Roots of Resilience:

OVERCOMING INEQUITIES IN ABORIGINAL COMMUNITIES

December 12, 2013

Canadian Council
on Social Determinants of Health

Roots of Resilience: Overcoming Inequities in Aboriginal Communities

Également disponible en français sous le titre : *Les racines de la résilience : aplanir les inégalités dans les communautés autochtones*

ISBN: 978-0-9937151-2-9

To obtain additional copies, please contact:
Canadian Council on Social Determinants of Health
E-mail: CCSDH.Correspondence@phac-aspc.gc.ca

This publication can be made available in alternative formats upon request.

Preface

This document is based on research commissioned by the Canadian Council on Social Determinants of Health (CCSDH), previously known as the Canadian Reference Group on Social Determinants of Health (CRG).

The CCSDH is a collaborative multi-sectoral stakeholder group established to:

- Provide the Public Health Agency of Canada (PHAC) with advice on matters relating to the implementation of the *Rio Political Declaration on Social Determinants of Health*, including planning, monitoring, and reporting; and
- Facilitate and leverage action on the social determinants of health through member networks and targeted, intersectoral initiatives.

The CCSDH brings together organizations from a wide array of sectors that have a role to play in addressing the factors that shape health. The CCSDH also includes individuals selected on the basis of their knowledge and experience regarding policy, research or intersectoral action on the social determinants of health.

The CCSDH fulfills its mandate through various activities, including the creation or adaptation of knowledge tools and reports to leverage action on social determinants of health. *Roots of Resilience: Overcoming Inequities in Aboriginal Communities* is one such report.

The development of this report was guided by the Aboriginal Approach Task Group of the CCSDH. The CCSDH commissioned this report to build knowledge of the underlying factors that influence the health of Aboriginal peoples in Canada, and how these factors can be addressed. The CCSDH decided that the best way to achieve this goal was to feature communities who had been successful in overcoming barriers, rather than focusing on the barriers themselves. It is the hope of the CCSDH that this report will facilitate a dialogue on self-determination and cultural appropriateness.

THE CANADIAN COUNCIL ON SOCIAL DETERMINANTS OF HEALTH

KRISTA OUTHWAITE
CO-CHAIR
Associate Deputy Minister, Public Health Agency of Canada

PEGGY TAILLON
CO-CHAIR
President and CEO, Canadian Council on Social Development

KIMBERLY ELMSLIE (EX OFFICIO)
Acting Assistant Deputy Minister, Public Health Agency of Canada

MICHAEL BLOOM
Vice-President, Organizational Effectiveness and Learning, Conference Board of Canada

PAUL BORN
President and CEO, Tamarak Institute for Community Engagement

ED BULLER
Elder

BARBARA BYERS
Exec. Vice-President, Canadian Labour Congress

CONNIE CLEMENT
Scientific Director, National Collaborating Centre for Determinants of Health

IAN CULBERT
Executive Director, Canadian Public Health Association

JEFFREY CYR
Executive Director, National Association of Friendship Centres

ERICA DI RUGGIERO
Associate Director, Canadian Institutes for Health Research Institute of Population and Public Health

JOEY EDWARDH
Director, Community Development Halton

GERRY GALLAGHER
Acting Executive Director, Social Determinants and Science Integration Directorate, Public Health Agency of Canada

MARGO GREENWOOD
Academic Leader, National Collaborating Centre for Aboriginal Health

TREVOR HANCOCK
Professor and Senior Scholar, School of Public Health and Social Policy, University of Victoria

JEAN HARVEY
Director, Canadian Population Health Initiative, Canadian Institute for Health Information

BEN HENDERSON
Representative, Federation of Canadian Municipalities, and City Councillor, City of Edmonton

KATHY LANGLOIS
Director General, Strategic Policy, Planning & Information, First Nation and Inuit Health Branch, Health Canada

CORY NEUDORF
Chief Medical Officer of Health, Saskatoon Health Region

HILARY PEARSON
President, Philanthropic Foundations Canada

LOUISE POTVIN
Scientific Director, Centre Léa-Roback sur les inégalités sociales de Montréal

ANDREW SACRET
Director of Policy and Public Affairs, Canadian Institute of Planners

Aboriginal Approach Task Group

MARGO GREENWOOD (LEAD)
Academic Leader, National Collaborating Centre for Aboriginal Health

ED BULLER
Elder

JEFFREY CYR
Executive Director, National Association of Friendship Centres

JOEL DENIS
Acting Director, Intergovernmental and Stakeholder Policy, Public Health Agency of Canada

GERRY GALLAGHER
Acting Executive Director, Social Determinants and Science Integration Directorate, Public Health Agency of Canada

TREVOR HANCOCK
Professor and Senior Scholar, School of Public Health and Social Policy, University of Victoria

CORY NEUDORF
Chief Medical Officer of Health, Saskatoon Health Region

ARUNA SADANA
Acting Director General, Strategic Policy, Planning & Information, FNIHB, Health Canada

PEGGY TAILLON
President and CEO, Canadian Council on Social Development

Acknowledgements

This report is based on work completed in 2012–13 for the Canadian Council on Social Determinants of Health by Charlotte Reading, Ph.D., Professor, School of Public Health and Social Policy and Director, Centre for Aboriginal Health Research, University of Victoria. The Council thanks Dr. Reading for the early draft of this report.

The CCSDH would also like to thank the members of the Aboriginal Approach Task Group, who provided guidance on the development of this report. The contribution of Andrea Long, Policy Analyst, Social Determinants and Science Integration Directorate, Public Health Agency of Canada, in revising the document to integrate the input from various stakeholders, is also much appreciated.

Table of Contents

Executive Summary

Aboriginal peoples in Canada experience significant and persistent inequities that affect their health, social and community well-being. Some Aboriginal communities and collectivities[1] across Canada have taken important steps to address the structural origins of inequity by increasing local community control over underlying social, economic, political and cultural conditions.

This report explores the experiences of three Aboriginal communities and two Aboriginal collectivities in Canada that have successfully pursued greater self-determination as an approach to target the structural causes of inequity. These five examples are:

- The formal legal recognition of the Ouje-Bougoumou Cree community in northern Québec, including the design and development of a community site and local structures that reflect and advance Cree cultural traditions.
- The creation of a successful restorative justice model — Community Holistic Circle Healing — in the Métis and First Nation communities of Hollow Water, Manitoba. Community members created a unique approach to address abuse, violence and other problems, the root causes of which often originate with residential school experiences.
- The signing of the Tripartite Framework Agreement on First Nations Health Governance in British Columbia (BC) by the federal and provincial governments and First Nations leadership. The Plan increases First Nations control over the governance and delivery of health care services for all 203 First Nations in BC.
- The establishment of self-government for the Westbank First Nation outside of Kelowna, BC. The community is responsible for shaping the structure, accountability and law-making powers of its own government, which in turn is responsible for the economic and social well-being of community members.
- The formation of the territory of Nunavut as a self-governing jurisdiction uniquely based on Inuit culture, values, traditions and language.

The types of measures adopted by these communities and collectivities to advance self-determination are diverse. One group pursued legal recognition of territory on which to reestablish a community, two groups designed and implemented new approaches to service delivery based on Indigenous values and traditions, and two groups established formal self-government structures. Despite these different trajectories, the actions of the groups share some common elements: a strong commitment to maintaining Indigenous cultures and values, and a willingness to create and adopt new approaches outside of the models provided by broader Canadian society to address the root causes of inequity.

The self-determining achievements of the communities and collectivities profiled in this report exemplify the strength and resilience of Aboriginal peoples, adapting when necessary and innovating where possible. An important implication of these findings is that Aboriginal communities are successfully pursuing self-determination in many different ways. The positive experiences documented in this report can provide examples for other Aboriginal peoples.

1 A collectivity is defined as "the collective whole; *especially* the people as a body" (Merriam-Webster, n.d.).

The report also helps to identify potential roles for various sectors in supporting and building healthier Aboriginal communities. Government support at various levels is important for creating and maintaining infrastructure, training and retaining human resources and developing and implementing culturally and locally relevant programs and services. Non-profit organizations can provide information, individual and community development and access to supportive services and networks. The private sector can train and recruit Aboriginal peoples for local jobs, and develop businesses on reserve land. Finally, researchers can help to gather and share Aboriginal stories of resilience to leverage current achievements and provide evidence of success.

> *"A resilient community is one that takes intentional action to enhance the personal and collective capacity of its citizens and institutions to respond to, and influence the course of social and economic change"* (Canadian Centre for Community Renewal 2000, p.5).

