

Aboriginal Peoples' Wellness in Canada: Scaling Up the Knowledge

Cultural Context and Community Aspirations

*Summary Report from March 3,4th Roundtable

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Report from the Roundtable
March 3rd and 4th, 2011
Ottawa, Ontario, Canada

** The proceedings from the conference incorporated into this document reflect notes taken at the event. The complete report, a video record of the March 3rd discussions, PowerPoint presentations, and a synthesis of findings are all available at <http://www.ihe.ca/research/ihe-Aboriginal-roundtable/>*

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Purpose of the Forum

The purpose of the roundtable held on March 3rd and 4th in Ottawa was to discuss Aboriginal Knowledge Translation/Exchange in Canada. We hoped to highlight successful knowledge translation approaches in First Nation, Métis, and Inuit populations across Canada, and to begin discussing why these initiatives work and how we can continue such success in other communities. The Canadian Institutes of Health Research (CIHR) Institute of Aboriginal Peoples' Health (IAPH) has recognized the importance of intervention research (*the body of knowledge—what worked, what did not, and why*) and knowledge translation (*the transformation to different contexts and scaling up*) as a means of achieving models of good practice that will benefit First Nations, Inuit, and Métis Peoples throughout Canada to achieve wellness.

Background

While much knowledge has been generated, particularly through the investments of CIHR-IAPH in Network Environments for Aboriginal Health Research (NEAHR) and strategic research initiatives, there is still a significant need to support capacity building and knowledge translation

The CIHR has embraced the need to reduce health inequities in Aboriginal Peoples as one of its main strategic directions. In the past, the IAPH has supported community engagement, capacity building, and network development as key platforms in creating health equity for Aboriginal Peoples, but has recognized the need to move beyond this to support more intervention research and knowledge translation. This roundtable was timely in informing the IAPH business case, *Pathways to Health Equity*, being developed for the Institute's next five-year plan.

Responding to the identified research needs and building on the international experiences in support for indigenous health research, *Pathways to Health Equity* proposes several points that were echoed during the roundtable discussion. For example:

- CIHR should adopt an approach similar to Australia's "population plus" funding model and allocate 5-6% of its overall budget to FN/I/M research;
- Research awards must recognize the additional cost of gathering information in small, remote, or northern communities; and,
- Communities actively participate in all stages of research—this requires the creation of funding mechanisms to support community leadership in appropriate projects.

Factors that Affect Knowledge Translation for Improved Health Outcomes in Aboriginal Communities

- Systemic issues of governance and accountability for health services (overlap and conflict)
 - Many of the recent changes in Aboriginal policy were guided by the Royal Commission on Aboriginal Peoples (1996). This landmark report identified a number of problems that persist today:

Aboriginal people endure ill health, run-down and overcrowded housing, polluted water, inadequate schools, poverty and family breakdown at rates found more often in developing countries than in Canada. These conditions are inherently unjust. They also imperil the future of Aboriginal communities and nations.

The report talked about the need to build cultural competency and to work towards more services integrated with those of provinces and territories

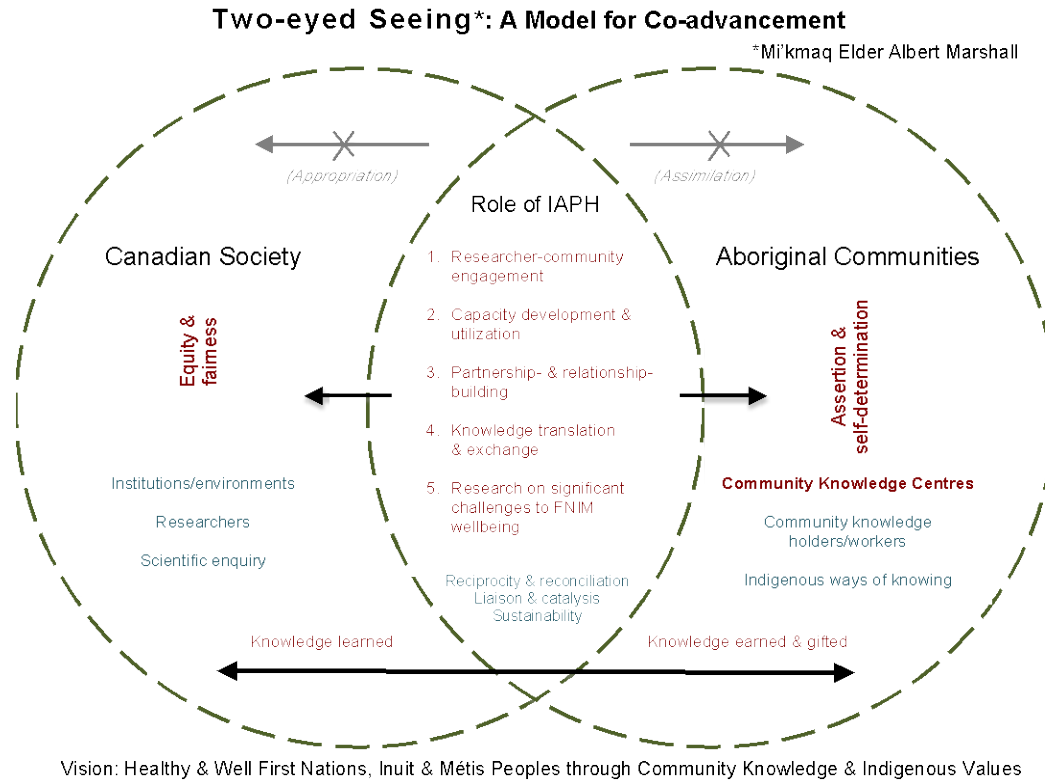
- Access to effective interventions/programs/diagnostic capacity and treatment
 - Access and use of health services continues to pose challenges for FN/I/M. A recent review of this issue among indigenous people in North America, Australia and New Zealand¹ identified several key factors that lessen access to the use of health services even in publicly-funded healthcare systems: the rural and remote locations of many indigenous communities; challenges in recruiting and retaining healthcare professionals in rural communities; communication barriers, particularly with respect to cultural values and experiences; and, socio-economic status.
- Ongoing community data collection/surveillance to identify where the problems are and what is working. Data collection is improving but must accelerate
 - There are persistent and significant gaps in data pertaining to First Nations, Inuit and Métis health. Disaggregated data are essential to recognize unique differences among First Nations, Inuit and Métis and across regions of the country. Useful and reliable FN/I/M data would support research and evaluation, as well as program and policy development.
- Social determinants of health (income, education, environmental health) that impact overall health status (major factors for health improvement may be outside the health system)
 - Recent publications from the National Collaborating Centre for Aboriginal Health (NCCA) highlight the importance of an approach to health care that considers social determinants—this approach targets the underlying causes of illness and disease, such as poverty, substandard housing, and barriers to education.

In addition to the factors outlined above, a key barrier affecting approaches to improved knowledge translation activities on health in Aboriginal populations is the lack of a systematic understanding of, and approach to, integrating traditional knowledge and community approaches to healing with western scientific approaches to the study and adoption of health interventions. The “Two-Eyed Seeing” model advocated by CIHR-IAPH *Pathways to Health Equity* is one way of addressing this issue.

¹ Marrone, S. Understanding Barriers to Health Care: A Review of Disparities in Health Care Services Among Indigenous Populations, *International Journal of Circumpolar Health* 66:3 2007

Key Themes from the Roundtable Discussions

Importance of “Two-Eyed Seeing”: There was a strong acceptance that the advance of Aboriginal wellbeing there requires efforts to honour traditional Aboriginal healing approaches and mainstream medicine simultaneously. It was recognized there are inherent conflicts between indigenous ways of knowing and the scientific inquiry that serves as the basis for evidence in mainstream medicine.



