The Respiratory Health Awareness Community Outreach and Engagement Model in First Nations, Inuit and Métis Communities: Pilot Intervention

SUMMARY REPORT

June 2012

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Introduction

Respiratory health is an important issue facing First Nations, Inuit and Métis communities in Canada. The risk factors for chronic respiratory disease play a significant role in the development of asthma and associated allergies, as well as other chronic respiratory diseases. The social determinants of health (i.e., indoor and outdoor air quality, environmental tobacco smoke, mould, etc.) have become the subject of much attention by researchers and policy makers given substantial increases in disease prevalence over the past few decades. It has been estimated that the prevalence of asthma is 40% higher in First Nations, and Inuit communities than in the general Canadian population (Life and Breath, 2007). There is no current prevalence data available for Métis communities.

In 2010 as part of the first phase of the Lung Health Program, the Asthma Society of Canada conducted a study entitled: "*An Exploration of First Nations and Inuit Perspectives on Community Respiratory Health Awareness Initiatives*". Key results of this study indicated that there was a lack or, indeed, absence of resources on respiratory health at the community level that specifically target First Nations, Inuit and Métis community members. Important findings from this project also revealed that overall there was low level of knowledge on how social determinants of health can affect respiratory health.

The study also showed that there was a high need to bring awareness of risk factors for chronic respiratory disease (namely, outdoor and indoor air quality, mould, second- and third-hand smoke exposure, etc.) to First Nations, Inuit and Métis communities. The project also helped identify potential educational and awareness strategies to bring the right information and resources to Aboriginal community members and make them more relevant to their cultural and traditional practices. As a main Phase I project outcome, a *Respiratory Health Awareness Community Outreach and Engagement Model* (the Model) was developed and recommended for pilot implementation.

Project Summary "The Respiratory Health Awareness Community Outreach and Engagement Model in First Nations, Inuit and Métis Communities: Pilot Intervention"

Purpose

This project was built on the key findings of the Phase I study. The main goal of the Phase II project was to evaluate the effectiveness of the Model in selected Aboriginal communities by conducting a pilot intervention and to make recommendations for its future application in Aboriginal communities across Canada. It also aimed to empower First Nations, Inuit and Métis communities to create better awareness of lung health, to improve their knowledge about the risk factors for chronic respiratory conditions, and to enable Aboriginal communities to establish community-based resources on respiratory health.

Objectives

The main objectives of this project were aligned with the overall objectives of the Lung Health Program (Public Health Agency of Canada, Lung Health Program Phase II, Guidelines for Applicants, 2010) and related to the increase in awareness, the prevention early detection of lung diseases, and risk factors (social determinants of health) for development of chronic respiratory disease. The primary objectives of the project were as follows:

- Engage the selected communities in the model implementation process by identifying appropriate resources and applying strategies to build community capacity
- Develop the core content for awareness and educational materials that will be used to implement various model components (e.g., Community Education, Community Participation, Community Awareness, etc.) based on common learning objectives and key topics identified during the projects conducted by the ASC and its partners
- Develop a comprehensive toolbox/toolkit of tools, resources and materials that offer a variety of communication and learning methods to target different audiences within Aboriginal communities (people directly or indirectly affected by chronic respiratory disease, broader community members and general public)
- Pilot the *Respiratory Health Awareness Community Outreach and Engagement Model* in selected communities and adapt it to the unique needs and priorities of these communities ensuring their ownership of the process
- Identify and train community leaders in delivering respiratory health education messages and becoming respiratory health “champions/advocates”
- Establish a National Coordination Centre (e.g., National Aboriginal Asthma/Respiratory Health Information Centre) to provide administrative and resource support to the communities involved in the Model testing as well as distribute educational materials on respiratory health to Aboriginal communities across Canada
- Assess the effectiveness of Model implementation and determine next steps for broader Model application in Aboriginal communities across Canada

The project was also designed to empower communities to have better awareness and better information resources, services, and materials on respiratory health, and the risk factors for chronic respiratory disease available at the community level. These resources are normally comprised of general practical resources, as well as tips, actions and strategies that could be applied to support actions taken to reduce the risk of chronic respiratory disease, improve overall respiratory health and prevent chronic respiratory disease from occurring.

