Aboriginal Health Systems in Canada: Nine Case Studies

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Abstract

This paper investigates Aboriginal health systems in Canada, in urban and rural First Nations communities, Inuit communities and Métis Settlements. A summary of the primary strengths and challenges of Aboriginally-controlled health systems is presented. Strengths include holism, synergy of western and traditional health philosophies, focus on primary care, collaboration with provincial services, integrated health service delivery, and administrative reform. Aside from the challenge of health status, Aboriginal health systems must contend with small community size, remoteness, lack of human resources including Aboriginal health professionals, a growing and aging population, inadequacy of funding accompanied with non-sustainability of the system, and jurisdictional barriers. Through nine case studies, successful approaches are presented to providing effective, responsive and culturally-appropriate community health services. These case studies underscore the diversity in Aboriginal health systems necessary to accommodate vast differences in cultural expectations, health service needs, jurisdictional complexity, and geographic location.

Key Words

Aboriginal, health systems, case studies, First Nations communities, Métis Settlements, Inuit communities

INTRODUCTION

This paper focuses on Aboriginal health systems existing in urban and rural First Nations communities, Inuit communities and Métis Settlements. Why are Aboriginal-specific health systems needed? The answer is complex and encompasses health needs of Aboriginal Peoples, cultural uniqueness, federal and provincial roles in health service delivery, and the physical geography of many Aboriginal communities. There are exciting and promising initiatives in Aboriginal health systems described in this paper. They are succeeding in overcoming jurisdictional, cultural and other barriers. This paper provides an answer to the questions federal committees and other groups often sincerely ask: What works? What changes can be made to the health care system to improve the health and well-being of Aboriginal Peoples?

This document is an excerpt from a larger paper on Aboriginal health systems commissioned by the National Aboriginal Health Organization in which all profiled communities agreed to their participation as case studies. This wider report also addresses Aboriginal health usage and expenditures, health system recommendations from the Royal Commission on Aboriginal Peoples, provincial health system reform, and international perspectives on Aboriginal health systems.¹

STRENGTHS OF ABORIGINAL SYSTEMS

Aboriginal communities – whether located on-reserves, in northern reaches of the country or in urban cores – have inherent resources that are proving to be attributes in designing effective and cost-efficient health services. Communities that have been successful in creating responsive, sustainable, accessible, and client-focused health systems share many common characteristics:
self-empowerment;
holistic approach;
synergy of traditions and western health philosophies;
primary care;
collaborations with provincial services;
integrated health services delivery; and
administrative reform.

Self-Empowerment

Aboriginal ownership and control of health services can contribute to a climate of self-empowerment in the community and can improve access to services through a supportive, culturally-appropriate environment. Thought provoking research into youth suicide among British Columbia’s First Nations communities provides convincing evidence of the impact of Aboriginal control of institutions and other measures to preserve cultural continuity in dramatically lowering youth suicide rates. In B.C., First Nation community suicide rates vary from 800 times the national rate to zero. This research evaluated six markers of cultural continuity:

1. land claims or steps to secure Aboriginal title to traditional lands prior to the establishment of the province-wide settlement process;
2. achievement of self-government allowing economic and political independence within their traditional territories;
3. band-controlled education services;
4. band-controlled police and fire protection services;
5. health services - divided between bands that had funding for permanent health care providers in their community and those that relied on temporary clinics, fly-in providers or out-of-community health services; and
6. presence of a facility designated for cultural use.

The research found that for communities where all of the measures of cultural continuity were present, no suicides occurred in the five-year study period. The suicide rate for those communities that possessed none of these factors was 137.5 per 100,000. A minimum of three factors was necessary to significantly lower the suicide rate. Taken individually, the reduction of relative risk provided by these factors ranged from 20 per cent (police and fire services) to 85 per cent (land claims).²

Holistic Approach

The Aboriginal concepts of holism and wellness are similar to a broad health determinants approach. Holism should not be regarded as just another health determinant as it is a philosophy embracing all life processes, whether they are physical, mental, spiritual, or emotional components. The concept of holism is integrated into community program design, from the level of patient care to administrative integration of health and social services and integrated planning with housing, training, justice, and corrections, schools and other community-based services.

The Aboriginal Healing and Wellness Centre in Winnipeg uses a health promotion framework where well-being is pursued through attaining balance of the spiritual, emotional, physical, and intellectual aspects of a child, youth, adult, or Elder as individuals, members of families, communities, and nations, and within the cultural, social, economic, and political environments.³

Synergy of Traditional and Western Health Philosophies

Traditional (also referred to as Indigenous) healing practices, which encompass physical, spiritual, emotional, social, and mental well-being, may be synergistically combined with western medical approaches to develop uniquely Aboriginal approaches to health services. Traditional and western practices each have their own strengths and weaknesses. Community preferences with regards to each will vary. Health centres in Ontario, which provide culturally-appropriate primary care to urban and rural Aboriginal populations, have the option of including traditional healers on their multidisciplinary team. A recent evaluation found clients most often accessed health promotion services related to traditional knowledge and skills (and nutritional and dietary issues) over a variety of other subjects including substance abuse, specific diseases or illnesses, stress management, depression, or empowerment. The majority of respondents reported that these services had helped them “a lot.” Urban-based health centres were more likely than rural health centres (which serve First Nations living on-reserve) to have included a traditional component to their health services.⁴ There may be a variety of reasons for this, such as the availability of traditional healers outside of the structured health system.

Not all communities may wish to include traditional healers in their health systems. In an innovative Health Transition Fund project involving primary care reform in the Eskasoni First Nation, a traditional component was not included or requested by the community.⁵ Some Aboriginal Peoples recognize the value of
traditional culture even though specific healing approaches may not be desired. The 1997 First Nations and Inuit Regional Health Survey, which polled about 10,000 adult respondents in First Nations and Inuit communities, found that more than 80 per cent of respondents answered positively to the question “Do you think a return to traditional ways is a good idea for promoting wellness?”

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Primary Care

The health system is organized around primary care and features multidisciplinary teams and linkages to external health resources. Access to adequate, culturally-appropriate primary care is still an issue in many communities. In these cases, the current approach to move resources from treating illness to promoting healthy lifestyles and preventing disease may be premature as primary care services may never have had a chance to make a significant difference because of under funding or low usage.

A prominent feature of primary care reform is the move from fee for service to salaried forms of physician remuneration. The multidisciplinary team can also include nurses, nurse practitioners, nutritionists/diabetes educators, pharmacists, psychologists, social workers, traditional healers, etc. Various models of primary care will be explored more thoroughly in case studies of the Eskasoni First Nation and urban Aboriginal health systems.

Collaborations With Provincial Services

Working linkages exist with external health authorities and solutions to jurisdictional issues are proactively sought. Provincial health systems are an integral part of the Aboriginal health system. Under the Canada Health Act, provincial governments are the administrators of physician and hospital services. All parties, be they Aboriginal, provincial or federal, have the same objective: to use limited health dollars to the greatest effect in order to improve the health system. Health usage studies have shown that Aboriginal Peoples are high users of provincial physician and hospital services. These studies are powerful evidence in favour of provincial collaboration in Aboriginal health systems. A later section of this paper will look more thoroughly at health care usage and expenditures of Aboriginal Peoples.

Good working relationships between Aboriginal and non-Aboriginal systems need not be more than instituting effective referral mechanisms and sharing of patient information as required. The success of instituting collaborative relationships will depend on the

HEALTH SYSTEM CHALLENGES

Aboriginal systems must deal with similar issues to those seen in all health systems, including the prioritization of programs in a climate of scarce resources, accommodating wage increases of the workforce, rationalizing services to achieve workable economies of scale, and shifting from a disease model to one that is based on health promotion and disease prevention. In addition, there are a set of challenges in the environment that largely define the Aboriginal situation:

- health status;
- community size;
- remoteness;
- human resources;
- Aboriginal health professionals;
- demographics;
- funding; and
- jurisdiction.
Health Status

Table 1 provides an overview of the Aboriginal health environment from the perspective of broad health determinants. This data has been gleaned from Statistics Canada Census and surveys, Health Canada indicators, Indian and Northern Affairs Canada administrative databases, and research studies. The picture is one of a population experiencing a disproportionate measure of illness, mortality, injury, addictions, and family violence. There are also overcrowded conditions, often inadequate housing and community infrastructure (water and sewage), with lower levels of employment, average income, and education. Simply put, Aboriginal Peoples rate significantly lower on virtually every measure of health and well-being when compared to the general Canadian population. Although not exclusively, these measures are heavily weighted on physical health and do not adequately cover the spiritual, mental, so-

Table 1a: First Nations and Inuit

Selected Health Status Measures
Mortality
The 1993 age standardized mortality rate for First Nations People was 10.8 deaths per 1,000 compared to 6.9 deaths per 1,000 for the Canadian population.\(^i\)

Life Expectancy
In 2000, First Nations and Inuit: males 68.9 years (7.4 years less than Canadian males); females 76.6 years (5.2 years less than Canadian females)\(^ii\)

Chronic Diseases
First Nations on-reserve to Canada ratio of age-adjusted prevalence for diabetes in 1997: 3.3 (males) and 5.3 (females); for heart problems: 3.0 (M) and 2.9 (F); for cancer: 2.0 (M) and 1.6 (F); for hypertension: 2.8 (M) and 2.5 (F) and for arthritis/rheumatism: 1.7 (M) and 1.6 (F).\(^iii\)

Selected Health Behaviours
Smoking
62% of First Nations People on-reserve smoked in 1997, which was double that of Canadians. Rates for First Nations under 30 years of age were more than 70%.\(^iv\)

Alcohol Use
In 1991, 73% of First Nations respondents to the Aboriginal Peoples Survey said alcohol was a problem in their communities and 59% said drug abuse was a problem.\(^v\)

Selected Health Determinants
Unemployment Rate
On-reserve First Nations had an unemployment rate of 29% in the 1996 Census, almost three times higher than the non-Aboriginal rate (10%). The Inuit rate was 22%.\(^vi\)

Income
First Nations People’s average income is lower than Canadians at any age or educational level. On-reserve First Nations People’s income levels were only half that of Canadians in the 1996 Census.\(^vii\)

Educational Attainment
In the 1996 Census, 63% of First Nations People completed secondary school compared to 79% in the Canadian population. More than four times as many Canadians possessed a university degree in the Census than First Nations (14% compared to 3% respectively). Most Census educational attainment indicators for Inuit were lower or comparable to First Nations.\(^viii\)

Water Systems
41.4% of First Nations and Inuit communities had piping to centralized water treatment plants in 1999-2000.

