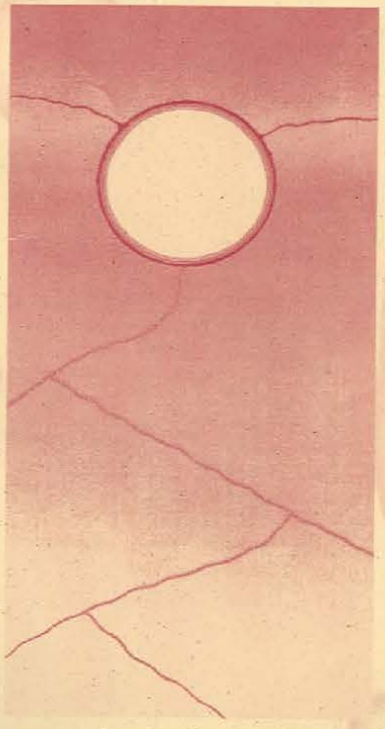
New Directions



Aboriginal Health Policy for Ontario

Ministry of Health
Ontario

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Message from the Minister

I am pleased to present the first Aboriginal Health Policy for Ontario. This is a milestone for our province, the beginning of a new relationship between Aboriginal people and the health care system.

The policy is a turning point. It allows for health care designed, developed and delivered by Aboriginal people. This is in keeping with their goal of self-determination and self-government.

The policy also presents a challenge. Government and non-Aboriginal and Aboriginal people and groups will all have to work together on these new directions. We'll need to re-evaluate our assumptions and take risks in developing new relationships. And we'll need to trust, co-operate and be willing to listen to each other to help this succeed.

This policy is part of our government's Aboriginal Healing and Wellness Strategy and the result of nearly three years of work and collaboration. More than 7,000 Aboriginal people were involved in more than 250 communities. I offer my special thanks to the many dedicated people who contributed to this important work.

I am deeply committed to the new directions in Aboriginal health. And I believe this policy sets us on the course to better access to health care, better standards of care and culturally appropriate services for Ontario's Aboriginal people. Success – and improved health – need strong alliances.

Ruth Grier
MINISTER OF HEALTH

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CHIEFS OF ONTARIO

A MESSAGE FROM THE ONTARIO REGIONAL CHIEF

GREETINGS!

On behalf of the First Nations in the Province of Ontario, we congratulate the efforts of the Ontario Ministry of Health, First Nation and Aboriginal organizations in the development of the Aboriginal Health Policy. This document represents the culmination of three years' dedicated effort.

The First Nation communities and leadership look forward in anticipation to the implementation of the Policy and program directives which will provide for a new relationship with the health care system in Ontario. This relationship will provide for a greater understanding and respect of our traditional, customary and holistic approaches to health care, as well as facilitate health care delivery to be designed and controlled by our First Nation people.

In recent years there have been great strides and achievements made by our First Nation communities in addressing the critical health and social care needs of our people. We have seen our communities struggle and strive for funding and resources to provide urgently needed health care services which would address prevention, treatment and support services that are culturally appropriate, accessible and delivered by and for our First Nations people. The dedication we have witnessed in our communities can now be enhanced and supported through the policy directives established within the Aboriginal Health Policy.

Throughout the development of this important document, there have been many people involved who truly wish to improve the health of the First Nation and Aboriginal peoples and their efforts are to be acknowledged and commended. There is much work yet ahead and we extend our hands in that journey toward a healthy future for our children.

Gordon B. Peters
Ontario Regional Chief

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MESSAGE FROM THE PRESIDENT OF THE

ONTARIO FEDERATION OF INDIAN FRIENDSHIP CENTRES

Atikokan Native Friendship Centre
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Cochrane, Ontario
Dryden Native Friendship Centre
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United Native Friendship Centre
Fort Frances, Ontario
Thunderbird Friendship Centre
Geraldton, Ontario
Hamilton Regional Indian Centre
Kapuskasing Friendship Centre
Ne'Chee Friendship Centre
Kenora, Ontario
Katarokwi Friendship Centre
Kingston, Ontario
N'Amerind Friendship Centre
London, Ontario
Georgian Bay Native Friendship Centre
Midland, Ontario
Moosonee Native Friendship Centre
North Bay Indian Friendship Centre
Odawa Native Friendship Centre
Ottawa, Ontario
Parry Sound Friendship Centre
Sault Ste. Marie Friendship Centre
Nishnawbe-Gamik Friendship Centre
Sioux Lookout, Ontario
N'Swakamok Friendship Centre
Sudbury, Ontario
Thunder Bay Indian Friendship Centre
Timmins Native Friendship Centre
Council Fire Native Cultural Centre
Toronto, Ontario
CanAm Indian Friendship Centre of Windsor

On behalf of the Ontario Federation of Indian Friendship Centres and those communities the Federation consulted with respect to Aboriginal health, we commend the Ontario Ministry of Health and First Nation and Aboriginal organizations for developing the Aboriginal Health Policy. We recognize the efforts of three years of commitment to working together to create a document we can all be proud of.

The Federation anticipates a continued partnership in implementing the policy and the program and service initiatives identified in the document. We believe these initiatives will, undoubtedly, improve the quality of health experienced by Aboriginal people accessing Aboriginal health service delivery agencies and the mainstream health care system. Friendship Centres appreciate having been equal partners in developing the Aboriginal Health Policy and look forward to maintaining current and creating new relationships with the health care system. Health in Aboriginal communities has been a great concern for all Aboriginal leaders regardless of constituency over the past many years. This policy initiative provides hope for improved health for Aboriginal people regardless of residency and a renewed commitment to maintain good relationships with the Province of Ontario.

Again, on behalf of the 25 member centres of the Ontario Federation of Indian Friendship Centres I extend our appreciation. We certainly recognize the enormity of the tasks ahead in implementing the policy and the initiatives it brings; however, Friendship Centres are no strangers to hard work and commitment to improving the lives of Aboriginal people and communities. In 1995, we will be celebrating 25 years of a commitment to improving the quality of life of urban Aboriginal people in Ontario. We look forward to another 25 years and more, and to maintaining an open and respectful relationship with the Province of Ontario.

Respectfully,

Vera Pawis-Tabobondung
President

2 ABORIGINAL HEALTH POLICY FOR ONTARIO

New Directions: Aboriginal Health Policy for Ontario Executive Summary

Introduction

The Aboriginal Health Policy will provide the First Nation/Aboriginal communities and Ministry of Health with broad direction and guidelines for Aboriginal involvement in planning, design, implementation and evaluation of programs and services directed at Aboriginal communities.

It will assist the Ministry of Health to address access inequities in First Nation/Aboriginal health programming, respond to Aboriginal priorities, adjust existing programs to respond more effectively to needs, support the reallocation of resources to Aboriginal initiatives, and improve interaction and collaboration between ministry branches to support wholistic approaches to health.

For the First Nation/Aboriginal community, the policy is a vehicle by which barriers to Aboriginal participation in regional and local health planning structures can be addressed and Aboriginal priorities in health care planning and delivery can be communicated to the ministry.

Vision Statement

The Vision Statement originates from extensive consultations with Aboriginal people and communities:

Aboriginal health is wholistic and includes the physical, mental, emotional, spiritual and cultural aspects of life. Through this understanding of self, a vision of wellness which balances body, mind and spirit is promoted throughout the healing continuum.

Committed partnerships of First Nation/Aboriginal and non-Aboriginal people and governments will recognize and respect the diversities in lifestyles and traditions of Aboriginal people regardless of residency and status.

The goal of the Aboriginal Health Policy is to improve the health of Aboriginal individuals, families, communities and nations through equitable access to health care, First Nation/Aboriginal health care facilities, improved standards of care, the provision of culturally appropriate health services, and promotion of a healthy environment. Self-determination in health will be 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.

Principles

1. Nothing in this policy suggests either directly or by implication the consent of the First Nation or Aboriginal communities to any amendment in the meaning and intent of their original treaties or Aboriginal rights or to any measure that would constrain or prevent the full implementation of their treaties or Aboriginal rights.

2. A wholistic approach, through all developmental stages of life, will guide Aboriginal health programs and services.

3. First Nation/Aboriginal people and communities have diverse needs pertaining to their cultures, traditional ways, languages, lifestyles, geographic locations and status. Flexible policies, programs and services are required to respect and address Aboriginal diversity.

4. Traditional Aboriginal approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system.

5. Addressing Aboriginal health determinants in a wholistic manner will require co-ordination and collaboration between First Nation/Aboriginal communities and government ministries.

6. First Nation/Aboriginal people must have control of health planning and resource management processes pertaining to Aboriginal polices, programs and services.

7. To realize the goal of improving Aboriginal health, effective co-ordination of all health services is required.

8. Access to and effectiveness of programs and services delivered off reserve will be increased when First Nation/Aboriginal people are involved in planning, consultation, delivery and evaluation.

9. Equitable access to provincial health services must be assured for all Aboriginal people, regardless of residency.

10. An Aboriginal person's choice of services will be acknowledged and respected.

11. First Nation/Aboriginal communities' control of health needs assessment, planning, design, development and delivery of community-based health programs and services is essential to improving Aboriginal health. Aboriginal people will define and negotiate the level of their participation in the governance of health programs and services available to and accessed by their communities.

12. Accountability processes require assessment of program effectiveness and financial expenditures with annual reports to Aboriginal people and governments.

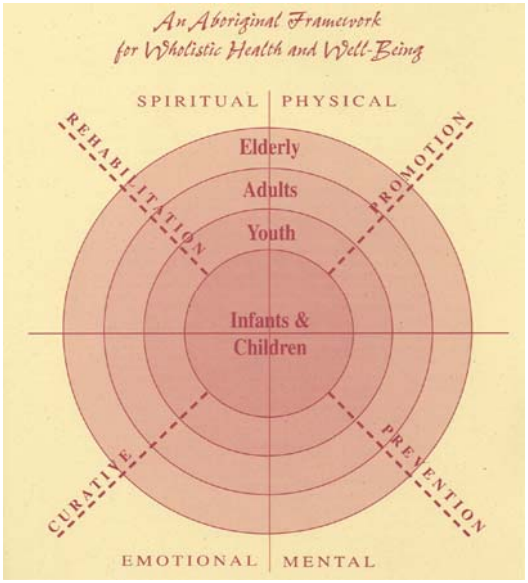
13. The interrelationship between the environment and individuals, families and communities, as well as protection of the environment, is essential to the survival of all Aboriginal people.

14. Aboriginal people are distinct and not part of a multicultural mosaic.

15. The Aboriginal communities and Ontario will continue their collaborative relationship through a First Nation/Aboriginal communities' process which will include joint and regular review and evaluation of the Aboriginal Health Policy to ensure it continues to meet the needs of all Aboriginal communities.

An Aboriginal Framework for Wholistic Health and Well-Being

The Aboriginal Health Policy is guided by a conceptual framework for understanding Aboriginal health and for facilitating the changes required to improve Aboriginal health. The framework incorporates three interrelated concepts: the life cycle, wholistic health, and continuum of care. These are described briefly here.



The life cycle explains life through the passage of stages including infancy and childhood, youth, adulthood and senior years. These stages of life are celebrated and correspond to the four directions, seasons and gifts such as kindness, honesty, caring and strength within Aboriginal culture, and the four elements of the environment: water, air, mineral and fire. The life cycle incorporates all members of the community at different phases in their lives. Each person has a gift to bring and a role to play in the community as explained in the teachings below. In a healthy community each member is able to share his or her gifts and assume responsibilities.

From preconception, the Aboriginal life cycle reflects the interrelationship and interdependency of individuals, families and communities and their responsibilities to each other. People have different and evolving needs throughout the life cycle which must be addressed through appropriate health policies and programs.

Wholistic health incorporates the physical, mental, emotional and spiritual needs of the individual, family and community.

The continuum of care, or healing continuum, incorporates health promotion, prevention, treatment and curative programs and services, and rehabilitation.

These three complementary concepts, life cycle, wholistic health and the healing continuum, are interrelated. Health is addressed throughout the life cycle of an individual, in a wholistic way, within a continuum of care. This forms a multidimensional matrix for Aboriginal health. The illustration provides a pictorial interpretation of these descriptions as well as the relationship between the concepts.

The Strategic Directions: Overview

Thirteen major issues were identified during the First Nation/Aboriginal communities' consultations and later grouped into three strategic directions. The first direction is health status, which includes issues related to health promotion and wellness, mental health and addiction, disease and illness prevention, long-term care and disability. The second direction is access to services, which includes languages and communications, patient advocacy, transportation, health facilities, training, co-ordination of services and traditional healing. The third direction is planning and representation, which includes health planning processes, representation and public appointments.

