



PROMOTING MENTAL HEALTH IN INDIGENOUS POPULATIONS. EXPERIENCES FROM COUNTRIES



Pan American
Health
Organization



World Health
Organization
REGIONAL OFFICE FOR THE
Americas

PROMOTING MENTAL HEALTH IN INDIGENOUS POPULATIONS. EXPERIENCES FROM COUNTRIES

A COLLABORATION BETWEEN PAHO/WHO, CANADA, CHILE
AND PARTNERS FROM THE REGION OF THE AMERICAS

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Health
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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
PROJECT TEAM AND PARTNERS	2
PURPOSE	3
Objectives.....	3
Action	3
INTRODUCTION	4
Background	4
PERSPECTIVE & OBJECTIVES	7
Methodology.....	9
OVERVIEW OF THE MEETINGS	
Santiago de Chile, 27-29 October 2014	10
Nunavut, Canada, 9-11 September, 2015	11
Meeting with Nunavut’s Health Authority about WHO’s mhGAP Intervention Guide	13
ANNEX A. Meeting Agendas	
Santiago de Chile, Chile, 27-30 October, 2014	19
Iqaluit, Nunavut, Canada, 7-11 September, 2015	20
ANNEX B. Overview of participating countries’ indigenous population and presentations	
Argentina.....	22
Brazil	23
Canada	25
Chile	32
ANNEX C. Intercultural Health Program	34
ANNEX D. The mhGAP-IG adaptation for Community Health Workers	39
ABBREVIATIONS	43
REFERENCES	44

EXECUTIVE SUMMARY

In 2007, the countries of the Region of the Americas approved the Health Agenda for the Americas 2008-2017 establishing a priority for mental health. In 2014, the Pan American Health Organization's Plan of Action on Mental Health (2015-2020) identified cross-cutting themes including ethnicity, equity and human rights, in line with the World Health Organization's Global Mental Health Action Plan (2013).

Specialized literature indicates that the rates of mental health problems among indigenous communities are growing consistently around the world. Common issues include high suicide and substance abuse rates among indigenous youth. These, combined with numerous unfavourable social determinants result in high psychosocial vulnerability. Notwithstanding these circumstances, indigenous populations are the least likely to have access to adequate mental health services.

Such realities have motivated several projects addressing issues related to indigenous well-being since 2009. The current collaborative project furthers work initiated by PAHO/WHO aimed at finding solutions to this complex health situation. The first goal of this project was to exchange experiences on indigenous mental health issues among participating countries from the Americas. The hope was that comparing initiatives and practices used to approach common mental health issues in different indigenous communities would yield useful new ideas. Furthermore, there was interest in exploring the potential relevance and adaptability of a standardized WHO mental health training tool – the Mental health Gap Action Programme Intervention Guide - in Nunavut.

The project reported here was set up as a series of meetings and opportunities to facilitate attaining these aims, coordinated by PAHO in 2014-15. Two of these meetings, held in Chile (Santiago) and in Canada (Iqaluit), involved the active participation of representatives for indigenous healthcare.

As expected, different indigenous groups are grappling with an array of common mental health issues. They have different ways of conceptualizing their problems and of organizing care, as determined by historical, geographic and cultural factors. While local, culturally-rooted solutions were not unanimously proposed, some successful intercultural interventions were reported.

Representatives from the different indigenous groups expressed support for the usefulness of this project and enthusiastically requested that PAHO continue bridging indigenous mental health and global mental health. Preliminary discussions outlined possible future actions focusing on training and interventions in mental health.



Photo: Dévora Kestel

PROJECT TEAM AND PARTNERS

The project team was led by the Pan American Health Organization (PAHO/WHO) and by partners from Canada and Chile, along with Chilean and Canadian indigenous groups and health authorities. Other countries of the Americas, including Argentina and Brazil, participated due to their shared interest in indigenous mental health.

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PURPOSE

The purpose of this collaborative project on mental health was for PAHO/WHO to facilitate the exchange of knowledge about indigenous mental health practices between different countries of the Americas. This collaboration partnered Canadian and Chilean ministries of health and health departments involved with indigenous affairs, along with interested parties from Brazil and Argentina. It facilitated interactions between indigenous practitioners, clinical health, public health, anthropology, and mental health specialists who shared practices spanning different indigenous communities. Projects such as this, emphasizing an exchange of experiences and strategies between different indigenous communities, are to date lacking in both the literature (1) and the clinical practice.

Objectives

1. To further foster and develop an exchange of experiences in the field of mental health among participating countries;
2. Document, present and share innovative experiences related to mental health promotion, including suicide prevention and initiatives with young indigenous people from Chile and Canada;
3. To explore the potential relevance and adaptability of a standardized WHO training tool for the integration of mental health care in primary health care (PHC): the Mental health Gap Action Programme Intervention Guide (mhGAP-IG) in Nunavut; and
4. To publish and disseminate the experiences and conclusions of these proceedings.

Action

Collaborations on the theme of indigenous mental health must be seen as part of the global mental health mission. Healthcare based on the biomedical approach can and should interact in fundamental ways with cultural and local practices and realities. Future collaborative projects were discussed in the course of this project, and will be developed and submitted for funding. The aim now will be towards implementing actions, including preventive and intervention strategies.

Mental health and health, more generally, require a team approach for a variety of reasons. Training can be adapted to enhance team-building and useful interactions between levels of prevention and care.

WHO's mhGAP-Intervention Guide is a revolutionary tool aimed at reducing the suffering of people with mental health problems. This project has confirmed its relevance and hinted at its adaptability to settings where indigenous groups are represented.

Based on the successful project collaboration, with concrete results achieved between Nunavut (Canada) and Chile, there is a willingness from several countries of the Americas to pursue this process, identifying modalities for collaboration among indigenous populations in the area of mental health.



Photo: Candice Waddell

INTRODUCTION

This report presents the process, the information and knowledge exchanged, and the conclusions and lessons learned from this project. It will also lay out our thinking, based on the project, regarding ways for our group to move forward on indigenous mental health issues, which are becoming ever more significant.

This project was financed by Health Canada through PAHO/WHO “Biennial Workplan” agreement. The project was implemented by the PAHO/WHO Mental Health Program.

Background

CULTURAL DIVERSITY AND MENTAL HEALTH

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The Pan American Health Organization (PAHO/WHO) has the mandate to look after the health of the population of the Region of the Americas. It provides technical cooperation and mobilizes partnerships to improve health and quality of life in the countries of the Americas. PAHO is the specialized health agency of the Inter-American System and serves as the Regional Office for the Americas of the World Health Organization (WHO). Together with WHO, PAHO is a member of the United Nations system.

In 2009, PAHO Mental Health Program, through collaboration with Health Canada, organized a regional workshop in Guatemala, to exchange mental health-related experiences in indigenous

populations. In 2011, PAHO promoted an exchange of health experiences between Tierra del Fuego (Argentina) and Nunavut (Canada). In 2012-2013, there was a first exchange project between Nunavut and Chile in the area of mental health. These projects created the impetus for a more sustained collaboration in the field of mental health and indigenous populations.

Mental and substance use disorders accounted for 7.4% of the global burden of disease, and for 37% of healthy years lost from non-communicable diseases worldwide in 2010, confirming these as the leading disease category of years lived with disabilities, and the 5th leading category of DALYs globally (1). Mental and substance use disorders were responsible for 22.5 million of the total 36.2 million DALYs allocated to suicide in 2010. Depression was responsible for the largest proportion of suicide DALYs (46.1%) and anorexia nervosa the lowest (0.2%) (2). While mental disorders are responsible for relatively low mortality rates, with higher prevalence and chronicity compared to other diseases, depression and substance use disorders are in fact related to more than 90% of all suicide cases. It is estimated that someone dies of suicide every 40 seconds. Suicide is among the leading causes of death among those aged 15-44 years, being the second cause of death (after road traffic injuries) in the group aged 10-24 years (3).

Comparing the prevalence of these disorders with the available records of care by mental health services allows us to recognize a treatment gap. A treatment gap represents the percentage of people with severe mental disorders that do not receive treatment (4). At the global level, data from 2004 showed the extent of the treatment gap: 35.5% to 50.3% of severe cases did not receive any treatment within the prior year in developed countries, while 76% to 85% of cases not receiving any treatment in developing countries was much higher. These figures clearly indicate how the challenges relating to the availability of mental health services is not just of concern in developing countries (5).

One possible explanation of this gap is related to the limited resources that mental health receives at the national level, where 70% of countries dedicate only 5% or less of their health budgets to mental health (a median of 2.3%). In addition to this small attribution of funds, it is significant to highlight that most of these funds - an average of 88% of the mental health budget of LMICs - are allocated to sustaining mental health hospitals (6).

To address these and other concerns, Member States of the Region have requested PAHO/WHO to develop a Plan of Action on Mental Health 2015-2020 (7). The Plan of Action reflects the experience gained in our Region and articulates governments' commitments. It is based on an overall view of the Region, although marked differences persist among countries and even within each individual country.

The Plan contains the following four strategic lines of action to guide the Member States in accordance with their national contexts and priorities:

- **Strategic line of action 1:** Develop and implement policies, plans, and laws in the field of mental health and mental health promotion, to achieve appropriate and effective governance.
- **Strategic line of action 2:** Improve the response capacity of systems and services for mental health and the care of psychoactive substance-related disorders, to provide comprehensive, quality care in community-based settings.
- **Strategic line of action 3:** Prepare and implement promotion and prevention programs in the area of systems and services for mental health and for the care of alcohol- and substance-related disorders, with particular attention to the life course.
- **Strategic line of action 4:** Strengthen information systems, scientific evidence, and research.

Among its priorities, PAHO recognizes the need to address the ethnic, social and cultural diversities that exist within its Member States in order to create health policies and services that are accessible to entire populations. Throughout the past decade, PAHO - in collaboration with governments and other health organizations - developed and carried out several projects and initiatives in order to address the public health needs and problems of these specific groups (8).



PERSPECTIVE AND OBJECTIVES OF THE PROJECT

1. To develop an exchange of experiences among participating countries, namely Canada, Chile and Brazil;
2. To discuss topics related to mental health promotion, including suicide prevention and initiatives with young people;
3. To adapt and validate mental health training in primary health care (based on the mhGAP) in Nunavut; and
4. To disseminate experiences and information through web pages (Nunavut, PAHO, McGill) and publications.

A number of documents and events inspired this project. The most relevant drivers include the Health Agenda for the Americas 2008-2017, approved in 2007 by the countries of the Region of the Americas, which emphasizes the need to consider mental health among its priorities (9). Then, on October 1, 2014, the 53.^o Directing Council of the Pan American Health Organization (PAHO/WHO) approved the Plan of Action on Mental Health (2015-2020) (10). The plan is based on four cross-cutting themes: gender, ethnicity, equity and human rights, which appear intertwined. These priorities are also in keeping with the Global Mental Health Action Plan adopted by the World Health Organization (WHO) in 2013.

Literature shows that the rates of mental health problems among indigenous communities are growing consistently across the world. Examples from Canada, Australia, Denmark, among others, have highlighted gaps between non-indigenous and indigenous populations on a number of important wellbeing indicators. Indeed, indigenous populations appear to occupy a vulnerable position among societies around the world. In Australia, the literature highlights a shorter life expectancy, worse social, economic and health indicators, as well as higher rates of drug and alcohol abuse. Although Australia's indigenous population represents only 3-4 % of the total population, its members represent 27% of the prison population (11). Studies conducted in the arctic population covering Alaska, Canada, Greenland, Nordic Countries and Russia also highlight higher suicide rates and substance abuse among indigenous youth (12). Yet very little has changed with respect to this situation. For example, US national suicide rates have improved very little between 2002 and 2010, especially in Amerindian and Alaskan natives, where rates are approximately 250% higher than the national average, and represent the second leading cause of death in this population (13).

