In our aboriginal diversity, we acknowledge the Supreme Being we call the Creator. When we were created our first instruction was to honour and respect all living things. We are many Nations within one great Nation. We are also many families within the Human Family. It is our duty to respect, support and nurture each member of this family so they might fulfill their hopes and dreams.

In today’s complex and busy world these challenges are met daily via Aboriginal Health Access Centres. These Centres provide Place, deliver culturally-oriented, inter-generational programs and services that enhance the well-being of the clients they serve.

In this Place one finds Community, Acceptance, and Healing with Spiritual and Cultural nourishment to ensure a healthy future for our coming generations.
ACKNOWLEDGEMENTS
This report was produced through the collective efforts of the AHAC Report Working Group

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This report was made possible through an Aboriginal Health Transition Fund grant from the Ontario Ministry of Health and Long-Term Care
OUR STORY AS FIRST PEOPLES within the history of Canada is one of terrifying exclusion and abuse; one which includes Canadian government policy that once sought to “take the Indian out of the Indian”. This history of mistreatment and broken promises has resulted in inter-generational trauma, felt by our communities, and our families. It deeply affects both our health and our spirit, touching us still, across the life cycle. The ways in which illness and crisis among Aboriginal communities are rooted in this history cannot be overstated.

But ours is also a story of resilience, and the incremental triumph of family, community and Spirit in the face of astonishing odds. Across centuries, our traditions have survived. Our community leaders and elders have preserved the memory and practice of our traditional ways, grounded in a profound respect for all creation and the earth we walk. Gradually, from generation to generation, we have travelled a difficult path, but one that has led us to a place where healing and progress can once again become the defining characteristics of our story.

Aboriginal Health Access Centres provide a place where this healing and community strength are anchored. In our daily lives, First Nations, Métis and Inuit peoples continue to inhabit a world that seldom reflects our diverse stories, our rich traditions, and our role as custodians of this land. AHACs, however, provide an oasis that helps our people make sense of a highly confusing and conflicting reality. We do this by placing culture and traditional practices at the core of all health, health care and community development practices.

AHACs provide a place of safety and belonging, where individuals, families and our communities find meaning. Health care and support are promoted and provided by staff who not only understand the inter-generational traumas that have affected our people, but have lived their own journeys to health and healing.
Cultural practice is key, as reflected through the teachings of the medicine wheel and the four directions of creation. From the ways in which we conduct our meetings, to the type of programs and services we offer and the manners in which individuals are invited to participate in the circle of care, cultural relevance is paramount. There is simply no other way to heal and to be well.

Across the province of Ontario, AHACs are playing a pivotal role in restoring health and well-being in our communities. From high quality clinical care, to traditional healing, health promotion, illness prevention and community development programs, AHACs are building toward a healthy seventh generation.

As this report demonstrates, AHACs have made remarkable strides since they were first established in the mid-1990s. In the face of incredible community challenges and complex care needs, AHAC are making a difference. This is reflected not only in the tangible health outcomes experienced by our clients and their families, but in the ways in which many of our clients go on to become AHAC staff, Board Members and active partners in the community.

We invite you to read and hear our stories of health and healing. We encourage you to support the work that we do. And, we urge you to consider the tremendous difference that could be made in Ontario if all First Nations, Métis and Inuit community members could access AHAC services. Most importantly, we wish you health.

Miigwetch! Skennen!

Pamela Williamson — AHAC Network Co-Chair
Executive Director, Noojmowin Teg AHAC, Manitoulin Island

Allison Fisher — AHAC Network Co-Chair
Executive Director, Wabano Centre for Aboriginal Health, Ottawa

AHACs are building toward a healthy seventh generation.
Where we are

Ontario

- N’ Mninoeyaa Community AHAC (North Shore Tribal Council)
- Anishnawbe Mushkiki AHAC (Thunder Bay)
- Waasegiizhig Nanaandawe’iyewigamig AHAC (Kenora and area)
- Southwest Ontario AHAC (London and Chippewa of the Thames)
- Gizhewaadiziwin AHAC (Rainy River District)
- Kanonhkwa’tshero:io AHAC (Mohawk Council of Akwesasne)
- Shkagamik-Kwe AHAC (Sudbury)
- Noojmowin Teg AHAC (Manitoulin Island)
- Wabano Centre for Aboriginal Health (Ottawa)
- De dwa da dehs nye’es AHAC (Hamilton and Brantford)
- Gizhewaadiziwin AHAC (Rainy River District)
What are AHACs?

Aboriginal Health Access Centres (AHACs) are Aboriginal community-led, primary health care organizations. They provide a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services to First Nations, Métis and Inuit communities. There are currently ten AHACs in Ontario, providing services both on and off-reserve, in urban, rural and northern locations.

First announced in 1995, AHACs were closely modelled after Ontario’s Community Health Centres (CHCs), whose wide basket of services and supports had become the preferred mechanism to improve the health and well-being of communities in Ontario facing various barriers in accessing health care. In fact, two CHCs had already been established, one in Toronto and another in Timmins, with a mandate to apply this CHC model as the framework for services to local Aboriginal community members.

Ontario’s experience with CHCs, including these two Aboriginal CHCs — Anishnawbe Health Toronto CHC and Misiway Milopemahtesewin CHC in Timmins — provided strong evidence that such organizations could play a powerful role in improving the health and well-being of Aboriginal communities throughout Ontario.

That’s why, in 1994, when the province implemented the Aboriginal Health Policy for Ontario — a policy developed in broad consultation with First Nations, Métis and Inuit communities — Aboriginal community-led primary health care was identified as a key pillar of the vision for the future. Beginning the following year, AHACs started to open their doors. By 2000, all ten were operational. And so were born Ontario’s Aboriginal Health Access Centres. Since then, AHACs have made a powerful contribution to health and well-being in Ontario, helping to bring tens of thousands of Aboriginal community members into the circle of care and support.

