Program Review of the

Aboriginal Health Human Resources Initiative (AHHRI)

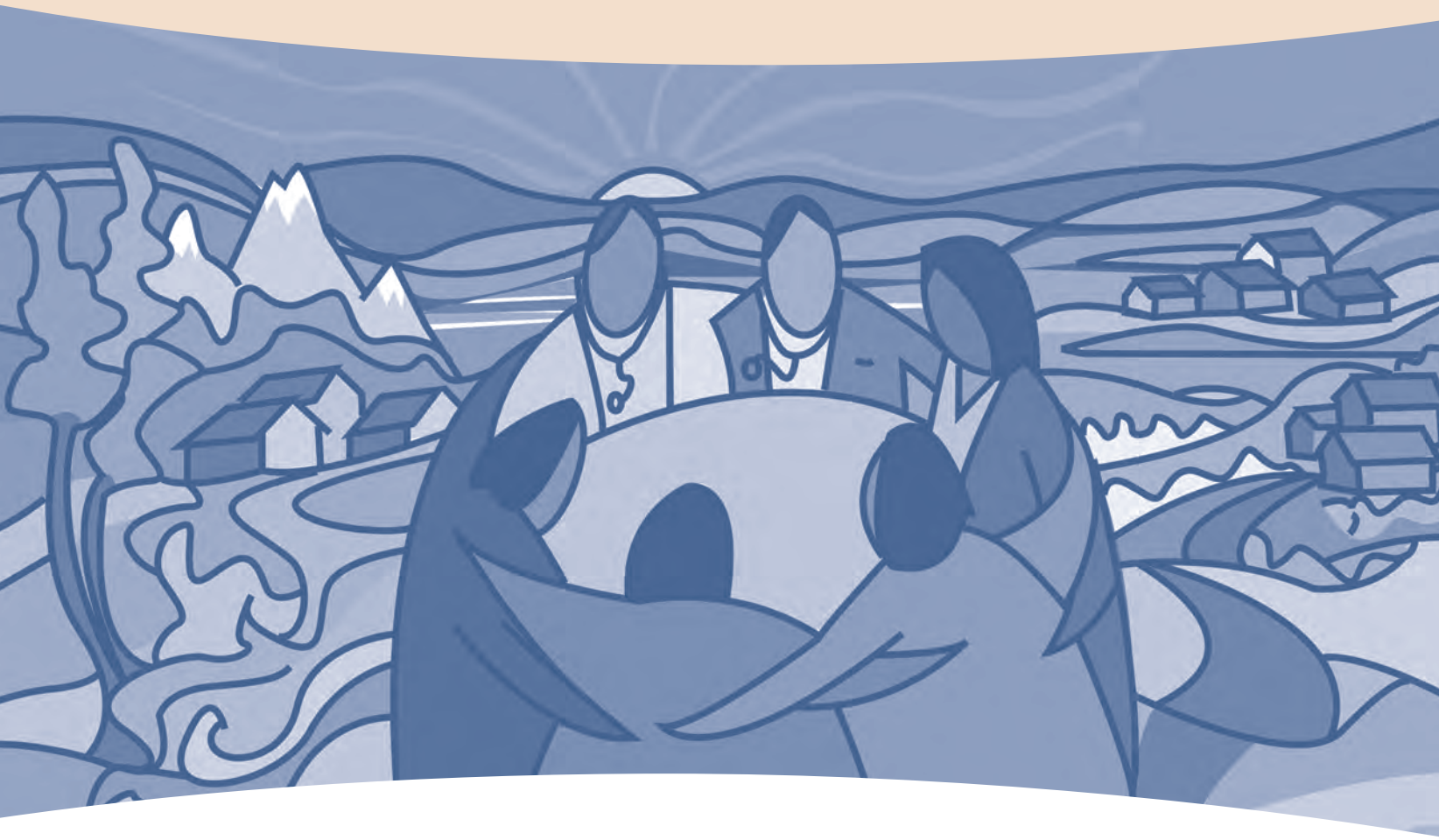


Table of Contents

Acronyms v
Executive Summary vii
- Introduction vii
- Methodology vii
- Conclusions and Findings viii
- Recommendations ix

1 Introduction 1

2 Review Framework 3

A. Objective and Scope 4
B. Approach and Methodology 4
- Phase 1: Development of the Review Framework 4
- Phase 2: Data Collection 4
- Phase 3: Data Analysis and Reporting 5

3 Profile of the Aboriginal Health Human Resources Initiative 7

A. Background 8
B. AHHRI's Purpose and Objectives 9
C. AHHRI's Partners, Target Groups and Stakeholders 10
D. AHHRI's Activities, Outputs and Outcomes 10
E. AHHRI's Governance and Roles and Responsibilities 11
- Advisory Committees 11
- First Nations and Inuit Health Branch, Health Canada 11
- Human Resources and Skills Development Canada 14
- Indian and Northern Affairs Canada 14
- National Aboriginal Organizations 14
- Provinces and Territories 14
- Post-Secondary Institutions 14

F. Program Delivery 14
- National-Level Activities 14
- Regional-Level Activities 15

G. AHHRI's Funding 15
- Funding Profile 15
- Funding Approach 15
- Funding Criteria 15
- Activities That Are Not Funded 16

4 Review Findings and Conclusions 17

A. AHHRI's Reach or "Footprint" 18
- Distribution of Projects Across the Country 18

Distribution of Expenditures Across the Country 19
Size of Projects in 2008–09 20
Types of Projects in 2008–09 20
Type of Project Leads in 2008–09 21
Summary of Findings and Conclusions 21
B. Achievement of Outcomes/Results Against the Five-Year Objectives 22
AHHRI as a Catalyst in a Health Human Resources Development System 22
Mapping AHHRI's Five-Year Objectives 23
Objective 1: Health Career Awareness 24
Objective 2: Increasing Number of Aboriginal Students Entering and Succeeding in Health Career Studies 26
Objective 3: Increasing Number of Supportive Post-Secondary Institutions (Curricula, Access Programs, and Student Support) 28
Objective 4: Supportive Work Environments to Support Retention 31
Objective 5: Establishing Standards of Practice and Certification Initiatives 32
Objective 6: Collaboration and Partnerships 33
Objective 7: Promote Research, Best Practices and Support for Policy Planning and Program Decisions 34
C. Program Design and Delivery 36
Overview 36
Summary of Consultations 36
Summary of Findings and Conclusions 37
D. Governance and Accountability 37
Overview 37
Summary of Consultations 38
Summary of Findings and Conclusions 38

5 Overall Conclusions and Recommendations 41
A. Conclusions 42
B. Recommendations 42

Annex A: List of Key Informants 44
Annex B: Fundamental Concepts in the Field of System Dynamics 48
Unique Characteristics of "Systems-Based" Analysis 48
A Dialogue-Based Approach 48
The Power of Mental Models 48
Discovering, Analyzing, and Communicating Through Graphical Representations 48
A Focus on Understanding Systems Structure and Behaviour Over Time 48
Using Qualitative Models to Understand System Performance 49
Gaining Insight Through Systems Simulation Models 50
Annex C: Number of Projects and Expenditures Touching Each Category of the AHHRI Logic Model in 2008–09 52

Acronyms

A

AFMC Association of Faculties of Medicine of Canada
AFN Assembly of First Nations
AHHRI Aboriginal Health Human Resources Initiative
AHRDA Aboriginal Human Resource Development Agreement (holders)
ANAC Aboriginal Nurses Association of Canada

B

BN Bachelor of Nursing

F

FNIHB First Nations and Inuit Health Branch
FNHM First Nations Health Managers
FSIN Federation of Saskatchewan Indian Nations

H

HHR Health human resources
HR Human resources
HRSDC Human Resources and Skills Development Canada

I

INAC Indian and Northern Affairs Canada
IPAC Indigenous Physicians Association of Canada
ITK Inuit Tapiriit Kanatami

M

MDS Minimum data set

N

NAAF National Aboriginal Achievement Foundation
NAHO National Aboriginal Health Organization
NESA Nursing Education in Southwestern Alberta
NITHA Northern Inter-Tribal Health Authority

P

PSE Post-secondary education
PTO Provincial and territorial organization

R

RFP Request for proposal
RN Registered nurse

S

SAHO Saskatchewan Association of Health Organizations
SPANS Support Program for Aboriginal Nursing Students

Executive Summary

Introduction

This report presents the findings, conclusions and recommendations of the program review of the Aboriginal Health Human Resources Initiative (AHHRI). The review is a key accountability requirement and is intended to inform internal management processes and to inform all partners and stakeholders in the AHHRI about progress, successes and opportunities for improvement. The review covers the period from AHHRI's inception in 2005 until December 2008.

Methodology

The program review was conducted in three phases—development of review framework; data collection; and data analysis and reporting. The review framework was undertaken in consultation with key internal and external stakeholders. The framework included a logic model and review questions tied to parts of the logic model. As well, the idea of a system dynamics diagram was introduced to tie together the AHHRI objectives and components of the logic model, with "timing" considerations added.

The data collection phase included review and synthesis of information in administrative and program files, review of available literature, and consultations with 77 stakeholders. This included focus groups, meetings with the First Nations and Inuit Advisory Committee and telephone and in-person interviews.

The review team employed the systems analytical methodology to carry out the analysis of the data and information gathered in the second phase. The systems analytical methodology enables conceptualization of the various elements of the AHHRI so as to gain insight into how it has operated as a whole. In taking this approach, the activities and objectives of the AHHRI were mapped out at varying levels of detail against the seven principal objectives of the Initiative. These are to:

- increase the number of First Nations, Inuit and Métis who are aware of health careers as viable career options, focusing particularly on youth awareness;
- increase the number of First Nations, Inuit and Métis students entering into, and succeeding in, health career studies;

- increase the number of post-secondary educational institutions that are supportive of and conducive to First Nations, Inuit and Métis students in health career studies (e.g., with culturally appropriate curricula; student support and access programs; mentorship and reduced barriers to admissions);
- identify the conditions that create supportive and conducive work environments that will increase the retention of First Nations, Inuit and Métis health care workers, and non-Aboriginal health care workers working in First Nations, Inuit and Métis communities;
- establish standards of practice and certification processes for First Nations, Inuit and Métis community-based allied health care workers which will help to ensure a properly trained and mobile health work force, and help improve retention of community-based allied health care workers;
- establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them; and
- initiate the establishment of baseline information; initiate targeted research and analysis on the supply and demand for First Nations, Inuit and Métis health care workers; and identify best practices and approaches in order to support policy, planning and program decisions.

To achieve these objectives, AHHRI provided strategic investments within this system by creating and strengthening partnerships, funding projects either delivered by First Nations and Inuit sponsors or direct funding to stakeholders in the health care system that supported AHHRI objectives. It also involved capacity development and the linking of existing programs and initiatives in order to leverage resources. Several of these projects are highlighted within the seven strategic objectives.

Conclusions and Findings

The Aboriginal Health Human Resources Initiative (AHHRI) was designed to lay the foundation for longer term systemic change in the supply, demand and creation of supportive environments for First Nations, Inuit and Métis health human resources for Aboriginal communities with the goal of improving health status, with a particular emphasis on increasing the numbers of Aboriginal health professionals.

We have found on the whole that the Initiative has made significant inroads in facilitating the conditions for increased Aboriginal participation in the health care system in Canada. Many more Aboriginal people are aware of the educational requirements necessary to pursue a health care career. There is greater awareness and attraction to the broad array of careers available within the health care system. There are innovative pilot bridging programs that will increase the number of Aboriginal people who will be in a position to qualify for entry into health professions and these pilot initiatives form a best practice that can in the future be used to further increase the number of qualified Aboriginal candidates.

There have been a number of projects that have sought to increase the number of culturally competent health professionals. This has included the development of culturally sensitive and relevant curricula that will be used into the future. While there have not been significant volumes of work in the area of Aboriginal retention, the work that has been undertaken has provided some promising results that if adopted more broadly can have a meaningful impact on the health care system as a whole.

More specifically, by 2008–09, AHHRI built a reasonable "footprint" or reach in terms of where it invested in projects, how much it invested, who it invested with, and what areas/interventions it invested in. This pattern was being continued in the formulation of plans for 2009–10. These are all important dimensions in terms of meeting the expectations of many stakeholders. At the same time, it would be appropriate to validate that desired impacts are being achieved by the large number of smaller-sized projects in the regions. This would appear to be an ongoing challenge—managing the tradeoffs and risks involved, or in other words, the balance between reach and impact, when the needs are great across the country.

Although we found the design and governance of AHHRI to be fundamentally sound, we did discover a number of significant areas where performance can be improved in the future. These include the need to:

- enhance strategic communications and establish sustainable networks;
- adopt an improved knowledge management system to share best practices, improve efficiencies, and avoid duplication of lessons learned; and
- streamline administration and enhance the governance mechanism in the Initiative.

Recommendations

These conclusions led the review team to make the following set of recommendations to the program management and partners in the Aboriginal Health Human Resources Initiative (AHHRI). These recommendations go beyond the normal continuous management improvement that is expected of any such initiative.

1. Develop a knowledge management and dissemination strategy including the need to improve upon communications between Health Canada and Aboriginal stakeholders to ensure that the goals, objectives, priorities and best practices are understood and shared.
2. Increase the capacity and role of regions to strengthen regional planning and implementation processes including:
    a. providing regions with the opportunity to establish regional plans, priorities and selecting regional projects (consistent with AHHRI's seven objectives);
    b. over time, moving towards clustering capacity and human resources for both Health Canada regions, First Nations provincial territorial organizations and the four Inuit regions into single-window entities (this could be outsourced like the Aboriginal Human Resource Development Agreement Strategy to regional First Nations and Inuit entities);
    c. elevating responsibility in Health Canada for regional results to Regional Directors; and
    d. developing more effective regional partnerships with Aboriginal, provincial/territorial and federal departments who are responsible for education and training.
3. Develop human resource strategies and approaches that are Inuit-specific.
4. Ensure that northern and rural strategies are reflective of the unique health human resources conditions and needs of those people and regions.
5. Facilitate the development of community-based health human resources planning tools and methodologies including further identifying and strengthening core competencies of community-based health and allied workers.
6. Improve data gathering and reporting mechanisms. These mechanisms need to go beyond simply reporting against project plans, to benefits/impacts and sharing of such assessments and best practices.
7. Strengthen and understand the roles and responsibilities of governance committees and to adopt approaches to reduce turnover and enhance knowledge transmission within governance structure.

1

Introduction

This report presents the findings, conclusions and recommendations of the program review of the Aboriginal Health Human Resources Initiative (AHHRI or the Initiative).

The AHHRI originates from a commitment made by the federal government at the Special Meeting of the First Ministers and Aboriginal Leaders in September 2004. The commitment builds on the previous Health Accord in 2003, which directed provincial, territorial and federal governments to work together with Aboriginal people to advance a health care system that is more responsive to the needs of Aboriginal people. The scope of the AHHRI was broadened at the First Ministers' Special Meeting (September 2004), who determined that the Initiative would be Pan-Aboriginal to also include Métis, non-status and off-reserve First Nations.

The AHHRI is managed by the First Nations and Inuit Health Branch (FNIHB) of Health Canada. It is funded for five years, ending March 2010. The total funding amount is $100 million.

This program review is an accepted accountability requirement for a federal government initiative or program. It is required for internal management purposes (e.g., supporting management excellence, value-for-money, continuous improvement) and for external reporting (e.g., return on investment, accountability). It is also expected to inform all partners and stakeholders in the AHHRI about progress and successes to date and opportunities for improvement.

The timing of the program review is ideal in terms of providing a snapshot of what the Initiative has accomplished, as program managers in FNIHB, together with their partners in the AHHRI, will soon embark upon an application for renewal of the Initiative.

2

Review Framework

A Objective and Scope

The program review represents an opportunity to verify to managers and stakeholders that Aboriginal Health Human Resources Initiative (AHHRI) resources have been used as planned, intended activities have been implemented and outputs accomplished. Furthermore, it is an opportunity to determine how effectively the AHHRI is fulfilling its broader ranging goals, objectives and outcomes.

The scope of the review addresses the following questions:

- Is the Initiative (i.e., AHHRI) doing what it was supposed to do?
- What can be learned about what is working and what is not working?
- What difference is the Initiative making?
- What could or should be done differently?
- What existing AHHRI data sources are there and what are the limitations for these data sources?
- How will the review findings and lessons learned be used to make the Initiative better?

The findings from these questions set the stage for mid-course adjustments as required. For example, capturing best practices and formulating lessons learned informs any design refinements and future activities of the Initiative.

The scope of the mid-term program review also covers the three main objectives outlined in the AHHRI Treasury Board Submission. This provides continuity between the present and the genesis of the Initiative.

To what extent

- did AHHRI progress in increasing the number of Aboriginal people working in health care?
- did AHHRI progress in improving the retention of health workers in Aboriginal communities? and
- have current health care educational curricula been adapted to improve cultural competence in Aboriginal care?

Since AHHRI's inception, five-year objectives were developed and key indicators and questions were selected from the detailed AHHRI long-term review and evaluation table. These five-year objectives are listed in Part B.

The review covers the period from AHHRI's inception in 2005 until December 2008.

B Approach and Methodology

The program review was conducted in three phases—review framework; data collection; and data analysis and reporting.

Phase 1: Development of the Review Framework

In this first phase, the detailed framework and plan for the review was developed. The framework included a logic model and review questions tied to parts of the logic model. As well, the idea of a system dynamics diagram was introduced to tie together the Aboriginal Health Human Resources Initiative (AHHRI) objectives and components of the logic model, with "timing" considerations added.

The results of this phase were documented in the report *Initiative Review Framework and Plan*, which was reviewed with the AHHRI research and evaluation working group, and approved by the project authority.

Phase 2: Data Collection

The data collection phase included review and synthesis of information in administrative and program files, review of available literature, and consultations. The following categories of files were reviewed:

- AHHRI initiation
- program framework documents, plans, scans
- research framework
- evaluation framework
- National project plans, funding, reports

- Regional project plans, funding, reports
- advisory bodies
- Minimum Data Set
- Aboriginal organizations
- Health Canada and other Health Canada programs
- other Government of Canada organizations
- other organizations—including contribution agreements

Consultations included key informants from organizations in the following list. A total of 77 key informants were interviewed. A complete listing is shown in Annex A.

1. First Nations and Inuit Health Branch (FNIHB) headquarters (managers and program officers)
2. Regional FNIHB AHHRI coordinators and other staff
3. AHHRI First Nations and Inuit Advisory Committee
4. Project coordinators for AHHRI funded projects
5. National Aboriginal organizations
6. National Aboriginal health organizations
7. Canadian Institute for Health Information
8. Business Planning and Management Directorate project officer within FNIHB
9. Provincial/territorial organization contacts
10. Other federal government departments—Human Resources and Skills Development Canada

Information from the data collection was documented in working notes that the review team used to support analysis in the next phase.