Community Sewage Systems
33.6% of First Nations and Inuit communities had at least 90% of their homes connected to community sewage disposal systems in 1999-2000.

Shelter
56.9% of First Nations dwellings on reserve were considered adequate in 1999-2000. In addition, 19% of on-reserve dwellings had more than one person per room, compared to 2% for Canada as a whole.\(^ix\)
Table 1b: Aboriginal Population (Excluding First Nations on-reserve)

2000-01 Canadian Community Health Survey (preliminary results)x

Selected Health Status Measures
Self-Rated Health Status 42.4% of Aboriginal People reported very good or excellent health compared to 61.2% of non-Aboriginal people.

Diabetes The prevalence of diabetes was two times that of non-Aboriginal Canadians (8.7% versus 4.3% respectively).

Restrictions in Functional Status 40% reported limitations in physical ability compared to 26.0% among non-Aboriginal people.

Major Depressive Episodes Almost twice as many Aboriginal People reported an occurrence of a major depressive episode as non-Aboriginal people (13.3% versus 7.3%).

Selected Health Behaviours
Smoking More than half of the Aboriginal population were smokers (1.9 times the non-Aboriginal rate). The largest difference in light daily and occasional smokers.

Obesity As defined by the body mass index, 24.2% of the Aboriginal population were obese compared to 14.1% of the non-Aboriginal population.

Alcohol Use Although Aboriginal People were less likely to report being weekly drinkers, and more likely to be former drinkers, over three times more Aboriginal people were assessed as being alcohol dependent than non-Aboriginal people (6.0% versus 1.8% respectively).

Selected Health Determinants
Educational Attainment Aboriginal Peoples were less likely to graduate from high school (43.8% versus 23.1% for the non-Aboriginal population did not graduate) and less likely to be post-secondary graduates (32.5% versus 50.8% respectively).

Work Status 38.1% of Aboriginal People worked the whole year compared to 53.2% of non-Aboriginal people.

Low income Based on total income and number of persons in the household, 27.3% of Aboriginal Peoples were evaluated as having a low income compared to 10.1% of non-Aboriginal people.

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ii Canada, Department of Indian Affairs and Northern Development, *Basic Departmental Data 2001* (Ottawa: Minister of Indian Affairs and Northern Development, 2002).

iii First Nations and Inuit Regional Health Survey National Steering Committee, *First Nations and Inuit Regional Longitudinal Health Survey* (Ottawa: First Nations and Inuit Regional Health Survey Steering Committee, 1999).

iv First Nations and Inuit Regional Health Survey National Steering Committee, 1999.


x Draft data provided to the National Aboriginal Health Organization from Statistics Canada, May 2002. All rates age-standardized. The definition of Aboriginal Peoples in the Canadian Community Health Survey included North American Indian, Métis and Inuit/Eskimo. This survey was not administered in First Nations communities, therefore included only the Aboriginal population not living on-reserve, including all communities in the territories. The 1991 APS is the most recent source of Métis-specific health data. It found for Métis aged 15 and older: 59% reported excellent or very good health, 43% reported at least one health problem; 27% reported high blood pressure; 25% bronchitis, 16% heart problems and asthma, 13% diabetes. Métis women were more likely than men to report one health problem and 54% of the Métis population were smokers.
cial, and emotional health of individuals and communities.

Poor health status by itself does not mean that the health system has failed to meet the needs of a population. Certainly, health services as a whole is only one of the many pieces of the puzzle that influences the health of a population. It is arguably of lesser importance than socio-economic factors such as income, education, lifestyle, and employment; the environment; and genetic predisposition.

For the majority of the Aboriginal population, however, the mainstream Canadian health system has often been inaccessible in physical terms (due to distance and jurisdictional divisions between federal and provincial governments) and also in cultural and psychological terms. Barriers to service involve language, cultural appropriateness, the scarceness of Aboriginal health providers, and lack of community involvement in the administration of health services. One effect of this is that health needs may be ignored until they become so serious as to require emergency attention. Lack of knowledge of the language and local culture of the Aboriginal community has obvious ramifications on simple communications between health provider and client. Health promotion efforts, not a flagship program of the mainstream health system by any means, have a limited target audience as Aboriginal Peoples in need may not be known by health system workers, or the health message may not be couched in terms that are compatible with Aboriginal culture.

**Community Size**

Aboriginal communities tend to be small. For example, 43 per cent of First Nations communities in the provinces and Yukon have populations of 400 or less. A further 34 per cent have populations between 401 and 1,000. For Inuit, Dene and Métis communities in the territories, community size is inversely related to the proportion of Aboriginal Peoples in the population. Communities that are virtually all Aboriginal are small and remote. There are eight Métis Settlements in Alberta, which comprise about 5,000 people. Métis may live in rural areas removed from small centres of 1,000 to 2,000 people. However, the majority are located in larger urban environments as part of the Aboriginal population that also includes off-reserve First Nations, urban Inuit and non-status Indians.

Small community size is not an issue in urban environments. The 1996 Census reported that 171,000 Aboriginal Peoples lived in seven of the country’s 25 Census metropolitan areas: Winnipeg (45,750), Edmonton (32,825), Vancouver (31,140), Saskatoon (16,160), Toronto (16,100), Calgary (15,200), and Regina (13,605). These populations are a mixture of all three Aboriginal groups. For example, in the 1996 Census, the Métis component of the population varied from 18 per cent in Toronto to 54 per cent in Winnipeg. The challenge for urban environments is the lack of a focus from which a community can be identified and a health system built. Friendship centres have played a significant role in providing a meeting place for the Aboriginal population. They have become involved in federally funded health programming such as urban Aboriginal Head Start and diabetes health promotion. As health services to the entire population, including Aboriginal People, are under provincial jurisdiction in these cities, it has been the exception, rather than the rule, that provincial governments have provided resources for Aboriginal health services. There have been varying levels of involvement within and among provinces, regions and territories in dealing with Aboriginal health issues. This involvement varies from Aboriginal representation on regional health boards to the rare allocation of health resources for Aboriginal-specific programs and services. The section on Urban Aboriginal Health Services, which follows, illustrates the success that these few Aboriginal urban-based initiatives have had in designing health services that have provided supportive, culturally-appropriate care and in the process become virtual communities. In these cases, the characteristics described above for Aboriginal health systems apply, and prove that “Aboriginal community” is a mind set, a culture, not a physical piece of geography.

In today’s fiscal environment, economies of scale are necessary considerations in creating program efficiencies. This would suggest that communities, particularly small ones, must work together to share resources. In some areas, co-ordinating services can impose additional costs to the system, such as in remote environments that have fly-in-only access. There, multicommunity co-ordination faces challenges such as securing sufficient transportation resources for travel of health professionals to multiple communities.

Desire for autonomy may not always be set aside in the spirit of reducing costs or challenges of geography dealt with by pooling resources. For example, in British Columbia it is estimated that six per cent of the First Nations population in communities are too distant from other communities to facilitate intercommunity approaches to health services.
Remoteness

Remoteness is an issue when delivering health service in many Aboriginal communities. For 35 per cent of First Nations communities, physician services are more than 90 km away. About three out of five of these communities do not have road access and must rely on either scheduled or special flights to bring in health professionals and take out patients requiring specialized services, emergency care or other hospital-based treatments. Dealing with remoteness is the rule, rather than the exception, in the territories. In Nunavut, for example, where most Inuit communities are located, 21 of 25 communities rely on visiting physicians. Ensuring a continuity of care between community and larger secondary and tertiary health systems is an issue with all Aboriginal health systems, but compounded in a remote environment.

Recently, British Columbia has set standards on how far patients must travel to receive medical care. There, 98 per cent of patients in any health area will be guaranteed 24-hour emergency services within one hour’s travel time or 50 km from their home and acute care services within two-hours’ travel time or 100 km. Generally, communities that are small and distant from emergency services are Aboriginal. Therefore, if there is a two per cent segment of the population that falls outside of the standards in a health region that is geographically large and has a concentrated urban area, this population will likely be Aboriginal. As such, this standard could be interpreted as biased against equitable Aboriginal access to services.

