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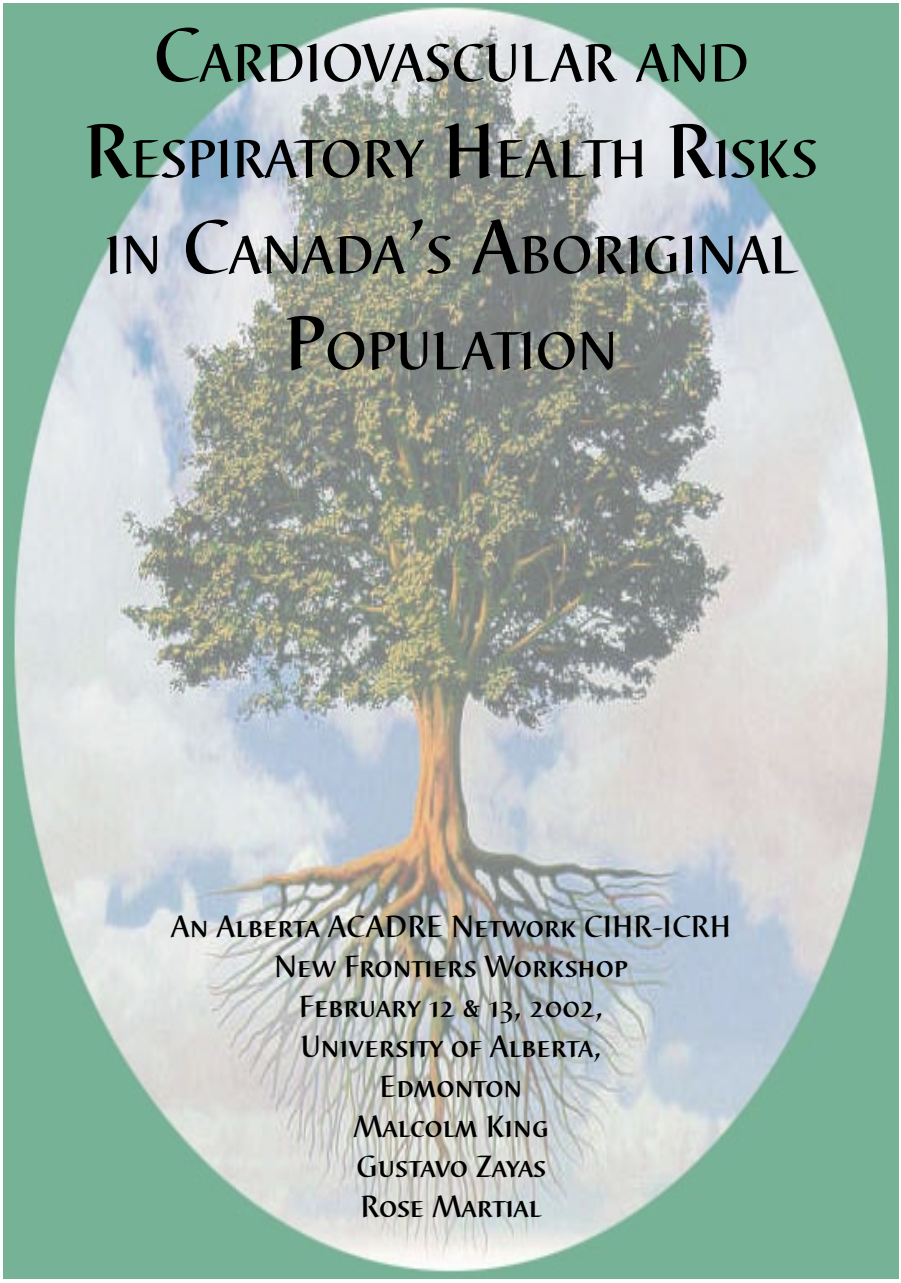


Cardiovascular and Respiratory Health Risks in Canada's Aboriginal Population

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Cardiovascular and Respiratory Health Risks in Canada's Aboriginal Population



An Alberta ACADRE Network CIHR-ICRH
New Frontiers Workshop
February 12 & 13, 2002,
University of Alberta,
Edmonton

Malcolm King
Gustavo Zayas
Rose Martial

Acknowledgements

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Thanks to all the speakers. Special thanks to Gustavo Zayas for leading the development of the proposal, to Rose Martial for guiding the discussions, and to Brenda Cameron for her leadership in the follow-up to the workshop.

Introduction

A workshop on Cardiovascular and Respiratory Health Risks in Canada's Aboriginal Population was held at the Telus Centre, University of Alberta in Edmonton, Canada, on February 12-13, 2002. A follow-up meeting was held on March 7. The workshop was organized by the University of Alberta's recently established ACADRE Network for Aboriginal health research training and funded by the New Frontiers Program of the Canadian Institutes of Health Research (CIHR) and the Heart and Stroke Foundation of Canada.