From clinical care services, to integrated chronic disease prevention and management, family-focused maternal/child health care, addictions counselling, traditional healing, mental health care, youth empowerment and other programs, AHACs continue to serve as a key gateway to overall family and community health and development.
Core attributes of Aboriginal Health Access Centres

**Culturally-congruent**
AHAC services, supports and programs are all grounded in Aboriginal community understandings of creation, being and health. This means that all programs and services are considered and planned from a holistic perspective, promoting integration of traditional Aboriginal perspectives and healing methods with western medicine.

**Interdisciplinary**
Traditional healers, Western health care providers, and health program staff at AHACs work in a collaborative, team-based approach. This 'wrap around' care places the client at the centre of an interconnected, holistic circle where a community of care occurs. The contributions of all team members are valued as special and essential components of this circle and community of care.

**Community-governed**
In addition to being community-oriented, AHACs are also community-driven. AHACs are all governed by either community Boards of Directors with local constituency positions or are governed by elected First Nations Band Councils. This community governance ensures that health services remain grounded in traditional and local practice, and that services adapt to the changing needs of the community over time.
In 2005, the AHAC Network developed a “strategy map” to outline their common approach to health and health care. The strategy map identifies a set of core attributes that describe the AHAC model of care, connecting cultural values to organizational structures and services.

**Community-oriented**

AHACs engage the community as active participants in shaping health and support services, building healthy communities. By actively partnering with local agencies and Political Territorial Organizations (PTOs), and by hosting regular community forums, providing volunteer services and training programs, AHACs build capacity and draw from the strengths of the community.

**Family-oriented**

AHACs care for Aboriginal community members across the life cycle. Key to improving the health of our communities is nurturing family as central to the health and well-being of individuals across the life cycle. Programs and services at AHACs enable care and support for individuals but are built to foster and encourage family participation, renewal and health.

**Inclusive of the social determinants of health**

First Nations, Métis and Inuit wisdom and practices have long been grounded in an understanding of the interconnection of all things. AHACs are fundamentally, culturally grounded in an approach to health and health care that incorporates efforts to address the lived environment and social, economic, political and spiritual health as essential parts of individual, family and community well-being.
Aboriginal health and healing in Canada

History

Since first contact with Europeans, Aboriginal peoples in Canada have faced tremendous challenges to their individual and community health and well-being. From the onset of pandemic disease, to ensuing discrimination that characterized much of British, French, and Canadian colonization, First Nation, Métis and Inuit peoples in Canada today occupy a world-space shaped by a five-centuries old legacy of exclusion and broken promises. In Ontario, as in other parts of Canada, this legacy includes the impact of formal government policy that once aimed at completely de-threading the fabric of Aboriginal life. This was pursued by forbidding first peoples from practising political, cultural and healing traditions, and by tearing apart families in order to assimilate children and adults alike. These impositions endured well into the twentieth century, perpetuated through well-known, state-sanctioned institutions such as the residential school system, something for which Canada is now slowly beginning to make amends. The impact of this legacy is shaping the realities, development and health of Aboriginal families and communities cannot be overstated.

Challenges and Barriers

The impact of this history could best be described as a complex, inter-generational trauma. It touches First Nations, Métis and Inuit communities across the life cycle of its members. Far too often in Aboriginal communities, be they on-reserve or in small or large urban settings, life is characterized by a series of challenges and barriers. Very often, these are rooted in impoverished social conditions, leading to substance abuse and other unhealthy activities that are formed as means of coping with the deeply-rooted experience of trauma, depression and social alienation. As with many communities that face collective pain and historical marginalization, these forms of poverty, exclusion and unhealthy activity multiply across families and communities at large, meaning that illness is both individual and social. The obstacles faced in attempting to address these individual and social illnesses are great, particularly since an underlying distrust, fear and scepticism of non-Aboriginal services and institutions have been formed over a period of centuries. In fact, the ongoing encounter of Aboriginal peoples with many of these “mainstream” services commonly re-enforces perceptions and experiences of racism and abuse. The need for Aboriginal-led, culturally relevant health and social services is great. The need for investment in addressing the underlying conditions of illness within Aboriginal communities, such as poor housing, poverty and other factors, is also great. And, services and supports, even when provided through Aboriginal-led, culturally-relevant organizations, are challenging. Individuals and families alike are managing complex health issues, including multiple co-morbidities and a lack of personal resources with which to support change.

Opportunities

Despite these many persistent barriers and obstacles to health, the future for First Nation, Métis and Inuit communities is looking brighter. The key is cultural practice, anchoring life and community activity in many of the practices that were taken away from Aboriginal communities over the course of centuries. Affiliation and a sense of belonging through language, nation and clan connections, and a collective re-discovery of tradition help clear a path toward individual, family and community healing. There is tremendous community leadership in realizing this vision and situating this shared journey within Aboriginal-led organizations. These organizations not only respect and exemplify the link between services, culture, and collective identity, but have earned the trust of, and recognition by community members. Often, a member of the community may not be actively seeking health care, employment or education in the first place, but rather a place of comfort and belonging or a hot meal. Aboriginal-led organizations provide this, helping build connections to health care, education, employment and other positive resources for life. The key is starting from where people are, building toward healing.
Role and importance of Aboriginal-led, primary health care

Aboriginal Health Access Centres play a central role in this individual, family and community healing journey because they are primary health care organizations. Primary health care has been identified, around the world, as key to any country or nation’s effort to build an effective health system, moving toward the World Health Organization’s (WHO) definition of health: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This WHO definition and the WHO’s promotion of primary health care align closely with the centuries-old vision for health that is common to all Aboriginal communities, connecting physical, emotional, mental and spiritual well-being in an interconnected circle. Within the process of individual, family and community healing that is grounded in reclamation of traditional cultural practice and belonging, Aboriginal primary health care organizations, like AHACs, play a particularly important role. As the first point of access and services within the health system, AHACs are close to where people live and work. They are designed to connect clinical care, traditional medicine, health promotion and illness prevention and to use health as the lens by which to build partnerships in the community.
From principle, to practice
the evolution of AHACs in Ontario

Rooted in Aboriginal Health Policy for Ontario

Based on broad-based consensus, this provincial policy was implemented in 1994 and grounded in a spirit of partnership between the Government of Ontario, Aboriginal Political Territorial Organizations (PTOs), Aboriginal service organizations and First Nations, Métis and Inuit community members.