Phase 3: Data Analysis and Reporting

The review team employed the systems analytical methodology to carry out the analysis of the data and information gathered in the second phase. This analysis led to the production of this first draft report, and will support subsequent drafts and the final version of the final report, as well as presentations to the AHHRI advisory and management teams.

The systems analytical methodology enables conceptualization of the various elements of the AHHRI so as to gain insight into how it has operated as a whole. System dynamics is a way of analyzing that sees beyond what appear to be isolated and independent components of a process and seeks instead to identify the causes of deeper patterns of process behavior.

A fundamental premise of system dynamics is that the behaviour of complex systems is determined by their generic structures and the policies that operate within the system, not by any individual actor or isolated elements within the system.

In taking this approach, the activities and objectives of the AHHRI have been mapped out at varying levels of detail. The review team then identified and examined the causal connections linking each of the human resources development stages, the sequencing of those stages, and the key "drivers" within each of the stages. By understanding how the various human resources development stages (comprising elements of the system) are wired together, we are able to better understand and influence them. In the "systems" approach, we study the whole human resources chain in order to better understand the links. It is the opposite of reductionism—the concept that the whole is simply the sum of its parts. It is a methodology that has resonated with the Aboriginal holistic view of the world.[1]

Our first step in our analysis was to outline the parameters of the broader health human resources development system and how the AHHRI was designed to influence various stages of the system. The AHHRI implementation approach was intended to be a strategic catalyst for changes within this system. The health care system is very large and maintains its existence and functions as a whole through the interactions of its parts. As Health Canada recognized:

> The complexities of First Nations, Inuit and Métis health care involve federal, provincial, territorial and Aboriginal jurisdictions, as well as many interested parties, and a multitude of stakeholders. Each has mandated roles and responsibilities, specific areas of priority and must work within their jurisdictional reach.[2]

The AHHRI was designed to provide strategic investments within this system by creating and strengthening partnerships, funding projects either delivered by First Nations and Inuit sponsors or direct funding to stakeholders in the health care system that supported AHHRI objectives. It also involved capacity development and the linking of existing programs and initiatives in order to leverage resources.

[1] Annex B provides an elaboration of the fundamental concepts in the field of system dynamics, including an explanation of methods used to develop qualitative and quantitative systems models.

[2] AHHRI Program Manual

A distinguishing feature of the systems analytical method is that it relies on the development of graphical representations (pictures) of systems in order to understand what the components are, how they are linked together, and how they interact over time. These may be qualitative representations (i.e., models) of systems structures or, where necessary, simulatable (quantitative) models. This report uses both methods.

Our report highlights some of the critical process components and who is responsible and accountable for those processes. The project team was able to take advantage of the diagnostic function of our systems-based analytical approach in assessing both the design and implementation of the AHHRI. Not only were we able to analyze the appropriateness and efficiency of the overall design and implementation approach to date, but we also identified possible areas for further review and possible redesign.

3

Profile of the Aboriginal Health Human Resources Initiative

This section of the review report is intended to provide key information about the Aboriginal Health Human Resources Initiative (AHHRI) to provide context for understanding the program review findings, conclusions and recommendations. Much of this information is summarized from the AHHRI Program Framework document. Additional, more detailed information about the AHHRI is available from the Health Canada website at http://www.hc-sc.gc.ca/fniah-spnia/services/career-carriere/hum-res/index-eng.php.

A Background

The shortage of health care workers is a national and international issue, but the shortage is particularly acute in First Nations and Inuit communities. Additionally, Aboriginal people are underrepresented in all health care fields, compared to the general population.

To ensure that First Nations, Inuit and Métis have access to the health providers they need both now and in the future, Health Canada created the Aboriginal Health Human Resources Initiative (AHHRI) in 2005. It is funded for five years, ending March 2010.

The AHHRI comes from a commitment made by the federal government at the Special Meeting of the First Ministers and Aboriginal Leaders in September 2004. The commitment builds on the previous Health Accord in 2003, which directed provincial, territorial and federal governments to work together with Aboriginal people to advance a health care system that is more responsive to the needs of Aboriginal people. The scope of the AHHRI was broadened at the First Ministers' Special Meeting (September 2004), who determined that the Initiative would be Pan-Aboriginal to also include Métis, non-status and off-reserve First Nations.

More specifically, as outlined in the AHHRI Program Framework document, the AHHRI is closely aligned with the Pan-Canadian Health Human Resources Strategy (Pan-Canadian HHR Strategy), which was one of several primary initiatives to come out of the 2003 First Ministers' Accord on Health Care Renewal. As part of the work to meet their goals, A Framework for Collaborative Pan-Canadian Health Human Resources Planning (2007) was endorsed by the Advisory Committee on Health Delivery and Human Resources. The Framework promotes a systems-based, collaborative, population needs-based approach to human resource planning. The Framework recognizes the jurisdictional responsibility for health system design and HHR planning, as well as determining the resources available to deliver health care. It also affirms that—because there are a small number of training programs across the country and because of the mobility of the health work force—jurisdictions cannot plan in isolation. Thus, there is an imperative to adopt a collaborative pan-Canadian approach to HHR planning, including HHR planning for Aboriginal communities. Because the Framework is pan-Canadian in scope, priorities for collaborative action among partners and stakeholders are identified to achieve a more stable and productive health work force.

In 2004, funds were committed to target specific First Nations, Inuit and Métis health human resources issues, in particular, to address the severe shortages of First Nations, Inuit and Métis health care providers, and to find ways to make the health care system more responsive to the needs of First Nations, Inuit and Métis in a manner that is culturally appropriate. The guiding principles of the Pan-Canadian HHR Strategy harmonize well with the Aboriginal Health Human Resources Initiative (AHHRI), in particular, the need to accommodate the unique concerns and interests of First Nations, Inuit and Métis communities. The Pan-Canadian Framework, in concert with the AHHRI, promotes the view that each jurisdiction will determine the needs and scope of health service delivery and the types of service delivery models that best suit the population's needs. By adopting this comprehensive, collaborative and needs-based approach it will be possible to more appropriately determine HHR requirements in a manner that is both practical and sustainable over the long term. This will lead to a more responsive and appropriate health

system to meet the unique cultural and socio-economic needs of First Nations, Inuit and Métis across Canada. Needs-based assessment and planning applied to First Nations, Inuit and Métis communities can provide a comprehensive framework within which population needs can be identified and service requirements met.

The limited number of training programs for HHR workers across Canada and the mobility of health human resources generally only highlight the need for collaborative planning between federal, provincial and territorial governments and Aboriginal organizations representing the interests of Aboriginal communities to ensure the needs of First Nations, Inuit, and Métis communities are met in a manner that is culturally relevant and appropriate. In this regard, there is a growing imperative to address existing disparities between the numbers of non-Aboriginal versus Aboriginal health professionals that provide health services to First Nations, Inuit and Métis. In short, there is a need to increase the number of Aboriginal health professionals working in Aboriginal communities.

There are challenges, however, to achieving a successful integration of the Pan-Canadian HHR Strategy and the AHHRI. Paramount among these concerns is the need for governments and educational institutions to be attentive to the unique features of First Nations, Inuit, and Métis communities and their diverse cultures when planning initiatives, curriculum and training approaches. Some of these unique features include, for example, the challenges associated with delivering health care in remote and isolated areas, low population density, and unique considerations such as the social and cultural diversity existing among Aboriginal communities, including distinctive languages and histories.

Purpose

The AHHRI aims to lay the foundation for longer term systemic changes in the supply, demand and creation of supportive environments for First Nations, Inuit, and Métis health human resources.

B AHHRI's Purpose and Objectives

The Aboriginal Health Human Resources Initiative (AHHRI) helps to develop and implement health human resources strategies that respond to the unique needs and diversity among First Nations, Inuit and Métis. By working in collaboration with First Nations, Inuit and Métis, provincial and territorial partners, and the Pan-Canadian Health Human Resources Strategy, the five-year AHHRI builds a foundation for a longer term systemic change in the supply of, demand for, and retention of First Nations, Inuit and Métis health human resources.

Over the long-term, the AHHRI is intended to:

- provide conditions for optimizing the future supply, mix and distribution of the First Nations, Inuit and Métis health work force in ways that are responsive to the unique and diverse health needs of First Nations, Inuit and Métis;
- achieve and maintain an adequate supply of qualified First Nations, Inuit and Métis health care providers who are appropriately educated and supported to ensure culturally competent and safe health care for First Nations, Inuit and Métis; and
- facilitate the adaptation of health care educational curricula so that the cultural competence of graduates providing health care services to First Nations, Inuit and Métis is improved.

Through strategically targeted activities some of which may be First Nations-, Inuit- or Métis-specific and others, which are pan-Aboriginal in nature, the seven objectives for the five-year AHHRI are to:

- increase the number of First Nations, Inuit and Métis who are aware of health careers as viable career options, focusing particularly on youth awareness;
- increase the number of First Nations, Inuit and Métis students entering into, and succeeding in, health career studies;
- increase the number of post-secondary educational institutions which are supportive of and conducive to First Nations, Inuit and Métis students in health career studies (e.g., with culturally appropriate curricula; student support and access programs; mentorship and reduced barriers to admissions);
- identify the conditions that create supportive and conducive work environments that will increase the retention of First Nations, Inuit and Métis health care workers, and non-Aboriginal health care workers working in First Nations, Inuit and Métis communities;
- establish standards of practice and certification processes for First Nations, Inuit and Métis community-based allied health care workers which will help to ensure a properly trained and mobile health work force, and help improve retention of community-based allied health care workers;

Guiding Principles

- First Nations, Inuit and Métis will be meaningfully engaged in all aspects of HHR planning;
- Activities will be respectful of the diversity of First Nations, Inuit and Métis cultures and traditions;
- Activities will be collaborative and aligned with the needs of First Nations, Inuit and Métis;
- Processes put in place through the AHHRI will be based on equity, transparency and accountability;
- The AHHRI will be accessible and priority-driven; and
- The AHHRI will not replace, but rather build upon and leverage, existing activities.

- establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them; and
- initiate the establishment of baseline information; initiate targeted research and analysis on the supply and demand for First Nations, Inuit and Métis health care workers; and identify best practices and approaches in order to support policy, planning and program decisions.

C AHHRI's Partners, Target Groups and Stakeholders

The four target groups for the Aboriginal Health Human Resources Initiative (AHHRI) are:

1. First Nations, Inuit and Métis regardless of their status and where they reside;
2. health care providers who provide services to First Nations, Inuit and Métis;[3]
3. universities and colleges (including those controlled by First Nations, Inuit and Métis) delivering health science programs that are interested in making changes in the curricula in order to provide more culturally relevant health science programming; and those that would like to provide culturally relevant health care programs; and
4. First Nations, Inuit and Métis and non-Aboriginal health professional and para-professional associations and organizations, and associations representing colleges and universities.

[3] Includes providers serving First Nations, Inuit and Métis in urban, rural, remote and isolated geographic areas. It is also understood that health care providers include First Nations, Inuit, Métis and non-Aboriginal health personnel.

D AHHRI's Activities, Outputs and Outcomes

The logic model provides an overview of the outcomes to be achieved (immediate outcomes) or influenced (intermediate and final outcomes) by the Aboriginal Health Human Resources Initiative (AHHRI), and how outputs and supporting activities contribute to these outcomes. The questions asked in this review were very strongly linked to the logic model.

The activities and related outputs in the AHHRI are described as clustering into four main groups that relate to the AHHRI's seven objectives for its five-year mandate:

A. intervention: Early education system—Students' awareness about health careers during primary and secondary school;

B. intervention: Post-Secondary Education (PSE) system—Students' access to, choices about and success in post-secondary education;

C. intervention: Health Care Workplaces—Health care employers and First Nations, Inuit and Métis health care employees; and

D. intervention: Building Capacity

These activities and related outputs lead to a number of direct outcomes over which the AHHRI has a high degree of influence and control. These, in turn, contribute to the achievement of intermediate (shared) outcomes which are shared with other stakeholders, and ultimate outcomes which are the high level benefits.

The logic model and the linkages to the AHHRI's five-year objectives are shown on pages 12–13.

E AHHRI's Governance and Roles and Responsibilities

The development and implementation of the Aboriginal Health Human Resources Initiative (AHHRI) is managed and coordinated by the First Nations and Inuit Health Branch (FNIHB) of Health Canada. Regional First Nations and Inuit Health offices only work with, and fund, First Nations and Inuit projects and partners. The AHHRI staff at the national FNIHB office work with and fund projects with these partners as well as with Métis, non-status and off-reserve First Nations (i.e., the broader scope decided upon at the First Ministers' Special Meeting in September 2004).

The work of the AHHRI is overseen by two advisory committees; the First Nations and Inuit Advisory Committee; and the Métis and Off-Reserve Advisory Committee, which is currently inactive. The First Nations and Inuit Advisory Committee is co-chaired by Health Canada and the Assembly of First Nations. The national Aboriginal organizations and federal, provincial and territorial governments are represented on these committees. Linkages with provinces, territories and the Pan-Canadian Health Human Resource (HHR) Strategy are reinforced through the advisory committees. In addition, the AHHRI is represented on the Advisory Committee on Health Delivery and Human Resources and its sub-committees which further reinforce the linkages with provinces and territories and the Pan-Canadian HHR Strategy. FNIHB regions have a large role in establishing liaison with the provincial/territorial and regional level First Nations and/or Inuit organizations in the AHHRI. Other key partners such as professional health organizations and universities are engaged to facilitate and support the achievement of the AHHRI objectives.

More detail is provided below.

Advisory Committees

The two advisory committees meet yearly to share successes and to provide advice on the AHHRI's overall plan for the coming year. The mandate of the advisory committees is to:

- provide input, to help direct the implementation of the AHHRI's framework and to help ensure that it addresses the current and future needs of First Nations, Inuit, Métis, non-status and off-reserve Aboriginal people;
- promote the joint planning for all components of the AHHRI between Health Canada and its partners (First Nations, Inuit, Métis, non-status and off-reserve Aboriginal peoples);
- provide guidance over the Initiative's framework implementation and evaluation plans; and
- support and enhance linkages with federal, provincial, territorial and Aboriginal HHR activities.

First Nations and Inuit Health Branch, Health Canada

Health Canada has overall responsibility for the development and implementation of the AHHRI and ensuring that funding is appropriately allocated and spent according to established criteria and guidelines. Health Canada also ensures the necessary engagement of partners in the process, and adherence to government procedures and reporting and accountability standards.

National responsibilities:

- develop the program framework;
- develop and implement the evaluation framework, research plan, year 2 to 5 plan, communications plan and governance structures;
- liaise with national Aboriginal organizations on the AHHRI;
- maintain linkages with the Pan-Canadian HHR Strategy and its governing committees (e.g., Advisory Committee on Health Delivery and Human Resources);
- liaise with other federal departments involved in HHR initiatives such as Human Resources and Skills Development Canada (HRSDC) and Indian and Northern Affairs Canada (INAC);
- support the AHHRI advisory committees and activity-specific working groups;
- implement national-level activities of the Initiative; and
- implement and manage the Métis, non-status and off-reserve components of the Initiative.

Regional responsibilities:

- develop regional plans and participate as members of a national and regional HHR team;
- work with First Nations and/or Inuit regional-level organizations in the development and implementation of the regional plans;
- ensuring the Indian and Inuit Health Careers Program and the AHHRI are linked at the regional level;

AHHRI Logic Model

5. Ultimate Outcomes

A foundation is built for longer term systemic change in the supply of, demand for and retention of FN/I/M health human resources, addressing acute shortages and making system more responsive

4. Intermediate Outcomes

Health Career Awareness Strategy	FN/I/M Health Careers Students	Education System Transformation	Curriculum Cultural Inclusion
FN/I/M students choose to pursue Health Careers	FN/I/M students enrol and graduate from PSE health career studies		

3. Direct Outcomes

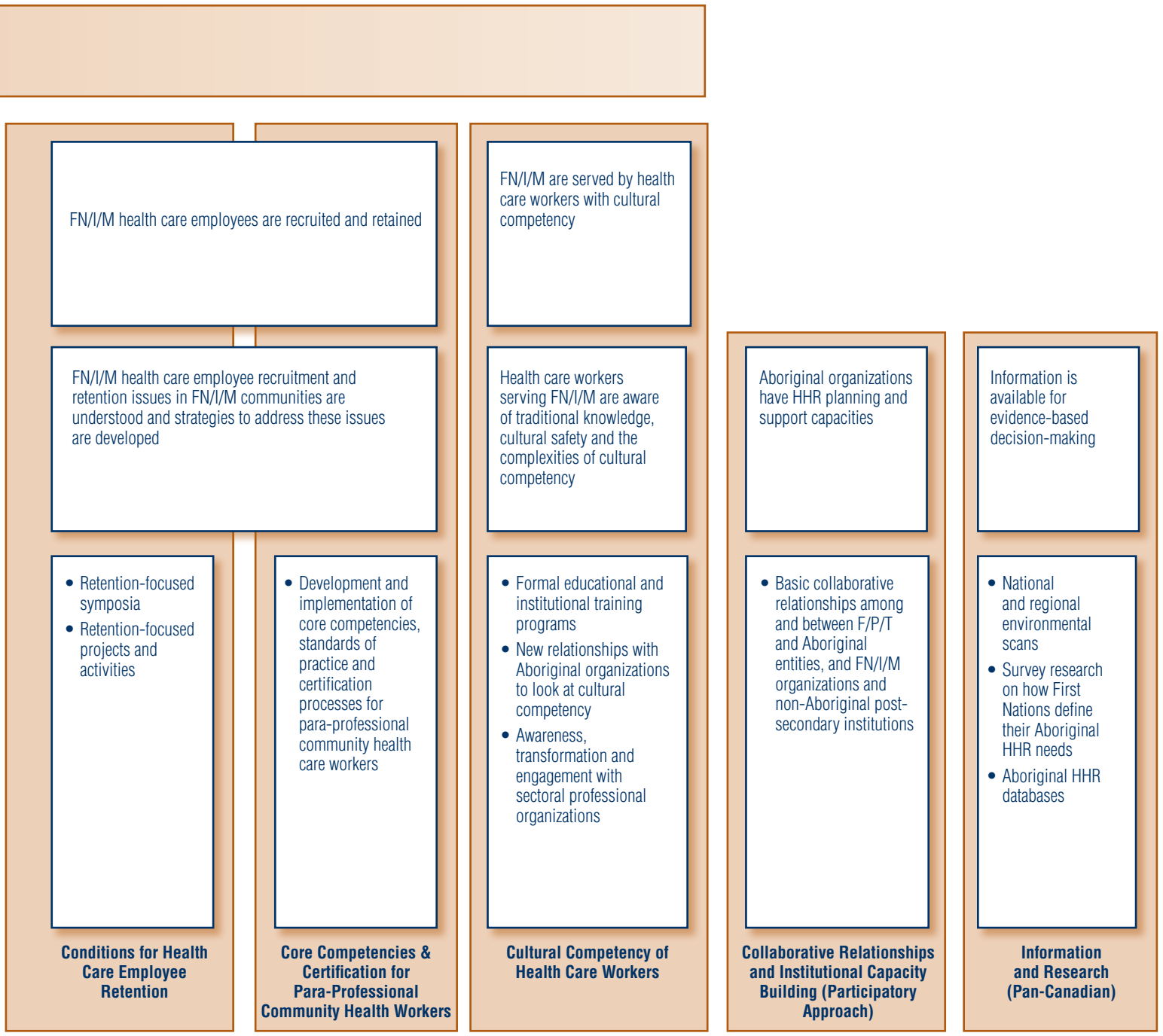
Health Career Awareness Strategy	FN/I/M Health Careers Students	Education System Transformation	Curriculum Cultural Inclusion
FN/I/M students are aware of Health Careers	Financial barriers are reduced and financial investments/ incentives provided for FN/I/M students	Non-financial barriers are reduced for FN/I/M students	

