



**CANADA-ABORIGINAL PEOPLES ROUNDTABLE**

**HEALTH SECTORAL FOLLOW-UP SESSION  
FACILITATORS' REPORT**

**November 4 - 5 2004**

**Marriott Hotel  
Ottawa, Ontario**





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## 1) INTRODUCTION

The Health Sectoral Follow-up Session (HSS) held on November 4-5, 2004, was the first in a series of sessions intended to fulfill the commitment made by Prime Minister Paul Martin at the conclusion of the Canada-Aboriginal Peoples Roundtable on Strengthening the Relationship that was held on April 19, 2004. The Sectoral Follow-up Sessions are intended to explore new and innovative ideas through which the Government of Canada, national Aboriginal leaders and provincial/territorial governments can work together to close the quality of life gap between Aboriginal peoples and all Canadians. In addition to Health, Sectoral Follow-up Sessions are to be convened for Lifelong Learning, Housing, Economic Opportunities, Negotiations and Accountability for Results.

Following the distribution of the April 19, 2004 Canada-Aboriginal Peoples Roundtable report, the Aboriginal Affairs Secretariat (AAS) within the Privy Council Office (PCO) established an overall Planning Committee to develop the proposed Sectoral Follow-up Sessions. The Planning Committee is comprised of representatives from:

- five National Aboriginal Organizations, including, Assembly of First Nations (AFN), Métis National Council (MNC), Inuit Tapiriit Kanatami (ITK), Congress of Aboriginal Peoples (CAP), and the Native Women's Association of Canada (NWAC);
- key federal departments and agencies that serve as lead departments or have

related responsibilities, including Indian and Northern Affairs Canada, Health Canada, Canada Mortgage and Housing Corporation, Industry Canada, Treasury Board Secretariat, the Privy Council Office; and

- provincial and territorial officials.

A Health Planning Sub-Committee, chaired by Health Canada and comprising federal, Aboriginal, and provincial/territorial members, applied the overall session planning guidelines established by the Planning Committee to the particular needs of the health field. The Health Planning Sub-Committee responsibilities included:

- identification of policy priority topics, focus questions and the agenda to guide discussions at the session;
- development of background papers to provide participants with an overview of key issues;
- selection of participants and officials (who attended as observers to support the process); and
- review of the facilitator's report on the session.

The five National Aboriginal Organizations (NAOs) were given the opportunity to select 10 participants from their organizations and/or communities at all levels. Other participants were selected, based on their areas of expertise and in an effort to balance regional, distinction and gender representation, from additional names submitted by the NAOs, provinces, territories and federal departments. There were a total of 96 participants at the Health Sectoral Follow-up Session. The NAOs and



the participating governments identified officials to provide support to their selected participants and to report back on the discussions. Each NAO had up to three officials, the federal government had up to 15 officials, and the provincial and territorial governments divided a total of 15 officials' seats. There were a total 43 officials identified (see Annex B).

The Health Sectoral Session (HSS) was designed to bring experts and practitioners' together to put forth new and innovative suggestions for improving the health of Aboriginal peoples and discuss how those ideas or recommended actions could be implemented to achieve on-the-ground success. It was agreed at the Planning Committee that the Sectoral Follow-up Sessions be open to an exploration of a wide range of ideas that could inform the subsequent work, rather than seek to achieve consensus on any particular idea or position.

The specific objectives for the HSS established by the Planning Committee were to engage participants in a discussion of health matters affecting Aboriginal peoples and communities and to recommend options for improving:

- the health status of Aboriginal peoples;
- the health services available to Aboriginal peoples;
- the health systems of delivery; and
- health governance and accountability.

The results from the technical level discussions at the HSS are contained in this Facilitators' Report. The report is based on the flip chart notes prepared by the participants and facilitators during the

session and a template approved by the Planning Committee. All flip charts were transcribed verbatim and are contained in Annex C of this report. The daily summaries were prepared by the facilitators and presented in the plenary session at the end of each day. These summaries have been used to help prepare this report; and are included in Annex C. As a practical matter, it is not possible to reflect every idea placed on the flip charts during the breakout group in the narrative of this report. The facilitators have attempted to draft this report in a manner that highlights the content of the flip charts as succinctly and objectively as possible. As a result, this report should be read in tandem with the detailed ideas contained in the flip chart notes. As well, discussion at the session built on the content of the background papers prepared in advance of the HSS. These background papers can be found on the Roundtable website (<http://www.aboriginalroundtable.ca>).

The discussions themselves, the HSS Facilitators' Report, the Facilitators' Reports from the other Sectoral Follow-up Sessions, and the Facilitators' Final Report on all Sectoral Sessions are intended to support and inform the development of Aboriginal policy in Canada as well as the events leading to:

- a spring 2005 policy retreat with members of the Cabinet Committee on Aboriginal Affairs, national Aboriginal leaders, and provincial/territorial representatives<sup>1</sup>; and

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<sup>1</sup> Discussions are ongoing with provinces and territories regarding their participation in the planned spring policy retreat and this matter will be clarified as work proceeds toward this proposed initiative.



- the fall 2005 First Ministers' Meeting (FMM) on Aboriginal Issues.

It is also anticipated that the participating governments and organizations may develop their own reports and analysis of the Sectoral Sessions (for example, ITK is convening an Inuit-specific forum on the environment). It is also understood that the brainstorming at the Sectoral Session in no way commits any particular government or organization to a discussion on any particular idea at upcoming political level forums.

## **2) OVERALL SUMMARY OF THE SESSION**

### **Workshop Methodology**

Each Sectoral Session provided that the majority of time be allocated to breakout group sessions where the participants were organized into one of the three distinct groups: First Nation, Inuit and Métis. The participant's lists (Annex B) indicate that there were 35 identified participants in the Health First Nations breakout group; 31 participants in the Inuit breakout group; and 30 participants in the Métis breakout group. The agenda called for the distinct breakout groups to address the following policy issues:

- jurisdiction and control;
- improving access and integration;
- building capacity and sustainability; and
- broad determinants of health.

Launch questions for each theme were posted to help participants focus on recommended actions. These questions were a guiding tool and were contained on the agenda distributed to participants prior to the session. The launch questions were designed to help participants focus their discussion on issues that support achievement of the session objectives. Facilitators used the launch questions in tandem with other process questions to help participants drill down in their discussions when making recommendations. Where time permitted, participants were asked to apply short-medium-and long-term time frames to their recommended actions and prepare key message summaries of their small group discussions and recommended actions.

Within each of the above discussions and at the end of each day participants were asked to provide input into:

- defining success;
- recommended actions;
- how we will work together with other stakeholders; and
- how we will know that we are making progress.

Participants were also asked to apply two "lens" questions in their discussions on the aforementioned policy issues. The lens provided for the inclusion of perspectives on issues of gender equality and geographic residence (i.e. urban Aboriginal or rural/remote, northern and non status Indians). Specific lens questions were applied directly to each theme, and in some circumstances (e.g. the Métis breakout



group) a separate discussion focused specifically on the lens was held. Generally the following questions were used to generate discussion on the crosscutting themes:

- Do the statements provide Aboriginal (i.e., First Nations, Métis, Inuit) women an opportunity to participate and/or address issues of concern to their health status?
- Have the needs and concerns of Aboriginal people (i.e., First Nations, Métis, Inuit) in urban, rural/remote and northern situations been addressed?

Each breakout group was facilitated by two co-facilitators selected from a list, recommended by the NAOs during the planning process. For each theme, facilitators used a variety of facilitation exercises to maximize input and output from the participants. The exercises included facilitated discussion methods that were adapted to fit the circumstances, such as time allotment, number of participants, size of the breakout room, and subject of the theme. In most cases, the exercises required participants to work in smaller groupings to gain greater participation from all participants.

