, where possible, risks to human and environmental health, and liability associated with contaminated sites in the North" in a cost-effective and efficient manner (INAC, 2009b). The program is primarily funded through the Federal Contaminated Sites Action Plan, with additional funding provided by INAC. In 2006/07, \$110.9 million was spent on the program (INAC, 2007).

The second program, the Northern Contaminants Program, was launched in 1991 to ensure that the wildlife that is part of the traditional Aboriginal diet is safe for consumption. The key objective of the program is to "work towards reducing, and where possible, eliminating contaminants in traditional/country foods, while providing information that assists individuals and communities in making informed decisions about their food use" (INAC, 2006, 2). Information on budget allocations for the program could not be readily obtained through Internet sources; however, funding for the program is shared by INAC and Health Canada.

Environmental Public Health Program

The Environmental Public Health Program was established by the federal

government to identify and prevent environmental public health risks that could affect the health of residents in First Nations communities south of the 60th parallel (Health Canada, 2008b). North of the 60th parallel, this responsibility has been transferred to either territorial governments or to First Nations and Inuit control as part of land claim agreements. Activities funded under this program are delivered according to the needs of communities. They may include inspections, training sessions and public education in the areas of drinking water, food safety, health and housing, waste water, solid waste disposal, communicable disease control, and environmental contaminants, research and risk assessment (Health Canada, 2008b).

Budget information for this program is not readily available on the Internet.

Urban Aboriginal health programs and initiatives

The federal government provides a limited number of health programs and initiatives for urban Aboriginal populations, including off-reserve First Nations, Inuit and Métis.

Aboriginal Friendship Centre Program

There is currently a network of 117 Aboriginal friendship centres across the country, with seven provincial and territorial associations and a National Association of Friendship Centres, providing culturally enhanced programs and services to urban Aboriginal people (National Association of Friendship Centres [NAFC], 2010). The centres play a vital role in improving the quality of life for Aboriginal peoples by offering a range of health and wellness programs, broadly conceptualized. The importance of these centres in providing quality services in the communities they serve was recognized by the federal government in 1972 when it implemented the Migrating Native Peoples Program and began directing funds to the program

(NAFC, 2010). In 1988, the centres received permanent core funding from the Department of the Secretary of State. Administrative responsibility for the Aboriginal Friendship Centre Program rested with Canadian Heritage until 1996, when it was transferred to the National Association of Friendship Centres (NAFC, 2010).

Since 1996, the Aboriginal Friendship Centre Program has received \$16.1 million annually to maintain its centres across the country. This funding has been used to deliver 1,200 programs and services worth almost \$108 million to almost one million participants (German, 2009). Additional funding for these programs is secured by leveraging funding from other provincial, territorial, regional and municipal governments. The health programs and initiatives offered by Aboriginal friendship centres differ widely across the country. (More information is included in Chapter 4, Provincial and Territorial Health Programs and Initiatives.)

Cultural Connections for Aboriginal Youth (formerly Urban Multipurpose Aboriginal Youth Centre Program)

Heritage Canada's Urban Multipurpose Aboriginal Youth Centre program aims to provide accessible, community-based, culturally relevant projects for Aboriginal youth. Among other things, funded projects focus on health, life skills, and personal or cultural development, and can include providing or increasing access to indoor and outdoor sports and recreation events, sex education and addictions awareness, and health and safety workshops (Canadian Heritage, n.d.). To qualify for funding, projects must be located in an off-reserve, urban or northern community with a population over 1,000. Projects must also meet the needs of urban Aboriginal youth aged 15-24 (though youth aged 10-14 and young adults aged 25-29 may also be included). Not-for-profit Aboriginal

organizations, societies and community groups; Aboriginal academic institutions; Aboriginal cultural, educational and recreational organizations or centres; and Aboriginal youth and women's organizations are eligible to receive funding for projects under this program (Canadian Heritage, n.d.). Many of these projects are funded through provincial or territorial Aboriginal friendship centres.

The program was launched in February 1999 and was initially approved to March 31, 2003. However, the program has been extended at least twice since that time –first to March 31, 2005 (Canadian Heritage, n.d.) and then to 2010 (Nation Talk, 2009b). The program recently changed its name to “Cultural Connections for Aboriginal Youth” (Canadian Heritage, 2010b). No information is readily available regarding an annual budget for this program, though a November 8, 2010, press release did commit the government to an additional \$75,250 for this program (Canadian Heritage, 2010b). (More information on the youth projects is included in Chapter 4, Provincial and Territorial Health Programs and Initiatives.)

Urban Aboriginal Strategy

According to the 2006 census, more than half of Canada's Aboriginal population resides in urban areas (INAC, 2010b). The federal government developed its Urban Aboriginal Strategy in 1997 to help address the needs of Aboriginal people living in urban centres. The aim of the strategy is to promote self-reliance and increase life choices for Aboriginal people in key centres across Canada (INAC, 2009c). Projects must respond to local priorities and advance at least one of three national priority areas: improving life skills; promoting job training, skills and entrepreneurship; and supporting Aboriginal women, children and families (INAC, 2009d). Thirteen centres have been identified as priority cities in the strategy: Vancouver, Prince George,

Table 3.1: Urban Aboriginal Strategy projects, by province, 2008/09

Province	Number of projects	Total expenditures
British Columbia	30	\$1,376,218
Alberta	33	2,322,922
Saskatchewan	30	2,039,530
Manitoba	43	2,034,083
Ontario	19	1,125,244
Total	155	\$8,897,997

Source: Calculated from INAC, 2010d

Lethbridge, Calgary, Edmonton, Prince Albert, Regina, Saskatoon, Thompson, Winnipeg, Thunder Bay, Toronto and Ottawa (INAC, 2010c).

Projects identified as local priorities are funded through federal government partnerships with other governments, community organizations and Aboriginal people (INAC, 2009c). In 2008/09, 155 projects across Canada received federal funding of nearly \$9 million (see Table 3.1). (More information about these projects within each province can be found in Chapter 4, Provincial and territorial Health Programs and Initiatives.)

3.4 Summary

This chapter summarizes major programs (or targeted components of programs) that are funded and administered by the federal government and its agencies/departments specifically for Aboriginal peoples. The summary is not intended to be comprehensive. It does not include the transfer of funds from the federal government for the building of infrastructure or for First Nations communities to develop their own health programs and services. Also excluded are programs and initiatives that may indirectly improve health and well-being, such as those that relate to Aboriginal

economic development or justice, and those that are available to all Canadians, including Aboriginal peoples.

It is clear from this summary that some health issues facing Aboriginal peoples are well recognized by the federal government, and are being addressed through the development of specific programs and initiatives. Most notably, a number of programs specifically target the healthy development of infants and children, and there are some prominent programs to address the issues of obesity, cardiovascular disease and diabetes (the Aboriginal Diabetes Initiative and a number of programs related to physical activity and nutrition, for example). There are, however, a number of noticeable gaps in the programs and initiatives provided to address other prominent health issues identified in the literature, such as cancer, injury, mental health problems, respiratory illness, and use of tobacco. There are also few federal programs and initiatives available for Métis and urban Aboriginal populations.

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Chapter 4:

PROVINCIAL AND TERRITORIAL ABORIGINAL HEALTH PROGRAMS AND INITIATIVES



The provinces and territories are responsible for providing health care services for First Nations people living off-reserve, Métis, those not eligible for registration, and Inuit people not living within their traditional territories. They are also responsible for hospital care and primary health care services for all Aboriginal peoples, including First Nations on-reserve and Inuit (Health Canada, 2009b). This chapter presents health-related programs and initiatives for Aboriginal peoples in each province and territory in Canada; the programs and initiatives included were identified through a search of the Internet and were in place in 2009.³⁵

The provision of health care for Canada's Aboriginal population is very complex, and a great many programs and initiatives aimed at improving Aboriginal peoples' health are available across the country. Multiple levels of government may work in partnership with each other and with Aboriginal governments and organizations to implement health initiatives and deliver health programs and services. In this chapter, therefore, for each province and territory, there are two general sections: health-related programs and initiatives

funded and administered directly by provincial and territorial governments and those that are provided through alternative and more complex arrangements.

Health-related programs and initiatives funded and administered directly by provincial and territorial governments were identified through a search of health and Aboriginal Affairs ministry websites and reports and are included in each province's and territory's profile. They were limited to those identified by governments as being a health-related concern and applied to all Aboriginal people living within their jurisdiction. Thus, if programs and initiatives were not identified as a health-related concern, if they were administered by non-profit Aboriginal organizations or governments, or if their scope applied only to particular regions, they were excluded from this section of the province's or territory's profile. Every effort was made to identify relevant health-related programs and initiatives; however, this is a difficult undertaking because the framework for providing health programs and initiatives for Aboriginal peoples is not uniform across provinces and territories. As such, this chapter is not necessarily inclusive of all programs and initiatives available.

The second section for each province and territory focuses on examples of other types of programs and initiatives available to improve the health of Aboriginal peoples. It is organized into three sub-sections:

- The first sub-section focuses on examples of health programs and initiatives that are more regional in scale, such as those offered by regional health districts or by Aboriginal organizations within certain regions. This may include programs and initiatives where provincial and/or federal funding could not be identified.
- The second sub-section focuses on examples of health programs and initiatives that emerged through a more complex arrangement involving federal partnerships with the provincial or territorial government and/or Aboriginal organizations.
- The third sub-section focuses on health programs and initiatives available through the province's or territory's friendship centres. Friendship centres play a significant role in improving the health of the urban Aboriginal population either directly, through health programs and services, or indirectly, through focusing on the socio-economic determinants that

³⁵ The initial search for programs was undertaken in 2009 and the programs listed herein were in place in that year. However, subsequent revisions to this document and the need to verify information, sometimes through updated Internet web pages, means that citation dates may be after 2009.

often lead to poor health. They receive significant funding from federal and/or provincial or territorial levels of government.

The examples provided in this section were identified through government and non-government Internet sources, using search terms that included “Aboriginal,” “health,” “program,” “initiative,” “strategy” and the name of the relevant province or territory. The section is not meant to be inclusive of every program and initiative available, but rather simply to illustrate the diversity of health-related programs and initiatives available within the provinces and territories.

There is a great deal of diversity in the terminology used and ambiguity in how those terms are applied; for example, the terms “programs,” “initiatives” and “services” are often used interchangeably. For the purposes of this chapter, the term “initiatives” refers to strategic directions of provincial and territorial governments; “programs” refers to health-related services or projects initiated by governments directly or indirectly through other departments, agencies or Aboriginal organizations; and “services” refers to professional activities by individuals to address specific health issues.

This chapter focuses on programs and initiatives only, and includes only those available at the time the Internet search was conducted early in 2009.³⁶ It provides a brief description of the goals or objectives of each program or initiative.

4.1 British Columbia

In 2006, the governments of British Columbia, Canada and the First Nations Leadership Council of British Columbia developed a 10-year Tripartite First Nations Health Plan. The plan

was based on the 2005 Transformative Change Accord and identifies 29 actions that might be taken to alleviate health disparities between First Nations and non-First Nations people in British Columbia (First Nations Leadership Council, Government of Canada & Government of British Columbia, 2007). Part of the mandate of the Tripartite First Nations Health Plan was to create a First Nations Health Council, with representatives from the province’s First Nations, which would serve as an advocate for First Nations in health-related matters (First Nations Leadership Council et al., 2007). The First Nations Health Council’s Health Advisory Committee reviews the Aboriginal health plans that have been developed by each of British Columbia’s six regional health authorities, monitors health outcomes in First Nations communities and recommends actions that can be taken to close the health gaps (First Nations Health Council, British Columbia [BC] Ministry of Healthy Living and Sport, & Health Canada, BC Region, 2009).

The primary focus of the 2005 Transformative Change Accord is on health promotion and disease and injury prevention, while the Tripartite First Nations Health Plan outlines the nature of the collaborative partnership and defines the principles that underscore the development of a new governance system to address systemic change (First Nations Leadership Council et al., 2007). Under the Tripartite First Nations Health Plan, the provincial government committed to spending \$14 million annually on improving Aboriginal peoples’ health status (Government of BC, n.d.-b). Currently, advancements are being made in areas such as governance, injury, prevention, e-health, and maternal and child health (First Nations Health Council et al., 2009).

Programs and Initiatives Funded and Administered by the Provincial Government

Health programs and initiatives for Aboriginal people in British Columbia can be initiated on a broad, province-wide scale through the provincial health ministry or on a regional scale through regional health authorities that receive their funding from the provincial government. Of those programs and initiatives that are funded and administered directly by the provincial government through its health ministry, most focus on providing culturally appropriate health care, early childhood development programs and broad-based health promotion initiatives.

Culturally appropriate health services

The government of British Columbia has undertaken several programs and initiatives to ensure that health services are provided to Aboriginal peoples in a culturally appropriate way. These programs and initiatives focus on strategies to increase the numbers of Aboriginal nurses and to ensure that Aboriginal perspectives are incorporated into the Tripartite First Nations Health Plan.

Aboriginal Nursing Strategy

The government of British Columbia has invested \$2 million in its Aboriginal Nursing Strategy to increase the number of nurses of Aboriginal ancestry working in British Columbia and the number of Aboriginal communities in the province with quality nursing care (BC Ministry of Health Services, 2010).

Aboriginal Health Physician Advisor

In 2007, the British Columbia government appointed its first Aboriginal Health Physician Advisor. The Aboriginal Health Physician Advisor has specific responsibility for monitoring and reporting on the health of British Columbia’s

³⁶ The initial search for programs was undertaken in 2009 and the programs listed herein were in place in that year. However, subsequent revisions to this document and the need to verify information, sometimes through updated Internet web pages, means that citation dates may be after 2009.

Aboriginal population and tracking progress against performance measures in the Tripartite First Nations Health Plan (BC, Office of the Premier, 2007).

Early childhood development

Early childhood development programs can play an important role in improving the health and well-being of Aboriginal children by instilling an interest in lifelong learning, which can improve educational outcomes and help to reduce the socio-economic disparities that can lead to poorer health outcomes later in life, and by fostering healthy living practices.³⁷ The government of British Columbia has recognized the importance of early childhood development by implementing several Aboriginal programs and initiatives, including the Aboriginal Infant Development Program, Aboriginal Supported Child Development Program and Aboriginal Early Childhood Development Program. In addition, a preschool vision screening initiative aims to identify vision problems early in childhood so that these problems do not become a barrier in a child's ability to learn.

Aboriginal Infant Development Program

The Aboriginal Infant Development Program provides voluntary, family-centred and culturally relevant supports and services for families of children up to school entry age who have or are at risk of developmental delays (Government of BC, n.d.-c). It is currently offered in 44 locations across the province.

Aboriginal Supported Child Development Program

The Aboriginal Supported Child Development Program assists families of children who require extra support to access inclusive child care, enabling children who have special needs to interact and develop along with their peers, and allowing their parents or caregivers to

participate in the workforce or pursue their own education (Government of BC, n.d.-d). The program is currently available in 20 communities, with another 35 communities developing the program to fit their needs (Government of BC, n.d.-d).

Aboriginal Early Childhood Development Program

The Aboriginal Early Childhood Development Program focuses on increasing the health and well-being of Aboriginal children by strengthening the capacity of Aboriginal communities to deliver a full range of services with an emphasis on early childhood development (Government of BC, n.d.-a). The program is currently available in 43 locations across the province.

Aboriginal Preschool Vision Screening Initiative

The Aboriginal Preschool Vision Screening Initiative is a component of a larger province-wide initiative, announced in 2005, to provide universal hearing, dental and vision screening to every child in British Columbia under the age of 6 (Government of BC, 2010; Aboriginal ActNow, 2009). The provincial government provided funds to the National Collaborating Centre for Aboriginal Health to support the Aboriginal component of the initiative in 2006. The initiative focuses on early intervention and treatment of Aboriginal children for common vision conditions, including strabismus, amblyopia and refractive errors (Medterms.com, 2004).

Health promotion

A major thrust of the government of British Columbia's strategy to improve the health of Aboriginal populations has been to target the risk factors that often underlie poor health by promoting healthy and active lifestyles. Two major province-wide health promotion initiatives are currently being undertaken: Aboriginal

ActNow and the Honouring Your Health Challenge.

Aboriginal ActNow BC

Aboriginal ActNow BC is a health promotion initiative launched in 2005 supporting healthy choices in the four pillars of health: nutrition, physical activity, pregnancy and tobacco use (Aboriginal ActNow, n.d.). This initiative is a collaboration of ActNow BC, First Nations communities, the First Nations Health Council, the National Collaborating Centre for Aboriginal Health, the Métis Nation British Columbia, the British Columbia Association of Aboriginal Friendship Centres, and regional health authorities. It is aimed at preventing chronic diseases, such as high blood pressure and diabetes, among British Columbia's Aboriginal populations (Aboriginal ActNow, n.d.).

Honour Your Health Challenge

The Honour Your Health Challenge is a community-based health initiative designed to encourage healthy and active lifestyles. It began as an Aboriginal tobacco reduction program in 2000 but has expanded to include the four pillars of health (Aboriginal ActNow – Honouring Our Health, n.d.). The program is funded by the province's Ministry of Health, Aboriginal Health Branch, and supports individual, community, and elementary and high school healthy lifestyle challenges. It also features the Sun Run Aboriginal InTraining Program, a 13-week program that supports individuals in preparing for the annual 10-km Sun Run in Vancouver.

Alternative Mechanisms for Providing Health Programs and Initiatives

In addition to the Aboriginal programs and initiatives implemented by the government of British Columbia on a province-wide scale, there are a number of programs and initiatives that are more

³⁷ For more information about the relationship between early childhood development and health, please see Chapter 2.

regional or local in scale or that are federal initiatives administered provincially and/or through Aboriginal organizations such as the British Columbia Aboriginal Friendship Centre Association. A number of innovative programs and initiatives have been implemented in British Columbia to improve the health of the Aboriginal population. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in British Columbia to improve the health of its Aboriginal population.

Local and regional examples

Individual regional health authorities have many programs and services to meet the specific needs of Aboriginal people within their service areas. These typically include programs, initiatives or services that improve engagement with Aboriginal communities, improve cultural competency of services, or increase effectiveness of services. A number of regional health authorities have Aboriginal liaison programs that act as a voice for Aboriginal people in interacting with health care staff and professionals, as well as community programs that focus on the specific health needs of Aboriginal people, including programs focusing on mental health, sexual abuse intervention, HIV/AIDS, home and community care, child development, and addictions. For example, the Aboriginal Health Initiative Program is offered in several regions, including the Northern Health Authority. In addition, the government of British Columbia has invested money directly to support at least one unique initiative that will be administered by a First Nations band: the Stehiyáq Healing and Wellness Village in the Chilliwack area.

Aboriginal Health Initiative Program

Northern Health has administered the Aboriginal Health Initiative Program

since 2002. Approximately \$6.4 million in funding has supported 196 projects specifically targeted at Aboriginal health (Northern Health, 2010). These projects incorporate traditional culture and practices and are designed to assist communities in developing health initiatives that meet their needs. They can include holistic wellness; mental health; addictions; youth, Elders', men's and/or women's wellness; residential school recovery; chronic disease management and education; HIV/AIDS awareness; suicide awareness and prevention; grief and loss support; or a combination of these (Northern Health, 2010).