Amerindians in the Americas are among the most impoverished peoples in the world, a socio-political reality captured in the expression "Fourth World population" (14). In some communities, young people have high rates of social adversity, school dropout and mental health problems, including suicide (15). Little literature is available regarding the alarming impact of social determinants and access to health and mental health resources among indigenous communities across Latin America. These include, among other social problems, poverty in Mexico, malnutrition in Guatemala, high incidence of infectious diseases and child mortality in Argentina, Peru and Ecuador, and very high rates of alcoholism (exceeding 85%) in Venezuela (1, 16, 17). Beyond the Americas, young indigenous people in countries such as Australia and New Zealand face lower health-related quality of life. Canadian and the American indigenous young people are likewise directly affected by such factors (18, 19).

An overview of health indicators of indigenous peoples from the regions involved in this project reveals some similarities. Latin America and the Caribbean (LA&C) have an indigenous

population of 55 million people, approximately 10% of the total population. Overall, these people are disproportionately affected by poverty, with high illiteracy rates and fewer opportunities for employment. These factors, in turn, contribute to a complex health situation compounded by poor access to health services. The result is an increased psychosocial vulnerability, with indigenous youth being at particularly high risk. This is exemplified by substantially higher suicide rates than those of non-indigenous youth. In Canada, 4% of the population is indigenous and represents the fastest growing segment. Inuit (indigenous people of northern Canada) youth show this same confluence of determinants – they are 11 times more likely to die from communicable diseases, 11 times more likely to die of injury than youth in the rest of the country, and twice as likely to die from a non-communicable disease. The suicide rate was 30 times that of other Canadian youth in 2004-2008. Poor health status is widely attributed to a combination of low income, unemployment, low educational attainment, and crowded housing with poor air and water quality (20).

Nevertheless, indigenous populations are the least likely to have access to adequate mental health services (21). Different lines of investigation seeking to understand mental health issues have confronted western vs indigenous epistemologies, intervention vs community development models, deficit-based vs strengths-based studies, and bottom-up vs top-down approaches (13). Community-based and participatory strategies seem to be culturally appropriate and tend to be successful in improving mental health issues (22-24).

These realities have driven previous projects aimed at learning about and addressing some of these issues of indigenous wellbeing in the following projects:

- The 2009 Regional Workshop on Exchanges of Experiences on the Mental Health Protection of Indigenous Peoples, Guatemala City; and
- The 2011 technical cooperation in health project, with the participation of the Province of Tierra del Fuego, Argentina, and the territory of Nunavut, Canada.

The 2012- 2013 collaboration between Nunavut, Canada, and Araucanía Region, Chile, with an exchange of visits, identified the topics of common interest that form the basis for this project. These include the following:

- Suicide;
- Alcoholism;
- Integrating traditional healers in health centers;
- The role of traditional healers and cultural facilitators;
- Mental health care in health services lacking psychiatric and psychological care;
- Integrating mental health (MH) into primary health care (PHC); and
- Mental health promotion.

Methodology

This project favored an open exchange of practices related to indigenous mental health.

The planned cooperation between various indigenous communities of the Americas was expected to reveal adaptations to different realities, conceptualizations of health and mental health that could diverge, and interactions with the healthcare system that could vary.

Because of this, we avoided imposing any preordained structure to the way indigenous groups would relate their practices and experiences.

This made for open discussion, where participants compared not only practices but also paradigms. These discussions were carefully monitored and captured in a series of points, which were then gathered and recirculated as draft texts to all participants for input, approval and corroboration.



Photo: Candice Waddell

OVERVIEW OF THE MEETINGS

Santiago de Chile, 27-29 October 2014

This meeting was the result of several months of preparation, exchanges and agreements between participating partners on what would be relevant to all in terms of processes and contents.

The attitude of all parties was one of openness and willingness to learn, wishing to consider and confront different models of health and mental health care for indigenous people. A number of very important ideas were put forward at this workshop, which in many ways appeared to be paradigmatic for indigenous representatives.

A workshop format was chosen, emphasizing local innovative practices considered to be adapted to the indigenous people of each area.

Following this meeting, there was a call for reports from participating countries regarding the current situation for the indigenous populations concerned, and a brief description of a successful experience from each country (Annex B).

Health vs. Illness

Illness is primarily conceptualized not as a biomedical problem, but as a sign of being somehow out of harmony with one's environment, culture and value system. Health is seen as a sign of harmony. How far this is taken into account remained unclear. For example, there seems to be a sense that there are illnesses that can be "expected", for example, in old age. The divide between when illness is perceived as something one is responsible for or not, remained blurry. There seemed to be an agreement on this view between indigenous representatives.

Cultural reinforcement, land and health

The view of health as being related to "harmony" with your environment and culture underscores how important culture is for the indigenous representatives who were present. The notion of "cultural reinforcement" was, to them, an important component for creating a healthy environment. It promises to offer the values that make sense to their communities and that are relevant to them, to permit interaction based on sharing those values, and to increase people's sense of harmony within their culture. This, in turn, was intimately connected to the notion of protecting the land of indigenous populations, with which many of the values, food and behaviors are equally tied.

Health vs. Mental health

For several indigenous communities, mental health is not seen as distinct from health in general. This seems to be a view of health in these communities that differs from the way health-related problems are defined in the medical literature. First and foremost, this represents a conceptual shift, one that is shared by many of these communities. But it can also be understood as relating to the overlap observed between illness, mental illness, social determinants of health, wellbeing indicators, and the historical marginalization and trauma that many of these communities have suffered. This overlap makes it difficult to take only one perspective into account.

Suicide for example, often involves psychosocial problems, which are much more prominent to most people than a psychiatric explanation or a biomedical illness.

Community based interventions and "treatment gap"

For indigenous representatives, there was a consensus on the idea that most care, support and help will be useless if the people requiring it do not recognize themselves in the explanatory

model, human approach, language and physical environment that care is couched in. Basing care within their community is for them the way to reduce the gap between needing help and seeking it out, as well as adhering to the recommendations that are congruent with the sufferer's values.

Interactions with biomedical medicine

Indigenous representatives claimed to have openness to interacting between the biomedical and the social-cultural models. Indeed, they often encourage the combination of approaches and are not exclusive. The way the decision is made to go from a local, indigenous approach, to a biomedical one, is not sharp. In fact, the mechanisms involved were seen as a potentially rich avenue to investigate further.

All in all, exchanging experiences and knowledge led to rich, respectful, exciting exchanges. The feeling was that this opportunity served to break isolation, to reduce the indigenous representatives' idiosyncratic sense of being marginal.

Nunavut, Canada, 9-11 September, 2015

The second joint meeting of this project took place in Iqaluit, the capital of the Territory of Nunavut, Canada, on 9-11 September, 2015.

This meeting was the end result of several months of planning, with at least one face-to-face meeting in Washington D.C. between the main organizers from PAHO and Nunavut, and an ongoing process of collaboration to build an agenda relevant to all.

There were some persons due to participate who were in the obligation to cancel. Brazil was not able to send a representative, nor was Argentina.

A mixed process including presentations and workshops was chosen. There was an emphasis on local innovative practices adapted to indigenous people from Nunavut and Chile, interacting with representatives of a purely biomedical model of practice.

Following this meeting, there was a call for reports from presenters and note-takers, which were included in the draft report circulated back to participants for input, approval and corroboration.

Prevention and cultural reinforcement

Many of the activities described by the different representatives of Nunavut resonated for the Chilean delegate. Activities, such as community work, and traditional arts and craftwork, such as sewing, are seen by both communities as important for promoting mental health, while providing a link to traditional values and reinforcing participants' cultural identity.

There was a discussion about the use of health interventions based on well-defined cultural-historical practices in Chile. The Chilean delegate gave the example of the Mapuche group (the group he belongs to), which both understands and treats health problems along a formulation congruent with their cultural traditions. In addition, Mapuche health programs are found within health facilities and they fully integrate the work of the "cultural facilitator".

In contrast, the Inuit delegates felt that comparable traditional interventions have largely been lost as the traditional practices were acculturated and assimilated.

Sustainability and relevance of programs

Within Nunavut, some felt there are many activity programs that have been available only for limited amounts of time, in different settings, sometimes overlapping, and not always sustainably funded. This has at times proven to be confusing to service users, and ultimately affects the usefulness of the programs. Another difficulty is that some programs do not have a dedicated facility.

In terms of accessing available mental health services, the concern of service users for privacy and anonymity reflects voices in other smaller communities across the Region of the Americas, and can result in suboptimal use of available resources. Of course, the geographical realities in Nunavut are very unusual. Indeed, the distances between communities are often very great, rendering accessibility exceptionally difficult.

In terms of serving indigenous populations, the Chilean experience is one of dedicated indigenous health facilities integrating mental health as part of the overall offer of services. Such organizational adaptations became possible when the Ministry of Health started to fund settings and service-delivery to, and adapted to, indigenous populations. Again, discussing the example of the Mapuche, the Chilean delegate explained how members of this cultural group can be served mostly within certain identified geographical agglomerations.

Beliefs and health/mental health

The issue was discussed about the relationship between cultural beliefs and mental wellness. Is wellness defined, or perceived, as congruence with cultural beliefs? Does this affect treatment? Both Chilean and Inuit beliefs were described and contrasted, and there were some remarkable commonalities between some of them. For instance, changes in the phase of the moon are sometimes thought to explain people's changing behaviour. However, for the Mapuche there is congruence, hence the Chilean indigenous notion of "Cosmovision" was described as encompassing health.

For the Inuit of today the line between beliefs and wellness is blurry. While, traditionally, there seemed to be a sense that there was a clear link between the Inuit world-view and health / wellness, this holistic perspective has become more blurred in modern days.

One Inuit delegate reported an example of how beliefs can clash across cultures and approaches. There was a report about very different ways of dealing with a person having fallen in the extremely cold waters of the region. The Inuit would, based on a belief stated to be a shared traditional one, rescue the person who should then remain untouched, lying on their back. In an instance where a victim died after receiving medically-based care from an emergency professional, the locals understood the death as a consequence of having disrespected the traditions.

A number of other examples of Inuit beliefs and traditions were shared. Language, traditional stories, and beliefs become intertwined, making it challenging to distinguish the relationships between cultural beliefs and mental wellness.

Healers

For the Chilean Mapuche people, the "Machi" (healer for the Mapuche communities) is part of the culture, society and health system. For the Inuit, on the other hand, discussing Shamanism remains difficult, perhaps uncomfortable. Although one elder Inuit delegate declared that he did believe in Shamans and that Shamanism is very important to wildlife, the role of the Shaman and of Shamanism within Inuit communities appears to be absent or limited. It was discussed that this may be due to the historical representation of Shamanism as sinful by the Catholic Church.

Conclusions

The overall notion was that certain actions are fundamental to ensure the health of indigenous peoples. Reinforcing their cultural traditions and communities, together with reclaiming their traditional land, is perceived as a means to connect with the traditional lifestyles and world-views that are rooted there. While actions in this direction are not “medical”, they are considered to relate to the health and wellbeing of these communities.

Of course, this relates to the congruence, discussed by indigenous representatives, between their natural environment and their traditional activities and lifestyle associated with surviving in that environment, which connects with the ways of relating to other members of their community, their own self-worth and “health”.

Modern health and mental health problems were understood as reflecting a complex array of factors. But the disruption of this congruence was seen as one of the most important social factors, often forced and traumatic.

Meeting with the Nunavut Health Authority about WHO’S mhGap Intervention Guide

Objectives

The objective of this discussion was to consider the relevance of this training tool for Nunavut. It had been previously agreed with the Nunavut Health Authority. Beforehand, partners agreed that a way to approach the meeting could be to present a few chapters of the mhGAP Guide for Community Health Workers (CHWs), so that participants could understand how it was structured and written, as well as its uses.

From there, it was hoped that it would be possible to engage in a discussion about the training tool and about adaptations that may be required or desired to optimize its relevance to the situation in Nunavut. Many issues were finally debated.

We report here the views of medical staff, including GPs, a pediatrician, a surgeon (not present), a GP anaesthetist (not present), an occasional visiting psychiatrist, community health workers, community health nurses, community psychiatric nurses, community health practitioners, nurse practitioners (not present), teachers, and a non-profit wellness centre.

What is the “mhGAP Intervention Guide (mhGAP-IG)”?