The co-facilitators were also flexible in responding to the needs and issues identified by the breakout group participants. This flexibility resulted in slight variations among each breakout session. For example, in the First Nations breakout group a vision statement for health was developed in response to the agenda/facilitation requirement to address definitions of success. During the Inuit breakout session

on the broad determinants of health, a strong emphasis was placed on the impact of other sectors on individual, family and community health. As well, the facilitators in the Métis and Inuit breakout groups added a brief discussion to evaluate the breakout sessions at the end of day two.

All participants were clearly notified that issues, options and/or recommendations had to be recorded on the flipcharts in order to be included in the final HSS Facilitators' Report. When required, facilitators were flexible to record statements or opening remarks from participants on health issues. In the Inuit session, participants provided recommendations, which were building on the Inuit background paper provided by ITK. In specific cases this meant that recommendations that were included in the discussion paper were not always expanded on or discussed in the breakout session. It is therefore essential that the sections of this report that address Inuit issues be read in conjunction with the ITK background paper.

At the end of each day all participants were asked to return to the main plenary session to hear a summary of input that was generated by the facilitators on what they heard and had recorded for that day. These summaries were put into a PowerPoint presentation and shared with all participants. As well, it should be noted that Day 1 of the HSS was opened and Day 2 was closed by three Elders representing First Nations, Inuit and Métis. Their opening and closing remarks and invocations were often instrumental in setting the tone for the discussions to follow.



## Overall Summary

Most of the participants indicated that a pan-Aboriginal<sup>2</sup> approach was not supported. It was stressed by many participants that addressing the issues impacting the health and wellness of Inuit, Métis and First Nations would require the implementation of specific strategies that were responsive to the unique cultural needs of these populations. However, two of the three breakout groups indicated that they would continue to meet with other Aboriginal partners on common issues. As well, the need for joint partnerships and greater collaboration from all levels of government was noted. While participants in each of the breakout groups provided distinct recommended actions, there were some that were similar in nature. The following is a brief look at the similarities among the three breakout groups.

### Jurisdiction and Control

Participants in all three breakout groups spoke about expanding health authorities. Each group also indicated that greater collaboration between and amongst governments is needed to break down jurisdiction and control issues for First Nations, Inuit and Métis. They suggested that more partnerships and joint protocols are needed to move the health agenda forward.

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<sup>2</sup> Pan-Aboriginal is a term describing an approach that is applied to all Aboriginal peoples and groups regardless of nation, distinct identity, geographic location, gender or status.

## Access and Integration

Participants recognized the importance of, and supported efforts directed at, strategic planning, accords and the use and accreditation of traditional approaches and medicines in health. Each breakout group identified solutions that would respond to the need to make program funding more flexible and long term. New models are needed, but these must be built with input from the community if they are to be successful.

### Capacity and Sustainability

All the breakout groups emphasized that more attention and support is required in building human capacity at the community level and that more professionals are needed in all health fields. To accommodate this goal, significant educational programming, training and accreditation support is needed at all levels. Strengthening the relationships among governments and Aboriginal groups through partnerships, clarifying relationships, and changes to a non-population-based health funding formula were seen as providing a basis for sustainability as one option.

### Broad Determinants of Health

The breakout groups recommended strong collaboration among sectors, particularly housing, education and environment. In each breakout group part of the solution included recommended actions calling on governments to work together and more collaboratively.



## Application of the Crosscutting Themes

The lens questions were applied in three ways: to recommended actions after they were developed for each topic area; directly during the development of recommended actions; and, in some cases (e.g. Métis breakout), as a separate discussion point to ensure clarity regarding what the lens meant earlier in the breakout group.

The facilitators observed that initial uncertainty around applying the lens questions to the discussions and recommended actions in the breakout sessions was often clarified when participants were informed about what was meant by a gender-based analysis<sup>3</sup> and that the lens questions were intended to ensure that the needs and concerns of these segments of the Aboriginal population were addressed, and were not necessarily about the needs and concerns of organizations.

The breakouts, particularly the Métis and First Nations, emphasized the need for increased:

- application of a gender-based analysis to the development and implementation of plans and strategies;

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<sup>3</sup> Gender-based analysis (GBA) is an analytical tool. It uses sex and gender as an organizing principle or a way of conceptualizing information—as a way of looking at the world. It helps to bring forth and clarify the differences between women and men, the nature of their social relationships, and their different social realities, life expectations, and economic circumstances. It identifies how these conditions affect women's and men's health status and their access to, and interaction with, the health system.

- involvement of women in consultations, decision making and leadership processes;
- access to current and gender-specific services; and
- recognition of the links between other broad determinants (e.g., housing and education) to improved health for Aboriginal women and First Nations, Inuit and Métis in urban/off-reserve/non-status rural/remote and northern circumstances.

Within the Inuit session environmental issues were considered as a crosscutting lens that is essential to the health and well-being of Inuit communities. Readers are also directed to the ITK background paper on health for additional information regarding this lens.

## 3) SUMMARY OF DISCUSSIONS

### i) FIRST NATIONS BREAKOUT GROUP

#### Jurisdiction and Control

##### Launch Question:

*How will we address the issues of jurisdiction and control that are impacting on the delivery of, and access to, health services?*

To facilitate the discussion on the launch question the participants were provided with a more focused question to explore:

*What would you do if you had First Nations jurisdiction in health?*



- clear First Nations government roles and responsibilities/legislative mandate;
  - define the scope of acute care, public health and rehabilitation services;
  - require qualified human resources and professionals (capacity);
  - require more funding and accountability; and
  - support First Nations control of integration of different jurisdictions.
- First Nations need to articulate a vision of a “healthy community”;
  - First Nations want to develop Health Authorities;
  - a Health System Framework that is not illness based needs to be defined; and
  - regular gender-based analysis within First Nations communities needs to be conducted.

### **Definition of Success**

The First Nations group determined that their definition of success would be best articulated through a vision statement. Participants in the breakout sessions came to a consensus on the following statement:

*We would have sufficient resources to provide our clients with integrated, holistic, accessible and universally available services which ensure proper governance structures based on inherent rights and ensures First Nations health is standard with the rest of Canada.*

### **Short-term Recommendations/Actions**

Many of the participants in this breakout session identified various strategies, the need for more health authorities and, frameworks, as well as the need for analysis. Specific data collection and community visioning were identified as part of the short term recommendations, which included:

- First Nations require a youth strategy;
- reliable data required on First Nations population;

### **Medium-term Recommendations/Actions**

Participants discussed issues around traditional knowledge, sharing medical models internationally, and enhancing educational opportunities for First Nations students pursuing careers in health care. Some of the actions include:

- First Nations want to develop an open medical model that will integrate traditional knowledge and practices. This would include the Aboriginal world view and concepts on health while integrating traditional knowledge, ceremonies and medicines into First Nations health practices;
- First Nations want to enhance support to all First Nations students;
- all universities need to have Aboriginal recruitment and retention policies; and
- First Nations need to articulate and develop appropriate governance models for health.

