



**HEALTH SECTORAL FOLLOW-UP SESSION
FLIP CHART NOTES
FIRST NATIONS BREAKOUT GROUP**

The following reflects a transcription of the comments posted on flipcharts in response to the questions indicated below in boldfaced text, during the breakout group discussions.



**FIRST NATIONS BREAKOUT GROUP
HEALTH SECTORAL FOLLOW-UP SESSION
FLIP CHART NOTES**

ADDRESSING ISSUES OF JURISDICTION AND CONTROL

Working in breakout groups at six tables, the participants identified how a shared definition of success could look.

The launch question to focus discussion for this segment was:

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

LAUNCH QUESTION: WHAT WOULD YOU DO IF YOU HAD FIRST NATIONS JURISDICTION IN HEALTH?

- Will have legislation that will recognize and guarantee inherent treaty rights;
- Will have jurisdictional clarity;
- Adequate resources/funding;
- Portable, fair, accessible equal services for people living on and off reserve recognizing gender issues and people with disabilities. More representation of health specialist First Nations and Métis political vs. specialist;
- Capacity building;
- Need to provide adequate resources to support a process of communication;
- Have a “human face” to policy making and issues;
- Ownership, control, access and possession (OCAP);
- Control is shared not advisory;
- Jurisdiction and control needs to be a tool used from the bottom-up in all areas – not just a concept or idea;
- Holistic health model comprised of physical, spiritual, emotional, mental and environmental (air, fire, water, rock) has to be good;
- Jurisdiction and control requires:
 - Legislative mandate (role/responsibilities);
 - Defined scope: acute care, NIHB (Non-Insured Health Benefits), public health, rehabilitation;
 - Qualified Human Resources (capacity);



- Funding and accountability;
- Trend: Integrating jurisdiction.
- Jurisdiction and control must be based on a health determinants approach (13 determinants);
- Adopting and modifying successful models which incorporate/integrate/utilize an array of successful working models from others;
- Partnerships/support/resources from various levels of government;
- Human resource development i.e. developing health managers, professionals;
- Adequate resourcing;
- Developing institutions at the local, regional levels (i.e. hospitals, training facilities etc.);
- We need to be able to manage our own (i.e. organizations and public sectors as well);
- In these jurisdictions, we would provide services to anyone within the catchment area including First Nations, Inuit and Métis and non-Aboriginal people;
- Naming our institutions, we need to be more inclusive including looking at the language/definitions which suit our new role;
- Evidence-based decision-making – we do not want to inherit a bad/potentially unsuccessful situation without remedial action traditions/culture would be front and centre;
- Traditional/culture would be front and centre;
- We need to pay attention to the various health acts;
- Treaties – how secure are they? (spirit and intent);
- Care for the caregivers/educators;
- Gender equity in health professions;
- Medical model has to encompass more than the western ideology;
- Jurisdiction controlled system;
- Off-reserve/status/non-status issues;
- Special needs and other services and national programs that are accessed by some and not others:
 - Families that are divided by eligibility;
 - Less dollars that make infighting with Aboriginal groups;
- Constitutional question needs to be answered:
 - 3 groups (First Nation, Métis and Inuit) to standard with the rest of Canada;
 - To redress FN issues at a dialogue, table should have happened 30 years ago.
- Redress Issues in terms of status, non-status including delivery of services;
- Prioritize programs that have worked with universal, indigenous terms (language and appropriate approaches) to be encompassing and inclusive;
- Proper governance structures would be developed to:
 - Support equal partnership for FNs to be involved in F/P/T negotiation and transfer payments;
 - Use of dollars received by provinces on our behalf to be determined by FNs. We bring authority to the table to direct policy and fiscal discussions;
 - First Nations would be able to respond to new and emerging health issues;
 - First Nations to develop and control partnerships/protocols with service delivery organization is for off-reserve/urban health services;



- “one size fits all” approach does not always work;
 - Key principles to be developed by FNs regionally and nationally that will guide health service delivery – inclusivity, accessibility, universality;
 - Sustainable funding for:
 - Service delivery;
 - Governance;
 - Capital/infrastructure;
 - Triggers for escalation funding;
 - Research respecting OCAP;
 - Response to Cross-cutting themes:
 - Principles within the *Canada Health Act* to be used in ensuring urban/off-reserve/remote health services delivery. Funding to support this is necessary;
 - Recognize self-government;
 - FN ownership and control;
 - Original title to land;
 - Right to services without compromise (pay up-front, not qualify, need data);
 - Dual accountability;
 - Jointly managed (local, regional, national);
 - Equal and meaningful partnerships, if it affects the community involve them.
 - Community-driven;
 - There is **no** measurement of health, there is only cost containment measures;
 - Funding into communities NOT for administration i.e. FNIHB – Health Canada – Northern Secretariat;
 - Ownership that is unique. Not an interest group;
 - Directly in *Constitution*;
 - Angry at system;
 - Government (FN works) (statement);
 - Nation to National level (not an after-thought);
 - Treaties implementation (peace and friendship);
 - Services required (need in community);
 - People don’t go to hospital unless they are dying;
 - People have suffered;
 - No distinction on delivery of services.
-

Jurisdiction

- Centralized to decentralized role;
- Need to set up services for our community needs:
 - E.g. youth services – can not be from 8:30-5PM. Children come out of school when the service is not available.



Holistic view on health: justice, housing, economics, social

- Addressing all needs;
- Mental and where the spirituality is before you can address health issues;
- When do we become healthy, our elders tell us;
 - when babies aren't having babies;
 - concern our youth at risk in becoming homeless;
 - WE NEED TO VALUE WHO WE ARE;
 - Pride on our cultural, spiritual values – doing this in everything we do!
 - Having control of what our children learn in their education;
 - **Health human resources** to meet: What are the community issues on health;
 - **Gender equality** is in our communities. Our grandmothers, mothers, aunts are the ones deciding on where our children go. No government intervention. Our women decide.
 - Client focused rather than program focused/region changes;
 - Services need to be brought together under one roof – one body directed by people;
 - (community) not government – set this up – have services come to people;
 - Address gaps – Elders aren't part of the system. Integration will deal with all ages. Youth is vital;
 - Surface needs of users;
 - Community of practice and knowledge management, e.g. Alberta telehealth. Users – get service in control. Health Canada definition of community. Tribal Council not appropriate. Policy needs examination;
 - Knowledge needs to recommend;
 - Decision has to be made by community;
 - Knowledge has to be collected differently (funding disseminated differently);
 - Philosophy of community of P and K. community empowered, government out (only resource). People create research tools and methodology work differently;
 - “Let me do it for you” is not acceptable. Need job/train to help ourselves;
 - Notion of power – we have it – we choose – how do we facilitate empowerment.

Family violence

- We need capacity to be able to respond when called upon
- Leadership is a part of this responsibility;
- Have a program capacity for community needs;
- Treatment centres of cultural appropriateness e.g. detox centres;
- Our kids need to be cared for in a new way. A new system. We can be proud of who we are;
- Have urban safe places. Extended family helps within the community structures to help in giving positive directions to families having difficulty;
- Map out cultural empowerment.