The invited participants included community members, Elders, health care providers and researchers. Their common purpose was to develop an agenda for healing, that is for restoring, cardiovascular and respiratory health in Aboriginal communities.

The Idea

In May, 2001, before the Alberta ACADRE Network existed, the Canadian Institutes of Health Research and the Heart and Stroke Foundation offered funding for workshops on cardiovascular and respiratory health in Canada. We wanted to bring together a group of people to talk about cardiovascular and respiratory health risks in Aboriginal peoples. A working group was established in the Faculty of Medicine and Brenda Cameron, from the Faculty of Nursing, and a couple of students were invited to join us. We had an Aboriginal medical student and one of Korean descent. They were both very interested in the topic of smoking in youth and thought they could contribute something. With only a few weeks to develop the grant proposal and submit it, we started to work up the ideas on a workshop on cardiovascular and respiratory health in Aboriginal people. A lot of the ideas came from Gustavo Zayas, who comes from El Salvador. He had some valuable experience with Community Participatory Research. So he brought a lot of the key original ideas in it to give people an overview of the topic from experts in the field. Gustavo used the metaphor of the tree with its roots, its branches, its trunk, its leaves to represent four levels of applicability: systemic, community, family, individual, plus the idea that all levels — the whole tree — might be affected. The workshop was an introduction to Participatory Action Research.

The Plan

Once the grant was approved, we began to organize the workshop. We started with the idea of eight facilitators — thinking we would move from

the plenary sessions to discussions in four groups with two facilitators each. About two weeks before the workshop, we had a training session for the facilitators. A number of the facilitators were students. One facilitator was Rose Martial, a Community Health Representative who had rather more workshop facilitation experience than we realized. We showed them the concept of the tree and the Medicine Wheel in order to suggest ways of presenting the material. Then Rose got up and put both the ideas together with great clarity. It was an important process for the success of the New Frontiers Workshop itself. We discovered Rose's great interest in and involvement with urban Aboriginal health, both as a trained Community Health Representative and as an individual.

By the time of the facilitators' workshop, the ACADRE grant application had also been successful. We made the New Frontiers Workshop the first official activity of the new Alberta ACADRE Network.

To publicize the event, we used the official pathways that were familiar to us as academics: the health directors for community organizations, sending a letter to almost every band in Alberta. A lot of those letters probably ended up on someone's desk or directly in the recycle box because they didn't know about us. Those who came did so because the topic was important to them.

There was also some word of mouth communication, as we went about our regular jobs. Brenda Cameron was placing nursing students at the Yellowhead Tribal Council and spoke to people there about the workshop. A nurse, who came from the Treaty 8 region of the province, said "Well, we didn't know really what this was about, but we thought we'd better come. It is an important topic for the health of our people. We thought we'd better come and check it out."

Purpose of the Workshop

The primary theme of the workshop was "improving the health status of Aboriginal people" and the secondary theme was "building human capacity." An important difference of this workshop was our intention of asking community people who were not researchers to participate. Research is important, but there is a difference between intellectually understanding the need to improve health status and living with that need. We wanted the community people who live with the need to decide what health issues *they* considered important, to develop strategies to deal with them, and to form working groups to develop an action plan and carry it forward.

The specific objectives of the workshop were to:

1. collect information that would be useful to
   a. the Institute of Circulatory and Respiratory Health, the Institute of Aboriginal Peoples' health and other interested CIHR institutes,
   b. funding partners and voluntary agencies, and
   c. Health Canada
2. sensitize and educate scientific and lay communities
3. establish working groups to address specific issues
4. formulate and design research protocols
5. prepare grant applications
6. form action groups

There were private conversations with academic colleagues before the workshop to let them know that this was going to be a different workshop than they usually had. They were invited to be part of a discussion circle afterwards and several of them did that. The condition was that we went around the circle in our turn and they had to take their turn with everybody else. That's often a new experience for academic people in a community meeting. They were all cautioned not to be prescriptive about what they thought ought to be the strategies. This to be a vital element of community participation research. It is a temptation, even common practice, for academics and health professionals, as "experts" to identify smoking, or exercise, or diet as the number one health issue. We didn't want our colleagues to be the "experts." It could only be community participation research if the identification of important issues came from the community people. Our colleagues still contributed their thoughts, but they didn't — as they normally might have done at such a conference — give their opinions more weight. That made a big difference to the outcomes.

Organization of the Workshop

At plenary sessions held at the beginning of each day, guest speakers from a variety of disciplines provided information and different perspectives about:

1. the magnitude and current status of cardiovascular and respiratory problems among Aboriginal people;
2. risk factors and concurrent problems such as diabetes, nutrition and smoking;
3. ethical issues in conducting research in Aboriginal communities;

4. the value of partnership with the communities in addressing health problems.