Stehiyáq Healing and Wellness Village

The provincial government has provided \$3 million in funding and a donation of land near Chilliwack for the Stehiyáq Healing and Wellness Village, a unique health facility that incorporates traditional healing practices with modern approaches (Government of BC, 2008). The village serves at-risk Aboriginal youth, ages 13-17, and their families, from all First Nations in the province. It is designed to help youth and their families who are struggling with addictions and have been victims of abuse, including residential school survivors (Stó:lō Nation, n.d.). The facility consists of 28 healing beds and accommodates 32 people, including staff. Residents have access to counselling and program space, kitchen and dining facilities, and indoor and outdoor recreation and healing space (Government of BC, 2008).

Federal examples

Several of the programs addressing Aboriginal health that are funded by the federal government (as described in Chapter 3) are administered by the provinces and territories or by Aboriginal organizations such as friendship centres. In British Columbia, examples of federal programs that are administered within the province include the Urban Aboriginal Strategy, initiatives that meet the goals

of the Integrated Pan-Canadian Healthy Living Strategy, and a number of CPNP programs, in both the PHAC and FNIHB administered streams, which specifically serve the needs of First Nations, Inuit and Métis women and their infants. The provincial government has also provided core funding for the British Columbia Aboriginal Friendship Centre Program and contributed \$3.5 million to the North American Indigenous Games in 2008 (BC 2010 Olympic and Paralympic Winter Games Secretariat, 2008). Short descriptions of the Urban Aboriginal Strategy, the Pan-Canadian Healthy Living Strategy and the British Columbia Aboriginal Friendship Centre Association are provided below. (Since these are federal government initiatives, further information about them can be found in Chapter 3.)

Urban Aboriginal Strategy – British Columbia

Introduced by the federal government in 1999, the Urban Aboriginal Strategy aims to address the socio-economic challenges faced by many urban Aboriginal people. The government of British Columbia is responsible for making Urban Aboriginal Strategy funds accessible to two communities: Vancouver and Prince George. In Vancouver, health-related projects for 2008/09 included capacity-building programs such as the Aboriginal Front Door Society – HOW Program, which provided counselling sessions, traditional healing ceremonies and development of personal wellness and learning plans, as well as support for participants recovering from substance addiction; and an Aboriginal culture, life skills and health program delivered through West Coast Alternative School for high school students with FASD. In Prince George, health-related projects for 2008/09 included the Healing Our Elders program, the Fire Pit Cultural HIV/AIDS Prevention Program, and several capacity-building programs. (For more information about Urban Aboriginal Strategy projects

funded in British Columbia, please go to <http://www.ainc-inac.gc.ca/ai/ofi/uas/prj/stp5-eng.asp> [Indian and Northern Affairs Canada (INAC), 2010].)

Integrated Pan-Canadian Healthy Living Strategy – Aboriginal initiatives in British Columbia

In addition to the Aboriginal ActNow BC initiative identified earlier, the government of British Columbia has undertaken several health promotion initiatives that are designed to meet the objectives of the Integrated Pan-Canadian Healthy Living Strategy. While these initiatives are accessible across the province for the general population, they do have Aboriginal peoples as one of their focuses. For example, the Sport Participation Program seeks to increase child and youth participation in sport, with a particular focus on inner-city children and youth, Aboriginal youth, persons with disabilities and seniors (Public Health Agency of Canada [PHAC], 2010b). Similarly, the Active Communities Initiative, a cross-sectoral initiative focused on helping communities increase their physical activity levels by 20%, has Aboriginal communities as one of its focuses (PHAC, 2010b).

British Columbia Association of Aboriginal Friendship Centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. However, the British Columbia Association of Aboriginal Friendship Centres (BCAAFC), which represents British Columbia's 23 Aboriginal friendship centres, gets much of its core funding from the provincial government (BC Association of Aboriginal Friendship Centres [BCAAFC], 2010; Government of BC, n.d.-e).

BCAAFC is a partner in the Aboriginal Sport, Recreation and Physical Activity Partners Council, along with the First Nations Health Council and the Métis Nation British Columbia, which together developed the Aboriginal Sport, Recreation and Physical Activity (ASRPA) Strategy. ASRPA is a youth-focused strategy aimed at increasing the involvement of Aboriginal people and communities in sports and physical activities to achieve better health, fostering healthier lifestyles, and improving confidence and self-esteem. The five pillars of the strategy are active communities, leadership and capacity, excellence, system development, and sustainability (BCAAFC, 2010).

The BCAAFC also administers the federal Urban Multipurpose Aboriginal Youth Centres initiative (also known as Cultural Connections for Aboriginal Youth), the purpose of which is “to create a network of cultural connections to support Aboriginal youth” (BCAAFC, 2010). (More information about this program can be found in Chapter 3.)

4.2 Alberta

In 2000, the Alberta government implemented the Aboriginal Policy Framework, a cross-ministry initiative that sets out the government's policies with respect to First Nations, Métis and other Aboriginal people in Alberta. The framework reflects the government's commitment to working in partnership with Aboriginal governments, organizations and people to improve the health status and well-being of Aboriginal people, improve educational attainment and cultural appreciation, increase the participation of Aboriginal people in the Alberta economy, and clarify federal, provincial and Aboriginal roles and responsibilities (Government of Alberta, 2007). It calls for all government ministries, including Alberta Health and Wellness, to address Aboriginal issues in

their business plans and report on progress in their annual reports (Government of Alberta, 2000).

Alberta Health and Wellness, the provincial government ministry charged with health policy, standards, funding and evaluation, has implemented an Aboriginal Health Strategy, which “encourages partnerships among Aboriginal communities and health providers to improve the cultural appropriateness of health services, increase access to health services by Aboriginal people and increase the number of Aboriginal people working throughout the health system” (Canadian Heritage, 2009b, para. 15). The strategy provides funding for a variety of community-based, collaborative projects aimed at improving Aboriginal health. It also provides bursaries for Aboriginal students taking post-secondary education in any health field, with the goal of increasing Aboriginal participation at all levels of health care (Alberta Health and Wellness [AHW], 2000).

Programs and Initiatives Funded and Administered by the Provincial Government

Programs and initiatives specifically targeted at improving the health of Alberta's Aboriginal population are developed and implemented through either Alberta Health and Wellness, the provincial ministry responsible for health, or Alberta Health Services, the provincially funded body responsible for providing health services for the general Alberta population. Alberta Health and Wellness programs and initiatives for Aboriginal peoples have focused on addressing chronic and communicable diseases, while Alberta Health Services has focused on programs and initiatives that improve access to health services for Aboriginal people by making them more culturally relevant, and on mental health and addictions.

Communicable and chronic disease
An Internet search identified two programs and initiatives funded and administered directly by the provincial government for improving the health of the Aboriginal population. These focused on diabetes and on HIV.

Alberta Diabetes Strategy

The Alberta Diabetes Strategy is a 10-year plan initiated in 2003 by Alberta Health and Wellness to address diabetes prevention and health promotion. The strategy includes \$1 million in funding for “Aboriginal organizations and other key stakeholders to develop and implement a diabetes screening program for Aboriginal populations living off reserve” (AHW, 2003, p. 1).

Aboriginal HIV Strategy

Alberta’s Aboriginal HIV Strategy was initiated in 1996 with a goal of providing “a culturally appropriate approach to the prevention of HIV... as well as the care and support of Aboriginal people with HIV” (AHW, 2001, p. 30). The strategy was implemented by Alberta Health and Wellness in 2001 for a three-year period, after which ongoing responsibilities were delegated to key stakeholders in order to move some of the responsibility from Alberta Health and Wellness to Aboriginal communities, organizations and other provincial and federal governments. Since 2001, Alberta Health and Wellness has provided funding to the Alberta Community HIV Fund under the stewardship of the Alberta Community Council on HIV. Creating this pool of funding fulfills one of the goals of the Aboriginal HIV Strategy by providing links between Aboriginal-focused HIV/AIDS organizations and HIV/AIDS programs targeting the general population (Alberta Community Council on HIV, 2010; AHW, 2001).

Culturally relevant health services
Through Alberta Health Services, a number of programs and initiatives

have been put in place to make health services more accessible to the Aboriginal population. Two liaison programs are highlighted here: the Aboriginal Liaison Program and the Aboriginal Hospital Liaison Program.

Aboriginal Liaison Program

The Aboriginal Liaison Program “acts as a voice within the healthcare system to create awareness of aboriginal culture” (Alberta Health Services [AHS], 2011a). The program partners with Aboriginal friendship centres to improve Aboriginal peoples’ access to and understanding of the health system (AHS, 2011a).

Aboriginal Hospital Liaison Program

The Aboriginal Hospital Liaison Program provides a direct service to Aboriginal clients and their families to facilitate access to resources and to promote cultural understanding on the part of hospital staff (AHS, 2011b).

Mental health and addictions

Alberta Health Services works to identify and reduce barriers to the mental health system for Aboriginal people, and supports cross-regional and cross-ministry Aboriginal initiatives. Two such initiatives identified through an Internet search are an Aboriginal youth suicide prevention strategy and the Aboriginal Mental Health Framework.

Honouring Life: Aboriginal Youth and Communities Empowerment Strategy

The Honouring Life: Aboriginal Youth and Communities Empowerment Strategy evolved from the Aboriginal Youth Suicide Prevention Strategy, a cross-ministry initiative led by Alberta Health and Wellness and implemented in 2005 to address the high rate of suicide among Aboriginal children and youth (AHS, 2009b). The name change occurred in 2009 along with a shift in focus to “resiliency, empowerment and holistic wellness approaches, which are more culturally appropriate in addressing risk

factors of Aboriginal youth” (AHS, 2009b, p. 3). The strategy has three main goals: to support communities, identify strengths and build capacity to contribute to well-being and resiliency of Aboriginal youth and communities; to establish partnerships to support awareness, education and training in the areas of well-being and resiliency for Aboriginal youth and communities; and to establish partnerships to support research and evaluation that will inform future planning (AHS, 2009b, p. 9).

Aboriginal Mental Health Framework

In 2006, Alberta Health and Wellness developed its Aboriginal Mental Health Framework to provide strategic direction to health care providers on how to address Aboriginal mental health issues. The framework was developed as part of the Provincial Mental Health Plan Initiative, with feedback from multiple stakeholders, including representatives from the federal and provincial governments, researchers and various Aboriginal organizations (AHS, 2010; Alberta Mental Health Board, 2006).

Alternative Mechanisms for Providing Health Programs and Initiatives

In addition to the Aboriginal programs and initiatives implemented by the Alberta government on a province-wide scale, there are a number of programs and initiatives that are more regional in scale or that are federal initiatives administered provincially and/or through Aboriginal organizations such as the Alberta Aboriginal Friendship Centre Association. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Alberta to improve the health of its Aboriginal population.

Local and regional examples

As in British Columbia, many of the programs and initiatives available to the

Aboriginal population in Alberta are implemented by regional offices of the Alberta Health Service and apply only to Aboriginal people within that specific health region. They include programs and initiatives designed to improve access to health services for Aboriginal peoples, to improve effectiveness of service provision, and to serve the specific health needs of Aboriginal peoples in the service region. Three examples are described here: the Elbow River Healing Lodge in Calgary, the Aboriginal Diabetes program, and Population Health Aboriginal Community Health Representatives located in several regions.

Elbow River Healing Lodge

The Elbow River Healing Lodge provides culturally appropriate services and focuses on choice and increasing accessibility for Aboriginal populations within the Calgary and Area service region (AHS, 2009a). The lodge provides patients with a variety of types of care, including triage and assessment, education and lifestyle counselling, health examinations, coaching for self-care, Elder consultation, prenatal care, immunization, and foot and wound care (AHS, 2011d).

Aboriginal Diabetes Programs

In the Lethbridge and Edmonton areas,³⁸ Alberta Health Services regional offices have implemented Aboriginal diabetes programs that offer a variety of educational programs in order to meet the needs of Aboriginal people, and their families, who are living with diabetes. The programs support both traditional and Western lifestyles and treatment, and actively collaborate with regional Aboriginal Community Health Representatives and other neighbouring services. The goals of this program are to increase awareness, provide education on early detection, encourage self-care management, and prevent complications (AHS – Lethbridge and Area, 2007; AHS, 2011c).

Population Health Aboriginal Community Health Representative

The Population Health Aboriginal Community Health Representative is a position created by Alberta Health Services in some regions. For example, in the Lethbridge area, the representative acts as an advocate for Aboriginal clients and their families by providing health promotion and education through a wide range of culturally appropriate initiatives. Initiatives are directed at individuals, families, groups and communities, with community representatives working in close collaboration with other health professionals to ensure equitable health promotion and disease prevention for all Aboriginal people (AHS – Lethbridge and Area, 2007).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the provinces and territories, or by Aboriginal organizations such as Aboriginal Friendship Centres. This section presents examples of these types of programs in Alberta. The provincial government plays a role in administering the federal government's Aboriginal Diabetes Initiative, the Urban Aboriginal Strategy, the Integrated Pan-Canadian Healthy Living Strategy, and the Aboriginal Friendship Centres Program. In addition, the federal government has also funded a number of CPNP programs, in both the PHAC and FNIHB administered streams, which specifically serve the needs of First Nations, Inuit and Métis women and their infants. A brief summary will be provided here only for the Urban Aboriginal Strategy, the Integrated Pan-Canadian Healthy Living Strategy, and the Alberta Aboriginal Friendship Centre Association. (Since these are federal initiatives, more information about them can also be found in Chapter 3.)

Urban Aboriginal Strategy – Alberta

The federal Urban Aboriginal Strategy is implemented in three Alberta cities: Calgary, Lethbridge and Edmonton. In Calgary, health-related projects that received funding in 2008/09 included the Awo Taan Paediatric and Family Wellness Clinic, which provides comprehensive holistic health care for women and children; the Sunrise Youth and Family Program, which provides individual and family counselling, parenting skills training for caregivers, drug awareness education for children and youth, and promotion of healthy living choices for individuals with addictions problems; suicide prevention capacity-building for the Il Paa Taa Pii – Distress Centre; and the Oskayi Kiskinotahn Aboriginal Women's and Children's Program for prevention of domestic violence. Lethbridge projects funded in 2008/09 included Creating Safe and Healthy Communities workshops on abuse, neglect, harassment, violence, bullying, safety training, first aid and injury prevention training; and funding to relocate the Lethbridge Native Women's Transition House for women escaping violent family situations. In Edmonton, 2008/09 projects included the Circle of Safety Family Violence Program for women and children who were victims of family violence, and several capacity-building and cultural awareness programs. (For more information about funded Urban Aboriginal Strategy projects in Alberta, please go to <http://www.ainc-inac.gc.ca/ai/of/oi/uas/prj/stp5-eng.asp> [INAC, 2010].)

Integrated Pan-Canadian Healthy Living Strategy – Aboriginal initiatives in Alberta

The Alberta government has initiated a number of programs to meet the objectives of the Pan-Canadian Healthy Living Strategy to improve healthy eating and physical activity for the general population. However, at least one of

³⁸ There may be other regions that also offer this program.

these, the Alberta Healthy Living Fund Partnership, has Aboriginal peoples as one of its priorities, by supporting Treaty Six reserve schools in incorporating healthy eating, active living and mental health as one of its specific project outcomes (PHAC, 2010b).

Alberta Native Friendship Centre Association

The federal government provides financial support for Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. In Alberta, the Alberta Native Friendship Centre Association (ANFCA) receives financial support from both the federal and provincial governments to support the provision of health-related programs and services delivered by the 20 Aboriginal friendship centres in the province.

Province-wide health initiatives delivered through friendship centres include the Aboriginal Urban Diabetes Initiative and the New Dawn Rising Project (Alberta Native Friendship Centre Association [ANFCA], 2007a; 2007b).

As part of the Aboriginal Urban Diabetes Initiative, in 2009 ANFCA partnered with the Aboriginal Diabetes Wellness Program of Alberta Health Services – Edmonton Area to produce *The Sacred Circle*, “a set of culturally-relevant and age-specific type 2 diabetes resources for Alberta’s Aboriginal children ages 8-12 years old” (AHS & ANFCA, 2009). This project has now been concluded, but several Aboriginal friendship centres in Alberta continue to offer diabetes educational programming (ANFCA, 2007a).

The New Dawn Rising Project, funded by Health Canada from January 1, 2009, to March 31, 2010, involved background research related to drug addictions and the development of a community readiness assessment tool, in order for

new addictions prevention programs to be developed and delivered by friendship centres throughout Alberta in an integrated and culturally sensitive way (ANFCA, n.d.). Several friendship centres in Alberta now offer addictions support programs (ANFCA, 2007a).

ANFCA also administers the federal Urban Multipurpose Aboriginal Youth Centres initiative (also known as the Cultural Connections for Aboriginal Youth), designed “to provide urban Aboriginal youth with a wide range of culturally based projects, services and activities” (ANFCA, 2007a). (Further information about this program can be found in Chapter 3.)

4.3 Saskatchewan

Like the BC Government, the Government of Saskatchewan has been working to develop an approach that focuses on improving the standard of living and health care services for Aboriginal people in the province through systemic change. They have been working to develop a formal tripartite relationship with the Federation of Saskatchewan Indian Nations and the Government of Canada to more effectively address First Nations health issues in the province. In August 2009, the three parties signed a Memorandum of Understanding (MOU) on First Nations Health and Well-Being in Saskatchewan. The spirit and intent of the MOU is to improve the mental, physical, spiritual, emotional and traditional well-being of First Nation individuals, families and communities. The six priority areas to be addressed through the MOU are: chronic disease prevention and management, mental health and addictions, strengthening health human resources, improving health care system experience, long-term care, and engagement and involvement. Identifying and implementing collaborative solutions to address short- and long-term priorities will assist in addressing the gaps in services

that First Nations continue to encounter. Next steps for the MOU partners include drafting and implementing a 10 year First Nations health and wellness plan for Saskatchewan.

Developing a culturally safe and competent health care system has been a provincial government priority. In October of 2009, the province released recommendations from their Patient’s First Review of the Health Care System. Recommendations included that Regional Health Authorities and all healthcare organizations work with First Nations, Métis, Elders and patients to develop partnerships aimed at improving the health of First Nations and Métis people; and that the province, in collaboration with First Nations and Métis elders and other advisors, develop a culturally safe and competent health system that better serves First Nations and Métis citizens (Government of Saskatchewan, 2009). In 2008, the province’s Ministry of Health also entered into a Memorandum of Understanding on E-Health Initiatives in First Nations Communities with the Northern Inter-Tribal Health Authority and Health Canada’s First Nations and Inuit Health-Saskatchewan Region with the aim of improving access, quality and efficiency of health care to First Nations in the north through e-health initiatives (Sask. Ministry of Health, FNIIH – Saskatchewan Region, and NITHA, 2008).

Programs and Initiatives Funded and Administered by the Provincial Government

In addition to establishing a formal working relationship to improve Aboriginal health, the Saskatchewan government is developing programs and initiatives to improve the delivery of health services and make them more culturally appropriate, and to address issues related to mental health and women’s and maternal health (Government of Saskatchewan, 2007a). However, of the provincially funded and

administered programs and initiatives targeted specifically at Aboriginal peoples that were identified in an Internet search, none were province-wide in scale. Examples of these programs and initiatives are therefore provided in the “Alternative mechanisms” section below.