1. Introduction

The significant and persistent inequities experienced by Aboriginal[2] peoples in Canada are well documented. Remote residence on land with meager or inaccessible natural resources, inadequate housing, limited access to health care, lack of employment or educational opportunities and insufficient infrastructure all contribute to disproportionately high burdens of disease (tuberculosis, HIV, diabetes, heart disease), mental health issues (drug and alcohol abuse, suicide) and social problems (violence, abuse) (Butler-Jones 2008). It is also widely accepted that the historical imposition of colonial structures adversely affected the sovereignty and health of Aboriginal peoples (Adelson 2005; Backhouse 1999; Waldram, Herring & Young 1995).

Aboriginal peoples, community organizations and governments are taking action to address these inequities through programs and services that foster education and job training, promote diverse dimensions of health and mental health, support healing, and strengthen community capacity. Many of these interventions are successfully improving the well-being and living conditions of Aboriginal peoples. While such immediate action to improve current circumstances is necessary, attention must be paid to the underlying or root causes of inequity. These root causes are typically grounded in economic, political, legal, cultural and social factors often referred to as structural determinants of health (NCCAH 2012; WHO 2007).

The World Health Organization (WHO) defines structural determinants as "those that generate or reinforce social stratification in the society and that define individual socioeconomic position. These mechanisms configure the health opportunities of social groups based on their placement within hierarchies of power, prestige and access to resources" (WHO 2007, p.26; see also Singh-Manoux, Clarke & Marmot 2002). Resolving inequities at the structural level ultimately benefits a population through what might be called a 'trickle-up' effect on community infrastructure, resources, capacities and cohesion. This in turn influences more immediate factors that affect health such as income, employment, education, and housing (Marmot & Wilkinson 2003).

This report profiles the experiences of three Aboriginal communities and two Aboriginal collectivities that have acted to address the structural origins of the inequities confronting their members. In each case, they have sought to alter the broader economic, political, legal, cultural and social context by increasing local control over land, resources, services and decision-making structures. In effect, they have taken important steps towards greater self-determination as a pathway to target the structural causes of inequity.

Self-determination is understood as the affirmation of Indigenous rights to participate in decision-making on issues of community relevance and the establishment of state-recognized roles for Indigenous organizations and political structures (Anderson 2007; Poole 2004).

2 "Aboriginal" is a term established by the 1982 Constitution Act to define First Nations, Inuit, and Métis peoples (Department of Justice, 1982).

Self-determination has "important implications for Aboriginal health because it fosters empowerment and allows individuals to take control of their lives and health development" (NCCAH 2012; see also Cornell 2006; Marmot 2005). In this way, self-determination can help to counter the loss of autonomy that was one result of colonial processes (Royal Commission on Aboriginal peoples 1996). Research demonstrates that greater self-determination is linked to positive health and social outcomes for Aboriginal populations, and can help to generate economic development that can serve as a tool to alleviate poverty and other social conditions that lead to ill health (Chandler & Lalonde 1998; Cornell & Kalt 1989; Ladner 2009; Nelson 2012; O'Neil 2004; Royal Commission on Aboriginal Peoples 1996; Webster 2009).

The activities of the five communities and collectivities profiled in the report are:

- the formal legal recognition and development of the Ouje-Bougoumou Cree community in northern Québec
- the creation of a restorative justice model in the Métis and First Nation communities of Hollow Water, Manitoba
- the signing of the Tripartite Framework Agreement on First Nations Health Governance in British Columbia
- the establishment of self-government for the Westbank First Nation in British Columbia
- the formation of the territory of Nunavut as a self-governing jurisdiction

The activities of each community or collectivity illustrate some of the different avenues through which self-determination has been pursued by Aboriginal peoples. The Ouje-Bougoumou Cree regained control over land and resources to support community development, while the Westbank First Nation and the Inuit of Nunavut created formal, legal governance structures. The Métis and First Nation communities of Hollow Water in Manitoba and First Nations in British Columbia focused on developing new models for control and delivery of services to community members. In each profile, the historical experiences which helped to motivate the pursuit of a particular approach to self-determination are briefly discussed. Also presented are the successes each group has achieved and the challenges or barriers encountered, focusing primarily on the way in which diverse factors operated at the structural level to influence the economic, political, legal, cultural and social context.

The communities and collectivities profiled in this report were selected to represent the geographic and cultural diversity of Aboriginal peoples in Canada, and to demonstrate the various avenues Aboriginal groups have taken to advancing self-determination. The specific criteria according to which examples were selected include: region (eastern, northern, central, pacific), Aboriginal group (First Nations, Inuit, Métis), dimension(s) of health considered (physical, spiritual, mental, emotional), and activities to advance self-determination (legal recognition, governance, development of Indigenous systems/processes).

Section 2 presents the profiles of the five Aboriginal communities and collectivities included in this report. Some key cross-cutting themes in the experiences of all five communities or collectivities are discussed in section 3. Section 4 proposes broad implications that can be drawn from the experiences of these communities and collectives with respect to Aboriginal self-determination.

2. Profiles of Aboriginal communities and collectivities

2.1 OUJE-BOUGOUMOU, QUÉBEC

http://www.ouje.ca/content/index.php

The Cree community of Oujé-Bougoumou is located approximately 60 kilometres west of Chibougamau Québec. Ouje Bougoumou has a population of approximately 725 (Statistics Canada 2011) with a median age of 24.2 years; 91% of the population speaks its ancestral language. The majority of people over the age of 15 are active in the labour force with an employment rate of 55.7% and a median income of $20,000, 80% of which is derived from earnings. Fifty two percent of adults have a high school, trade, college or university education (Statistics Canada 2006).

BARRIERS TO EQUITY

Historically, the people of Ouje-Bougoumou were one of nine Cree bands that inhabited Northern Québec. During the later half of the 1900s, these Cree lands became increasingly pursued for use by forestry and mining as well as by the provincial electric utility (Hydro-Québec). While these industries removed natural resources from Indigenous ancestral territories, without formal recognition of a land base by the federal government Cree and Inuit peoples received no reparation (Bosum 2001; Patrick & Armitage 2001). In fact, in their pursuit of resources, developers forced Ouje-Bougoumou Cree people to relocate seven times between 1920 and 1970. As a result, people became dispossessed and identified as "squatters" on their own land, dispersed in small, fragmented settlements away from the natural resources that had once sustained them (Bosum 2001; Goddard 1994).

The resulting decline in physical, emotional, mental, spiritual and social well-being among the Ouje-Bougoumou people was best described by Matthew Coon Come:

> *"One does not have to be an Aboriginal person to understand that any dispossession of our legal status and fundamental rights is a root cause of our ongoing social disadvantage and underdevelopment... We have discovered that our way of life, our economy, our relationship to the land, our system of knowledge, and our manner of governance are an interlinked whole. Remove us from the land, and you destroy it all. We are then left with social disruption, suicide, epidemics of disease and violence, and loss of hope..."* (Blaser, Feit & McRae 2004).

OVERCOMING THE BARRIERS

The 1975 signing of the James Bay and Northern Québec Agreement which recognized the land rights of Inuit and Québec Cree peoples prompted the Ouje-Bougoumou Cree to formalize their band status and claim government compensation for the extraction of natural resources from their ancestral lands. The ten-year process of seeking provincial and federal recognition involved the committed and collective efforts of Ouje-Bougoumou members to legitimate their land claim through documenting the history of their community (Bosum 2001).

After several years of negotiation, in 1989 the Québec government agreed to fund ($25M) the construction of a new village, to establish economic and social programs for community members and to assign limited jurisdiction over a portion of the Ouje-Bougoumou Cree territory to the community (Bosum 2001). Three years later, Ouje-Bougoumou was formally recognized as Québec's ninth Cree village under the James Bay Agreement, with exclusive service rights to 167 square kilometers and a $50M commitment by the federal government under the Ouje-Bougoumou/ Canada Agreement (Patrick & Armitage 2001).

In developing the community's design, Aboriginal architect Douglas J. Cardinal and his team sought counsel from all interested community members. The guiding objectives were that the village would embody Cree culture, dwelling style and design as well as preserve the vital features of Cree values, world-view and traditions. Situated on a rise just above Lake Opemisca, the village was built in a series of concentric circles, the core of which consists of a gathering place and public buildings. The outer circles include a youth centre, a school, and residences for teachers, nurses and elders as well as individual residences and public areas (Stevens & Reid Acland 1999).

In 1995, just three years after construction, the United Nations honored the Ouje-Bougoumou Cree with the "Global Citizen" Award of excellence in environmental and sustainable development. The community was also recognized for its innovative heating program in which heat for homes and other buildings is provided by burning waste products from local sawmills in a central furnace and distributing the heat through a system of underground pipes. As well, Ouje-Bougoumou has established a housing program in which a portion of rental payments can be applied to the eventual purchase of a home. To reduce the purchase price, residents can also contribute sweat equity in the construction of their home (Stevens & Reid Acland 1999).