Establishment of AHWS

As a component of the Aboriginal Health Policy for Ontario, the Aboriginal Healing and Wellness Strategy (AHWS) was established as a vehicle through which the provincial government, PTOs and Aboriginal organizations could jointly manage health and social services for Aboriginal communities.

AHACs begin opening in 1995

Based on the success of Ontario’s Community Health Centres (CHCs), and its two Aboriginal CHCs — Anishnawbe Health Toronto CHC (Est 1984) and Misiway Milopemahtesewin CHC (Est 1988) — AHACs were developed and implemented through AHWS as the key vehicle for primary health care to Aboriginal communities. Ten AHACs were opened from 1995 to 2000.

<table>
<thead>
<tr>
<th>Year</th>
<th>AHACs opened</th>
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<tbody>
<tr>
<td>1995</td>
<td>N’Mninoeyaa AHAC</td>
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<td>1996</td>
<td>Akwesasne AHAC</td>
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<td>1998</td>
<td>Shkagamik-Kwe AHAC</td>
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<td>1999</td>
<td>Waasegiizhig – Nanaandawe’iyewigamig AHAC</td>
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<td>2000</td>
<td>Anishnawbe Mushkiki AHAC</td>
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Growth and expansion of services; birth of a new crisis

From 1995 to 2005 AHACs undergo significant expansion as new AHACs are opened and as each centre brings more and more community members into the circle of care. However, by 2005, it is clear that demand for services has quickly outpaced AHAC funding levels. Waiting lists for services grow; centres face major barriers recruiting and retaining staff due to funding shortfall; and AHACs are not included in government initiatives made available to non-Aboriginal primary health care organizations.

Development of the AHAC Network

In response to this growing crisis, the AHAC Network is established and formalized with the support of the Association of Ontario Health Centres (AOHC). In 2005, the AHAC Network and AOHC first diagnose the character and scale of this crisis, documenting it in Waseskun: Enhancing Aboriginal Primary Health Care in Ontario. AOHC and AHACs describe the "second class status" of AHACs within Ontario health system and begin to advocate urgency of change with AHWS and the Ontario Government.

Toward equity

Despite lack of support to eliminate the second class status of AHACs, the Government of Ontario begins, in 2007, to provide targeted policy and funding support to AHACs for specific services. This helps AHACs from falling further behind. Still, major inequities continue to define funding/support for AHACs. A revised diagnosis of this is undertaken by the AHAC Network/AOHC and Eliminating the Second Class Status of AHACs is published, in 2007, re-valuing the growing crisis and inequity at AHACs at $15 million.
Who is accessing services?

Whom do AHACs serve?

AHACs serve a large and diverse demographic throughout Ontario, including individuals and families across the life cycle, both on and off-reserve, in the North, in rural areas, towns and cities. An age breakdown of clients across AHACs shows this wide range of clients.
AHACs serve a diverse Aboriginal population

AHACs in Ontario provide a place of belonging, community and healing for the province’s diverse Aboriginal population. Services are available to all Aboriginal people, with programs and services tailored to the diverse populations within each of the AHAC’s local regions. In addition to serving First Nation, Métis and Inuit clients, seven of the ten AHACs already currently provide services to “non status” family members.

Native languages and cultural reclamation critical to AHAC success

Culture and identity are key to belonging and to health. In the course of providing primary health care services, AHACs infuse cultural practices into all of their activities and programs. One of the ways in which AHACs achieve this is through use and promotion of native languages. All ten AHACs provide services in English as well as at least one other national language, be it Ojibwe, Oji-Cree, Mohawk or Oneida. Three AHACs also currently provide services in at least two first nation languages.

Aboriginal men still less likely to access health services

Similar to other segments of the population, AHAC services are accessed more frequently by girls/women than boys/men – nearly twice as often, in fact. AHACs are making a concerted effort to actively reach out to men in the community, inviting participation in health services through group programs, sweats and other group activities. Still, AHACs face an uphill battle in bringing male community members into routine care, particularly due to significant levels of stigma, depression and distrust of institutions by First Nations, Métis and Inuit men, dating back to the legacy of residential schools and other mainstream institutions.
Challenge of reaching children and youth

The most recent Canadian census data show that First Nations, Métis and Inuit populations in Canada are growing faster than non-Aboriginal populations. And, the population is increasingly younger. Forty-eight percent of Canada’s Aboriginal population is aged 24 years or younger, compared to just 31% of the non-Aboriginal population.