The “mental health Gap Action Programme” (mhGAP) was created by the World Health Organization (WHO) with the objective of scaling up care for mental, neurological, and substance use disorders, specifically in low- and middle-income settings. The “mhGAP Intervention Guide” (mhGAP-IG) was then developed to facilitate the delivery of mhGAP interventions in non-specialized health-care settings. Primary health care providers are often targeted by these training programs because of their strategic place in the health care system. It is felt that offering this program to primary health care providers (i.e., doctors and nurses) in the area, followed by community health workers, is a logical way to develop teams with aligned abilities to assess and treat individuals with mental disorders (25).

Within the mhGAP programme, community health workers (CHW) are understood as playing an important role in identifying and following up individuals with mental disorders. Primary health care providers and community health care workers that have received the training might be encouraged to further communicate regularly with individuals with the suspected

mental disorder. By communicating with and finding support from community health workers as well as primary health care providers, individuals with mental disorders are more likely to obtain relief and be able to effectively manage their disorder (25).

What is the mhGAP-IG for community health workers (CHWs)?

The mhGAP-IG for CHWs is a training tool developed by WHO that exists only in its draft form at this juncture. It is meant to help define the roles of CHWs in mental health, and to provide general principles of management for working with individuals who have mental disorders, their caregivers and families. It also focuses on how to work at the community level to help individuals link to resources and to advocate for those with mental disorders.

What are the key messages of the mhGAP-IG for CHWs?

- Community health workers play a critical role in suspecting, referring, supporting, and following-up individuals living with mental disorders;
- Community health workers can provide practical and emotional support for individuals with mental disorders, their families and caregivers;
- Individuals with mental disorders have the same rights as anybody else and they need to be treated with respect;
- Community health workers can reduce stigma and discrimination in their communities through advocacy; and
- As a community health worker, it is important to take care of your own well-being and be able to work productively.

Which chapters of the mhGAP-IG for CHWs were discussed at the meeting?

1. Role of the community health worker
2. Suspecting mental disorders
3. Referring to primary health care providers
4. Follow-up and support
5. Linking to resources
6. Advocacy
7. Self-care

See ANNEX D for further mhGAP-IG discussion.

Fundamental questions regarding the relevance of mhGAP-IG training

- Are the language used and topics covered in the mhGAP-IG meaningful and relevant for Nunavut professionals?
- Are the topics compatible with the ways problems are understood culturally and socially in Nunavut?

Medical staff were unanimous in saying that mental health issues are important in Nunavut. They also noted that they have many other competing medical issues and responsibilities which make considerable demands of their time and energies.

For the medical staff, the mhGAP-IG at first appeared simplistic, but as participants looked more carefully at the diagnostic and treatment algorithms, it appeared quite relevant. The overall view was that training would be used to improve knowledge and skills. Further, motivation for guide training would increase if the content was better adapted to the medications available in the area, and if a proper choice of modules were made.

CHWs felt that the guide was quite relevant to their work. They saw the potential of the mhGAP-IG to provide a common clinical language between them, with users, and with physicians. They were also impressed with the way clinical significance is outlined, and could identify the topics as being relevant and understandable.

Interestingly, all participants felt that the section on General Principles of Care was of central importance, but would require some adaptation to the cultural realities of Nunavut.

For example, the mhGAP starts from a biomedical perspective and builds a comprehensive training based on that premise. How best to combine the biomedical model with culturally-situated practice? This would require integrating local practitioners at the very least. The questions asked, the ways of asking them, the knowledge of and sensitivity to non-verbal behaviors, the respect for personal limits, would all have to be worked out. It is felt that there are local specificities even within Nunavut, which one would have to be sensitive to.

Intercultural practitioners bridged a discussion about differences between Chile and Nunavut in terms of accessing traditional care. In Nunavut, most (but not all) agree that the traditional shamanistic tradition has been lost, despite the presence of some elders having survived through the years of colonialism. In Chile on the other hand, the equivalent traditional Machi are very present in the Mapuche communities. Healers (with different names) are also present in other indigenous communities, offer counsel and prescribe local traditional herbal medicines.

The intercultural practitioners/facilitators help to bridge the gap between the indigenous community and the hospital. Facilitators advocate for health issues that might otherwise fall between biomedical and traditional health. These facilitators are at the center of a multidisciplinary team.

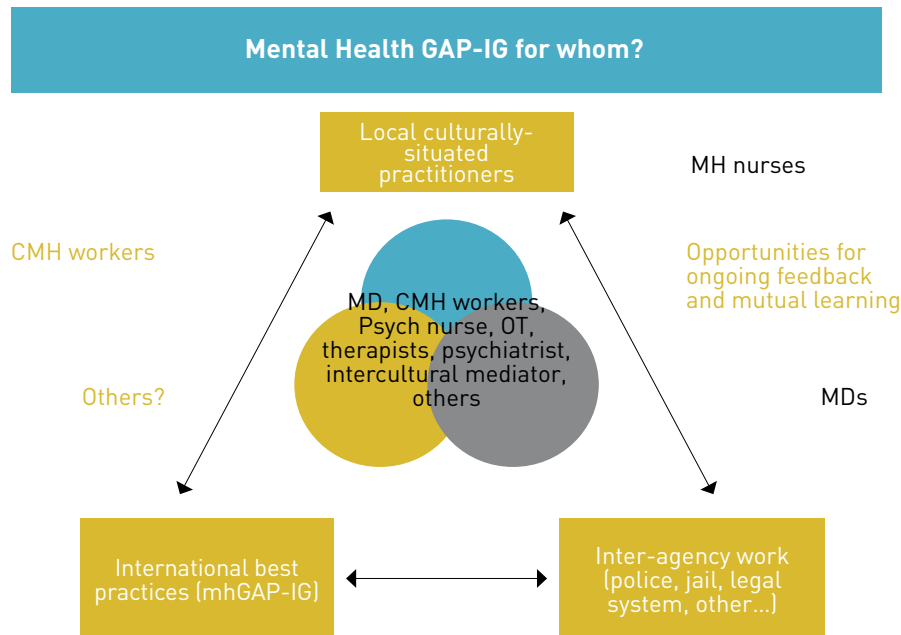
Team-building for mental health through training

- Given the distances, isolation of some communities, and non-homogeneity of available human health resources, may the mhGAP-IG tool provide opportunities for different professionals to speak a common language?
- We discussed whether this in turn could support how different services and professional bodies coordinate their mental health care, and whether this would be desirable.

The group of medical practitioners agreed that the mhGAP-IG could help clinicians and practitioners speak a common clinical language between levels of professional care, but this was not unanimously seen as high on the list of priorities.

From the perspective of the non-medical professionals, there was discussion about how to bring the guide to bear concretely in their clinical practices. One suggestion was that professionals from other levels of care could also use the mhGAP-IG as a common tool, implemented along with continuous ongoing supervision and professional development based on the tool. Several CHWs agreed that integrating an “evaluation” piece along the mhGAP-IG lines should be thought of from the start.

CHWs also felt strongly that using it as a base for mental health training for workers in shelters, schools and police (RCMP) officers, would help in its integration into care planning. This corresponded to a view of coordinated care that can be represented diagrammatically as follows:



CHWs agreed that some adaptation would be required, not only in terms of medications, but also in terms of available community resources and therapies, as well as local practices associated with resilience. Importantly, the terminology and language used would have to be adapted, with an emphasis on avoiding stigmatizing terms. Equally, the video demonstrations that are available through WHO would require adaptation and, ideally, re-enacting with actors from the Inuit culture. The Illisqsiq or Inusiq (Embrace Life Council) has made videos and may be able to assist in this respect.

How might mhGAP-IG training be implemented? What would the optimal modalities for such training be?

Training in the use of the mhGAP-IG could advantageously serve as a basis for team-building, and as such, training should be targeted at teams. Of course, the sheer geographical distances between Nunavut communities, as well as the kind of cross-sectoral coordination that most recommended, will require careful planning and adaptation. For example, training may combine teaching that could be web-based, in-person or team-based. The web-based mode may not be as simple as it seems, as internet access is not always dependable throughout the territory.

While the mhGAP-IG is relevant, it definitely requires some of the adaptation mentioned above. Topics from the mhGAP-IG that are of immediate concern include substance abuse and suicide. Of course, such social determinants of ill health –as lodging problems, domestic violence, and historical trauma- are constant issues not falling neatly under the division of health, but interacting with it at many levels.

For example, suicide is formulated in a complex manner, taking into account historical colonial abuse and loss of traditions, identity and self-control. Exposure to drugs of abuse may contribute to increased risk of impulsivity and vulnerability. At the meeting, suicides were seen locally as being triggered by stress, which interacts rapidly and intensely with these factors, leading to what appears often as impulsive risk behaviour (notwithstanding literature pointing to underlying depressive syndromes preceding suicides).

The notion of “cultural safety” was discussed in the context of implementation. How could this be assured? How can the resilience of the Inuit communities in Nunavut be reinforced?

In parallel, the notion of implementing a training program along a process of “participatory research,” integrating knowledge and adapting the process as it evolves, was also discussed.

The advantages of training offering a common language and process were highlighted in the context of the high turnover of health workers, often arriving from outside the community. The idea of targeting teams including community workers was favored, as this would ensure some continuity in knowledge, skills and actions undertaken.

Survey of participants about the mhGAP-IG

We surveyed participants anonymously about their understanding of the mhGAP-IG, and their impression about its applicability for Nunavut. We distributed the survey on day-1 before any discussion about the guide, and on day-3, after the guide was presented and discussed.

Clearly, given the small number of persons and differences in the number and composition of the groups answering each survey, there is no intent here to represent anything but trends. Indeed only some of the persons answering the pre-survey (n=20) were present for the post-survey (n=15).

There was a higher proportion of people answering to the titles of “policy maker and manager” and “public health specialist” in the pre-survey (40% pre vs. 25% post), but otherwise clinicians made up 45% (pre) and 58% (post) of the group, and community members made up 15% (pre) and 17% (post) of the group.

Comfort level with the mhGAP-IG

As expected, we see a clear increase in the comfort level (rating 4 or 5, on a scale of 5) with the mhGAP-IG, which goes from 0% on the pre- test, to 60% on the post-test.

Applicability

In terms of its applicability, while about 40% of respondents considered it applicable at the outset (albeit with adaptations), at the end of the workshop, following the presentations and discussion, 93% of respondents thought it would be applicable. Only one participant (7%) in the post survey thought that it would not be applicable.

Comments included: “Adapt a few of the case studies”; “Create a plan for implementation to include case presentation and practitioners’ involvement”; “Cultural adaptation is the most important element to making the mhGAP successful in Nunavut”. The negative comment was as follows: “I feel this is too basic for our practitioners here. We would need ‘more’ on psychosis, drugs/ethyl alcohol (ETOH), resistant psychosis and multiple medications”.

Action

It was suggested that an implementation committee be created that would recommend and carry out a process to adapt and roll out an mhGAP-IG training for CHWs, under the supervision of Amelia Rajala, Candice Waddell and Lynn Ryan MacKenzie.

The point was made that training should also be about coordinating mental health actions across levels of care in Nunvaut, from community care through hospital-based care, including local best-practices.

Participants upheld the notion that interventions should be combined with preventive strategies, in complementary and coordinated ways. This will certainly include building on programs already proven to be successful.

Interestingly, there were positive indications about the integration of traditional models of care with a bio-medically based model as that of the mhGAP-IG, which would not be mutually exclusive. Of course, we would gain by understanding the pathways to care across care models.

Finally, an evaluative approach to implementing any training is favored, and should be part of any future collaborative ventures aiming at implementation.