Economic development activities undertaken by the community are demonstrating success in the service sector, sustainable forestry, and culture-based tourism. Tourism activities have been especially successful and include: cultural and village tours, snowmobile and dogsled excursions, evenings in the Cree Cultural Village, mini powwows, and other cultural events. Future plans include sustainable silviculture[3] and wood manufacturing, greenhouse gardens using excess heat from the community furnace, a museum, motel and restaurant (Ouje-Bougoumou Community Website).

CHALLENGES

Since the establishment of Ouje-Bougoumou, the community reports substantial success in language revitalization, community cohesion, parent-teacher relations, economic development as well as reduced vandalism and alcohol abuse. Yet, the people faced a number of challenges in their quest for recognition as a band and the restoration of their traditional territory. In attempting to negotiate with provincial and federal governments for mining and forestry compensation, their lack of band status represented a major challenge.

The James Bay and Northern Québec Agreement itself also created challenges in that, while it preserved some rights (e.g. hunting, fishing, trapping), it terminated

3 Silviculture is the practice of controlling the establishment, growth, composition, health, and quality of forests to meet diverse needs and values (Nyland 2002).

others such as further rights to land claims (Aboriginal Affairs and Northern Development Canada, n.d.). Despite several challenges over the years, in November 2011 an amendment to the James Bay Agreement formally incorporated the community of Oujé-Bougoumou (Aboriginal Affairs and Northern Development Canada 2011).

2.2 HOLLOW WATER, MANITOBA

The Métis communities of Manigotagan, Ahbaming, Seymourville, and Hollow Water First Nation are situated one hundred fifty miles northeast of Winnipeg, Manitoba. The four communities constitute what is commonly referred to as "Hollow Water" with a combined population of approximately 1000 people. Hollow Water First Nation has a population of about 600 with slightly less than half under the age of 15 and 23% speak their ancestral language. Just over half the adults participate in the labour force, with an employment rate of 38% and a median income of $10,800, 73% of which is derived from earnings. Of the 365 adults over age 15, 35% have received education through high school, trade, college or university (Statistics Canada, 2006a).

BARRIERS TO EQUITY

Like other Aboriginal communities in Canada, the members of Hollow Water experienced colonization by European settlers, the imposition of the *Indian Act*, and the physical, sexual and emotional abuse of children who were forced to attend residential schools. As a consequence of this historic trauma, by the 1960s the community was suffering from high rates of alcohol abuse and sexual victimization (Aboriginal Peoples Collection 1997).

Like many other Aboriginal and non-Aboriginal people, the people of Hollow Water had little understanding of the long-term personal trauma associated with sexual abuse. Most people (including victims) either refused to acknowledge the abuse or denied the extent to which it was occurring (Bushie 1999). During that time, perpetrators of sexual violence convicted within the Canadian judicial system faced lengthy prison sentences (2–5 years) during which they were cut off from their family, and were often not encouraged to re-enter the community. This meant that they were isolated from the potential healing elements of their Anishinabe values, traditions, and spirituality. In addition to failing to rehabilitate or reconnect offenders, the traditional approach of incarceration did not address victims' need for healing, or the community's need for collective healing from generations of sexual trauma (Couture, Parker, Couture & Laboucane 2001).

OVERCOMING THE BARRIERS

> *In the early 80's a few of us decided to sober up... At first we were saying alcoholism was the problem; child neglect was the problem; kids dropping out of school was the problem. The more we learned about ourselves, the more we learned about our community. Those were awesome times that sent us deeper. Then we started touching on sexual abuse* (Bushie 1999).

In 1984, a Resource Team was formed to address healing and development in the four communities of Hollow Water. It was comprised of political leaders, service providers from local agencies and a strong base of community volunteers. The resulting *Community Holistic Circle Healing (CHCH) Program* evolved from a desire by community members to address their problems within

an Indigenous context (Solicitor General Canada and the Aboriginal Healing Foundation 2002). Drawing on a holistic Anishinabe world-view and the Wellness Circle model used in Esketemc (Alkali Lake), the program began by addressing alcohol and drug use, unemployment and the cultural education of youth. However, it soon became clear that the roots of these problems were deeply embedded in a shared history of sexual trauma. The resource team began the work of exploring the extent of this trauma and how the philosophy of *Pimadaziwin* (life in the fullest sense, for one's family) might help to restore community wellness, balance and harmony (Bushie 1999).

Pimadaziwin is achieved through cooperation and socially appropriate behaviour. It "counters such socially disapproved and collectively disruptive acts as inhospitality, stinginess, pettiness, and, especially, ridicule" (Hallowell 1955, p. 121). The goals of Ojibwe justice are to restore relational balance and to hold offenders accountable to the entire community. The CHCH Team proposed to implement a more culturally grounded approach, seeking collective healing by blending traditional Ojibwe values with community accountability as an alternative to the less integrative western approach. Inclusion of all affected community members in healing and sentencing circles reflects beliefs about the healing and empowering nature of collective thought and action. The approach emphasizes mutual respect and caring as well as healing not just for victims but also for offenders, their respective families and affected community members. The goal is to restore balance and create cohesive, safe, healthy environments for children and their families (Bushie 1999).

The CHCH team envisioned community healing through integration of the program across several sectors such as education, child welfare, mental health, and the criminal justice system (Bushie 1999). CHCH workers undertake a myriad of activities including assessment in response to disclosure of sexual abuse, support and counseling for victims and family members, education of victims and victimizers as well as liaising with relevant professionals, service providers and the justice system. In addition to ensuring the protection of sexual abuse victims, the 13-step process of the CHCH Program involves the voluntary participation of the victimizer (in lieu of formal sentencing), preparation of all family and affected community members, a 10-step healing circle, a healing contract, as well as a cleansing ceremony and a sentencing circle (Solicitor General Canada and the Aboriginal Healing Foundation 2002).

In less than a generation, the CHCH program has become recognized as a model for restorative justice among Aboriginal people in Manitoba and Canada. Aside from the savings that accrue to the justice system as a result of diverting people from court proceedings and traditional incarceration, the benefits of the program are widespread and evident in enhanced perceptions of community unity, accountability and safety, exceptionally low recidivism rates for sexual abuse, increased school completion, family cohesion and community wellness as well as decreasing rates of alcohol addiction (Couture, Parker, Couture & Laboucane 2001). The following quotes from community members show these progressive changes in community relations (Couture, Parker, Couture & Laboucane 2001):

"There was a lot of alcoholism in the community... lots of violence, lots of sexual abuse....It was all hidden. No one talked about it" (1986)

"Gradually we awakened to our needs and the things that were going on. We went through training, and that helped us" (1995)

"People are nicer now. They will do something for you now without expecting money. There are hardly any house parties anymore" (2000)

CHALLENGES

It takes an average of five years to fully complete the CHCH process and many victimizers do not conclude their healing journey. Additional resources for this critical intervention might address this barrier, providing greater support for the program and its workers (Aboriginal Peoples Collection 1997).

Given the rapid growth of the population of Hollow Water, the demand on CHCH workers is immense. This is further complicated by funding issues regarding infrastructure support and expansion of CHCH services, particularly those aimed at young offenders. Despite the overwhelming success of the program, further investment in training is required to fully realize the potential of Aboriginal community-based restorative justice. Alternatives to the court system remain controversial, particularly as they relate to victims' rights (Solicitor General Canada and the Aboriginal Healing Foundation 2002). It is unclear whether the current legal system will ever fully embrace the concept of restorative justice beyond a supplement to the existing process of incarceration, which appears to have little impact on recidivism (Nunes et al. 2007).

2.3 TRIPARTITE FRAMEWORK AGREEMENT, BRITISH COLUMBIA

http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2012/2012-194bk-eng.php

http://www.pnwbha.org/wp-content/uploads/2011/10/Tripartite-Agreement.pdf

http://www.fnhc.ca/

British Columbia (BC) is the ancestral home of 203 First Nations, representing almost 130,000 people with a median age of 28, 13% of whom speak their ancestral language. Among those aged 25 to 64, 65% have completed high school, trade, college or university and 75% participate in the labour market, with an unemployment rate of 18%. The median income is $22,600 (Statistics Canada, 2006b).

BARRIERS TO EQUITY

Like many Aboriginal peoples across Canada, First Nations in BC face socio-economic and political inequities that give rise to a disproportionate burden of ill-health (Adelson 2005; Anand et al. 2001; First Nation Governing Council 2005). The origin of these inequities has been linked to colonial structures and systems, which continue to disadvantage most Aboriginal peoples in Canada (Harper 2008; Tait 2003; Travers 1995; Waldram, Herring & Young 1995). The evidence is clear that strategies intended to narrow the gap between the health of First Nations and other British Columbians must address self-determination. In fact, researchers have demonstrated a clear relationship between the health of Aboriginal peoples and the degree of control communities have over the programs, processes and events that affect them (Ladner 2009; O'Neil 2004; Webster 2009).