Information was also provided about interventions that have been implemented, and the reasons for their success or failure.

It was recognized that everyone would agree with some of the facts and evidence presented but not necessarily with all of them. Some evidence is controversial or not universally accepted, and some may be biased by the perspective of the reporters. The goal was to present First Nations perspectives as well as academic ones.

The rest of the time was devoted to group discussions that focused on:

1. problems and risk factors,
2. solutions or remedies and
3. interventions (preventative or restorative).

The concept of the tree and the four levels of impact didn't work entirely in the way we thought it would. Many things ended up in the roots of the tree, as root causes of this and that. Access to health services, for instance, was either a root or a trunk. The academic people had thought that community people would focus on problems of tobacco use or diet and nutrition — individual things which would be conceptually out in the leaves and branches of the tree — and come up with strategies. That's the way academics would do it, but that's not how it worked out.

Our four discussion groups quickly become two. Rose Martial facilitated one and Angeline Letendre facilitated the other. This meant larger groups with more than one person to record the conversations and someone to keep track of important points at the front. It taught us that effective workshops can't be planned into a fixed schedule. An agenda is a useful starting point, no more.

Perhaps it was our willingness to adjust the format to suit the participants' needs that led to a remarkable depth of sharing. Stories were told about experiences with illness, disease, and death — and the ordinary sorts of problems that academics and health care professionals hardly ever face.

For instance, it is easy to forget that the doctor-patient relationship is not one of equals. The doctor has all the authority. If you're coming in because you have a spot on the lung or bronchial constriction, they deal with that and don't ask you what difficulty you had getting to the clinic or what else is going on in your life. They don't know that you have a cousin that just committed suicide — things that happen to real people. One physician

commented afterward, "I've never really heard Aboriginal people speak about these things."

The Context

The Health Status of Canada's Aboriginal Peoples

Any assessment of the health status of Canada's Aboriginal people, whether by national or international standards, produces results that are far from acceptable. For example, the Royal Commission on Aboriginal Peoples (1996) reported that nearly all health indicators for Aboriginal people were disproportionately worse than those for the general population.

The results of a First Nations and Inuit Regional Health Survey (1999) were equally alarming. This survey, which explored health issues in an integral manner and from an Aboriginal perspective, confirmed that the prevalence of self-reported chronic diseases and their burden is increasing, with cardiovascular conditions assuming a prominent position. Respiratory conditions were less well defined, but regional studies indicated high health burdens related to asthma and chronic obstructive lung disease. The survey also explored associated risk factors such as smoking and obesity that contribute to the cardio-respiratory disease burden, and eight out of ten respondents said they were ready to solve the problem by promoting wellness in a traditional way.

The presentations made by guest speakers at this workshop confirmed and enlarged on the data presented above. One speaker described the current situation as an epidemic of health challenges. Nonetheless, the workshop was characterized by an attitude of hopefulness and willingness to begin working together to solve the problems. Participants developed a greater understanding of health issues and of ways to work towards taking an integral approach to the healing process. Clearly, an increasing number of Aboriginal people are preparing to define, manage, interpret and disseminate newly generated knowledge about their health.

The CIHR Institute of Aboriginal Peoples' Health and the Alberta ACADRE Network

The Canadian Institutes of Health Research (CIHR) was formed in June 2000 to continue the research excellence of the Medical Research Council and to translate health research knowledge for the benefit of all Canadians. In recognition of the lower health status of Canada's Aboriginal population and

its unique relationship with government, the Institute of Aboriginal Peoples' Health (IAPH) was established within CIHR to address these specific needs and issues. The IAPH's mandate covers all aspects of Aboriginal health, particularly areas where Aboriginal people are inordinately affected, from diabetes and cardiovascular disease to addictions and fetal alcohol syndrome. The initial focus of the IAPH has been on capacity building in this emerging discipline, and on establishing priorities for targeted research funding, generally in collaboration with one or more of the other 12 CIHR institutes. The strategic plan of the IAPH is being developed in consultation with the Aboriginal community, through an advisory board. In the short time since its establishment, the IAPH has initiated several important programs designed to stimulate research capacity and address critical needs in Aboriginal health research.

The Workshop Program

"Here's where we are now, but we don't need to stay there."
— Ruby Jacobs, Director of Health Services, Six Nations

Welcome, Opening Comments and Overview

The workshop was opened with a prayer by Josie Cardinal Auger and a sweetgrass and smudging ceremony. Dr. Lorne Tyrrell, Dean of Medicine and Dentistry, welcomed all the participants. Dr. Jeff Reading, Scientific Director of IAPH, provided an overview of the respiratory health challenges facing Aboriginal people.