DEFINITION OF SUCCESS - Summary

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

RECOMMENDED ACTIONS

The participants were regrouped at three tables to develop action plans based on the definitions of success. Following are the results of that exercise:

RECOMMENDED ACTIONS

SHORT-TERM: 0-3 YEARS

- Erase all existing plans not inclusive of First Nations by governments;
- Ask communities “what does health mean in their community”;
- Establish structures with budget attached;
- Establish structure (roles and responsibilities, political and technical, policies);
- Development of goals;
- Health system framework (holistic) not illness, community driven models;
- Needs assessment;
- Revisit and revise existing government structure – too much money put into it and not to community;
- Recognize diversity;
- Integration of inter-agencies;
- We share our jurisdiction with other agencies and governments;
- Proactive not reactive;
- Community development;
- Networking and linkages;
- Training needs;
- Environmental assessment;
- Develop structured plan at local level;
- Vision: healthy community:
 - Development of a health delivery system framework locally;
- Establish committees;
- Needs assessment – PRP providers. Snapshot of community: HR, environment, infrastructure, health and illness status of community members:
 - Forms foundations of database;
- Community driven:
 - Development of programs/policies (health promotion and prevention);



- Recruitment/retention;
- Internal resources;
- Identify external resources;
- Dependence – responsibility – ownership;
- Focus on individual – family – community ;
- 3-dimensional: design, development, delivery by community/First Nation.

SHORT TERM: 0-3 YEARS

Develop structured plan at the local level.

- Develop FN Health Authorities that mirror provincial RHAs (Regional Health Authorities)
- Include all mixes
- T.C./NNADAP (National Native Alcohol and Drug Abuse Program /Community-Based/women/off-reserve
- Policy table not service delivery
 - Develop boards
 - Protocol/economies
 - Agreed upon plan
 - Recognition/respect for all FNs on/off reserve (status and non-status)
- Recognition needs to be from a National level and provincial to community
- Establish a knowledge base
 - Nationally: identifiers, determinants, needs assessment
- Infrastructure investments
 - Telehealth
 - High tech equipment
- To continue to deliver “best practices” models (midwifery/Six Nations)
 - Share information – promote success stories and knowledge of what doesn’t work
 - Need money for change in services/transition
- Need to continue to maintain and sustain current community-based programming
 - Title/Log
 - Community generated, nationally supported
- Career Fairs/Promotion of health careers immediately
 - Secure seats in university/in professional schools
 - Increase cap on professional schools.
- Scope of practices/Professional association need to be standardized e.g. CHR
 - Integration with cultural regulatory/practice/safety



MEDIUM TERM: 3-5 YEARS

(if we had jurisdiction)

- **Human Resources**
 - Development of Infrastructure
 - Facilities
 - Curriculum
 - Technology
 - Development of targets
 - Negotiations of access programs
 - Enhancement of “pre” programs
 - Development of “laddering” programs
 - Social consciousness of existing universities to be raised
 - Enhanced support services to be developed for FN students (housing, child care, transportation etc.)
 - DIAND policies to be revisited and changed
 - Universities be encouraged to develop recruitment and retention programs
 - Promotion of health careers
 - Strengthening “maths and sciences” in reserve schools
- **Governance**
 - Development of appropriate governance models at the local, tribal council, regional, national level
 - “one size fits all” does not work.
 - Development of protocols with federal/provincial government that respect First Nations governance
 - Legislated authorities with appropriate funding
 - Development of First Nations’ data and information systems, research, ethics, OCAP principles, privacy codes.
 - Development of supportive services, public health, medical health officers, surveillance systems, planning dollars.

MEDIUM TERM: 3-5 YEARS

- Integrated primary care
- Community controlled health centres.
- On/off reserves, traditional and medicalized.
- Holistic model based on community input.
- Strategic plan must include gender-based analysis.
- Aboriginal human resources strategy in place at all health authorities.



National

- Gender-based analysis must be used in the process used to:
 - Developing trust between different jurisdictional partners, health determinant areas and regional integration (Aboriginal distinct from rural).
- Universities are working in partnership with Aboriginal communities: research,
- recruitment and retention of students.
- Harmonization of legislation (fed/prov).
- Aboriginal led process in health capacity building (i.e. decision making around who can access education opportunities) e.g. existing best practices models .
- Mandatory sensitization of current non-Aboriginal health professionals.
- Courses taught in university are designed and delivered by Aboriginal people.

LONG TERM: 5 YEARS AND MORE

General Comments:

Specific recommendations have already been made by First Nations, e.g. Royal Commission on Aboriginal Peoples (RCAP). These recommendations need to be implemented. What actions:

- Train 10,000 professionals in 5 years
- Do gender-based analysis on RCAP
- Replace *Indian Act* with First Nations Recognition Act
- Open up medical model to integrate traditional knowledge and practices.

- **Trained Professionals:**
 - Need well-trained Health Professionals in all areas (a balance of all types).
 - Better fund Aboriginal institutions to train and retain students – be inclusive.
 - Fully accredit Aboriginal institutions to be the “BEST” practice – which will attract people from all over the world – degrees are well-respected.
 - i. Implement RCAP recommendations relating to health professionals (e.g. suggestion was 10,000 in 10 years).
 - ii. Ensure cultural competency and safety by integrating this curriculum for both Aboriginal/non-Aboriginal students.
 - iii. F/P/T officials also need to be educated in cultural issues.

- 1. **Determinants of Health**
 - What makes Aboriginal people healthy?
 - Our determinants include: self-determination, treaty and good housing – everyone should have a home, everyone should have employment;
 - Our communities need to be healthy, positive environments to live and work in;
 - Need good community infrastructure – including wellness centres and healing lodges;
 - Provide good community home care programs that allow flexibility so that families can have Elders live at home with them (e.g. funding to renovate home to make space for an Elder);



- **Jurisdiction**
 - Replace Indian Act with legislation that empowers Nations.
 - See RCAP recommendations re: First Nations Recognition Act.
 - Implement Treaties.
- **Youth**
 - Listen to the voice of youth
 - Involve them in all planning and decision-making.
- **Beyond Medical Model**
 - Include Aboriginal worldview and concepts on health
 - Integrate Traditional Knowledge ceremonies and medicines into our health practices
 - By 5 years our “Best Concepts” should inform our “Best Practices”
 - One should continuously inform the other
 - Need to develop protocols to protect our Traditional Knowledge from cultural appropriation and commercialization.

LONG TERM: 5 YEARS AND MORE

- 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 the 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 level as deemed appropriate to meet the needs of communities involved.
 - Need defined definitions of Aboriginal communities that enable legal arrangements with municipalities etc. and ability to raise funds.
 - Need Aboriginal parallel health systems – like school boards – where Aboriginal peoples can control.
- **Human Resources:**
 - Short-term: remove caps on post-secondary funding
 - Long-term:
 - University recruitment and education process needs to encourage doctors to go back to their communities.
 - Can be achieved by providing financial support to Aboriginal medical students to complete their education on condition that they serve in Aboriginal communities for a minimum of five years.