In Canada, First Nations people receive health care through a complex mix of federally- and provincially-funded services, including a wide variety of programs and services on and off reserve. The administration and delivery of insured health services is the responsibility of each province or territory, guided by the provisions of the *Canada Health Act*. Provinces and territories fund these services with assistance from the federal government in the form of fiscal transfers. Insured health services as defined by the *Canada Health Act* are medically necessary "hospital services, physician services and surgical-dental services provided to insured persons" (Government of Canada 1984). Like most other provincial/territorial residents, First Nations people living on or off reserve are "insured persons" covered by the public health insurance program.

In addition to insured health services, the provinces and territories have discretion to provide some groups with supplementary health benefits, programs and services not covered by the *Canada Health Act*. These may include prescription drug coverage and home care services. The level and scope of coverage for such supplementary benefits and services varies across provinces/ territories. Supplemental coverage is typically not provided to First Nations people living on reserves (Government of Canada 1984).

Health Canada delivers certain health services and community health programs directly to First Nations on-reserve. Most often, Health Canada funds services that are delivered by First Nations organizations. Health Canada also delivers the Non-Insured Health Benefits program, which provides for a range of dental, vision, and pharmacy benefits as well as medical transportation for registered First Nations and recognized Inuit individuals regardless of residence. The medical transportation benefit helps First Nations people living in remote reserve communities to access provincial health services off-reserve.

In 1988 the federal government introduced the First Nations Health Transfer Policy which aims to enable First Nations Bands and Tribal Councils to manage and deliver community health programs previously delivered by Health Canada. Since the introduction of this policy, many First Nations communities have exercised significantly greater responsibility for designing programs, organizing services and allocating funds according to community health priorities (First Nations Health Council 2011).

There are long-standing disagreements between federal and provincial/territorial governments about the scope and boundaries of their respective roles in First Nations health, particularly with respect to health services that fall outside the *Canada Health Act*. As a result, it is not always immediately clear which services are covered under federal funding, and which are covered by provinces/ territories. First Nations people seeking care can become caught in jurisdictional conflicts or procedural delays which impede equitable access to health programs and services (First Nations Health Council 2011).

OVERCOMING THE BARRIERS

As noted above, in the 1980s the federal government offered to First Nations the opportunity to assume responsibility for certain aspects of health care administration through a process called health transfer. BC currently has the highest percentage of First Nation communities that have opted for increased control over health programs and services in Canada. Over 80% of the 203 First Nations in BC are currently involved in some form of transfer (First Nations Health Council 2011).

Signed in October 2011, the British Columbia Tripartite Framework Agreement on First Nations Health Governance (BCTFA) is the first of its kind in Canada. It is a 10-year arrangement between Health Canada, the provincial Ministry of Health and the First Nations Health Society through which BC First Nations will assume control of federally funded health services through the creation of a First Nations Health Authority. The overarching purpose of the Agreement is the "shared goal of improving the health and well-being of First Nations individuals and communities in British Columbia... by ensuring that BC First Nations are fully involved in health program and service delivery and decision-making regarding the health of their people in British Columbia" (Government of Canada 2011, pg. 33).

Accounting for yearly cost increases, the federal government will transfer approximately $380 million annually to the new First Nations Health Authority. The BC government will contribute an additional $83.5 million per year. These figures reflect current and projected federal and provincial spending on First Nations health programs and services, not an increase in spending (Government of Canada 2011).

The BCTFA aims to create a new structure for First Nations health service governance and delivery which integrates First Nations and non-First Nations health systems through regional design, delivery and administration that reflects the health care needs of First Nations in BC. Intended to improve the "quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations" (Government of Canada 2011, p.5), this new governance model acknowledges the importance of social determinants of health and involves BC First Nations in developing, delivering, and directing health programs and services. In addition to enhancing First Nations' control over health services, the new structure will reflect the cultural perspectives and wellness models of BC First Nations. This is of particular relevance for First Nations people who often face health care environments that are not perceived to be culturally safe (Aboriginal Nurses Association of Canada 2009).

The new health governance structure created by the BCTFA has four components:

(i) the First Nations Health Authority responsible for developing, directing, delivering and funding health programs,

(ii) the Tripartite Committee on First Nations Health that directs and supports the preparation and delivery of services between the First Nations Health Authority, other Regional Health Authorities and the BC Ministry of Health,

(iii) the First Nations Health Directors' Association that represents the Health Directors working in BC First Nation communities and provides advice on program planning, health research and policy development, and

(iv) the First Nations Health Council that provides leadership and support for implementing Tripartite commitments (First Nations Health Council 2011).

CHALLENGES

When the option for health transfer was initially introduced to First Nations in Canada, some communities were apprehensive about the long-term implications of such an arrangement. For some, it evoked concern that the agreement was a step toward First Nation health services being shifted

to the provinces. However, many First Nations now speak with pride about their accomplishments under transfer arrangements, though they continue to face underfunding and reporting burdens (Vogel 2011).

The new First Nations Health Authority will take on many of the roles of Health Canada's First Nations and Inuit Health Regional Office, and is expected to leave most local issues within the control of local communities. At the same time, taking steps to integrate the disparate health services of 203 communities under a single provincial authority is challenging. Of particular importance in this regard is developing and negotiating relationships between the First Nations Health Authority and existing Regional Health Authorities that will continue to play an important role in providing primary health care services to First Nations people in BC (First Nations Health Council 2011; Vogel 2011).

2.4 WESTBANK SELF GOVERNANCE AGREEMENT, BRITISH COLUMBIA

http://laws-lois.justice.gc.ca/PDF/W-6.2.pdf

http://www.wfn.ca/black-bear/photogallery.htm

Situated on the western shores of Okanagan Lake near Kelowna BC, Westbank First Nation is home to approximately 6,200 people, 600 of whom are Band members. Seven percent of Band members speak their ancestral language. The labour force participation rate of community members is 71%, while the employment rate is 65%. The median income is $18,000, 79% of which is derived from earnings. Among those over age 15, 70% have received high school, trade, college or university education (Statistics Canada 2006c).

BARRIERS TO EQUITY

Prior to contact with Europeans, the First peoples of BC sustained the health of their families and communities on game animals, fish and other seafood as well as wild plants. European settlers who colonized the province gradually encroached on traditional territories and restricted Indigenous hunting and gathering practices. Eventually, the First peoples were forced to relocate away from ancestral lands and onto reserves with limited or no access to traditional foods, thereby diminishing their capacity to meet basic survival needs or sustain their health (Adelson 2005; Waldram, Herring & Young 1995).

Throughout Canadian history, many government policies have restricted the meaningful engagement of First Nations people in the broader market economy and hindered opportunities for economic development within First Nation communities (Backhouse 1999; Royal Commission on Aboriginal Peoples 1996; Weaver 1981). Although the *Indian Act* continues to regulate almost every aspect of First Nation life, over time many provisions that violated the civil rights of First Nations people have been removed. In 1988, the Act was amended to increase access to band revenues through taxation of reserve lands as well as allowing individuals to hold mortgages on reserves (Makarenko 2008; Weaver 1981).

OVERCOMING THE BARRIERS

In 2005, the BC government announced a 'new relationship' with First Nations, acknowledging that "historic Crown-Aboriginal relationships in British Columbia have given rise to the present socioeconomic disparity between Aboriginal peoples and other British Columbians" (Government of BC, Ministry of Aboriginal Relations and Reconciliation. 2010, p.4).

At that time, the federal government, the provincial government and the First Nations Leadership Council signed the Transformative Change Accord, the purpose of which was to support the social and economic well-being of First Nation peoples through recognition of treaty rights, transparent political engagement and cultural accommodation (First Nations Leadership Council and the Ministry of Economic Development 2008).

Westbank First Nation was one of the first communities in Canada to achieve self-governance. Negotiated under the federal government's Inherent Right to Self-Government Policy, Section 35 of the Canadian Constitution and passed into law by Parliament in May 2004, the *Westbank First Nation Self-Government Act* transferred political and financial responsibility from the federal government to the Westbank government (Aboriginal Affairs and Northern Development Canada). The community determines the structure, accountability and law-making powers of its government, which is responsible for the economic and political stability of the community as well as for providing programs and services to their members. The Act also permits Westbank to partner with other governments and the private sector to develop natural, human and economic resources. To date, more than 20 laws have been enacted relating to matrimonial and property rights, language and culture, resource management, the environment, land management and taxation — all of which have supported progress and prosperity for community members.

Currently, more than 8,000 non-Aboriginal people have leased residential land from the Westbank community. The Westbank government has developed and maintained positive relationships with band and non-band members as well as surrounding non-Aboriginal communities. A five member Advisory Council meets monthly to represent the interests of member and non-member residents and other stakeholders to ensure an opportunity for input into decisions that directly affect them. In 2011, Westbank First Nation reached more than $1 billion in assessed property value. The community offers a wide range of educational, health and social development services and programs grounded in the traditions of the Okanagan peoples, including respect for elders, the environment and future generations (Westbank First Nation Community Website).

