



LANDSCAPES OF FIRST NATIONS, INUIT, AND MÉTIS HEALTH:


*An Environmental Scan of Organizations,
Literature and Research, 3rd Edition*

NATIONAL COLLABORATING CENTRE
FOR ABORIGINAL HEALTH



CENTRE DE COLLABORATION NATIONALE
DE LA SANTÉ AUTOCHTONE

SETTING THE CONTEXT



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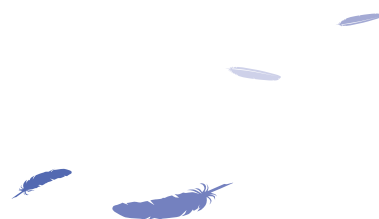
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CONTENTS



EXECUTIVE SUMMARY	6
National organizations working in First Nations, Inuit, and/or Métis public health	6
A changing landscape	7
Health priorities of national Aboriginal organizations	8
Review of literature and CIHR funded research	8
Health priorities of literature, research, and national organizations: Commonalities and gaps	9
1.0 INTRODUCTION AND PURPOSE	11
2.0 METHODOLOGY	13
2.1 National organizations working in First Nations, Inuit, and/or Métis public health in Canada	14
2.2 Topic categories	15
2.3 Review of literature	15
2.3.1 Search strategy	15
2.3.2 Relevancy assessment	16
2.3.3 Analysis and coding	16
2.4 Review of funded research	17
2.4.1 Search strategy	18
2.4.2 Relevancy assessment	18
2.4.3 Analysis and coding	19



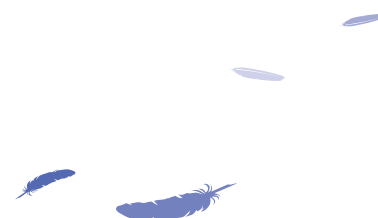
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CONTENTS...



3.0 SUMMARY OF FINDINGS	21
3.1 National organizations working in First Nations, Inuit, and Métis public health in Canada	21
3.1.1 National Aboriginal organizations.....	22
3.1.2 National Aboriginal health organizations.....	26
3.1.3 Federal government organizations.....	30
3.1.4 Other organizations/agencies that do health-related research and/or knowledge translation/exchange with Aboriginal peoples.....	32
3.1.5 Summary of the health priorities of national Aboriginal organizations and national Aboriginal health organizations	34
3.2 Review of literature	38
3.2.1 Peer-reviewed literature	38
3.2.2 Non-peer-reviewed literature.....	48
3.3 Canadian Institutes of Health Research Funding	54
3.4 Population representation	66
3.4.1 Cultural identity	66
3.4.2 Life stage.....	66
3.4.3 Gender	66
3.4.4 Geography	68
3.5 Organizations, literature, and research topics	68
4.0 KEY OBSERVATIONS.....	71
4.1 National Aboriginal organizations: A changing landscape	71
4.2 Population representation	71
4.3 Priorities of literature, research, and national Aboriginal organizations: Commonalities and gaps	72
4.4 Emerging knowledge: Making a difference through translation and exchange.....	72
REFERENCES.....	73
5.0 APPENDICES	77
APPENDIX A: National organizations working in First Nations, Inuit, and Métis public health in Canada	78
APPENDIX B: Non-exclusive topic categories	96
APPENDIX C: Peer-reviewed literature	100
APPENDIX D: Non-peer-reviewed literature	164

LIST OF ACRONYMS

AANDC	Aboriginal Affairs and Northern Development Canada
ACADRE	Aboriginal Capacity and Development Research Environment
ADI	Aboriginal Diabetes Initiative
AFN	Assembly of First Nations
AHF	Aboriginal Healing Foundation
AHRNets	Aboriginal Health Research Network
ANAC	Aboriginal Nurses Association of Canada
APACC	Aboriginal Physical Activity and Cultural Circle
ASC	Aboriginal Sport Circle
CAAN	Canadian Aboriginal AIDS Network
CAHR.....	The Centre for Aboriginal Health Research
CAP	Congress of Aboriginal Peoples
CIHR	Canadian Institutes of Health Research
CINE	Centre for Indigenous Peoples' Nutrition and Environment
DIAND	Department of Indian Affairs and Northern Development
FAS	Fetal Alcohol Syndrome
FASD	Fetal Alcohol Spectrum Disorder
FNCFCSC	First Nations Child and Family Caring Society of Canada
FNEHIN	First Nations Environmental Health Innovations Network
FNHMA	First Nations Health Managers Association
FNIGC	First Nations Information Governance Centre
FNHIB	First Nations and Inuit Health Branch
HC	Health Canada
HHR	Health Human Resources
IAPH	Institute of Aboriginal Peoples' Health
INAC	Indian and Northern Affairs Canada
IPAC	Indigenous Physicians Association of Canada
ITK	Inuit Tapiriit Kanatami
KSTE	Knowledge Synthesis, Translation, and Exchange
MNC	Métis National Council
NACAFV	National Aboriginal Circle Against Family Violence
NACM	National Aboriginal Council of Midwives
NADA	National Aboriginal Diabetes Association
NAFC	National Association of Friendship Centres
NAHO	National Aboriginal Health Organization
NAMHR	National Network for Aboriginal Mental Health Research
NCCAH	National Collaborating Centre for Aboriginal Health
NEAHR	Network Environments for Aboriginal Health Research
NGO	Non-Governmental Organization
NIICHRO	National Indian & Inuit Community Health Representatives Organization
NMHAC	Native Mental Health Association of Canada
NNAPF	National Native Addictions Partnership Foundation
NWAC	Native Women's Association of Canada
NYSHN	Native Youth Sexual Health Network
PHAC	Public Health Agency of Canada
SIDS	Sudden Infant Death Syndrome



EXECUTIVE SUMMARY



Since the National Collaborating Centre for Aboriginal Health's (NCCAH) inception, it has undertaken periodic environmental scans to provide information on national-level organizations, peer- and non-peer-reviewed published literature, and funded research concerned with First Nations, Inuit, and Métis public health in Canada. *Landscapes of First Nations, Inuit, and Métis Health: An Environmental Scan of Organizations, Literature and Research, 3rd Edition* is the third iteration of this report, with the first two published in 2006 and 2010. This third report provides information on the national organizations working in First Nations, Inuit, and/or Métis health up to the end of 2012, and an analysis of relevant literature (peer- and non-peer-reviewed) published between January 2010 and December 2012 and research funded during the 2010-11, 2011-12, and 2012-13 fiscal years. The objective of this report is to map the current landscape of knowledge production in Canada on First Nations, Inuit, and Métis health, as well as the current health priorities of national organizations working in the field.

The *Landscapes 3rd Edition* report has been developed as a resource for researchers, organizations, publishers, policy makers, funding agencies, and others working in Aboriginal¹ health, allowing individuals to identify current trends, needs, and gaps in the field. The report provides an overview of the current state of public health evidence, the landscape of research (including culturally relevant research), and opportunities for establishing new (and strengthening existing) partnerships with national organizations that focus on First Nations, Inuit, and Métis public health. The *Landscapes 3rd Edition* report is also a key resource for the NCCAH in charting future directions to meet our goal of reducing health inequities and supporting all Aboriginal peoples to achieve optimal public health.

National organizations working in First Nations, Inuit, and/or Métis public health

This portion of the environmental scan identifies the national level organizations active up to the end of 2012 that perform work relating to First Nations, Inuit, and/or Métis

public health in Canada, to provide information on their current projects, strategies, and priorities. The thirty-one organizations identified have been divided into four categories: National Aboriginal Organizations, National Aboriginal Health Organizations, Federal Government Organizations, and Other National Organizations.

National Aboriginal Organizations

National Aboriginal Organizations are those organizations directed by and for Aboriginal peoples that have a broad mandate that includes health. These include:

- Assembly of First Nations (AFN)
- Congress of Aboriginal Peoples (CAP)
- First Nations Child & Family Caring Society of Canada (FNCFCSC)
- First Nations Information Governance Centre (FNIGC)
- Inuit Tapiriit Kanatami (ITK)
- Métis National Council (MNC)
- National Association of Friendship Centres (NAFC)
- Native Women's Association of Canada (NWAC)
- Pauktuutit – Inuit Women of Canada

¹ Throughout this document, the words “Aboriginal” and “Indigenous” are used to refer to First Nations, Inuit, and Métis peoples inclusively. In the literature and descriptions of various organizations, First Nations will sometimes be subdivided by Indian Act status (status/non-status) or by residence (on/off reserve). However, while documents external to the NCCAH cited here are likely to employ the terms in a similarly inclusive manner, the terminology of the external researchers and organizations remains their own. Inconsistent application of population terminology remains a challenge in accurately assessing populations addressed by the current research and literature.

National Aboriginal Health Organizations

National Aboriginal Health Organizations are organizations directed by and for Aboriginal peoples that are focused specifically on health-related issues. These include:

- Aboriginal Nurses Association of Canada (ANAC)
- Aboriginal Physical Activity and Cultural Circle (APACC)
- Canadian Aboriginal AIDS Network (CAAN)
- First Nations Environmental Health Innovations Network (FNEHIN)
- First Nations Health Managers Association (FNHMA)
- Indigenous Physicians Association of Canada (IPAC)
- National Aboriginal Circle Against Family Violence (NACAFV)
- National Aboriginal Council of Midwives (NACM)
- National Aboriginal Diabetes Association (NADA)
- National Indian & Inuit Community Health Representatives Organization (NIICHO)
- National Native Addictions Partnership Foundation (NNAPF)
- Native Mental Health Association of Canada (NMHAC)
- Native Youth Sexual Health Network (NYSHN)

Federal Government Organizations

Federal Government Organizations are branches or agencies of the Government of Canada. These include:

- Aboriginal Affairs and Northern

Development Canada (AANDC, formerly the Department of Indian Affairs and Northern Development, DIAND, and Indian and Northern Affairs Canada, INAC)

- First Nations and Inuit Health Branch, Health Canada (FNIHB, HC)
- Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health (CIHR-IAPH)
- Statistics Canada, Health Analysis Division

Other National Organizations

Other National Organizations are independent health-related organizations that do research and/or knowledge translation/exchange with Aboriginal peoples but are not Aboriginal-controlled. These include:

- Active Circle
- Centre for Aboriginal Health Research (CAHR)
- Centre for Indigenous Peoples' Nutrition and Environment (CINE)
- National Collaborating Centre for Aboriginal Health (NCCAH, Public Health Agency of Canada)
- Network Environments for Aboriginal Health Research (NEAHRs)

A changing landscape

The landscape of Aboriginal health-related organizations saw dramatic changes in 2012. Deep funding cuts included reductions of 40% for the Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK), the

complete elimination of health funding for Pauktuutit and the Native Women's Association of Canada (NWAC), and the closure of the National Aboriginal Health Organization (NAHO) (NCCAH, 2012). In addition to overseeing many research and outreach programs, NAHO published the peer-reviewed *Journal of Aboriginal Health* and a wide range of other health-related documents.² Additionally, the Aboriginal Healing Foundation (AHF), which provided healing resources and initiatives addressing the legacy of abuse in the Residential School system (including intergenerational impacts), closed its doors in 2012 having reached the end of its mandate (AHF, 2013).³ The First Nations Statistical Institute and the Aboriginal Statistical Training Program were also eliminated in 2012. While the full impact from these cuts and closures remains to be seen, they seem likely to leave a substantial negative impact on Aboriginal health research, promotion, and policy capacity in the coming years.⁴

At the same time as funding cuts are making it more difficult for long standing organizations to do their work, the current scan revealed several new Aboriginal-controlled organizations focused on specific aspects of health and health care, including information governance, physical activity, environmental health, sexual health, midwifery, and health management professionals. The growth in these areas suggests a desire for increased self-determination and agency in developing policy and programming for health-related activities affecting First Nations, Inuit, and Métis peoples.

² As of January, 2013, the *Journal of Aboriginal Health* has been transferred to a new publisher, the Aboriginal Health Research Network (AHRNet) Secretariat at the University of Victoria, where it will continue to be published with two years of funding support from the NCCAH. <http://www.naho.ca/journal/>

³ As of January 18, 2013 the AHF website is continuing to be updated.

⁴ See, for example, Paul Christopher Webster, "Aboriginal health programming under siege, critics charge," CMAJ, <http://www.cmaj.ca/content/184/14/E739.full.pdf+html?ct>, and Michael Orsini and Martin Papillon, "Death by a Thousand Cuts," *The Mark*, <http://www.themarknews.com/articles/8446-death-by-a-thousand-cuts>.

Health priorities of national Aboriginal organizations

An analysis of the priority health topics of the existing national Aboriginal organizations (both general and health-focused) shows health care as the top priority (100%), followed by socio-economic and cultural determinants of health (59.1%), and then lifestyle and healthy living (45.5%). Chronic disease, maternal, fetal, and infant health, and mental health and wellness are all ranked fourth most frequent areas of concern for the organizations scanned.

Review of literature and CIHR funded research

This portion of the environmental scan provides an analysis of peer- and non-peer-reviewed literature to identify Aboriginal health knowledge production and dissemination priorities for the period 2010-2012. It also provides an analysis of CIHR funded research for the fiscal years 2010-11, 2011-12, and 2012-13.

Peer-reviewed literature

This edition of the *Landscapes* report found a total of 1939 peer-reviewed documents pertaining to First Nations, Inuit, and/or Métis health for the years 2010-2012, an average of 646 per year. Because of differences in the methodology between the current scan and the previous one, no direct comparisons can be made between the scans. It is therefore not possible to conclude that the apparent substantial increase in numbers in this scan is due solely to more research being *published* on First Nations, Inuit, and Métis

health. Instead, it may reflect that much more research can now be *found* using the search methods utilized in this scan. Overall, it can be concluded that there has been a dramatic increase in the amount of research being successfully identified through peer-reviewed channels.

An analysis of the peer-reviewed literature published during this period reveals that health care including research, policy, human resources, programming, and delivery (57.8%) was the main focus, followed by socio-economic and cultural determinants of health (32.7%). Secondary focuses in the literature were chronic disease (15.8%), lifestyle/healthy living (15.0%), environmental health (12.8%), communicable disease (11.1%), mental health and wellness (10.4%), and child and youth health (9.8%). Maternal, fetal, and infant health (6.7%), violence, injury, and abuse (5.1%), general health status (4.4%), and genetics (3.8%) received less attention over this period.

Non-peer-reviewed literature

A total of 379 non-peer-reviewed documents pertaining to First Nations, Inuit, and Métis health were identified in this scan, an average of 126 per year. The main focuses in non-peer-reviewed literature were similar to the peer-reviewed literature. Health care was the most common focus (62.3%), followed by socio-economic and cultural determinants (39.0%). Secondary prominence was given to environmental health (17.1%), child and youth health (11.1%), and lifestyle/healthy living (9.2%). Receiving a smaller share of attention in the literature were the items focused on chronic disease (8.2%), mental health and wellness (7.4%),

violence, injury, and abuse (6.3%), maternal, fetal, and infant health (5.5%), general health status reports (5.3%), communicable disease (3.7%), and genetics (0.3%).

CIHR funded research

To round out the picture of current Aboriginal health research priorities, this portion of the environmental scan provides a review of research projects funded through the Canadian Institutes of Health Research (CIHR) in fiscal years 2010-11, 2011-12, and 2012-13. This data illustrates the type of work currently in progress and generally expected to lead to published results.

There are 13 institutes associated with CIHR.⁵ Of 416 CIHR funded projects identified as related to Aboriginal health, approximately 57% were aligned with the Institute of Aboriginal Peoples' Health (IAPH). However, in terms of dollars allocated for the research projects, less than half of projects are aligned with IAPH. Funding levels for Aboriginal health research continues to remain high, and most funding dollars continue to be directed towards large scale, multi-year, research and networking activities. There are, however, several institutes with mandates that cover health topics identified as major health concerns for First Nations, Inuit and Métis peoples that are not currently as involved in Aboriginal health research as one would expect them to be, including the Institute of Nutrition, Metabolism, and Diabetes, the Institute of Cancer Research, and the Institute of Neurosciences, Mental Health and Addiction.

⁵ These are: Institute of Aboriginal People's Health; Institute of Aging; Institute of Cancer Research; Institute of Circulatory and Respiratory Health; Institute of Gender and Health; Institute of Genetics; Institute of Human Development, Child and Youth Health; Institute of Health Services and Policy Research; Institute of Infection and Immunity; Institute of Musculoskeletal Health and Arthritis; Institute of Neurosciences, Mental Health and Addiction; Institute of Nutrition, Metabolism and Diabetes; and Institute of Population and Public Health.

A detailed analysis by topic was conducted for all CIHR funded projects on Aboriginal health. Most projects fit within the ‘Social/Cultural/Environmental/Population Health’ theme, and most focused on health care (70.2%), followed by socio-economic and cultural determinants (25.5%), communicable disease (23.8%), mental health and wellness (18.5%), lifestyle/healthy living (17.8%), chronic disease (14.7%), child and youth health (13.2%), and environmental health (12.3%). All remaining topic categories were the focus of less than 10% of research projects. Within these main topic categories, several subtopics dominated the research projects funded including, health care research, HIV/AIDS, preventive care/health promotion/public health services, access to and use of health care services, and general socio-economic determinants of health.

Population representation

An analysis was also undertaken to assess the representation of various Aboriginal populations, including by cultural group, life stages, gender, and geography (including by urban/on reserve/ off-reserve location), within three categories: peer-reviewed literature, non-peer-reviewed literature, and funded research. Use of the term “Aboriginal” by researchers to designate aggregated and undefined study populations is an ongoing problem, particularly in the peer- and non-peer-reviewed literature. While some documents and projects specify that they intend the term to inclusively cover the three groups of Aboriginal peoples, it is more often unclear and appears likely that many are using the term to refer to unspecified First Nations communities. Métis people

(33% of the total Aboriginal population) are dramatically under-represented, particularly in the peer-reviewed literature (2.6%) and CIHR funding (7.5%), while Inuit people (4% of the total Aboriginal population) are overrepresented, especially in peer-reviewed (19.9%) literature.

Of literature and research focused on a specific life stage, adults were by far the most common group in both peer- and non-peer-reviewed literature (34.3% and 19.3% respectively), while youth were the most common group in CIHR funded research (20.7%). Children were represented in both peer- and non-peer-reviewed literature and funded research equally (ranging from 12.5% to 13.6%). Infants received more attention in CIHR funded research (4.6%) than in both types of literature (ranging from 1.6 to 1.8%), while seniors received slightly more attention in peer-reviewed literature (4.7%) compared with both non-peer reviewed literature (3.2%) and the funded research (3.1%). Of the literature and research with a gender-specific population, females were studied far more often in all categories (ranging between 7.1% and 14.4%) than males (between 0.5% and 2.2%). The scan also revealed that there are significant disparities for urban and off reserve populations, which when combined, represent more than 50% of the population, yet represent only between 7.7% and 10.3% of the peer- and non-peer-reviewed literature and funded research. While population numbers are not the only indicator of “health needs,” these large discrepancies point to areas where research may not be addressing the needs of people and communities.

Health priorities of literature, research, and national organizations: Commonalities and gaps

In bringing together data on the health priorities of national Aboriginal organizations, peer-reviewed literature, non-peer-reviewed literature, and CIHR funded research, it is clear that the topics of health care (including research, policy, human resources, programming, and delivery) and socio-economic and cultural determinants are the top priorities for the Aboriginal organizations included in this scan and also for the three categories of peer-reviewed, non-peer-reviewed literature and funded research.

Several other topics are stronger concerns for organizations but receive less emphasis in literature and research, including: lifestyle and healthy living (especially smoking cessation, sexual health, and diet and nutrition); child and youth health; chronic disease (especially diabetes); maternal, fetal, and infant health; mental health and wellness; and violence, injury, and abuse. Environmental health is an almost equally significant health concern for Aboriginal organizations as it is in the peer-reviewed literature and funded research, though it is somewhat more important in the non-peer-reviewed literature. All of these gaps indicate areas where the existing and forthcoming knowledge may not be adequately addressing the concerns of the organizations that represent the needs of communities. General health status and genetics are not major priorities for literature, research, or Aboriginal organizations.







1.0 INTRODUCTION AND PURPOSE



Landscapes of First Nations, Inuit, and Métis Health: An Environmental Scan of Organizations, Literature and Research, 3rd Edition is the third iteration of a report produced first in 2006 and again in 2010 by the National Collaborating Centre for Aboriginal Health (NCCAH). This third report identifies information on national organizations working in First Nations, Inuit, and/or Métis public health up to the end of 2012. This report also reviews literature published between January 2010 - December 2012 and research funded by the CIHR in fiscal years 2010-11, 2011-12, and 2012-13. Its purpose is to identify the areas of Aboriginal health that researchers and Aboriginal organizations have considered priorities during this period, and to determine whether there is congruence between what health researchers and organizations are focusing on. In addition, the report assesses whether specific Aboriginal populations are over or under-represented in the research in order to identify where the needs of communities are or are not being addressed. This information will be useful for researchers, organizations, publishers, and funding agencies who wish to identify current trends, strengths, and gaps in Aboriginal health research.

In charting the landscape of Aboriginal health research in Canada, this report is an important piece in the NCCAH's mandate to support "a renewed public health system in Canada that is inclusive and respectful of First Nations, Inuit and Métis peoples" and to foster "links between evidence, knowledge, practice and policy while advancing self-determination and Indigenous knowledge in support of optimal health and well-being" (NCCAH, n.d.- a, para. 2). In support of this mandate, the NCCAH has the following goals:

- ensure the use of reliable, quality evidence to achieve meaningful impact on the public health system on behalf of Aboriginal peoples in Canada
- increase knowledge and understanding of Aboriginal public health by developing culturally relevant materials and projects
- facilitate a greater role for First Nations, Inuit, and Métis peoples in public health initiatives that affect Aboriginal health and well-being (NCCAH, n.d.- a).

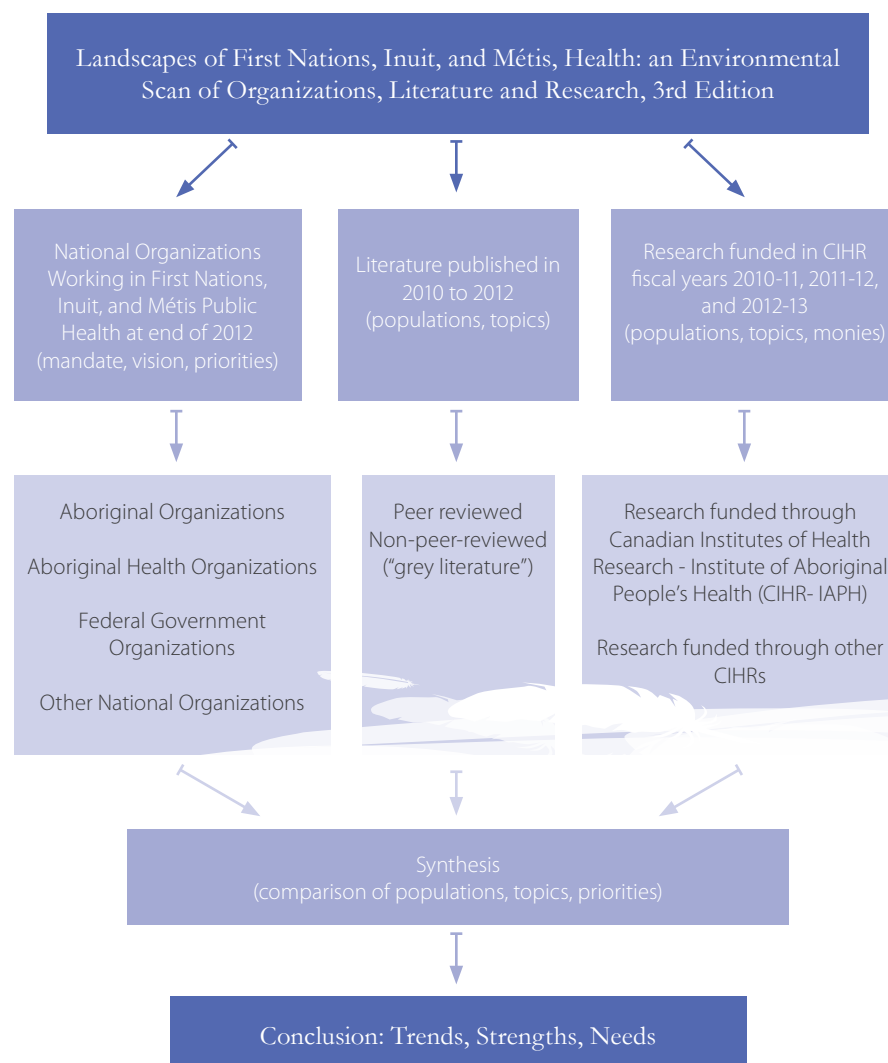
This new *Landscapes* report is an important resource for meeting these goals. The document aims to provide an overview of the current state of public health evidence, the landscape of research (including culturally relevant research), and opportunities for establishing new (and strengthening existing) partnerships with national organizations that focus on First Nations, Inuit, and Métis public health.



2.0 METHODOLOGY

Landscapes of First Nations, Inuit, and Métis Health: An Environmental Scan of Organizations, Literature and Research, 3rd Edition brings together a scan of national organizations working in First Nations, Inuit, and Métis public health in Canada with a review of literature and research funding. Several methodological changes, detailed in sections 2.1 to 2.4 below, were made from the 2010 *Landscapes* report. However, the overall structure of the report remains the same and is represented in Figure 1.

FIGURE 1: STRUCTURE OF ENVIRONMENTAL SCAN



2.1 National organizations working in First Nations, Inuit, and/or Métis public health in Canada

A scan was undertaken of national organizations active as of December 2012 that perform work relating to First Nations, Inuit, and/or Métis public health in Canada, in order to provide information on their current projects, strategies, and priorities. Information has been gathered exclusively from the websites of relevant organizations. Organizations that were included in the 2010 report but are no longer active were removed from the discussion, while several new organizations (either newly formed or newly identified) were added to our listings. The resulting thirty-one organizations have been divided into four categories:

- National Aboriginal Organizations (organizations directed by and for Aboriginal peoples with a broad mandate that includes health)
- National Aboriginal Health Organizations (organizations directed by and for Aboriginal peoples that are focused specifically on health-related issues)
- Federal Government Organizations (branches/agencies of the Government of Canada)
- Other National Organizations (independent organizations/agencies that do health-related research and/or knowledge translation/exchange with Aboriginal peoples but are not Aboriginal-controlled).

For the purposes of this scan, an organization was considered an agency or branch of the Federal Government if its website is hosted within the Government of Canada (.gc.ca) domain, rather than having an independently hosted website. Detailed information

on the health-related agendas of all organizations is provided below in Section 3, “Summary of Findings.” In addition, Appendix A contains a summary table of information on each organization, including their vision, mission, mandate, objectives, priorities, and contact information, to function as a concise reference. Appendix A also includes contact information for organizations that continue to have a web presence even though they are no longer operational (specifically NAHO and AHF).

As there is no agreed-upon terminology or standard for defining what constitutes an organizational priority, to capture this information our scan relied on a general assessment of website information, taking into account aspects of the organization’s stated goals, recent publications, and current projects to determine which topics appear to have the most urgency or relevance. An assumption was made that generally, of all the national organizations, those that are Aboriginal-directed are most closely in touch with the needs of Aboriginal communities. Therefore, the priorities of national Aboriginal organizations and national Aboriginal health organizations were taken to be broadly representative of the health-related needs of people and communities for comparison against the topics being addressed by literature and research.

2.2 Topic categories

To facilitate a comparison between topics that are priorities for Aboriginal health organizations and those that are being given emphasis in recent literature and funded research, a set of non-exclusive topic categories was developed. A scan was made of topics used previously by researchers, the NCCAH,

and other health organizations to determine the most commonly used topic terms and subject matter divisions. This data was synthesized and condensed to avoid category duplication as much as possible, and thirteen main topic areas were identified covering the three primary sectors of population health: health care, health determinants, and health status. The thirteen main topics within these three primary sectors are outlined in Table 1.

Inconsistent use of category terms by researchers and organizations can make data comparison difficult or impossible; therefore, it is hoped that by establishing a consistent set of topics, future environmental scans and other research that choose to use these categories may be able to more accurately chart changes and trends. Appendix B shows the chosen topic structure including a list of subtopic areas that were identified and used in coding the data for this report. It provides further insight into what is included in each main topic.