The provincial government’s 2004 Diabetes Plan, though not targeted specifically at the health of the province’s Aboriginal population, does have several Aboriginal-specific components. For example, under its goal of providing diabetes education for health care providers, one of the plan’s objectives is to establish processes to include the participation of educators and care providers from First Nations, Métis and Inuit communities in regional health authority plans so as to determine the best ways of providing services to this target group (Saskatchewan Health, 2004). Similarly, to meet its diabetes surveillance goals, the plan seeks Aboriginal peoples’ participation in the development of an electronic system intended to facilitate team-based management of diabetes.

Alternative Mechanisms for Providing Health Programs and Initiatives

A number of programs and initiatives have been implemented by the Saskatchewan government on a more regional scale for the province’s Aboriginal population, either directly through the Ministry of Health or through the various regional health authorities. In addition, there are programs and initiatives that stem from federal initiatives but that are administered by the provincial government and/or various Aboriginal organizations, such as the Saskatchewan Aboriginal Friendship Centre Association. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been

implemented in Saskatchewan to improve the health of the Aboriginal population.

Local and regional examples

This section presents three examples of regional health-related programs and initiatives targeted at Saskatchewan’s Aboriginal population: a suicide prevention strategy, a maternal care program, and the All Nations Healing Hospital.

Northern Saskatchewan Métis Youth Suicide Prevention Strategy

This project involves health regions in northern Saskatchewan, as well as the Ministry of Health, the Métis Addictions Council of Saskatchewan, and two universities (Government of Saskatchewan, 2007c). The goals of the project are to identify suicide risk among Métis youth in the northern part of the province, to work towards suicide prevention, and to provide input into the province’s anticipated mental health strategy (Government of Saskatchewan, 2007c).

Maternal Care Program

The Regina Qu’Appelle Health Region, the Five Hills Qu’Appelle Tribal Council and the All Nations’ Healing Hospital are involved in the Maternal Care Program. The primary goal of the program is to provide significant and continuous strengthening of the maternal health services of the All Nations’ Healing Hospital and community-based health services, with a primary focus on Aboriginal peoples. It is designed to improve pre- and post-natal outcomes by increasing capacity to identify childbearing clients at all levels of risk (Government of Saskatchewan, 2007c).

All Nations Healing Hospital

A unique feature of Saskatchewan’s health care landscape is the All Nations Healing Hospital (ANHH), located in Fort Qu’Appelle. The ANHH is an innovative healing facility with 14 acute-care beds, as well as a range of

services, including the All Nations’ Healing Centre (incorporating mental health and addictions and residential school support services, as well as family therapy), water quality testing, and access to traditional ceremonies, Elders and helpers (All Nations Healing Hospital, n.d.). The ANHH was built to replace the Fort Qu’Appelle Indian Hospital, and was funded by the federal and provincial governments, the Five Hills Qu’Appelle Tribal Council, and the hospital’s fundraising committee. The majority of ongoing funding comes from the Regina Qu’Appelle Health Region. The ANHH is located on-reserve and is owned and operated by the 34 First Nations that signed Treaty 4.

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by provincial or territorial governments or by Aboriginal organizations such as friendship centres. In Saskatchewan, the provincial government collaborates with Health Canada on several initiatives under the Aboriginal Health Transition Fund and on a First Nations Community Public Health Pilot Project. It plays a role in PHAC’s Integrated Pan-Canadian Healthy Living Strategy, and collaborates with Aboriginal Affairs and Northern Development Canada in the delivery of the Urban Aboriginal Strategy. It also provides tuberculosis prevention and control services to First Nations in the province (Government of Saskatchewan, 2007f). The federal government has also funded a number of community-based maternal and child health programs (through for example the Canada Prenatal Nutrition Program). Brief descriptions are provided below for only the Aboriginal Health Transition Fund, the Integrated Pan-Canadian Healthy Living Strategy, the First Nations Community Public Health Pilot Project, and the Urban Aboriginal Strategy. (Further information about them can be found in Chapter

3.) This section also profiles some of the health-related programs and services offered through Aboriginal Friendship Centres of Saskatchewan.

Aboriginal Health Transition Fund – Saskatchewan

Three examples of programs and initiatives funded through the federal government's Aboriginal Health Transition Fund³⁹ are described below. These programs and initiatives focus on enhancing coordination of health services through improved communication mechanisms, making services more culturally relevant in the area of mental health, and improved health service coordination in northern regions.

The "Adaptation of the Provincial Health System to Better Meet the Needs of Métis People in Prevention, Health Promotion and Health Environment – Métis Nations – Saskatchewan" project is a partnership between the federal government, the Métis Nation of Saskatchewan and the Saskatchewan Ministry of Health. The project is intended to improve communication between the Métis Nation of Saskatchewan and the provincial government in relation to health, as well as to develop the internal capacity of the Métis Nation of Saskatchewan for policy and strategy development in health care (Government of Saskatchewan, 2007b).

The Tri-First Nations' Sauleaux Healing Project is a collaboration of three Nakawé communities: Fishing Lake First Nation, Kinistin First Nation, and Yellow Quill First Nation (Fishing Lake First Nation, Kinistin Sauleaux Nation, & Yellow Quill First Nation, 2010). The first phase of the project developed a Cultural Framework concept, and the project is currently in its second phase, converting this concept to a program design and implementation plan. The intent of this phase is to find out whether, and how, it may be possible

to respectfully combine elements of best practices in health with best practices in Sauleaux healing so as to address the healing needs of Sauleaux and other First Nations families (Government of Saskatchewan, 2007e).

The Northern Health Strategy brings together 13 partner agencies to address common health challenges from across northern Saskatchewan. The primary goal of the strategy is to improve the health status of northern Saskatchewan residents by decreasing duplication of services and eliminating gaps between them (Government of Saskatchewan, 2007d; Northern Health Strategy, 2011). While the strategy does not focus specifically on Saskatchewan's Aboriginal population, it does have programs targeted specifically at this population, including mental health and addiction programs, and the transfer of health authority to approximately 21 First Nations.

Integrated Pan-Canadian Healthy Living Strategy – Aboriginal initiatives in Saskatchewan

Saskatchewan's targets for the Integrated Pan-Canadian Healthy Living Strategy are to increase the proportion of the Saskatchewan population who are physically active by 10% by 2010 (Secretariat for the Intersectoral Healthy Living Network et al., 2005). As part of this strategy, the provincial government has implemented some general province-wide initiatives, such as Saskatchewan in Motion, which is aimed at increasing physical activity for health benefits, and a population health promotion strategy called "Healthier Places to Live, Work and Play" (PHAC, 2009). Under "Healthier Places to Live, Work and Play," the provincial government has also implemented an Aboriginal Participation Initiative, "designed to build capacity and leadership for Aboriginal people through participation in sport,

culture and recreation activities" (Saskatchewan Health, n.d.). The initiative involves several key partners, including the Federation of Saskatchewan Indian Nations, the Métis Nation of Saskatchewan, the Northern Recreation Coordinating Committee, Sask Sport Inc., and the Saskatchewan Parks and Recreation Association (Saskatchewan Health, n.d.).

First Nations Community Public Health Pilot Project

In 2007, a multi-jurisdictional public health pilot project was initiated under the leadership and coordination of the Assembly of First Nations to help inform future directions in the delivery of on-reserve public health, leading to improved health outcomes and increased First Nations control over delivery of their own public health services (Assembly of First Nations, 2011). The pilot project is funded by Health Canada and will run for a period of five years in three provinces (Saskatchewan, Manitoba and Ontario). In Saskatchewan, the project is being carried out in Five Hills Qu'Appelle Tribal Council communities.

Urban Aboriginal Strategy – Saskatchewan

In Saskatchewan, the federal Urban Aboriginal Strategy has been implemented in the cities of Prince Albert, Regina and Saskatoon. The strategy funds a number of cultural awareness, capacity-building and health-related projects. Examples of health-related projects funded during in 2008/09 are, in Saskatoon, a chronic disease prevention initiative, support and housing for individuals with FASD, and the White Buffalo Youth Lodge Fitness-Food-Fun project, which assisted Aboriginal people living with diabetes and raised awareness on prevention; in Regina, the Prairie Spirit Connections – Tending the Fire Healing Project, which piloted the addition of a pre-employment development component to the Tending

³⁹ This fund has wound down in March 2011 and will be replaced by the Health Services Integration Fund.

the Fire Healing Project; and in Prince Albert, projects to develop youth judo skills and provide transitional housing for abused women. (For more information about funded Urban Aboriginal Strategy projects in Saskatchewan, please go to <http://www.ainc-inac.gc.ca/ai/ofi/uas/prj/stp5-eng.asp> [INAC, 2010]).

Aboriginal Friendship Centres of Saskatchewan

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. Programs administered by the Aboriginal Friendship Centres of Saskatchewan include the Urban Multipurpose Aboriginal Youth Centres initiative and the Young Canada Works program, both of which are funded by the federal government (Aboriginal Friendship Centres of Saskatchewan, n.d.).

While these programs are not directly health-related, activities run through the Friendship Centre Program and the Urban Multipurpose Aboriginal Youth Centres initiative often promote physical activity and foster cultural identity, leading to better health and well-being. In addition, programs like Young Canada Works attempt to reduce inequities that can lead to poorer health. Information on whether the Aboriginal Friendship Centres of Saskatchewan receives any provincial funding to support its programs and services could not readily be obtained on the Internet.

4.4 Manitoba

Since 2003, the Government of Manitoba has been working in partnership with First Nations and federal departments through the Intergovernmental Committee on Manitoba First Nations Health (ICMFNH). Their mandate is to

identify approaches to improve the health of First Nations people in Manitoba and ‘close the gap’ between health outcomes of First Nations and non-First Nations Manitobans. The goal of the ICMFNH is to address key issues affecting the health and well-being of First Nations citizens. It works to achieve this goal through developing innovative and sustainable strategies and solutions to ensure equity of health outcomes comparable to that of other Canadians. The committee funds studies in identified priority areas and works toward policy changes based on findings (Assembly of Manitoba Chiefs, 2010a). It has made recommendations that include an overview of gaps in service and issues associated with jurisdiction, and a financial analysis of current health care expenditures for First Nations health care in Manitoba (Health Council of Canada, 2007).

In addition to participating in the Intergovernmental Committee on Manitoba First Nations Health, the Manitoba government has been developing the Manitoba Blueprint on Aboriginal Health to close the health gaps between the Aboriginal and non-Aboriginal populations. However, since development of the blueprint document has not included input from First Nations, Manitoba’s First Nations have developed their own health and wellness strategy (Assembly of Manitoba Chiefs, 2006). The Manitoba First Nations Health and Wellness Strategy envisions improved health status for Manitoba First Nations within a framework of First Nations–controlled and administered health and social services, and building inter-sectoral, inter-departmental and inter-governmental relationships (Assembly of Manitoba Chiefs, 2006).

Programs and Initiatives Funded and Administered by the Provincial Government

The Manitoba government funds and administers programs, initiatives and

services for its Aboriginal population either through Manitoba Health and its affiliated regional health authorities or through Manitoba Aboriginal and Northern Affairs. An Aboriginal and Northern Health Office, established through Manitoba Health, works in partnership with multi-sector stakeholders to improve Aboriginal health (Manitoba Health, n.d.-b). The office’s responsibilities include recognizing and respecting the diversity of Aboriginal cultures, languages and traditions, and the mandates and jurisdictions of Aboriginal groups in Manitoba; providing insight into Aboriginal culture and awareness of Aboriginal wellness practices; working in partnership and acting as a liaison with other jurisdictions; analyzing evidence-based research and best practices; and consulting with various groups and assisting in the development of Aboriginal strategies, policies and health education training programs (Manitoba Health, n.d.-b).

Province-wide health-related programs and initiatives funded and administered directly by the provincial government for the Aboriginal population address communicable and chronic disease, health human resources, maternal and child health, and mental health and addictions.

Communicable and chronic disease

Two province-wide health-related programs and initiatives targeting Manitoba’s Aboriginal population were identified in an Internet search. They focus on HIV/AIDS and diabetes.

As Long As the Waters Flow: An Aboriginal Strategy on HIV/AIDS

Manitoba’s 1996 provincial AIDS strategy identified “recognizing the special needs of Aboriginal people” as one of its priorities in addressing HIV/AIDS (Manitoba Health, 2004). As Long As the Waters Flow: An Aboriginal Strategy on HIV/AIDS resulted from the

identification of this priority. The strategy has four primary goals: prevention and education; care, treatment and support; coordination of services; and research and evaluation (Manitoba Health, 2004). It was developed in consultation with Aboriginal communities in Manitoba and its recommendations include involvement of Aboriginal communities in their own program development for education, prevention and treatment of HIV/AIDS (Manitoba Health, 2004).

Regional Diabetes Program Framework: A Manitoba Strategy

Manitoba Health's Regional Diabetes Program Framework outlines the implementation of 29 of the 53 recommendations contained in Diabetes: A Manitoba Strategy, the goal of which is to reduce the burden of illness from diabetes in Manitoba. The strategy was developed in 1998 in response to "the growing burden of Type 2 diabetes in First Nations people and the elderly of all populations" (Manitoba Health, n.d.-d, p. 3). The Regional Diabetes Program Framework recognizes that First Nations people are among the populations most affected by type 2 diabetes, and emphasizes a holistic approach to health, primary care and community participation in education, research, care and support for individuals living with diabetes. The Regional Diabetes Program's goal is to implement better infrastructure and services for diabetes education, care and support in each regional health authority in the province (Manitoba Health, 2002).

Health human resources

In order to improve health services for Aboriginal people in Manitoba in a more culturally appropriate way, and to address the challenges associated with the recruitment and retention of health care professionals, the Manitoba government has implemented a program that encourages more Aboriginal people to become health care professionals through funding assistance.

Aboriginal Medical Student Financial Assistance Program

The Aboriginal Medical Student Financial Assistance Program was established by the Manitoba government in order to increase the number of Aboriginal physicians graduating from the University of Manitoba and working in the province. Medical students can apply for funding for each year that they are in the medical program, and the money must be repaid only if the students work outside of Manitoba upon graduation (Manitoba Health, n.d.-a).

Maternal and child health

In 2007, the provincial Minister of Health established the Maternal and Child Healthcare Services Task Force to make recommendations for improving maternal and child health care services in Manitoba. While not Aboriginal-specific, several recommendations that came from this initiative were targeted specifically at First Nations, Métis and Inuit people living in Manitoba. In September 2008, the provincial government confirmed a funding commitment of \$1.1 to implement 13 immediate priorities identified by the task force. This included funding for training of peer support workers to offer prenatal and postnatal social support and labour support in a culturally appropriate manner; a referral system to help expectant women who must relocate from First Nations, Inuit and Métis communities for extended periods of time to access prenatal and social supports; and the establishment of a working group to engage the community in the development of resources to support women who must relocate from these communities for extended periods of time to give birth (Manitoba Health, n.d.-c).

Mental health and addictions

An Internet search identified one provincial government mental health and addictions initiative targeted at Aboriginal populations in Manitoba: a youth suicide prevention strategy.

Manitoba's Youth Suicide Prevention Strategy

Manitoba's Youth Suicide Prevention Strategy is aimed at helping all youth in Manitoba, but it includes a significant component on Aboriginal communities and youth. The strategy is consistent with the federal government's National Aboriginal Youth Suicide Prevention Strategy, and one of its key goals is to improve service delivery and access to services in Aboriginal communities in Manitoba (Manitoba Health, 2008). The report *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy* provides an overview of existing and new mental health and suicide prevention and awareness programs across the province (Manitoba Health, 2008).

Alternative Mechanisms for Providing Health Programs and Initiatives

In addition to the programs and initiatives implemented by the Manitoba government on a province-wide scale for its Aboriginal population, there are a number of programs and initiatives that are more regional in scope or that are federal initiatives administered provincially and/or through Aboriginal organizations such as the Manitoba Aboriginal Friendship Centre Association. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Manitoba to improve the health of its Aboriginal population.

Local and regional examples

Several programs and initiatives available to Manitoba's Aboriginal population are implemented and/or administered by regional health authorities or apply only to Aboriginal people in a specific location. Two are highlighted here: the Native Women's Transition Centre is specific to Winnipeg, and the Northern Healthy Foods Initiative has a northern regional scope.

Native Women's Transition Centre

Since 1979, the Native Women's Transition Centre, located in Winnipeg, has worked to support and strengthen Aboriginal women and mothers who have experienced family violence. The centre offers two long-term residential facilities for women and their children who are rebuilding their lives after episodes of domestic violence or systemic neglect. Women and their children are able to spend up to a year living in each facility as they make the transition back into the community. The centre offers a variety of programs, including an after-hours crisis/addictions counsellor, a compulsive coping behaviour program, family violence prevention, children's programs to encourage bonding and healthy child development, a parenting program and a mentorship program (Native Women's Transition Centre, n.d.).

Northern Healthy Foods Initiative

The Northern Healthy Foods Initiative, funded and administered by Manitoba Aboriginal and Northern Affairs, strives to promote healthy living, diabetes awareness and community involvement; the creation of community gardens in order to increase access to and reduce costs of healthy foods; and increased physical activity and community involvement. The program provides resources, training in gardening, and materials such as soil, frames, seeds and tools (Northern Association of Community Councils, 2009; Manitoba Aboriginal and Northern Affairs, n.d.). While this program is not exclusive to Manitoba's northern Aboriginal population, it does target all northern communities, including Aboriginal communities, and incorporates elements that are of particular interest to Aboriginal peoples, such as medicinal plants (Northern Association of Community Councils, 2009; Manitoba Aboriginal and Northern Affairs, n.d.).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by provincial or territorial governments and/or by Aboriginal organizations such as friendship centres. In Manitoba, the provincial government contributed \$2.5 million to the North American Indigenous Games held in Winnipeg in 2002 (Government of Manitoba, 2002). It "has endorsed and is participating in the development of the national Integrated Pan-Canadian Healthy Living Strategy" (Government of Manitoba, 2004). It partners with the federal government on its Urban Aboriginal Strategy, and with the federal and Nunavut governments on an Aboriginal Health Transition Fund midwifery training program. It has provided support, along with other levels of government, academic, and non-profit organizations, for the Winnipeg Aboriginal Sports Achievement Centre; and in 2008, contributed \$1 million to the Manitoba Association of Friendship Centres for upgrades and repairs of its member centres (Government of Manitoba, 2008).

The federal government is also involved in funding maternal and child health pilot projects in First Nations communities under the Assembly of Manitoba Chiefs Strengthening Families Maternal Child Health Program, and a number of CPNP programs which specifically serve the needs of First Nations, Inuit and Métis women and their infants. In addition, they fund a First Nations Community Public Health Pilot Project in the province. Short descriptions are provided below for only the Midwifery Education Program, the Integrated Pan-Canadian Healthy Living Strategy, the Urban Aboriginal Strategy, the Strengthening Families Maternal Child Health Program, the Winnipeg Aboriginal Sports Achievement Centre, the First Nations Community Public Health Pilot Project, and the Manitoba Association of Friendship Centres.

Aboriginal Midwifery Education Program

The Aboriginal Midwifery Education Program is a partnership of the governments of Manitoba and Nunavut, and is jointly administered by Manitoba Health and Manitoba Advanced Education and Training. The program received funding of approximately \$1.69 million for the development phase through Health Canada under the Aboriginal envelope of the Primary Health Care Transition Fund (Health Council of Canada, 2007; Health Canada, 2006). The overall goal is to develop a four-year degree program designed specifically for Aboriginal adult learners studying midwifery that uses Aboriginal teachings and culture.