Data collected from AHACs, however, show that just 29% of clients receiving care are 19 years or younger, cutting counter to population growth needs. This reflects the heavy and complex care and support needs of adult and senior community members, exhausting the majority of AHAC time and resources. Support is urgently needed to help AHACs meet the growing needs of children and youth within the communities they serve in order to avoid a tsunami of illness among children and youth.
Clinical care: Trends in client visits

Top 10 reasons for clinical visit, by diagnosis

1. Diabetes
2. Well baby/Child exams/Immunizations
3. Annual health/Well adult exams
4. Mental health problems (depression, anxiety and other)
5. Musculoskeletal system diseases
6. Hypertension/High blood pressure
7. Other chronic illnesses (asthma, arthritis)
8. Pregnancy/delivery
9. Metabolic disorders and obesity
10. Alcohol and substance use/abuse

Top 10 individual client diagnoses

1. Well baby/Child exams/Immunizations
2. Annual health/Well adult exams
3. Diabetes
4. Musculoskeletal system diseases
5. Mental health problems (depression, anxiety and other)
6. Hypertension/High blood pressure
7. Other chronic illnesses (asthma, arthritis)
8. Metabolic disorders and obesity
9. Alcohol and substance use/abuse
10. Pregnancy/delivery
AHAC CLIENTS MAKE MORE FREQUENT VISITS
to their clinical health providers than the Ontario average; almost twice as many, in fact. This speaks to the complexity of health issues faced by First Nations, Métis and Inuit community members.

Community members are not only living with the intergenerational trauma that affects their health, it manifests in many ways, including a high rate of co-morbid health conditions.

The success of AHACs is marked, first, by their success in bringing individuals and families into the regular circle of care. Many community members have gone without services for years, often because of their distrust and fear of government and other institutions/authorities. Others still are trapped in cycles of poverty and hopelessness.

In the face of these complex social and health conditions, AHACs are making remarkable progress in providing hope; in imparting a sense of individual and family empowerment over health; and in taking early interventions to prevent illness and illness progression.

As the diagnosis and clinical visit data from the previous page demonstrate, AHACs are prioritizing illness prevention and health promotion through a focus on child and adult immunization, routine maternal health and well-child visits, and routine health check-ups for adults. In the clinical setting, these complement routine AHAC community and cultural programming that stress cultural reclamation and empowerment around one’s health, and the health of family and community.

2009–10 clinical visits
110,649 visits were made by 21,273 clients at AHACs. This average of 5.2 visits per client, per year is 58% higher than the Ontario population average, as studied in 2008, 2009.

This underscores the complexity of care required by clients of AHACs, with high rates of co-morbidity and need for extended primary health care.
Diabetes and co-morbidity

Individual diabetes diagnoses: **2095**

Diabetics with one or more co-morbidity: **83%**

Average number of co-morbidities for clients with diabetes: **5.06**

Of the 21,273 clients who made clinical visits to Ontario’s AHACs in 2009-10, 2095 are diabetic. Of these, 83% have one or more other clinical diagnosis. For those with co-morbid diabetes, the average number of co-morbidities is 5.06.

Mental health conditions and co-morbidity

Individual mental health condition diagnoses: **1553**

Individuals with mental health conditions who have one or more co-morbidity: **92%**

Average number of co-morbidities for clients with diagnosed mental health conditions: **5.92**

Of the 21,273 clients who made clinical visits to Ontario’s AHACs in 2009-10, 1553 are diagnosed with one or more mental health conditions (depression, anxiety, and other).

Of these, a staggering 92% have one or more other clinical diagnoses. For those with co-morbid mental health diagnoses, the average number of co-morbidities is 5.92.
MEDICINE WHEEL TEACHINGS PROVIDE MANY
Aboriginal people with guidance and insight into life and living. Within the Eastern doorway are many teachings that address the physical component of one’s being, the importance of belonging, such as to a family or community, the importance of the heart and feeling, and of the need for protection and sharing. It is in these teachings that Aboriginal Health Access Centres find their strength and vision.

AHACs are a place of protection for many Aboriginal people who have lost the safety and security of their families and communities through devastating assimilation policies such as the residential school and child welfare systems. AHACs have become a sanctuary of sorts for Aboriginal people, a place where they are encouraged and assisted to explore and reclaim their culture and encouraged to take pride in who they are.

When clients walk through the doors of an AHAC, they see their cultures reflected in the staff, in the artwork hanging throughout the centre, and the spaces used for ceremonies and healing. AHACs provide a place where clients can find their voice, speaking and sharing their experiences with others, creating the relationships that are a necessary part of the healing process. The sense of belonging created by AHACs makes them essential to the Aboriginal communities they serve.

These values are reflected in every facet of AHACs throughout Ontario. Programs and services, staff, management, Boards of Directors, clients and volunteers alike embrace the importance of this meaning. In understanding clients and their daily and systemic challenges, AHAC staff are better situated to meet their needs.

AHACs carry this philosophy into service provision, embracing a continuum of care that is holistic in nature, supporting individuals and families across the lifecycle. This care and support is literally wrapped around the client. AHACs are home to a wide range of services and programs designed to meet the complex needs of their clients. Due to these complex needs, clients typically require the services of several programs and health care providers at an AHAC at any given time. An informal, collaborative approach is undertaken by AHAC clinical and program staff to ensure their clients are served according to needs.

AHACs successfully refer clients internally, to and from different clinical providers, traditional healers, and programs within the centre. Keeping clients within the centre is a critical approach for a population resistant to waiting lists, travelling to unfamiliar locations, and to building new relationships with service providers, especially those who are not within Aboriginal organizations. The safety of the AHAC and the familiarity of its staff help clients to keep their medical appointments and to get the care they require. It also allows service providers to see clients progress through the continuum of care described earlier.

