

A stylized sunburst graphic composed of numerous thin, golden-yellow lines radiating from a central point, creating a fan-like shape. The lines vary in length and are arranged in a semi-circular pattern. The text is overlaid on this graphic.

ASSESSING THE QUALITY
OF PRIMARY CARE SERVICES
AVAILABLE TO
ONTARIO'S ABORIGINAL RESIDENTS
PHASE I REPORT

Mae Katt

Bruce Minore

Mary Ellen Hill

Rylee Kuzik

Mark Rantala

© Centre for Rural and Northern Health Research

Lakehead University, 955 Oliver Road

Thunder Bay, Ontario, Canada

2006

ASSESSING THE QUALITY
OF PRIMARY CARE SERVICES
AVAILABLE TO
ONTARIO'S ABORIGINAL
RESIDENTS

PHASE I REPORT

SUBMITTED TO:

THE ONTARIO HEALTH QUALITY COUNCIL

BY:

MAE KATT, BRUCE MINORE, MARY ELLEN HILL
RYLEE KUZIK AND MARK RANTALA

CENTRE FOR RURAL AND NORTHERN HEALTH RESEARCH
LAKEHEAD UNIVERSITY

2006

TABLE OF CONTENTS

Acknowledgments.....	ii
EXECUTIVE SUMMARY	iii
INTRODUCTION	1
Approach.....	2
Ontario’s Aboriginal Population.....	4
Aboriginal Population’s Health Status.....	5
PRIMARY HEALTH CARE SERVICES IN ONTARIO.....	9
Programs Delivered By Ontario.....	10
Services Delivered By Health Canada.....	17
Federal-Provincial Integration Initiatives	22
THE ATTRIBUTES OF A HIGH-PERFORMING HEALTH SYSTEM	25
Accessible	25
Effective	31
Safe	34
Patient-Centred	37
Equitable	40
Appropriately Resourced	43
Integrated	48
Focused on Population Health	50
CONCLUSION.....	53

ACKNOWLEDGMENTS

The authors wish to acknowledge the financial support provided for this study by the Ontario Health Quality Council. The results and conclusions are the authors' alone; no official endorsement by the Council is intended or should be inferred.

EXECUTIVE SUMMARY

Recognizing that the majority of Aboriginal people living in Ontario have less access to quality primary health care than is true for the province's population as a whole, the Ontario Health Quality Council commissioned a two part study entitled *Assessing the Quality of Primary Care Services Available to Ontario's Aboriginal Residents*. This report covers the first phase – an environmental scan framed around two broad questions: (a) what is the nature of the services available to Aboriginal people across the province? And (b) what do we (and can we) know about the quality of that care? The answers came from a comprehensive review of published literature, as well as government and non-government reports and websources, combined with in-depth interviews of individuals responsible for administering and delivering primary care to Aboriginal clients across the province, whether they live in rural, remote or urban settings.

The report starts with an overview of Aboriginal Ontarians' demographic situation, their health status, and the culture group-specific health programs that are available to them. Approximately one-fifth of Canada's Aboriginal population lives in the province; 61.1 percent in cities, 21.5 percent on First Nation reserves, and 17.4 percent in rural areas. While their health status has improved over the past two decades, it continues to fall behind that of the general population on virtually every indicator. However, attempts to address the gaps are being made through a number of primary health care programs designed for Aboriginal clients; these are

funded by either the federal or provincial governments, depending on the location, type of service and jurisdictional responsibilities involved. Moreover, the two levels of government are now working together, along with Aboriginal organizations, to develop some jointly sponsored, integrated services.

Key findings about the provision of Aboriginal health in this province are summarized according to the attributes which the Ontario Health Quality Council has defined as characteristic of any high-performing health system. Eight of the nine are considered, in turn. Since there were virtually no references regarding efficiency in the domain of Aboriginal health, either in the literature or the interviews, that attribute is not addressed separately. But the following were examined in detail.

Access

Aboriginal people's comparative disadvantage in terms of accessing primary health care is due to causes that vary by place and clients' Aboriginal status (whether First Nation, Métis or Inuit). The latter factor determines their eligibility for specific services (e.g. of federally funded programs, the Métis can only access a few related to health promotion). However, place of residence is the major determinant. Those who live in remote and rural communities experience the effects of geographic isolation, which limits the services available as well as the number and type of providers. On First Nation reserves in the north, because of chronic health human resource shortages, the focus is on acute care at the expense of follow-up or preventive care. Moreover, clients often have to leave the communities even for routine services like mammography screening. In urban centres, many Aboriginal people live on the margins of city

life and get lost in the shuffle between conventional services. Or, the services available are not culturally appropriate and the caregivers not culturally aware. These system-wide access barriers remain despite great efforts on the part of Aboriginal organizations and all levels of government, as well as considerable financial investments.

Effective

Clients deserve to receive care which meets their needs and is based on the best available evidence, including clinical information, case-based data, and for Aboriginal peoples, community consultations. With respect to clinical services there is no reason to think that the professional care received by Aboriginal clients differs from that offered to other provincial residents. However, there are concerns about the preparation of paraprofessionals and their integration into health care teams, especially in rural and remote communities where they play a fairly significant role. Overall, the information required to properly assess effectiveness is not available. Case-based data for federally funded services are limited and largely inadequate. At a provincial level, data from the wider health care system is blind to ethnicity. And, although Aboriginal-specific health care facilities collect good data for accountability and other purposes, it is not linked to databases from other provincial sources.

Safe

Although safety within the health care system generally means protection from harm, Aboriginal Canadians may face additional risks associated with cultural safety. Caregivers' failure to understand such socio-cultural differences as a strong belief in holistic care contributes to dissatisfaction among Aboriginal clients, who in turn exhibit poor adherence to plans of care.

Failure to appreciate the consensus approach to decision-making, involving family and other community members, also may give rise to tension, miscommunication and interruptions in care. Generally it appears that Aboriginal people are more intimidated in their interactions with the health care system and, thus, access it less effectively than most Canadians. It is hoped that having more First Nation, Inuit and Métis in health science careers will foster culturally competent care and increase people's willingness to access health services; in 2004 the federal government committed one hundred million dollars to enhance recruitment and training of Aboriginal professionals over a five year period.

Patient-Centred

To provide patient-centred care, practitioners must be sensitive to individual needs and preferences, including those based on religion, language and culture. Even routine care can be disempowering if policies do not allow clients to assume responsibilities for their own care (e.g. the northern nursing station practice of controlling medication use by dolling out a few pills at a time). Care can also be disempowering if treatments do not fit with Aboriginal people's ideas of wellness. The situation is improving, however. Cultural competence is increasingly reflected in formally stated professional expectations respecting therapeutic relationships. And the programs instituted through Ontario's Aboriginal Healing and Wellness Strategy have well developed components that address clients' situational needs and take into account underlying causative factors such as the residual affects of the residential school experience on several generations.

Equitable

The services available to Aboriginal Ontarians vary depending upon their place of residence and status, as well as any applicable jurisdictional considerations. The fact that services are different does not make them inequitable, of course, although this is the subject of considerable debate. Nonetheless, the split in jurisdiction between the federal and provincial governments for on- and off-reserve services, together with the transfer of responsibilities to Aboriginal Health Authorities in many First Nation communities, has resulted in a complex system of care. Not surprising, it has also created anomalies and gaps. Information on usage patterns is limited; however, some evidence suggests that a lack of access to primary care results in clients having to be hospitalized for more advanced care later. They may also have to relocate for purposes of diagnoses and treatment, which disrupts their lives and cuts them off from their network of support.

Appropriately Resourced

Of the resources needed for any health system to function – financial, infrastructural and human – the latter are of particular concern in the case of Aboriginal health in Ontario. High turnover in the health workforce, especially in northern parts of the province, is costly, undermining the continuity of care for clients and straining budgets that must be in constant recruitment mode. Existing primary care services are reasonably well supported, however; the health human resource deficit is not due to a lack of financial resources. The way funding is structured does affect service delivery in several ways. Across-the-board “envelope” funding targeted for specific purposes may not meet local needs, yet it restricts the flexibility available to

those making decisions. Moreover, program financing based on historic patterns of utilization means that many Aboriginal-specific service organizations are hard pressed to meet client needs. This is compounded by reliance on annualized funding, which requires continual reapplication and creates an environment of uncertainty and programming instability. Current funding policies also fail to address the socio-economic conditions that partially determine the health of community members.

Integrated

Although all parts of the health system should interconnect and function in a harmonious fashion, jurisdictional divisions prevent that from happening in the realm of Aboriginal health. While there are signs of change, federal/provincial silos still exist. The same can be said of Aboriginal-specific services in any given locale. Albeit a common health sector phenomenon, adherence to their individual mandates restricts the extent of inter-agency cooperation and coordination. Inclusion of traditional medicine into the spectrum of care has occurred to some extent, but usually as a parallel system of care; referrals occur between traditional and western practitioners, but a fully integrated, interdisciplinary model has not yet been tried.

Focused on Population Health

It is not sufficient for a health system to have a curative orientation; it must also be preventive. Although the Aboriginal health system in Ontario has both elements, they are not always in balance, due to the pressure of primary health concerns. In the south or mid-north, where there is easier access to general primary care services, Aboriginal health programs can focus on preventive and public health programs; in the more remote north, the overwhelming

pressure to provide primary care effectively restricts the resources available for public health. Where they are in place, successful health promotion activities depend on understanding individual behaviours within a given environment or context. Determining the content of a given program requires local lay knowledge and a recognition that this may differ from one community to the next.

In sum, while considerable challenges remain, there are reasons to celebrate. One is the province's strengthening role in the provision of inclusive, holistic and culturally-specific care to Aboriginal people. Another is the increased collaboration between Aboriginal, provincial and federal levels of government in developing policies and programs to meet particular population's needs. But the most important is the increasing presence of Aboriginal people as decision-makers and providers within Ontario's health care system.

INTRODUCTION

The majority of Aboriginal people living in Ontario have less access to quality primary health care than is true for the province's population as a whole. In some cases this is due to geographic isolation,¹ while in others it is the result of cultural or psycho-social isolation,² residence in off-reserve³ rural areas, and unavailability of appropriate care providers.⁴ Even in cities where the system of care is adequate, a marginalized status cuts many Aboriginal people off from mainstream services.⁵ Yet, as a group they are among those residents of the province who most need access to primary care, the keystone in preventive services, diagnosis and treatment of ambulatory conditions, chronic disease management, and specialist referrals.⁶

Recognizing Aboriginal people have unique needs and challenges, the Ontario Health Quality Council is committed to gathering the information necessary to take an informed position regarding the primary care services available to Ontario's Aboriginal citizens. To this end, the council commissioned a two part study entitled *Assessing the Quality of Primary Care Services Available to Ontario's Aboriginal Residents*. The first phase, an environmental scan framed in terms of the attributes of a well functioning primary health care system, will answer two broad questions: (a) what is the nature of the services available to Aboriginal people across the province? And (b) what do we (and can we) know about the quality of that care? The second phase will explore the weaknesses or gaps in the existing data and constraints on their use, as well as the geographic and population level comparisons (within the province) that are possible.

It will also consider how Aboriginal people themselves understand or conceptualize the attributes identified as indicators of a high performing health system.

APPROACH

The present report covers the first phase of the study. It is based on a comprehensive review of published literature, as well as government and non-government reports/websites, combined with key informant interviews. The latter include in-depth, semi-structured conversations with provincial and federal decision makers, as well as individuals responsible for direct care delivery in northern and southern Ontario settings—rural, remote and urban.

Since the literature provides the foundation for this first report, a few comments about its scope and quality are worth considering at the outset. While there is an extensive body of literature about the health of Canada's Aboriginal people, the coverage is far from being either comprehensive, or adequate. Although certain populations, including the Cree and Ojibwa of northern Ontario, are the subject of numerous articles, comparatively little has been written about those who live off-reserve in rural areas and urban centres,⁷ or the Métis and those who do not have registered First Nations or Inuit status.⁸ A relatively recent review of research completed across Canada concluded that: "a few prolific research groups have generated a disproportionate amount of publications from a few communities and regions."⁹

In Ontario the focus has been on the First Nation communities of the Sioux Lookout Zone,¹⁰ which covers the northernmost part of the province; much less information is available on Aboriginal communities in other areas, or off-reserve residents. Where comparisons are

made, it is usually with the Canadian population as a whole, which Young notes is reasonable since we strive for a national standard of well-being for all, although geographic, cultural, socioeconomic, and health differences may be overlooked in the process.¹¹

The existing literature falls into two distinct categories: epidemiological and cultural.¹² The former addresses some of the most pressing health concerns, such as diabetes, but largely ignores others, such as injuries (a leading cause of death). Studies of the first type are also criticized for their lack of historical and political context.¹³ The qualitative methods used for most of the studies that consider cultural dimensions of health, however, mean the findings cannot be generalized beyond a specific population or situation.¹⁴ As well, there is a scarcity of scientific frameworks that take into account multiple and complex factors affecting health status, for example multi-generational trauma.¹⁵

Similarly, multifaceted approaches to evaluate programs, not only in terms of outcomes but community-defined measures of success as well, are under-developed.¹⁶ There is only one article, for example, that examines the quality of primary care for Aboriginal clients in Ontario.¹⁷ And, except for the occasional paper,¹⁸ little has been written that is publicly available¹⁹ about the indigenous primary health sector,²⁰ despite its emerging importance through the province's Aboriginal Healing and Wellness Strategy and the federal government's Health Transfer Policy. To an overwhelming extent, the published material on Aboriginal health is deficit oriented, focusing on problems, failures and negative comparisons.²¹ With a few exceptions,^{22 23} there is little by way of strengths-based analyses that acknowledge the resilience and resourcefulness of either Aboriginal People or their cultures. A much richer, more nuanced body of literature remains to be written.

ONTARIO'S ABORIGINAL POPULATION

The last national census, completed in 2001, revealed that 188,315 Ontario residents identified themselves as being of Aboriginal heritage, whether First Nation, Inuit or Métis.²⁴ This number is an underestimation for several reasons. First, seventeen reserves or settlements were not fully enumerated.²⁵ In certain cases communities refused to take part as a matter of principle; they do not believe the Canadian government has the right to take a census of their People. Second, if patterns from the 1996 census repeated, it is likely that a significant number, both on- and off-reserve, did not self-identify as Aboriginal.²⁶ Smylie notes some individuals will not reveal their ancestry or claim an Aboriginal identity when dealing with non-Aboriginal census takers because of “historic, systemic, and attitudinal inequities.”²⁷ Third, because this population tends to be very mobile within cities, and to be over-represented among those who are homeless, an untold number would have been missed in the count.²⁸ And, fourth, the status of some individuals who rightfully are Aboriginal may not be recognized within the multiple systems and jurisdictions that provide their care.²⁹

Although identified Aboriginal residents represent only one percent of the province's population, it appears more than one-in-five Aboriginal Canadians are Ontarians.³⁰ The majority live amidst the general population, with only 21.5 percent residing in some 139 First Nation communities scattered across the province, with most First Nations concentrated in the north.³¹ Of the rest, 61.1 percent are city dwellers and 17.4 percent live in rural areas. Compared to the province's population as a whole, because of continuing higher (albeit declining) birthrates, Aboriginal people tend to be younger, with about 46 percent under 25 years of age.

ABORIGINAL POPULATION'S HEALTH STATUS

In the past quarter century, while some disease indicators of Aboriginal people have shown improvement, such as childhood infectious disease rates, epidemiological studies show the health status of Aboriginal populations continues to fall behind the general population³² on virtually every indicator.³³ The provincial situation mirrors the national picture. Results from the Ontario First Nations Regional Health Survey indicate the prevalence of chronic conditions reported are significantly higher than those found in the Ontario part of the National Population Health Survey.³⁴ This relationship is also confirmed in a review focusing on one region, the area along the Hudson and James Bay coasts.³⁵ This latter study noted that once infrequent chronic conditions are now more prevalent than in the non-Aboriginal population and that injuries resulting from accidents or deliberate violence are at epidemic levels.