- All medical schools incorporate Aboriginal cultural education into their programming for both Aboriginal and non-Aboriginal professionals.
- Funding available for proper training and accreditation for para-professionals and traditional healers.
- **Health Status Reporting:**
 - Need methodology and Aboriginal specific indicators, tenable, consistent reporting across the country on the health status of all Aboriginal peoples – status, non-status, Métis, Inuit, on-reserve, off-reserve, urban, rural, remote, male, female and by age grouping.
 - Could be done through blind identifier attached to health card. Identifier is private and not accessible to service providers or insurance companies, but is accessible only in the data run (when it is no longer tied to a name).

INTEGRATION AND ACCESS - IMPROVING ACCESS (AND RECOGNITION)

The launch question to focus discussion for this segment was:

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

VISION/DEFINITIONS

Local

- Community driven vision.
- Holistic health care model.
- Ability of individual to access services without consideration of who, how, where.
- Advocacy is part of services available to the Aboriginal client.
- Services provided at local area include public health, primary care, women's health, school health, health and social services, maternal health.

Regional

- Networking, partnering, clustering communities – share resources and freedom of choice.
- Portability of rights goes with us whether we live on or off reserve.
- Rehabilitation services are accessible – i.e. physiotherapy, occupational, mental health services.

National

- Sharing best practices and setting standards of care
- F/P/T and First Nation representation and decision making authority must include the voices of women and persons with disability.



- Decisions are made respecting accountability and transparency, Government to Government.

Local

- Stakeholders to conduct community led Health Needs Assessment to identify needs and gaps (women, people with disabilities, seniors, children, grandparents, teachers, social workers, health care providers, off and on reserve members).
- Community Health Plans.
- Health Policy/Protocols.

Regional

- Cluster communities (respecting political jurisdiction and reduce all barriers), agencies, organizations that deliver services.
- map all services available and protocols of how to work together.

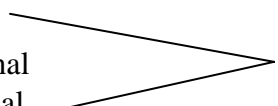
National

- National Health Action Plan to be reviewed, consultation process conducted and community approval including women and persons with disabilities, on and off reserve.

Principles/Process behind Integration

- Respect the distinct culture and identity of Métis, Inuit and First Nations. Avoid “one size fits all ‘Pan Aboriginal’ approaches.
- Emphasize health promotion and prevention.
- Identify and build on existing successful models of health prevention and promotion (e.g. Nechi).
- Sustainability should not be what drives integration. Good health outcomes should be the driver.
- Means having First Nations controlled and owned health systems that are linked at all levels, both on and off reserve.

What decision-making should look like:

- Local
 - Regional
 - National
-  All up to communities to determine
- Development of framework to guide this
 - First Nations to have leverage (legislative and financial) to ensure integration with federal/provincial services



Wholism

- Services should be “people-centred” not program or funder-centred;
- Healthy living promotion/education of the public, including cultural relevance (e.g. successful, role models/Elders, asset mapping, family values, volunteers, community members).
- Mandatory community volunteerism for public health professionals (i.e. incentives based).
- Could apply in other social service sectors, i.e. learning, family services.

Integration and Access

- Representation at the regional level on Health Authorities representation by the number of service users rather than population.
- Establish something like a “Public Health Professional” Organization where CHRs, A&D workers, health promotion professionals can receive standardized training and accreditation as “Wellness Workers” and integrate at service level.
- Establish 2 or 3 national centres of First Nations Health Excellence for research training, information clearinghouse and health promotion each linked with the other (e.g. NAHO and other NGOs).
- First Nations Leaders need to be at the First Ministers’ Tables (e.g. FMM)
- First Nations NGO, leaders and health professionals at the F/P/T process develop Aboriginal Health Reporting Framework – “bless the process”
- Re-connect to our own Indigenous knowledge and healers and Elders – attach to our home communications and provincial/territorial systems.

Reclaim our own health wisdom!

- How do we measure/define improvements in health.
- Do not currently have a means of measuring.
- There is a need to address global issues that we have in common, e.g. child health, Elder health, chronic diseases.
- National diabetes program.
- These are no simple solutions – not enough time in this workshop to address problems and propose solutions.
- Need an on-going process that engages Aboriginal People and governments at the national, provincial, territorial, regional, local levels to work out details of integrated health services.
 - National level – set general parameters to guide discussions. Establish task groups with Elders, leaders, experts to develop proposals and recommendations that outline a general approach.
 - Provincial level – develop provincial parameters to guide local discussions through task groups.



- Service details – at local level.
- Means having FN controlled and owned health systems that are linked at all levels, both on and off reserve – “No one size fits all”.
- What decision-making should look like: local, regional, national – all up to communities to determine.
- Development of framework to guide this.
- First Nations’ need to have leverage (legislative and financial) to ensure integration with federal/provincial services.
- Le mot “integration” one fait pas de sens.
- Needs to be FN controlled at each level (community driven).
- Needs to be wellness (holistic) based – not illness based.
- Needs to build capacity and support given for training – long-term strategic plans and continuing.
- Jurisdiction FN government to government – recognition.
- Need continuity – people are falling through the cracks.
- Share the almighty power.
- Transfer process needed to transfer knowledge as well.
- Need “community (includes on-off reserve) development model”.
- Some communities need more help with capacity and getting well.
- An emergency “help” team for bands in need.
- Decision making should be done jointly with the lead being at the community level.
- Health status is measured by wellness and NOT cost containment.
- Make it easy to take care of your people.
- Reduce bureaucracy – it only takes our money.
- Respect FN Government process.
- Funding need is not per capita.
- Funding formula needs to reflect Northern and remote factors.
- All of the above, if actually implemented, will improve access and integration to health.
- It has to start at the local level with the same respect given at each level (hopefully not too many).

RECOMMENDED ACTIONS

SHORT-TERM: 0-3 YEARS

This plan is built towards legislative change

- Develop common definition.
- Community, leadership and service delivery buy-in.
- Establishment of interagency councils.
- Multi-disciplinary development of a “Vision”.



- Develop guiding principles: local, regional, national
- Changes in the federal funding approach to ensure dollars are targeted to ALL First Nations through one funding source.
- Development of service delivery protocols that include services for on and off reserve First Nations citizens.
- Raise awareness on cross-cultural training for health professionals.
- First Nations need to be well informed about their rights.
- Making provinces accountable to the dollars they receive on our behalf.
- Making Feds accountable for dollars that are targeted to First Nations that includes federal operations and management.
- Development and establishment of First Nations owned and controlled information management systems – OCAP.
- First Nations access all data that is collected on our behalf.