2.3 Review of literature

A scan was undertaken of literature published from January 2010 to December 2012 to identify Aboriginal health research priorities. It is important to note that this review, while quite comprehensive, did not follow formal systematic review procedures and may not be inclusive of all relevant literature. It must also be stressed that the methodology of the current scan differs in several respects from that used in the 2010 *Landscapes* report.⁶ The current scan consists of three parts: a search of Google Scholar, hand searching of specific journals and tables of contents, and a search of the websites of national organizations that focus on improving the health of First Nations, Inuit, and Métis peoples in Canada.

⁶ These methodological differences may have influenced the resulting data in ways that are impossible to quantify, and this must be kept in mind when comparing results from the two reports.

Table 1: Topic structure used for coding	
Category	Main Topic Area
Health Care	1) Health care research, policy, human resources, programming, and delivery
Health Determinants	2) Genetics/human biology
	3) Lifestyle/healthy living
	4) Socio-economic and cultural determinants
	5) Environmental health
Health Status	6) Chronic disease
	7) Communicable disease
	8) Maternal, fetal, and infant health
	9) Child and youth health
	10) Mental health and wellness (including addictions and suicide)
	11) Violence, injury, and abuse
	12) General health status reports
	13) Other

- child development, early childhood development
- women and health
- oral health
- respiratory health/tuberculosis/pneumonia/bronchitis/asthma/obstructive pulmonary
- chronic disease/diabetes/obesity/cardiovascular disease/hypertension
- pain/rehabilitation/hemodialysis/epilepsy/arthritis/Crohn's disease/mortality
- sexual health/human immunodeficiency (HIV)/pregnancy/sexually transmitted
- suicide/mental health/addiction/substance use
- violence/abuse
- environmental health/climate change
- knowledge translation/transfer
- evidence-based research/research evidence
- holistic health
- health data/health status
- social determinants
- urban

It is noteworthy that using these additional, increasingly specific keywords turned up many new entries several pages deep into the search. It is surprising that more of these documents were not also indexed under the more general health-related keywords that the search began with. This finding must be kept in mind when attempting to do any broad scan, as the full range of search terms potentially needed cannot be known in advance.

In addition to the Google Scholar search, hand searching was undertaken in the following:

- Pimatisiwin: A Journal of Indigenous and Aboriginal Health
- Journal of Aboriginal Health
- Journal of Circumpolar Health
- International Indigenous Policy Journal
- Canadian Geographer (special editions focused on Aboriginal people)

2.3.1 Search strategy

Google Scholar was chosen as the primary search strategy because of its relative ease of use and its ability to access literature indexed in other specialist databases such as PubMed, Ovid MEDLINE, and Biomed Central, which were searched individually in the previous scan. Initial search terms were 'Aboriginal' or 'First Nations' or 'Métis' or 'Inuit' combined with 'health,' 'health care/healthcare,' 'health services,' 'health promotion,' and 'public health.' As the search progressed, additional search terms were added based on keywords that appeared in the resulting publications, including:

- seniors
- cultural competency, cultural safety, cultural sensitivity
- nutrition
- physical activity
- food security, food safety, food sovereignty
- communicable/infectious disease/illness, botulism, influenza, zoonotic, staphylococcus, immunization, hepatitis, foodborne
- cancer
- injury/injuries, disability/disabilities, attention deficit disorder, fetal alcohol
- maternal, infant health, child health, youth health

- tables of contents in books where one chapter was identified using search terms

In the 2010 *Landscapes* report, non-peer-reviewed literature was identified by searching the online databases of NAHO, NEARBC, and NCCAH.⁷ In the current scan, Google Scholar appeared to access, in addition to the peer-reviewed literature, most of the major reports produced by Statistics Canada, Indian and Northern Affairs Canada, provincial/territorial governments, and agencies such as the Alzheimer's Society and the Cancer Society. A follow-up search of the websites of all organizations listed in this report was conducted to identify additional non-peer-reviewed literature produced by those organizations.

Since our intent was to identify only literature that is readily identifiable by the public, we did not contact any organizations/agencies directly to identify any documents/literature produced by them. As a result, there may be gaps in the non-peer-reviewed literature captured by our search strategy, but these will reflect the relative inaccessibility of the documents missed (and perhaps encourage broader dissemination methods in the future).

2.3.2 Relevancy assessment

In all three search methods, duplicates and entries not relating to Canadian Aboriginal peoples or to health were removed. We then assessed the relevancy of the literature to Aboriginal health in Canada using the following criteria. Literature was included if it was: 1) focused exclusively on the health of Aboriginal (First Nations, Inuit and/or Métis) people in Canada, including literature that focused on social

determinants like education, income, housing, self-determination, and others as long as the connection between these determinants was discussed in relation to Aboriginal peoples' health; 2) if it compared the health of Aboriginal people (First Nations, Inuit, and/or Métis) with other population groups (general Canadian population or other ethnic groups) as long as analysis was undertaken highlighting differences between Aboriginal people and other population groups; and 3) if the item was more generally focused on Aboriginal people internationally or on the Canadian population but was on a health topic identified as being of particular importance to Aboriginal people in Canada and included a minimum of a paragraph discussion on the Canadian Aboriginal context.

General literature that made only passing reference to Aboriginal people in Canada or that showed the search terms 'Aboriginal,' 'First Nation,' 'Inuit,' or 'Métis' only in the references was excluded. Working documents, drafts, or items marked 'not for circulation' were also excluded from the search, as were news articles, editorials, and letters-to-the editor.

2.3.3 Analysis and coding

Once the relevancy of the literature was determined, each document was identified as either peer-reviewed or non-peer-reviewed (which may be produced by government, academics, business, industry, or non-government organizations, but has not been submitted to a formal peer-review process before publication). Dissertations and theses were considered peer-reviewed since they have undergone a review and revision process by experts in the field. Though

this process is not 'blind peer-review,' it typically involves an external examiner identified later in the process who is not involved in the initial review/revision process. Academic presses and other publishing companies were checked for peer-review status: if their webpages did not indicate peer-review status in an obvious location (e.g. under Information for Authors), we operated on the assumption that they did not use peer-review but rather in-house editors.⁸ We also checked the peer-review status of relatively obscure journals and research/knowledge translation institutes. All sources that self-identified as peer-reviewed were accepted on that basis. No attempt was made to evaluate the rigour of the peer-review process.

Documents were further identified as having either a general focus (items of a general nature with a distinct Aboriginal-related component) or Aboriginal focus (items primarily concerned with Aboriginal contexts). Each item was then coded for the population characteristics shown in Table 2.

Population information was generally taken from the title, abstract, or in some cases the methodology sections of each document. Unfortunately, the term "Aboriginal" continues to be used inconsistently in the body of literature, and it is often not possible to assess whether the term is being used inclusively or refers to an unspecified First Nations, Inuit, and/or Métis community or population. For the most part only the title and abstract were read, so it is possible that the populations were defined more precisely in the body of the study. However, especially in general focus studies where 'Aboriginal' was included as a

⁷ In the NCCAH's early years, some knowledge products (e.g. fact sheets) may not have been reviewed by individuals external to the organization. The organization's review practices have evolved over the past four years to a double blind peer-review process for all products.

⁸ One exception to this is Canadian Scholars' Press, which we believed to be peer-reviewed but which did not clearly state peer-review status on its website; here peer review status was confirmed via email communication.

Table 2: Population characteristics used in coding

Culture	Life stage	Gender	Geography
Aboriginal (all or unspecified)	All or unspecified	All or unspecified	National or unspecified Regional or Provincial/Territorial
First Nations	Infant	Male	Specific community
Métis	Child	Female	Urban
Inuit	Youth	Other	Rural/remote
	Adult		On reserve
	Senior		Off reserve
			International

variable, the term was often used as a synonym for First Nations. Therefore, all demographic results should be read with caution.

Each item was then assigned up to three main topic areas and up to four non-exclusive subtopics, to accommodate the complex interrelations of subject matter in the literature. On average, documents were coded for two main topics and four subtopics each, reflecting the ways that Aboriginal health issues often lie at the intersection of different subject areas; for example diabetes linked to physical activity and colonialism, or maternal health linked to food security and environmental health. Further details on the topic structure used for coding can be found in Appendix B.

2.4 Review of funded research

The Canadian Institutes of Health Research (CIHR) is the federal government's primary mechanism for funding research related to the health of Canadians. It consists of 13 Institutes, one of which focuses specifically on health research related to Aboriginal peoples and the other 12 focusing on specific health topics.⁹ These institutes each have a budget of \$8.5 million which they allocate to strategic initiatives relative to their mandates.¹⁰ When grant proposals are submitted to CIHR, applicants indicate which institute(s) the research is primarily aligned with. However, this alignment does not necessarily mean that the research will in fact be funded by that

particular institute. Funding may come from another institute if the research is deemed to be relevant to that institute's mandate, or from CIHR's Open Operating Grants or other grant and awards programs. Thus, while research related to the health of Aboriginal Canadians is often funded by the Institute of Aboriginal Peoples' Health, it may also be funded through other means. As a result, CIHR funding for Aboriginal health can be considerably higher than the \$8.5 million allocation.¹¹ To capture all research related to Aboriginal health funded by the CIHR, this scan includes all relevant research regardless of the institute the research is aligned with.

The CIHR maintains two databases for funded research on their website. The first is the Funded Research Database which provides a record of all projects funded by the CIHR and the actual financial amounts dispersed annually throughout the life of the grant or award. The second is the Funding Decisions Database which provides a record of all successful applicants (regardless of whether the grant or award was accepted), along with the total amount of the award indicated in the original decision. For several reasons, this scan utilizes the data from the Funding Decisions Database.¹² For the purposes of this scan it was considered more important to be able to identify what CIHR's research priorities are for any given year and the amount they were prepared to allocate for each project rather than how much money was actually dispersed to each

⁹ These are: Institute of Aboriginal People's Health, Institute of Aging, Institute of Cancer Research, Institute of Circulatory and Respiratory Health, Institute of Gender and Health, Institute of Genetics, Institute of Human Development, Child and Youth Health, Institute of Health Services and Policy Research, Institute of Infection and Immunity, Institute of Musculoskeletal Health and Arthritis, Institute of Neurosciences, Mental Health and Addiction, Institute of Nutrition, Metabolism and Diabetes, and Institute of Population and Public Health.

¹⁰ Personal communication, CIHR.

¹¹ Personal communication, CIHR.

¹² This database can be found at http://webapps.cihr-irsc.gc.ca/cfdd/db_search?p_language=E.

ABORIGINAL INUIT ARCTIC CIRCUMPOLAR NORTH

project during each fiscal year. Since the Funded Research Database also includes information about projects that received funding approval prior to the period covered by this scan but were ongoing during a portion or all of the period covered in this scan, it was felt that the Funding Decisions Database more clearly reflected CIHR's willingness to commit a certain amount of funding to a particular project based on its funding priorities for that particular year. All data obtained reflects information publically available on the online database as of December 2013. The conclusions are based solely on this publically available information.

2.4.1 Search strategy

A two-pronged approach was used in searching the CIHR database for relevant health research. The first involved a search of all CIHR research institutes and all research themes using the "research subject" search mechanism. A number of keywords were utilized along with the criteria that "Any of these words" could be used. They included the population keywords: "Metis", "Métis", "First Nation", "Inuit", "Aboriginal", "Indian", "Cree", "Dene", and "Indigenous," as well as the additional keywords "northern", "arctic", and "circumpolar." These keywords allowed us to identify research that was most relevant to

Aboriginal health that was aligned with, or funded by, one of the 12 general research institutes. The second approach involved limiting the search for research associated with only the Institute of Aboriginal Peoples' Health (IAPH), without limiting the theme of the research. On the assumption that applicants would align their research with the Institute of Aboriginal Health only if their primary focus was on Aboriginal health, no additional search terms were utilized in this search. Results from each search were then further refined to include only those projects which received approval for funding between April 1 and March 31 for each of the fiscal years 2010-11, 2011-12, and 2012-13.

2.4.2 Relevancy assessment

For research aligned with the IAPH, no further relevancy assessment was conducted, as it could be assumed all were relevant to Aboriginal health and therefore all were used in our scan. For each of the other CIHR Institutes, each resulting database entry was scanned to verify that one of our subject keywords appeared in the project title, keywords, or abstract. If one of our population keywords (with the exception of "Indian") appeared somewhere in the project description, this was considered adequate grounds for inclusion in our scan.

For project descriptions that did not include one of these population keywords in either the project title, keywords or abstract, further relevancy assessment was undertaken. In some cases, relevancy was assessed simply by identifying the community in which the research would be taking place and determining whether more than 50% of its population was Aboriginal. In other cases, determining relevancy was more complex, especially for research that was identified using the keywords "Indian", "northern", "Arctic," and "circumpolar." The term "Indian" was utilized to capture research that described Indigenous people as either "Native Indian" or "North American Indian", while the other three terms were utilized to capture research undertaken in areas where a significant proportion of the population may be expected to be Aboriginal. For project descriptions which included the word "Indian", only those which focused on "North American" Indian were included in this scan. For project descriptions which included the word "northern", only those focused on Nunavut and the Northwest Territories (where more than 50% of the population is considered Aboriginal) were automatically included in this scan. For other northern areas like the Yukon or northern parts of provinces, additional criteria included that the



NORTHERN INDIAN MÉTIS CREE DENE INDIGENOUS

research occur within a community in which the Aboriginal population constitutes a majority or be focused on a health issue identified in the project description as being of particular relevance to Aboriginal populations. For project descriptions that included the terms “arctic” or “circumpolar”, only those which included Canadian Arctic or circumpolar regions were included in this scan.

In addition, the search for research approved by CIHR brought up a wide range of research types, including those aimed at developing a more in-depth research proposal; facilitating the development of collaborative research; undertaking knowledge synthesis; hosting knowledge translation and dissemination events; supporting graduate and post-graduate students and fellows; supporting researchers to present results from their research at various conferences; and funding the operation of large scale research projects, institutes or networks. On the assumption that all these types of activities can reasonably be expected to lead to published research in the future,

including the development of more in-depth research proposals (many of which can be seen in the CIHR database as having received funding in future years) and travel awards (presenting a paper at a conference is often seen as a first step in the development of a paper for publication), all types of research activities were included in this scan.

2.4.3 Analysis and coding

Projects funded through all institutes, including the IAPH, were totaled for number of relevant projects and dollar amount. While the 2010 *Landscapes* report provided a detailed breakdown by type of funding and subject matter only for projects aligned with the Institute of Aboriginal Peoples’ Health,¹³ this report provides a detailed breakdown of type of subject matter for all CIHR approved research regardless of the institute it is affiliated with. This is because such a significant proportion of research related to Aboriginal health is now funded by other CIHR research institutes or grant and award programs. To facilitate comparison with the topic information from our organization and literature scans, the same non-mutually

exclusive subject areas were coded (a table of these categories can be found in Appendix B).

It is important to note that, as in the literature portion of our report, there are significant limitations to the representation of CIHR funded research by its target population. Many projects indicate “Aboriginal” peoples as the target population, but it is most often unclear from the limited information we accessed whether they are specific to particular First Nation, Inuit, or Métis communities or populations, or whether a more broadly defined “Aboriginal” population was the subject of research.

¹³ This decision was made due to time constraints and the fact that the general subject area would already be clear for the other research institutes.





3.0 SUMMARY OF FINDINGS



This section presents the findings of *Landscapes of First Nations, Inuit, and Métis Health: An Environmental Scan of Organizations, Literature and Research, 3rd Edition*. Detailed information is provided on the national organizations working in Aboriginal, First Nations, Inuit, and Métis public health; current peer- and non-peer-reviewed literature; and the funding patterns of the Canadian Institutes of Health Research. Overall, this section provides a view into further opportunities for collaboration, clarity on the current landscape of research on First Nations, Inuit, and Métis public health in Canada, and insight into the gaps in research.

3.1 National organizations working in First Nations, Inuit, and Métis public health in Canada

A scan was completed of national level organizations that have involvement in First Nations, Inuit, and/or Métis public health in Canada. This includes national First Nations, Inuit, and/or Métis organizations, as well as government, health, and research organizations in the field. Detailed information on each organization is below, and is also accessible in a concise table form in Appendix A. Currently there are thirty-one national organizations that fall into one of four categories:

- National Aboriginal Organizations (organizations directed by and for Aboriginal peoples with a broad mandate that includes health)
- National Aboriginal Health Organizations (organizations directed by and for Aboriginal peoples with a focus on health-related issues)
- Federal Government Organizations (branches/agencies of the Government of Canada)
- Other National Organizations (independent organizations that do health-related research and/or knowledge translation/exchange with Aboriginal peoples but are not Aboriginal-controlled).

The year 2012 saw deep funding cuts to many of these organizations (outlined below), as well as the total loss of the National Aboriginal Health Organization (NAHO), which published the *Journal of Aboriginal Health* and a wide range of other health-related documents, in addition to overseeing many research and outreach programs. NAHO's website will continue to be available until 2017 and the organization is negotiating with universities and research institutions to take over

its assets (CBC News, 2012a).¹⁴ The Aboriginal Healing Foundation (AHF), which provided healing resources and initiatives addressing the legacy of abuse in the Residential School system (including intergenerational impacts), also closed its doors in 2012, having reached the end of its mandate (AHF, 2013). The First Nations Statistical Institute and Aboriginal Statistical Training Program were also eliminated in 2012. While the full impacts from these closures and other significant budget cuts remain to be seen, they seem likely to result in a significant reduction in health promotion, research, and policy capacity that will ultimately be felt at the “human level” (NCCAH, 2012). In addition to NAHO and AHF, two other organizations that were in our previous report do not appear in the current one: the Aboriginal Sport Circle, which was removed because at the time of writing it had no active website (Active Circle, 2012), and the Prairie Women’s Health Centre of Excellence which was determined to have a primarily regional focus.

New inclusions in this updated report are eleven organizations with a variety of professional, research, promotion, and programming focuses: the Aboriginal Physical Activity and Cultural Circle, Active Circle, Centre for Aboriginal Health Research, First Nations Environmental Health Innovations Network, First Nations Health Managers Association, First Nations Information Governance Centre, National Aboriginal Circle Against Family Violence, National Aboriginal Council of Midwives, National Native Addictions Partnership Foundation, Native Mental Health Association of Canada, and Native Youth Sexual Health Network. Seven of

these organizations were founded since 2008, when the last scan was conducted, while three existed previously but were not identified or included in the previous report.

3.1.1 National Aboriginal organizations

National Aboriginal organizations are those organizations directed by and for Aboriginal peoples whose scope transcends provincial/territorial boundaries. One new organization was added to the category from the 2010 *Landscapes* report: the First Nations Information Governance Centre (FNIGC). With this change, nine First Nations, Inuit, and/or Métis national organizations have been identified:

- Assembly of First Nations (AFN)
- Congress of Aboriginal Peoples (CAP)
- First Nations Child and Family Caring Society of Canada (FNCFCSC)
- First Nations Information Governance Centre (FNIGC)
- Inuit Tapiriit Kanatami (ITK)
- Métis National Council (MNC)
- National Association of Friendship Centres (NAFC)
- Native Women’s Association of Canada (NWAC)
- Pauktuutit – Inuit Women of Canada.

Nearly all of these national organizations have a broad mandate, and undertake advocacy, representation, or lobbying work. All of the organizations have health as one of their concerns, and their health-related agendas are outlined below. Recent funding cuts to some of these organizations, including health funding cuts of 40% for the Assembly of First Nations and Inuit Tapiriit Kanatami, and the complete elimination

of health funding for the Native Women’s Association and Pauktuutit, are likely to constrain the ability of these organizations to carry out these agendas.

Assembly of First Nations

The Assembly of First Nations (AFN) is a national organization representing and advocating for First Nations in Canada. Within the AFN, health issues are the responsibility of the Health and Social Secretariat, whose activities and goals are organized into seven areas: Strategic Policy, Public Health, Mental Wellness, Children and Youth, Information Management, Primary Care, and Social Development. AFN’s health strategies and decisions are developed in partnership with the National First Nations Health Technicians Network (NFNHTN) and the Chiefs Committee on Health (CCOH)(AFN, n.d.- a).

Within its seven areas of primary concern, AFN identifies a number of key health topics including:

- social determinants of health
- non-insured health benefits (NIHB)
- mental health, suicide prevention, and addictions needs
- physical activity, sport, and obesity
- increasing First Nation health managers and community-based workers
- cultural competency
- cancer
- tobacco use
- tuberculosis, asthma, and respiratory health
- H1N1 and pandemic preparedness
- environmental health issues
- food security and nutrition
- injury prevention
- HIV/AIDS and sexual health
- immunization

¹⁴ As of January, 2013, the Journal of Aboriginal Health has been transferred to a new publisher, the Aboriginal Health Research Networks (AHRNet) Secretariat at the University of Victoria, where it will continue to be published with two years of funding support from NCCAH (please see <http://www.naho.ca/journal/>).

- diabetes
- maternal and child health and FASD (AFN, n.d. – b).

The AFN has produced a series of sexual health videos for youth and also published the *Assembly of First Nations Health Bulletin* (available in PDF format on the AFN website), the last issue of which (Spring 2011) contains articles covering such issues as tobacco use, non-insured vision care and dental benefits, tuberculosis, Indigenous sport and fitness, sexual health, eHealth applications, and the Nutrition North Canada food subsidy program.

In April 2012 the AFN saw an immediate 40 per cent reduction in federal funding for its health capacity, “resulting in staff lay-offs and impacting its supportive and facilitative role in informing the development of health policies and programs for First Nations” (AFN, 2012, para. 3). Prior to the funding cut, AFN was developing a comprehensive work plan within a collaborative AFN—Health Canada (HC)—Public Health Agency of Canada (PHAC) Task Group (AFN, n.d. – b).

Congress of Aboriginal Peoples

The Congress of Aboriginal Peoples (CAP) is a national umbrella organization that represents the interests of its provincial and territorial affiliate organizations across Canada. Health has been a long term concern of the organization. Focused on the needs of off-reserve Aboriginal peoples, CAP works from the understanding that the health of people is “often a reflection of the communities in which they live,” many of which have been affected by “changing environments, economic limitations, legislative gaps and jurisdictional challenges to effective governance” (CAP, 2012, para. 2). Guided by an awareness of diversity in climate, economies, and cultures, CAP is committed to “fostering community-specific understanding and improvements to the health of

off-reserve Aboriginal Peoples and their communities” (Ibid., para. 3). The organization works with Health Canada, FNIHB, in the following priority policy and program areas:

- Health Services Integration Fund (HSIF)
- jurisdictional issues
- Aboriginal Diabetes Initiative (ADI)
- living conditions and environment
- healthy eating and traditional foods
- childhood obesity
- mental health issues and services accessibility
- cancer diagnosis and treatment
- arthritis
- cardiovascular and respiratory diseases.

CAP’s goal is “to develop a better understanding of community-specific health conditions, and to utilize that understanding to foster and facilitate the development of federal and provincial policies, projects and programs that will enhance the health of both off-reserve Aboriginal Peoples and the communities in which they live” (CAP, 2012, para. 6).

First Nations Child and Family Caring Society of Canada

The core mission and vision of the First Nations Child and Family Caring Society of Canada (FNCFCS) is to provide research, policy, networking, and professional development services to build helping communities so as to ensure “First Nations children and their families have equitable opportunities to grow up safely at home, be healthy, achieve their dreams, celebrate their languages and culture and be proud of who they are” (FNCFCS, 2013). The organization has a number of ongoing projects and priorities within its mandate, including the following:

- First Nations child and family services funding (Jordan’s Principle)
- Touchstones of Hope movement for reconciliation in child welfare

- Caring Across Boundaries photo exhibit
- Sub Group on Indigenous Child Rights
- Ethical Youth Engagement
- First Nations child welfare research and knowledge mobilization (FNCFC, 2012a; 2012b).

FNCFCS publishes an online journal entitled *First Peoples Child and Family Review*, the most recent issue of which contains articles on evidence-based research and knowledge translation, Aboriginal pride, family and community support services, and the need for moral courage in Canadian child welfare. The organization also publishes a number of information and fact sheets (including Canadian Human Rights Complaint, Jordan’s Principle, Profile on First Nations Child Welfare in Canada, Aboriginal Child Population Statistics, Shannen’s Dream and others); research reports (on child welfare, FASD training, Aboriginal child welfare, and others); and organization newsletters. FNCFCS also provides a current list of First Nations Aboriginal Child and Family Service Agencies in Canada, links to a range of documents produced by governmental and non-governmental organizations, and hosts a free database of literature reviews, reports, guides, films, booklets, studies, journal articles, and presentations all related to Aboriginal children and families in Canada and similar countries, following OCAP principles (Ownership, Control, Access, and Possession).

First Nations Information Governance Centre

The First Nations Information Governance Centre (FNIGC) was created in 2010 from the former FNIG Committee (which had grown out of the prior RHS National Steering Committee). FNIGC permanently houses the First Nations Regional Longitudinal Health Survey (RHS) and oversees other research initiatives being conducted among First Nations. The RHS is the only First Nations governed

national health survey in Canada, designed to fill a substantial knowledge gap that existed due to the exclusion of First Nations from other major national health surveys.

Entirely devoted and accountable to First Nations, the FNIGC promotes and advances the principles of OCAP (Ownership, Control, Access, and Possession) to provide an abundance of high quality, reliable information, research, training, data collection, analysis, and dissemination services to First Nations (FNIGC, 2013). The organization aims to measure improvements in First Nations health and well-being, and to ensure that data is used to truly benefit the health and well-being of First Nations, at community, regional, and national levels. Survey data and reports are available for download on the FNIGC website.

Inuit Tapiriit Kanatami

Inuit Tapiriit Kanatami (ITK) is the national Inuit organization in Canada, representing Inuit peoples from four regions: the Inuvialuit Settlement Region of the Northwest Territories, Nunavut, Nunavik (northern Quebec), and Nunatsiavut (Labrador) (ITK, n.d.- a). ITK “represents and promotes the interests of Inuit,” and undertakes this work through four Inuit regional organizations (Inuvialuit Regional Corporation, Nunavut Tunngavik Incorporated, Makivik Corporation, and Nunatsiavut Government), the National Inuit Youth Council, and the Inuit Circumpolar Conference (Ibid., para. 1).

In 2011 the Department of Environment and Wildlife was re-established following a temporary amalgamation with ITK’s Department of Health. The two departments combined set priorities on a number of areas related to health and wellness:

- northern contaminants,
- food security and wildlife,
- climate change,
- public health (especially tobacco usage, cancer, tuberculosis, diabetes, chronic disease, and pandemic planning),
- Non-Insured Health Benefits (NIHB) and dental care,
- health human resources,
- mental wellness,
- addictions,
- eHealth,
- Health Services Integration Fund (HSIF),
- youth suicide prevention,
- early childhood development,
- maternal child health,
- Aboriginal languages, and
- education (ITK, n.d. – b; n.d. – c).

In addition to publishing *Inuktitut Magazine*, which frequently includes material on health and wellness, ITK provides access to several health-related publications in the Knowledge Centre on its website, including a recent environmental health guide and reports on early Inuit child health. The site also has historical and contemporary information on Inuit life and culture, and an archive of podcasts, videos, presentations, and editorial cartoons.

Funding cuts announced in 2012 of 40% of ITK’s health budget are expected to have major, direct, negative impacts. Former ITK President Mary Simon believes, “[t]hese cutbacks to ITK’s health capacity will severely reduce the ability of Inuit to participate, even in a modest way, in the development of policies and programs aimed at combatting enormous health challenges experienced so graphically in Inuit regions, communities and families” (ITK, 2012, para. 4).

Métis National Council

The Métis National Council (MNC) has represented the Métis Nation nationally and internationally since 1983. Health is a key focus of the MNC’s work, and it hosts the Métis Nation Health/Well-Being Research Portal, which brings together information on the following topics:

- the health and well-being status of the Métis population;
- broader health determinants;
- Métis Nation demographics which determine how health needs will evolve; and
- programs that address those needs (Métis Nation Health/Well-Being Research Portal, n.d., para. 2).