Condition specific studies, completed within and outside Ontario, provide detailed comparisons. The incidence of non-insulin-dependant diabetes mellitus, for example, is 3 to 5 times higher than the Canadian norm,³⁶ with onset sometimes at very early ages (diagnosed in children as young as five years old in northern Ontario).³⁷ With regard to obesity, a cross-group study done in British Columbia³⁸ and another one comparing the men and women of a large reserve in southern Ontario with non-Aboriginals in Hamilton, Toronto and Edmonton found a much higher incidence of overweight and obese people in the Aboriginal samples.³⁹ They also fared less favourably when other risk factors associated with cardiovascular disease, such as smoking and poverty, were looked at in the latter study.⁴⁰ Other research has shown hypertension

levels are higher overall,⁴¹ although varying by age, with Aboriginals younger than 45 above the national average and those older below the norm.⁴²

Looking at disease after disease, study after study it is evident that Aboriginal Ontarians and those in other parts of the country have poorer health than the majority of Canadians. Anaemia among Cree children in remote northern Ontario First Nations (and Inuit in Nunavut) was eight times higher than among urban Canadian children, attributed in part to their consumption of evaporated cow milk.⁴³ Dental caries among three to five year olds living in seven First Nation communities on Manitoulin Island also was much higher than would normally be expected.⁴⁴ Oncology rates are below the national average, as would be expected due to the younger population of Aboriginal communities.⁴⁵ But in northern Ontario, survival rates are poorer, generally because Aboriginal clients present with the disease at a more advanced stage.⁴⁶ Cancer ranks third after heart disease and violent or accidental deaths as the cause of Aboriginal mortality in Ontario.⁴⁷ The leading cause of death for women, however, is alcoholism and cirrhosis.⁴⁸

Despite the higher rates of morbidity, the factors that determine the health of Aboriginal people are the same as those for the population as a whole.⁴⁹ Their relative health status simply reflects their disadvantage on most of these variables. Water supplies contaminated by raw sewage in many First Nation communities, for example, cause shigellosis, a preventable bacterial infection, at levels more than 19 times the national average.⁵⁰ Aboriginal people, whether on- or off-reserve, are also more likely to live in over-crowded houses,⁵¹ conditions which encourage the spread of infectious tuberculosis.⁵² Of course, housing choice (especially in urban or rural non-reserve areas) is largely dictated by people's disadvantaged socioeconomic situation.

Poverty also contributes to food insecurity, a phenomenon linked to poor health that Aboriginal people have high odds of experiencing.⁵³ For individuals living in northern Ontario's First Nation communities, the exorbitant cost for fresh produce⁵⁴ results in people opting for the type of high fat, low fibre diets that lead to diabetes and obesity.⁵⁵ The problem is compounded by environmental contamination of the fishing stock,⁵⁶ a staple among their traditional "country" foods. The Anishnawbe of Grassy Narrows still contend with the results of methyl mercury poisoning which came to light in the 1970s, believed to be the result of consuming fish caught in waters downstream of pulp and paper mills.⁵⁷

As a result of lack of health education, individual's choices also introduce significant health risks. A study of patterns of sexual partnering and sexually transmitted diseases among individuals from eleven Ontario First Nations communities concluded that HIV would likely spread rapidly if introduced into the communities.⁵⁸ Another case in point is smoking rates; in the province's First Nation's Regional Health Survey (2003), some 79 percent of males and 72 percent of females living on-reserve report being smokers, compared to 30 and 27 percent, respectively, for the provincial population as a whole.⁵⁹ The prevalence of this health risk co-exists with rising lung cancer rates.⁶⁰

Although large-scale epidemiological studies establishing prevalence rates of mental health problems for this population are not available, there is no reason to believe that the highest risk categories would differ from those in other jurisdictions – people who are homeless,⁶¹ incarcerated,⁶² or who have alcohol and drug problems.⁶³ A marginalized status, combined with cultural oppression, contributes to mental health deviations for many individuals.⁶⁴ A common root cause in Ontario and elsewhere in Canada are the abuses that occurred in residential schools,

which not only affect the former students, but also their children and grandchildren.⁶⁵ Reactions to this social and psychological trauma manifest in the form of “dissociation, mood, personality, or behaviour problems, alcohol or other substance abuse, self harm and suicide.”⁶⁶ Moreover, community-based counsellors working with victims are themselves vicariously traumatized by their clients’ experiences.⁶⁷ Addressing the intergenerational impact of the schools is an issue of compelling and continuing concern.⁶⁸

Eight out of every ten Aboriginal women in Ontario report having been subjected to violence.⁶⁹ It is perhaps not surprising, then, that a study of female victims of spousal abuse presenting at an emergency department in Sudbury found 14 percent were Aboriginal,⁷⁰ although Aboriginal-identified individuals made up only 4.6 percent of the city’s total population. Abuse, together with social losses such as an absence of positive parenting, translate into a sense of “guilt, shame and low self-esteem” for the victims,⁷¹ to the detriment of their health seeking behaviour. As for any client group, the disadvantaged circumstances of these women, and Aboriginal individuals suffering from other conditions, is a significant factor in the process of care.⁷² For example, an investigation of childhood immunization statistics show that First Nation children in northern Ontario have lower vaccination coverage than the Canadian norm; some mothers elected not to have their children vaccinated because of earlier traumatic immunization experiences, side-effects, and negative interactions with health professionals.⁷³ The importance of the latter factor is among the most compelling findings in studies of cancer,⁷⁴ mental health and diabetes care completed in Northwestern Ontario.⁷⁵

PRIMARY HEALTH CARE SERVICES IN ONTARIO

There are Aboriginal Ontarians making use of the full range of publicly-funded primary care services in place for any residents of the province; specific choices depend on the services available where they live or at a distance. However, many of them rely on Aboriginal-specific health services provided through various provincial, federal or integrated program initiatives. Whether individuals can use these options depends on their geographic location, their type of Aboriginal status, and/or the programs' other eligibility criteria or capacity.

Since client data in the general system of health care does not include ethnic identifiers, comprehensive analyses of Aboriginal people's utilization of "open-to-all" primary care services are unavailable.⁷⁶ Consequently, the following program scan focuses on those programs exclusively dedicated to meeting the needs of Aboriginal citizens of Ontario. Provincial, federal and Aboriginal programs designated as falling under the rubrics of primary care, public health, population health, health promotion, community health and wellness were all included in the scan, recognizing that there are overlapping scopes and sometimes interchangeable uses of terminology among these various specialties.

PROGRAMS DELIVERED BY ONTARIO

The province of Ontario has adopted a policy framework that is oriented to Aboriginal self-determination in the area of health, “supported by appropriate levels of financial and human resources for Aboriginal-designed, -developed and -delivered programs and services that respect and promote community responsibility, autonomy and local control.”⁷⁷ This philosophy reflects the structure of the principal programs directly funded by the Ministry of Health and Long-Term Care and indirectly funded in collaboration with other ministries through the Aboriginal Healing and Wellness Strategy (AHWS).⁷⁸ As described in the following paragraphs, these initiatives include Aboriginal Health Access Centres and Aboriginal Community Health Centres,⁷⁹ the Ontario Aboriginal Diabetes Strategy,⁸⁰ the Aboriginal HIV/AIDS Strategy⁸¹ and the Aboriginal Tobacco Strategy,⁸² along with several Aboriginal Child Health Programs.⁸³

Aboriginal Healing and Wellness Strategy (AHWS)

The Aboriginal Healing and Wellness strategy originated as a response to a 1992 province-wide consultation among Aboriginal peoples about the need to address family violence, health and well-being issues.⁸⁴ This collaborative strategy, developed through partnerships among the Ontario Ministries of Community and Social Services, Health, the Ontario Native Affairs Secretariat, the Ontario Women’s Directorate, and the province’s First Nations, Métis and off-reserve Aboriginal Groups, was designed to improve Aboriginal health by promoting equitable access to care, culturally-appropriate approaches to healing and wellness, and program support for health promotion, advocacy, traditional practices, and Aboriginal health planning. AHWS funds 18 programs for on-reserve and off-reserve Aboriginal people province-wide.⁸⁵

Aboriginal Health Access Centres (AHAC)

At the heart of the Aboriginal Healing and Wellness Strategy program delivery initiatives are the 10 Aboriginal Health Access Centres (AHAC), which provide culturally-appropriate primary care. Although the mix of services varies from one centre to another, all offer adult and child assessments, health education, disease prevention, nutrition education, counselling and traditional healing. Most also deliver outreach services for populations at risk, through street health harm reduction programs, school health clinics, and shelter-based programs.

Six AHACs are located in the north (N’Mninoeyaa in Cutler; Gizhewaadizaiwin in Fort Frances; Shkagamik-Kwe in Sudbury; Wassay-Gezhig Na-Nahn-Dah-We-Igamig in Keewatin; Noojmowin Teg Centre on Manitoulin Island; and Anishawbe Mushkiki in Thunder Bay). The other four AHACs serve Southern Ontario Aboriginal populations (Wabano Centre in Ottawa; De dwa da deha nye>s Aboriginal Health Centre in Hamilton and Brantford; Kanohkwatshero:io in Cornwall; and the Southern Ontario Aboriginal Health Access Centre in London and Muncey). All Aboriginal Health Access Centres serve status and non-status First Nations and Métis families; the Wabano centre also offers culturally-appropriate services for Inuit peoples.

Aboriginal Community Health Centres (ACHC)

Under Community Health Centre funding initiatives, the Ministry of Health and Long-Term Care also supports two Aboriginal Community Health Centres, Anishnawbe Health located in central Toronto, and Misiway Milopemahtesewin Community Health Centre in Timmins.⁸⁶ Anishnawbe Health provides a broad range of health and community-based services to an urban Aboriginal population⁸⁷ and through a partnership with George Brown College, delivers training for Aboriginal community health workers.⁸⁸ Misiway Milopemahtesewin offers coordinated and

multidisciplinary primary health care to Aboriginal residents of Timmins and surrounding rural and northern communities. Services include prenatal, well-woman and well-baby clinics, along with individual education and community workshops on healthy lifestyle choices.⁸⁹ Based on 2005 estimates from the Association of Ontario Health Centres, the ten Aboriginal Health Access Centres and two Aboriginal Community Health Centres provide primary care to an estimated 22 percent of Ontario's citizens of Aboriginal ancestry.⁹⁰

Other AHWS Initiatives

As well as operational support for 10 Aboriginal Health Access Centres, the Aboriginal Healing and Wellness Strategy offers salary support for staff in each of the following areas: (a) community-based wellness workers (117 workers in 105 communities); (b) volunteer crisis intervention teams (in 48 remote communities); (c) health liaison staff (in 8 Aboriginal organizations); and (d) health outreach workers (at 14 urban centres). Through what are termed *specialized projects*, AHWS supports: (e) 7 Aboriginal Regional Health Authority Planners (see below); (f) 4 Health Advocacy Developers; (g) 8 Healing Lodges and Treatment Centres; (h) a Maternal and Child Centre; (j) three Outpatient Hostels; (k) 9 Women's/Family Shelters; (l) 4 Translator Services; (m) and an Information Clearinghouse for Aboriginal health resources. Time-limited project funding also allows Aboriginal organizations to develop targeted community-based health outreach services. Additional funding covers training and development supports for AHWS staff employed by Aboriginal organizations delivering the programs.

Aboriginal Health Planning Authorities

To support Aboriginal health planning at the community, regional and provincial levels, AHWS funds seven Aboriginal Health Planning Authorities. Four Aboriginal health planning authorities serve northern Aboriginal communities and tribal organizations (Fort Frances Tribal Area Health Authority, Paawidigong First Nation Forum, Kenora Chiefs Advisory, Nishnawbe-Aski Nation) and three support southern Aboriginal communities and organizations (Anishnawbek Nation Health Commission, Association of Iroquois and Allied Indians, Noojimawin Health Authority).

The planning authorities assist local Aboriginal communities in their development of health and social services, conduct and commission health research, and work with the provinces' regional health planning and health service organizations to improve Aboriginal access to care. Several of the authorities are also working towards coordination of provincial and federal programs to better address the health care needs for the First Nations communities and populations they serve.

Aboriginal Diabetes Strategy

The Ontario Aboriginal Diabetes Strategy was developed in 1996 as a long-term approach to diabetes prevention, treatment, care, education, research, and coordination.⁹¹ It funds Aboriginal-specific initiatives delivered through three existing programs. First, the Aboriginal Diabetes Education and Health Promotion/Prevention Program provides funding to eight Provincial organizations and independent First Nations to support the development of Aboriginal diabetes education and care programs. Second, the Northern Diabetes Health Network (Thunder Bay, Sudbury) sponsors 38 diabetes education programs for adults in northern communities, as

well as 34 programs for children across the province. Aboriginal components are delivered by two regional diabetes outreach workers. Third, the Southern Ontario Aboriginal Diabetes Initiative (St. Catherines) delivers culturally appropriate diabetes education, prevention and management services to off-reserve and on-reserve communities in Southern Ontario, using five regional diabetes workers. Diabetes education programs are also part of the Ontario Native Women's Association and Ontario Federation of Indian Friendship Centres' Health Outreach Worker initiatives funded through the Aboriginal Healing and Wellness Strategy.

Aboriginal HIV/AIDS Strategy

The Ontario Aboriginal HIV/AIDS Strategy was developed to address the needs of off-reserve Aboriginal populations. It is a joint effort of the Ministry of Health, the Ontario Native Women's Association, the Ontario Métis Aboriginal Association, the Métis Nation of Ontario, the Ontario Federation of Indian Friendship Centres and Two-Spirited People of the First Nations, as well as the Aboriginal Health Office and the AIDS Bureau.⁹² Services include advocacy, counseling, crisis intervention, education, housing, outreach, traditional medicine, information and referrals.

Outreach services are delivered by 10 Aboriginal HIV/AIDS workers located in four southern communities (Toronto, Kingston, Chatham, London) and two northern communities (Cochrane, Thunder Bay). With funding from the strategy, the Ontario Association of Indian Friendship Centres delivers an Urban HIV/AIDS Training Program to Aboriginal workers in various specialties: healing and wellness, alcohol and drug, family and criminal court, health outreach and long-term care.⁹³ As well, the Ontario Métis and Aboriginal Association has

received funding to develop community-based workshops, designed to increase awareness of HIV/AIDS among youth and older adults.⁹⁴

Aboriginal Tobacco Strategy

Through Cancer Care Ontario, the Province supports an Ontario Aboriginal Tobacco Strategy.⁹⁵ The strategy, which was developed and is delivered in partnership with Provincial Aboriginal organizations, funds community projects to promote smoking prevention and cessation, as well build community capacity to address tobacco control issues. During 2004-2005, 11 community-based programs were delivered (Akwasasne First Nation, Attawapiskat First Nation, Beausoleil First Nation, Garden River First Nation, Métis Nation of Ontario, Pays Plat First Nation, Sheshegwaning First Nation, Six Nations of the Grand River, Wabano Aboriginal Health Centre, Wauzhushk Onigum First Nation, Webique First Nation), along with a province-wide Traditional Tobacco Scan.

Aboriginal Healthy Babies/Healthy Children Programs

Working through the Aboriginal Healing and Wellness Strategy and the Early Years Strategy, the province funds a number of primary care and prevention initiatives designed to improve the health of Aboriginal children and youth. The Aboriginal Healthy Babies/Healthy Children Program (AHBHC) supports community and regional programs to improve the long-term health of children aged 0 to 6 years, through pre- and post-natal screening and assessment, home visiting, service co-ordination and integration.⁹⁶

With programs both on- and off-reserve, Aboriginal organizations are active in delivering AHBHC programs to over 160 communities across Ontario. These include the Anishinabek of

Kabapitowangag (7 First Nations), Association of Iroquois and Allied Indians (6 First Nations), Fort Frances Tribal Area Health Authority (7 First Nations), Kenora Chiefs Advisory (7 First Nations), Métis Nation of Ontario (7 urban and 3 rural sites), Nishnawbe Aski Nation (46 remote First Nations), the Ontario Federation of Indian Friendship Centres (13 urban sites), the Ontario Native Women's Association (6 urban-rural programs), Paawidigong (5 First Nations), Union of Ontario Indians (32 First Nations), and Independents (10 First Nations). Aboriginal families can also access the Healthy Babies Healthy Children Programs delivered through the province's 36 public health units.

Aboriginal Fetal Alcohol Spectrum Disorder and Aboriginal Child Nutrition Programs

Coordinated by 19 Aboriginal organizations, Aboriginal Fetal Alcohol Spectrum Disorder Program (FASD) and Aboriginal Child Nutrition Programs (ACN) promote healthy pregnancy, birth and infancy in 145 on- and off-reserve Aboriginal communities located throughout the province.⁹⁷ Working with the province's Early Years initiatives, FASD projects provide culturally-appropriate health promotion, prevention, family supports and advocacy, as well as community education and provider training workshops. Companion ACN projects offer nutrition and lifestyle education, healthy breakfast and lunch programs, along with parenting workshops designed for families of infants, toddlers and preschoolers.

Aboriginal Community-Based Support Services

Through the Aboriginal Healing and Wellness Strategy and additional direct funding by the Ministry of Health and Long-Term Care, the province funds Aboriginal-specific health education and promotion outreach, as part of long-term care and community care funding.⁹⁸ The

majority of these programs are directed towards off-reserve First Nations and Métis peoples; some programs are also delivered to on-reserve First Nations and agencies. Although programs vary in content and structure from one organization to another, all are designed to ensure Aboriginal communities and individuals have the knowledge and supports required to access needed primary and preventive care.