Integrated Pan-Canadian Healthy Living Strategy – Aboriginal initiatives in Manitoba

The Manitoba government has initiated the Aboriginal Youth Healthy Living Mentor Program to meet some of its goals with respect to the Pan-Canadian Healthy Living Strategy. The program delivers nutritional education for elementary school-aged children (PHAC, 2010b), and has implemented the Northern Healthy Foods Initiative, which can also be considered a component of the Pan-Canadian Healthy Living Strategy.

Urban Aboriginal Strategy – Manitoba

In Manitoba, the Urban Aboriginal Strategy has been implemented in two urban centres: Winnipeg and Thompson. In addition to cultural awareness/reconnection and capacity-building programs, health-related projects in Winnipeg funded in 2008/09 included an Aboriginal youth strategy; several culturally based intervention/prevention initiatives addressing the risk factors associated with youth violence and gang involvement; several programs targeting Aboriginal women and girls who have experienced violence, including the Sisters in Spirit project and the Native Women's Transition Centre; and an addictions

after-care program. In Thompson, projects funded in 2008/09 included a health promotion video to educate Aboriginal people about sexually transmitted infections and a domestic violence treatment program for Aboriginal men. (For more information about funded Urban Aboriginal Strategy projects in Manitoba, please go to <http://www.ainc-inac.gc.ca/ai/of/uas/prj/stp5-eng.asp> [INAC, 2010].)

Strengthening Families Maternal Child Health Program

The Strengthening Families Maternal Child Health Program is a family-focused home visiting program for pregnant women, fathers and families of infants and young children aged 0-6 years with a vision of strong, healthy, supportive First Nations families and communities. The program provides support and referral services to families through the use of nurses and trained home visitors. These home visits focus on enhancing the physical, psychological, cognitive and social development of family members. The program began with federal government funding for pilot projects in 16 Manitoba First Nations communities in 2005, with 11 added in 2006 and a further five in 2007. The projects are co-managed through a structure that involves First Nations and Inuit Health providing overall administration and funding for the projects to communities and the Assembly of Manitoba Chiefs providing regional support to the sites, with a First Nations Advisory Committee overseeing the overall implementation of the program (Assembly of Manitoba Chiefs, 2010b).

The Winnipeg Aboriginal Sports Achievement Centre (WASAC)

The Winnipeg Aboriginal Sports Achievement Centre has been in operation since 2000. Its mission is to make a difference in the lives of Aboriginal children and youth in Winnipeg and northern communities through programming, mentorship and

leadership development. The range of programming (all free of charge) includes sports, cultural awareness, recreation and community service.

WASAC is currently supported by the Province of Manitoba, the City of Winnipeg, Canadian Heritage, the University of Winnipeg, Sport Manitoba, the Manitoba Aboriginal Sport and Recreation Council, the Centre for Aboriginal Human Resource Development Inc., among others.

First Nations Community Public Health Pilot Project

In 2007, a multi-jurisdictional public health pilot project was initiated under the leadership and coordination of the Assembly of First Nations to help inform future directions in the delivery of on-reserve public health, leading to improved health outcomes and increased First Nations control over delivery of their own public health services (Assembly of First Nations, 2011). The pilot project is funded by Health Canada and will run for a period of five years in three provinces (Saskatchewan, Manitoba and Ontario). In Manitoba, the project is being carried out in Four Arrows Regional Health Authority communities.

Manitoba Association of Friendship Centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. In Manitoba, the Manitoba Association of Friendship Centres also receives some funding from the provincial government to support it and its 11 affiliated friendship centres. Health-related programs and initiatives offered through the Manitoba Association of Friendship Centres include Parent Child Centre Programs that support “culturally appropriate parenting and family support,

nutrition, literacy, and community capacity building as priority areas for healthy child development” (Manitoba Association of Friendship Centres [MAC], n.d.-b). These programs are designed to promote healthy outcomes for children and families through parent-child centred activities that focus on parenting and family support, nutrition, literacy and community capacity-building. The federal government’s Cultural Connections for Aboriginal Youth Program is also administered by the Manitoba Association of Friendship Centres (MAC, n.d.-a).

4.5 Ontario

The government of Ontario has been at the forefront of addressing health inequities between Aboriginal and non-Aboriginal populations through health policy. In 1990, it developed an Aboriginal Health and Wellness Strategy, followed in 1994 by an overarching Aboriginal Health Policy, considered one of the most comprehensive Aboriginal health policies currently in place (NCCAH, 2011).

Ontario invests about \$600 million annually in Aboriginal programs and services designed to address not only health issues, but also social and economic determinants that can lead to poor health (Ontario Ministry of Aboriginal Affairs, 2009). Approximately half of this funding supports child and social services, \$80 million supports justice and policing initiatives, \$45 million supports education and training programs, and \$49.5 million goes to the Aboriginal Healing and Wellness Strategy, including \$8.5 million for the Aboriginal Healthy Babies, Healthy Children program (Ontario Ministry of Aboriginal Affairs, 2009). The Aboriginal Healing and Wellness Strategy is a unique policy and service initiative involving a partnership between Aboriginal peoples and the Ontario government to promote health and healing among Ontario’s Aboriginal peoples. The strategy funds three types

of initiatives, encompassing 18 different programs (Aboriginal Healing and Wellness Strategy, 2007b). The goal of the strategy is to improve the health and well-being of Ontario's Aboriginal peoples and communities by providing access to culturally appropriate and competent primary health and healing services and programs, including prevention, treatment and support; building on the strengths and enhancing the capacities of Aboriginal communities; and promoting equitable, violence-free relationships and healthy environments (Aboriginal Healing and Wellness Strategy, 2007b).

Programs and Initiatives Funded and Administered by the Provincial Government

The Aboriginal Healing and Wellness Strategy and the Ontario government offer Aboriginal health programs related to child and youth health, communicable and chronic diseases, mental health and addictions, and women's health.

Child and youth health

An Internet search identified one provincially funded and administered health-related program targeted at improving child and youth health among Ontario's Aboriginal population. The program focuses on healthy early child development.

Aboriginal Healthy Babies, Healthy Children

Established in 2004 as a component of the Aboriginal Healing and Wellness Strategy, the Aboriginal Healthy Babies, Healthy Children program offers access to culturally appropriate, early intervention and prevention services, supporting parents through pregnancy, birth and child-rearing to promote the health and development of infants and young children. Goals of the program include assisting all Aboriginal families in providing the best opportunities for

healthy development for children aged 0-6 years, and acting as a means for a coordinated, effective, integrated system of services and supports for healthy child development. The program is open to any Aboriginal family that requests service (Aboriginal Healing and Wellness Strategy, 2009).

Communicable and chronic diseases

An Internet search identified four provincially funded and administered health-related programs and initiatives focused on communicable and chronic diseases among Ontario's Aboriginal population. Three of these were strategies implemented to address diabetes, cancer and HIV/AIDS, while a fourth was a health promotion program targeted at diabetes education and prevention.

Ontario Aboriginal Diabetes Strategy

The Ontario Aboriginal Diabetes Strategy, announced in 2008, represents a collaborative effort between Ontario's Ministry of Health and Long-Term Care and Ontario Aboriginal organizations and independent First Nations. It sets out a long-term approach to diabetes prevention, care and treatment, education, and research and coordination (Ontario Aboriginal Diabetes Strategy Steering Committee, 2006). For each of these activities, the strategy sets out a goal, current gaps, and objectives and actions required to close the gaps and achieve the goal. Providing better access to care for communities with high rates of diabetes is a key priority of the strategy.

In providing better access to care, key principles that are considered foundational to the strategy include: Aboriginal holistic perspectives of health; Aboriginal self-determination in all aspects of health care delivery; the right of Aboriginal people to choose different models of health care; the impact of social, economic, and physical

environments on health status; the need for appropriate and accessible health care services to all Aboriginal people regardless of residency; the need for health services to be provided in a culturally secure environment and manner; a coordinated and collaborative intersectoral approach is required; and that improved, guaranteed funding and political willingness and commitment be cornerstones of all health strategies for Aboriginal people (OADSSC, 2006).

Aboriginal Diabetes Education and Health Promotion/Prevention Program

The Aboriginal Diabetes Education and Health Promotion/Prevention Program was established in 2001 by the Ontario Ministry of Health and Long-Term Care. The program provides funding for eight Aboriginal organizations to support Aboriginal-specific diabetes education and care programs (Ontario Ministry of Health and Long-Term Care, 2006). One example is the Métis Nation of Ontario's Diabetes Awareness Strategy, which is aimed at increasing Métis peoples' awareness of the seriousness of diabetes, the risk factors and warning signs associated with it, and potential strategies for preventing diabetes and its complications (Métis Nation of Ontario, n.d.).

Aboriginal Cancer Strategy

As one of four priority areas identified by Cancer Care Ontario⁴⁰ in its 2020 action plan, the Aboriginal Cancer Strategy aims to decrease cancer incidence and mortality among Aboriginal people in Ontario by 2020, based on a holistic approach to cancer screening, prevention and research. The Joint Cancer Care Ontario – Aboriginal Cancer Committee (JOACC), which includes Aboriginal representatives from each of nine Aboriginal organizations and from Cancer Care Ontario, provides guidance and advice on developing and implementing strategies to reduce the incidence of cancer

⁴⁰ Cancer Care Ontario is an operational service agency of the Ministry of Health and Long-Term Care, funded by the provincial government (Cancer Care Ontario, 2011).

among Ontario's Aboriginal populations (Cancer Care Ontario, 2009).

Ontario Aboriginal HIV/AIDS Strategy

The Ontario Aboriginal HIV/AIDS Strategy is a provincially mandated service organization providing support services to Aboriginal people living off-reserve who are living with, or are affected by, HIV/AIDS (Ontario Ministry of Health and Long-Term Care, 2010). Implemented in 1995, the goal of the strategy is "to provide culturally respectful and sensitive programs and strategies to respond to the growing HIV/AIDS epidemic among Aboriginal people in Ontario through promotion, prevention, long term care, treatment and support initiatives consistent with harm reduction" (Ontario Aboriginal HIV/AIDS Strategy, 2010).

Mental health and addictions

An Internet search identified three programs that address issues related to mental health, two providing access to mental health services and another related to the issue of family violence. (While not directly a mental health-related program, the latter is included here because family violence has been identified as a significant challenge in many Aboriginal communities and families, and mental health issues are often at the root of, or become a repercussion of, family violence.)

Mental Health Service Information Ontario

Mental Health Service Information Ontario (MHSIO) is a province-wide information and referral program, funded by the Ontario Ministry of Health and Long-Term Care, providing Ontarians with 24-hour access to information about mental health services and support systems across the province. While not specifically targeted at Ontario's Aboriginal population, the MHSIO website offers an online service directory that includes 28 Aboriginal health care organizations across Ontario, with numerous branches

throughout the province (Mental Health Service Information Ontario, 2005).

Mental Health Program

Under the Aboriginal Healing and Wellness Strategy, the Mental Health Program was established to develop, plan and implement demonstration or pilot programs that seek to improve Aboriginal mental health in a culturally relevant way (AHWS, 2007b). This may include intake, screening, assessment and referral services for mental health clients; service and support teams for people diagnosed with mental health conditions; crisis intervention, early intervention and peer counselling and support for at-risk individuals and their families; specialized case management and after-care support for individuals with mental health conditions; and initiatives to provide or improve access to therapeutic mental health services, both contemporary and traditional (AHWS, 2007b).

Family Violence Healing Program

Under the Aboriginal Healing and Wellness Strategy, the Family Violence Healing Program was established to expand pre-existing family violence healing programs. Two examples are the Ganohkwa Sra program at Six Nations and the le thi nisten: Ha le thi non ronh kawa at Akwesasne. These programs respond to community needs and utilize community support in addressing the issue of family violence within their communities.

Women's health

A number of programs for the protection, empowerment and education of Aboriginal women have been established under the Aboriginal Healing and Wellness Strategy. For example, shelters and safe houses in nine different locations in Ontario provide a safe, short-term residence for women and their children who are seeking safety from partners, families or selves; and six healing lodges

offer Aboriginal people traditional healing approaches to address the impacts of family dysfunction, sexual assault, and physical, mental and emotional abuse (Aboriginal Healing and Wellness Strategy, 2007a).

Alternative Mechanisms for Providing Health Programs and Initiatives

In addition to the Aboriginal programs and initiatives implemented by the Ontario government on a province-wide basis, there are a number of programs and initiatives that are more regional in scale or that are federal initiatives administered by the provincial government and/or through Aboriginal organizations such as the Ontario Association of Aboriginal Friendship Centres. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Ontario to improve the health of its Aboriginal population.

Local and regional examples

Many programs and initiatives available to the Aboriginal population in Ontario are implemented and/or administered by the 14 Local Health Integration Networks⁴¹ or apply only to Aboriginal people in a specific location. Four examples are provided here: two regional diabetes initiatives, an addiction and mental health program for urban Aboriginal people in Toronto, and the Maternal and Child Centre at Six Nations.

Northern Ontario Aboriginal Diabetes Initiative

The Northern Ontario Aboriginal Diabetes Initiative (NOADI) was implemented in 2006 by the Northern Diabetes Health Network (NDHN), a larger initiative funded by the Ontario Ministry of Health and Long-Term Care

⁴¹ In 2006, regional health authorities were replaced by Local Health Integration Networks (LHINs) to facilitate effective and efficient integration of health services. Further information about these LHINs can be found at http://www.health.gov.on.ca/transformation/lhin/lhin_history.html.

to address the lack of services for people with diabetes in northern Ontario. A 2006 assessment of the diabetes-related needs of Aboriginal people living in northern Ontario was used to inform NDHN's funding criteria for community-based diabetes prevention and awareness projects. In 2008/09, the NOADI was allocated \$425,000 to support Aboriginal individuals, communities and organizations to implement diabetes prevention and management initiatives. This funding supported 91 Aboriginal communities/organizations to take part in at least one initiative, as well as 49 community/organization-initiated projects for primary and/or secondary prevention (NDHN, 2009). In addition, 23 nurses took part in two basic nursing foot care workshops, 37 individuals were funded to complete a diabetes education module/certificate program, 50 individuals participated in two five-day community mobilization workshops, and 21 individuals completed peer leader training in chronic disease self-management (NDHN, 2009).

Southern Ontario Aboriginal Diabetes Initiative

The Southern Ontario Aboriginal Diabetes Initiative supports communities in southern Ontario in preventing, managing and decreasing the occurrence of diabetes. The program is administered by five regional diabetes workers in on- and off-reserve Aboriginal communities in southern Ontario (Ontario Ministry of Health and Long-Term Care, 2006).

Toronto Aboriginal Care Team

Funded through the Aboriginal Healing and Wellness Strategy and administered through Native Child and Family Services of Toronto, the Toronto Aboriginal Care Team helps First Nations, Inuit and Métis people in the Toronto area who have addiction- or mental health-related issues. Programs focus on both client-based and family-centred healing

processes, as well as networking with other community agencies to build a continuum of care. Client and family-based services include intake and assessment meetings, early intervention and care planning, referral and follow-up, as well as ongoing specialized case management and after-care for clients (Toronto Aboriginal Care Team, n.d.).

Maternal and Child Centre

The Maternal and Child Centre provides pre- and postnatal care for Aboriginal women and families in Six Nations and other areas in southern Ontario. Services are delivered by midwives rather than physicians, and can incorporate traditional practices if desired (AHWS, 2007a).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by provincial and territorial governments and/or by Aboriginal organizations such as friendship centres. This section provides examples of these types of programs and initiatives. In Ontario, the provincial government supports the federal Urban Aboriginal Strategy, has initiatives under the Integrated Pan-Canadian Healthy Living Strategy, and has contributed funding for programs offered by friendship centres in the province. (Since these are federal initiatives, further information about them can be found in Chapter 3.) In addition, the federal government has funded a number of CPNP programs which specifically serve the needs of First Nations, Inuit and Métis women and their infants; several projects under the Aboriginal Health Human Resources Initiative, and a First Nations Community Public Health Pilot Project. Short summaries are provided below for initiatives under the Integrated Pan-Canadian Healthy Living Strategy, the Urban Aboriginal Strategy, the Aboriginal Health and Human Resource Initiative, and for the Ontario Federation of Indian Friendship Centres.

Integrated Pan-Canadian Healthy Living Strategy – Aboriginal initiatives in Ontario

Programs and initiatives implemented by the Ontario government under the Integrated Pan-Canadian Healthy Living Strategy apply to the general Ontario population, but do target investments at at-risk populations such as Aboriginal peoples. For example, Ontario's comprehensive four-year diabetes strategy, released in 2008, aims to prevent, manage and treat diabetes (PHAC, 2010b). Similarly, the Child and Youth Health and Wellness After-School Strategy, which provides Ontario school-aged children with safe, active and healthy after-school activities, is initially focusing on providing services to at-risk children and youth, including those in Aboriginal communities (PHAC, 2010b). Finally, the Northern Fruits and Vegetable Pilot Project is a health promotion initiative designed to educate northern elementary school-aged children and their families about healthy eating and physical activity.

Urban Aboriginal Strategy – Ontario

The Urban Aboriginal Strategy is implemented in three Ontario cities: Toronto, Thunder Bay, and Ottawa. In addition to cultural awareness/reconnection and capacity-building programs, a health-related project in Ottawa funded in 2008/09 involved undertaking a community needs assessment for Inuit families. In Toronto, funded programs included an Aboriginal emergency preparedness workshop and the hiring of a registered dietician to provide culturally sensitive nutritional education and counselling. The only projects funded under this strategy in Thunder Bay in 2008/09 were capacity-building projects. (For more information about projects funded in Ontario under the Urban Aboriginal Strategy, please go to <http://www.ainc-inac.gc.ca/ai/of/ias/prj/stp5-eng.asp> [INAC, 2010].)

Aboriginal Health Human Resources Initiative – Ontario

The Chiefs of Ontario entered into a Contribution Agreement with First Nations and Inuit Health, Ontario Region (FNIH-OR) to facilitate ongoing engagement in the Aboriginal Health Human Resources Initiative (AHHRI) process between the various Aboriginal stakeholders and FNIH-OR to develop requests for proposals, review and approve proposals, develop a regional work plan based on approved projects, and evaluate the projects (Chiefs of Ontario, 2009). Projects funded in 2008/09 include two think-tanks; establishment of an AHHRI intersectoral network to improve the acute shortage of health care workers in First Nations communities; development of cultural safety curriculum for an e-learning course for health care students and providers; design of a health care role model program and campaign; and a March Madness Science Camp for students interested in health careers (Chiefs of Ontario, 2009).

First Nations Community Public Health Pilot Project

In 2007, a multi-jurisdictional public health pilot project was initiated under the leadership and coordination of the Assembly of First Nations to help inform future directions in the delivery of on-reserve public health, leading to improved health outcomes and increased First Nations control over delivery of their own public health services (Assembly of First Nations, 2011). The pilot project is funded by Health Canada and will run for a period of five years in three provinces (Saskatchewan, Manitoba and Ontario). In Ontario, the project is being carried out in Kenora Chiefs Advisory communities.