This approach is also culturally appropriate for Aboriginal clients who seek services not just for their physical ailments, but also for issues pertaining to their mental, emotional and spiritual needs.
“Wrap around” care by program

Community Programs
Community Events, Workshops, Symposia

Clinic
Nurse Practitioners, Physicians, Chiropractor, Dietitian, Footcare, Gynecology

Health Programs
Diabetes, FASD, Health Promotion, HIV, Smoking Cessation

Mental Health
Art Therapy, Client Advocacy, Counseling, Cultural Reclamation

Individual Family Community

Social Programs
Cultural Program, Seniors Program, Tween Program, Perinatal Program, Youth Program

Homelessness
Addictions Support, Cultural Reclamation, Medical/Mental Health Street Outreach, Spiritual Support

A snapshot of services at Wabano Centre for Aboriginal Health, Ottawa
NOOJMOWIN TEAG TRANSLATES AS “A PLACE of healing”. The AHAC, on Manitoulin Island, has made tremendous strides integrating traditional Aboriginal approaches to health and wellness within the overall framework of primary health care. As with all AHACs, Noojmowin Teg identified traditional healing as an essential component of its overall services right from the start.

When the centre first opened in 1998, it collaborated with two other AHACs already in operation and with the area First Nations Chief and Councils, health staff, and elders to convene a traditional healing gathering at Dreamer’s Rock — a sacred, spiritual site and meeting place located on Whitefish River First Nation.

Together, the group guided the formation of a Traditional Healing Advisory Committee for Noojmowin Teg, composed of Elders and other representatives from the seven First Nations served on the island, including off-reserve membership. The rest, as the saying goes, is history.

Since 1999, traditional healing and medicine have flourished at the centre. The Traditional Healing Program is administered by a Traditional Program Coordinator who guides the activities of local traditional healers and helpers, in a collaborative approach with the seven community services providers and/or traditional programs.

Program staff also harvest local medicines, host workshops and coordinate teachings, support research on traditional healing, and provide program support and advice to other Noojmowin Teg health providers such as dietitians and mental health counsellors, and prevention and awareness programs such as children’s recreation, nutrition, and Fetal Alcohol Spectrum Disorder (FASD).

The role of the Traditional Program Coordinator, in particular, is multi-faceted and critical to the program’s success. A nurse, counsellor and herbalist by training, the Coordinator is a liaison between the Executive Director and other staff and programs at Noojmowin Teg. She supervises traditional healers, helpers, a traditional counsellor, and an art facilitator; liaises between Manitoulin Island First Nations and the AHAC; harvests medicines; acts as research associate on various projects; and, most importantly, acts as a cultural mediator, to balance clinical accountability at the centre with the integrity of Anishinabe traditional healing practices. The traditional advisory committee is a critical support to the Program and the Coordinator with their knowledge and support in all these activities.

Program activities are diverse. They include:

- In-take, assessment and referral to Traditional Healers
- Networking and referrals to other health care providers, where appropriate
- Traditional teachings, ceremonies and traditional healing services
- Traditional/family healing circles
- Supportive counselling
- Traditional medicine walks

A key to AHAC success
Our health, our future

The development and implementation of a policy specific to traditional activities was undertaken in collaboration with First Nation traditional staff and elders. The policy has been requested and shared with fellow AHACs, First Nations, and other aboriginal organizations across the country.

Among the major operational achievements of the Traditional Healing Program are development of a bi-cultural Traditional Healing Services Policy and Program Manual, launched in 2006, and participation in a 2009 research study that assessed the effectiveness of integrating traditional healing and medicine with Western health care practices. The report provides recommendations, grounded in participant and community engagement, that are being used to guide program and service enhancements, and to support traditional healing practices elsewhere.

Community participation in traditional healing programs and services at Noojmowin Teg has increased steadily since 1999. In 2009-10, a total of 717 clients accessed traditional healing programs offered through the centre, up from 220 in 2004, when data collection began. Resource constraints remain the major barrier in bringing more community members into care and access to traditional services. Word-of-mouth referrals remain the main gateway for community members who access traditional healing programs, since positive family and friend referrals foster trust and help build individual, family and community reclamation of cultural practice, including traditional healing.

Community participation in traditional healing programs and services at Noojmowin Teg has increased steadily since 1999.
Quality and service improvement in health promotion and illness prevention

N’Mninoeyaa AHAC WORKS WITH INDIVIDUALS, families and communities as a whole to promote healthy living, with emphasis on traditional Anishnawbe practices and customs. The centre, which is part of the overall services delivered by the North Shore Tribal Council, supports clients on seven First Nation reserves as well as the urban Aboriginal population of Sault Ste Marie.

In 2009-10, N’Mninoeyaa AHAC offered 56 different health promotion courses, group programs and seminars. These included healthy living sessions led by Traditional Healers, baby-food making classes, after-school children’s nutrition programs, regional youth health camps, women’s wellness days and many other programs, reaching over 1700 community members in 2009-10 alone.

One program that has had a particularly important impact is the centre’s smoking cessation program. Smoking and second-hand smoke have crisis-level impact on the communities served by N’Mninoeyaa AHAC.

Tobacco misuse in First Nation communities is three times higher than the rest of Canada, and second and third hand smoke has been shown to cause 30% of all heart disease, 30% of all strokes and 90% of lung cancer (Health Canada, 2005).

The centre sees all of these trends in its eight sites. In fact, the number of clinic visits is higher for those who smoke or are exposed to smoke than the number of visits for diabetes. A survey of one community in particular found that nearly 80% of the youth are exposed to second hand smoke (see chart). In response to this crisis, the centre initiated a coordinated smoking cessation program, in 2004, across its eight sites. Training and quality improvement are key. Through the program, six nurse practitioners, a physiotherapist, a registered dietitian and an occupational therapist were initially trained in culturally-appropriate tobacco and smoking cessation counselling. While this worked well for those that wanted to or were ready to quit, continued assessment showed that the majority of clients in 2005 were not ready to quit or even consider it (60% in 2005).