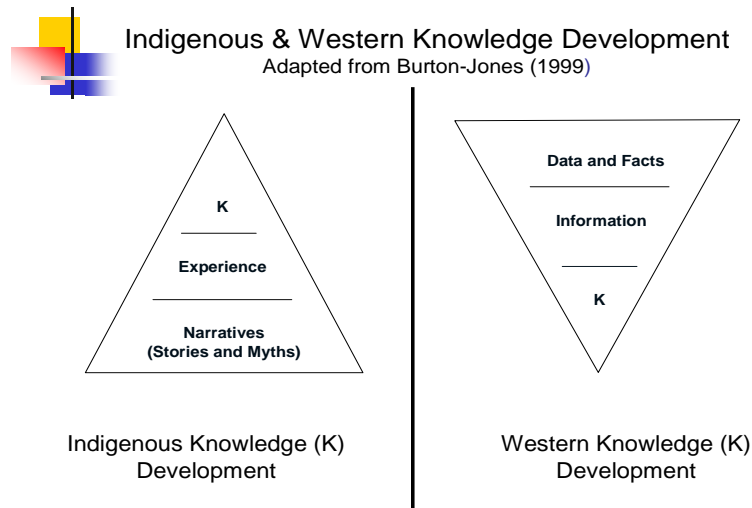
The diagram above will serve as the basis for the business case under development with the Institute of Aboriginal Peoples Health in their current programs. The roundtable served as a platform for Dr. Malcolm King to present the model, and the concept of “Two-Eyed Seeing” became a powerful theme that resonated throughout the deliberations and dialogue.

There was a strong call at the meeting for narratives to frame approaches to knowledge translation with Aboriginal peoples. Because of the community engagement efforts of the IAPH and partners such as the CIHR Ethics Office, the negative attitude in many Aboriginal communities towards health research that existed in 2000 has largely been replaced with a willingness to work with the academic community to find solutions through knowledge gathering and sharing. Thus, a number of entry points to finding health solutions are valid, and common ground can be found between the needs of health decision-maker, such as programs to reduce health risk factors, and community health priorities. Regardless of the entry point—diabetes, cardiovascular disease, suicide, or violence—if the research is conducted “in a good way,” the benefits will be holistic and extend beyond the narrow bounds of the project. There is

now a willingness to work with the priority programs of government agencies and the voluntary sector, provided that the approach is community-based and collaborative, and respectful of community knowledge and a broad, holistic perspective on health.

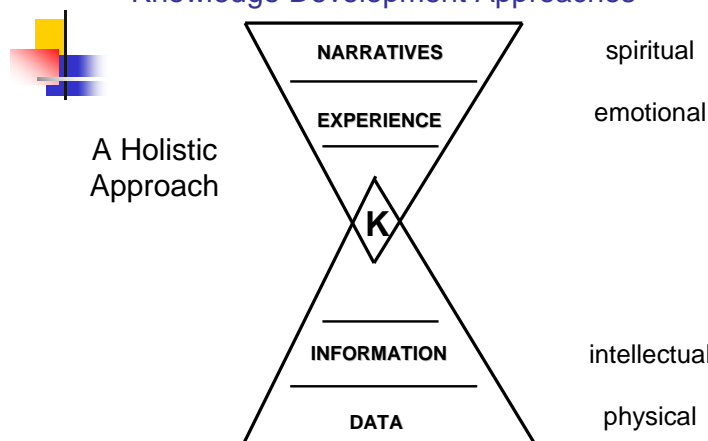
The illustration below offers a different visual representation, showing the two approaches to knowing. Indigenous knowledge is based on narratives and experience, while Western knowledge is predicated on data, facts and statistics. Both can be used for knowledge translation to improve health outcomes for Aboriginal communities.

Approach to KT based on adapting work of others



The next illustration represents how the two types of knowledge might come together. Western science often fails to address improved health in the context of spiritual and emotional wellbeing; it tends to communicate “facts” rather than the stories revealed through narrative and experience.

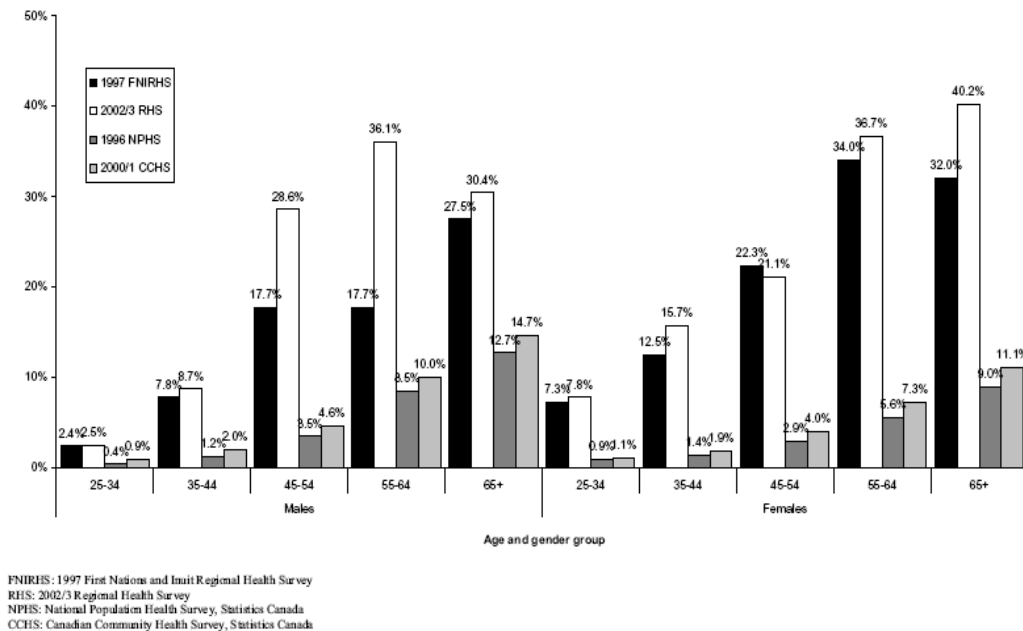
Combining Indigenous & Western Knowledge Development Approaches



Developed Sept 6, 2003 by Judith G. Bartlett MD, MSc, CCFP, FCFP

“A Crisis Exists”—There is an ongoing need to recognize that the health status of Aboriginal peoples is at unacceptable levels compared to that of non-Aboriginal populations. Below is a slide presented at the roundtable demonstrating the significant differences between trends in diabetes in First Nations and the general adult population in Canada. Similar statistics exist for other conditions. Urgent action is required to address the obvious disparities. The urgency of the situation facing Aboriginal populations cannot be overemphasized and should be a catalyst for action.

Figure 2. Diabetes trends among First Nations and the general adult population in Canada



CIHR currently spends about 3.5% of its budget on Aboriginal health research. This represents health research equity, given that the Aboriginal (FNIM) peoples represent about 3.5% of Canada’s overall population. Closing the gap in Aboriginal health requires a *population plus* approach—that is, equity based on population and health burden. With the business case for Aboriginal health, CIHR’s financial commitment to Aboriginal health will increase to 5-6%. IAPH is advocating that other Canadian health research organizations increase their Aboriginal financial commitments accordingly.