Ontario Federation of Indian Friendship Centres

The federal government provides financial support to Aboriginal friendship centres

across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. The Ontario Federation of Indian Friendship Centres (OFCIC) represents the collective interests of the 29 friendship centres in Ontario. It administers a variety of programs, including dopenen.ca, a website designed to provide culturally appropriate information about substance use and abuse to Aboriginal youth; the Ontario Aboriginal Health Advocacy Initiative, administered in tandem with the Aboriginal Healing and Wellness Strategy, which provides information and supports Aboriginal self-determination in health; *Kanawayhitowin: Taking care of each other's spirit*, a campaign to raise awareness about the signs of domestic abuse in Aboriginal communities; and *I am a kind man*, a program designed to “engage and educate youth to speak out about abuse against Aboriginal women” (Ontario Federation of Indian Friendship Centres, n.d.). The Public Health Agency of Canada provides funding to most of the 29 friendship centres in Ontario for Community Action Programs for Children and Canada Prenatal Nutrition programs. OFCIC also administers the federal Cultural Connections for Aboriginal Youth program.

The Ontario government has also provided funding for friendship centre programs and services. For example, in 2005 it committed to providing \$2 million annually to the Ontario Federation of Indian Friendship Centres to operate a new community-based program, *Akwe:go*, to help at-risk urban Aboriginal youth develop the skills they need to succeed in life (Ontario Ministry of Aboriginal Affairs, 2005). The program, tailored to meet the specific needs of each community, operates in 27 communities for children aged 7-12 and their parents.

It offers teachings by Elders and other culturally relevant supports, after-school programs, referrals to community resources, and support and training using traditional parenting practices (Ontario Ministry of Aboriginal Affairs, 2005).

4.6 Quebec

Aboriginal peoples in Quebec are gaining increasing control over their health planning and programming. In 1975, the first modern treaty, the James Bay and Northern Quebec Agreement, was signed by the Inuit and Cree of Quebec and the federal and provincial governments. This agreement has given rise to a unique model of health care, co-funded by the federal and provincial governments, that provides Nunavik Inuit and James Bay Cree with self-administration of health services (NCCA, 2011). Roles and responsibilities have been further clarified for both the Cree and the Inuit. In 2007, an agreement was signed that was intended to lead to the creation of the regional government of Nunavik, overseeing all Nunavik structures created as a result of the James Bay and Northern Quebec Agreement (INAC, 2007).⁴² For the James Bay Cree, an agreement with the federal government was signed in 2008 to clarify areas of federal responsibility that the Cree Regional Authority will administer for the next 20 years, including justice and economic and social development (INAC, 2008).

In addition to the self-governance structures established through the James Bay and Northern Quebec Agreement, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) was also established in 1994 to serve as a technical advisor and consultant for First Nations communities and the Assembly of First Nations of Quebec and Labrador in the area of health and social services (First Nations of

⁴² A referendum was held in April 2011 and a majority of Inuit people rejected the agreement to create a regional government (Rogers, 2011).

Quebec and Labrador Health and Social Services Commission [FNQLHSSC], 2008). It is an integral partner in the development of culturally appropriate community initiatives that address the needs of First Nations people living in Quebec and Labrador (FNQLHSSC], 2008).⁴³ The FNQLHSSC, in conjunction with the Assembly of First Nations of Quebec and Labrador, recently drafted the Quebec First Nations Health and Social Services Blueprint, 2007-2017, which proposes actions to be taken to establish a new governance strategy predicated on First Nations self-determination; alleviate major health issues; develop innovative, accessible and sustainable social services; address inequalities in health determinants; encourage human resources development; and establish a progress-tracking framework (FNQLHSSC, 2007). Unlike recent Aboriginal health 'blueprint' initiatives in the provinces west of Quebec, the Quebec First Nations Health and Social Services Blueprint was developed without direct federal or provincial government participation. Rather, it is a call for action that emphasizes First Nations self-determination in health policies, and the coordination and integration of health care and social services delivery across sectors, disciplines, institutions, and various government levels.

Health-related programs and initiatives in Quebec are funded and administered quite differently from those in the western provinces. Most are funded by provincial and federal governments through either the James Bay Cree or Nunavik health structures, or the First Nations of Quebec and Labrador Health and Social Services Commission. In addition, several federal health initiatives are administered through these institutions and through the Regroupement des centres d'amitié autochtones du Québec (Coalition of

Native Friendship Centres of Québec). Few health-related programs and initiatives are funded and administered directly by the Quebec government. Quebec's profile is therefore organized somewhat differently from those of the western provinces. It begins by listing programs and initiatives funded and administered directly by the provincial government, which, unlike those in the western provinces, are not province-wide. Programs and initiatives established by the First Nations of Quebec and Labrador Health and Social Services Commission are described next. These are followed by regional examples, those primarily offered through the regional health boards established to provide the Nunavik Inuit and James Bay Cree with self-administration of health services. Finally, federal health-related programs and initiatives delivered in partnership with either the FNQLHSSC or Friendship Centers in Quebec are described.

Programs and Initiatives Funded and Administered by the Provincial Government

An Internet search identified only two Aboriginal programs or initiatives funded and administered directly by the Quebec government. Both provide financial support: travel grants to improve rural Aboriginal peoples' access to health services, and financial support for Aboriginal sports and recreation programs.

Gratuité de transport [Travel grants]

Aboriginal people who live in the northern part of Quebec can have their travel covered if they need to access medical care in other parts of the province. The travel must be recommended by a physician, and is available for all Aboriginal peoples of Quebec, subject to certain conditions (Government of Quebec, 2009a).

Financial aid program for sports and recreation coordinators

In 2009, the Quebec Aboriginal Affairs Secretariat, Youth Secretariat, and Minister of Education, Leisure and Sport renewed their commitment to providing financial aid for sports and recreation coordinators and community involvement in sports in 15 Aboriginal communities in the province. The goal of the program is to involve more Aboriginal youth who live in remote communities in sports and other activities that promote a healthy lifestyle (Government of Quebec, 2009b).

Programs and Initiatives Established by the First Nations of Quebec and Labrador Health and Social Services Commission

The First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) is involved in developing strategies aimed at supporting the implementation of culturally appropriate community initiatives that meet the needs of First Nations, including prevention, promotion, awareness and information tools to support and promote these community initiatives (FNQLHSSC, n.d.). Health-related programs and initiatives developed by the FNQLHSSC have focused on health human resources and health promotion.

Health human resources

Quebec First Nations and Inuit Faculties of Medicine Program

The Quebec First Nations and Inuit Faculties of Medicine Program was established by the four Quebec universities with a faculty of medicine, with the goal of increasing the number of First Nations and Inuit doctors in the province. The program, now endorsed by the Ministère de la santé et des services sociaux du Québec and the Ministère de l'Éducation, du Loisir et du Sport, sets aside four positions for First Nations people registered under the *Indian Act*

⁴³ Conducting research is one key aspect of the FNQLHSSC's role as a consultant on issues related to First Nations health and social services. For example, the FNQLHSSC publishes research on topics such as injuries in Aboriginal communities.

or Inuit people who are enrolled on the register of Inuit beneficiaries. The main objectives of the program are “to facilitate admissions for First Nations and Inuit candidates, improve the ability of all physicians in Canada to provide high quality and culturally-safe care to First Nations and Inuit patients and to increase the cultural safety of the learning environment in the Quebec Faculties of Medicine” (FNQLHSSC, n.d.-a).

Health promotion

On the path to health!

On the path to health! is an elementary school nutrition education program for the First Nations communities of Quebec, with the goal of fighting obesity and diabetes among First Nations youth. The program consists of 28 nutrition workshops – four different workshops for each elementary grade level from Kindergarten to Grade 6. Each workshop contains recipes and activities, and is designed to be fun and interactive and to promote the use of traditional First Nations foods (FNQLHSSC, 2009).

Alternative Mechanisms for Providing Health Programs and Initiatives

In addition to the Aboriginal programs and initiatives implemented by the Quebec government and the FNQLHSSC, there are a number of programs and initiatives that are more regional in scope, or that are federal programs or initiatives administered through either the FNQLHSSC or Aboriginal organizations such as the Regroupement des centres d'amitié autochtones du Québec [Coalition of Native Friendship Centres of Quebec]. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Quebec to improve the health of its Aboriginal population.

Local and regional examples

Most regional examples of programs and initiatives available to Quebec's Aboriginal population are implemented and/or administered by the public health departments of the Cree Health Board or Nunavik Regional Board of Health and Social Services, two institutions that were established to provide for Aboriginal self-administration of health services. This section will provide a brief summary of the health programs and activities provided by these two health boards. In addition, brief discussion will be provided for the Kateri Memorial Hospital Centre, a successful model of providing health programs to First Nations in Kahnawake.

Nunavik Regional Board of Health and Social Services

The Nunavik Regional Board of Health and Social Services works to adapt health and social service programs to meet the needs of the residents of Nunavik (Nunavik Regional Board of Health and Social Services, 2011). This includes administering two health centres (Inuulitsivik and Ulattavik), two rehabilitation centers, two patient services centres, two transit houses, and points of service in 14 communities in the region (Nunavik Regional Board of Health and Social Services, 2011). At present, very little information about health programs and services is available on the Nunavik Regional Board of Health and Social Services website.

James Bay Cree Health Board

The Public Health Department of the Cree Health Board has health programs and initiatives targeted at children aged 0-9 (Awash programs), children and youth aged 10-20 (Uschiniichisuu programs), and adults aged 30 and older (Chishaayiyuu programs) (Public Health Department of the Cree Health Board, n.d.). Awash programs focus on midwifery, early child development, maintaining adequate vaccination coverage, preventing and controlling infectious diseases, and

ensuring dental health. Uschiniichisuu programs focus on ensuring the health and success of school children and well-balanced adults. Chishaayiyuu programs focus on promoting healthy lifestyles and preventing and controlling chronic diseases. This includes integrating the use of traditional medicines into diabetes care and integrating Aboriginal approaches into the clinical environment (Public Health Department of the Cree Health Board, n.d.).

Kateri Memorial Hospital Centre

The Kateri Memorial Hospital Centre has been in operation in the Mohawk community of Kahnawake since 1955. The Centre is administered by a Board of Directors from the community under a mandate from the Mohawk Council. It receives its funding from two primary sources. First, it has been designated by the provincial government as a hospital centre, and thus receives funding from the provincial government on the same basis as other hospitals in the province. In 1986, it received capital and operational financing from the provincial government to centralize existing health services into a new facility. Second, the Centre also administers several health programs under contract to the federal government.

A wide range of programs and initiatives are offered through the Kateri Memorial Hospital Centre (Kateri Memorial Hospital Centre, 2008). The Centre provides patient activities designed to enhance physical, mental, emotional and social pursuits so that clients can experience a high quality of life. Its Community Health Unit provides primary health care through culturally relevant public education, consultations, clinics and awareness programs. The Family Medicine Unit provides holistic family-centered, primary and preventive care for clients. In addition, the Centre provides home care nursing, transportation assistance, occupational therapy, physiotherapy, speech therapy,

assistance with transportation needs, inpatient short and long term care, and a host of professional services such as dental care, laboratory services, ophthalmology, optometry, and pharmacy. The Centre has been presented as a model of a successful program on other reserves. Community control of health services is considered one of the most important factors in this success, as it allowed health services to grow slowly from within, and adapt to meet the needs and trust of the people of Kahnawake (Macaulay, 1988).

Federal examples

Several of the programs and initiatives addressing Aboriginal health that are funded by the federal government (as described in Chapter 3) are administered by the provincial government and/or Aboriginal organizations such as the FNQLHSSC or the Regroupement des centres d'amitié autochtones du Québec. Most of the examples identified through a search of the Internet are delivered through these two Aboriginal organizations. In addition, the federal government has also funded a number of CPNP programs, in both the PHAC and FNIHB administered streams, which specifically serve the needs of First Nations, Inuit and Métis women and their infants. This section includes several examples of these types of programs and initiatives, including an Aboriginal Health Human Resources Initiative project, addiction utilization and prevention strategies, initiatives to combat HIV/AIDS, and the First Nations and Inuit Home and Community Care Program, all delivered through the FNQLHSSC, and some health-related programs and services provided by the Regroupement des centres d'amitié autochtones du Québec.

Aboriginal Health Human Resources Initiative – Quebec

The Aboriginal Health Human Resources Initiative (AHHRI) in Quebec was allocated \$100 million in funding over five years, starting in 2004 ((First Nations of Quebec and Labrador, 2008b). In 2008,

the FNQLHSSC and Health Canada held a consultation with regional Quebec First Nations communities in order to introduce AHHRI, present Health Canada data on Aboriginal workers and students in the health field, consult the communities on their needs regarding Health Human Resources, establish a network of contacts for First Nations health human resources, and improve the province's health human resource practices and policies (First Nations of Quebec and Labrador, 2008b).

Addiction prevention and promotion

FNIHB has been working since 2006 on developing an effective, evidence-based, culturally appropriate prescription drug abuse prevention and control strategy for First Nations and Inuit communities. Using a \$2.67 million grant from the federal government, FNQLHSSC selected the Timiskaming First Nation Community for a pilot project aimed at increasing awareness and understanding of prescription drug abuse issues, motivating healthy behaviours and lifestyles related to prescription drugs, and encouraging traditional behaviours and healing methods. In addition, the FNQLHSSC developed tools to foster and promote health and sobriety in communities, including addictions awareness weeks and information booklets on alcohol and drug use, and has provided training sessions in collaboration with the Université du Québec à Chicoutimi for those who work in the field of youth interventions (FNQLHSSC, n.d.-b).

Gambling prevention has also been a recent focus of the FNQLHSSC. Three campaigns have been launched to address pathological gambling, in 2006/07, 2007/08 and 2008/09. Training programs have also been initiated to help National Native Alcohol and Drug Abuse Program interveners get to know the issues related to gambling and be able to effectively screen for those with excessive gambling problems (FNQLHSSC, n.d.-b).

HIV/AIDS Circle of Hope Strategy

The Circle of Hope is the Quebec First Nations and Inuit communities' strategy to combat HIV/AIDS. Programs are funded by the Public Health Agency of Canada and are accessible to those living on- and off-reserve. The HIV/AIDS in the Urban Environment program carries out prevention activities in federal prisons, and off-reserve First Nations and urban Inuit receive culturally appropriate information and services (FNQLHSSC, n.d.-c).

Women's and maternal health

The FNQLHSSC has been working with Health Canada to establish appropriate nutrition information for Quebec's Aboriginal communities, and to increase awareness of and promote breast-feeding and folic acid intake through posters and discussions (FNQLHSSC, n.d.-d).

Regroupement des centres d'amitié autochtones du Québec [Coalition of Native Friendship Centres of Quebec]

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. In Quebec, health-related activities of the Regroupement des centres d'amitié autochtones du Québec (RCAAQ) include a project aimed at improving psychosocial health services in urban areas under the Aboriginal Health Transition Fund, implementing Aboriginal Head Start programs at several of Quebec's Native Friendship Centres, and administering the federal Cultural Connections for Aboriginal Youth program (Regroupement des centres d'amitié autochtones du Québec, 2010.). (Since these are federal initiatives, further information about them can be found in Chapter 3.)

While there is no readily available information on the Internet indicating whether the RCAAQ receives any

core funding for its programs from the provincial government, the coalition's website does indicate that the RCAAQ partners with a number of provincial ministries on unspecified programs and initiatives.

4.7 New Brunswick

In 1999, the New Brunswick government formed an Aboriginal Affairs Secretariat to improve the provincial government's capacity to address the increasing number of complex issues in Aboriginal affairs and devote greater attention to Aboriginal issues (Government of New Brunswick, 2011a). The Secretariat works with other provincial departments on a host of issues, including, among others, family and community services, sport and culture, and health. It acts as a liaison with Aboriginal communities and organizations to ensure the development of positive relationships between them and government, and ensures that the public service is educated and aware of Aboriginal issues and cultural differences. While a search of the Internet could not identify any health-related programs or initiatives offered through the Secretariat that target Aboriginal peoples in the province specifically, a number of programs and initiatives available to the general population may be of special interest to New Brunswick's Aboriginal population. These include early childhood initiatives, Healthy Learners in School, regional addiction services youth treatment programs, rehabilitation services, transition houses for abused women, and a suicide prevention program, among more general health services (Government of New Brunswick, 2011b).

In its 2008-2012 provincial health plan, the Government of New Brunswick stated the need to develop partnerships in order to improve the overall health of its citizens at an individual and collective level. For Aboriginal communities in New Brunswick, the focus is on developing structures, processes and opportunities to

work on issues such as health inequalities, barriers to access, and provision of culturally sensitive mental health and addictions services (Government of New Brunswick, 2008a). Several major initiatives of interest to New Brunswick's Aboriginal population, though not targeted specifically at them, have been undertaken to meet the goals established in the health plan. For example, the Early Childhood and Youth Strategy includes a New Beginnings program focusing on reproductive care initiatives, prevention strategies targeted at children diagnosed with Fetal Alcohol Spectrum Disorder, and improved mental health programs and services for youth. For youth and adults, there are programs promoting healthy lifestyle changes and addressing mental health and addictions.

Most health-related programs and initiatives targeted specifically at improving Aboriginal health in New Brunswick appear to be funded and administered directly by the federal government (specifically for the on-reserve population) or funded by the federal government through Aboriginal organizations such as the New Brunswick Aboriginal Peoples' Council or through the province's one friendship centre. The New Brunswick Aboriginal Peoples Council, established in 1972, is a "community of Aboriginal people residing off-reserve in Mi'kmaq/Maliseet/Passamaquoddy traditional territory of New Brunswick" (New Brunswick Aboriginal Peoples Council [NBAPC], 2009c). The council endeavours to improve the social and economic standards of New Brunswick's off-reserve Aboriginal population through the implementation of programs in housing, economic development, the environment and health.

Alternative Mechanisms for Providing Health Programs and Initiatives

This section provides examples of health-related programs and initiatives targeted at Aboriginal populations in New Brunswick

that are more regional in scope or that are federal initiatives administered through the provincial government and/or Aboriginal organizations in the province. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in New Brunswick to improve the health of its Aboriginal population.

Local and regional examples

Several programs and initiatives available to New Brunswick's Aboriginal populations are implemented and/or administered by regional health authorities or Aboriginal organizations, or apply only to Aboriginal people in a specific location. One example is presented here.

Aboriginal Gateway to Youth Futures

Aboriginal Gateway to Youth Futures is a Fredericton-based drop-in-style resource centre that offers Aboriginal youth a safe place to interact with their peers and share their ideas in a culture where those ideas can flourish. The program is administered by the New Brunswick Aboriginal Peoples Council and its goals and objectives include cultural heritage preservation and education, community capacity development and support, life readiness and skills enhancement, continued learning and health promotion (NBAPC, 2009a).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the provincial government and/or by Aboriginal organizations. In New Brunswick, the provincial government collaborates with the federal government on the Canada Prenatal Nutrition Program (New Brunswick Department of Health and Wellness, 2005) and the Go NB! Taking Action through Sport program, and has contributed more than \$200,000 to support the provincial team at the 2008

North American Indigenous Games (New Brunswick Aboriginal Affairs, 2008). Since no further details can be obtained on the Canada Prenatal Nutrition Program in New Brunswick or the North American Indigenous Games, only the Go NB! program is described below.