2. Outputs and 1. Activities

Health Career Awareness Strategy	FN/I/M Health Careers Students	Education System Transformation	Curriculum Cultural Inclusion
• Promotional materials • School materials and programs • Support to career fairs • Health care professionals and para-professionals participating in career fairs • Linkages with Indian Inuit Health Careers Program (IIHCP)	• FN/I/M scholarships and bursaries designated for health careers	• Access, bridging and mentorship programs in PSE institutions • Modified entry criteria and adapted admissions processes for PSE institutions	• Development and modification of medical, nursing and para-professional curricula to be more culturally relevant to FN/I/M contexts

AHHRI's Five-Year Objectives

A. Early Education	B. Post-Secondary Education System	
Increase the number of First Nations, Inuit and Métis who are aware of health careers as viable career options, focusing particularly on youth awareness	Increase the number of First Nations, Inuit and Métis students entering into, and succeeding in, health career studies	Increase the number of post-secondary educational institutions which are supportive of and conducive to First Nations, Inuit and Métis students in health career studies (e.g., with culturally appropriate curricula, student support and access programs, mentorship and reduced barriers to admissions)



C. Health Care Workplaces

Identify the conditions that create supportive and conducive work environments that will increase the retention of First Nations, Inuit and Métis health care workers, and non-Aboriginal health care workers working in First Nations, Inuit and Métis communities

Establish standards of practice and certification processes for First Nations, Inuit and Métis community-based allied health care workers which will help to ensure a properly trained and mobile health work force and help improve retention of community-based allied health care workers

D. Building Capacity

Establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them

Initiate the establishment of baseline information; initiate targeted research and analysis on the supply and demand for First Nations, Inuit and Métis health care workers; and identify best practices and approaches in order to support policy, planning and program decisions

- liaising with provincial and/or territorial ministries of health and their HHR personnel;
- liaising and coordinating with regional INAC and HRSDC offices;
- coordination with provincial- and/or territorial-level health professional regulatory bodies;
- coordination with the FNIHB regional health program staff for HHR planning; and
- implementation of regional-level activities of the Initiative.

Human Resources and Skills Development Canada

The achievement of the Initiative's objectives requires the involvement of other federal departments. The role of Human Resources and Skills Development Canada (HRSDC) is to ensure horizontal integration of federal investments in HHR skills development by targeting HHR skills development for funding, promotion of health careers, providing linkages with the Aboriginal Human Resource Development Agreement (AHRDA) holders, and by supporting innovative Aboriginal HHR pilot projects.

Human Resources and Skills Development Canada also works with Health Canada to ensure that funding in skills development is made available to support health care workers in skills training.

Indian and Northern Affairs Canada

Indian and Northern Affairs Canada (INAC) has a role to play in ensuring that primary and secondary educational programs for First Nations are up to provincial standards so that First Nations youth are meeting the necessary standards in mathematics, sciences and basic literacy to enable them to enter into health careers training and post-secondary health careers studies. Indian and Northern Affairs Canada's Aboriginal Workforce Participation Initiative will assist in the development of strategies to encourage retention of Aboriginal health care workers. There are also strong linkages to be developed with the Social Framework Strategy.

National Aboriginal Organizations

National Aboriginal organizations' roles are to advance the specific priorities of their peoples within the context of health human resources, and to become engaged in all aspects of HHR planning and implementation, to ensure that the needs of First Nations, Inuit and Métis are being met. The national Aboriginal organizations have the responsibility of representing their constituencies to Health Canada to ensure that their specific needs are met within the context of the AHHRI.

Provinces and Territories

Provinces and territories have a responsibility for overall HHR planning within their area of jurisdiction, and through the work of the First Ministers' Meetings, have committed to participating in a pan-Canadian HHR framework process to help ensure that a national HHR planning process can be implemented to help deal with issues related to health human resources. Provinces and territories also have responsibility to ensure access to health care for their citizens, and as such, need to ensure the quality and supply of health care workers in their jurisdictions through the Advisory Committee on Health Delivery and Human Resources and their own HHR plans. Provinces and territories fund a significant percentage of post-secondary education for health careers and ensure that primary and secondary school students are provided with a solid foundation in mathematics, sciences and basic literacy (i.e., that they have access to education that provides them with the prerequisites for post-secondary education).

Post-Secondary Institutions

The role of post-secondary educational institutions is to provide a learning environment that supports Aboriginal students, the provision of health studies curricula that are culturally relevant, and the development of health care providers who are culturally competent to provide care to Aboriginal peoples.

F Program Delivery

The AHHRI is delivered through both national-level and regional-level activities.

National-Level Activities

National-level activities are those which maximize investment and which target activities that will impact First Nations, Inuit and Métis on a national level. These activities can include increasing bursary and scholarship funds for First Nations, Inuit and Métis health career students; data collection and research; development of core competencies and standards for allied health care workers; work with national associations to facilitate post-secondary health education

curricula changes to enhance cultural competency; national program evaluation; and research.

The National office manages the relationship with the Métis National Council, the Congress of Aboriginal Peoples, and the Native Women's Association of Canada for activities targeting Métis, non-status and urban Aboriginal people.

Regional-Level Activities

The intention of the Initiative has and continues to be to strategically target regional investments and projects based on agreed upon priorities that have been mutually established through environmental scans/needs assessments and through a work plan in each regional office. These plans are developed in collaboration with First Nations or Inuit partners, provinces or territories and other stakeholders, and include, among other elements, funding for access, bridging and support programs at educational institutions and organizations in the regions.

The FNIHB regions are not responsible for activities related to the Métis and non-status components.

G AHHRI's Funding

Funding Profile

As a follow-up to the commitment made at the 2004 First Ministers' Meeting with First Nations, Inuit and Métis leaders, the federal budget of 2005 allocated $100M over five years towards the Aboriginal Health Human Resources Initiative (AHHRI). Funding ramped-up over the first two years of the program, and levelled-out in the third, fourth and fifth years.

Information about how these funds were allocated to the AHHRI's different components is shown in Section 4 (see page 20–21).

Funding Approach

Funding authority for the AHHRI is currently for five years only and, as such, is not eligible for transfer. The funding is intended to build the foundation for systemic change in health human resources and much of that work is considered to be best accomplished through strategic investments made with national or regional organizations or institutions. Funding is not allocated directly to communities or regions on either community-based or population-based formulae, in order to ensure that existing investments in health human resources can be enhanced and duplication of efforts avoided.

To support effective delivery of the $100M in funding over the five years of the AHHRI, both the national projects and regional work planning approaches are used to implement the Initiative priorities, and distribute funds in an equitable and transparent manner. This approach was developed based on the feedback received from stakeholders and partners, and bilateral discussions with First Nations, Inuit and Métis organizations and other governmental departments.

For the most part, funding for the AHHRI flows through First Nations and Inuit Health Branch (FNIHB) national and regional contribution agreements or contracts to a variety of organizations, institutions, associations, agencies, universities and/or colleges as outlined in the FNIHB's Health Governance/ Infrastructure Support Authority.

Funding Criteria

The following funding criteria generally apply for all activities:

- consistency and alignment with the AHHRI's objectives;
- alignment with the Pan-Canadian HHR Strategy;
- cultural appropriateness taking into account traditional knowledge and practices;
- designed and/or delivered in partnership with First Nations, Inuit and Métis and their organizations and recognition of their unique health priorities and needs;
- potential to be applicable/transferrable to multiple regions, schools, institutions, associations and/or jurisdictions;

Funding Profile

Year	2005–06	2006–07	2007–08	2008–09	2009–10
Amount	$5.5M	$24.5M	$23.0M	$23.5M	$23.5M

- compatibility with other projects/activities under the AHHRI;
- sustainability that will ensure that activities are completed within the time span of the funding agreements without the need for incremental or ongoing funding;
- consideration of a gender-based analysis;
- where applicable, inclusion of a tripartite agreement (federal, provincial/territorial and First Nations/Inuit/Métis authorities); and
- an evaluation plan that includes a methodology for monitoring and evaluation with measurable targets.

Activities That Are Not Funded

In order to maximize the AHHRI's achievements, the decision was taken to focus funding on priority areas, and, as such, some investments are excluded. The following activities are not funded through the AHHRI:

- continuing education costs for current community-based health care workers (these costs are the responsibility of programs);
- purchase of seats at post-secondary educational institutions for health care students (these costs fall within the purview of provincial and territorial ministries of education);
- salary dollars to provide wage parity for health care workers, or monetary recruitment and retention packages or incentives;
- major capital or building expenses;
- equipment costs related to ongoing service delivery of health programs; and
- elementary or secondary school programs (e.g., mathematics, sciences and literacy programs—these costs fall within the purview of provincial and territorial ministries of education or Indian and Northern Affairs Canada).

4

Review Findings and Conclusions

This section outlines the review findings and conclusions. It is organized into four main sections. Part A describes the "footprint" that the Aboriginal Health Human Resources Initiative (AHHRI) has achieved through its projects and expenditures with a variety of partners in the health care system serving First Nations, Inuit and Métis. This picture was created from a review of the national projects and regional work plans and related documents.

Part B is more specific in terms of what has been accomplished against each of the AHHRI's seven objectives for its first five-year period. It takes the "footprint" in Part A a step further in answering the "so what" question. Particular projects are highlighted to illustrate where the AHHRI has served as a catalyst for innovation or to remove barriers or more generally to advance transformation in the health care system. The systems analytical methodology was used to analyze data collected from consultations and documentation and develop the findings in this section.

Parts C and D deal with the program design and delivery and governance and accountability aspects of the AHHRI.

A AHHRI's Reach or "Footprint"

The following sections describe the Aboriginal Health Human Resources Initiative's (AHHRI) reach or footprint in 2008–09 by:

- distribution of the number of projects across the country;
- distribution of expenditures across the country;
- size of projects, in terms of dollars;
- types of projects, in terms of touching education settings, workplace settings and/or capacity building; and
- type of project leads, in terms of First Nations, Inuit or Métis organizations, or post-secondary education institutions, or other.

The year 2008–09 was chosen because it best describes the extent of the "build-up" or "ramp-up" of the AHHRI.[4] For example, some regions such as Saskatchewan were early off the mark in terms of moving forward on the AHHRI, while others such as Quebec were slower getting started. However, all regions had achieved significant "traction" by 2008–09. Consultations with the AHHRI regional coordinators and a review of 2009–10 work plans suggested that this base would be solidified during the current year.

Findings on the appropriateness of the footprint are given in the *Summary of Findings and Conclusions* (see page 21–22).

Distribution of Projects Across the Country

In the AHHRI's first year, a number of national projects were started. Beginning in 2006–07 and ramping up in 2007–08, projects were launched in regions across the country. By 2008–09, there were 162 projects underway in the regions and nationally. They were spread across the country. They were about equally divided between new projects and those carried over from the previous year. Many projects were ongoing because their contribution agreements lasted for more than one year.

Another 126 projects had already been completed, making a total of 288 projects under way or completed as of the end of 2008.

[4] As noted in Section 2, Part A, *Objectives and Scope*, the review covered the period up to December 2008. Project information for fiscal year 2008–09 was used here as being representative of the situation as of December 2008.

Distribution of Projects Across the Country

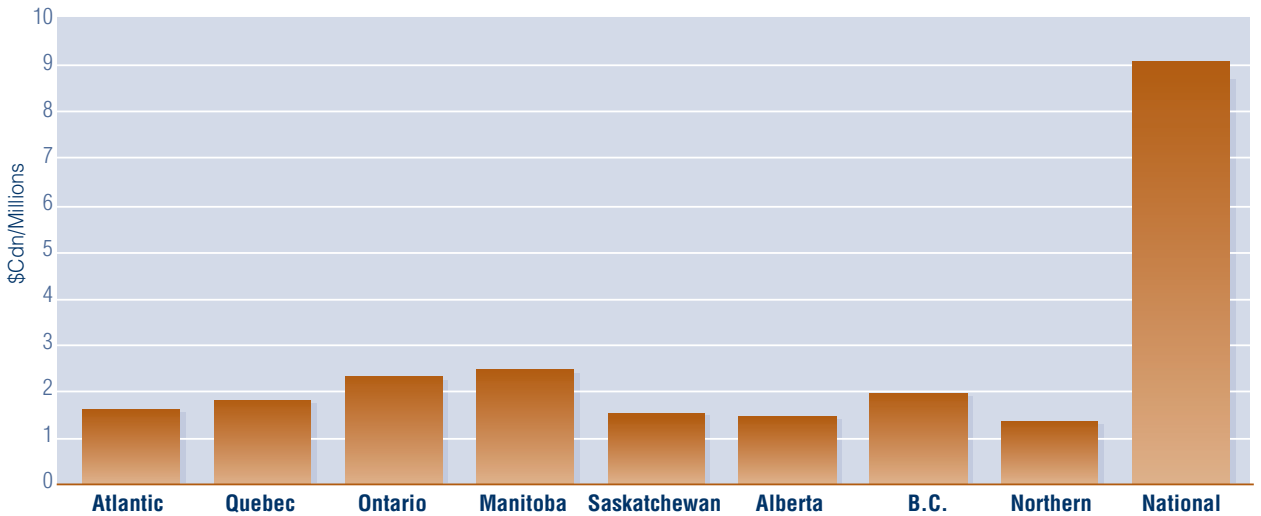
National / Region	2005–06 Projects			2006–07 Projects			2007–08 Projects			2008–09 Projects			Totals
	New	Ongoing	Total	New	Ongoing	Total	New	Ongoing	Total	New	Ongoing	Total	# Projects
Atlantic							18	0	18	14	5	19	32
Quebec							17	0	17	14	5	19	31
Ontario				3	0	3	20	3	23	13	13	26	36
Manitoba				12	0	12	8	6	14	4	11	15	24
Saskatchewan				10	0	10	21	5	26	7	8	15	38
Alberta							11	0	11	7	5	12	18
B.C.							39	0	39	4	20	24	43
Northern							9	0	9	6	4	10	15
Total Regional				25	0	25	143	14	157	69	71	140	237
National	14	0	14	21	4	25	8	19	27	8	14	22	51
Total AHHRI	14	0	14	46	4	50	151	33	184	77	85	162	288

Notes:
1. Shaded cells for regions in 2005–06 and 2006–07 indicate that these regions were still in the planning phase.
2. New projects are ones which were started in the fiscal year. Ongoing projects are those that were continued from the previous fiscal year.

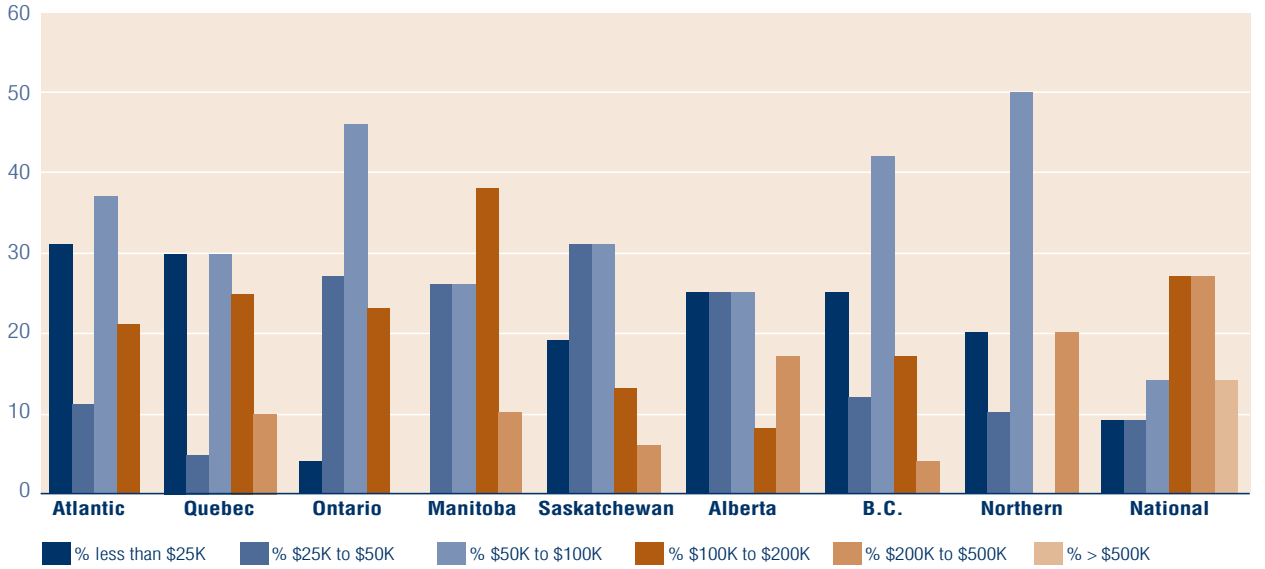
Distribution of Expenditures Across the Country

In 2008–09, expenditures across the country were approximately $23.5 million. Of this total, approximately 88.4 percent funded contribution agreements, and 11.4 percent funded salaries and operations and maintenance in the regional and national offices. National office expenditures constituted approximately 39 percent of the total expenditures. Expenditures by each region varied between 6 and 10 percent of the total.