ANNEX A

Meeting Agendas

Santiago de Chile, Chile, 27-29 October 2014

Monday, October 27^h

Time	Topic	Organization
8:45 – 9:00	Registration of participants	Ministry of Health of Chile
9:00 – 9:10	Opening-Welcome	PAHO/WHO Chile - MoH Chile
9:10 – 9:35	Report on the results of the Project between Nunavut and Chile, developed in 2013	PAHO/WHO WDC
9:35– 10:00	PAHO Cultural diversity work in the Region	PAHO/WHO
10:00 –11:00	Special Program Health of Indigenous People (PESPI): History and description	OPS/OMS
11:30 –12:30	Health provision to Inuit people in Nunavut: History and description	Office of Health and Indigenous People from MoH Chile
12:30 – 13:00	Questions and dialogue	Nunavut delegates
14:30 – 16:00	Mental health care with an intercultural approach: presentation of three Chilean experiences	
16:30–17:30	Experience in Nunavut: Suicide prevention program - Presentation and discussion	MoH
17:30 –18:00	Questions and dialogue	Nunavut
18:00	End of the session	

Tuesday, October 28

Time	Topic	Responsible
8:45 - 9: 00	Registration of participants	MoH Chile
9:00 - 10: 00	Experience in Nunavut: Mental health services delivery in small and isolated communities - Use of telemedicine Presentation and discussion	Nunavut
10: 00 - 11: 00	Health Indigenous Systems in Chile	MoH Chile
11:30 - 12: 00	Brief presentation on health care to indigenous populations in Brazil	Brazil delegation
12: 00 - 1230	Brief presentation on health care to indigenous populations in Argentina	Argentina delegation
12:30 - 13: 00	Brief presentation on health care to indigenous populations in Guatemala	Guatemala delegation
13: 00 - 13:30	Questions and dialogue	
15: 00 - 16: 00	Future of technical cooperation: main areas of cooperation, identification of key issues	Coordination: PAHO/WHO WDC
16:30 - 17:30	Plenary Session: groups presentations	
17:30 - 18: 00	Conclusions and closure of the event	PAHO/WHO WDC – MoH Chile
18: 00	End of the session	

Wednesday October 29

Field visit: Health Center with intercultural service in Santiago de Chile

Iqaluit, Nunavut, Canada, 7-11 September, 2015

DAY 1- Wednesday, September 9th 2015

9:00 - 9:45	Greetings: <ul style="list-style-type: none"> • Minister of Health • Deputy Minister of Health • Assistant Deputy Minister of Health
9:45 - 10:00	Introduction of delegates
10:00 - 10:30	Presentation from Nunavut delegates -3 regions
10:45 - 11:00	Presentation from PAHO/WHO
11:10 - 11:00	Presentation from Chile Cultural facilitator
11:00 - 12:00	Presentation of the <i>pre-post questions and distribute</i> Presentation about the <i>Brazil "models"</i>
12:00 - 13:00	Arctic Lunch – Provided by the Government of Nunavut
13:00 - 13:30	Presentation from Ilisaqsivik Programs not funded by government but part of regular available services
13:30 - 14:30	Pilot Training of mhGAP – depression, psychosis and suicide (Community Worker Version)
14:45 - 17:00	Continuation of mhGAP Evaluation of mhGAP

DAY 2 - Thursday, September 10th 2015

	* GROUP A – Baffin Room (Territorial Resource Team, Regional Managers, CPN's, Dr Allison Crawford)	* GROUP B- Kitikmeot Room (GN – Child & Youth Outreach Workers, Chile Intercultural facilitator, Rep from Ilisaqsivik)
9:00 - 10:30	Orientation for mhGAP for primary care practitioners <ul style="list-style-type: none"> • Discussion on the adaptation of the curriculum in the Nunavut Context • Facilitated by Devora Kestel (PAHO/WHO) and Dr. Marc Laporta (McGill University) 	Cultural Facilitator Role <ul style="list-style-type: none"> • Discussion facilitated by Mary Ashoona Bergin (Cross Sector Planning Coordinator)
10:45 - 12:00	Continued Discussion with Groups	
13:00 - 17:00	Community Psychiatric Nurse/ Mental Health Consultant (mhGAP) <ul style="list-style-type: none"> • How to adapt curriculum specifically for this target group 	Cultural Activities <ul style="list-style-type: none"> • Cultural Movie • Tour of Sylvie Grinnell Park

DAY 3 - Friday, September 11th 2015

Morning - Optional Tour of Iqaluit Mental Health Services
Short discussion on next steps

ANNEX B

Overview of participating countries' indigenous populations and presentations

1. Overview of points of relevance about participating countries' indigenous populations

Theme	Canada	Brazil	Argentina	Chile
Territory (km ²)	9,984,670	8,514,877	2,791,810	756,102
Population	35,540,400	202,656,788	40,117,096	17,363,894
Ethnic Group	Canadian 32.2%, English 19.8%, French 15.5%, Scottish 14.4%, Irish 13.8%, German 9.8%, Italian 4.5%, Chinese 4.5%, North American Indian 4.2%, other 50.9%	White 47.7%, mixed white and black 43.1%, black 7.6%, Asian 1.1%, indigenous 0.4% (2010 est.)	White (mostly Spanish and Italian) 97%, mestizo (mixed white and Amerindian ancestry), Amerindian, or other non-white groups 3%	White and non-indigenous 88.9%, Mapuche 9.1%, Aymara 0.7%, other indigenous groups 1% (includes Rapa Nui, Likan Antai, Quechua, Colla, Diaguita, Kawesqar, Yagan or Yamana), unspecified 0.3% (2012 est.)
Life expectancy at birth (years)	81.67	73.28	75.73	78.44
GDP	\$ 1,518 billion	\$ 2,416 billion	\$ 771 billion	\$410.3 billion
GDP per capita	\$43,100	\$12,100	\$18,600	\$23,200
Health (%GDP)	11.20%	9.30%	10.20%	7.20%
Education expenditures (%GDP)	5.4	5.8	6.3	4.50%
Inflation rate	1	6.2	20.8	4.30%
Health System	Public and universal	Public and Universal	Private, public and social programs	Private and public
Physicians density	2.07 physicians/1,000 population	1.89 physicians/1,000 population	3.16 physicians/1,000 population	1.02 physicians/1,000 population (2009)
Hospital bed density	2.7 beds/1,000 population	2.3 beds/1,000 population	4.7 beds/1,000 population	2.1 beds/1,000 population (2011)

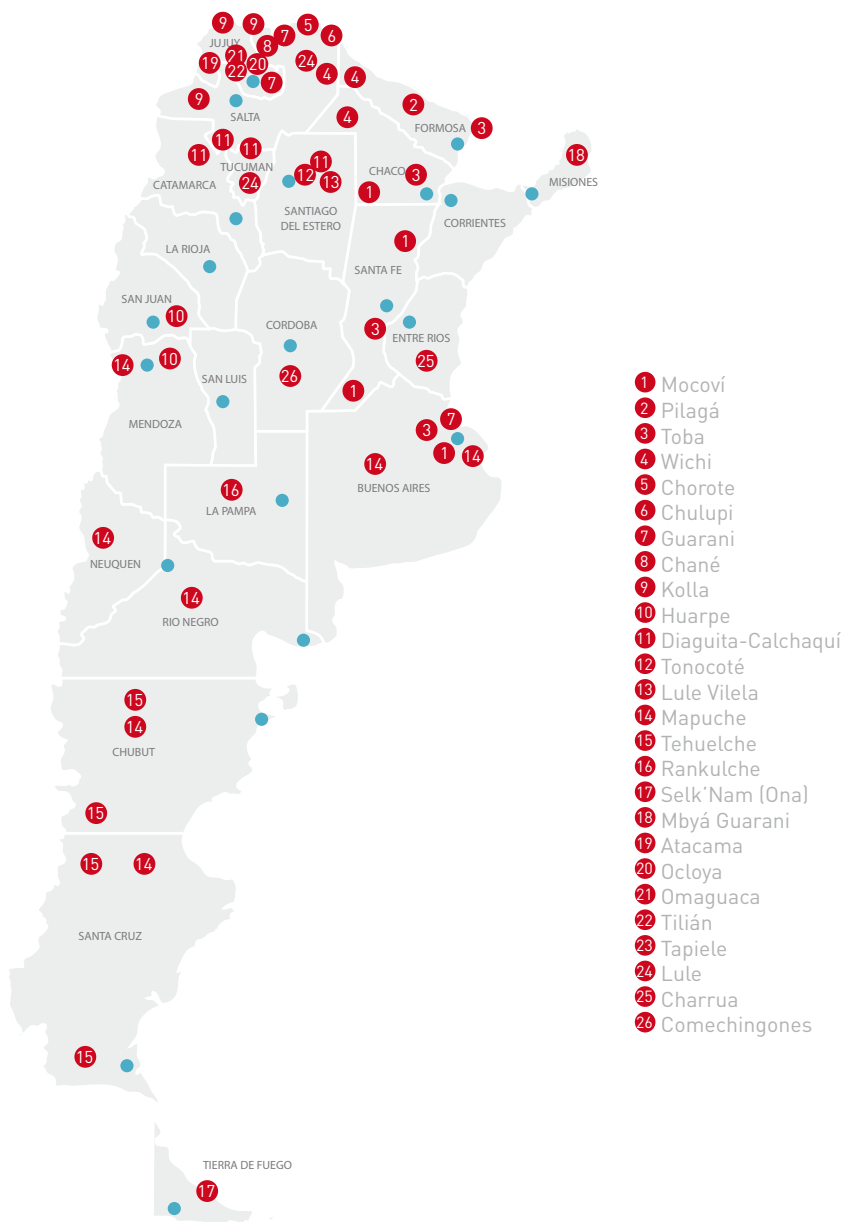
Note: Some of this information has been extracted from official internet sources.

2. Presentations from participating countries (in alphabetical order)

ARGENTINA

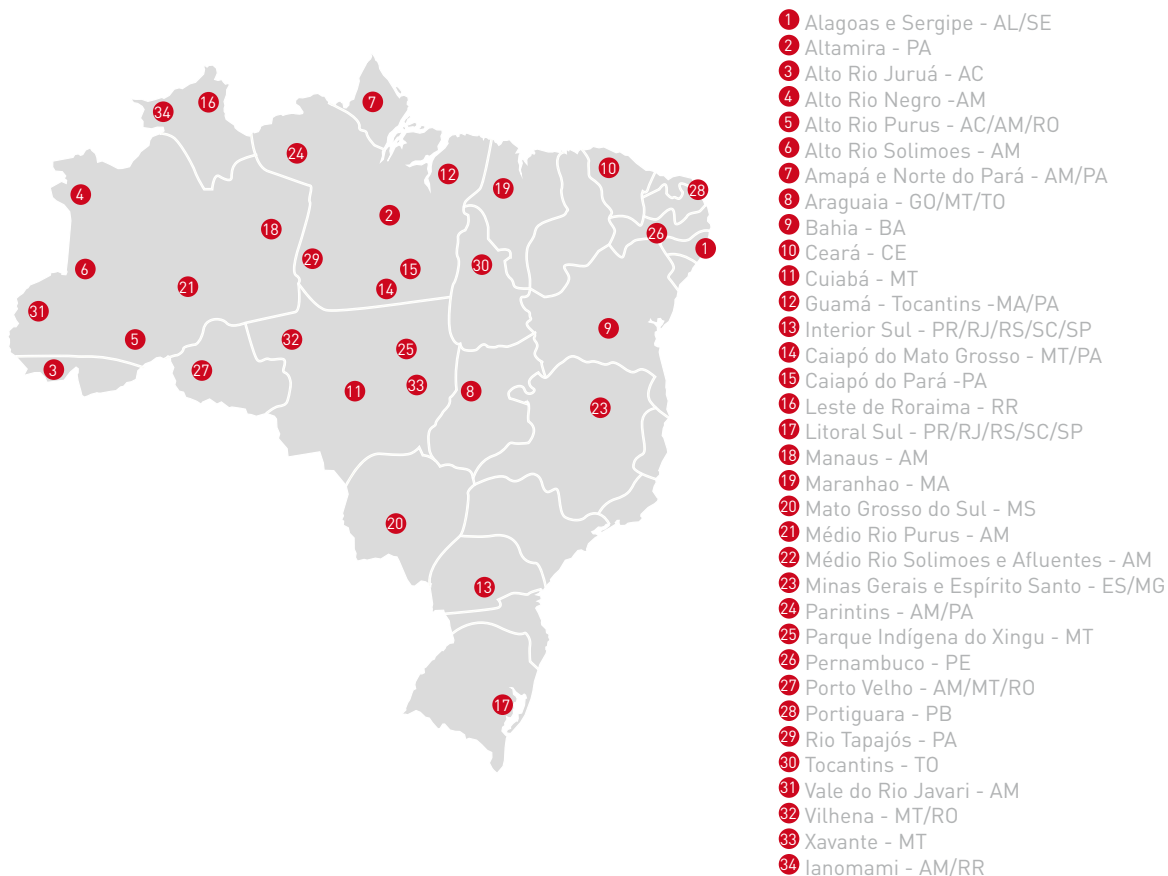
About 40 million people live in Argentina, the second largest country in South America. Indigenous cultures and populations are distributed all over the territory with predominance in the North. The Mapuche are the most populous group, with 114,000, followed by the Kolla (70,500), and the Toba people (69,500).