Interestingly, research in Saskatchewan has challenged the concept that health status is directly related to proximity to acute care. Mortality patterns were analyzed in communities before and after 1993 reforms that closed 52 small rural hospitals. Mortality rates decreased in communities where hospitals closed, even those due to life-threatening events such as heart attack and motor vehicle accidents. As well, residents’ perceptions of their own health or their family’s health were consistent with this lowered mortality data. First Nations mortality patterns were not specifically identified due to issues with identification of residence. Although this study has raised more questions than it answered, it shows that a simple causal relationship between immediate access to acute care and health status does not exist. There are likely a multitude of factors that could influence health status, such as access to better care in larger hospitals, dependencies and patterns of care in small hospitals that result in worse outcomes, or even movement of people with severe health problems to larger urban centres.

The Saskatchewan work did not look specifically at remote communities where emergency services are in place and access to acute care is via air transport. However, it raises the intriguing possibility that perhaps the most effective secondary and tertiary acute care already exists via the large urban hospitals that receive patients from remote communities. Furthermore, a focus on improvements to these communities’ health systems could be better directed to primary health care and health promotion initiatives. This hypothesis would require further investigation to validate. Even so, it does have some support from recent research on Manitoba First Nations health and health care usage. One of its findings was that two tribal councils in the northern areas of the province have the highest rates of referrals to specialists, compared to other tribal councils including those near Winnipeg and Brandon. One of these two northern tribal councils also has the highest life expectancy of all First Nations in the province.

Human Resources

Staff turnover and recruitment of qualified personnel are major issues for small or remote communities. Working conditions can be burdensome, particularly if there are no back-up systems for staff. Achieving equity with provincial wages has been a perennial issue for health systems operating on fixed budgets. About 45 per cent of the 223 nursing positions in northern isolated First Nations communities (in the provinces) were vacant or filled on a temporary basis in 1999. In the north, nurse shortages are critical and threaten the existence of some health centres. Most northern nurses are recruited from the south with turnover and burnout a common issue aggravated by 24-hour call, lack of sufficient supplies, and isolation from family and friends. Strategies involving the recruitment of immigrant physicians to alleviate staff shortages can bring other issues such as different cultural norms that prevent male physicians from seeking assistance from female nurses in the primary care team.

The distinction between north and south can be somewhat fluid, with north generally relating to the territories or to northern areas of provinces where Aboriginal communities are often semi-isolated, isolated or remote by Health Canada standards. These standards use a categorization based on distance from physician services and type of transportation access.
Semi-isolated communities possess road access, but are more than 90 km away from physician services. Isolated communities have scheduled flights, good telephone services, but no year-around road access. Remote communities are without scheduled flights or road access and possess minimal telephone or radio service. Semi-isolated communities can also be found occasionally in sparsely populated and/or mountainous areas in central to southern parts of provinces, such as in British Columbia, Manitoba and Ontario.13

Just providing a higher salary does not always solve the problem of recruitment and retention in northern or geographically challenging areas. The James Bay and Northern Quebec Agreement (JBNQA), a land claim settlement affecting the northern Cree and Inuit in Quebec, explicitly recognizes the challenges in health professional recruitment. It states that the province is obligated to “recognize and allow to the maximum extent possible for the unique difficulties of operating facilities and services in the North.” In implementing this, factors to be addressed include attractive working conditions and benefits, opportunities for education, employment and advancement of Aboriginal Peoples, and sufficient resources to cover the high costs of developing and operating health and social services in the north. In addition, the province’s collective agreement with nurses allows nurses to take a one-year leave to work in the north, with a second year optional, without losing seniority.14

Aboriginal Health Professionals

A major part of breaking down barriers to health care in Aboriginal populations is to make health services more familiar and non-threatening. A second factor is to tailor the service so it reflects, or at least is understanding of, a culture’s norms. Aboriginal Peoples in front line health delivery have tangible positive effects on access to primary care. The Ontario Health Access Centres evaluation found that the use of Aboriginal Peoples as service providers was seen to provide a powerful statement of belonging and self-determination. Respondents to the survey said Aboriginal workers were very important in their sense of comfort and the quality of delivered services. They were perceived as understanding people’s needs better and as being more competent in grasping the nuances of people’s circumstances.15 This is not to say that there are not many excellent non-Aboriginal health professionals who are knowledgeable about Aboriginal culture and are warmly received by a community.

The Royal Commission on Aboriginal Peoples (RCAP) recommended an intensive effort be directed to ensuring that 10,000 Aboriginal Peoples were trained in health professions over the next decade. Progress in increasing the Aboriginal workforce has occurred, albeit slowly. A recent study has reported that 0.7 per cent of first-year students in Canadian medical schools in 2000 were Aboriginal, despite Aboriginal Peoples making up four per cent of the Canadian population.16 This number (seven Aboriginal students in total) is considerably lower than earlier reports of Aboriginal physician student numbers (see below). Possible explanations could include the design and coverage of the survey, which excluded Quebec, and the participation rate by Aboriginal respondents in this survey.

Aboriginal Peoples in all health professions are a scarce commodity. Educational attainment can serve as an indicator of a population’s professional makeup. In 1996, only three per cent of the First Nations population (aged 15 years and older and not attending school full time) and four per cent of the Métis population possessed a degree, compared to 14 per cent in the general population. The Inuit population fared even more poorly at just more than one per cent. This is also reflected in public school educational attainment. The 1996 Census showed 39 per cent of Inuit had not completed Grade 9 compared to 25 per cent of First Nations and 17 per cent of Métis.17

The Aboriginal Nurses Association of Canada currently has a membership of about 300 registered nurses, licensed practical nurses and registered nursing assistants. Not all Aboriginal nurses are members of this organization.18 The Canadian Public Health Association (CPHA) in a brief to RCAP in 1993 estimated that there might be as much as 3,000 Aboriginal registered nurse graduates in Canada.19

There are no recent figures available for the number of graduated Aboriginal physicians. In 1996, the Native Physicians Association in Canada reported that there were 67 Canadian Aboriginal physicians with a further 33 in medical school.20 RCAP estimated, based on earlier reports of 51 self-identified Aboriginal physicians, that the ratio of Aboriginal physicians to Aboriginal population was about 1:33,000 compared to a corresponding ratio of 1:515 in the non-Aboriginal population.21

Data is even more limited on Aboriginal representation in other disciplines, such as health administration, population health, health policy and research, sociology, psychology, anthropology, justice, social work, and education. In the 1993 CPHA submission
Demographics

It is generally accepted that the annual growth rate of Aboriginal Peoples exceeds the general Canadian population, the latter which has only grown by four per cent in the five-year period between the 1996 and 2001 Censuses, or an average of about 0.8 per cent annually. It has been more than a decade since projections on the entire Aboriginal population were completed by both RCAP and Human Resources Development Canada. RCAP projected that the annual Inuit growth rate for 2001 would be somewhere between 1.6 per cent and 2.2 per cent depending on the assumptions employed. For rural Métis, the rate would be between 1.6 per cent and 2.4 per cent, whereas urban Métis rates were predicted to be between 1.2 per cent and 1.6 per cent. More recent projections (1998 to 2008) are available for First Nations. The growth rate of on-reserve First Nations People has been estimated to be three per cent annually, with those living off-reserve possessing a growth rate of one per cent. A portion of this difference is due to anticipated migration of First Nations People from cities to their communities.

All Aboriginal Peoples have a large youth cohort or baby boom generation. The maturing of this youth cohort combined with increases in life expectancy suggests that Aboriginal population aging will have a greater impact on the health system than what is anticipated for the general population. For example, it has been predicted that the 65 and older segment of the general population will increase by 0.78 per cent annually in 1999-2000 to 1.24 per cent annually by 2019-2020, or by 1.5 times. The most recent First Nations population projection has projected that First Nations People aged 65 and older will increase by 2.09 times over the same time period (from an annual 4.25 per cent increase in 1999 to 8.89 per cent in 2021) or 40 per cent more than the Canadian population. In certain regions, the higher growth rate of Aboriginal Peoples has been credited with changing demographics of the population as a whole. The age profile of Manitoba and Saskatchewan 2001 Census results were heavily influenced by the high fertility of their Aboriginal populations. Saskatchewan had the second lowest medium age of all 10 provinces at 36.7 years. The significant numbers of Aboriginal Peoples in the Northwest Territories and Nunavut resulted in these territories having the lowest medium age in Canada in 2001 and the highest proportion of their population aged younger than 20.

Funding

Federal funding is provided for health programs and services in First Nations and Inuit communities. For some, however, the amount of funds is limited by the presence of transfers to territorial governments or land claim agreements. All First Nations People and Inuit, regardless of territorial transfer or other agreements, are eligible for new federal programs such as the Aboriginal Diabetes Strategy (ADI), First Nations and Inuit Home and Community Care Program (HCC), Aboriginal Head Start (AHS), and the Canada Prenatal Nutrition Program (CPNP). Métis are eligible for ADI and AHS funding.