2008–2009 Expenditures



Size of Projects by Region/National in 2008–2009



Size of Projects in 2008–09

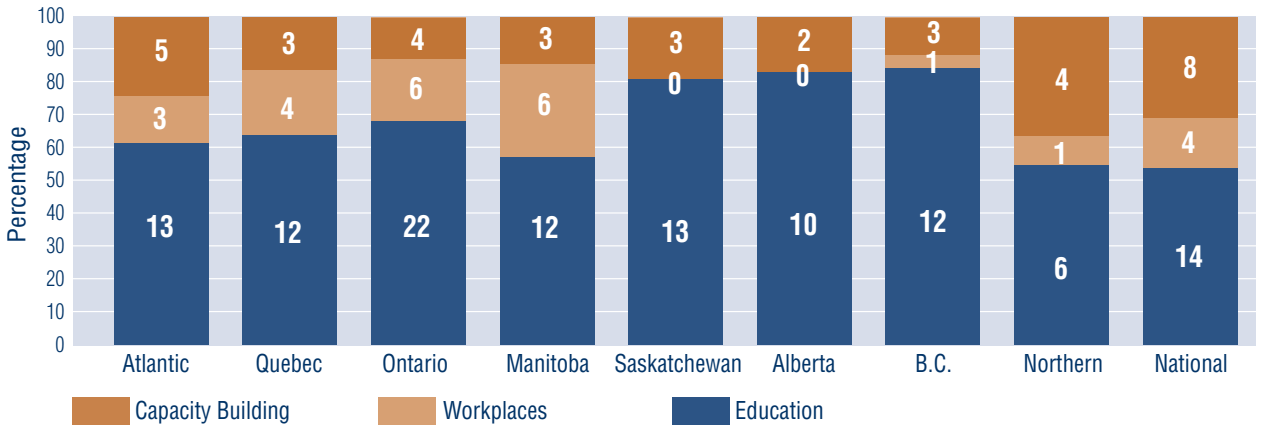
The majority of projects in every region were funded for less than $100,000 in 2008–09. A significant number were funded for less than $25,000. National projects tended to be larger in dollar value, with a few over $500,000 in 2008–09.

Types of Projects in 2008–09

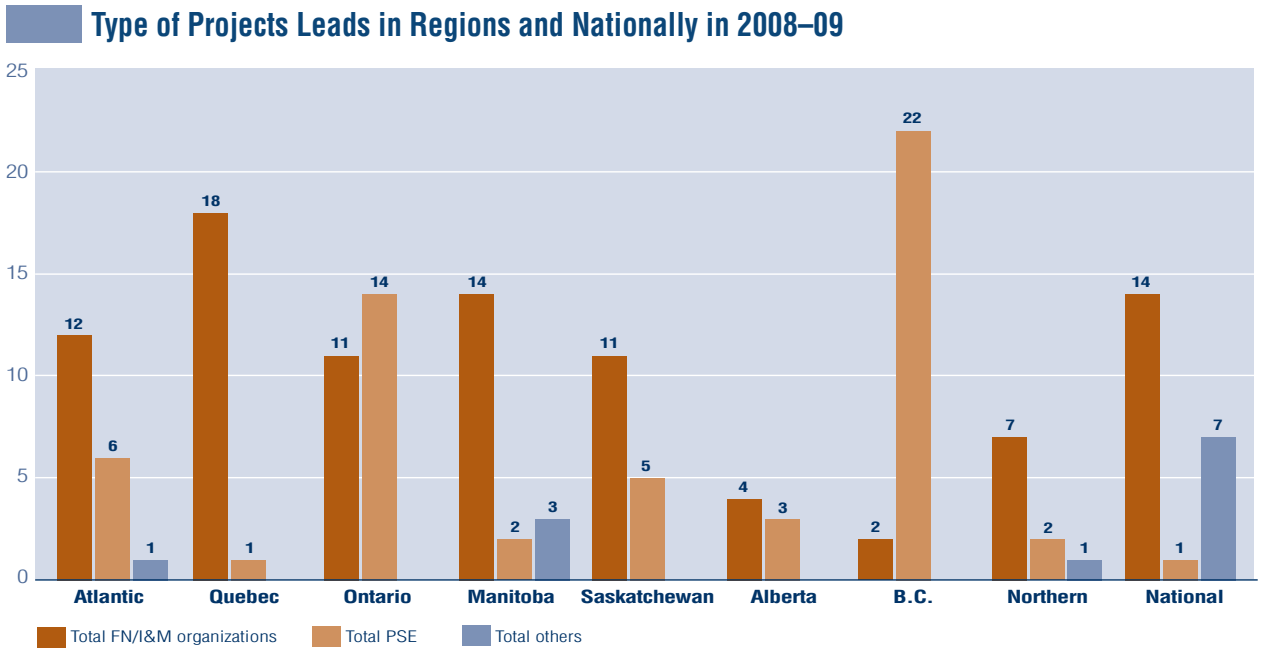
In 2008–09, continuing the pattern from earlier years, the majority of projects touch upon educational settings, primarily post-secondary education, with some early education (K–12). Similarly, projects impacting education settings account for 71 percent of expenditures, while those related to workplace settings and capacity building account for 29 percent.

The chart below shows the number of projects touching each target area. A degree of aggregation is used in order to reduce "double counting" to a significant degree, because many projects cover more than one of the categories of the AHHRI projects (as per the more detailed logic model on pages 12–13). Here "Education" includes both early education and the post-secondary education system and, more specifically, the Health Career Awareness Strategy, First Nations, Inuit and Métis Health Careers Students,

Number of projects touching target areas in Regions and Nationally in 2008–09



Note that the project counts in this graph, for each region or nationally, equal or are higher than those in the table on page 19. The reason is that the counts here represent the number of "touches." For example, if a project in Atlantic region touches both education and workplace settings, then it is counted twice, once against each category.



Education System Transformation, and Curriculum Cultural Inclusion categories in the logic model. "Health Care Workplaces" includes the categories Conditions for Health Care Employee Retention, Core Competencies and Certification for Para-professional Community Health Care Workers, and Cultural Competency of Health Care Workers. "Building Capacity" includes the categories Collaborative Relationships and Institutional Capacity Building, and Information and Research.

A detailed table showing number of projects and expenditures touching each of the categories in the logic model is shown in Annex C. In that table, it can be seen that a significant number of individual projects deal with more than one category of the logic model.

Type of Project Leads in 2008–09

In 2008–09, 56 percent of projects were led by First Nations, Inuit, and Métis organizations and another 37 percent by post-secondary institutions (PSE). Post-secondary institutions led a particularly large percentage of projects in Ontario and British Columbia regions. It should, however, be noted that some of these projects include First Nations, Inuit and Métis partners, and in Ontario, the PSEs include First Nations-run organizations.

[5] We have not counted 2005–06 as a year of operation because it was more appropriately a start-up year.

Summary of Findings and Conclusions

Based upon the objectives, guiding principles and design of the AHHRI, as described in the AHHRI documentation, and especially the Program Framework document, there appear to be number of expectations that reasonably could be made of AHHRI by 2008–09, its third full year of operations.[5]

It appears reasonable to expect that the AHHRI's footprint would:

- Include projects in every region and nationally, with significant levels of investment across the country. The profile data presented on pages 18–19 confirms that this is happening.
- Focus upon catalytic projects that respond to community needs and have lasting, sustainable impacts. The large number of small dollar-value projects in regions (see page 20) suggests that a number of community needs are being addressed, but that there also might be a risk that many projects are too small to have such impacts. The extent to which this is the case is explored more in Part B below.
- Include projects across the spectrum of the five-year objectives for the AHHRI. Indeed, as shown in *Types of Projects in 2008–09* (see pages 20–21), there are projects in educational and workplace settings, and capacity building. However, many focus on health careers as doctors and nurses, rather than other health care careers often more appropriately delivered in community settings.

- Have a significant number of projects being led by First Nations, Inuit and/or Aboriginal organizations, be they national Aboriginal organizations, provincial/territorial organizations or others. As shown in *Type of Project Leads in 2008–09* (see page 21), this is the case for the most part, although there are provinces such as British Columbia or Ontario where PSE institutions lead a disproportionate (when compared to the rest of the country) number of projects.

In conclusion: By 2008–09, the AHHRI built a reasonable "footprint" or reach in terms of where it invested in projects, how much it invested, who it invested with, and what areas/interventions it invested in. This pattern was being continued in the formulation of plans for 2009–10. These are all important dimensions in terms of meeting the expectations of many stakeholders. At the same time, it would be appropriate to validate that desired impacts are being achieved by the large number of smaller-sized projects in the regions. This would appear to be an ongoing challenge—managing the tradeoffs and risks involved, or in other words, the balance between reach and impact, when the needs are great across the country.

We explore this challenge, particularly the impact side of the balance, in the next section.

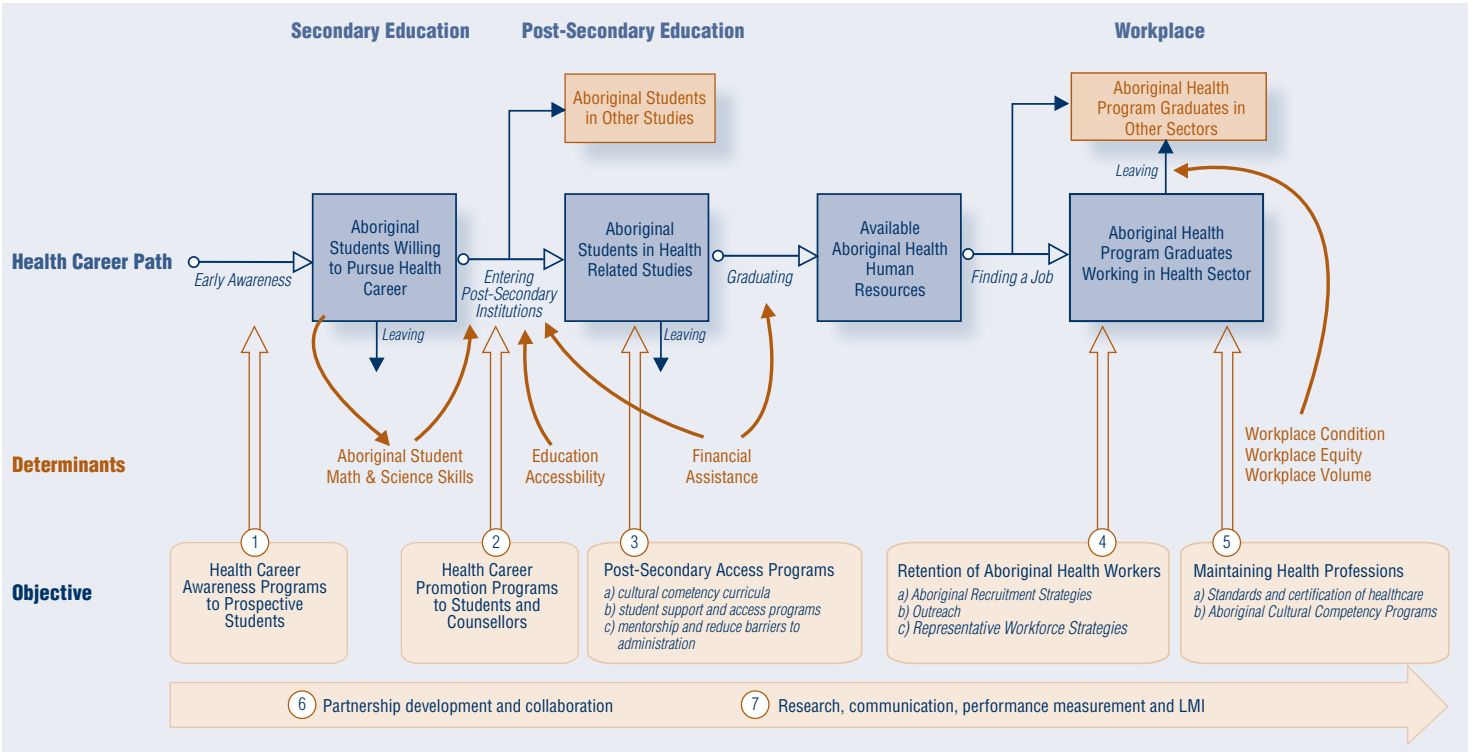
B Achievement of Outcomes/ Results Against the Five-Year Objectives

AHHRI as a Catalyst in a Health Human Resources Development System

Policy design, in both private and public sector contexts, is primarily about finding methodologies, policies and strategies that will enable an initiative to move a real-world situation from one state to another. In this case, the desired change involves sensitizing the health care system to Aboriginal peoples' needs and increasing the number and quality of Aboriginal health care professionals within the health care system.

The systems approach employed by the review team differs from other quantitative methodologies that rely on periodic static snapshots and statistical analysis of historical data to assess performance. The systems approach is specifically aimed at helping design policies that exert maximum leverage for change in the future, by first learning how and why the performance of complex systems changes over time.

Aboriginal Health Human Resources System



In our systems-based analysis of the Aboriginal Health Human Resources Initiative (AHHRI), we sought to identify and understand the drivers that enable more First Nations and Inuit to consider and subsequently enter into health careers thus increasing the stock of human capital in the health care sector (the desired state of affairs sought by the AHHRI). Although we found that the design of the Initiative is fundamentally sound, we did discover a number of significant areas where performance can be improved in the future. These are discussed in more detail later but can summarily be stated as the need to:

- enhance strategic communications and establish sustainable networks;
- adopt an improved knowledge management system to share best practices, improve efficiencies, and avoid duplication of lessons learned; and
- streamline administration and enhance the governance mechanism in the Initiative.

The diagram on the previous page shows a simplified systems model of the AHHRI. This model provides the conceptual framework for our systems-based analysis of the Initiative's performance. It supplements the logic model already presented by highlighting linkages, process flows and timing (including lags).

Mapping AHHRI's Five-Year Objectives

When "systems-based" analytics are applied to a strategy, one cannot make normative judgments about the performance unless one understands the objectives sought by instituting the strategy in the first place. In the case of the AHHRI, it is difficult to gauge the relative success of each of the activities undertaken without understanding the specific objectives or developmental purposes of the Initiative as a whole. Understanding the objectives in context is an essential prerequisite to identifying leverage points in the system and developing strategies to improve performance of the Initiative in the future.

The AHHRI adopted seven principal objectives over the five-year period. Each of these seven objectives is mapped in the systems diagram. The seven objectives cover the full landscape of the health human resources system. The graphic also provides insight into how the program management, personnel and the AHHRI national and regional advisory committees chose to prioritize projects and resources to achieve these broad objectives. As we will come to see and for reasons that are explained, the bulk of the resources for the initial five-year Initiative have been targeted at facilitating change at the post-secondary institutional level. The seven objectives, previously given in Section 3, Part B, are listed again for the reader's convenience:

- increase the number of First Nations, Inuit and Métis who are aware of health careers as viable career options, focusing particularly on youth awareness;
- increase the number of First Nations, Inuit and Métis students entering into, and succeeding in, health career studies;
- increase the number of post-secondary educational institutions which are supportive of and conducive to First Nations, Inuit and Métis students in health career studies (e.g., with culturally appropriate curricula; student support and access programs; mentorship and reduced barriers to admissions);
- identify the conditions that create supportive and conducive work environments that will increase the retention of First Nations, Inuit and Métis health care workers, and non-Aboriginal health care workers working in First Nations, Inuit and Métis communities;
- establish standards of practice and certification processes for First Nations, Inuit and Métis community-based allied health care workers which will help to ensure a properly trained and mobile health work force, and help improve retention of community-based allied health care workers;
- establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them; and
- initiate the establishment of baseline information; initiate targeted research and analysis on the supply and demand for First Nations, Inuit and Métis health care workers; and identify best practices and approaches in order to support policy, planning and program decisions.

This section of the Report provides an overview of activities undertaken to achieve each of these seven objectives; provides an overview of stakeholder feedback on the issues and challenges for achieving the specific objective; and identifies some promising best practice examples of some of the AHHRI success stories. This is followed by a summary of progress in the AHHRI's efforts to achieve the principal outcomes established for the five-year Initiative.

Objective 1: Health Career Awareness

a) Overview of Activities Related to This Objective

Health Canada has sponsored a wide variety of projects aimed at increasing awareness of Aboriginal people and youth across the country.[6] This has included supporting math and science camps at the primary level, participating in career counseling and job fairs at the secondary level, supporting primary and secondary awareness through the creation of brochures, educational tools, videos and distribution of the AHHRI branded promotional materials. The AHHRI also provided First Nations and Inuit communities with resources, communications materials and other information to support personnel to conduct outreach initiatives at the primary and secondary levels. This work was supported by periodic meetings of the AHHRI regional coordinators that provided opportunities for each region to share their successful awareness initiatives with other regions.

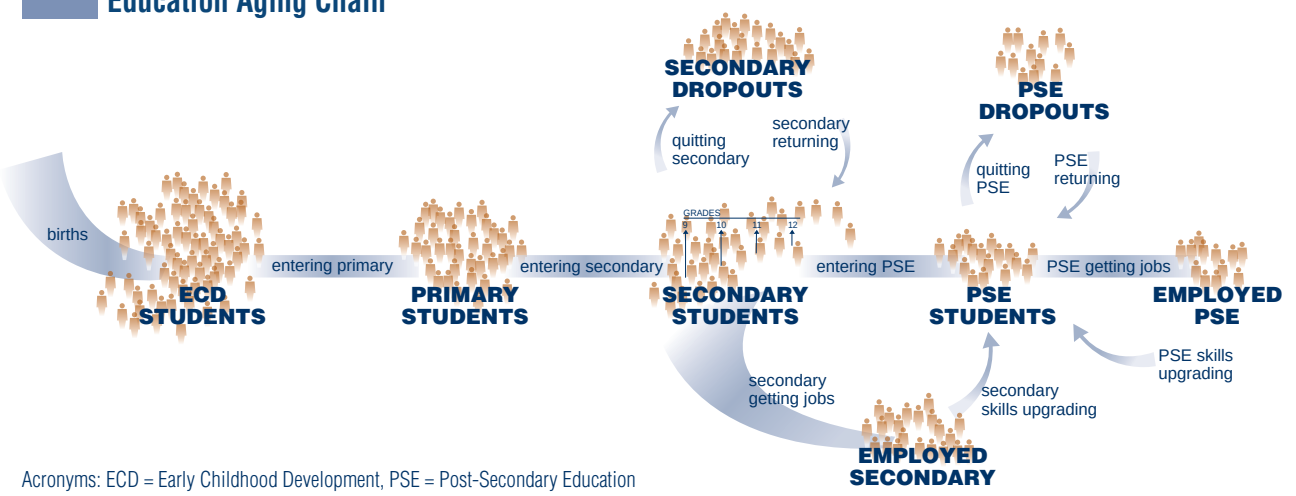
It is also to be noted that Health Canada operates a stand-alone Indian and Inuit Health Careers Program and a Pan-Canadian Health Human Resources Strategy. The First Nations and Inuit Health Careers Program, a small program funded for approximately $3 million per year, has operated for over two decades and provides direct funding assistance to First Nations and Inuit students by way of bursaries and scholarships, career fairs, health career learning tools and health care career related employment information. As outlined in Section 3, Part A, the Pan-Canadian Health Human Resources Strategy complements the AHHRI, having similar guiding principles. However, the former is broad-based, whereas the AHHRI targets issues particular to First Nations, Inuit and Métis. These programs and their information tools were leveraged by the AHHRI.