CHALLENGES

Creating a transparent and equitable governance model required a substantial commitment of human and financial resources as well as the support and engagement from Westbank community members. This becomes particularly salient when regulations and laws have to be enforced, which has presented challenges in terms of perceptions of clarity and justice in this close-knit community. Westbank's commitment to justice has established trust in the new government, "that rules will be followed and that members will be treated in an equitable manner" (National Centre for First Nations Governance 2012).

Westbank's control and use of natural resources is foundational to the success of most economic development initiatives, but there are a number of significant barriers to reaping the benefits of these opportunities. For example, inequities in financial and human resources have disadvantaged Westbank in negotiations to secure revenue and

benefit sharing agreements for renewable and non-renewable resources. Similarly, due to a lack of adequate financial and human resources, the cost and timelines associated with regulatory approvals, environmental assessments and approval processes for outside developers can be challenging (First Nations Leadership Council and the Ministry of Economic Development 2008).

One of the most significant challenges facing Westbank is developing capacities to negotiate fair and equitable partnerships with the private sector. Expertise in developing corporate governance models is limited, as are resources for developing and implementing economic development activities. With few conventional sources of capital and barriers to communication with potential investors and partners, First Nations like Westbank face additional challenges to achieving self-sustaining governance and economic success.

2.5 NUNAVUT

http://www.gov.nu.ca/en/Home.aspx

The territory of Nunavut is home to approximately 34,000 people, the majority of whom are Inuit, 82% of whom speak their ancestral language. With a median age of 22, Nunavut has the youngest population in Canada. It is also one of the fastest growing jurisdictions with an annual growth rate of approximately 10%. Almost 60% of adults participate in the labour force, with a 47% employment rate. The median income is $16,000, 80% of which is derived from earnings. Fifty percent of adults over age 15 have achieved high school, trade, college or university education (Statistics Canada 2006d).

BARRIERS TO EQUITY

Although first contact between Inuit and Europeans occurred during the 1500s, the impact of this encounter on the lives of Inuit people was not experienced until the 19th century with the near decimation of sea mammals by whalers, severely hampering the Inuit's ability to remain self-sufficient. During the 1950s the federal government ordered the relocation of 250 Inuit, formerly a migratory people, to three small, isolated settlements in the High Arctic with false promises of increased economic opportunities (Dussault & Erasmus 1994; McGrath 2006). In reality, occupation of this region was intended to reinforce Canadian sovereignty in the Arctic Archipelago (Campion-Smith 2010). Poor planning and organization resulted in the near demise of 87 families who spent their first winter in tents, inadequately prepared to survive the severe weather (20–40 degrees colder than their home region), the 24 hours of darkness through winter and the desert-like terrain. Most of these lands were barren, resulting in widespread starvation and the subsequent relocation of families to communities like Rankin Inlet. In 1953, the creation of the Department of Northern Affairs and National Resources saw federal officers (often Royal Canadian Mounted Police) posted to Inuit communities to administer government programs and 'keep the peace'.

Like other Aboriginal peoples, the health and well-being of Inuit people has been negatively impacted by the political, economic and cultural implications of colonial values and practices (Jenkins et al. 2003; Inuit Tapiriit Kanatami 2004; Young 1996). Widespread poverty and over-crowding in poorly designed houses in under-funded communities without adequate infrastructure have resulted in high rates of communicable disease, addictions and abuse (Billson 2006; Little 2006; Steenbeek et al. 2006).

OVERCOMING THE BARRIERS

In 1971, the Inuit Tapirisat of Canada (ITC) was formed to pursue land claims in the Northwest Territories, followed closely by formation of the Northern Québec Inuit Association that began negotiating land claims in the James Bay region of Québec (Dewar 2009; Jull 1998). In 1973, historic Inuit occupation and use of northern lands was recognized by the federal government in the form of Aboriginal title, followed by a proposal for a new territory (Nunavut) in 1976. After 16 years, the federal government formally accepted the territory of Nunavut in 1992. Among Inuit votes, 85% endorsed the agreement, which represented the largest land claim settlement in Canadian history (Bell 1999; Dewar 2009).

Officially formed on April 1, 1999, the parliamentary-style government of Nunavut is considered unique in that it reflects the culture, values, language and traditions of the Inuit. The formation of a public government also helped to pave the way to achieving the objective of territorial status, and ensures that the rights and responsibilities of residents are protected under the *Canadian Charter of Rights and Freedoms* (Fabbi 2003; Government of Nunavut, n.d.).

With elected representatives in 11 communities, the Nunavut government ensures regional input into decision-making and enhances opportunities for public sector employment across the territory. The government functions with the same legislative, executive and judicial powers as the provinces and is responsible for the operation and management of the Nunavut territory. Government policies are informed by the priorities of the majority Inuit population. The Nunavut Land Claims Agreement facilitates Inuit employment by stipulating that the number of Inuit people employed in the public sector must be proportional to the number of Inuit living in the territory. This figure began at 50% percent and is expected to increase to at least 85% of the workforce (Fabbi 2003; Government of Nunavut, n.d.).

Nunavut has no political parties at the territorial level. The legislative assembly operates on the principle of consensus, with political parties only existing to support candidates competing in federal elections. The system blends the principles of parliamentary democracy with the Inuit values of cooperation, effective use of leadership resources and common accountability that are historically deeply connected to Inuit survival in the relatively harsh northern environment. A minister heads each of Nunavut's ten government departments and elections are held every five years by popular vote. The daily business of the government is conducted primarily in Inuktitut, with French and English as the other official languages. Nunavut bears its own flag and coat of arms, which distinguish it as a territory and a government respectively. One Member of Parliament and one Senator represent Nunavut at the federal level.

Like other jurisdictions, Nunavut receives transfers from the federal government under the Canada Health Transfer, Canada Social Transfer and the Territorial Financing Formula. Funds support government operations and programs. In 2012–13, Nunavut received $1.3 billion (an increase of $462 million from 2005-06) from transfers plus direct-targeted support in in specific areas like labour market training and health-care wait time reductions (Government of Nunavut, n.d.).

CHALLENGES

Dramatic improvements in the political autonomy of Inuit people over the past

30 years are due in large part to the leadership and commitment of Inuit people. The process of engaging the federal government and negotiating contentious issues such as the legal powers of self-governing institutions and benefit sharing of natural resource development and extraction was challenging (Bonesteel & Anderson 2006).

The Government of Nunavut is the largest employer in the territory and makes substantial investments in its workforce by providing educational opportunities, personal and professional development, recognition programs, partnership development and support for positive working environments that reflect Inuit values. Nunavut's economy was historically based on the harvesting traditions of the Inuit people, who continue to maintain strong ties to the land. A recent study estimated that the current harvesting economy is worth approximately $40 million annually (Government of Nunavut, n.d.). New jobs are also rapidly emerging in the mining, resource development, tourism and fisheries sectors, as well as in Inuit art. The realization of Nunavut's full economic potential will be contingent in part on infrastructure improvement. Existing housing, sewage and waste management, transportation and telecommunications systems are already stretched beyond their limits, and will come under increasing pressure from a rapidly growing population.

Despite the persistent challenges associated with scarce resources, distant markets, limited tax revenue, a harsh climate and an unstable global environment, the Inuit have come together to form several regional and local organizations that share a common agenda: uniting and supporting Inuit life. Distinguished as one of the most adaptive people on earth, the Inuit have created a nation, and the government to administer it, in less than one generation.

3. Key Themes

Any analysis of the experiences of Aboriginal communities in Canada must acknowledge the diversity of First Nations, Inuit and Métis peoples as well as the differential impact of geography, language and colonial history on the health of these populations. The communities and collectivities profiled in this report have pursued different paths to advancing self-determination. Two of the profiled groups established new models of governance, one created a new community after achieving legal recognition of land and resource claims, and two have designed and implemented models of service delivery that reflect Aboriginal values and traditions. Nevertheless, the different actions taken by these communities and collectivities reflect two important themes: preserving cultural identity and traditions by reasserting Indigenous models and addressing the root causes of inequity. Each of these themes is discussed below.

3.1 REASSERTING INDIGENOUS MODELS

Indigenous models of health are generally grounded in the following shared values:

- holism, which emphasizes the body, emotions, thoughts, and spirit as well as the complete person in the entirety of their life
- autonomy, which places importance on individual and collective liberty
- connection, which acknowledges responsibility toward self, community, environment and cosmos
- balance, which emphasizes equal attention to all dimensions of life and equal respect for all humans and non-humans (McMillan 1995).

Within this paradigm, healing requires balance and harmony in all dimensions of health and in all relationships (Poonwassie & Charter 2001). Many Indigenous cultures seek the cause of major illness within the web of interpersonal relations between all beings, to the extent that treatment may include bringing those relationships back into balance (Poonwassie & Charter 2001; Waldram, Herring & Young 1995).

