NDPHS Working Group on Expert Groups' Terms of Reference
Fourth Meeting
Helsinki, Finland
9 June 2010

Reference	EGTOR 4/4.8/1
Title	Proposed Terms of Reference for the NDPHS Indigenous Mental Health, Addictions and Parenting Task Group
Submitted by	Canada and the NCM
Summary / Note	The Task Group has already had its first official meeting on 24-26 March 2010.
Requested action	For endorsement

Northern Dimension
Partnership in Public Health
and Social Well-being
www.ndphs.org

NDPHS Task Group on Indigenous Mental Health, Addictions and Parenting

TERMS OF REFERENCE

As adopted by [CSR 17 in Moscow, Russia]
on [29-30 June 2010]

I. Background and Rationale

During its 6th annual conference held in Oslo, Norway on 25 November 2009, the Northern Dimension Partnership in Public Health and Social Well-being adopted a new NDPHS Strategy. The Strategy places focus on policy and strategy development, as well as coordination and project facilitation. There are four thematic areas specified by the Strategy, for each of which a number of Goals as well as corresponding mid-term Operational Targets (OTs) and indicators have been identified (cf. Annex 1).

One of the goals where the Partnership plans to take action is to improve public health and social well-being among indigenous peoples in the Northern Dimension area (Goal 11).

Thus, pursuant to the "Declaration Concerning the Establishment of a Northern Dimension Partnership in Public Health and Social Well-being" adopted by the Ministerial Meeting in Oslo, Norway, on 27 October 2003, the CSR decided at its [17th meeting in Moscow, Russia, on 29-30 June 2010] to establish the **NDPHS Task Group (TG) on Indigenous Mental Health, Addictions and Parenting (IMHAP).**

II. Objectives

The main role of the Task Group is, through the NDPHS Partners (including international organizations and national authorities) as well as its close links with health care bodies, to contribute to policy formulation and strengthening coordination of activities aimed at **facilitate and promote that public health and social well-being among indigenous peoples in the ND area are improved**. Further, the Task Group will contribute to the implementation of the Operational Targets specified within Goal 1 and Goal 11 of the NDPHS Strategy.

III. Scope of Responsibilities

The IMHAP TG will provide opportunities for the exchange of information and promising practices related to Indigenous mental health between members. It shall strive to improve mental health (including increased resiliency, self-esteem and hope), prevent addictions

(including harm reduction- and abstinence-based approaches), and promote child development and family / community health (supporting indigenous family values, structures, restoring parenting skills) among Indigenous people through:

- Focusing on Goal 11 as specified in the NDPHS Strategy through the implementation of the Operational Target 11.1 of the Strategy. The outcome of action will be monitored through Indicator 11.1A as described by the Strategy;
- Fostering collaboration on social inequalities in population mental health;
- Identifying opportunities for collaboration with other Task and Working Groups within NDPHS;
- Initial planning for a work plan includes the following key activities:
  - Best Practices for Indigenous people parenting and associated counselling skills;
  - Development of common indicators for Indigenous mental health services;
  - Telemedicine: how this can benefit and enhance Indigenous people's mental health services;
  - Kick-off conference: A two day kick off conference that will invite relevant experts on indigenous people and health to further develop proposals for concrete joint action and pilot projects based on the three prioritised areas mentioned above;
  - Producing fact sheets / diagnostic of mental health status (Sámi, Inuit, First Nations, others) with a focus on these priority areas.

By end of 2010, the IMHAP Task Group will have developed a work plan which will clearly specify steps to be taken towards: (i) improving mental health, (ii) preventing addictions, and (iii) promoting child development and family/community health among indigenous peoples. The work plan will be implemented by 2013.

The official language of the Task Group is English.

IV. Timeframe

The mandate of the Task Group is valid until the end of 2013.