### **Long-term Recommendations/Actions**

Participants identified recommendations that stretch from the implementation of the recommendations on health from the Royal Commission on Aboriginal Peoples (RCAP)



to specific legislation to replace the *Indian Act*. Further drill-down on accreditation and training was identified, as well as ideas of how First Nations can use best practices and performance measurement to inform best concepts within health environments. Other recommendations included:

- Aboriginal peoples are equal partners with governments in all discussions on Aboriginal health care and service delivery (government-to-government relationship);
- removal of jurisdictional barriers to health services (including culturally appropriate) through negotiation with, and among, governments (Aboriginal and non-Aboriginal) and service providers of fully reciprocal agreements for the provision of health services to Aboriginal peoples. Specific details of such agreements to be negotiated at the provincial/regional/local levels as deemed appropriate to meet the needs of communities involved;
- need an ongoing process that engages Aboriginal peoples and governments at the national, provincial, territorial, regional, local levels to work out details of integrated health services;
- set general parameters to guide discussions at the national level. Establish task groups with Elders, leaders and experts to develop proposals and recommendations that outline a general approach;
- develop provincial parameters to guide local discussions through task groups;
- develop service details at the local level;
- achieve accreditation and training of 10,000 professional in five years. Increase the number of First Nations

health care professionals (doctors, nurses, dentists, specialists, etc.), health policy, health planners, community practitioners and traditional healers;

- share and document best practices within five years (First Nations best concepts should inform our best practices, one should continuously inform the other);



- implement the RCAP recommendations and consistently do gender-based analysis on the recommendations; and
- replace the *Indian Act* with a First Nations Recognition Act.

### Determining Success

Participants determined that success in health jurisdiction and control will be measured through some very tangible indicators such as better health for First Nations, the involvement of women in decision making, more resources, and a full menu of health services close to the communities that are culturally appropriate. First Nations will have:

- services that are available close to home;
- a full continuum of primary health care;
- improved health status;
- resources that match health needs;
- smoking, drinking, prescription drugs and gambling addictions are gone;
- women involved in health decision making;



- policy makers, academics and community people sitting at the same table for a common purpose; and
- culturally appropriate services available and accessible where people live.

### **Other Recommendations**

Participants provided two specific recommendations related to issues around Aboriginal health status reporting and data needs:

- a requirement for the development of data collection methodology and Aboriginal-specific indicators that allow for consistent reporting across the country on the health status of all Aboriginal peoples; and
- such data collection methodology to include the implementation of a blind identifier attached to provincial health cards. Such an identifier would be private, not accessible by service providers or insurance companies, but only accessible in data runs when it is tied only to a number, not a name.

### **Access and Integration**

To facilitate discussion of the launch question, the following question was put forward to the group:

#### Launch Question:

*What are the key issues and adaptive approaches that would contribute to improved levels of access to, and integration of health programming and services?*

### **Definition of Success**

Participants at this stage of the workshop organized their discussions by defining approaches at the local, regional and national levels for the topic of integration of health programming and services. Principles and processes were defined and dictated to include:

- respect for the distinct culture and identity between and among specific Aboriginal peoples (First Nations, Métis and Inuit). Avoid the “one size fits all” pan-Aboriginal approaches;
- health approach needs to emphasize promotion and prevention, building on existing successful models of health prevention; and
- sustainability should not drive integration; good health outcomes should be the driver.

At the local level, the recommendations focused on community-driven solutions with greater access to health programming and a menu of services, including public health, primary care, women’s health and advocacy for clients. It was suggested that community needs assessments with community health plans include health policies and protocols. Participants also recommended that Health Canada define integration from a government standpoint.

At the regional level, participants focused on specialized services such as physiotherapy, occupational therapy, and mental health service availability. It was repeatedly recommended that regional networking and partnering is imperative. Clustering communities (while respecting political affiliation) to share resources is a logical



recommendation. Portable rights must be acknowledged and supported for First Nations living off-reserve.

Participants recommended at the national level and federal/provincial/territorial tables that the voices of women and people with disabilities must be present and included in all decision-making processes. When the National Health Action Plan is reviewed, women and people with disabilities must be included in the consultation processes. Nationally, best practices helping to set standards need to be shared.

### **Short-term Recommendations/Actions**

- Regionally clustered communities need to respect political jurisdiction, agencies and organizations that deliver services and map all services.
- Changes in federal funding approaches are needed to ensure monies are targeted to all First Nations through one funding source.

### **Medium-term Recommendations/Actions**

- Establish public health professional organizations where community health workers, alcohol and drug workers, health professionals, etc. receive standardized training and credentials.
- Build on successful health promotion strategies.
- Make provinces accountable for the monies they receive on behalf of First Nations.

### **Long-term Recommendations/Actions**

- First Nations communities must develop strategic plans in health.
- The community development process must be flexible and issue-driven so communities can take ownership of their health.
- Educational reform is needed
  - in the development of a framework and business plan to promote lifelong learning to ensure the cultural competencies of educators and health providers (future and current); and
  - to encourage youth to enter health programs and health professional career paths.
  - Elders and traditional healers must be included to ensure a complementary balance of western scientific approaches and traditional knowledge.
  - Adequate resources need to be provided.

### **Determining Success**

Participants reported the following keys to determining success:

- the establishment of new health models that exist across the country;
- the establishment of educational programs;
- First Nations pride and ownership of their health agenda, programs and services;
- accommodation of First Nations community timetables;



- more First Nations graduates in all sectors who return to their communities to live and work; and
- full implementation of RCAP recommendations.

## Capacity and Sustainability

### Capacity

To facilitate discussion of the launch question the following question was put forward to the group:

#### Launch Question:

***What and how should capacity need be built? How do we know we have achieved success?***

#### Professionals:

- A vast selection of health professionals, para-professionals and associated professions are needed in First Nations communities to support health positions, including primary care givers, specialists, health administrators, researchers, counsellors, educators, traditional caregivers, recreational workers and environmental health officers.

#### What and how to build capacity:

- internships for traditional practitioners;
- implementation of the approach in health programs and policies such as the Aboriginal Healing and Wellness Strategy in Ontario;
- more healing and birthing lodges;
- Accreditation Centre of Excellence for Aboriginal peoples;

- include mentorship programs;
- local training and support;
- post-secondary recruitment strategies that target First Nations youth;
- encourage more women to enter health science programs;
- establish internship programs for Aboriginal health professions;
- develop and provide summer science programs;
- accessible and available funding to provide extensive cultural awareness; and
- create targeted funding and investments to support Aboriginal post-secondary institutions.

#### Success for building capacity would include:

- a collaborative effort by/from all players;
- First Nations leadership at all decision-making tables;
- creating support systems that will help students in returning to communities;
- greater support for technology in communities;
- early education as a tool for improving health outcomes;
- the establishment of a First Nations Educational Advisory Group for Indian and Northern Affairs Canada;
- addressing the determinants of health;
- breaking away from the “right to welfare”; and
- secure agreements with all partners, status, non-status and women’s groups.

#### Making progress would mean:

- 10,000 more Aboriginal health care workers;



- Aboriginal control over reproductive and mental health;
- lower statistics of teenage births;
- more Aboriginal people with disabilities participating in health activities;
- improved health indicators;
- funding would no longer be an issue;
- less unknowns;
- First Nations jurisdiction and control over health; and
- all First Nations people, on and off reserve having access to NIHB.

### **Sustainability**

#### Launch Question:

***What and how sustainability needs be built? And how do we know we have achieved success?***

Participants addressed the questions in various sections. The summaries are as follows:

#### Definition of sustainability

- continued progress, existence and evolution in meeting needs, as well as a commitment to resources, monitoring, evaluation, quality control, accountability, and systems and supports; and
- in the short term, building processes to achieve long-term goals, such as establishing long-term agreements for self-sufficiency (without impacting on fiduciary obligation).

#### Environmental scan

- all areas need to be sustainable;

- external influences include governments and other organizations; and
- weakness includes lack of resources.

#### What needs to be done?

- First Nations needs, role modelling and mentorship should be defined;
- current investments to support business and strategic planning need to be reviewed;
- First Nations human resources and organizational development need to be increased; and
- strong commitments with provinces and territories must be established.

#### Who is going to do it?

- all stakeholders and players in government and First Nations communities.

#### How do we sustain First Nations health care?

- continue making agreements and partnerships with non-governmental organizations (NGOs), and private/public sectors; and
- improve infrastructure and adequate financial and human resources.