The portal provides a model of holistic health and well-being, maps charting Métis population data and health programs and services by region, and information on MNC health research activities, including those relating to diabetes, health human resources, Métis Nation capacity, indicators, suicide, and early childhood development. Several recent publications available on the MNC website relate to environmental health, with topics including species at risk, climate change, traditional environmental knowledge, and mercury use.

National Association of Friendship Centres

The National Association of Friendship Centres (NAFC) was established in 1972 and represents 119 Friendship Centres across Canada. Friendship Centres are the most significant service delivery infrastructure for the increasing off-reserve Aboriginal population. Centres operate on a status blind basis, that is, they serve status and non-status First Nations, Inuit, Métis, and non-Aboriginal peoples, and they provide culturally-enhanced programs and services to facilitate the transition

of Aboriginal people from rural, remote, and reserve life to an urban environment (NAFC, 2012a).

Health is the top area of concern for NAFC, with 25% of their programs falling within this category (NAFC, 2012b). In partnership with Health Canada, NAFC has delivered youth tobacco cessation programs and conducted diabetes needs assessments. In partnership with Canadian Heritage, the NAFC administers Cultural Connections for Aboriginal Youth programs which support “culturally-focused, community-based, youth led activities that connect Aboriginal youth with culture, build self-confidence and self-esteem” ... and foster “motivation to make positive life choices” (NAFC, 2012c, para. 1). NAFC is also supported by the Public Health Agency of Canada (PHAC) for various health-related projects and research, including providing early childhood programming through the Aboriginal Head Start programs (NAFC, 2012d).

Native Women's Association of Canada

The Native Women's Association of Canada (NWAC) was founded in 1974 and is viewed as the national voice representing Aboriginal women in Canada, particularly First Nations and Métis women (NWAC, 2013a). The Health Department of NWAC, launched in 2005, acts as a producer, collector, and disseminator of research-based knowledge to provide renewed public health opportunities to support First Nations, Inuit, and Métis women and their families (NWAC, 2013b). The department maintains a holistic approach to health, which views mental, emotional, spiritual, physical, social, economic, and environmental realms as being equally important (NWAC, 2013c).

Current NWAC projects involve health human resources, suicide prevention, and diabetes. NWAC has also targeted the following areas as of primary concern:

- maternal/child health,
- mental health,
- early childhood development,
- sexual exploitation and STD's,
- violence against women,
- FASD,
- Cancer,
- pandemic planning, and
- senior abuse (NWAC, 2013b).

The Health Department publishes a quarterly newsletter covering a variety of health topics and upcoming health-related events, as well as many health-related research publications that can be downloaded from their website, including topics such as HIV/AIDS needs assessment, best practices, health careers, social determinants, and tobacco reduction.

NWAC's overall health-related goal is to reduce the documented inequities that Aboriginal women in Canada experience. For example, over 40% of Aboriginal women live in poverty and they have the highest rates of chronic disease, experience unacceptably high levels of violence and abuse, are newly diagnosed with HIV at a rate three times higher than their non-Aboriginal counterparts, and live on average almost six years less (NWAC, 2012).

In 2012 Health Canada, citing the priority need to preserve direct services to First Nations living on-reserve, cut 100% of NWAC's Health Department. This loss of program and policy capacity will particularly affect the over 70% of First Nations, Inuit, and Métis women who do not live on reserves (NWAC, 2012).

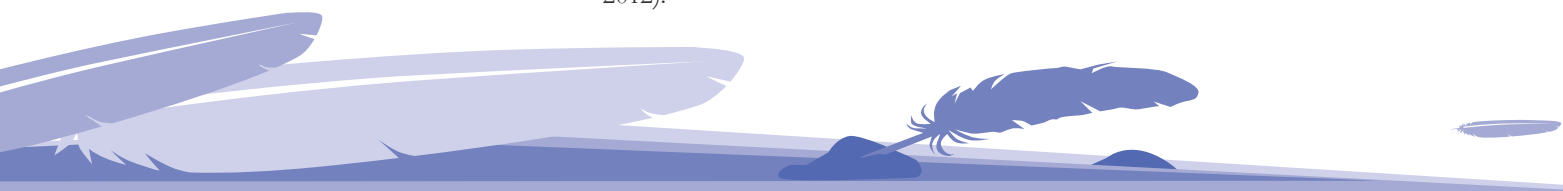
Pauktuutit: Inuit Women of Canada

Pauktuutit is the representative organization for Inuit women in Canada, advocating for equality, social improvements, policy development, and community projects (Pauktuutit, 2013a). Improving the health status of Inuit women, their families, and communities has been a priority of the organization since its incorporation in 1984. Pauktuutit works with many national, regional, and community partners, but also seeks advice from Inuit subject matter experts. Successful health prevention and promotion projects have been implemented on many issues including:

- maternal child health and midwifery,
- violence and abuse prevention,
- tobacco cessation,
- substance abuse,
- FASD,
- early childhood development,
- injury prevention, and
- sexual health and HIV/AIDS (Pauktuutit, 2013b).

An important part of Pauktuutit's work has been raising awareness and building the capacity of Inuit to deliver health programs (Pauktuutit, 2013b). The organization's website provides access to a wide variety of resources relating to Inuit health, with a particular focus on women's health. These documents cover topics ranging from family violence and child sexual abuse to midwifery, aging, tobacco cessation, injury prevention, and mental well-being. Resources are translated into several dialects of Inuktitut.

In 2012, all funding to Pauktuutit from the First Nations and Inuit Health Branch (FNIHB) of Health Canada for Inuit-specific health projects was eliminated (Pauktuutit, 2012).



3.1.2 National Aboriginal health organizations

The following section provides a profile of the work of national organizations which focus specifically on matters pertaining to health for First Nations, Inuit, and/or Métis peoples:

- Aboriginal Nurses Association of Canada (ANAC)
- Aboriginal Physical Activity and Cultural Circle (APACC)
- Canadian Aboriginal AIDS Network (CAAN)
- First Nations Environmental Health Innovations Network (FNEHIN)
- First Nations Health Managers Association (FNHMA)
- Indigenous Physicians Association of Canada (IPAC)
- National Aboriginal Circle Against Family Violence (NACAFV)
- National Aboriginal Council of Midwives (NACM)
- National Aboriginal Diabetes Association (NADA)
- National Indian & Inuit Community Health Representatives Organization (NIICHO)
- National Native Addictions Partnership Foundation (NNAPF)
- Native Mental Health Association of Canada (NMHAC)
- Native Youth Sexual Health Network (NYSHN)

For this *Landscapes 3rd Edition* report, three organizations were lost from this category: the Aboriginal Healing Foundation (AHF) which reached the end of its funded mandate in 2012, the Aboriginal Sport Circle which at the time of writing had no active website, and the National Aboriginal Health Organization (NAHO) which, in an unprecedented move by the federal government, lost all of its funding in 2012. NAHO will maintain its website until 2017 and is negotiating to have its substantial resources hosted by another agency or institution.

There are eight additions to this *Landscapes 3rd Edition* report, bringing the new total to 13. The newly added

organizations are: the Aboriginal Physical Activity and Cultural Circle, First Nations Environmental Health Innovations Network, First Nations Health Managers Association, National Aboriginal Circle against Family Violence, National Aboriginal Council of Midwives, National Native Addictions Partnership Foundation, Native Mental Health Association of Canada, and Native Youth Sexual Health Network.

Aboriginal Nurses Association of Canada

Officially founded in 1975, the Aboriginal Nurses Association (ANAC) recognizes that Aboriginal nurses are an important resource, both for providing culturally appropriate services and for contributing crucial knowledge to health policy and services. Its mission is to “improve the health of Aboriginal people, by supporting Aboriginal Nurses and by promoting the development and practice of Aboriginal Health Nursing” (ANAC, n.d. - a).

Activities related to education, research, recruitment and retention, support for members, and consultation are all emphases of the ANAC. Its key objectives, updated in 2010, are to:

- work with communities, health professionals, the Canadian health system, and government institutions on issues and practices to improve the health and well-being of Aboriginal peoples;
- engage and conduct research on Aboriginal nursing and access to health care;
- consult with government, non-profit, and private organizations to develop programs for applied and scientific research;
- develop and encourage cultural safety education;
- promote awareness nationally and internationally of the health needs of Canadian Aboriginal peoples;
- facilitate and foster increased participation of Aboriginal peoples in health care decision making;

- support recruitment and retention of Aboriginal nurses and other health science professionals; and
- disseminate information to all levels of community (ANAC, n.d. – b).

The organization’s website provides a fact sheet on Aboriginal nursing, a newsletter, nursing links and resources, a members-only forum, as well as the capacity to order larger publications on a range of topics pertinent to Aboriginal nursing, including human resources issues, curriculum, cultural competency and cultural safety, primary care, tobacco cessation, Hepatitis C, HIV/AIDS, injury prevention, and family violence. The organization also hosts an annual conference and is developing the “Cultural Competence and Cultural Safety in Nursing Education” curriculum in partnership with the Canadian Association for Schools of Nursing (CASN) and the Canadian Nurses Association (CAN) (ANAC, n.d. – c).

Aboriginal Physical Activity and Cultural Circle (APACC)

The Aboriginal Physical Activity and Cultural Circle (APACC) was founded in 2011 to address barriers and promote access to participation in physical activity as a means to health and wellness (APACC, n.d. - a). They aim to create a community of mentors, leaders, participants, and supporters who promote physical activity in the realms of competitive and recreational sports, fitness, and traditional physical and cultural activities.

APACC provides its members with networking opportunities, mentorship, workshops, seminars, webinars, tournaments, newsletter, classifieds, and conferences to educate and improve access to resources and sponsors for Aboriginal athletes. As well, they develop fundraising projects for community grants, and are working on their first fundraising e-book featuring stories from Aboriginal runners, to inspire others to be healthy and well

(APACC, n.d. – b). Their website contains links to research and other resources pertinent to physical activity.

Canadian Aboriginal AIDS Network

The Canadian Aboriginal AIDS Network (CAAN) was established in 1997 to provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS. The organization aims to face these challenges “in a spirit of wholeness and healing that promotes empowerment, inclusion, and honours the cultural traditions, uniqueness and diversity of all First Nations, Inuit and Métis people regardless of where they reside” (CAAN, 2013, para. 2). The organization’s current projects include:

- Assessing Community Readiness,
- leadership projects for youth and women,
- International Indigenous Working Group on HIV and AIDS, and
- 21st Century Moccasin Telegraph Research Project (using innovative communications technologies).

CAAN publishes the annual, peer-reviewed *Canadian Journal of Aboriginal Community-Based HIV/AIDS Research (CJACBR)*, available on the organization’s website. CAAN also publishes a newsletter, blog, and several fact sheets and other resources on such topics as community readiness to address HIV/AIDS risk reduction, environments of nurturing safety, population statistics, HIV and non-insured health benefits, and research methods.

First Nations Environmental Health Innovations Network (FNEHIN)

Founded in 2008 and currently based at the Assembly of First Nations, Environmental Stewardship Unit, the First Nations Environmental Health Innovations Network (FNEHIN) is a national network that provides information and tools to assist First Nations communities to “participate in environmental health research and

to address their environmental health concerns” (FNEHIN, n.d., para. 1). Approaching environmental health in an integrated, holistic manner that includes the welfare of all living things, the organization focuses on developing capacity and partnerships through activities including:

- supporting growth of First Nations programs on human health impacts of environmental conditions;
- enabling information exchange and collaboration between First Nations, researchers, and other environmental health stakeholders;
- promoting use of Aboriginal traditional knowledge in research; and
- building linkages between First Nations’ organizations and communities, academic and research departments, federal and provincial governmental organizations, the corporate sector, and non-governmental organizations (FNEHIN, n.d.).

The FNEHIN website provides information on research ethics and protocols, a listing of funding sources, directories of individual projects and researchers, a newsletter, and links to relevant resources and publications.

First Nations Health Managers Association

The First Nations Health Managers Association (FNHMA) was founded in 2010 to provide leadership in health management by promoting quality standards, research, certification, and professional development. Arising from the recognition that increasing capacity of First Nations health managers is crucial for improving health service delivery at the community level, the organization represents and supports First Nations health managers as “leaders who honour, maintain and uphold inherent ways of knowing while balancing management principles to bring excellence to their communities and health programs” (FNHMA, n.d., para. 1).

FNHMA facilitates career development, mentoring, networking, and professional development through workshops, educational resources, a national conference, and online courses.

Indigenous Physicians Association of Canada

The Indigenous Physicians Association of Canada (IPAC) is comprised of Indigenous physicians and medical students with the collective aim to “advance the health of our nations, communities, families and individuals” (IPAC, 2011a). Mentoring and supporting the personal and professional development of new physicians and medical students is a key component of IPAC’s mandate, along with encouraging other Indigenous students to consider a career in medicine. To this end, they offer a number of resources through their website, as well as publishing a book of stories about how members became doctors, and offering medical school entrance interview preparation workshops.

In addition to supporting medical professionals, IPAC renewed its strategic plan in 2012 to include the goal of positively influencing health policy as it impacts First Nations, Inuit and Métis people (IPAC, 2011b). IPAC operates with a holistic view of health encompassing body, mind, spirit, and heart, including traditional knowledge and practices, and based on values of love, respect, courage, honesty, wisdom, humility, and truth (IPAC, 2011c). It has partnered with the Association of Faculties of Medicine of Canada (AFMC) and the Royal College of Physicians and Surgeons of Canada to produce publications covering a number of key issues in human resources, curriculum, and care, including cultural safety, core competencies, and best practices, which can be downloaded from the IPAC website.

National Aboriginal Circle against Family Violence

The National Aboriginal Circle against Family Violence (NACAFV) emerged in 1999 out of grassroots-level consultations with Aboriginal family violence service providers. It exists to develop a coordinated approach and secure funding and supportive partnerships at the national level. Recognizing the need for sustainable, effective, and culturally appropriate services aimed at long-term healing, the organization works with communities “to gather information on family violence that will strengthen the case for better supported Aboriginal-specific programs and facilities” (NACAFV, n.d., Why a national organization?, para. 4). In the spirit of “Aboriginal people taking responsibility and ownership for addressing the issues surrounding family violence,” the NACAFV serves as a national clearinghouse for local information, an advocate for standards and training programs, and a support for isolated service providers (NACAFV, n.d., How does the NACAFV work?, para. 1).

NACAFV hosts an annual training event, has published a newsletter and a variety of reports, and through its website offers relevant links on family violence, women’s issues, health, government, international, and other resources, as well as an online directory of Aboriginal shelters across the country.

National Aboriginal Council of Midwives

Officially formed in 2008 as a sister organization working in cooperation with the Canadian Association of Midwives, the National Aboriginal Council of Midwives (NACM) supports the development of Aboriginal midwifery in First Nations, Inuit, and Métis communities across Canada and advocates for reproductive rights and cultural safety within childbearing practice for all Indigenous women. NACM’s membership includes approximately seventy Aboriginal

midwives, midwife Elders, and student midwives (NACM, 2012a).

Aboriginal women and their infants currently have 2-4 times higher morbidity and mortality rates than non-Aboriginal Canadians (NACM, 2012b). Colonization and changes in the health care system in Canada have resulted in many rural and remote Aboriginal communities losing their traditional midwifery practices, requiring women to deliver their babies and access care outside their communities in settings that do not always respect their cultures and unique needs. In addition, many Aboriginal communities have higher birth rates than non-Aboriginal communities, as well as a younger overall population. For all these many reasons, NACM’s vision is to restore choice in birthing and one day see “Aboriginal midwives working in every Aboriginal community” (NACM, 2012c, para 2).

To promote the good health and well-being of Aboriginal mothers and their babies, NACM upholds ten core values: healing, respect, autonomy, compassion, bonding, breastfeeding, cultural safety, clinical excellence, education, and responsibility (NACM, 2012d). The organization holds an annual national gathering, and its website provides birth stories, a list of Aboriginal midwifery practices, educational programs, posters, and other video, web, and print resources. In the last year, NACM also launched the *Aboriginal Midwifery Toolkit*. The Toolkit includes jurisdiction specific sections covering topics such as pertinent legislation, governance and funding options, ways of assessing community specific maternal health needs and ways to develop midwifery services closer to home. The Toolkit speaks to the impact midwifery can have on improving maternal and infant health outcomes but also how birth closer to home builds stronger community ties, connection to the land and space for self-determination. The

Toolkit is available both in an online and a print format. With the closure of NAHO in 2012, NACM will house midwifery-related materials currently on the NAHO website, to ensure continued availability “in an accessible, online format that respects this indigenous and cultural knowledge” (NACM, 2012e, para. 4).

National Aboriginal Diabetes Association

Formed in 1995, the National Aboriginal Diabetes Association (NADA) has the mission to “be a leader in addressing diabetes in Aboriginal people as a priority health issue through advocacy and education” (NADA, 2009, Our mission). Based on values of respect, honour, caring and sharing, integrity, Aboriginal community and family, and freedom, the Association has five stated goals:

- to support individuals, families and communities to access resources for diabetes prevention, education, research, and surveillance;
- to establish and nurture working relationships with those committed to persons affected by diabetes;
- to inspire communities to develop and enhance their ability to reduce the incidence and prevalence of diabetes;
- to manage and operate NADA in effective and efficient ways; and
- to be the driving force in ensuring diabetes and Aboriginal people remain at the forefront of Canada’s health agenda (NADA, 2009, Our goals and objectives).

NADA produces a newsletter, and a variety of diabetes wellness and prevention resources, some in Ojibwe, are available on the organization’s website, including:

- a resource directory,
- how-to and care guides on many subtopics,
- *Pathway to Wellness* handbook,
- *What Does Diabetes Mean to Me* booklet,
- *Warning Signs of Diabetes for Youth*

- poster, and
- *Healthy Living Activities for Grades 4 to 6* booklet.

National Indian and Inuit Community Health Representative Organization

Formed in 1986, the National Indian and Inuit Community Health Representative Organization (NIICHRO) represents First Nation and Inuit Community Health Representatives in Canada. Its goal is to improve the quality of health care of First Nation and Inuit people to the standard of health enjoyed by the rest of the population of Canada, by promoting communication about, understanding of, and making improvements to the Community Health Representatives (CHR) program (NIICHRO, n.d.). Projects currently being undertaken by NIICHRO include tobacco control, Aboriginal health human resources, and physical activity and nutrition.

The organization has research and resource reports available for download on topics including:

- SIDS,
- physical activity and nutrition, and
- injury prevention.

NIICHRO has also produced resource booklets and training kits (available for order) on a wide range of health-related issues, including diabetes, FAS, HIV/AIDS, and tobacco cessation.

National Native Addictions Partnership Foundation

The National Native Addictions Partnership Foundation (NNAPF) was incorporated in 2000 to facilitate the capacity to pursue funds to follow up on a review of the National Native Alcohol and Drug Abuse Program (NNADAP). The NNAPF provides a national voice for culturally-based addictions services for First Nations and Inuit peoples. By cultivating and empowering relationships that connect people to their cultural strengths and identity, the organization hopes to build community

capacity to address addictions and related issues (NNAPF, 2013).

The NNAPF has developed cultural safety training materials and its website provides directories of treatment centres, as well as several downloadable resources on topics such as community of practice resource development, community emergency response, continuous care, indigenous culture as an intervention, and human resources issues.

Native Mental Health Association of Canada

Established in 1983 to promote professional awareness of Native mental health and cooperation between the Canadian Psychiatric Association (CPA) and the health personnel in Aboriginal communities, the Native Mental Health Association of Canada (NMHAC) exists to improve the lives of Canada's First Nations, Inuit, and Métis populations in the areas of healing, wellness, and other mental health challenges (NMHAC, n.d.). Its current long term goals include:

- educating Government of Canada departments, Indigenous community leaders, professionals, and caregivers about Aboriginal mental health issues, including mood disorders, underlying contributors to addictions, treatments, best practices, and the need for ongoing and consistent support for optimum outcomes;
- promoting cultural competency and safety in mental health care;
- doing research in house, with Aboriginal communities, and with academic and service organizations;
- providing leadership to build capacity for whole health and prevention; and
- collaborating with organizations to promote Indigenous health and wellness, family restoration, self-determination and self-management in mental health issues (NMHAC, n.d.).

The NMHAC has also organized an annual conference since its inception. Its 2012 conference, however, had to be cancelled due to lack of funding from Health Canada's FNIHB.

Native Youth Sexual Health Network

The Native Youth Sexual Health Network (NYSHN), officially founded in 2006 from earlier grassroots beginnings, is an organization by and for Indigenous youth that works across the full spectrum of sexual and reproductive health, rights, and justice issues throughout Canada and the United States (NYSHN, n.d. - a). Guided by principles of youth empowerment, cultural safety, reproductive justice, sex positivity, and healthy sexuality, NYSHN works with youth, service providers, media, organizations, adults, and Elders to "advocate for and build strong, comprehensive, and culturally safe sexuality and reproductive health, rights, and justice initiatives" in communities (NYSHN, n.d. - b, para. 1). Key areas of work are in:

- culturally safe sex education,
- reclaiming rites of passage and traditional knowledge,
- healthy relationships,
- harm and violence prevention,
- pregnancy options, youth parenting, and families,
- Two-Spirited and LGBTTIQQA advocacy and awareness,
- STDs and HIV/AIDS,
- sex trade,
- Indigenous feminisms and masculinities, and
- sexual self-esteem and empowerment (NYSHN, n.d. - c).

NYSHN's website hosts a variety of resources including articles by founder Jessica Danforth, a sexual health toolkit created in partnership with NAHO, and links to 24-hour toll-free information, peer-support, and referral services.

3.1.3 Federal government organizations

Federal government organizations in this section are federally directed and managed organizations with an Aboriginal branch or directive pertinent to health. For the purposes of this report, an organization was considered an agency or branch of the federal government if its website is hosted within the Government of Canada (.gc.ca) domain, rather than having an independently hosted website.¹⁵ With our revised criteria, four federal government organizations were identified for this report:

- Aboriginal Affairs and Northern Development Canada (AANDC, also known as the Department of Indian Affairs and Northern Development, DIAND, formerly Indian and Northern Affairs Canada)
- First Nations and Inuit Health Branch, Health Canada (FNIHB, HC)
- Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health (CIHR- IAPH)
- Statistics Canada

Aboriginal Affairs and Northern Development Canada

Aboriginal Affairs and Northern Development Canada (AANDC) is the new applied title, in use since 2011, for the Department of Indian Affairs and Northern Development (DIAND), formerly Indian and Northern Affairs Canada (INAC). Its mandate is to support First Nations, Inuit, and Métis peoples and Northerners in their efforts to:

- improve social well-being and economic prosperity;
- develop healthier, more sustainable communities; and

- participate more fully in Canada's political, social, and economic development (AANDC, 2013, Mandate, para. 1).

AANDC's health-specific responsibilities include providing safe water supplies on reserves; funding social programs such as early childhood development, housing, family violence prevention, help for persons with disabilities, and income assistance; eliminating contaminants in traditionally harvested foods; and ensuring access to healthy, affordable food in remote areas (AANDC, 2010). The AANDC website has information on activities being undertaken to fulfill these responsibilities. It also produces a range of publications and reports related to its mandate, including research reports, program information and updates, and statistical information. Recent publications include considerations of:

- the community well-being index,
- national emergency management plan,
- well-being in Inuit communities,
- B.C. First Nations success stories, and
- contaminated sites in the NWT.

All publications are available free of charge either by mail or electronic download from the AANDC website.

First Nations and Inuit Health Branch, Health Canada

The First Nations and Inuit Health Branch (FNIHB) of Health Canada (HC) supports the delivery of public health and health promotion services for on-reserve and Inuit communities. The organization also provides drug, dental, and ancillary health services to First Nations and Inuit people regardless of residence, and primary

care services in remote and isolated areas where there are no provincial services readily available. FNIHB's mandate is to ensure the availability of and access to health services for First Nations and Inuit communities; to assist them in addressing health barriers, disease threats, and attaining health levels comparable to other Canadians living in similar locations; and to build strong partnerships with First Nations and Inuit to improve the health system (Health Canada, 2012).

Ongoing FNIHB programs for Aboriginal health include:

- non-insured health benefits (a range of medically necessary goods and services provided to status Indians and eligible Inuit that supplement private or provincial/territorial programs);
- community programs (healthy child development, mental wellness, suicide prevention, addictions, nutrition and activity promotion, disease and injury risk factor prevention, and community capacity building);
- primary health care (in remote and isolated communities); and
- public health (communicable diseases, safe water and other environmental health and contaminant issues) (Health Canada, 2008).

FNIHB has a Health Information, Analysis and Research Division (HIARD) responsible for health surveillance, information, analysis, and evaluation to support policy development, programming decisions, and strategic planning (Health Canada, 2010).

¹⁵ As a result of this change, both Statistics Canada and IAPH were moved into this category from "Other," where they appeared in the 2010 report. While the main site of Network Environments for Aboriginal Health Research is also on the .gc.ca domain, the individual NEAHRs are independent organizations with separately hosted websites, so they remain in the "Other" category in the current report.

Canadian Institutes of Health Research - Institute of Aboriginal Peoples' Health (CIHR- IAPH)

One of thirteen Institutes of the Canadian Institutes of Health Research (CIHR), the Institute of Aboriginal Peoples' Health (IAPH), established in 2000, advances a national health research agenda to promote the health of First Nations, Inuit, and Métis peoples in Canada, through leadership, collaboration, research, funding, support, knowledge translation and dissemination, capacity building, and training. The Institute's "pursuit of research excellence is enhanced by respect for community research priorities and Indigenous knowledge, values, and cultures" (CIHR, 2013, para. 1).

Funding from IAPH supports research in universities (including by/for graduate students), hospitals, and other research centres, including those in the Network Environment for Aboriginal Health Research (NEAHR) (CIHR, 2011). Priority research areas include but are not limited to:

- culturally relevant health promotion strategies;
- identification of health advantage and health risk factors in Aboriginal populations related to the interaction of environments (cultural, social, psychological, physical, genetic);
- health determinants - to elucidate the multi-dimensional factors that affect the health of populations and lead to a differential prevalence of health concerns;
- disease, injury and disability prevention strategies;
- social, cultural, and environmental research that will contribute to the development of appropriate health policies and health systems;
- addiction and mental health strategies from prevention to intervention to policy formation
- psychosocial, cultural, epidemiological, and genetic investigations to determine causal

factors for increased prevalence of certain conditions (e.g. diabetes, heart disease, cancer, infectious diseases);

- clinical trials or other methodologies to determine the most effective interventions with Aboriginal populations in order to address a variety of health needs (e.g. assessment of alternative and complementary medicine);
- health services research to address the unique accessibility and provider issues such as funding and continuity of care, with particular regard to issues of child and elder care;
- international research recognizing and exploring the commonalities among Indigenous populations worldwide with respect to health concerns; and
- ethics issues related to research, care strategies, and access to care (e.g. community consent, sensitivity to culture) (CIHR, 2011).

CIHR is the major Canadian funder of research in Aboriginal health. They produce a variety of publications for each of their Institutes, as well as tools to support scientific mentorship and materials on ethics, knowledge translation, partnerships, research funding, and strategic initiatives.

Statistics Canada

In Canada, providing statistics is a federal responsibility, and Statistics Canada is the central agency that gathers information and undertakes statistical research, including information on population, resources, economy, society, culture, and health. The agency conducts a Census every five years and manages approximately 350 active surveys covering different aspects of Canadian life (Statistics Canada, 2013).

Statistics Canada's Aboriginal Statistics Program (ASP) conducts the Aboriginal Peoples Survey (APS) every five years (most recently in 2012), to identify the needs of First Nations (except people living on-reserve and in the territories), Métis, and Inuit six years

of age and over, focusing on issues such as education, employment, health, language, income, housing, and mobility. Within the health sector, the APS looks at general health, pregnancy and childbirth, height and weight, chronic conditions, injuries, mental health, smoking, alcohol, drug use, food security, and community support, as well as indicators such as income, access to and use of health care services, and housing conditions. The ASP also has plans to conduct an Aboriginal Children's Survey (ACS) once every five years, which provides information on the early health and development of off-reserve First Nations, Inuit, and Métis children less than six years of age. However, no funding was available for the 2011 survey, so the 2006 survey is the most recent data available.