Each strategic direction consists of an issue statement, a description of the barriers identified by Aboriginal people, and proposed approaches to addressing the issue. A series of recommendations categorized by program service, policy, legislative and resource requirements is contained in the full report.

Strategic Direction 1: Health Status

Loss of identity, language, self-esteem and nurturing ways are some of the multiple, multigenerational losses, which have contributed to erosion of Aboriginal self-reliance and collective responsibility for health. These losses are results of assimilation policies and practices, removal of children through residential schools and adoptions, and implementation of the Indian Act.

It is also acknowledged that inequities in education, employment, incarceration, housing and infrastructure have had a negative impact on Aboriginal health.

Barriers

- poor community health
- lack of co-operation and co-ordination among First Nation/Aboriginal communities and providers
- inequity of funding of health programs between communities
- overemphasis on treatment as opposed to wellness

Approaches

Community Health
Healing and wellness will be guided by Aboriginal beliefs, values, customs, languages and traditions which complement current and future health systems. These values and beliefs must be respected and accepted in the design, development and delivery of health promotion, prevention and treatment programs and services for Aboriginal people.

For health empowerment to occur, individuals, families and communities must possess information and have the ability to influence choices and make decisions that support wellness. A healthy lifestyle may help prevent or reduce complications of diabetes, heart disease, some forms of cancer, alcoholism, fetal alcohol syndrome, acquired immune deficiency syndrome, hypertension and other conditions.

Health empowerment includes enabling individuals, families and communities to understand all the factors which affect health and to recognize personal responsibility. Strategies might address physical health and lifestyle as well as the mental, emotional and spiritual aspects of health.

Flexibility is required in order to support Aboriginal approaches to community health. The family unit is the pivotal point in the delivery of community health programs and services.

Co-operation and Co-ordination
Health care providers include healers, medicine people, elders, midwives, community health workers, community support systems, external health and other agencies. Removal of system barriers and rigid role definitions will improve the ability of these providers to work together to support the healing of First Nation/Aboriginal individuals, families and communities.

To promote physical, mental, emotional and spiritual healing and wellness, all providers need to recognize, redirect and accept their roles and responsibilities within a "healing network". The healing network cannot function without cross-cultural respect, equality, partnership, interdependent practices and linkages.

Aboriginal people who are recognized, respected and accepted by their communities, and by health providers, are valuable members of the health team with a role in planning, design, development and delivery of health programs and services.

Equity
Equitable funding is required to support First Nation/Aboriginal communities' health programs and services, and will address community location, size, Aboriginal status, need, the establishment of community infrastructure, opportunities for education and economic development and other factors.

Emphasis on Treatment
Shifting the emphasis from treatment of ill-health to prevention will require promotion, education and an increased self-reliance regarding the appropriate use of health services.

Strategic Direction 2: Access to Services

The existing health system has legislative, policy, administrative and program barriers that restrict the effective delivery of culturally appropriate programs and services to Aboriginal

people. A comprehensive identification of barriers, and their removal, will improve Aboriginal access to health programs, services and decision-making structures. Health care services for Aboriginal people must be planned, designed and developed by Aboriginal people and be available in locations identified by First Nation/Aboriginal communities.

Barriers

- inadequate transportation services for health care
- inadequate and inappropriate facilities
- language, communication and culture
- lack of client advocacy, processes and supports
- lack of recruitment, retention and professional development of health care workers
- lack of recognition and acceptance of traditional healing

Approaches

Transportation
The provincial government's medical transportation program must be reviewed. This assessment should result in recommendations for equitable access to, and availability of, transportation services for all Aboriginal people.

Supportive Facilities
This policy supports community-based initiatives such as hostels, hospices and community health centres and the provision of appropriate funding.

Language, Communication and Cultural Barriers
Cross-cultural training and awareness programs are required for all health care workers within, and providing services to, the First Nation/Aboriginal community.

Funding and training are required for translation services, cultural interpreters and appropriate communications materials.

Client Advocacy
Service providers and clients require education and information regarding client rights. Advocacy services need to be recognized, identified and developed where necessary.

Recruitment, Retention and Professional Development of Health Care Workers
There is a crucial need to establish a strategy and programs aimed at recruitment, training and retention of Aboriginal health care workers.

Increased consultation and professional development opportunities for health care providers in First Nation/Aboriginal communities are required to enhance their effectiveness.

Traditional Healers and Midwives
Support is required for First Nation/Aboriginal communities' efforts to promote and encourage traditional Aboriginal teachings of wholistic health.

Health care providers require training and education to increase awareness and sensitivity towards traditional healers and midwives in the health care system.

Co-ordination is required between the First Nation/Aboriginal and non-Aboriginal communities to facilitate access to, and work with, traditional healers and midwives.

Strategic Direction 3: Planning and Representation

First Nation/Aboriginal communities lack participation, resource support, influence over decision-making and involvement in health planning processes. As a result, programs and services are not appropriate for Aboriginal people.

Barriers

District Health Councils (DHCs) are mandated to plan health services on a regional basis and make recommendations to the Ministry of Health. The ability of DHCs to respond effectively to the needs of the First Nation/Aboriginal community is restricted by:

- lack of recognition of Aboriginal priorities due to a relatively small target population;
- cultural biases and attitudes, as well as a lack of respect for, and understanding and acceptance of, the Aboriginal culture by the non-Aboriginal community, resulting in lack of consideration and frequent rejection of Aboriginal proposals;
- lack of respect, understanding and acceptance of First Nation/Aboriginal community consultation, communication, representation, decision-making and accountability processes;
- lack of awareness of programs, services and resources available in the First Nation/Aboriginal community;
- lack of access to and participation in health governance structures.

It is acknowledged that hospitals and other health service agencies plan activities at local and regional levels. In these processes Aboriginal people experience similar barriers to those described earlier.

Approaches

Planning Authorities
First Nation/Aboriginal-defined planning processes, with appropriate resources, are necessary. These processes will involve the design, development and delivery of strategies which will facilitate the achievement of a First Nation/Aboriginal community health vision.

The First Nation/Aboriginal communities will develop structure and roles with respect to planning, co-ordinating and funding. These processes must be recognized by government as the proper structure for planning and allocating resources to address Aboriginal health needs.

Representation
Aboriginal people must have a role in governance of health programs and service agencies and institutions. Until First Nation/Aboriginal processes are created, Aboriginal people must have a role in existing health planning bodies.

Government Relations

In terms of Aboriginal health, there has never been a process for dialogue regarding governments' roles and responsibilities. Lack of clarity has caused significant confusion, gaps in programs and services, and concern for funding responsibilities.

Barriers

- federal government off-loading and capping of program funding
- failure of federal and provincial governments to co-ordinate programs
- federal focus on status Indians who reside on reserve
- need for protection of federal programming
- narrow interpretations by the federal government of policy and program guidelines
- funding inconsistencies across and within ministries
- issues related to federal inmates

Recommendations

A process is required which will lead to clarification of the roles and responsibilities of the federal, provincial and Aboriginal governments.

The process to clarify governments' roles and responsibilities cannot be used to hold up the implementation of provincial initiatives aimed at improving First Nation/Aboriginal communities' health.

Formal processes are required through which commitments of the federal government will be sought to continue to fund First Nation/Aboriginal communities' health programs at current or enriched levels.

The Ministry of Health will support First Nation/Aboriginal communities in advocating with the federal government for fulfilment of federal responsibilities.

Inconsistencies across and within provincial ministries with respect to funding programs and services on reserve that are not cost-sharable with the federal government must be resolved.

The First Nation/Aboriginal communities and the Ministry of Health will mutually pursue a process to explore the co-ordination of federal and provincial funding to support implementation of the Aboriginal health policy and achievement of its vision.

Conclusion

Aboriginal people have experienced 500 years of colonization and the health effects of ethno-cultural stress. A long-term commitment, over many generations, by the Government of Ontario and First Nation/Aboriginal communities is required to restore health and well-being within the Aboriginal population.

Introduction

Aboriginal people have experienced 500 years of colonization and the effects of ethno-cultural stress on health status. A long-term commitment, over many generations, by the government of Ontario and First Nation/Aboriginal communities is required to restore health and well-being to the Aboriginal population.

Prior to the province's 1985 corporate native affairs policy framework, Ministry of Health involvement in Aboriginal-specific programming was minimal.

The 1985 document signalled a new level of provincial support for Aboriginal programs and services and opened discussions related to self-government. It enhanced access to provincial program funding both on and off reserve and recognized the need for Aboriginal involvement in the planning, design and implementation of programs and services delivered in First Nation/Aboriginal communities. In 1990, the province gave priority to improving the quality of life in First Nation/Aboriginal communities as part of the government's Aboriginal reform agenda. In August 1991 Ontario signed the *Statement of Political Relationship* with First Nations. The statement recognizes the inherent right of self-government for First Nations and commits the province to further negotiations to articulate that right.

Substantial changes in the relationship between the First Nation/Aboriginal communities and the province have recently become apparent. For the ministry, changes in Aboriginal policy have resulted in greater interaction with the First Nation/Aboriginal communities. There has been a significant increase in the number of requests from the communities for Ministry of Health involvement, support and funding for Aboriginal health initiatives, both on and off reserve. In fiscal 1992/93, ministry expenditures for Aboriginal people exceeded $103 million. Of this amount, $69 million came under the Ontario Health Insurance Plan or hospital costs expended for status Indians living on reserve. The balance of Aboriginal Health programming includes community mental health, community health, emergency health services, health promotion, home support services on reserve and the nursing home program.

Despite the increased ministry involvement with Aboriginal health programming, statistics related to the health status of Aboriginal people reveal significantly higher rates of morbidity and mortality than the general population. The ministry recognizes the need to address the significant health status inequities that exist between Aboriginal and non-Aboriginal communities. For a summary of the Aboriginal Health Policy development process see Appendix A.

The Aboriginal Health Policy will provide the First Nation/Aboriginal community and the Ministry of Health with broad direction and guidelines for Aboriginal involvement in planning, design, implementation and evaluation of programs and services directed at the First Nation/Aboriginal communities. It will not replace the need for specific dialogue or consultation on various programs. However, it will promote a common understanding of Aboriginal expectations, priorities and perspectives related to health planning and program design activities.

The Aboriginal Health Policy will assist the Ministry of Health to address access inequities in First Nation/Aboriginal communities' health programming, respond to Aboriginal priorities, adjust existing programs to respond more effectively to needs, support the reallocation of resources to Aboriginal initiatives, and improve collaboration between ministry branches to support wholistic approaches to health.

For the First Nation/Aboriginal communities, the Aboriginal Health Policy is a vehicle through which barriers to Aboriginal participation in regional and local health planning structures can be addressed and Aboriginal priorities in health care planning and delivery can be communicated to the ministry. The policy supports recognition and respect throughout the ministry for the unique status of First Nation/Aboriginal people and their decision-making processes and timetables, and raises the profile of Aboriginal issues in the ministry.

By implementing the policy, the ministry will continue to promote recognition of the wholistic approach to health and help to promote common understanding of First Nation/Aboriginal consultation processes and expectations. As well, the policy supports the identification, securing and protection of resources for First Nation/Aboriginal planning structures and processes, ensures the involvement of First Nation/Aboriginal organizations in planning, and recognizes the need for intergovernmental and interministerial processes to address health determinant issues.

Vision Statement

The vision statement originates from extensive consultations with Aboriginal people and communities:

Aboriginal health is wholistic and includes the physical, mental, emotional, spiritual and cultural aspects of life. Through this understanding of self, a vision of wellness which balances body, mind and spirit is promoted throughout the healing continuum.

Committed partnerships of First Nation/ Aboriginal communities and non-Aboriginal people and governments will recognize and respect the diversities in lifestyles and traditions of Aboriginal people regardless of residency and status.

The goal of the Aboriginal Health Policy is to improve the health of Aboriginal individuals, families, communities and nations through equitable access to health care, First Nation/ Aboriginal health care facilities, improved standards of care, provision of culturally appropriate health services, and promotion of a healthy environment. Self-determination in health will be 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.

Principles

1. Nothing in this policy suggest either directly or by implication the consent of the First Nations or Aboriginal communities to any amendment in the meaning and intent of their original treaties or Aboriginal rights or to any measure that would constrain or prevent the full implementation of their treaties or Aboriginal rights.

2. A wholistic approach, through all developmental stages of life, will guide Aboriginal health programs and services.

3. First Nation/Aboriginal people and communities have diverse needs pertaining to their cultures, traditional ways, languages, lifestyles, geographic locations and status. Flexible policies, programs and services are required to respect and address Aboriginal diversity.