### **Broad Determinants of Health**

#### Launch Question:

***What needs to happen to address health determinants? What role can I/we play?***

Participants identified a vast number of determinants that can be summarized as follows :



- better education from kindergarten to post-secondary for First Nations and Aboriginal peoples on health;
- better living and disease prevention teachings;
- more housing that is better built and available to all Aboriginal peoples (with emphasis on single parents);
- environmental safeguards and greater clean-up of water, air and land;
- access to technology;
- First Nations health legislation, laws and a framework for Aboriginal health policy;
- greater communication to, and education of, all stakeholders on health issues;
- balanced attention to health issues, including mental health, traditional approaches and tools, and access to country and traditional foods;
- establish gender-specific issues, reproductive health, maternal health and data collection;
- establish more services for working with persons with disabilities; and
- reduce duplication by implementing interdepartmental discussions at the community level.

### **Application of the Crosscutting lens**

Clear references were made to health issues and recommended actions as they relate to women, people living off-reserve, non-status Indians and the additional lens of First Nations people living with disabilities. A review of the flip chart notes also suggests that the references to provinces in some cases reflect an application of the urban lens.

The geographic lens (urban, rural, remote) was addressed in terms of “portable rights” to “... fair, accessible equal services...recognizing gender and disabilities issues”; First Nations control of service delivery protocols/partnerships; establishment of community development models that include off-reserve; and funding and changes to the *Canada Health Act* to ensure urban/off-reserve service delivery.

The gender lens was applied through the provision of health programming of particular concern to women (e.g. maternal and reproductive health, community care supports); improved access to other health services; and the inclusion of gender issues and gender-based analysis in a variety of areas such as off-reserve access to services; equity within health professions/salaries; strategic planning; involvement in consultations, decision making and leadership; a National Health Action Plan/Strategy and the report of the Royal Commission on Aboriginal Peoples; and as a means of developing trust among partners at all levels.

A disabilities lens was applied in terms of on and off-reserve service access; increased participation in health activities and decision making processes; recognition of special needs in a national housing strategy; increased efforts to inform people with disabilities; and implementation of existing recommendations.



## ii) INUIT BREAKOUT GROUP

### Jurisdiction and Control

#### Launch Question:

*How will we address the issues of jurisdiction and control that are impacting on the delivery of, and access to, health services?*

Participants recommended specific actions on the topic of jurisdiction and control. Developing an Inuit Health Directorate, supporting Inuit-specific policy, expanding Inuit health authorities, increasing collaboration between governments, and implementing Inuit land claims are some of the significant solutions raised in this part of the discussions. The participants worked at four tables and provided the following input:

#### Definition of Success

- establishment and implementation of Inuit-specific policies, Health Directorate (immediate), Federal Inuit Secretariat (short to medium term), and direct funding to appropriate Inuit organizations that is multi-year based;
- Inuit-specific data collection;
- creation of a health system that supports and communicates the needs of individuals (especially the youth) in addressing mental wellness; and
- implementation of recommendations resulting in healthy, independent individuals, families and communities both physically and mentally, who have taken ownership of personal health, community health and health care.

### Clarification of Roles (Recommendations)

- federal/Provincial/territorial/Inuit are all the stakeholders (including land claim organizations and urban organizations) that need to participate in clarifying roles (and implementing Inuit-specific policy);
- all relevant stakeholders should collaborate and be brought together to complement and integrate programs and services for Inuit;
- legislation and licensing barriers require consistency and support to reduce the barriers for health professionals (e.g. in-Quebec licensing of nurses);
- the Inuit health agenda must be established by Inuit;
- establishment of an Inuit Health Directorate (with broad authority); and
- Inuit involvement in health care policy/planning/delivery is necessary regardless of geographic location (urban/political affiliations).

### Implementation of Inuit Policies

- requires the acknowledgement and establishment of clearly defined Inuit-specific health policies (e.g. for Inuit midwifery);
- federal/provincial/territorial and Inuit organizations must participate in seamless policy making and implementation;
- establishment of a “single Arctic” jurisdiction policy that includes Nunavik (Northern Quebec) and Nunatsiavut (Labrador) instead of the current “North of 60” designations;



- implementation of land claims in a timely manner;
- Inuit authority and capacity to deliver and train health care workers in a culturally appropriate and specific manner; and
- collaborate and bring together all relevant stakeholders, e.g. land claim organizations/provincial/territorial/federal/urban organizations, etc. to complement and integrate programs and services for Inuit.

At the Policy Retreat the agenda should include:

- Inuit-specific health protocols and partnerships;
- Inuit-specific cultural approaches to health policy development, programs and services;
- the creation of a level playing field for Inuit and federal/provincial/territorial relationship building, partnerships and protocols;
- the creation of new common legislation that will define cross-jurisdictional authorities to advance and support Inuit health;
- submission of all recommendations from the Inuit roundtable on health to the Aboriginal Cabinet Retreat scheduled for spring 2005; and
- creation of an Inuit-specific health agenda.

A Federal Inuit Secretariat should include:

- all sectors (not just Indian and Northern Affairs Canada), including health and human resources, environment, housing, education;

- direct reporting to Cabinet;
- a direct relationship with the Prime Minister;
- Inuit staff; and
- implementation of articles in Inuit Land Claims Agreements related to Inuit employment opportunities.

Inuit control and design of the proposed Inuit Health Directorate should:

- support and implement a broad-based consultation on the design and implementation, and authorities for the Inuit Health Directorate within INAC; and
- ensure that the Inuit Health Directorate has presence in each Arctic region and staff complements in Health Canada.

Inuit-specific Authority for Funding should include:

- a funding formula for health that matches the extent of Inuit health needs and be based only on population numbers;
- legislation is needed to support multi-year and direct health funding at F/P/T levels;
- commitment from Treasury Board to support the “new blueprint” for Inuit health in terms of priorities and funding matters;
- flexible funding arrangements and guidelines must be established to accommodate Inuit health issues;
- funding for Inuit health that is not streamed through other levels of governments such as federal/provincial or territorial; and



- collection of Inuit-specific data that is reliable and relevant to guide and influence funding allocations.
- Inuit philosophy and focus on well-being and prevention (rather than illness):
- creation of training programs on Inuit culture and way of life in the north for health care workers from the south who come to work with Inuit communities in the north;
- build a more holistic approach and integrate these principles in all sectors, such as economic, housing and social, not just health; and
- address in concrete ways, issues related to food security (i.e., getting safe, nutritious and affordable food).

Participants agreed by consensus that all of the above recommendations are prioritised as either immediate or short-term action items.

How do we know we are making progress?

- commitment from Treasury Board to fund Inuit organizations directly and support the Aboriginal blueprint;
- commitment from the federal/provincial/territorial governments to fund Inuit agenda on a multi-year basis;
- creation of Inuit structures where the administration does not outweigh programs and services;
- resolutions and commitments by Cabinet to support the Inuit health agenda, including implementation of the Inuit Health Directorate;

- collection of Inuit-specific data to support programs/services and document evidence to shift funding to respond to Inuit needs;
- expand wording that is used by the federal government when referring to Aboriginal peoples. (e.g. on/off-reserve does not cover Inuit, therefore there is a need to specifically identify Inuit consistently in wording used in announcements, etc.); and
- Inuit will continue to meet with other Aboriginal groups on areas of common interest.

### **Access and Integration**

#### Launch Question:

*What are the key issues and adaptive approaches that would contribute to improved levels of access to, and integration of, health programming and services?*

### **Definition of Success**

- clear Inuit involvement in all aspects of program design, delivery and evaluation;
- accomplishing an Inuit health agenda that is based on Inuit leadership in policy, program development/design, implementation, and is broad and inclusive of Inuit all over Canada;
- less reliance on the health care system;
- implementation of an Inuit health database, increased communications, adequate human resources, mental illness programming, respect for Inuit culture, and flexible programming, and



- capacity is developed that ensures quality health delivery at a community level.