Statistics Canada includes a Health Analysis Division (HAD) with a mandate to "provide high quality, relevant, and comprehensive information on the health status of the population and on the health care system" (Statistics Canada, 2011a, para. 1). HAD publishes the Health Research Working Paper Series, as well as *Health Reports*, a peer-reviewed journal of population health and health services research aimed at an audience of health professionals, researchers, policy-makers, educators, and students. Using data from the Census, the APS and ACS, as well as from other sources not Aboriginal-specific, such as the Labour Force Survey, the Canadian Community Health Survey (which includes off-reserve First Nations, Inuit, and Métis peoples), the National Longitudinal Survey of Children and Youth, and administrative data such as Vital Statistics, justice and hospital data, the HAD produces a number of research publications on health generally and Aboriginal health specifically. When possible, data is disaggregated in a number of ways including by Aboriginal identity, Aboriginal ancestry, location of residence, registered versus

non-registered status, age, and other identifiers.

Examples of Statistics Canada publications from the period of this scan (2010-2011) include:

- Proportion of Aboriginal population by health region, 2006 (2011)
- Population Projections by Aboriginal Identity in Canada, 2006-2031 (2011)
- Associations between household food insecurity and health outcomes in the Aboriginal population (excluding reserves) (2011)
- The Health of First Nations Living Off-Reserve, Inuit, and Métis Adults in Canada: The Impact of Socio-economic Status on Inequalities in Health (2010)
- Acute-care Hospitalizations and Aboriginal Identity in Canada, 2001/2002 (2010)
- 2006 Aboriginal Population Profiles for Selected Cities and Communities (2010)
- Healthy People, Healthy Places (2010).

Budgetary reductions in 2012 have led to a number of Statistics Canada program cuts, including the cancellation of the long-form census, the end of the Aboriginal Statistical Training Program (though course material is still available on request), the National Population Health Survey, and the National Longitudinal Survey of Children and Youth (CBC News, 2012b; Statistics Canada, 2012a, 2012b). These cuts are in addition to the loss of the 2011 ACS, mentioned above. Cumulatively, these program changes will reduce the data available to researchers, particularly in the crucial areas of ethnicity, language and child health.

3.1.4 Other organizations/agencies that do health-related research and/or knowledge translation/exchange with Aboriginal peoples

The following section provides an overview of five health research and knowledge/exchange organizations that have a particular focus on First Nations, Inuit, and/or Métis health and wellness:

- Active Circle
- Centre for Aboriginal Health Research (CAHR)
- Centre for Indigenous Peoples' Nutrition and Environment (CINE)
- National Collaborating Centre for Aboriginal Health (NCCAH)
- Network Environments for Aboriginal Health Research Centres (NEAHRs).

The first two of these organizations are new inclusions in this third report.

Active Circle

Active Circle was founded in 2008 by Motivate Canada, in partnership with the Aboriginal Sport Circle. It supports Aboriginal youth and communities to become vibrant, active, and healthy through sport and recreation (Active Circle, 2013a). The organization's activities include:

- working with program, funding, and government partners to alleviate the administrative burden on communities and leaders;
- providing funding, human resources, and training to develop, deliver, and sustain sport and recreation programs in communities;
- supporting communities to design and develop programs that address their specific needs; and
- providing skill development and experience for Aboriginal youth and community leaders (Active Circle, 2013b).

In addition, Active Circle participates in research evaluating the impact of sport and recreation on communities, and provides information on programs and funding, research links, and educational resources on its website.

Centre for Aboriginal Health Research

The Centre for Aboriginal Health Research (CAHR) was formed in 2008 at the University of Victoria, BC to improve the health and well-being of Aboriginal peoples through the

products and processes of community-based research and knowledge translation and exchange. The Centre provides a supportive environment for students, researchers, and communities to engage in research activities; engages with stakeholders in Aboriginal health across Canada and internationally; and assumes an advocacy role in promoting relevant and ethical health research related to Aboriginal health (CAHR, n.d., para. 2). Some of the Centre's programs include:

- Cultural safety in healthcare,
- Cultural safety in education,
- Indigenous water ways,
- Global Indigenous health,
- Community-based research,
- Seniors fall prevention,
- Student mentorship,
- Knowledge translation and ethics, and
- Competencies for Indigenous public health, evaluation and research (CIPHER) (CAHR, n.d.).

In addition, CAHR, in partnership with the NCCAH, hosts the Aboriginal health resources site Network Environments for Aboriginal Health Research (NEARBC, not to be confused with the NEAHRs, detailed below). NEARBC offers relevant news, databases, links, and an e-library.

Centre for Indigenous Peoples' Nutrition and Environment

The Centre for Indigenous Peoples' Nutrition and Environment (CINE) was created by Canada's Aboriginal leaders as a permanent multidisciplinary research institution to conduct community-based, participatory research related to the environment and traditional food systems. Opened on the McGill University campus in 1993, CINE's guiding principles include considerations of traditional knowledge, responsiveness to local concerns, community involvement in research, consultation with and recognition of elders, ethics and intellectual property

rights, training, communication of findings, and contributions to policy (CINE, 2011).

The Centre's work aims to make the following contributions:

- work towards quantifying nutrients, non-nutrients, and contaminant levels in traditional food systems;
- contribute to the understanding of the many health benefits associated with consumption of traditional food resources, as well as health risk from contaminants;
- contribute to the development of techniques to identify trends in deterioration in quality of traditional food systems, and to suggest possible remedial actions;
- contribute to the development of the necessary tools, methods, and protocols for nutritional and related environmental studies; and
- undertake collaborative international research and exchange among Indigenous peoples (CINE, 2011).

CINE delivers short courses in nutrition to communities across the north, and its website hosts a number of online resources stemming from CINE research that are available for download, including global health data tables for food and nutrition, an Inuit health survey, and information on participatory research.

The National Collaborating Centre for Aboriginal Health

Established in 2005, the National Collaborating Centre for Aboriginal Health (NCCAH) is one of six National Collaborating Centres (NCCs) for Public Health located across Canada, each focusing on a different aspect of public health. The NCCAH uses a coordinated, holistic, and comprehensive approach to the inclusion of Aboriginal peoples in the public health system, to support First Nations, Inuit, and Métis peoples in realizing their public health goals

and reducing the health inequities that currently exist for Aboriginal populations in Canada (NCCAH, n.d. – a).

The NCCAH is involved in knowledge production, synthesis, translation, sharing, and mobilization. All its activities are guided by five principles:

- respect for Indigenous knowledge and building bridges between western scientific approaches to research and evidence and Indigenous ways of knowing and being;
- recognition of diversity among First Nations, Inuit, and Métis peoples and the need for disaggregated data;
- a holistic approach to public health that addresses a broad range of factors, from the cultural to the spiritual and the economic to the historical;
- fostering culturally appropriate materials, information, projects, and activities that show tangible and meaningful results for individuals and communities; and
- a strengths-based approach to programs and activities, recognizing that many Aboriginal peoples draw resilience from spiritual connections, cultural and historical continuity, and ties with family, community, and the land (NCCAH, n.d. – a).

Building on partnerships, relationships, and collaborations with researchers, practitioners, policy makers, and First Nations, Inuit, and Métis communities and organizations, the NCCAH publishes many research and educational resources aimed at multiple audiences, including videos, fact sheets, a newsletter, and many longer reports, all of which are available for download on the organization's website. The NCCAH has a priority focus on the contexts of Aboriginal health, child and youth health, social determinants, and topics that are emerging as health priorities such as environmental health, infectious diseases, and chronic diseases

(NCCAH, n.d. – b). In addition, the NCCAH also works collaboratively with other NCCs to generate knowledge products, workshops and presentations on topics that are of mutual interest and concern, including health inequities, influenza pandemics, small drinking water systems, water and ethics, health impact assessment, tuberculosis, and public health home visiting.

Network Environments for Aboriginal Health Research

Launched in 2007 to build on the momentum of the earlier Aboriginal Capacity and Developmental Research Environments (ACADRE) centres, Network Environments for Aboriginal Health Research centres (NEAHRs) are nine centres (seven regional and two national) that together form a national network known as the Aboriginal Health Research Networks (AHRNets). The nine centres are:

- Alberta NEAHR (formerly ACADRE Network), Edmonton,
- Anisnawbe Kekendazone, Ottawa,
- Atlantic Aboriginal Health Research Program, Halifax,
- Kloshe Tillicum (NEAHR BCWA), Vancouver,
- Manitoba Centre for Aboriginal Health Research, Winnipeg,
- Indigenous Health Research Development Program, Toronto,
- Indigenous Peoples' Health Research Centre, Regina,
- Nasivvik Centre for Inuit Health and Changing Environments, Quebec City, and
- National Network for Aboriginal Mental Health Research, Montreal.



All NEAHR centres share the following broad objectives:

- to pursue scientific knowledge based on international standards of research excellence;
- to advance capacity and infrastructure in Aboriginal health research;
- to provide the appropriate environment for scientists from across the four research pillars - 1) biomedical research, 2) clinical research, 3) health services/systems research, and 4) social, cultural, environmental and population health research - to pursue research opportunities in partnership with Aboriginal communities;
- to provide opportunities for Aboriginal communities and organizations to identify important health research objectives in collaboration with Aboriginal health researchers;
- to facilitate the rapid uptake of research results through appropriate communication and dissemination strategies; and
- to provide an appropriate environment and resources to encourage Aboriginal and non-Aboriginal students to pursue careers in Aboriginal health research (CIHR, 2011).

NEAHR centres across the country take up a wide range of research themes including, but not limited to:

- nutrition,
- violence and trauma,
- traditional knowledge,
- health services and policy,
- population and public health,
- child health,
- environmental influences on health, and
- mental health (CIHR, 2011).

Information on the individual centres and their priorities is contained in Appendix A at the back of this *Landscapes* document.

3.1.5 Summary of the health priorities of national Aboriginal organizations and national Aboriginal health organizations

Based on the information about the organizations above and summarized

in Appendix A, Table 3 presents a ranking of topic priorities for the national Aboriginal organizations and health organizations described in 3.1.1 and 3.1.2, which are managed and directed by and for Aboriginal leaders, and which therefore are assumed to be focusing on health issues that are identified as priorities within Aboriginal communities. As it shows, health

Table 3: Priority health topics of national Aboriginal organizations (N=22) ¹⁶		
Main Topic	Number	Percentage
Health care research, policy, human resources, programming, and delivery	22	100
Socio-economic and cultural determinants	13	59.1
Lifestyle/healthy living	10	45.5
Child and youth health	7	31.8
Chronic disease	6	27.3
Mental health and wellness (including addictions and suicide)	6	27.3
Maternal, fetal, and infant health	5	22.7
Communicable disease	4	18.2
Violence, injury, and abuse	4	18.2
Other	4	18.2
Environmental health	3	13.6
Genetics/human biology	0	0
General health status	0	0

¹⁶ 'N' represents the number of organizations with an obvious, strong stated interest in each topic and/or a related subtopic (non-mutually exclusive). As most organizations have multiple priorities, 'N' does not equal the number of organizations scanned.

care, including research, policy, human resources, programming, and delivery, is by far the top priority focus of these organizations. This is followed by socio-economic and cultural determinants, a priority focus of 59.1% of organizations.

Lifestyle/healthy living; chronic disease; maternal, fetal, and infant health; and mental health and wellness are mid-level priorities overall, with environmental health; communicable disease; child and youth health; and violence, injury, abuse, and disability being lesser health priorities. General health status data and genetics were not priorities for any organization.

Health care

Breaking this data down further, Table 4 shows that one of the most common areas of concern within health care was research, particularly with respect to community involvement, culturally appropriate and ethical research, data ownership, and knowledge translation and exchange, to ensure research is impactful at the community level. Cultural competency and safety in health care was also a key priority for several organizations, as were human resources issues including recruitment, retention, and leadership, and policy. Jurisdictional and insurance issues, as well as traditional knowledge, medicines, and approaches to healing, were each highlighted by a number of organizations, while access to health care services, Aboriginal-controlled and participatory health care, best practices, and senior's care were lesser priorities overall.

Table 4: Organizational priorities breakdown for Health Care, by subtopic (N=22)

Subtopic	Number	Percentage
Research, including community involvement, culturally appropriate research, ethics, data governance, knowledge translation and exchange.	12	54.5
Cultural competency and safety	8	36.4
Human resources (including leadership, recruitment, retention, careers)	8	36.4
Policy	7	31.8
Aboriginal-controlled and participatory health care services	5	22.7
Traditional knowledge, medicines, and approaches to healing & health	4	18.2
Preventative care, health promotion and public health services	3	13.6
Jurisdictional & insurance issues (e.g. Jordan's Principle, non-insured benefits, HSIF)	3	13.6
Best practices	3	13.6
Holistic Health	2	9.1
Program evaluation	2	9.1
Access to and use of health care services	2	9.1
Diagnostic services, screening and surveillance	1	4.5
Psychology, psychiatry and counseling services	1	4.5
Senior's housing and care	1	4.5

Socio-economic and cultural determinants

Within the category of socio-economic and cultural determinants, commonly referred to simply as “social determinants,” Table 5 shows that culture and language and self-government, self-determination, and rights were top priorities. This finding correlates closely with the emphasis within health care on community involvement and control.

Lifestyle and healthy living

Priorities within the Lifestyle/healthy living category are broken down in Table 6. The table reveals that smoking cessation and sexual health were the top priorities, followed by diet and nutrition, and physical activity.

Child and youth health

Child welfare and general health were the priority subtopics within child and youth health, as shown in Table 7.

Chronic disease

Table 8 shows that of chronic diseases, diabetes is the greatest concern for Aboriginal organizations. Cancer and obesity are lesser priorities.

Mental health and wellness

As shown in Table 9, within the main topic of mental health, most organizations expressed only a general interest in the subject, followed by suicide and self-injury and addictions.

Maternal, fetal, and infant health

Within maternal, fetal, and infant health, most organizations displayed more of a general interest in the

topic rather than being focused on specialized subtopics, as shown in Table 10. Two organizations were concerned with birth outcomes. Subtopics that were highlighted as concerns by one organization each were pregnancy options (i.e. abortion/adoption), birthing and midwifery practices, and FAS/FASD.

Communicable diseases

Table 11 shows that HIV/AIDS was the highest priority within communicable diseases, with Tuberculosis and STDs also receiving some attention.

Violence, injury, and abuse

Table 12 shows that within violence, injury, and abuse, partner or family violence was the top priority, followed by accidental injury and child abuse and neglect.

Table 5: Organizational priorities breakdown for Social-economic and Cultural Determinants, by subtopic (N=22)		
Subtopic	Number	Percentage
Culture and language	6	27.3
Economic status	6	27.3
Community and family relationships	4	18.2
Self-government/self-determination and rights	3	13.6
Education and literacy	3	13.6
Food security (including access and costs)	2	9.1
Resiliency (linked to social-economic and cultural environment)	2	9.1
Colonialism (including residential schools and treaties)	1	4.5

Table 6: Organizational priorities breakdown for Lifestyle, by subtopic (N=22)		
Subtopic	Number	Percentage
Tobacco use including smoking cessation and second-hand smoke	4	18.2
Sexual health, including reproductive and two-spirited	4	18.2
Diet and nutrition, including traditional foods	4	18.2
Physical activity	3	13.6

Table 7: Organizational priorities breakdown for Child and Youth Health, by subtopic (N=22)

Subtopic	Number	Percentage
General child and youth health	7	31.8
Child welfare	3	13.6
Children's rights	1	4.5
Early childhood development	1	4.5

Table 10: Organizational priorities breakdown for Maternal, Fetal, and Infant Health, by subtopic (N=22)

Subtopic	Number	Percentage
General maternal, fetal, and infant health	6	27.3
Birth outcomes	2	9.1
Pregnancy options	1	4.5
Birth and midwifery	1	4.5
FAS/FASD	1	4.5

Table 8: Organizational priorities breakdown for Chronic Disease, by subtopic (N=22)

Subtopic	Number	Percentage
Diabetes	6	27.3
Cancer	3	13.6
Obesity	1	4.5

Table 11: Organizational priorities breakdown for Communicable Disease, by subtopic (N=22)

Subtopic	Number	Percentage
HIV/AIDS	4	18.2
Tuberculosis	1	4.5
STDs	1	4.5

Table 9: Organizational priorities breakdown for Mental Health, by subtopic (N=22)

Subtopic	Number	Percentage
General mental health and wellness	4	18.2
Suicide/self-injury and prevention	3	13.6
Addictions	2	9.1

Table 12: Organizational priorities breakdown for Violence, Injury, and Abuse, by subtopic (N=22)

Subtopic	Number	Percentage
Partner/family violence	3	13.6
Accidental injury and trauma and prevention	2	9.1
Child abuse and neglect	1	4.5

Other topics

Two organizations had gender as a priority, both focused specifically on women’s health, while one organization each had a priority of asthma, adult respiratory health other than asthma, and foot care.

Environmental health

Within environmental health, outdoor/natural environment received the most emphasis. As Table 13 shows, other priorities were evenly distributed over a range of subtopics.

3.2 Review of literature

A review was completed of peer- and non-peer-reviewed literature published between January 2010 and December 2012 in the field of Aboriginal health, to provide an overview of recent publications and the populations and themes they focused on.

3.2.1 Peer-reviewed literature

A total of 1939 peer-reviewed documents pertaining to Aboriginal health were identified (listed in Appendix C), an average of just over 646 publications per year. This represents a substantial increase over the yearly average of peer-reviewed documents identified in the previous scan. Because of methodological differences between the scans, however, it cannot be assumed that this increase represents an actual increase in documents published, though it might explain some of the difference. Possible explanations for the significant increase in the number of peer-reviewed publications identified in this scan might include:

- Google Scholar may be providing access to more literature than the specialized databases used for the previous scan can;

Table 13: Organizational priorities breakdown for Environmental Health, by subtopic (N=22)		
Subtopic	Number	Percentage
Outdoor/natural environment	3	13.6
General environmental health	1	4.5
Indoor and built environment	1	4.5
Land use (including resources)	1	4.5
Climate change	1	4.5
Environmental impact assessment and planning	1	4.5

- More publications approaching health issues from a broader, social determinants perspective are being identified in this scan compared to the previous one (i.e. those not indexed by specialized databases);
- The use of additional specific search terms are yielding more items;
- Possible differences in the methodology used to determine relevance are yielding more items;
- Some items included in the previous scan may have also been included in this scan, if they were released early online and subsequently in journal format; and
- A greater number of unpublished Masters and Doctoral theses accessed via Google Scholar are included in this scan (only four of these were included in the previous scan, and they were placed in the non-peer-reviewed category, while the current scan identified 236 graduate theses

and dissertations, all of which were categorized as peer-reviewed¹⁷).

Target population

Data was collected from the peer-reviewed publications to identify the target population. Of the literature identified in the scan, most (76.6%) focused exclusively on Aboriginal peoples (either collectively or on a specific cultural group such as First Nations, Inuit or Métis) rather than being broader in scope (e.g. Canadian non-Aboriginal population) but making mention of the literature’s relevance to the Aboriginal health context (23.4%).¹⁸ However, because of the more general nature of this latter type of literature, it is quite likely that more of it exists than can be identified using our very specific search terms. Both of these types of literature are included in the breakdown below by cultural identity, life stage, gender, and geography.

¹⁷ For an explanation, see methodology section above.
¹⁸ An example might include an article on obesity within the Canadian population as a whole that includes a paragraph or section focused on obesity in an Aboriginal context.

Table 14: Peer-reviewed literature, population by cultural identity (N=1939)		
Population	Number	Percentage ¹⁹
Aboriginal	1139	58.7
First Nations	469	24.2
Inuit	386	19.9
Métis	50	2.6

Within the peer-reviewed literature, the cultural identity of the target population is most often identified as ‘Aboriginal’ rather than as a specific cultural group (First Nations, Inuit, or Métis). As Table 14 shows, 58.7% of the peer-reviewed publications focused on the Aboriginal population in general or did not identify a specific cultural group as its target population. As with the previous Landscapes scans, it is not always possible to determine whether the term ‘Aboriginal’ is being used to refer to all Aboriginal peoples collectively or if it is being used to refer to unspecified First Nations, Inuit, or Métis peoples. Many researchers continue to use the term as a synonym for First Nations (for instance as seen in the phrase “on-reserve Aboriginals”). As a result, it is almost certain that the percentage of peer-review literature

focusing on First Nations is much higher than shown in the table.

Table 14 also shows that Inuit people, who represent approximately 4% of the Aboriginal population in Canada, are greatly over-represented in the peer-reviewed literature (at nearly 20% of all publications), while Métis people, who constitute approximately 33% of the Aboriginal population in Canada, are considerably under-represented in the literature (at less than 3% of publications).

In terms of life stage, nearly half (45.4%) of the peer-reviewed literature included all life stages or did not identify a specific life stage for the target population (Table 15). Just over

Table 15: Peer-reviewed literature, by population life stage (N=1939)		
Life stage	Number	Percentage ²⁰
Adult	666	34.3
Child	264	13.6
Youth	255	13.1
Senior	91	4.7
Infant	32	1.6
All or not specified	880	45.4

one third of the literature specified an adult population (34.3%), and over one in ten documents specifically addressed children (13.6%) and youth (13.1%). Very little of the literature specified seniors (4.7%) and infants (1.6%). Because of differences in how age categories are defined by researchers and census data, it is not possible to compare these percentages to those in the actual population. However, given that the Aboriginal population in Canada is youthful and growing, it is surprising that more research is not focusing on infants, children, and youth.

¹⁹ Note that a document could be coded for more than one population; therefore, percentage column does not add up to 100.

²⁰ Note that a document could be coded for more than one life stage; therefore, percentage column does not add up to 100.



An analysis of population by gender is presented in Table 16, which shows that the majority of all peer-reviewed literature (88.0%) either did not specify gender for the target population or specified a mixed gender population of both male and female. The majority of literature with a single gender target population was focused on females (11.2%), while males were the target population in only a small portion of the literature (0.8%).

In terms of the target Aboriginal population by geography, Table 17 shows that nearly half (46.1%) of the peer-reviewed literature either specified a national context (looking at populations from across Canada) or did not specify the geography (thus implying a generalized 'national' population). About a third specified a regional or

provincial/territorial focus (34.0%), while only 12.5% of literature clearly identified a specific community. Both on reserve and urban populations were specified as the focus approximately 9.0% of the time, while rural/remote populations were specified as the focus 5.0% of the time. A portion (7.4%) of the literature had an international focus, with Canadian Aboriginal peoples as a major component.

Main topics of peer-reviewed literature

Table 18 shows the breakdown of peer-reviewed literature by main topic. As is shown, almost 60% of the literature is focused on health care. Socio-economic and cultural determinants also have a strong showing, appearing in 32.7% of the literature. Quite far behind these two leading topic categories are lifestyle/healthy living; environmental

health; communicable disease; chronic disease; child and youth health; and mental health and wellness, each appearing in between 10 and 15.8% of the literature, followed by maternal, fetal, and infant health; and violence, injury, and abuse. General health status, genetics, and other topics that did not fit into our main subject areas received the least attention.

The sections below provide breakdowns of the subtopics within each topic area which received attention in more than 5% of the literature reviewed. Since each publication may be coded for up to four subtopics, in the tables below the data for number of publications do not add up to the total number of publications in the topic categories and percentages for each subtopic do not add up to 100%.

Table 16: Peer-reviewed literature, by population gender (N=1939)		
Gender	Number	Percentage
All or unspecified	1707	88.0
Male only	15	0.8
Female only	217	11.2

Table 17: Peer-reviewed literature, by population geography (N=1939)		
Geography	Number	Percentage ²¹
National or unspecified	894	46.1
Regional or Provincial/Territorial	659	34.0
Specific community	243	12.5
Urban	172	8.9
Rural/remote	97	5.0
On reserve	174	9.0
Off reserve	18 ²²	0.9
International	143	7.4

Table 18: Peer-reviewed literature, by main topic area (N=1939) ²³		
Topic	Number	Percentage
Health care research, policy, human resources, programming, and delivery	1121	57.8
Socio-economic and cultural determinants	635	32.7
Chronic disease	306	15.8
Lifestyle/healthy living	291	15.0
Environmental health	248	12.8
Communicable disease	215	11.1
Mental health and wellness (including suicide)	201	10.4
Child and youth health	190	9.8
Maternal, fetal, and infant health	135	6.7
Violence, injury, and abuse	99	5.1
General health status	85	4.4
Genetics/human biology	74	3.8
Other	47	2.4

²¹ Note that a document could be coded for more than one geography (ie. on reserve populations across Canada would be coded as both national and on reserve); therefore, percentage column does not add up to 100.

²² Please note that all literature with a focus on urban Aboriginal populations would also be considered 'off-reserve'.

²³ Because topics were assigned on a non-mutually exclusive basis, that is, each document could be assigned up to three main topics, the data here for number of documents and percentage of documents do not add up to N and 100% respectively.

Table 19: Peer-reviewed Health Care literature, by subtopic (N=1121)		
Subtopic	Number	Percentage
Preventive care/health promotion/public health services	283	25.2
Research	220	19.6
Traditional knowledge, medicines and approaches to health and healing	161	14.4
Curative services, intervention and treatment programs	143	12.7
Access to and use of health care services	118	10.5
Policy	93	8.3
Cultural competency and safety	97	8.6
Program Evaluation	85	7.6
Diagnostic services, screening and surveillance	66	5.9
Psychology/psychiatry/counseling services	36	3.2
Human resources	32	2.8
Aboriginal-controlled health care services	31	2.8
Parenting supports & resources	31	2.8
Holistic health care	27	2.4
Jurisdictional and insurance issues	22	2.0
Seniors Housing and Care	19	1.7
Rehabilitation (most often categorized under curative services)	15	1.3
Care giving/support	12	1.1
Best/promising practices	12	1.1
Other ²⁴	11	1.0
Hospitalization	8	0.7
Family violence programs and supports	2	0.2

²⁴ The subtopics coded as “other” included patient experience, cost, creative arts (3), transplant/surgery outcomes (2), health care experiences, palliative care (4), social worker, and telehealth.

Table 20: Peer-reviewed Socio-economic and Cultural Determinants literature, by subtopic (N=635)		
Subtopic	Number	Percentage
Economic status (including income, employment, poverty, and economic development)	165	26.0
Food security (including access and costs)	91	14.3
Culture and language	89	14.0
Colonialism (including residential schools & treaties)	88	13.8
Education and literacy (incl. school readiness & success)	82	12.9
Discrimination and social exclusion	72	11.3
Community/family relationships (including parenting & father involvement, social support)	61	9.6
Housing /homelessness	58	9.1
Self-government/self-determination/rights	32	5.0
Resilience (related to socio-economic and cultural environment)	20	3.1
Spirituality	13	2.0
General social determinants of health	8	1.2

Health Care Research, Policy, Human Resources, Programming, and Delivery

Health care Research, Policy, Human Resources, Programming, and Delivery is by far the most prominent topic in the peer-reviewed literature, representing 57.8% of the literature. The most frequent subtopics within this main topic are shown in Table 19. The table shows that preventive care, health promotion, and public health services received the most attention in the literature (just over 25% of the literature in this topic area), followed closely by research, a topic which includes methodologies, community involvement, ethics, health data, and knowledge translation. Traditional knowledge, medicines, and approaches to healing was the third most frequent subtopic, followed by curative

services and treatment programs, and access to and use of health care services. All remaining subtopics were found in less than 10% of the literature.

Socio-economic and Cultural Determinants

The second most prominent topic in the peer-reviewed literature is socio-economic and cultural determinants, often referred to simply as “social determinants.” The World Health Organization (WHO) defines the social determinants of health as “the conditions in which people are born, grow, live, work and age, including the health system” (World Health Organization [WHO], 2013a, para. 1). These social determinants are “circumstances ... shaped by the distribution of money, power and resources at global, national

and local levels” (Ibid.). In the view of the WHO, health inequities between populations are largely the result of inequities in the underlying social determinants (Ibid.).

As Table 20 shows, economic status is the most frequent subtopic (26.0%), followed by food security, culture and language, and colonialism, each representing approximately 14% of the literature in this topic area. Education and literacy (12.9%), and discrimination and social exclusion (11.3%) are also important subtopics. Approximately one in ten documents focus on community/family relationships and housing/homelessness. All remaining subtopics received lesser attention.