“Safe Space needed”—Need to create “safe and ethical places” for dialogue between Aboriginal and non-Aboriginal partners involved in initiatives to improve First Nations, Inuit and Métis health, and develop tools to support their effective engagement. It was recognized at the roundtable that barriers exist for both representatives of both groups to safely engage in dialogue. Many organizations want to engage in activities to address Aboriginal health but there is anxiety on all sides as to how to do this in a respectful, impactful way. Tools, educational support, and best practice examples to guide these efforts would help.

Margo Greenwood of the National Collaborating Centre for Aboriginal Health told of the Gatherings they support. The Centre brings together Elders, youth, children, healers, Métis, Inuit, and First Nations, as well as leading researchers and experts in the field. Sound approaches include choosing culturally-

appropriate locations and honouring the traditional territories by opening the Gathering with smudging or prayers of welcome and gratitude.

“Know our History”—Need to educate all populations on the history of Canadian Aboriginal culture. A key point raised in discussions was the general lack of knowledge within non-Aboriginal society of the history of Aboriginal peoples and the intergenerational impact resulting from the trauma of colonization and oppression.

Canadian Aboriginal people die earlier than their fellow Canadians, on average, sustain[sic] a disproportionate share of the burden of physical disease and mental illness. This burden is associated with unfavorable [sic] economic and social conditions that are inextricably linked to Native people history of oppression. (1996:155:11)

The roundtable also acknowledged the loss of traditional knowledge and history amongst Aboriginal youth and the benefits of engaging them more broadly. Several presenters relayed stories of positive outcomes when Elders have the opportunity to work directly with youth.

“Information is needed”—Need to engage communities and Aboriginal leadership on health data sharing and analysis. Informed policymaking at all levels requires administrative data linkage, as well as processes to make better use of surveillance data. This must be done in accordance with the OCAP Principles: Ownership; Control; Access; Possession. The National Collaborating Centre for Aboriginal Health has noted the systematic exclusion of certain sub-populations of Aboriginal peoples from data collection according to ethnicity, place of residence and/or Indian Act grouping. The Health Council of Canada has also remarked on the difficulty of obtaining reliable, accurate health status data for FN/I/M populations.

There are positive developments underway through the Regional Health Survey. However, urgent attention is still needed to ensure that information is available to support knowledge-based decisions. http://www.naho.ca/firstnations/english/documents/FNC-OCAP_001.pdf.

“Share what works!”—It is essential to share knowledge-translation initiatives that have proven effective. Western knowledge-translation efforts involve the organization of individual data into abstract theoretical systems. They are described as linear, hierarchical, specialized and written. Conversely, indigenous knowledge systems and the generation of knowledge begin with “stories” and proceed to “knowledge” and integrating the values and processes described in the stories. They are believed to culminate in wisdom. Indigenous knowledge systems are described as holistic, relational, pluralistic, communal, oral and narrative-based. There are examples of effective initiatives which should be gathered in appropriate ways—and shared and communicated so as to make sense to specific audiences. Support for a “shared” web space was discussed—one where people could “speak” of their successes and develop direct-engagement forums to present inventories of positive stories.

“Focus on Youth!”—Need to intervene early with Aboriginal youth through education on health improvement, mainstream science and traditional healing practices. Educational support must be directed to lower levels of education to engage children early and provide them with knowledge of how to improve their own health through traditional learning as well as Western wellness information. There is a need to support increasing Aboriginal participation in health-sector roles, including research, health professions and knowledge-translation activities.

“Adapt Research and KT Funding Processes to Acknowledge Context”—Need to recognize the unique context of Aboriginal communities in development of research initiatives and Knowledge translation activities. Examples were given of knowledge translation research grants that were refused according to “scientific merit” criteria. Perhaps approaches for review and granting funding to KT initiatives should be adapted. These could include ensure that specific contextual issues relating to Aboriginal health are considered among the criteria, applied when forming review panels, and included in assessing what constitutes “evidence,” etc.

The roundtable discussions suggested that there is a need to reform the peer-review process for awarding KT research grants, and to acknowledge the specific difficulties encountered, and increased expenses incurred, when working in remote Aboriginal communities.

Key Action Points from the Roundtable Discussions

Support for Collaboration

The Roundtable discussions pointed out that one of the most important factors in successful Aboriginal KT research is collaborative relationships. There should be investment in processes that recognize traditional learning along with partnerships between traditional learning and Western research. The Community Knowledge Centres proposed in the *Pathways to Health Equity* can be instrumental in facilitating these relationships. An effective approach to supporting collaborative KT could include promoting the establishment of more community-based knowledge centres through dedicated multi-year grants from government with incentives for matching funds from private sources.

One suggestion for a simple, practical way to support collaboration was that Health Authorities provide more joint training opportunities for Aboriginal and non-Aboriginal healthcare workers.

Capacity Building

The Roundtable discussions voiced the need to support capacity building to enable Aboriginal communities to determine what research they want done, involve them in the process and, therefore, own the outcomes. Providing increased support to educate more Aboriginal healthcare workers and researchers is one way of addressing this inequity.

- Partnering between CIHR and public and private funders through scholarships and educational internship opportunities for Aboriginal youth in health professions, as well as career paths in science education

During the Roundtable dialogues, suggestions were put forth to support community-based KT that had been used successfully elsewhere. These included:

- Providing more opportunities for indigenous knowledge holders and western knowledge users to dialogue by using the Network Environments for Aboriginal Health Research (NEAHR) to hold conferences on issues of importance to Aboriginal people
- Include Aboriginal healers in traditional healthcare teams

Support for Traditional Methods and Community-Based KT Research

Preserving knowledge is important but applying it is even more-so. During the Roundtable discussions, suggestions included several practical ways of supporting traditional healing methods:

- Provide Western medical practitioners with continuing education opportunities in Aboriginal traditions
- Explore possibilities to provide financial support for some of the traditional healing ways

Developing and articulating these forms of educational opportunities to bridge Western and indigenous views of knowledge demonstrates that one values other ways of understanding, developing and using health.

Support for Narratives

As indicated above, indigenous knowledge systems are described as holistic, relational, pluralistic, communal, oral and narrative-based. Western knowledge translation efforts are described as linear, hierarchical, specialized and written. There is a need to find ways to put the Aboriginal traditional healing concepts (transformation, magic, stories, ancestors) into modern medicine through participatory research that involves the Aboriginal communities and respects the traditional knowledge and teachings through narratives.

- Use the “Two-Eyed Seeing” model to develop a guide for health organizations and others interested in advancing their own activities in supporting Aboriginal knowledge transfer. In addition to this, develop an inventory of “Two-Eyed Seeing” best practice examples where traditional and Western approaches to knowledge have worked well together
- Knowledge translation in Aboriginal research is based on narratives. Therefore, funding should be provided to synthesize these stories along with opportunities and places to publish and share them
- Explore visual ways of representing knowledge along with traditional text

Recognition of the Unique Challenges/Barriers Inherent in Conducting Aboriginal KT Research

During the discussions issues were raised regarding the difficult logistics of carrying out Aboriginal KT research. These include *the need for recognition and funding that acknowledges the expense (time and dollars) of carrying out effective participatory research within remote Aboriginal communities.*

Reform of the peer-review process for Aboriginal health research was also discussed. Many important projects are refused funding because they do not meet the stringent methodological requirements of most peer-review processes. These are currently imbedded in the history of biomedical research rather than community engagement and intervention research.

- Incorporate more iterative mechanisms of review into the review process, such as:
 - Having the researchers review the reviewers and make changes to the process based on feedback, and
 - Provide opportunities for projects that do not meet the methodological requirements to “fix” these issues.