### **Recommendations/Actions**

#### **Inuit philosophy/knowledge:**

- recognize and incorporate Inuit knowledge and practices to improve health accessibility;
- incorporate and blend Inuit traditional knowledge with western practices;
- greater emphasis on traditional teaching of Inuit knowledge in the home;
- support traditional Inuit wellness teachings and provide ongoing cultural awareness teachings; and
- educate Inuit youth through cultural and traditional teaching.

#### **Programs and services:**

- increase client support, including improved access to transportation and interpretation services;
- increase awareness of health services for all Inuit;
- provide adequate facilities and infrastructure for programs and services;
- more capacity building, training and support resources for communities;
- involve Inuit in the design and development of programs and services;
- flexible, integrated level of programming to improve delivery of comprehensive health services; and
- accessible program guidelines for all Inuit in the north and south.

#### **Capacity building:**

- capacity and educational support is needed to increase traditional Inuit skills and cultural values which enhance well-being;
- traditional Inuit medicine should be supported;
- increase skill sets in administration and policy development to increase Inuit staff in professional positions;
- be innovative in the retention and support of health professionals/staff (e.g. rotating shifts and respite); and
- provide ongoing Inuit culture approach to business in the Arctic for “southern visitors” (people who come to work in the north).

#### **Funding:**

- block and capital funding are required on a flexible and multi-year basis;
- all Inuit regions need to be made aware of funding opportunities;
- resources for Tele-Health to improve diagnosis and reduce the negative health impacts of remoteness are necessary; and
- all program criteria/guidelines must have a human resource and capital capacity-building requirement.

#### **Research:**

- Inuit-specific research (including a database) is needed to provide the baseline evidence for the development of effective, culturally appropriate programs and services;
- technology needs to be improved to provide better health care to the North;



- best practice modules should be shared among Inuit regions through the establishment of a clearinghouse;
- asset mapping and comparable analysis is needed; and
- training is required for Inuit in research skills.

### **Capacity and Sustainability**

#### Launch Question:

*What capacity supports are needed to ensure progress on shared health priorities and improved health status?*

The participants stated that many of the capacity and sustainability issues were already addressed in the discussions related to Jurisdiction and Control, as well as Access and Integration, therefore this section covers only those areas that were not adequately covered in the other sections.

#### **Definition of Success**

- Inuit pride and ownership of health systems;
- more trained and professional Inuit servicing Inuit in the communities, with programs and services Inuit have designed and developed;
- implementation of the Inuit traditional approach to health (holistic); and
- less reporting requirements with more emphasis on delivery of programming that is flexible enough to meet the needs in each community.

### **Recommendations/Actions**

- develop a single Inuit jurisdiction including Nunavik and Nunatsiavut instead of applying a “North of 60” approach;
- implementation of land claims;
- develop Inuit-specific cultural approaches required in health policy development, programs and services;
- create level playing field for Inuit in F/P/T relationship building, partnerships and protocols;
- develop new common legislation that will define cross-jurisdictional authorities advancing an Inuit authority (short term/immediate priority);
- submit recommendations for the 2005 Policy Retreat (short term/immediate priority);
- ensure that the Inuit Health Directorate will be present in all regions, with Inuit staff in Health Canada and INAC (short term/immediate priority); and
- develop specific legislation and obtain a Treasury Board commitment that allows the government to fund Inuit directly (short term/immediate priority).

#### **How will we know there has been progress?**

- a partnership agreement will be in place with a commitment to implement all of the above recommendations (must be a focus of the Policy Retreat agenda);
- formalize an F/P/T/Inuit partnership, including clarification of provincial and territorial jurisdictions in Quebec, Newfoundland/Labrador and Ontario, which have significant Inuit populations;



- funding will be made available to allow for broad consultation in the regions on the Inuit Health Directorate regarding the structure, mandate and implementation strategy; and
- implement existing agreements (land claims) as well as desired processes and outcomes.

### **Broad Determinants of Health**

#### Launch Question:

***How could a “broad determinants of health approach” be applied within an Inuit context?***

Participants indicated that the “stovepipe” approach prevents the development of relationships that would help establish partnerships, to work effectively on the broad determinants of health. In addressing broad determinants, participants suggested that greater access to education at all levels, both in the north and south are required. Joint partnerships and greater collaboration from all levels of governments are needed.

### **Recommendations/Actions**

- develop a common understanding of approaches to working together, and addressing how wellness is impacted by broad determinants of health (e.g. overcrowding and violence);
- enforce processes that ensure that sectors share information across programs and government departments on the design, development and delivery of programs;

- eliminate barriers for joint partnerships at the regional/community level through flexible program guidelines (e.g. Fetal Alcohol Spectrum Disorder strategy, inclusive of Department of Education as well as Health);
- implement specific articles in Inuit comprehensive land claims agreements related to Inuit employment and training opportunities;
- develop processes where the Inuit can report directly to the Prime Minister and Cabinet; and
- provide access to educational funding (all levels) regardless of geographic location.

### **Working with Other Stakeholders**

#### Launch Question:

***In what areas of our recommended action and definitions of success will we work with other “stakeholders” and how will we do that?***

- continue to meet with Aboriginal partners on common issues; and
- pursue and create an Inuit-specific agenda.

### **Inuit vision for wellness:**

*Physically and mentally healthy, independent individuals and families who have taken ownership of personal and community health, and Inuit-specific processes, developed and driven by Inuit, with adequate support (e.g. funding, resources, information and infrastructure) to implement the strategies developed and put into action.*



Participants indicated an urgent need for multi-year, needs-based funding that is flexible, equitable and streamlined. The key objectives are to have health (physical and mental) programs and services that are fully accessible in all regions, without barriers of jurisdiction or resources.

Inuit identified some common issues and priorities among Aboriginal groups, but Inuit have recommended Inuit-specific approaches for a long time. Due to jurisdiction, geography, culture and values, Inuit-specific programs and actions are recommended to improve community wellness.

### **Application of the Crosscutting Lens**

The Inuit breakout included the crosscutting lens in all the discussions. Inuit health policies would include all Inuit in Canada regardless of their geographical residence, gender or age. Specific strategies would be required to deal with unique needs faced within these lenses.

### **iii) MÉTIS BREAKOUT GROUP**

#### **Jurisdiction and Control**

##### Launch Question:

*How will we address the issues of jurisdiction and control that are impacting on the delivery of, and access to, health services?*

#### **Definition of Success**

Working in four table groups, the participants identified approximately 55 points that could constitute successful outcomes if jurisdictional and control issues affecting Métis health were addressed. Jurisdictional issues were described in terms of how they limit access to existing health programs and services and fragment the Métis identity. Clarifying what the jurisdictional issues are, shifting relationships (e.g. fiduciary responsibility, bilateral relationships, devolution, Métis control, etc.) to address them, and evaluating progress were noted as key success outcomes. The suggested ideas provide a mix of broad, immediate and longer term ideas that support the development of definitions of success, as well as provide insight into the development of strategies and recommendations to increase:

- awareness of needs;
- access to Métis-specific and other health systems, services and programs;
- respect for Métis governance;
- equal participation in decision-making and political processes;
- partnerships with other governments and among Aboriginal groups; and
- securing a direct funding relationship with the federal government.

The definitions of success were grouped into the following four main categories and participants were asked to develop more detailed recommended actions pertaining to these categories:

- health services, status and improved data (Ownership, Control, Access and Possession) OCAP– “we know where we started”;



- clear roles and responsibilities;
- Métis-specific health strategies; and
- evaluation of progress.