This initiative was conducted in selected First Nations, Inuit and Métis communities targeting the communities as a whole, including people directly or indirectly affected by chronic respiratory disease, broader community members, the general public, parents of children affected by asthma and associated allergies and their extended family members, as well as community leaders, Elders, and knowledge keepers.

Governance

To guide the pilot Model implementation on the national level, a National Advisory Committee (NAC) was created and was comprised of **26** members who were representatives from the key partner organizations (i.e., Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), Métis Nation of British Columbia (MNBC), and AllerGen, and Social Support Research Program (SSRP)); project supporters (National Collaborating Centre for Aboriginal Health (NCCAH), the Division of e-Learning Innovation, McMaster University, the Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT), and Healthy Indoors Partnership (HIP)); community representatives; respiratory health experts, and key opinion leaders in the area of First Nations, Inuit and Métis community health. (See Appendix 1)

To be compliant with the Canadian Institute of Health Research (CIHR) guidelines for heath research involving Aboriginal people (CIHR, 2007), relevant ethics approval was received prior to the Model implementation. An application was submitted to the Research Ethics Board (REB) of Health Canada and the Public Health Agency of Canada (PHAC) in December 2010 followed by an oral presentation about the project to the REB panel on January 20, 2011. The presentation was delivered by Dr. Wayne Warry (McMaster University) and Dr. Oxana Latycheva (ASC) via a conference call. Approval was granted by the REB of Health Canada and the PHAC on February 14, 2011 (Principal Investigator- Dr. Wayne Warry, McMaster University) and renewed on February 28, 2012 (see Appendix 2). Additionally, a renewed application was submitted to the Nunatsiavut government to continue conducting the project in Postville, Newfoundland and Labrador with an approval letter received on June 06, 2011 (Appendix 3).

Design & methodology

The Phase II project design was primarily based on the principles of the community-based participatory approach; therefore, Aboriginal communities were engaged and participated in all aspects of Model implementation including the development of educational materials and resources. This pilot intervention was conducted in selected Aboriginal communities from Western and Eastern Canada, as well as one French-speaking First Nations community in Quebec.

In total, the project was piloted in **seven** communities including five First Nations, one Inuit and one Métis community as follows: Postville, Newfoundland and Labrador (Inuit community); Prince George, British Columbia (Métis community); Wendake, Quebec City (First Nations French-speaking community); Listuguj, Quebec (First Nations community); Conne River, Newfoundland and Labrador (First Nations community); Saddle Lake, Alberta (First Nations community); and Enoch, Alberta (First Nations community).

The project was conducted over a period of 13 months, beginning March 07, 2011. The ASC worked closely with the main project partners (the AFN, ITK, MNBC, SSRP, and AllerGen) and applied a step-by-step approach to the model implementation ensuring proper community engagement of community members as well as focusing on capacity building within the participating communities. Thus, the main project activities were conducted in four main stages:

Stage 1) Community Engagement (March-May, 2011)

The *first stage* of the project consisted of actions aimed at engaging participating communities in the Model implementation process by identifying appropriate resources and appointing community personnel (e.g., Community Outreach Coordinators and Liaisons (COCLs)) to conduct project activities at the community level. Community-based Advisory Groups consisting of the key community stakeholders, community leaders, Elders and/or Knowledge Keepers were also established to oversee the Model implementation at the community level, as well as to ensure that the Model-related activities were appropriately modified according to the community's needs and practices. In all communities combined, **52** individuals were involved in the work of Community Advisory Groups and **30** meetings were held over the course of the project implementation.