V. Lead Partner and co-Lead Partner

The Task Group will be led by Canada and co-led by Nordic Council of Ministers. The role of the Lead Partner and co-Lead Partner is to initiate and jointly lead the Task Group's activities.

In the case that the Lead Partner or the co-Lead Partner decides to step down, prior to its resignation, it should inform the CSR of its intentions and propose a replacement. Accordingly, the CSR will decide whether to approve the proposed replacement, as appropriate.

VI. Composition of the Task Group

1. Chair and Vice Chair

The Task Group shall elect its Chair and Vice Chair from the individuals nominated (the Lead Partner has a privilege of proposing the Chair of the Task Group). In doing so, it is responsible for keeping the CSR and the NDPHS Secretariat informed of its decision.

The Chair is responsible for providing effective leadership concerning the Group's overall scope of responsibilities spelled out above. In addition, the Chair is responsible for:

- Ensuring that the Task Group meets at appropriate intervals, and that the minutes of meetings and any reports to the Partnership bodies accurately record the decisions taken and, where appropriate, the views of individual Task Group representatives;
- Ensuring that the Task Group reaches clear conclusions on the matters it discusses;
- Ensuring that the views of the Task Group are passed on to the CSR, PAC and the Secretariat;
- Briefing new representatives upon their appointment, as appropriate.

In the event that the Chair can no longer perform his/her duties, the Vice Chair shall serve as Interim Chair pending the election of a new Chair. In the event that both the Chair and Vice-Chair no longer hold their positions, a Task Group Lead Partner representative shall serve as the Interim Chair pending the election of a new Chair and Vice Chair.

2. Coordination of the Task Group

The Lead Partner shall ensure proper coordination of the Task Group. The CSR and the NDPHS Secretariat shall be kept informed of the Task Group's decisions.

The coordination, which shall be performed by a Lead Partner representative, shall ensure that all of the activities described in the Task Group's mandate are performed, as appropriate. In addition, he or she shall be responsible for:

- Preparing provisional meeting agendas, meeting documents, and preparing the minutes from the Task Group meetings as well as periodic progress reports;
- Keeping the representatives of the Task Group informed on a regular basis about the progress of activities;
- Maintaining dialogue and cooperation with the NDPHS SIHLWA EG (Social Inclusion, Healthy Lifestyles & Work Ability) to ensure the co-ordination and mutual support between other Task Groups related to Thematic area 4: Lifestyle-related non-communicable diseases and good social and work environments;
- Maintaining dialogue with the NDPHS Secretariat to ensure the co-ordination of activities within the Partnership;
- Encouraging the involvement of external actors in the Task Group's work.

3. General Representation and Participation

General representation within the Task Group shall consist of high-level experts in the field, including from the administrative sector, from the research community as well as from relevant NGOs. These high-level experts shall be appointed to the Task Group by the interested Partner Countries and Partner Organisations.

In appointing representatives to the Group, the Partner Countries and Organisations will be guided by the following requirements for nomination of experts:

- High level expertise in the field covered by the Task Group;
- Experience in networking and reaching out to individuals and groups of scientists familiar with the regional aspects;
- Experience in project facilitation and assessment
- Ability to actively take part in and contribute to the Task Group work (both during meetings and in-between them).

Before nominating its representative(s) to the Task Group, the nominating Partner Country or Partner Organisation will ensure that the nominated expert(s) will have covered his/her/their travel and other expenses related to the participation in the Task Group meetings.

If a Partner Country or Partner Organisation decides to change its appointed representative(s), it should inform the Task Group Chair and the NDPHS Secretariat immediately.

In addition to the appointed Partner Country and Partner Organisation representatives, the Task Group is entitled to invite external actors, i.e. other “eligible participants” and “interested parties” as defined in the Oslo Declaration, to be involved in the work of the Task Group.