### **Recommendations/Actions (We know where we started):**

Improve health services, status and data by:

- addressing gaps in knowledge by providing for Métis identifiers in data collection, providing financial resources, capacity building and developing partnerships;
- increasing Métis capacity to translate data into Métis-specific policy; and
- creating a gender equality frameworks and applying it to both governance processes, and developing protocols and mechanisms.

### **Recommendations/Actions (Clear roles and responsibilities)**

Establish a direct Métis/federal relationship and partnerships with other governments, Aboriginal organizations, etc., in order to pursue:

- an agreement to immediately establish a Métis-specific health table with equal federal/provincial/Métis partnerships;
- support for, and implementation of, a Métis-specific health strategy that includes a direct relationship with Métis leadership;
- clarification of federal/provincial responsibilities to Métis;
- mechanisms to demonstrate what federal/provincial governments do on Métis issues;
- community-driven consultations with

both political and non-political dimensions; and

- application of the gender and geography lens as a natural component of community based approaches.

### **Short-term Recommendations/Actions**

- primary care pilot projects;
- a federal commitment to, and recognition of, the Métis Nation;
- involvement of Métis in all F/P/T health discussions and decision-making processes;
- development of Métis registries;
- targeted funding for Métis-specific programming based on a negotiated allocation formula; and
- program guidelines to access funding to be developed by Métis with community input.

### **Medium-term Recommendations/Actions**

- community based planning processes that feed into programming and services;
- increased number of Métis health care professionals;
- implementation and extension of basic primary health care services and programs; and
- implementation of a Métis Non-Insured Health Benefits Program.



## Evaluation of Progress Recommendations/Actions

- design and implement processes to achieve success and recommended actions.

## Access and Integration

### Launch Question:

*What are the key issues and adaptive approaches that would contribute to improved levels of access to, and integration of, health programming and services?*

## Definitions of Success

Working as a single group, the participants engaged in a brainstorming exercise that generated 22 ideas for what would constitute success in improving access and integration. The participants used a quick dot-voting technique to provide a sense of how this particular group of participants might rank the identified success indicators. While it is important that this be read in the context of the full list contained in the flip chart notes, key issues include:

- the narrowing and elimination of disparities between Métis and other Canadians;
- consideration of the impact of long-term systemic racism, including gendered racism, as a critical determinant of health;
- community-directed, Métis-focused promotional activities that build on knowledge and values of the community;
- ownership, control, access and

- possession of the health system;
- equitable and acceptable access to comprehensive high quality health care services (confidential, culturally appropriate, gender sensitive/specific);
- equitable and knowledgeable access to the current health system;
- Métis proportion of health care professionals that mirrors the Métis population; and
- a focus on improved access and recognition, not integration.

## Recommendations/Actions

Given the time available, the group was unable to identify a working set of categories or themes upon which to develop recommended actions and as a result each table group was asked to review the entire list and develop recommended actions. The resulting recommended actions reflected and provided more detail to some of the ideas generated in the previous section (e.g. Métis Nation involvement in all F/P/T health discussions and decision making, Métis health drug benefits insurance, etc.), as well as additional recommended actions including:

## Short-term/Intermediate Recommendations/Actions

- develop a federal access point for Métis;
- research and address knowledge gaps (e.g. access to government programs, gender equality analysis);
- develop and implement Métis-specific cultural accreditation of health care facilities and providers who serve Métis;



- implement Métis/community-controlled primary health care, health promotion and services and programs;
- develop a Métis Health Accord with Métis governance structures to build policy development capacity that represents the distinct needs of Métis people;
- allocate resources for capacity building through the development of a National Métis Health Action Plan inclusive of all Métis (provincial, women, people with disabilities, and remote Métis communities); and
- develop a comprehensive Métis health human resources capacity development strategy.

### **Medium-term/Intermediate Recommendations/Actions**

- develop a Métis-specific health strategy and policy framework that respects communities and is protected by a federal/provincial/Métis accord;
- target funding and devolution for Métis-specific health care system and programming based on a negotiated allocation formula; and
- create a Métis health policy centre.

### **Capacity and Sustainability**

#### Launch Question:

*What capacity supports are needed to ensure progress on shared health priorities and improved health status?*

### **Definitions of Success/Recommendations/Actions**

There were approximately a dozen ideas suggested for what would constitute success in the area of capacity and sustainability. These ideas reflected and added to previous definitions of success statements and recommended actions (e.g. Métis governance structures, research, partnerships, etc.). Additional ideas include:

#### Capacity:

- comprehensive health and human resources capacity building and development strategies;
- Métis recruitment and retention initiatives; and
- development of post-secondary health professional programs.

#### Sustainability:

- targeted and multi-year resources (including core funding vs. proposal/competition based);
- development of health policy; and
- engaging all stakeholders in planning processes.

### **Broad Determinants of Health**

#### Launch Question:

*How could a “broad determinants of health approach” be applied within a Métis context?*



## Recommendations/Actions

- develop partnerships between government ministries and Métis government structures to support and resource joint holistic community-based health planning, promotion and prevention initiatives that empower communities to improve determinants of health;
- holistically address socio-economic marginalization, classism, violence and racism at all stages of planning, implementation and evaluation;
- recognize racism (including gendered racism) as a determinant of health and take this into account at all stages;
- consider health on all agendas, including other Sectoral Follow-up Sessions; and
- collaborate between Métis policy people across all sectors (i.e., health, housing, education).

## Working with other stakeholders

### Launch Question:

***In what areas of our recommended actions and definitions of success will we work with other “stakeholders” and how will we do that?***

The participants provided suggested areas to work together and details on how to work together (see flip charts), which are summarized as:

- Métis networking (starts by bringing Métis stakeholders together);
- instituting a single Métis access point within the federal system;
- pursuing Métis workforce development;

- engaging Métis-specific health prevention research;
- facilitating the inclusiveness of all Métis; and
- building partnerships with other groups in Canada (e.g. Indigenous/non-Indigenous).

## Knowing we are making progress

### Launch Question:

***How will we know that progress is being made on our definitions of success and recommended actions?***

Participants generated over a dozen responses relating to their internal environment and another dozen or so related to their external environment. These ideas reflect implementation of many of the recommended actions (e.g. agreements, processes, resources, plans) and the elements of success (e.g. Métis-specific health services, respect for community knowledge) raised throughout the breakout group discussions. The ideas also reflect the desire to see that the gap in key quality-of-life indicators (i.e. health status improvements, comparable life expectancy) is being closed. These ideas are summarized as:

- self-determined and self-governed design and delivery of health services and programs;
- sufficient resources, infrastructure and capacity in place to support Métis health initiatives;
- an inclusive Métis health accord signed with the federal government;



- measured improvement in Métis health status; and
- a representative Métis health workforce.

### **Application of the Crosscutting lens**

At every stage of the discussions, the participants were asked to review their recommendations from the perspectives of providing Métis women an opportunity to participate and/or address issues of concern to their health status; and addressing the needs and concerns of Métis people in urban and northern/rural/remote situations.

A focused discussion on what applying Métis gender equality might entail was led by two participants. A lively discussion emphasized to all the participants that there are different health and social realities for men and women (e.g. access to pap

tests/breast screening; rates of physical, emotional, sexual violence against Métis women, children and families; high rates of male youth suicide and low screening rates for adult males). The discussion indicated that a successful approach would include:

- a built-in Métis gender-equality analysis by all stakeholders and health officials when dealing with services, data, planning, development, implementation and evaluation;
- a specific focus on women's issues within research, cultural safety and community activities;
- increased participation by women in leadership/governance and program delivery; and
- include a gender-based analysis clause within Métis National Health Accord.



***FOLLOW-UP TO THE CANADA -ABORIGINAL PEOPLES ROUNDTABLE  
HEALTH SECTORAL SESSION  
NOVEMBER 4-5, 2004  
OTTAWA, ONTARIO  
MARRIOTT HOTEL  
ANNOTATED AGENDA***

**INTRODUCTION:**

The objective for the Health Sectoral Session is to provide input and discuss options for improving:

- the health status of Aboriginal peoples;
- the health services available to Aboriginal peoples;
- the systems of delivery; and
- governance and accountability.