The centre realized that given the significant challenges that were seen in 2006 and 2007 in preparing people to begin, and then to continue to abstain from smoking, a renewed effort was required. That’s why four nurse practitioners were supported to take TEACH training, and have since become certified Intensive Tobacco Cessation Counsellors. The centre also developed a program to cover cessation products for those who didn’t qualify under the federal government’s coverage for First Nations people, or those who have used up their annual allotment. And, as of Fall 2010, training of staff is being expanded to include Motivational Interviewing, a specialized counselling technique to assist people manage change. While a tremendous amount of work still lies ahead, already from 2005 to 2009 the percentage of smokers who have identified as “not ready to quit”, after encounters with program staff, has decreased from 60% in 2005 to 31% in 2009.
The rate of type 2 diabetes in Canada is three to five times higher among Aboriginal people than the national average.
IT IS WELL KNOWN THAT DIABETES HAS reached alarming rates in Canada and around the world. The rate of type-2 diabetes in Canada is three to five times higher among Aboriginal people than the national average. Far too often, however, addressing diabetes has been made strictly a medical issue or left to basic public messaging around healthy eating and healthy lifestyles. While these are both important elements of a diabetes strategy, they do not account for many of the barriers faced by individuals and families, including low-income or poverty, language or cultural barriers and other factors. Progressive health organizations have learned that a wider basket of supports is typically needed, and focused education and support greatly increase the likelihood of individuals preventing or stabilizing diabetes.

The Department of Health at the Mohawk Council of Akwesasne has responded to these challenges in a variety of ways, including the recent launch of a diabetes education program (DEP) through its Aboriginal Health Access Centre and other health services. The program is provided by a Certified Diabetes Nurse Educator (RN/CDE) and a Registered Dietitian who work in collaboration with local family physicians and a staff endocrinologist. Services are provided to all three districts in Akwesasne, ensuring that all have access to services. The goal of the program is to aid in the prevention of diabetes, and to educate people how to self-manage their diabetes in order to reduce their risk of diabetes-related complications.

The DEP offers a unique variety of services, providing: home visits, clinic visits, and community presentations/workshops. Since its launch in March 2010, 100 people have been supported through the DEP, with over 150 client contacts made. These clients have been referred by their physician, or have contacted the DEP directly for self-referral. The DEP receives approximately 2-3 referrals per week. Once seen in the DEP, clients have access to a variety of up-to-date information and tools to help them manage their diabetes, with DEP staff available to help address their questions.

As part of the diabetes strategy, the Department of Health has made gym memberships and exercise kits, including pedometers and walking program resources, available to individuals living with diabetes. The DEP also provides community workshops that address the issue of diabetes prevention through physical activity and diet, with a focus on traditional practices, games, sports and food. The DEP has seen more than 60 people alone since March 2010 at “Lunch and Learns” (community presentations). More than 90% of all participants have indicated an increase in knowledge about diabetes prevention and management (as seen in evaluation).

The CDE nurse and registered dietician can be heard on the local radio station every three months, where community members can call in and speak to the CDE nurse and RD. Information about diabetes screening and diabetes prevention is provided, as well as tips on diabetes self-management. Cookbooks from the CDA are given out as prizes to those that call in. A diabetes newsletter is also developed every three months and given out to those who prefer written information. This newsletter includes recipes, information about diabetes related medications, and other vital information for diabetes self-management. Delivery of care from the DEP is tailored to an individual’s learning style and level of understanding, meaning that every client receives information that is relevant to them, and which meets their unique needs.
Improving child and youth health in Hamilton and Brantford

Addressing service gaps through research

As data from the 2006 census demonstrate, the Aboriginal population across Canada is younger and growing faster than national averages. However, the tremendous health care and support needs of adult Aboriginal community members mean that resources available to Aboriginal health organizations to adequately reach this growing, younger population are greatly limited (see page 16 of this report).

The gap in care for First Nations, Métis and Inuit children and youth is perhaps nowhere more evident than in the area of mental health. In the Hamilton and Brantford areas, for instance, community assessments persistently show major gaps in Aboriginal children’s mental health services including, but not limited to FASD services, and child protection service supports. In Brantford, the 2005 closure of the Pine Tree Native Centre of Brant alone meant a loss of over 20 child-focused Aboriginal social service programs. And, the amendment of the Child and Family Services Act has meant that the number of Aboriginal children and adolescents taken into care within Ontario has doubled in recent years. This has sparked wide concern that the effects of past colonial practices, such as Residential Schools and the “1960s swoop”, when thousands of Aboriginal children across Canada were forcefully swooped up and away from their families, will be repeated and perpetuated through current services.

In response to these and other growing concerns in Hamilton/Brantford, De Dwa Da Dehs Nyes’s AHAC carried forward a ground-breaking research project in 2009-10, to determine appropriate, system-wide responses to these service gaps. Far from seeing itself as the sole vehicle for improving Aboriginal child and youth health and support, the AHAC focused on fostering and creating systemic change.

Through the support of the Hamilton Niagara Haldimand Brant LHIN, the Building Community Pathways: Aboriginal Children’s Mental Health Project identified and began to initiate culturally-appropriate pathways to care for children involved, or at-risk

In response to growing concerns in Hamilton/Brantford, De Dwa Da Dehs Nyes’s AHAC carried forward a ground-breaking research project in 2009-10, to determine appropriate, system-wide responses to service gaps.
The project has begun to help stakeholders in the region understand the conditions required to establish a collaborative services network dedicated to Aboriginal infant and children’s mental health.

of becoming involved in the child welfare system. Aboriginal children, families and service agencies — both Aboriginal-led and non-Aboriginal — were interviewed to ensure broad input into research findings and recommendations.

Based on research findings, project recommendations were developed for Aboriginal and non-Aboriginal frontline mental health professionals and organizations. Special attention was paid to increasing levels of understanding and awareness about Aboriginal children’s mental health care competencies, leading to development of culturally-relevant screening and monitoring tools for all service providers, along with professional development training materials and supports. The project has begun to help stakeholders in the region understand the conditions required to establish a collaborative services network dedicated to Aboriginal infant and children’s mental health.