VII. Meetings

The Task Group shall hold meetings per year as considered necessary and appropriate. The location of meetings will rotate based on the interest expressed by the Partners. When appropriate and feasible, the Thematic area 4: Lifestyle-related non-communicable diseases and good social and work environments Task Groups aim to coordinate their meetings together at the same time and place to facilitate synergistic benefits. However, it is to be expected the Task Group will need to have additional meetings, video- and telephone conferences, field-visit and other forms of working contacts in-between the SIHLWA EG meetings.

The NDPHS Secretariat has the right to attend and submit documents to the Task Group’s meetings, as well as to intervene during these meetings.

Except as otherwise herein stated, the Task Group will determine its own methods of work, including the preparation of agendas, the keeping of records and other procedures.

VIII. Coordination, Supervision and Financial Aspects

The CSR is responsible for supervising the work of the Task Group.

As the Partnership cannot bear the travel and other costs related to Task Group representatives’ participation in Task Group meetings, all expenses incurred by the representatives to attend Task Group meetings will be covered by their respective countries or organisations. Costs for holding meetings will be borne by the host country unless otherwise agreed.

Notwithstanding the above, individual Partner Countries or organisations may provide voluntary support for the attendance of a participant at Task Group meetings, if sufficient funds are available.

The Lead Partner shall provide financial support to the Task Group to aid its activities.

IX. Decision Making and Reporting

The Task Group is answerable to the CSR and PAC. To this end, it will provide feedback and report to the CSR, as well as PAC, as necessary.

The Task Groups relationship to SIHLWA EG is not a subordinate one, but aims to be a cohesive link with other Task Groups working on closely related topics. SIHLWA EG provide logistic advice and helps in disseminating the results and seeks for additional support for project funding opportunities

The Task Group, supported by the Chair, will prepare an annual Progress Report in accordance with the reporting rules adopted by the CSR as well as a draft Activity Plan for the following year, both to be submitted to the autumn CSR or PAC event.

A final report shall be made available in due time before the PAC in 2013. This report should reflect activities having been undertaken by the Task Group towards achieving the respective Goal and its Operational Targets.

Decisions within the Task Group shall be reached by consensus.

The outcomes of IMHAP Task Group meetings shall be documented in the meeting minutes and published on the NDPHS website. The Task Group will ensure that all decisions are communicated to the NDPHS Secretariat and other Partnership bodies, as appropriate, and that the Secretariat will be included as a recipient of all meeting documents and other relevant documents that are circulated to its representatives.

X. Relationship with other NDPHS Groups

The Task Group shall seek, when appropriate, to establish and maintain collaborative relationships with other Groups on cross-cutting Operational Targets and other issues included in the NDPHS Strategy, which are of immediate relevance to the Task Group's scope of responsibilities. In case of IMHAP TG, special collaborative arrangements will be arranged and maintained between the other Task Groups active on Thematic area 4: Lifestyle-related non-communicable diseases and good social and work environments (Goals 7-10) through the help and coordination of **NDPHS Expert Group (EG) on Social Inclusion, Healthy Lifestyles and Work Ability (SIHLWA**).

XI. Amendments to the Terms of Reference

These Terms of Reference can be amended, when deemed necessary. Proposed amendments shall be co-ordinated with the NDPHS Secretariat and approved in the Group before being submitted to the CSR for possible adoption.

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NDPHS Goals, Operational Targets and Indicators

Adopted during the Sixth Partnership Annual Conference (PAC)
25 November 2009, Oslo, Norway

Introduction

This document specifies the NDPHS goals and, linked to them, the operational targets and indicators adopted during the 6th Partnership Annual Conference (PAC) on 25 November 2009. They are meant to be an effective tool for the Partnership to ensure progress toward its mid-term vision adopted during the same PAC and have been divided into (i) an overall goal and operational targets, and (ii) goals and operational targets for thematic areas.

When justified and necessary, within the limits consistent with the EU Strategy for the Baltic Sea Region, the operational targets can be modified by the CSR based on the outcome of the *ad hoc* Working Group on NDPHS Expert Groups' Terms of Reference.