Higher suicide rates, alcohol abuse and dependence are the main mental health problems identified. Understanding the health network is important to improve these populations' access to services. As an example, in Chaco Province, the local indigenous community built a concrete model in the existing health network. It aims to improve knowledge of the health system in this community. Although the results have not yet been measured, there are early indications demonstrating the positive impact of improved health system knowledge for the indigenous population.



BRAZIL

Brazil has 200 million inhabitants, with 900.000 indigenous people (0,5% of the population) belonging to 305 ethnic groups, speaking 274 different languages, in almost all states of the Federative Republic of Brazil. Approximately 20% of the indigenous people do not speak Portuguese. Distributed across 688 protected indigenous areas in 12.64% of the national territory, 905 of these communities have no more than 100 people.



Communities throughout Brazil experience different levels of contact with non-indigenous populations, ranging from zero contact to full inclusion in the mainstream Western lifestyle. An important particularity in Brazil is the presence of approximately 60 communities that do not have any registered contact with non-indigenous people.

Indigenous populations experience higher indices of infant mortality, tuberculosis and malaria in comparison with the non-indigenous Brazilian population. From the mental health perspective, there are high rates of suicide, alcohol abuse and domestic violence. Some regions have indigenous population suicide rates that are up to 12 times higher than those of non-indigenous populations.

Karajá and Kamajurá intercultural exchanges

Since 2002, there has been a gradual increase in reports of suicide by hanging among young men of the Karaja population. This phenomenon was identified and considered a crisis both by the community and by the government. Thus, consensual strategies began to be devised.

In attempting to understand this phenomenon, numerous possible influences were posited, including witchcraft, mourning and alcohol abuse, among others. Different strategies are reported to have been developed:

- Anthropological investigation;
- Support for health care workers;
- Educational and preventive strategies concerning suicide;
- Increased statistical and health surveillance;
- Active identification and follow-up of vulnerable persons;
- Increased presence of health teams; and
- Making a variety of activities (physical, cultural, social) available to this population, as well as creating opportunities for different kinds of traditional healers to share and interchange with other communities.

The following is an example of this latter strategy. The Karajá community asked the health administration for support from a traditional healer from the Kamajurá community. The name given to these traditional healers is “*pajés*”. The services of a “*shaman*” (“*Xamã*”) from a very different cultural group within Brazil were requested since the local understanding for this problem was mainly that it was due to witchcraft. Within months of the intervention of this traditional healer, the Karajá community reported a dramatic decrease in the number of suicides.

This project sparked a new line of intercultural cooperation between groups across the country, supported by the government. Regular meetings between representatives of indigenous communities and governmental agents have been set up to facilitate the identification of needs, and to mount an adequate and relevant response. The role of state health agencies is to support these decisions and provide some tools and mechanisms to facilitate the process. Based on this project, another intercultural exchange between two indigenous communities was set up to deal with a problem of alcohol abuse and domestic violence.

As these experiences were reported to yield positive results, a wider agenda for meetings between different indigenous and non-indigenous populations has been developed to include the empowerment of the communities to foster their autonomy and improve management of their resources beyond health. A new meetings schedule has been agreed for 2015 and 2016.

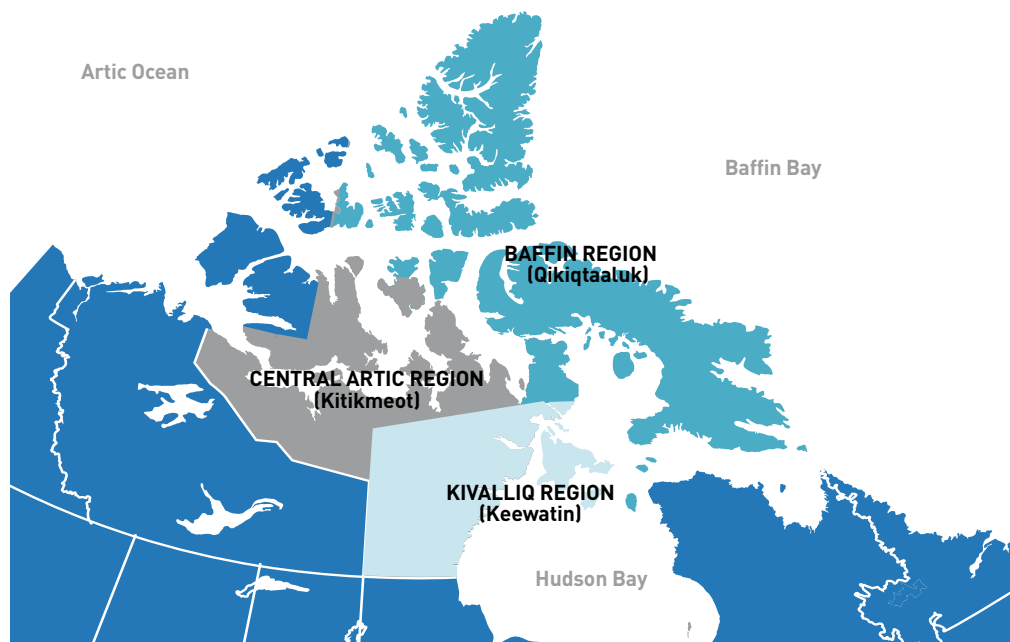
CANADA

Nunavut

Nunavut is Canada's largest territory, with about 1% (37,500) of the country's total 36.5 million population. Over 1.4 million people identify themselves as being of indigenous origin. Within the country's geographic borders, Inuit, Metis and First Nations peoples have been recognized as Canada's indigenous population. However, this general categorization is limiting. For example, currently, there are over 600 First Nations governments or bands and 4 distinct Inuit groups within the boundaries of Canada.



Nunavut is a Territory that comprises three main regions: the Baffin Region (Qikiqtaaluk), the Central Arctic Region (Kitikmeot), and the Kivalliq Region.



In contrast to the Federal system, the Territory of Nunavut has a nonpartisan consensus style government that is more consistent with Inuit Qauimmajjtagit and the Inuit societal value of Aajiiqatigiinni (decision through consensus and discussion). The twenty two members of the Legislative Assembly are elected as independent candidates in their home constituencies. After being elected by the general public, individuals meet together as the “Nunavut Leadership Forum” to select the Speaker, Premier and ministers in a secret ballot election.

Canada has a complex history with the aboriginal people. The Indian Act was first passed in 1876 and the detailed nature of these negotiations is beyond the scope of this paper. Inuit were not included in the first negotiations with the Canadian Federal Government. So when negotiations began between the Inuit of Nunavut and the government, the Inuit decided that they did not want reserves under the Indian Act (Nunavut Tunngavik Incorporated, 2004). In exchange for the title to all the traditional lands in the Nunavut settlement area, the Nunavut Land Claims agreement allotted specific rights and benefits for the Inuit within the region, including a cash settlement of \$1.173 billion; ownership of approximately 18 percent of the land in Nunavut; mineral rights to two percent of those lands; and the creation of the territory of Nunavut. In 1999, the Territory of Nunavut became a realization and the Government of Nunavut was established.

Canada has the modern conveniences of all other developed countries as well as a Public Health System. Canada’s health care system is based on the concept of “universal coverage for medically necessary health care services provided on the basis of need rather than the ability to pay” (Government of Canada) and is offered to all citizens. Notwithstanding this universal health coverage, Canada continues to experience diversity in health among its constituents. For instance, the newest Territory in Canada, Nunavut, which has a population that is 88 % Inuit, has higher mortality rates, a lower life expectancy and low literacy rates. Nunavut also experiences suicide rates that exceed all other provinces and territories.

Historically, changes in traditional lifestyles, such as an end to the nomadic lifestyle, were forced upon these populations. The legacies of residential schools, forced relocation, colonization, the slaughter of the dog sled teams and rapid modernization have all impacted today’s Inuit society (26, 27).

The Government of Nunavut recognizes that many Nunavummiut and their families struggle with mental illness, addictions, suicide and domestic violence. For this reason, the Government of Nunavut 2014-2015 Mandate “*Sivumut Abluqta: Stepping Forward Together*” (28) makes commitments to Nunavummiut such as:

- Addressing mental illness, addictions and domestic violence by recognizing and providing resources for community based solutions;
- Recognizing the role of both traditional and clinical approaches to helping people regain their health and wellbeing;
- Ensuring the availability of clinical expertise and facilities to the Nunavummiut; and
- Working with all the partners to renew and strengthen the efforts towards suicide prevention.

These commitments guide the overall mental health and addictions divisions’ initiatives.

Most communities in Nunavut are fly-in communities. This poses important problems of access to care, human resources, and supplies. Despite this, there are health centers available with mental health staff 24/7. In addition, there are psychiatrists available to provide support to these teams in weekly rounds (present or telemedicine). The arrows in the picture below give an idea of medical travel.



Delegates from the three Nunavut regions - Kivalliq, Kitikmeot and Qikiqtaaluk - participated in the September 2015 meeting. Each of the delegates presented programming and work provided by their mental health and addictions staff. The Territory considers mental health a priority. Among the issues requiring special attention are suicide prevention, domestic violence and alcohol.

Kivalliq Region

In the Kivalliq Region, pods of beluga whales can be seen in the many small bays close to communities. Herds of caribou migrate through inland regions and polar bears migrate along the coast (29). Baker Lake, in the Kivalliq, is Nunavut's only inland community. It is located around 40 km (25 miles) from the exact geographic centre of Canada (30).

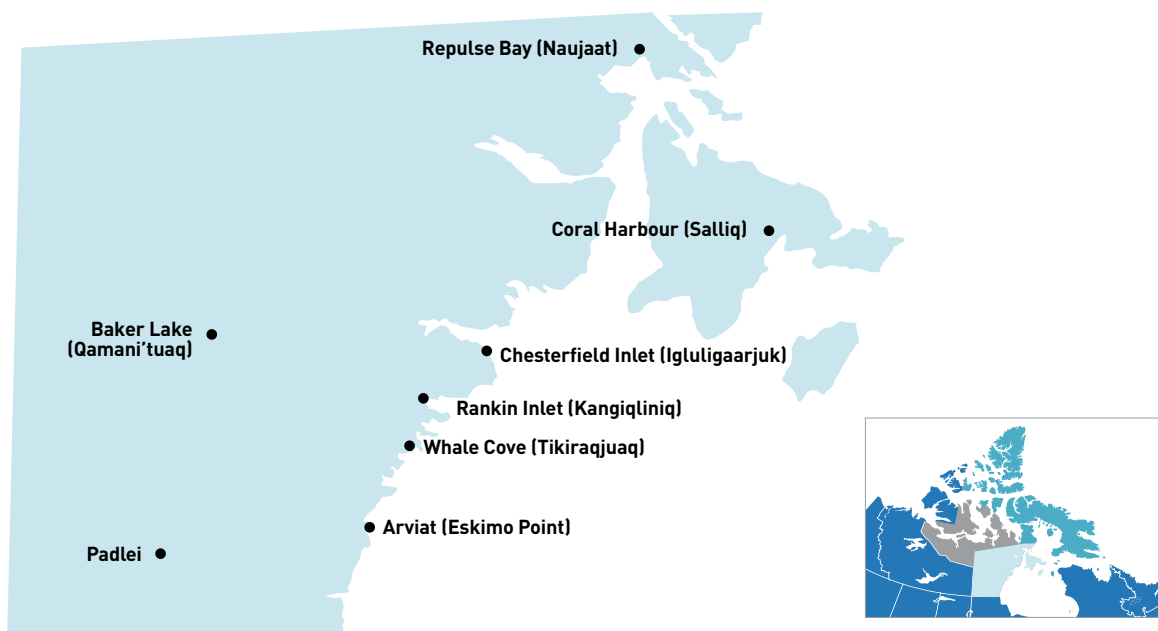




Photo: Young Hunters Program

Arviat, in the Kivalliq, is known for its talented musical artists, including the well-known singer-songwriter Susan Aglukark. Unique sculptures and carvings are made using an extremely tough local stone and often depict maternal or family themes (29).