Youth

Youth are the key to improving health outcomes for Aboriginal Communities. Accordingly, *there should be greater investment in Aboriginal programs to engage youth in their own health and the health of their communities through education.* “Right to Play” is an example of a program to build on. The Roundtable put forth several actionable suggestions:

- Governments and schools should develop a curriculum for schools on Aboriginal peoples’ history –challenges and triumphs
- Provide more opportunities for youth to engage with Elders
- Provide support to educate more Aboriginal healthcare workers and researchers

Support for Sharing Best Practices

In his presentation to the Roundtable, Dr. Jeff Reading spoke to the fact that KT is imbedded in the process of engaging in research in partnership with Aboriginal communities and policy makers, thereby promoting rapid application of evidence. Scaling up of the lessons learned in Aboriginal health research and sharing successful best practices in Aboriginal Knowledge Transfer requires identifying any common characteristics of success. Participants discussed the importance of creating safe spaces to house KT:

- Develop and provide support for an online knowledge-sharing space for best practices and stories in Aboriginal knowledge translation
- Celebrate success through annual awards
- Conduct engagement exercises involving those holding traditional knowledge so as to capture and share that knowledge

Continue the Dialogue

There was unanimous support for the Roundtable process and the development of follow-up dialogues regarding specific issues, such as:

- Approaches for use of new media in engaging Aboriginal youth
- Studies targeted to special needs of disadvantaged and marginalized populations and approaches to transmit knowledge for improved health (inner-city IV drug use)
- Development of new criteria/processes for scientific merit in assessing KT research proposals in Aboriginal health

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What is Knowledge Translation (KT)?²

There are many different and complex descriptions of knowledge translation (KT), and no single agreed-upon definition. One that has been used to describe KT in Aboriginal contexts is: sharing what we know about living a good life.³ This is quite different from the Canadian Institutes of Health Research (CIHR) definition:

...a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system⁴.

The CIHR further explains:

...this process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user³.

In Western science-based contexts, KT has also been described by its purpose: to reduce the know-do gap. Closing the know-do gap is a recent concern for the Western research community, as the worlds of research-based knowledge and action have traditionally been separated. This separation of knowledge and action arises from a paradigm that differs from that of Aboriginal knowledge traditions, where knowledge is often inherently practical. "Sharing what we know about living a good life" speaks to the fact that Aboriginal people have been doing and applying their own science for centuries: rich oral traditions, experiential knowledge, and cross-cultural sharing form the foundations of their KT tradition. This rich history provides a framework for researchers and policy-makers interested in Aboriginal health to learn from, and integrate into, their work.

The combination of a traditional KT in Aboriginal communities and a growing interest in KT among the Western scientific research community provides a unique opportunity to develop partnerships to use and apply knowledge to improve Aboriginal health and wellbeing. These partnerships are particularly important today, as large disparities in health status persist, accentuating the gap between Aboriginal and non-Aboriginal populations. KT approaches that are driven by Aboriginal community members and

² Excerpt from- Canadian Institute of Health Research (2009). Aboriginal Knowledge Translation: Understanding and respecting the distinct needs of Aboriginal communities in research. Accessed online at <http://www.cihr-irsc.gc.ca/e/41392.html>

³ Kaplan-Myrth, N. & Smylie, J (Eds). Sharing what we know about living a good life. Regina: Indigenous KT Summit Steering Committee.

⁴ Canadian Institutes of Health Research (2008). About Knowledge Translation. On the Knowledge Translation and Commercialization Branch Website.

their knowledge systems address the health status disparities⁵ more effectively than will imposing Western standards.

Canadian Institute of Health Research: Understanding the "K" of KT²

There are many different types and sources of knowledge that must be respected by the worlds of research and policy. Respect for a multiplicity of perspectives is built into many Aboriginal knowledge traditions. Increased recognition and understanding of the strength and time-tested traditions of Aboriginal knowledge systems is essential to creating greater respect for different ways of knowing and building strength and depth into Aboriginal health research and policy-making.

Understanding and building on the many sources of knowing is necessary to fill the large gaps in our knowledge about all Aboriginal health -status First Nation, non-status First Nation, Inuit, Métis, rural and remote Aboriginal, and urban Aboriginal health. Such knowledge must be carefully evaluated and analyzed. For instance, continuing to apply Western science-based evidence perspectives will only further marginalize Aboriginal ways of knowing and perpetuate Aboriginal/non-Aboriginal inequities. This is particularly the case for Aboriginal health interventions, which are complex both in terms of the intervention and the community context and are not easily evaluated by the standard RCTs. The multiplicity of knowledge sources, therefore, requires a multiplicity of evaluation approaches.

The translation of knowledge into action necessarily requires community input and support at the onset. The involvement of Aboriginal Peoples in all research (from primary data collection at a local level to regional and secondary data collection) and action (from policy-making to program development) is an ethical requirement. Engaging the community in KT also contributes to its effectiveness: it increases relevance, facilitates community support, increases community knowledge, builds capacity, and encourages sustainability.

What are the current issues affecting Canadian Aboriginal peoples?

The health needs First Nations, Inuit and Métis in Canada may be driven by specific health issues within those populations, such as anomalously high rates of infectious diseases, endemic rates of Type II diabetes, and catastrophic levels of substance abuse. Other needs may be driven by unique geographic locations, such as rural, or even extremely remote, locations. These geographic realities can make access to healthcare services difficult and require individuals to travel to receive acute care services and/or diagnostic testing.

Other issues may be related to the difficulties in providing consistent levels of health services to those populations, in both rural and remote locations, as well as in urban areas. The risk of adverse outcomes in health delivery can greatly increase with the number of co-morbidities, distance from diagnostic testing facilities, polypharmacy and number of interactions with the healthcare system. In addition, risk

⁵ Ermine, W. (2006). In Kaplan-Myrth, N. & Smylie, J. (Eds). Sharing what we know about living a good like. Regina: Indigenous KT Summit Steering Committee.

of harm may increase if the physician is unfamiliar with the patient's lifestyle and customs, or if communication is complicated by language barriers. These risk factors are apt to apply to Aboriginal peoples. The Human Development Index, which measures and compares quality of life between nations, has consistently ranked Canada as one of the top countries in the world. However, when this Index has been applied to Canada's Aboriginal populations, registered Aboriginals living on reserve ranked a disturbingly low 78th place, which is comparable to Peru (79th) or Brazil (80th)⁶. This large discrepancy highlights the many health inequalities persistent within Canadian society, and suggests the urgent need for further health policy development to tackle this complex issue.

Maternal and Child Health - There is a huge gap in life chances between Aboriginal and non-Aboriginal children in Canada based on their early experiences/development of adaptive coping skills, etc. Early and tailored interventions are keys to long-term health and support is required to ensure that Aboriginal communities/families have access to and capacity to benefit from effective programs. This includes, but is not limited to, educational services, screening counselling, and nutritional services. There have been successful Aboriginal head start programs which hold great promise for the future.

Chronic Disease Conditions - Diabetes rates among Aboriginal peoples in Canada are two-to-five-times higher than those experienced by non-Aboriginal Canadians⁷. This population tends to have more risk factors for diabetes, including elevated random plasma glucose (RPG), increased rates of obesity, and higher waist circumference⁸. In Alberta, the prevalence of diabetes mirrors Canadian disparities, with First Nations and non-First Nations diabetes rates being reported as 12% and 5%, respectively⁵.