**AGENDA ACTIVITIES:**

**Day One - Thursday, November 4, 2004**

<b>7:30 am</b>	Coffee and Registration	<i>2nd Floor Lobby</i>
<b>8:30 am</b>	Opening Invocation	<i>Elders</i>
<b>8:45 am</b>	Welcoming Remarks Purpose, Context and Next Steps	<i>The Honourable Ujjal Dosanjh, Minister of Health</i>
<b>9:15 am</b>	Review of the Background Papers	<i>Facilitation Team</i>
<b>9:35 am</b>	Introduction to the Forum Agenda Description of Breakout Group Process	<i>Harold Tarbell, Lead Facilitator</i>
<b>9:45 am</b>	Health Break	
<b>10:00 am</b>	3 Breakout Groups to discuss Policy Area 1:	<i>First Nations, Métis and Inuit issues breakout groups</i>



### **Issues of Jurisdiction and Control**

- Shared Definition of Success
- Recommended Actions
- Crosscutting Themes (i.e. Urban Aboriginal and Aboriginal Women lens, with crosscutting theme of Rural/Remote)

#### **Launch Question:**

How will we address the issues of jurisdiction and control that are impacting on the delivery of, and access to, health services?

**12:30 noon** Lunch

**1:30 pm** 3 Breakout Groups to discuss Policy Area 2: *First Nations, Métis and Inuit issues breakout groups*

### **Improving Access and Integration**

- Shared Definition of Success
- Recommended Actions
- Crosscutting Themes (i.e. Urban Aboriginal and Aboriginal Women lens, with crosscutting theme of Rural/Remote)

#### **Launch Question:**

What are the key issues and adaptive approaches that would contribute to improved levels of access to, and integration of, health programming and services?

**4:00 pm** Health Break

**4:15 pm** Reports from Breakout Sessions 1 and 2 *Métis, First Nations and Inuit Session Reporters*

**4:45 pm-5:00 pm** Facilitator Summary of Day One *Facilitation Team*

**7:30 pm** Delegates' Reception co-hosted by Minister of Health and Minister of State

### **Day Two – Friday, November 5, 2004**

**8:15 am** Coffee



<b>8:45 am</b>	Opening Invocation	<i>Elders</i>
<b>9:00 am</b>	Wrap-up of day 1/ Introduction to day 2	<i>Facilitation Team</i>
<b>9:15 a.m.</b>	3 Breakout Groups to discuss Policy Area 3:	<i>First Nations, Métis and Inuit issues breakout groups</i>
	<b><u>Building Capacity and Sustainability</u></b>	
	<ul style="list-style-type: none"><li>• Shared Definition of Success</li><li>• Recommended Actions</li><li>• Crosscutting Themes (i.e. Urban Aboriginal and Aboriginal Women lens, with crosscutting theme of Rural/Remote)</li></ul>	
	<u>Launch Question:</u> What capacity supports (e.g. human resources, infrastructure, sustainability, etc.) are needed to ensure progress on shared health priorities, and improved health status?	
<b>11:45 am</b>	Lunch	
<b>12:45 am</b>	3 Breakout Groups to discuss Policy Area 4:	<i>First Nations, Métis and Inuit issues breakout groups</i>
	<b><u>Broad Determinants/Health Issues</u></b>	
	<ul style="list-style-type: none"><li>• Shared Definition of Success</li><li>• Recommended Actions</li><li>• Crosscutting Themes (i.e. Urban Aboriginal and Aboriginal Women lens, with crosscutting theme of Rural/Remote)</li></ul>	
	<u>Launch Question:</u> How will we build linkages with other programs (i.e. social, education, housing, economic, etc.) to improve health outcomes in the short, medium and long term?	
<b>3:15 pm</b>	Health Break	
<b>3:30 pm</b>	Reports from Breakout Sessions 3 and 4	<i>Métis, First Nations and Inuit Session reporters</i>



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**4:00 pm**      Facilitator's Overall Summary      *Facilitation Team*

**4:30 pm**      Closing Ceremony and Adjournment      *Elders*

**PARTICIPANT LIST-FIRST NATIONS BREAKOUT  
HEALTH SECTORAL FOLLOW-UP SESSION NOVEMBER 4 – 5, 2004**

Ms.	Kim	Brooks	Institute for Aboriginal People's Health - University of British Columbia
Chief	Shirley	Clarke	Assembly of First Nations
Chief	Allan	Claxton	Assembly of First Nations
Ms.	Helen	Cromarty	Nishnawbe Aski Nation
Ms.	Doreen	Demas	Manitoba Disability Directorate
Ms.	Madeleine	Dion-Stout	Consultant
Ms.	Bernice	Downey	National Aboriginal Health Organization
Ms.	Lori	Duncan	Council of Yukon First Nations
Chief	Bill	Erasmus	Assembly of First Nations
Chief	Ron	Evans	Assembly of First Nations
Ms.	Alma	Favel-King	Federation of Saskatchewan Indian Nations
Ms.	Allison	Fisher	Wabano Centre for Aboriginal Health
Ms.	Randi	Gage	Congress of Aboriginal Peoples
Ms.	Shelley	Garnier	Federation of Newfoundland Indians
Chief	Jason	Goodstriker	Assembly of First Nations
Ms.	Nadine	Gros-Louis	Quebec-Labrador Health and Social Services Commission
Mr.	Richard	Jock	Assembly of First Nations
Chief	Doug	Kelly	Assembly of First Nations
Dr.	Malcolm	King	University of Calgary - ACADRE Network
Mr.	Rick	Kotowich	Regional Qu'Appelle Health Region
Ms.	Cathy	Mandoka	Association of Iroquois and Allied Indians
Ms.	Pat	Mandy	Hamilton Health Sciences Corporation
Ms.	Kluane	Martin	Council of Yukon First Nations
Dr.	Ron	Martin	Dentist
Ms.	Heather	McNeill	Congress of Aboriginal Peoples
Ms.	Ruby	Miller	Six Nations Health Services
Ms.	Ruth	Morin	Nechi Institute
Ms.	Katherine	Morriseau-Sinclair	Mother of Red Nations Women's Council of Manitoba
Ms.	Claudia	Simon	Elsipogtog Health and Wellness Centre
Dr.	Esther	Tailfeathers	Blood Tribe Health Services
Ms.	Vicki	Thomas	New Brunswick Aboriginal Peoples Council
Dr.	Mamoru	Watanabe	University of Calgary
Chief	Morley	Watson	Federation of Saskatchewan Indian Nations
Ms.	Josephine	Worm	Kawacatoose First Nation
Ms.	Debra	Wright	Congress of Aboriginal Peoples