Sustainability of funding for community health services in First Nations communities in the provinces and the Inuit communities in Labrador is currently an issue. The base funding envelope of the First Nations and Inuit Health Branch (FNIHB) for both community health programs and the Non-Insured Health Benefits (NIHB) program has been limited to three per cent annually since 1996-97. The NIHB program consumes about 50 per cent of the total budget and provides pharmaceutical, vision, dental, medical transportation, and medical supply benefits to First Nations People. This program routinely exceeds the three per cent funding cap. This has made it difficult to divert new resources to established community health programs. This has meant that the core community programs of nursing, community health representatives (CHR's) and the National Native Drug and Alcohol Abuse Program (NNADAP) have had to deal with population growth and cost-of-living increases within a static budget for four years. The 2000 federal budget provided some short-term relief with a commitment of $50 million annually over the next two years. FNIHB is now reviewing the issue of financing and how to ensure sustainability in the First Nations and Inuit health system. Health Canada has recently received an adjustment to its base: 7.7 per cent for the NIHB program and three per cent for community health programs.

As health services for Aboriginal Peoples outside of First Nations and Inuit communities are considered the jurisdiction of the provincial governments, the development of Aboriginal health services in this environment is dependent on provincial funding. Provinces certainly include Aboriginal Peoples as prioritized target groups in overall strategies and may include Aboriginal representation in certain health ini-
tiatives. It is rare that a provincial government will divert resources to Aboriginal-specific programs, and much more rare that funding will be provided to Aboriginal groups to develop comprehensive primary care services. As will be covered below, Ontario, British Columbia and Manitoba have all invested to varying degrees in urban Aboriginal health centres. In addition, Métis-specific health initiatives that receive provincial funding are described: the Métis Settlement Health Project, the Métis Nation of Ontario Health Services Branch, and the Métis Addictions Council of Saskatchewan Inc.

Jurisdiction

Table 2 provides an overview of the health programs and services that are provided by federal, provincial and territorial jurisdictions to Aboriginal Peoples. The split of services among these jurisdictions is complex and an interaction of ancestry (type of Aboriginal group), place of residence, legislation, and land claim agreements.

For Aboriginal Peoples where the federal government has acknowledged a policy role in health (i.e. First Nations and Inuit), Aboriginal-specific health systems have evolved. These systems are in communities that are on First Nations and Inuit land and where provinces have no jurisdiction over on-site health and social programs. In the territories – as a reserve system was not established and the territorial governments in the mid 1900s did not have the capacity to develop and administer health services to the population – the federal government assumed the role of service provider to the entire population. This set the stage for the present health system which is transparent to both Aboriginal and non-Aboriginal Peoples. When the territorial governments took over health service delivery, they did so for the entire population and the federal government transferred the health resources for the Inuit and First Nations populations. The only programs that were kept under federal jurisdiction were those that did not have a territorial counterpart, basically the NIHB Program. Since these transfers have taken place, new federal programming to First Nations and Inuit communities has remained under federal control.

The federal government does not acknowledge a fiduciary (trustee-like) responsibility or jurisdiction of Métis. Generally, the provincial governments’ positions have been that Métis can access health services on the same basis as the rest of the population, and therefore no Métis-specific provincial programming exists. Despite this, there are some limited examples of Métis-specific health programming, which will be covered later in this paper.

The issue of jurisdiction is slightly different in Newfoundland and Labrador. When the two domains were united in 1949, the Indian Act was not applied. A limited, ad hoc federal involvement in Aboriginal Peoples’ health began, such as the reimbursement of tuberculosis treatments for Aboriginal Peoples in Labrador. An attempt to clear up the ambiguity surrounding federal funding of Aboriginal health services was made with the negotiation of the Canada/Newfoundland/Native Peoples Health Agreement. This agreement resulted in federal dollars being provided to the Newfoundland government to fund public health nurses, operating costs of nursing stations and medical transportation.

Any other federal involvement in Newfoundland and Labrador has been on an individual basis with Aboriginal groups. Since the early 1980s, the Labrador Inuit Association has directly dealt with the federal government to secure health funding for its membership and created the Labrador Inuit Health Commission (LIHC). The province’s Innu and Mi’Kmaq communities receive some health programming funds from FNIHB, such as the NIHB Program (Mi’Kmaq) and community health services, medical transportation, and NNADAP prevention programming (Innu) and recent initiatives (e.g. ADI). The Labrador Métis (descendents of Inuit) do not receive any federal health programming other than what is available to all off-reserve and northern Aboriginal populations.

FIRST NATIONS COMMUNITY-CONTROLLED HEALTH SYSTEMS

Historically, the first federal approach to providing health services to Aboriginal communities was essentially public health driven. It dealt with and contained infectious diseases such as measles, small pox and tuberculosis, which were sweeping through the communities. It also provided emergency health services to those who were at a distance from medical care in towns and villages.

As provincial health systems matured throughout the 20th century, then conformed to the requirements of the Medical Care Act 1966 and the Canada Health Act 1984, the federal approach to First Nations has remained consistent. Although evolving as required to complement or fill gaps in the provincial services, some of those services may not be accessible by these communities, such as health promotion programs,
### Table 2: Aboriginal Health Programs and Services by Jurisdiction

<table>
<thead>
<tr>
<th><strong>First Nations living on-reserve in provinces</strong></th>
<th><strong>Federal</strong>&lt;sup&gt;ii&lt;/sup&gt;</th>
<th><strong>Provincial/Territorial</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health services: public health nursing, CHRs, NNADAP, HCC, ADI. Wellness programs: HIV/AIDS, FAS/FAE, CNCP, BF/BHC, AHS, dental health promotion, tuberculosis. NIHB Program. Some hospitals in northern locations. Emergency and non-urgent treatment services in remote and isolated communities in addition to the above.</td>
<td></td>
<td>Physician services and hospital services as covered under the <em>Canada Health Act</em>. First Nations People can generally access other provincial services in off-reserve locations.</td>
</tr>
</tbody>
</table>

| **First Nations People under the JBNQA** | NNADAP, BF/BHC, Mental Health, HCC, CPNP, ADI, NIHB Program. | Quebec: Oversees the JBNQA and provides same scope of health services as for the rest of the population |

| **First Nations People in Yukon** | Community health services: CHRs, ADI, HCC. Wellness Programs: HIV/AIDS, FAS/FAE, CNCP, BF/BHC, AHS, tuberculosis. NIHB Program | Yukon: All universally available health services. |

| **First Nations People living off-reserve in provinces** | AHS<br>ADI (health promotion)<br>HIV/AIDS<br>NIHB Program | All health services |

| **Inuit living in Inuit communities** | Labrador: same as First Nations People living on-reserve Northwest Territories, Nunavut and Quebec: BF/BHC, HCC, ADI, CPNP, NNADAP (training only in territories), FAS/FAE (territories only), mental health (Quebec only) | Labrador: Physician services and hospital services. Some primary care services to Inuit communities through the Labrador Health Corporation. Northwest Territories and Nunavut: All universally available health services. The NWT and Nunavut territorial governments administer all federal programs (see previous column) through contribution agreements. Quebec: Oversees the JBNQA and provides same scope of health services as for the rest of the population. |

| **Inuit living outside of Inuit communities** | AHS<br>HIV/AIDS<br>ADI (health promotion)<br>NIHB Program | All health services |

continued...
community-based substance abuse programs, and home care. Until the 1990s, First Nations community health services were designed around the positions of community health nurses, CHRs and NNADAP workers. With the establishment of programs in the last 10 to 15 years directed at early childhood development – Brighter Future/Building Healthy Communities (BF/BHC), AHS and the CPNP followed more recently with the Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) Program – the breadth of community-based health programming has increased. Other community-based health promotion resources are directed to ADI, dental health, HIV/AIDS, and tuberculosis.

The fit of provincial services into the First Nations health environment has never been seamless. Visiting physicians, dentists and other primary care professionals are a fact in many, if not most, First Nations communities. This reality is the same for all small communities in northern and remote areas, regardless of whether they are federal or provincial jurisdiction. The Canada Health Act specifies a narrow portion of health services, namely physician and hospital care, which must be provided in order for provinces to obtain federal transfer payments. Therefore, jurisdiction can be a significant impediment to provision of many of the health services that are outside of the Canada Health Act. The grey area between provincial jurisdiction and federal policy can be enormous for First Nations, affecting a wide range of services from mental health programming and home-based palliative care to community long-term care institutions.