Chronic Disease

Chronic disease is the third most prominent topic addressed in the peer-reviewed literature, representing 15.8% of the literature. As Table 21 shows, the most common subtopics are diabetes (36.3%) and obesity (20.3%). Approximately one in ten documents focus on cardiovascular disease, cancer, or kidney/liver disease. Aging diseases constitute 6.7% of the literature, with arthritis, general chronic disease, and neurological disorders receiving lesser attention.

Lifestyle/Healthy Living

Lifestyle and healthy living topics account for 15% of the peer-reviewed literature. Table 22 shows that by far the most common subtopic was diet and nutrition, including traditional foods, which represented over half of the literature (53.9%). This is followed by physical activity (17.2%), sexual health (14.8%), and tobacco use, primarily oriented toward smoking cessation (8.9%). Gambling and physical safety appear in a smaller number of documents (3.4% and 2.7% respectively).

Table 21: Peer-reviewed Chronic Disease literature, by subtopic (N=306)		
Subtopic	Number	Percentage
Diabetes	111	36.3
Obesity	62	20.3
Cardiovascular disease	37	12.1
Cancer	32	10.4
Kidney/liver disease	30	9.8
Aging diseases (including dementia, Alzheimer's)	21	6.7
Other ²⁵	14	4.6
Arthritis	9	2.9
General chronic disease	8	2.6
Neurological disorders (including multiple sclerosis, epilepsy)	5	1.6

Table 22: Peer-reviewed Lifestyle/Healthy Living literature, by subtopic (N=291)		
Subtopic	Number	Percentage
Diet and nutrition, including traditional foods	157	53.9
Physical activity	50	17.2
Sexual health (including reproductive health, body image, sexuality, Two-spirited)	43	14.8
Tobacco use (including smoking cessation, second hand smoke)	26	8.9
Gambling	10	3.4
Physical safety (e.g. in 'risky' activities such as hunting)	8	2.7
Other	2	0.7

²⁵ Other subtopics included pain, chronic anemia, albuminuria, autoimmune inflammatory myopathy, asthma and lupus.

Table 23: Peer-reviewed Environmental Health literature, by subtopic (N=248)

Subtopic	Number	Percentage
Toxicology (including environmental contamination and safe drinking water)	81	32.7
Land use (incl. resources & extraction)	73	29.4
Climate change	65	26.2
Environmental impact assessment & planning	30	12.1
Interconnectedness of land and people	26	10.5
Outdoor/natural environment	21	8.5
Indoor and built environment	7	2.8
Environmental justice	2	0.8

Environmental Health

The World Health Organization (WHO) considers environmental health to encompass “all the physical, chemical, and biological factors external to a person,” in other words, all aspects of the environment except for the social and cultural environment (WHO, 2013b, para. 1). This category overall is represented in 12.8% of the peer-reviewed literature. Table 23 demonstrates that the top research priorities in this area are divided fairly evenly across three subtopics: toxicology (32.7%), land use (29.4%), and climate change (26.2%). Secondary emphasis was placed on environmental impact assessment and planning (12.1%), and just under one in ten documents (8.5%) dealt with the outdoor or natural environment or interconnectedness of land and people. Indoor or built environment and environmental justice received little attention in the literature.

Communicable Disease

Communicable disease was represented in just over one in ten peer-reviewed documents (11.1%). Table 24 shows that the most common subtopics addressed were HIV/AIDS (39.5%) and influenza (23.2%), including the H1N1 virus. These were followed by tuberculosis (15.3%), STDs (13%), and hepatitis (7%).

Table 24: Peer-reviewed Communicable Disease literature, by subtopic (N=215)

Subtopic	Number	Percentage
HIV/AIDS	85	39.5
Influenza (incl. H1N1)	50	23.2
Tuberculosis	33	15.3
Sexually transmitted diseases (STDs, incl. HPV)	28	13.0
Hepatitis (B, C, and/or E)	15	7.0
Other ²⁶	12	5.6
Zoonotic	7	3.2

²⁶ Other subtopics included adenovirus, necrotizing fasciitis, staphylococcus aureus, T-cell lymphotropic virus, botulism, syncytial virus, trichinosis, and Epstein-Barr virus.

Mental Health and Wellness, including Suicide and Addictions

Mental health and wellness received attention in 10.4% of the peer-reviewed literature. The breakdown in Table 25 shows that just under half of the literature pertained to addictions (47.8%), followed by general mental health (11.9%), and suicide and self-injury (10.4%). Psychological trauma, including intergenerational trauma caused by colonialism and the residential school system, depression (both of which may be causally related to addictions and suicide), and personal or psychological resilience²⁷ were discussed in 7.5%, 7.0% and 7.0% of the literature, respectively. Stress, psychosis, stigma around mental health issues, eating disorders, and well-being all received little attention.

Child and Youth Health

Child and youth health represents 9.8% of the peer-reviewed literature in this report. Table 26 shows that child welfare (32.1%) and early childhood development (24.2%) were the most common subtopics, followed by general health issues (15.8%), youth welfare (12.1%), and respiratory health (11.6%). Oral/dental health (5.3%), learning disabilities (3.1%), children’s rights (2.1%), and vision health (2.1%) received less attention. Childhood illnesses, otitis media and appendicitis were each represented in just 0.5% of the literature.

Maternal, Fetal, and Infant Health

Perhaps surprisingly, given the growing birth rate amongst Aboriginal populations, the maternal, fetal, and infant health category comprised just 6.7% of the peer-reviewed literature. Of the literature pertaining to this topic, a clear majority (55.5%) dealt with maternal health including prenatal care, followed by birth outcomes (25.9%), FAS/FASD (17%), fetal health (8.9%),

and birthing and midwifery (9.6%), as shown in Table 27. General infant health (7.4%) and breastfeeding and infant nutrition (2.2%) received less attention.

Violence, Injury, Abuse, and Disability

Literature on violence, injury, and abuse comprise 5.1% of the peer-reviewed literature identified in this scan. As shown in Table 28, partner and family violence was the most frequently discussed subject (33.3%), followed by the justice system (22.2%), accidental

injury and trauma (19.2%), child abuse and neglect (16.2%), and sexual violence and abuse (11.1%). Elder abuse appeared in 3% of the literature.

3.2.2 Non-peer-reviewed literature

A total of 379 documents published between January 2010 and December 2012 were identified as relevant to our review, an average of 126 per year. These are listed in the bibliography in Appendix D. Similar to the peer-reviewed literature, the majority of the non-peer-reviewed literature we

Table 25: Peer-reviewed Mental Health literature, by subtopic (N=201)		
Subtopic	Number	Percentage
Addictions (other than tobacco use)	96	47.8
General mental health	24	11.9
Suicide/self-injury prevention	21	10.4
Psychological trauma (including intergenerational)	15	7.5
Depression	14	7.0
Personal/psychological resilience	14	7.0
Stress	6	3.0
Psychosis	4	2.0
Other ²⁸	4	2.0
Stigma around mental health issues	2	1.0
Eating disorders	2	1.0
Well-being	2	1.0

²⁷ This must be distinguished from resilience related to social and cultural factors, which is coded under the Socio-cultural and Economic Determinants category in this document.

²⁸ Other subtopics included community mental health, grief, and social support.

Table 26: Peer-reviewed Child and Youth Health literature, by subtopic (N=190)

Subtopic	Number	Percentage
Child welfare	61	32.1
Early childhood development	46	24.2
General health	30	15.8
Youth welfare	23	12.1
Respiratory health (including asthma, allergies, chronic obstructive pulmonary disease (COPD), bronchitis, and pneumonia)	22	11.6
Oral/dental health	10	5.3
Learning disabilities	6	3.1
Children's rights	4	2.1
Vision health	4	2.1
Childhood illnesses (may also be discussed in "general health" papers)	1	0.5
Otitis media (middle ear infection)	1	0.5
Appendicitis	1	0.5

Table 27: Peer-reviewed Maternal, Fetal, and Infant Health literature, by subtopic (N=135)

Subtopic	Number	Percentage
Maternal health (including prenatal care)	75	55.5
Birth outcomes	35	25.9
Fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorder (FASD)	23	17.0
Fetal health	12	8.9
Birthing and midwifery	13	9.6
General infant health	10	7.4
Breastfeeding and infant nutrition	3	2.2

Table 28: Peer-reviewed Violence, Injury, and Abuse literature, by subtopic (N=99)

Subtopic	Number	Percentage
Partner/family violence	33	33.3
Justice system	22	22.2
Accidental injury and trauma (and prevention)	19	19.2
Child abuse and neglect	16	16.2
Sexual violence and abuse	11	11.1
Elder abuse	3	3.0
Other (trauma, gang violence and bullying)	3	3.0



identified for inclusion in this scan was focused exclusively on Aboriginal populations (83.6%) with a much smaller percentage (16.4%) focused on the general Canadian population but having content relevant to Aboriginal peoples. Both categories were included in our breakdown by cultural identity, life stage, gender, and geography.

Target population

In terms of cultural identity, the non-peer-reviewed literature was only marginally less likely than the peer-reviewed literature to address Aboriginal peoples in general. The non-peer reviewed literature was slightly more likely to focus specifically on First Nations or Métis populations, and less likely to focus specifically on Inuit populations than the peer-reviewed literature. Where the term 'Aboriginal' has been used, it was more likely to denote inclusivity of all sub-groups of Aboriginal peoples rather than reflect a lack of specificity. Table 29 illustrates the population classification in the non-peer-reviewed literature, with work pertaining to Aboriginal peoples

occurring most frequently (58.3%), and considerations of First Nations (27.4%), Inuit (16.6%), and Métis peoples (9.5%) receiving less attention. As in the peer-reviewed literature, Inuit were over-represented and Métis were under-represented in the non-peer-reviewed literature.

In terms of population life stage, Table 30 shows that well over half of the non-peer-reviewed literature focused on all life stages or did not specify a life stage. An adult population was specified in 19.3% of documents, while children and youth were represented in 13.4% and 13.2% of documents respectively. Seniors (3.2%) and infants received the least attention (1.8%). Again, given the relative youth of the Aboriginal population in Canada, it is somewhat surprising that the literature focuses so heavily on the adult population.

Breaking down the gender focus of the non-peer-reviewed literature, Table 31 shows that a vast majority (92.3%) did not identify the population gender, and can therefore be assumed to include

both genders, or clearly identified both males and females as a focus. Of the literature with a gender-specific population, females were represented more often (7.1%) than males (0.5%). This pattern is similar to that found in the peer-reviewed literature.

An analysis of the data to determine the geographic focus of the population under study reveals that about half of the non-peer-reviewed literature was focused on a national Aboriginal population or did not specify a geographic focus (Table 32). Approximately 37% of the literature adopted a regional or provincial/territorial population focus, with fewer documents focused on specific communities (7.9%), or on urban (6.6%), on-reserve (6.3%), rural/remote (1.3%), and off-reserve (1.1%) populations. Five percent of the non-peer-reviewed literature focused primarily on Indigenous people in an international context but included a component focused on Canadian Aboriginal populations.

Table 29: Non-peer-reviewed literature, population by cultural identity (N=379)

Population	Number	Percentage ²⁹
Aboriginal	221	58.3
First Nations	104	27.4
Inuit	63	16.6
Métis	36	9.5

Table 31: Non-peer-reviewed literature, by population gender (N=379)

Gender	Number	Percentage
All or unspecified	350	92.3%
Male only	2	0.5%
Female only	27	7.1%

Table 30: Non-peer-reviewed literature, by population life stage (N=379)

Life stage	Number	Percentage ³⁰
Adult	73	19.3
Child	51	13.4
Youth	50	13.2
Senior	12	3.2
Infant	7	1.8
All or unspecified	266	70.2

Table 32: Non-peer-reviewed literature, by population geography (N=379)

Geography	Number	Percentage ³¹
National or unspecified	191	50.4
Regional or Provincial/ Territorial	146	38.5
Specific community	30	7.9
Urban	25	6.6
Rural/remote	5	1.3
On-reserve	24	6.3
Off-reserve	4	1.1
International	19	5.0

²⁹ Note that a document could be coded for more than one population, therefore percentage column does not add up to 100.

³⁰ Note that a document could be coded for more than one life stage, therefore percentage column does not add up to 100.

³¹ Note that a document could be coded for more than one geography, therefore percentage column does not add up to 100.

Main topic priorities

This section will identify the main health topics and sub-topics covered in the non-peer-reviewed literature. As shown in Table 33, a majority of non-peer-reviewed literature had health care (62.3%) and/or socio-economic and cultural determinants (39%) as one of its main topics. Environmental

health was represented in 17.1% of the literature, followed by child and youth health (11.1%) and lifestyle/healthy living (9.2%). Chronic disease, mental health and wellness, and violence, injury and abuse were represented in between 8% and 6% of the literature, while maternal, fetal and infant health, along with communicable disease and general

health status were represented in 5% or less of the non-peer-reviewed literature.

The sections below provide breakdowns of the subtopics within each topic area which received attention in more than 5% of the literature reviewed. Since each publication may be coded for up to four subtopics, in the tables below the data

Table 33: Non-peer-reviewed literature, by main topic area (N=379)		
Topic	Number	Percentage ³²
Health care research, policy, human resources, programming, and delivery	236	62.3
Socio-economic and cultural determinants	148	39.0
Environmental health	65	17.1
Child and youth health	42	11.1
Lifestyle/healthy living	35	9.2
Chronic disease	31	8.2
Mental health and wellness (including suicide)	28	7.4
Violence, injury, and abuse	24	6.3
Maternal, fetal, and infant health	21	5.5
General health status	20	5.3
Communicable disease	14	3.7
Other	10	2.6
Genetics/human biology	1	0.3

³² Note that a document could be coded for up to three main topics, therefore percentage column does not add up to 100.

for number of publications do not add up to the total number of publications identified in the topic categories and percentages for each subtopic do not add up to 100%.

Health care

The subtopic breakdown of the 236 documents dealing with the broad

category of health care is shown in Table 34. The largest focus of this literature was on preventive care, health promotion, and public health services (26.7%), followed by research (22%). Traditional knowledge (16.1%), policy (12.3%), and program evaluation (10.7%) were also important subtopics in this category. Receiving lesser attention are

the subtopics cultural competency and safety (8.5%), Aboriginal-controlled services (6.3%), access to and use of health services (6.3%), curative services (5.9%), and jurisdictional and insurance issues (5.5%). All other subtopics received attention in less than 5% of the literature.

Table 34: Non-peer-reviewed Health Care literature, by subtopic (N=236)

Subtopic	Number	Percentage
Preventive care/health promotion/public health services	63	26.7
Research	52	22.0
Traditional knowledge, medicines and approaches to health and healing	34	14.4
Policy	29	12.3
Program evaluation	24	10.7
Cultural competency and safety	20	8.5
Aboriginal-controlled health care services	15	6.3
Access to and use of health care services	15	6.3
Curative services, intervention and treatment programs	14	5.9
Jurisdictional and insurance issues	13	5.5
Seniors housing and care	8	3.4
Diagnostic services, screening and surveillance	7	3.0
Psychology/psychiatry/counseling services	6	2.5
Parenting supports & resources	5	2.1
Human resources	5	2.1
Best/promising practices	3	1.3
Palliative care	1	0.4

Table 35: Non-peer-reviewed Socio-economic and Cultural Determinants literature, by subtopic (N=148)

Subtopic	Number	Percentage
Economic status (including income, employment, poverty, and economic development)	44	29.7
Culture and language	28	18.9
Education and literacy (incl. school readiness & success)	19	12.8
Housing and homelessness	21	14.2
Discrimination and social exclusion	20	13.5
Community and family relationships (including parenting & father involvement)	17	11.5
Food security (including access and costs)	16	10.8
Self-government/self-determination/rights	10	6.7
Colonialism (including residential schools & treaties)	9	6.1
Resilience (related to socio-economic and cultural environment)	7	4.7
Spirituality	3	2.0
General SDOHs	1	0.7

Socio-economic and cultural determinants

Socio-economic and cultural determinants was the second most prevalent topic in the non-peer-reviewed literature, with 148 documents comprising 39% of the non-peer-reviewed literature. As shown in Table 35, the main subtopics in the literature on socio-economic and cultural determinants included economic status (29.7%), culture and language (18.9%), education and literacy (12.8%), housing and homelessness (14.2%), discrimination and social exclusion (13.5%), community and family relationships (11.5%), and food security (10.8%). The remaining subtopics received attention in less than 10% of the literature in this category.

Environmental health

Environmental health was the third-most prevalent topic in the non-peer-reviewed literature, with 65 documents (17.1% of the non-peer-reviewed literature). Of the documents that had environmental health as a main topic (Table 36), the largest subtopic was land use, including resources and extraction (50.8%). Other significant topics were toxicology (29.2%) and climate change (21.5%), followed by outdoor/natural environment (13.8%) and environmental impact assessment and planning (12.3%). Interconnectedness of land and people and indoor and built environment received less attention.

Child and youth health

Child and youth health was the main topic in 42 documents, or 11.1% of the non-peer-reviewed literature. Table 37 shows that the most frequent subtopic within child and youth health was child welfare (40.5%), followed by general health (28.6%), early childhood development (21.4%), and youth welfare (14.3%). Children's rights, respiratory health, hearing, and oral/dental health all received attention in less than 5% of the literature in this category.

Table 36: Non-peer-reviewed Environmental Health literature, by subtopic (N=65)

Subtopic	Number	Percentage
Land use (incl. resources & extraction)	33	50.8
Toxicology (including environmental contamination and safe drinking water)	19	29.2
Climate change	14	21.5
Outdoor/natural environment	9	13.8
Environmental impact assessment & planning	8	12.3
Interconnectedness of land and people	2	3.1
Indoor and built environment	1	1.5

Table 37: Non-peer-reviewed Child and Youth Health literature, by subtopic (N=42)

Subtopic	Number	Percentage
Child welfare	17	40.5
General health	12	28.6
Early childhood development	9	21.4
Youth welfare	6	14.3
Children's rights	2	4.8
Respiratory health (including asthma, allergies, chronic obstructive pulmonary disease (COPD), bronchitis, and pneumonia)	1	2.4
Hearing	1	2.4
Oral/dental health	1	2.4

Lifestyle and healthy living

Lifestyle and healthy living was the focus of 9.2% of the non-peer-reviewed literature. Of the 35 documents relating to lifestyle and healthy living, Table 38 shows that diet and nutrition, including traditional foods, was the most common subtopic (54.3%), followed by tobacco use (22.8%). Physical activity received attention in 17.1% of documents and sexual health in 8.6%. Physical safety and gambling were each the focus of 5.7% and 2.8%, respectively, of the literature in this category.

Table 38: Non-peer-reviewed Lifestyle/Healthy Living literature, by subtopic (N=35)

Subtopic	Number	Percentage
Diet and nutrition, including traditional foods	19	54.3
Tobacco use (including smoking cessation, second hand smoke)	8	22.8
Physical activity	6	17.1
Sexual health (including reproductive health, body image, sexuality, Two-spirited)	3	8.6
Physical safety (e.g. in 'risky' activities such as hunting)	2	5.7
Gambling	1	2.8

Table 39: Non-peer-reviewed Chronic Disease literature, by subtopic (N=31)		
Subtopic	Number	Percentage
Diabetes	12	38.7
Obesity	10	32.2
Cancer	7	22.6
Aging diseases (including dementia, Alzheimer's)	3	9.7
Other (general chronic disease)	2	6.4
Arthritis	1	3.2

Chronic disease

Chronic disease was covered by 31 non-peer-reviewed documents, a total of 8.2% of the literature. Within this category, diabetes was the main subtopic in 38.7% of the literature (Table 39). The next most frequent subtopics were obesity (32.2%), followed by cancer (22.6%) and aging diseases (9.7%). Two documents focused on chronic disease in general, while one focused on arthritis.

Mental health and wellness

Mental health and wellness was the main focus in 28 documents, comprising 7.4% of the non-peer-reviewed literature. As shown in Table 40, suicide/self-injury and addictions were the most common subtopics in the category, each at 32.1% of the literature. However, the remaining two categories, general mental health (28.6% of the literature) and personal/psychological resilience (21.4%) followed close behind. The subtopics of psychological trauma and depression were notably absent from the non-peer-reviewed literature.

Table 40: Non-peer-reviewed Mental Health literature, by subtopic (N=28)		
Subtopic	Number	Percentage
Suicide/self-injury prevention	9	32.1
Addictions (other than tobacco use)	9	32.1
General mental health	8	28.6
Personal/psychological resilience	6	21.4

Violence, injury, and abuse

Violence, injury and abuse was the focus of 24 articles, comprising 6.3% of the non-peer-reviewed literature. Table 41 shows that the justice system was the most common focus at 41.7% of the literature, followed by partner/family violence at 29.2%. Sexual violence and abuse received attention in 16.7% of the literature, and accidental injury and trauma in 12.5%. Less attention was given to elder abuse, victimization, and child abuse and neglect.

3.3 Canadian Institutes of Health Research Funding

The Canadian Institutes of Health Research (CIHR) are the major sources of federal funding for work in health-related fields. Therefore, a review of the CIHR Funded Decisions Database, detailing research funded by the institutes during the fiscal years 2010-11, 2011-12, and 2012-13, adds to the information on peer-reviewed and non-peer-reviewed literature by showing research currently in progress and expected to lead to eventual publication. The Institute of Aboriginal People's

Health (IAPH) is focused solely on health research related to First Nations, Inuit, and Métis peoples while the other twelve institutes are focused on various health subject themes and fund Aboriginal-related research relevant to their mandates.

Table 42 shows that, overall, 416 Aboriginal health-related projects were funded during the 2010-11, 2011-12, and 2012-13 fiscal years, representing \$78,575,708. When an application is submitted, applicants generally indicate which institute(s) the research is most aligned with. Of the 416 projects funded by CIHR over this three year period, over half (56.7%) expressed alignment with the IAPH, totaling approximately \$37.8M. Sixty-five projects, totaling approximately \$12.4M, did not specify an alignment with a specific institute. This was followed by the Institutes of Population and Public Health (34 projects totaling approx. 7% of monies), Health Services and Policy Research (30 projects totaling approx. 8% of monies), and Infection and Immunity (19 projects totaling 7.9% of monies). It is noteworthy, however, that there

Table 41: Non-peer-reviewed Violence, Injury, and Abuse literature, by subtopic (N=24)

Subtopic	Number	Percentage
Justice system	10	41.7
Partner/family violence	7	29.2
Sexual violence and abuse	4	16.7
Accidental injury and trauma (and prevention)	3	12.5
Elder abuse	2	8.3
Victimization	1	4.2
Child abuse and neglect	1	4.2

Table 42: CIHR funded Aboriginal health research, by institute affiliation

Institute	# of projects	% of total projects	\$ amount	% of total dollars
Aboriginal Peoples' Health	236	56.7	37,790,195	48
No Institute Specified	65	15.6	12,435,691	15.8
Population & Public Health	34	8.2	5,484,744	7.0
Health Services & Policy Research	30	7.2	6,305,513	8.0
Infection & Immunity	19	4.6	6,238,591	7.9
Gender & Health	10	2.4	3,797,721	4.8
Human Development, Child & Youth Health	9	2.2	4,327,858	5.5
Circulatory & Respiratory Health	3	0.7	1,829,061	2.3
Neurosciences, Mental Health & Addiction	3	0.7	138,996	0.2
Nutrition, Metabolism & Diabetes	2	0.5	10,000	0
Genetics	2	0.5	164,870	0.2
Aging	1	0.2	24,667	0
Cancer Research	1	0.2	3,000	0
Musculoskeletal Health & Arthritis	1	0.2	25,000	0
TOTALS	416	100%	\$78,575,708	100%

are several institutes with mandates that cover health topics identified as major health concerns for First Nations, Inuit, and Métis peoples that have very few projects aligned with them. This includes the Institutes of Nutrition, Metabolism, and Diabetes (2 projects), Cancer Research (1 project), and Neurosciences, Mental Health and Addiction (3 projects).

Type of award

CIHR provides funding for a wide range of research-related activities, nearly all of which can be expected to lead to publications. As can be seen from Table 43, the vast majority of CIHR's funding dollars are directed at projects that are large scale, multi-year, research and networking activities. Operating grants constitute more than half of all CIHR funding, followed by team grants (13.5%) and the Network Environments for Aboriginal Health Research (13.1%). All other types of projects receive less than 10% of CIHR funds.

Population representation

A detailed analysis was conducted to assess population representation in the 416 projects that were funded through the CIHR (Table 44). The majority (51.7%) indicated that their population involved Aboriginal peoples, but it was not always clear from the very limited data accessed whether this referred inclusively to First Nations, Inuit, and Métis peoples, or to unspecified First Nations. Taken together, 89.7% of funding dollars went to projects that identified either Aboriginal or First Nations as all or part of their population base. Like the peer- and non-peer-reviewed literature, Inuit (who represent 4% of the total Aboriginal population) were over-represented with 13% of total CIHR research funding, while Métis (who represent 33% of the total Aboriginal population) were dramatically under-represented with only 7.5% of funding dollars.

An analysis of population by life stage is presented in Table 45. The data shows that a majority of funded research (58.2%) applied to all life stages or did not specify a life stage. Of the projects that did specify a life age, youth were

Table 43: CIHR funded research, by type of award

Type of Award	# of Projects	Funding Amount	% of total Funding
Operating grant	94	39,430,258	50.2
Team Grant	5	10,631,180	13.5
CIHR NEAHR	2	10,297,961	13.1
Doctoral awards/scholarship	48	5,146,500	6.5
Fellowship	28	2,675,000	3.4
Planning grant	70	1,616,993	2.1
Partnership for Health System Improvement	4	1,608,269	2.0
Collaborative Centres of HIV/ AIDS Community-based research	1	1,500,000	1.9
Knowledge Translation Supplement	13	1,089,391	1.4
Meetings, Planning or Dissemination grant/ award	51	1,052,887	1.3
New investigator	4	760,000	0.97
Catalyst grant	20	595,183	0.76
Synapse – CIHR Youth Connection Program	4	569,200	0.72
Knowledge Synthesis	5	446,245	0.57
Healthcare Renewal Policy Analysis	2	284,545	0.36
Graduate scholarship or Master's award	15	259,750	0.33
Collaborative Health Research Projects	1	237,525	0.3
LOI – Operating grant, team grant or network	18	209,315	0.27
CIHR Journalism Award	6	109,835	0.14
Travel award	20	40,871	0.05
Café Scientifique	5	15,000	0.02
Total	416	\$78,575,908	100%

Table 44: CIHR research funding, by population breakdown ³³

Population	# of Projects	Percentage
Aboriginal	215	51.7
First Nations	158	38.0
Inuit	54	13.0
Métis	31	7.5

Table 45: CIHR funded Aboriginal health research, by population life stage ³⁴

Life stage	Number	Percentage
Adult	57	13.7
Child	52	12.5
Youth	86	20.7
Infant	19	4.6
Senior	13	3.1
All or unspecified	242	58.2

Table 46: CIHR funded Aboriginal health research, by gender ³⁵

Gender	Number	Percentage
All or unspecified	361	89.6
Male only	9	2.2
Female only	60	14.4

Table 47: CIHR funded Aboriginal health research, by geography ³⁶

Geography	Number	Percentage
National or unspecified	159	38.2
Regional or Provincial/Territorial	188	45.2
Specific community	54	13.0
Urban	43	9.6
Rural/remote	30	1.9
On-reserve	84	20.2
Off-reserve	3 ³⁷	0.7
International	33	7.9

most commonly identified in 20.7% of funded research, followed by adult (13.7%), children (12.5%), infants (4.6%), and seniors (3.1%).

In terms of gender, Table 46 shows that the majority of funded research (86.8%) dealt with both genders or did not specify the gender. Of projects or grants that focused on gender-specific populations, research involving females (14.4%) was far more prevalent than that focused on males (2.2%). A similar pattern of priority for female-focused research was also identified in the peer- and non-peer-reviewed literature.

In contrast to both the peer- and non-peer-reviewed literature, where the most common geographic focus was national or unspecified, Table 47 shows that a greater proportion of CIHR funded research (45.2%) adopted a regional or provincial/territorial focus compared with a national or unspecified focus (38%). An additional 13% adopted a specific community focus. Research specifying an urban, rural, and international focus each comprised less than 10% of the funded projects.