Similarly, heart disease is 1.5 times higher within this population¹. While cardiovascular disease is declining in non-Aboriginal peoples, both acute myocardial infarctions and ischemic heart disease prevalence rates among Aboriginal peoples is continually increasing¹. Further, stroke rates among First Nations are almost twice as high as the comparable Canadian figure,⁶ and unsurprisingly hospitalization rates related to heart disease has more than doubled among First Nations peoples since 1997¹.

Environmental Health - Issues relating to environmental health remain another leading cause of disparities to Canadian Aboriginal peoples. A 2009 Health Canada Report discussing drinking water quality among Aboriginal communities indicated a significant increase in the number of drinking water advisories which were in effect between 2003 and 2007. In total 654 advisories were issued, with 162 of these advisories remaining in effect for longer than one year.⁹ Almost a quarter of on reserve households have water that is considered deficient in quality or quantity, and nearly one fifth of

⁶ Reading, J. (2010). The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy, *University of Victoria; Centre for Aboriginal Health Research*.

⁷ Oster, Richard T., Virani, Shainoor, Strong, David, Shade, Sandra & Toth, Ellen L. (2009). Diabetes care and health status of First Nations individuals with Type 2 diabetes in Alberta, *Canadian Family Physician*, 55: 386-93.

⁸ Toth, Oster RT. (2009). Differences in the prevalence of diabetes risk-factor among First Nation, Métis and non-Aboriginal adults attending screening clinics in rural Alberta, Canada, *Rural and Remote Health*, 9: 1-8.

⁹ Health Canada (2009). Drinking Water Advisories in First Nations Communities in Canada: A National Overview, Accessed April 28, 2010 at http://www.hc-sc.gc.ca/fniah-spina/pubs/promotion/_environ/2009_water-qualit-eau-canada/index-eng.php

households have deficient sewage effluent systems¹⁰. Housing contaminants are also a major concern for many Aboriginal communities. Mould prevalence is high on many reserve structures including homes, and this factor alone has been linked to several adverse health effects¹¹. Health Canada reports on-reserve homes experience more overcrowding and poorer housing conditions than do off-reserve, non-Aboriginal homes⁷.

Mental Health and Addictions - Of all the manifestations of ill health that are seen in Aboriginal peoples, the reality of substance abuse may illustrate most convincingly the need for a convergence of the four components of well-being—physical, emotional, spiritual and mental—in ensuring the health of a community and a person. Solutions lie not only in individual behaviour but also in the community and culturally-appropriate actions. There are systemic problems with addictive behaviours and chronic mental illness in the Aboriginal population. This is linked to a complex set of factors including societal discrimination of Aboriginal peoples, intergenerational trauma from treatment in residential schools, and sometimes acute trauma through family violence, as well as damage from disorders during pregnancy such as FAS and FASD. There is a high degree of suicide among Aboriginal youth and adults compared to the rest of the population.

Health Care Access - Almost half of the 700 Aboriginal communities in Canada are located in remote or isolated locations¹², which introduces significant challenges to health care access. In most of these communities first contact with the healthcare system is through a nurse or nurse practitioner. A 2006 survey conducted by Statistics Canada revealed that only 56% of Inuit adults had contact with a medical doctor during that year (compared with 79% in the general population), while 81% of Métis adults reported they had access to a family doctor¹³. There are also differences in Aboriginal population's coverage to specific therapeutic interventions and significant issues of non-compliance and non-adherence to care plans.

Looking to the future - The projections for Aboriginal health status are extremely disheartening. The extent of certain problems is at a crisis level which should not be tolerated in a society which prides itself on having "one of the best health systems in the world." There is evidence in many areas of what can be done to improve the situation. All that is needed is action.

¹⁰ Health Canada (2009). A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999 to 2003, Accessed April 29, 2010 at <http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/index-eng.php>

¹¹ Durbin, Anna. (2009). Canada's Response to the On-Reserve Housing Crisis: A Study of the Kelowna Accord, *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 7(2): 181-199.

¹² Maar, MA., Seymour, A., Sanderson, B. & Boesch, L. (2010). Reaching agreement for an Aboriginal e-health research agenda: the Aboriginal telehealth knowledge circle consensus method, *Rural and Remote Health*, 10: 1299-1313.

¹³ Statistics Canada (2006). Aboriginal peoples survey. Accessed on April 29th, 2010 from http://cansim2.statcan.gc.ca/cgi-win/cnsmcgi.pgm?Lang=E&SP_Action=Result&SP_ID=10003&SP_Par=10000&SP_TYP=50&SP_Sort=-0&SP_Portal=2

Appendices

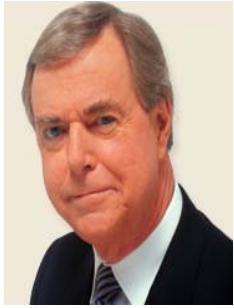
Appendix 1—Outline of Programs

Thursday, March 3rd, 2011, Program

The purpose of the March 3rd evening program was to engage with a broader community around cultural awareness of the Aboriginal community. This was facilitated by having a celebrated cultural figure, Giller Prize-winning author Joseph Boyden present some of his work and engage in discussion in a panel session with Aboriginal health experts. Mr. Boyden is Métis, the son of a non-Aboriginal physician father and an Aboriginal mother. Dr. Evan Adams is an Aboriginal physician, and Madeline Dion Stout, also Aboriginal, is a nurse and former Vice-Chair of the Mental Health Commission of Canada.

1630 – 1700	Registration
1700 – 1710	Blessing - Laura Commanda & Dr. Malcolm King
1710 – 1720	Welcome and Opening Remarks John Sproule, Senior Policy Director, Institute of Health Economics Dr. Malcolm King, Scientific Director, CIHR Institute of Aboriginal Peoples' Health; Professor, Department of Medicine, University of Alberta
1720 – 1805	Keynote address and reading Joseph Boyden, Giller Prize-Winning Author of <i>Through Black Spruce</i>
1805 – 1845	Panel presentation and audience discussion Moderator: Don Newman, Canada 2020 Dr. Madeline Dion Stout, President, Dion Stout Reflections Dr. Evan Adams, Aboriginal Health Physician Advisor, Office of the Provincial Health Officer, British Columbia Ministry of Health
1845 – 1930	Reception and Speakers' Dinner

Speakers: Thursday Forum



Don Newman, Journalist; Chair, Canada 2020

Don Newman, one of Canada's most respected journalists, is the Chairman of Canada 2020, a non partisan centre working to develop programs to further the political, social and economic well being of Canadians. He is Member of the Order of Canada, a life member of the Canadian Parliamentary Press Gallery, and has received numerous awards including a Gemini lifetime achievement award in public affairs broadcasting, the Hy Solomon Award for excellence in public policy journalism, and the Charles Lynch Award for outstanding coverage of national affairs. He is also on the Boards of Canada's National History Society and the Science Media Centre of Canada, the Canadian Committee of World Press Freedom and the Advisory Board of the Canadian International Council's Ottawa Foreign Policy Initiative; Chair of the Nominating Committee of the Canadian Broadcast Standards Council; Chair of the Jury for the 2010 Canadian Foreign Service Officer Awards; and has also served as a judge of Canada's National Newspaper and Charles Lynch Awards. He holds honorary degrees from Queen's and Winnipeg universities.