Josie Cardinal Auger

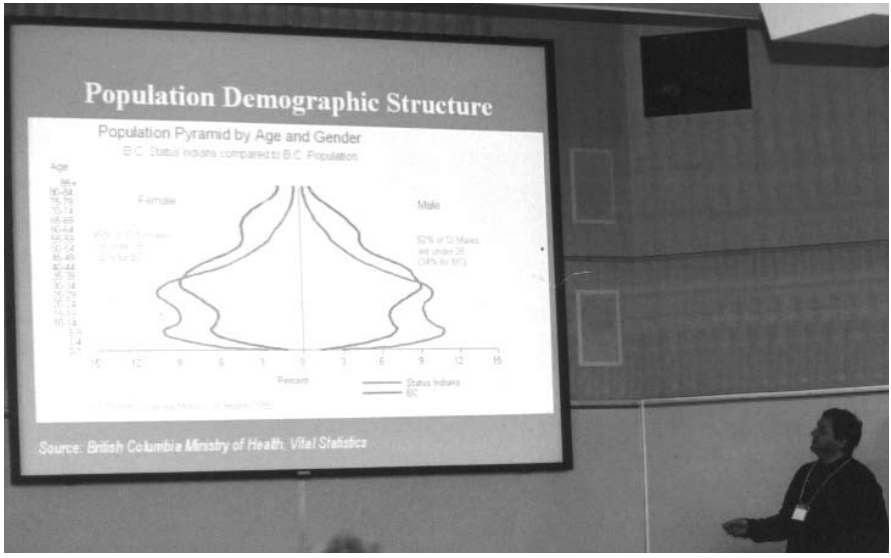


Dr. Lorne Tyrrell

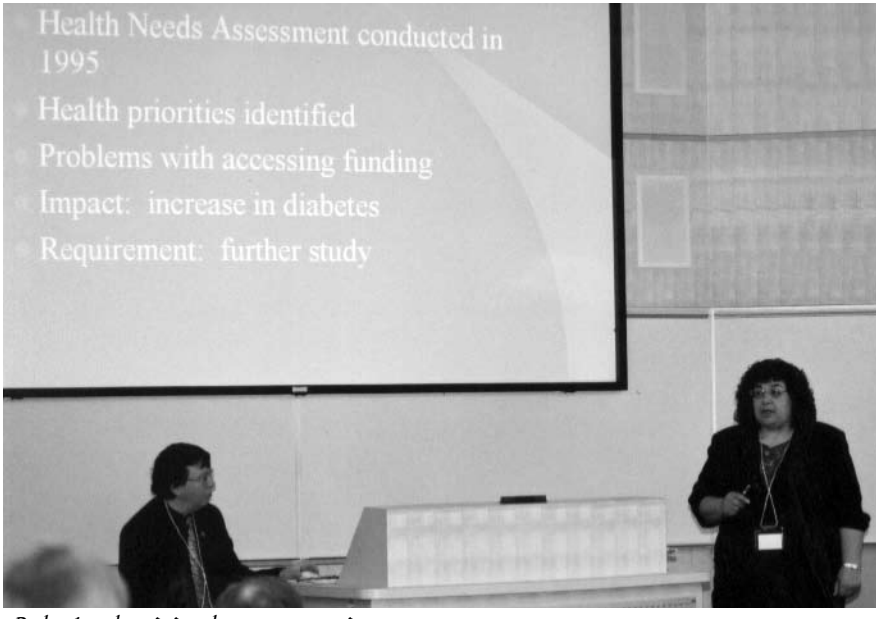
It was then Malcolm King's turn to set the tone for the two days to follow. He pointed out that the process we were using was unusual for an academic conference. We had experts to let us know what they had done, and why their work was important to respiratory and cardiovascular problems in Aboriginal people. Then people from the community would discuss the evidence presented and put it in perspective. They would work with us to develop strategies for the most important issues.

The challenge of the workshop was finding a way to translate the successes of research into improved health for the people in the communities. To

Dr. Jeff Reading's overview presentation



really achieve this goal, we need to work together — scientists and community people — to understand the important issues and develop the strategies to address them.



Ruby Jacobs giving her presentation.

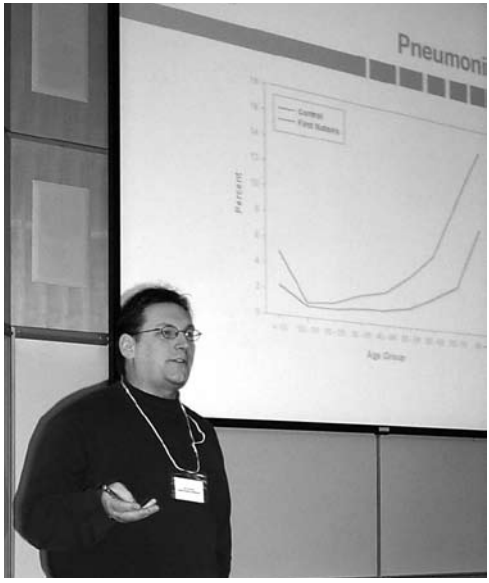
Cardiovascular Health Assessments

Ruby Jacobs, Director of Health Services, Six Nations

Ruby Jacobs showed a process of developing a community approach to understanding health. She brought up more than just statistics about cardiovascular risk factors measure by blood tests. She related the statistics to income, education and social factors. Most medical researchers don't think about those things very much. It really struck a chord with the community people who participated, because those issues kept coming up in the dialogue afterwards.