³³ Note that some projects were coded for multiple populations (ie. a study involving both First Nations and Métis), therefore percentages add up to more than 100 and number of projects will not add up to 416.)

³⁴ Note that some projects were coded for multiple life stages (ie. a maternal health study may be coded as both infant and adult), therefore percentages add up to more than 100 and number of projects will not add up to 416.

³⁵ Note that some projects were coded for multiple genders (ie. a maternal health study may be coded as both female for the mother and unspecified gender for infants), therefore percentages add up to more than 100 and number of projects will not add up to 416.

³⁶ Note that some projects were coded for multiple geographies (ie. a specific First Nations community in remote Ontario, might be coded as on-reserve, specific community, remote), therefore percentages add up to more than 100 and number of projects will not add up to 416.

³⁷ Please note that urban Aboriginal people can also be considered as “off-reserve”.

Table 48: CIHR funding, by theme of grant or award (N=416)				
Theme	# of Funded Projects	total Monies	% of Total monies	Average Grant or Award
Social/Cultural/ Environmental/ Population Health	266	39,693,738	50.5	149,224.60
Health Systems/ Services	60	20,571,797	26.2	342,863.30
Biomedical	6	3,545,990	4.5	590,998.30
Clinical	15	2,261,762	2.9	150,784.10
None specified	69	12,502,621	15.9	181,197.40
Total	416	\$78,575,908	100%	\$188,884.40

Funding priorities by theme and topic

Table 48 demonstrates that the vast majority of CIHR funded research projects fit within the social/cultural/ environmental/population health theme (50.5% of monies). This is followed by health systems/services (26.2%), no specified theme (15.9%), biomedical (4.5%), and clinical (2.9%). The table also shows that Biomedical and Health Systems/Services projects tend to receive, on average, a much higher level of funding per project (approx. 2-3 times greater than the average), while funding for the Social/Cultural/ Environmental/Population Health and Clinical themes tend to receive, on average, a much lower level of funding per project.

The remainder of this section will focus on the main topics and subtopics of CIHR funded research. Each project could be coded for up to three main topic categories and up to four primary

Table 49: CIHR Aboriginal health research, by main topic (N=416)		
Topic	# of Projects	% of Projects
Health care research, policy, human resources, programming & delivery	292	70.2
Socio-economic & cultural determinants	106	25.5
Communicable disease	99	23.8
Mental health & wellness (including suicide)	77	18.5
Lifestyle/health living	74	17.8
Chronic disease	61	14.7
Child & youth health	55	13.2
Environmental health	51	12.3
Maternal, fetal, & infant health	38	9.1
Violence, injury, abuse, & disability	16	3.8
Genetics/human biology	14	3.4
Other	7	1.7
General health status	3	0.7

subtopics. As a result, percentages will not add up to 100.

Table 49 shows the breakdown of all CIHR funded research over the three fiscal years by main topic. The vast majority of projects had health care as one of their main topics (70.2%), followed by socio-economic and cultural determinants (25.5%), and communicable disease (23.8%). Other topics that were important included mental health and wellness, lifestyle/

healthy living, chronic disease, child and youth health, and environmental health.

The sections below provide breakdowns of the subtopics within each topic area receiving attention in more than 5% of the funded research. Since each project may be coded for up to four subtopics, in the tables below the data for number of projects do not add up to the total number of projects in the topic categories and percentages for each subtopic do not add up to 100%.

Health care

Table 50 shows the breakdown by subtopic for those projects involving health care research, policy, human resources, programming and delivery. As shown, the majority of these were concerned with health care research (50%), a broad category including methodology, community involvement, culturally appropriate research, ethics, health data, data governance, disaggregation of data, and knowledge translation and exchange. This was

Table 50: CIHR funded Health Care research, by subtopic (N=292)		
Subtopic	Number	Percentage
Research	146	50.0
Preventive care/health promotion/public health services	60	20.5
Access to and use of health care services	43	14.7
Policy	34	11.6
Cultural competency and safety	26	8.9
Program Evaluation	25	8.6
Curative services, intervention and treatment programs	24	8.2
Traditional knowledge, medicines and approaches to health and healing	20	6.8
Best practices	15	5.1
Human resources	12	2.9
Diagnostic services, screening and surveillance	10	3.4
Aboriginal-controlled health care services	10	3.4
Seniors Housing and Care	6	2.1
Care giving/support	3	1.0
Holistic health care	3	1.0
Jurisdictional & insurance issues	1	0.3
Hospitalization	1	0.3
Parenting supports and resources	1	0.3
Other	7	2.4

followed by preventive care, health promotion, and public health services (20.5%), access to and use of health care services (14.7%), and policy (11.6%). Of the seven projects identified as 'other', six focused on changes to the health care system and delivery and one focused on evidence informed health care.

Socio-economic and cultural determinants

Of the 106 CIHR funded projects involving socio-economic and cultural determinants, the most prominent subtopic was general socio-economic determinants of health (33%), a subtopic meant to cover research projects that focused on a breadth of socio-economic and cultural determinants (Table 51). Of the remaining determinants, food security was represented in the largest number of projects (20.8%), followed by housing and homelessness (11.3%) and colonialism (10.4%). Each of the remaining determinants was a subtopic of less than 10% of projects. Of the 14 'other' projects, eight were focused on geography (including urban/rural/reserve mobility), three were focused on race or ethnicity, while one project was focused on each of gender, incarceration, and inequities in national policies.

Communicable disease

As shown in Table 52, funded research on communicable diseases was dominated by HIV/AIDS research (72.7%). Tuberculosis received attention in 11.1% of the funded research. All other sub-topics were represented in less than 10% of the funded research in this topic area. Of the 7 'other' projects, four were focused on helicobacter phylori, two on HPV, and one on staphylococcus aureus infection.

Table 51: CIHR funded Socio-Economic and Cultural Determinants research, by subtopic (N=106)

Subtopic	Number	Percentage
General social determinants of health	35	33.0
Food security (including access and costs)	22	20.8
Housing and homelessness	12	11.3
Colonialism	11	10.4
Economic status (including income, employment, poverty, and economic development)	10	9.4
Culture and language	7	6.6
Education and literacy (incl. school readiness & success)	5	4.7
Community and family relations	5	4.7
Discrimination and social exclusion	4	3.8
Other	14	13.2

Table 52: CIHR funded Communicable Disease research, by subtopic (N=99)

Subtopic	Number	Percentage
HIV/AIDS	72	72.7
Tuberculosis	11	11.1
Sexually transmitted diseases (STD's, incl. HPV)	5	5.1
General communicable diseases	4	4.0
Influenza (incl. H1N1)	3	3.0
Other	7	7.1

Table 53: CIHR funded Mental Health and Wellness research, by subtopic (N=77)		
Subtopic	Number	Percentage
Addictions (other than tobacco use)	34	44.2
Suicide/self-injury prevention	13	16.9
Psychological trauma (including intergenerational)	13	16.9
General mental health	12	15.8
Personal/psychological resilience	7	9.1
Depression	1	1.3
Stigma around mental health issues	1	1.3
Other	1	1.3


Mental health and wellness

Table 53 shows that within mental health and wellness research, the topic of addiction was addressed in the largest proportion of funded research projects (44.2%). This was followed by psychological trauma and suicide/self-injury, each of which was a focus in 16.9% of funded research. The general mental health of Aboriginal peoples was the focus of 15.8% of funded research, while all other subtopics received attention in less than 10% of projects.

Lifestyle and healthy living

Lifestyle and healthy living research by subtopic is represented in Table 54. Of the 74 projects, diet and nutrition received the most attention (45.9%), followed by sexual health (28.4%) and physical activity (20.3%). Tobacco use was a subtopic in eight projects, while the remaining five projects in this topic category were focused generally on healthy or risky lifestyle behaviors.

Table 54: CIHR funded Lifestyle/Healthy Living research, by subtopic (N=74)		
Subtopic	Number	Percentage
Diet and nutrition, including traditional foods	34	45.9
Sexual health (including reproductive health, body image, sexuality, Two-spirited)	21	28.4
Physical activity	15	20.3
Tobacco use (including smoking cessation, second hand smoke)	8	10.8
General health behaviours	5	6.8



Chronic disease

In the chronic disease category, diabetes was the leading subtopic (39.3%), as shown in Table 55, followed by cardiovascular disease (18%), cancer (14.8%), and aging diseases and obesity (11.5% each). Of the seven ‘other’ projects, food allergies were represented in two projects, while congenital long QT syndrome, anemia, kidney and liver disease, chronic pain, and atherosclerosis were each represented in one project.

Child and youth health

As shown in Table 56, within the topic of child and youth health, general health was the primary focus (36.4%), followed by child welfare and early childhood

development (14.5% each), learning disabilities (12.7%), and respiratory health (10.9%). The remaining subtopics all comprised less than 10% of funded research in this category. Of the three ‘other’ projects, two were focused on childhood injuries and one on special needs.

Environmental health

Table 57 shows that within projects focused on environmental health, more than half (52.9%) dealt with matters of toxicology, including environmental contamination and safe drinking water. Land use, including resources and extraction (13.7%), the indoor and built environment (13.7%), and environmental impact assessment and

planning (11.8%) were also significant themes. The interconnectedness of land and people, and the outdoor or natural environment each received attention in just under one in ten funded projects (9.8% each). Environmental justice was the focus of the single ‘other’ project.

Maternal, fetal, and infant health

Of the 38 projects identified in the category of maternal, fetal, and infant health, Table 58 shows that maternal health was the primary focus (39.5%), followed by infant health (23.7%), birth outcomes (18.4%), fetal health (13.2%), and fetal alcohol syndrome/fetal alcohol spectrum disorder (10.5%). All remaining subtopics were represented in less than 10% of funded research.

Table 55: CIHR funded Chronic Disease research, by subtopic (N=61)		
Subtopic	Number	Percentage
Diabetes	24	39.3
Cardiovascular disease	11	18.0
Cancer	9	14.8
Aging diseases (including dementia, Alzheimer’s)	7	11.5
Obesity	7	11.5
Arthritis	2	3.3
General chronic diseases	1	1.6
Other	7	11.5

Table 56: CIHR funded Child and Youth Health research, by subtopic (N=55)		
Subtopic	Number	Percentage
General health	20	36.4
Child welfare	8	14.5
Early child development	8	14.5
Learning disabilities	7	12.7
Respiratory health (including asthma, allergies, chronic obstructive pulmonary disease (COPD), bronchitis, and pneumonia)	6	10.9
Youth welfare	3	5.5
Childhood diseases	2	3.6
Otitis media	1	1.8
Oral health/dental	1	1.8
Other	3	5.5

Table 57: CIHR funded Environmental Health research, by subtopic (N=51)

Subtopic	Number	Percentage
Toxicology (including environmental contamination and safe drinking water)	27	52.9
Indoor and built environment	7	13.7
Land use (incl. resources & extraction)	7	13.7
Environmental impact assessment & planning	6	11.8
Interconnectedness of land and people	5	9.8
Climate change	5	9.8
Outdoor/natural environment	2	3.9
General environmental health	1	2.0
Other	1	2.0



Table 58: CIHR funded Maternal, Fetal, and Infant Health research, by subtopic (N=38)

Subtopic	Number	Percentage
Maternal health (including prenatal care)	15	39.5
Infant health	9	23.7
Birth outcomes	7	18.4
Fetal health	5	13.2
Fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorder (FASD)	4	10.5
Birthing and midwifery	2	5.3
Breastfeeding and infant nutrition	2	5.3

Priority subtopics

In identifying the main topic areas that CIHR research funding has been directed to, we are able to get a sense of what general theme areas have been the priority over the three year fiscal period of CIHR research funding. However, this does not allow us to identify the most prevalent health topics that were addressed during the period of this scan. By identifying which subtopics

were the most prevalent across all topic categories, we are able to identify the specific health topics that dominated the funded research during the period of this scan. Table 59 highlights the top 15 subtopics addressed in this research across all main topic categories. As can be seen from this table, only a few subtopics were addressed in more than 10% of all funded research. Research was the most prevalent subtopic at

more than double that of the second most prevalent subtopic. Only HIV/AIDS (17.3%), Preventive Care/Health Promotion/Public Health Services (14.4%), and Access to and Use of Health Care Services (10.3%) were addressed in more than 10% of all funded projects. Also of note from the table is that more subtopics were drawn from the topic category of Health Care Research, Policy, Human Resources,

Table 59: CIHR funded research by main subtopics – Top 15

Sub-Topic	# of Projects	% of All Projects Funded	Main Topic Category
Research	146	35.1	Health care research, policy, human resources, programming and delivery
HIV/AIDS	72	17.3	Communicable disease
Preventive care/health promotion/public health services	60	14.4	Health care research, policy, human resources, programming and delivery
Access to and use of health care services	43	10.3	Health care research, policy, human resources, programming and delivery
General socio-economic determinants of health	35	8.4	Socio-economic and cultural determinants
Addiction	34	8.2	Mental health and wellness
Diet and nutrition	34	8.2	Lifestyle/healthy living
Policy	34	8.2	Health care research, policy, human resources, programming and delivery
Toxicology	27	6.5	Environmental health
Cultural competency and safety	26	6.3	Health care research, policy, human resources, programming and delivery
Program evaluation	25	6.0	Health care research, policy, human resources, programming and delivery
Diabetes	24	5.8	Chronic disease
Curative services, intervention and treatment programs	24	5.5	Health care research, policy, human resources, programming and delivery
Food security	22	5.3	Socio-economic and cultural determinants



Programming and Delivery than from any other topic category (six of the top 15 subtopics).

Ongoing research

As Table 60 illustrates, while the majority of CIHR projects described in this report were completed as of March 2013, in terms of actual funding amounts, 70.4% of CIHR funding was devoted to projects that were ongoing. These results are slightly higher than those found in the 2010 *Landscapes* report (which found 60.3% ongoing and 39.7% completed). While this finding may seem contradictory, the high percentage of completed projects largely represents projects devoted to smaller-scale, shorter term, activities such as for planning meetings, dissemination events, or developing fuller research proposals. These types of projects generally come with lower levels of funding. In contrast, CIHR funds fewer large scale, multi-year, projects, however, these types of projects generally tend to come with considerably higher levels of funding. The high percentage of funding for projects that continued to be ongoing as of March 2013 provides an indication that a significant amount of research pertaining to First Nations, Inuit, and Métis health remains in progress and that a significant number of publications can be expected in the short and medium term.

Table 60: CIHR-IAPH funding, by year and completion status (N=416)

Fiscal Year	Project Status	Number	Funding Amount	Percentage of Funding
2010-2011	Ongoing	12	6,875,385	27.3
	Completed	95	18,271,492	72.7
	Fiscal year total	107	25,146,877	
2011-2012	Ongoing	33	15,065,714	71.5
	Completed	106	6,015,822	28.5
	Fiscal year total	139	21,081,536	
2012-2013	Ongoing	78	28,228,775	87.3
	Completed	92	4,118,520	12.7
	Fiscal year total	170	32,347,295	
All three fiscal years	Ongoing	123	\$50,169,874	63.9%
	Completed	293	\$28,405,834	36.2%
	Fiscal year total	416	\$78,575,708	

3.4 Population representation

This section brings together the findings on representation of Aboriginal populations, including by cultural identity, life stages, gender, and geography, within the three categories of peer-reviewed literature, non-peer-reviewed literature, and CIHR funded research.

3.4.1 Cultural identity

Use of the term “Aboriginal” by researchers to designate aggregated and undefined study populations is an ongoing problem, particularly in the peer-reviewed literature and CIHR funding database. While some documents and projects specify that they intend the term to inclusively cover the three groups of Aboriginal peoples, it is more often unclear and appears likely that many are using the term to refer to unspecified First Nations communities. Table 61 shows the representation of various cultural groups in the literature and funded research. Métis people (constituting 33% of the total Aboriginal population) are dramatically under-represented, particularly in the peer-reviewed

literature (2.6%) and CIHR funding (7.5%). Conversely, Inuit (constituting 4% of the total Aboriginal population) are over-represented, especially in peer-reviewed (19.9%) and non-peer-reviewed (16.6%) literature. While population numbers are not the only indicator of “health needs,” these large discrepancies point to areas where research may not be addressing the needs of people and communities.

3.4.2 Life stage

An analysis of the literature and research by life stage reveals that non-peer-reviewed literature is more likely than funded research and peer-reviewed literature to either deal with all life stages or to not specify life stage (Figure 2). Of the literature and research that did identify a life stage, there was a notable difference between CIHR funded research and both peer- and non-peer-reviewed literature. While youth (20.7%) were the most prevalent group in CIHR funded research, followed by adults (13.7%), children (12.5%), infants (4.6%) and seniors (3.1%), in the literature (both peer- and non-peer-reviewed) adults were by far the most common group (ranging

between 19.3 and 34.3%), followed by youth (approx. 13%) and children (13.4-13.6%). Seniors and infants received considerably lower levels of attention in both the funded research and in the literature. While there may be obvious reasons for this low representation, for instance the difficulties of conducting research on infants, given the youthfulness of the Aboriginal population, these results highlight that infant health may not be receiving the attention it needs.

3.4.3 Gender

An analysis of the representation of male and female gender within Aboriginal health literature and research (Figure 3) shows that the vast majority of funded research and literature, both peer- and non-peer-reviewed, did not disaggregate population by gender or included both males and females in the population. Of the literature and research with a gender-specific population, across the three categories females were studied far more often in all categories (ranging between 7.1% and 14.4%) than males (between 0.5 and 2.2%).

Table 61: Population representation by cultural identity				
Population	% of total Aboriginal population	% of Peer-reviewed literature	% of Non-peer-reviewed literature	% of Funded research
Aboriginal (unspecified)	97 ³⁸	58.7	58.3	51.7
First Nations	60	24.2	27.4	38.0
Inuit	4	19.9	16.6	13.0
Métis	33	2.6	9.5	7.5

³⁸ The remaining 3% are principally either people who provided a multiple response to the identity question (who reported being two or all three of First Nations, Inuit, or Métis) or people who reported having Registered or Treaty Indian status and/or membership in a First Nation or Indian band but who did not report being First Nations, Inuit, or Métis. Population statistics derived from Statistics Canada, 2008.



FIGURE 2: POPULATION REPRESENTATION BY LIFE STAGE

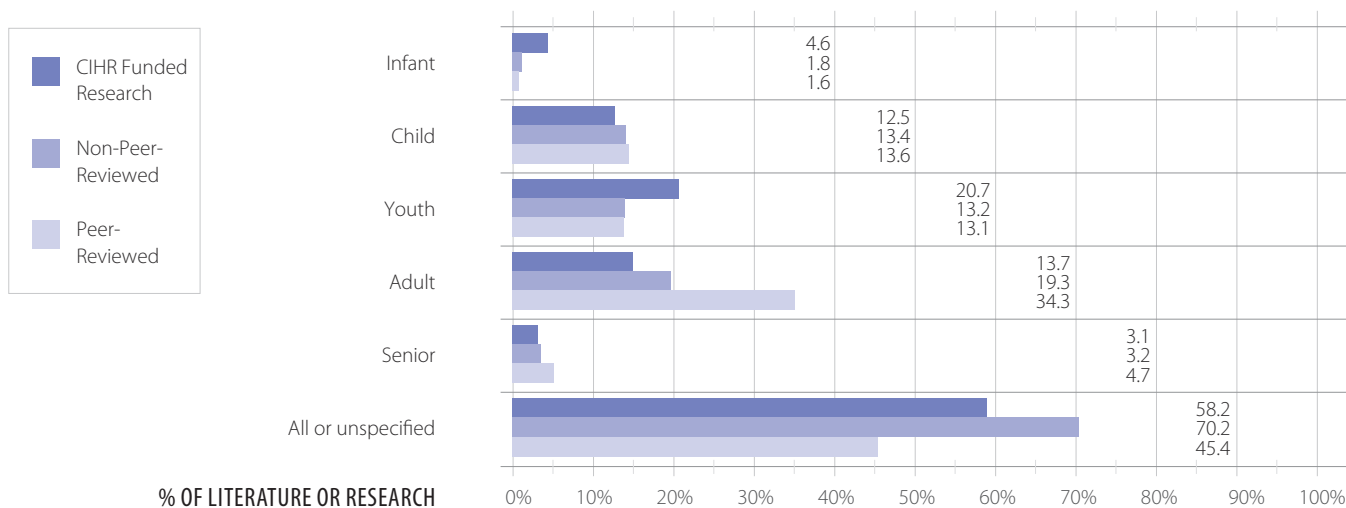
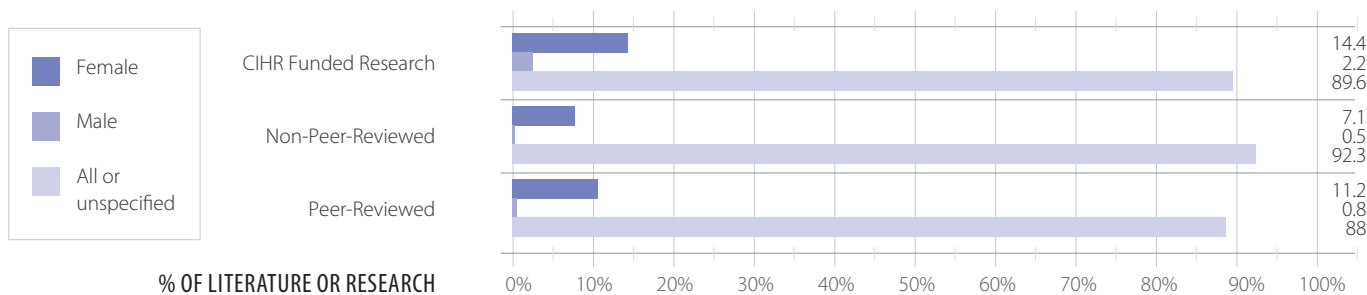


FIGURE 3: POPULATION REPRESENTATION BY GENDER



3.4.4 Geography

An analysis of the representation of the Aboriginal population by geographic focus (Figure 4) revealed some minor incongruencies across the three categories of literature and funded research included in this scan. In terms of the geographic focus, both the peer- and non-peer reviewed literature focused primarily on a national or unspecified scale (ranging between 46-50.4%), followed by a regional or provincial/territorial scale (ranging between 34-39%). For CIHR funded research, these two geographic scales were reversed, with more research being focused on a regional or provincial/territorial scale (45.2%) than on a national or unspecified scale (38.2%). There were also slight incongruencies in terms of the third to fifth most prevalent geographic focuses across the three categories of funded research and literature. CIHR funded research also focused more often on “on reserve” populations compared with both the

peer- and non-peer-reviewed literature. Across all three categories, ‘rural/remote’ and ‘off reserve’ populations were seldom the geographic focus.

Given that such a large percentage of literature and research is not disaggregated by geography, it is difficult to make comparisons between these percentages and those in the actual population census data. This is especially the case since on reserve populations may still be the primary focus of much of the literature and research that adopts a “regional or provincial/territorial” or “national/unspecified” scale. It may be somewhat easier to draw comparisons for the urban/off reserve population. Since more than 50 percent of Aboriginal people live off reserve (Statistics Canada, 2012a), when the urban and off reserve geographic focuses are combined, it appears that the off reserve population is significantly under-represented in all three categories of research and literature.

3.5 Organizations, literature, and research topics

This section brings together data on the health priorities of national Aboriginal organizations, peer- and non-peer-reviewed literature, and CIHR funded research, to determine whether the research being funded and published is meeting the health needs of Aboriginal communities, as represented by Aboriginal controlled organizations. As Figure 5 shows, the topics of health care (including research, policy, human resources, programming, and delivery) followed by socio-economic and cultural determinants are the top priorities for the Aboriginal organizations included in this scan as well as for the three categories of peer and non-peer-reviewed literature and funded research. However, these two main topic areas are considerably more important to organizations than in the funded research or literature.

FIGURE 4: POPULATION REPRESENTATION BY GEOGRAPHY

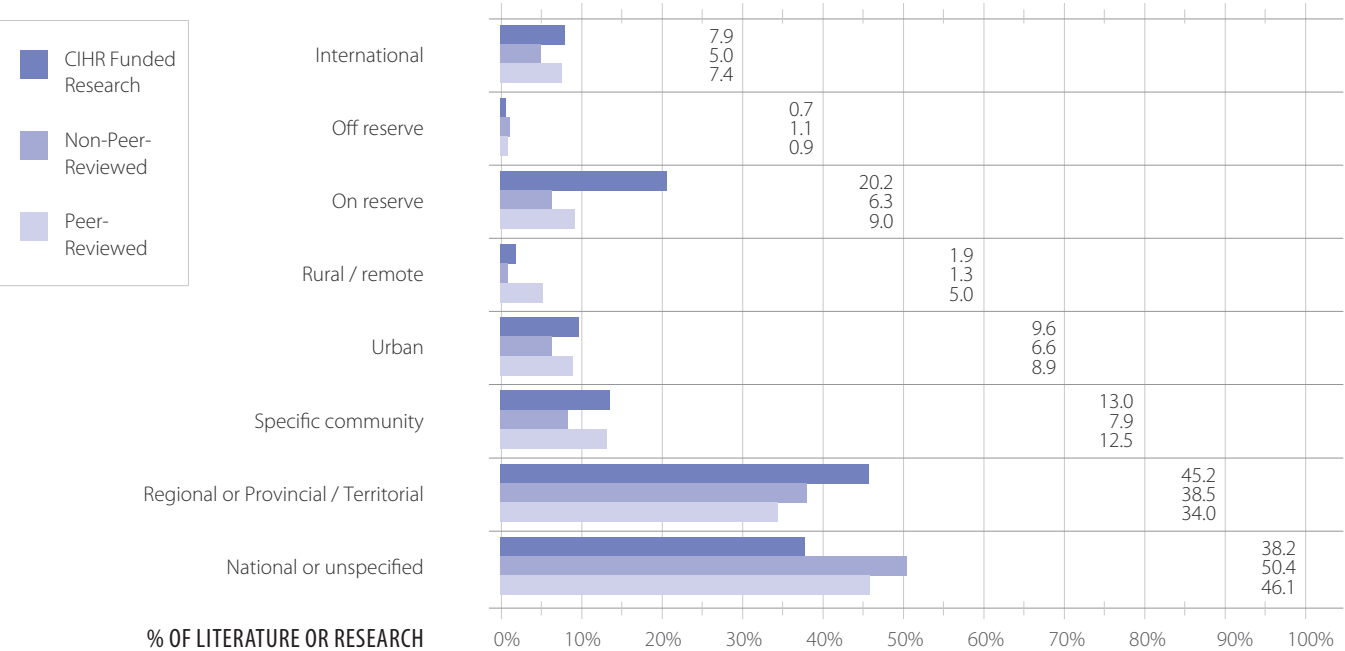
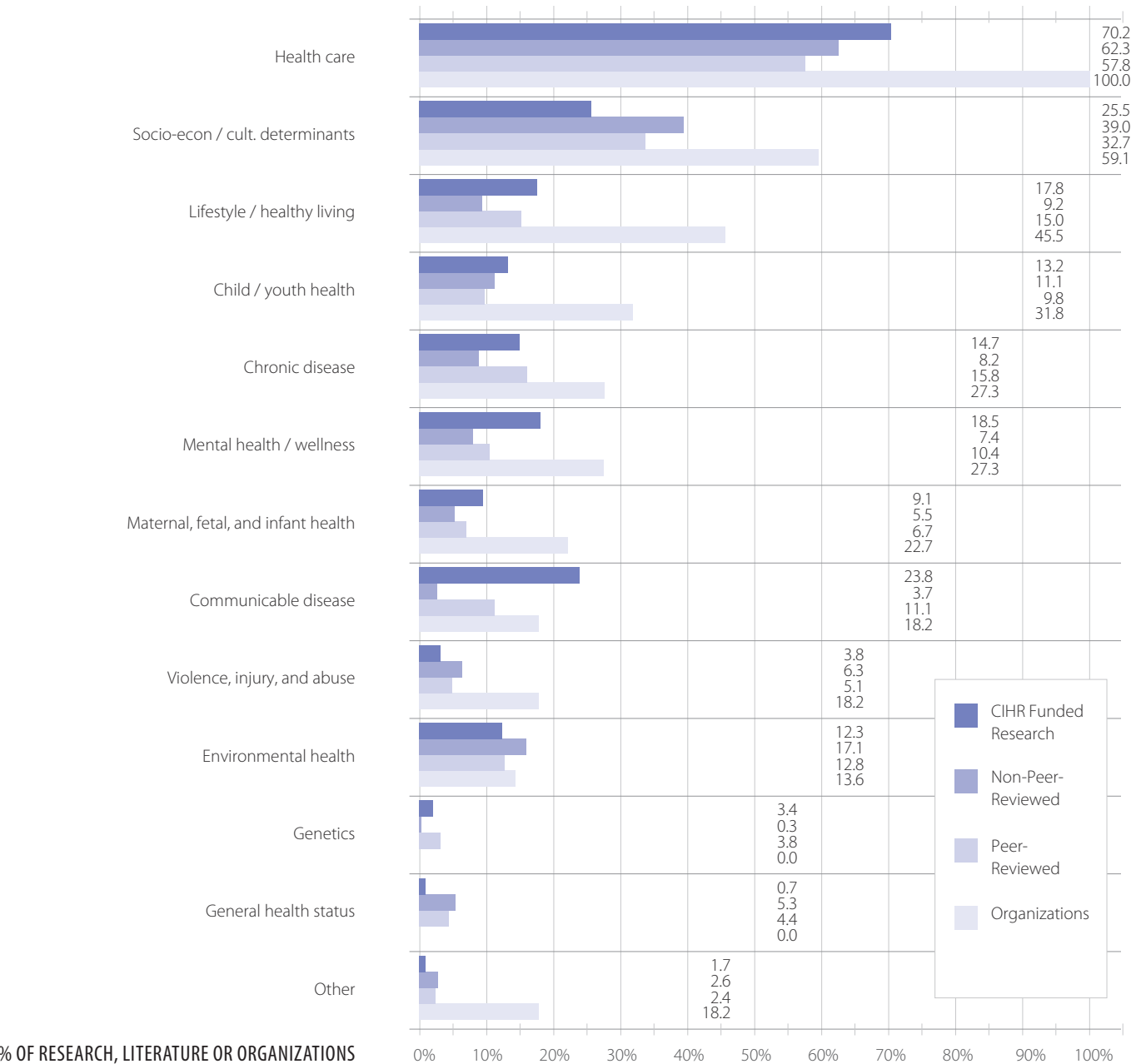


FIGURE 5: SUMMARY OF PRIORITIES OF RESEARCH, LITERATURE, AND ORGANIZATIONS



Likewise, lifestyle and healthy living; child and youth health; chronic disease; mental health and wellness; maternal, fetal, and infant health; and violence, injury, and abuse are all more important priorities of organizations compared with funded research and literature. The topic of environmental health is given almost an equal priority in

organizations, peer-reviewed literature, and funded research, but receives more attention in non-peer-reviewed literature. The topic of communicable disease also receives more attention in CIHR funded research than in the literature and among Aboriginal organizations, signaling that more publications may be forthcoming in

this area in the future. In the 'Other' category, the primary difference is a significant concern by Aboriginal organizations with gender and adult respiratory health, neither of which is a large priority in the literature and research. Genetics is not a major priority for literature, research, or organizations.