Dr. Evan Adams, Aboriginal Health Physician Advisor, British Columbia Ministry of Health

Dr. Evan Adams, Sliammon First Nation (Powell River, BC) completed his Medical Degree at the University of Calgary, his Aboriginal Family Practice residency at St Paul's Hospital at the University of British Columbia in Vancouver, and is currently the Director of the Division of Aboriginal People's Health with the Faculty of Medicine and the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer at the BC Ministry of Health Services in Victoria. He has a Masters of Public Health degree from Johns Hopkins Bloomberg School of Public Health in Baltimore, MD.



Joseph Boyden, Author

A Canadian of Irish, Scottish, and Métis heritage, Joseph Boyden has written a collection of stories, *Born with a Tooth*, and two novels, *Three Day Road*, and *Through Black Spruce*. *Through Black Spruce* won Canada's most prestigious literary prize, the ScotiaBank Giller Award, on November 11, 2008, as well as the Libris Book of the Year and Author of the Year awards. To date, *Through Black Spruce* has been published internationally in a dozen languages. He is a contributing writer for Canada's *Maclean's* and *Zoomer* magazines and has published and continues to publish fiction and nonfiction in a variety of places, including *Spirit Magazine*, *Black Warrior Review*, *Walrus*, *Driven*, and *Globe and Mail*.



Madeleine Dion Stout, President, Dion Stout Reflections

Madeleine Dion Stout, a Cree speaker, was born and raised on the Kehewin First Nation in Alberta. After graduating from the Edmonton General Hospital as a Registered Nurse, she earned a Bachelor's Degree in Nursing, with Distinction, from the University of Lethbridge and a Master's Degree in International Affairs from the Norman Paterson School of International Affairs at Carleton University. Ms. Dion Stout was President of the Aboriginal Nurses Association of Canada and member of the National Forum on Health. In August, 2007 she was appointed to the Mental Health Commission of Canada as an inaugural Vice-chair of the Board of Directors. She was a Professor in Canadian Studies and founding Director of the Centre for Aboriginal Education, Research and Culture at Carleton University. Now self-employed, she continues to work as a researcher, writer and lecturer on First Nations, Inuit and Métis health and health care and is increasingly adopting a Cree lens in this work. She has received the Assiniwikamik Award from the Aboriginal Nurses Association of Canada; a Distinguished Alumnus Award from the University of Lethbridge; and Honorary Doctor of Laws from the University of British Columbia and the University of Ottawa.

Friday, March 4th, 2011, Program

0700 – 0800	Registration and Continental Breakfast
0800 – 0840	Blessing - Elder Thomas Louittit Welcome and Opening Remarks John Sproule, Senior Policy Director, Institute of Health Economics Malcolm King, Scientific Director, CIHR Institute of Aboriginal Peoples' Health; Professor, Department of Medicine, University of Alberta
0840 – 0950	Setting the Stage: Cultural Context Judy Bartlett, Associate Professor, Department of Community Health Sciences, University of Manitoba Dawn Martin-Hill, Academic Director, Indigenous Studies Program, McMaster University
0950 – 1010	Refreshment Break
1010 – 1215	Knowledge Exchange Discussion: Presentation of Some Examples Kora de Beck, Knowledge Translation Coordinator, BC Centre for Excellence in HIV/AIDS Carol Hopkins, Executive Director, Native Addictions Partnership Foundation Margo Greenwood, Academic Lead, National Collaborating Centre for Aboriginal Health Frederic Wien, Nominated Principal Investigator, Atlantic Aboriginal Health Research Program, Dalhousie University Margaret Akan, Chief Executive Officer All Nation's Hope AIDS Network
1215 – 1315	Lunch
1315 – 1415	Moving Forward: Identification of Principles & Priorities for Aboriginal Wellness Knowledge Exchange Jacqueline Tetroe, Senior Advisor, Knowledge Translation, Canadian Institutes of Health Research Jeff Reading, Professor, University of Victoria John O'Neil, Professor and Dean, Faculty of Health Sciences, Simon Fraser University
1415 – 1615	Breakout Discussions & Reflection Back This time will identify some key actions/policy options and principles to support addressing the know-do gap in Aboriginal wellness research John Sproule, Senior Policy Director, Institute of Health Economics Malcolm King, Scientific Director, CIHR Institute of Aboriginal Peoples' Health; Professor, Department of Medicine, University of Alberta
1615 – 1630	Closing Comments

Speakers: Friday Roundtable



Margaret Poitras Akan, Chief Executive Officer, All Nations Hope AIDS Network

Margaret Akan has been in the position of leadership for 12 years. She is of Cree ancestry and is from Muskowekwan First Nation. She has dedicated her career to working in the community for over 20 years; she has been involved in the field of HIV/AIDS since 1988. Past achievements include: Keynote speaker at the 19th Annual Canadian Conference on HIV/AIDS Research May 2010, Past Founder of the Dream Catchers Girls Softball teams, Past Board Member of the Canadian Aboriginal AIDS Network representing Saskatchewan Region 2001 -2006, Co- Principal Applicant on ANHAN Gathering of Support Research Grant 2006-08, Recipient of Certificate of Honour from Art of Living Foundation in 2006, Speaker at the Harm Reduction 2008: International Harm Reduction Association's 19th International Conference in Barcelona Spain. She is currently the First Nation Co-Chair of the National Aboriginal Council on HIV/AIDS, a council to advise Health Canada on HIV/AIDS issues that affect all Canada's Aboriginal peoples. NACHA, developed and launched in May 2001 with the strong participation of Aboriginal people, reflects the needs of First Nations, Inuit and Métis. Margaret is currently involved with numerous committees, gatherings, conferences, and meetings to address HIV/AIDS and HCV among the Aboriginal peoples of Canada.



Dr. Judith Bartlett, Associate Professor, Department of Community Health Sciences, University of Manitoba; Associate Director (Programs) and Manager ACADRE Program

Judith G. Bartlett M.D., CCFP, MSc. is a Métis family physician with 17 years of clinical, administrative and research experience in Aboriginal health. She has an appointment as an Associate Professor and serves in the position of Associate Director, Programs and ACADRE Manager at the Centre for Aboriginal Health Research, Department of Community Health Science, University of Manitoba. Additionally, Dr. Bartlett is active in private consulting in developing holistic approaches and tools for health and wellness services, and is co-owner and CEO of JADE Enterprises Inc., an aerospace manufacturing company. She is active on boards and committees, the majority of which are related to the health and well-being of Aboriginal/ Indigenous peoples. Recent board roles include Chair, National Aboriginal Health Organization (2000-04); Chair, United Way of Winnipeg (2002-03); Advisory Board Member - Institute on Aboriginal Peoples Health (2001-05); Advisory Board Member - Canadian Health Network (2002-06); National Expert Committee Member - Inter-Professional Education for Collaborative Patient Centre Practice (2004-07)



Dr. Kora Debeck, Knowledge Translation (KT) Coordinator, BC Centre for Excellence in HIV/AIDS

Dr. Debeck is responsible for developing and implementing the Centre's KT dissemination strategy; identifying KT funding opportunities and aiding the development of funding proposals; managing and tracking KT activities and reporting and evaluating the impact of these activities.



Dr. Margo Greenwood, Academic Lead, National Collaborating Centre for Aboriginal Health

Dr. Margo Greenwood is an indigenous scholar of Cree ancestry with more than 20 years' experience in the field of early childhood education.

She is recognized regionally, provincially, nationally and internationally for her work on Aboriginal children. She has served with over 20 national and provincial federations, committees and assemblies, and has undertaken work with UNICEF, the United Nations, and the Canadian Reference Group to the World Health Organization Commission on Health Determinants. In recognition of her years of work to promote awareness and policy action on the rights and well-being of Aboriginal children, youth and families, Dr. Greenwood was the recipient of the Queen's Jubilee medal in 2002 and was recently awarded the Confederation of University Faculty Associations' Academic of the Year Award.