Community Health Outreach programs delivered through the Métis Nation of Ontario (Midland, North Bay, Sault Ste. Marie, Fort Frances) and the Ontario Métis Aboriginal Association (Red Lake, Wabigoon, Thunder Bay, Timmins, Chapleau, Iron Bridge, Sault Ste. Marie, Hornepayne), for example, include referrals, health seminars, client advocacy, assistance to the homeless, medical transportation and counseling, as well as workshops on environmental issues, such as water testing.⁹⁹ For its part, the Ontario Native Women's Association, supports Community Health Outreach initiatives which focus on diabetes education, problem gambling, and mental health issues (Thunder Bay, Greenstone, Sioux Lookout and Georgian Bay).¹⁰⁰ Some First Nations also receive provincial funding to provide health education as part of community-based support services; a few First Nations have made arrangements to obtain professional community care supports, including educational programs, through the provincial system.¹⁰¹

SERVICES DELIVERED BY HEALTH CANADA

Although most Aboriginal Ontarians, like the rest of the population, access primary care from the nearest community offering general practitioner or family physician services, many also receive health care from Health Canada, which has a mandate to ensure First Nations and Inuit

communities have access to health services, including primary care, health promotion and prevention.¹⁰² As described in subsequent sections, these include Primary Care and Community Care Programs, Aboriginal Diabetes, HIV/AIDS and Tuberculosis Strategies, as well as Aboriginal Child Health Programs.¹⁰³ Some programs are delivered directly by Health Canada; others are delivered through collaborative partnerships with Aboriginal communities and organizations.

Primary Care

For First Nations reserves and Inuit communities whose residents must travel more than 90 km to access provincial physician services,¹⁰⁴ the Primary Care Program delivers primary, acute and continuing care through a system of nursing stations and health centres. Facilities are staffed by extended practice nurses, with backup from contracted physicians, who provide 24/7 consultations via telephone. Physicians also visit the communities on a regular schedule, generally once a month.¹⁰⁵ In some communities, primary care services are provided directly by Health Canada; in other locations, some or all of the primary care services are delivered by First Nations health authorities, with funding provided through transfer or contribution agreements.¹⁰⁶

Through the Non-Insured Health Benefits Program, the federal government also provides registered First Nations and Inuit peoples with additional primary care services and supports not covered through provincial health programs.¹⁰⁷ The program covers costs of prescription drugs, over-the-counter medications, medical supplies and equipment, short-term crisis counselling, dental care, vision care, and medical transportation.

Health Promotion and Prevention

Health Canada's Community Nursing Programs, along with Home and Community Care Programs, give First Nations and Inuit communities access to health promotion and prevention.¹⁰⁸ Community nurses, with support of community health representatives, deliver community-based well-woman, well-baby, diabetes education, sexual health and school health programs.¹⁰⁹ Nurses also manage mandatory immunization and communicable disease reporting. The Home and Community Care Program offers in-home health education, promotion and prevention services to the elderly and disabled, with emphasis on wellness, fitness and risk reduction.¹¹⁰

In addition, Health Canada funds a wide range of targeted health promotion programs delivered by Aboriginal communities and organizations. These programs include Aboriginal Diabetes, HIV/AIDS, Tobacco Control, and Tuberculosis Strategies, as well as Aboriginal Head Start and FASD initiatives. While most of these health prevention strategies have been developed for on-reserve First Nations and Inuit communities, several programs have health promotion components directed to all Aboriginal peoples, regardless of their status or where they live.

Aboriginal Diabetes Strategy

Health Canada's Aboriginal Diabetes Strategy includes two components: the Aboriginal Diabetes Program for on-reserve First Nations and Inuit communities¹¹¹ and the Métis, Off-reserve Aboriginal and Urban Inuit Diabetes Prevention and Promotion Program.¹¹² The on-reserve Aboriginal Diabetes Program offers treatment, prevention, health promotion and lifestyle support services, delivered by trained diabetes care workers and educators, who work with

community nursing and home care programs. In Ontario, First Nations residents can access the on-reserve Aboriginal Diabetes Program through one of 26 projects delivered through their respective Provincial Tribal Organizations.¹¹³

The Métis, Off-reserve Aboriginal and Urban Inuit Diabetes Prevention and Promotion Program (MOAUIPP), provides time-limited funding for Aboriginal organizations to develop diabetes prevention and health promotion programs. In Ontario, the MOAUIPP program is delivered through partnerships with the Ontario Métis Aboriginal Association, Métis Nation of Ontario, Ontario Federation of Indian Friendship Centres, the Ontario Native Women's Association, Aboriginal Health Access Centres and Community Health Centres. Programs operate in seven locations in northern Ontario (Dryden, Thunder Bay (2), Sault Ste. Marie (2), Timmins, Kirkland Lake) and four sites in southern Ontario (Ottawa (2), Hamilton, London).¹¹⁴

Aboriginal HIV/AIDS Strategy

As part of the Canadian Strategy on HIV/AIDS, Health Canada supports community-based prevention and education programs to both on- and off-reserve Aboriginal populations.¹¹⁵ On-reserve, programs are delivered through community health centres and community nursing initiatives. Off-reserve, the programs are delivered through Aboriginal HIV/AIDS Service Organizations, Aboriginal Friendship Centres, and Aboriginal Health Centres. National organizations, such as the Assembly of First Nations and Pauktuutit Inuit Women's Association have developed a number of HIV/AIDS education and training resources.¹¹⁶

Aboriginal Tobacco Strategy

As well as developing media and educational resources, Health Canada's Aboriginal Tobacco Strategy has given funding to First Nations and Inuit organizations to establish tobacco prevention and cessation programs, including initiatives targeted towards youth.¹¹⁷ In 2003-2004, a national mail-out campaign delivered information on smoking dangers to all First Nations and Inuit homes. Health Canada has also funded 12 national demonstration projects to create tobacco control toolkits and establish training programs for community health providers.¹¹⁸

Aboriginal Tuberculosis Strategy

In partnership with First Nation Health Authorities, Health Canada has established a Tuberculosis Elimination Strategy for First Nations and Inuit communities.¹¹⁹ National registries are used to monitor the effectiveness of surveillance and control programs, while at the community level case identification, surveillance, immunization, and treatment are implemented by primary care nurses. Additional programs have been designed to enhance community capacity through tuberculosis health education and training.¹²⁰ In Ontario, tuberculosis control and surveillance programs operate in the Sioux Lookout, Thunder Bay, James Bay, and Southern Ontario Zones; Sioux Lookout Zone has the unfortunate distinction of having the highest rate of tubercular infections in Canada.

Aboriginal Head Start, Canada Prenatal Nutrition, and FAS/FAE Programs

Health Canada, in partnership with Aboriginal communities and provincial organizations, has developed a number of specialized programs to promote healthy development among

children aged 0-6. The Aboriginal Head Start in Urban and Northern Communities (AHSUNC) is an early intervention program for First Nations, Inuit and Métis families living in urban centres and larger northern communities, designed to meet children's emotional, social, health, nutritional and psychological needs. As well, First Nations and Inuit communities can access funding from Health Canada's Brighter Futures program which supports child health, mental health, injury prevention, solvent abuse, and parenting initiatives, the Canada Prenatal Nutrition Program (CPN) and the Aboriginal Fetal Alcohol Spectrum Disorder (FASD) and Fetal Alcohol Syndrome/Effects (FASE) Projects.¹²¹

All of these programs, designed to build community awareness and capacity to respond to prenatal health concerns, are currently being offered at various locations throughout the province. Eighteen Aboriginal Head Start programs, eight located in northern Ontario and ten in southern First Nations, collectively serve a total of 573 children.¹²² The Brighter Futures program, with funding provided to all communities on a per capita basis, operates in 119 Ontario First Nations.¹²³ FAS/FAE demonstration projects have been developed by three Ontario Aboriginal organizations (Kettle and Stony Point Health Services, North Shore Tribal Council, and Pauktuutit Inuit Women's Association).¹²⁴

FEDERAL-PROVINCIAL INTEGRATION INITIATIVES

As outlined in the *Blueprint on Aboriginal Health* (2005), Federal and Provincial Governments, along with Aboriginal organizations, have made a commitment to work towards "improved delivery of and access to health services to meet the needs of all Aboriginal peoples

through better integration and adaptation of health systems” (p. 21).¹²⁵ Within Ontario, there has already been significant progress towards improved access through two Federal-Provincial First Nations Health Integration Projects located in the far northern part of the province.¹²⁶ These are the Sioux Lookout First Nations Health Authority, which serves remote Nishnawbe Aski communities in the Northwest and Weeneebayko Health Ahtuskaywin, which delivers care to Mushkegowuk communities along the James Bay coast.

Both the Sioux Lookout and Weeneebayko health authorities were established by First Nations as a response to needs identified through a process of consultations with communities in their respective regions. The Sioux Lookout Health Authority was established in March 1990, as a result of a series of community consultations that occurred in conjunction with the Scott, McKay and Bain Health Panel Report.¹²⁷ Weeneebayko Health Ahtuskaywin was incorporated in December 1993, following a similar consultative process.¹²⁸ Both initiatives are developing broad-based and coordinated health programming, including comprehensive primary care, health promotion, mental health, public and environmental health services. The goal is to create holistic and culturally-responsive regional health care systems that meet the needs of remote First Nations.

Sioux Lookout Integration Initiative

In partnership with Health Canada, the Sioux Lookout First Nations Health Authority, and the associations responsible for contracted health professional services (e.g. physicians), the Ministry of Health and Long-Term Care is participating in the development of an integrated health initiative for 28 remote First Nations communities in the Sioux Lookout area of northern Ontario.¹²⁹ The objective is to design, develop and deliver a comprehensive integrated health care

model, providing primary care, acute care, treatment, health promotion and public health services for the region. At the present time, activities are centered around the integration of services and finalization of agreements to support the creation and management of multidisciplinary teams. Discussions are currently underway concerning the transfer of funding and management of contracted physician services from the federal government to the Health Authority. Construction of the Menoyawin Health Centre, including a new acute care hospital replacing the former federal Sioux Lookout Zone Hospital and the provincially-funded Sioux Lookout General Hospital, is expected to be completed in 2009.

Weeneebayko Integration Initiative

This federal-provincial integration initiative, led by Weeneebayko Health Ahtushkaywin, is working toward establishing an integrated health services system for the coastal communities located along James Bay area in northern Ontario.¹³⁰ The initiative calls for the development of a plan for primary care, nursing, mental health, diabetes, home care, community care, long-term care, addictions treatment, acute care and emergency services. At the present time, the initiative is in the process of finalizing agreements to merge services provided by Weeneebayko General Hospital, the James Bay General Hospital and the Town of Moosonee, with those provided through Health Canada's nursing stations and health centres serving the First Nations populations of Moose Factory, MoCreebec, Fort Albany, Kashechewan, Attawapiskat and Peawanunk.

THE ATTRIBUTES OF A HIGH-PERFORMING HEALTH SYSTEM

Through a careful process of consultation and research, the Ontario Health Quality Council identified nine attributes that characterize a well-functioning health system. Each can be thought of as a continuum along which performance can be measured. Although all are relevant to assessing the way in which care is provided to any client group within the population, certain attributes may be of greater or lesser importance for a given one. In the case of Aboriginal people, for example, indications the system of care is efficient must be weighed against considerations of its accessibility, safety and equity as well as some of the other attributes. There is very little in the literature about the elimination of waste to create a more efficient Aboriginal health system, nor was it a topic about which those interviewed had much to say. Consequently, this report does not address efficiency, but covers the other eight attributes in turn.

ACCESSIBLE

Ideally people should be able to get the care they need, when they need it, from the right provider in the right place. But the situation for Aboriginal people throughout this province is far from this ideal. Whether they live in an urban centre, a rural community or in a remote First Nation, myriad factors interfere with their access to primary care. This is the case despite great efforts on the part of First Nations organizations and all levels of government, as well as

considerable investment in the system of care: Aboriginal status, income, and geographic place continue to create disparities in health.¹³¹

Although not a great deal of attention has been paid to comparing urban vs. rural or remote experiences, what evidence there is suggests geographic “place” does affect health status, largely due to the range of services available and relative ease of access. Individuals with diabetes who resided in remote communities, for example, were three times more likely to have acute complications that might have been avoided had they lived elsewhere.¹³² It is hypothesized that individuals in remote communities may put off seeking help in early stages of a diabetic emergency because they lack ready access to ambulatory primary care services, with the delay necessitating later hospital treatment.

Certainly the extent and type of services vary dramatically by locale. Individuals involved in direct service delivery to residents of large and mid-sized cities in southern Ontario describe a comprehensive range of on-site and outreach programs available through their Aboriginal Health Access Centres, noting that by going off-site they can help specific groups. For instance, “there is a high prevalence of Aboriginal kids living on the street, so we go to where they collect for their evening meals and evening programs, and we try and meet their needs there.”

Similarly, women forced to move because of domestic violence are often separated from their source of primary care, “so we go to the shelter to provide services,” including offering advice about such things as “serving healthy meals on a low budget.” These efforts are seen as critical, not only for the specific services rendered, but in building awareness and confidence. Speaking about an outreach worker in a sterile needle exchange program, it was observed:

“Many Aboriginal people who are quite disenfranchised will meet her first [in a shelter], and then on the basis of their trust in her, they’ll access services at the health centre.”

While larger urban centres in the north, like Thunder Bay and Sudbury, have developed primary care services to respond to the needs of their Aboriginal populations, smaller northern centres, which often lack adequate primary care coverage generally, find that meeting the special needs of Aboriginal residents is a challenge. Sometimes individuals who are members of a First Nation experience so much difficulty accessing appropriate services in other communities that they “try and go back to their home community to access services . . . which is not always, but can be difficult.”

In certain instances, adequate primary care services may be available in a community, but none are tailored to fit particular Aboriginal needs. It is argued this occurs because – all too aware of the potential for discrimination – enough people choose not to identify themselves as Aboriginal, so the demographic picture and assessment of population needs is distorted. Without accurate information about the Aboriginal population, there is not a recognized need for “Aboriginal services in a given area and then [people] can’t access culturally appropriate treatment.” Of course, the extent to which this phenomenon occurs is unknown and unknowable.

Health services in First Nation communities concentrate on primary care through community health centres or nursing stations,¹³³ where registered nurses, often with an expanded scope of practice, take the lead in working with visiting physicians, other specialists and paraprofessionals.¹³⁴ However, “anything that the nurse has to do that’s beyond her scope of practice, [Health Canada] has 24/7 coverage by physicians on call.” Similar consultant

arrangements exist in those parts of the province where services are managed by Aboriginal health authorities.

Although the province of Ontario coordinates and fund emergency medical transportation via air ambulance, which ensures individuals in need of immediate care receive prompt and appropriate attention, access to follow-up care is less consistent. For example, in remote communities where physicians only fly-in once a month, the sheer volume of cases interferes with maintaining continuity of care. A nurse from one community explained why: “[Our doctor] usually gets here on a Monday afternoon so she can start seeing patients probably around 3 pm and then you know, she leaves Friday morning, so you have three full days and a bit of care . . . she can probably see maybe 60 people . . . and sometimes there are like 90 people on the list to be seen.”¹³⁵ The result is that priority cases are attended to, but the rest have to wait for another month until the doctor returns.

For communities in more remote parts of the province, transportation and weather are the most frequently cited causes for access-to-care problems. Thirty-three communities across the north can be reached only by air or, in the winter months, some places, by winter roads ploughed along frozen waterways. Inclement weather can compound the issue; physician visits are cancelled, or patient’s out-of-town appointments are missed because a community’s airport is fogged or snowed in, which means rescheduling and delays.¹³⁶ Of course community-based primary care providers depend on having drugs and other medical supplies available, but these have to be flown in, so treatment is also “dependent on the weather, on the planes being able to get off (and to have [the required] room and weight tolerance),” in other ways, too.

While acknowledging that essential primary care is available in most communities from the resident nursing staff, “there is a concern that people often need more specialized kinds of services like dieticians” to help address the high rates of diabetes. Obtaining the services of such people is difficult, however. One manager observed: “The big issue here is trying to get specialists up from the larger centres . . . [because] we don’t have the money.” Northern patients also have to leave the communities to obtain services that would be considered routine primary and preventive care elsewhere in the province. For example, to have their biannual mammograms, older women from more remote communities in the northwest have to fly down to one of the road accessible communities in the mid-north that are visited by a breast screening van. But unless a woman is at risk and has been referred specifically for a scan, the transportation costs do not fall under the Non-insured Health Benefits program. The situation is the same for other programs that cannot be delivered on-reserve, leading an interviewee to conclude: “if there’s anything that really impedes getting access to primary care, that’s basically it.” Another person said, with respect to the program’s constraints, that “a lot of measures they put in place [are] geared towards saving costs rather than . . . what is best for the clients.”