In addition to the federal programs and initiatives administered in partnership with the provincial government, some federal programs and initiatives are also administered by Aboriginal organizations such as the New Brunswick Aboriginal Peoples' Council or the Fredericton Native Friendship Centre. Examples of these types of programs are a diabetes program and a mental health program administered through the New Brunswick Aboriginal Peoples' Council.

Go NB! Taking Action through Sport

The Go NB! Taking Action through Sport program is a bilateral agreement between the governments of New Brunswick (Wellness, Culture and Sport) and Canada (Sport Canada) that aims to increase the number of children and youth participating in sport. An Aboriginal-specific component of this program directs funding and support to sport leadership and program development in First Nations communities (Government of New Brunswick, n.d.).

Community Diabetes Education and Prevention Program

The Community Diabetes Education and Prevention Program was established by the New Brunswick Aboriginal Peoples' Council in 2003 as part of the federal government's Aboriginal Diabetes Initiative. The program is targeted at off-reserve Aboriginal peoples living in New Brunswick and focuses on activities aimed at holistic wellness, type 2 diabetes prevention, and promotion of healthy lifestyles (NBAPC, 2009b).

Improving Pathways to Mental Health

This initiative received \$598,881 from the Pan-Canadian envelope of the Aboriginal Health Transition Fund to improve access to mental health services in Nova Scotia and New Brunswick communities affiliated with the Atlantic Policy Congress of First Nations Chiefs, improve mental health knowledge of community workers, and increase the efficiency of the mental health system through the introduction of "health navigators" (Health Canada, 2008). The project involves three health authorities (Colchester East Hants, Pictou County and River Valley) and eight First Nations (Milbrook, Indian Brook, Tobique, Woodstock, Kingsclear, St. Mary's, Oromocto, and Pictou Landing).

Friendship centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. In New Brunswick, there is no provincial association of friendship centres. An Internet search provided no information about health-related programs and services offered by the one friendship centre in New Brunswick, the Fredericton Native Friendship Centre.

4.8 Prince Edward Island

In Prince Edward Island, the Department of Health and Wellness, and its Aboriginal Affairs Secretariat division, are responsible for the health and well-being of the province's Aboriginal population. The Aboriginal Affairs Secretariat provides centralized coordination and management of Aboriginal affairs, including "the development of strategic policy, priority planning, discussions and negotiations with the Government of Canada and organizations representing the Mi'kmaq and other Aboriginal people, and the

management of federal-provincial agreements" (Aboriginal Affairs Secretariat, n.d.), including those related to health programs and initiatives. As in New Brunswick, most health-related programs and initiatives offered by the provincial government are available to all provincial residents, not targeted specifically at the Aboriginal population. This may be a reflection of the province's relatively small Aboriginal population. However, some of these programs and initiatives do, however, recognize the unique needs of the Aboriginal population. For example, development of the framework for the province's Youth Substance Use and Addiction Strategy involved consultation with stakeholders that included Aboriginal communities and recognized the need to integrate Aboriginal spiritual services into a client's case plan (Prince Edward Island [PEI] Department of Health, 2007).

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted specifically at Prince Edward Island's Aboriginal population are funded and administered directly by the federal government (see Chapter 3), indirectly by the federal government through partnerships with the provincial government and/or Aboriginal organizations, or through Aboriginal organizations directly. For example, many of these programs and initiatives are delivered through the Native Council of Prince Edward Island. The council was established in 1973 as the self-governing authority for off-reserve Aboriginal people living in Prince Edward Island. It works in collaboration with the Office of the Federal Interlocutor and Indian and Northern Affairs Canada to advocate on behalf of Aboriginal people in the province (Native Council of Prince Edward Island [NCPEI], 2009a).

This section presents examples of these types of programs and initiatives. The

list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Prince Edward Island to improve the health of its Aboriginal population.

Local and regional examples

An Internet search identified few regional or Aboriginal organization examples of health-related programs and initiatives targeted specifically at Prince Edward Island's Aboriginal population. Two examples are provided below: the Aboriginal Survivors for Healing group and Grandmother's House.

Aboriginal Survivors for Healing Group

The Aboriginal Survivors for Healing Group is a Charlottetown-based organization established in 2000. Its main source of funding is the Aboriginal Healing Foundation, which receives funding from the federal government (Armstrong, 2010). The group aims to break the cycle of residential school inter-generational trauma and sexual abuse through providing counselling services, traditional healing methods, a men's healing group, and training of staff by existing mental program health providers and Elders (AHF, 2011).

Grandmother's House

Operated by the Native Council of Prince Edward Island, Grandmother's House, located in Charlottetown, is a safe, short-term residence for women where they can receive the support and resources they need to take control of their lives and empower their futures. In addition to basic shelter, Grandmother's House provides life skills coaching to build self-esteem and improve living skills; case management and appropriate referrals for services such as medical care, job training and legal services; and substance use services (NCPEI, 2009c).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the provincial government and/or Aboriginal organizations. In Prince Edward Island, most programs and initiatives identified through a search of the Internet were federal initiatives administered through the Native Council of Prince Edward Island, the Mi'kmaq Confederacy, or the province's one friendship centre. These programs and initiatives were in the areas of substance abuse prevention, child and youth health, and health promotion. In addition, the federal government has also funded a number of CPNP programs which specifically serve the needs of First Nations, Inuit and Métis women and their infants. This section will provide a summary of the friendship centres within Prince Edward Island, as well as some examples of the programs administered through the Native Council of Prince Edward Island and the Mi'kmaq Confederacy.

Alcohol and drug programs

The Native Council of Prince Edward Island uses both provincial and Health and Welfare Canada funding to develop and enhance alcohol and drug abuse programs in the province. Federal funding for these programs is part of the National Native Drug and Alcohol Abuse Program, which is dedicated to the elimination of drug and alcohol abuse among Aboriginal populations, with the goal of ensuring that Aboriginal people are empowered to address addiction problems (NCPEI, 2009d). A key feature of these programs is the availability of AA meetings in communities across the province.

Hep'd Up on Life

Hep'd Up on Life, established in 2007, is sponsored by the Native Council of Prince Edward Island and funded by the Public Health Agency of Canada. It is designed to inform Aboriginal youth about sexually

transmitted infections and encourage them to pass knowledge on to others. The goal of the program is to decrease the occurrence of Hepatitis C, HIV/AIDS and other sexually transmitted infections among Aboriginal youth and community members (O'Neill, 2008; NCPEI, 2009b). It is guided by a youth advisory committee.

Cultural Connections – Prince Edward Island

The Native Council of Prince Edward Island also operates the federal government's Cultural Connections youth program, funded through Heritage Canada's Urban Multipurpose Aboriginal Youth Centres initiative. Health-related activities offered through this program include recreational activities for youth to keep them active.

Native Council of Prince Edward Island diabetes program

The Native Council of Prince Edward Island diabetes program was established in 2000 with funding from Health Canada. The program supports activities aimed at increasing awareness of diabetes, its risk factors, and the value of healthy lifestyle practices (NCPEI, 2009c). Funding for the program expired in 2009 and the council has been actively lobbying the federal government to renew funding.

Sport and Recreation Program

The Sport and Recreation Program is administered by the Mi'kmaq Confederacy of Prince Edward Island. Established by the Aboriginal Sport Circle (a national Aboriginal sports development organization) and the Capacity Development Bilateral in 2007 (a partnership between the federal and provincial governments), the program is aimed at increasing grassroots participation in sport and recreation for First Nations peoples in Prince Edward Island to help improve health outcomes (Aboriginal Sport Circle, n.d.; Knockwood, 2008). The program offers

a variety of activities for First Nations people, technical advice for community programs, and training and certification for individuals who want to assist in sport and recreation (Knockwood, 2008).

Friendship centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. There is no provincial association of friendship centres in Prince Edward Island. An Internet search provided no information about health-related programs and services offered through the province's only friendship centre, the Ogoisig Native Friendship Centre.

4.9 Nova Scotia

The Province of Nova Scotia's approach to Aboriginal issues is coordinated through the Office of Aboriginal Affairs. The majority of its work is conducted through the Mi'kmaq-Nova Scotia-Canada Tripartite Forum, a partnership of the three governments that targets collaborative action on social and economic issues, and the Made-in-Nova Scotia Process, which is focused on resolving Aboriginal and treaty rights issues in Nova Scotia (Province of Nova Scotia, 2011). The Tripartite Forum has seven working committees; Culture & Heritage, Education, Justice, Sports & Recreation, Economic Development, Health, and Social. The Tripartite Forum's Health Working Committee discusses issues, develops solutions, and recommends actions with respect to the health of Nova Scotia Mi'kmaq.

In 2005, the Health Working Committee directed a community engagement process to inform the Nova Scotia submission to the National Aboriginal Blueprint. Out of this engagement process came the

report, *Providing Health Care, Achieving Health* which provides the context for the working relationship between the provincial government and the Mi'kmaq people of Nova Scotia. *Providing Health Care, Achieving Health* identifies six current health priorities: mental health, addictions/substance abuse, Non-Insured Health Benefits coverage, Elder care, obesity-related issues, and funding. It represents a collaborative effort between First Nations communities (including youth) and the provincial and federal health system partners (Paul, English, & Were, 2008).

Like other provincial governments in the Maritimes, the Nova Scotia government offers few health-related programs and initiatives targeted directly at the province's Aboriginal population. Those that are currently available through the provincial government are also available to the general population. However, the provincial government did provide \$23,000 in funding to Team Mik'maw for the 2008 North American Indigenous Games (Nova Scotia Office of Aboriginal Affairs, 2009).

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted at Nova Scotia's Aboriginal population are funded and administered through alternative mechanisms, including directly by the federal government (see Chapter 3) or indirectly through partnerships with the provincial government and/or Aboriginal organizations, or through Aboriginal organizations such as the Native Council of Nova Scotia. This section provides examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Nova Scotia to improve the health of its Aboriginal population.

The Native Council of Nova Scotia, established in 1974, "is the self-governing authority for the large community of Mi'kmaq/Aboriginal peoples residing off-reserve in Nova Scotia throughout traditional Mi'kmaq territory" (Native Council of Nova Scotia [NCNS], 2011c). The council has established 13 "community zones," each with its own board of directors and that together encompass the province in its entirety (NCNS, 2011c). They receive their funding from the federal government and are affiliated with the National Congress of Aboriginal Peoples (Congress of Aboriginal Peoples, n.d.).

Local and regional examples

Several programs and initiatives available to Nova Scotia's Aboriginal population are implemented and/or administered by regional health authorities or other Aboriginal organizations, or apply only to Aboriginal people in a specific location. Three examples are described below: the Journey of Healing Program, the Native Social Counselling Agency and the Healing Our Nations initiative.

Journey of Healing Program

Established in 1971, the Native Alcohol and Drug Abuse Counselling Association of Nova Scotia provides a range of substance abuse education and treatment programs, including the Journey of Healing Program. The program's counselling services, workshops and support groups offer specific assistance relevant to the legacy of residential schools, as well as prevention and maintenance programs such as counselling, referral, follow-up and after-care programs; a solvent abuse program; a post-traumatic stress crisis team; an educational youth program; peer counsellors; and other public information programs (Native Alcohol and Drug Abuse Counselling Association of Nova Scotia, 2011).

Native Social Counselling Agency

The Native Social Counselling Agency operates through the Native Council of Nova Scotia to assist off-reserve Aboriginal clients facing social problems and conditions. The program provides case intervention, counselling referral and follow-up services.

Healing Our Nations

Healing Our Nations evolved from the concern of 15 First Nations communities across the province about the spread of HIV/AIDS in their communities. They formed the Nova Scotia Mi'kmaq AIDS Task Force, which was renamed in 2000 as Healing Our Nations (Healing Our Nations, n.d.). The purpose of the Healing Our Nations initiative is to educate First Nations people about HIV/AIDS. Healing Our Nations provides information on treatments for HIV/AIDS, financial assistance for individuals living in Atlantic Canada with HIV/AIDS, and a toll-free information line. The initiative receives support through the Union of Nova Scotia Indians, the Native Council of Nova Scotia, and the Micmac Native Friendship Centre (Healing Our Nations, n.d.).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the provincial government and/or in partnership with Aboriginal organizations. In Nova Scotia, most programs and initiatives identified through a search of the Internet were federal initiatives that were undertaken in partnership with either the provincial government or the Native Council of Nova Scotia, or both. These programs and initiatives were in the areas of early child development, maternal health, health care accessibility, mental health and chronic disease. In addition, some programs are offered through the province's one friendship centre. Brief summaries are provided below for the Friendship Centre, two Native Council of Nova Scotia

programs, and several Aboriginal Health Transition Fund Programs.

Child Help Initiative Program

The Native Council of Nova Scotia's Child Help Initiative Program is funded by the Public Health Agency of Canada through the Community Action Program for Children. The program helps to form Aboriginal Parent Groups "to provide guidance, advice and a link to resources and/or programs that lead to a stronger and brighter future for Aboriginal families and their children" (NCNS, 2011b). Program facilitators offer services in such areas as prenatal care and nutrition. The program is available to all Aboriginal children ages 0-6 and their families living off-reserve in Nova Scotia (NCNS, 2011b).

E'pit Nuji Ilmuet (Prenatal) Program

The Native Council of Nova Scotia's E'pit Nuji Ilmuet (Prenatal) Program serves off-reserve Aboriginal women with the greatest need who are pregnant or are nursing infants, and whose social and economic conditions cause a higher risk for prenatal nutrition deficiency. The primary goal of the program is to promote good pre- and postnatal care, by promoting the importance of good nutrition, breast-feeding and economical food preparation; providing food supplements of milk and orange juice to expectant or nursing mothers whose need is greatest, for up to a 28-week period; and providing access to a dietician who works closely with the facilitators and can provide individual counselling or nutrition information sessions (NCNS, 2011a). The program is funded through the federal government's Canada Prenatal Nutrition Program.

Midwifery in Aboriginal Community Settings

The Midwifery in Aboriginal Community Settings project received \$199,900 through the Pan-Canadian envelope of the Aboriginal Health Transition Fund. The funding supports a research project

on traditional midwifery with a view to developing and recommending an implementation strategy for midwifery services in Aboriginal communities.

The project involves five First Nations (Chapel Island, Eskasoni, Membertou, Wagmatcook and Waycobah), the Nova Scotia Department of Health, the Cape Breton Regional and Inverness Consolidated Memorial hospitals, and the Association of Nova Scotia Midwives (Health Canada, 2008).

Aboriginal Health Awareness Project

The Aboriginal Health Awareness Project was launched in 2008 with \$223,500 in funding through a contribution agreement between Health Canada and the Nova Scotia Health and Wellness Department under the Adaptation stream of the Aboriginal Health Transition Fund (NCNS, n.d.; Government of Nova Scotia, 2011). The project involves a health needs assessment of all Mi'kmaq and other Aboriginal peoples living off-reserve in Nova Scotia, conducted by the Native Council of Nova Scotia (NCNS, n.d.; Government of Nova Scotia, 2011). The data gathered will assist the Department of Health and Wellness and district health authorities in program and service delivery planning to improve health care accessibility for off-reserve Aboriginal peoples in Nova Scotia.

Aboriginal Health Policy Framework

The Nova Scotia Department of Health and Wellness also received funding through the Aboriginal Health Transition Fund to develop an Aboriginal Health Policy Framework in partnership with First Nations and other Aboriginal partners, and relevant federal and provincial departments and agencies. The framework will outline approaches, using an Aboriginal health policy lens, to ensure that barriers to accessing care are identified and mitigated, and to develop a conflict resolution process to address issues of roles and responsibilities (Government of Nova Scotia, 2011).

Mental Health and Addictions Prevention and Promotion Initiative

The Mental Health and Addictions Prevention and Promotion Initiative is a partnership between the Colchester East Hants Regional Authority with Indian Brook and Millbrook First Nations to adapt tools and processes related to mental health and addictions services delivery in a culturally appropriate way. Funding of \$208,000 is provided for this initiative through the Nova Scotia Department of Health and Wellness under the Adaptation stream of the Aboriginal Health Transition Fund (Health Canada, 2008; Government of Nova Scotia, 2011).

Improving Pathways to Mental Health

This initiative received \$598,881 from the Pan-Canadian envelope of the Aboriginal Health Transition Fund to improve access to mental health services in Nova Scotia and New Brunswick communities affiliated with the Atlantic Policy Congress of First Nations Chiefs, improve mental health knowledge of community workers, and increase the efficiency of the mental health system through the introduction of “health navigators” (Health Canada, 2008). The project involves three health authorities (Colchester East Hants, Pictou County and River Valley) and eight First Nations (Millbrook, Indian Brook, Tobique, Woodstock, Kingsclear, St. Mary’s, Oromocto and Pictou Landing).

The Path Less Traveled Program

The Path Less Traveled Program received \$275,000 through the Adaptation stream of the Aboriginal Health Transition Fund, administered by the provincial government’s Department of Health, to adapt education materials and referral processes for Aboriginal people diagnosed with chronic diseases like cancer, in order to improve their experience with the health care system. The project involves the Potlotek (Chapel Island), Eskasoni, Membertou, Wagmatcook and We’koqmaq First Nations in partnership

with the Guysborough Antigonish Strait and Cape Breton District Health Authorities, Cancer Care Nova Scotia and the Diabetes Care Program of Nova Scotia (Health Canada, 2008; Government of Nova Scotia, 2011).

Friendship centres

In Nova Scotia, there is no provincial association of friendship centres. There is one friendship centre, the Mi’kmaq Native Friendship Centre, but little information on the health-related programs and services it offers can be readily obtained from the Internet other than that it offers a needle exchange and health education programs.

4.10 Newfoundland and Labrador

The implementation of health programs and initiatives in Newfoundland and Labrador is affected by the terms of the Labrador Inuit Land Claims Agreement, which resulted in regional self-government for the Inuit of northern Labrador. The Nunatsiavut Government, established in 2005, has the power to pass laws concerning land and resource management, education, culture, language and health. The Nunatsiavut Government’s Department of Health and Social Development implements programs and services related to the health and social development of its residents. It has a regional office in Happy Valley-Goose Bay and seven local community offices. The regional office is responsible for oversight, policy development and program development and implementation, while local community offices work closely with Labrador-Grenfell Health to deliver health and social services to residents of Nunatsiavut (Nunatsiavut Department of Health and Social Development, 2009).

Most Aboriginal-specific health-related programs and initiatives in the province have been implemented through either the Nunatsiavut Government or partnerships between the federal government and the

provincial government and/or Aboriginal organizations or government. Few Aboriginal programs and initiatives are implemented directly by the government of Newfoundland and Labrador.

Programs and Initiatives Funded and Administered by the Provincial Government

The government of Newfoundland and Labrador generally provides health programs and services to its general population through its Health and Community Services Department and its four regional health authorities (Eastern, Central, Western and Labrador). While the department has implemented several programs and initiatives that target health challenges facing the province’s Aboriginal population and has indicated its commitment to addressing Aboriginal issues in its provincial wellness plan and mental health and addictions policy framework (Government of Newfoundland and Labrador, 2005; 2006b), it has not targeted any health-related programs or initiatives specifically at this population group. While the 2010 budget provided funding to hire a dedicated Aboriginal Health Liaison for the department, no health programs or initiatives dedicated specifically to Aboriginal health could be identified prior to 2009.