Actions: Short Term

- Fund a process that actions the previous items.
 - Each community is diverse but use models of success, i.e. AHWS Ontario.
 - Communities need to develop strategic plan – issue driven.
 - This community development process has to be flexible, issue driven so communities can take ownership of their health.
 - Assets inventory in each community.
 - Define capacity; human resource needs, etc.
 - Need help with coordination but not through the many levels of bureaucracy.
 - First Nations direct to Treasury Board.
 - Dual accountability community driver.
 - Program indicators.
- Advocate and lobby with government regarding health issues and health professional association;
 - Progress the development of Aboriginal policy/legislation;
 - Secure resolution process;
 - Adequate human and financial resources.
 - First Nations lead, govern, design, oversee the comprehensive delivery system through the full continuum of care (e.g. health promotion, primary care/territory and other upstream initiatives).
 - Development of/building our own professional institutions to increase FN professional capacity with a culturally relevant curriculum to ensure graduation, recruitment, retention at community level. Develop a Faculty of Aboriginal Health Sciences. Lifelong learning.
 - All above apply to Aboriginal off reserve, rural/urban and non-status.

Respect for all Aboriginal People from F/P/T an Aboriginal leadership has to come first before success. No marginalization/coexistence.



LONG-TERM: 5 YEARS OR MORE

- Educational reform
 - Framework/Business Plan to promote lifelong learning to ensure development of cultural competency of educators, health care providers (future/current).
 - Youth have access to health programs/curriculum/professions.
- Inclusion of Elders/Traditional healers to ensure a complimentary balance of western scientific approaches and traditional knowledge.
- Adequate resource allocation/buy-in.

Question: How will we know we are making progress on our definition and action?

- Services are available close to home
- full continuum of primary health care
- More Aboriginal health professionals employed
- Health status improved
- Culturally appropriate services available and they (we) are using them
- Establish our own standards
- Collaborative health care services within First Nations communities
- Resources match need
- Culturally appropriate curricula
- Development of cultural competencies in provision of health
- Disabled First Nations living in home communities and getting services they need
- First Nations people determining services they can access - rather than Ottawa determining
- Infrastructure in place
- Services match data
- Smoking, prescription drug abuse, drinking and gambling addictions are gone
- No more FAS babies
- Other health determinants are addressed
- Cut wait times for services
- When women are part of decision making
- Increased knowledge basis which increased resources and creates transformation change
- Policy makers, academics and community people sitting at same table for a common purpose
- Inherent right is backed up by legislative authority



- Community development models are role model for the country
- Replace *Indian Act* to inherent right to self-government.

Make sure you define ‘access’ and ‘integration’ at local, provincial and national level

HC - how various health systems can work better together/how various health professionals can work better together

- focus on individual and not organization or funding bodies
- holistic
- if patient - seamless service and doesn't have to begin each level of interventions
- see integrated and holistic models popping up across the country;
- when educational programs are in place;
- access & attain health services regardless of residency and status;
- when First Nations believe they are getting holistic health services;
- First Nations pride and ownership in their own health systems;
- First Nations are educated and understand health issues/impacts;
- More emphasis on delivery less on reporting;
- Children are proud & healthy;
- When the Aboriginal Healing Foundation is renewed;
- Adequate funding for public health on reserve;
- Progress that allows for people to advance at their own pace;
- No more proposals – a base funding forever;
- First Nation professional graduate at all levels;

- Retained at community level;
- Once RCAP system recommended is put in place (e.g. healing strategy);

CAPACITY AND SUSTAINABILITY FLIP CHARTS

The launch question to focus discussion for this segment was:

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

Professionals

- Physicians;
- Community Health Representatives (CHRs);
- Nurses;
- Occupational therapists/Physiotherapists;
- Dentists;
- Pharmacist;



- Therapists;
- Health administrators;
- Researchers;
- Addictions counsellors;
- Mental health workers;
- Psychologists/social workers;
- Counsellors;
- Educators;
- Recreational specialists;
- Personal workers;
- Community health;
- Community water monitors;
- Environmental Health Officers;
- Community medicine specialists;
- Community Health Nurses/Public Health Nurses;
- Nurse Practitioners;
- Traditional Medicine Practitioners;
- Ceremonialists;
- Healers;
- Advocates (i.e. liaison officers);
- Translators/interpreters;
- Crisis counsellors;
- Aboriginal emergency medical services;
- Policy Planners;
- Health services administrators;
- Financial officers (Aboriginal Financial Officers Association);
- Aboriginal police.

How capacity needs to be built:

- Accreditation;
- Centre of excellence – designed and delivered by Aboriginals;
- Recruitment strategies;
- Specific number of seats assigned in post secondary education;
- Local support/training;
- Early evaluation of an integration strategy promoting health sciences at the elementary level;
- Community board education programs;
- Increased Aboriginal control over reproductive and mental health programs;
- Mentorship programs;
- Summer science programs for First Nations students;
- Extensive cultural awareness;



- Targeted investments – funding;
- Encourage young females to enter health sciences programs;
- Establish internship programs with all Aboriginal health professions;
- Traditional Practitioner – acknowledgement of validity;
- Expand role in health services teams (community, hospital);
- Health Sciences Centre; Internship with Traditional practitioners – community validation policy e.g. Ontario Aboriginal Healing and Wellness Strategy, Traditional Healers Policy;
- Build a healing lodge and birth centre.

Success is:

- a collaborative effort from all players;
- FN people/leaders at all decision-making tables;
- Continuing to support processes that are committed to developing young leaders;
- Access to education (i.e. funding, support, etc.);
- Creating support systems;
- Changing attitudes in education systems;
- Creating support systems – assisting students in going back to communities;
- Support for greater technology in communities.

What and how capacity needs to be built:

- Return to and re-emphasize RCAP recommendations;
- Don't forget human development;
- Must build from foundations up:
 - FN spirituality;
 - Treaty right;
 - Health, prosperity, peace, happiness;
 - Knowledge and Wisdom (traditional and scientific);
 - History;
- Build “incentives” for wisdom of Elders to be passed on (e.g. oral, written, native tongue/English ceremonies);
- Build respect for the diversity of First Nations (language groups, ability, age, sexual orientation, gender, rural/urban, north/south, status/non-status);
- Increase post-secondary funding;
- Support Aboriginal colleges and institutions.

Success is – breaking away from the “right to welfare”:

- Enriching programs;
- Advocates in school districts;
- Leaders to press for FN students;
- Addressing determinants of health (support of family education);
- Early education as a tool for improving health outcomes;



- gather/more information about what already exists. e.g. individual education institutions.
- FN education advisor group – Indian and Northern Affairs Canada (INAC);

What and How capacity needs to be built:

- Promote “Cultural Safety” (developed by Maori nurses) in health systems;
- Well-trained FN human resource sector to maintain a healthy/sustainable lodge/nation/community;
- Specifics to be worked out at local level;
- When brainstorming is replaced by ground breaking work, progress will have been made.
- Nurture supportive NGOs e.g. Nechi, NAHO, ANAC, AHF, FN Statistics Institute, etc.