Increasing Aboriginal student awareness to the importance of completing high school with proper math and sciences is critical in the health care field as the vast majority of jobs require this educational baseline. While it is true that there are a number of health care positions that do not require this basic level of education, these positions represent the minority of the positions in the health care sector. Although these positions are not any less important, they cannot be expected to attract as high an income or benefits and, therefore, tend to have lower retention and higher turnover. Moreover, as the education aging chain graphic below depicts, the more Aboriginal people that graduate from high school, the greater the number of candidates that will be available to pursue health careers.

The graphic below highlights the declining number of Aboriginal learners that will be in a position to pursue a post-secondary education. It also shows that people who do not complete high school may in later life decide to return to complete Grade 12 equivalency (which is the approach of a significant number of Aboriginal learners). For those who achieve the level

[6] A summary of the number of projects and expenditures by region and national touching this objective in 2008–09 is shown in the table in Annex C. This table also includes the same information for each of the other objectives that are discussed later on in this section (see pages 26–36).

Education Aging Chain



Acronyms: ECD = Early Childhood Development, PSE = Post-Secondary Education

of educational attainment to be considered available to pursue a post-secondary health career, the AHHRI awareness initiatives provide a competitive career awareness advantage that facilitates Aboriginal streaming into the health care sector. This "awareness" advantage coupled with other student support (financial and other) is part of the incentive approach adopted by the AHHRI.

b) Summary of Consultation Findings

Increasing awareness of health careers was viewed as a priority by all respondents, although Aboriginal project sponsors were more likely to suggest that future AHHRI initiatives should devote more resources and focus on this activity. This was particularly the case in northern and remote regions of Canada. All agreed that there is a need to increase the number of Aboriginal high school graduates and to encourage these graduates to obtain the appropriate math and science classes in order for them to pursue the majority of health careers that require them. Participants pointed to the volume of promotional materials that the AHHRI has supported and how positively these materials had been received by stakeholders.

Participants also felt that the lack of a community-based approach hampered the AHHRI's ability to achieve its objectives. It was felt that a more integrated approach involving HRSDC, INAC and other stakeholders was needed given the broader socio-economic challenges facing many communities. It was felt that a bottom up community-based approach would lead to more graduates and more cost-effective results. Off reserve many suggested the need to work with boards of education in provinces and territories.

While all urged increasing awareness of the importance of Aboriginal students completing high school, it was acknowledged that increasing the high school completion rate was a shared but broader outcome that could not be accomplished with the AHHRI funding alone.

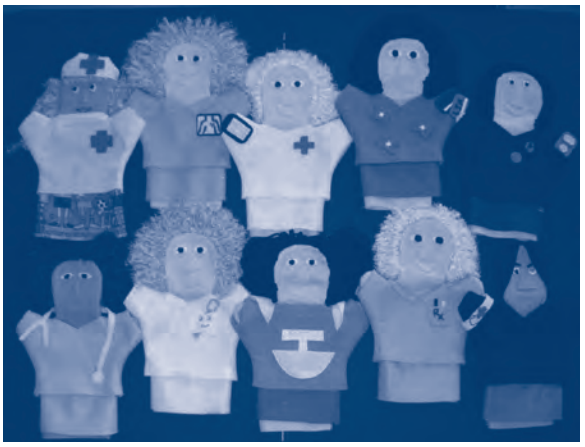
Participants believed that there was a need for a long-term and sustainable approach to health career promotions including ongoing efforts to participate in career fairs and to create other health career published promotion materials.

c) Examples of Awareness Projects

Nunatsiavut Government

The approach to increasing awareness of primary and secondary students varied by region under the AHHRI. By way of example, some impressive work has been undertaken by the Inuit in Labrador. There the Nunatsiavut Government launched an educational awareness program aimed at primary school children on the various professions in the health care field. In order to increase awareness of the number of different occupations in the health care field (most children were only aware of nursing, dental and doctors positions) the coordinator created finger puppets each with its own health career personnel outfit.

Health Professional Puppets



This was coupled with the development of a bingo game where students would be awarded a square if they could guess the occupational name for the particular health profession that was described to them.

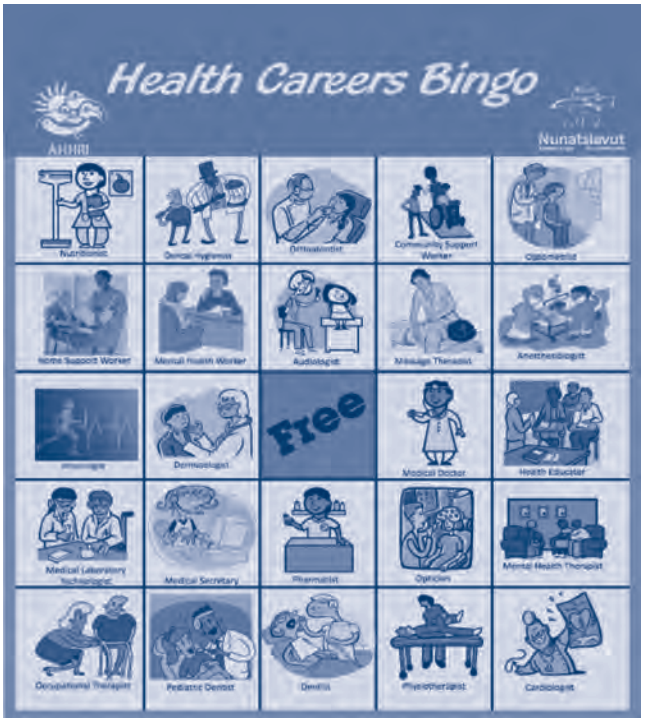
Students Using Puppets to Explore Health Careers

The Federation of Saskatchewan Indian Nations (FSIN) Health and Social Commission developed a comprehensive health careers website aimed at First Nations youth. The website provides interested youth with information on health careers, prospects for employment within certain health care occupations and

information on bursaries, scholarships and educational institutions. The following is a snapshot of the website's home page and can be viewed at: http://www.fsin.com/healthandsocial/AHHRI.html

Another unique initiative at the FSIN is their Education and Training Secretariat's Sciences program—designed to promote math, science and technical career choices with Saskatchewan First Nations. Activities include the development of science curriculum to enhance text books, summer science festivals, and mobile science workshops. The home page can be viewed at: http://www.fsin.com/educationandtraining/yis_scienceprogram.html

Health Professional Jeopardy Card/Bingo Health Careers Card



Health Career Website—Federation of Saskatchewan Indian Nations

Objective 2: Increasing Number of Aboriginal Students Entering and Succeeding in Health Career Studies

a) Overview of Activities Related to This Objective

There have been a number of projects that have attempted to increase the numbers of First Nations and Inuit students entering into health career studies and in supporting those students to succeed in those studies. There are two components to this objective: first, facilitating entry into the health profession; and second, supporting students to succeed in those studies. There have been several projects funded to achieve these two complementary objectives. They address the needs of younger learners as well as those persons who may have left school some time ago and are returning to school later in life.

Probably the most important activity here has been funding of scholarships and bursaries through the National Aboriginal Achievement Foundation (and in the second and third years of the Initiative, the Métis National Council). These organizations provided direct financial assistance to First Nations, Inuit and Métis students who were pursuing health careers. This initiative was an application-driven process providing much needed financial aid to several hundred Aboriginal students.

Increasing the number of students entering health studies requires students to be furnished with information that attracts them to the health care profession. Once attracted to the idea of pursuing a profession in health care, they need the necessary educational qualifications to obtain admission into the appropriate college, university or training program. As the data reveals, the First Nations and Inuit dropout rate from high school is higher than for non-Aboriginal people and this has tended to limit the number of qualified Aboriginal people who can gain admission into post-secondary institutions. In order to address this educational gap, the AHHRI funded a number of educational bridging programs that were designed to furnish First Nations and Inuit with the necessary educational requirements so that they could, upon completion of the bridging program, apply for admission into the relevant post-secondary health field. The purpose of bridging programs was aptly put as follows:

> Barriers to Aboriginal student success in post-secondary environments are multi-dimensional

and often systemic. They include social barriers and inadequate skills development, institutional inflexibility, and lack of academic support and pedagogical awareness concerning Aboriginal learners. A bridging program which addresses all of these issues is necessary to ensure the future success of Aboriginal students, as they endeavor to complete post-secondary studies, and become professionals within their communities.[7]

It is important to note that this did not involve watering down the curricula. Instead, it recognized a student's prior experiential learning and created a curriculum which provided the necessary baseline of education required for entry into a health career.

b) Summary of Consultation Findings

Participants believed strongly in the need to develop programs to increase the number of Aboriginal people with the academic credentials to apply for and obtain admission into health professions. Participants also felt that it was important to invest in remedial initiatives and other student support mechanisms to facilitate greater completion rates at the post-secondary levels.

Given the educational profile of Aboriginal people, many participants spoke of the need to target the large number of Aboriginal people who may have left school without a high school diploma but yet possessed the life and care-giving skills to succeed in the health care field. Respondents felt that the added advantage of upskilling or upgrading the education of existing members from the community was that they would more likely agree to work within their own communities once they had completed their training or education. In this respect, participants spoke of the need to provide local training and education initiatives as this would tend to facilitate greater completion rates. Participants spoke of the need to ramp-up bridging-type initiatives and to share best practices in this area more broadly.

c) Examples of Success

Partnership with the National Aboriginal Achievement Foundation

In 1998, Health Canada transferred the bursaries and scholarships management of its Indian and Inuit Health Careers Program to the National Aboriginal Achievement Foundation (NAAF). The program provides support to students who are pursuing accredited health studies leading to employment in the health professions and who have demonstrated the potential for academic success. Under the AHHRI, the National Aboriginal Achievement Foundation undertook to provide a one-time special bursary program to increase the number of Métis who wished to pursue health careers in areas such as: medicine, nursing, dentistry, biology, chemistry, physiotherapy, pharmacy, clinical psychology, laboratory research and technology and any other health field in which a study of the hard sciences is a prerequisite. Under this initiative, 172 Métis were provided financial assistance.

Huron-Wendat Training and Manpower Development Centre

A good example comes from a project sponsored by Huron-Wendat Training and Manpower Development Centre where a professional studies diploma in nursing and social work techniques (mental health) has been created as well as a college diploma in Ambulance techniques.

College of the North Atlantic

The College of the North Atlantic developed a culturally appropriate bridging program that involved establishing entrance requirements, course outlines and curricula. The bridging program includes academic courses, life skills such as reading comprehension, personal awareness, study skills, Aboriginal culture as well as personal and academic counseling. The program is not intended to duplicate educational programs such as basic adult education but to provide necessary support for those Aboriginal students who are on the cusp of post-secondary success. The pilot project recognized the need to provide supplementary student support both in the intake component of the project as well as during the duration of the educational offering. The college partnered with Sheshatshiu Innu First Nation, the Nunatsiavut Government and the Labrador Grenfell Regional Health Authority.

Manitoba First Nation Education Resource Centre and the University of Manitoba

The AHHRI facilitated an innovative partnership between the Manitoba First Nation Education Resource Centre, Red River and Yellowquill Colleges and the University of Manitoba to develop an innovative health career access program. The Initiative helped prepare Aboriginal students for entry into the University of Manitoba's Health Career Access Program. The project involved the development of promotional

[7] College of the North Atlantic, Powerpoint Presentation January 2009.

materials, diagnostic instruments to recruit promising Aboriginal students and customized curricula that focused on developing the necessary math and science proficiencies of Aboriginal students. It consisted of 21 hours of first-year accredited courses that served as an indicator of the students' potential to complete further studies in the health professions at the University of Manitoba. It is in essence a feeder program for entry into the university.

The program has experienced remarkable growth and success with over a 70 percent success rate in the first year. Demand for the program has increased with some 42 applications for 2008–09. This is expected to increase in subsequent years as the program improves its intake assessments. Building upon the lessons learned from the results of the first year student intake, administrators are more aware of the need to ensure that attention is paid to the social and life skill challenges facing students. The program is now examining how it can add additional educational components, including introducing Indigenous knowledge and teaching methods. However, the program has recognized that there is a need for a structured learning environment and that there is a need to shape learning contracts to the particular needs and personal social support required by students. It has been acknowledged that there is a need to find ways to motivate students so that they adhere to their learning goals and if necessary to build in appropriate and enforceable consequences to ensure students meet those goals.

Objective 3: Increasing Number of Supportive Post-Secondary Institutions (Curricula, Access Programs, and Student Support)

a) Overview of Activities Related to This Objective

The majority of the AHHRI-funded projects have been devoted to facilitating transformative change to the post-secondary education system. This priority was established at the outset of the program and has continued to shape the overall activities under the program. As we outlined in the systems diagram, post-secondary institutions play a central role in the development of the majority of health professionals. It is the conduit that most health professionals must pass through. Projects funded under this objective have aimed at increasing the flow of Aboriginal people through these institutions and at sensitizing those who pass through these institutions to the cultures and needs of Aboriginal people. Specifically, projects funded to date have supported post-secondary institutions to:

- create Aboriginal post-secondary access programs;
- amend their curricula to make them more culturally sensitive of Aboriginal inclusion;
- create additional curricula to promote cultural competencies of health care students and health professionals; and
- provide Aboriginal students with support to succeed in health studies.

This has included a number of projects with virtually all of the 17 medical schools, numerous schools of nursing and a large number of colleges and universities that provide health education and training. These initiatives were undertaken directly with post-secondary institutions or through Aboriginal project sponsors working in partnership with post-secondary institutions. In all cases, post-secondary institutions were required to demonstrate participation of Aboriginal organizations and/or communities. National initiatives have included work between AHHRI headquarters and faculties of medicine in Canada and the Indigenous Physicians Association of Canada (IPAC) to facilitate curriculum changes within the 17 medical schools. As a result, similar work has started with the Aboriginal Nurses Association of Canada (ANAC), the Canadian Association of Schools of Nursing, and the Canadian Nurses Association.

b) Summary of Consultation Findings

The AHHRI has had great success in having universities and colleges pay attention to core cultural competencies. Eleven of 17 colleges of medicine have established seat set-asides for Aboriginal students. Many of the colleges indicated that had it not been for the AHHRI funding, they would not have had the level of buy-in or support necessary to pursue unique Aboriginal project initiatives.

It was noted that changes or additional course development could not be accomplished overnight and that cultural components required the participation of the local or regional Aboriginal community. Post-secondary institutions each have their own internal processes for creating new courses and course materials that also can involve their internal governance and management decision-making bodies, such as their Senates.

Determining the right balance of AHHRI investments: One of the topical issues raised during the interviews with participants focused on whether the AHHRI had invested too much of its emphasis and resources attempting to influence the intake processes and cultural orientations of post-secondary institutions. Several First Nations and Inuit community stakeholders suggested that, given the low level of educational achievement within the Aboriginal community, there was a need to focus on youth and, particularly, to grow the number of Aboriginal high school candidates who could participate at the post-secondary level. Many participants focused on the need to establish coordinated multi-jurisdictional projects at the community level aimed at increasing the number of students who were aware of the prior educational requirements to participate in the health care professions.

Other stakeholders believed that while growing the number of Aboriginal people with high school diplomas was mission critical, the relatively short-term finite funding made it necessary to focus funding on elements of the health human resources development system where there was an acknowledged bottle-neck, i.e., the post-secondary system. It was suggested that this approach would lead to a more open and culturally supportive environment for the large number of Aboriginal youth who will be completing high school over the coming years. This in turn would continue to facilitate the "indigenization" of these post-secondary Aboriginal health professional role models and higher retention rates down the road.

c) Examples of Success

University of Ottawa

In September 2005, University of Ottawa, Faculty of Medicine in collaboration with Ministry of Training, Colleges and Universities and Akwesasne First Nation launched an innovative Aboriginal Program to respond to the severe shortage of Aboriginal health professionals across Canada. The goal of the program is to graduate 100 new Aboriginal physicians by 2020 and combine traditional activities such as healing ceremonies and elder mentoring with medical electives at the First Nations reservations to prepare doctors to deliver holistic health care to on-reserve and urban Aboriginal populations. The university just celebrated their first major milestone in the program with the first class admitted in 2005 graduating with medical doctor degrees at the faculty's 2009 spring convocation. The AHHRI core funding (2007–08) helped facilitate the development of this program along with the production and distribution of printed and audiovisual promotional material to recruit and retain mature Aboriginal students into medicine. Fourteen Aboriginal medical students are currently enrolled at the University of Ottawa, Faculty of Medicine and six new students will be starting in September 2009. This will bring the total number of students in the Aboriginal Program to 20 in the fall. The university has also established an Aboriginal Medical Students Association and a Medical Diversity Awareness Group to support other Aboriginal students and promote a commitment to Aboriginal health issues within the Faculty.

This success can be attributed to the AHHRI core funding (2007–08), the university's unwavering vision and intent, and the Ministry of Training, Colleges and Universities' designating seven medical school positions at the University of Ottawa for eligible Aboriginal students since 2005. Accordingly, other medical schools in Eastern Canada in particular have been stimulated to look at how they can increase the number of Aboriginal students enrolled and graduating from medicine.

Indigenous Physicians Association of Canada

The Association of Faculties of Medicine of Canada (AFMC) collaborated with the Indigenous Physicians Association of Canada to develop cultural competency in the undergraduate level curricula (i.e. bridging and pre-medical health science programs) and a tool kit for recruitment and retention of First Nations students.[8] The Royal College of Physicians and Surgeons included cultural competency in curricula for graduates and continuing medical education.

As a result of the success of this work, the Canadian Association of Schools of Nursing, Aboriginal Nurses Association of Canada and the Canadian Nurses Association held forums on cultural competency with special emphasis on recruitment/retention of Aboriginal nursing students and designed a framework for cultural competency.[9] Fluent native speakers and

[8] Available from IPAC at http://www.ipac-amic.org/publications.php , or from AFMC at http://www.afmc.ca/social-aboriginal-health-e.php

[9] Available from ANAC at http://www.anac.on.ca/Documents/Making%20It%20Happen%20Curriculum%20Project/FINALReviewofLiterature.pdf, or from CASN at http://www.casn.ca/en/Making_it_Happen_:_Strengthening_Aboriginal_Health_Human_Resources_118/items/2.html, or from CNA at http://www.cna-aiic.ca/CNA/documents/pdf/publications/First_Nations_Framework_e.pdf

teachers, medicine people, traditional healers, traditional counselors, ceremony helpers and elders are among those who were actively recruited in recruitment, retention and curricula advisory capacities.