**PARTICIPANT LIST-INUIT BREAKOUT  
HEALTH SECTORAL FOLLOW-UP SESSION NOVEMBER 4 – 5, 2004**

Ms.	Eva	Aariak	Languages Commissioner of Nunavut
Ms.	Karliin	Aariak	Nunavut Tunngavik Inc.
Ms.	Iris	Allen	Labrador Inuit Health Commission
Mr.	Tony	Andersen	Labrador Inuit Association
Ms.	Celeste	Anderson	Labrador Inuit Health Commission
Ms.	Laureen	Angalik	Arviat Health Centre
Ms.	Hannah	Ayukawa	Montreal Children's Hospital
Ms.	Susie	Bernier	Laval University - Nasivvik Centre
Ms.	Tracy	Brown	Tungasuvvingat Inuit
Ms.	Edith	Cloutier	Regroupement des centre d'amitiés autochtone du Québec
Ms.	Laura	Commanda	Institute for Aboriginal People's Health
Ms.	Rosemary	Cooper	Government of Nunavut
Ms.	Debbie	Dedam-Montour	National Indian and Inuit Community Health Representative Organization
Mr.	Mike	Degagne	Aboriginal Healing Foundation
Mr.	Qajaaq	Ellsworth	National Inuit Youth Council
Ms.	Roselyne	Ferguson	Nunavik Regional Board of Health and Social Services
Mr.	Larry	Gordon	National Inuit Committee on Health
Ms.	Lori	Idlout	Isaksimagit Inuusirmi Katujjiqatigiit (Embrace Life Council)
Dr.	Penny	Jennett	Canadian Society of Telehealth
Ms.	Michelle	Kinney	Labrador Inuit Health Commission
Ms.	Rhoda	Kokiapik	Avataq Cultural Institute
Ms.	Kathleen	MacMillan	First Nations and Inuit Health Branch -Office of Nursing Services
Dr.	Jane	McGillvray	Labrador Health Centre
Ms.	Leesie	Naqitarvik	Pauktuutit Inuit Women's Association
Ms.	Tracy	O'Hearn	Ajunnginiq (Inuit) Centre
Ms.	Mary	Palliser	Pauktuutit Inuit Women's Association
Ms.	June	Perry	Labrador Inuit Association
Dr.	RoseMarie	Ramsingh	First Nations and Inuit Health Branch - Office of Community Medicine
Ms.	Onalee	Randell	Inuit Tapiriit Kanatami
Ms.	Mina	Tulugak	Inulitsivik Hospital
Ms.	Darlene	Wall	Labrador Métis Nation
Dr.	Wadieh	Yacoub	First Nations and Inuit Health Branch - Alberta/NWT Regional Office



**PARTICIPANT LIST-MÉTIS BREAKOUT  
HEALTH SECTORAL FOLLOW-UP SESSION NOVEMBER 4 – 5, 2004**

Ms.	Deborah	Barron-McNabb	Manitoba Métis Federation
Mr.	Roman	Bittman	National Aboriginal Achievement Foundation
Mr.	David	Boisvert	Manitoba Métis Federation
Ms.	Rose	Bortolon	Métis Provincial Council of British Columbia
Ms.	Carol	Carifelle-Brzezicki	Métis Settlements General Council
Ms.	Judy	Chapman-Price	Ontario Métis Aboriginal Association
Mr.	David	Chartrand	Manitoba Métis Federation
Ms.	Lisa	Dutcher	Aboriginal Nurses Association Canada
Ms.	Germaine	Elliott	Algoma University College
Mr.	George	Erasmus	Aboriginal Healing Foundation
Mr.	Don	Fiddler	Métis Nation of Ontario
Ms.	Jocelyn	Formsma	National Aboriginal Youth Council
Ms.	Fran	Hyndman	Métis Nation of Alberta
Ms.	Mary	Kapelus	Métis National Council
Ms.	Marlene	Lanz	Alberta Métis Federation
Dr.	Barry	Lavallee	Aboriginal Health & Wellness Centre of Winnipeg
Dr.	Charlotte	Loppie	School of Health and Human Performance- Dalhousie University
Mr.	Alastair	MacPhee	Congress of Aboriginal Peoples
Ms.	Noreen	McAteer	National Aboriginal Health Organization
Ms.	Lisa	McCallum-McLeod	Prairie Women's Health Centre of Excellence
Ms.	Celeste	McKay	Native Women's Association of Canada
Dr.	John	O'Neil	University of Manitoba - Centre for Aboriginal Health Research
Ms.	Sandra	Opikokew	Licensed Practical Nurse
Ms.	France	Picotte	Métis Nation of Ontario
Mr.	Al	Rivard	Métis Nation of Saskatchewan
Ms.	Todd	Russell	Labrador Métis Association
Ms.	Erica	Samms-Hurley	Native Women's Association of Canada
Dr.	Janet	Smylie	Saskatchewan Indigenous Peoples Health Research Centre
Ms.	Patricia	Thompson	Regional Qu'Appelle Health Region
Dr.	Jay	Wortman	First Nations and Inuit Health Branch - British Columbia Regional Office



## OFFICIALS LIST

### HEALTH SECTORAL FOLLOW-UP SESSION NOVEMBER 4 – 5, 2004

<b>AFN</b>		
	Valerie Gideon	Director, Health and Social Policy
	Jennifer Brennan	Director, Strategic Policy and Planning
	Dean Janvier	AFN Special Advisor, National Chief's Office
<b>ITK</b>		
	Shani Watts	Inuit Tapiriit Kanatami
	Catherine Dallas	Inuit Tapiriit Kanatami
	Pat Angnakak	Nunavut Tunngavik Inc.
<b>MNC</b>		
	Marie Van Humbeck	Métis Provincial Council of British Columbia
	Marilee Nault	Manitoba Métis Federation
	Duane Morriveau	National Health Coordinator - Métis National Council
<b>CAP</b>		
	Bob Gairns	Congress of Aboriginal Peoples
	Lorraine Foreman	Congress of Aboriginal Peoples
<b>Federal</b>		
<b>Health</b>	Ian Potter	ADM, First Nations and Inuit Health Branch (FNIHB)
	Katherine Stewart	Strategic Policy, Planning and Analysis, FNIHB
	Keith Conn	First Nations/Inuit Relations, FNIHB
	Catherine Adam	Strategic Policy and Planning, FNIHB
<b>INAC</b>	Havelin Anand	Indian and Northern Affairs Canada
<b>TBS</b>	Catherine Newell	Treasury Board Secretariat
	Pamela Simpson	Treasury Board Secretariat
<b>FIMNSI</b>	Jeffrey Cyr	Federal Interlocutor for Métis and Non-Status Indians
<b>StatsCan</b>	Andy Siggner	Statistics Canada
<b>PCO</b>	Howard Green	PCO-Aboriginal Affairs Secretariat
	Heather McLean	PCO-Aboriginal Affairs Secretariat
	Elizabeth Logue	PCO-Aboriginal Affairs Secretariat
<b>Industry</b>	Georgina Wainwright-Kemdirim	Aboriginal Business Canada, Industry Canada
<b>Provincial/territorial</b>		
<b>NFLD</b>	David Hughes	Department of Aboriginal Affairs
	Beverly Griffiths	Department of Health/Community Services
<b>NS</b>	Frank Reinhardt	Department of Health
	Ernest Walker	Office of Aboriginal Affairs
<b>NB</b>	Don Richardson	Department of Health and Wellness
<b>QC</b>	Marc-André Maranda	Ministère du Santé et des services sociaux
	Louis Rivard	Ministère du conseil exécutif (affaires Autochtones)
<b>MB</b>	Brian Gudmundson	Department of Aboriginal and Northern Affairs
	Lorretta Bayer	Aboriginal Health - Manitoba Health
<b>AB</b>	Phil Burke	Department of Health and Wellness
	John McDonough	Department of Aboriginal Affairs
<b>BC</b>	Debra Schwartz	Ministry of Health Services
	Lisa Nye	Aboriginal and Women's Services
<b>ON</b>	Miriam Johnston	Ministry of Health and Long-term Care



Background information and flip chart notes are available on the Internet at:  
[www.aboriginalroundtable.ca](http://www.aboriginalroundtable.ca)

The following is a list of documents available on the website:

- Flip Chart Notes
  - First Nations Breakout Room
  - Inuit Breakout Room
  - Métis Breakout Room
- Government of Canada Background Paper
- Assembly of First Nations Background Paper
- Inuit Tapiriit Kanatami Background Paper
- Métis National Council Background Paper
- Congress of Aboriginal Peoples Background Paper
- National Women's Association Background Paper
- Statistics Canada Overview