Success is:

- involvement of FN in the design, delivery, implementation and management of all processes and services – ensure culture and ownership;
- must include training and support for FN involvement in process;
- Secure commitment from political leadership, F/P/T and community;
- Secure agreement from all partners (inclusive of target groups) status, non-status, women, disable, urban, rural, youth, elders;
- Need for capacity to write proposals;
- Cross-cutting – targeted groups involved meaningfully in all processes created.
- Secure Aboriginal “spaces/seats” in health professions e.g. nurse, medical doctor, psychologist - all health professions.

What capacity needs to be built:

- LPN's;
- Nurses;
- Nurse practitioners;
- Midwifery;
- Planners (health);
- Family physicians;
- Nutritionists;
- Physiotherapists;
- Dentists;
- Pharmacists;
- Dieticians;
- Psychiatrists;
- Podiatrists;
- Health administrators;
- Laboratory technicians;
- Health card/guides have been developed – these guides should be referenced for this listing;



- Traditional healers;
- Economic development planners/managers;
- Policy makers;
- Human Resources Officers.

How capacity needs to be built:

- Expanded number of seats in post-secondary institutions;
- Pre programs to be expanded;
- Laddering programs;
- Expanded mathematics and sciences programs at elementary and high school levels;
- Support services for students;
- Housing, child care, access to elders;
- Monitoring programs;
- More post secondary funding;
- More programs developed to meet FN needs;
- Training closer to home;
- Distance training; Expanded “e” learning opportunities;
- Protocols between FNs, INAC, Health Canada, Human Resources Development Canada, provinces to break down barriers to access;
- Life long learning;
- Role model programs;
- Early intervention to discourage drop out;
- Explore different approaches to education/training.
- Set targets/long and short term;
- Establish FN standards for training;
- FN health professional and paraprofessional associations;
- Appropriate resources to be available to FN to enable them to recruit and retain health professionals;
- Creative approaches to attract health personnel;
- Long term sustainability;
- Local and regional strategies to assist small remote communities to sustain health professionals;
- Alternative programs to be introduced to welfare recipients to attract them to health careers;
- Life skills programs to be introduced at all elementary and secondary levels to address:
 - self esteem;
 - coping;
 - hope;
 - alcohol and drugs;
- address and meet needs of persons with disabilities to promote health careers;
- local/regional strategies for traditional healers.



How we know were making progress – sustainability:

- when the recommendations of the FNs peoples with disabilities workshop have been implemented;
- When a gender based analysis has been completed and utilized;
- When adequate on-going funding that meets all needs is in place;
- Health status indicators reflect that we have healthier communities (on/off reserve, women-reduced violence, disabilities).

What and How capacity needs to be built:

- Community governance is operating;
- Community Health Plan;
- Research & Development Team (using community members);
- Community based and driven;
- Emergency response team;
 - To address all areas of crisis/diseases/infrastructure;
- Health Care Providers;
- Nurses/practitioners;
- LPN nursing – training and support;
- Managers – personal care;
- Number of providers match reports;
- CHR & LPN to home care nurses – personal care workers;
- Managers;
- Environmentalists;
- Belief in ourselves;
- Show others our beliefs;
- Cultural awareness/traditional;
- Health activities;
- Staff development and wellness education - culturally and community values;
- Skills development up to date in schools, band offices, health, SIS;
- Development of data base;
- Protection of personal information;
- School level: community health programs i.e. immunizations;
- Youth (self-esteem) for the whole community;
- Suicide prevention programming;
- Elders/seniors program and youth working together;
- Community functions/special events;
- Traditional ceremonies;
- Specialized FN professionals.



How we know we're making progress:

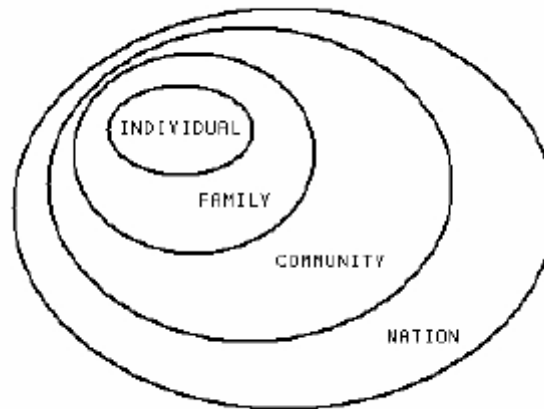
- 10,000 or more Aboriginal health care workers – wake up – alive;
- Aboriginal control over reproductive and mental health;
- More positions funded and created in colleges/universities;
- When babies are not having babies;
- Stop having brainstorming sessions;
- When Aboriginal students graduate;
- When Aboriginal students think about health careers;
- Health system that Aboriginal people are not afraid to use;
- When professionals/instructors are Aboriginal people;
- When provinces and federal agencies back off;
- Transfer money;
- Proactive and not reactive;
- More people with disabilities participate in these kinds of activities;
- FN control and delivery of their health;
- FN are specialist in their community;
- When non-Aboriginal people come to aboriginal professionals;
- Choice (??) available between traditional and western medicine;
- Hospitals aren't full of our people;
- Improved health indicators.

What and How capacity needs to be built:

- FN health needs are presented regardless of residency and status;
- Determine what community has;
- Undertake community needs assessment;
- Identify gaps;
- Develop community plan with infrastructure and human resources requirements e.g. professionals, para-professional, policy people;
- Cost the community plan;
- Update community plan periodically (every 5 years);
- Determine future needs on an ongoing basis based on periodic review;
- Build capacity for political process;
- Negotiators (to negotiate with F/P/T and local levels);
- Policy development and planning;
- Health professionals to put plan into practice;
- Capacity (funding, human resources) for the sustainability of the plan;
- Few FN people employed in the health sector;
- More health jobs must go to FN communities;
- Need more infrastructure (facilities) to employ more FN people in FN communities;
- All capacity building processes must reflect the diversity of FN and other Aboriginal communities;
- All doctors must undertake cross cultural training and must be trained by FN people;



- Inherent rights follow individual, on or off reserve, from womb to tomb;
- Inclusive Framework:



How do we know we are making progress:

- Funding is no longer an issue;
- Less unknowns;
- FNs have jurisdiction and control over health;
- All FN peoples have NIHB (on and off reserve and non-status);
- When we have health, self-sufficient and self-determining FN communities.

LAUNCH QUESTION: WHAT AND HOW SUSTAINABILITY NEEDS TO BE BUILT? HOW DO WE KNOW WE HAVE ACHIEVED SUCCESS?

Sustainability – definition

- Commitment;
- Adequate resources;
- Meet the needs – growth;
- Dynamic – growth;
- Monitor/quality control;
- Effective evaluations (that are utilized);
- Human resources (adequate);
- Giving back for what you take – return on investment;
- Components – accountability;
- Recognition and addressing needs;
- Longevity;
- System and supports;



- A vision of good health;
- Constant not precarious;
- Individual;
- Family;
- Community;
- Nation.