Initially, the federal government directly administered and delivered all health services in First Nations:

<table>
<thead>
<tr>
<th>Métis Settlements and communities</th>
<th>AHS</th>
<th>HIV/AIDS</th>
<th>ADI (health promotion)</th>
<th>All health services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: In the Northwest Territories, a Métis Health Benefits Program is offered which is similar in coverage to the NIHB Program, except it is non-portable to other jurisdictions and covers 80 per cent of full costs.</td>
</tr>
<tr>
<td>Innu and Mi’Kmaq in Newfoundland and Labrador</td>
<td>NIHB (Mi’Kmaq)</td>
<td>Community health services, medical transportation and NNADAP prevention (Innu)</td>
<td>All health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AHS</td>
<td>HIV/AIDS</td>
<td>ADI (health promotion): all</td>
<td>All health services</td>
</tr>
<tr>
<td>Non-status Indians</td>
<td>AHS</td>
<td>HIV/AIDS</td>
<td>ADI (health promotion)</td>
<td>All health services</td>
</tr>
</tbody>
</table>

AD: Aboriginal Diabetes Initiative  
AHS: Aboriginal Head Start  
BF/BHC: Brighter Futures/Building Healthy Communities  
CHR: Community Health Representative  
CPNP: Canada Prenatal Nutrition Program  
FAS/FAE: Fetal Alcohol Syndrome/Fetal Alcohol Effect  
HCC: Home and Community Care  
NIHB: Non-insured health benefits  
NNADAP: National Native Alcohol and Drug Abuse Program.

xi For First Nations People and Inuit living outside of their communities and all Métis and non-Status Indians, the programs listed are those to which these groups are eligible for funding. The entries in the table do not denote actual funded programs.  
xii All Aboriginal People in the territories and all Aboriginal People outside of First Nations and Inuit communities in the provinces are eligible to apply for funding offered by Population and Public Health Branch (PPHB) of Health Canada. These programs include Canada Action Plan for Children, Canada Prenatal Nutrition Program, Hepatitis C, Population Health, AIDS Community Action Program, Community Animation Program. PPHB also administers the AHS to all off-reserve Aboriginal populations, including the territories.  
xiii The programs and services described for Inuit communities in the Northwest Territories also apply to First Nations communities in the Northwest Territories.
communities. The change over to First Nations administration and control has been a phased-in process, first through contribution agreements, then since the late 1980s, through the Health Transfer process. The early focus in communities was to build the capacity and infrastructure to effectively manage and govern the health system. More recently, this focus has shifted to more fundamental changes within the system. In this respect, First Nations have had to deal with many of the same issues as provincial health reform: merging of program administrations and creation of more efficient management structures; effective governance models, recruitment and retention strategies; integration, mergers and other collaborative relationships with neighbouring First Nations; and primary care reform. In addition, provincial measures to reduce hospital admissions and length of stays and promote community-based services has meant First Nations systems have contended with increased pressures for home and long-term care services in their communities.

**Case Study #1:**

**Eskasoni First Nation**

Among the Health Transition Fund (HTF) projects that addressed primary care reform in Aboriginal communities, the Eskasoni Primary Care Project has provided valuable lessons on community integrated health services that are transportable to other First Nations. The project was created from a realization by Eskasoni leadership that a new approach was needed to deal with the high morbidity and mortality rates from substance abuse, diabetes, heart disease, and respiratory illness that gripped the community. Inadequacy of resources did not seem to be a primary issue. Eskasoni residents visited their physician at a rate four times the provincial average. Prescription abuse suggested widespread addictions were rampant, not lack of access to needed medications. Rather, a different model for delivering care was championed and culminated in an HTF pilot project on integrated primary care.28

Although many of the right health resources were already in place, existing health programs had their own administrations and were highly competitive instead of collaborative. There was no integration of health information or health professionals, or even a clear health strategy. Primary care was fragmented with most community members simply visiting the local physician who also possessed the pharmacy license for the community. The Eskasoni Primary Care Project was designed to improve access and co-ordination of local health services, with particular emphasis in three areas: prenatal care, diabetes management and prescription drug abuse.

In the project, the Eskasoni First Nation collaborated with three other partners: the federal government, the provincial government and Dalhousie University Department of Family Medicine. The university partners provided the quantitative tools necessary to evaluate the impact of the project in changing the pattern of provincial hospital and physician service usage. Provincial funding of $500,000 per year was instrumental in achieving one of the most often recommended changes in primary care – the shift from fee-for-service to salaried physicians. HTF funding was directed to a nurse clinician, health educator, counsellor, project manager, and evaluation consultant. Existing federal funding provided for community health nurses, CHRs and part-time prenatal care co-ordinator and diabetes educator. A pharmacist is now located on site and is an integral part of the primary care team.

The achievement of a more integrated, accessible health system was not without challenges. Community and health provider acceptance and involvement of multiple jurisdictions cannot be adequately covered in a short profile. The project evaluation has provided the following evidence of improvements to the health system:

- The per capita number of physician visits decreased from 11 per year in 1997 to four per year in 2000. This decline has been attributed to a lack of incentives for physicians to maximize patient volumes and the presence of other health professionals such as primary care nurse, community health nurses, health educator/nutritionist, and pharmacist.
- The increase in family physician availability (regular office hours Monday to Friday) is credited with decreasing the medical transportation budget from $545,000 in 1997 to about $370,000 in 2000-2001. When the five-day, full-time physician availability was introduced, outpatient/emergency visits by Eskasoni residents to the local hospital decreased by 40 per cent.
- Physicians and community health nurses follow almost all pregnancies from prenatal care through delivery and post-natal care. Prior to the project, all deliveries were classified as high risk due to the absence of co-ordinated prenatal care.
- Referrals to the team nutritionist/health educator for diabetic management have increased by 850 per cent.
The successes of the project have also highlighted areas for system reform at a provincial policy level in order to maximize the integrated model of care. For example, the province will only provide primary care funding for physicians with a small amount of overhead included in physicians’ contracts that can be applied to nurse clinician or nurse practitioner positions. This has resulted in a ratio of three funded physician positions to one nurse clinician and a heavy medical bias to the Eskasoni model. Secondly, savings in the provincial hospital system (estimated to be $250,000 annually) from reduced outpatient and emergency room use have not been recoverable by the community and cannot be re-invested into extending the integration model to further areas such as substance abuse and mental health.

Eskasoni and its partners are now considering how to share this model of health services with other First Nations in Cape Breton. One of the challenges will be how to adapt the model to smaller population bases that will not have access to the same economies of scale on an individual basis and may need to collaborate on a multi-community approach.

Care Study #2: Kahnawake First Nation

Kahnawake is one of three communities that make up the Mohawk Nation in Quebec. It is close to the second largest metropolitan area in Canada, being only 10 km southwest of Montreal on the south shore of the St. Lawrence River. In many respects, the community resembles small-town Canada, but with an Aboriginal focus. Kahnawake, with a population of about 8,000, has a thriving commercial sector with about 600 people employed within its territory. Five schools are also located in the territory, providing preschool, primary and secondary education to 800 students. An impressive range of community institutions are present including a museum, library, gymnasium, and arena.

The health system includes a community health unit offering public health services, a hospital with an extensive complement of health professionals for both inpatient and outpatient care, a medical centre offering specialty services, a dental clinic, and a nationally renowned diabetes education program. A community service centre provides a comprehensive range of mental health and social services including alcohol and drug abuse treatment.

Kahnawake has had extensive experience in managing its health system. As a result, it brings a mature perspective to a discussion on the issues faced by a community in developing an Aboriginal health system. One current challenge is the ongoing tension, brought on by change, that exists between health professionals and the community’s governance. It is similar to that seen in non-Aboriginal environments when programs are restructured to meet community needs. On the client side, Kahnawake must deal with apathy among its residents in taking charge of their own health and their unquestioning reliance on the health system to treat all ills.

Health service oversight is provided from the Kahnawake Health and Social Services Commission. It plans, co-ordinates and reviews all health and social programs. A number of initiatives have been undertaken under the auspices of this commission:

- Memorandums of understanding (MOUs) have been developed with collateral provincial agencies. These MOUs clearly define roles and responsibilities of all concerned and establish protocols for situations requiring joint service provision.
- A single entry point into the mental health and social services system provides triaging on a timely basis. The team meets every morning to go over the previous day’s cases.
- Program flexibility from Health Transfer and the budget process are fully exploited in order to reduce redundant or inefficient programming. As well, the directors of the various health and social programs meet regularly to participate in long-term global community planning, reduce duplication and share resources.
- The process of obtaining community input has been refined with a focus on reducing community resistance to change.

Managing change and successfully dealing with organized resistance in the community have proven to be pivotal areas in creating a Mohawk-controlled health system. Integral to their success to date has been a critical mass of visionary leadership who have been committed to stay the course. An early area of focus has been the development of Mohawk institutions where there is less reliance on external sources of financing. Currently, the community has constructed a 20-bed Elders lodge without assistance from government for capital costs.

Kahnawake’s vision of an Aboriginal health system is one where holistic practices supersede the medical model and prevention strategies provide the means for community members to be responsible for their own
health. This has meant that the community has had to clearly establish lines of authority over health professionals working in their jurisdiction to create a climate receptive to Aboriginal health practices and philosophy. In future plans, Mohawk law will support Mohawk policy and service delivery. As well, all institutions and health professionals working in the community will be internally regulated and licensed. This will ensure an acceptance of Mohawk standards and provide a direct line of accountability to the community. Health is seen as integrally connected to nation building and self-determination of the community and its people.

Case Study #3:

Nisga’a Valley Health Board

The Nisga’a Valley Health Board (NVHB) is located in the scenic Nass Valley of British Columbia, the home of the first modern-day treaty in B.C. involving First Nations and the federal and provincial governments. The health board, delegated under treaty from Nisga’a Lisims Government, provides treatment and preventative health services to a population of about 3,500 with a further 2,000 living in urban areas who are recipients of the Nisga’a administered NIHB Program. The Nisga’a Nation includes four communities, one of which is remote and serviced by air at the present time. There are four major hospitals within a 300 km radius, and one within 100 km.

From its origins in 1986 as a diagnostic and treatment (D & T) centre in one community, the NVHB has expanded to include four clinics (one per community), three doctors and a staff of 60. Its programs and services are organized around three themes: acute care, preventative care and the NIHB Program.

Funding is provided from both federal and provincial sources, the latter comprising 12 per cent of the health budget. Provincial funding has allowed the establishment of the D & T centre and the payment of physicians on a salaried basis. The NVHB provides health services to all residents within its territory, including the non-Aboriginal population. All village clinics are capable of first response treatment. Physician clinics are held in each community on a scheduled basis and 24/7 coverage is provided from the D & T centre and the nursing stations in the Valley.