Respiratory Diseases

Larry Svenson, Alberta Health and Wellness



Dr. Larry Svenson's presentation.

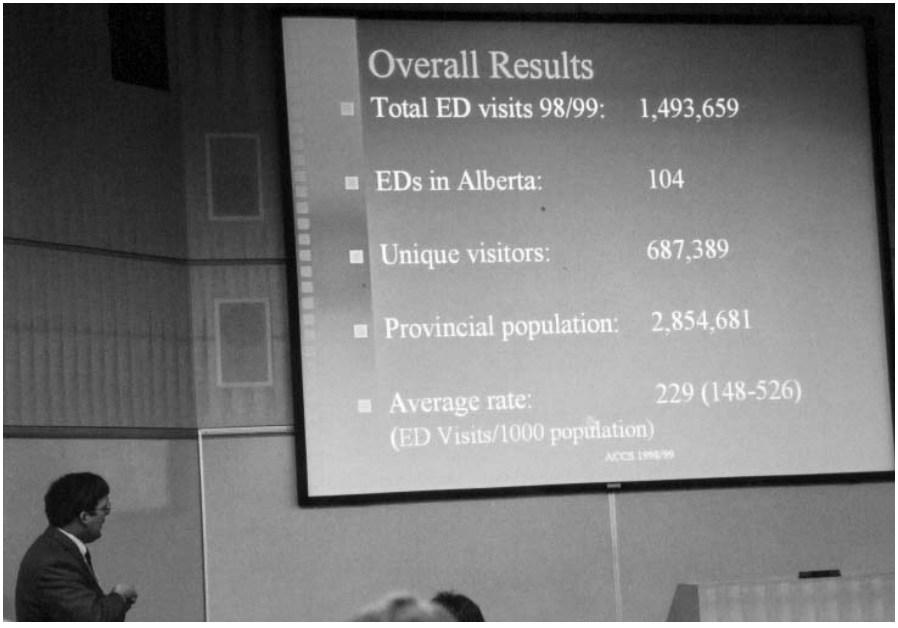
Ethics

Josie Cardinal Auger, Doctoral Candidate, Public Health Sciences, University of Alberta and Researcher, Alberta Health and Wellness

Diabetes

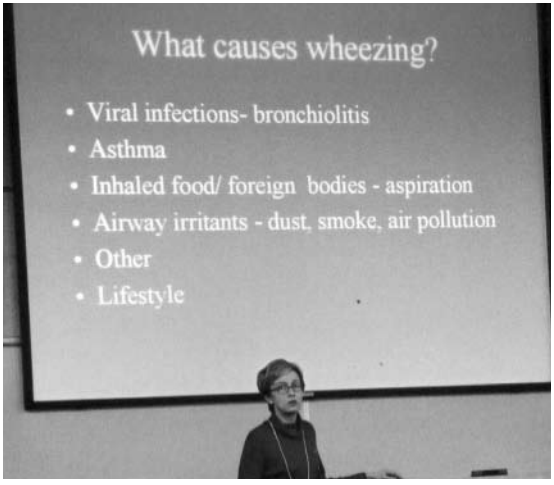
Dr. Ellen Toth, Department of Endocrinology, University of Alberta

Emergency Utilization
Dr. Brian Rowe, Emergency Medicine, University of Alberta



Dr. Brian Rowe's presentation

Childhood Respiratory Illness
Dr. Carina Majaesic, Department of Pediatrics, University of Alberta



Dr. Carina Majaesic's presentation.

Pneumonia

Dr. Tom Marrie, Chair, Department of Medicine, University of Alberta



Dr. Tom Marrie's presentation.

Community Partnerships

Brenda Cameron, Faculty of Nursing, University of Alberta



Brenda Cameron's presentation

Addiction to Tobacco
Richard Jenkins, Nechi Training and Health Promotions Institute



Richard Jenkins' presentation.

Themes Emerging from the Presentations

Each speaker responded to questions and invited comments. Various issues were explored, but the following three points seemed especially significant.