The Partnership's mission is to promote sustainable development of the Northern Dimension area by improving peoples' health and social well-being. The adopted overarching **goals** are what the Partnership should strive to achieve, either independently or as one of many actors in the ND area. The latter can be done either together with other organizations or by the Partnership alone.

The **operational targets** are specific, measurable and time-targeted objectives that should be achieved by the Partnership on its own or with the involvement of other actors during 2010 – 2013.

For each operational target at least one **indicator** is included, meant to serve as a tool for monitoring the accomplishment of that target by the Partnership and the overall progress towards the respective goal.

1. Overall goal, operational targets and indicators

Goal 1: The role and working methods of the NDPHS are strengthened

Operational target 1.1: By 2013, international/regional, national, sub-national and local health authorities or other actors have recognized the NDPHS as a renowned source of knowledge and expertise in the region and contacted it for cooperation and/or advice in their own planned activities (at least two actors from each level).

Indicator 1.1A: Number of actors per each of the abovementioned levels who have contacted the NDPHS for cooperation and/or advice.

Operational target 1.2: Social well-being aspects are systematically and concretely included in the work of the NDPHS including, but not limited to its Expert Groups.

Indicator 1.2A: The percentage of NDPHS activities (projects, policy papers) including social well-being aspects out of the total number of respective NDPHS activities in a given period of time.

Operational target 1.3: By 2013, external expertise is involved in the NDPHS policy development. This will be achieved through, *inter alia*, identifying relevant actors and subsequently approaching them with an invitation to take part in the Partnership policy development as well as project development and implementation. Activities will be undertaken to promote the establishment of cooperation frameworks, such as partnerships involving national, local and sub-regional actors and expert networks (e.g. universities, hospitals and prisons). In this way the NDPHS will be able to

promote practical cooperation contributing to its own goals through activities run beyond its institutional framework.

Indicator 1.3A: Number of organizations and/or authorities, not currently participating in the NDPHS, involved in NDPHS policy development.

Operational target 1.4: By 2013, external expertise (especially of relevant national, sub-national and local actors in the area of public health and social well being, when available) is involved in the NDPHS project development and implementation.

Indicator 1.4A: Number of external organizations and/or authorities involved in NDPHS project development and implementation.

Operational target 1.5: By 2013, the regional dimension of the NDPHS is further developed among other things by facilitating projects involving partners from more than only two countries.

Indicator 1.5A: Number of projects facilitated by the NDPHS which involve regional cooperation (partners from more than two countries are involved).

Operational target 1.6: By 2013, new sources of funding, such as EU programmes and private funds, are mobilized.

Indicator 1.6A: Number of projects funded completely or partly by new sources of financing.

Indicator 1.6B: Percentage of funding raised from new sources of financing out of the total raised project funding.

Operational target 1.7: Relevant international projects are included in the NDPHS Database for improved coordination and facilitation.

Indicator 1.7A: Number of new projects added to the NDPHS Database.

2. Goals, operational targets and indicators for thematic areas

The NDPHS goals and operational targets for thematic areas are closely aligned with the EU Strategy for the Baltic Sea Region. This is so considering that **the NDPHS has agreed to take the Lead Partner role for the Health priority sub-area in the EU Strategy for the Baltic Sea Region adopted by the European Council on 29-30 October 2009.**

Subject to further considerations and agreement, the NDPHS needs to make proper arrangements now to be able to play the above role, and the reflection of the above in the goals and operational targets is meant to be the first step.

At least one strategic project will be implemented for each thematic area by the NDPHS or other actors in the area.