A key outcome of the project is a strong recommendation to develop an Aboriginal infant and children’s “coordinated continuum mental health care model”. The integrated model would be fully supported by an Aboriginal Patient Navigator for Aboriginal infants and children (ages 0-6) and their families and/or caregivers. If supported and implemented, this service-delivery model will benefit Aboriginal communities in Hamilton and Brantford in a number of ways: providing a culturally-sensitive framework for service delivery; engaging Aboriginal and mainstream service providers in an integrated way to meet the individual needs of Aboriginal children and their families and/or caregivers; and by improving rates of communication.

Through partnership and local leadership, De Dwa Da Dehs Nyes’s AHAC is carrying the process of healing that occurs within its centre out into the broader community.
WAASEGIIZHIG NANAANDAWE’IYEWIGAMIG AHAC has a strong commitment to improving oral health as part of its holistic approach to overall health for First Nation people in and around Kenora, in northwest Ontario. This commitment has grown over time, sparked by needs identified in the community. When the AHAC first opened in the late 1990s, concerns were raised by community leaders that many young children were undergoing traumatic and expensive surgical extractions of baby teeth at the local hospital. These procedures were deemed completely preventable, and had far-reaching impacts on overall childhood health. In response to these concerns, the centre took steps in 1999 to develop and implement a pilot dental program.

The program delivery model that was piloted was widely-praised, and ultimately contributed to the establishment of, and framework for Health Canada’s Children’s Oral Health Initiative (COHI) in Ontario. COHI is designed to prevent and control tooth decay in First Nations and Inuit children.

Through Waasegiizhig Nanaandawe’iyewigamig’s program, now a full COHI participant, staff provide preventive dental services to 9 of the 10 First Nations communities in the AHAC’s catchment area. A Dental Health Educator visits communities regularly to provide oral health education and preventive strategies, including the application of fluoride varnish (2 to 4 times a year, as required) to the teeth of participating children. She also organizes and supports tooth-brushing programs in all daycares and the majority of Junior Kindergarten to Grade 2 classrooms.

Part-time Registered Dental Hygienists also visit each community to screen children for referral to COHI services, or for restorative and surgical treatment where needed. These hygienists also bring portable dental equipment to each school to apply fissure sealants. Outreach and partnership in the community are clearly key to the success of the program.

In 2009-10, the centre’s COHI staff completed 126 community visits, and provided services to a total of 1866 children. The centre’s chronic under-funding results in a lack of data collection staff, thereby posing challenges in documenting service outcomes beyond participant numbers. However, a great deal of anecdotal evidence has shown that the centre’s preventive strategies are having a positive impact on the oral health of younger children, reducing the number of surgical extractions carried out under full anaesthesia.
National leadership in urban Aboriginal health

How one centre is addressing Canada’s crisis of homelessness

THE WABANO CENTRE FOR ABORIGINAL HEALTH, in Ottawa, has been widely acknowledged as a leader in health care for urban Aboriginal populations. With a growing and highly-transient Aboriginal population in the City of Ottawa, Wabano has had to become flexible and highly innovative in its approach to improving health in the face of great odds. The centre’s homelessness program — the Getcha-Nishing Mashkiki Mobile Health Outreach Unit and Homelessness Initiative — is a prime example.

The situation faced by Ottawa’s homeless Aboriginal population is grim. A 2007 report by the Ontario Federation of Indian Friendship Centres found that Aboriginal people make up 19% of Ottawa’s homeless population, despite that fact that only 2% of the overall Ottawa population is Aboriginal1. Of these, 70% are men and a growing number are youth. Statistics from Wabano’s homelessness program show that 90% of street-involved and homeless Aboriginal people in Ottawa are dealing with alcohol and drug addictions, mental illness, and co-morbid physical health problems. Many of the women within this population are involved in the sex-trade, either directly or in more subtle ways such as offering sex in return for a place to stay, food or drugs.

Providing care to homeless clients is always a complex enterprise. Wabano’s mobile outreach and homelessness initiative was designed to not only meet these complex needs, going to people instead of only providing somewhere to go, but in ways that are consistent with the centre’s cultural approach to health and wellness. This includes integration of culture into all program dimensions, with a focus on traditional and holistic healing to improve emotional, spiritual, mental, and physical health. Program staff include a Program Manager, an Addictions Outreach Worker, a Mental Health Outreach Worker, a Nurse Practitioner, a Grandmother, a Youth Outreach Worker, and a Housing Outreach Worker. Together, this team — adapted from the Assertive Community Treatment model — provides a wide range of services.

The Getcha-Nishing Mashkiki Addictions Outreach Worker (AOW) promotes access to and provides culturally-based addictions programming specific to the unique needs of homeless and street-involved Aboriginal people, including access to a full network of community, health and housing supports in accordance with client needs and aspirations. The AOW also works with Aboriginal clients to help stabilize them so that they may be bridged to housing and/or organizational addictions supports.


Addressing the physical needs of the client

The Nurse Practitioner brings services to clients on the streets, such as:

- Diagnosis and treatment of common illness, disease and injuries
- Immunizations
- Assessments or referrals for mental or psychiatric illness
- Blood testing services
- Case management and referral or linkage to medical services
- On-call back-up for clinical supervision

Addressing the mental needs of the client

The Mental Health Outreach Worker brings services to clients on the streets, such as:

- Crisis intervention
- Brief assessments
- Housing or legal advocacy, referrals or linkages
- Individual counselling
- Social assistance or support services
- Referrals for mental or psychiatric illnesses
In an effort to reach homeless or at-risk Aboriginal youth, the Getcha-Nishing Mashkiki team also consists of a Youth Outreach Worker (YOW) who is tasked with providing culture-based outreach to Aboriginal youth within existing programs and services such as youth programs and drop-in centres. The YOW is also engaged in a city-wide Education and Awareness initiative aimed at enhancing services to better meet the needs of Aboriginal people who are homeless or at risk of becoming homeless.