The Nisga’a Nation is well known for its long treaty negotiation process, which came to a successful conclusion in 2000. The Nisga’a treaty did not change the funding levels for health services. Its real benefit has been in providing administrative flexibility through block funding and the means to change programs and be more responsive to community issues. Ingredients of an effective health system that are offered by the Nisga’a experience include:

- The flexible program base is respectful of culture and community needs and is subject to regular reviews. This review process may result in the closing of programs no longer deemed necessary for the Nation. In these cases, block funding provides the mechanism to address all supplemental issues that may result from health service changes.
- The governance structure is segregated from administration of health services. Accountability to communities is achieved through a community-elected board, dialogue between communities and the NVHB chief executive officer and annual community-based consultations.
- Fiscal responsibility provides accountability and professionalism in financial processes. Required data is accurate and timely.
- The strong budgetary system clearly defines the scope of the services funded and the value for money on a program-specific basis. Benchmarks and goals are set and regularly evaluated.
- The sizable population base allows a critical mass of health professionals, which can absorb fluctuations in staffing levels brought on by education leave, patients with high health needs or staff turnover.

A key area of focus for the NVHB is education, both to self-empower the client base and to improve the internal training of health staff. The balance between community autonomy and centralized service delivery is an ongoing developmental process. It requires considerations not only of economies of scale, but also of community-based capacity development and their need for a critical base of health funding.

Interestingly, the health and social systems are not integrated at an administrative level, but co-operate on an operational basis. The social services programs are delivered under the Nisga’a Lisims Government and Village Governments while health programs are through an independent, delegated health authority (NVHB). Overall program oversight and integrated health and social planning occur within the Nisga’a Nation’s governance.
MÉTIS HEALTH SYSTEMS

The Métis homeland encompasses parts of present-day Ontario, Manitoba, Saskatchewan, Alberta, British Columbia, and the Northwest Territories. As of 1991, only one per cent of Métis resided on lands designated for Métis, including the eight Métis Settlements in Alberta, several parcels of land in Saskatchewan designated as Métis farms, and reserve land allocated to the Métis population of Rainy River, Ont., who were treated as Registered Indians under the Indian Act.

Métis are acknowledged as one of the Aboriginal Peoples in Canada under Section 35 of the Constitution Act, 1982 where the term Aboriginal is defined to include Métis along with Inuit and Indian Peoples. Although existing Aboriginal rights are recognized and affirmed in the Constitution Act, the federal government has not fully accepted fiduciary responsibility for the Métis. Métis are expected to access the same health services available to the general population. There is no comprehensive government policy to address Métis health issues. Métis are not eligible for most of the health care, education and social programs offered by the federal government to First Nations and Inuit.

Notwithstanding the above, federal involvement in Métis health programming has occurred recently, prompted by several developments over the past decade. These developments have included the recognition of the inherent right of Aboriginal Peoples to self-government; the release of the RCAP report and the federal government’s response “Gathering Strength;” and court rulings clarifying existing Aboriginal rights, the fiduciary responsibility of the federal government, and consultation requirements with Aboriginal Peoples on programs and services that affect the Aboriginal population. Even so, there is only scattered federal health programming directed to the Métis. It usually involves a health promotion focus, such the ADI, AHS and HIV/AIDS.

Métis voice similar needs as other Aboriginal groups in culturally appropriate, accessible, and community-controlled health programming. Métis health systems are at an early stage of evolution compared to First Nations and Inuit systems. There is little in the way of Métis infrastructure for health and social programs and scarce research on health statistics that would provide evidence to successfully lobby for health resources. What data does exist, primarily through the 1991 Aboriginal Peoples Survey, points to similar health concerns as other Aboriginal Peoples.

Métis-specific health initiatives are seen in some provinces and territories, for example, Saskatchewan, Ontario, Alberta, and the Northwest Territories. In Saskatchewan, the Métis Addictions Council of Saskatchewan Inc. (MACSI) has been provincially funded for more than 30 years to provide alcohol and drug recovery, reintegration and healing programs to all residents of Saskatchewan with a focus on Métis and off-reserve First Nations. MACSI provides a 28-day inpatient program in three treatment centres, outpatient programs, outreach, youth services, and a detoxification program. In addition, an extension program in collaboration with Corrections Canada provides 24-hour services to federal offenders on parole. MACSI is governed by a board of directors appointed by the Métis Nation of Saskatchewan and its regional councils.

The Métis Nation of Ontario administers health promotion programs through funding from the provincial and federal governments. These include long-term care, diabetes and gambling. It receives Ontario Aboriginal Healing and Wellness Strategy (AHWS) funds for Métis community-based programming such as prenatal care, disability outreach and liaison, diabetes education, stress and suicide prevention, healing circles, child safety education, and nutrition and fitness health promotion. As well, Ontario Métis are partners with other Aboriginal groups in the province’s health centres funded by the AHWS and the Métis Nation of Ontario sits on the AHWS Board.

The Northwest Territories offers a Métis Health Benefits Program which provides eligible Métis recipients 80 per cent coverage of full benefits similar to what First Nations and Inuit receive under the federal NIHB Program. The Métis Health Benefits Plan is a payer of last resort and assists eligible recipients who require health services beyond the N.W.T. Health Care Plan.

Case Study #4:

Métis Settlement Health Project

The Métis Settlement Health Project was a collaborative project between the Lakeland Regional Health Authority and the four eastern Métis Settlements in Alberta. The intent of the project, and a preceding one funded by the Health Transition Fund, was to address some of the inequities in health service delivery and health status that had been previously identified in the Settlements. These projects fo-
cused on the addition of an on-site Settlement nurse for public health and home care services. Previously, all health services were provided to the Settlements on a visiting basis from the health authority. The Métis Settlement Health Project was deemed to be a great success and has resulted in the permanent funding of on-site Settlement nurses by the province. The project evaluation reported that up to 83 per cent of respondents felt that the on-site service was very important. A majority judged the Settlement nurse to have helped a great deal or somewhat in improving personal or family health.33 Immunization rates of children doubled after the first project was completed.34

The success of the project depended on the contributions of many parties. The Lakeland Regional Health Authority provided services with its mandate, including the supervision of Settlement nurses. The community allocated municipal affairs funding to provide homemakers. Individual residents took the initiative to obtain suicide prevention training. Community health counsellors gained understanding in where and how to access additional funding in order to supplement the existing health services.35

This project makes a number of points regarding primary health services and an Aboriginal community:
• Community involvement in establishing the community health service is critical to its success. The four Settlements formed a provincially-recognized community health council which worked in partnership with both the Settlements and the health authority in addressing common health issues and goals.
• A trust relationship between Aboriginal communities and provincial health authorities will often take time to occur and will require an understanding of both Aboriginal and health authority cultures and ways of doing things. Only then can the resulting partnership be directed to other collaborative endeavours.
• Once the Settlement nurses were accepted in the communities, access to primary care services increased significantly, as did linkages to other health authority services such as mental health. Acceptance was made easier because Métis community representatives were active participants in the hiring process and the project was communicated through various activities. However, the most important factor was the nurses’ ability to relate to the community, be non-judgmental and caring, and have good interpersonal skills.
• The Settlements increased their capacity to take charge of their own needs and find creative ways to meet those needs in partnership with a number of organizations. The most important of these partnerships was the local health authority.36

Case Study #5:
Métis Nation of Ontario Health Services Branch

The Métis Nation of Ontario (MNO) Health Services Branch delivers provincially-funded long-term care services, AHWS programs and the Aboriginal Healthy Babies, Healthy Children Program, as well as diabetes and anti-gambling programming to 9,000 Métis in Ontario. This is an impressive list for an organization that only formally created a health branch four years ago in response to a call for proposal from the Ontario Ministry of Health for Aboriginal Long Term Care. The organization credits this rapid rise into the health care field as a combination of both soft and hard factors. Key soft factors include public relations activities, networking, timing, and innovative funders and programs. Key hard factors include well thought-out proposals (in the case of the long-term care application, the organization undertook a community health needs assessment), proven experience and political expertise.

The Branch operates 13 MNO health service sites throughout Ontario and employs 30 health service workers and a small, efficient administrative unit.

In addition to service delivery, the work of the Branch includes policy development, advocacy and evaluation. The MNO cites collaboration with MNO councils, citizens and stakeholders as essential for the success of its programs. The Branch also supports independent work of communities in seeking community health program funding through advocacy and support for proposal development.

INUIT HEALTH SYSTEMS

Inuit communities are located in Labrador, Northwest Territories, Nunavut, and Quebec. Each of these jurisdictions has unique circumstances which have influenced the development of its health system.

Labrador

The Labrador Inuit Health Commission (LIHC) is funded by the federal government and has a similar scope of services to that found in health systems in
First Nations communities. These are essentially public health, health promotion and targeted initiatives such as diabetes and home care. These are supplemented by provincial health services, including primary care nurses, through the Health Labrador Corporation (HLC). Other than the largest community, Happy Valley/Goose Bay, Inuit communities receive physician services every four to six weeks. The LIHC was the first Aboriginal organization to administer the NIHB program.