Transportation issues are not limited to the remote north; albeit on a different scale, there are significant barriers in urban centres as well. Because many clients live hand-to-mouth existences in cities, “they can’t afford to get on the bus and come [to the health centre]” for care. And in a case where a mother needs to bring in one sick child, she may have to pay bus fare “for two other kids and [herself] . . . [she] can’t leave anyone at home because there is no one to baby-sit.” In addition, in many “southern places folks may not have access to an Aboriginal health program, so they have to travel to get to one.”

Telecommunication advances are widely seen as a way of overcoming some of the transportation barriers, in the north especially, but not exclusively. “Because we have the access issue, [Health Canada] is trying to focus on Telehealth as a way of bringing services to people on a less painful basis,” although there are still gaps in the infrastructure and a lack of funding. For instance, the northwest is covered by an extensive and well used network; however, “it’s always teetering on the brink of financial disaster because it survives on proposal-based, year-to-year funding.” In contrast, the James Bay coastal area does not yet have a system in place; fibre optics installation is not due to be completed there until December, 2007. As currently used in the north, the video-based telehealth systems primarily facilitate consultations with specialists (dermatology and psychiatry were identified as two areas where the system has proven to be particularly effective). They are also routinely used for in-service educational rounds by northern practitioners.

In the south, the term telehealth is applied to telephone-based systems that facilitate communication between health centres and their clients, giving clients access to health care advice on a twenty-four hour, seven-days-a-week basis. As well as recommending clients use *Telehealth Ontario* for general health advice and information, Aboriginal Health Care Access Centres routinely offer after-hours coverage via telephone and answering machine. The services direct clients to emergency departments, crisis lines or other urgent care. One centre also provides telephone access to “an on-call service for medical assessment if it’s more than telehealth that is needed.” A note of caution exists amidst the general enthusiasm for these technological solutions; the recognition that “telehealth isn’t universally accepted by clients and service providers yet.”

EFFECTIVE

Clients deserve to receive care which meets their needs and that is based on the best available evidence. The latter includes not only clinical information, but case-based data that allows for effective patient and systems management. Nor is evidence just clinical or statistical, in the case of Aboriginal health it also includes “interactions with the community . . . how often do primary health care services in a given community engage that community, get their opinion and document all of the results . . . and try to act on them.”

With respect to clinical services there is no reason to think the professional care received by Aboriginal clients differs from that offered to other provincial residents. After all, these practitioners have to maintain levels of competency established by their respective regulatory colleges. Indeed, there was only one flag raised in the literature related to this matter. With so many Ontario communities having taken responsibility for their nursing services under transfer agreements, during the 1990’s support for the nurses who continued to be employed by Health Canada apparently began to decline.¹³⁷ For example, professional development opportunities decreased; this was perceived as a major loss by practitioners anxious to keep current, despite their isolated and sometimes difficult work environments. Nonetheless, one participant pointed out, “we don’t have any concrete data to indicate that the health clinical decision making and health care outcomes for the primary care that [Health Canada] provides is poor or wrong. The health status of individuals is poor, but that is much bigger than the primary care clinical decision making.”

Concerns remain about the knowledge base of paraprofessionals, however. The latter are individuals from the community specially prepared to provide health promotion and prevention services, as well as some clinical interventions. They are recognized as an integral part of health care on-reserve, who bring local knowledge and cultural awareness to teams of caregivers that often consist, largely, of outsiders.¹³⁸ But some interviewees question the adequacy of the training received by those practicing in more remote communities. In the words of one, “we have people in positions that really aren’t trained . . . skilled people should be running these programs . . . right now we have warm bodies in there.”

The critical area of mental health, where there is heavy reliance on paraprofessionals,¹³⁹ is cited as a case in point: “the communities themselves provide some services through NNADAP [Health Canada’s National Native Alcohol and Drug Abuse Program]¹⁴⁰ for counselling and addictions . . . these aren’t trained people, they’re not trained at all.” Such comments confirm the long-standing uncertainty about the effectiveness of paraprofessional providers who must work in remote communities with limited supports.¹⁴¹ That having been said, the literature includes testimonies that show admiration on the part of professionals for the dedication and skills of their paraprofessional colleagues.¹⁴²

With respect to patient and system data, there is consensus that it is inadequate, with a few notable exceptions. Individuals speaking from the perspective of the federal, provincial and provincial/territorial organizations that have roles in making management decisions concur on this point. Certainly, efforts have been made to address this deficit. To ensure transferred communities in this province had the data necessary for case management, planning and evaluation, Health Canada implemented a computerized First Nations and Inuit Health

Information System, designed to give reliable epidemiological data.¹⁴³ However, the system is not actively in use, and “it will no longer exist after the end of March [2007] because the funding has been cut.” This loss is seen as regrettable by at least one interviewee: “. . . we had it in place for the longest time and now it isn’t in place it’s difficult to track the clients that go through the system.”

Two federally funded programs do collect good information. First, the Non-Insured Health Benefits program compiles accurate statistics on usage because “we use a computerized approach to accounts payable.” Second, the Home Care Program rolled-out over the past seven years, has established sophisticated data collection templates to capture client- and system-level information for quality assurance and accountability purposes. “At the community level they collect much more detailed [information] than [the federal program] wants, so they have the ability to use their own information to help them plan and look at trends and that sort of thing.” As well, the program has developed an evaluation toolkit in collaboration with First Nation communities to assist them with quality improvement and risk management.

Provincially, while individual facilities like the Aboriginal Health Access Centres may collect good data “on the diagnoses we are seeing”, which they provide to the Aboriginal Healing and Wellness Strategy and, in the case of infectious diseases, to the Ontario Ministry of Health and Long-Term Care, “there is no central database that keeps track of where folks are ending up” in the provincial health care system.

SAFE

Safety within the health care system generally means protection from harm; this was explicitly acknowledged by interviewees. For instance, the First Nations and Inuit Home Care Program recognizes that providing services in their homes to clients, some of whom “are quite ill” raises “a lot of issues around safety, for the client as well as for the caregiver . . . and communities that are providing these services” which need to be mitigated through the development of guidelines and other information resources.

While management of risks within the health care system is an ongoing concern, there is also a particular safety issue affecting Aboriginal Canadians, cultural safety. Culture is recognized as a major determinant in the health of this part of the population,¹⁴⁴ in part because of its influence on the care they receive.¹⁴⁵ Culture also shapes their perceptions about what constitutes health and wellness, as well as other health beliefs and behaviours. For example, a group of Aboriginal women who were asked to define health responded that “spirituality was viewed as a central element, and when the person was balanced and whole, the physical was healthy.”¹⁴⁶ To the extent that these holistic views conflict with the dominant bio-medical paradigm, they may influence interaction with the health care system in ways that undermines the quality of care they receive, a phenomenon common to minority groups.¹⁴⁷ It is also known that Aboriginal Canadians access care less effectively and are more intimidated by the health care system.¹⁴⁸ Consequently, a deep understanding of socio-cultural factors affecting the health care system is essential, in both the practice and policy spheres, to overcome the chronic disparities experienced by Aboriginals and other racial minorities.¹⁴⁹

Although there is a widely-recognized need to develop what is commonly called *cultural competence*^{150 151 152} or *cultural safety*^{153 154 155} on the part of health care practitioners, settings and systems, there are many definitions of the term *cultural competence*. Some definitions are worded in a straight forward way: “the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.”¹⁵⁶ The most frequently cited definition is stated in more complex language: “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.”¹⁵⁷ While both systemic characteristics and individual behaviours are encompassed in most definitions,¹⁵⁸ greater attention is paid to the latter, with an emphasis on interpersonal communications and respect for diversity.¹⁵⁹ However, the elements that constitute cultural competence for specific populations, including Aboriginals,¹⁶⁰ have yet to be clearly delineated.¹⁶¹

As well, there is a danger in practitioners assuming that all members of a broad cultural group share the same beliefs.¹⁶² Among Aboriginal peoples there is considerable variation from one tribal group to the next, and even between generations within a given group,¹⁶³ so practitioners have to consider each client’s subjective experiences of their particular culture. Simplistic, broad generalizations about a whole group can reinforce stereotypes,¹⁶⁴ and undermine an appreciation of the socio-political factors that contribute to Aboriginal people’s differential access to health services.¹⁶⁵

While recruiting practitioners of Aboriginal heritage might ameliorate the extent of cultural misunderstandings, this is not guaranteed. Individuals may know their own Aboriginal

traditions, but if they choose to practice elsewhere might be unfamiliar with local beliefs and customs, like any outsider. One person gave an example: “I’ve hired a First Nations nurse . . . [it] turns out she’s Mohawk . . . and she goes to work in an Oji-Cree community [where] she doesn’t know the language and many of her cultural components coming from the Mohawk culture are not the same [among] the Oji-Cree.”

Good communication, in terms of both language familiarity and cross-cultural awareness, is a health care requisite.^{166 167} Aboriginal people who are not comfortable communicating in English or French may experience delays or disruptions in their care, for example, through missed appointments, and be less compliant to a care regimen that they do not fully understand.¹⁶⁸ Reliance on translators from the community or family members may not help if patients are unwilling to share information they consider private in front of “known” others.¹⁶⁹ Communication issues are also a concern when Aboriginal clients need care outside their communities. The magnitude of the issue is apparent when one considers that Weeneebayko Health Ahtuskaywin based in Moose Factory sends “1600 people a year down to Timmins [and] about 2200 people a year down to Kingston, so we need translators down there.”

Language aside, a failure to understand socio-cultural differences on the part of the caregiver contributes to dissatisfaction among clients, who in turn exhibit poor adherence to their plans of care and, so, have poorer health outcomes.¹⁷⁰ For instance, the consensus approach to decision-making, involving consultation with family and other community members before deciding on a course of treatment, may take longer than the practitioner expects, giving rise to tension and miscommunication.¹⁷¹ In First Nation communities things sometimes deteriorate to a point where “occasionally a community demands the removal of a nurse” employed by another

organization, although when it comes to sorting out the reasons, “it’s hard to separate out cultural versus interpersonal versus the community’s political agenda, versus other things.”

PATIENT-CENTRED

Culturally-based disparities in health care are seen as a by-product of the diverse, often conflicting values and beliefs found in multicultural societies. These are grounded, at best, in a lack of knowledge and ethnocentrism among the dominant majority; at worst, they manifest racism or other forms of prejudice.¹⁷² To provide patient-centred care, practitioners must be sensitive to individual needs and preferences, including those based on religion, language and culture.

It is thought that relatively few care providers actually reflect on how actions, even well-intentioned ones, might “diminish, demean or disempower the cultural identity and the wellbeing of the individual.”¹⁷³ Rather, the goal is to fit all patients into the accustomed care paths and practices, unmindful of the impact on the client or their ultimate compliance with their plan of care.¹⁷⁴ Essentially, the notion of a “passive and compliant ‘patient’ for whom treatments are prescribed” does not fit with Aboriginal people’s ideas of wellness.¹⁷⁵ Perhaps this is most evident in the practice of transferring expectant mothers out of their home communities in the north, so they can give birth at a tertiary-care centre further south.¹⁷⁶ Reportedly, “if [expectant mothers] can’t bring a coach (usually their partners) . . . they won’t come, and that provides the nursing stations and the hospitals on the James Bay coast with quite a task to try and deal with or try to coax the people to come down [to Moose Factory].”

Even routine care can be disempowering if the health care system has adopted policies that do not allow clients to assume responsibilities for their own care. For example, the nursing stations in northern communities take responsibility for self-care out of the hands of their clients: “we hand out Tylenol in very small amounts,” conveying the message that they are totally dependant on the nurses for all care decisions. At a system level, health care institutions are sometimes reluctant to introduce programs that would foster culturally appropriate care, due to the financial and time investment required for their implementation.¹⁷⁷ Or, the agencies’ concepts of culturally appropriate services may not accord with Aboriginal opinions on the issue.¹⁷⁸ One person observed: “A lot of times non-Aboriginal programs, even ones that purport to be culturally sensitive aren’t necessarily [so].” Alternately, providers may “panic when they see an Aboriginal person coming and not do a proper assessment . . . [thinking] I’m not sure if I can work with them.”

Attitudinal shifts are occurring, however, and these are increasingly reflected in formally stated professional expectations.¹⁷⁹ The importance of cultural competence, for example, is recognized in the College of Nurses of Ontario practice standard respecting therapeutic nurse-client relationships.¹⁸⁰ Indeed, the need to comply with new legislative, regulatory, and accreditation mandates is now driving adoption of culturally-appropriate programs and practices.¹⁸¹

As would be expected, health programs specifically designed to serve Aboriginal clients, such as the Aboriginal Health Access Centres, have well developed components that address client’s situational needs, but which also take into account underlying causative factors “like historical trauma and residential school syndrome.” Complex client conditions, such as fetal

alcohol effect, require multiple assessments, ongoing monitoring and specialized supports. Even more routine care may be improved with attention to the particular circumstances affecting Aboriginal clients. At a large-city health centre serving Aboriginal families who have migrated from smaller communities which lack health services, for example, pre-school children are specifically screened for auditory and visual acuity, so “they’re not in the school system for two or three years before somebody finds out they need glasses.”

Paradoxically, “sometimes people are treated with excessive cultural sensitivity.” They may be Aboriginal, but not be aware of or want care based on traditional practices; providers have to be aware that “people are at different stages of learning about their culture.” A non-judgemental mindset is the one core attribute that practitioners see as key for cultural competence, regardless of discipline.¹⁸² Indeed, the extent of consensus on this point is considered to be striking.¹⁸³

The practitioner must also be aware of their own belief system and how adherence to it can affect the care they provide.¹⁸⁴ Nurses working in isolated northern First Nation communities, in most cases, outsiders, have to be cognizant of their “other” status while quietly building relationships of trust.¹⁸⁵ Such reflective, self-awareness is seen as an essential foundation for cross cultural clinical practice.¹⁸⁶ Yet, Canadian preparatory programs in the health sciences, even those specifically oriented to practice in northern First Nations, do not address this issue to any extent.¹⁸⁷ Instead the curricula concentrate on developing the clinical skills that will be required in more isolated settings, where a greater range of competencies is expected.¹⁸⁸

EQUITABLE

Ideally all residents of this province should get the same quality of care, regardless of whom they are or where they live. But Aboriginal Ontarians do not enjoy equity with their non-Aboriginal neighbours for a number of reasons, many of which have already been discussed, including geography, their type of Aboriginal status, and jurisdictional responsibilities. All of these dictate which of the three health care systems people turn to for primary care -- Aboriginal-specific provincial or federal service networks *versus* the general provincial programs open to everyone.

On-reserve health care funded by the federal government is restricted by mandate to those who have official First Nation status, by fiscal constraints, and by care philosophy. “We don’t mirror a community health centre where somebody in the urban world would access their primary care. The nursing stations don’t provide that kind of resource. We’re very focused on a medical model and treatment of disease.” In contrast, the Aboriginal Health Access Centres are more inclusive in determining who is eligible (even including non-Aboriginal partners), and are committed to more holistic approaches to care.

The fact that services are different does not necessarily make them inequitable, of course. Indeed, there has been active debate about the relative merits of each system. One person set out the parameters of the dialogue nicely, and deserves to be quoted at length: “The off-reserve Aboriginal community will say . . . that First Nations on-reserve have the benefits of the federal programs – all the nursing stations, the mental health, the NNDAP workers, the community program workers, diabetes, all of the federal funding that goes to First Nations. We don’t get all

that so we are underserved compared to First Nations. What the First Nations will say [is] . . . yes, but the off-reserve have access to the general health system . . . you've go the hospitals, you've got all the doctors, you've got the nurses, you've got community health programs. [To which] off-reserve organizations would say is yes, but these programs aren't culturally specific, we have a lot of trouble accessing them, there's long wait lists [etc.].” And so the dialogue goes.

The root cause of many systemic issues is the split in jurisdictional responsibility. The federal government, or in the case of transferred communities an Aboriginal health authority, ensure provision of primary care services to Aboriginal people on-reserve,¹⁸⁹ but the provincial government does so everywhere else.¹⁹⁰ There is only one exception to this rule. The federal government does fund some services (e.g. dental, vision, and pharmacy) for First Nation or Inuit people, no matter where they live, through the Non-Insured Health Benefits Program.¹⁹¹ Métis people are not eligible for most federal initiatives, although they are included in some health promotion programs funded by both levels of government.¹⁹² Obviously, divided responsibilities can give rise to anomalies. For example, primary care services on reserves in the mid-north may be superior to those found in neighbouring non-Aboriginal communities.¹⁹³ The latter face similar difficulties attracting care providers, but can not offer the same level of employee benefits as those available through the federal government.