1. Although the statistics on the high level of burden of respiratory and cardiovascular disease among Aboriginal people are already disturbing enough, this burden is likely even higher than indicated because so many Aboriginal people are not receiving any medical treatment and are therefore not showing up in the databases. Access to medical treatment is definitely an issue in Aboriginal communities.
2. The ethical conduct of research among Aboriginal people is a major concern. It was suggested that the Alberta ACADRE Network engage the next generation of researchers in this question. Perhaps Aboriginal people should control the storage of biological samples taken from their group, but who would decide? What constitutes a collectivity? Is it the AFN? Certain individuals?
3. Some people wondered about how much interrelationship there is (or will be) among the different institutes of the CIHR. It was also noted that

although the CIHR budget has doubled, its mandate has quadrupled.

Group Discussions

"Anger and blaming do no good. We're past that stage and now it's time for action."
— Rose Martial, Facilitator

"There are no health care workers who are not going to be presented with Aboriginal patients."
— Workshop participant

With the help of trained facilitators, each discussion group participant was encouraged to share his or her perspective. The group was asked to reach a consensus about:

1. Problems and risk factors related to Aboriginal peoples' health.
2. Possible solutions and interventions.

During the discussion of problems and risk factors, each group was provided with a large image of a tree, and participants were asked to sort the problems/risks into categories by writing them down on cards and placing each card on a particular section of the tree. Structural (societal) problems/risks were to be placed in the roots, community problems/risks on the trunk, family problems/risks on the branches and individual problems/risks on the leaves.

The participants soon concluded that most of the problems they had identified needed to be placed in all four categories ("structure" or society as a whole, community, family and individual). They said that health relates to everything in life, and that most problems are "deep-rooted."

Some participants suggested that a model using concentric circles would be more appropriate, with the individual at the centre, then the family, then the community and finally the whole society or "structure." Others said that the tree is a good image to use because the sap goes everywhere — to the leaves, branches, trunk and roots — and suggests the inter-relatedness of every aspect of health.

Problems and Risk Factors

The long list of problems and risk factors identified during group discussions was broken into nine categories. "Communication" was identified as

an overarching category, and the other eight categories were physical health, mental health, life balance, behaviour and violence, family, community, geography/access, education and training, and economics/poverty — as presented below. Problems identified by more than one group are marked with an asterisk (*). The group also identified the level (individual, family, community and/or structural) that is *most* concerned with each problem (Table 1).

During the extensive brainstorming and deliberation that produced the list of problems and risks, participants raised many interesting ideas and provided a lot of contextual information. Members of the health community recognized that people are at risk and what they are at risk for: they are so busy "putting out fires" that they have little time for education and awareness-raising. Newsletters take time to produce, and there is some doubt that many people today are willing to take the time to read them.

Extending the Workshop

By the end of the second day, it was clear that there was more to discuss. It was quite remarkable — and another measure of how unusual this workshop was — that the participants felt strongly enough to set a date to continue the discussion. People were very passionate about the issue of Aboriginal health and the opportunity to really focus on the major, underlying causes. It was agreed to meet again on March 7, 2002.

At the second meeting, we came back to the image of the tree. Although there was some support for the idea that, just as sap flows through the tree from the roots to the leaves, so improvements in Aboriginal health were bound to come. For most people, however, the problems were still at the root level. Nothing could flow until those root problems were addressed.

The root problems — those which most needed to be addressed — were major systemic factors: income, education, housing, isolation. While the specifics of these issues varied somewhat between urban Aboriginal people and those living on reserves, the issues themselves were constant. These systemic issues, however, were all beyond the scope of any one conference. They require policy changes and point out the necessity of involving various levels of government in health concerns.

Arising from these root problems was the more practical issue of access to health care. Again, the specifics differ from urban to rural to reserve, but access itself is always a concern. The level of smoking, diet, exercise — determinants greatly favoured by academics and health professionals — were all of least concern to the community participants. The community members were

Table 1

Problem and Risk Factors	*Additional Comments*
Communication	Communication: We have to get to the bottom of the problem. Is it drugs and depression and violence, or is it figuring out who you are? One of the central issues in all areas is improving communication.
Physical Health *Nutrition: lack of knowledge and awareness, e.g., traditional dietary knowledge — Obesity; women's health issues; illnesses: diabetes, blood pressure, HIV/AIDS, hepatitis C	
Mental Health Suicide and parasuicide; Depression; Stress, good and bad; Jealousy; Low self-esteem; Lack of praise, criticism, negative feedback	*Additional Comments* Stress is a factor in the development of many diseases, including diabetes and cardiovascular disease. However, stress is not a new thing, and it can be managed, for example, by not letting a community problem become a personal problem. We should also avoid talking about stress without really knowing what it means.
Life Balance *Youth boredom — Finding a balance; Gender roles	
Behaviour and Violence *Violence; Murder — Accidents/injuries; Jail, justice	
Family Family violence; Lack of home visits; Single parent families; Foster homes outside Aboriginal communities; Lack of family-centred services	*Additional Comments* Concerns were expressed about the longstanding child welfare practice of removing children from the communities. Participants saw a need for educating young families and finding ways for children who have to be removed from their biological families to remain in the community — to be raised by Aboriginal people in an Aboriginal culture.
Community *No strategic planning Need for empowerment; Lack of community participation; Segregation of services	*Additional Comments* Various agencies have overlapping responsibilities but they are not communicating with each other. We wait for a crisis before acting; we don't work on prevention together. In most communities, a few people do all the work and many do nothing. Too many people are asking, "What do I get out of it?" or saying "It's not my job." Communities need to be accountable for the resources they receive. In most cases, the ideas and the plans have to come from the community. Funding generally comes from a higher level, but if the community is not involved, the amount of funding makes little difference.