Currently, Dr. Greenwood is an Associate Professor in both the Education and First Nations Studies programs at the University of Northern British Columbia. Her current research interests include the structural impetus for the development and subsequent implementation of early childhood development programs and services in Canada and with the Kohanga reo in New Zealand; the social determinants of health with particular emphasis on colonialism and early childhood; and cross-cultural communication and children's transition from preschool to the formal education system. Her scholarship and research also includes issues pertaining to Indigenous ways of knowing and being, or Indigenous epistemologies and ontologies.



Carol Hopkins, Executive Director, National Native Addictions Partnership Foundation

Nozhem ("Mother Wolf"), of the Wolf Clan, is from the Delaware First Nation of Moraviantown, Ontario.

Carol Hopkins is the Executive Director of the National Native Addictions Partnership Foundation, an organization whose mandate is to support Canada's First Nations Addictions programs. She came to this position from Nimkee

NupiGawagan Healing Centre Inc., a youth solvent abuse treatment centre that is founded on Indigenous culture and life ways, where she was the founding Director since 1996.

Ms. Hopkins was the Co-Chair of the First Nations Addictions Advisory Panel whose mandate was to develop a renewal framework for the national Native Alcohol and Drug Abuse and the Youth Solvent Abuse programs. She now co-chairs the Leadership Team whose mandate is to implement the renewal framework. This process is a partnership between the Assembly of First Nations, National Native Addictions Partnership Foundation, and First Nations and Inuit Health Branch of Health Canada.

Ms. Hopkins, has taught for various post-secondary institutes, including Anishinabek Education Institute, Native Social Work program at Laurentian University and currently is also a Professor in the Social Work Program at Kings University College of the University of Western Ontario. She holds a Masters of Social Work Degree from the University of Toronto. Carol has received the Walter Dieter Award from the Assembly of First Nations in recognition of academic achievements made in the field of Social Work with First Nations.



**Malcolm King, Professor, Department of Medicine, University of Alberta;
Scientific Director, CIHR Institute of Aboriginal Peoples' Health**

Dr. Malcolm King is a health researcher at the University of Alberta and the founding Principal Investigator of the Alberta ACADRE Network, a training program for Aboriginal health research funded by the CIHR Institute of Aboriginal Peoples' Health since 2001. A member of the Mississaugas of the New Credit First Nation (Ontario), Dr. King obtained his doctorate in polymer chemistry from McGill University in 1973.

After an initial faculty appointment at McGill University, he moved to the University of Alberta in 1985, and was promoted to Professor in the Department of Medicine in 1990. In 2007, he was appointed Adjunct Professor in Public Health, where he co-leads the development of an indigenous public health research training program. In his career in pulmonary research, he has developed new approaches to treat mucus clearance dysfunction in cystic fibrosis and chronic obstructive lung disease, and is now working on addressing the issues in disease transmission by bio-aerosols. He served as Chair of the Faculty of Medicine and Dentistry Aboriginal Healthcare Careers Committee from 1993 to 2009; this training program has graduated more than 70 health professionals. Dr. King served as President of the Canadian Thoracic Society in 1999-2000, and from 2000-2004 was a member of the Governing Council of the Canadian Institutes of Health Research. Since January 2009, he has served as the Scientific Director of the CIHR Institute of Aboriginal Peoples' Health. He has been recognized for his achievements by the Alberta Lung Association (1999), the National Aboriginal Achievement Foundation (1999), and the University of Alberta Board of Governors (2003).



Dr. Dawn Martin-Hill, Academic Director, Indigenous Studies Program, McMaster University

Dr. Martin-Hill (Mohawk, Wolf Clan) holds a PhD in Cultural Anthropology and is one of the original founders of the Indigenous Studies Program at McMaster University.

Her research includes: Indigenous knowledge & cultural conservation, Indigenous women, traditional medicine and health and the contemporary practice of Indigenous traditionalism. She is a PI of a SSHRC grant for the Digitization of Ceremonies in the Hewitt collection and is Co-investigator of a CIHR-IAPH funded NEAHR grant (Network Environments in Aboriginal Health Research), the Indigenous Health Research Development Program.

She has contributed chapters to several books including 'Lubicon Women: a bundle of voices in the book,' In the Way of Development 1997 and "She No speaks" in the book Strong Women Stories and Indigenous women & Tradition in Women's & Religious Traditions Oxford, 2009. She has her own book titled, The Lubicon Lake Nation Indigenous knowledge and Power: 2007 University of Toronto Press. The book outlines the human and environmental impact of rapid development on the cultural survival of the Lubicon Cree. She is the Chair of the Indigenous Elders and Youth Council that promotes the protection and preservation of Indigenous Knowledge systems and is in partnership with the Amazon Conservation Team and the National Aboriginal Health Organization. She has produced three documentaries from a six day Elder's Summit that she organized that was attended by over 600 elders and youth from across the Americas. The first film is 'Jidwá: doh - Let's Become Again' 2005, a documentary focusing on Elders' understandings of historical trauma and directions to begin to heal collectively using Indigenous knowledge and traditional practices. The second is 'Onkwànistenhsera - Mothers of our Nations' 2006, which examines the need for Indigenous women to reclaim, restore and revitalize their traditional knowledge and the most recent "Sewatokwa'tshera't – The Dish with One Spoon" 2008, a film about the Haudenosaunee reclaiming of traditional lands.

Recently, Dawn partnered with Six Nations Polytechnic & McMaster University in developing the Ogwehoweh language diploma and is the Chair of Indigenous Knowledge Centre Steering Committee. Dawn is a single mother of four children and a grandmother of four. She resides at Six Nations of the Grand River.



Dr. John O'Neil, Professor and Dean, Faculty of Health Sciences, Simon Fraser University

Dr. John O'Neil is Professor and Dean in the Faculty of Health Sciences at Simon Fraser University. Previously, he was Director of the Manitoba First Nations Centre for Aboriginal Health Research and Professor and Head of the Department of Community Health Sciences in the University of Manitoba's faculty of medicine. He currently serves on the Board of Directors of the Michael Smith Foundation for Health Research, Science Advisory Board of Health Canada, the Advisory Board of the National Collaborating Centre on Aboriginal Health at the Public Health Agency of Canada. He was the

founding chair of the Advisory Board for the CIHR Institute for Aboriginal People's Health (2000 to 2006). He has also served as a consultant to the Bill and Melinda Gates Foundation and the World Bank on HIV/AIDS prevention projects in India and Afghanistan. Dr. O'Neil has a doctorate in medical anthropology from the University of California (San Francisco/Berkeley).



Dr. Jeff Reading, Professor, University of Victoria

Dr. Jeff Reading is Mohawk from the southern Ontario. He earned his PhD in Public Health Sciences in the Faculty of Medicine at the University of Toronto and was the inaugural Scientific Director (2000-2008) of the Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health (CIHR-IAPH). Presently, Dr. Reading is the Inaugural Director of the Centre for Aboriginal Health Research based at the University of Victoria where Jeff is Professor in the School of Public Health and Social Policy in the Faculty of Human and Social Development, and a faculty associate with the Indigenous Governance Program. He held the first endowed research chair at the department of Public Health Sciences at the University of Toronto, the Trans-Canada Pipelines Chair in Aboriginal Health and Well-being. His dedication to the pursuit of excellence in research is broadly recognized in academic and government circles and by Aboriginal leadership in Canada. In 2005, he was elected as a Fellow into the Canadian Academy of Health Sciences; this distinction is considered the highest honor for an individual in the health sciences. In March 2008, Dr. Reading was selected by Aboriginal peers to receive a National Aboriginal Achievement Award in the Health category. Each year, he is invited to numerous speaking engagements regionally, nationally and internationally to highlight the achievements and important research being done to improve Aboriginal peoples' health.