4.0 KEY OBSERVATIONS

Four key observations arose from this environmental scan of literature, research, and national organizations working in First Nations, Inuit, and Métis public health.

4.1 National Aboriginal organizations: A changing landscape

Despite some positive developments, many health status indicators point to continued serious health disparities for First Nations, Inuit, and Métis people. There is an urgent need to improve methods and resources for increasing Aboriginal participation and ownership in research, policy, and programming to improve health and wellness of people and communities. However, recent major funding cuts to several national Aboriginal organizations have put this needed progress in jeopardy. Communities, academics, medical professionals, including the Royal College of Physicians and Surgeons of Canada, and others have questioned how it will be possible to maintain the positive changes, let alone accelerate the process of improvement (Royal College of Physicians and Surgeons of Canada, 2012).

At the same time, another trend has seen the emergence of several new Aboriginal-controlled national organizations focused on specific aspects of health, including information governance, environmental health, midwifery, health management, and physical activity. This growth suggests a desire for self-determination, knowledge ownership and exchange, niche networking, development of best practices, and the power of collective voice to shape policy and programming. Whether these organizations will be able to secure the funding, resources, and community support needed to make a major impact at the national level remains to be seen.

4.2 Population representation

Two important themes arose from the scan on how populations are represented in the literature and research. One of these is the need for more consistent disaggregation of data. The use of the term “Aboriginal” by researchers to designate aggregated or undefined study populations continues to be problematic, particularly in the peer- and non-peer reviewed literature. While some documents and projects specify that they intend the term to cover the three groups of Aboriginal peoples inclusively, it is more often used either unclearly or in reference to unspecified First Nations. Similarly, the scan revealed that literature and research often do not clearly disaggregate population data based on gender, life stage, and geography. Population disaggregation in research is an important analytical step

that respects the diversity of cultures, regions, and communities in order to avoid the pitfalls associated with a generalized ‘pan-Aboriginal’ approach. By reflecting the distinct, lived experiences of specific groups of people, disaggregated data can lead to more accurate identification of needs and the development of more appropriate solutions.³⁹

A second theme that was identified in terms of population representation is that infants and children, males, urban and off reserve Aboriginal populations, and Métis people in general continue to be dramatically under-represented. Although population numbers are not the only indicator of “health needs,” large discrepancies point to areas where research may not be addressing the needs of people and communities. More effort is needed to identify and address possible barriers and encourage more research in the areas of infant and child, male, Métis, and urban Aboriginal health.⁴⁰

4.3 Priorities of literature, research, and national Aboriginal organizations: Commonalities and gaps

There continues to be a considerable body of research being undertaken in Aboriginal health. Our scan revealed a proliferation of peer- and non-peer-reviewed literature. In the 2010 edition of the *Landscapes* report, a total of 384 peer-reviewed documents were located pertaining to First Nations, Inuit, and/or Métis health in the years 2007-2008, an average of 192 documents per year. The current review found a total of 1939 peer-reviewed documents for the years 2010-2012, an average of 646 per year. A similar increase was found in the volume of non-peer-reviewed

literature identified for this iteration of the *Landscapes* report compared to the 2010 edition (an average of 126 per year compared to 42 per year). Because of differences in methodology used for the two scans, it cannot be concluded that the increase is entirely due to more research being published. However, an important finding of this report is that there has been a dramatic increase in the amount of relevant research successfully identified through the current methodology. The scan also revealed that despite a decline in funding for health research during the 2011-12 fiscal year, there continues to be high levels of funding for CIHR research related to Aboriginal health, suggesting that more published research will be forthcoming.

The scan also revealed some congruence between the health priorities of Aboriginal organizations and the primary focuses identified in both peer and non-peer reviewed literature and funded research. Health care and socio-economic and cultural determinants represent the top priorities of the Aboriginal organizations in the current *Landscapes* report, and these also have very strong showing in the published literature and funded research. Several other topics are stronger concerns for organizations but receive lesser emphasis in literature and research, including: lifestyle and healthy living (especially smoking cessation, sexual health, and diet and nutrition); child and youth health; chronic disease (especially diabetes); maternal, fetal, and infant health; mental health and wellness; and violence, injury, and abuse. Environmental health is an almost equally significant health concern for Aboriginal organizations as it is in the peer-reviewed literature and funded research, though it is

somewhat more important in the non-peer-reviewed literature. All of these gaps indicate areas where the existing and forthcoming knowledge may not be adequately addressing the concerns of the organizations that represent the needs of communities. General health status and genetics are not major priorities for either literature, research or Aboriginal organizations.

4.4 Emerging knowledge: Making a difference through translation and exchange

With continued serious health disparities affecting First Nations, Inuit, and Métis communities and people, it is more imperative than ever that researchers and other knowledge translation and exchange professionals and organizations work to ensure that the body of emerging knowledge documented in this report is disseminated in culturally relevant forms to communities and front line practitioners. New research also needs to be readily accessible to public health decision makers at all levels so that high quality, informed, evidence-based policies can assist First Nations, Inuit, and Métis peoples to achieve their public health goals and achieve optimum health and well-being.

³⁹ See, for example, The Importance of Disaggregated Data (NCCAH, 2009-2010).

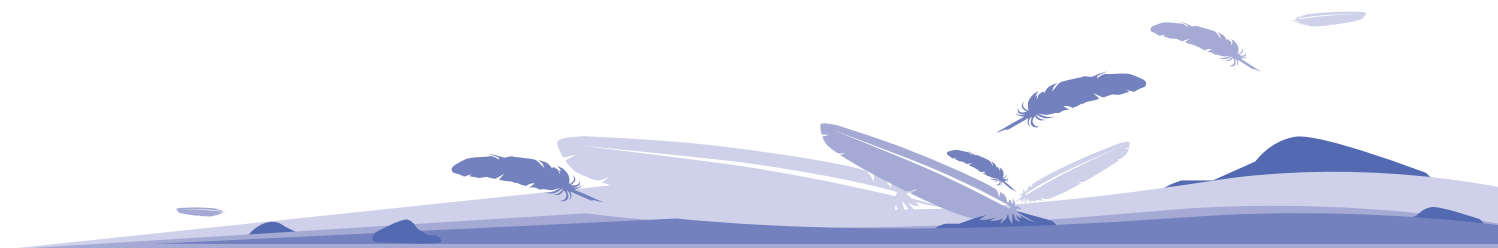
⁴⁰ Some of the barriers are discussed in Paucity of Métis-specific Health and Well-being Data and Information: Underlying factors (NCCAH, 2011).

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5.0 APPENDICES



Appendix A

National organizations working in First Nations, Inuit, and Métis public health in Canada

Appendix B

Non-exclusive topic categories

Appendix C

Peer-reviewed literature

Appendix D

Non-peer-reviewed literature

APPENDIX A: National organizations working in First Nations, Inuit, and Métis public health in Canada

Table 62: National Aboriginal organizations			
Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/Strategies
Assembly of First Nations (AFN) Trebla Building 473 Albert Street, Suite 900 Ottawa, ON, K1R 5B4 Tel: (613) 241-6789 Fax: (613) 241-5808 TF: 1-866-869-6789 Web: www.afn.ca Twitter: @AFN_Updates	Health and Social Secretariat Mandate: Activities and goals organized into seven areas: Strategic Policy, Public Health, Mental Wellness, Children and Youth, Information Management, Primary Care, and Social Development Strategies and decisions are “developed in partnership with the National First Nations Health Technicians Network (NFNHTN) and the Chiefs Committee on Health (CCOH).” ⁴¹ Health funding cut by 40% in 2012. ⁴²	Lobbying Policy analysis Provide information	Diabetes Maternal child health HIV/AIDS Cancer Social determinants of health Injury prevention Non-Insured Health Benefits Cultural competency Suicide prevention & mental health Tobacco control strategy Tuberculosis, asthma, respiratory health Food security, nutrition
Congress of Aboriginal Peoples (CAP) 867 St. Laurent Blvd. Ottawa, ON, K1K 3B1 Tel: (613) 747-6022 Fax: (613) 747-8834 Email: info@abo-peoples.org Web: www.abo-peoples.org Twitter: @CAPChief	Mandate: Working with the Government of Canada to improve the health of Canada’s off-reserve Aboriginal peoples. ⁴³ Objectives: “to develop a better understanding of community-specific health conditions, and to utilize that understanding to foster and facilitate the development of federal and provincial policies, projects and programs that will enhance the health of both off-reserve Aboriginal Peoples and the communities in which they live.” ⁴⁴	Representation Advocacy Working with Health Canada, First Nations and Inuit Health Branch (FNIHB)	Health Services Integration Fund (HSIF) Coordinating health policies Jurisdictional issues Diabetes Healthy eating and traditional foods Living conditions and environment Childhood obesity Mental health Access to services Cancer care for off-reserve Aboriginal peoples

⁴¹ <http://www.afn.ca/index.php/en/policy-areas/health-and-social-secretariat>

⁴² CBC News. “AFN lays off staff after losing health funding.” [News report]. Retrieved November 15, 2012, from <http://www.cbc.ca/news/politics/story/2012/04/19/pol-afn-health-funding-cut.html>

⁴³ <http://www.abo-peoples.org/health/>

⁴⁴ Ibid.

Table 62: National Aboriginal organizations (continued)

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
<p>First Nations Child and Family Caring Society of Canada (FNCFCSC)</p> <p>Suite 401 – 309 Cooper Street, Ottawa, ON, K2P 0G5</p> <p>Tel: (613) 230-5885 Fax: (613) 230-3080</p> <p>Email: info@fncaringsociety.com Web: www.fncaringsociety.com Twitter: @Caringsociety</p>	<p>Mission: “building helping communities”⁴⁵</p> <p>Vision: “A generation of First Nations children who have the same opportunities to succeed, celebrate their culture and be proud of who they are as other children in Canada.”⁴⁶</p> <p>Value statement: “We value and promote the holistic knowledge and practices that support the sharing of national First Nations communities to love, respect and nurture First Nations children, young people, families, communities and nations.”⁴⁷</p>	<p>Research</p> <p>Advocacy</p> <p>Policy</p> <p>Provide resources</p> <p>Professional development</p> <p>Networking</p> <p>Engage people in creating solutions</p>	<p>Child welfare best practices and funding</p> <p>Culturally appropriate research and evaluation</p> <p>Empowerment of families and communities</p> <p>Children’s rights</p> <p>Inequities on First Nations education, health, and child welfare</p>
<p>First Nations Information Governance Centre (FNIGC)</p> <p>49 Ford Lane, Unit 1 Akwasasne, ON , K6H 5R7</p> <p>Tel: (613) 733-1916, ext. 108 Fax: (613) 936-8974 TF: 1-866-997-6248</p> <p>Email: info@fnigc.ca Web: www.fnigc.ca Twitter: @fnigc</p>	<p>Mission: “build capacity and provide credible and relevant information on First Nations using the highest standards of data research practices, while respecting the rights of First Nations self-determination for research and information management and in true compliance with the First Nations principles of Ownership, Control, Access and Possession (OACP).”⁴⁸</p> <p>Vision: “Founded on First Nations Principles, the First Nations Information Governance Centre is a premier Indigenous model of research and data excellence for the well-being of our Peoples and Communities.”⁴⁹</p>	<p>Houses First Nations Regional Longitudinal Health Survey</p> <p>Provide information, research, training, data collection, analysis, and dissemination services to First Nations</p> <p>Promote OACP</p> <p>Build First Nations data management capacity</p>	<p>Governance over information and information management</p> <p>Providing sound quality data to lobby for policy changes, etc.</p> <p>Community change</p> <p>OACP</p> <p>First Nations languages, cultures, education, health, employment, and socio-economic indicators</p>

⁴⁵ <http://www.fncaringsociety.com/about/mission>

⁴⁶ <http://www.fncaringsociety.com/who-we-are>

⁴⁷ <http://www.fncaringsociety.com/about/strategic-directions>

⁴⁸ <http://www.fnigc.ca/node/16>

⁴⁹ <http://www.fnigc.ca/node/15>

Table 62: National Aboriginal organizations (continued)

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
Inuit Tapiriit Kanatami (ITK) 75 Albert St., Suite 1101 Ottawa, ON, K1P 5E7 Tel: (613) 238-8181 Fax: (613) 234-1991 TF: 1-866-262-8181 (CAN) Web: www.itk.ca Twitter: @ITK_CanadaInuit	<p><i>Mandate/Vision:</i> “represents and promotes the interests of Inuit on a wide variety of environmental, social, cultural, and political, issues and challenges facing Inuit on the national level.”⁵⁰</p> <p>Health funding cut by 40% in 2012.⁵¹</p>	Representation Organization Advocacy/policy influence Educational resources Public awareness	Resource development Environmental health and wildlife Climate change Suicide prevention Inuit human rights and sovereignty Health and social development Local and traditional knowledge, languages, and culture NIHB and HSIF Food security Addictions Maternal child health
Métis National Council (MNC) #4-340 MacLaren St. Ottawa, ON, K2P 0M6 Tel: (613) 232 - 3216 Fax: (613) 232 - 4262 TF: 1-800-928-6330 Email: info@metisnation.ca Web: www.metisnation.ca Twitter: @MNC_tweets	<p><i>Mission:</i> The Métis National Council represents the Métis Nation and Métis rights, desires, and aspirations at the national and international levels.</p> <p><i>Objectives:</i> to “secure a healthy space for the Métis Nation’s on-going existence within the Canadian federation.”⁵²</p>	Policy influence/development Delivering programs and services Advocacy Representation Information dissemination Research	Métis rights and self-government Socio-economic development Culture and heritage Environmental health Diabetes
National Association of Friendship Centres (NAFC) 275 MacLaren St. Ottawa, ON, K2P 0L9 Tel: (613) 563-4844 Fax: (613) 594-3428 TF: 1-877-563-4844 Email: nafcgen@nafc.ca Web: www.nafc.ca Twitter: @NAFC_ANCA	<p><i>Mission:</i> “to improve the quality of life for Aboriginal peoples in an urban environment by supporting self-determined activities which encourage equal access to, and participation in, Canadian Society; and which respect and strengthen the increasing emphasis on Aboriginal cultural distinctiveness.”⁵³</p>	Policy Program and service delivery Skills training Counselling	Literacy Aboriginal language/culture Human resources development Tobacco cessation Matrimonial real property Diabetes

⁵⁰ <https://www.itk.ca/about-itk>

⁵¹ Nunatsiq News. (2012, April 17). “Health Canada slashes half of ITK’s health budget. [News report]. Retrieved November 15, 2012, from http://www.nunatsiaqonline.ca/stories/article/65674health_canada_cuts_will_slash_almost_half_of_itks_health_budget/

⁵² <http://www.metisnation.ca/index.php/who-are-the-metis/mnc>

⁵³ <http://nafc.ca/en/content/our-mission>

Table 62: National Aboriginal organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/Strategies
Native Women's Association of Canada (NWAC) 1 Nicholas St., 9 th Floor Ottawa, ON, K1N 7B7 Tel: (613) 772-3033 Fax: (613) 772-7687 TF: 1-800-461-4043 Web: www.nwac.ca	<p>Mandate: "to achieve equality for all Aboriginal women in Canada."⁵⁴</p> <p>Goal: "to enhance, promote, and foster the social, economic, cultural and political well-being of First Nations and Métis women within First Nation, Métis and Canadian societies."⁵⁵</p> <p>Vision: Aboriginal communities where women: have opportunities to develop their talents; are encouraged to live healthy, balanced lives; are encouraged to learn Aboriginal history and traditional ways; accept and exercise responsibilities to contribute to strong communities; and are accepted in a society free of racism and discrimination."⁵⁶</p> <p>All funding to Health Department cut in 2012.⁵⁷</p>	Advocacy Representation Policy analysis and development Program development and delivery Research Knowledge mobilization Education	Violence against women Aboriginal cultures and languages Women's equality Human resources and leadership development Traditional health knowledge and practices Diabetes, cancer Healthy babies, children, youth, and seniors Suicide prevention Sexual health Mental health
Pauktuutit – Inuit Women of Canada 520 – 1 Nicholas St. Ottawa, ON, K1N 7B7 Tel: (613) 238-3977 Fax: (613) 238-1787 TF 1-800-667-0749 Email: info@pauktuutit.ca Web: www.pauktuutit.ca	<p>Mandate: "to foster a greater awareness of the needs of Inuit women, and to encourage their participation in community, regional and national concerns in relation to social, cultural and economic development."⁵⁸</p> <p>Objectives: (health specific): "Work for the betterment of individual, family and community health conditions through advocacy and program action."⁵⁹</p> <p>All funding for health projects cut in 2012.⁶⁰</p>	Advocacy Research Program initiatives Disseminate information and resources	Violence and abuse Maternal child health Residential schools Early childhood development FASD Sexual health and HIV/AIDS Injury prevention Tobacco cessation

⁵⁴ <http://www.nwac.ca/>

⁵⁵ Ibid.

⁵⁶ http://www.nwac.ca/sites/default/files/imce/NWAC%20Strat%20Plan%20-%20March%202011_0.pdf

⁵⁷ http://www.nwac.ca/sites/default/files/imce/April%2013,%202012%20Health%20post%20budget%20cuts%20to%20NWAC_Press_Release.pdf

⁵⁸ <http://www.pauktuutit.ca/index.php/about-us/>

⁵⁹ Ibid.

⁶⁰ <http://www.pauktuutit.ca/index.php/funding-for-pauktuutits-national-inuit-health-projects-eliminated/>

Table 63: National Aboriginal health organizations

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
Aboriginal Healing Foundation Web: www.ahf.ca	Reached the end of its funded mandate September 2012 and is closing its doors. ⁶¹ Publications to have copyright transferred and resources to be available beyond the life of the organization. ⁶²		
Aboriginal Nurses Association of Canada (ANAC) 16 Concourse Gate, Unit 600 Ottawa, ON, K2E 7S8 Tel: (613) 724-4677 Fax: (613) 724-4718 TF: 1-866-724-3049 Email: info@anac.on.ca Web: www.anac.on.ca Twitter: @aboriginalnurse	<p>Mission: "to improve the health of Aboriginal people, by supporting Aboriginal Nurses and by promoting the development and practice of Aboriginal Health Nursing."⁶³</p> <p>Objectives: activities that promote recruitment and retention of Aboriginal nurses, foster support, consultation, research and education.</p>	Education/professional development Lobbying/policy Research Mentorship/support Providing resources Information dissemination	Recruitment & retention Cultural safety Aboriginal participation in health decision making Access to health care
Aboriginal Physical Activity and Cultural Circle (APACC) 6520 Salish Drive Vancouver, BC, V6N 2C7 Tel: (604) 537-7777 Web: www.a-pacc.com	<p>Mission: "to create a community of mentors, leaders, participants, and supporters who promote physical activity as a way to health and wellness."⁶⁴</p> <p>Vision: "to establish and expand relationships between individuals engaged in physical activity by improving access to resources, and promote exposure to health and wellness opportunities."⁶⁵</p>	Networking Education Sponsorship co-ordination Fund raising Disseminate research	Corporate discounts and funding Fitness Support for traditional physical and cultural activities Running

⁶¹ <http://www.ahf.ca/faqs>

⁶² <http://www.ahf.ca/downloads/2010-corp-plan-eng.pdf>

⁶³ <http://www.anac.on.ca/mission.php>

⁶⁴ <http://www.a-pacc.com/>

⁶⁵ <http://www.a-pacc.com/vision>

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
Canadian Aboriginal AIDS Network (CAAN) 6520 Salish Drive Vancouver, BC, V6N 2C7 Tel: (604) 266-7617 Fax: (604) 266-7612 Web: www.caan.ca Twitter: @CAAN_says	<p>Mandate and Mission: to provide “leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS, regardless of where they reside.”⁶⁶</p> <p>Goals and Objectives: “To provide accurate and up-to-date information about the prevalence of HIV in the Aboriginal community and the various modes of transmission; to offer leaders, advocates and individuals in the AIDS movement a chance to share their issues on a national level by building skills, education/awareness campaigns, and acting in support of harm reduction techniques; to facilitate the creation and development of regional Aboriginal AIDS service agencies through leadership, advocacy and support; to design material[s] which are aboriginal specific for education and awareness at a national level, and to lessen resource costs of underfunded, regional agencies by distributing and making available these materials wherever possible; to advocate on behalf of Aboriginal people living with HIV/AIDS (APHA's) by giving them forums in which to share their issues and to facilitate the development of healing and wholeness strategies among the infected Aboriginal population; to build partnerships with Aboriginal and Non-Aboriginal agencies which address the issues of Aboriginal people across jurisdictions, thereby improving the conditions in which Aboriginal people in Canada live through a continuous and focused effort.”⁶⁷</p>	Education and empowerment Leadership Advocacy Support Research Knowledge dissemination	Aboriginal strategy on HIV/AIDS Diagnosis and care of HIV in Aboriginal women and youth HIV/AIDS prevention Harm reduction Strengthening Aboriginal community-based research capacity Cultural safety Community readiness

⁶⁶ <http://www.caan.ca/about/mission/>

⁶⁷ Ibid.

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
First Nations Environmental Health Innovations Network (FNEHIN) Assembly of First Nations 473 Albert St. Ottawa, ON, K1R 5B4 Tel: (613) 241-6789 TF: 1-866-869-6789 Email: environment@afn.ca Web: www.fnehin.ca Twitter: @FNEHIN	<i>Mission:</i> “provides information to assist First Nation communities to participate in environmental health research and to address their environmental health concerns.” ⁶⁸	Networking Communication Research and funding information dissemination Support program development	Aboriginal traditional knowledge Research ethics and protocols
First Nations Health Managers Association (FNHMA) 300 March Rd., Suite 202 Ottawa, ON, K2K 2E2 Web: www.fnhma.ca Twitter: @FNHMA	<i>Mission:</i> “The FNHMA provides leadership in First Nation health management activities by developing and promoting quality standards, practices, research, certification, networking and professional development to expand capacity for our members and First Nations.” ⁶⁹ <i>Vision:</i> “The FNHMA recognizes that First Nations Health Managers are leaders who honour, maintain and uphold inherent ways of knowing while balancing management principles to bring excellence to their communities and health programs.” ⁷⁰	Professional development Networking Research	Leadership Health management services Ethics and cultural awareness Quality standards and best practices

⁶⁸ <http://www.fnehin.ca/>

⁶⁹ <http://www.fnhma.ca/>

⁷⁰ Ibid.

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
Indigenous Physicians Association of Canada (IPAC) 305 - 323 Portage Ave Winnipeg, MB, R3B 2C1 Tel: 204-219-0099 Fax: 204-940-2560 Email: info@ipac-amic.org Web: www.ipac-amic.org	<p>Mission: "As Indigenous physicians and students, diversely rooted in our traditional teachings and our respective communities, IPAC embraces and commits to the responsibility to work together to use our skills, abilities and experiences to advance the health of our nations, communities, families and individuals."⁷¹</p> <p>Vision: "IPAC holds a vision of healthy and vibrant Indigenous nations, communities, families and individuals, who are supported by an abundance of well-educated, well-supported Indigenous physicians working with those who contribute to the physical, mental, emotional and spiritual well-being of our peoples and communities which has a positive impact on the social determinants of health."⁷²</p>	Personal and professional development Mentoring/networking Policy influence Advocacy Monitoring Curriculum development and standards Provide knowledge and resources Medical workforce development	Recruitment and retention strategies Indigenous knowledge and knowledge translation Culturally safe care Social determinants
National Aboriginal Circle Against Family Violence (NACAFV) Kahnawake Business Complex P.O. Box 2169 Kahnawake, QC, J0L 1B0 Tel: (450) 638-2968 Fax: (450) 638-9415 Web: www.nacafv.ca	<p>Mandate: "Initiate, design and deliver culturally appropriate programs and services to address family violence and to support shelters and family violence prevention centres."⁷³</p>	Gather information Promote awareness Advocate Support Education	Culturally appropriate programs and services Best practices

⁷¹ <http://ipac-amic.org/who-we-are/our-mission>

⁷² <http://ipac-amic.org/who-we-are/our-vision>

⁷³ <http://nacafv.ca/en/mandate>

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
National Aboriginal Council of Midwives (NACM) 59 Riverview Montréal, QC , H8R 3R9 Tel: (514) 807-3668 Fax: (514) 738-0370 Web: www.aboriginalmidwives.ca	<p>Mission: "to promote excellence in reproductive health care for Inuit, First Nations, and Métis women. We advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities, consistent with the U.N. Declaration on the Rights of Indigenous Peoples."⁷⁴</p> <p>Vision: "Aboriginal midwives working in every aboriginal community."⁷⁵</p>	Advocacy Networking Support Resource development and circulation	Maternal/infant health Promote education Restoration of birthing choice Uphold core values Improve birthing and health outcomes
National Aboriginal Diabetes Association (NADA) B1-90 Garry St. Winnipeg, MB, R3C 4H1 Tel: (204) 927-1220 Fax: (204) 927-1222 TF: 1-877-232-6232 Email: diabetes@nada.ca Web: www.nada.ca Twitter: @nadasugarfree	<p>Mission: "to be the driving force in addressing diabetes and Aboriginal people as a priority health issue by working together with people, Aboriginal communities and organizations in a culturally respectful manner in promoting healthy lifestyles among Aboriginal people today and for future generations."⁷⁶</p> <p>Vision: "diabetes-free people"⁷⁷</p>	Advocacy Education Support Promoting healthy lifestyles Disseminate research and resources	Healthy eating Foot care Mental health Healthy living Prevention Complications Youth outreach and leadership
National Aboriginal Health Organization (NAHO) Web: www.naho.ca	Closed on June 29, 2012 due to loss of all Health Canada funding. Website will remain available until December 22, 2017. ⁷⁸		

⁷⁴ <http://www.aboriginalmidwives.ca/>

⁷⁵ <http://www.aboriginalmidwives.ca/about>

⁷⁶ <http://www.nada.ca/>

⁷⁷ <http://www.nada.ca/about/about-nada/>

⁷⁸ <http://www.naho.ca/media-centre/>

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
National Indian and Inuit Community Health Representative Organization (NIICHO) P.O. Box 1019 1 Roy Montour Lane Kahnawake, QC, J0L 1B0 Tel: (450) 632-0892, ext. 224 Fax: (450) 632-2111 Email: niichro@niichro.com Web: www.niichro.com	Goals: "To upgrade the quality of health care of First Nation and Inuit people to the standard of health enjoyed by the rest of the population of Canada; to provide a forum for CHRs to communicate and exchange information with each other on various community health initiatives and on the improvement of the CHR program at national level; to create and promote awareness and understanding of the CHR program in Canada; to provide a mechanism and a means for advising First Nations and Inuit communities, First Nations and Inuit Health Branch (FNIHB), Health Canada and others on all matters pertaining to CHRs." ⁷⁹	Information Exchange Advisory Role Development of training resources	Tobacco control Aboriginal health human resources Physical activity/ nutrition
National Native Addictions Partnership Foundation (NNAPF) Main Office, Box 183 Muskoday, SK, S0J 3H0 Tel: (306) 763-4714 Fax: (306) 763-5993 TF: 1-866-763-4714 Email: info@nnapf.org Web: www.nnapf.com Twitter: @NNAPF	Mission: "NNAPF commits to working with Inuit and First Nations in furthering the capacity to address addictions and related issues." Vision: "Cultivating and empowering relationships that connect us to our cultural strengths and identity within holistic and healthy communities." Mandate: "NNAPF is the national voice advocating for Inuit and First Nations culturally-based addictions services." ⁸⁰	Networking Research and Development Best Practices Training Communications Resources/capital Continuum of Care	Cultural competency and safety Holistic health Underlying determinants Participatory and self-directed care Indigenous culture as an intervention Human resources issues

⁷⁹ <http://www.niichro.com/2004/?page=history&lang=en>

⁸⁰ http://nnapf.com/?page_id=879

Table 63: National Aboriginal health organizations (continued)

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
Native Mental Health Association of Canada (NMHAC) P.O. Box 242 Chilliwack, BC, V2P 6J1 Tel: (604) 793-1983 Fax: (604) 793-4557 Email: info@nmhac.ca Web: www.nmhac.ca	<p>Mission: "The NMHAC builds on knowledge, history, legacy, aspirations and the spirit of First Nations, Inuit and Métis to foster and promote wellness and whole health of all peoples."⁸¹</p> <p>Vision: "A Canada where First Nations, Inuit, and Métis people and communities embrace physical, emotional, mental and spiritual health and wellness, while maintaining their diverse cultural and traditional values and beliefs, so we may share the same social justice and economic opportunities as all other Canadians."⁸²</p> <p>Lost national conference funding in 2012.⁸³</p>	Education at all levels Leadership Collaboration Advocacy Research	Underlying contributors to addictions Best practices Cultural competence and safety Holistic health and prevention Family restoration Self-determination and self-management
Native Youth Sexual Health Network (NYSHN) 2345 Yonge St. PO Box 26069 Broadway Toronto, ON, M4P 0A8 Web: www.nativeyouthsexualhealth.com Twitter: @NYSHN	<p>Mission: Guided by principles of youth empowerment, cultural safety, reproductive justice, sex positivity, and healthy sexuality, NYSHN works with youth, service providers, media, organizations, adults, and Elders to "advocate for and build strong, comprehensive, and culturally safe sexuality and reproductive health, rights, and justice initiatives" in Indigenous communities in Canada and the United States.⁸⁴</p>	Advocacy Education Peer support Programming Policy	Culturally safe sex education Rites of passage and traditional knowledge Healthy relationships Harm and violence prevention Pregnancy options, youth parenting Two-spirited and LGBTTIQQA advocacy STD's and HIV/AIDS Sex trade

⁸¹ <http://www.nmhac.ca/>

⁸² Ibid.

⁸³ Ibid.

⁸⁴ <http://nativeyouthsexualhealth.com/whatwedo.html>

Table 64: Federal government organizations

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
Aboriginal Affairs and Northern Development Canada (AANDC) Room 1415 Les Terrasses de la Chaudière, 10 Wellington St. Hull, QC, K1A 0H4 Tel: (819) 997-0380 Email: InfoPubs@aadnc-aandc.gc.ca Web: www.aadnc-aandc.gc.ca Twitter: @AANDCanada	<p>Formerly called, and still legally known as, Department of Indian Affairs and Northern Development (DIAND), formerly Indian and Northern Affairs Canada (INAC).⁸⁵</p> <p>Vision: “a future in which First Nations, Inuit, Métis and northern communities are healthy, safe, self-sufficient and prosperous – a Canada where people make their own decisions, manage their own affairs and make strong contributions to the country as a whole.”⁸⁶</p> <p>Mandate: support First Nations, Inuit, Métis, and Northerners to “improve social well-being and economic prosperity; develop healthier, more sustainable communities; and participate more fully in Canada’s political, social and economic development.”⁸⁷</p>	<p>Funding</p> <p>Delivering programs</p> <p>Regulation</p> <p>Legislation</p> <p>Consultation</p> <p>Planning</p> <p>Directing research and other activities</p> <p>Education and knowledge dissemination</p>	<p>Safe water</p> <p>Early childhood development</p> <p>Housing</p> <p>Family violence</p> <p>Disability assistance</p> <p>Contaminants in traditionally harvested foods</p> <p>Food security</p> <p>Pandemic preparedness</p> <p>H1N1</p> <p>Climate change</p>
First Nations and Inuit Health Branch (Health Canada) (FNIHB, HC) Health Canada Jeanne Mance Building Tunney’s Pasture Postal Locator 1921A Ottawa, ON, K1A 0K9 Tel: (613) 957-7701 TF: 1-866-225-0709 Email: info@hc-sc.gc.ca Web: www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index-eng.php	<p>Mission: “supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It also provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence. The Branch also provides primary care services on-reserve in remote and isolated areas, where there are no provincial services readily available.”⁸⁸</p> <p>Mandate: “ensure the availability of, or access to, health services for First Nations and Inuit communities; assist First Nations and Inuit communities [to] address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and build strong partnerships with First Nations and Inuit to improve the health system.”⁸⁹</p>	<p>Provide/manage services</p> <p>Strategic planning</p> <p>Funding</p> <p>Developing capacity</p> <p>Community-based programming</p> <p>Manage NIHB benefits</p> <p>Provide leadership and expertise</p> <p>Support and consultation</p>	<p>Manage cost-effective delivery of services within fiscal limits</p> <p>Transfer existing health resources to First Nations and Inuit control</p> <p>Support action on health status inequalities</p> <p>Establish renewed relationship with First Nations and Inuit people</p>

⁸⁵ <http://www.aadnc-aandc.gc.ca/eng/1314808945787/1314809172051>

⁸⁶ <http://www.aadnc-aandc.gc.ca/eng/1100100010023/1100100010027>

⁸⁷ Ibid.

⁸⁸ <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index-eng.php>

⁸⁹ <http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/mandat-eng.php>

Table 64: Federal government organizations (continued)

Organization	Mission/Vision/Mandate/ Objectives	Scope/Role	Relevant/Current Priorities/ Strategies
<p>Institute of Aboriginal Peoples' Health (Canadian Institutes of Health Research) (IAPH, CIHR)</p> <p>Simon Fraser University 11012 Blusson Hall Faculty of Health Sciences 8888 University Drive Burnaby, BC, V5A 1S6</p> <p>TF: 1-888-603-4178</p> <p>Email: info@cihr-irsc.gc.ca Web: http://cihr-irsc.gc.ca/e/8668.html Twitter: @CIHR_IRSC</p>	<p>Vision: "CIHR-IAPH will strive to improve the health of First Nations, Inuit and Métis people by supporting innovative research programs based on scientific excellence and aboriginal community collaboration."⁹⁰</p> <p>Mission: "CIHR-IAPH will play a lead role in building research capacity in the First Nations, Inuit and Métis communities, and will support partnerships and alliances between aboriginal communities and non-aboriginal health research organizations/institutes at the local, regional, nation and international levels. CIHR-IAPH supports health research that respects aboriginal cultures, while generating new knowledge to improve the health and well-being of aboriginal people."⁹¹</p>	<p>Stimulate research through funding, collaboration, and leadership</p> <p>Knowledge translation</p> <p>Advancing capacity and infrastructure</p> <p>Evaluate funding applications</p> <p>Training for aboriginal researchers</p> <p>Support for graduate students</p>	<p>Culturally relevant health promotion</p> <p>Health advantage and health risk factors</p> <p>Health determinants</p> <p>Disease, injury, and disability prevention</p> <p>Addiction and mental health</p> <p>Appropriate health policies and health systems</p> <p>Causal factors for health conditions</p> <p>Clinical trials</p> <p>Health services research</p> <p>International research</p> <p>Ethics issues⁹²</p>
<p>Statistics Canada</p> <p>150 Tunney's Pasture Driveway Ottawa, ON, K1A 0T6</p> <p>Tel: (613) 951-8116 Fax: (613) 951-0581 TF: 1-800-263-1136</p> <p>Email: infostats@statcan.gc.ca Web: www.statcan.gc.ca Twitter: @StatCan_eng</p>	<p>Mission: "produces statistics that help Canadians better understand their country—its population, resources, economy, society and culture."⁹³</p> <p>Health Analysis Division (HAD) Mandate: "to provide high quality, relevant, and comprehensive information on the health status of the population and on the health care system. The information is designed for a broad audience that includes health professionals, researchers, policy-makers, educators, and students."⁹⁴</p>	<p>Data collection and surveys</p> <p>Research</p> <p>Analysis</p> <p>Dissemination</p>	<p>Health care access</p> <p>Social determinants</p> <p>Mental health</p> <p>Chronic disease</p> <p>Injury</p> <p>Vulnerable populations including Aboriginal peoples</p>

⁹⁰ <http://cihr-irsc.gc.ca/e/27062.html>

⁹¹ Ibid.

⁹² <http://cihr-irsc.gc.ca/e/27069.html>

⁹³ <http://www.statcan.gc.ca/about-apercu/about-apropos-eng.htm>

⁹⁴ <http://www.statcan.gc.ca/pub/82-003-x/2011004/had-das-eng.htm>

Table 65: Other organizations/agencies that do health-related research with Aboriginal Peoples

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
Active Circle Aboriginal Sport Circle Motivate Canada: 11 Rosemount Ave., Suite 408 Ottawa, ON, K1Y 4R8 Tel: (613) 789-3333 Web: www.activecircle.ca Twitter: @ActiveCircle	Mission: <ul style="list-style-type: none"> • Support Aboriginal youth and communities to become vibrant, active, and healthy through sport and recreation. • Work with program, funding, and government partners to develop a single means of engagement with communities to alleviate the administrative burden on communities and leaders. • Make long-term commitments to communities to develop, deliver, and sustain sport and recreation programs by providing funding, human resources, and training. • Develop and support programs that are designed by the community to address their specific needs. • Provide skill development and experience for Aboriginal youth and community leaders.⁹⁵ 	Support Funding Providing resources Skill development	Provide information and resources Support development of meaningful programs Inspire leaders to start programs in their own communities
Centre for Aboriginal Health Research (CAHR) University of Victoria P.O. Box 1700, STN CSC Victoria, BC, V8W 2Y2 Tel: 250-472-5456 Fax: 250-472-5450 Email: cahr@uvic.ca Web: http://www.uvic.ca/research/centres/cahr/home/index.php Twitter: @CAHR_UVic	Mission: aims to promote the health and well being of First Nations, Inuit and Métis Peoples whose health disparities require urgent attention. The Centre provides a physical and interdisciplinary intellectual environment for research, training and for the generation and dissemination of basic and applied knowledge. It focuses on the strengths, challenges, opportunities and problems of Aboriginal Peoples' and the societal structures and institutions that affect them. The Centre fosters Aboriginal contributions to society through research that values First Nations, Inuit, and Métis culture, community collaboration, experience and knowledge and world views. ⁹⁶ Goal: To promote and advance population health research, knowledge translation, interdisciplinary training and advocacy related to the health and well being of Aboriginal peoples' and the circumstances that affect them. ⁹⁷	Research Capacity building Knowledge translation Students support Advocacy	Aboriginal knowledge in health research Cultural competency Seniors fall prevention Community-based research Drinking water quality Health human resources

⁹⁵ <http://www.activecircle.ca/en/aboutus>

⁹⁶ <http://www.uvic.ca/research/centres/cahr/about/home/mission/index.php>

⁹⁷ Ibid

Table 65: Other organizations/agencies that do health-related research with Aboriginal Peoples (continued)

Organization	Mission/Vision/Mandate/Objectives	Scope/Role	Relevant/Current Priorities/Strategies
<p>Centre for Indigenous Peoples' Nutrition and Environment</p> <p>c/o McGill University Macdonald Campus 21111 Lakeshore Road Ste-Anne-de-Bellevue, QC H9X 3V9</p> <p>Tel: (514) 398-7757</p> <p>Web: www.mcgill.ca/cine</p>	<p>Mission: "In concert with Indigenous Peoples, CINE will undertake community-based research and education related to traditional food systems. The empirical knowledge of the environment inherent in Indigenous societies will be incorporated into all its efforts."⁹⁸</p>	<p>Research Knowledge dissemination Training of researchers Information exchange Education</p>	<p>Traditional knowledge and food systems Nutrition and environment Community-based and participatory research Research ethics and intellectual property rights</p>
<p>National Collaborating Centre for Aboriginal Health (NCCAH)</p> <p>University of Northern British Columbia 3333 University Way Prince George, BC, V2N 4Z9</p> <p>Tel: (250) 960-5986 Fax: (250) 960-5644</p> <p>Email: nccah@unbc.ca Web: www.nccah-ccnsa.ca Twitter: @NCCAH_CCNSA</p>	<p>Mission: "The NCCAH will pursue its vision through knowledge synthesis, translation and exchange and the creation and fostering of linkages among First Nations, Inuit and Métis peoples and communities, stakeholders, the population and public health community, and researchers."⁹⁹</p> <p>Mandate: "The NCCAH supports a renewed public health system in Canada that is inclusive and respectful of First Nations, Inuit and Métis peoples. Using a holistic, co-ordinated and strengths-based approach to health, the NCCAH fosters links between evidence, knowledge, practice and policy while advancing self-determination and Indigenous knowledge in support of optimal health and well-being."¹⁰⁰</p> <p>Vision: "The optimal health and well-being for First Nations, Inuit and Métis peoples will be achieved through a population health framework addressing structure and policy, and through public health systems that are inclusive and respectful of First Nations, Inuit and Métis peoples. These will advance self-determination over health and well-being, and be strengthened by the cultures and knowledge of First Nations, Inuit and Métis peoples."¹⁰¹</p>	<p>Research Knowledge synthesis, translation, dissemination, and exchange Education Networking Partnerships Production of tools and resources</p>	<p>Child and Youth Health Indigenous Knowledge Social Determinants of Health Emerging Public Health Priorities Aboriginal Health Policies</p>

⁹⁸ <http://www.mcgill.ca/cine/about>

⁹⁹ http://nccah-ccnsa.ca/317/Mandate__Vision_and_Mission.nccah

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

Table 65: Other organizations/agencies that do health-related research with Aboriginal Peoples (continued)

Organization	Mission/Vision/Mandate/Objectives	Relevant/Current Priorities/Strategies
Network Environments for Aboriginal Health Research (NEAHRs)	<p>Mission: NEAHR centres (formerly ACADRE centres) “focus solely on exploring critical aboriginal health issues and are the initial links in a developing network of centres across Canada responsible for developing the next generation of aboriginal health researchers and for focused research efforts on determinants of health in aboriginal communities.”¹⁰²</p> <p>Objectives: pursue scientific knowledge based on international standards of research excellence; advance capacity and infrastructure; provide the appropriate environment for scientists to pursue research opportunities in partnership with aboriginal communities; provide opportunities for aboriginal communities and organizations to collaboratively identify research objectives; facilitate the rapid uptake of research results; provide an appropriate environment and resources to encourage aboriginal and non-aboriginal students to pursue careers in Aboriginal health research.¹⁰³</p> <p>There are seven regional organizations and two national organizations across Canada, outlined below.</p>	Each centre has its own areas of focus (see below)
		Scope/Role <ul style="list-style-type: none"> Research Knowledge dissemination Infrastructure development Human resource development
1. Alberta NEAHR Edmonton, AB Tel: (780) 492-1827 Fax: (780) 492-2024 Email: abneahr@ualberta.ca Web: www.neahr.ualberta.ca	The research goals of the Alberta Network (formerly Alberta ACADRE Network) evolve in a responsive manner through collaborative community partnerships and research requests. ¹⁰⁴	Traditional knowledge and ethics; northern community environmental health; access to health services

¹⁰² <http://cihr-irsc.gc.ca/e/27071.html>

¹⁰³ Ibid.

¹⁰⁴ Ibid.

Table 65: Other organizations/agencies that do health-related research with Aboriginal Peoples (continued)

Organization	Mission/Vision/Mandate/Objectives	Relevant/Current Priorities/Strategies
2. Anishnawbe Kekendazone (AK-NEAHR), Ottawa, ON Tel: (613) 562-5393 Fax: (613) 562-5392 Email: neahr-iph@ciet.org Web: http://akneahr.ciet.org	One of two national NEAHRs, AK-NEAHR aims to build capacity for health research and planning in Aboriginal communities across Canada by supporting Aboriginal health researchers and encouraging strong community leadership and participation in all research initiatives. ¹⁰⁵	Perinatal health; youth at risk and resilience; knowledge translation; gender and family violence; diabetes prevention and traditional foodways
3. Atlantic Aboriginal Health Research Program (AAHRP) Halifax, NS Tel: (902) 897-9199 Fax: (902) 494-1653 Email: aahrp@Dal.Ca Web: www.dal.ca (search AAHRP)	The Atlantic region-wide program fosters community-generated Indigenous research. ¹⁰⁶	Prevention (smoking and alcohol use); mental health and addictions; determinants of health (housing, income, cultural and spiritual factors)
4. Kloshe Tillicum Vancouver, BC Web: www.kloshetillicum.ca	Formerly British Columbia NEAHR (NEAHRBC) and NEAHR British Columbia Western Arctic (NEAHRBCWA), Kloshe Tillicum: Healthy People/Healthy Relations is the British Columbia and Yukon Territory NEAHR. Its goal is to build Aboriginal capacity in health research by linking the academics, students, and communities who are conducting Aboriginal research. ¹⁰⁷	Indigenous knowledge including traditional medicine; complex interactions determining population health; infectious disease; aboriginal research ethics
5. Manitoba First Nations Centre for Aboriginal Health Research (MFN CAHR) Winnipeg, MB Tel: (204) 789-3250 Fax: (204) 975-7783 Web: www.umanitoba.ca/centres/cahr	MFN CAHR initiates, conducts, and supports research programs to integrate scientific, indigenous, and transformative research and evaluation methodologies to produce new knowledge about the health and wellbeing of indigenous peoples. ¹⁰⁸	Population health; health services; child health and development; ethical issues in Aboriginal health research; biomedical-genetics; health information systems

¹⁰⁵ <http://akneahr.ciet.org/>

¹⁰⁶ <http://cihr-irsc.gc.ca/e/27071.html>

¹⁰⁷ <http://www.kloshetillicum.ca/about/who-we-are/>

¹⁰⁸ http://umanitoba.ca/faculties/medicine/units/community_health_sciences/departamental_units/cahr/about/6694.html

Table 65: Other organizations/agencies that do health-related research with Aboriginal Peoples (continued)

Organization	Mission/Vision/Mandate/Objectives	Relevant/Current Priorities/Strategies
6. Indigenous Health Research Development Program (IHRDP), Ohsweken, ON Tel: (519) 445-0023 ext. 236 Web: www.ihrdp.ca	The IHRDP will assist with building a career structure for students in Aboriginal health research and will focus its resources on community-driven research projects that will identify health-related issues in First Nations communities. ¹⁰⁹	Chronic diseases; mental health of women and children; culture, health, and healing
7. Indigenous Peoples' Health Research Centre, Regina, SK Tel: (306) 337-2461 Fax: (306) 585-5694 Email: wendy.whitebear@uregina.ca Web: www.iphrc.ca Twitter: @IPHRCsask	IPHRC is a collaboration between the University of Regina, First Nations University of Canada, and the University of Saskatchewan, and is primarily focussed on building capacity in community-based health research among Aboriginal people through trainee support and promoting research in Aboriginal health. ¹¹⁰	Chronic diseases; nutrition and lifestyle; Indigenous healing (addiction, FAS, mental health, judicial system); health delivery and control (ethics, community development and governance); prevention and environmental health
8. Nasivvik Centre for Inuit Health and Changing Environments Peterborough, ON Tel: (705) 748-1011, ext. 7242 Fax: (705) 748 1416 Web: www.nasivvik.ulaval.ca	The Nasivvik Centre (formerly Université Laval NEAHR) is investigating the complex interactions which determine the health of individuals and communities in the four Inuit regions of the Canadian North: Nunatsiavut, Nunavik, Nunavut, and the Inuvialuit Settlement Region. ¹¹¹	Environmental health in the key areas of food, water, and traditional and natural medicines and remedies
9. National Network for Aboriginal Mental Health Research (NAMHIR) Montreal, QC Tel: (514) 340-8222, ext. 5244 Fax: (514) 340-7503 Web: www.namhr.ca	NAMHIR is a network of researchers from across Canada committed to building capacity for mental health and additions research and knowledge translation in remote, rural, and urban settings by working in close partnership with Aboriginal organizations and communities. ¹¹²	Develop research capacity Networking and training Pilot projects Culturally responsive research Role of cultural continuity and discontinuity Mental health services Best practices

¹⁰⁹ <http://www.ihrdp.ca/our-centre/objectives/>

¹¹⁰ <http://cihr-irsc.gc.ca/e/27071.html>

¹¹¹ <http://cihr-irsc.gc.ca/e/27071.html>

¹¹² <http://www.namhr.ca/>

APPENDIX B: Non-exclusive topic categories

Table 66: Non-exclusive topic categories		
Top-level Category	Main Topic Area	Subtopics
Health Care	1) Health care research, policy, human resources, programming, and delivery	<p>Research (including methodologies, community involvement, culturally appropriate research, ethics, health data, data governance, disaggregation, and knowledge translation and exchange)</p> <p>Policy</p> <p>Human resources (including leadership, recruitment, retention, careers)</p> <p>Access to and use of health care services</p> <p>Cultural competency and safety</p> <p>Holistic health care</p> <p>Jurisdictional & insurance issues (e.g. Jordan's Principle, non-insured benefits, HSIF)</p> <p>Traditional knowledge, medicines, and approaches to healing & health</p> <p>Aboriginal-controlled and participatory health care services</p> <p>Preventive care/health promotion/public health services (including immunization)</p> <p>Diagnostic services/screening/surveillance</p> <p>Curative services, intervention and treatment programs (incl. addictions programs)</p> <p>Hospitalization</p> <p>Rehabilitation</p> <p>Care-giving/support</p> <p>Parenting supports & resources</p> <p>Family violence programs & supports</p> <p>Program evaluation</p> <p>Best/promising practices</p> <p>Psychology/psychiatry/counseling services</p> <p>Senior's housing and care</p> <p>Other</p>
	2) Genetics human biology	
Health Determinants	3) Lifestyle healthy living	<p>Diet and nutrition, including traditional foods</p> <p>Physical activity</p> <p>Tobacco use (including smoking cessation, second hand smoke)</p> <p>Sexual health (including reproductive health, body image, sexuality, two-spirited people)</p> <p>Gambling</p> <p>Physical safety (e.g. in 'risky' activities such as hunting)</p> <p>Other</p>

Table 66: Non-exclusive topic categories (continued)

Top-level Category	Main Topic Area	Subtopics
Health Determinants Continued	4) Socio-economic and cultural determinants	<p>Food security (including access and costs)</p> <p>Community and family relationships (including parenting & father involvement)</p> <p>Culture and language</p> <p>Spirituality</p> <p>Economic status (including income, employment, poverty, and economic development)</p> <p>Housing and homelessness</p> <p>Colonialism (including residential schools & treaties)</p> <p>Discrimination and social exclusion</p> <p>Education and literacy (incl. school readiness & success)</p> <p>Self-government/self-determination/rights</p> <p>Resilience (related to socio-economic and cultural environment)</p> <p>Other</p>
	5) Environmental health (WHO definition: “all physical, chemical, & biological factors external to a person”)	<p>Indoor and built environment</p> <p>Outdoor/natural environment</p> <p>Interconnectedness of land and people</p> <p>Land use (incl. resources & extraction)</p> <p>Toxicology (including environmental contamination and safe drinking water)</p> <p>Climate change</p> <p>Environmental impact assessment & planning</p> <p>Other</p>
Health Status	6) Chronic disease	<p>Diabetes</p> <p>Cancer</p> <p>Kidney/liver disease</p> <p>Cardiovascular disease</p> <p>Arthritis</p> <p>Neurological disorders (including multiple sclerosis, epilepsy)</p> <p>Obesity</p> <p>Aging diseases (including dementia, Alzheimer’s)</p> <p>Other</p>

Table 66: Non-exclusive topic categories (continued)

Top-level Category	Main Topic Area	Subtopics
Health Status Continued	7) Communicable disease	<ul style="list-style-type: none"> HIV/AIDS Tuberculosis Hepatitis (B, C, and/or E) Influenza (incl. H1N1) Sexually transmitted diseases (STD's, incl. HPV) West Nile Virus (WNV) Other
	8) Maternal, fetal, and infant health	<ul style="list-style-type: none"> Maternal health (including prenatal care, pregnancy options) Fetal health Birthing and midwifery Birth outcomes Breastfeeding and infant nutrition Infant health Fetal alcohol syndrome(FAS) and fetal alcohol spectrum disorder (FASD) Other
	9) Child and youth health	<ul style="list-style-type: none"> General health Children's rights Otitis media (middle ear infection) Childhood illnesses Vision health Oral/dental health Respiratory health (including asthma, allergies, chronic obstructive pulmonary disease (COPD), bronchitis, and pneumonia) Hearing Child welfare Youth welfare Early childhood development Learning disabilities Other

Table 66: Non-exclusive topic categories (continued)

Top-level Category	Main Topic Area	Subtopics
Health Status Continued	10) Mental health and wellness (including addictions and suicide)	<p>Suicide/self-injury prevention</p> <p>Psychological trauma (including intergenerational)</p> <p>Stress</p> <p>Depression</p> <p>Psychosis</p> <p>Eating disorders</p> <p>Addictions (other than tobacco)</p> <p>Sleeping disorders</p> <p>Stigma around mental health issues</p> <p>Personal/psychological resilience</p> <p>Other</p>
	11) Violence, injury, and abuse	<p>Partner/family violence</p> <p>Child abuse and neglect</p> <p>Sexual violence and abuse</p> <p>Elder abuse</p> <p>Accidental injury and trauma (and prevention)</p> <p>Justice system</p> <p>Other</p>
	12) General health status reports	<p>Life expectancy and mortality</p> <p>General health inequities</p> <p>Other</p>
	13) Other	<p>Gender</p> <p>Gastrointestinal</p> <p>Disability (cognitive or physical, except child/youth learning disabilities)</p> <p>Adult oral health</p> <p>Adult respiratory health (including asthma)</p> <p>Adult vision health</p> <p>Bone mass/density and joints</p> <p>Other</p>



APPENDIX C: Peer-reviewed literature

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