The pursuit of holism, autonomy, connection and balance represent critical avenues through which each of the profiled communities overcame structural barriers to equity. In designing a new village, the people of Ouje-Bougoumou worked collaboratively to maintain traditional Cree values of living in harmony with the land. The circular design of the village reflects values of connection and balance, with a central meeting place (shaptuwan) for celebration as well as healing and close proximity between the school (youth) and the elders' residence to promote intergenerational learning. Similarly, the Hollow Water restorative justice model pursues physical, emotional, mental and spiritual healing for victims, victimizers, families and community members, based on the underlying principles of holism and balance.

The diversity of the 203 First Nations in British Columbia (BC) means that the new First Nations Health Authority needs to employ an Indigenous governance model based on the values of respect and connectivity, that is inclusive of community voices in the planning and delivery of health services. These values are reflected in the many forums that were organized to engage First Nations in the

Tripartite process and to identify local priorities (e.g. Regional Caucuses on Self Governance). Partnerships at the grassroots level have also been facilitated through the creation of Community Engagement Hubs, tribally and geographically affiliated First Nations working together to share resources and capacities to develop community health plans.

The government of Westbank is grounded in Okanagan traditions of respect and responsibility for all of creation. This is reflected in the commitment to sustainable and responsible development by the Westbank forest management division, and the emphasis on equitable decision-making by community members as well as non-member residents. Similarly, historical Inuit commitments to a close and respectful relationship with the land, animals and plants are evident in the current Nunavut government structure, which operates on the basis of consensus of the majority of members rather than along party lines. Political debates also follow Inuit protocols of respect and composure. The maintenance of balance between the needs of humans and non-humans is carefully maintained through the responsible use of resources from the land and sea. The Nunavut government is also reflecting the value of the Inuit world-view through the use of Inuktitut as the official language with which it conducts business.

3.2 ADDRESSING THE ROOT CAUSES OF INEQUITY

At present, many approaches to health and the factors that shape it "do not comprehensively target Aboriginal peoples' needs, nor do they properly address the health disparities that exist in Aboriginal communities" (NCCAH 2012, p. 40).

Common definitions and models of health determinants can be broadened to include determinants specific to Indigenous well-being, including the legacy of colonialism, cultural continuity, access to and control of territory, and most importantly to the actions profiled in this report, self-determination.

The actions taken by each of the communities and collectivities profiled in this report are underpinned by an understanding of health determinants that recognizes the importance of self-determination as a means to influence the structural factors that underlie the inequities facing Aboriginal people. These actions are consistent with research findings which suggest that increased community control over social, political and physical environments is linked to improvements in health (Chandler and Lalonde 1998 & 2008; Cornell & Kalt 1989; Ladner 2009; NCCAH 2012; O'Neil 2004; Webster 2009).

For example, increased control by First Nations over the delivery of health care services in British-Columbia and Manitoba was shown to lead to better health despite funding and administrative obstacles (Webster 2009). Literature on community empowerment — understood as "the process by which relatively powerless people work together to increase control over events that determine their lives and health" (Laverack 2006, p. 113) — suggests that supporting empowerment of individuals can enhance competencies and self-esteem, which in turn positively influence health. Measures of empowerment include participation in local groups or activities, the presence of community-based organizations and local leadership (Laverack 2006; Rifkin 2003; WHO Europe 2006).

A clear connection between self-determination and mental health was established by Chandler and Lalonde (1998)[4]. Their research identified a number of factors that appear to create a protective environment against youth suicide in Aboriginal communities. They determined that neither socio-economic status nor rural isolation explained wide variation in suicide rates. What helped to explain these differences was a constellation of community characteristics associated with the preservation and promotion of traditional cultures, and self-determination expressed through self-government and control over traditional lands, education and social services. A high degree of community "cultural continuity" seemed to be the most influential factor in diminishing the risk of youth suicide, based on the following criteria (Chandler & Lalonde, 1998 & 2008):

- a community that has taken steps to secure Aboriginal titles to traditional lands
- a community that has taken back agencies of self-government
- community control of education
- community control of police and fire services
- community control of health delivery services
- a community that has developed 'cultural facilities' to preserve and enrich culture
- meaningful roles for women in local governance
- community control of child and family services.

Related research in the United States — the Harvard Project on American Indian Economic Development — also concluded that community well-being and governance are positively associated (Cornell & Kalt 1989).

This study found that "there exists a direct correlation between good governance and economic success both of which are necessary to provide for community well-being, to create resiliency and to address those conditions that enable/disable communities" (Ladner 2009 p. 94). Data from more than 130 projects suggest that the factors contributing most to the economic, political and social well-being of Native Americans are sovereignty, self-governance and competent institutions and sound policies that support economic, political and social success based on the needs of the Nation, and that integrate relevant cultural traditions. Policies supporting self-determination lead to self-governance, which in turn leads to greater control of critical economic, political and social decision-making (Begay, Cornell & Kalt 1998).

The Aboriginal groups profiled in this report have pursued self-determination through increased control over land, services and governance. For the people of Ouje-Bougoumou, assertion of their Nation status represented a crucial step on the path to self-determination. In addition to creating a fiduciary relationship with the federal government and formalizing a connection to their ancestral lands, it signified the capacity of community members to define their own identity and culture. The people of Hollow Water took control of their own systems and institutions by creating a culturally-based, restorative justice and healing model that attends to the responsibility and well-being of all community members. Similarly, BC First Nations assumed control of health care

4 Between 1987 and 1992, Chandler and Lalonde sought to understand differences in suicide rates among 200 of the First Nations in BC: more than half of the First Nations experienced no youth suicides, while 10 of the communities account for 90% of all Aboriginal youth suicides.

funding, planning and delivery, and are now in a position to influence the structures and systems through which all First Nations people access health services. Under the control of a First Nation Health Authority and with active involvement from communities, health funding is more likely to be allocated where it is needed most and a strong commitment will be made to addressing the unique social determinants of Aboriginal health in BC.

The Westbank First Nation has become a model for Aboriginal self-determination. Local control of land, resources and services has positioned Westbank to engage in equitable partnerships with industry and government agencies, enabling the community to build a strong economic base and to enhance educational and employment opportunities for all members. In establishing a formally recognized territory and government, the Inuit of Nunavut have achieved an extraordinary level of self-determination. The Nunavut government plays a pivotal role in shaping the determinants of Inuit health. At a time when interest in the North is increasing, the Inuit now have a voice in international decisions on sustaining and developing Arctic resources.

4. Implications

> *"Just as social problems spring in part from collective experience, so solutions require change at the collective level. Aboriginal people acting alone cannot shift the weight of disadvantage and discrimination. But solutions that lift the weight for Aboriginal people collectively shift it for everyone."* (Royal Commission on Aboriginal Peoples 1996).

4.1 ABORIGINAL COMMUNITIES

A key learning from this report is that Aboriginal peoples in Canada have had success in establishing self-determining communities and collectivities. Inequities may persist, however the achievements profiled in this report should be showcased as examples from which other Aboriginal communities can learn. To the extent that research suggests that self-determination can have beneficial impacts on the economic and social well-being of Aboriginal communities, further progress in this area has the potential to empower Aboriginal communities to change the trajectory of their overall health.

These five profiles also indicate that increased Aboriginal self-determination can be achieved in many different ways, and should reflect local priorities, contexts and concerns. Interventions cannot be standardized across populations in a "one-size-fits-all" approach. Self-determination means control over decisions, including the most appropriate approaches to achieving this goal.

4.2 GOVERNMENTS

The inequities facing Aboriginal communities are diverse and multi-faceted. In order for governments to contribute to the reduction of these inequities, a collaborative approach across sectors is needed. This is particularly the case with respect to acting on the complex and underlying structural determinants of health.

There is no single path for supporting Aboriginal communities to move towards greater self-determination. As illustrated by the profiles in this report, successful action can be undertaken in many different areas and at different levels. It is important for governments to allow for and support leadership and initiative from Aboriginal peoples. Priorities for action may be cooperatively determined through meaningful and effective engagement between Aboriginal, provincial/territorial and federal decision-makers. As suggested by the profiles in this report, the active participation of First Nations, Inuit and Métis peoples and respectful negotiation between Aboriginal communities and governments are important preconditions for success.

In order for Aboriginal peoples to advance self-determination, support is needed for creating and maintaining infrastructure, training and retaining human resources and developing and implementing culturally and locally relevant programs and services. It is important for Aboriginal communities and governments to work together to determine how best to utilize available resources.

4.3 NON-GOVERNMENT ORGANIZATIONS

Non-government organizations (NGOs) can play an important role in facilitating self-determination within Aboriginal communities by providing information, individual and community development and access to supportive services and networks. Critical to this process is developing long-term partnerships based on respect for the capacities of Aboriginal people, and supporting initiatives tailored to the diverse needs and aspirations of Aboriginal communities. Rather than focusing on short-term projects, the goal of sustained change with continued support is optimal (Hunt 2010).