Several health-related programs and initiatives offered through other government departments identify Aboriginal peoples as a priority target group or would be of considerable relevance to many Aboriginal peoples (though are not specifically targeted at this group). For example, the Women’s Policy Office coordinates the Violence Prevention Initiative, which has a strategic priority targeted at Aboriginal women. The Aboriginal Affairs Department also provides two health-related programs that would be relevant to many Aboriginal people in the province: the Air Foodlift Subsidy Program, aimed at improving

diet and nutrition; and the Suicide and Detrimental Lifestyles Program, aimed at improving youth health. Brief descriptions of these programs and initiatives are provided below.

Violence Prevention Initiative

Family violence has been identified as an important social and health issue in many Aboriginal communities. The Violence Prevention Initiative reflects the government of Newfoundland and Labrador's commitment to addressing violence in the province. Established in 2006 as a government and community partnership, the six-year initiative is developing a strategic plan for violence prevention, focusing on the populations most at risk. The government of Newfoundland and Labrador committed an annual investment of \$1.25 million to developing this comprehensive plan of action to reduce violence (Government of Newfoundland and Labrador, 2006a). Aboriginal women and children are considered target populations and are the primary focus of Strategic Priority #4 – Supporting Aboriginal women and children. The goals of this priority are to establish new partnerships to advance violence prevention in Aboriginal communities and “to help facilitate processes led by Aboriginal communities to deal with the impact of violence and increase culturally appropriate violence prevention strategies” (Government of Newfoundland and Labrador, 2006a, p. 25).

Air Foodlift Subsidy

The Air Foodlift Subsidy Program was established in 1997 to ensure that nutritious, perishable food products are available to Labrador's coastal communities during winter months when ice conditions make the shipping of food through marine service unfeasible. While the program is not specifically targeted at the province's Aboriginal population, Aboriginal people constitute much of the population in these coastal communities. The program is voluntary

and provides a subsidy to participating retail stores to offset the high cost of flying perishable foods into these communities. The program operates during the period when marine service is no longer available due to ice conditions, and covers 80% of air freight costs for all communities (Labrador and Aboriginal Affairs, 2009a).

Suicide and Detrimental Lifestyles Grant Program

The Suicide and Detrimental Lifestyles Grant Program provides funding up to a maximum of \$20,000 for projects targeted at assisting Aboriginal youth in areas such as drug and alcohol abuse, delinquency and other detrimental lifestyle issues (Labrador and Aboriginal Affairs, 2009b). These projects can be focused on prevention, intervention or training, but must demonstrate a culturally appropriate approach.

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted at Newfoundland and Labrador's Aboriginal population are funded and administered through alternative mechanisms, including directly by the federal government (see Chapter 3), indirectly by the federal government through partnerships with the provincial government and/or Aboriginal organizations, or through Aboriginal organizations directly. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Newfoundland and Labrador to improve the health of its Aboriginal population.

Local and regional examples

Several programs and initiatives available to Newfoundland and Labrador's Aboriginal population are implemented and/or administered by regional health authorities or other Aboriginal

organizations, or apply only to Aboriginal people in a specific location. Most of these are offered through the Nunatsiavut Government or through the Federation of Newfoundland Indians.

Nunatsiavut Department of Health and Social Development

The Nunatsiavut Department of Health and Social Development provides community-based health programs and services for this region in the areas of injury prevention, addictions, communicable disease control, healthy children initiatives, home and community care, sexual health, healthy lifestyles and mental health (Nunatsiavut Department of Health and Social Development, 2009). No further details of these programs and initiatives can be readily obtained from the Internet.

The department also undertook a series of community hearings in 2006 under the Community Healing Initiative to discuss alcohol, drugs and suicide. The community hearings led to the establishment of an Alcohol and Drug Hearings Committee to develop action plans to address the recommendations that came out of this initiative.

Pathway to a Healthier Lifestyle Initiative

The Federation of Newfoundland Indians has undertaken a diabetes prevention initiative referred to as the “Pathway to a Healthier Lifestyle Initiative.” The initiative may receive its funding through the federal government's Diabetes Initiative, but since this information cannot be acquired directly through a search of the federation's website, it is included here rather than in the federal programs and initiatives section below. The “Pathway to a Healthier Lifestyle Initiative” provides information about type 2 diabetes and how to prevent it, through publications, public education and consultation (Federation of Newfoundland Indians, 2008).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the provincial government and/or in partnership with Aboriginal organizations. In Newfoundland and Labrador, the provincial government participates in the administration of the Canadian Prenatal Nutrition Program as well as Community Action Programs for Children, overseeing projects in the province (Government of Newfoundland and Labrador, 2004). The government of Newfoundland and Labrador also collaborated on the development of the federal Integrated Pan-Canadian Healthy Living Strategy (Government of Newfoundland and Labrador, 2008a) and in 2008 provided \$50,000 for Team Newfoundland and Labrador's participation in the North American Indigenous Games (Government of Newfoundland and Labrador, 2008b).

While not all of these programs are specifically targeted at the health of Aboriginal populations, they affect Aboriginal people. For example, programs under the Canadian Prenatal Nutrition Program and Community Action Programs for Children are in place in communities with substantial Aboriginal populations, and the health of Aboriginal peoples is specifically recognized as a key priority in the province's Recreation and Sport Strategy, an initiative undertaken as part of the Integrated Pan-Canadian Healthy Living Strategy (Newfoundland and Labrador Ministry of Tourism, Culture and Recreation, 2007).

The federal government has also partnered with the provincial government and various Aboriginal organizations on a number of projects under the Aboriginal Health Transition Fund. Under the Adaptation envelope, for example, the Federation of Newfoundland Indians and Labrador Métis Nation have received funds to conduct needs assessments.

Under the Integration envelope, the Mushuau Innu received funds to create mental health and addictions protocols, the Labrador Inuit/Innu received funds for the development and delivery of an FASD worker training program, and the Miawpukek received funds to develop and implement a technology plan for a community health information system that links the regional health authority and provincial systems (Atlantic Policy Congress, n.d.).

In addition to these programs and initiatives, the federal government (through Indian and Northern Affairs Canada, Health Canada and the Solicitor General) has initiated the Labrador Innu Comprehensive Healing Strategy. (More details on this strategy can be found in Chapter 3.) Some programs are also offered through the province's friendship centres.

Friendship centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. In Newfoundland and Labrador, although there is no provincial association of friendship centres, there are two friendship centres: the St. John's Native Friendship Centre Association and Labrador Friendship Centre. Information about additional provincial funding for the St. John's Native Friendship Centre Association could not be readily obtained from the Internet, but it is clear from the Labrador Friendship Centre website that it receives additional funding from the government of Newfoundland and Labrador for its programs (Labrador and Aboriginal Affairs, 2009c).

Health-related programs and services offered by the St. John's Native Friendship Centre Association include the Shanawdithit Shelter for individuals

experiencing temporary or regular homelessness; the Four Winds Aboriginal Youth Centre, which offers cultural and recreational activities such as drumming and dancing; and referrals and counselling on matters of employment, housing, education and health (St. John's Native Friendship Centre, n.d.). Health-related programs and services offered by the Labrador Friendship Centre include the Aboriginal Family Centre for children aged 0-6 and their families, which promotes social, cultural, educational, physical, emotional and nutritional growth (funded through the federal government's Aboriginal Head Start initiative); the HIV/AIDS Labrador Project funded by the Public Health Agency of Canada and the Canadian Strategy on HIV/AIDS to increase individual and community awareness; and cultural and recreational activities (Labrador Friendship Centre, n.d.).

4.11 Yukon

The development of health-related programs and initiatives in Yukon is influenced by the terms of past treaty negotiations. Final agreements have been signed with 11 of the First Nations, with three First Nations still in negotiations (Council of Yukon First Nations, n.d.). As a result, health-related programs and initiatives targeted at Aboriginal peoples in the territory can be initiated by the Yukon government, the Council of Yukon First Nations (the central Aboriginal political organization representing First Nations in Yukon), various First Nations, or the federal government either directly or in partnership with the territorial government and/or Aboriginal organizations.

It is also influenced by the relatively high proportion of the population that is Aboriginal: with approximately 25% of the population of Yukon being Aboriginal (Yukon Bureau of Statistics, 2006). Most programs and initiatives offered by the

Yukon government to improve the health of the Aboriginal population are also available to the general population.

Programs and Initiatives Funded and Administered by the Territorial Government

An Internet search identified only one health-related program or initiative funded and administered directly by the Yukon government specifically for Aboriginal peoples within the territory in 2009. This initiative focused on women's health through the prevention of violence.

Prevention of Violence against Aboriginal Women Fund

Family violence has been identified as an important social and health issue in many Aboriginal communities. With annual funding of \$200,000, the Prevention of Violence against Aboriginal Women Fund supports communities in developing and implementing programs designed by Aboriginal women (Government of Yukon, 2009). The purpose of these programs is to eliminate violence against Aboriginal women.

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted at Yukon's Aboriginal population are funded and administered through alternative mechanisms, including directly by the federal government (see Chapter 3), indirectly by the federal government through partnerships with the territorial government and/or Aboriginal organizations, or through Aboriginal organizations directly. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Yukon to improve the health of its Aboriginal population.

Local and regional examples

Several programs and initiatives available to Yukon's Aboriginal population are implemented and/or administered by Aboriginal organizations or apply only to Aboriginal people in a specific location. An example is the First Nations Health Programs provided by the Yukon Hospital Corporation in Whitehorse.

First Nations Health Programs – Yukon Hospital Corporation

To promote the provision of quality, culturally sensitive, holistic care to Aboriginal people, the Yukon Hospital Corporation has implemented First Nations Health Programs. These programs advocate for and guide Aboriginal people through the acute care health system; recognize the impacts of residential school and colonialism on the health of Aboriginal people; provide social and spiritual support, as well as access to traditional food, medicine and healing practices in an acute care environment; and educate health care providers to increase understanding and awareness of Aboriginal culture to enhance safety and competence (Whitehorse Hospital, n.d.).

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the territorial government and/or in partnership with Aboriginal organizations. In Yukon, a number of First Nations deliver programs that fall under the federal government's Canadian Prenatal Nutrition Program (the Carcross/Tagish First Nation and Teslin Tlingit Council, and in Dawson City, Watson Lake and Whitehorse), the National Native Alcohol and Drug Abuse Program, and Aboriginal Head Start initiatives. No further details about these programs can be readily acquired from Internet sources beyond what is described in Chapter 3.

In addition, a First Nations Community Health Scan was undertaken in 2008 by

the Council of Yukon First Nations, in collaboration with Health Canada, to discover ways to improve health care in these communities, and to enable health care professionals to help build capacity in communities (Council of Yukon First Nations, 2008). There is also a friendship centre in Yukon that provides health-related programs and services.

Friendship centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. There is no territorial branch of the National Association of Friendship Centres in Yukon. However, there is one friendship centre, located in Whitehorse. The Skookum Jim Friendship Centre provides several health-related programs, including a diabetes prevention program that offers education sessions, community kitchens, active living activities, traditional food gathering workshops, and harvesting and preserving traditional foods workshops; a prenatal nutrition outreach program; recreation and leisure programs, such as an after school sports program, arctic sports and Dene games, and a rediscovery wilderness camp; and a traditional parenting program aimed at improving the health and quality of life of Aboriginal peoples through the teaching of parenting skills (Skookum Jim Friendship Centre, 2011). The centre also administers the federal initiative, Cultural Connections for Aboriginal Youth Centres, in Yukon. The centre's website provides no information about territorial funding for the programs.

4.12 Northwest Territories

Most health-related programs and initiatives in the Northwest Territories are those offered by the territorial government for the general population or

are federal initiatives targeted specifically at the Aboriginal population and funded through Health Canada or the Public Health Agency of Canada. Federal initiatives may include Aboriginal Head Start, substance use prevention, chronic and communicable disease prevention, and family health promotion (Northwest Territories [NWT] Health and Social Services, 2009a). The lack of Aboriginal specific health-related programs and initiatives may be a reflection of the large Aboriginal population living in the territories, where approximately 50% of the population is Aboriginal (Invest in Canada Bureau, n.d.).

Programs and Initiatives Funded and Administered by the Territorial Government

An Internet search identified only one health-related program funded and administered by the government of the Northwest Territories that specifically targets the Territory's Aboriginal population. The Northwest Territories is the only jurisdiction in Canada that provides a supplementary health benefits program specifically for indigenous Métis residents. The Métis Health Benefits Program covers 100% of expenses associated with dental services, eyeglasses, medical supplies and equipment, medical travel and prescription drugs for eligible recipients (NWT Health and Social Services, 2009d).

Given the large Aboriginal population living in the Northwest Territories, however, it seems relevant to mention some of the health programs and initiatives that are available to all residents of the Northwest Territories and that address some of the most challenging health issues facing Aboriginal people. These programs and initiatives make up the four prongs of the Northwest Territories Health Promotion Strategy. Introduced in 1999, the strategy proposed four target areas for improving the overall health and well-being of the

territories' peoples: healthy lifestyles, injury prevention, tobacco reduction and maternal health (NWT Health and Social Services, 2000).

Active Living

The Northwest Territories' Active Living concept targets all ages – from infants to Elders – and promotes a healthy lifestyle through proper nutrition (either from a variety of northern/traditional food sources or from other nutritious food sources) and being physically active each day (NWT Health and Social Services, 2010).

Injury Prevention Strategy

With more Northwest Territories residents dying from injuries than from any other cause, the Injury Prevention Strategy aims to create a culture of safety by increasing injury prevention awareness, knowledge and skills; reducing the rate of heavy-drinking-related injuries; and strengthening injury prevention practices, public policy and legislation. The strategy is a collaboration between the Northwest Territories government and other non-governmental organizations (NWT Health and Social Services, 2009c).

Tobacco harm reduction and cessation

Almost twice as many residents of the Northwest Territories smoke compared with other Canadians (NWT Health and Social Services, 2009e). The Department of Health and Social Services is working to discourage tobacco use and support residents of the territories who wish to quit, and to protect residents from second-hand smoke through a variety of tobacco cessation/reduction strategies and programs (NWT Health and Social Services, 2009e).

Healthy Pregnancies

In partnership with several other Northwest Territories initiatives, Healthy Pregnancies supports pregnant women, new mothers and young families in making healthy choices during and after pregnancy (NWT Health and Social Services, 2009b).

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted at the Northwest Territories' Aboriginal population are funded and administered through alternative mechanisms, including directly by the federal government (see Chapter 3), indirectly by the federal government through partnerships with the territorial government and/or Aboriginal organizations, or through Aboriginal organizations directly. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in the Northwest Territories to improve the health of its Aboriginal population.

Local and regional examples

No regional or Aboriginal organization examples of health-related programs and initiatives targeted specifically at the Northwest Territories Aboriginal population could be readily identified through an Internet search.

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the territorial government and/or in partnership with Aboriginal organizations. Most of the programs and initiatives in the Northwest Territories that could be identified through a search of the Internet involved federal government partnerships with the territorial government or with friendship centres.

In the Northwest Territories, the territorial government's Department of Health and Social Services administers the Canada Prenatal Nutrition Program, as well as the Brighter Futures program, on behalf of the federal government (NWT Health and Social Services, 2006a, 2006b). In addition, the government of

the Northwest Territories has also initiated the Healthy Foods North program as part of the federal government's Pan-Canadian Healthy Living Strategy. The program aims to "reduce risk for chronic disease by working in partnership with the Inuit, Inuvialuit and First Nations communities to develop, implement and evaluate culturally appropriate community-based intervention programs aimed at improving diet, increasing physical activity and providing education concerning healthy lifestyle choices" (PHAC, 2010b, p. 9). The program is being implemented in small, primarily Aboriginal, communities. The territorial government also provided funding for more than 250 athletes, coaches and officials to attend the North American Indigenous Games in 2008 (Government of NWT, 2008).

Friendship centres

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. While the National Association of Friendship Centres indicates that there is a territorial branch of the association in Hay River, neither the association nor the individual friendship centres have websites. According to a Government of Northwest Territories database, there are seven Friendship Centres located in the Northwest Territories, providing the following health-related programs and services:

- Behchoko Friendship Centre – alcohol and drug prevention/counselling, special needs, youth, women's well-being and men's healing
- Fort Simpson Friendship Centre – fitness centre, youth programming
- Ingamo Hall Friendship Centre, Inuvik – youth wellness program that includes HIV/AIDS education; Healthy Babies program, Elder services
- Soaring Eagle Friendship Centre, Hay

River – aside from a food bank and referrals and advocacy services, focuses primarily on community capacity development initiatives and cultural programs

- Tree of Peace Friendship Centre, Yellowknife – programs to develop a positive self-image, alcohol and drug prevention/counselling, programs to develop positive self-image
- Uncle Gabe's Friendship Centre, Fort Smith – counselling and referral services, youth recreation room, victims/witness assistance program; wellness facilitator and youth mentor programs
- Zhahti Koe Friendship Centre, Fort Providence – counselling services (NWT Health and Social Services, n.d.).

No information can be readily acquired from Internet sources about the degree of federal or territorial funding that supports health-related programs offered through these friendship centres.

4.13 Nunavut

As the population of Nunavut is primarily Inuit, the federal government provides most of the funding for Nunavut health care programs and services. With the establishment of Nunavut in 1999, administrative responsibilities were centralized from regional health and social services boards to the Nunavut Department of Health and Social Services in Iqaluit. The Health and Social Services Department provides a broad range of programs and services in primary and acute health – inpatient and ambulatory, child protection, family services, mental health, health promotion and protection, and injury prevention – for all residents of Nunavut.

Programs and Initiatives Funded and Administered by the Territorial Government

Most health-related programs and initiatives offered by the government

of Nunavut are available to the general population. Given that the majority of the territory's population is Aboriginal, while these programs and initiatives are not considered Aboriginal-specific, they are particularly important for the health and well-being of its Aboriginal population and thus warrant some mention. They include programs and initiatives in the areas of health promotion, communicable disease, violence prevention, mental health, maternal health and health human resources.

Health promotion

Health promotion has been a key focus of initiatives and programs offered by the government of Nunavut. Health promotion initiatives have focused on public health from a social determinants perspective, as well as on reducing tobacco use and improving nutrition.

Public Health Strategy

In 2008, the Nunavut government released its first public health strategy, *Developing Healthy Communities: A Public Health Strategy for Nunavut*, to improve the health status of all residents of Nunavut (Nunavut Health and Social Services, 2008). The strategy adopts a holistic approach to improving health with a vision of creating "the conditions that enable all Nunavummiut to enjoy excellent health and reach their full potential" (Nunavut Health and Social Services, 2008, p. 6). It is guided by the following principles: approaches that address the root causes of poor health, community participation in public health decision-making, collaboration and partnerships for collective action, multiple strategies in multiple settings, accountability and evidence-based decisions.

Nutrition in Nunavut: A Framework for Action

Nunavut's nutrition framework aims to ensure that the people of Nunavut have access to a healthy diet, by addressing

areas such as improving food security and reducing or eradicating malnutrition (Nunavut Health and Social Services, 2007a). The vision of the framework is that all residents of Nunavut enjoy healthy eating to support good health, well-being, and self-reliant and productive lives by having access to safe, nutritious and culturally valued foods.