4. Traditional Aboriginal approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system.

5. Addressing Aboriginal health determinants in a wholistic manner will require co-ordination and collaboration between First Nation/Aboriginal communities and government ministries.

6. First Nation/Aboriginal people must have control of health planning and resource management processes pertaining to Aboriginal policies, programs and services.

7. To realize the goal of improving Aboriginal health, effective co-ordination of all health services is required.

8. Access to and effectiveness of programs and services delivered off reserve will be increased when First Nation/Aboriginal people are involved in planning, consultation, delivery and evaluation.

9. Equitable access to provincial health services must be assured for all Aboriginal people, regardless of residency.

10. An Aboriginal person's choice of services will be acknowledged and respected.

11. First Nation/Aboriginal communities' control of health needs assessment, planning, design, development and delivery of community-based health programs and services is essential to improving Aboriginal health. Aboriginal people will define and negotiate the level of their participation in the governance of health programs and services available to and accessed by their communities.

12. Accountability processes require assessment of program effectiveness and financial expenditures with annual reports to Aboriginal people and governments.

13. The interrelationship between the environment and individuals, families and communities, as well as protection of the environment, is essential to the survival of all Aboriginal people.

14. Aboriginal people are distinct and not part of a multicultural mosaic.

15. The Aboriginal communities and Ontario will continue their collaborative relationship through a First Nation/Aboriginal communities' process which will include joint and regular review and evaluation of the Aboriginal Health Policy to ensure it continues to meet the needs of all Aboriginal communities.

An Aboriginal Framework for Wholistic Health and Well-Being

The Aboriginal Health Policy is guided by a conceptual framework for understanding Aboriginal health and for facilitating the changes required to improve Aboriginal health. The framework shown on page 16 incorporates three interrelated concepts: the life cycle, wholistic health and continuum of care.

Life Cycle

The life cycle explains life through the passage of stages, including infancy and childhood, youth, adulthood and senior years. These stages of life are celebrated and correspond to the four directions, seasons and gifts such as kindness, honesty, caring and strength within Aboriginal culture, and the four elements of the environment: water, air, mineral and fire.

The life cycle incorporates all members of the community, all at different phases in their lives. Each person has a gift to bring and a role to play in the community, as explained in the teachings below. In a healthy community each member is able to share his or her gifts and assume responsibilities.

Infants and children bring joy, love, curiosity and sharing to their families. This is a time for bonding, learning and nurturing during the child's formative years. The eastern direction represents peace and light and celebrating infants and children, in the same way as the new day or a new season is welcomed.

Youth and young adults bring activity and enthusiasm for life in the preparation for maturity. This is a time of choice among many paths in the search for meaning and understanding. The southern direction represents growth.

Adults bring love, hope, caring, sharing and teaching. They have responsibility to provide for children, themselves and their extended families to live a good life. As role models they make clear the vision for the future generations. The western direction represents introspection or looking into one's spirit.

Elders bring wisdom, love and spiritual understanding in their roles as healers, counsellors, guides and keepers of the Aboriginal teachings and ceremonies. The northern direction represents spiritual strength, purity and wisdom.

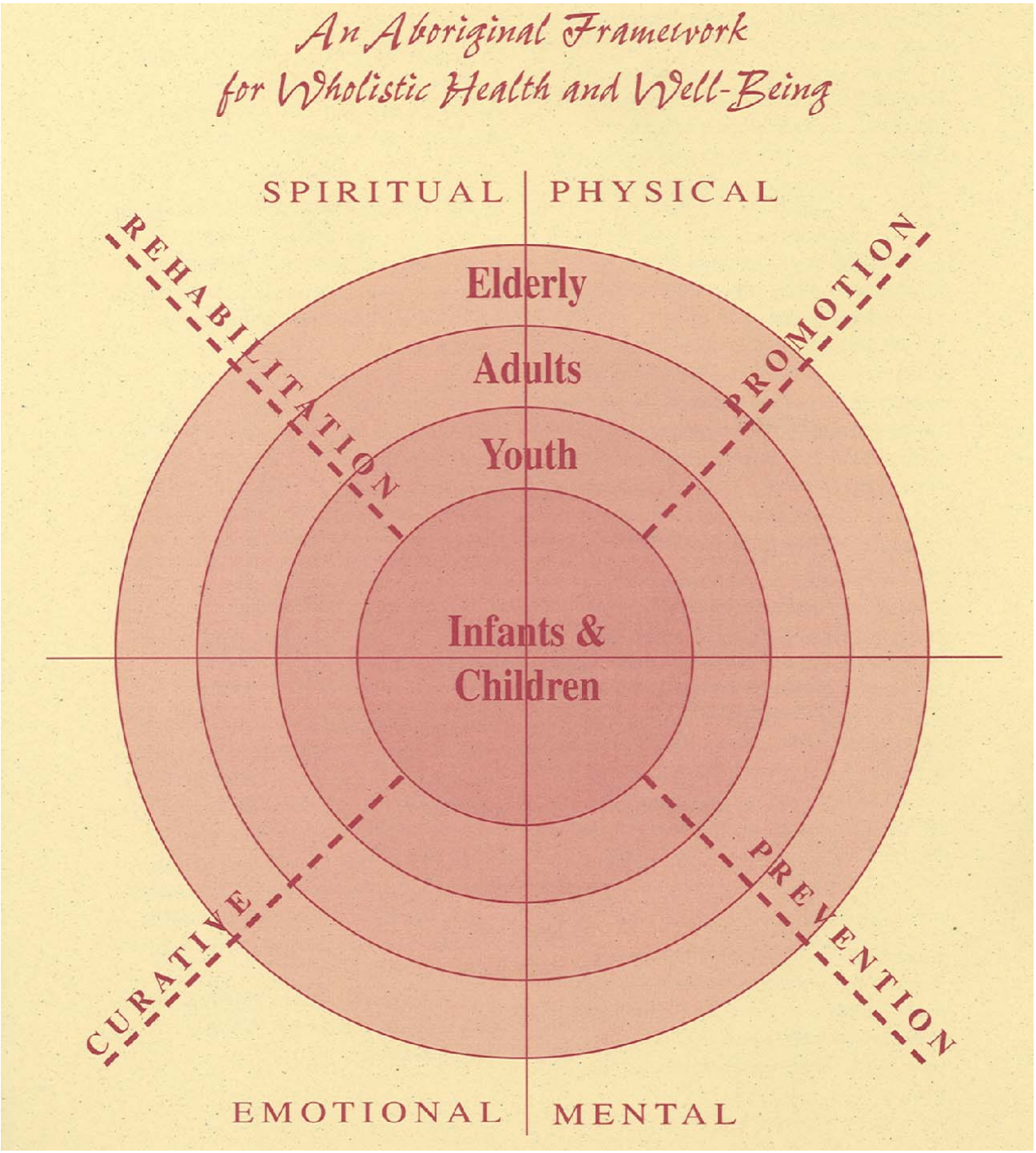
From pre-conception, the Aboriginal life cycle reflects the interrelationship and interdependency of individuals, families and communities and their responsibilities to each other. First Nation/Aboriginal peoples have different and evolving needs throughout the life cycle, which must be addressed through appropriate health policies and programs.

Wholistic Health

Wholistic health incorporates the physical, mental, emotional and spiritual needs of the individual, family and community.

Continuum of Care

The continuum of care, or healing continuum, incorporates health promotion, prevention, treatment/curative programs and services, and rehabilitation.



Promotion encourages individuals, families and communities to enjoy a healthy and balanced life. It includes sharing health information, increasing awareness of health and determinants of health, and building social networks to support self-determination and self-reliance.

Prevention activities address one or a group of health conditions experienced by individuals, families and communities. These activities include health education, screening and immunization, risk reduction (such as weight management programs), counselling and crisis intervention.

Treatment or curative services are active interventions to address specific health conditions. Included are diagnosing, treating and curing a person experiencing ill health.

Rehabilitation activities assist individuals, families and communities to become fully functional and/ or to maintain the highest level of wellness. They include after-care, supportive care and ongoing monitoring after the initial condition has been identified and treated.

Interrelationship of the Three

These three complementary concepts – life cycle, wholistic health and the healing continuum – are inter-related. Health is addressed throughout the life cycle of an individual, in a wholistic way, within a continuum of care. This forms a multi-dimensional matrix for Aboriginal health. The illustration provides a pictorial interpretation of the descriptions above, as well as the relationship between the concepts.

The following four examples from the matrix illustrate how the framework can be used to understand Aboriginal health issues and implement wholistic approaches to health:

a) *Children, mental health, promotion*
The health workers in a southern First Nation are concerned that some new mothers are having difficulty coping. A parenting program is developed to support mothers' efforts to promote and foster the mental health of their children through enhancement of parenting skills.

b) *Youth, emotional health, curative*
The young people attending secondary school in an urban area approach the local Friendship Centre to assist them in establishing a treatment program for students who have contemplated or attempted suicide.

c) *Adults, physical health, prevention*
The men of a Métis settlement have become aware of the risks of eating fish, which may contain environmental contaminants. They approach the public health nurse to assess their families' level of risk and to provide information about safe levels of fish consumption.

d) *Elderly, spiritual health, rehabilitation*
A number of elders in a northern First Nation have chronic health conditions and have become depressed about their inability to contribute to community life. Community workers meet with the group and discover that they would like to share their traditional skills with the young people. Not only would this provide the elderly with a higher level of activity but the

program would also enable them to share their traditional skills and knowledge, thus helping them and the youth to feel worthwhile.

These examples illustrate the flexibility required to respond to Aboriginal health needs from a wholistic perspective. Depending upon the needs and priorities within each community, different approaches will be required to support Aboriginal people in achieving wellness. If at any point a First Nation/Aboriginal community proposes an initiative for wholistic health that is as described in the framework but cannot be accommodated within existing program guidelines, the barriers must be removed.

A glossary is provided as a reference for words which have particular meanings for First Nation/Aboriginal peoples.

Strategic Directions: Overview

Thirteen major issues were identified during the First Nation/Aboriginal community consultations and later grouped into three strategic directions (see Appendix B)

The first direction is health status, which includes issues related to health promotion and wellness, mental health and addiction, disease and illness prevention, long-term care and disability. The second direction is access to services, which includes languages and communications, patient advocacy, transportation, health facilities, training, co-ordination of services, and traditional healing. The third direction is planning and representation, which includes health planning processes, representation and public appointments.

Other issues, such as government relations, have been addressed separately in the policy. Each strategic direction contains an issue statement, a description of the barriers identified by Aboriginal people, proposed approaches to addressing the issue, and a series of recommendations categorized by programs and services, policy, legislative and resource requirements.

The recommendations address some of the most significant gaps and common needs of the First Nation/Aboriginal communities within Ontario as identified through the community consultations. They must not be construed as the only supports required to improve health and well-being. The development of detailed strategies on long-term care, mental health and addictions are proposed.

The health status strategic direction focuses on community health and the supports required to achieve individual, family and community health, while the access to health services strategic direction focuses on health services utilized by Aboriginal people. For First Nation people who live on reserve, these services tend to be located in urban areas. The Aboriginal health framework described earlier has specific application to these two strategic directions.

Strategic Direction 1: Health Status

Issues

Loss of Aboriginal identity, language, self-esteem and nurturing ways are some of the multiple, multi-generational losses which have contributed to erosion of Aboriginal self-reliance and collective responsibility for health. These losses are results of assimilation policies and practices, removal of children through residential schools and adoptions, and implementation of the *Indian Act*.

It is also acknowledged that inequities in education, employment, incarceration, housing and infrastructure have had a negative impact on Aboriginal health.

Barriers

1. Community Health

Within many First Nation/Aboriginal communities, physical, mental, emotional and spiritual health are imbalanced, resulting in overall poor health. In some instances, entire families and communities are in crisis and are unable to independently take the initial steps towards healing and wellness.

While some agencies have attempted to meet Aboriginal needs, reliance on these programs and services has undermined First Nation/Aboriginal communities' self-determination and disempowered Aboriginal people.

2. Co-operation and Co-ordination

System barriers, rigid role definitions, different funders and funding arrangements currently limit the ability of providers to work together, resulting in inappropriate, ineffective, costly and uncoordinated programs and services.

Lack of co-operation, cross-cultural partnerships and accountability to and within First Nation/Aboriginal communities also hinder the achievement of optimum health.

Existing financial, human, and information resources available to and within First Nation/Aboriginal communities are inadequate and demonstrate a lack of sensitivity and respect for Aboriginal values, languages, beliefs and traditions.

3. Equity

The provision, availability and funding of health programs and services by governments are inconsistent between communities and throughout Ontario.