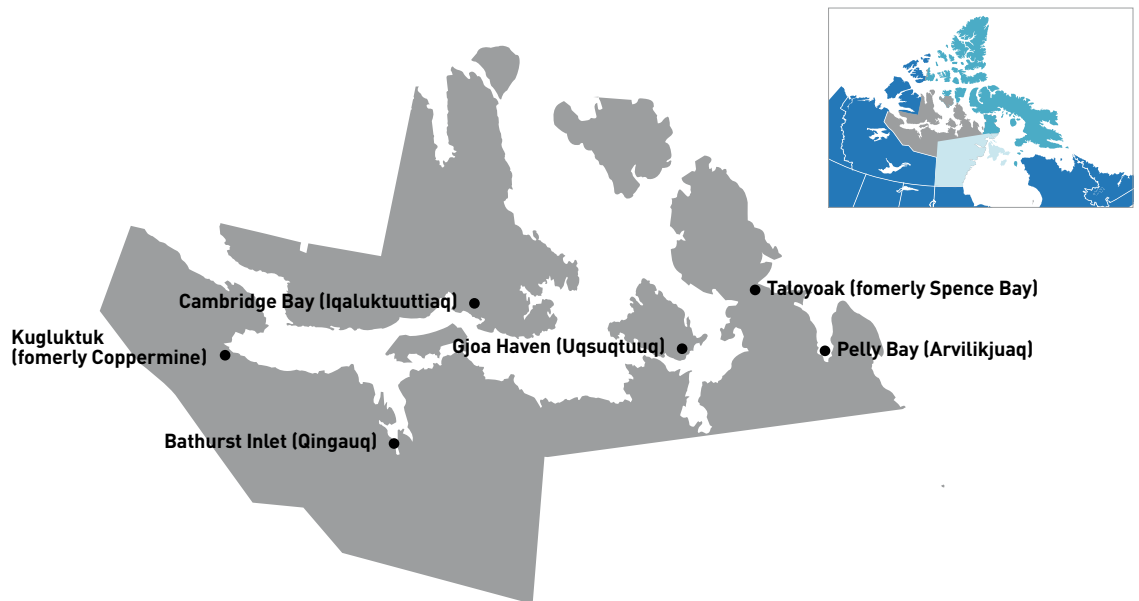
Young Hunters Program

The program described during the September 2015 meeting for the Kivalliq Region was the Young Hunters Program. The program was developed in response to an identified need for more indigenous food and more youth programming in the community of Arviat. Elders that worked for the department of education as advisors were asked for input. The Young Hunters Program targets young boys in Arviat aged 10-12. A selection process was established to pick out those who would benefit the most if chosen. Funding for this program is provided by the Government of Nunavut (Health Funds), Movember Funds, and Nunavut Hunter's support program.

The boys selected go through an 8-week program, where they learn the importance of Inuit values and beliefs, avatimik kamatsiarnig (environmental stewardship) and traditional Inuit hunting practices. The program was developed by Jimmy Napayok, Augaaj Karatak and Jukik Baker, with the help of Dr. Donald Uluadluak Sr., and Louie Angalik.

Región Kitikmeot

Inuinnaqtun is a language spoken in the western area of the Kitikmeot Region. It is the mother tongue of only 1.5% of Nunavummiut. Barren-ground caribous, muskoxen, Arctic charrs, lake trouts and ringed seals are important food sources.



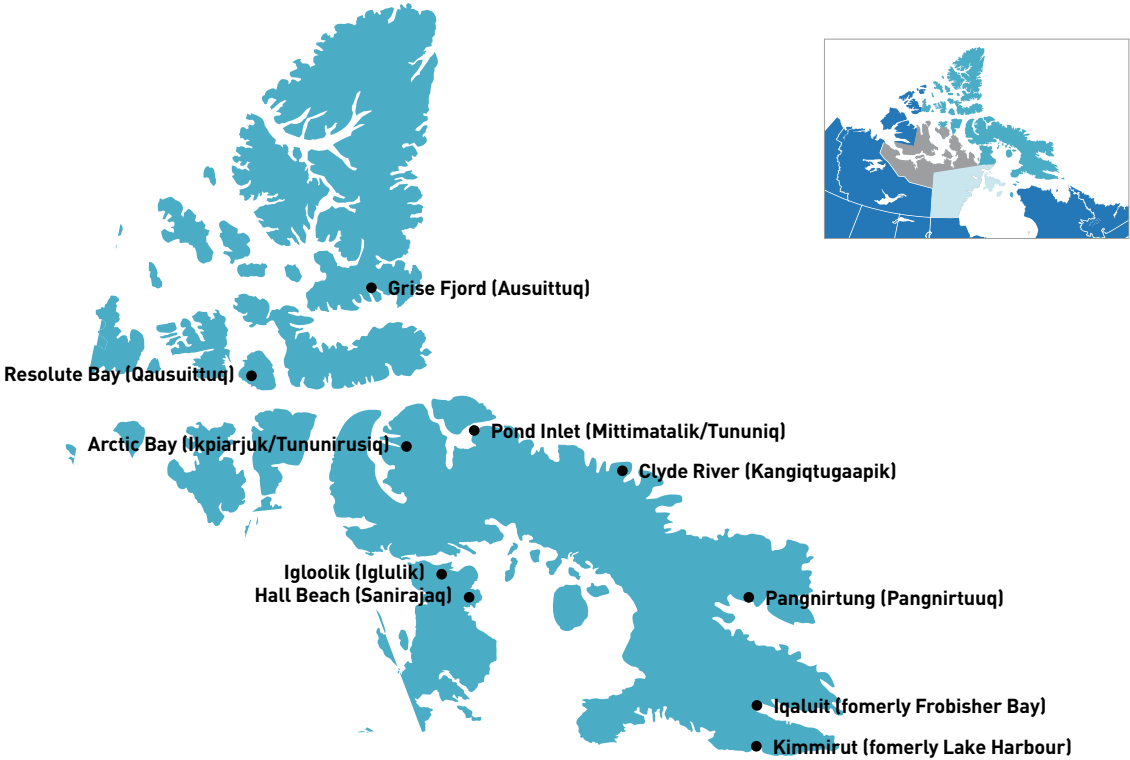
Inuit people living in the region have their own distinct and unique traditions. They were known to make arrowheads, spearheads, ulu blades, chisels, harpoons and knives from copper that was traded amongst Inuit peoples. Owayok Territorial Park is located just east of Cambridge Bay. The central feature of the park is the mountain called Owayok (Mount Pelly), which stands out from the surrounding landscape (31).

Cambridge Bay Mental Health Facility

On 4th February, 2014, this Kitikmoet Region facility opened to its first clients. Many Nunavummiut have since been repatriated to the facility from out-of-territory facilities in the South. The facility has 12 beds and provides residential treatment, day programming and drop-in support. Programs and services delivered are evidence-informed and reflect Inuit values. The presence of the facility has helped staff decrease the stigma around mental illness in the region.

Qikiqtaaluk Region

All communities in the Quikiqtaaluk (Baffin) Region are located on islands, making many of them very remote and isolated. For example, Grise Fjord, is the northernmost community in Canada and is 1,160 kilometers (721 miles) north of the Arctic Circle. Grise Fjord has constant 24-hour sunshine from April 22 to August 20. The Baffin Region is well known for its scenery and landscape, along with its many breathtaking national and territorial parks (32).



Programs description

The Quikiqtaaluk Region mental health teams have:

- After school programs, including the Mentorship program (Pangnirtung, Cape Dorset), and Sewing Club (Pond Inlet);
- In-school outreach, including education and social emotional learning; and
- Regular community groups, including community yoga and summer sports programs.

These programs have helped community members to connect with the mental health staff, learn new skills, and learn where to seek help. They are described in more detail below.

The Sewing Club

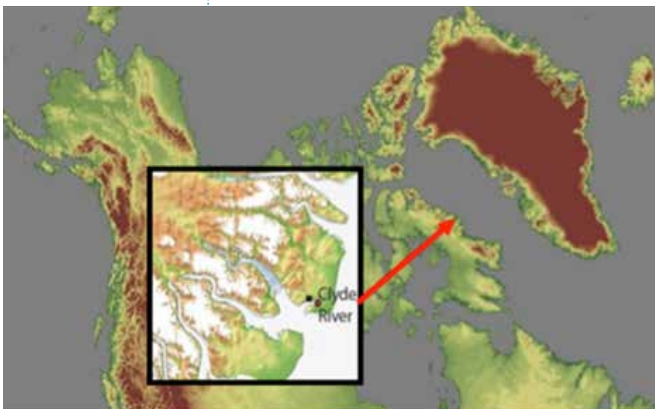
The Sewing Club is a program for grades 4-6 (ages 10-13) that runs once a week, for 8 weeks. The program occurs in Pond Inlet. The community found it helped increase the participants' self-confidence.

Mentorship

The Mentorship Program is a free after-school program for children in grades 1 to 6 (ages 6-13). It is led by carefully selected high school students (or youth mentors) who serve as role models to the youth. The child and youth outreach workers and wellness counselors facilitate the program. The community found that the program helped participants in school, taught them healthy eating habits, and allowed them to learn hands-on traditional knowledge from elders. Due to the success of the Mentorship Program in Pangnirtung and Cape Dorset, a pilot project has been approved to fund the program for 5 months in communities across the territory, starting in January 2016.

Yoga

A yoga class runs every Tuesday after work in Pangnirtung. It is open to everyone in the community to help with stress management and anxiety.



Ilisaqsivik Society programs

Ilisaqsivik, created in 1997, is a Canadian charity and a Nunavut Society, located in the community of Clyde River, on the east coast of Baffin Island.

Ilisaqsivik is an Inuit organization, founded, led and staffed by the residents of Clyde River, a community of about 1000 people. Ilisaqsivik owns and operates the Community Family Resource Centre, the Heritage and Research Centre buildings, and most recently, the Naujaaraaluit Hotel.

Ilisaqsivik's Board of Directors is elected every year during the annual general meeting. All directors are community members and volunteers. Ilisaqsivik's board sets priorities, which the organization adopts. Community feedback comes through annual general meetings, radio shows, word of mouth, telephone calls, surveys (children's programming), meetings with other community groups (hamlet, justice, elders, health), and workshops.

Ilisaqsivik's mission is to promote community wellness, as well as to provide space, resources, and programming to help families and individuals develop their strengths. Ilisaqsivik achieves this mission by:

- Providing access to educational, health and nutrition, as well as cultural and counselling programs;
- Promoting the participation and leadership of elders in all programs and activities;
- Promoting and demonstrating healthy lifestyle choices, positive attitudes, creativity and resourcefulness;
- Providing a safe, healthy and accepting place for Clyde River residents to meet;
- Promoting Inuit culture, values, livelihoods, knowledge, language, and traditions in all programs and activities;
- Providing assessment and referral services to individuals and families;
- Providing therapeutic counselling services to individuals and families;
- Coordinating workshop delivery for Clyde River and other communities;
- Providing on-the-land retreats to individuals, families and groups; and
- Providing Critical Incident Management Services for Clyde River and other communities.

CHILE

Important laws were approved in Chile in order to provide better access and support to the indigenous populations' initiatives. About 8.1% of the Chilean population is indigenous. The Aymara, Mapuche, Atacameños, Quechuas, RapaNui, Colla, Diaguitas, Kawésqar and Yamana are several of the country's ethnic groups.