Communicable diseases

Two programs were identified in the area of communicable diseases: one related to controlling tuberculosis and the other to preventing communicable diseases through immunization.

Tuberculosis Control Program

The Tuberculosis Control Program aims to decrease and prevent the incidence of tuberculosis – in particular the emerging multidrug-resistant TB – in Nunavut by increasing education, surveillance and clinical services throughout the territory, and ensuring that all patients diagnosed with TB receive prompt, appropriate treatment. A TB Consultant advocates for multidisciplinary projects in order to create comprehensive prevention and treatment strategies for TB (Nunavut Health and Social Services, 2000).

Nunavut Immunization Program

The Department of Health and Social Services provides funding for all childhood and most adult immunizations in Nunavut. Prevnar, a new vaccine that has been shown to act against pneumococcus (a major cause of meningitis, blood infections and ear infections), is being offered to children younger than two years (Nunavut Health and Social Services, 2000).

Family violence

Family violence has been acknowledged as an important social and health problem in many Aboriginal communities. The government of Nunavut has established one program to address the issue of family violence.

Family Violence Relocation Program

The Nunavut Department of Health and Social Services' Family Violence Services section aims to reduce the incidence of family violence and to protect and support victims of family violence. The Family Violence Relocation Program assesses each situation individually and assists victims of family violence in moving to a safe place or a shelter. The Department of Health and Social Services also funds shelters and safe homes throughout the territory (Nunavut Health and Social Services, 2009a).

Human resources

The recruitment and retention of health professionals in the North has been identified as a major challenge to Aboriginal peoples' access to health care (Rohan, 2003). The government of Nunavut has implemented one initiative directed at this critical health issue.

Nunavut Nursing Recruitment Strategy

In 2007, the government of Nunavut implemented the Nunavut Nursing Recruitment Strategy to address the long-term health care needs of Nunavut through recruitment, retention and education of nursing personnel (Nunavut Health and Social Services, 2007b). The strategy incorporates a number of initiatives and programs to support its goals, including the recruitment and training of Inuit candidates for careers in nursing and other public health professions. The strategy is designed to be ongoing, with major targets for evaluation set for a five-year period.

Maternal and child health

In order to ensure that infants have the best start in life, the government of Nunavut has implemented a strategic plan to address challenges to maternal and newborn health.

Maternal and Newborn Health Care Strategy

The five-year Maternal and Newborn Health Care Strategy was implemented in

2009 to guide the Department of Health and Social Services in providing quality maternal and newborn health care to its residents. Specific goals set out in the strategy include increasing local capacity and participation in health care; increasing the number of maternity care workers and registered midwives; increasing the number of pregnant women receiving early comprehensive and culturally relevant prenatal care; and increasing pregnancy planning and parenting support and skills (Nunavut Health and Social Services, 2009b).

Mental health and addictions

When this Internet search was conducted, the government of Nunavut was working on two initiatives relating to mental health and addictions: a revision to an addictions and mental health strategy and a suicide prevention strategy.

Addictions and Mental Health Strategy

The Addictions and Mental Health Strategy implemented by the Nunavut government in 2002 was intended to facilitate the implementation of a wide range of new and enhanced addictions and mental health services, including individual counselling, group healing sessions, community wellness workshops, screening and referrals, and case management (Murphy, 2002). When this Internet search was conducted, the government was working to revise the strategy (Government of Nunavut, Nunavut Tunngavik, Embrace Life Council & RCMP, 2010; Nunavut Tunngavik, Health Canada & Government of Nunavut, 2009). Revision of the strategy was one of the recommendations that emerged from the Suicide Prevention Strategy's commitment to strengthening the continuum of mental health services so as to improve well-being and reduce the level of suicide risk.

Suicide Prevention Strategy

In response to calls for a coordinated approach to suicide prevention, in 2008

a partnership was formed between the Government of Nunavut, Nunavut Tunngavik Inc., the Embrace Life Council and the Royal Canadian Mounted Police to create a suicide prevention strategy. The strategy was intended to provide a comprehensive set of programs and services incorporating prevention, intervention and postvention components (Government of Nunavut et al., 2010). One of the main recommendations that emerged from the strategy was to revise the Addictions and Mental Health Strategy so as to improve well-being and reduce the level of suicide risk.

Alternative Mechanisms for Providing Health Programs and Initiatives

Most health-related programs and initiatives targeted specifically at Nunavut's Aboriginal population are funded and administered through alternative mechanisms, including directly by the federal government (see Chapter 3), indirectly by the federal government through partnerships with the territorial government and/or Aboriginal organizations, or through Aboriginal organizations directly. This section presents examples of these types of programs and initiatives. The list is not intended to be inclusive, but is provided to give readers a better understanding of some of the innovative programs and initiatives that have been implemented in Nunavut to improve the health of its Aboriginal population.

Local and regional examples

No regional or Aboriginal organization examples of health-related programs and initiatives targeted specifically at the Nunavut Aboriginal population could be readily identified through an Internet search.

Federal examples

Several of the federally funded Aboriginal health programs and initiatives (as described in Chapter 3) are administered by the territorial government. The

government of Nunavut administers the Brighter Futures program, Canada Prenatal Nutrition Program, Aboriginal Diabetes Initiative, and the National Aboriginal Youth Suicide Prevention Strategy and solvent abuse programs on behalf of the federal government (Nunavut Health and Social Services, 2010). Nunavut also joined the federal FAS/FAE Initiative in 1999 (McKechnie, 2000). In addition, the territorial and federal governments, through Canada Health Infoway, have been working in partnership to expand access to telehealth for Nunavut communities (Canada Health Infoway, 2008, 2011b). Since most of these initiatives are profiled in Chapter 3, a description of only the Canada Health Infoway Telehealth project is provided below.

As well as working in partnership with the government of Nunavut, the federal government has worked in partnership with Aboriginal organizations on some initiatives. Examples are two programs that emerged as part of the federal government's Tobacco Control Strategy, and programs offered through the territory's one friendship centre, in Nunavut.

Canada Health Infoway Telehealth Project

Canada Health Infoway is a federally funded, independent, not-for-profit organization that is working in partnership with the country's federal, provincial and territorial governments to create and implement increased access to health care in remote northern communities through telehealth (Canada Health Infoway, 2005, 2008, 2011a). In 2005, the government of Nunavut and Canada Health Infoway announced a joint capacity-building project that included a training program for telehealth technicians. In 2008, the federal Minister of Health and the CEO of Canada Health Infoway announced a further \$2-million federal investment to upgrade current telehealth sites and expand access to the Chesterfield Inlet Naja Isabelle Home and southern boarding homes.

Tobacco Control Strategy projects

In 2009 the federal government funded two projects in Nunavut to teach Aboriginal youth about the dangers of smoking (Health Canada, 2009c). The "Quit to Win! Challenge" is a contest for Aboriginal youth aged 8-17 who agree to quit smoking. The challenge is a two-year project involving a partnership with the National Indian and Inuit Community Health Representatives organization and the government of Nunavut.

The "For Youth By Youth Trainer Training Program" provides Aboriginal youth with the skills required to educate and positively influence their peers about the dangers of tobacco. The program involves a partnership between the Nunavut government's Health and Social Services Department and community health representatives, nurses and teachers in communities throughout Nunavut (Health Canada, 2009c).

Aboriginal Friendship Centre Association

The federal government provides financial support to Aboriginal friendship centres across Canada through the Aboriginal Friendship Centre Program, which is administered by the National Association of Friendship Centres with help from regional friendship centre associations. While there is no territorial branch of the National Association of Friendship Centres in Nunavut, there is one friendship centre: the Pulaarvik Kablu Friendship Centre, located in Rankin Inlet. The centre offers a wide range of health-related programs and services for infants through to Elders, including the Piruqsagtigiiktuut (Prenatal Nutrition) program for expectant and new mothers; early childhood education programs that include physical activities and nutrition education; a spousal abuse counselling program; the Kivalliq Outreach Program to foster improved family relationships; and a Victims' Services program (Pulaarvik Kablu Friendship Centre, n.d.). In addition, the centre administers

programs under the federal government's Aboriginal Diabetes Initiative and Children's Oral Health Initiatives (Pulaarvik Kablu Friendship Centre, n.d.).

4.14 Summary

In summarizing conclusions that can be drawn from an Internet search for health-related programs and initiatives targeted at Aboriginal peoples within the provinces and territories, it is important to again remind readers that there are challenges associated with conducting Internet-based searches, which can bring into question the accuracy of some of the information collected. As a result, this chapter may not be inclusive of all programs and initiatives available for Aboriginal peoples in the provinces and territories, nor is it certain that all identified programs and initiatives were in fact still in place at the time the Internet search was conducted in 2009. In some cases, for example, programs and initiatives were identified through the Internet search as having been implemented in the past, yet there was no confirmation of their ongoing status.

From the information obtained through the Internet search, a picture emerges of the complex and fragmented nature of the mechanisms through which health-related programs and initiatives for Aboriginal peoples are implemented across the provinces and territories. It is also a picture of inconsistency in the types of programs and initiatives that are offered specifically for Aboriginal peoples. Few programs and initiatives are funded and administered directly by provincial or territorial governments for their Aboriginal populations. Instead, most are provided through a complex financial and administrative arrangement involving the federal government working in partnership with either the provincial or territorial governments or Aboriginal organizations, or both. In addition, most programs and initiatives are not province-wide in scope, but are more local or regional.

Most health-related programs and initiatives for Aboriginal peoples are provided in one of four loosely clustered types:

- Programs and initiatives funded and administered directly by the provincial or territorial government are more common in the western provinces, where there are substantial Aboriginal populations and few treaty settlements that involve self-government. These programs and initiatives may be administered directly by the provincial or territorial government or indirectly through regional health districts.
- In Canada's northern regions, where population density is generally low and a high proportion of the population is Aboriginal, most health-related programs and initiatives funded and administered by the territorial governments tend to be available to the general population rather than being targeted specifically at the Aboriginal population. Those that do target Aboriginal populations tend to involve some type of partnership with the federal government.
- In the Maritime Provinces where Aboriginal populations are relatively small (New Brunswick, Prince Edward Island and Nova Scotia), few health-related programs and initiatives that target the health of Aboriginal people are available beyond those provided by the federal government directly or in partnership with Aboriginal organizations.
- In Quebec and Newfoundland and Labrador, where self-government agreements have been signed, there is also little direct involvement by provincial governments in implementing health programs and initiatives for Aboriginal populations, as most programs and initiatives are offered through the health departments of Aboriginal self-governments or through the FNQLHSS Commission, which provides health programs for First Nations across Quebec and Labrador.

There also appears to be a lack of consistency in the types of health-related programs and initiatives being offered to Aboriginal peoples within the provinces and territories. While early child development, maternal health, diabetes and healthy eating programs are fairly typical, less common are suicide prevention, substance abuse, violence against women, and programs and initiatives related to cancer and communicable diseases. Generally fewer such programs and initiatives are available in provinces that have low Aboriginal populations.

Given the diversity of Aboriginal peoples across the country – a diversity that is reflected in Aboriginal cultures, socio-economic indicators and differences in health priorities and needs – it is not surprising that diversity and complexity is also reflected in program and initiative implementation to reflect the lived-world realities of Aboriginal families and communities in particular places. Nevertheless, in many provinces and territories, too many health needs of Aboriginal people are expected to be satisfactorily met through programs and initiatives available to the general public, without regard for the unique context in which these health issues have arisen, Aboriginal peoples' understanding of the issues, and the underlying socio-economic circumstances. Given the prevalence of certain health issues facing Aboriginal peoples across the country (as discussed in Chapter 1), it is also clear that there is a greater need for more equality in the types of health-related programs and initiatives offered to Aboriginal peoples across the provinces and territories in order to improve health and well-being in a culturally appropriate and respectful way.

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CONCLUSION



One of the primary goals of this report is to inform policy-makers, health care workers and others on the current state of knowledge of the health issues facing Aboriginal peoples and the available programs and initiatives targeting these issues. To provide a comprehensive overview of what is known about and being done to address Aboriginal health in Canada, this report has presented four substantive chapters. The first two focused on current knowledge about Aboriginal health, with Chapter 1 identifying health issues facing Aboriginal Canadians and Chapter 2 setting these health issues within a conceptual framework that considers the socio-economic, cultural and political context of Aboriginal peoples' health in Canada. The second two chapters shifted from what is known to what is being done to address the health disparities facing Aboriginal Canadians, with Chapter 3 focusing on federal programs and initiatives and Chapter 4 focusing on examples of programs and initiatives at the provincial and territorial level. What is clear from this report is that while there is a general understanding of the health issues facing Canada's Aboriginal population, there are considerable gaps in knowledge of the health of First Nations, Inuit and Métis specifically, and of what is being done to address their unique health issues at multiple levels.

Using current research and data on Aboriginal health, Chapter 1 highlighted the fact that while Canadians, on average, enjoy some of the world's best health care and quality of life, Aboriginal peoples generally have poorer health than the general population, despite considerable improvements in recent decades. The poorer

health of Aboriginal peoples can largely be attributed to the social, economic, cultural and political factors that have shaped, and continue to shape, their lives and to various barriers to addressing their health issues, including geographic, educational and economic barriers. However, the health issues facing Aboriginal peoples, and the barriers they face, are not uniform across First Nations, Inuit and Métis peoples, and public health interventions, if they are to be effective, must consider the unique contexts in which these peoples live.

Chapter 1 also highlighted the serious limitations in health research and data for Canada's Aboriginal population. Effective implementation of public health interventions requires current and relevant data. At present, much of the available research and data consider Aboriginal people as a homogenous group, yet there are differences among First Nations, Inuit and Métis; among urban and rural Aboriginal; and among on-reserve and off-reserve Aboriginal with respect to the health issues faced, the factors underlying these issues, and the challenges in addressing them. Likewise, data that are cross-national and longitudinal and that compare the same variables across the same cohort over the same time period are lacking. These limitations impede our understanding of the health of First Nations, Inuit and Métis peoples; developing strategies to address their unique health concerns and challenges will therefore be challenging.

Given that health is determined not only by genetics and lifestyle decisions, but by a host of other social, economic, cultural

and political factors that influence physical, mental and social health and well-being, an understanding of the health issues facing Canada's Aboriginal population requires a more holistic perspective. Chapter 2 conceptualized Aboriginal health within a broad social determinants of health framework. It began by defining what is meant by social determinants of health from international, national and Indigenous perspectives. The chapter highlighted current social and economic disparities between the general population and Aboriginal (First Nations, Inuit and Métis) populations and discussed the impacts of these disparities, as well as Indigenous-specific determinants, on the health and well-being of Aboriginal peoples.

Two key findings emerged from this chapter. The first is that international and national perspectives on social determinants are inadequate for understanding the health inequities faced by Canada's Aboriginal population. Indigenous-specific social determinants, such as the impacts of colonialism on Aboriginal languages, culture and identity, underlie some of the most pervasive socio-economic inequities between Aboriginal and non-Aboriginal Canadians. However, Aboriginal peoples do not uniformly experience the same social and economic disparities, nor are they equally affected by colonial policies, and these differences must be taken into consideration in the development of public health interventions. The second key finding is that while attempts to examine each social determinant of health in isolation can be made, the determinants are in fact multifaceted and interactive. This

implies that if there are to be meaningful improvements in the health and well-being of Aboriginal Canadians, not only must public health strategies address the socio-economic disparities between Aboriginal and non-Aboriginal Canadians, but they must also adopt an integrated and multi-sectoral approach.

Chapters 3 and 4 examined the role of the federal and provincial governments and Aboriginal organizations in funding and administering health-related programs and initiatives for Aboriginal peoples. The Internet was used as a research tool to identify available programs and initiatives for these chapters. While the Internet can be useful for providing an overview of the types of health-related programs and initiatives available for Canada's Aboriginal population, it also creates many challenges that can bring into question the accuracy and comprehensiveness of the information collected. As such, the programs and initiatives included in these chapters should not be considered to be inclusive of all programs and initiatives for Aboriginal people.

Chapter 3 focused on the federal government's role in providing health programs, initiatives and services to Aboriginal people. Several health issues facing Aboriginal peoples that were identified in Chapter 1 are well recognized and addressed by the federal government through targeted programs and initiatives. Most notably, the federal government has implemented several programs and initiatives targeted at the healthy development of infants and children, at improving overall health and reducing diabetes, and at reducing substance use/abuse. Other health issues are less well addressed by the federal government, including those related to cancer, injury, mental health and respiratory illness. There are also few federal programs and initiatives available for Métis and urban Aboriginal populations.

Health-related programs and initiatives implemented at the provincial or territorial level were the focus of Chapter 4. Our

search of the Internet for these types of programs revealed the complexity and fragmented nature of the mechanisms through which such programs and initiatives are implemented across the provinces and territories, as well as the inequitable access to programs and initiatives across Canada. Few programs and initiatives are funded and administered directly by the provincial or territorial government specifically for the Aboriginal population. These types of programs and initiatives are more common in provinces west of Quebec. Instead, most are provided through a complex financial and administrative arrangement involving the federal government working in partnership with either the provincial or territorial government, Aboriginal organizations or governments, or both. In addition, most are not province-wide in scale but rather are implemented to address the specific health needs of a local or regional Aboriginal population. Two factors that appear to play a role in the way in which health programs and initiatives are predominantly implemented in particular provinces and territories are the presence of Aboriginal self-government and the proportion of Aboriginal peoples living within the province or territory.

As with federal programs and initiatives, some health issues are recognized and addressed more consistently across the provinces and territories, while others are less consistently addressed. While programs and initiatives related to early child development, maternal health, and healthy living (physical activity/nutrition) programs are fairly typical across the provinces and territories, others in the areas of suicide prevention, substance abuse, violence against women, cancer and communicable diseases are less common, particularly in provinces with low proportions of Aboriginal people. Programs and initiatives in the territories tend to be available more commonly to the general public than to Aboriginal peoples specifically, and despite a fairly substantial Aboriginal population, programs and initiatives targeted by the provincial governments specifically for this group

are surprisingly limited in Manitoba and Saskatchewan.

Given the diversity of Aboriginal peoples across the country – reflected in Aboriginal cultures, socio-economic indicators, and differences in health priorities and needs – it is not surprising that diversity and complexity are features of program and initiative implementation in particular places. Nevertheless, in many provinces and territories, too many health needs of Aboriginal peoples are expected to be satisfactorily met through programs and initiatives that are available to the general public, without regard for the unique context in which these health issues have arisen. There is clearly a great need for programs and initiatives that reflect the lived-world realities of the population they are intended to serve, and for equity in the types of health-related programs and initiatives offered to Aboriginal peoples across the provinces and territories, in order to improve health and well-being in a culturally appropriate and respectful way. As well, there is a great need to enhance access to programs and initiatives for Aboriginal peoples living outside urban centres (where most health programs and services are located) and for non-status First Nations and Métis peoples who are currently excluded from most programs and initiatives and whose health needs are not being adequately addressed.

One limitation of this report is that its focus is on federal and provincial/territorial government programs and initiatives. Aboriginal organizations and governments have been implementing some innovative health programs in particular places that are more culturally appropriate and reflect the specific health needs of those communities. Some of these programs also incorporate Aboriginal approaches to health and healing and are having positive impacts on improving health. The success of such programs draws attention to the need to recognize existing Aboriginal approaches to health and healing.