University of British Columbia

The University of British Columbia established a unique community-based elective course, Interprofessional Health and Human Services 408 Topics in Aboriginal Health. This course is framed as a "lived experience" of a university-community partnership incorporated into conventional health curriculum that brought an Aboriginal perspective to health professional training. Developed and delivered with Aboriginal community members in two British Columbia communities, the course provides students with an opportunity to recognize the importance of culture as a social determinant of health for Aboriginal wellness.

Key insights into the challenges and rewards of establishing positive working relationships between the university and Aboriginal communities are explored. Both university and community partners' perspectives on building the relationship, conducting research in an Aboriginal community, and the strategies used to manage any culture shock experienced by students, faculty, staff and community members are investigated. This course helps students to recognize the value and impact of diverse ideals, priorities and perspectives when developing collaborative, university-community relationships. It is an immersive inter-professional elective that takes place in Aboriginal communities. The overall goal is to address the need for Aboriginal health professionals and culturally competent non-Aboriginal health professionals in Aboriginal communities, as well as to support the teaching of Aboriginal knowledge by Aboriginal experts. This course enhances student learning at both the general and discipline-specific levels by utilizing a combination of community-based, immersion activities (enabling students to become more caring, reflective practitioners as a whole) and student-preceptor models of learning (thereby enabling students to become better technical practitioners of their discipline). It was developed with Aboriginal communities using participatory methods in curriculum development, course delivery and evaluation. Communities have worked with the University of British Columbia to create a learning experience that a number of students have described as transformative.

Evaluations have shown that this transformation has taken place in the students' attitudes towards other professionals, Aboriginal peoples, communities and indigenous perspectives on health. Students are passionate about what they've learned. They have consistently rated the course highly. Two particular outcomes are that (1) students feel they have improved on their skills and comfort levels in working with Aboriginal people and communities and (2) they are more likely to work in an Aboriginal community as a result of this course.

The two communities in which the course has been delivered have also benefited from this course. Student generated health promotion projects were developed with and returned to the communities. Community members enhanced both their teaching and curriculum development skills and now wish to find more ways to partner with the university. They feel their work in the long term will benefit Aboriginal communities through the creation of health care professionals better able to provide culturally appropriate care for their members.

Centre for Aboriginal Health Education, University of Manitoba

The Centre for Aboriginal Health Education Student Support Services has led the implementation of a mentorship program at the University of Manitoba for Aboriginal students in health education degree programs building on the Faculty of Medicine mentorship program framework. The Centre fulfills a dual purpose: it provides a supportive environment to Aboriginal students in health education degree programs; and it provides access to resources for staff and students with an interest in Aboriginal health issues at the university. The Centre provides a comprehensive resource base providing academic support and career development. It provides access to personal and cultural support and works in collaboration with the university's Aboriginal Health Careers Access Program.

University of Lethbridge Support Program for Aboriginal Nursing Students

The AHHRI has made a three-year commitment to support Aboriginal students pursuing nursing careers. *"The demand for registered nurses is high in southern Alberta and is particularly evident in rural and First Nations, Métis and Inuit (FNMI) communities across Canada. These communities are in critical need for members to become nurses to address the health issues experienced among First Nations, Métis and Inuit and to provide appropriate health services within their communities.*

The Support Program for Aboriginal Nursing Students (SPANS) includes a one-year pre-nursing transition program to help First Nations, Métis and Inuit students meet the entrance requirements for the Nursing Education in Southwestern Alberta (NESA) program. SPANS will provide sustained academic and personal support throughout the four-year Bachelor of Nursing program.

Support services and courses are specifically designed to meet the needs of FNMI students and to help students succeed in nursing education. SPANS has been funded by Health Canada (Aboriginal Health Human Resources Initiative [AHHRI]), Scotia Bank and Astra Zeneca. It is a collaborative partnership with the University of Lethbridge Faculty of Health Sciences, Red Crow Community College, Blood Tribe Department of Health, Aakom-Kiyii Health Services (Piikani Nation), Siksika Health Services and the Blackfoot Confederacy.

The program has five major elements to help increase the success of FNMI students in the NESA program: (1) Pre-nursing program; (2) Incorporation of elders; (3) Mentorship program; (4) Social networking; and (5) Designated staffing and infrastructure." (Note: This is copyrighted material taken directly from the U of L's website http://www.uleth.ca/healthsciences/spans)

Upon successful completion of the BN program, the student is prepared to write the Canadian Registered Nurse Examination provided by the College and Association of Registered Nurses of Alberta. The university also has arranged with the Blood Tribe Health Center to host students for their clinical practicums. At the end of the four years, the university expects to have 70 students in the BScN.

Objective 4: Supportive Work Environments to Support Retention

a) Overview of Activities Related to This Objective

The AHHRI supported several projects aimed at increasing the cultural competencies of prospective health professionals that were attending post-secondary institutions. It also participated in projects to sensitize the existing complement of health care professionals and allied/non-regulated health care workers to Aboriginal cultures. The premise of this activity is that a more culturally aware health care sector will lead to better care, decrease Aboriginal barriers to participation in the health care system and lead to greater Aboriginal retention within the health care system as a whole. The AHHRI research was aimed at understanding more about the conditions that optimize retention and a number of forums were convened with Aboriginal health care providers to discuss those conditions.

b) Summary of Consultation Findings

Participants believed that the AHHRI had to some degree created some retention deliverables (activities) but had yet to produce measurable retention outcomes. Participants felt that enhancing retention of both Aboriginal health care workers and culturally competent non-Aboriginal health care workers would need more time to achieve as it was a broader "systems" change. It was noted that these broader systematic changes could not be achieved within a five-year time period. Participants also believed that over the longer term retention would be improved as increased numbers of First Nations, Inuit and Métis students adopt health careers and as the system adopts more culturally supportive and competent approaches.

In terms of cultural competencies, it was felt that there was a need to adopt a building block approach over a number of years. It was felt that the first five-year period was merely a developmental phase where materials could be produced by post-secondary institutions and be implemented by others down the road. It was also felt that measuring this type of system change would be difficult but necessary. If you cannot measure it, you cannot track it. In short, the program has been successful in raising awareness of the importance of cultural competency but real change will take time.

Participants felt that cultural competencies were an important driver in improving the quality of health care services and in achieving greater population health outcomes for Aboriginal people. Participants felt that, in the future, the AHHRI should expand its focus on promoting the transmission of traditional healing practices and cultural safety initiatives.

Participants also felt that there was a need to place a priority on working with the provincial and territorial health care agencies on cultural awareness and Aboriginal representative work force strategies aimed at increasing employment for Aboriginal people. Although there were only a few projects funded by the AHHRI that focused on the work force needs of regional health districts, there was more activity in this area being funded under the Aboriginal Health Transition Fund. Representatives consulted from the territorial governments noted their recruitment and retention challenges and strategies, and their support from the AHHRI in addressing them.

In terms of reducing the personnel turnover rate within Aboriginal communities, participants felt that this should be viewed through a longer-term outcomes lens. Participants felt that the program was still in the fact-finding phase and that the AHHRI had been successful in identifying opportunities for engagement and had also identified some gaps. More was needed to be done in investigating why there was such a high turnover rate and what could be done to change the trend line. Others felt that the turnover rate could be improved if more focus was placed on enhanced awareness and cultural safety awareness.

Still others pointed to the jurisdictional challenges within the HR health care system and that lower wages for health professionals serving the Aboriginal community impacted negatively on retention. Participants felt that it would take some time to increase the awareness and education of the health care system so that it would be more inviting for health professionals to service the Aboriginal community. The most that could be done at this point was to lay a foundation for change.

c) Examples of Success

The Northern Inter-Tribal Health Authority

The Northern Inter-Tribal Health Authority (NITHA) developed a customized and culturally responsive human resources development approach that factored in the socio-economic environment of their northern First Nations communities. Working with the Saskatchewan Association of Health Organizations (SAHO), NITHA adapted the SAHO career-pathing process. The approach was to take a more holistic approach to personal and organizational development. The approach that was adopted was informed by extensive consultations throughout northern Saskatchewan with community health workers. The AHHRI supported these consultations and provided the project with the resources to develop a well thought out logic model to support the development of the HR development approach.

First Nations health organizations within NITHA are now benefiting from increased retention rates for key staff positions such as health directors and addictions/mental health workers. In addition, the staff involved in career pathing are gaining increased self-confidence and a greater recognition of their own competencies and knowledge from the recognition of prior learning components of career pathing.

Objective 5: Establishing Standards of Practice and Certification Initiatives

a) Overview of Activities Related to This Objective

The AHHRI supported work to identify the core competencies and certification for allied health care workers with the expectation that this cadre of community-based health care workers would have greater capacity to provide culturally competent and effective services. This would lead in turn to greater job satisfaction and lower levels of burnout and turnover in personnel. The AHHRI funded a number of regional and national projects aimed at core competencies, standards of practice and certification processes. Although the AHHRI recognized the need to integrate skills upgrading/continuing education into the workplace of all health professionals, it placed a priority on community health representatives, health directors and administrators as well as mental health/addictions workers.

b) Summary of Consultation Findings

Participants spoke of the importance of building the capacity of the current complement of Aboriginal health workers and of the need to develop core competencies. Participants felt that establishing core competencies would not only professionalize the working environment, it would ensure that people are properly trained and supported. This in turn would lead to less stress and frustration, and would lead to greater job satisfaction and higher retention rates.

c) Examples of Success

The First Nations Health Managers Continuing Competencies Project[10]

This national project addressed the need, identified by First Nations, to have trained community health managers/directors in their health centres. The objectives of the project were to establish a knowledge and information sharing network for First Nations Health Managers (FNHM), complete an environmental scan (through a needs assessment and situational analysis) of the current levels of training for FNHM and their employment context, and propose a set of core and continuing competencies for FNHM to possess to do their job effectively.

[10] Material adapted from Continuing Competencies Fact Sheet, October 2007, available on AFN website at http://www.afn.ca/misc/FNHM.pdf

The FNHM Advisory Committee advised on the project. The Committee is co-chaired by the FNIHB and the Assembly of First Nations (AFN), and has representation from each region. Members are appointed by the National First Nations Health Technicians Network and First Nations and Inuit Health regions, and confirmed by the AFN Chiefs Committee on Health.

Over the fall and winter of 2007–08, focus groups and telephone interviews were conducted with FNHM by the First Nations Centre at the National Aboriginal Health Organization. National forums were also held in 2007–08 and 2008–09. Information collected informed the environmental scan, which in turn led to a draft framework for continuing competencies. The now final framework is posted on the website for FNHM at www.FNHealthManagers.ca.

The FNHM website also is intended to:

- create a home on the internet for First Nations Health Managers to network, and increase communication among themselves as a support system;
- build the networking between FNHM to share successful practices in doing their job;
- ensure transparent communication and discussion from FNHM on the development of the core and continuing competencies; and
- make available examples and documents that would be helpful for FNHM in various aspects of health human resource management.

In consultations with both AFN and FNIHB, this project is considered to be a success that will be a legacy of the AHHRI's first five years.

Objective 6: Collaboration and Partnerships

a) Overview of Activities Related to This Objective

The AHHRI was designed as a collaborative initiative aimed at facilitating transformative change to the way the health care system approached Aboriginal people. The vast number of stakeholders within the health care system fostered a need for the AHHRI to focus on partnerships development at different levels and across a broad health care spectrum. This included national, regional and community level partnerships between governments and with non-governmental organizations. There has been an effort to integrate opportunities for collaboration in the management of the Initiative at the national and regional levels with a number of advisory committees composed of First Nations, Inuit and federal and sometimes provincial/territorial government participation.

b) Summary of Consultation Findings

The AHHRI has led to a very large number of collaborative activities and initiatives. These are evident in the number and quality of partnered projects. While there have been many partnerships, participants told us of the need to deepen the engagement between the AHHRI and key training and health care sector stakeholders. Much was made of the need to work more closely with Aboriginal education and training providers, particularly the Aboriginal Human Resources Development Agreement (AHRDA) holders who administer some $300 million annually in human resources programming. Human Resources and Skills Development Canada (HRSDC) indicated that they welcomed these partnerships and had a sufficient regional presence to engage but that this had not been prioritized by the AHRDA holders. Specifically, the AHRDA holders set their own priorities at the regional/local levels, so that HRSDC has the ability to influence and suggest, but that regional Aboriginal groups set the AHRDA priorities.

Participants also singled out the need for a deeper engagement between the AHHRI and provincial/territorial health districts. It was felt that more needs to be done in this area and in particular following the Aboriginal representative work force model adopted in the province of Saskatchewan. As the primary players in the health care field, it was felt that there was a need to build a nexus between the AHHRI and these major primary health care providers.

c) Examples of Success

Saskatchewan Health Care Representative Work Force

The AHHRI supported the development of a career pathing partnership project with four tribal council health organizations, the Saskatchewan Association of Health Organization (SAHO), Saskatchewan Institute of Applied Science and Technology, the Province of Saskatchewan and Northlands College. This initiative was designed to increase the professional competencies of existing workers which in turn was to lead to greater retention rates within the northern health district work force.

Objective 7: Promote Research, Best Practices and Support for Policy Planning and Program Decisions

a) Overview of Activities Related to This Objective

The AHHRI undertook extensive engagement with the Aboriginal community on the design of the program framework. The program framework included the establishment of a research component. Early on in the Initiative, it was recognized that there was a lack of statistical information on the number of Aboriginal people who were enrolled in health educational and training programs and who were currently participating in the health care field. To inform program personnel of the situation in each region, the AHHRI supported the development of environmental scans on the level of participation of Aboriginal people in the health care sector. Research was to have provided baseline data to:

- permit ongoing measurement of the positive influence of the AHHRI in the short-, medium- and long-terms;
- determine employee recruitment and retention rates in Aboriginal community-based health services facilities, including attrition rates; and
- provide evidence based information to inform policy, planning and program decisions, and to inform resource allocations.

In order to optimize support for policy planning and program decisions, the AHHRI provided First Nations and Inuit national and regional organizations with resources to develop their capacity to effectively engage with Health Canada. This provided national organizations with resources to retain staff and to engage in HHR planning and implementation. Capacity funding was also provided to the 10 First Nations provincial and territorial organizations (or their delegates) and the four Inuit land claims organizations (or their delegates). These resources have been provided in each year of the Initiative and provided for regional level First Nations and Inuit input into policy planning and program decisions. The regional organizations provided input at the regional level by way of participation in regional advisory committees and also carried out coordination and promotional activities with First Nations and Inuit communities.

The regional advisory committees participated in the development of priorities in the regions and in the selection of projects in those regions. Following review of the projects by the regions, projects were reviewed by national headquarters staff for conformity with the AHHRI objectives. Projects were also reviewed by personnel from the Assembly of First Nations (AFN) and the Inuit Tapiriit Kanatami (ITK). Health Canada headquarters would then provide comments on the projects submitted before they were approved.

b) Summary of Consultation Findings

The environmental scans provided some baseline information but also revealed that there were significant limitations on the existing data sets. There were also a number of definitional issues. Ownership, control, access and possession (OCAP) principles were also cited as a reason for not developing the data sets.

While the project did provide resources for both Health Canada regions and First Nations provincial and territorial organizations and Inuit land claims groups, there was a concern raised as to the overall combined capacity of regions to achieve the transformative changes sought by the AHHRI. We were informed of the significant amount of multi-tasking that was taking place and this was undertaken in tight time frames with significant staff turnover rates. It was suggested that these turnover rates created confusion over Initiative priorities at the regional level. We were also informed that there were significant time delays in staffing or retaining professional support for new regional projects.

Regional respondents agreed that the character and commitment of the Health Canada regional coordinators and the First Nations and Inuit regional leads was essential to making progress. Participants felt that it was important to provide incentives to these individuals by way of their classification level and salary. Others suggested that there was a need to increase the overall capacity of regions by vesting it with more authority to set regional priorities and more latitude in project selection.

c) Examples of Success

Census Data Project

This national project is part of the AHHRI's information and research agenda, developed in consultation with First Nations, Inuit and Métis. Overall, the intent of the agenda is to establish baseline information on the number and distribution of First Nations, Inuit and Métis health care workers and educational pro-

grams targeted to these populations; to develop processes for data collection; and to develop a research agenda aimed at determining the optimal numbers and mix of health care workers required.

The census data project is being done by FNIHB headquarters staff in collaboration with Statistics Canada. As noted on FNIHB's website,[11]

> Data from the 1996, 2001, and 2006 Census databases have been analyzed (in preparation to be published with Statistics Canada) as a means to establish baseline information on the supply and distribution of Canada's Aboriginal and non-Aboriginal health care providers. Based on the 1996 and 2001 Census findings, preliminary results indicate the following:
>
> - 1.57 percent of Canadian health care providers identified as Aboriginal. Of this, approximately 50 percent were First Nations, while 43 percent were Métis, and 3 percent, Inuit; and
> - upward trends were noted for registered nurses, midwives, practitioners of natural healing, dietitians, nutritionists, and physicians.
>
> The baseline information established by this research will be valuable in informing the design, that is, the planning, implementation and evaluation, of HHR programs and policies, specifically the AHHRI.

Although there are recognized deficiencies in the census data (e.g., veterinarians being included in data; lower rates of self-identification of Aboriginal status in the past compared to today, leading to misleading trend lines), the feeling among many respondents is that this is useful research, and the findings from it helps fill the gap in the absence of a minimum data set.

Minimum Data Set

The minimum data set (MDS) is critical foundational information needed for evidence-based decision-making within and about the AHHRI. The National Aboriginal Health Organization (NAHO)[12] has worked in partnership with the Canadian Institute for Health Information (CIHI) and FNIHB to develop an Aboriginal health human resource minimum data set. This work has produced some key deliverables that represent milestones in "thinking about the minimum data set" over time.

Regional scans were analyzed and rolled up through Tomblin Murphy Consulting Inc.'s assessment. The work focused on a comprehensive scan and survey of the Aboriginal health human resources landscape.[13] Led by NAHO, with support from CIHI and FNIHB, this study focused upon gaining a better understanding of the role played by professional associations, recruitment organizations, educational institutions, and other Aboriginal organizations with respect to Aboriginal health human resources. The resulting information provided insights about the elements and sources for the minimum data set.