Environmental scan;

- Identify and quantify needs;
- Knowns and unknowns.

Internal –FN communities:

- Strengths;
- Culture and language revival;
- Strong leadership;
- Current effective programming;
- Traditional knowledge.

External – government, other organizations, etc.:

- Opportunities;
- Recent commitment from the Prime Minister;
- Voluntary sector;
- Transition fund;
- Current supportive structures (i.e. health professionals' organizations).

Weaknesses

- “Indian Crab bucket”;
- Strong leadership;
- Lack of resources (human, financial);
- Lack of culture and language revival;
- Not enough super women and men.

Threats:

- NIHB (under funded/non-funded);
- Government cut-backs;
- Exclusion of non-status;
- Western lifestyles;
- Values and prejudice misconception;
- Accountability (funding) (needs to meet needs of population);
- Prov. cuts
- Prov. ignorance jurisdiction/obligation
- Need to be inclusive of targeted groups (lens)

What needs to be done:

- Role modeling – mentorship;
- Successful women, youth, men, children;
- Defining needs;



- Reviewing current investments;
- Lobby to meet needs (government partners, private sector);
- Strategic community development;
- Business plan;
- Human resources;
- Organization development;
- Political development;
- Inclusion of FN leaders at decision-making tables;
- Strategic planning specifically for future needs and pressures – surveillance;
- Develop, identify and fund upstream proactive programs – prevention/promotion as well;
- Address NIHB under funding – significant investment;

Who's going to do it?

- Leadership (FN, non-political family);
- Leadership – technical-community;
- Political—national, provincial;
- FN;
- Youth;
- Organizational support;
- Current decision-makers;
- Health care professionals – researchers - leaders
- Health professionals – policy makers
- FN leadership – gov. – policy makers – health organizations

What needs to be done for sustainability:

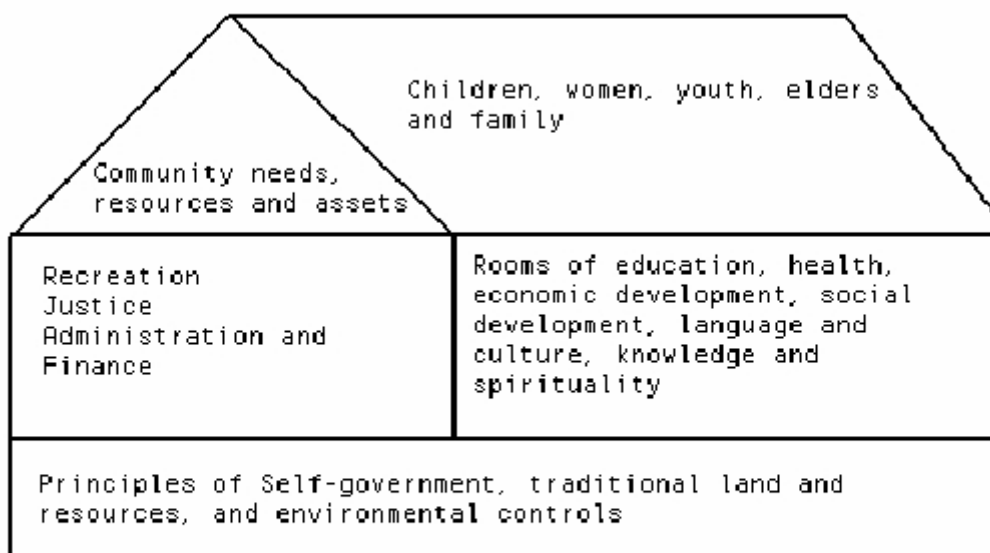
- Need for accountability;
- Address provincial cuts and jurisdiction/obligation issues;
- Address oppression of traditional values and prejudice towards Aboriginal People.

Who's going to do it?

- Aboriginal Leadership;
- Government;
- Community;
- Policy makers;
- Aboriginal organizations;
- Support organizations;
- Targeted groups;
- Government and non-government - all Canadian society – voluntary sector.



Wellness Lodge:



Pillars of Support: Public and private sectors, NGO's
Requirements: Safe water, food and air

Sustainability is:

- Continued progress;
- Continued existence;
- Continued evolution and meeting needs;
- Continually resources.

Knowns:

- Existing health professional models for recruitment;
- Some health career programs;
- Current programs don't meet needs;
- On-going funding;
- FN population growing – greatest is youth;
- FN health is in critical stage;
- FN traditional medicine not valued by mainstream providers.

Unknowns:

- Which programs work – models;
- Best practice models;
- Pattern of disease burden will change;
- Lack of reliable data – hospitals – provincial;



- Gender-based analysis;
- Existing Aboriginal models i.e. healing lodges, birthing center advocacy;
- Other indigenous cultures around the world;
- Disability data;
- How to sustain traditional medicine – existing models to share;
- Linkages – systems.

How do we sustain FN health care:

- Funding – long term;
- Learn to trust ourselves;
- Traditional ways;
- Our capabilities;
- System - trusting FN to plan and deliver services;
- Disability lens – must be there;
- Laddering opportunities;
- Education;
- Training;
- Employment;
- FN plan and deliver health services;
- Cultural safety – able to be accepted as who we are;
- FN program accreditation;
- Holistic continuum of programs on/off reserve;
- Strategic plan (measurable indicators includes gender based analysis and disabilities).

Sustainability – Definition:

- Short term goals which will build, nurture and strengthen processes to achieve the long term goals;
- Establishing long term agreements for self-sufficiency, powering-up and power to control.
- Knowns: We're here to stay!
- Current existing successful models in non-Aboriginal/Aboriginal communities;
- Political will to work towards sustainability;
- Initial financial commitment to work toward it;
- Large, growing, young population;
- Significant array of health problems that must be addressed (e.g. diabetes, substance abuse, suicide).

How do we build sustainability?

- Agreements (health, etc.);
- Financial resources;
- Partnerships with government and the private sector;



- Unified positions;
- Legislation;
- Self-governments;
- Professional human resources (administrative and medical professionals).
- Unknowns:
- Unsure financial commitment;
- Unsure how long political will is there;
- Unsure of provincial, territorial, and federal communication and commitment together
- Give “life” to FN sustainability.

How do we sustain FN health care?

- Political will;
- Honour agreements;
- Fulfilled treaties;
- Adequate financial resources;
- Ensuring adequate human resources;
- Continued building of partnerships with private/public/NGO sectors;
- Proper infrastructure;
- Healing the nations;
- Cooperation and confidence in and amongst ourselves;
- “Crab and grab” system replaced by harmony, support, love and trust one another system - “buddy system”;
- Nurture healthy good/relationships wherever they arise;
- Build better bridges/perceptions of/between Aboriginal and non-Aboriginal peoples;
- Ground relationships in human beings – interpersonal communication skills i.e. balance; Hi tech = Hi touch - avoid cynical “put-down” humour and comments that erode trust and respect;
- We need to cultivate and encourage positive attitudes and ways of nurturing with each other.
- Leadership needs to model constructive language, attitudes and behaviour and work through conflict in a respectful way.
- Assertive not aggressive;
- Sustainability;
- Inflation rate and capital funding + demographic increase + cost of health delivery + needs and base-funding + real cost drivers;
- Requires funding matched to population growth, health needs and real cost drivers, as well effective as measurements to monitor and track spending and results.