4. Emphasis on Treatment

Governments focus on, and disproportionately fund, the treatment of physical aspects of ill health.

Doctors and hospitals have significant power and influence in the health care system. Their approach to health emphasizes the treatment and care of physical health.

Most Aboriginal people, like other Ontario residents, have come to rely on the health care system.

Approaches

1. Community Health

Healing and wellness will be guided by Aboriginal beliefs, values, customs, languages and traditions that complement those of the current and future health systems. These values and beliefs must be respected and accepted in the design, development and delivery of health promotion, prevention and treatment programs and services for Aboriginal people.

For health empowerment to occur, individuals, families and communities must possess information and have the ability to influence choices and make decisions that support wellness. A healthy lifestyle may help prevent or reduce complications of diabetes, heart disease, some forms of cancer, alcoholism, fetal alcohol syndrome, fetal alcohol effects, human immuno-deficiency virus, acquired immune deficiency syndrome, hypertension and other conditions.

Health empowerment includes enabling individuals, families and communities to understand all the factors which affect health and to recognize personal responsibility. Most Aboriginal health promotion efforts have focused on issues of physical health and lifestyle. Other strategies might address the mental, emotional and spiritual aspects of health. Acknowledging the autonomy of each community, these strategies may include, but not be limited to, developing recreation, literacy, adult education and training programs and encouraging community members to share their knowledge, skills and abilities.

Flexibility is required in order to support Aboriginal approaches to community health (e.g. talking circles, informal gatherings). The family is the pivotal point in the delivery of community health programs and services.

Government resources are required to support the efforts of First Nation/Aboriginal communities to achieve optimal health.

With respect to the severe needs, additional money will be required for Aboriginal-controlled programs and services which facilitate wholistic and preventive approaches.

Resources are required to enable communities to evaluate the effectiveness of programs and services.

The interrelationship between the environment and individuals, families and communities is essential to the healing and survival of all First Nation/Aboriginal communities.

2. Co-operation and Co-ordination

In addition to those providers represented in Ontario's *Regulated Health Professions Act*, First Nation/Aboriginal communities recognize the following as health care providers: healers, medicine people, elders, midwives, community health workers, community support systems, and

external health and other agencies. Removal of system barriers and rigid role definitions will improve the ability of health care providers to work together to support the healing of First Nation/Aboriginal individuals, families and communities.

To promote physical, mental, emotional and spiritual healing and wellness, all providers need to recognize, redirect and accept their roles and responsibilities within a "healing network". The healing network cannot function without cross-cultural respect, equality, partnership, interdependent practices and linkages.

There is a responsibility on governments to remove barriers and to support the efforts of communities and providers to work co-operatively.

Aboriginal people who are recognized, respected and accepted by their communities, and by health providers, are valuable members of the health team with a role in planning, design, development and delivery of health programs and services.

Increased access to Aboriginal-specific information and financial and human resources for programs and services is required.

Effective co-ordination of Aboriginal and non – Aboriginal programs and services is required to reduce overlap, address gaps, ensure continuity of care, and provide appropriate case management.

3. Equity

Equitable funding is required to support First Nation/Aboriginal communities' health programs and services and will address community location, size, Aboriginal status, need and other factors.

Governments' support for the establishment of community infrastructure such as housing, clean water and sanitation, and opportunities for education and economic development, is essential in the development of healthy First Nation/Aboriginal communities.

4. Emphasis on Treatment

Shifting the emphasis from treatment of ill-health to prevention will require promotion, education and increased self-reliance regarding the appropriate use of health services.

Community-based programs and services which focus on promotion, education and awareness of wholistic health are required.

Program Recommendations

The Ministry of Health will provide resources for the following community-based programs and services, but will not be limited to the following items:

Promotion

- promotion and education regarding the healing network among individuals, families, communities and providers to support the use of traditional teaching, counselling and approaches to health;

- flexible health promotion programs determined by the community – examples may include transferring information and facilitating skill development within the community,

understanding factors that affect health, the appropriate use of the health care system, personal responsibility for healthy lifestyles, and promoting the sharing of community members' knowledge, skills and abilities;

- programs which focus on nutrition, healthy lifestyles, family planning, well babies, immunization, dental health, hygiene, accident prevention, first aid, child health assessment, positive parenting and family healing, prevention of unplanned pregnancies, poor mental health, sexual abuse, suicide, addictions, sexually transmitted diseases, human immunodeficiency virus, acquired immune deficiency syndrome, accidents, injuries and violence, infections, diabetes and other chronic illnesses;

- implementation of effective pre- and post-natal programs, including the promotion of breast-feeding, designed by Aboriginal people and which incorporate Aboriginal teachings with respect to birthing.

Prevention

- expansion of programs and services which focus on preventive care for the elderly and disabled to enable them to remain in their homes or community environment for as long as possible (such as the provision of homemakers, foot care and assistive devices);

- expansion of the ministry's community health centre program to meet the health needs of Aboriginal people living in urban and rural areas as well as First Nation/Aboriginal communities – this health program model offers the opportunity to address health promotion, prevention and primary care in a wholistic and culturally appropriate manner.

  i. Analysis of existing hospitalization patterns and Aboriginal demographics supports the need for a minimum of 16 Aboriginal health access service centres throughout the province. These programs, through specified geographic responsibility areas, will provide a minimum level of coverage including a combination of advocacy, medical interpretation, co-ordination of traditional healers, cross-cultural awareness and primary care.

  ii. Priority and final locations of centres, within specific geographic areas, will be determined by the First Nation/Aboriginal communities during the implementation process. Existing programs and services will be reviewed to determine the most serious gaps. This initiative will not abrogate or derogate the right of First Nations/Aboriginal communities to negotiate for the development, enrichment and enhancement of other community health services.

  iii. Administration of these centres will be determined by local communities and provide services to Aboriginal people, regardless of status, accessing the health care system. Options for administration could include community boards, tribal councils, friendship centres, or other arrangements as determined by the First Nation/Aboriginal community.

Treatment/Curative

- community-based detoxification and addiction treatment programs and centres for individuals and families – Aboriginal people seeking treatment should have a choice of traditional Aboriginal or non-traditional program approaches;

- specialized child, youth, adult and elderly mental health and addictions programs, services and facilities for identification, intervention, and counselling – specific needs include emotional, physical and sexual abuse treatment for victims and abusers, spiritual healing, depression counselling and suicide intervention programs, all utilizing Aboriginal traditional or culturally appropriate non-traditional approaches to healing;

- development and implementation of employee assistance programs and other forms of counselling to address work-related stresses and maximize the effectiveness of providers.

Rehabilitation

- after-care programs and services, including support groups or healing circles, to maximize the success of individuals and families who have sought addiction or mental health treatment, ensuring a continuum of care;

- home care, home support, homemakers, home nursing, transportation, social support and other rehabilitation programs, services and facilities for recuperating, elderly and disabled persons, to achieve and maintain wellness.

Community Support Recommendations

In collaboration with appropriate ministries, the Ministry of Health will support implementation of:

- programs such as housing, life skills training, literacy, adult education, child care, vocational counselling and training, and employment to maintain wellness;

- fitness recreation and leisure programs for individuals of all ages, families and communities, including equipment, supplies and facilities;

- environmental protection programs to sustain healthy individuals, families and communities as required – such programs involve water quality testing, rabies, testing for toxicity in foods and plants, waste disposal and recycling, and monitoring environmental contaminants which affect health and reproduction (such as carcinogens or PCBs. Aboriginal organizations, the Ministry of Health and other provincial ministries will consider the development of an Aboriginal environment policy and appropriate programming.

Equity

Equitable distribution of programs throughout the province of Ontario is required:

- to support development of infrastructure for all smaller First Nation/Aboriginal communities;

- to recognize existing and emerging access to services and resources in some areas;

- to recognize the lack of culturally appropriate services and resources in other areas;

- to recognize the burden of increased costs of programming, delivery of services and travel in remote communities;

- to recognize that demographics have an effect on the cost of delivery of services; and

vi) to support co-ordination between communities and Nation rebuilding.
(These criteria were accepted by the Ontario Chiefs through Resolution 94/10 at the Special Chiefs' Assembly held March 30, 1994.)

Policy Recommendations

The Ministry of Health Supports:

- recognition of the role of First Nation/Aboriginal communities in governance, including administration, development of role definition and job description, recruitment, and selection and evaluation of personnel and programs. Incorporation should not be required as a prerequisite for the receipt of financial resources by a single community;

- support of First Nation/Aboriginal communities' efforts to require all providers within a healing network to co-operate and to demonstrate sensitivity and respect for Aboriginal values, beliefs and traditions;

- implementation of flexible program criteria and funding guidelines;

- remuneration and travel costs for traditional healers and midwives from within and outside Ontario;

- community control over program delivery, including the authority to redefine programs to address changing needs (for instance from an individual treatment program model to family treatment);

- birth options for Aboriginal women, including home birth, birth assisted by a traditional Aboriginal or licensed midwife, birthing centres or hospitals and the option to incorporate traditional practices in the birth process;
- development and implementation of policies to support programs to assist parents/caregivers with children or elderly dependents who seek addiction treatment or are accessing other health services or require respite support;

- implementation of a wholistic healing network and wholistic approaches to health. Specifically, program funding must be co-ordinated so that divisions between branches, ministries and governments do not fragment community-based services;

- development and implementation of a comprehensive, wholistic, and culturally appropriate strategy for the delivery of community-based mental health and addictions policies, programs and services for First Nation/Aboriginal communities, families, youth and children;

- development and implementation of a comprehensive, wholistic and culturally appropriate strategy for the delivery of community-based long-term care and support policies, programs and services, including palliative care, for First Nation/Aboriginal communities, families, youth and children;

- additional strategies may be required to address particular community health needs, such as those related to human immunodeficiency virus and acquired immune deficiency syndrome, diabetes and other diseases and conditions;

- First Nation/Aboriginal-specific allocations within all new community health initiatives and annual grant programs to address inequitable health status.

The Ministry of Health supports the following non-community-based policy recommendations (insofar as they do not impede the ability of First Nations to exercise their jurisdiction under s.81 of the *Indian Act*):

- development of protocols between governments to address reporting requirements and jurisdictional issues in the area of public health (communicable disease control, environmental/occupational health and safety, emergency response planning and so on);

- development of protocols between public health units and First Nation /Aboriginal communities to facilitate access to public health unit programs to supplement and complement existing First Nation/Aboriginal health programs and services;

- development of protocols between First Nation/Aboriginal communities and other health programs and services accessed by their members regarding continuity of care, follow-up for patients, co-ordination of information, and referrals;

- initiation and co-ordination of a government review involving First Nation/Aboriginal communities, the Ministry of Health and other ministries to review, consider and co-ordinate government-wide programs and services and policy initiatives which affect the health status of individuals, families and communities. First Nation/Aboriginal communities will have access to the information produced.

Human Resource Recommendations

The Ministry of Health supports:

- development and implementation of a comprehensive and culturally appropriate strategy for the development of Aboriginal health human resources, including health professionals, administrators and community health workers. This will include the development of recommendations for recruitment, promotion, incentive and Aboriginal grants for service programs which address the inequitable distribution of providers and meet the needs of rural and remote First Nation/Aboriginal communities for health professionals;

- the use of health professionals, community health workers, health administrators and related support staff, community development workers, health educators, homemakers and home support workers, translators, interpreters, advocates and midwives as determined by First Nation/Aboriginal communities;

- culturally appropriate training and professional development for First Nation/Aboriginal health workers in the areas of child and adult mental health, suicide prevention, addictions, abuses, counselling, health education and promotion, various home supports, midwifery and advocacy;

- provision of funding for Aboriginal policy analysts to support Aboriginal ownership and involvement in the implementation of recommendations within the Aboriginal Health Policy.

Information Recommendations

The Ministry of Health supports:

- informing First Nation/Aboriginal communities of program availability and eligibility criteria and providing sufficient time for the submission of proposals;

- informing First Nation/Aboriginal communities and agencies of financial resources to support the development and promotion of culturally appropriate health resource materials, including translation into Aboriginal languages and syllabics;

- providing information to First Nation/Aboriginal communities pertaining to expenditures for Aboriginal health, including analysis and identification by First Nation/Aboriginal governments of options for allocating funding to Aboriginal-controlled programs and services;

- developing and establishing a central clearinghouse(s) to increase access to information on programs and services, patient advocacy, available human and financial resources and Aboriginal-specific health education materials. The purpose of the clearinghouse(s) is to facilitate and promote sharing of information, improve co-ordination, reduce duplication and empower Aboriginal communities in their efforts to achieve wellness.