Table 1: Participating communities and community leadership, by community

Community	Community Leaders/Representatives	Community Outreach Coordinator and Liaison (COCL)
Wendake, QC First Nations (French-speaking)	Micheline Roy *Health Director*	Marie-Pier D. Coulliard *(March – July 2011)* Jeanette Daigle *(July – March 2012)*
Listuguj, QC First Nations	Donna Metallic *Director of Health*	Monica Barnaby Patricia Gray
Conne River, NL First Nations	Theresa O'Keefe *Director, Health & Social Services* Ada Roberts *Nurse Practitioner*	Elaine Jeddore
Prince George, BC Métis	Tom Spence *President, Prince George Metis Community Association (PGMCA)* *(March – May 2011)* Patrick Pocha *Acting President of PGMCA* *(May – March 2012)*	Kimberly McLeod
Postville, Labrador Inuit	Shirley Goudie *Town Clerk* Joan Goudie *Community Health Nurse, Department of Health and Social Development*	Margaret Edmunds

Saddle Lake, AB First Nations	Theresa Cardinal *Health Director, Saddle Lake* Sharon Anderson *Research Associate, Social Support Research Program* Roxanne Blood *Alberta Coordinator, Saddle Lake*	Rosina Stamp *(March – December 2011)* Maureen Cardinal *(December 2011-March 2012)*
Enoch, AB First Nations	Ron Morin *Chief, Enoch* Elaine Papin *Director, Enoch Health Centre*	Amber Ward

Stage 2) Toolkit Development and Community Training (June-September, 2011)

The development of the *Respiratory Health Awareness Toolkit* (the Toolkit) was conducted during the *second stage* of the project with input from the communities and guidance provided by NAC members. During the development of the Toolkit, special considerations were given to making materials and resources culturally relevant and appropriate by applying strategies identified during the Phase I project (Asthma Society of Canada, 2011). Educational materials on respiratory health and the risk factors for chronic respiratory disease were developed for the Toolkit, including:

- 18 types of printed materials (information cards, posters, and brochures)
- 21 themed conversation cards to be used during support circles
- 10 digital stories with personal messages related to the main environmental factors that can impact respiratory health
- 1 Master Group Presentation to be used during community events and programs

Other activities during *Stage 2* included training of communities to prepare them for Model implementation, and recruiting community leaders, Elders and Knowledge Keepers to become *Respiratory Health Champions* in their communities. Based on the results of the nomination process, as well as decisions made by Community Advisory Groups, 56 Respiratory Health Champions were recruited. These Community champions hold different roles in their communities, including Elders, community leaders, teachers or school personnel (i.e. retired or assistant, school secretary), students

(i.e. nursing or Health Science), Church Board members, community healthcare professionals (i.e. community nurse or healthcare worker), as well as representatives from community-based organizations (i.e. housing, Justice Manager). A special instructional web-based Training Module (information session) was developed in partnership with the Division of e-Learning Innovation, McMaster University, to educate on the main issues related to respiratory health, and **52** Respiratory Health Champions completed the Module.

Table 2: The number of Respiratory Health Champions identified and recruited, by community

Community	Number of nomination forms submitted	Number of champions identified
Listuguj, QC	105	10
Wendake, QC (French-speaking)	5	4
Conne River, NL	10	9
Postville, NL	10	4
Prince George, BC	8	7
Saddle Lake, AB	n/a	15
Enoch, AB	n/a	7
Grand Total	**138**	**56**

Stage 3) Model Implementation (October-December, 2011)

During the *third stage*, the main Model-related activities were implemented by the COCLs in consultation with the Community Advisory Groups. Respiratory Health Champions delivered the main education messages related to respiratory health to fellow community members by using a “word of mouth” approach. Community members were also informed about the risk factors for chronic respiratory disease through multiple outreach strategies, including participating in health and wellness fairs, conducting presentations at community celebrations and programs, and by providing respiratory health information during social gatherings and cultural events (i.e., BINGO games, powwows, etc.). **44** presentations were delivered with approximately **3157** community members in attendance. The French-speaking First Nations community also organized a radio podcast reaching out to **8,000** individuals.