Problems and Risk Factors	
Geography/Access	
* Migration between communities — lack of trained personnel, insufficient numbers of Aboriginal health care workers as well as health care workers in general; lack of access to appropriate health care services; lack of technical resources; the need to serve non-Aboriginal members of communities (who are not funded); lack of collaboration and data integration in service delivery planning	
Education and Training	*Additional Comments*
*Need for awareness of Aboriginal traditions (Learning from Elders) Language barriers (need for interpreters and cultural sensitivity; need for awareness of the history of Aboriginal people/Canada; need for increased knowledge among Aboriginal people about CVD risks, treatments, prevention; need for increased knowledge among Aboriginal people about health and social issues; need for a research protocol (for Aboriginal people, by Aboriginal people); need for practitioners of Western medicine to respect traditional medicine; Increased responsibility, staff shortages; overwork; no leadership, no support, lack of organization	Discussions about having Elders pass on traditional knowledge led to a discussion of what an Elder is. It was agreed that they are role models, and that they are not all the same. Some are spiritual leaders, some are teachers, some know about medicine and healing, and some are politically astute. Elders are not judgmental, they listen, they respect everyone and they speak from the heart. They help people to find their individuality as a child of the creator. One of the Elders who was present said, "To get respect, you give respect."
Economics/Poverty	
*Smoking, drugs, alcohol, addictions (gambling), sex trade — Socioeconomic burdens not addressed; Need for more money; Housing; Employment; Lack of community infrastructure and environmental issues (hospital services, sewers, etc.)	

acutely aware that healthy diet relies on income and adequate housing; exercise relies on healthy diet; smoking becomes the most easily afforded form of recreation.

From this it was clear that the issue that could be developed into an action plan by a working group was access to health care for Aboriginal people. There were a number of innovative and important initiatives discussed during this session.

One idea was having an Aboriginal person in the hospitals to meet and interact with Aboriginal patients. It was suggested that Community Health Representatives would be the ideal group to undertake this. It isn't enough to have an Aboriginal person who speaks the language and knows the culture. In order to be an accurate liaison between patient and health professional staff,

medical knowledge is also necessary. This becomes particularly important when patients are seen by resident doctors who rotate in and out of hospital departments in a matter of weeks.

Even doctors wanted to see the process continue. They spoke of the difficulties in getting medical histories from Aboriginal patients. A request for information, necessary to assess treatment options, seemed always to be received as an accusation of fault. Hearing medical people share their concerns with community people added to the impetus for the new initiative.

Out of that second day came the decision to continue the research into Aboriginal access to health care, under the leadership of Brenda Cameron, funded by the new Alberta ACADRE Network as its pilot project. As Rose Martial remarked, for the first time research on access to health service *for* Aboriginal people was going to be done *by* Aboriginal people.

Solutions and Interventions

Participants noted the complexity of the solutions to problems and appropriate interventions. Therefore, they said, in most cases solutions/interventions must be related to all levels or categories described in the tree model: the individual, family, community and society. Following is a report on recommendations that arose out of the workshop and a follow-up meeting held on March 7, 2002.

Training and Personnel

IT IS RECOMMENDED THAT *workshops be held for hospital staff (particularly staff in emergency departments) on the importance of having qualified Aboriginal people available to help with translation, spiritual guidance, etc.*

This recommendation is based on information received about large numbers of Aboriginal people going to emergency departments of hospitals for primary medical care rather than to walk-in clinics or individual physicians. Also, many health sciences workers are not culturally sensitive, and Aboriginal health workers are under-represented in these environments.

Some participants stated that various hospitals already have cultural workers, for example, the Royal Alexandra, University of Alberta and Glenrose Rehabilitation hospitals in Edmonton. An extensive program is in place at the High Prairie hospital as well.

Discussions at the March 7 follow-up meeting brought out the observation that training workshops for cultural awareness don't necessarily work

well because people don't have time for them. It is more effective to have culturally competent people simply working alongside others to answer their questions as they encounter new situations.

It was noted as well that medical staff have little training in interviewing skills, and that when working with Aboriginal patients they may feel distrust and/or misinterpret what is being said because of cultural differences. For example, Aboriginal people might give vague answers to questions about time, and this is frustrating to professionals who work under pressure to accomplish a lot in a short period of time. They give lip service to the goal of understanding Aboriginal culture, but "time is money."