Strategic Direction 2: Access to Services

Issues

The existing health system has legislative, policy, administrative and program barriers that restrict the effective delivery of culturally appropriate programs and services to Aboriginal people. A comprehensive identification of barriers, and their removal, will improve Aboriginal access to health programs, services and structures. Health care services for Aboriginal people must be planned, designed and developed by Aboriginal people and be available in locations identified by First Nation/Aboriginal communities.

Priority issues include the need for wholistic and comprehensive health services as determined by First Nation/Aboriginal communities, transportation, translation services, the retention, recruitment and training of health care workers, traditional healers and midwives, client advocacy, and supportive facilities (hostels, hospices, health centres and hospitals). First Nation/Aboriginal people will define the provision of services by health care providers in their communities.

Barriers

1. Transportation

Aboriginal people do not have adequate service and information about eligibility for provincial transportation programs. There is no provision for advance funding.

Factors such as residency, Aboriginal status, income level and availability of transport all influence access to transportation services for health care.

Funding levels for escort and compassionate travel are inadequate or unavailable, dependent on Aboriginal status and residency.

2. Supportive Facilities

There is limited infrastructure to support health service delivery within First Nation/Aboriginal communities.

There are insufficient hostels and hospices available to provide support for Aboriginal patients and their families requiring health services away from their communities.

Currently no designated capital or operational funding is available for the development of hostels and hospices or the provision of culturally appropriate programs and services in these facilities.

3. Language, Communication and Cultural Barriers

There is limited access to interpreter/translation services for members of the First Nation/Aboriginal community. Hospitals and agencies do not have (or have not allocated) funds to hire interpreters or to translate written material into Aboriginal languages and syllabics.

The First Nation/Aboriginal community lacks sufficient numbers of culturally sensitive professional and para-professional health care workers to fulfil the wholistic requirements of Aboriginal health care delivery.

4. Client Advocacy

Historical patterns of paternalism have weakened opportunities for community and individual self-advocacy. This situation is exacerbated by language, literacy and other communication barriers.

There is a lack of knowledge of clients' rights, a lack of opportunities for client empowerment and a lack of Aboriginal people to provide client advocacy services.

5. Recruitment, Retention and Professional Development of Health Care Workers

There are insufficient human and program resources and training opportunities to meet the health needs of First Nation/Aboriginal communities

Many First Nations experience a high turnover of health care providers. Factors which contribute to this situation include lack of training opportunities, social, geographic and professional isolation, application of inappropriate standards of care, extended scope of practice, excessive workload and cross-cultural barriers.

6. Traditional Healers and Midwives

Owing to the limited number of traditional healers and midwives, there are access, availability and co-ordination issues.

Traditional health care providers are not recognized, respected or accepted in the health care system or by some First Nation /Aboriginal communities.

Traditional healers and midwives lack support to work in other First Nation/Aboriginal communities.

Approaches

1. Transportation

The provincial government's medical transportation program must be reviewed. This reassessment should result in recommendations for equitable access to, and availability of, transportation services for all Aboriginal people.

2. Supportive Facilities

This policy supports community-based initiatives such as hostels, hospices and community health centres and the provision of appropriate funding.

3. Language, Communication and Cultural Barriers

Cross-cultural training and awareness programs are required for all health care workers within, and providing services to, the First Nation/Aboriginal community.

Funding and training are required for translation services, cultural interpreters and appropriate communications materials.

4. Client Advocacy

Service providers and clients require education and information regarding client rights.

Advocacy services need to be recognized, identified and developed where necessary. Funding and training are required for community-based First Nation/Aboriginal client advocates with fluency in Aboriginal languages.

5. Recruitment, Retention and Professional Development of Health Care Workers

There is a crucial need to establish a strategy and programs aimed at recruitment, training and retention of Aboriginal health care workers.

A redirection of health care from institutions to the communities is required to support culturally appropriate health care. This will result in increased employment opportunities at the community level.

Increased consultation and professional development opportunities for health care providers in First Nation/ Aboriginal communities are required to enhance their effectiveness.

6. Traditional Healers and Midwives

Support for First Nation/Aboriginal communities' efforts to promote and encourage traditional Aboriginal teachings of wholistic health is required.

Health care providers require training and education to increase awareness and sensitivity towards traditional healers and midwives in the health care system.

Co-ordination is required between the First Nation/Aboriginal communities and non-Aboriginal communities to facilitate access to, and work with, traditional healers and midwives within the health care system.

Program Recommendations

The Ministry will:

- provide First Nation/Aboriginal communities with information on existing and available health programs and services, particularly transportation services;

- provide comprehensive transportation services for health travel for Aboriginal people who are ineligible for federal non-insured benefits;

- provide transportation services for compassionate travel for all Aboriginal people;

- support specialized health training opportunities for Aboriginal interpreters and translators;

- provide increased access to Aboriginal interpreters, translators and escorts who speak the appropriate Aboriginal dialect or language;

- support and provide for further development of programs that provide visitation and interaction services for Aboriginal people in health facilities;

- support and provide for patient advocacy services designed, developed and delivered by First Nation/Aboriginal communities to document and respond to Aboriginal concerns regarding treatment, diagnosis, access to second opinions, complaints to regulatory bodies, referrals to specialists, eligibility for services and like matters;

- direct public health units that provide services to First Nations/Aboriginal communities to offer culturally appropriate programs and services designed by, or with the involvement of, Aboriginal people. These programs must involve Aboriginal resource people and materials;

- work with the Ministry of the Solicitor General and Correctional Services to provide Aboriginal inmates with culturally appropriate health programs and services and ensure that Aboriginal people are involved in the design of these programs;

- support and provide for the development of community-based programs for Aboriginal health workers, especially in areas of mental health, suicide prevention, addictions, abuse, counselling, health promotion and prevention;

- provide programs to assist Aboriginal people in securing the services of traditional healers and midwives;

- provide for the development of culturally appropriate programs and services for Aboriginal patients and their families staying in hostels, hospices and boarding facilities or accessing community health centres;

- provide for the participation of Aboriginal people in community program evaluation processes to ensure the effectiveness of these programs for Aboriginal people.

Policy Recommendations

The Ministry of Health, in conjunction with First Nation/Aboriginal communities, will:

- translate or provide for translation of health information and materials into Aboriginal languages and syllabics where Aboriginal numbers and requests warrant;

- provide trained and qualified medical interpreters and translators to improve and advocate quality of care for Aboriginal people within health institutions and agencies;

- support the development and implementation of wholistic approaches to health, including after-care and client follow-up, by all health programs and services;

- guarantee prompt, accessible and well co-ordinated emergency air transportation for First Nation/Aboriginal communities;

- develop policies which encourage and influence doctors, specialists, nurses, and other health professionals to serve in First Nation/Aboriginal communities, particularly in northern and isolated locations, through incentives, salary options and other creative and appropriate mechanisms;

- support Aboriginal participation and involvement in role definition, recruitment and selection of health workers who serve First Nation/Aboriginal communities;

- support compensation for traditional Aboriginal healers and midwives, as determined by First Nation/Aboriginal communities, recognizing the equitable value of their service to other health professionals;

- facilitate, support and promote Aboriginal contracts and licences for the provision of ambulance services in First Nation/Aboriginal communities;

- exempt from existing non-smoking policies the traditional use of tobacco, sage, cedar and sweetgrass in health facilities, excluding areas where oxygen therapy is necessary;

- support recognition, facilitation and inclusion of traditional healers and traditional teachings in health programs and services;

- support changes to out-of-country and out-of-province insured services policies which will facilitate access to culturally appropriate treatment for Aboriginal people when such programs and services are unavailable or non-existent in Ontario or are closer to an Aboriginal person's place of residence (First Nation/Aboriginal communities and the Ministry of Health will determine jointly which facilities to recognize and an approval process for the purposes of this policy);

- advocate with the Ministry of the Solicitor General and Correctional Services to implement policies which support provision of and access to traditional medicine and healing in correctional facilities;

- respect Aboriginal patients' preference for traditional foods provided by family members or significant others;

- work with local health facilities, local providers, and the ministries of Natural Resources and Agriculture, Food and Rural Affairs to develop and implement arrangements for access to and preparation of traditional foods, including game, within facilities where Aboriginal people access services;

- work with local providers, professional associations and regulated colleges to promote, support, develop and implement cross-cultural awareness and sensitivity programs for health professionals which focus on Aboriginal culture, traditional medicine and healing, thereby improving the quality of health care;

- support the development of a patient rights advocacy policy and strategy for Aboriginal people which includes rights to information regarding diagnosis and treatment, programs and services, and complaint and appeal processes;

- support and promote the development of a healing network to implement more effective case management and improved continuity of care between community-based and non-community-based program and service providers.

Legislation Recommendations

The Ministry of Health will introduce legislative amendments to:

- exempt from existing non-smoking policies the traditional use of burnt offerings such as, but not limited to, tobacco, sweetgrass, sage and cedar in health and other facilities;

- facilitate the use and preparation of traditional foods, including game, within health facilities;

- facilitate access to and payment for culturally appropriate treatment programs and services located out of country and out of province for Aboriginal people; and

- other acts which would assist the implementation of the Aboriginal Health Policy.

The Ministry of Health will:

- in conjunction with First Nation/Aboriginal communities and the federal government, review other health legislation to determine the need for further amendments;

- in conjunction with First Nation/Aboriginal organizations, consider the introduction of an Aboriginal Health Act to provide a legislative basis for the Aboriginal Health Policy which would augment existing authorities and responsibility for First Nation/Aboriginal communities.

Resources Recommendations

The Ministry of Health will provide:

- immediate and ongoing funding to enable First Nation/Aboriginal communities to develop and translate audio-visual and written health information and materials into Aboriginal languages and syllabics;

- First Nation/Aboriginal communities with designated capital and operational funding for the development of hostels, hospices, boarding facilities and community health centres;

- opportunities to enable First Nation/Aboriginal communities to develop special initiatives to recruit and retain health professionals;

- funding for incentives to improve the retention and increase the numbers of doctors, nurses and other health professionals in northern and isolated First nation/Aboriginal communities;

- funding for working partnerships between First Nation/Aboriginal communities and educational institutes to develop and incorporate cultural awareness and sensitivity modules into accredited professional training programs;

- funding for First Nation/Aboriginal communities' health programs, including compensation for traditional healers and midwives;

- funding for First Nation/Aboriginal communities to develop and provide advocacy services for Aboriginal people;

- funding to enable First Nation/Aboriginal communities to develop and provide cultural awareness and sensitivity training for health professionals;

- funding for transportation services for Aboriginal people who are ineligible for non-insured benefits;

- funding for transportation services for compassionate travel for all Aboriginal people.

Strategic Direction 3: Planning and Representation

Issues

First Nation/Aboriginal communities lack participation, resource support, influence over decision-making and involvement in health planning processes. As a result, programs and services are not appropriate for Aboriginal people.

Barriers

District Health Councils (DHCs) are mandated to plan health services on a regional basis and make recommendations to the Ministry of Health. The ability of DHCs to respond effectively to the needs of the First Nation/Aboriginal community was restricted by these factors:

- use of Aboriginal demographic and health status data to justify district needs which may not directly benefit the First Nation/Aboriginal community;
- lack of recognition of Aboriginal priorities due to a relatively small target population;
- cultural biases and attitudes, as well as a lack of respect for, understanding and acceptance of the Aboriginal cultural by the non-Aboriginal community, resulting in lack of consideration and frequent rejection of Aboriginal proposals;
- lack of respect, and understanding and acceptance of First Nation/Aboriginal community consultation, communication, representation, decision-making and accountability processes;
- lack of awareness of programs, services, and resources available in the First Nation/Aboriginal community;
- lack of training and education for board members, inhibiting full participation of Aboriginal people;
- program guidelines and criteria developed by the Ministry of Health and/or adapted by DHCs during calls for proposals which have been used to disqualify innovative Aboriginal proposals;
- the absence of Aboriginal-specific calls for proposals, resulting in competition between Aboriginal and non-Aboriginal submissions;
- lack of clarity of federal, provincial and municipal roles and responsibilities in health.

It is acknowledged that hospitals and other health service agencies also undertake planning activities at local and regional levels. In these processes, Aboriginal people experience similar barriers to those described above.

Without access to and participation in health governance structures, Aboriginal people have not been able to influence decisions related to health. In the limited instances where Aboriginal people have been invited to participate, they are frequently the only Aboriginal representative on the planning body. This results in the perception, and often the effect, that they are token members with a marginal role.

Approaches

1. Planning Authorities

First Nation/Aboriginal communities' defined planning processes, with appropriate resources, are necessary. These processes will involve the design, development and delivery of strategies which will facilitate the achievement of a First Nation/Aboriginal community health vision.