After NAHO completed the environmental scan, work continued on the definition and specification of the minimum data set.[14] A detailed analysis of options for the minimum data set was then completed.[15] This study concluded that:

> No single data source currently exists to meet the needs for Aboriginal health human resource planning. Establishing a suitable source is unlikely over the next two years—the current horizon for the AHHRI. Issues of efficiency, data quality, data stewardship, the scope of data collected, the timeline necessary to achieve reliable data, and the costs are all factors that make it difficult to identify a suitable option.
>
> Fulfilling the minimum data set in its current format is a potentially ambitious exercise. The options presented in this document would populate the data elements to varying degrees. A minimum requirement is to provide Aboriginal identifiers within existing HHR databases but this may not be the least expensive avenue. The costs of adding additional MDS data elements varies with the options presented in this document. Conducting surveys, for example, is far less expensive.

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[11] http://www.hc-sc.gc.ca/fniah-spnia/services/career-carriere/hum-res/prog-elem-eng.php#collab

[12] NAHO Website, http://www.naho.ca/english/hhr.php

[13] National Environmental Scan: Comprehensive Survey of the Aboriginal Health Human Resource Landscape, NAHO, July 12, 2007

[14] Establishing a Minimum Data Set to Support the Advancement of NAHO's Aboriginal Health Human Resource Initiative: Next Steps, Version: August 20, 2007, Prepared by Tomblin Murphy Consulting Inc.

[15] Aboriginal Health Human Resource Initiative: Options for a Minimum Data Set, October 2007, prepared for National Aboriginal Health Organization, prepared by Phillip Bird.

After looking at various options, involving NAHO, CIHI and other organizations, the report goes on to conclude that a mixed strategy option is most appropriate:

> A combination of strategies is likely to be the most effective in fulfilling the MDS requirements. Coordinating the data sources and managing the disparate data will prove challenging. This strategy is not the most cost-effective—start-up costs to bring all the data sources together and to house and manage the data will be high. Ongoing operating costs also will be required. This strategy recognizes the value of different data sources and supports a collaborative approach.

and that NAHO should play a significant role:

> NAHO is the obvious focal point for undertaking Aboriginal HHR planning. The three Centres provide the expertise for culturally appropriate analysis and coordinated planning. Ultimately, whatever the option or path that is chosen, a NAHO-centered initiative will be more cost effective and will assure consistent data quality than if the tasks are fragmented among the national Aboriginal organizations. An opportunity exists to move forward but there is a need for the long-term commitment of financial resources. Financial realities, however, suggest a common Aboriginal HHR planning initiative under one roof will survive the test of time.

Despite the attention placed upon and work done on the minimum data set, it does not exist as of today. While respondents in our consultations expressed some disappointment that more progress was not made, it is also noteworthy that the Pan-Canadian HHR Strategy also has not finalized its minimum data set. Programs in Human Resources and Skills Development Canada were also reported as having similar issues in agreeing upon their minimum data sets, for many of the same reasons. One of the principal difficulties in developing a minimum data set can be attributed to the diffusion of actors who are in possession of the data. The data is not held by any one institution per se and this raises issues as to who should own, access, control and possess the data. While there has not yet been an agreement on a minimum data set, there does now appear to be a shared consensus and willingness to work together to identify a minimum data set.

C Program Design and Delivery

Overview

As outlined in Section 3, the Aboriginal Health Human Resources Initiative (AHHRI) is managed and coordinated by the First Nations and Inuit Health Branch (FNIHB) in Ottawa. FNIHB national headquarters has been responsible for developing the program and investment framework and designing the delivery mechanism for the Initiative while regions work directly with stakeholders to develop, monitor and implement regional plans. Two advisory committees composed of representatives from National Aboriginal organizations, provinces, other federal departments and stakeholders have been established to provide input into the AHHRI. The program sponsored projects at the national and regional levels. Regional projects were reviewed at headquarters for consistency with program terms, conditions and priorities. Project recipients included Aboriginal and non-Aboriginal communities and organizations. The funding criteria were clearly articulated outlining what activities were eligible and what activities would not be funded.

Summary of Consultations

Participants were universally of the view that the implementation time line for establishing the AHHRI was a major challenge. The first year (2005–06) of the program was focused upon getting government approvals in place, starting the regional engagement, and in the meantime, identifying and launching some national projects. As was shown in *Distribution of Projects Across the Country* (see pages 18–19), some regions were able to start regional projects in the second year (2006–07). However, other regions were not ready to start projects until the third year (2007–08). The majority of the projects didn't really begin until the third and fourth (2008–09) years. These lead times necessary to ensure readiness to implement projects, when balanced with the need to have the program operational in all of the regions as soon as possible, complicated the development of networks, partners and the overall coordination of the program. The top-down approach coupled with the pace of implementation did not initially allow for the establishment of bottom-up community-based partnership approaches. This led to divergent approaches in terms of program criteria and the nature of the host delivery organizations (some administered

by First Nations while others were implementing Request for Proposal (RFP) processes).

Regional concerns were raised with the level of information provided by national headquarters with respect to project feedback, resource sharing, and accountability to First Nations/Aboriginal people.

It was suggested that any renewal discussion should incorporate a greater level of consultation with other levels of government, Aboriginal and First Nations governments and organizations. It was suggested that the new strategy should be Aboriginal driven, reflect the regional differences among Aboriginal people and take into consideration the roles and mandates of Aboriginal entities (provincial and territorial organizations, land claims organizations, tribal councils, First Nations, and the Assembly of First Nations) from the beginning. This should include the worldview of Aboriginal people from an ecological consciousness, culture, traditions and language point of view.

Participants also suggested that the Initiative should be multi-year and build in a strong integrated network of stakeholders including post-secondary institutions, medical associations, and federal, provincial, and territorial ministries. Regional and cultural flexibility needs to be built into the contribution agreements with the ability to establish regional specific objectives and activities. This includes providing regional advisory committees with a greater role in determining program priorities and criteria. Participants suggested that Aboriginal partnerships must be a priority and must build upon existing successful partnerships.

We were also advised that the program requires a greater level of communication both between national headquarters to regions and from FNIHB to Aboriginal communities. The AHHRI also needs to improve communication with other jurisdictions and to address jurisdictional needs and opportunities.

Finally, capacity issues were raised, and in particular, the need for a new program to facilitate the participation of more Aboriginal communities. Participants recognized that resource challenges make it difficult to engage with Aboriginal communities in a timely way. Participants believe that it was particularly important for FNIHB to be accountable to Aboriginal peoples. Other suggested improvements included the need to simplify the program process instruments in terms of forms, reports, workplans, etc. Participants felt that there should be greater flexibility and respect of regional processes.

Summary of Findings and Conclusions

The program design and delivery mechanisms were sound. The significant time delays in rolling out the Initiative provided for the development of appropriate planning processes, coordinated decision-making processes, project workflows and evaluative processes. However, the delays in rolling out the Initiative left very little time in each fiscal year 2005–06 and 2006–07 for Health Canada and its project sponsors to appropriately launch and complete projects within a particular fiscal year. This was particularly true for the First Nations and Inuit AHHRI coordinators and Health Canada regional coordinators who were required to undertake strategy- or capacity-type undertakings in their own right, liaise with First Nations and Inuit potential project sponsors on new projects and review and submit projects as members of regional advisory committees to FNIHB in Ottawa. This implementation delay had a spillover effect for regions in the first full three years of the Initiative and coloured what was otherwise a sound delivery mechanism. The relatively large number of personnel who were newcomers to this strategy also created delivery challenges, and this was further exacerbated by the relatively large turnover in several key staff positions and the classification levels of the AHHRI regional coordinators.

As the delivery mechanism matured and as lessons learned have been absorbed, these regional advisory committees have built up their capacity and are now fully functional. In the last year, they have become more and more focused on handling and developing more strategic approaches to Aboriginal HR issues and have focused less on the paper, process and report burdens. We believe that these regional advisory committees have the capacity and the resident knowledge to develop regionally-tailored AHHRI projects going forward.

As we have mentioned earlier, we believe that given the unique circumstances of the North and of Inuit in particular, that consideration should be given to developing regionally tailored and Inuit-specific delivery mechanisms.

D Governance and Accountability

Overview

Health Canada has the responsibility to manage and account for the Aboriginal Health Human Resources Initiative (AHHRI) resources. As described above, it has invited the participation of First Nations and Inuit

stakeholders to participate on an advisory committee that is co-chaired jointly by Health Canada and an Aboriginal organization (currently the Assembly of First Nations). Provinces/territories and other key health stakeholders are also invited to participate on the advisory committee. Indian and Northern Affairs Canada (INAC) and Human Resources and Skills Development Canada (HRSDC) are members of the committee. This national committee is to provide overall direction for the Initiative as a whole. Health Canada also established a research and evaluation working group.

Health Canada has also established regional advisory committees that are composed of First Nations and Inuit representatives. Many of the regional advisory committees also included provincial/territorial representatives and representatives from other federal departments, including HRSDC. These regional advisory committees provide input into the identification of initiative priorities and on locally submitted projects.

Summary of Consultations

First Nations and Inuit stakeholders have taken the view that there should be more meaningful engagement at the national and regional levels, particularly in regard to establishing overall AHHRI priorities and investment areas. Inuit seek their own Inuit-specific AHHRI governance and delivery mechanisms. Regional First Nations stakeholders believe that they are in the best position to establish regional priorities and that they should have the authority to determine regional priorities and projects.

Participants on the national advisory committees and working groups believed that their work was not as focused as it could have been. Others questioned whether participants were organizationally committed to the activities undertaken by the advisory committees and working groups. Still others questioned how the AHHRI had become so focused on supporting initiatives aimed at nurses and doctors rather than adopting community-based programming.

Some participants suggested that the responsibility for the Initiative should not rest solely on national headquarters personnel. Since most regional AHHRI staff in Health Canada are the responsibility of the Regional Director, it was suggested that the Regional Director should bear more responsibility for the success or failure of the Initiative. In this regard, it was suggested that if the Regional Director is more accountable, then he or she would be more willing to invest more time in making the strategy a higher priority and would use his or her leverage in bringing important stakeholders to the table (such as provinces/territories, regional First Nations and Inuit leaders).

Participants felt strongly in the need to have a more effective national communications strategy and for this to factor in the regional approaches implemented in the regions. Participants also felt that there should be more communications-based activities and that these should be targeted throughout the education continuum (from K–12, post-secondary and life-long learning). The strategy and tools should be more holistic and pro-active and should seek to facilitate educational promotion beyond health careers. They also spoke of the need to share best practices.

Summary of Findings and Conclusions

The AHHRI has had a strong internal governance model. Its approach to establishing national and regional advisory mechanisms in the administration and delivery of federal programming follows best practice approaches adopted at the federal level over the last decade. The AHHRI was not designed or intended to be a program that was to be developed and devolved over time.

Key decisions made in the program framework in relation to funding priorities not only shaped the national and regional agendas but also the character of projects funded in the first three years. The reason for the focus on doctors and nurses had to do with the fact that these two professions were identified as key shortage areas by a number of sources (Pan-Canadian Health Human Resources Strategy, provinces and territories, previous reports such as the Royal Commission on Aboriginal Peoples, and others) and there was significant pressure on government to do something in these areas. In addition, the overall numbers of Aboriginal registered nurses and medical doctors was far below an equitable level. Bringing these numbers closer to parity was seen as a priority by partners. It has been suggested that these funding priorities were not or are not now the priorities that should be pursued under a renewed AHHRI. While we were provided no evidence to suggest that the initial AHHRI framework priorities were not supported by First Nations and Inuit, we could understand the need for greater regional flexibility and for a need to adopt Inuit-specific approaches. This, however, speaks for the need for the development of a shared

renewal process and strategy that incorporates greater dialogue and commitment in developing a new shared and transparent AHHRI framework. The renewed framework would need to have the right mix of approaches to systemic change and the right regional role in setting and determining regional priorities.

It is clear that the AHHRI shared governance mechanism needs to be strengthened and invigorated with a meaningful forward-looking agenda. Given the late start to the AHHRI, this should include ongoing work in the area of evaluation, improving communications and sharing best practices.

5

Overall Conclusions and Recommendations

A Conclusions

Having reviewed the objectives and sampled a number of projects, we come now to whether the Aboriginal Health Human Resources Initiative (AHHRI) has achieved the principal outcomes that it had identified at the outset of the Initiative. The AHHRI was designed to lay the foundation for longer-term systemic change in the supply, demand and creation of supportive environments for First Nations, Inuit and Métis health human resources for Aboriginal communities with the goal of improving health status, with a particular emphasis on increasing the numbers of Aboriginal health professionals.

We have found on the whole that the Initiative has made significant inroads in facilitating the conditions for increased Aboriginal participation in the health care system in Canada. Many more Aboriginal people are aware of the educational requirements necessary to pursue a health care career. There is greater awareness and attraction to the broad array of careers available within the health care system. There are innovative pilot bridging programs that will increase the number of Aboriginal people who will be in a position to qualify for entry into health professions. These pilot initiatives form a best practice that can in the future be used to further increase the number of qualified Aboriginal candidates.

There have been a number of projects that have sought to increase the number of culturally competent health professionals. This has included the development of culturally sensitive and relevant curricula that will be used into the future. While there have not been significant volumes of work in the area of Aboriginal retention, the work that has been undertaken has provided some promising results that, if adopted more broadly, can have a meaningful impact on the health care system as a whole.

More specifically, by 2008–09, the AHHRI built a reasonable "footprint" or reach in terms of where it invested in projects, how much it invested, who it invested with, and what areas/interventions it invested in. This pattern was being continued in the formulation of plans for 2009–10. These are all important dimensions in terms of meeting the expectations of many stakeholders. At the same time, it would be appropriate to validate that desired impacts are being achieved by the large number of smaller-sized projects in the regions. This would appear to be an ongoing challenge—managing the tradeoffs and risks involved, or, in other words, the balance between reach and impact, when the needs are great across the country.

Although we found the design and governance of the AHHRI to be fundamentally sound, we did discover a number of significant areas where performance can be improved in the future, such as:

- enhancing strategic communications and establishing sustainable networks;
- adopting an improved knowledge management system to share best practices, improve efficiencies, and avoid duplication of lessons learned; and
- streamlining administration and enhancing the governance mechanism in the Initiative.

These conclusions led the review team to make the following set of recommendations to the program management and partners in the AHHRI. These recommendations go beyond the normal continuous management improvement that is expected of any such initiative.

B Recommendations

1. Develop a knowledge management and dissemination strategy including the need to improve upon communications between Health Canada and Aboriginal stakeholders to ensure that the goals, objectives, priorities and best practices are understood and shared.
2. Increase the capacity and role of regions to strengthen regional planning and implementation processes including:

a. providing regions with the opportunity to establish regional plans, priorities and selecting regional projects (consistent with the AHHRI's seven objectives);
b. over time, moving towards clustering capacity and human resources for both Health Canada regions, First Nations provincial and territorial organizations and the four Inuit regions into single-window entities (this could be outsourced like the Aboriginal Human Resource Development Agreement strategy to regional First Nations and Inuit entities);
c. elevating responsibility in Health Canada for regional results to Regional Directors; and
d. developing more effective regional partnerships with the Aboriginal, provincial/territorial and federal departments who are responsible for education and training.

3. Develop health human resources strategies and approaches that are Inuit-specific.
4. Ensure that northern and rural strategies are reflective of the unique health human resources conditions and needs of those people and regions.
5. Facilitate the development of community-based health human resources planning tools and methodologies including further identifying and strengthening core competencies of community-based health and allied workers.
6. Improve data gathering and reporting mechanisms. These mechanisms need to go beyond simply reporting against project plans, to benefits/impacts and sharing of such assessments and best practices.
7. Strengthen and understand the roles and responsibilities of governance committees and to adopt approaches to reduce turnover and enhance knowledge transmission within governance structure.

Annex A: List of Key Informants

Last Name	First Name	Position	Organization
Achtenberg	Melanie	Sr. Policy Advisor	Human Resources and Skills Development Canada Aboriginal Affairs Directorate Skills Employment Branch
Antone	Tracy	Health Coordinator	Chiefs of Ontario
Armstrong	Daphne	AHHRI Regional Project Coordinator	Kenora Chiefs Advisory
Arnault- Pelletier	Val	Aboriginal Student Advisor	University of Saskatchewan
Bale	Susan		Nishnawbe Aski Nation
Beaudin	Roger	AHHRI Regional Project Coordinator	M'Chigeeng Health Services
Benisty	Billie-Jean	Sr. Policy Advisor	Health Canada First Nations and Inuit Health Ontario Region
Binks	Janet	Sr. Policy Manager, AHHRI	Health Canada First Nations and Inuit Health Branch Headquarters
Blake	Lena	Comptroller	Nunatsiavut Government Health and Human Resources
Bobich	Nancy	Nurse Advisor	Cree Board of Health and Social Services of James Bay (Membre du Comité aviseur régional)
Boyd	Joni	Sr. Policy Advisor	Inuit Tapiriit Kanatami Health and Environment
Brascoupe	Simon	Former Team Leader, AHHRI (now retired)	Health Canada First Nations and Inuit Health Branch
Burton	Pam	AHHRI Coordinator	PTO - Chiefs of Ontario
Cachagee	Joan	AHHRI Regional Project Coordinator	Sioux Lookout First Nation Health Authority Meno Ya Win Health Centre
Campbell	Paulette	Capacity Development Advisor	Northern Inter-Tribal Health Authority
Chalifoux	Janice	Health Careers	Treaty 8 First Nations of Alberta Health Department
Cohen	Deborah	Manager	Canadian Institute for Health Information
Colomb	Emmanuel	Program Officer, Continuing Education Department	Université du Québec à Chicoutimi
Cornell	Sandra	Manager	Lakehead University Native Nurses Entry Program

Last Name	First Name	Position	Organization
Cox	Jennifer	Legal Advisor	Atlantic Policy Congress of First Nations Chiefs
Cuthbertson	Leslie	Coordinator	ACUA re: Dalhousie University Projects
Dallas	Catherine	AHHRI Regional Coordinator Ontario Region	Health Canada First Nations and Inuit Health Branch
Doxator	Sheri		Association of Iroquois Allied Indians
Duncan	Lori	Director of Health and Social Development	Council of Yukon First Nations Council
Ferland	Damien	Director, Continuing Education Department	Université du Québec à Chicoutimi
Gagnon	Corina	Executive Director	Kenora Chiefs Advisory
Gillis	Debra	Director Primary Health Carde Division	Health Canada First Nations and Inuit Health Branch Headquarters
Gladue	Helen		Treaty 6
Goldie	Claire	AHHRI Regional Coordinator Northern Region	Health Canada First Nations and Inuit Health Branch
Goodchild	Melanie	AHHRI Regional Project Coordinator and Director of Health	Nishnawbe Aski Nation
Gotts	Dave		Lampton College
Gravel	Barbara	Education Counsellor	Conseil en Éducation des Premières nations
Grossner	Shawn	Recruitment and Training Specialist	Government of Nunavut Health and Social Services
Hammi	Samir	AHHRI Regional Coordinator Quebec Region	Health Canada First Nations and Inuit Health
Harlow	Phyllis	AHHRI Coordinator	Atlantic Policy Congress of First Nations Chiefs
Horton	Jan	Health Human Resources Coordinator	Government of the Yukon Health and Social Services
Horton	Laura	Director Post-Secondary Education	Seven Generations Education Institute
Humpage	Kate	Director	Human Resources and Skills Development Canada Aboriginal Affairs Directorate Skills Employment Branch
Jagodzinsky	Darcy	AHHRI Regional Coordinator Alberta Region	Health Canada First Nations and Inuit Health Branch
Jones	Jen	Manager, Aboriginal Health Transition Fund	Council of Yukon First Nations Council
Kinney	Michelle	Deputy Minister	Nunatsiavut Government Health and Human Resources