12. THAT *the health services community build on existing capacity; for example, input could be sought from Community Health Representatives (CHRs) whose potential is currently being underutilized.*

One suggestion was that CHRs be invited to help with professional development activities.

13. THAT *existing health services workers (not just those who are currently being trained) be taught more about how to build relationships with Aboriginal groups and individuals.*

The example given in the discussion was activities in the Alberta Justice department designed to work more effectively with Aboriginal people, both in remote communities and in urban centres — two areas that are quite different. Again, the participants emphasized the importance of "starting from the bottom," of asking the communities to take ownership and control what happens in any such educational programs.

Dissemination and Translation of Research

14. THAT *the health system make more effort to get information to Aboriginal people about HIV/AIDS and women's health issues.*

This recommendation is based on information provided at the workshop that young Aboriginal women are the fastest-growing group of people contracting HIV/AIDS.

5 THAT *programs be set up to send students of the health sciences into Aboriginal communities to provide specific health information and advice in the area of prevention and promotion, with the communities identifying the topics they would like to have addressed.*

This activity could be set up as a project that is required in one of their courses, for example, an interdisciplinary studies course. The program might be similar to the SLICK program for diabetes that was launched at the University of Alberta this year or the "Do Bugs Need Drugs?" program, which involves medical students visiting Grade 2 classrooms in Alberta.

It was noted that the health sciences students would learn as much as — if not more than — the people they are targeting. One participant said, "There are no health care workers who are not going to be presented with Aboriginal patients."

The group emphasized strongly the importance of giving ownership of these projects to the Aboriginal communities. As well, every activity that takes place in an Aboriginal community needs to have the approval of the chief and council.

Opportunities for Innovation

6 THAT *a pilot project be conducted on the use of field liaison workers to welcome and assist Aboriginal people who go to hospitals and clinics.*

This recommendation, which came out of the March 7, follow-up meeting, is meant to ensure that people who understand the culture and speak Aboriginal languages are available to hospitals and clinics 24 hours a day, seven days a week. The goal is to ensure that Aboriginal people are treated fairly and feel as comfortable as possible in these unfamiliar environments.

There are some cultural workers in big hospitals, but many work from 8 AM to 4 PM. Currently, many Aboriginal people who are in hospital don't see another Aboriginal person unless they are dying. There is support now for people who come from the Far North and in children's wards, but those who come from two hours outside the City of Edmonton are also uncertain about medical treatment and need support.

- To provide adequate service, there would need to be a team of Aboriginal field liaison workers, with one of them on call at all times. "This job can

make you really tired, really fast," one person commented, "and you need the support of colleagues."

- The project should also include a mechanism for telling people, while they are still in their communities, what to expect when they go to a big hospital, clinic or specialists' office. This could be achieved in several ways, for example, Aboriginal people are often sent to a hospital with an escort; perhaps ensure that the escorts are qualified to provide such information.
- CHRs are aware of who is coming and going in their community. They are a good contact for the liaison worker in the hospital but their workload is heavy. They can answer questions but not take on the job of informing community members of what to expect when they go to a hospital or clinic.
- The project should be handled by Aboriginal people. They are not only ready to take on the responsibility but also are the only ones in a position to ensure that the pilot program is effective.
- Ethics may come into the project planning, as well: justice and equality and respect.



THAT *the health care system pilot different models of service delivery that involve increased teamwork among health professionals.*

One model that was suggested is increasing the use of nurse practitioners who assist doctors in ways that they have not done traditionally.



THAT *awareness raising and communication initiatives be used to encourage Aboriginal communities to work together to solve Aboriginal health challenges. Such communication should involve not only health professionals but also politicians and decision makers.*

Some first steps in this direction might include:

- Distributing these conference proceedings widely to "get the information past the door of this meeting room."
- Showing practitioners of Western medicine how traditional healing can support and complement their work ("We are all saving lives") and studying the impact on health of Elders' intervention (in a respectful way)
- Setting up meetings of participants in the New Frontiers workshop and

leaders and decision makers such as the Minister of Health and First Nations leaders ("Governments have to listen as well. We are all standing on common ground.")

Other Actions

Other generic action steps were suggested, including:

- Providing information to communities about information and services that are already available.
- Using a "train the trainer" system of professional development.
- Focusing on health promotion.
- Having health promoters inform agencies and organizations about their activities and purposes.
- Raising cultural awareness.
- Asking communities, "What can we help you with?"
- Targeting school-age children.

The Access to Health Care Services for Aboriginal Populations project, which is a direct result of these meetings, is another article in itself and will be published in a subsequent issue of this journal. For now, the last word belongs to Rose Martial, who became the first Elder to work with the Alberta ACADRE Network: "The most important thing is that we have to work together."

References

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