Ms. Jacqueline Tetroe, Senior Advisor Knowledge Translation, Canadian Institutes of Health Research

Jacqueline Tetroe has a Master's Degree in developmental psychology from the university of Western Ontario and studied cognitive and educational psychology at the Ontario Institute for Studies in Education. She currently works as a senior advisor in knowledge translation at the Canadian Institutes of Health Research. Her research interests focus on the process of knowledge translation and on strategies to increase the uptake and implementation of evidence-based practice as well as to increase the understanding of the barriers and facilitators that impact on successful implementation. She is a strong advocate of the use of conceptual models to both guide and interpret research.



Dr. Frederic Wien, Nominated Principal Investigator, Atlantic Aboriginal Health Research Program, Dalhousie University

Fred Wien has an Honours B.A. in Political Studies and Spanish from Queen's University (1962-66), and an M.A. and PhD. in Development Sociology, Government and Latin American Studies from Cornell University (1966-71).

Between 1992-96, Dr. Wien served as the Deputy Director of Research at the

Royal Commission on Aboriginal Peoples where he headed the research program on employment and economic development.

Upon his return to Dalhousie University in 1996, he continued as Professor in the School of Social Work, an appointment that changed to Adjunct Professor in June, 2009 and Professor Emeritus in July, 2010. He serves as the nominated principal applicant for the Atlantic Aboriginal Health Research Program (AAHRP), funded by CIHR/IAPH. He is the co-chair of the Steering Committee and chairs the Research Committee for the Atlantic Aboriginal Economic Development Integrated Research Program (AAEDIRP). This project is a partnership between the Atlantic Policy Congress of First Nation Chiefs and twelve of the region's universities.

At the national level, he has until recently chaired the Advisory Board for the Institute of Aboriginal Peoples Health (CIHR). He also chairs the "Make Poverty History" Expert Advisory Committee serving the Assembly of First Nations, which was successful in obtaining a major research grant from CIHR for the project: "A Poverty Reduction Approach to Improving the Health and Well-being of First Nation communities in Canada".

Appendix 2—Resource Guide

Useful Organizations/Websites

Aboriginal Healing Foundation: <http://www.ahf.ca>

Assembly of First Nations: <http://www.afn.ca>

Canadian Health Services Research Foundation (CHSRF): www.chsrf.ca

Canadian Institute for Health Information (CIHI): www.cihi.ca

Canadian Institute for Health Research (CIHR): www.cihr.ca

First Nations and Inuit Health: <http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php>

First Nations Health Council: <http://www.fnhc.ca/index.php/about/background>

Health Canada: <http://www.hc-sc.gc.ca/index-eng.php>

Health Council of Canada: <http://healthcouncilcanada.ca>

Institute of Aboriginal Peoples' Health (IAPH): <http://www.cihr-irsc.gc.ca/e/8668.html>

Inuit Tapiriit Kanatami: <http://www.itk.ca>

Indian and Northern Affairs: <http://www.ainc-inac.gc.ca/ai/mr/is/abhl-eng.asp>

Knowledge Translation Canada: <http://ktclearinghouse.ca/ktcanada/about/centres/toronto>

Métis National Council: <http://www.metisnation.ca>

National Aboriginal Health Organization (NAHO): <http://www.naho.ca/english>

National Collaborating Centre for Aboriginal Health (NCCAHA): <http://www.nccah-ccnsa.ca/en>

National Indian and Inuit Community Health Representatives Organization (NICHRO): www.niichro.com

Native Women's Association of Canada: <http://www.nwac.ca>

World Health Organization: Health of Indigenous Peoples:
<http://www.who.int/mediacentre/factsheets/fs326/en/index.html>

Useful Knowledge Exchange Review Reports/ Documents

Aboriginal Knowledge Translation: Understanding and Respecting the Distinct Needs of Aboriginal Communities in Research. (2009). Canadian Institute of Health Research
http://www.cihr-irsc.gc.ca/e/documents/Aboriginal_knowledge_translation_e.pdf

Aboriginal Peoples Survey: Inuit Health and Social Conditions, Supporting Data Tables. (2006). Statistics Canada
<http://www.statcan.gc.ca/pub/89-637-x/89-637-x2008002-eng.htm>

Broadening the Lens. (2003). Proceedings of a Roundtable on Aboriginal Peoples' Health
Canadian Institute for Health Information
http://secure.cihi.ca/cihiweb/en/downloads/CPHIBroadeningtheLens_e.pdf

CIHR Guidelines for Health Research Involving Aboriginal People (2010). Canadian Institute for Health Research
<http://www.cihr-irsc.gc.ca/e/29134.html>

Healthy Populations. (2009). Institute of Wellbeing/ Ronald Labonte, Nazeem Muhajarine, Brandace Winquist, Jacqueline Quail
http://www.ciw.ca/Libraries/Documents/HealthyPopulation_DomainReport.sflb.ashx

How are Canadians Really doing? A Closer Look at Select Groups. (2009). The Institute of Wellbeing
http://www.ciw.ca/Libraries/Documents/ACloserLookAtSelectGroups_FullReport.sflb.ashx

Highlights from the Report of the Royal Commission on Aboriginal Peoples. (2010). Indian and Northern Affairs Canada
<http://www.ainc-inac.gc.ca/ap/pubs/rpt/rpt-eng.asp>

Knowledge Translation Backgrounder [Draft]. (2009). Aboriginal Health Transition Fund
<http://www.horizonscda.ca/ahtf/ktbackground.pdf>

Knowledge Translation for Indigenous Communities: Policy Making Toolkit (2006). Indigenous KT Summit Steering Committee/ P. Gaye Hanson and Janet Smylie
http://www.iphrc.ca/Upload/KT_Policy_Toolkit_Sept26%5B1%5D.pdf

Mentally Healthy Communities: Aboriginal Perspectives. (2009). Canadian Institute for Health Information
http://secure.cihi.ca/cihiweb/products/mentally_healthy_communities_Aboriginal_perspectives_e.pdf

Ownership, Control, Access, and Possession (OCAP) or Self-Determination Applied to Research. (2004). National Aboriginal Health Organization/ Brian Schnarch
www.research.utoronto.ca/ethics/pdf/.../OCAP%20principles.pdf

Pathways to Health and Healing. (2009). Office of the Provincial Health Officer, British Columbia
<http://www.hls.gov.bc.ca/pho/pdf/abohlth11-var7.pdf>

Proceedings of the Roundtable on the Health of Urban Aboriginal People. (2003). Canadian Institute for Health Information

http://secure.cihi.ca/cihiweb/en/downloads/UrbanAboriginalProceedings_e.pdf

Research that Benefits Native People: A Guide for Tribal Leaders (2005). Foundations of Research: An Indigenous Perspective

http://www.ncaiprc.org/files/10-5-09_PRC_Module_1.pdf

The Health Indicators Project (2009). Report from the Third Consensus Conference on Health Indicators; Canadian Institute for Health Information

http://secure.cihi.ca/cihiweb/products/82-230-XWE_e.PDF

Toward Recovery and Wellbeing. (2009). Mental Health Commission

http://www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf