A FRAMEWORK FOR INDIGENOUS SCHOOL HEALTH:

Foundations in Cultural Principles

NATIONAL COLLABORATING CENTRE FOR ABORIGINAL HEALTH

CENTRE DE COLLABORATION NATIONALE DE LA SANTÉ AUTOCHTONE

A collaborative project by
the National Collaborating Centre for Aboriginal Health,
the Canadian Council on Learning Knowledge Centre on Aboriginal Learning
and the Canadian Association for School Health

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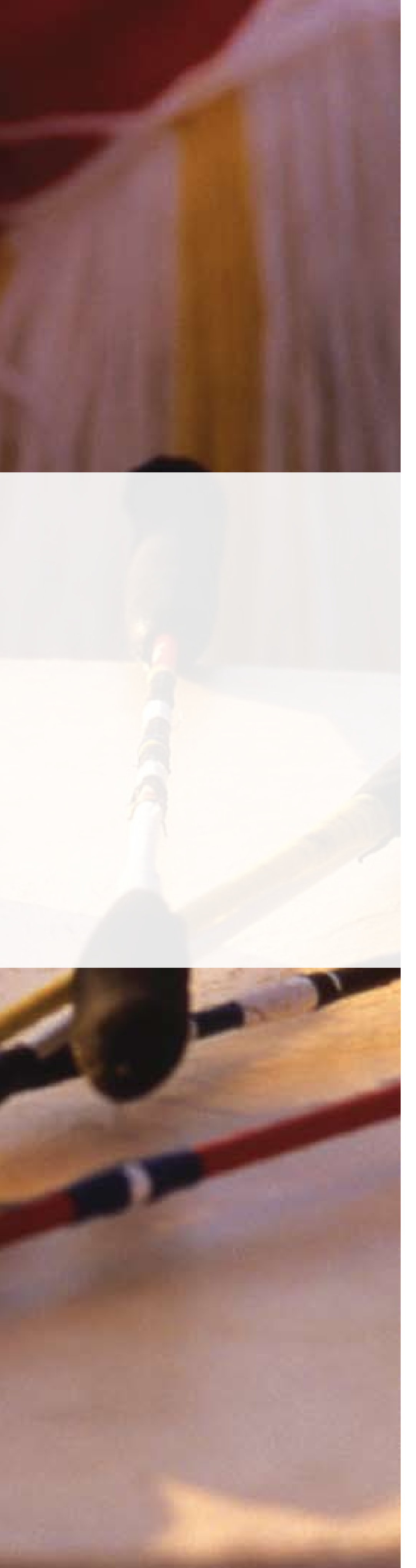

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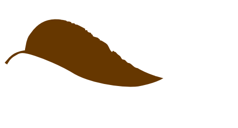

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THE CONTEXT

School health programs and approaches were initially developed in Europe, Canada, the United States of America and the Western Pacific in response to their respective dominant, western cultures and traditions. Over the past several years, there have been many excellent school health approaches adopted by jurisdictions that are making significant impacts in schools. Although these comprehensive school health strategies are intended to be holistic and rooted in the local context of the schools and communities in which they are implemented, research and practice has shown that current school health programs are not sufficiently relevant to, or appropriate for, the cultures and contexts of Indigenous regions, schools and students to result in improved health status.

Much of this mismatch stems directly from the basic differences in conceptualizing health between Indigenous and mainstream populations. In fact, most Indigenous[1] health services and programs, including school health curricula, are focused on issues of ill health, rather than a holistic approach to wellness. As well, funding for new health programs is generally targeted at specific health issues and does not follow an inclusive focus. The National Collaborating Centre for Aboriginal Health reminds us that:

[1] For the purposes of this document, the terms Aboriginal and Indigenous are both used to signify a first people population.

"The year 2006 marked the 60th anniversary of the adoption of the World Health Organization's Constitution, a document containing one of the most influential modern definitions of health:

'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'" - (NCCAH, 2006:18).

Although one would hope that after 60 years this view of health, even for the mainstream, is changing, in practice still the pervasive educational and medical frameworks that have been used to define Indigenous health and programs tend not to represent this holistic worldview of health and wellness; a shift in focus is needed. As well, many of the funding sources and new focuses for both research and programming continue to be issue-specific.

For Indigenous populations, the shift that is needed has always been from the prevention or intervention of a disease or illness to a focus on care for the whole individual. This approach must be grounded in the core values and beliefs held within the cultural context of community and environment, respectful of the significant relationships which interconnect all of these, in order to begin to approach a more culturally appropriate mode of practice.

The term "cultural appropriateness" is sometimes used but rarely defined. It is taken here to mean the delivery of programs and services that are consistent with the communication styles, meaning systems and social networks of clients, or programme participants, and other stakeholders (Thomas, 2002:2).

In order to begin to address school health for Indigenous populations in a culturally appropriate manner, it is necessary to ensure that the process is grounded in an understanding of Indigenous philosophies, specifically worldviews, and to address the divergences between those approaches and mainstream assumptions.

Essential cultural differences can be found in the basic ideas that drive school health programs. For example, the western cultural view of "health" is as a personal possession – a resource for daily living, while most Indigenous cultures define health as a set of relationships and responsibilities held across a continuum, and which include the environment, families, the tribe and ancestors. The challenge facing health educators and practitioners today is one of decolonizing existing curricula and programs so there is a cultural fit for the Indigenous client.

Colonizing involves a relationship which leaves one side dependent on the other to define the world. At the individual level, colonialism involves a situation where one individual is forced to relate to another on terms unilaterally defined by the other (McCaskill, 1983:289).

These different cultural orientations can have significant impacts on programs. For example, a stay-in-school program was initiated in one northern Canadian territory which provided targeted support to pregnant teens. Although the program was based on some very successful southern models, few pregnant Inuit teens became involved in the program. Healey & Meadows (2008) found that on the topic of teenage pregnancy, Inuit women were considered of marriageable age by mid-teens, therefore teenage pregnancy was a normal occurrence. It is not seen as a negative repercussion for a young woman

to drop out of school to have a child. Neither is the practice of custom adoption, where Inuit families give a child to a family member to raise. Rather, custom adoption is seen as a positive practice that ensures the child's needs are met. Typically, a western approach is to identify a "problem" and then attach the problem from a deficit-focused perspective. Indigenous communities are more likely to focus on the strengths of a situation which will lead to solution seeking in collaborative and consensus-building approaches. These very different paradigms require different frameworks to support practice, planning and policy development. From this standpoint, decolonizing school health approaches requires that programs, policy and practices be grounded in the Indigenous worldview and the reality of the Indigenous contexts for health and wellbeing. As well, the distinctness of Indigenous philosophy must be foundational to the design and development of programs. Essentially, Indigenous programs must be relevant to and owned by the Indigenous community itself.

Indigenous populations are extremely diverse. This diversity lies in both the cultural uniqueness and the specific contexts of place and geography that characterizes a culture. These "differences" are based in the values and beliefs of specific Indigenous peoples. Values define who we are as a people and structure our beliefs and subsequent choices and practices. They have been referred to as cultural ethics or rules of behaviour (Brant, 1990). These values and beliefs are uniquely understood within the specific worldview or distinct philosophy of a people. When the values themselves are identified – such as honesty, sharing, humility, kindness – there is sometimes a tendency to regard these as universal values and therefore, negate the cultural context within which they are applied. This can lead to either a kind of appropriation or denial of the unique aspect of worldview or cultural philosophy. Rather, it is through recognition of the distinctness of worldview that allows us to approach the heart of cultural appropriateness for Indigenous populations.

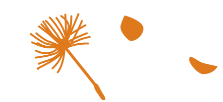
By developing our understanding about these traditional values and their uniqueness within the Aboriginal worldview or 'philosophy,' we might use our knowledge about the past, our understanding about the contemporary realities facing Aboriginal peoples, along with our critically reflective practice skills, to ensure that genuinely supportive services, programming, and resources are designed in ways to meet the needs of Aboriginal parents (NCCAH, 2009a:28).

When we try to examine meaning systems and worldviews for Indigenous populations we find much diversity of specific practices, but also a good deal of consensus. It is the shared elements of ways of knowing and being which can be drawn upon to build a framework for doing Indigenous school health programming differently. In thorough examinations of Indigenous philosophies, the following summarizes the conceptual elements common to most Indigenous worldviews:

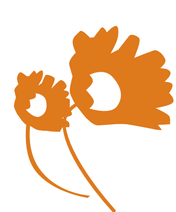
> *Indigenous philosophies are underlain by a worldview of interrelationships between the spiritual, the natural, and the self, forming the foundations or beginnings of Indigenous ways of knowing and being. ...The foundations of Indigeneity, then, are comprised, in part, of values that privilege interrelationships among the spiritual, the natural and the self; reflect a sacred orientation to place and space; encompass a fluidity of knowledge exchanged between past, present and future, thereby allowing for a constant and dynamic knowledge growth and change; and honour language and orality as an important means of knowledge transmission (Greenwood, 2005:554).*

It is with this definition of Indigenous worldview that the process of identifying a common framework for school health was undertaken.

Voyageur



PURPOSE OF THE PROJECT



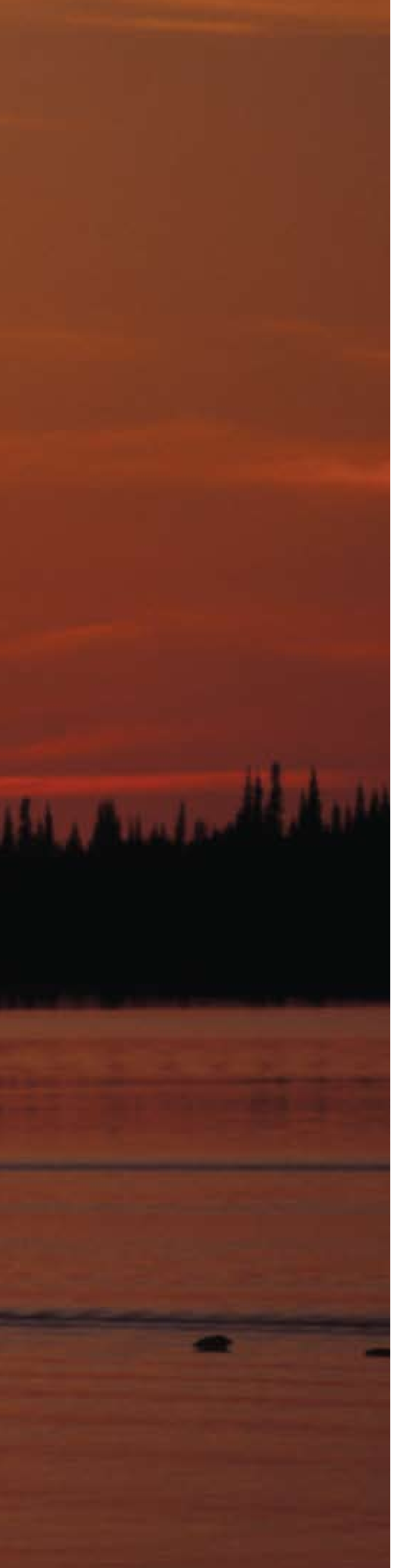
A redesign of school-based and school-linked approaches, programs and practices, suitable for Indigenous communities, must be grounded in the strengths, knowledge, traditions and values of those communities. This redesign process must build on the excellent work already being done in Indigenous communities, and must address the current priorities for school health as identified by the Indigenous communities themselves. The redesign must result in school health initiatives and policies which support all Indigenous children's health, but also reflect the various Indigenous ways of knowing, being and learning. These are the strengths of Indigenous culture and also the protective factors for health and wellness.

Despite the historical and contemporary colonial assaults upon Aboriginal peoples, Waller and Yellow Bird (2002) maintain that insight into Aboriginal culture offers us "a vibrant, colourful tapestry of strengths" (p. 50). ...However, Waller and Yellow Bird (2002) suggest that by providing an overview of the strengths of Aboriginal peoples, we might begin to frame understandings for those working with Aboriginal [peoples] so that they can draw upon existing strengths and discover many more. (NCCAH, 2009a:15).

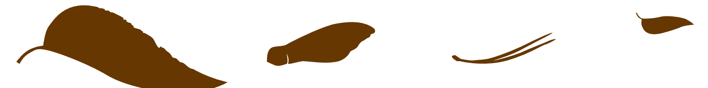
A starting point for the redesign process was to identify the strengths of Indigenous communities which support health and wellness. A strength-based approach includes drawing from the strength of Indigenous communities in areas such as Indigenous knowledge; building on the influential role of elders, extended families, and relationship structures including connections to nature and spirituality. As Jennifer Espey (2002) has stated:

> *Each culture is uniquely suited to produce knowledge of some aspects of our selves, our society and our environments even as each culture is uniquely suited to foster ignorance of other aspects of our selves, our society and our environments. Knowledge cannot be divorced from the culture that creates it. Nor is our culture immune from the affects of our knowledge. Knowledge and culture are co-constructive.*

The purpose of this project was to establish a format through which a dialogue circle approach could be initiated and a co-constructive process could be established that was inclusive of Indigenous voices internationally and which would result in the design of a common framework for school health programming for Indigenous schools and communities. In order to accomplish this, a focus on the common aspects of existing Indigenous frameworks for both health and education was used. From these frameworks, a consultation document was developed and posted on a website where interested contributors could add and build on the concepts, components, and contribute new ideas. As well, face-to-face presentations and discussions took place in several venues in order to shape and validate this on-going work. Various culturally diverse approaches to school health were presented and included work by Maori, Navajo, Seminole, Hawai'ian, Aborigine, Inuit, Métis and First Nation practitioners.



INDIGENOUS FRAMEWORKS



Culture is the social framework for participating in and understanding the world. Every culture has key elements. The first is worldview… (Alberta Education, 2005:10). Worldview permeates all aspects of effective education of Aboriginal students. Worldviews are like stones thrown into the water from which other circles grow (Alberta Education, 2005:vi).

Each Aboriginal group expresses its culture in various ways – a result of geographic circumstances and each group's unique history. At the same time, many Aboriginal peoples throughout North America share similar guiding thoughts and traditional values.

These common threads running through many Aboriginal cultures are sometimes referred to as foundational worldviews. They reflect the guiding principles and traditional values of Aboriginal societies. (Alberta Education, 2005:13).

There are five strong threads common to Aboriginal worldviews:

- a holistic perspective
- the interconnectedness of all living things
- connection to the land and community
- the dynamic nature of the world
- strength in "power with."[2]

Also from an educational perspective, the report *Redefining How Success is Measured in First Nations, Inuit and Métis Learning*, by the Aboriginal Learning Knowledge Centre (2007) has identified these foundations for First Nation, Inuit and Métis learning and education:

[2] "Power with" is conceptualized as a circle where all things come together face-to-face in equal relationship to each other. It is the antithesis of "power over" which is hierarchical relationships. (Alberta Education, 2005:18)

1. Aboriginal peoples view education as holistic, lifelong and essential to their economic livelihood

2. Learning requires both formal and informal opportunities for all ages

3. Land, the knowledge and skills in and from place, language and culture are integral parts of learning and the education process among Aboriginal people

4. Learning development must focus in a holistic manner based on their spiritual, intellectual, emotional and physical selves and acknowledge and foster their gifts and abilities.

These elements are apparent in the three learning frameworks which the Aboriginal Learning Knowledge Centre has developed (www.cclcca.ca/CCL/Reports/RedefiningSuccessInAboriginalLearning). Although each is culturally specific and has some variations, foundationally there are more similarities than not. The four foundations identified above are central to all models. In addition, these models all contain the component of community and the importance of community-owned and directed learning in terms of sustaining cultural vitality and wellness.

The Hawai'ian model for culture-based education has four elements which include beginning with the needs and strengths of the individual, focusing on the cultural context for the learner, establishing the cultural content, and ensuring an integration of spirituality.

A holistic Maori model of educational program delivery is based on the elements of participation, protection and partnership. Participation ensures that Maori governance is in place; protection ensures that there is ownership and self-determining processes are used; and partnership ensures that a holistic approach to programs and services best meets the needs of the communities. The New Zealand government has recently released a new guiding document. Te Aho Matua sets out six conceptual principles which form the framework for Maori education and include language entrenchment, cultural expectations for building character, operationalization of social institutions within Maori traditional practices, dealing with the global aspects which impact the individual, spiritual endowment, and setting out hope for the future through dynamic assessments. These are linked in a balanced approach to the four cornerstones of Maori wellness. These pillars are spiritual, mental, physical, relational. These are foundational to the document, Kura Hauora: Health Promoting Schools, which is focused on a number of key concepts and is being used to ensure cultural embeddedness in all school programs. As well, processes which are supportive of the implementation of this framework are the Holistic Relational Approach which grounds the way in which things are done and the creation of an inclusive school ethos where the context to support implementation is based on shared voices and collective participation across the community. In work by Mihi Ratima (2000) – a Maori-centred approach to health promotion based on the principles of interconnectedness, self-determination, identity, quality, kinship relationships (Whanau), community credibility, has been used very successfully.

The document – *Inuit Qaujimajatuqangit Education Framework for Nunavut Schools* – is also premised on cultural embeddedness. This document outlines four core beliefs which are foundational: working for the common good, respect for all living things, maintaining harmony and balance, and continually preparing for the future. These core beliefs are further articulated through eight guiding principles which are expressed

as cross curricular competencies and are supported by forty key values which are expressed as educational expectations. The term Inuit Qaujimajatuqangit refers to the Inuit worldview. The document describes this as a system of belief which considers the importance of relationship/interconnectedness to the environment/sila and to other people. These critical relationships are embedded within circles of belonging, seasonal changes and of a continuum of life. Taken as a whole, the conceptualization is described as the strengths of the individual.[3]

There are very strong similarities between educational and health-based frameworks for Indigenous communities. In describing the characteristics of Indigenous conceptions of wellness, terms which consistently emerge from the literature include: holistic, respectful, inclusive, collaborative, harmonious, strength-based and enhanced through community. These are the conceptual foundations which programs being implemented in Indigenous communities must engage with and be measured against.

Indigenous health frameworks also identify the four aspects of spiritual, emotional, physical and mental in the medicine wheel, the Sacred Tree and Sacred Circle frameworks.

In the medicine wheel, the four directions are represented—north, east, south, west, and the four colours depict the four human races. The mental, emotional, physical and spiritual aspects of humanness are represented along with the four seasons, the four primary elements of earth, air, fire and water, and the four stages of human life. All of these aspects form the whole of the medicine wheel. While achieving balance requires constant adjustment, Hart (2002) explains that:

> *"[b]alance occurs when a person is at peace and harmony within their physical, emotional, mental and spiritual humanness; with others in their family, community and nation; with all other living things, including the earth and natural world" (As cited in NCCAH, 2009a:29).*

While there is no one version of the medicine wheel, the circle symbolizes the foundational cultural understandings of wholeness, interconnectedness, and balance (NCCAH, 2009a:28).

As well, health and wellness is often described in terms of a lifelong journey which is supported by many gifts and lessons which are culturally described and often involve some sort of rite of passage which leads us to greater self-understanding and deeper respect for the values and cultural practices which support that. For example, spiritual development is also described in terms of four capacities: the capacity for dreams, vision and ideals; the capacity to accept change and the unknown; the capacity to communicate these understandings; and the capacity to translate thoughts into actions. (Lane, 1984:30). The journey itself moves us towards greater wellness and wisdom and it is the journey that is seen as "true learning."

Within Nunavut, a collaboration amongst Nunavut Tunngavik, Health Canada and

[3] Inuuqatigiit: The Curriculum from the Inuit Perspective, p.36.

the Government of Nunavut, resulted in the publication of a document entitled *Working together for the common good: A health integration initiative project for Nunavut.* The document promotes a population health approach which focuses on the interrelated conditions and factors, and presents a health framework which addresses environmental, social, and economic issues, and personal habits and behaviours as determinants of health and well-being amongst Nunavutmiut. In taking this approach, a foundation of Inuit cultural values and principles, a holistic community focus, and ownership of a flexible basket of services which can meet varying needs, will be directed through a community-driven wellness planning process. Similar initiatives are underway in both Australia and New Zealand, which are marked by community ownership, capacity building, and assessment of services against a continuum of cultural competence (Craven & Parente, 2003: Durie, 2004).

Based on the existing literature regarding successful Indigenous wellness approaches, the following synthesis of broad principles form a foundation for most of the existing frameworks that were examined: interconnectedness/relationship; cultural identity and worldview; and self-reliance/ collective ownership. These principles are defined in the following way:

Interconnectedness and Relationship

Indigenous communities encompass more than just human social organizations. In Indigenous worldview, the individual is part of the much larger community that includes the natural world and the spiritual world. There are great strengths gained through respecting these relationships. A strength-based approach includes drawing from the strength of Indigenous communities, the environment and spiritual connections, and celebrating those connections in sharing and caring ways. Because Indigenous ways of being are grounded in strong networks of relationship and engagement across the community, these relationships provide the foundations for wellbeing. They are built in cultural knowledge and practices; building on the influential role of elders, extended families, and relationship structures including connections to nature and spirituality. Respecting relationship in new initiatives involves initiating community-driven and community-led approaches which use culturally relevant strategies and systems that are culturally embedded. The strength of reliance on the collective is also embedded in a belief that survival requires never giving up and perseverance is a gift which must be respected in seeking solutions to adversity.

> Aboriginal reality in Canada has become a vicious circle of cause and effect. If that vicious circle is to become a healing circle, the roots of injustice must be addressed. Instead of problem feeding problem, solution must feed solution (Erasmus & Dussault, 1996).

Cultural Identity and Worldview

There are intrinsic cultural ways of being, knowing and viewing the world. This identity is entrenched in specific beliefs, values and principles that guide behaviours, set expectations, and govern our success both as individuals and social beings. Who we are cannot be separated from what we do, how we do it and how we feel about things. Our sense of health and wellbeing is inextricably linked to our sense of who we are in the world and how we are linked to that world. These connections recognize and build from the healing power of cultural renaissance and positive self-identity.

> [Indigenous] Health means caring for the environment, water, air; preserving cultural knowledge, language and traditions; promoting peaceful relationships among cultures and religions; and promoting well being so that generations to follow inherit the essentials of life, a strong identity and peace (Canadian Association of School Health, 2008:7).

Self-Reliance and Collective Ownership

Self-reliance is valued in the Indigenous world to the extent that we each need to develop skills which will contribute to improving the lives of others. In this way, there is an expectation of individual achievement as a contribution to mutual wellbeing. The Métis lifelong learning model describes living a good life as "a sacred act." For Inuit living a good life is the primary expectation, and the process of inunnguiniq, or "making a human being," is dedicated to ensuring this occurs. For Hawai'ians these aspects are embodied in the kanawai or laws around providing hospitality and sharing with others. This emphasis on building relationship is understood in the term 'aloha' and serves as a way of binding the collective in mutually supportive relationships. From these worldviews, the ability of the individual to contribute to improving the common good is part of a network of interconnected and mutually supportive alliances which establish a strong sense of the collective. Feelings of wellness in many Indigenous groups are reflected in this sense of mutual reliance, belonging and collective determination. In Hano Tewa Navajo cultural belief, cooperative helpfulness is part of the requirements of retaining a strong sense of balance between all things in life. Essential to this is that everyone is working for the good of the whole. This is true to the extent that illness, prolonged draught, famines and other misfortunes are believed to occur when a state of imbalance disturbs the natural order (Dozier, 1967).

> To serve others, to be of some use to family, community, nation and world, is one of the main purposes for which human beings have been created. Do not fill yourself with your own affairs and forget your most important task. True happiness comes only to those who dedicate their lives to the service of others. Observe moderation and balance in all things. Know those things lead to your well being and those things that lead to your destruction (Lane, 1985:81).

Recognition and assertion of the aspects of collective ownership become very important in terms of decolonizing and reasserting traditional understandings of wellness.

THE INITIATIVE

In order to build on the work done around synthesizing the information from existing frameworks and in articulating the broad principles, a consultation process was initiated. The process used two approaches. The first was a virtual consultation where a summary paper which outlined these broad principles was circulated for feedback to interested parties and was also made available on the website for feedback. In order to help us with this articulation, the following questions were posed to focus discussions:

1. What are the fundamental principles that should guide our discussions in this project and support the re-development of school health programs for Indigenous students, schools and communities?

2. What are the key Indigenous cultural concepts, knowledge and practices that need to be understood and acted upon in redesigning school health programs for Indigenous communities?

3. What are the cultural, community and individual strengths and resilience of Indigenous populations? How can these strengths be harnessed for effective school health programs?

4. What are the health, social and educational issues that are most relevant to Indigenous communities and which school health programs need to address?

There was also a face-to-face consultation where key Indigenous leaders and practitioners, policy-makers and researchers – those who can provide an authentic voice for the issues – were invited to participate in the dialogue circle. The purpose of the international

dialogue circles was to identify current contexts and initiatives based on Indigenous frameworks, to focus on the culturally appropriate approaches, and to identify priority wellness issues relevant to Indigenous communities.

This international dialogue was initiated by several Indigenous leaders in several countries, in cooperation with their national school health associations and with the support of two Canadian organizations: the National Collaborating Centre for Aboriginal Health (NCCAH) and the Aboriginal Learning Knowledge Centre (ABLKC). The NCCAH is funded by the Public Health Agency of Canada and works with Indigenous health promotion organizations in Canada. The ABLKC is co-led by the First Nations Adult and Higher Education Consortium (FNAHEC) and the Aboriginal Education Research Centre (AERC), College of Education, University of Saskatchewan and is funded by the Canadian Council on Learning. The Canadian Association for School Health (CASH) facilitated the project in cooperation with the International School Health Network (ISHN).

From their environmental scan and consultation, *Landscapes of Indigenous Health*, the National Collaborating Centre for Aboriginal Health (Greenwood 2006) identified the following five priorities for Indigenous public health in Canada: mental health, maternal and early childhood health, injury and violence, addictions and the social determinants of health. Although these issues may be common to all communities of school health practice, effective program responses need to be developed from a culturally specific health promotion framework. The importance of looking at Indigenous school health through a social determinants of health lens is critical to the social inclusion approach of a holistic model. In Inuit jurisdictions, there has been significant work in the area of population health:

> *In January 1997, the Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) defined population health as follows: A population health approach recognizes that any analysis of the health of the population must extend beyond an assessment of traditional health status indicators like death, disease and disability. A population health approach establishes indicators related to mental and social well being, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health. These factors are also called the "determinants of health", and include income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.*
>
> *It is well understood by governments that nonmedical determinants of health issues such as unemployment, income levels, the changing family, education and literacy affect the health and well being of a population. As such, Nunavut communities with high unemployment rates, low education levels, low income levels, a large number of single parent families and poor housing conditions are at high risk for poor health. In addition, other factors such the trauma left from the experience of residential schools, cultural dislocation, forced gathering of families into communities, and other historical events must be taken into account when assessing the health of Nunavut's Inuit population.*
>
> *Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, person health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to development and implementation policies and actions to improve the health and wellbeing of those populations. The population health framework recognizes that environmental issues, social problems, economic factors, and personal habits and behaviors are all important determinants of the health and well being of the population (NTI, 2008: 13).*

Historically, programs and research on Inuit health have focused on narrow indicators of health status without investigating a holistic view of social determinants of health as they relate to Inuit specifically. Therefore, future health initiatives must focus on issues such as food security, acculturation, level of political involvement/self-determination, and productivity, as well as specific health outcomes. This change in focus would facilitate a more realistic perspective of Inuit health for Inuit organizations and governments (ITK, 2009:16).

An elaboration of the social determinants of health as applied to Indigenous populations was also needed. Important contributions to this work have recently been completed by the NCCAH. They have published a series of fact sheets on Indigenous determinants of health, notably employment, family violence, education, economic development, culture and language, housing and poverty. A core premise expressed in this work is that:

> *Health is understood to be the physical, spiritual, mental, economic, emotional, environmental, social and cultural wellness of the individual, family, and*

community." Illness can be understood as a failure to maintain harmony or balance in all aspects of life (NCCAH, 2009b:1).

In their examination of social determinants of health, the World Health Organization has reported the following:

At least four groups of theories have been proposed to explain inequities in health across socioeconomic position. The materialist/ structuralist theory proposes that inadequacy in individual income levels leads to a lack of resources to cope with stressors of life and thus produces ill health (Goldberg et al., 2003; Frohlich et al., 2001; Macintyre, 1997). The psychosocial model proposes that discrimination based on one's place in the social hierarchy causes stress which causes a neuroendocrine response that produces disease (Karasek, 1996; Siegrist & Marmot, 2004; Evans & Stoddart, 2003; Goldberg et al., 2003). The social production of health model is based on the premise that capitalist priorities for accumulating wealth, power, prestige and material assets are achieved at the cost of the disadvantaged. The eco-social theory brings together psychosocial and social production of health models, and looks at how social and physical environments interact with biology and how individuals "embody" aspects of the contexts in which they live and work (Goldberg et al., 2003; Krieger, 2001). It builds on the "collective lifestyles" approach and the neoWeberian theory that lifestyle choices are influenced by life chances defined by the environment in which people live (Frohlich, 2001; Cockerham, 1997).

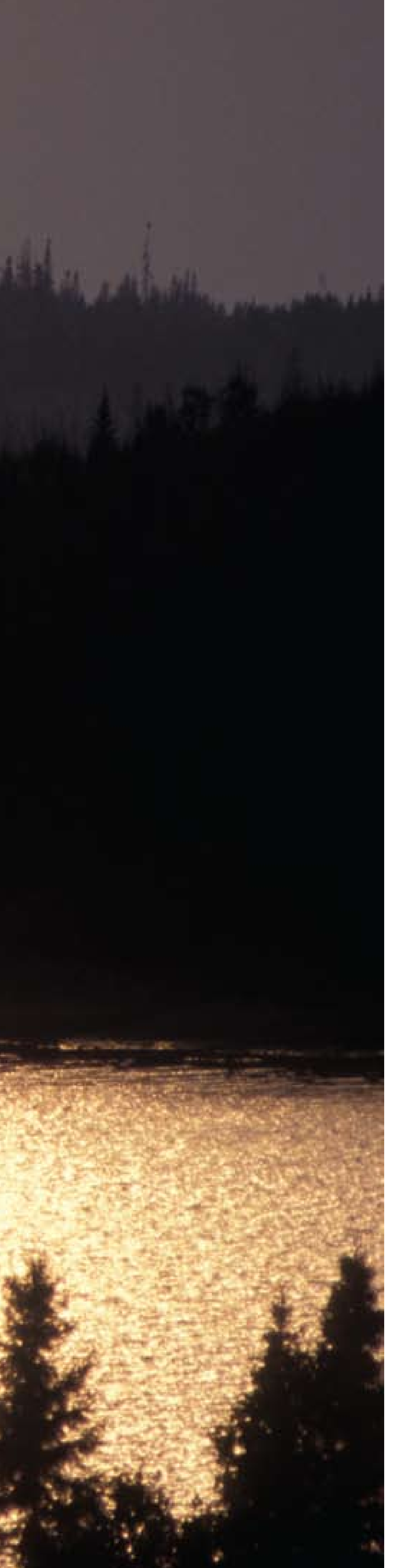
Because of the uncertainty about the precise causal mechanisms and the theoretical differences in explanations, there is little guidance available internationally to assist policy makers and practitioners to incorporate and act upon the full range of social determinants of health. Still less are there easily available tools and techniques for integrating equity considerations into policy and programme design or into the collection of data and evidence (Oxman et al., 2006) (WHO, 2007:12).

For Indigenous populations this theoretical dilemma is less complicated since most Indigenous peoples would find themselves fitting into the lowest rungs for each of these theories. From that place, taking a holistic worldview, all the social interactions described in the theories would be addressed in a similar way from the strength-based perspective of cultural collective expectation, identity and value systems. In terms of what is required to bring equity to the Indigenous health context, the National Collaborating Centre for Aboriginal Health concluded that:

The elements of a culturally appropriate health care strategy for Aboriginal Canadians include:

- *Health professionals who work in Aboriginal communities learning to communicate in the local language;*
- *Practitioners combining local knowledge on health and healing with western medicine;*
- *Community development and control of health care systems to make services responsive to local needs;*
- *Applying Aboriginal concepts of health and wellness in health care policy and practice; and*
- *Utilizing traditional healing practices. (NCCAH, 2009b:4)*

In order to define what this might look like, it is important to provide a broad framework for Indigenous health as a starting place for the redesign work required in the policy and program arenas and to be able to clearly articulate how an approach embedded in Indigenous beliefs may be different from other mainstream approaches.



FINDINGS

Responses to the Questions

1. What are the fundamental principles that should guide our discussions in this project and support the re-development of school health programs for Indigenous students, schools and communities?

Interconnectedness and relationship

Knowledge and culture are co-constructive. Each culture is uniquely suited to produce knowledge based on beliefs, geography, social contexts and understandings. This knowledge has been applied over many generations and is essential to the wellness of a culture as it defines how spiritual, physical, emotional and relational elements are connected through the specific worldview. This co-constructive ability needs to be recognized and respected by the mainstream. It needs to be nurtured and honoured by the specific Indigenous group as they seek to improve their own health and wellness. This speaks to the need to build respectful relationships, using co-constructive processes with the policy and program designers and the Indigenous communities themselves. It also speaks to the need to move this design and development process into community so that the redesign is owned and truly representative of the community itself.

The strengths of Indigenous cultures, communities, families and organizations are the building blocks for effective approaches, strategies and programs. This includes Indigenous value and belief systems which support a deep

spirituality; relationships and networks of interdependence and connection; language, stories and cultural ceremonies; and expectations and social wholeness. These Indigenous strength-based approaches to school health programming must promote advocacy and link to other sectors and public policy forums to address the health effecting issues of poverty, inequity and discrimination.

Cultural identity and worldview

Indigenous ways of being and knowing provide the foundation for health and wellness and, therefore, must be foundational to school health programs for Indigenous children. These ways are different and unique to each cultural group. Although some values and beliefs may appear to be universal in nature, in application the values and beliefs are part of a cultural tapestry which is unique and must be regarded as central and reflected in the very essence of curricula and program design. A core element of wellness is strength of identity. Specifically with regards to youth, this cannot be overlooked or under emphasized. Addressing the promotion of Indigeneity and building an understanding of the strengths and values of that identity are essential to health and wellness. Language and cultural identity and ways of being are each important to sense of self, sense of belonging, self-esteem and empowerment. They are also critical protective factors against youth suicide which plagues Indigenous communities worldwide.

The positive promotion of Indigeneity in itself may be the most effective health promoting action which can be implemented. Positive collective cultural identity is a powerful healing factor and a core strength which underpins personal wellness.

Self-reliance and collective ownership

Ownership and community control is essential—for the development, implementation and evaluation of programs as well as monitoring/reporting and needs assessments. Indigenous peoples were very specific in health and wellness practices and made use of every possible resource from their environment to ensure the continuation of healthy generations to come. Indigenous peoples continue to nurture a significant relationship with their environments and the resources provided for their use. They are the most knowledgeable and the best advocates for promoting improved health outcomes.

> *Community driven processes, culturally appropriate strategies, considerations of Indigenous knowledge, Aboriginal influence in decision making, and facilitation of the transition to Aboriginal responsibility for public health were all seen as important (NCCAH, 2006:5).*

Community control implies regaining control of institutions and resources taken from Indigenous peoples in their colonial past and providing for re-articulation of culturally defined health promoting policies and institutions. This includes educational and health institutions and the social environments which support these. This involves fundamental changes and a willingness for the mainstream to embrace change and to "get out of the way" to allow Indigenous peoples to reassert their understandings in these areas.

2. What are the key Indigenous cultural concepts, knowledge and practices that need to be understood and acted upon in redesigning school health programs for Indigenous communities?

Different ways of knowing (concepts and other sources of knowledge)

- health is not simply a possession (eg. WHO defines health as a resource for daily living) but rather a set of relationships with the land, tribe, family and ancestors
- learning is embedded in a cultural construct and way of being
- community ownership and control ensure knowledge uptake and sustainability
- collective approaches of sharing – wealth, possessions, property and shared accountability – build interdependencies
- environmental and social relationships create bonds of stewardship and responsibility
- future orientation/sense of history is part of a continuous orientation which requires a sense of role and relationship with generations past, present, and future
- meanings are often represented through

symbols (often sacred) and metaphors
- concepts are usually multi-faceted and imply layers of deeper meanings
- everything is known by its relationship to everything else – there is a universal wholeness of relationship and no one thing can be separated from the view of the whole
- seasons are part of all change and part of the continuous cyclic progression
- balance between the physical and spiritual worlds is maintained by a series of beliefs and practices – these are both core aspects of life

Different ways of doing (cultural practices)

- collaboration and consensus approaches are expected ways of doing
- open and honest communication, respectful of relationship
- values, beliefs and principles are culturally defined and underpin ways of being and behaving
- family, extended family and the collective identity are a foundational strength
- interpersonal communications with a reliance on relationships and role are to be modelled in schools as a reflection of the Indigenous community
- shared leadership and accountability structures should be promoted with high expectations for the learner
- cultural ways of child rearing, parenting come with cultural expectations which follow the child through life and should be understood by educators
- concepts of continuing improving and developing are basic to ways of learning with the expectation of levels of mastery in specific skill areas
- being in the here and now – grounded in the continuum, but operating within in the whole context

3. What are the cultural, community and individual strengths and resilience of Indigenous populations? How can these strengths be harnessed for effective school health programs?

Strengths and resilience of Indigenous populations

i. cultural strengths

- relationality
- spirituality
- view of centredness in place and interconnectedness with the environment and natural world
- defined roles and systems of accountability
- processes for maintaining balance and harmony
- reliance on and respect for knowledge holders
- cultural histories captured through stories/songs/cultural ceremonies, sacred practices
- concept of time continuum which is "time outside of time" (responsibility to ancestors and to seven generations – sense of the limitless universe)
- mutually beneficial social relationships
- recognition of cyclicity and continual acts of cultural renewal – sense of journeying
- importance of sustainability – expectation in service and sacrifice for others

ii. collective/community strengths

- collective identity
- sense of co-existence across time – mutual reliance
- shared system of beliefs and values, concepts of time and interconnectedness through time and across time to seven generations
- continually preparing
- recognition of the contributions of each member – expectations of inclusivity and valuing of the individual
- every aspect of life is enhanced through community
- capacity is understood through strength of community and culture
- recognition of the importance of social capability

iii. individual strength

- culturally defined identity, role expectations
- self-discipline
- humility which leaves one open to learning and improving and is embedded in the 'awe of the other'
- expectations for kindness, honour and

ethical rules for behaviour
- status achieved through contribution to others and the way life is lived
- non-competitive
- emotional restraint and patience
- non-interference, but accountability to the collective
- expectation to develop high level of skilled independence in order to contribute skills to community
- individuals are expected to develop attitudes and volition (self-reliance) in order to be successful and live "a good life" – our wellness ultimately depends on this
- a balance between self and other must be maintained
- personal potential is determined by the individual – is represented through a lifelong journey

iv. resiliency factors
- expectations for contributing to the common good
- expectation of persevering and not giving up – carrying on to completion of a cycle (achieving a goal)
- sense of culture as the aspect which nourishes the individual and community
- attitude of respect with which learning and life experiences are approached
- well articulated value systems
- interconnectedness
- protective factors exist as gifts from the Creator/Protector and natural world
- ancestral wisdom is always available through stories and sacred teachings and provides resilience to each generation
- struggle is an expectation
- healing processes and spiritual lessons are available to restore wholeness to an individual or group
- courage and honesty are highly valued and set in balance with humility and wisdom

4. What are the health, social and educational issues that are most relevant to Indigenous communities and which school health programs need to address?

The partners in this international dialogue have identified some of the issues that are of particular concern to Indigenous students, schools and communities. These issues are similar to those identified by Greenwood (2006) and Battiste (2005). These issues were also presented and discussed at a June 2007 Technical Meeting sponsored by the World Health Organization that led to the initiation of this project. There would appear to be a very strong consensus around the issues. They include:

- healing/reconciliation programs to address injustices of colonization
- redefining academic success and assuming control of monitoring and reporting (and other related governance issues) based on Indigenous ways of knowing
- suicide prevention and addressing other wellness issues which have roots in loss of culture, identity, relationship, language and cultural balance
- programs for building resiliency to offset child neglect and family violence which have resulted from breakdowns in cultural relationships, especially parenting
- reduction of the incidence of FASD and adult alcoholism and substance use, and supporting children of alcoholics and substance abusers through support for healing programs that deal with both self-medication and also the deeper rooted causal issues of abuse
- provision of inclusive supports and services for health problems related to early childhood ailments, hearing

and vision problems, genetic problems, and similar challenges – supports and services built around culturally specific ways of doing
- family and student-centred programs to offset families not having sufficient food, clothes or financial resources – using principles of sharing to establish equality and restoring balance
- provision of culturally defined parental supports which address geographical, linguistic, cultural or other barriers families face in accessing services
- addressing the high levels of poverty, unemployment, family violence, youth suicide and crime
- advocacy for improved housing and school facilities where overcrowding, infestations of lice and other parasites as well as poor quality of water, ventilation, and heating often limit student success or threaten student health
- advocacy for safe recreation in isolated communities and access to more cultural programming
- advocacy for safe or adequate public transportation
- advocacy and programs to address lack of basic health literacy among parents, the community and students in order to address the rapid changes in environment and new exposures that Indigenous populations have had to cope with
- strategic planning to prevent culture and language losses, family dislocation, early school leaving and dropouts/push-outs, unemployment and issues around food security
- tailored, responsive vocational training programs to match Indigenous community economic development plans and wellness initiatives which provide full access for Indigenous populations
- prevention programs targeting higher levels of tobacco and alcohol use as well as inhalants, and address gambling and other addictions

International Dialogues

The international dialogues provided information and an overview of several unique approaches to school health. These dialogues were carried on in connection with both the United States' Association of School Health (ASHA) in Tampa, Florida and the World Indigenous Peoples' Conference on Education in Melbourne, Australia in 2008. There were presentations on school health approaches from a variety of sources including Maori, Navajo, Seminole, Hawai'ian, Aborigine, Inuit, Métis and First Nation.

At the ASHA conference, keynote presentations were made by Darlene Begay on the Navajo coordinated school health model, by Ku'ulei Serna in her presentation on *The Application of Terror Management Theory to Native Hawaiian Wellbeing*, by Tracey Tana from the New Zealand Northland School District on Kura Hauora: Health Promoting Schools and by Kanat Wano on the Australian program *Feeling Deadly; Not Shame!* which is a community-delivered approach to addressing the loss for Aborigine youth of cultural identity and self-esteem.

The Navajo model was based on the model of the corn plant, similar to the Métis and First Nation education framework models based in the tree.[4] This model links health and wellness understandings and activities to the relationship of the Navajo people to the corn plant and the sacred responsibility in respecting that relationship. The model illustrates how all health based teaching can be culturally entrenched in this system of relationship so that the responsibility for wellness is seen as an individual and a shared cultural way of being. The Seminole people's presentation provided a model of cultural healing and reasserting of cultural strength through understanding the Seminole history and worldview and applying that to new contexts. This was a

[4] www.ccl-cca.ca/CCL/Reports/RedefiningSuccessInAboriginalLearning

"looking back in order to move forward," which is well documented as a successful methodology from addressing the hurts and harms of colonization and rebuilding the cultural strength of a people. The Hawai'ian presentation reinforced this as a healing and decolonizing methodology and provided some examples of how decolonizing strategies can be effective in promoting wellness in Indigenous communities. The Maori presentation focused on the Maori ways of doing and how, when applied as actual teaching and delivery strategies, a refocusing on wellness across the school curricula can transform schools into culturally driven institutions which reflect a healthy way of being. Discussions provided background to the Canadian models for Inuit, Métis and First Nation education and also the work that had been done to date on the school health framework itself.

Kanat Wano presented on behalf of the Australian School Principals' Association on the Mind Matters health promotion program which is being implemented in communities across Australia. This is a community development approach which engages schools in a shared capacity building plan that targets youth, but engages parents and community in mutually supportive roles. Based on the premise that socio-emotional wellbeing is the cornerstone of all wellness, the program seeks to address trans-generational trauma through a community development process for reviving the human spirit based on the motto "Feeling deadly; not shame." The approach builds social capital and capacity through a mental health promotion approach targeting youth in esteem and resiliency-building activities which focus on telling the stories of their lives in order to break down the barriers of hopelessness, poverty and despair that have created this poverty of spirit plaguing Aborigine youth. The three component parts consist of interventions with youth (Feeling Deadly), which are then supported by parents and parental social networking through Community Yarning, and further at the community level where community leaders are engaged in taking ownership of the program and extending it within the school and beyond. The approach is grounded in four key processes of community organizing, community capacity building, using community strengths and community engagement. The uptake in Australian schools has been extremely positive and steps to institutionalize the program are underway. This program is a demonstration of the concerns of the Australian National Aboriginal Health Strategy which stated:

> *The solution to address the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling the process of health care delivery. Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures.*
>
> *Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life (NAHS, 1989).*

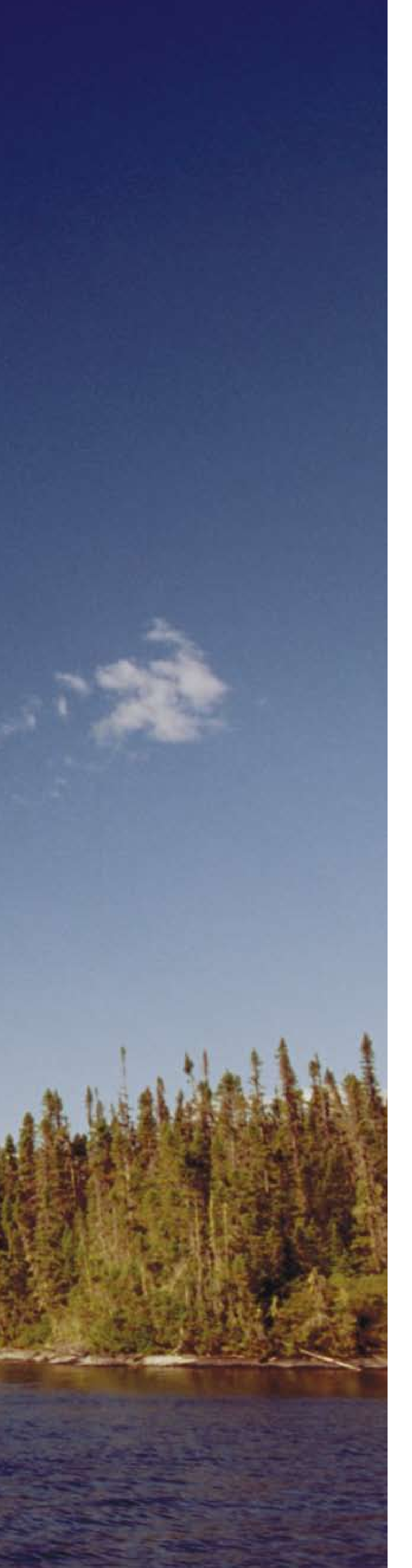
This Australian strategy further defines health as inclusive of the following:

- Concepts of health as holistic
- The right to self determination
- The impact of history in trauma and loss
- The need for cultural understanding
- The recognition of human rights
- The impact of racism and stigma
- Recognition of the centrality of kinship
- Recognition of different communities and needs
- Aboriginal strengths
- Universal access to basic health care
- High quality health care services, and
- Equitable funding for health care

This definition fits well with the collective work from other Indigenous jurisdictions, but goes the farthest in defining the impacts of colonial trauma, cultural loss and racism on health and wellbeing and on the importance of self-determining approaches to rectify that situation and to bring about healing. It is reminiscent of the outcomes from the 1986 Ottawa Charter for Health Promotion. The NCCAH reports that this suggests that the baseline foundation for health requires the following: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, and social justice and equity (NCCAH, 2006: 19). These are important aspects of health and well-being which speak again to the specific social determinants of health which impact so forcefully on Indigenous communities.

The discussion amongst participants included some suggestions about the terminology to use in order to garner support for this kind of initiative, especially funding support. This may vary across Indigenous populations. The hope is that an inter-nation set of principles can be arrived at which will assist with culturally based policy development, planning and practice. It was suggested that some international organizations such as CARE International might be invited to assist with the exploration of definitions of the shared issues. Participants were reminded that frameworks are only as good as the people who use them and there also needs to be regard paid to how to apply these frameworks and how to build community buy-in and ownership, dealing with resistance and the barriers which frustrate socio-cultural development projects. It was also suggested that there be strong prevention approaches and not just intervention approaches taken in the programming that will be developed and that young children should be the recipients of these prevention programs. Another target audience is educators, both pre and post service. Both course work and professional development should include exposure to the framework and culturally specific issues. The use of cultural competency continuums was mentioned in terms of setting benchmarks for the employment and advancement of educators.

Discussion at WIPCE followed similar lines. Participants at WIPCE were exposed to several presentations which focused on the fact that a good health self-concept was vital for Indigenous students, especially when considering the very high levels of health concerns amongst this population. There was also concern that Indigenous students were often reluctant to seek help when suffering from a health problem. It was generally expressed that many Indigenous students had a low health self-concept. From an educational perspective, the good health of students directly impacts their ability to participate and be successful in the educational process. As a result of these discussions, a further dialogue circle was being planned for participants from the 14 Oceania countries. Proposed for June, 2009 in Townsville, Australia and titled "Topix in the Tropixs," it was hoped that this regional discussion would provide additional input and further collaboration in this international dialogue.



CONCLUSIONS

The major gaps in understanding are about what Aboriginal peoples consider important and desire in future learning opportunities and is about their languages, cultures, knowledge, relationships, sociocultural, political and economic survival. The 'what is' then is not 'what ought to be', nor are the exemplary practices all that can be. Decisions about the future are still to be localized to the many First Nations, Inuit and Métis Nations to consider as they have repeatedly urged that their voices be heard, their participation be respected in any policies and programs that affect them, and decisions be based on the contexts in which they live, on their languages, and on their cultures, world views, knowledge foundations, and diverse ways of knowing and learning (Battiste, 2005: 12).

The expected outcome of this project is that a school health framework for Indigenous communities will contribute to reducing these gaps and to facilitating exemplary practices which will enable the development of policies and programs which are embedded in Indigenous ways of knowing and learning.

The dialogue about a common school health framework for Indigenous communities is a dynamic, on-going process. Additional ideas and active discussions can be contributed using the website: *www.aboriginalschoolhealth.wetpaint.com*. Based on the international dialogue to date, the following framework for school health is being presented as a place marker for this continuing process.

Indigenous School Health Framework

Indigenous worldview is centred in a holistic conceptual framework. Wholeness is often equated with wellness. It is represented in the framework as a circle, but this should be viewed as a sphere. This represents the understanding that life is cyclic and iterative, that it is embedded in nature in relationships that also cross time in a continuum of life-death-regeneration and, as such, is multi-dimensional. The sphere also encompasses the sacred and spiritual relationships which are part of the wholeness that defines Indigenous beliefs. All that is contained within the sphere is linked and interconnected and dynamically engaged.

Foundational Principles

Within this wholeness are the fundamental principles with which we build our ways of being in the world. These are the principles which should guide our actions and sustain our development, and craft our identities. They are basic to defining worldview and to establishing our place in the universe.

Interconnectedness and Relationship

Indigenous communities encompass more than just human social organizations. In Indigenous worldview, the individual is part of the much larger community that includes the natural world and the spiritual world. There are great strengths gained through respecting these relationships. A strength-based approach includes drawing from the strength of Indigenous communities, the environment and spiritual connections, and celebrating those connections in sharing and caring ways. Because Indigenous ways of being are grounded in strong networks of relationship and engagement across the community, these relationships provide the foundations for wellbeing. They are built in cultural knowledge and practices; building on the influential role of elders, extended families, and relationship structures including connections to nature and spirituality.

Cultural identity and worldview:

There are intrinsic cultural ways of being, knowing and viewing the world. This identity is entrenched in specific beliefs, values and principles that guide behaviours, set expectations and govern our success both as individuals and social beings. Who we are cannot be separated from what we do, how we do it and how we feel about things. Our sense of health and wellbeing is inextricably linked to our sense of who we are in the world and how we are linked to that world. These connections recognize and build from the healing power of cultural renaissance and positive self-identity.

Self-reliance and collective ownership:

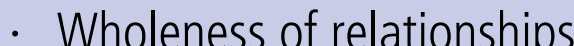
Self-reliance is valued in the Indigenous world to the extent that we each need to develop skills which will contribute to improving the lives of others. In this way, there is an expectation of individual achievement as a contribution to mutual wellbeing through living a good life as a sacred act.

Cultural Concepts

What we know and what we do are linked through experience. It is expected that each individual will become skilled, knowledgeable and accomplished in order to use the gifts to serve the collective and give back to the community. This requires two equal processes – becoming skilled and applying those skills in the service of others. Experiences which enable us to apply skills and knowledge reinforce our understandings, hone our skills and create opportunities to serve. In this way knowledge is generated through action and action expands knowledge. Indigenous worldview values these dual processes as co-constructive and complementary.

Conceptual Model

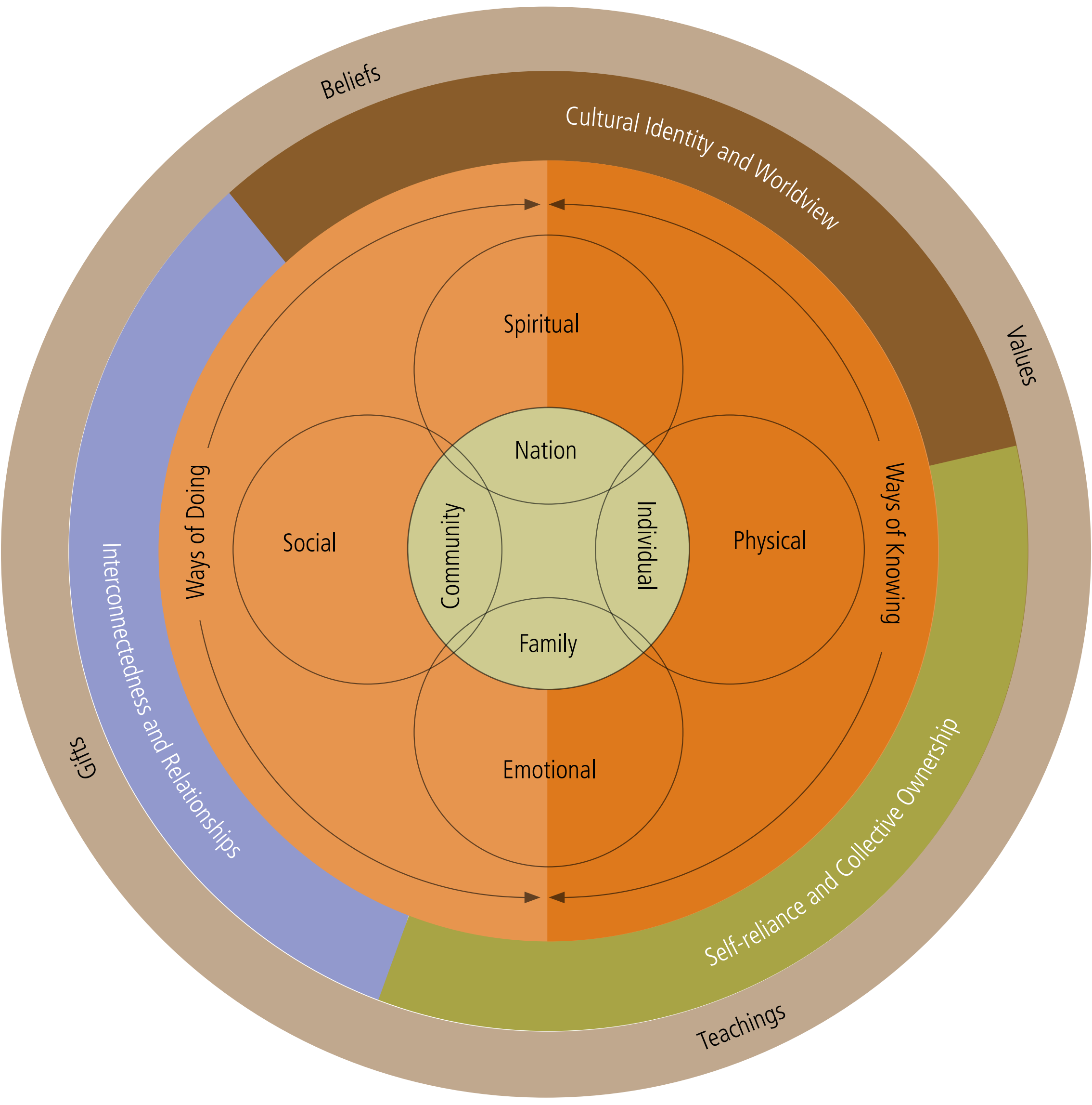
The model is represented by a circle/sphere to indicate the wholeness/wellness dichotomy. Within the sphere are three foundation principles. These are equal in importance and permeate all other dimensions of the framework. Within these lie the cultural concepts of learning – ways of knowing and ways of doing. These concepts are not static, but are always in rotation around the sphere. They also represent growth which builds from knowledge, application of knowledge,



Ways of Knowing Are holistically based on:	Ways of Doing Are holistically based on:
· Wholeness of relationships	· Consensus-building
· Cultural constructs	· Respect
· Ownership and sustainability	· Values, beliefs, principles
· Interdependence and collaboration	· Individual and collective identity
· Continuous cyclic progression	· Open communications
· Balanced views	· Collective over self

experiences gained towards wisdom and application of wisdom. Within this are the four aspects of human nature which also embed the elements, the directions, the seasons of life and the continuum of being. These aspects are physical, emotional, social and spiritual. These are seen to exist continuously in time. At the intersections of these operate the individual, the family, community and Nation or People. These are all interconnected and linked through the embedded circles to all other aspects of the framework. Finally, supporting these interconnections are the spiraling strengths of Indigenous communities which are articulated in beliefs, values, teachings and gifts.

Indigenous School Health: Framework



The framework continues to be a work in progress. Additional definitions, explanation, conceptual supports and aspects can be added through the website: www.aboriginalschoolhealth.wetpaint.com.

References

Alberta Education (2005). Our words, our ways: Teaching First Nations, Métis and Inuit Learners.

Battiste, M. (2005). State of Aboriginal Learning. Background paper for the "National Dialogue on Aboriginal Learning, Canadian Council on Learning.

Brant, C. (1990). Native ethics and rules of behaviour. Canadian Journal of Psychiatry, 35(6), 534-539.

Canadian Association for School Health. (2008). An Overview of Culturally Relevant Approaches & an Inventory of Good/Promising Programs In Aboriginal School Health and Well-being.

Canadian Council on Learning (2009). Aboriginal Learning Knowledge Centre Holistic Lifelong Learning Models. Retrieved April 21, 2009 from www.cclcca.ca/CCL/Reports/RedefiningSuccessInAboriginalLearning/?Language=EN

Canadian Council on Learning (2007). Redefining How Success is Measured in First Nations, Inuit and Métis Learning, Report on Learning in Canada. Ottawa: CCL.

Craven, R. & Parente, A. (2003). Unlocking Indigenous Educational Disadvantage: Indigenous community members' perceptions of self-concept research as a potent potential key. A paper presented at NZARE AARE, Aukland, NZ.

Dozier, E. P. (1967). Hano: A Tewa Indian Community in Arizona. San Francisco: Holt, Rinehart & Winston.

Durie, M. H. (2004). Understanding health and illness: research at the interface between science and Indigenous knowledge. International Journal of Epidemiology, 33, 1138-1143.

Economic Development Group. (2006) Piliriqatiginngniq—Working together for the common good. A health integration initiative project I Nunavut. Nunavut Tunngavik Inc., Government of Nunavut Department of Health and Social Services, Health Canada. Retrieved from www.gov.nu.ca/health/PublicHealth-StrategyEnglish.pdf

Erasmus, G. & Dussault, R. (1996). Address for the launch of the report of the Royal Commission on Aboriginal Peoples. Retrieved April 6, 2009, from www.ainc-inac.gc.ca/ch/rcap/spch_e.html

Espey J. OCAP and Stewardship (2002). A Discussion Paper for the First Nations Statistical Institute. Ottawa: Delsys Research Group Inc.

Government of the NWT (1996). Inuuqatigiit: The curriculum from the Inuit perspective.

Government of Nunavut. (2008). Inuit Qaujimajatuqangit Education framework for Nunavut Schools. Retrieved March 12,2009 from www.gov.nu.ca/education/eng/css/curr/IQ_Ed_Frawk_rev05.pdf

Greenwood, M. (2005). Children as citizens of First Nations: linking Indigenous health to early childhood development. Pediatric Child health, Vol 10 No 9 November 2005 (pp. 553-555).

Greenwood, M. (2006). Landscapes of Indigenous health: An environmental scan by the National Collaborating Centre for Aboriginal Health.

Healey, G. & Meadows, L.M. (2008). Tradition and culture: An important determinant of Inuit women's health. Journal of Aboriginal Health, 25-33, http://www.naho.ca/jah/english/jah04_01/05TraditionCulture_25-33.pdf

Inuit Tapiriit Kanatami (2009). Determinants of Inuit health in Canada: A discussion paper. Ottawa: ITK.

McCaskill, D. (1983). Native people and the justice system. In I. Getty & A. Lussier (Eds.). As long as the sun shines and the water flows (pp. 288-298). Vancouver, BC: University of British Columbia Press.

National Collaborating Centre for Aboriginal Health. (2009a). Supporting Aboriginal Parents: Teachings for the future. Prepared by K. Irving for the 'Messages From the Heart': A showcase of Aboriginal childrearing – Caring for our Children and Families Conference.

National Collaborating Centre for Aboriginal Health (2009b). Culture and Language as a Social Determinant of First Nations, Inuit, and Métis Health. Prince George, BC: NCCAH.

Lane, P. Jr. et al. (1984). The Sacred Tree. Lethbridge, AB: Four Worlds International Institute for Human and Community Development.

Ratima, M. (2000). Tipu Ora – a Maori-centred approach to health promotion. Health Promotion Forum Newsletter, 52, 2-3.