Under the 1986 federal Transfer Policy, First Nations communities and organizations can take responsibility for providing primary care services on-reserve using funding from the federal government.¹⁹⁴ They must ensure that mandatory programs are provided, but beyond that are able to set priorities, hire staff and administer programs. Although “[l]ittle information relating to evaluation on the transfer process is currently in the public domain,”¹⁹⁵ and despite

implementation problems, there are some indications of success and satisfaction with the results.¹⁹⁶ A review of transferred services in three communities under the Shibogama First Nations' Health Authority in northwestern Ontario found that issues such as the chronic problems recruiting and retaining nurses had been resolved under the new management structure.¹⁹⁷ Yet the fix seems to have been temporary, in light of the situation a few years later when these communities once again faced serious nursing shortfalls.¹⁹⁸

Systemic differences are only part of the equity equation. However, information on usage patterns by Aboriginal residents is scarce; only two Ontario-specific studies were found. The first of these, a large-scale comparison of various ethnic and cultural groups' use of general practitioners, specialists and hospital emergency services over a 12 month period, found that Aboriginals relied on emergency rooms to a greater extent than members of other minority groups.¹⁹⁹ The reasons may be found in the other study, which is highly relevant to the present report. In order to evaluate access to and quality of primary care for Aboriginal people in northern Ontario, Shah, Gunraj and Hux²⁰⁰ compared defined cohorts of Aboriginals and non-Aboriginals from similar geographic and economic situations in terms of two indirect indicators of primary care adequacy: the frequency of hospitalization for ambulatory care sensitive conditions, and the frequency of referrals for specialist care sensitive procedures. Aboriginal rates for the first indicator are higher, and for the second, lower. The authors argue that hospitalization for conditions that could have been treated earlier in a primary care setting suggests that such services are inaccessible or inadequate, possibly causing delays in seeking attention and hence patients presenting with more advanced symptoms that require in-hospital

treatment. Similarly, the fact that referrals to specialists are lower with this population may indicate a lack of access to those primary care providers who could make referrals.

The absence of certain types of equipment required for purposes of diagnoses and treatment in smaller or remote places sometimes means that clients must relocate to an urban centre, although it is recognized that doing so cuts people off from their support networks.²⁰¹ Various strategies have been proposed (and tried) to provide better care closer to where people live. In one case, comparisons were made of the efficacy of using retinal photography with portable digital cameras *versus* having retinopathy screening done by traveling retina specialists in the James Bay coastal area.²⁰² Similarly, there is support for the establishment of satellite services, such as a dialysis unit at the Weeneebayko General Hospital in Moose Factory, provided that supports are in place to ensure that staff are properly trained to provide quality care.²⁰³

APPROPRIATELY RESOURCED

The resource demands of any well functioning health system are not limited to the financial or infrastructural, although both are essential. As important in the case of Aboriginal health are the human resources required. Regrettably, long-standing deficits in terms of numbers and training exist in the health workforce dedicated to meet the needs of Aboriginal people in Ontario. As well, there are gaps in the disciplines represented on the health care teams. Various interviewees identified each of the following as underrepresented professions: dentists, rehabilitation therapists, naturopaths, dieticians, psychologists and Aboriginal midwives.

While acknowledging that shortages of certain categories of health professionals, especially physicians, is an emerging issue in cities across Canada,²⁰⁴ a much larger and persistent recruitment and retention problem faces rural^{205 206} and remote²⁰⁷ parts of the country. The situation is particularly dire in remote Aboriginal communities, where persistent nursing shortages sometimes severely restrict the level of services available.²⁰⁸ Moreover, a number of vacant or under-filled positions adds to the workload of those who stay, compounding the retention problem. In remote parts of Northern Ontario, for example, it is not uncommon for one-third of the funded nursing positions to be unfilled at a given time. As a result, if they can not attract full-time staff, local Aboriginal health authorities and Health Canada's First Nations and Inuit Health programs are forced to rely on agency nurses to provide vital services, each for a few weeks at a time. One small community had 42 different nurses in and out during a one-year period.²⁰⁹ This situation can seriously compromise continuity of care in a system where nurses are the principal primary care providers.²¹⁰

A defining characteristic of working as a nurse in Canada's remote Aboriginal communities is the interplay between one's professional and personal life.²¹¹ In contrast, nurses employed in most settings are able to maintain a high degree of separation between the two. Even those working in rural communities can set limits; although there is some erosion of boundaries since the nurses' clients are also neighbours.²¹² However, efforts to keep a professional distance when employed in an isolated northern Aboriginal community can negatively affect the community's acceptance of the services offered.²¹³

The chronic difficulties recruiting and retaining professionals²¹⁴ extend to paraprofessionals too. The stresses of physical and social isolation for the professionals,

combined with high expectations from community members (which affects paraprofessionals as well), result in high staff turnover. A lack of understanding about, and appreciation for the paraprofessionals' roles on the part of the professional staff, can add to their shared discomfort.²¹⁵ Professionals leave the community, paraprofessionals leave the job.²¹⁶

Many of the reasons both rural and Aboriginal communities face chronic health human resource shortages are shared in common. Both settings face problems associated with distance, isolation, high prevalence of diseases, inadequate professional supports, lack of amenities and funding.²¹⁷ Spouses who are discontented,²¹⁸ either because their practitioner partners' heavy professional obligations erodes family time,²¹⁹ or because there are inadequate employment and educational opportunities available for themselves and their children,²²⁰ contribute to the turnover of staff.

Other factors are unique to Aboriginal communities. Prime among these is the lack of health professionals among their own people. In 1996, Canada's Royal Commission on Aboriginal Peoples called for intensive efforts to increase the Aboriginal presence in the nation's health work force to 10,000 in ten years,²²¹ a ten-fold increase. Finally, in 2004, the federal government committed to spending one hundred million dollars over five years to train Aboriginal health professionals.²²² It is anticipated that increasing the presence of First Nation, Inuit and Métis in these roles will foster more culturally competent care and increase their people's willingness to access health services.²²³

A major Canadian report on Aboriginal nursing²²⁴ calls for increased enrolment at the undergraduate level and in graduate programs -- needs to which the country's schools of nursing are trying to respond.²²⁵ Several also offer preparatory programs which provide students with

learning skills and training in the core sciences before they enter a nursing program.²²⁶ These entry initiatives are rooted in the realization that many Aboriginal learners face a cluster of barriers to successful completion of a program of study in the health sciences: inadequate academic preparation, family commitments, poverty, lack of supports, and fear of community rejection. The last mentioned concern continues for those who graduate, a feeling that their education alienates them from their heritage, making them unwelcome at home. Recognizing such concerns, another Canadian health human resources report emphasizes “learning must flow from the cultural roots from which the learners arise.”²²⁷

Beyond targeting certain groups for recruitment, programs can excite interest in rural or Aboriginal practice by giving them critical content and learning experiences.²²⁸ For example, the Northern Ontario School of Medicine is committed to integrating indigenous health into its curriculum.²²⁹ Ontario’s nurse practitioner program also created Aboriginal modules at its outset.²³⁰ Ideally, some of a students’ training will take place in an Aboriginal setting. First hand exposure to the challenges and rewards of practicing in such places encourages students to consider them as a career destination.

Other factors contribute to determining the adequacy of the resources committed to Aboriginal health in Ontario. For instance, the type and level of services are dictated by the type and level of funding, although only in part. On-reserve First Nation primary care services are reasonably well supported; the health human resource deficit is not due a lack of financial resources.²³¹ Having to rely on agency nurses to temporarily fill positions, however, has a significant impact on the bottom line because “agency nurses cost more than regular nurses . . . so [Health Canada] is constantly in the search for money to support our nursing program.”

The manner in which funding is structured can affect service delivery in two ways. First, so-called “envelope funding” provides money for specific purposes and requires that programs be designed to operate within strict parameters, which may not reflect local conditions or priorities. Second, communities may buy-in to programs offered on short-term funding (in hopes that this will roll into sustained support), only to have the plug pulled despite success.²³² “Each and every year we have to go back to the federal government to justify our expenditures,” someone from an Aboriginal health authority stated. This level of accountability may be necessary, he acknowledged, but nonetheless it is burdensome for individual agencies and Aboriginal Health Authorities alike.

Still, one person said: “if you added up all the investments, both federally and provincially, people would be surprised at how high the number is . . . [although she did not know] whether or not it is always effective” or sufficient. A case in point is the Aboriginal home care program, which “hasn’t received any additional funds since 1999, so you can well imagine the pressures that communities [which are responsible for providing the services] face if they haven’t had any budget increases.” As the client load increases, the number of hours of service each individual receives declines. Moreover, financial constraints contribute to a loss of personal care workers, all of whom are certified in the province; “they leave and go to work for provincial agencies because [the latter] pay more.” In sum, while more federal and provincial dollars are required, they must “be strategically directed by actual service need.”

Significant monetary problems linked to implementing transfer agreements have emerged with time. The funding that a transferred community receives to support services is based on the population living on-reserve at the time an agreement is signed. The funding formula does not

take into consideration increases in the number of residents; this has created shortfalls in the succeeding years because of the comparatively high rates of population growth in Aboriginal communities.²³³ Moreover, calculation of some transferred funds is based on historic expenditures, which serves to magnify existing inequities.²³⁴ There is also some evidence that the transfer policy fails to address socio-economic conditions that partially determine the health of community members; without such supports, communities may be limited in their ability to improve the health status of their residents.²³⁵

INTEGRATED

Obviously all parts of the health system should interconnect and function in a harmonious fashion. By virtue of the split in jurisdiction that does not happen when it comes to Aboriginal health, although there are signs of increased collaboration and co-operation. Witness the merging of provincial and federally hospitals in Sioux Lookout, and on-going efforts to create greater federal/provincial collaboration in the James Bay area. Nonetheless, as yet a fundamental division remains.

Funding mechanisms can create barriers as well. A given agency or health authority may manage a number of programs, each paid for from a different source, with different mandates and lines of accountability. At the health authority level, “trying to provide these services from a number of agencies [means] there are probably people who are falling through the cracks.” On the other hand, some agencies report success developing and managing integrated health programs with multiple funding sources. An Aboriginal Health Access Centre reports “we have a

SAE healthy child nutrition health promotion stream which is funded from separate dollars outside of the strategy, but integrated in such a way that it's managed as part of the whole [primary care] program delivery.”

Characteristic of our health care system generally, clients with multiple-diagnoses may be left to flounder amidst a sea of services that are pathology-specific in nature. “So even if there is an Aboriginal mental health program, someone shows up with a concurrent disorder – [say] they have a substance abuse issue as well – so they get transferred to a substance abuse program, but it can't treat [the mental health] issue.” In urban centres like Thunder Bay there are a number of Aboriginal specific health programs, but this raises several questions: “Is everything co-ordinated in the best way? Are the service providers working together, are they developing good relationships? Do health organizations have a relationship with the hospital, and is it a positive relationship or are there problems? Why are there problems [and so on]?” In terms of the Aboriginal home care program, establishing good protocols with other agencies is key “in terms of discharge planning from the local hospital [and] other agencies that potentially would be referring clients.”

Inclusion of traditional practices in the spectrum of care has occurred to some extent, although this varies by location. Urban-based health centres are more likely than rural ones to offer clients access to traditional healers, perhaps due to the fact that such healers are more available outside the formal system of care in First Nation communities.²³⁶ Moreover, the presence of these services may be of particular importance for urban migrants, who have little access to traditional activities on which psycho-social identities are founded.²³⁷

Speaking about the situation at a large urban Aboriginal Health Care Centre, a primary care provider talked about parallel programs that worked co-operatively: “it’s not integrated, but there are many bridges between the primary care program and traditional healing program.” So, for example, the clinical team may refer an individual struggling with grief or bereavement issues to the traditional healers, but the latter also send clients who they feel are quite depressed to the clinicians for care. A case study on Manitoulin Island found “traditional and western health care providers usually work in a co-operative, multidisciplinary fashion, mainly interacting through referrals back and forth,”²³⁸ but that a fully integrated, interdisciplinary model had not yet been tried.

FOCUSED ON POPULATION HEALTH

It is not sufficient for a health system to have a curative orientation; it must also be preventive. The system of Aboriginal health in Ontario has elements of both, but they are not always in balance. Although primary care programs sponsored by the province through the Aboriginal Healing and Wellness Strategy are designed to make sure that “prevention and population health . . . are pretty much built into almost everything,” access to other preventive programming, such as the Aboriginal Diabetes, HIV/AIDS or Tobacco Strategies, varies considerably depending on the structure and populations served by the organizations which deliver care.

Similar variation occurs in Health Canada’s preventive and population health programming. In the south or mid-north, federal programs on-reserve “are exclusively [for]

public health.” On the other hand, in northern First Nations where the government sponsors both primary care and public health initiatives, efforts are concentrated on the former at the expense of the latter. “On paper we provide health promotion, prevention programs . . . well-woman, well-baby, health education regarding chronic illness such as diabetes, lung disease, etc. [But] in real life we focus on immunization and communicable disease management . . . mandatory programs that the federal government is obligated to provide.”

Generally, primary care takes precedence in northern communities because “the lack of meeting primary care needs is much more overtly obvious than the lack of effectively meeting public health, health promotion needs.” Often understaffed, the nurses must address the clinical needs of presenting clients first.²³⁹ A graphic illustration, characterized as the type of thing “that happens day in and day out,” was offered: “We had a pre-natal teleconference and clinic scheduled in a community today, and we had three serious suicide attempts among children under age thirteen in that community. Well, the suicide attempts and the care of those children and the arrangements to transfer them out [for care in another community] just overruns the fact that there was a pre-natal clinic scheduled this morning. The clinic has to be cancelled because all of the resources have to be put towards the crisis.” The situation is such that a spokesperson for a northern health organization said: “for the most part, there is no public health in our communities.” While perhaps an overstatement, this declaration appears to be essentially true.

The literature is replete with calls – and suggestions – for improving health promotion strategies, usually linked to specific conditions like diabetes^{240 241} and obesity.²⁴² Reviews of various initiatives have identified one common principle for success: community direction. Sometimes expressed as *active participation*²⁴³ or *empowerment*,²⁴⁴ to be most effective some

authors argue it should incorporate the OCAP principles (Ownership, Control, Access and Possession) espoused by the National Aboriginal Health Organization.²⁴⁵

To be successful, health promotion activities depend on understanding individual behaviours within a given environment or context.²⁴⁶ Aspects of both have been identified in various studies, ranging from the physical (geographic remoteness),²⁴⁷ through socio-economic factors (e.g. illiteracy),²⁴⁸ to cultural considerations (body shape preferences).²⁴⁹ Determining what must be taken into account depends on having lay knowledge²⁵⁰ and recognizing that programs must be considered on a community-by-community basis.²⁵¹

CONCLUSION

Considering the attributes of a well-functioning system of health, the environmental scan summarized in the present report set out to answer two questions: (a) what is the nature of the services available to Aboriginal people across the province of Ontario? And (b) what do we (and can we) know about the quality of that care? The answers to both are closely linked. Because, at present, the overall system of primary care on which Aboriginal Ontarians rely is complicated by multiple jurisdictional responsibilities, troubled by both human and financial resource deficits, still adjusting to a fundamental philosophical shift, and facing increasing service demands, the issues which emerge are complex and have a negative impact on quality.

Despite the challenges, however, things are changing and there are reasons for celebration. One is the strengthening role of the province in providing inclusive, holistic, and culturally-specific care to Aboriginal people. Another is the increased collaboration between the First Nation, provincial and federal levels of government in developing policies and programs to meet specialized needs. But most important is the increasing presence of Aboriginal people as decision-makers and providers. They are shaping the future of Aboriginal health in this province. Despite the challenges, “Aboriginal people will continue to advocate, lead, and sustain change towards a health-care delivery system that respects and supports their cultural values and beliefs, responds to the historical, geographical, and intercultural issues that impact on their health, and ultimately facilitate greater self-determination.”²⁵²

-
- ¹ Booth, G., Hux, J., Fang, J. & Chan, B. (2005). Time trends and geographic disparities in acute complications of diabetes in Ontario, Canada. *Diabetes Care*. 28(5), 1045 – 1050.
- ² Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ³ Health Canada. Certain circumstances: Issues in equality and responsiveness in access to health care in Canada. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ⁴ Shah, B., Gunraj, N. & Hux, J. Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. *American Journal of Public Health*. 2003; 93 (5): 798 – 802.
- ⁵ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61.
- ⁶ Shah, B., Gunraj, N. & Hux, J. Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. *American Journal of Public Health*. 2003; 93 (5): 798 – 802.
- ⁷ Wigmore, M. & McCue, D. No information on a forgotten people: How healthy are Native people in Canada when they live off reserve. *Arctic Medical Research*. 1991; Suppl.: 90 – 93.
- ⁸ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ⁹ Young, T. K. Review of research on Aboriginal populations in Canada: Relevance to their health needs. *British Medical Journal*. 2003; 327: 419 – 422.
- ¹⁰ An organizational division of the First Nations and Inuit Health, Health Canada.
- ¹¹ Young, T. K. Review of research on Aboriginal populations in Canada: Relevance to their health needs. *British Medical Journal*. 2003; 327: 419 – 422.
- ¹² Wilson, K & Rosenberg, M. Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*. 2002; 55: 2017 – 2031.
- ¹³ Mitchell, T. & Maracle, D. Healing the generations: Post-traumatic stress and the health status of Aboriginal populations in Canada. *Journal of Aboriginal Health*. 2005; 2(1): 14 – 23.
- ¹⁴ Wilson, K & Rosenberg, M. Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*. 2002; 55: 2017 – 2031.
- ¹⁵ Maar, M. Clearing the path for community health empowerment: Integrating health care services at an Aboriginal health access centre in rural north central Ontario. *Journal of Aboriginal Health*. 2004; 1(1): 54 – 64.
- ¹⁶ Macaulay, A., Harris, S., Lévesque, L., Cargo, M., Ford, E. et al. Primary prevention of type 2 diabetes: Experiences of two Aboriginal communities in Canada. *Canadian Journal of Diabetes*. 2003; 27(4): 464 – 475.
- ¹⁷ Shah, B., Gunraj, N. & Hux, J. Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. *American Journal of Public Health*. 2003; 93 (5): 798 – 802.

-
- ¹⁸ Hiebert, S., Angees, E., Young, T.K. & O’Neil, J. The evaluation of transferred health care services in Wunnimin Lake, Wapekeka and Kingfisher Lake First Nations: a nursing perspective. *International Journal of Circumpolar Health*. 2001; 60: 473 – 478.
- ¹⁹ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ²⁰ Lavoie, J. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*. 2004; 1(1): 6 – 24
- ²¹ Reading, J. & Nowesic, E. Improving the health of future generations: the Canadian Institutes of Health Research Institute of Aboriginal Peoples’ Health. *American Journal of Public Health*. 2002; 92: 1396 – 1400.
- ²² Migone, J. & O’Neil, J. Social capital has a health determinant in First Nations: An exploratory study in three communities. *Journal of Aboriginal Health*. 2005; 2(1): 26 – 33.
- ²³ Wilson, K & Rosenberg, M. Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*. 2002; 55: 2017 – 2031.
- ²⁴ Statistics Canada. *Aboriginal population profile: 2001 Census of Canada*. Found at: <http://www12.statcan.ca/english/profil01ab/Details1pop.cfm> . Accessed August 24, 2006.
- ²⁵ Statistics Canada. *Aboriginal population profile: 2001 Census of Canada*. Found at: <http://www12.statcan.ca/english/profil01ab/Details1pop.cfm>. Accessed August 24, 2006.
- ²⁶ Statistics Canada. 1996 Aboriginal Census Data. *The Daily*. January 13, 1998. Found at: <http://www.statcan.ca/Daily/English/980113/d980113.htm>. Accessed September 10, 2006.
- ²⁷ Smylie, J. (2000). SOGC Policy Statement: A guide to health professionals working with Aboriginal peoples: The socio-cultural context of Aboriginal peoples in Canada. *Journal of the Society of Obstetrics and Gynaecology of Canada*. 2000; December: 1 – 12. (p.3).
- ²⁸ Smylie, J. (2000). SOGC Policy Statement: A guide to health professionals working with Aboriginal peoples: The socio-cultural context of Aboriginal peoples in Canada. *Journal of the Society of Obstetrics and Gynaecology of Canada*. 2000; December: 1 – 12. (p.3).
- ²⁹ Smylie, J. & Anderson, M. Understanding the health of indigenous people in Canada: key methodological and conceptual challenges. *Canadian Medical Association Journal*. 2006; 175(6): 603-605.
- ³⁰ Statistics Canada. *Aboriginal population profile: 2001 Census of Canada*. Found at: <http://www12.statcan.ca/english/profil01ab/Details1pop.cfm> . Accessed August 24, 2006.
- ³¹ Indian and Northern Affairs Canada. List of First Nations: Ontario. Found at: http://pse2-esd2.ainc-inac.gc.ca/FNProfiles/FNProfiles_List.asp?Province1=ON . Accessed September 26, 2006.
- ³² Young, T. K. Review of research on Aboriginal populations in Canada: Relevance to their health needs. *British Medical Journal*. 2003; 327: 419 – 422.
- ³³ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.

-
- ³⁴ MacMillan, H., Walsh, C., Jamieson, E, Wong, M. et al. The health of Ontario First Nations people. *Canadian Journal of Public Health*. 2003; 94(3): 168 – 172.
- ³⁵ Stieb, D & Davies, K. Health and development in the Hudson Bay/James Bay region. *Arctic Medical Research*. 1995; 54: 170 – 183.
- ³⁶ Macaulay, A., Harris, S., Lévesque, L., Cargo, M., Ford, E. et al. Primary prevention of type 2 diabetes: Experiences of two Aboriginal communities in Canada. *Canadian Journal of Diabetes*. 2003; 27(4): 464 – 475.
- ³⁷ Morrison, N. & Dooley, J. The Sioux Lookout Diabetes Program: Diabetes prevention and management in northwestern Ontario. *International Journal of Circumpolar Health*. 1998; 57, Suppl 1: 364 – 369.
- ³⁸ Tremblay, M., Perez, C., Ardern, C., Bryan, S. & Katzmarzyk, P. Obesity, overweight and ethnicity. *Health Report*. 2005; 16: 23 – 34.
- ³⁹ Anand, S., Yusuf, S., Jacobs, R., Davis, A., Yi, Q., Gerstein, H. et al. Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: The Study of Health Assessment and Risk Evaluation in Aboriginal Peoples (SHARE-AP). *Lancet*. 2001; 358: 1147 – 1153.
- ⁴⁰ Anand, S., Yusuf, S., Jacobs, R., Davis, A., Yi, Q., Gerstein, H. et al. Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: The Study of Health Assessment and Risk Evaluation in Aboriginal Peoples (SHARE-AP). *Lancet*. 2001; 358: 1147 – 1153.
- ⁴¹ MacMillan, H., Walsh, C., Jamieson, E, Wong, M. et al. The health of Ontario First Nations people. *Canadian Journal of Public Health*. 2003; 94(3): 168 – 172.
- ⁴² Young, T. K. Prevalence and correlates of hypertension in a subarctic Indian Population. *Preventive Medicine*. 1991; 20: 474 – 485.
- ⁴³ Christofides, A., Schauer, C., & Slotkin, S. Iron deficiency and anemia prevalence and associated etiological risk factors in First Nations and Inuit communities in Northern Ontario and Nunavut. *Canadian Journal of Public Health*. 2005; 96: 304 – 307.
- ⁴⁴ Peressini, S., Leake, J., Mayhall, J., Maar, M. & Trudeau, R. Prevalence of early childhood caries among First Nation children, District of Manitoulin, Ontario. *International Journal of Paediatric Dentistry*. 2004; 14: 101 – 110.
- ⁴⁵ Marrett, L. & Chaudhry, M. Cancer incidence and mortality in Ontario First Nations, 1968 – 1991 (Canada). *Cancer Causes and Control*. 2003;14: 259 – 268.
- ⁴⁶ Lightfoot, N., Fehringer, G., Bisset, R., McChesney, D & White, J. Cancer incidence and mortality trends in Northeastern Ontario. *Canadian Journal of Public Health*. 1996; 87: 17 – 24.
- ⁴⁷ Marrett, L. & Chaudhry, M. Cancer incidence and mortality in Ontario First Nations, 1968 – 1991 (Canada). *Cancer Causes and Control*. 2003;14: 259 – 268.
- ⁴⁸ Grace, S. A review of Aboriginal women’s physical and mental health status in Ontario. *Canadian Journal of Public Health*. 2003; 94(3): 173 – 175.
- ⁴⁹ Wilson, K & Rosenberg, M. Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*. 2002; 55: 2017 – 2031.
- ⁵⁰ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61.

-
- ⁵¹ Canadian Mortgage and Housing Commission. "Housing need among off-reserve status Indian households in Canada, 1991." *Socio-Economic Series*. 1997; Issue 37.
- ⁵² Clark, M., Riben, P. & Nowgesic, E. The association of housing density, isolation and tuberculosis in Canadian First Nation communities. *International Journal of Epidemiology*. 2002; 31: 940 – 945.
- ⁵³ Che, J. & Chen, J. Food insecurity in Canadian households. *Health Report*. 2001;12: 11 – 122.
- ⁵⁴ Skinner, K., Hanning, R., & Tsuji, L. Barriers and supports for health eating and physical activity for First Nation Youths in Northern Canada. *International Journal of Circumpolar Health*. 2006; 65 (2): 148 – 161.
- ⁵⁵ Gittelsohn, J., Wolever, T., Harris, S., Harris-Giraldo, R., Hanley, A. & Zinman, B. Specific patterns of food consumption and preparation are associated with diabetes and obesity in a Native Canadian community. *Journal of Nutrition*. 1998; 128: 541 – 547.
- ⁵⁶ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ⁵⁷ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61.
- ⁵⁸ Calzavara, L., Bullock, M., Myers, S., Marshall, V. & Cockerill, R. Sexual partnering and risk of HIV/STD among Aboriginals. *Canadian Journal of Public Health*. 1999; 90: 186 – 191.
- ⁵⁹
- ⁶⁰ Marrett, L. & Chaudhry, M. Cancer incidence and mortality in Ontario First Nations, 1968 – 1991 (Canada). *Cancer Causes and Control*. 2003;14: 259 – 268.
- ⁶¹ Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ⁶² Howell, T. & Yuille, J. Healing and treatment of Aboriginal offenders: A Canadian example. *American Journal of Forensic Psychology*. 2004; 22(4): 53 – 76.
- ⁶³ U.S. Department of Health and Human Services. *Surgeon General's Report: Mental health: A report of the surgeon general, 1999*. Washington, DC: Department of Health and Human Services. Found at: <http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-1.html>. Accessed August 24, 2006.
- ⁶⁴ Kirmayer, L., Simpson, C. & Cargo, M. Healing traditions: culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*. 2003; 11: 515 – 523.
- ⁶⁵ Brown, L. Residential schools cast long shadow. *Toronto Star*. March 28, 2006. Found at: <http://www.thestar.com>. Accessed September 20, 2006.
- ⁶⁶ Lederman, J. Trauma and healing in Aboriginal families and communities. *Native Social Work Journal*. 1999; 2(1): 59 – 90, p. 60.
- ⁶⁷ Morrisette, P. & Naden, M. An interactional view of traumatic stress among First Nations counsellors. *Journal of Family Psychotherapy*. 1998; 9(3): 43 – 60.
- ⁶⁸ Smith, D., Varcoe, C., & Edwards, N. Turning round the intergenerational impact of residential schools on Aboriginal people: implications for health policy and practice. *Canadian Journal of Nursing Research*. 2005; 37: 38 – 60.

-
- ⁶⁹ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61.
- ⁷⁰ Cox, J, Bota, G., Carter, M., Bretzlaff-Michaud, J., Sahai, V. & Rowe, B. Domestic violence: Incidence and prevalence in a northern emergency department. *Canadian Family Physician*. 2004; 50: 90 – 97.
- ⁷¹ Burglehaus, M. & Stokl, M. Sheway: Supporting choice and self-determination. *Journal of Aboriginal Health*. 2005; 2(1): 54 – 59. (p.54).
- ⁷² Minore, B., Boone, M., Katt, M., Kinch, P. & Cromarty, H. How clients choices influence cancer care in northern Aboriginal communities. *International Journal of Circumpolar Health*. 2004; 62 (2): 129 – 132.
- ⁷³ Tarrant, M. & Gregory, D. Exploring childhood immunization uptake with First Nation mothers in north-western Ontario Canada. *Journal of Advanced Nursing*. 2003; 41: 63 – 72.
- ⁷⁴ Minore, B., Boone, M., Katt, M., Kinch, P. & Cromarty, H. How clients choices influence cancer care in northern Aboriginal communities. *International Journal of Circumpolar Health*. 2004; 62 (2): 129 – 132.
- ⁷⁵ Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, C. The effects of nursing turnover on continuity of care in isolated First Nation communities. *Canadian Journal of Nursing Research*. 2005; 37(1): 87 – 100.
- ⁷⁶ Shah, B., Gunraj, N. & Hux, J. Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. *American Journal of Public Health*. 2003; 93 (5): 798 – 802.
- ⁷⁷ Ontario Ministry of Health and Long-Term Care. (1994). *New directions: Aboriginal health policy for Ontario*. Aboriginal Health Office, pp. 55.
- ⁷⁸ Aboriginal Healing and Wellness Strategy. *About AHWS*. Found at: <http://www.ahwsontario.ca>. Accessed October 2, 2006.
- ⁷⁹ Ontario Ministry of Health and Long-Term Care. *Community Health Centres*. Found at: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html. Accessed October 2, 2006.
- ⁸⁰ Ministry of Health and Long-Term Care. *Ontario Aboriginal Diabetes Strategy*. Found at: http://www.health.gov.on.ca/english/public/pub/ministry_reports/oads_06/oads_06.html . Accessed September 20, 2006.
- ⁸¹ Ministry of Health and Long-Term Care. Epidemiological Fact Sheet on HIV/AIDS in Ontario. Found at: www.aids2006.org/admin/images/upload/1031.pdf . Accessed October 30, 2006.
- ⁸² Cancer Care Ontario, Aboriginal Cancer Care Unit. *Newsletter: Aboriginal Tobacco Strategy*. Volume 2(1); 2005. Found at: <http://www.cancercare.on.ca/documents/ATSNewsletterVol2Num1.pdf> . Accessed October 30, 2006.
- ⁸³ Ontario Native Affairs Secretariat. (2005). *Ontario's New Approach to Aboriginal Affairs: Prosperous and Healthy Aboriginal Communities Create a Better Future for Aboriginal Children and Youth*. Queen's Printer for Ontario; Toronto, ON. Found at: <http://www.aboriginalaffairs.osaa.gov.on.ca/english/news/brochure.html> . Accessed October 30, 2006.
- ⁸⁴ Aboriginal Healing and Wellness Strategy. *Annual Report 2002-2003: The History of AHWS*. Found at: http://www.ahwsontario.ca/publications/AHWS_AR_2002-03.pdf . Accessed September 6, 2006.

-
- ⁸⁵ Aboriginal Healing and Wellness Strategy. (2006). *Programs and Services: Overview*. Found at: <http://www.ahwsontario.ca/about/overview.html>. Accessed September 12, 2006.
- ⁸⁶ Ministry of Health and Long-Term Care. *Community Health Centres*. Found at: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html. Accessed October 20, 2006.
- ⁸⁷ Anishnawbe Health Toronto. *About Anishnawbe Health Toronto*. Found at: http://aht.ca/about_anishnawbe_health_toronto. Accessed October 20, 2005.
- ⁸⁸ Anishnawbe Health Toronto. *Community Health Worker Training*. Found at: http://aht.ca/services/community_health_worker_training_program. Accessed October 20, 2005.
- ⁸⁹ Association of Ontario Health Centres. (2005). *Waseskun: Enhancing Aboriginal Primary Health Care in Ontario*. Association of Ontario Health Centres; Toronto, ON. Found at: http://www.aohc.org/app/DocRepository/2/Research/Waseskun_Enhancing_Aboriginal_PHC_Ontario_05.pdf. Accessed September 20, 2006.
- ⁹⁰ Association of Ontario Health Centres. (2005). *Waseskun: Enhancing Aboriginal Primary Health Care in Ontario*. Association of Ontario Health Centres; Toronto, ON. Found at: http://www.aohc.org/app/DocRepository/2/Research/Waseskun_Enhancing_Aboriginal_PHC_Ontario_05.pdf. Accessed September 20, 2006.
- ⁹¹ Ministry of Health and Long-Term Care. (2006). *Ontario Aboriginal Diabetes Strategy*. Toronto, ON: Government of Ontario. Found at: (http://www.health.gov.on.ca/english/public/pub/ministry_reports/oads_06/oads_06.pdf/). Accessed September 18, 2006.
- ⁹² Ministry of Health and Long-Term Care, AIDS Bureau. *HIV/AIDS in Ontario*. Found at: (http://www.health.gov.on.ca/english/providers/pub/aids/hiv_aids_e.pdf). Accessed September 18, 2006.
- ⁹³ Ontario Association of Indian Friendship Centres. *HIV/AIDS Program*. Found at: (<http://www.ofifc.org/ofifchome/page/programs/hivaids.htm>). Accessed September 18, 2006.
- ⁹⁴ Ontario Métis and Aboriginal Organization. *HIV/AIDS Education and Prevention Program*. Found at: (http://www.oma.org/page_18_HIV_AIDS_program.htm). Accessed September 18, 2006.
- ⁹⁵ Cancer Care Ontario. *Aboriginal Cancer Care Strategy: Aboriginal Tobacco Strategy*. Found at: http://www.cancercare.on.ca/index_AboriginalCancerStrategy.htm. Accessed October 30, 2006.
- ⁹⁶ Aboriginal Healing and Wellness Strategy. *Aboriginal Healthy Babies/Healthy Children Program*. Found at: (http://www.ahwsontario.ca/programs/ahbhc/ahbhc_top.html). Accessed September 20, 2006.
- ⁹⁷ Government of Ontario. *Ontario's Early Childhood Development and Early Learning and Child Care Investments: 2004-05 Annual Report*. Found at: <http://www.children.gov.on.ca/NR/rdonlyres/emywkdjuupyurshgijv2x3bjxptuuur3ikc7ukypeqpl64qhf5rh75n3rnmeufp64gcqdrbpcxjhnh/ECDreportENGfinal.pdf>. Accessed October 30, 2006.
- ⁹⁸ Ministry of Citizenship and Immigration. *Community-Based Health Services*. Found at: http://www.citizenship.gov.on.ca/seniors/english/guide-community.htm#P136_8341. Accessed October 23, 2006.
- ⁹⁹ Aboriginal Healing and Wellness Strategy. Community services fund. *In the Spirit of Healing and Wellness*, 3(1). April 2000.