Knowns:

- Refer to the AFN blueprint;
- No common FN’s identifiers;
- Treaty and inherent rights;
- Current funding not keeping pace with current realities;



- Current funding stove-piped;
- No incentives for linkages.

Unknowns:

- Current backlog to bring FN up to current sustainability levels;
- Don't know funding to current provincial system.

What do we as a government need to know about sustainability:

- Need to know;
- Legislated;
- participation;
- Community – based program – controlled;
- Organizational structures (in every area);
- Leadership support;
- Transparency;
- Dual - accountability;
- Meaningful partnerships;
- Co-management (with other government).

Unknowns:

- Budgets/resources;
- “Economics”;
- Government to government relationships;
- Funding of Human Resources (i.e. nurses, expertise, etc.)
- Cost of housing equipment, professionals – comparable costs;
- Fiscal building;
- Health needs;
- New diseases i.e. emergencies.

Sustainability – definition:

- Keeping current program/services at (up to par) optimal level;
- Leaving room for growth;
- Enhancement;
- Flexibility;
- Protect it;
- Not just over time but sometimes when objectives have been met;
- Measurable/on-going evaluation;
- Priorities identified, maintained, revised, without stress;
- Being able to set long-term goals/plans;
- Realistic funding (and formula);
- Good communications skills;
- Community ownership;
- Recruitment and commitment/retention of Aboriginal professionals;



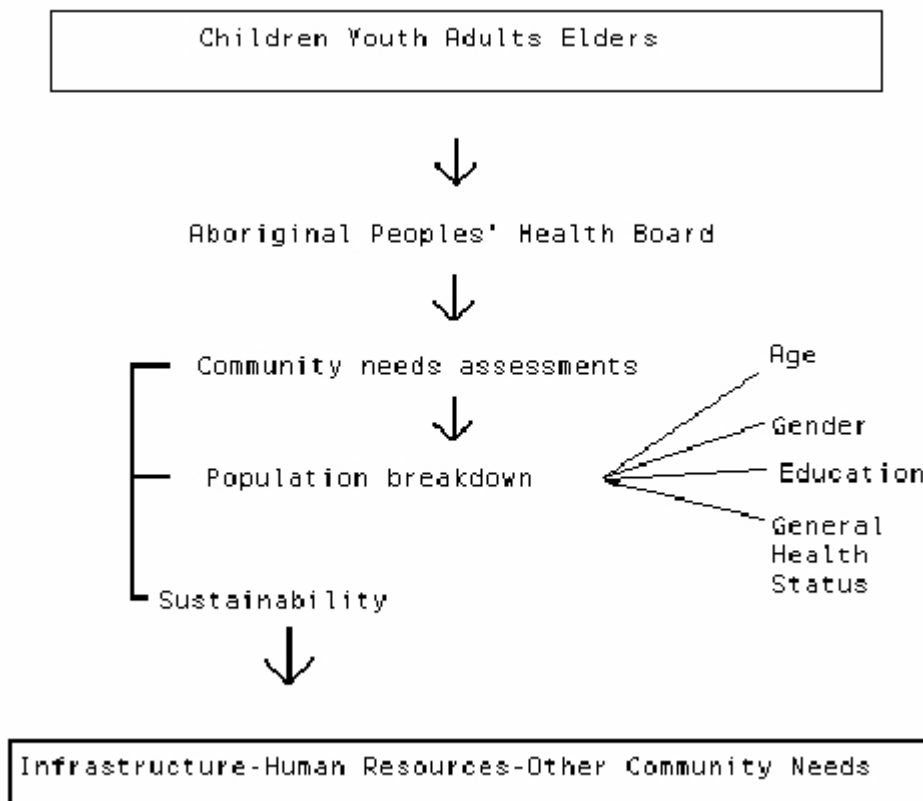
- Government in power – government knows its legal obligations to FN's;
- Wage parities of professionals;
- Security and benefits for Aboriginal professionals;
- Political interference (local) and threats;
- Liability issues (i.e. risks/responsibilities).

How do we sustain FN health care?

- Long term funding/planning (visioning);
- Strategic planning;
- Evaluation;
- Goal-vision-principles (values);
- Community ownership/participation – “values”;
- “Communication” – linkages;
- Networking – with others;
- Best practices;
- Positive attitude/thinking;
- Healthy community vision;
- Professional development and wellness;
- Investment funding;
- Professionals;
- Cultural activities;
- Alternative ways;
- Educational awareness (historical-skills-environment);
- Aboriginal (FN decision-makers – at all levels (i.e. management));
- Equity – all aspect of work force;
- Sustainability is the acknowledgement of Aboriginal peoples' contribution of resources to Canada and a commitment on the part of all partners (F/P/T/Aboriginal) to maintain structures and entities which have been developed and/or are to be developed in the future;
- Resourcing of (financial & human) health systems must be tied to community needs assessment, population growth and characteristics of the population, living conditions, geographic location, cost of living;
- What needs to be built:
 - Capacity for ongoing evaluation;
 - Capacity for political infrastructure and leadership to execute mandate from community for ongoing and other discussions/negotiations with governments;
- Sustainability is Aboriginal peoples' engagement in the design, development and delivery of programs and services, as well as decisions regarding the retention or discontinuance of programs/services;
- Recognition of Aboriginal peoples' leadership in the F/P processes.



Community:



- How to promote the health profession/sciencens to younger and newer generations
- How to enable FN people to get into for e.g. medical schools

BROAD DETERMINANTS OF HEALTH

Focusing on the following question, the participants summarized how this can be addressed in the First Nations community:

How could a “Broad Determinants of Health Approach” be applied within a First Nation context?