The First Nation/Aboriginal communities will develop and determine structure and roles with respect to planning, co-ordinating and funding. The communities' process must be recognized by government as the proper structure for planning and allocating resources to address Aboriginal health needs.

2. Representation

Aboriginal people must have a role in governance of health programs and service agencies and institutions. Until Aboriginal planning processes are created, Aboriginal people must have a role in existing health planning bodies.

Recommendations

1. Processes must be developed and implemented by First Nation/Aboriginal communities with support from the Ministry of Health to provide a mechanism for Aboriginal control of health planning, including development of policies, programs and services, allocation of resources and selection of representatives on planning bodies.

2. Until Aboriginal processes are implemented, the Ministry of Health must provide policy direction to health service boards and District Health Councils for increased responsiveness to First Nation/Aboriginal communities' health priorities, issues and resource requirements.

3. A series of protocols between First Nation/Aboriginal communities' health authorities, health service boards, District Health Councils and the Ministry of Health must be developed to clarify roles and responsibilities, facilitate planning, and support co-ordination of regional and provincial health programs and services.

4. A strategy is required to facilitate First Nation/Aboriginal communities' representation and participation on governing bodies for health programs and services to ensure that the communities are involved in health planning activities at local, regional and provincial levels.

5. The Ministry of Health and the First Nation/Aboriginal communities will develop and implement a strategy to support nominations and appointments of Aboriginal people to public boards, and provide board training and education and accountability terms of reference for these members.

6. A strategy is required to address and remedy racism and discrimination within public boards. Activities should include cross-cultural awareness, promote recognition, acceptance and respect of Aboriginal cultures, and be consistent with other Aboriginal anti-racism strategies.

7. A system for ongoing assessment and evaluation of First Nation/Aboriginal health status, including socio-economic indicators, must be jointly developed to facilitate planning and resource allocation. Aboriginal communities will have access to products from the evaluation process.

8. A system for ongoing joint assessment and evaluation of existing First Nation/Aboriginal health programs and services, and non-Aboriginal programs and services available to Aboriginal people, must be developed.

9. Research is required to support planning and informed decision-making regarding First Nation/Aboriginal communities' health. In keeping with the principles of this policy, First Nation/Aboriginal people must control, prioritize and be involved in all health research projects, including decisions regarding resource allocation.

10. Specific research is required to expand and enrich the knowledge and understanding of First Nation/Aboriginal communities' health, particularly wholistic and traditional approaches to health and well-being, health determinants and conditions and the etiology of disease within the First Nation/Aboriginal population.

Government Relations

Issues

1. Federal Government Off-Loading

a) *Generally*
Off-loading results from the federal government's efforts to limit the growth of expenditures by capping existing programs, cutting program funding and refusing to implement new programs to address emerging needs. These actions cause frustration within First Nation/Aboriginal communities and increase their reliance on the provincial government as a source of financial support.

For example, the federal government has capped transfer payments to the provinces' Established Programs Financing (EPF). As a result, the provincial government is forced to allocate more of its resources to offset this loss of revenue. Another example is Health Canada's current efforts to control non-insured benefits which until now have been demand-driven and open-ended. These changes could have an impact on access to health services and health supports, thus requiring recipients to turn to similar Ontario programs for aid.

b) *Potential for further off-loading*
There is concern that once the Aboriginal Health Policy is implemented, the federal government could use enhanced provincial programs as an opportunity to withdraw federal funding currently spent on related programs. This would be unacceptable to both the Ontario and Aboriginal governments.

2. Failure to Co-ordinate Programs

To date, there has been little co-ordination of programs and services between the federal and provincial governments, even in cases where the process is trilateral and/or the province is involved in the delivery of the program or service. As a result, integration, restructuring, co-ordination and complementary programming are required both on and off reserve.

An example is the governments' current efforts to review care of the elderly. Ontario and the First Nation/Aboriginal community initiated a consultation and planning process leading to policy and program development. In the meantime, Canada has undertaken a review of adult care among First Nation communities.

To date, there has been no substantive discussion among the parties despite the common subject matter, nor has there been recognition by the federal government of the unique situation in Ontario with respect to the 1965 Indian Welfare Agreement.

3. Federal Focus on Status Indians Who Reside On Reserve

Historically, the federal government has refused to provide services, except in a limited way, to any Aboriginal people other than status Indians living on reserves. In the context of the Aboriginal Health Policy, this is a problem. The Aboriginal Health Policy focuses on all

Aboriginal people in Ontario regardless of status or residency. Therefore it may be difficult to involve the federal government in more than a limited way in addressing any of the needs identified.

4. Protection of Federal Programming

It is important that the province endeavour to ensure that the extension of its services to status Indians on reserve under the Aboriginal Health Policy does not jeopardize federal programming. This is of vital importance to First Nation communities as a result of their historic relationship with Canada.

5. Narrow Interpretations

The federal government's interpretation of the 1965 Indian Welfare Agreement has, to date, been very narrow. Although the principal objective of the agreement is "to provide provincial welfare services and programs to Indians on the basis that needs in Indian communities should be met according to standards applicable in other communities", only a limited number of programs available to Ontario residents are cost-shared under the agreement. These are general welfare, child welfare, day care and homemakers. As new programs and services are introduced within Ontario, the gap between the services generally available and those provided under the agreement widens.

The Aboriginal Health Policy recommends new approaches to the use of existing program resources. Flexibility on the part of both governments will be required to respond to these proposals. For example, there are 11 native treatment centres funded by Health Canada, three of which receive provincial funding. The Aboriginal Health Policy recommends shifts to include both individuals and families in wholistic health programs; funders will be required to consider the evolving needs of the First Nation/Aboriginal communities. Governments have used their control over program objectives and contractual terms and conditions to limit support of Aboriginal initiatives.

6. Funding Inconsistencies Across and Within Ministries

There is inconsistency across and within provincial ministries with respect to funding on-reserve programs and services that are not cost-sharable with the federal government. Some areas take the view that they cannot and/or will not fund on-reserve programs that do not fall under one of the cost-sharing arrangements with the federal government, while others do fund such programs. From the work on jurisdictional issues conducted by Aboriginal groups and Ontario ministries, it is clear that there are no jurisdictional barriers to the province providing services on-reserve. The primary barriers lie in entrenched historical practices and policy concerns regarding payment.

7. Lack of Mechanism for Dialogue

There is no mechanism for dialogue between the federal and provincial governments on funding programs and services integral to Aboriginal heath. The only formal tripartite mechanism in Ontario is the Indian Commission of Ontario (ICO). Although social services, as a sector, have

been discussed under the auspices of this structure, Aboriginal health has not been an agenda item and considerable time is required to resolve issues through this process. There is also a lack of involvement of off-reserve Aboriginal groups in the ICO.

There are many issues related to federal/provincial/Aboriginal relations, including concerns regarding responsibility, funding and program co-ordination and delivery. These issues can be addressed only through a forum that provides for the participation of all parties.

8. Issues Related to Federal Inmates

The federal government takes the position that Aboriginal inmates in provincial facilities are the responsibility of the province. Health Canada has refused non-insured health benefits for status Indian inmates, even though this is one of the few federal programs available to status Indians regardless of residency.

Another issue is that implementation of the health policy may result in some wholistic programs and supports being extended to provincial inmates. Without a comparable federal initiative, Aboriginal inmates incarcerated in federal institutions may not have access to culturally appropriate health program and services.

Recommendations

1. A process is required which will lead to clarification of the roles and responsibilities of the federal, provincial and First Nation/Aboriginal governments. Further discussions with the First Nation/Aboriginal political leadership are required to review options and propose recommendations for an appropriate process. The Ministry of Health will have to undertake similar discussions within government.

2. The process to clarify governments' roles and responsibilities cannot be used to hold up the implementation of provincial initiatives aimed at improving First Nation/Aboriginal communities' health.

3. Formal processes through which commitments of the federal government will be sought to continue to fund First Nation/Aboriginal communities' health programs at current or enriched levels must be established.

4. The Ministry of Health will support First Nation/Aboriginal communities in advocating with the federal government for fulfilment of federal responsibilities and addressing of gaps in programming.

5. Inconsistencies across and within provincial ministries with respect to funding programs and services on reserve that are not cost-sharable with the federal government must be resolved.

6. The First Nation/Aboriginal community and the Ministry of Health will mutually pursue a process to explore the co-ordination of federal and provincial funding to support implementation of the Aboriginal Health Policy and achievement of its vision.

Relationship Between the Aboriginal Health Policy and Other Ministry of Health Initiatives

Development of the Aboriginal Health Policy began in December 1991 and continued throughout 1992 with community consultations led by the Aboriginal organizations, preparation of consultation reports by the organizations and, over the spring and summer of 1993, joint drafting of the policy. Throughout this period, the Ministry of Health began or continued work on several major health reform initiatives. These included a review of the *Public Hospitals Act*, the diabetes strategy, drug benefit reform activities, long-term care redirection, the *Regulated Health Professions Act*, the *Tobacco Control Act*, and development of an AIDS strategy involving education, prevention, treatment, palliative care and research.

As the health policy was being developed over 1992 and 1993, Aboriginal groups were receiving requests from Ministry of Health branches to respond to, participate in, comment on or consult with them on other major health reforms. Given that the Aboriginal Health Policy would likely affect every major ministry activity, Aboriginal groups were concerned about request to participate in other policy initiatives before the broader Aboriginal policy was developed and approved. They also expressed concern about how the Aboriginal policy related to other ministry policy and program development activities.

The amount and type of input most appropriate for effective Aboriginal participation in an initiative varies according to the degree of impact and priority accorded it by First Nation/Aboriginal communities. It is also difficult for Aboriginal groups with limited resources to participate effectively in numerous Ministry of Health initiatives. At present there is no forum or process through which First Nation/Aboriginal communities and the ministry can effectively plan for Aboriginal participation in policy and program initiatives.

To date, First Nation/Aboriginal involvement has ranged from broad community-based consultation processes to more limited forums and meetings, consistent with the impact the initiative would have on the First Nation/Aboriginal community. There is no criteria for determining the appropriate type of Aboriginal involvement. First Nation/Aboriginal communities have made it clear that they want to be informed of all ministry initiatives and be involved in decisions about the degree and type of participation.

To facilitate this, a joint Ministry of Health/First Nation/ Aboriginal community policy planning committee will be established to serve as a forum for discussing Aboriginal involvement in health planning initiatives.

The First Nation/Aboriginal community leadership and the Ministry of Health will determine the composition and mandate of the committee. Each party will appoint its own representatives.

Glossary

Aboriginals:
Indian, Métis and Inuit people (*Constitution Act, 1982*).

Aboriginal communities:
First Nations, Métis people, Friendship Centres, Ontario Native Women's Association locals, urban-based Aboriginal organizations and political/non-political organizations.

Aboriginal community:
A group of Aboriginal people who share similar beliefs, traditions and culture. These groups share political, cultural and spiritual identities and/or are jointly organized for the purposes of improving the quality of life for Aboriginal people in the community.

Aboriginal status:
An Aboriginal person may be a status Indian pursuant to the *Indian Act*, or may not have status under this Act.

Abrogate:
To annul, cancel, repeat or destroy a former law in its entirety by legislation or by usage.

Accountability:
A process through which a person is responsible for his or her actions to a designated group or body. In terms of appointments and representation, it involves the nomination of a person by a group and a reporting relationship between the parties.

Addiction:
Dependency on a substance such as drugs, alcohol or solvents, or a behaviour such as gaming or eating.

Agencies:
Programs and services both within and outside First Nation/Aboriginal communities.

Client advocacy:
Assisting a person by speaking on his or her behalf or explaining his or her wishes about health care.

Community health centre:
A place that offers a variety of health and related services focusing on health promotion, prevention and primary care.

Community support systems:
Non-health services, such as housing, education and social services.

Curative:
Curative health care encompasses such strategies as treatment centres, counselling services, professional and paraprofessional care.

Derogate:
The abolition or partial repeal of a law which limits its scope or impairs its utility and force.

Developmental stages of life:
Infant, child, toddler, youth, adult, elderly.

Disability:
Limitation on everyday living.

Environmental protection:
Conservation, preservation, rehabilitation of the environment.

Equity:
Fairness, justice.

Family unit:
Children, parents and their blood relations.

First Nation:
Also known as a band under the *Indian Act*, with or without a land base.

Governance:
The act of making decisions.

Governments:
Aboriginal, municipal, provincial and federal governments.

Healing network:
A team of providers.

Health empowerment:
Transference of a personal sense of control over health and health-related issues to individuals or groups of individuals.