Last Name	First Name	Position	Organization
Large	Eric		Saddle Lake First Nation
Leung	Derek	AHHRI Regional Coordinator British Columbia Region	Health Canada First Nations and Inuit Health Branch
Mandamin	Betsy	Health Coordinator	Shawanaga Independent First Nations
Mandoka	Catherine	Health Director	Association of Iroquois Allied Indians
Maracle	Murray	Executive Director	Anishnabek Educational Institute
Marchand	Daniel	Sr. Evaluation Analyst	Health Canada First Nations and Inuit Health Branch Business Support and Capital Division Program Evaluation
Maurice	Dr. Jacqueline	Policy Analyst, Health and Human Resources	Federation of Saskatchewan Indian Nations
McLean	Bobbi	Aboriginal Resource Specialist	College of the North Atlantic
Mesher	Lisa	Planning Agent	Nunavik Regional Board of Health and Social Services (Membre du Comité aviseur régional)
Michelin	Gillian	Human Resources Project Coordinator	Nunatsiavut Government Health and Human Resources
Moore	Elizabeth	Senior Policy Analyst, AHHRI	Health Canada First Nations and Inuit Health Branch Headquarters
Osterberg	Trisha	Aboriginal Health Human Resources Initiative Coordinator	First Nations Health Committee
Pellerin	Francine	Health Director	Matawa First Nation Management
Poole	Karen	Director of Nursing	Lakehead University School of Nursing Native Nurses Entry Program
Prince	Holly	Aboriginal Palliative Care Research Coordinator	Lakehead University Centre for Education and Aging Research
Richer	Valerie	Sr. Policy Analyst	Assembly of First Nations Health and Social Development Secretariat
Ross	Gordon	Manager Recruitment Support	Government of the Northwest Territories Human Resources
Ryan	Kevin	AHHRI Regional Coordinator Atlantic Region	Health Canada First Nations and Inuit Health Branch
Sanders	Larry	AHHRI Regional Coordinator Saskatchewan Region	Health Canada First Nations and Inuit Health Branch
Sanderson	Lora	Coordinator, Aboriginal Health and Human Resources	Assembly of Manitoba Chiefs
Sheppard	Valerie	Counselor	College of the North Atlantic

Last Name	First Name	Position	Organization
Sheshequin	Loretta	AHHRI Coordinator	Nishnawbe Aski Nation
Sitting Eagle	Margo	Health Careers Coordinator	Treaty 7
Sones	Rose	Sr. Policy Analyst	Assembly of First Nations Health and Social Development Secretariat
Soucy	Danielle	Aboriginal Affairs Officer	McMaster University
Staats	Linda	Executive Director	Six Nations Polytechnic Inc.
Stevenson	Darrin	AHHRI Regional Coordinator Manitoba Region	Health Canada First Nations and Inuit Health Branch
Stewart	Maureen	Sr. Policy Manager, AHHRI	Health Canada First Nations and Inuit Health Branch Headquarters
Stomich	Susan	Program Manager Representative Work Force	Saskatchewan Association of Health Organizations
Sylliboy	John	AHHRI Coordinator	Atlantic Policy Congress of First Nations Chiefs
Taylor	Mindy	AHHRI Coordinator	Union of Ontario Indians
Toulouse	May	Sr. Policy Analyst, AHHRI	Health Canada First Nations and Inuit Health Branch Headquarters
Turner	Gail	Director of Health Services	Nunatsiavut Government Health and Human Resources
Vanloffeld	Steve	Research Officer	National Aboriginal Health Organization
Wolski	Erin	Health Director	Native Women's Association Canada

Annex B: Fundamental Concepts in the Field of System Dynamics

B

Unique Characteristics of "Systems-based" Analysis

This study applied System Dynamics analytical methods to understand and diagnose performance issues associated with the Opting-In Process under Part II of the Framework Agreement. The Process itself was viewed as a "system" operating within the larger context of the First Nations Land Management Initiative (FNLMI).

System Dynamics is a powerful and highly disciplined methodology first developed at the Massachusetts Institute of Technology (MIT) in the late 1960's. System Dynamics is a branch of "systems science" that examines how complex systems are structured and how that structure (including feedback relationships within the system) influences their behaviour dynamically over time. The focus of the analysis is on how the system functions as a whole over time, not on the individual parts.

A fundamental premise of System Dynamics is that the behaviour of complex systems is determined by their generic structures and the policies that operate within the system, not by any individual actor or isolated elements within the system.

The System Dynamics discipline is now taught in universities throughout the world and is used extensively in both private and public sector contexts to help develop a more cohesive and more complete picture of

- the elements that comprise complex social, economic, or biological systems;
- the causal relationships among those elements; and
- the system's dynamic behaviour as a whole.

A Dialogue-Based Approach

The system-based analytical approach is dialogue-based and offers a non-confrontational path to collective learning that helps reconcile and integrate differing conceptions of "how things work" in reality (i.e., the mental models). In practice, the method narrows areas of disagreement and builds consensus on common understandings—a shared, disciplined examination of the "problem" that is engaging the parties.

The Power of Mental Models

Individuals possess deep-rooted assumptions, premises, guiding ideas or general ways of looking at things and bring these to any given situation. In systems thinking these are known as "mental models." These mental models, which are influenced by our education and by our experience, determine what we see and what we do not see, how we interpret what is happening, and how we think the future will unfold. Ultimately, they shape the decisions that we make about how to change the anticipated behaviour of the many complex systems that we engage with in the real world.

Everybody's mental models differ and everybody's are deficient in some respect. It is only by clearly articulating these differing mental models and integrating them that the weaknesses of each can be overcome and a common framework for discourse and for action can be established.

Discovering, Analyzing, and Communicating Through Graphical Representations

A distinguishing feature of the systems analytical method is that it relies on the development of graphical representations (pictures) of systems in order to understand what the components are, how they are linked together, and how they interact over time. These may be qualitative representations (i.e., models) of systems structures or, where necessary, simulatable (quantitative) models.

A Focus on Understanding Systems Structure and Behaviour Over Time

One of the most important characteristics of the "systems" approach is that the focus is on understanding how the structure of the system (i.e., the various elements and the ways in which they influence each other as a functioning whole) determines

performance over time. In this case, the focus was on performance of the Opting-In Process. Since the analytical method is founded on the principle that system behaviour is largely determined by system structure, not by specific actors within the system, a preoccupation with determining "blame" and "accountability" for performance short-falls becomes less meaningful (and not particularly helpful). The system itself, including the policies that operate within the system, is the determinant of performance. Therefore, to understand why things happened as they did, one must first understand the system.

Using Qualitative Models to Understand System Performance

A qualitative systems model maps the constituent elements of the system and the causal connections that link them together as a cohesive whole. The polarity of each causal connection must be unambiguously determined. Feedback loops that comprise the high-level architecture of the system are also mapped and their polarity is specified. Positive feedback loops reinforce change within the system (either growth or decline). Negative feedback loops generate a balancing force within the system, driving it toward an implicit or explicit goal.

Figure 1 shows an example of a simple qualitative systems model, one that is often used in introductory System Dynamics courses and in the leading textbook for the field. In this system, the number of chickens is influenced by the number of eggs. The number of eggs, is likewise influenced by the number of chickens. Each relationship in a qualitative systems model is represented by a linkage with a clear specification of its causal polarity (positive or negative). Where the causal relationship is positive, a change in one variable will cause the second variable to change "in the same direction."

As shown in Figure 1, the polarity of each causal linkage in the chicken and egg system is marked with an "S," for "same." In this system, if the number of eggs increases, the number of chickens will increase (i.e., change in the same direction). Likewise, if the number of eggs decreases, the number of chickens will decrease. As depicted in the model, the same logic also applies to the relationship that links chickens to eggs.

Together, the two causal linkages in this system create a closed-loop structure that is marked with a "snowball rolling down the hill" symbol. This indicates that the feedback loop is a positive, or self-reinforcing loop.

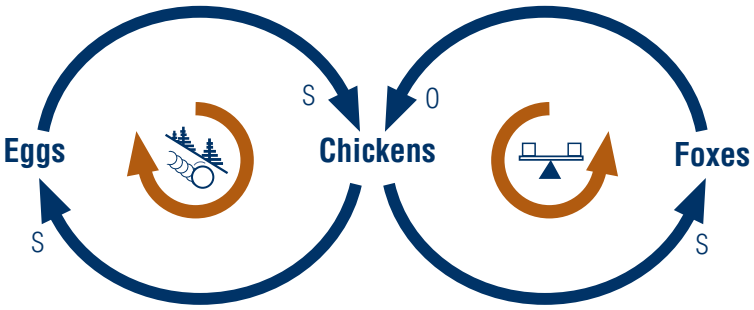
Figure 1: *Chicken and Egg System*

This simple system structure will generate exponential change over time (change at an ever-increasing rate) in both chickens and eggs.

The system also works in the opposite direction, however. If the number of eggs decreases for some reason (e.g., disease or predators), the number of chickens will decrease, which will then lead to an accelerating decline over time in the number of eggs.

Figure 2 expands our understanding of the "system" by adding structure for the role of foxes in the henhouse.

Figure 2: *The Chicken—Fox Ecosystem*



Foxes play a "balancing" role in this more complex system, creating a dynamic that counteracts the powerful self-reinforcing growth that would result if the system included only chickens and eggs. The more foxes we have, the fewer chickens we will have. Conversely, if the number of foxes declines the number of chickens would increase.

As shown in Figure 2, the polarity of this causal linkage in the system is marked with an "O", for "opposite." The two linkages in the "chicken-fox" portion of this model create a closed loop that is marked with a teeter-totter. This indicates that the loop is a balancing, or negative loop. This kind of

"predator-prey" system can create complex, non-linear, and counter-intuitive dynamics. In real life, all systems are composed of both self-reinforcing and balancing feedback loops.

The qualitative systems models developed for this report also incorporated "stock-flow" representations of the Framework Agreement Opting-In Process within the larger context of the overall FNLMI system. Figure 3 shows a simple systems model of a generic work process.

In systems models, "stocks" represents accumulations of things within the system. These could be anything that, in real life, can accumulate: people, money, pollution, houses, tasks, fatigue, animosity, trust, animals, food, or First Nations involved in the FNLMI, etc. It is often helpful to think of stocks as "bathtubs" that hold things. In the case of the generic work process model, the stock represents the accumulation of work to be done (tasks).

The inflow "pipe" represents how additional tasks are added to the stock over time. Like the tap for a bathtub, this rate of inflow can vary. The outflow pipe from the stock represents how the stock is depleted by completing tasks (i.e., "doing the work"). Again, like a bathtub, the rate at which the stock is drained can vary.

The rate at which work is completed is determined by two variables: the amount of resources applied to the work and the productivity of those resources (i.e., the number of tasks that can be completed by the resources in a given time period). If the amount of resources available to do the work increases, the rate of completing work (draining the stock) will increase. If the amount of available resources decreases for any reason, the rate of completing work will decline and the stock of work to be done will not decrease as quickly. The longer it takes to complete a task, the longer the backlog of tasks will remain in the stock of uncompleted work.

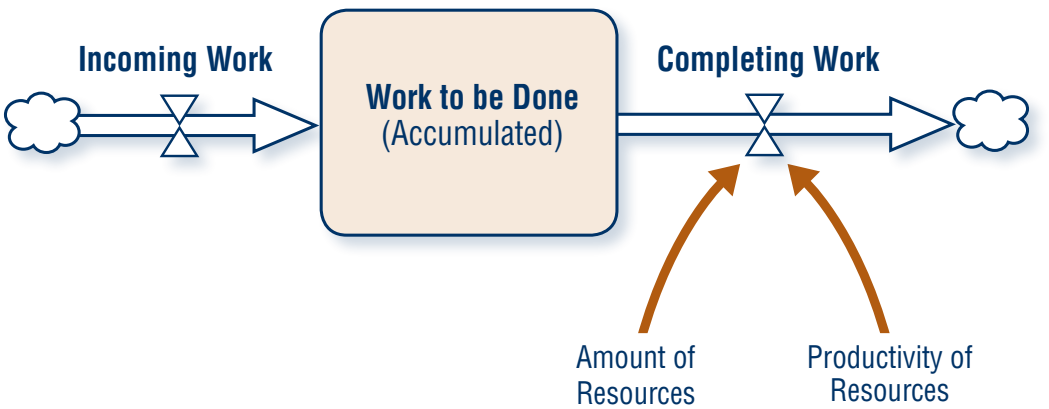
At any point in time, the level of the stock representing work to be done is determined by the balance between the rate at which new tasks have been added and the rate at which the tasks are being completed through the work process. (Using the bathtub analogy, the level of water in the bathtub is determined by the balance between the rate of inflow from the tap and the rate of outflow through the drain. If the water flows in more quickly than it drains out, the water level will get higher.)

In System Dynamics, the average time that a "thing" remains in a stock is called the "residence time." One of the key issues associated with the First Nations Land Management Initiative is that the average residence time for First Nations in the Opting-In Process (which can be represented as one of the stocks in a model of the FNLMI system) is much longer than anticipated. This reality has had implications for the perceived effectiveness of the Framework Agreement and for the cost of sustaining its continued implementation.

Gaining Insight Through Systems Simulation Models

Qualitative systems models can be extremely valuable in helping generate understanding and facilitating creative thinking about how to deal with complex problems. They also can be valuable in discovering systemic structures that are known to generate characteristic patterns of behaviour that have been experienced in real life.

Figure 3: ***Stock-Flow Systems Model of Generic Work Process***



- Qualitative systems models, however, have limitations. Human brains have inherent "wiring" limitations that make it difficult for them to mentally simulate the operation of complete systems that have anything more than a handful of feedback relationships. (This helps explain why there is such a prevalence of "unanticipated side-effects" from public and private sector policies that are intended to effect changes in complex economic and social systems.)

Since, in real life, systems are more likely to be complex than simple, it can often be helpful to go beyond the first step and re-articulate a qualitative model as a quantitative (simulatable) system dynamics model. This study was not intended to produce a full-developed, calibrated, simulatable System Dynamics model of the Framework Agreement Opting-In Process. However, the inter-connected nature of the issues discovered in the course of the project was sufficiently complex that it was necessary to develop a number of small, un-calibrated computer simulation "insight" models in order to test our conclusions and gain insight into their collective impact on performance of the developmental process and of the FNLMI as a whole.

Annex C: Number of Projects and Expenditures Touching Each Category of the AHHRI Logic Model in 2008–09

C

		1.1 Health Career Awareness Strategy	1.2 First Nations, Inuit and Métis Health Careers Students	1.3 Education System Transformation	1.4 Curriculum Cultural Inclusion	Total—Education	Number of Separate projects and cost
Atlantic	No.	7	1	7	6	21	13
	$	261,400	75,000	758,082	564,582	1,659,064	950,982
Quebec	No.	5	1	5	5	16	12
	$	225,500	3,300	825,483	643,083	1,697,366	1,065,283
Ontario	No.	7	1	9	10	27	22
	$	381,750	70,000	1,025,775	798,980	2,276,505	1,842,775
Manitoba	No.	8	2	4	1	15	12
	$	885,726	107,600	657,753	158,100	1,809,179	1,485,379
Saskatchewan	No.	2	0	7	4	13	13
	$	118,000	0	739,556	285,350	1,142,906	1,142,906
Alberta	No.	5	0	3	4	12	10
	$	188,049	0	790,167	531,032	1,509,248	1,039,081
B.C.	No.	4	3	12	13	32	22
	$	239,800	124,500	1,037,500	942,700	2,344,500	1,617,000
Northern	No.	4	1	1	2	8	6
	$	445,785	15,800	254,221	261,021	976,827	715,806
Total Regional	No.	42	9	48	45	144	110
	$	2,746,010	396,200	6,088,537	4,184,848	13,415,595	9,859,212
National	No.	6	2	5	5	18	14
	$	2,784,897	4,481,147	825,847	1,184,572	9,276,463	6,534,469
Total AHHRI	No.	48	11	53	50	162	124
	$	5,530,907	4,877,347	6,914,384	5,369,420	22,692,058	16,393,681

2.1 Conditions for Health Care Employee Retention	2.2 Core Competencies & Certification for Para-professional Community Health Care Workers	2.3 Cultural Competency of Health Care Workers	Total—Health Career Workplaces	Number of Separate projects and cost	3.1 Collaborative Relationships and Institutional Capacity Building	3.2 Information and Research	Total—Building Capacity	Number of Separate projects and cost
0	0	3	3	3	4	1	5	5
0	0	62,350	62,350	62,350	365,912	28,900	394,812	394,812
1	1	2	4	4	3	0	3	3
60,500	59,290	138,390	258,180	258,180	249,600	0	249,600	249,600
4	1	2	7	6	3	1	4	4
280,000	39,000	119,500	438,500	368,500	313,495	28,977	342,472	342,472
3	3	1	7	6	3	1	4	3
388,619	254,497	160,000	803,116	703,116	336,900	196,900	533,800	336,900
0	0	0	0	0	2	1	3	3
0	0	0	0	0	140,000	14,325	154,325	154,325
0	0	0	0	0	1	1	2	2
0	0	0	0	0	100,000	78,900	178,900	178,900
0	0	1	1	1	3	0	3	3
0	0	80,000	80,000	80,000	200,000	0	200,000	20,000
1	0	1	2	1	4	0	4	4
310,000	0	310,000	620,000	310,000	400,000	0	400,000	400,000
9	5	10	24	21	23	5	28	27
1,039,119	352,787	870,240	2,262,146	1,782,146	2,105,907	348,002	2,453,909	2,077,009
0	3	1	4	4	6	2	8	8
0	2,924,372	303,725	3,228,097	3,228,097	1,079,550	444,850	1,524,400	1,524,400
9	8	11	28	25	29	7	36	35
1,039,119	3,277,159	1,173,965	5,490,243	5,010,243	3,185,457	792,852	3,978,309	3,601,409