- Need our own health law/legislation;
- Need legal entity to represent Aboriginal people;
- Strategic planning (20 year approach) – proactive not reactive;
- Circle approach; Framework for Aboriginal health policy;
- Capacity for health policy development at regional and national levels;



- Discussions at Nov.4/5 health sectoral table should be reflected in federal processes;
- Ensure issues of off reserve people are taken seriously and reflected in decisions;
- Establishment of a fully equipped and operational adult care facility;
- 110 housing providers working to build consensus on how to achieve more and better quality housing for Aboriginal people;
- Delivery of housing resources to local Aboriginal community to build houses;
- National housing strategy for and by Aboriginal People (includes non reserve and special needs);
- Housing must be available, accessible and affordable;
- Define requirements based on core need (over-crowding, building condition and rent burden);
- Partnership of three entities:
 - FN communities, Provincial/Federal without threatening Aboriginal rights;
 - Leadership assume responsibility for communications to federal/provinces but also accountable to the electorate for process and evaluation;
 - Need to be at the table as equal partner and influence agenda and decisions about agenda;

Rural/remote

- access to services
- transportation without compromise;
- Access to affordable, fresh, nutritious food;
- Clean water;
- Access to telephone;
- Access to technology;
- Social support when you leave;
- Language;
- Recruitment and retention of health care professionals;
- Education on par with rest of Canada;
- Realistic funding;
- Access to disability specific services – vision, hearing;
- Access to continuity of care;
- Rehabilitative and supportive care;
- Access to second opinion;
- Access to communications and training;
- Access to traditional healers;
- Access to recreational activities and alternatives to alcohol and drugs;
- Realistic social service levels (welfare, allowance, disabilities);
- Facilities for projects, services and administration;
- Capacity building and retention;
- Clean air;
- Access to mental health services;
- Inclusion of family in terminal patient care;
- Address non-status access;



- Ownership of resources for economic development;
- Recognize transferable, urban, rural and remote;
- Political voice;
- Financial resourcing;
- Communications at all levels;
- Provision of health services must remain a central health determinants;
- Emphasize unique FN health determinants (e.g. self-governance, racism, effects on mental health, barrier to health care, etc.);
- Vertical and horizontal integration must occur – health, learning, research, social services, etc.;
- Reciprocal responsibility and accountability must occur between governments, communities, individuals;
- Practical working relationships between governments, educational and research institutions and communities;
- Integrate “Cultural openness” in service delivery – RESPECT! Take individual responsibility for your own health/behaviour;
- Be an advocate for a healthy lifestyle;
- Use what the Creator gave you to communicate and share commitment across sectors.
- Need to be at the table as equal partners in order to influence the agenda and decisions made about items on the agenda;
- Health care has to be measured by health status – not cost;
- Children have to be well – lens for children; Mentors needed (elders);
- Availability of volunteers to help in crisis situations (elders and children);
- Advocate or lobby for better education and social conditions;
- Share the wealth – resources (meat, wood);
- Support individuals (leads to) health and education;
- Parenting skills;
- Don't forget we need to take care of men's health;
- Language;
- Good housing;
- Support culture and traditions;
- Support family activities;
- Age and gender appropriate programs;
- Facilities available for health, living – laundromats, shavers;
- Need balance (physical, emotional, spiritual, mental);
- Role: Advocate, lobby, provide evidence (research);
- Expertise;
- Ensure community input; Information – communication;
- Mentor;
- Self-worth – believe in self;
- Ownership of health, but economically, like our own radio station and airline shares;



- Culturally appropriate;
- Give cultural awareness to people that are not from the community;
- Develop all standards in health care and in child care and parenting;
- Work with traditional parenting and teach social workers, nurses, etc. as well;
- Own Aboriginal health act, own department of health – eliminate other government departments;
- Eliminate and serve the ties with Health Canada when ready;
- Value our elders.

Broad Determinants of Health:

- Women;
- Nutrition;
- Social support networks: advocacy, self help groups, grandmothers;
- Housing - adequate, accessible, affordable, safe (physical and emergency);
- Shelter (safe house);
- Counsellors; Access and opportunity for professional and para-professional services;
- Mental health;
- Education for single parents;
- Child care – good, safe, cultural approach, flexible;
- Sandwich generations – elder care, grandchildren, require financial support;
- Community support for women – through customary care and other creative approaches;
- Reproductive health (promotion of health process);
- Maternal health;
- Available substance abuse treatment;
- Promotion of women in leadership roles;
- Equality of wages – respect; Reduced violence;
- Support for sex trade workers and choice;
- Life skills education for young moms;
- Advocate for young moms.
- URBAN; Access to culturally appropriate services and know how to access them (requires support system);
- Uptake of health services;
- Address critical doctor shortage;
- Connection to land;
- Access to traditional approach;
- Promote awareness in mainstream of benefits (e.g. NIHB)
- Safe, clean, accessible, affordable housing and safe streets, communities;
- Reduce waiting times in health care (doctor’s office) due to racism and discrimination;
- Doctors and nurses need to understand cultural “paradigms”;
- Alternative lifestyles support services;
- Transportation;
- Safe homes;



- Early discharge requires follow up (Home care);
- Cultural safety;
- Community acceptance;
- Language;
- Support for children at school;
- Anti-racism;
- Understand/awareness of disability related health;
- When new person requires orientation, transition time too short;
- Access to long term care;
- Access to after care;
- Life skills – nutrition and finance;
- Mental health;
- Co-operative housing – needs to be available for the disabled;
- Physical fitness and access to facilities;
- Access to country/traditional foods;
- Support for addictions, homelessness;
- Integrate work between legal and health service;
- Special needs of incarcerated women and their families.

What role can I/we play?

- Take key issues/report to our communities and work on implementing gender-based analysis and disability component;
- Take back to advocacy/board and staff of the health access centre;
- Use influence with university to advocate culturally appropriate training for health professionals;
- Use influence with university for enhanced recruitment and retention of Aboriginal health students;
- Creative recruitment to ensure appropriate public health staffing to serve communities;
- Use positions (i.e. director, chief, nurse, administrator) to further the Aboriginal health agenda;
- Advocate Aboriginal reproductive and maternal health control and training, and community accreditation;
- Promote traditional healing practices and educate non-Aboriginal colleagues;
- Advocate Aboriginal led research on FN people with disabilities;
- Ensure all communities that are served have access to public health services;
- Work with community stakeholders and provincial/federal governments to address public health issues and the determinants e.g. housing, Aboriginal housing committee;
- Work in Aboriginal traffic safety – Province, Federal Government and FN communities;
- Continue to get data so data is going to communities for decision making i.e. infectious diseases report;
- Participate in undergraduate and postgraduate training – building capacity;



- Participate in building capacity by sharing knowledge and skills on how to deal with issues;
- Continue to lobby for changes in services;
- Disseminate information about this process to Manitoba Aboriginal Women's membership;
- Educate and create an awareness both internally and externally, provincial and federal organizations/governments about Aboriginal determinants of health and this process;
- Ensure that persons with disabilities are informed;
- Look at follow-up to ensure that the "disability lens" is incorporated at all levels;
- Lobby and organize for a national Aboriginal disability forum.

What has to happen?

- Set aside political issues;
- Programs for nurturing infants/mothers in first three years;
- Start off with small community plans;
- Establish priorities;
- Set goals;
- Take responsibility for family/clan;
- Own decisions;
- Break down silos;
- Role to play – Advocacy; Accountability – take responsibility for decisions;
- Different groups work together and be inclusive of all target groups;
- Organize programs to meet needs of community i.e. liaison support between sectors;
- Membership must be involved in policy development;
- Support families and communities;
- Communications;
- Strong partnerships;
- Respect individual and community needs;
- Incorporate cultural and spiritual rituals into programs and service activities and council business;
- Role to play;
 - Trust others;
 - Lobby;
 - Talk to people who make decision;
 - Involve;
 - Raise awareness of programs/policies/decisions;