Northwest Territories

The Government of the Northwest Territories has a policy of universality in its health service delivery. All services are provided to all residents on an equal footing, unlike that seen in many provinces with respect to First Nations communities. This has a historical basis, stemming from the initial federal involvement as administrator of health services prior to these services being transferred to the territorial government.

Currently, a regional system of health and social service boards exists. The boards provide primary care, school health, community health, social services, addictions services, and visiting physicians and specialists. In this territory, Inuit (Inuvialuit) are primarily located in the Inuvik Region. The Inuvik Regional Health and Services Board has representation from Inuvialuit, Gwich’in, Sahtu, and non-Aboriginal residents. Many services are provided on a visiting basis to the 13 communities in the region and are populated by all Aboriginal groups: Inuit, First Nations and Métis. Federal health programs to First Nations and Inuit, which were established after transfer, are administered by the territorial government through contribution agreements. These include the NIHB Program, BF/BHC, HCC, CPNP, NNADAP (training), and ADI.

The Inuvialuit and Gwich’in are in the process of negotiating a self-government agreement for the Beaufort-Delta Region. The agreement will include a broad range of programs and services, including those related to health.

Nunavut

Soon after Nunavut was established, the previous Northwest Territories system of regional health and social service boards were disbanded in favour of a centralized administration. Local health committees exist in its 24 communities and advise the territorial government on local health priorities and goals. The vast majority of the territory’s population is Inuit and is reflected in its elected leadership, making the health system in essence Inuit controlled. As with the Northwest Territories, the Nunavut government administers federal Inuit health program funding through a contribution agreement.

Quebec

The James Bay and Northern Quebec Agreement (JBNQA) provides for an Inuit-controlled regional health and social services board in Nunavik. It is under the auspices of the provincial health and social services ministry. The federal government originally delivered health services to Inuit in Nunavik through nursing stations and health clinics. With the implementation of the JBNQA, the province assumed control of the stations and clinics on an interim basis, before transferring these institutions to the Inuit regional health and social services board. Federal funding included in the JBNQA is funnelled through the provincial government. The NIHB Program was also transferred to the Quebec government. It administers this program in collaboration with the regional board.

Federal programs created following this 1976 land claim agreement are provided directly to the regional board via contribution agreements.

Common Inuit Issues

An evaluation of models of health care delivery in Inuit jurisdictions found a number of recurring issues. Suicide is the most pressing health issue facing Inuit society today. It points to a need to improve or implement mental health services including suicide prevention, addictions, crisis intervention, and holistic programming that encompasses prevention to after-care. The most significant concern in primary health services is the chronic shortages of nurses and doctors in the north. Staff shortages strain the health care system and are found in the entire range of health workers, from community health workers to social workers to doctors. Difficulty in recruiting people in the community is related to the absence of training opportunities. As well, Inuit are seriously under represented in health professions.

Case Study #6:

Midwifery Practice in Nunavik

The Nunavik model of midwifery practice and education is an example of community-based, culturally-appropriate care where co-operation between health
care professionals and community-trained midwives serves the needs and interests of the community at large. Midwifery is an established component in the traditional health practices of the Inuit and Nunavik culture. However, it was suppressed beginning in the early 1970s when an evacuation policy was imposed on all pregnant women in Nunavik and they were transferred to southern institutions to give birth. The removal of this normal, but exceedingly important, life event from the community fabric had many negative effects on pregnant women and the families left behind. As well, community expertise in birthing was being lost.

In response, the communities led by women, advocated for the return of midwifery and found support in the Nunavik Regional Board of Health and Social Services. Community-based midwifery education was begun. It was initially a blend of expertise from Quebec midwives and the communities’ traditional knowledge. Today’s education program is entirely delivered as an apprenticeship in the communities and is reflective of northern needs, context and culture.

The Inuulitsivik Health Centre Maternity program in Puvirnituq began in 1986 as an integration of Inuit culture with western health care. It has been recognized by the World Health Organization, the Institute of Circumpolar Health and the Society of Obstetricians and Gynecologists in Canada as an excellent model of northern health care. Success has been measured in both qualitative and quantitative terms, through epidemiological and organizational studies. Perinatal statistics, once far below the Quebec average, are now equal to or, for some parameters, better than those of southern regions.

There are six Inuit communities in Nunavik that are part of the midwifery program. The Inuulitsivik Health Centre employs five Inuit and two non-Inuit midwives. As well as providing a birthing place, the centre co-ordinates prenatal and post-natal programs. In 2000-2001, 99 deliveries occurred at Inuulitsivik, with a further 35 births at the community health centre in Inukjuak. The University of Quebec at Trois-Rivières has indicated an interest in Inuulitsivik as a teaching site for Quebec midwives.

Nunavik communities are remote. As midwifery is a primary care service, it includes all women, not merely those judged as low risk or those who choose midwifery for at least part of their pregnancies. In practical terms, this means that northern midwives have a larger scope of practice than those in southern regions. Even so, Nunavik midwifery corresponds to the International Definition of the Midwife, with one exception being the recognition of its education program. This program has been tailored to the unique practice and specific living and learning needs of the people of Nunavik.

This midwifery initiative has had to deal with professional and legislative barriers. The scepticism on the part of the mainstream health system to this traditionally-based care have largely been overcome with physicians and nurses working collaboratively with midwives in the communities to deliver a unique blend of cultural and modern knowledge and skills. The legislative barriers still exist and have become more critical since 1999 when the Quebec government passed legislation related to the practice of midwifery. This legislation makes no mention of either the educational or practical component of midwifery as delivered in Nunavik. It has implied that Inuit women can no longer maintain responsibility for maternity care services and their administration, and must step aside to accommodate forced trusteeship from southern professionals. The Nunavik Regional Board of Health and Social Services is advocating for changes to this legislation to make it inclusive of the northern situation.

Other jurisdictions, both nationally and internationally, are now considering the Inuulitsivik perinatal program, including the Government of Nunavut that is in the process of designing a perinatal care system modeled after Nunavik.

Case Study #7:

Nunavik Regional Health and Social Services Board

In 1976, the Governments of Canada and Quebec, and the James Bay Inuit and Cree signed the James Bay and Northern Quebec Agreement. This land claim agreement contains a provision for the establishment of Inuit and Cree health boards to be locally operated with the support of the Quebec health and social services ministry. Today, the Nunavik Regional Health and Social Services Board is one of the province’s regional boards. It serves all of the 9,000 primarily Inuit residents of Nunavik. This board has 100 per cent Inuit representation from the 14 communities and two regional health establishments (hospitals/health centres) which deliver the region’s health and social services.

The regional board oversees an impressive list of programs and services. This is remarkable given the
remote geography of the communities. The two health centres provide beds for acute (short-term) care, long-term care, diagnostic services, and general and specialized medical care. These centres and the 12 other communities receive primary care (preventative and curative), physical rehabilitation and social reintegration services from local community health centres. The board is moving away from a physician-centred primary care model to one that includes nurses in expanded roles. This has been in response to the significant shortage of physicians to service the communities. Two child and youth protection centres are located in Nunavik. They include rehabilitation services and group homes for youth.

The board administers five federal programs: Brighter Futures, mental health, CPNP, family violence, and home and community care. This funding has resulted in 50 projects among the communities.

The health and social services system is not totally integrated at an administrative level as additional community-based programs are administered directly by the Quebec Ministry of Health and Social Services. This includes services targeted at women, men or youth at risk or in difficulty; home care services; and alcohol and drug rehabilitation services. The province administers benefits equivalent to the NIHB Program under the terms of the JB-NQA.

The board is involved in improving and enhancing many sectors of its mandate, which are too numerous to mention in this short case study. The development of professional resources is a current area of focus. It is directed to supplementing basic training and providing community-based continuing education. The board has been successful in instituting management and professional training for Inuit managers in the health and social services network. Through a collaboration with the Kativik School Board and McGill University, these managers will receive a professional certification after they complete the three-year program. Another training initiative involves a 16-module, 990-hour program leading to an Occupational Studies Diploma. The program has been offered to home support workers and will be broadened to other staff as resources permit. For the past 10 years, McGill and Kativik School Board have offered a Social Work Certificate Program. As well, the McGill approach to training all professions working in home care in team service delivery has been adapted to the Nunavik situation. Community-based specialized training in rehabilitation services is under development.

The goal of the regional board is to serve as a resource and support for the health centres, communities and municipalities. The challenges are extreme. For example, transportation expenditures take up 24 per cent of the board’s budget and more than 50 per cent of total salary costs go to remoteness-related benefits deemed by the collective agreement of the union. Even so, the turnover of human resources is high. There are few Inuit health professionals. This is compounded by the requirement under Quebec legislation that all employees speak French. In a population which is Inuktitut-English bilingual and requires these languages to effectively provide care, the need for trilingual staff is considered burdensome and a barrier to Inuit employment.

The board sees the development of health technologies, such as telemedicine, as crucial in lowering expenditures and increasing the availability of health and medical specialists in communities. The direct representation of all communities on the regional board ensures that a strong grassroots voice can facilitate the development of culturally-appropriate health services. Community-based solutions to significant health issues include the Tapiriilirmiq Committee. It is visiting all communities to develop local strategies to reduce the high rate of youth suicide and nurture better relations between Elders and youth.

The Board attributes its successes and progress in delivering culturally-appropriate and effective health services to the 100 per cent Inuit participation in the board, including all board member appointments from the municipal governments, the executive director and the two health centre executive directors. All of the 14 communities are represented by an elected Inuk on the health centre boards (seven to the Hudson establishment and seven to the Ungava establishment).