Table 3: The number of community members attended community events and programs, by community

Community	Community Attendance at the events	Community Attendance at the programs	Total
Listuguj, QC	400	45	445
Wendake, QC (French-speaking)	270	15	285
Conne Rivers, NL	8	7	15
Saddle Lake, AB	800	19	819
Enoch, AB	1,150	54	1204
Postville, NL	242	41	283
Prince George, BC	39	67	106
Grand Total	**2909**	**248**	**3157**

The materials and resources in the Toolkit were distributed to participating communities in a form of the Master Toolbox (one per each community, **7** in total), **36** Distribution Toolkits to various healthcare and community organizations, as well as **910** Individual Packages to community members. In total, **47** community-based healthcare professionals were involved in the project, and **18** Distribution Toolkits were disseminated to healthcare settings. Additionally, a National Coordination Centre/ online Clearing House (**BREATHE**: *Building Respiratory Education and Awareness for First Nations, Inuit and Métis: Tools for Health Empowerment*) was established at the ASC as a key point of contact for information on respiratory health for First Nations, Inuit and Métis communities.

Participating communities were also advised that they could add additional resources to the Distribution Toolkits from the Master Toolbox depending on where those Toolkits would be distributed within the community (e.g., schools, businesses, etc.). For example, if the Toolkit was being distributed to a business, additional resources that were listed for businesses could be included in the Distribution Toolkit, or if the Toolkit was going to a school, all additional resources listed for children and youth in the Master Toolbox could be included in the Distribution Toolkit.

Table 4: The number of distribution toolkits and places of distribution, by community

Community	Number of Distribution Toolkits distributed	Places of distribution
Listuguj, QC	5	1. Listuguj Mi'gmaq Development Centre (L.M.D.C.) 2. Alaqsite'w Gitpu School (A.G.S.) 3. Listuguj Band Office 4. Police Station 5. Daycare Education Centre
Wendake, QC (French-speaking)	5	1. Marie-Paule-Sioui-Vincent Health Centre (community physician) 2. Marie-Paule-Sioui-Vincent Health Centre (nurses) 3. Marie-Paule-Sioui-Vincent Health Centre (Ciga-Stop smoking cessation program) 4. Native Friendship Centre (Puniku Program) 5. First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)
Conne Rivers, NL	5	1. Tru Value 2. Health Clinic 3. Wellness Centre 4. School 5. Band Office
Saddle Lake, AB	5	1. Health Centre 2. Wah-Koh-To-Win Child Care Society 3. Onchaminahos School 4. Boys and Girls Club 5. St. Paul Alberta
Enoch, AB	5	1. Enoch Kitaskinaw School 2. Enoch Health Centre 3. Enoch Child Care Centre 4. Enoch Elders Centre 5. Enoch Housing
Postville, NL	5	1. Department of Health and Social Development (DHSD), Nunatsiavut Building 2. Dental Office, Nunatsiavut Building

		3. Town Office, Postville Inuit Community Government 4. Postville Clinic/Nursing Station 5. B.L. Morrison School
Prince George, BC	6	1. Kikino Métis Children and Family Services Society 2. Prince George Métis Housing society 3. Prince George Nechako Métis Elders 4. Blade Runners 5. Prince George Métis Elders Society 6. All Nations Elders
Grand Total	**36**	

Stage 4) Model Evaluation and Results Dissemination (January-March, 2012)

The *fourth stage* of the project was dedicated to assessing the early effectiveness of the Model at the pilot project stage. Using specifically designed project evaluation tools, a post-implementation assessment was completed. The ASC Project Team also summarized feedback on the Toolkit that was received from the participating communities and from the main Project Partners.

Organizational satisfaction - A report card for the Distribution Toolkit was used to assess organizations' satisfaction with the respiratory health awareness materials included in the Toolkit and gain a better understanding on how community and healthcare organizations intend to use the Toolkit. As the Toolkit differs slightly regarding target materials for First Nations, Inuit, and Métis communities, three versions of the report card for Distribution Toolkits were developed. The target audience for this evaluation tool was representatives from health care and community organizations/businesses.