Hospice:
A place where a person with a terminal illness is cared for.

Hostel:
A place where patients and/or their families stay when using health services away from their community.

Inherent right of self-government:
The Aboriginal right of self-government does not depend on federal or provincial endorsement or authority.

Lifestyle:
The way in which a person lives. A healthy lifestyle includes taking action and behaving in a manner which supports health.

Matrix:
A web or cluster of ideas and concepts which are related systematically.

Medical interpreter:
A person who explains the meaning of health information to patients or their families and who may also translate this information from one language to another.

Medicine person:
An Aboriginal person who assists the healing of a person or group using traditional medicines, ceremonies, counselling and other means.

Midwife:
A person who provides teaching and assistance to a woman and her family before, during, and /or after the birth of a child.

Nation:
A collective of Aboriginal people who share the same language, history, beliefs, culture and values. For example, the Ojibway, Mohawk and Cree nations.

Prevention:
Programs and services aimed at groups at risk of ill health or already affected by a health or social condition.

Promotion, health:
Activities which focus on improving or maintaining the health of the individual, family or community before the presence of a disease or illness.

Providers:
Includes healers, medicine people, elders, community health workers, community support systems and agencies/providers located outside the community.

Rehabilitation:
Assists individuals and their families within the healing continuum to become fully functioning in all aspects of their lives through follow-up, after-care and family/community reintegration opportunities.

Residency:
The place where an Aboriginal person lives, including on reserve or off reserve, in rural or urban communities.

Respite care:
Temporary or short-term support provided to a person caring for someone who is elderly, disabled or recuperating from treatment.

Scope of practice:
Duties specified within the *Regulated Health Professions Act* or by a professional college.

Spiritual abuse:
Hindering or prohibiting people from participating in spiritual practices.

Traditional healer:
An Aboriginal person who assists an individual or group using traditional methods of healing, including ceremonies and counselling, and is recognized as a traditional healer by the community.

Traditional medicine:
Herbal or other preparations used by a medicine person for healing purposes.

Traditional resources:
Includes natural resources, such as sweetgrass, tobacco, sage, cedar, herbs or plants; or physical resources, such as pipes, pouches and bowls, used by a person or group.

Traditional teachings:
The instructions of values, beliefs, customs and traditions about life that are passed orally from one generation to the next.

Training:
The development of knowledge, skills and attitudes to develop, implement, deliver and evaluate effective health programs and services. Training ranges from basic training to ongoing professional development.

Translator:
A person who translates health and related information for patients and health providers into or from another language.

Treatment:
Active intervention to diagnose, treat or care for an illness.

Trilateral:
Involving three parties, each of whom interacts with the other on a one-to-one basis.

Tripartite:
Involving three parties simultaneously.

Wellness:
Complete balance of the physical, mental, emotional and spiritual aspects of the human being. People experience varying levels of wellness.

Wholistic health:
The physical, mental, emotional and spiritual health of the human being.

APPENDIX A

The Aboriginal Health Policy Development Process

In October 1991, at a meeting with the Aboriginal organizations to discuss proposed amendments to the *Regulated Health Professions Act*, the Minister of Health committed the ministry to work collaboratively and in partnership with the organizations to develop an Aboriginal health policy. The ministry's *Goals and Strategic Priorities* document, approved in January 1992, identifies Aboriginal health as a ministry priority and commits the ministry to work in partnership with the First Nation/Aboriginal communities to develop a health policy that meet the needs of the Aboriginal population in Ontario.

Discussions between the Aboriginal organizations and the Ministry of Health identified a number of issues which called for the development of an Aboriginal health policy. These included:

- lack of Aboriginal influence in health planning;
- need for a framework to address Aboriginal involvement in legislative issues that affect Aboriginal health;
- need for guidelines or principles for use by all branches of the ministry to ensure consistency in the development of new initiatives;
- need for identification of strategic priorities;
- need for annualized/ongoing support for Aboriginal heath including wholistic approaches that may cross provincial ministries' boundaries;
- need to address resourcing of health needs on and off reserve;
- need to clarify Ontario's role on and off reserve with respect to federal fiduciary responsibilities;
- need for clarification of OHIP and federal non-insured services, especially when Ontario or the federal government pays only a portion;
- lack of significant references to the needs of the First Nation/Aboriginal communities in health initiatives; and
- need for a First Nation/Aboriginal communities/provincial position, should the Ontario government participate at national-level discussions.

Subsequently, objectives were developed by the Ministry of Health Aboriginal Health Office and the Aboriginal organizations to guide the health policy development process. They are:

- to identify ways to improve Aboriginal access to, participation in and the quality of service which Aboriginal people experience in the Ontario health care system;

- to identify ways to increase sensitivity of the Ontario health care system to Aboriginal health issues, needs and cultural traditions;

- to articulate priorities of First Nation/Aboriginal communities with respect to health services;

- to promote recognition and development of Aboriginal-designed health services in response to priorities articulated by the First Nation/Aboriginal people of Ontario;

- to establish a strategy by which governments, Aboriginal and provincial, will address Aboriginal health needs and priorities.

Following review of the objectives by the Aboriginal organizations and their commitment to participate in the process on the basis of the stated objectives, funding was provided by the ministry to support a province-wide community consultation process led by participating Aboriginal organizations. During 1992, the Aboriginal organizations undertook community consultations, utilizing formats which included:

- regional meetings;

- workshop with an Ontario-wide conference format;

- community meetings;

- meetings with health-related agencies;

- interviews with Aboriginal inmates in correctional facilities;

- traditional gatherings.

The original process was approved by the leaders of the First Nations' organizations through the Planning and Priorities Committee (PPC) in March 1992, as follows:

- The Ontario Indian Social Services Council (OISSC)/Provincial Territorial Organization (PTO) health directors will consult with their communities to identify issues and concerns pertaining to health and what they would like to see in a health policy (e.g., traditional healing).

- The PTO health directors and the OISSC will meet to compile a draft report for presentation to the PPC that will outline commonalities and differences pertaining to health and recommendation, for inclusion in a health policy.

- The OISSC/health directors will then meet with the Ontario Federation of Indian Friendship Centres (OFIFC) and the Ontario Native Women's Association (ONWA) to review all the consultation reports and identify commonalities and differences of health issues and how the groups can support each other.

- The on- and off-reserve organizations will compile a final report that reflects both groups' commonalties and differences.

- The final report will be presented to the PPC.

- The report will be reviewed and endorsed by off- and on-reserve organizations, and submitted to the All Ontario Chiefs Assembly for consideration.

- An Aboriginal/Ministry of Health retreat, including staff from relevant ministry program areas, was held to develop a first draft document based on the consultation findings.

- Working groups were established to develop specific recommendations (legislative, policy, administrative, programs and services and resource requirements).

- The draft document was circulated within the ministry and the Aboriginal organizations for further development.

- The policy document was submitted to the Ministry of Health and the Aboriginal organizations' policy approval and ratification processes.

- The document was submitted to Cabinet and Treasury Board for policy approval and funding.

APPENDIX B

Aboriginal Health Policy Consultations Summary of Issues

Introduction

The Aboriginal organizations received funding to carry out comprehensive consultations with their members to identify issues and concerns related to the provision of health care for Aboriginal people, to articulate Aboriginal communities' perspectives on health care priorities and needs, and to formulate recommendations. The following groups received consultation funding:

Association of Iroquois and Allied Indians (AIAI)
Grand Council Treaty #3 (GCT3)
Nishnawbe-Aski Nation (NAN)
Ontario Métis Aboriginal Association (OMAA)*
Ontario Native Women's Association (ONWA)*
Ontario Federation of Indian Friendship Centres (OFIFC)*
Union of Ontario Indians (UOI)
Chiefs of Ontario (on behalf of Independent First Nations)

*These organizations represent the interests of Aboriginal people living off reserve who may or may not have Indian status under the *Indian Act.*

Summary of Aboriginal Health Issues

1. Language and Communication Barriers

Language and communication barriers substantially reduce Aboriginal access to health care services and the effectiveness of service provision.

Aboriginal people whose first language is neither English nor French experience mistrust, fear and frustration in their dealings with health care professionals as a result of language barriers. The patient is unable to communicate symptoms, allergies and medical history, making proper diagnosis difficult. Follow-up treatment and instructions about medication and therapy cannot be effectively communicated. Language barriers only exacerbate the feelings of alienation, isolation and insensitivity from health care providers many Aboriginal patients already experience. These barriers can be life threatening as well.

The organizations' reports cited the need to address language and communication barriers by providing specialized translation services in health facilities, training Aboriginal health care workers and producing health programming resources in Cree and Ojibway.

2. Traditional Medicine and Healing Practices

Aboriginal people expressed concern about the lack of recognition and support for traditional medicine and healing practices in the health care system. Health care professionals are viewed as having little understanding or appreciation of the role of traditional healers or of the value of traditional medicine to Aboriginal people. Health facilities are not required to accommodate traditional healers and can prevent certain practices by referring to policy. A frequently cited example is the inability of healers to use tobacco in spiritual ceremonies as a result of no-smoking policies. The need for healing lodges and for elders to be more involved in the health care system was cited in the reports.

It is clear that the Aboriginal concept of health involves not only the physical aspect, but also mental, spiritual and emotional health. Concern was expressed regarding the reluctance or apparent inability of the health care system to provide programs and services which reflect the wholistic approach to health. Jurisdictional disputes, between both ministries and levels of government, contribute to this situation.

Western medicine's emphasis on the physical aspects of health is another contributing factor. Traditional medicine and healing practices, such as sweat lodges, sweetgrass ceremonies and smudges, along with teachings/counselling from elders and talking circles, are fundamental aspects of the wholistic healing process. Recognition and accommodation of them within the health care system will enhance the effectiveness of health care provision to Aboriginal people.

3. Training and Professional Development

Several training issues were identified in the reports.

a) *Aboriginal health care workers*

Aboriginal people identified the need for increased levels of culturally appropriate professional development/training programs for Aboriginal health care workers. Training should be provided in a First Nation language if necessary.

Areas in which there is a need for training include specialized mental health care, counselling for families and individuals, and specialized translation training for interpreters. The lack of basic training and effective professional development programs are viewed as important factors contributing to the inability of health care workers to effectively respond to the mental health problems and social conditions in remote northern communities.

The Aboriginal community also recognizes the need for increased numbers of Aboriginal health care professionals within the system. Their presence would support culturally appropriate health care, increased Aboriginal / non-Aboriginal communications and the redirection of health care from institutions to communities.

b) *Cross-cultural training*

Cultural insensitivity on the part of health care professionals is major concern in the Aboriginal community. This insensitivity is evidenced by lack of understanding and respect for traditional medicine and healers, lack of awareness of cultural differences, and instances of disrespectful and racist comments directed at Aboriginal patients.

Cross-cultural training for health care professionals is needed to ensure improved communication between Aboriginal people and health care professionals. Cultural insensitivity and racist attitudes contribute to mistrust and apprehension between the two groups and affect the quality of health care.

Aboriginal communities should be involved in developing and providing cross-cultural training for non-Aboriginal health care professionals working in those communities. Community involvement in cross-cultural training would also enhance relations between the non-Aboriginal health care providers and the communities.

4. Aboriginal Control and Culturally Appropriate Programs and Services

Culturally appropriate health programs and services are required in Aboriginal communities. Aboriginal people identified the need for Aboriginal control in the planning, development and delivery of programs and services to increase their effectiveness. Aboriginal people must also be involved in the development of policies and criteria for the receipt of services. There is a need for flexibility in provincial funding arrangements to ensure that program development is not hampered by jurisdictional disputes between ministries.

Criticism was directed at programming which focuses on treating the individual and ignores the family or community context within which the individual functions. The wholistic approach to healing and wellness must be respected in the development of programs and services directed at the Aboriginal community.

5. Health Planning System

District health Councils (DHCs) are seen to accord low priority to Aboriginal health priorities and proposals and do not adequately represent the Aboriginal communities' concerns. Aboriginal representation on DHCs is identified as a means of addressing this concern. The establishment of Native advisory committees to act as a liaison between government and health care agencies is identified as a means of ensuring that Aboriginal concerns are adequately represented to the Ministry of Health.