- **Thematic area 1: Containing the spread of HIV/AIDS and tuberculosis**

Disparities in morbidity and mortality related to communicable diseases such as HIV/AIDS and tuberculosis will have been addressed by the NDPHS through the achievement of the following:

Goal 2: Prevention of HIV/AIDS and related diseases in the ND-area has improved

As part of its efforts to contribute to the above-mentioned goal, the NDPHS will develop a project by 2011 that involves relevant stakeholders in the region and pays proper attention to the penitentiary system. This project will be implemented by 2014 and will aim to achieve the following:

Operational target 2.1: Reinforcing policy recommendations covering the above-mentioned goal.

Indicator 2.1A/B: Number and coverage of projects facilitated by the NDPHS that contribute to reinforcing policy recommendations in the above thematic area.

Indicator 2.1C: Number of policy documents developed by the NDPHS in the above thematic area.

Operational target 2.2: Geographical areas in urgent need of further local or regional projects are identified, and partners to be involved in these projects are recommended.

Indicator 2.2A/B: Number of geographical areas and number of partners that have been involved in the projects facilitated by the NDPHS.

Operational target 2.3: A best practices document covering the above-mentioned goal, to be used in further local or regional projects, is developed. The document will: (i) collect and disseminate the best practices on effective comprehensive HIV/AIDS prevention interventions and MDR TB management, (ii) evaluate and compare various intervention strategies feasible for the NDPHS region, and (iii) document and share research and evaluation results.

Indicator 2.3A: A jointly-developed best practices document is in place.

Required expertise on the NDPHS side: Expertise currently available in the HIV/AIDS EG and the PH EG is required. Expertise regarding social matters is additionally required.

Goal 3: Social and health care for HIV infected individuals in the ND area is integrated

Operational target 3.1: By 2011, evidence-based experiences and best practices on integration of social and health care services for HIV-infected individuals are shared among the partner countries. Special emphasis will be placed on coverage of the most vulnerable population groups.

Indicator 3.1A: A review reflecting the best practices has been published.

Required expertise on the NDPHS side: Expertise currently available in the HIV/AIDS EG and PHC EG is required (PH EG expertise could also be required). Expertise regarding social matters is additionally required.

Goal 4: Resistance to antibiotics is mitigated in the ND area

Through its partners, (including international organizations and national authorities) as well as its close links with health care bodies, the Partnership will contribute to policy formulation and strengthening coordination of activities aimed at counteracting the increasing resistance to antimicrobial agents. Where feasible, co-operation with the veterinary side should be sought.

Operational target 4.1: By 2012, the existing networks working on the above-mentioned goal are strengthened (steps are also taken to encourage the creation of the efficient surveillance of antimicrobial resistance and antibiotic consumption, with comparability between countries).

Indicator 4.1A: Number of new members added to the existing networks.
Indicator 4.1B: Increase in activity of the existing networks measured by conferences and trainings implemented.

Operational target 4.2: Series of trainings for professionals are organized, aimed to strengthen their capacity to help mitigate antibiotic resistance.

Indicator 4.2A: Number of trainings successfully implemented, including all of their components.

Required expertise on the NDPHS side: Expertise currently partly available in the HIV/AIDS EG and PHC EG is required.

- **Thematic area 2: Accessibility and quality of primary health care**

The NDPHS will have contributed to the improvement of access to and quality of health services through the achievement of the following:

Goal 5: Inequality in access to qualified primary health care in the ND area is reduced

As part of its efforts to contribute to the above-mentioned goal, the NDPHS will develop a regional flagship project by 2011 fighting health inequalities through improvement of primary health care and reducing inequalities in access to qualified primary health care. This project will be implemented by 2014 and aim to achieve the following:

Operational target 5.1: Differences in the accessibility and quality of primary healthcare in the ND region are assessed. Organization of primary health care in different countries and regions within the countries will be assessed as too how it fulfils core characteristics of a good PHC system: First contact, accessibility, continuity, comprehensiveness, coordination, and family and community orientation.

Indicator 5.1A: A report outlining the differences in the accessibility and quality of primary healthcare in partner countries and recommending further actions is developed.