Individual/community member satisfaction - A report card for Individual Packages was used to assess community members' satisfaction with the respiratory health awareness and educational materials in the Package, asking questions about the design, cultural imagery, and the language level of the materials provided; which resource community members liked the most and which the least; and assessed the willingness to use the information. The report card questions were organized around the three main levels of the framework as follows:

(a) Were the participants pleased with the program? (Reaction level);

(b) What did the participants learn in the program? (Learning level); and

(c) Did the participants change their behavior based on what was learned? (Behaviour level).

Similar to the report card for Distribution Toolkits, the report card for Individual Packages was available in three versions for First Nations, Inuit, and Métis communities.

Advisory group satisfaction - To enhance the evaluation of the Toolkit at the community level), members of the Community Advisory Groups were asked to review the Master Toolbox and organize a focus group discussion to summarize their feedback and comments. This methodology was strengthening by

collecting quantitative feedback as well by asking them to rate the materials included in the Master Toolbox by using a specially designed ballot. To evaluate the Toolbox, a two-pronged approach was followed.

First, the COCLs facilitated a focus group discussion with the members of their Community Advisory Group. The COCLs were provided with a discussion guide prepared by the ASC Project Team to help facilitate their dialogue with the Community Advisory Group members. The discussion guide provided questions on the following topics:

- Overall satisfaction with Toolkit materials;
- The Toolkit as an effective tool to educate community members and increase their awareness on the risk factors for chronic respiratory disease;
- Toolkit design and its ability to meet community's needs and educational preferences.

Second, following the discussion of the Toolbox, the COCL administered ballots to each member of the Community Advisory Group. After the distribution of ballots, the COCL presented each newly-developed product listed on the ballot, one at a time, making sure there was enough time to allow the group to score each item. Three community-specific ballots were developed and given to the appropriate community (i.e., First Nation, Inuit and Métis) due to the fact that the materials included in the Master Toolbox varied by community (for example, the Inuit community's ballot did not include the Seven Sacred Teachings Poster given that they do not use traditional tobacco).

Partner feedback - Three versions of a form were prepared to evaluate the Toolkit materials produced for First Nations, Inuit, and Métis communities. The form is organized into two tables for 1) Newly-developed materials and 2) Existing resources, each broken down into six major sections:

- Outdoor air quality
- Indoor air quality
- Traditional and commercial tobacco use (smoking)
- Exposure to second and third hand smoke
- Smoking Cessation
- Knowledge on chronic respiratory disease

The resources under each of these sections varied based on the specific materials that the partners were asked to review (for example, the AFN was tasked to review First Nations specific materials). In additional, some partners were asked to review specific resources according to their expertise (for instance, HIP reviewed materials related to indoor air quality; CAN-ADAPTT provided feedback on all smoking-related materials, etc.). The NAC members mostly reviewed materials and resources pertaining to their expertise.

When it came to the newly-developed materials, the main Project Partners were asked to rate each resource listed on their form, and included in their package, on a 5-point scale. They were encouraged to elaborate on their quantitative rating with some qualitative feedback in the space provided on the form or via an attachment. Since existing materials could not be modified by the ASC, we asked partners to indicate whether or not a resource should be kept in the Toolkit or not (i.e., a dichotomous

variable, yes/no). Again, they were encouraged to elaborate on their quantitative rating with some qualitative feedback in the free space provided on the form.

In addition to partners, expert reviewers from government agencies and other lung health stakeholders were asked to provide feedback on the educational materials that were created for the Toolkit. Expert reviewers were given specific materials pertaining to their expertise. For instance, Environment Canada was consulted on the outdoor air quality and the Air Quality Health Index (AQHI)-related materials.

Project Results

Evaluation revealed that the pilot Model implementation worked extremely well in participating communities. The process of implementing the Model incorporated substantial community engagement and capacity building activities. The participating communities showed high interest levels towards the project, were fully engaged in the process, and indicated that Model-related activities were positively received by, and were appealing to, community members. Overall, participating communities experienced increased levels of respiratory health awareness after the Model implementation. In addition, support for, and conversation on, respiratory health increased in most communities.