-
- ¹⁰⁰ Ontario Native Women's Association. *Newsletter update: July 2006*. Found at: www.onwa-tbay.com/newsletterjuly.pdf . Accessed September 10, 2006.
- ¹⁰¹ Ministry of Citizenship and Immigration. *Community-Based Services for Aboriginal People*. Found at: http://www.citizenship.gov.on.ca/seniors/english/guide-community.htm#P145_9018 . Accessed September 20, 2006.
- ¹⁰² Health Canada. *First Nations and Inuit Health. Mandate and Priorities*. Found at: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/mandat_e.html . Accessed September 20, 2006.
- ¹⁰³ Health Canada. *First Nations and Inuit Health. Family Health*. Found at: http://www.hc-sc.gc.ca/fnih-spni/famil/index_e.html .
- ¹⁰⁴ Health Canada. *First Nations and Inuit Control of Health Services: Communities by Location. Reports and Publications. Funding. Ten Years of Health Transfer First Nations and Inuit Control. (2005)*. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/agree-accord/10_years_ans_trans/index_e.html . Accessed September 29, 2006.
- ¹⁰⁵ Health Canada. *First Nations and Inuit Health*. Found at: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index_e.html . Accessed September 12, 2006.
- ¹⁰⁶ Health Canada. *First Nations and Inuit Control of Health Services: Communities by Location. Reports and Publications. Funding. Ten Years of Health Transfer First Nations and Inuit Control. (2005)*. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/agree-accord/10_years_ans_trans/index_e.html . Accessed September 29, 2006.
- ¹⁰⁷ Health Canada. *First Nations and Inuit Health. Non-Insured Health Benefits*. Found at: http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/benefit-prestatiion/index_e.html . Accessed September 15, 2006.
- ¹⁰⁸ Health Canada. *First Nations and Inuit Health. Home and Community Care Program*. Found at: http://www.hc-sc.gc.ca/fnih-spni/services/home-domicile/index_e.html . Accessed September 12, 2006.
- ¹⁰⁹ Health Canada. *First Nations and Inuit Health. Nursing Programs*. Found at: http://www.hc-sc.gc.ca/fnih-spni/services/nurs-infirm/index_e.html . Accessed September 12, 2006.
- ¹¹⁰ Health Canada. *First Nations and Inuit Health. Nursing Programs*. Found at: http://www.hc-sc.gc.ca/fnih-spni/services/nurs-infirm/index_e.html . Accessed September 12, 2006.
- ¹¹¹ Health Canada. *First Nations and Inuit Health. First Nations and Inuit Home and Community Care Program: Annual Report 2002-2003*. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/home-domicile/2002-2003_rpt/9_ontario_e.html . Accessed September 25, 2006.
- ¹¹² Health Canada. *First Nations and Inuit Health. Aboriginal Diabetes Initiative: Métis, Off-Reserve Aboriginal and Urban Inuit Prevention and Promotion Program*. Found at: http://www.hc-sc.gc.ca/dc-ma/diabet/abori-autoch/index_e.html . Accessed September 26, 2006.
- ¹¹³ Health Canada. *First Nations and Inuit Health. Aboriginal Diabetes Initiative: Ontario Region*. Found at: http://www.hc-sc.gc.ca/fnih-spni/diseases-maladies/diabete/index_e.html . Accessed September 26, 2006.
- ¹¹⁴ Ontario Métis Aboriginal Association. *Healing Trails Program*. Found at: <http://www.diabeteshealingtrail.ca/index.html> . Accessed September 28, 2006.

-
- ¹¹⁵ Health Canada. *First Nations and Inuit Health. HIV/AIDS Program*. Found at: http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/phcphd-dsspsp/cdcd-dcmt/aids-sida_e.html . Accessed October 6, 2006.
- ¹¹⁶ Health Canada. *First Nations and Inuit Health. 2003-2004 HIV/AIDS Work Plan*. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/aids-sida/2003-04_aids-sida_plan/index_e.html . Accessed October 3, 2006.
- ¹¹⁷ Health Canada. First Nations and Inuit Health. *Tobacco Control Strategy*. Found at: http://www.hc-sc.gc.ca/fnih-spni/substan/tobac-tabac/commun/control-lutte/index_e.html . Accessed October 3, 2006.
- ¹¹⁸ Health Canada. *Estimates, Plans and Performance. Annex E: Details on Transfer Payments, Actual Spending 2003-2004*. Found at: http://www.hc-sc.gc.ca/ahc-asc/performance/estim-previs/index_e.html . Accessed October 3, 2006.
- ¹¹⁹ Health Canada. *First Nations and Inuit Health. Tuberculosis*. Found at: http://www.hc-sc.gc.ca/fnih-spni/diseases-maladies/tuberculos/index_e.html . Accessed October 3, 2006.
- ¹²⁰ Health Canada. First Nations and Inuit Health. (1999). *Tuberculosis in First Nations Communities*. Government of Canada; Ottawa, ON. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/tuberculos/1999_commun/index_e.html . Accessed October 3, 2006.
- ¹²¹ Health Canada. *First Nations and Inuit Health. Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) Projects*. Found at: http://www.hc-sc.gc.ca/fnih-spni/finance/agree-accord/fas-saf_proj_e.html . Accessed September 28, 2006.
- ¹²² Health Canada. *First Nations and Inuit Health. 2000-2001 Aboriginal Health Start On Reserve: Annual Report*. Government of Canada; Ottawa, ON. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/develop/2000-01_ahs-papa-rpt/ontario_e.html .
- ¹²³ Chiefs of Ontario. *First Nations Early Childhood Education: 2004*. Found at: www.chiefs-of-ontario.org/education/manifesto/First%20Nations%20Early%20Childhood%20Education.doc. Accessed October 5, 2006.
- ¹²⁴ Health Canada. *First Nations and Inuit Health. Early Childhood Development Programs*. Found at: http://www.hc-sc.gc.ca/fnih-spni/famil/preg-gros/ecd-dpe_strateg_e.html . Accessed September 15, 2006.
- ¹²⁵ Government of Canada. *Blueprint on Aboriginal Health: a 10-Year Transformative Plan*. Prepared for the meeting of First Ministers and Leaders of National Aboriginal Organizations, November 24-25, 2005. A Work in Progress. Found at: http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan_e.pdf. Accessed September 6, 2006.
- ¹²⁶ Ministry of Health and Long-Term Care. *Primary Health Care Transition Fund Projects*. Found at: http://www.health.gov.on.ca/english/providers/project/phctf/phctf_mn.html . Accessed October 20, 2006.
- ¹²⁷ Sioux Lookout First Nations Health Authority. *History*. Found at: <http://www.nodin.on.ca/Client%20Services.html> . Accessed October 30, 2006.
- ¹²⁸ Weeneebayko Health Ahtuskaywin. *Our Mission*. Found at: <http://www.wha.on.ca/home.html> . Accessed October 30, 2006.
- ¹²⁹ Health Canada. First Nations and Inuit Health. *Improving Access to Health Services: a Model for the Delivery of Primary and Public Health Care Services to the Communities of Sioux Lookout Zone*.

-
- Found at: http://www.hc-sc.gc.ca/fnih-spni/services/acces/index_e.html . Accessed October 13, 2006.
- ¹³⁰ Health Canada. *First Nations and Inuit Health. Improving Access to Health Services: Weeneebayko Area Health Integration Initiative*. Found at: http://www.hc-sc.gc.ca/fnih-spni/services/acces/weeneebayko_e.html. Accessed October 13, 2006.
- ¹³¹ Frolich, K., Ross, N. & Richmond, C. Health disparities in Canada today: some evidence and a theoretical framework. *Health Policy*. 2006; 79(2-3): 132-143. Epub 2006 Mar 7.
- ¹³² Booth, G., Hux, J., Fang, J. & Chan, B. Time trends and geographic disparities in acute complications of diabetes in Ontario, Canada. *Diabetes Care*. 2005; 28 (5): 1045 – 1050.
- ¹³³ Smith, D. Maternal-child health care in Aboriginal communities. *Canadian Journal of Nursing Research*. 2003; 35(2): 143 – 152.
- ¹³⁴ Minore B., Boone, M. & Hill, M. Finding temporary relief: strategy for nursing recruitment in northern Aboriginal communities. *Canadian Journal of Nursing Research*. 2004; 36(2): 148-163.
- ¹³⁵ Minore, B., Boone, M., Cromarty, C., Katt, M., Kinch, P. & Power, M. (2002). *It's just so different up here: Continuity of care for Cancer Patients in northwestern Ontario First Nation communities*. Report prepared for the Norman M. Paterson Foundation, Northern Cancer Research Foundation and First Nations and Inuit Health Branch, Health Canada. Pp. 58.
- ¹³⁶ Minore, B., Boone, M., Katt, M., Kinch, P. & Birch, S. (2002). *Facilitating the continuity of care for First Nation clients within a regional context*. Report prepared for the Shibogama First Nations Council, The Canadian Health Services Research Foundation, The First Nations and Inuit Health Branch, and The Ontario Ministry of Health and Long-Term Care. Pp. 25.
- ¹³⁷ Smith, D. Maternal-child health care in Aboriginal communities. *Canadian Journal of Nursing Research*. 2003; 35(2): 143 – 152.
- ¹³⁸ Boone, M., Minore, B., Katt, M., & Kinch, P. (1994). Preparing health care workers for northern practice: Toward a solution for retention problems in the Nishnawbe-Aski First Nations of Ontario, Canada. In L. Heininen & T. Katermaa, (Eds.) *The Changing circumpolar North: Opportunities for Academic Development*. University of Lapland, pp. 54 – 64.
- ¹³⁹ Minore, B., Boone, M., Katt, M., Kinch, P. & Birch, S. (2002). *Facilitating the continuity of care for First Nation clients within a regional context*. Report prepared for the Shibogama First Nations Council, The Canadian Health Services Research Foundation, The First Nations and Inuit Health Branch, and The Ontario Ministry of Health and Long-Term Care. Pp. 25.
- ¹⁴⁰ National Native Alcohol and Drug Addiction Program (NNADAP) workers.
- ¹⁴¹ Ward, J. Developing community mental health services for indigenous people of Northern Ontario. *Arctic Medical Research*. 1991; Suppl: 256-60.
- ¹⁴² Minore, B., Boone, M., Cromarty, C., Katt, M., Kinch, P. & Power, M. (2002). *It's just so different up here: Continuity of care for Cancer Patients in northwestern Ontario First Nation communities*. Report prepared for the Norman M. Paterson Foundation, Northern Cancer Research Foundation and First Nations and Inuit Health Branch, Health Canada. Pp. 58.
- ¹⁴³ Johnson, R. The development of a computerized health information system to facilitate program planning/evaluation and enhanced First Nations control of community health services. *Canadian Journal of Public Health*. 1997; 88: 207 – 209.

-
- ¹⁴⁴ Dokis, L. (2002). Cultural competence for registered nurses. *The Canadian Women's Health Network Magazine*. 2001/2: 4/5. (online edition). Found at: <http://www.cwhn.ca/network-reseau/5-1/5-1pg9.html>. Accessed September 20, 2006.
- ¹⁴⁵ Vukic, A., & Keddy, B. Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing*. 2002; 40: 542- 548.
- ¹⁴⁶ Dodgson, J. & Struthers, R. Indigenous women's voices: Marginalization and health. *Journal of Transcultural Nursing*. 2008;16(4): 330 – 346.
- ¹⁴⁷ Betancourt J, Green A, Carrillo J, & Ananeh-Firemping, O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*. 2003; 118: 293-302.
- ¹⁴⁸ Moffatt, M. & Cook, C. How can the health community foster and promote the health of Aboriginal children and youth? *Paediatric Child Health*. 2005; 10(9): 549 – 552.
- ¹⁴⁹ Ahmann, E. Developing cultural competence in health care settings. *Pediatric Nursing*. 2002; 28(2): 133 – 137.
- ¹⁵⁰ Chin, J. Cultural competence and health care in Massachusetts. Issue Brief. *Massachusetts Health Policy Forum*. 1999(5); 1-20.
- ¹⁵¹ Donini-Lenhoff, F. G. & Hedrick, H. L. Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health*. 2000; 29(4): 241 – 245.
- ¹⁵² Davis-Murdoch, S. (2005). *A cultural competence guide for primary health care professionals in Nova Scotia*. Halifax, NS: Nova Scotia Department of Health. Found at: www.gov.ns.ca/.../primaryhealthcare/pubs/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf. Accessed September 24, 2006.
- ¹⁵³ First Nations Professional Practice Group. (2005). *Role of the community health nurse in Aboriginal communities of the Thompson Cariboo Shuswap Health Deliver Area*. Victoria, BC: Nursing Directorate of the British Columbia Ministry of Health Services.
- ¹⁵⁴ Wepa, D. An exploration of the experiences of cultural safety educators in New Zealand: An action research approach. *Journal of Transcultural Nursing*. 2003; 14(4): 339 – 348.
- ¹⁵⁵ Polaschek, N. Cultural safety: a new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*. 1998; 27: 452 – 457.
- ¹⁵⁶ Centre on an Aging Society. (2004). *Cultural competence in health care: Is it important for people with chronic conditions?* Washington, DC: Georgetown University.
- ¹⁵⁷ Cross, T., Barzon, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- ¹⁵⁸ Purden, M. Cultural considerations in interprofessional education and practice. *Journal of Interprofessional Care*. 2005; 19(S1): 224 – 234.
- ¹⁵⁹ California Task Force on Multicultural Competence. (1993). *Summary of findings*. Sacramento, CA: California Department of Health Services, Office of Multicultural Health.

-
- ¹⁶⁰ Weaver, H. The elements of cultural competence: applications with Native American clients. *Journal of Ethnic and Cultural Diversity in Social Work*. 2004; 13(1): 19 – 35.
- ¹⁶¹ Betancourt J, Green A, Carrillo J, & Ananeh-Firempong, O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*. 2003; 118: 293-302.
- ¹⁶² Campinha-Bacote, J. A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*. 1995; 8: 203 – 207.
- ¹⁶³ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61..
- ¹⁶⁴ Webb, E. & Sergison, M. Evaluation of cultural competence and antiracism training in child health services. *Archives of Disease in Childhood*. 2003; 88: 291 – 294.
- ¹⁶⁵ Purden, M. Cultural considerations in interprofessional education and practice. *Journal of Interprofessional Care*. 2005; 19(S1): 224 – 234.
- ¹⁶⁶ Donini-Lenhoff, F. & Hedrick, H. Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health*. 2000; 29(4): 241 – 245.
- ¹⁶⁷ Ramirez, A. Consumer-provider communication research with special populations. *Patient Education and Counselling*. 2003; 50: 51 – 54.
- ¹⁶⁸ Taylor, S., & Laurie, N. The role of culturally competent communication in reducing ethnic and racial healthcare disparities. *The American Journal of Managed Care*. 2004; 16: 1 – 4.
- ¹⁶⁹ Taylor, S., & Laurie, N. The role of culturally competent communication in reducing ethnic and racial healthcare disparities. *The American Journal of Managed Care*. 2004; 16: 1 – 4.
- ¹⁷⁰ Betancourt J, Green A, Carrillo J, & Ananeh-Firempong, O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*. 2003; 118: 293-302.
- ¹⁷¹ Dodgson, J. & Struthers, R. Indigenous women’s voices: Marginalization and health. *Journal of Transcultural Nursing*. 2006;16(4): 330 – 346.
- ¹⁷² Chevannes, M. Issues in educating health professionals to meet the diverse needs of patients and other service users from ethnic minority groups. *Journal of Advanced Nursing*, 2002; 39(3): 290 – 298.
- ¹⁷³ First Nations Professional Practice Group. (2005). *Role of the community health nurse in Aboriginal communities of the Thompson Cariboo Shuswap Health Delivery Area*. Victoria, BC: Nursing Directorate of the British Columbia Ministry of Health Services. (p. 5).
- ¹⁷⁴ Chin, J. Cultural competence and health care in Massachusetts. *Issue Brief*. Massachusetts Health Policy Forum. 1999(5); 1-20.
- ¹⁷⁵ Adelson, N. The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*. 2005; 96: S45 – S61. P. S46.
- ¹⁷⁶ Smith, D. Maternal-child health care in Aboriginal communities. *Canadian Journal of Nursing Research*. 2003; 35(2): 143 – 152.
- ¹⁷⁷ Hayashi, A. S. (2001, October). *Providing for culturally competent and linguistically appropriate mental health care services in Massachusetts: A legislative approach*. Paper presented at the 129th Annual Meeting of the American Public Health Association, Atlanta, GA.