**Case Study # 8:**

**Labrador Inuit Health Commission**

Less than 20 years ago, the Labrador Inuit Health Commission (LIHC) did not exist. Indeed, there was no Inuit-specific health programming provided to the seven Inuit communities of Labrador. Since 1985, when the Labrador Inuit Association formed the LIHC to address Inuit health issues, the LIHC has grown from one program, seven employees and $150,000 in funding to seven programs, 120 employees and $13 million in funding.

The creation of the present-day LIHC was a gradual process. It initially assumed the administration of
the NIHB Program in 1989, negotiated Health Transfer with FNHB in 1996 and assumed responsibility for community and public health services from the Government of Newfoundland and Labrador in 1997. The province continues to provide hospital, physician and primary care nursing to all residents in Labrador. This is expected to change somewhat when the Labrador Inuit land claim agreement-in-principle is successfully concluded. This agreement will include a provision for self-government. This will facilitate the transfer of responsibility of treatment clinics and nurses to the LIHC.

One of the key ingredients in LIHC’s health strategy is the development of partnerships both internally within the Inuit community and externally with the provincial system and academic organizations. A close relationship involving regular meetings and protocols in defined areas exists with the province’s HLC. The HLC provides community treatment clinics staffed by regional nurses and personal care workers who complement the LIHC’s community health nurses, community health aids, community service workers, and childcare workers.

The LIHC has developed a program in partnership with Torngasok. The Inuit cultural centre has the mandate for language and revival of cultural practices. The Language Nest Program provides cultural and social activities targeted to families with infants in Hopevale.

Through a partnership with the College of the North Atlantic, LIHC staff developed Inuit-specific training for home support workers. This 12-week program was offered in an Inuit community and was open to home support workers in all seven communities. As well, a training program for community health workers was developed with the college, again with the purpose of meeting Inuit-specific needs.

Inuit-specific training is included as a component of new programs as they are implemented, such as the community crisis response teams, which are comprised of both staff and community volunteers.

Recruiting Inuit into health careers continues to be a challenge. Through a partnership with the post-secondary education department of the Labrador Inuit Association, the LIHC is focusing on increasing the number of Inuit pursuing nursing. This evolving strategy is targeting students as they enter high school. Other issues related to service delivery involve jurisdiction barriers and eligibility for services, the lack of Inuit-specific data and research, and ensuring equity and access to health services on a comparable basis to other residents.

**URBAN HEALTH SYSTEMS FOR ABORIGINAL PEOPLES**

The APS was the first national survey that looked at all Aboriginal groups in Canada. It provided evidence to confirm what many people had intuitively known for many years, that the health status of Aboriginal Peoples, regardless of residence on-reserve or in other locations, was generally the same. Urban cities are home to a culturally diverse Aboriginal population. Notwithstanding the many healthy urban Aboriginal Peoples, the inner cores of Canadian cities contain a component of marginalized, transient Aboriginal Peoples who are disconnected from community or family supports and who experience poverty, unemployment and lack of education. Providing health services to this population of First Nations, Métis and Inuit has many hurdles including cultural barriers to health services, which may be even more profound than that seen in rural and remote Aboriginal communities. Transportation is an ever present consideration in urban environments as even bus and taxi costs are out of reach to the homeless or unemployed. Health clinics find it more difficult to maintain a continuity of health services to this population as many lack a permanent home or even a contact address.

Aboriginal Peoples are disproportionately represented among the urban homeless. Anishnawbe Health Toronto (AHT) has provided street outreach services to the homeless in Toronto since 1989. Although Aboriginal Peoples make up two per cent of the urban population, they accounted for 21 per cent of all encounters with AHT’s street outreach patrols in 1999-2000 and 2000-01. From 1992-93 to 2000-01, the usage of these patrols increased by almost 200 per cent. During this time, Aboriginal Peoples represented an average of 24.3 per cent of encounters. It is estimated that they accounted for 41 per cent of all deaths among the homeless.

Health services in cities are the jurisdiction of the provinces, except for the federal NIHB program, which is provided to First Nations and Inuit regardless of residence. Although the core funding for urban Aboriginal health services is provincial, some program-specific federal funds may be provided. Provincially-funded health clinics controlled and administered by Aboriginal Peoples exist in four locations in British Columbia, 11 in Ontario and one in Manitoba. These all provide culturally-appropriate primary care services in a multi-disciplinary team approach with salaried or contract physicians, nurses
or nurse practitioners and other health professionals offering a range of services such as health promotion and diabetes education, traditional healers and Elders, prenatal care, nutrition programs, community outreach, FAS/FAE programs, mental health, and health referrals. The Ontario Aboriginal health centres include both urban and rural models as some serve a primarily rural population including First Nations communities.

There are differences among the three provinces that have funded Aboriginal urban health centres – such as the degree of emphasis on traditional medicine, the method of remuneration of physicians (salaried or fee-for-service contracts), and the use of nurse practitioners. Despite these differences, all centres share a common philosophy where care is directed at improving and/or balancing the physical, mental, spiritual, and emotional well-being of an individual. Traditional healers may be part of the health team, depending on the needs expressed by the Aboriginal community served by the clinic. The centres provide a focal point for Aboriginal Peoples and contribute to community development and empowerment. These centres are Aboriginal first and foremost, from staffing and governance to visible expressions of Aboriginal culture and hosting community events. They have been successful in breaking down the barriers so often seen with mainstream health services and Aboriginal Peoples. A case study follows based on the experiences of the 10 health centres in Ontario.

Case Study #9:

Health Centres, Aboriginal Healing and Wellness Strategy, Ontario

The AHWS is a collaboration of four Ontario government ministries: Health and Long Term Care, Ontario Native Affairs Secretariat, Ontario Women’s Directorate, and Community and Social Services. It funds four main streams of programs including community workers and health outreach; shelters, healing lodges and treatment centres; health centres, maternal and child centre and medical hostels; and clearing house, translator and advocate services.

The health centres use a model of primary care. It has similarities with community health centres, but has incorporated Aboriginal culture and beliefs into the healing process. They have been designed to reflect the needs of the entire Aboriginal community in a geographic area and include approaches that are solely urban or a mixture of rural and urban. Most centres are located off-reserve, however, many serve on-reserve populations, sometimes through satellite clinics. Commonalties among the centres include salaried physicians and the use of different levels of nursing expertise. The latter are generally nurse practitioners who may be supplemented by registered nurses and/or licensed practical nurses. These are complemented by a mix of other primary health professionals such as a nutritionist, psychologist, traditional co-ordinator, diabetes educator, or exercise therapist. The centres do not operate on a nine-to-five philosophy. After clinic hours, the space is often used for community events.

The first phase of a six-year longitudinal evaluation of the health centres has been completed. It involved four centres which had been in operation for one to three years. A main result of this first evaluation was the description of the health centre model. Four components were identified which form the core of the centres’ effective, distinct service delivery:

- a supportive environment, providing a sense of safety and trust, inclusivity and accessibility, where staff are role models, mentors and friends;
- cultural teachings and spiritual development combined with seeking a balance in the physical, mental, spiritual, and emotional aspects of a person;
- integrated interventions involving both traditional and western approaches to care, which respect the ethic of choice, non-interference and self-responsibility;
- community development and empowerment through the use of centres as community resources.39

The health centres have been described as communities within communities. Incorporating community into service delivery has been an effective approach for health promotion to both adults and youth. One example is through videos or plays produced and performed by community members depicting personal experiences with HIV/AIDS or cultural teachings used to frame healthy lifestyle choices.

Key features of the centres are the use of a multi-disciplinary team, a single point of entry and the ability to access health professionals such as dieticians without a referral. Outreach services and street clinics provide an effective alternative to emergency room visits in many cases. The centres may partner with other agencies, including non-Aboriginal, to meet the needs of all street people.

One of the goals of the health centres is to increase accessibility to health services. In the Phase 1 evaluation, 87 per cent of the urban respondents and
64 per cent of the rural respondents reported that their centre had improved personal access to health care a lot or a great deal. A high level of satisfaction with the full range of services received was reported, including emotional and mental health services, health promotion activities, and spiritual guidance. This has been attributed, in part, to the way the services are provided, the non-judgmental attitude of staff and their respect for cultural and spiritual beliefs.40

SUMMARY

This paper provides a summary of the primary strengths and challenges of Aboriginal-controlled health care systems in Canada. It also provides several detailed illustrations of what works in Aboriginal health systems in different regions of the country. Clearly, Aboriginal health systems in Canada must accommodate vast differences in cultural expectations, jurisdictional complexity and geographic diversity.

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ENDNOTES


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**Vision Statement**

The National Aboriginal Health Organization, an Aboriginal-designed and -controlled body, will influence and advance the health and well-being of Aboriginal Peoples through carrying out knowledge-based strategies.

**NAHO and its First Nations, Ajunnginiq and Métis Centres are unique in that we:**

- Are founded on and are committed to unity while respecting diversity
- Gather, create, interpret, disseminate, and use knowledge on Aboriginal traditional and western contemporary healing and wellness approaches
- View community as the primary focus and view research methodologies as tools for supporting Aboriginal communities in managing health
- Reflect the values and principles contained in traditional knowledge and practices

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