- The project results demonstrated improved community members' perceptions of the programs on respiratory health available at the community level, specifically for those with a chronic respiratory condition.
- After the Model implementation, there was greater awareness and increased perceived availability of community-based materials on respiratory health at a variety of places within the communities. Integration or linkages of respiratory health programs with existing community structures and organizations improved as well.
    - Participating communities also showed marked progress in the development of capacity to address respiratory health issues.
    - Key findings demonstrated improved perceptions about community commitment and social environment in regard to dealing with issues related to community respiratory health.
    - Community leadership on respiratory health enhanced and there was increased availability and awareness of support and information offered by community leaders.
    - Community members indicated an increased comfort level in sharing information about their respiratory health and the ability to contact a community member for information and support.
    - Participating communities showed their increased willingness to help reduce negative effects of open burning and to provide help in improving indoor air quality in homes of community members.
- The Toolkit materials and resources were well-received, deemed to be good for educating community members, and were appreciated for the helpful, useful and interesting information; appropriate content and reading level; appealing design; locally and culturally relevant images; and the intergenerational applicability of the materials.
- The Master Toolbox, Distribution Toolkits and Individual Packages were adapted to the community's needs and were used to improve access to information on respiratory health, potentially overcoming barriers to accessing these types of resources.

Key Recommendations:

While culturally appropriate resources in the Toolkit now exist, and the Model has proven to be appropriate and successful in the pilot communities, further work needs to be done on finalizing the Toolkit materials and resources based on the feedback obtained during the pilot testing, as well as implementing the Model in other Aboriginal communities. The findings from this project support five key recommendations.

1. *First*, it is recommended that modifications be made to the newly-developed Toolkit materials and resources according to the feedback received from community members, as well as the comments provided by the main project partners;

2. The *second* recommendation is to implement the Model and distribute the modified Toolkit in additional Aboriginal communities located close to the initial pilot communities. The communities involved in the initial Model pilot would be used to showcase and introduce the Model and distribute the Toolkit to nearby communities located in the same region. Respiratory Health Champions from the pilot communities and other engaged community leaders would help both promote the Model and assist in Toolkit dissemination to additional communities. This intervention would be associated with a comprehensive, extensive evaluation of the Toolkit in these communities, which is necessary to ensure broader applicability of the Toolkit and its relevance to other Aboriginal communities, and is crucial to support its future use Canada-wide and internationally;

3. The *third* recommendation is to make final revision to the Toolkit based on the feedback received during the extended (modified) pilot. In addition, it is suggested to develop a knowledge mobilization package to facilitate further Toolkit dissemination and introduction to other Aboriginal communities across Canada. This package would include the final version of the Toolkit materials and resources, as well as an explanation on how to use the Toolkit at the community level and information on practical approaches that need to be applied to ensure successful and effective Toolkit implementation. The finalized Toolkit and Model-related activities would be available for use in Aboriginal communities across Canada, as well as other vulnerable populations (i.e., communities affected by poverty, poor housing, low socio-economical level, and multicultural communities);

4. To ensure the success of the Canada-wide Model implementation, a *fourth* recommendation is to bring together key Aboriginal and provincial health decision and policy makers, and program planners to exchange knowledge and information about the Model and the Toolkit in order to gather insights, share resources, plan effective strategies, and determine next steps for the broader implementation of the Model in Aboriginal communities across Canada. This would also help assess the capacity of Aboriginal organizations or regional health authorities to lead future Model implementation through knowledge translation and mobilization;

5. After the Toolkit is finalized, the knowledge mobilization package is prepared, and implementation strategies are defined, a *fifth* recommendation is to implement the Model and distribute the Toolkit in additional Aboriginal communities located in Provinces and Territories other than those involved in the initial or modified pilots, followed by comprehensive evaluation on health outcomes, capacity building and program reach. The ASC is planning to seek long-term

funding for incorporation of the Model in all interested Aboriginal Communities in Canada, widespread distribution of revised, culturally appropriate materials in the Toolkit among both urban and non-urban Aboriginal people, and a fully functioning National Coordination Centre (Clearing House) **BREATHE** to promote lung health in the Canadian Aboriginal population.