-
- ¹⁷⁸ Maar, M. Clearing the path for community health empowerment: Integrating health care services at an Aboriginal health access centre in rural north central Ontario. *Journal of Aboriginal Health*. 2004; 1(1): 54 – 64.
- ¹⁷⁹ Warner, J. Cultural competence immersion experiences: public health among the Navajo. *Nurse Educator*. 2002; 27(4): 187 – 190.
- ¹⁸⁰ College of Nurses of Ontario. (2006). *Practice standard: Therapeutic nurse-client relationship*. Toronto, ON: College of Nurses of Ontario. (p. 15).
- ¹⁸¹ Ahmann, E. Developing cultural competence in health care settings. *Pediatric Nursing*. 2002; 28(2): 133 – 137.
- ¹⁸² Wittig, D. Knowledge, skills, and attitudes of nursing students regarding culturally congruent care of Native Americans. *Journal of Transcultural Nursing*. 2004; 15(1): 54 – 61.
- ¹⁸³ Weaver, H. (2004). The elements of cultural competence: Applications with Native American clients. *Journal of Ethnic and Cultural Diversity in Social Work*. 2004; 3(1): 19 – 35.
- ¹⁸⁴ Katt, M., Kinch, P., Boone, M., & Minore, B. (1998). Coping with northern Aboriginal youth's suicides. In A. Leenaars, S. Wenckstern, I. Sakinofsky, R. Dyck, M. Kral, & R. Bland (Eds.), *Suicide in Canada* (pp. 212-226). Toronto, ON: University of Toronto Press.
- ¹⁸⁵ Vukic, A., & Keddy, B. Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing*. 2002; 40: 542- 548.
- ¹⁸⁶ Abdullah, S. Towards an individual client's care: Implications for education. The transcultural approach. *Journal of Advanced Nursing*. 1995; 22(4): 715 – 720.
- ¹⁸⁷ Boone, M., Minore, B., Katt, M., & Kinch, P. (1994). Preparing health care workers for northern practice: Toward a solution for retention problems in the Nishnawbe-Aski First Nations of Ontario, Canada. In L. Heininen & T. Katermaa (Eds.), *The Changing circumpolar North: Opportunities for Academic Development* (pp. 54-66). Roveneimi, Finland: University of Lapland.
- ¹⁸⁸ Minore, B. & Boone, M. Realizing Potential: Improving Interdisciplinary Professional/Paraprofessional Health Care Teams in Canada's Northern Aboriginal Communities Through Education. *Journal of Interprofessional Care*. 2002;16(2): 139 - 147.
- ¹⁸⁹ Lavoie, J. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*. 2004; 1(1): 6 – 24.
- ¹⁹⁰ Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ¹⁹¹ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ¹⁹² Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ¹⁹³ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.

-
- ¹⁹⁴ Lavoie, J. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*. 2004; 1(1): 6 – 24.
- ¹⁹⁵ Health Canada. *Certain circumstances: Issues in equality and responsiveness in access to health care in Canada*. Found at: http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acce/port1-doc-sec4_e.html. Accessed September 6, 2006.
- ¹⁹⁶ Lemchuk-Favel, L. (1999). *Financing a First Nations and Inuit Integrated Health System - A Discussion Paper*. Health Canada, First Nations and Inuit Health Branch; Ottawa, ON. Found at: http://www.hc-sc.gc.ca/fnih-spni/pubs/agree-accord/1999_finance_integr/index_e.html . Accessed September 13, 2006.
- ¹⁹⁷ Hiebert, S., Angees, E., Young, T.K. & O’Neil, J. The evaluation of transferred health care services in Wunnimin Lake, Wapekeka and Kingfisher Lake First Nations: a nursing perspective. *International Journal of Circumpolar Health*. 2001; 60: 473 – 478.
- ¹⁹⁸ Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, C. The effects of nursing turnover on continuity of care in isolated First Nation communities. *Canadian Journal of Nursing Research*. 2005; 37(1): 87 – 100.
- ¹⁹⁹ Wen, S., Goel, V. & Williams, J. Utilization of health care services by immigrants and other ethnic/cultural groups in Ontario. *Ethnic Health*. 1996; 1: 99 – 109.
- ²⁰⁰ Shah BR, Gunraj N, Hux JE. Markers of access to and quality of primary care for aboriginal people in Ontario, Canada. *American Journal of Public Health*. 2003; 93(5):798-802.
- ²⁰¹ Salvalaggio, G., Kelly, L. and Minore, B. Perspectives on Health: Experiences of Native Dialysis Patients in Thunder Bay. *Canadian Journal of Rural Medicine*, 2003, 8(1), 19- 24.
- ²⁰² Maberley, D, Walker, H., Koushik, A. & Cruess, A. Screening for diabetic retinopathy in James Bay, Ontario: a cost-effectiveness analysis. *Canadian Medical Association Journal*. 2003; 168: 160 – 164.
- ²⁰³ Wilson, R., Krefting, L., Sutcliffe, P., & Van, B. Native Canadians relocating for renal dialysis. Psychosocial and cultural issues. *Canadian Family Physician*. 1994; 40: 1934 – 1941.
- ²⁰⁴ Barer, M. & Stoddart, G. (1999). *Improving access to needed medical services in rural and remote Canadian communities*. Vancouver, BC: Centre for Health Services and Policy Research, the University of British Columbia.
- ²⁰⁵ Osmond, B. (2004). *Policy barriers to recruitment and retention of health professionals in rural areas of Nova Scotia*. Halifax, NS: The Atlantic Health Promotion Research Centre, Dalhousie University.
- ²⁰⁶ Minore, B., Pong, R. & Ariss, R. (2001). *A situational analysis of physician recruitment and retention in rural and northern Canada: models, programs and evaluations*. Report prepared for the Ministry of Health and Long-Term Care, Province of Ontario. Thunder Bay, ON: Centre for Rural and Northern Health Research, Lakehead & Laurentian Universities.
- ²⁰⁷ Nagarajan, K. Rural and remote community health care in Canada: Beyond the Kirby Panel Report, the Romanow Report and the federal budget of 2003. *Canadian Journal of Rural Medicine*. 2004; 9(4): 245 – 251.
- ²⁰⁸ Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.

- ²⁰⁹ Minore B., Boone, M. & Hill, M. Finding temporary relief: strategy for nursing recruitment in northern Aboriginal communities. *Canadian Journal of Nursing Research*. 2004; 36(2): 148-163.
- ²¹⁰ Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, C. The effects of nursing turnover on continuity of care in isolated First Nation communities. *Canadian Journal of Nursing Research*. 2005; 37(1): 87 – 100.
- ²¹¹ Gregory, D. (1992). Nursing practice in native communities. A. Baumgart & J. Larsen (Eds.), *Canadian nursing faces the future* (pp. 181-198). St. Louis: Mosby Yearbook.
- ²¹² MacLeod, M., Browne, A., & Leipter, B. Issues for nurses in rural and remote Canada. *Australian Journal of Rural Health*. 1998; 6: 72 - 78.
- ²¹³ O’Neil, J. (1989). The politics of health in the fourth world: A northern Canadian example. In K. Coates & W. Morrison (Eds.), *Interpreting Canada’s north: Selected readings* (pp. 279 - 298). Toronto, ON: Copp, Clark, Pittman.
- ²¹⁴ Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ²¹⁵ Minore, B. & Boone, M. Realizing potential: improving interdisciplinary professional/paraprofessional health care teams in Canada’s northern Aboriginal communities through education. *Journal of Interprofessional Care*. 2002;16(2): 139 - 147.
- ²¹⁶ Boone, M., Minore, B., Katt, M., & Kinch, P. (1994). Preparing health care workers for northern practice: Toward a solution for retention problems in the Nishnawbe-Aski First Nations of Ontario, Canada. In L. Heininen & T. Katermaa (Eds.), *The Changing circumpolar North: Opportunities for Academic Development* (pp. 54-66). Roveneimi, Finland: University of Lapland.
- ²¹⁷ Matthews, D. (2003). Literature review: *Documents/Reports Relevant to Labrador on Recruitment, Retention and Human Resource Development*. Report prepared for Labrador Regions of the Strategic Social Plan. St. John’s, NF: Government of Newfoundland and Labrador.
- ²¹⁸ Mayo, E. & Matthews, M. (2005). *Spousal Perspectives on Factors Influencing Recruitment and Retention of Rural Family Physician*. St. John’s NF: Memorial University of Newfoundland. Found at: <http://www.artc-hsr.ca/Documents%20linked%20to/Thesis%20Summary%20Erin%20Mayo.doc>. Accessed September 28, 2006.
- ²¹⁹ Society of Rural Physicians of Canada/Professional Association of Interns and Residents of Ontario. (1998). *From Education to Sustainability: A Blueprint for Addressing Physician Recruitment and Retention in Rural and Remote Ontario*. Toronto, ON: Society of Rural Physicians of Canada.
- ²²⁰ Goertzen, J. The four-legged kitchen stool: Recruitment and retention of rural family physicians. *Canadian Family Physician*. 2005; 51: 1 – 3.
- ²²¹ Royal Commission on Aboriginal Peoples. (1996). *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength*. Vol. 3. Ottawa, ON: Ministry of Supply and Services Canada.
- ²²² Ehman, A. Lack of Aboriginal health professionals a ‘huge issue.’ *Canadian Medical Association Journal*. 2004; 171(9): 1028.
- ²²³ Moffatt, M. & Cook, C. How can the health community foster and promote the health of Aboriginal children and youth? *Paediatric Child Health*. 2005; 10(9): 549 – 552.

-
- ²²⁴ Health Canada. (2002). *Against the Odds: Aboriginal Nursing*. Ottawa, ON: National Task Force on Recruitment and Retention Strategies.
- ²²⁵ Gregory, D. Aboriginal health and nursing research: Postcolonial theoretical perspectives. *Canadian Journal of Nursing Research*. 2005; 37(4): 11-15(5).
- ²²⁶ Morton, M., Boone, M. & Poole, K. (1999). Attrition: Failure or future: the experience of Aboriginal nursing students. In H. Myrlund & L. Carlsson (Eds.), *Circumpolar Change: Building a Future on Experiences From the Past* (pp. 139-150). Lulea, Sweden: Universitetstryckeriet.
- ²²⁷ Matthews, D. (2003). *Literature Review: Documents/Reports Relevant to Labrador on Recruitment, Retention and Human Resource Development*. Report prepared for Labrador Regions of the Strategic Social Plan. St. John's, NF: Government of Newfoundland and Labrador. (p. 10).
- ²²⁸ Spencer, A., Young, T. Williams, S., & Horsfall, S. Survey on Aboriginal issues within Canadian medical programmes. *Medical Education*. 2005. 39: 1101-09.
- ²²⁹ Rourke, J. Building the new Northern Ontario Rural Medical School. *Australian Journal of Rural Health*. 2002; 10: 112 – 116.
- ²³⁰ Boone, M. & Minore, B. (1999). Integrated or separated: teaching concepts of Aboriginal health to nurse practitioners. In H. Myrlund & L. Carlsson (Eds.), *Circumpolar Change: Building a Future on Experiences From the Past* (pp. 483-494). Lulea, Sweden: Universitetstryckeriet.
- ²³¹ Minore B., Boone, M. & Hill, M. Finding temporary relief: strategy for nursing recruitment in northern Aboriginal communities. *Canadian Journal of Nursing Research*. 2004; 36(2): 148-163.
- ²³² Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ²³³ Lavoie, J. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*. 2004; 1(1): 6 – 24.
- ²³⁴ Lavoie, J. Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health*. 2004; 1(1): 6 – 24.
- ²³⁵ Gregory, D., Russel, C. and Hurd, J. Canada's Indian Health Transfer Policy: the Gull Bay Band experience. *Human Organization*. 1992; 51 (Fall): 214-22.
- ²³⁶ Lemchuk-Favel, L. & Jock, R. Aboriginal health systems in Canada: Nine case studies. *Journal of Aboriginal Health*. 2004; 1(1): 28 – 51.
- ²³⁷ Wilson, K & Rosenberg, M. Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*. 2002; 55: 2017 – 2031.
- ²³⁸ Maar, M. Clearing the path for community health empowerment: Integrating health care services at an Aboriginal health access centre in rural north central Ontario. *Journal of Aboriginal Health*. 2004; 1(1): 54 – 64.
- ²³⁹ Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, C. The effects of nursing turnover on continuity of care in isolated First Nation communities. *Canadian Journal of Nursing Research*. 2005; 37(1): 87 – 100.
- ²⁴⁰ Macaulay, A., Harris, S., Lévesque, L., Cargo, M., Ford, E. et al. Primary prevention of type 2 diabetes: Experiences of two Aboriginal communities in Canada. *Canadian Journal of Diabetes*. 2003; 27(4): 464 – 475.

-
- ²⁴¹ Levesque, L., Guilbault, G., Delormier, T. & Potin, L. Unpacking the black box. A deconstruction of the programming approach and physical activity interventions implemented in the Kahnawake Schools Diabetes Prevention Project. *Health Promotion Practice*. 2005; 6: 64 – 71.
- ²⁴² Kuperberg, K. & Evers, S. Feeding patterns and weight among First nations children. *Canadian Journal of Dietetic Practice and Research*. 2006; 67: 79 – 84.
- ²⁴³ Harris, S. What works? Success stories in Type 2 diabetes mellitus. *Diabetic Medicine*. 1998; 15 (S4): S20 – S23.
- ²⁴⁴ Skinner, K. Hanning, R. & Tsuji, L. Barriers and supports for healthy eating and physical activity for First Nations youths in northern Canada. *International Journal of Circumpolar Health*. 2006; 65: 148 – 161.
- ²⁴⁵ Reading, J., Ritchie, A., Victor, J. & Wilson, E. Implementing empowering health promotion programmes for Aboriginal youth in two distinct communities in British Columbia, Canada. *Promotion and Education*. 2005;12(2): 62 – 65.
- ²⁴⁶ Willows, N. Overweight in First Nations children: Prevalence, implications, and solutions. *Journal of Aboriginal Health*. 2005;2(1): 76 – 86.
- ²⁴⁷ Morrison, N. & Dooley, J. The Sioux Lookout Diabetes Program: Diabetes prevention and management in northwestern Ontario. *International Journal of Circumpolar Health*. 1998; 57, Suppl 1: 364 – 369.
- ²⁴⁸ Skinner, K., Hanning, R., & Tsuji, L. Barriers and supports for health eating and physical activity for First Nation Youths in Northern Canada. *International Journal of Circumpolar Health*. 2006; 65 (2): 148 – 161.
- ²⁴⁹ Gittelsohn, J., Harris, S., Thorne-Lyman, A, Hanley, A., Barnie, A. & Sinman, B. Body image concepts differ by age and sex in an Ojibway-Cree community in Canada. *Journal of Nutrition*. 1996; 126(12): 2990-3000.
- ²⁵⁰ Bisset, S., Cargo, M., Delormier, T., Macaulay, A. & Potvin, L. Legitimizing diabetes as a community health issue: A case analysis of an Aboriginal community in Canada. *Health Promotion International*. 2004; 19(3): 317 – 326.
- ²⁵¹ Landau, T. The prospects of a harm reduction approach among indigenous people in Canada. *Drug and Alcohol Review*. 1996; 15: 393 – 401.
- ²⁵² Smith, D. Maternal-child health care in Aboriginal communities. *Canadian Journal of Nursing Research*. 2003; 35(2): 143 – 152.