6. Access to Programs and Services

Aboriginal communities continue to experience limited and inequitable access to culturally appropriate programs and services compared with the non-Aboriginal population. The same range of services is not available in or to all First Nation communities. Language and cultural barriers, along with incidents of racism, contribute to the perception that health care professionals provide Aboriginal patients with a lower quality of care.
Regarding specific areas of concern, there is a need for:

- more full-time doctors and nurses in communities;
- increased numbers of community visits and longer stays by health professionals;
- improved continuity of care;

- increased services by optometrists, physiotherapists, pediatricians and foot-care specialists;
- increased numbers of full-time mental health workers, including specialists in child mental health, particularly in the north;
- improved access to referrals, second opinions and specialist treatments;
- shorter waiting times for appointments;
- less stressful relocations of patients to urban centres for specialized health services;
- more home visits by nurses;
- follow-up care for patients, particularly in the north;
- on-reserve health care providers on evenings and weekends;
- prevention and promotion programs, related to such areas as sexually transmitted diseases, nutrition, food preparation, water treatment, child care, teen pregnancies, prenatal care, immunization, diabetes, fluoride rinses and dental care for children, hygiene, childhood diseases, first aid, cardiopulmonary resuscitation and fitness;
- pre/post-natal classes in Aboriginal communities;
- birthing centres;
- improved access to treatment centres in the United States;
- increased homemakers and home nursing services;
- better access to child mental health and resolution of jurisdictional issues;
- counselling and support for families dealing with family violence and sexual abuse;
- changes to eligibility criteria to enable smaller communities to qualify for some programs;
- preventive dental care and emergency treatment;
- appropriate evaluation mechanisms to measure the effectiveness of programs in meeting the mental and social service needs of northern communities.

7. Specific Areas Requiring Attention

a) *Suicide and mental health*
Suicide and mental health issues are major concerns in Aboriginal communities, particularly in the north. Historically, the few mental health services in First Nations have been funded by the federal government and focused on crisis intervention or have been small-scale programs insufficient to meet needs. Health workers today are barely able to respond to the crisis situations they face and so are unable to do prevention and early detection programming. Mental health training and counselling programs are required. The number of health workers must be increased.

Suicide and mental health programs must include the family in the treatment plan and respond to Aboriginal concepts of health and well-being and traditional medicine and healing. Western medicine's therapeutic approach of client care that focuses on the individual does not meet Aboriginal needs. There is a need for culturally appropriate community-based mental health programs based both on and off reserve. The lack of mental health and related support facilities in the north requires patients to be flown to urban centres for treatment. Given cultural and language issues, this is often the most effective form of service delivery.

Appropriate follow-up programming is required in Aboriginal communities. Northern communities also identify the need for more programs directed at children's mental health treatment and prevention. On-reserve organizations indicated the need for the federal government to be more responsive to mental health issues. A mental health policy for First Nations is required, preferably originating with the federal government.

b*) Alcohol and drug addiction*
Alcohol and drug addiction programming is insufficient to meet community needs. Programming should:

- be culturally appropriate;
- address prevention and intervention;
- include community-based detox and treatment centres which incorporate traditional healing and medicine;
- provide for follow-up after care and rehabilitative treatment;
- include specific focus on gasoline sniffing and solvent abuse.

As with suicide and mental health concerns, there is a need for increased numbers of community health workers to address addiction needs and provide counselling services.

c) *Health promotion*
Communities consulted recognized the need for increased emphasis on health promotion and prevention initiatives. Areas of need include:

- suicide and mental health;

- alcohol and drug abuse;
- nutrition and lifestyle;
- AIDS/STD education;
- parenting and elder abuse.

Currently, Aboriginal health workers spend too much time responding to crisis situations. Ideally, they should be spending much of their time addressing health promotion and education issues. Health promotion education is needed for Aboriginal and non-Aboriginal health professionals. The province should take a lead role in supporting health promotion programming.

d) *Hostels*
Hostels and boarding facilities are required to accommodate families of patients who must travel outside their communities for treatment. There are several reasons why hostel and boarding facilities may be necessary for both patients and family members, including:

- need for a translator for the patient;
- emotional support to reduce the impact of cultural dislocation;
- need for family support in cases of long-term care;
- recognition of high transportation costs in the north;
- necessity of family members to be involved in the treatment and care plan;
- accommodation for outpatients and prenatals;
- overcrowding in existing facilities.

e) *Transportation to health services*
The absence of many health services in Aboriginal communities requires patients to be transported to urban centres for treatment. As noted earlier, there are a variety of reasons why family members must often accompany patients to the treatment facilities. Transportation costs for family members who must go out of the community for treatment are not covered by the province. In many cases, families cannot afford to visit patients located off reserve, thus increasing alienation and stress caused by cultural dislocation. This removes the possibility of the family being integrated into the patient's treatment plan, decreasing the effectiveness of the health service.

In some communities, year-round accessibility to emergency services is hampered because of lack of infrastructure; for example, improper lighting on airstrips. Emergency transportation to hospitals is slow in the north, and more frequent medical van services are required.

Elders do not have access to transportation services to and from clinics in either urban centres or First Nation communities. As well, there is concern about the availability of escort services to meet the needs of those who require treatment outside the community, particularly elders and children. There is inadequate funding available to support escort fees required for reliable service.

f) *Nutrition*
Diabetes is a common ailment in the Aboriginal community. Lifestyle and poor eating habits contribute to its high incidence. For diabetics, access to nutritious food is a problem, especially in the north where high transportation costs contribute to the high cost of foods. Education programs are needed to address nutrition issues in the Aboriginal community.

8. Improved Regional/Community Co-ordination and Provision of Information

Both community health workers and community members need more information on the availability of health programs and services and eligibility criteria for programs and services, both on and off reserve. As well, communication between Aboriginal health service providers located on and off reserve should be increased to provide opportunities to share information on programs, services, priorities, issues, etc.

Improved regional and community co-ordination between Aboriginal and non-Aboriginal health care providers is needed to facilitate opportunities for professional development and dialogue and to address issues related to health service co-ordination.

First Nations have indicated the need to design their own administration system for health programs delivered on reserve. An advisory committee is required to work with government agencies and to act as a liaison between the Aboriginal community and government.

9. Patient Advocacy

A patient advocacy service is required to document and respond to inadequate or discriminatory treatment, or cultural insensitivity of health care professionals. The advocate should also provide assistance in obtaining health care services and devices such as assistive devices, eyeglasses and prostheses.

10. Funding/Resourcing

Funding is required to support initiatives addressed in the consultation reports and to redress health inequities. Specific areas to be addressed include:

- funding for on- and off-reserve community health workers, community mental health workers, addiction and drug abuse workers, homemakers and home support workers;

- the need for Aboriginal involvement in the development of funding criteria and approval of community-based programs;

- assurance of equal pay for Aboriginal and non-Aboriginal service providers;

- capital funding for health facilities, long-term care facilities, addiction treatment facilities;

- funding for Aboriginal health policy analysts.

11. Long-Term Care

The Long-term Care Redirection initiative is undertaking a separate consultation with the Aboriginal community to ascertain its issues and concerns. Within the Aboriginal Health Policy consultation, however, long-term care issues were raised. These included the need for supportive housing, group homes and chronic facilities in Aboriginal communities, Aboriginal control of home care and home support services, culturally relevant programs including traditional food and translation services, Aboriginal involvement in the establishment of funding criteria and approval of community-based long-term care programs for Aboriginal people, the need for more funding for homemakers and home support programs, the need for clear policies and procedures for receipt of homemaker and home support services developed at the community level, and cross-cultural training for health care professionals.

12. Elderly and Disabled

In addition to the concerns expressed regarding long-term care, advocacy services are required for the elderly to ensure protection from abuse, receipt of quality care in their homes and other facilities, and receipt of assistive devices.

Respite care is required for family members caring for elderly, disabled or terminally ill relatives. Transportation and escort needs have already been identified.

The complete absence of specialized services for disabled people living on reserve is a major issue that must be addressed.

13. Federal/Provincial Jurisdiction Issues

Issues of federal/provincial jurisdiction impede the delivery of health services to Aboriginal communities and are a source of frustration on and off reserve.

Both status and residency determine the availability and accessibility of health programs and services. Off-reserve Aboriginal people do not have equal access to services because of residency. Likewise, non-status and Métis people are unable to access programs available to status Indians. Organizations both on and off reserve report that jurisdictional issues negatively affect their communities. Off-reserve organizations want equal access to Aboriginal health programming for their memberships, regardless of residency or status. On-reserve organizations report limited access to some provincial health services due to jurisdictional disputes.

There is recognition of federal primacy in the provision of programs and services for Aboriginal people. The consultations report concerns about the federal government's unwillingness to provide complete health coverage to all status Indians off reserve. There is also concern about the inadequacy of federal funding in areas of mental health, child mental health and specialized counselling. The approval process for non-insured health services and the delay in or denial of services are sources of frustration.

The need for a specific cost-sharing arrangement between the province and the federal government was identified.

14. Health Determinants

There is recognition that environment plays an important role in determining an individual's or community's level of health. In north-western Ontario, the impact of environment was considered a major health issue.

High unemployment, inadequate housing, overcrowded living conditions, lack of water and sewage facilities, poor nutrition due to the high cost of food, transportation difficulties for the elderly and disabled, and the impact of the weather on service provision were sited as environmental factors which impact negatively on the health status of Aboriginal communities. Other contributing factors include the effects of cultural dislocation, discrimination and racism, and lack of community control over programs and services. These factors contribute to feelings of frustration and a sense of powerlessness both in the individual and in the community.

Improved health program and service provision will contribute to enhanced health in Aboriginal communities. At the same time, however, it is necessary to address health determinant issues to further support increased Aboriginal health.

Results of Related Aboriginal Consultations

Several consultations that affect provision of health care have concluded or are continuing. Summaries of their results follow.

1. Aboriginal Diabetes Strategy Development

In response to the high incidence of diabetes in the Aboriginal population, the Ministry of Health funded consultations with the community in 1991 and early 1992. The Aboriginal groups identified a number of areas which needed immediate and future attention. These included:

- funding support for community-based programming;
- development of culturally and linguistically appropriate resource materials;
- access to appropriate health services;
- special training for health professionals;
- research funding on Aboriginal diabetes;
- community control of programs and services.

In response to the consultations, the ministry developed the Aboriginal diabetes strategy, a three-year prevention-oriented plan to improve and enhance community-based diabetes programs and services directed at the Aboriginal community.

Funding was also committed for Aboriginal diabetes educators to provide services to Aboriginal people under the northern diabetes network in Northern Ontario.

2. Midwifery

In response to Aboriginal concerns regarding proposed changes to the practice of midwifery and their impact on traditional midwives under the *Regulated Health Professions Act* (RHPA), funding was provided to Aboriginal organizations in 1991 to consult with their memberships on traditional healing and midwifery practices. Consequently, the province amended the RHPA to exempt traditional midwives from its provisions when they provide services to members of Aboriginal communities. Most recently, funding has been provided to an Aboriginal group to conduct research on the practice of traditional midwifery in order to address training, accountability, recognition and other concerns. The results will help determine next steps in this process.

3. Aboriginal Family Violence

Consultations on Aboriginal family violence have resulted in these recommendations:

- that Ontario recognize Aboriginal family healing as a priority ;

- that the following principles guide the development of an Aboriginal family healing strategy:

    i) the strategy be wholistic and comprehensive, and include promotion, prevention, crisis intervention, promotion of stability, training, curative, rehabilitative and supportive services for the individual, family, extended family and community all at once

    ii) the strategy be flexible, evolving and ongoing, and support the development of alternative and culturally appropriate services and programs;

- that the strategy promote accessibility of programs and services relating to factors such as geographic, linguistic, spiritual and cultural diversity, lifestyle and disability issues;

- that services and programs required to implement the strategy be directed, designed, implemented and controlled by the Aboriginal community.

4. Public Hospital Act Reform

In November 1992, the Ministry of Health hosted an Aboriginal public hospital forum to provide Aboriginal organizations and service providers with the opportunity to submit concerns and recommendations related to the provisions of hospital services and reform of the *Public Hospital Act*.

A summary of issues and recommendations was produced following the meeting. Major issues related to:

- recognition and maintenance of the unique relationship between Aboriginal people and the federal government and the existence of treaty and Aboriginal rights – there should be a willingness to collaborate with the provincial government as long as it does not compromise treaty and Aboriginal rights;

- recognition of the placement of health planning processes under self-government in view of the *Statement of Political Relationship* between Ontario and First Nations;

- the need for Aboriginal representation and participation in health boards;

- recognition of the lack of Aboriginal involvement on district health councils;

- empowerment of Aboriginal health councils;

- governance, management and Aboriginal control of hospital programs and services in Sioux Lookout and Moose Factory zone areas;

- recognition of traditional healing;

- cultural insensitivity on the part of health care professionals;

- development of culturally appropriate, Aboriginally controlled programs and services;

- implementation of a patients' services function to review cases of neglect, mistreatment and cultural insensitivity.