Appendix 1 – National Advisory Committee Members

National Advisory Committee Members		
Name	**Affiliation**	**Role**
Atkinson, Donna	Manager National Collaborating Centre for Aboriginal Health and ActNow	Key Project Partner Representative (NCCAH)
Barker, Kim	Public Health and Preventative Medicine, University of Toronto	Member at Large
Buckle, Tina	Community Health Nursing Coordinator, Nunatsiavut Government Department of Health and Social Development	Community Partner
Cardinal, Theresa	Office Manager, Health Centre, Saddle Lake First Nations Community	Community Partner
Castleden, Heather	Assistant Professor, School for Resource and Environmental Studies, Dalhousie University AllerGen Researcher	Member at Large

Czyzewski, Karina (Representing Dr. Peter Selby)	Aboriginal Projects Coordinator/ Nicotine Clinic and Tobacco Control Projects The Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment	Key Project Partner Representative (CAN- ADAPTT)
Davoren, Tanya	Director of Health and Sport, Director of Veterans Métis Nation British Columbia	Key Project Partner Representative (MNBC)
Ford, Elizabeth	Director, Department of Health and Social Development Inuit Tapiriit Kanatami	Key Project Partner Representative (ITK)
Fowler, Anna	Assistant Director Department of Health and Social Development Inuit Tapiriit Kanatami	Key Project Partner Representative (ITK)
Garcia, Diego	Senior Public Health Analyst, Health and Social Development, Assembly of First Nations	Key Project Partner Representative (AFN)
Giles, Louise	Steering Committee, National Lung Health Framework Paediatric Respirologist, University of Manitoba, Canadian Paediatric Society	Member at Large

Goudie, Joan	Community Health Nurse Nunatsiavut Government Department of Health and Social Development	Community Partner
Gray, Patsy	Community Health Representative, Listuguj First Nations Community	Community Partner
Jobber, Craig	President, Healthy Indoors Partnership	Support Partner (HIP)
King, Malcolm	Scientific Director, Canadian Institutes of Health Research and Institute of Aboriginal Peoples' Health	Member at Large
Latycheva, Oxana	Vice President, Programming Asthma Society of Canada	Project Lead
Levinson, Anthony	Director, Division of e-Learning Innovation and machealth.ca Associate Professor, Department of Psychiatry and Behavioural Neurosciences, Michael G DeGroote School of Medicine, Faculty of Health Sciences, McMaster University AllerGen Researcher	Support Partner (machealth)
Pocha, Patrick	President, Prince George Métis Community Association	Community Partner

Roberts, Ada	Nurse Practitioner, Conne River Health, Newfoundland and Labrador	Community Partner
Roy, Micheline	Health Director, Wendake First Nations Community	Community Partner
Royce, Diana	Managing Director, AllerGen NCE Inc.	Key Project Partner Representative (AllerGen NCE)
Ryan, Robert	National Aboriginal Health Organization (NAHO) Research Officer, First Nations Centre	Communications Partner Representative (NAHO)
Stewart, Miriam	Health Senior Scholar, Alberta Heritage Foundation for Medical Research Professor, Faculty of Nursing and School of Public Health, University of Alberta	Key Project Partner Representative (SSRP)
Turner, Catherine	Chairperson, National Aboriginal Diabetes Association	Member at Large
Vethanayagam, Dilini	Associate Professor, Division of Pulmonary Medicine, University of Alberta	Member at Large
Warry, Wayne	Department Chair, Department of Anthropology, McMaster University	Principal Investigator

Waserman, Susan	Chair of the Medical and Scientific Committee, The Asthma Society of Canada Professor of Medicine, Division of Clinical Immunology and Allergy McMaster University	Member at Large Key Project Partner Representative (ASC)

Appendix 2 – Certificate of Ethics Review

Health Canada and Public Health Agency of Canada
Santé Canada et l'Agence de la santé publique du Canada