4.4 PRIVATE SECTOR

Self-determination is facilitated by economic strength and government funding alone is insufficient to solve the problems of poverty within many Aboriginal communities. In fact, within most non-Aboriginal communities in Canada, investment is 80% private and 20% public; the reverse is typically true for First Nations communities (First Nations Tax Commission 2007). In order to initiate and sustain economic growth, it is important for Aboriginal communities to pursue long-term funding and partnerships with the private sector.

Building community wealth means supporting local human and financial resources. The private sector can facilitate this goal by training and recruiting Aboriginal peoples for local jobs, and by developing businesses on reserve land (Working Group on Aboriginal Participation in the Economy 2011).

4.5 RESEARCHERS

In order to leverage current achievements and provide evidence of success to secure future funding, Aboriginal stories of resilience must be gathered and shared. Through ethical partnerships with Aboriginal communities, researchers can help Aboriginal people to identify opportunities for action and assess current gaps in resources or capacities that could help to foster increased local control. Research can also document the impact of measures to advance self-determination on community health and well-being. Community/academic research partnerships can help to document not only the health-related outcomes but also the degree to which increased self-determination helps to achieve community-articulated goals (Hawe & Potvin 2009).

4.6 CANADIAN PUBLIC

For Aboriginal communities and collectivities to move towards greater self-determination, support from other Canadians is critical. It is important that Canadians understand that the political, social, economic and health inequities currently confronting Aboriginal people are a challenge that we all must share. Aboriginal self-determination will ultimately contribute to a strong, vibrant Canada.

Conclusion

The roots of resilience are deeply embedded in Aboriginal communities. The communities and collectivities profiled in this report are fostering resilience, not only by working to address the immediate disadvantages faced by members, but also by identifying and acting on the root causes of these inequities. These root causes are grounded in the cultural, social, economic and political structures that importantly influence the health of Aboriginal peoples and communities.

The structural origins of inequity can be addressed by pursuing greater self-determination for Aboriginal peoples. The communities and collectivities profiled in this report have successfully gained legal recognition of land and resources, built local services consistent with Indigenous values and traditions and created new models of Aboriginal governance. The actions of these groups demonstrate that progress towards self-determination is possible, and is an important part of supporting the health and well-being of Aboriginal peoples in Canada.

References

Aboriginal Affairs and Northern Development Canada. *Westbank, British Columbia: A self-governing First Nation*. Retrieved from http://www.aadnc-aandc.gc.ca/eng/1100100014525/1100100014531

Aboriginal Affairs and Northern Development Canada. (November 7, 2011). *Oujé-Bougoumou status formalized in complementary agreement to the James Bay and Northern Québec Agreement*. Retrieved from http://news.gc.ca/web/article-eng.do?nid=636449.

Aboriginal Nurses Association of Canada. (2009). *Cultural competence and cultural safety in nursing education: A framework for First Nations, Inuit And Métis nursing*. Ottawa, ON: Author.

Aboriginal Peoples Collection. (1997). *The Four Circles of Hollow Water*. Ottawa, ON: Supply Services Canada.

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 96 (Suppl 2), S45.

Anand, S., Yusuf, S., Jacobs, R., Davis, A., Yi, Q, Gerstein, H., et al. (2001). Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: The study of health assessment and risk evaluation in Aboriginal peoples. *Lancet*, 358(9288), 1147–1153.

Anderson, I. (2007). The end of Aboriginal self-determination? *Futures*, 39(2), 137–154.

Backhouse, C. (1999). *Colour-coded: A legal history of racism in Canada, 1900–1950*. Toronto, ON: The Osgoode Society.

Begay, M., Cornell, S., & Kalt, J. (1998). Making research count in Indian country: The Harvard project on American Indian economic development. *Journal of Higher Education Outreach and Engagement*, 3(1), 42–51.

Bell, M. (1999). *Creating public government in Nunavut: The life-place model*. Retrieved from http://www.inukshukmanagement.ca/Life-place%20Model%20final.pdf.

Billson, J. (2006). Shifting gender regimes: The complexities of domestic violence among Canada's Inuit. *Études/Inuit/Studies*, 30(1), 2006, 69–88.

Blaser, M., Feit, H., & McCrae, G. (Eds.). (2004). *In the way of development: Indigenous peoples, life projects and globalization. Survival in the context of mega-resource development: Experiences of the James Bay Crees and the First Nations of Canada*. New York, NY: Zed Books.

Bonesteel, S. & Anderson, E. (Eds.) (2006). Canada's relationship with Inuit: A history of policy and program development. Ottawa, ON: Minister of Public Works and Government Services Canada. Retrieved from http:// www.ainc-inac.gc.ca/ai/rs/pubs/inuit-book-eng.pdf

Bosum, A. (2001). Community diaspera and organization: The Case of Ouje-Bougoumou, In, C. Scott (Ed.), *Aboriginal autonomy and development in northern Québec and Labrador* [electronic resource], (p. 277–288), Vancouver, BC: UBC Press. Retrieved from http://ezproxy.library.uvic.ca/login?url=http://site.ebrary.com/lib/uvic/Doc?id=10125058

Bushie, B. (1999). *Community Holistic Circle Healing. Hollow Water, Manitoba*. International Institute for Restorative Practices. Retrieved from http://www.iirp.edu/article_detail.php?article_id=NDc0.

Butler-Jones, D. (2008). *The state of public health in Canada: Report of the Chief Public Health Officer*. Ottawa, ON: Public Health Agency of Canada.

Campion-Smith, B. (August 18, 2010). *Ottawa apologizes to Inuit for using them as 'human flagpoles'*. The Star. Retrieved from http://www.thestar.com/news/canada/arctic/article/849273--ottawa-apologizes-to-inuit-for-using-them-as-human-flagpoles.

Canadian Centre for Community Renewal. (2000). *The community resilience manual*. Port Alberni, BC: Author.

Chandler, M. & Lalonde, C.(2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In, Kirmayer, L. & Valaskakis, G. (Eds.). *Healing traditions: The mental health of Aboriginal peoples in Canada (pp. 221–248)*. Vancouver, BC: University of British Columbia Press.

Chandler, M. & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's First Nations. *Transcultural Psychiatry*, 35, 2, 191–219.

Cornell, S. (2006). Indigenous peoples, poverty and self-determination in Australia, New Zealand, Canada and the United States. Tucson, AZ: Native Nations Institute for Leadership, Management, and Policy (Joint Occasional Papers on Native Affairs, no. 2006-02).

Cornell, S. & Kalt, J. (1989). *Pathways from poverty: Development and institution building on American Indian reservations*. Cambridge, MA: John F. Kennedy School of Government, Harvard University.

Couture, J., Parker, T., Couture, R. & Laboucane, P. (2001). *A cost-benefit analysis of Hollow Water's Community Holistic Circle Healing process*. Native Healing Services of Alberta, Edmonton. Aboriginal Healing Foundation, Ministry of the Solicitor General, Ottawa.

Department of Justice. (1982). *Section 35: Aboriginal rights*. Ottawa, ON: Government of Canada.

Dewar, B. (July-August 2009). *Nunavut and the Nunavut land claims agreement — An unresolved relationship*. Policy Options, 74-79.

Dussault, R. & Erasmus, G. (1994). *The high arctic relocation: A report on the 1953–55 relocation*. Ottawa, ON: Canadian Government Publishing.

Fabbi, N. (2003). *The North, the Inuit and Nunavut*. Retrieved from http://www.k12studycanada.org/files/Nanavut.pdf.

First Nations Health Council. (2011). *Implementing the vision: BC First Nations health governance: Reimagining First Nations Health in BC*. Vancouver, BC: Author.

First Nation Governing Council. (2005). *First Nations regional longitudinal health survey 2002/03: Results for adults, youth and children living in First Nations communities*. Ottawa, ON: National Aboriginal Health Organization — First Nations Centre.

First Nations Leadership Council and the Ministry of Economic Development (2008). Journey to economic independence: BC First Nations perspectives. Retrieved from www.tted.gov.bc.ca/Publications/Documents/FNReportPrintMeg.pd.

First Nations Tax Commission. (2007). *Five times larger: Why First Nation communities must engage the private sector*. Retrieved from http://fntc.ca.

Goddard, J. (1994). In from the cold. *Canadian Geographic*, 114(4), 38–47.

Government of Canada. (2011). *British Columbia Tripartite Framework Agreement on First Nations Health Governance*. Ottawa, ON: Aboriginal Affairs and Northern Development Canada.

Government of Canada. (1984). *Canada Health Act*. Retrieved from http://laws-lois.justice.gc.ca/eng/acts/C-6/.

Government of Nunavut. (n.d.). Facts about Nunavut. Government of Nunavut. Retrieved from http://www.gov.nu.ca

Hallowell, A. (1955) *Culture and experience*. New York, NY: Schocken Books.