Operational target 5.2: Mechanisms for promoting an equitably distributed and good quality primary care system, which corresponds to changing society health needs

and increases the cost efficiency of the overall public health systems in the region, are defined.

Indicator 5.2A: A jointly developed paper presenting the population health care needs and deployment and mobility of primary health care professionals in the ND region is in place.

Indicator 5.2B: A position paper on tomorrow's role of primary health care professionals in the context of changing society needs is in place.

Indicators 5.2C: Jointly developed recommendations for education and professional development of primary health care teams with particular attention to PHC nurses, patient empowerment and tools to increase the role of patients (in self-management) and community (in solving priority health problems) are in place.

Indicator 5.2D: Models of best practices in different countries are demonstrated and policy conclusions for dissemination are in place.

Operational target 5.3: Regarding the health of parents and their children, a symposium on babies with extremely low body weight is organized in 2010 and a conference on prenatal diagnostics in 2011.

Indicator 5.3A: Both the symposium and the conference are organized.

Operational target 5.4: By 2013, the advantages of e-health technology are better known and appreciated by policy makers and healthcare professionals.

Indicator 5.4A: Result of survey implemented among those from the target groups.

Required expertise on the NDPHS side: Expertise currently available in the PHC EG is required. Also, for the implementation of the Operational target 5.3 the expertise currently available in the SIHLWA EG is required. Expertise regarding social matters is additionally required.

- **Thematic area 3: Prison health care policy and services**

The NDPHS will have contributed to the number of changes towards improvement of inmates' health care, and condition of imprisonment and promotion of gender-sensitive prison policy through the achievement of the following:

Goal 6: Prison policy in the ND area provides for that the health and other needs of inmates are readily met and easily accessed, and that gender specific needs of women and the needs of children accompanying their mothers are addressed

As a follow-up on implementation of the approaches indicated in the NDPHS Declaration on Prison Health of NDPHS, Partnership in close collaboration with national authorities and international organizations will contribute to policy formulation, and strengthening coordination of activities aimed to develop closer links or integration between Prison Health and Public Health services, and, as a consequence, developing a safer society.

Operational target 6.1: By 2011, policy recommendations on provision of health care services in the penitentiary system, which are equivalent to the standard

available in the general community, are developed. Preliminary assessment of organizational structures of Prison Health services and their influence on access to health care institutions in different Partner countries has been carried out. International seminars on Prison Health care system to share knowledge, experiences and examples of evidence-based practice have been organized, if considered necessary.

Indicator 6.1A: A report outlining the organization of Health care services in the penitentiary system in the ND region, and recommending further actions is in place.

Indicator 6.1B: Number of seminars on Prison Health care system organized.

Operational target 6.2: By 2011, a set of recommendations for a gender-sensitive prison policy aimed at meeting the basic health and welfare needs of women and children accompanying their mothers in prison, are developed and shared with relevant professionals in the ND area.

Indicator 6.2A: Complete documentation is developed and distributed to relevant professionals in the ND area.

Operational target 6.3: By 2012, a documentation of lessons learned and best practices exists, and experiences and examples of effective practice regarding women in prison and children accompanying their mothers in prison are shared at national and international seminars. The documentation is distributed to relevant professionals in the ND area.

Indicator 6.3A: Successful compilation and completion of the NDPHS recommendations with external experts.

Required expertise on the NDPHS side: Expertise currently available in the PH EG and PHC EG is required. Expertise regarding social matters is additionally required.