The Getcha-Nishing Mashkiki Grandmother attends to the spiritual needs of the homeless Aboriginal population, including crisis intervention, visits and companionship, traditional teachings and cultural bridging. In addition to providing for the clients, the Grandmother also provides assistance to program staff in the form of cultural guidance and cultural interpretation for staff members not familiar with Aboriginal Traditional Teachings.

The success of this program lies in recognition that relationship building is crucial in meeting the needs of the urban Aboriginal homeless population. Program staff understand that in order to identify and meet client needs, they must be able to talk to them openly and gain their trust, being non-intrusive and non-judgemental. In addition to ongoing relationships of trust on the street, the Getcha-Nishing Mashkiki program has built meaningful relationships with 17 Aboriginal and non-Aboriginal programs within the City of Ottawa, including but not limited to the Sandy Hill Community Health Centre, 454 Drop In Centre, 510 Drop In Centre, and The Mission, as well as with the Ottawa Police Services.

A sign of both the program’s success as well as our collective failure to stem the growth of homelessness in Canada, the program’s client numbers continue to grow, year after year. In 2009-2010, the Getcha-Nishing Mashkiki program reached 946 clients and made 13,561 contacts with Aboriginal people on the streets.
NO ONE HEALTH ORGANIZATION ALONE CAN turn the tide of illness or overcome the barriers that First Nations, Métis and Inuit community members face in achieving health. And, health care services alone are not enough, since many of the root causes of illness and marginalization among clients lie in factors within the community such as inadequate housing, barriers in education, lack of access to adequate food and nutrition, challenges with the criminal justice system, and other factors. That’s why AHACs partner with both Aboriginal and non-Aboriginal health and social service agencies locally, to ensure that the wrap-around care and support found inside the AHAC also extends out into the community.

Some of the program partners with which AHACs routinely collaborate and coordinate within the health system are:

- Healing lodges
- Community Health Centres (CHCs)
- Community mental health and addictions programs
- Community support agencies
- Sexual and reproductive health organizations
- Local hospitals
- Long-term care homes, and others

Outside of the health system, AHACs also partner routinely with:

- Native Friendship Centres
- Shelters and housing authorities
- Children’s Aid Societies
- Local schools
- Community centres and resource centres, and others

Health care is about helping individuals, families and communities achieve a complete state of physical, mental, emotional and spiritual well-being. AHACs continue to foster bridges wherever they lead toward this shared goal.

AHACs are multi-funded, multi-partner health and wellness centres

Although AHACs receive their core funding from the Ministry of Health and Long-Term Care, through AHWS, the multi-faceted role of AHACs has increasingly been recognized by other Ontario Government Ministries, Local Health Integration Networks, Health Canada and other partners. In addition to the core primary health care services provided by AHACs, a few of these other services and partnerships include:

- FASD program partnerships through the Ministry of Children and Youth Services
- Targeted healthy eating, healthy living projects through the Ministry of Health Promotion
- Mental health projects through Local Health Integration Networks
- Aging at Home programs through Local Health Integration Networks
- HIV/AIDS prevention and care programs in partnership with the Ontario Aboriginal HIV/AIDS Strategy
- Several on-reserve programs and projects through Health Canada
AHACs are an integral part of Ontario’s health system. Since first implemented in the mid-1990s, they have earned trust and gained a solid reputation in the communities they serve. Along with this, demand for their services and programs has grown, and continues to grow.

For a number of years, this growth was not matched by new resources. AHACs developed core funding and infrastructure shortages, much of which still persists. Since 2006, however, momentum has shifted. AHACs have been invited by the Ministry of Health and Long-Term Care to play a larger role in provincial health programs and new initiatives. And, increased recognition of the AHAC funding shortfall has led to incremental funding enhancements, including new funding for physicians and nurse practitioners; base funding increases in each of 2009 and 2010; and funding for a number of new programs and initiatives, such as diabetes education, smoking cessation and mental health care.

AHACs anticipate that fully-equitable funding will soon be provided by the Government of Ontario. This will enable them to offer service levels, staffing and space on par with other primary health care organizations in Ontario, such as Community Health Centres. This equity will benefit Aboriginal families and communities. It will also benefit all Ontarians since it will help further reduce the burden on hospital emergency rooms, reduce avoidable in-patient stays and ease pressures on other more costly parts of the health system.

HOW AHACs are playing an increased role within the Ontario health system

• Expanded funding for physician and nurse practitioner salary levels, since 2007, to enable AHAC physicians and NPs to achieve greater equity and stability with colleagues working in other parts of the health system
• Targeted smoking cessation services at AHACs, beginning in 2008
• Implementation of Diabetes Education Teams, beginning in 2009
• Increased project funding through various Local Health Integration Networks, for strategies such as mental health services and Aging At Home programs
• A 2.25% core funding increase in each of 2009 and 2010 to support program and cost-of-living increases
Equitable funding for AHACs — anticipated in the near future — will enable centres to provide service levels, staffing and space equitable to that provided in other parts of the health system, to benefit Aboriginal families and their communities.
Aboriginal Health Access Centres (AHACs) have made a powerful contribution to health and well-being in Ontario, helping to bring tens of thousands of Aboriginal community members into the circle of care and support. From clinical care services, to integrated chronic disease prevention and management, family-focused maternal/child health care, addictions counselling, traditional healing, mental health care, youth empowerment and other programs, AHACs serve as a key gateway to overall family and community health and development.

For AHAC contact information, including website addresses, visit www.aohc.org