Depression, alcoholism and suicide rates are also often identified as important mental health disorders in Chilean indigenous populations. As regards general health issues, average rates of tuberculosis and cancer are higher among this group than among the non-indigenous population. Poverty rates of indigenous versus non indigenous populations are higher, with 19.2% vs. 14%. For extreme poverty, rates are 4.3% vs. 2.7%. Employment and years of education indices are also lower for the indigenous populations than for the general population.

Chile has begun to build bridges between cultures, hiring "cultural facilitators" to work at health and community institutions. Furthermore, it supports the maintenance of indigenous medicine by funding traditional places for these practices, and by adding indigenous health to general health institutions. Laws (especially Law No. 20.584, enacted in 2012) guarantee culturally based access and equity in health.

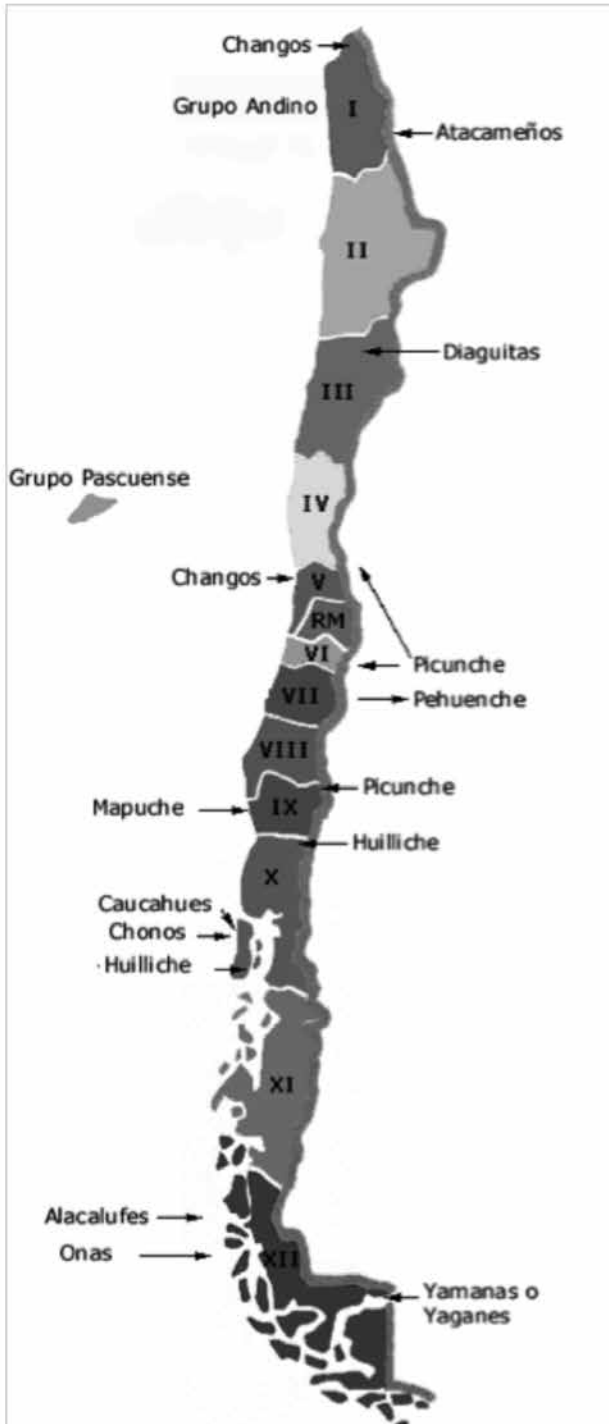
Health policy in indigenous populations is based on the respect for ancestral culture. The system recognizes that no health system is able to fulfill the necessities of a multicultural community unless there is an openness to alternate models to the biomedical model. In order to develop new and joint solutions, the "1st Seminar on Mental Health, Interculturalism and Indigenous Populations" (2010) engaged the active participation of indigenous communities, intercultural facilitators and professionals.

Arica and Parinacota

The Arica and Parinacota's Mental Health Team is a very well developed partnership program. Mental health teams at the secondary care level work side-by-side with traditional healers and offer the community the opportunity to have a consultation with the *Yatiri (Qulliri)* (traditional healer). Notwithstanding the limiting requirement to hire persons with at least a high school degree, the program has been successfully applied. Local communities have requested consultations with the Yatiri for various complaints including physical pain, family problems, advice, etc.

La Union

A Mapuche community, constituting 12% of the local population, lives in Los Ríos region inside "La Union" community. Until 2008, the Mapuches' suicide rates in this region were 3 times that of the non-Mapuche population. The regional strategy was to build a culturally appropriate health system around prevention, treatment and rehabilitation, based on the indigenous concept of health



-“*kume mogen*”- (a holistic sense of wellness comprising social, cultural, economic and spiritual conditions), and of disease -“*wesa mogen*”- (an imbalance with this holistic wellness). These perceptions transcend the individual level to seeing the person as living within his/her relationships, society and environment. This model of health seen from a holistic perspective is reflected in La Union’s sense that industrial development in their area (forestry) has had a significant negative impact on the health of the Mapuche population.

Malleco Province: Dr. Digno Stagno Hospital

This institution, located in Malleco Province, is considered a “transcultural policlinic”. It reflects the local reality, where 16% of the population is Mapuche. The community can choose between the biomedical mental health care model and the Mapuche health system. A protocol defines the necessity of referral to the Mapuche health system, to traditional healers (called “*machi*” and “*lawentuchefe*”), or to Mapuche health workers.



ANNEX C

Intercultural Health Program

A presentation by Mr. Adelmo Milaqueo
Intercultural Facilitator, Ministry of Health, Chile

Traiguén

Traiguén is a commune in the province of Malleco, located in the Chilean region of Araucanía. According to the 2012 census, it has a population of 17.807 inhabitants.

Traiguén Hospital

The general mission of the Traiguén Hospital is to provide quality services related to diagnostics, prevention and rehabilitation of Traiguén's population and its surroundings. An important component of these services is that they are intercultural.

The Traiguén Hospital has a program that specifically addresses indigenous health: "*Programa Especial de Salud y Pueblos Indígenas*" (PESPI, for its acronym in Spanish) (Special Health and Indigenous Peoples Program). Its objective is to improve the quality of life and health of the indigenous populations using a model that focuses on intercultural healing. It includes the active participation of the indigenous populations in planning, evaluating, delivering and implementing services. More specifically, the three pillars of this program are equality, intercultural health and participation.

A look at the law

There are a number of passages in the Chilean law that support a focus on intercultural health.

1. **ILO Convention N°. 169 (Article 25.2):** Health services should, to the extent possible, be community-based. It is primordial that these services are organized and delivered in collaboration with the indigenous populations, taking into account their economic, geographic, social and cultural conditions, as well as their traditional methods of prevention, healing practices and medication (33).

2. **Law No. 19.253 (Article 34):** Administrative services of the State and territorial organizations should listen and consider the opinion of indigenous organizations, and recognize them when developing and implementing services. Sets rules on protection, promotion and development of indigenous people, and creates the National Indigenous Development Corporation (34).
3. **Norm No. 16 of the Ministry of Health (Article 7):** Health services that have the presence of indigenous populations should be developed, delivered, implemented and evaluated with the participation of these peoples. This inclusion will allow for health programs and activities to include models that promote intercultural health, a requirement of the Ministry of Health and the Regional Health Authority (35).
4. **Law No. 20.584:** Regulates the rights and duties incumbent upon individuals with regard to actions related to their health care (36).

Epidemiology of mental health at Traiguen Hospital

Four main disorders are seen at the Traiguen Hospital:

- Depression
- Anxiety
- Behavioural disorders
- Substance use disorders

There are two different cultural visions of health that are recognized at Traiguen Hospital:

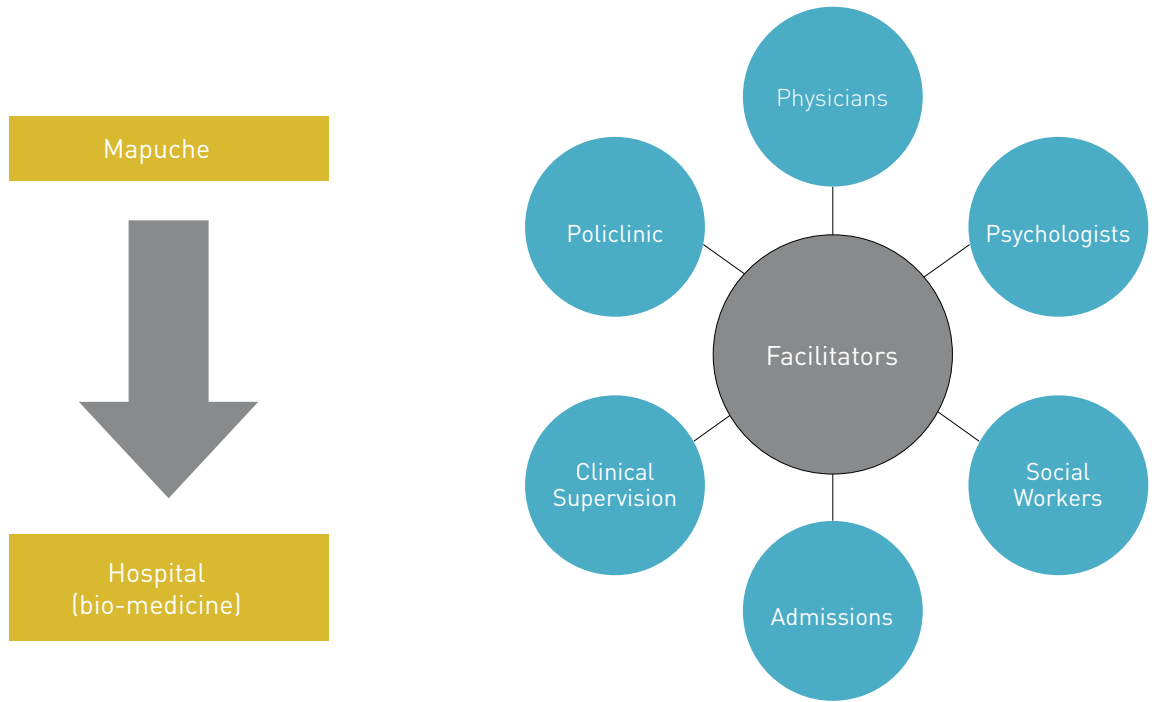
- Mapuche Health, which upholds an integral vision of health in which wellbeing implies being well on different levels: spiritually, psychologically, physically, and socially; and
- Kutran Health, which represents suffering, a being called che that is taken by the organism (37).

Description of the Intercultural Clinic

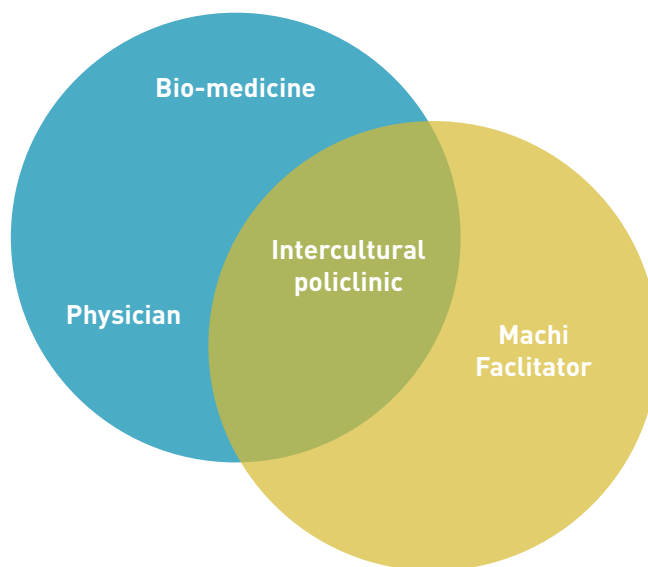
The Traiguen Hospital houses the Intercultural Clinic, which promotes a median between biomedical and Mapuche health. The program was created in order to meet the challenges of health systems for the rural and Mapuche populations, namely, health access challenges and difficulty in understanding indigenous population needs.