Research Ethics Board
Comité d'éthique de la recherche

CERTIFICATE OF ETHICS REVIEW

Type of Review: Annual Review of Continuing Research

Principal Investigator:
Name: Wayne Warry
Title: Professor
Branch/Institution: Faculty of Social Sciences, McMaster University
Address: 1280 Main Street West
Hamilton, ON L8S 4L8

Project Title: The Respiratory Health Awareness community outreach and engagement model in First Nations, Inuit and Métis communities: Pilot Intervention

Project File Number: REB 2010-0062

Contact Department/Agency: PHAC

Document Name:

List of all documents submitted to the REB on:	**Date:**
Annual Progress Report	February 14, 2012

ETHICS REVIEW:
Your application to the Health Canada and Public Health Agency of Canada's Research Ethics Board (REB) regarding the above-referenced research project has been reviewed on February 27, 2012. The most recent versions of the documents listed above were found to meet ethical requirements for research involving humans.

Janet L Storch
Janet Storch, RN, BScN, MHSA, PhD, DSc (Hon)
Chair, Research Ethics Board

FEB 28 2012
Date

Certificate Expiry Date:
February 14, 2013

Principal Investigator's responsibilities:

I confirm that I will:

1. Carry-out the research in accordance with the above-referenced protocol by the REB;
2. Obtain an annual ethical review until the research is complete (The certificate is given for one year);
3. Seek ethics review of the REB for any amendment or modification of the research protocol or

Canada

rev. PHAC September 2011

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consent form;

4. Report immediately to the REB Secretariat, any adverse or unexpected events resulting from the research involving humans; and
5. Submit an end of project report to the REB Secretariat upon termination or completion of the project

Principal Investigator   Date 4/23/2012

Once signed, please return a copy of this certificate to the REB Secretariat.

Research Ethics Board Secretariat
Holland Cross Building, Tower B
AL #3104A
#410 - 1600 Scott, Ottawa, ON K1A 0K9
Tel: (613) 941-5199
Fax: (613) 948-2419
Email: REB-CER@hc-sc.gc.ca
Web: http://www.healthcanada.gc.ca/reb

Appendix 3 – Letter of Approval, Nunatsiavut Government

NUNATSIAVUT
kavamanga Government

Nunaliginikmik amma Nunamiutanik
Ujaganik Imaniklu

Lands and Natural Resources

6th June 2011

Oxana Latycheva
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Re: Research Proposal: The Respiratory Health Awareness community outreach and engagement model in First Nations, Inuit and Métis communities: Pilot Intervention as Phase 2.

Dear Oxana Latycheva:

As per the Nunatsiavut Government (NG) Research Process, a review of your proposal was initiated involving appropriate Inuit Community Government and NG staff ensuring for a comprehensive review.

Thank you for the signed e-copy of the ethical approval letter.

Please accept this letter as confirmation that the NG supports the continuation of this research project as outlined in your Executive Summary - PHAC Phase II - 2011-2012, subject to the following suggestions:

1. The Department of Health & Social Development recommends that you work closely with Joan Goudie to ensure that community employment and involvement is done with Joan's guidance to ensure meaningful and relevant work continues.

2. For all research involving people, we require the researchers to provide us with a copy of the consent forms and survey questions prior to use (when they are available).

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Fax: 709.923.2366	Fax: 709.933.3746	Fax: 709.947.3371	Fax: 709.479.9891	Fax: 709.896.2610	Fax: 709.497.8311

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3. Please provide copies of any reports, journal articles, papers, posters or other publications related to this project to the Nunatsiavut Inuit Research Advisor, the NG Director of Health and the Inuit Community Governments of Postville upon completion of your work. A plain language summary detailing the work, translated into our dialect of Labrador Inuktitut (Roman Orthography) should also be provided.

We would also appreciate copies of any photographs that you acquire during your research in the Nunatsiavut area as the NG is developing a digital database of regional photos. Recognition will always be given to the photographer.

Please note that any changes to your proposal must be provided to, considered and supported by the NGRAC before they are implemented.

We thank you for considering our feedback on your work and look forward to more collaboration.

Sincerely,

John Lampe
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