Thomas, D. R. (2002). Evaluating the cultural appropriateness of service delivery in multi-ethnic communities. Paper presented at the 2002 Australian Evaluation Society International Conference, October/November 2002– Wollongong, Australia. Retrieved February 16, 2009 from www.aes.asn.au

Waller, M. & Yellow Bird, M. (2002). The strengths of First Nations peoples. In D. Saleebey (Ed.), The strengths perspective in social work practice (3rd ed., pp. 48-62). Boston: A Pearson Educational Company.

White, K. et al. (2007). Talking back to grownups: Healthy children, healthy communities. A report on the social determinants of health and middle childhood in Canada. United Nations Association in Canada.

World Health Organization, (2007). The social determinants of health: Developing an evidence base for political action, Final Report to World Health Organization Commission on the Social Determinants of Health.

Other Sources and Recommended Readings

Archibald, L. (2006). Decolonization and healing: Indigenous experiences in the United States, New Zealand, Australia and Greenland. Ottawa: Aboriginal Healing Foundation.

Anderson, I.P.S. (2004). Recent Developments in National Aboriginal and Torres Straight Islander Health Strategy, Australia and New Zealand Health Policy, 2004, 1:3.

Bartlett, J. G. (2003). Involuntary cultural change, stress phenomenon and Aboriginal health status. Canadian Journal of Public Health, 94(3), 93-96. Retrieved from lib.unbc.ca/

Bartlett, J. G., Iwasaki, Y., Gottlieb, B., Hall, D., & Mannell, R. (2007, August). Framework for Aboriginal-guided decolonizing research involving Métis and First Nation person with diabetes. Social Science & Medicine, 65, 2371-2382. Retrieved from lib.unbc.ca/ (doi:10.1016/j/socsimed.2007.06.011).

Barnhardt, R. and Kawagley, A. O. (2005). Indigenous Knowledge Systems and Alaska Native Ways of Knowing. Anthropology and Education Quarterly, 2005, 36(1): 8-23.

Blackstock, C. et al. (2006), Many Hands One Dream, Principles for a new perspective on the health of First Nations, Inuit, and Métis children and youth.

Boville, D., Saran, M., Salem, J. K., & Clough, L. (2007). An innovative role for nurse practitioners in managing chronic disease. Nurs Econ, 25(6), 359-364. Retrieved from www.medscape.com

Canadian Diabetes Association. (2003). Diagnosis of Type 2 Diabetes. Retrieved June 19, 2008, from www.diabetes.ca/ilt/diabetesanswers/what_is_type_2diabetes/diagnosis_of_type

Canadian Diabetes Association. (2003). Gestational diabetes mellitus. Clinical practice guidelines. Retrieved June 19, 2008, from www.diabetes.ca/cpg2003/downloads/gdm.pdf

Carter, J. S., Perez, G. E., & Gilland, S. S. (1999). Communicating through stories: Experience of the Native American diabetes project. The Diabetes Educator, 25, 179-188.

Centre for Aboriginal Economic Policy Research, Australian National University (2006). Indigenous Peoples and Indicators of Well-Being. Report submitted to the Permanent Forum on Indigenous Issues, Fifth Session, New York, May 15-16, 2006.

CHA (2004). Aboriginal people – population of special interest – Population health profiles. Retrieved from www.wrha.mb.ca/research/cha2004/files/Vol2/AboriginalPeople.pdf

Chartrand, L. & Chartrand, C. M. (2006). A review of research of criminal victimization and First Nations, Métis and Inuit Peoples 1990-2001. Ottawa: Government of Canada. Retrieved June 9, 2008, from www.justice.gc.ca

Crowshoe, C. (2005), Sacred Ways of Life, Traditional Knowledge, prepared for the First Nations Centre, National Aboriginal Health Organization.

Crespigny De, C., Groenkjaer, M., & Loon Van, A. (2004). Clinical management of Aboriginal people with co-existing diabetes and alcohol related health problems – A review. Flinders University Adelaide Australia, , 1-70. Retrieved from www.nursing.flinders.edu.au/research/index.php?id=282

Drurie, M. (1999). Te Pae Mahutonga: a model for Māori health promotion, Health Promotion Forum of New Zealand Newsletter, 49, 2-5.

Dyck, R., Klomp, H., Tan, L. K., Turnell, R. W., & Boctor, M. A. (2002, March). A comparison of rates, risk factors, and outcomes of gestational diabetes between Aboriginal and Non-Aboriginal women in the Saskatoon health district. Diabetes Care, 25(3), 487-493. Retrieved from http://lib.unbc.ca/

Ferraby, J. (2002). Non-insulin-dependent diabetes mellitus: An epidemic among Aboriginal peoples. Retrieved from UBC Web site: www.research2.csci.educ.ubc.ca/indigenation/jacqui.htm

Hardey, S., Apaquash, L., & Butcher, M. (2000). Merging traditional Aboriginal & western health practices. Australian Journal of Primary Health, 6(3 and 4), 1-23. Retrieved from www.latrobe.edu.au/aipc/ajph/6.3%20abstracts/hardy%20et%20al.pdf

Health Canada. (2002). Centre for chronic disease prevention and control. Population and public health branch. Diabetes in Canada, 2, 3-75. Retrieved from www.phac-aspc.gc.ca/ccdpc-cpcmc/index_e.html

Hunter, L., Logan, J., Barton, S., & Goulet, J-G. (2004). Linking Aboriginal healing traditions to holistic nursing practice. Journal of Holistic Nursing, 22(3), 267-285. Retrieved from http://lib.unbc.ca/

Iwasaki, Y., Bartlett, J., & O'Neil, J. (2005). Coping with stress among Aboriginal women and men with diabetes in Winnipeg, Manitoba. Ethnicity & Health, 9(2), 189-213. Retrieved from lib.unbc.ca/

Jones, E. R., & Huether, S. E. (2006). Alterations of hormononal regulation. In K.L. McCance & S.E. Huether (Eds.) (Eds.), Pathophysiology: the Biologic Basis for Disease in Adults and Children (2nd ed., pp. 700-708). St.Louis,MO: Mosby.

A La Page, F. (2006, April). The quest to improve Aboriginal health. CMAJ, 174(9), 1233. Retrieved from www.cmaj.ca

Laenui, Poka (2000). Processes of decolonization. In Battiste, Marie (ed.), Reclaiming Indigenous Voice and Vision (pp. 150-160). Vancouver, BC: UBC Press.

Letendre, A. D. (2002). Aboriginal traditional medicine: Where does it fit? Crossing BoundariesAn Interdisciplinary Journal, 1(2), 78-87. Retrieved from http://www.ualberta.ca/

Memmott, Paul and Anna Meltzer (2005). "Modelling Social Capital in a Remote Australian Indigenous Community." Social Capital and Sustainable Community Development: A Dynamic Balance. Edited by Ann Dale and Jenny Onyx. Vancouver: UBC Press.

Métis Centre, National Aboriginal Health Organization (2005). Through the Hands of Our Elders, Métis Perspectives and Traditional Health Knowledge Series, Profiles of Métis Elders, Spring.

Morse, J., Young, D., & Swartz, L. (2002). Cree Indian healing practices and western health care: A Comparative. Social Science Medicine, 32(12), 1361-1366. Retrieved from http://lib.unbc.ca/

Potvin, L., Cargo, M., McComber, A. M., Delormier, T., & Macaulay, A. C. (2002). Implementing participatory intervention and research in communities: lessons from the Kahnawake schools diabetes prevention project in Canada. Social Science & Medicine, 56, 1295-1305. Retrieved from http://lib.unbc.ca/

Reading, J. (2003). A global model and national network for Aboriginal health research excellence. The Canadian Journal of Public Health, 94(3), 185-189. Retrieved from http://lib.unbc.ca/

Smith, L. T. (2006). Decolonizing Methodologies: Research and Indigenous Peoples. New York: Zed Books.

Smylie, J. (2001). A guide for health professionals working with Aboriginal people. Journal SOGC, 23(12), 1-7. Retrieved from http://www.sogc.org/index_e.asp

Taylor, John (2006). Indigenous Peoples and Indicators of Well-Being: An Australian Perspective. Report submitted by the Centre for Aboriginal Economic Policy Research at the Australian National University to the Meeting on Indigenous Peoples and Indicators of Well-being, Aboriginal Policy Research Conference, Ottawa, March 22-23, 2006.

UNPFII (2006). Report of the meeting on Indigenous Peoples and indicators of well-being, Ottawa, October 22-23, 2006.

Wereta, Whetu and Darin Bishop (2006). Towards a Māori Statistic Framework. Report submitted by Māori Statistic Unit, Statistics New Zealand to the Meeting on Indigenous Peoples and Indicators of Well-Being, Aboriginal Policy Research Conference, Ottawa, March 22-23, 2006.

Young, K T., Reading, J., Elias, B., & O'Neil, J. D. (2000). Type 2 diabetes mellitus in Canada's First Nations: status of an epidemic in progress. Canadian Medical Association, 163(5), 561-566. Retrieved from www.cmaj.ca/cgi/content/full/163/5/561

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