Harper, S. (June 11, 2008). *Prime Minister Harper offers full apology on behalf of Canadians for the Indian residential schools system*. Retrieved from http://pm.gc.ca/eng/media.asp?id=2149.

Hawe, P. & Potvin, L. (2009). *What is population health intervention research?* Canadian Journal of Public Health, 100(1), 1–9.

Hunt, J. (2010). *Partnerships for Indigenous development: International development NGOs, Aboriginal organisations and communities*. Canberra, AU: Centre For Aboriginal Economic Policy Research.

Inuit Tapiriit Kanatami (ITK). (2004). *Backgrounder on Inuit and housing: For discussion at housing sectoral meeting*. Ottawa, ON: Inuit Tapiriit Kanatami.

Jenkins, A., Gyorkos, T., Culman, K., Ward, B., Pekeles, G. & Mills, E. (2003). An overview of factors influencing the health of Canadian Inuit infants. *International Journal of Circumpolar Health*, 62(1): 17–39.

Jull, P. (1988). Building Nunavut: A story of Inuit self-government. *The Northern Review*, 59–72.

Ladner, K. (November 2009). Understanding the impact of self-determination on communities in crisis. *Journal of Aboriginal Health*, 88–110.

Laverack, G. (2006). *Improving health outcomes through community empowerment: A review of the literature*. Governance and Social Development Resource Centre. Retrieved from http://www.gsdrc.org/go/display&type=Document&id=4046

Little, L. (2006) *A discussion of the impacts of non-medical determinants of health for Inuit mental wellness*. Ottawa, ON: Inuit Tapiriit Kanatami.

Marmot, M. (2005). Social determinants of health inequalities. Lancet, 365, 1099–1104.

Marmot, M. & Wilkinson, R. (Eds.). (2003). *Social determinants of health: The solid facts* (2nd ed.). Copenhagen, Denmark: World Health Organization.

Makarenko, J. (2008). The *Indian Act*: Historical overview. Judicial System and Legal Issues. Retrieved from http://www.mapleleafweb.com/features/the-indian-act-historical-overview.

McGrath, M. (2006). *The long exile: A tale of Inuit betrayal and survival in the high arctic.* New York, NY: Alfred A. Knopf.

McMillan, A. (1995). *Native peoples and cultures of Canada: An anthropological overview* (2nd ed.). Toronto, ON: Douglas & McIntyre.

Merriam-Webster Online Dictionary. Retrieved from http://www.merriam-webster.com/dictionary/collectivity

Ministry of Aboriginal Relations and Reconciliation. (2010). *New relationships with Aboriginal People and communities in B.C.: Measuring outcomes 2009–2010*. Victoria, BC: Intergovernmental and Community Relations Branch.

National Collaborating Centre for Aboriginal Health (2012). The state of knowledge of Aboriginal health: A review of Aboriginal public health in Canada. Prince George, BC: Author.

National Center for First Nations Governance. (2012). *Best Practices. Westbank First Nation. Principle: Transparency and Fairness*. Retrieved from http://fngovernance.org/toolkit/best_practice/westbank_first_nation.

Nelson, S. (2012).

Nunes, K., Firestone, P., Wexler, A., Jensen, T., & Bradford, J. (2007). Incarceration and recidivism among sexual offenders. *Law and Human Behavior*, 31, 305–318.

Nyland, R. (2002). *Silviculture: Concepts and Applications* (2nd ed.). New York, NY: The McGraw-Hill Companies.

O'Neil, J. (January 2004). Aboriginal health governance. *Journal of Aboriginal Health*, 4–5.

Ouje-Bougoumou Community Website. Retrieved from http://www.ouje.ca.

Patrick, D. & Armitage, P. (2001). Media contestation of the James Bay and Northern Québec Agreement: The social construction of the Cree problem. In, C. Scott (Ed.). *Aboriginal autonomy and development in northern Québec and Labrador* (pp. 206–232), Vancouver, BC: UBC Press.

Poole, R. (2004). The nation-state and aboriginal self-determination. Sydney, AU: Macquarie University ResearchOnline.

Poonwassie, A. & Charter, A. (2001). An Aboriginal worldview of Helping: Empowering approaches. *Canadian Journal of Counselling*, 35(1), 63–73.

Rifkin, S. (2003). A framework linking community empowerment and health equity: It is a matter of CHOICE. *Journal of Health, Population & Nutrition*, 21(3), 168–180.

Royal Commission on Aboriginal Peoples. (1996). *Royal commission report on Aboriginal Peoples*. Retrieved from http://www.collectionscanada.gc.ca/webarchives/20071115053257/http://www.ainc-inac.gc.ca/ch/rcap/sg/sgmm_e.html.

Singh-Manoux, A., Clarke, P. & Marmot, M. (2002). Multiple measures of socioeconomic position and psychosocial health: Proximal and distal measures. *International Journal of Epidemiology*, 31, 1192–1199.

Solicitor General Canada and the Aboriginal Healing Foundation. (2002). *Mapping the healing journey. The final report of a First Nation research project on healing in Canadian Aboriginal communities*. APC 21 CA. http://www.mbeconetwork.org/canoemap/pdfs/hollowwater.pdf.

Statistics Canada (2006). Aboriginal Population Profile — Oujé-Bougoumou. Statistics Canada. Retrieved January 28, 2013) Retrieved from: http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-594/search-recherche/lst/page.cfm?Lang=E&GeoCode=24&Letter=O

Statistics Canada. (2006a). Aboriginal Population Profile — Hollow Water. Statistics Canada. Retrieved from http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-594/search-recherche/lst/page.cfm?Lang=E&GeoCode=46&Letter=H

Statistics Canada. (2006b). First Nations compared to Metis population. British Columbia Statistics. Retrieved from https://www.google.ca/search?q=BC+Stats+%E2%80%93+First+Nations+compared+to+Metis+population.+2006.+&ie=utf-8&oe=utf-8&aq=t&rls=org.mozilla:en-US:official&client=firefox-a

Statistics Canada. (2006c). Aboriginal Population Profile — Westbank First Nation. Statistics Canada. Retrieved from recherche/lst/page.cfm?Lang=E&GeoCode=59&Letter=W

Statistics Canada (2006d). Aboriginal Population Profile — Nunavut. Statistics Canada. Retrieved from: http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-594/search-recherche/lst/page.cfm?Lang=E&GeoCode=62

Statistics Canada (2011). Aboriginal Population Profile — Oujé-Bougoumou. Statistics Canada. Retrieved from: http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=2499818&Geo2=PR&Code2=24&Data=Count&SearchText=Ouj%C3%A9-Bougoumou&SearchType=Begins&SearchPR=01&B1=All&Custom=

Steenbeek, A., Tyndall, M., Rothenberg, R., & Sheps, S. (2006). Determinants of sexually transmitted infections among Canadian Inuit adolescent populations. *Public Health Nursing*, 23 (6): 531–534.

Stevens, C. & Reid Acland, J. (1999). Building sovereignty: The architectural sources of Ouje-Bougoumou. *Canadian Issues*, 21, 124–142.

Tait, C. L. (2003). Fetal alcohol syndrome among Aboriginal people in Canada: Review and analysis of the intergenerational links to residential schools. Ottawa, ON: Aboriginal Healing Foundation.

Travers, K. (1995). Using qualitative research to understand the sociocultural origins of diabetes among Cape Breton Mi'kmaq. *Chronic Diseases in Canada*, 16(4).

Vogel, L. (2011). BC First Nations to run own health system. *Canadian Medical Association Journal*, 183, 17.

Waldram, J., Herring, A., & Young, T. (1995). *Aboriginal health in Canada: History, culture and epidemiological perspectives*. Toronto, ON: University of Toronto Press.

Weaver, S. (1981). *Making Canadian Indian policy: The hidden agenda 1968–1970*. Toronto, ON: University of Toronto Press.

Webster, P. (2009). Local control over Aboriginal health care improves outcome, study indicates. *Canadian Medical Association Journal*, 181,11, E249–50.

Westbank First Nation Community Website. Retrieved from http://www.wfn.ca/siya/comservices.htm?RD=1.

Working Group on Aboriginal Participation in the Economy. (2011). *Strengthening Aboriginal participation in the economy. Report of the working group on Aboriginal participation in the economy to Federal-Provincial/Territorial Ministers responsible for Aboriginal affairs and national Aboriginal leaders*. Winnipeg, MB: Government of Manitoba.

World Health Organization Commission On Social Determinants Of Health (2007). *A conceptual framework for action on the social determinants of health*. Geneva, CH: Author.

World Health Organization — Europe. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen, Denmark: Author.

Young, T. K. (1996). Sociocultural and behavioural determinants of obesity among Inuit in the central Canadian arctic. *Social Science and Medicine*, 43(11), 1665–1671.