A number of facilitators help ensure that these challenges are met:

1. **Intercultural facilitator:** An indigenous person who speaks the original language, maintains a strong dialogue with the indigenous community and the hospital, and is an advocate for health that falls between the biomedical and the Mapuche health. These facilitators are at the center of a multidisciplinary team.

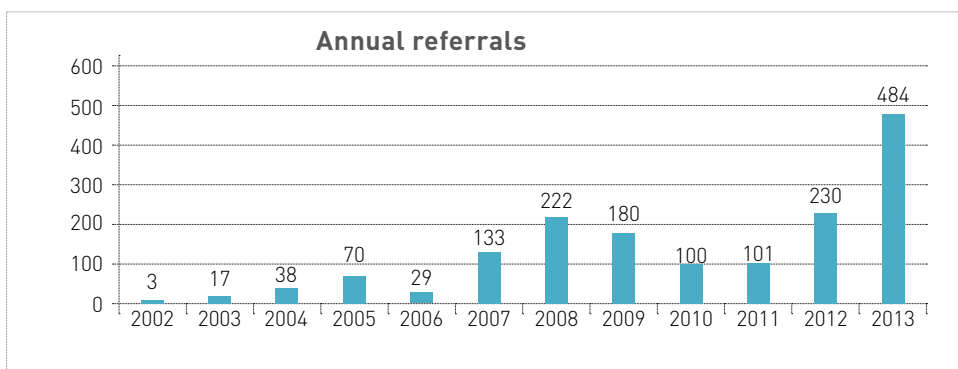


2. **Intercultural Clinic:** This clinic was established in 2001. In 2006, the need to acknowledge Mapuche health became apparent. Therefore, the need to include elements of Mapuche health in the already established and existing model was envisioned as a solution. “Complementary” is explained by valuing both, the biomedical and the Mapuche health models.



To acknowledge the complementarities of both, the biomedical and Mapuche health models, particular attention is given to intercultural and medical facilitators. Patients needing care are accompanied by a *nguen nutran*, either a family or community member who advocates or facilitates on behalf of the patient throughout the consultation process, with both the medical establishment and the *machi*, the *lawentuchefe* (herbal healer), or any other agent of Mapuche medicine. It is important to note that Mapuche culture requires a patient spokesperson to respond to questions about the health history that they believe may affect their symptoms. Two diagnostic hypotheses are then generated (biomedical and Mapuche), complementing each other.

The impact of this complementary model has been evaluated. The number of consultations of indigenous population has increased over the years, as shown by the graph below. This increase has tackled health access issues in the population.



There have been both successes and challenges to this complementary model that are worth noting.

Successes include:

- Increased access to services over the years;
- Meeting real health needs of the indigenous population;
- Sensitizing and integrating health functions that are valued by the indigenous population;
- Active participation and increased communication with the Mapuche community in Traiguén;
- Economic support from the health services; and
- Implication of other professionals, creating multidisciplinary health services.

Challenges that still need to be addressed when working with such complementary model include:

- Health professionals with very limited schedules for tasks that often require more time and energy;
- High dependency on the availability of a physician;
- Need to advocate for financial resources to sustain the model;
- Number of people who have still not "bought into" the model; and
- The need to further integrate the biomedical and the Mapuche health models in treatment (not only in diagnosis).

To address these challenges, a number of needs have been identified::

- The need to develop an intercultural space;
- The need to develop instruments that facilitate intercultural treatment;
- The need to improve staff qualifications, especially relating to mental health and interculturalism;
- The need to improve the integration of professionals who focus on community intervention; and
- The need to increase financial resources to sustain the complementary models.

ANNEX D

The mhGAP-IG adaptation for Community Health Workers

The mhGAP-IG has been described above, and can be found on the net for open consultation at: http://apps.who.int/iris/bitstream/10665/44406/1/9789241548069_eng.pdf

The document has been submitted to ongoing revisions. Training manuals, slide kits and video demonstrations are available, as well.

One adaptation that was of particular relevance to this meeting was the one targeting community health workers (CHWs). The corresponding set of slides is still in its draft version at WHO, but permission was granted to discuss it at this meeting.

Ahead of the meeting, representatives from Nunavut chose a few topics considered particularly relevant to practitioners in this area. The agenda was to present these sections not as a training opportunity, but as a stimulus to discuss their relevance and applicability, and consider their possible uses.

What follows is a description of these sections of the draft mhGAP-IG adaptation for CHWs.

Roles and responsibilities of the community health worker

Firstly, there was a discussion about the role of CHWs in Nunavut, as a starting point to establish the relevance of this version of the mhGAP-IG. It was followed by another rich discussion on what CHWs do, how they interact with the healthcare system, and on their role in detection and follow-up of people with mental health problems. This naturally led to a more specific discussion on the various roles, as prompted by several sections of the tool.

General principles of care

The mhGAP is important in that it highlights general principles of care for people with mental disorders: a) a positive and non-judgmental attitude towards the individual and his/her issues; b) an ability to "listen actively" and to observe over time; c) advocating for the person suffering; and d) ensuring a clear and respectful approach. These are all critical for a good relationship between the community health worker and the individual seeking care.

Establishing communication and building trust are important for the different roles community health workers play. Maintaining confidentiality and privacy are particularly important for mental health issues and should be given high value. One important reason for maintaining confidentiality and privacy is stigma. Stigma is defined as a "mark of shame, disgrace, or disapproval, which results in an individual being shunned or rejected by others". It is not uncommon for individuals with mental disorders to be perceived within their community as weak, inferior, inhuman, or dangerous because of their symptoms. This view of the suffering person, reflected back to them, in turn causes many to feel worse about themselves and about their illness. As a result of stigma, these people not only feel excluded, they actually are, or alternatively they exclude themselves.

Another important key action for community mental health workers to think about is helping individuals to feel comfortable when they start seeking care for mental disorders. This section

was adapted in the mhGAP from WHO's publication "Psychological First Aid: Guide for Field Workers" (WHO, 2011).

It is important to note that individuals with mental disorders have the same human rights as anyone, including the right to be treated with dignity and respect; the right to give permission or deny referral, treatment and follow-up; and the right to access to timely and effective services. Community health workers play an important role in encouraging individuals to seek help, protecting their human rights, and reducing stigma in the community.

Suspecting mental disorders

The mhGAP training helps trainees understand what different types of mental disorders might look like and to be able to suspect when someone has a mental health issue. After the training, trainees will be able to understand, detect and treat mood problems and sadness; bizarre behaviours and thoughts; drugs and alcohol problems; developmental delay; problem behaviours; convulsive movements or seizures; extreme forgetfulness and confusion; self-harm and suicide.

Mental disorders appear with a broad range of problems and various presentations. They are a combination of abnormal thoughts, emotions, behaviours and, often, relationship issues with others. Mental disorders can affect anyone and are common. What is important to note is that they can be treated. Knowing this, helps people maintain hope and avoid hiding away and refraining from treatment.

Mental health is determined by many factors including:

- Genetic and biological factors, such as chemical imbalances in the brain;
- Social factors, such as stigma, discrimination, poverty; and
- Psychological factors, such as severe stress, abuse and trauma.

This means that mental disorders are not contagious and can affect anyone.

Referring to primary health care providers

Community health workers often worry about under- or over-detecting mental disorders. This section provides general guidelines to help CMWs understand the significance of changes compatible with a mental disorder and decide whether to refer or not. The mhGAP will allow CMWs to understand when they should refer the individual with mental health problems to primary health care providers. CMWs play an important role in referring individuals to primary health care professionals if they suspect that an individual has a mental disorder. They can provide basic information about mental disorders, that they are common and can affect anyone, and that treatments can help. Such information can encourage people to seek the help they need.

Referrals can take place in different ways:

- By phone or by accompanying the individual to a primary health care clinic or general hospital; and/or
- By writing a letter or email to the primary health care provider to explain the individual's situation.

It is important to remember that before the primary health care provider is contacted, it is essential to make sure that the individual's permission is obtained. When referring an individual to a primary health care provider, it is recommended to carefully observe and take notes of symptoms that might be affecting his/her mental health.

Follow-up and support

The mhGAP teaches community health care workers that they have two very important roles in follow-up and support of people with mental health issues:

- Practical support: providing basic information about mental health; helping people get to a clinic; and offering help around the individual's home.
- Emotional support: listening non-judgementally; showing trust and compassion; encouraging people to seek help, adhere to treatment and live a healthy lifestyle.

It is also important to keep in mind that community health workers can provide support for caregivers and families who are overwhelmed or stressed. Some challenges that caregivers might face are:

- Caregivers may also experience stigma and discrimination;
- Caregivers may not be able to go to work or school due to their caregiving responsibilities;
- Caregivers may spend time and finances on medications or cures from traditional healers and travelling to medical clinics or hospitals; and
- Caregivers may experience stress and anxiety resulting from the responsibilities of care giving.

Linking to resources

The mhGAP mobilizes community health workers to help individuals identify and access resources in their respective communities. More specifically, the mhGAP allows trainees to consider how to make effective links with other resources.

Even if there are resources in the community, there may be barriers that prevent the individual from accessing these resources. These can include stigma, discrimination, transportation, misconceptions, access, motivation, fear, time, support, coping level, among others. Simple but effective ways of helping include making a phone call for an appointment, or writing a note for connecting patients to a staff member or community health worker escort, and working with family members and caregivers.

After providing or suggesting a resource, follow-up is important. It may be useful to ask about and discuss any barriers. Overcoming these barriers not only empowers the person and their families/caregivers, but also facilitates actually receiving care. Resources that are available in the community and barriers to accessing these resources constantly change, so it is important to be aware of these changes.

Advocacy

Community health workers have a powerful role at this level, which can have a large impact in the community, especially for people living with mental health issues. This power is stressed in the mhGAP, and rightly empowers non-specialized health care workers to see to it that mental health problems are effectively treated in a timely manner.

Strategies for promoting the inclusion of those with mental disorders, their families, and their caregivers in the community include:

- Openly talking about mental disorders and providing accurate information about mental disorders to those in the community;
- Working with community and religious leaders, local administrative staff, teachers, criminal justice system, and traditional healers;
- Helping those with mental disorders share their stories; and
- Not talking about individuals with mental disorders in negative ways, and discouraging others from doing so.

Self-care

As a community health worker, one may experience challenges and responsibilities that are stressful. Maintaining one's own wellbeing is not only important, but it will also enable community health workers to work more effectively and more consistently.

The mhGAP highlights some common signs of stress, which could indicate that the community health worker's wellbeing is affected. These include:

- Difficulty sleeping or concentrating;
- Feeling irritable or impatient;
- Feeling aches or pains;
- Increased use of alcohol or other substances; and
- Difficulty relaxing or having fun.

The Psychological First Aid: Guide for Field Workers (WHO, 2011) outlines the following healthy work habits, which contribute helping CMWs remain mentally healthy :

- Acknowledge even the small ways in which you helped others;
- Be kind to yourself, remember that you are not responsible for solving all of people's problems;
- Accept what you did well, what did not go well, and the limits of what you could do in the circumstances;
- Seek supervision from your supervisor or primary health care providers;
- Try to keep reasonable working hours and take breaks;
- Find support from other community health workers. Check in with them and have them check in with you;
- Take time to eat, rest and relax, even for short periods;
- Try to eat healthy and exercise;
- Try to minimize your intake of alcohol, caffeine and nicotine;
- Talk with friends and people you trust for support; and
- Take time to do the things you enjoy (e.g., sports, listening to music, watching videos).

ABBREVIATIONS

ALCCHS	Community health system
CHW	Community health workers
CMH	Community mental health
DALYs	Disability adjusted life years
ETOH	Ethanol
GP	General Practitioner
LA&C	Latin America and the Caribbean
LMIC	Low- and mid-income countries
MH	Mental health
mhGAP-IG	Mental health Gap Action Programme Intervention Guide
PAHO	Pan American Health Organization
PESPI	Programa Especial de Salud y Pueblos Indígenas
RCMP	Royal Canadian Mounted Police (Canada's national/federal police force)
WHO	World Health Organization

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