- **Thematic area 4: Lifestyle-related non-communicable diseases and good social and work environments**

Unequal socio-economic conditions and lack of empowerment among disadvantaged population groups play major roles in the development of non-communicable diseases (NCD). These circumstances contribute to increasing health inequities. However, policies and actions directed towards “vectors” of NCD will mitigate such health inequities. Hence, the NDPHS will have contributed to the development of comprehensive policies and actions in the entire region to prevent and minimize harm from tobacco smoking, alcohol and drug-use to individuals, families and society (especially young people) through the achievement of the following:

Goal 7: The impact in the ND countries on society and individuals of hazardous and harmful use of alcohol and illicit drugs is reduced

Operational target 7.1: By 2012, the Partnership will have developed a regional flagship project on alcohol and drug prevention among youth in cooperation with relevant actors and consistent with the provisions of the EU Strategy for the Baltic Sea Region’s Action Plan.

Indicator 7.1A: Project application submitted to donors for funding.

Operational target 7.2: By 2014, the above-mentioned project will have been implemented in coordination with other international actors active in this thematic area, such as the EU, the Council of Europe Pompidou Group and the WHO/EURO.

Indicator(s) 7.2A: Indicator(s) agreed by donors and implementing agencies will be used.

Required expertise on the NDPHS side: Expertise currently available in the SIHLWA EG, the PHC EG and PH EG is required.

Goal 8: Pricing, access to and advertising of alcoholic beverages is changed to direction, which supports the reduction of hazardous and harmful use of alcohol

Operational target 8.1: By 2011, the Partnership will have organized a side event back-to-back with the Baltic Sea Parliamentary Conference (BSPC) to promote parliamentarians' attention to and awareness of the impact of alcohol on society and to propose actions to be taken by national parliaments to reduce this impact and to support evidence based and cost effective preventive methods.

Indicator 8.1A: Number of BSPC parliamentarians who participated in the side event.

Indicator 8.1B: Number of countries represented by the parliamentarians.

Operational target 8.2: BSPC parliamentarians, as a result of the side event, will have included a plea to national parliaments in the ND area to adopt legislation aimed to limit the impact of alcohol on society in the BSPC Resolution 2011.

Indicator 8.2A: Number of countries in which BSPC parliamentarians have addressed national parliaments to limit the impact of alcohol on society.

Required expertise on the NDPHS side: Expertise currently available in the SIHLWA EG is required.

Goal 9: Tobacco use and exposure to tobacco smoke is prevented and reduced in the ND area.

Operational target 9.1: By 2012, experiences, legislation and best practices in tobacco control are exchanged through a series of seminars organized by the WHO EURO with the participation of other interested NDPHS Partners. Among the issues to be addressed are
(i) the strengthening of the national tobacco control surveillance systems in view of making them internationally comparable; and (ii) the strengthening of the use of data for the policy making. Actions to be taken will be consistent with and contribute to the implementation of the Framework Convention on Tobacco Control (FCTC) and will be run in close cooperation with the FCTC Secretariat.

Indicator 9.1A: Number of seminars organized.

Required expertise on the NDPHS side: Expertise currently available in the SIHLWA EG, PH EG and the PHC EG is required.

Goal 10: The NDPHS Strategy on Health at Work is implemented in the ND area

Operational target 10.1: By 2013, the Partner countries have implemented the agreed actions in the NDPHS Strategy on Health at Work.

Indicator 10.1A: A report on the implementation of the Declaration is in place.

Indicator 10.1B: Actions included in the Strategy are evaluated country by country.

Required expertise on the NDPHS side: Expertise currently available in the SIHLWA EG is required.

Goal 11: Public health and social well-being among indigenous peoples in the ND area is improved

Operational target 11.1: By 2010, the Partnership will have developed a work plan which will clearly specify steps to be taken towards: (i) improving mental health, (ii) preventing addictions, and (iii) promoting child development and family/community health among indigenous peoples. The work plan will be implemented by 2013.

Indicator 11.1A: A jointly-developed work plan addressing the above issues is in place.

Required expertise on the NDPHS side: If a Working Group on Indigenous Mental Health, Addiction and Parenting (IMHAP) is established with interested member countries, it should be responsible for the achievement of the above. It should also be carefully coordinated with the Arctic Human Health Expert Group (AHHEG).