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FINAL REPORT ON ABORIGINAL HEALTH BLUEPRINT ENGAGEMENT PROCESS

Prepared for Saskatchewan Health by the Saskatchewan Institute of Public Policy

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Introduction:

The Saskatchewan Institute of Public Policy facilitated five meetings across Saskatchewan that engaged key stakeholders including First Nations, Métis and non-Aboriginal community members and leaders, health service provider educators, and researchers in the Indigenous health field. The meetings focused on the development of national and provincial implementation plans for the Aboriginal Health Blueprint. Two meetings were held May 30, 2005 in Saskatoon with approximately 50 people in total in attendance. The first meeting involved community stakeholders including community members, leaders and health care service providers. The second involved primarily health care and community educators, along with some researchers, working in areas of Indigenous health. Similarly, two meetings were held May 31, 2005 in Regina with approximately 50 people in attendance. A fifth meeting was held June 7, 2005 in Prince Albert with approximately ninety people in attendance. Researchers affiliated with the Indigenous Peoples' Health Research Centre facilitated the Saskatoon and Regina meetings with educators and researchers.

This report summarizes the discussions that took place at the meetings and attempts to capture the priorities identified by participants for inclusion in the Aboriginal Health Blueprint. It also documents specific concerns, potential solutions, and current "promising" practices for future direction and improvement in areas of health care delivery targeting Aboriginal peoples. Information collected from participants has been organized into six action areas determined by the Federal/Provincial/Territorial/ Aboriginal National Blueprint Steering Committee. However, the report does not constitute a definitive record of the meetings.

Summary of Key Issues:

The consultations identified many important issues but seven issues, in particular, were identified in all the meetings as being of primary importance.

1. *Communication and cooperation*

- Good communication and cooperation is essential to effective responses to the needs of Aboriginal peoples
- Partners require sensitivity, listening, commitment to cooperation, and the building of trust among partners
- Good partnership work is already happening in communities and it is important that these successes be supported, rather than supplanted
- Aboriginal people seeking services need access to information on what is available to them and where it is available

- Relevant measures and acceptable, valuable evaluation processes are essential to good planning and partnerships
- Governments need to turn the Blueprint into an ongoing process of communication, planning and cooperation with communities – the Blueprint must be a “living document”

2. *Jurisdictional barriers and funding*

- Integrating services across boundaries is likely more important than simply clarifying jurisdictional boundaries, though there is interest in self-government and Aboriginal control of services
- Jurisdictional barriers serve to put Métis and off-reserve First Nations people at a disadvantage compared to on-reserve First Nations people
- Governments must address structural underfunding of community-level services
- Governments need to provide sustained funding for health service delivery and health promotion programs

3. *Cultural competence and respect in institutions*

- Cultural competence training for health care staff is necessary to make Aboriginal patients more comfortable in health care institutions
- Institutions need to integrate Aboriginal practices and traditional healing into the health care system

4. *Creating a representative workforce*

- Creating a representative workforce is part of increasing the comfort of Aboriginal patients with health care institutions
- Education, training, recruitment and retention of Aboriginal people in health professions is essential to create a sufficient supply of Aboriginal people to fill workforce needs
- Unions and rules of collective agreements need to be, and in some cases are, adapted to help create a representative workforce
- Workplaces must become more respectful and accommodating for Aboriginal employees – cultural awareness training for non-Aboriginal staff is important

5. *Determinants of health*

- Addressing the broad determinants of health, such as income, education, employment, nutrition, and housing, is essential for changing health outcomes of Aboriginal peoples
- As the health of communities affects the health of individuals within them, community health issues must also be addressed as a determinant of individual health
- The Blueprint should encourage a holistic approach to health across government departments, between governments, and with other organizations

- Targeting holistic strategies to particular target populations with particular needs or which would generate significant benefits is likely an effective strategy – mothers/parents and babies is one such population, as are youth
- Education and access to information about healthy lifestyles must be a component of any strategy to address health status

6. Transportation issues

- Transportation is a major barrier to the receipt of health services for Aboriginal people on reserves and in the north
- Services should be delivered in communities where possible – mobile service delivery and specialist circuits are one option
- Telehealth holds promise for rural and remote communities
- When transport necessary, people need better financial support for the travel costs of themselves and escorts, and they need access to accommodation

7. Specific health care issues

- Diabetes
- Availability of home care and long-term care for elders
- Inadequacy of addictions services
- Better mental health services
- More care for the disabled

Meeting 1 – Saskatoon, May 30, 2005

1. Delivery and Access

There were two different types of comments on this action item. Participants identified both priority areas for service improvements and cross-cutting issues that affect delivery of and access to all services. The priorities for service improvement included mental health, diabetes, long-term care, addictions treatment, and treatment of violent behaviour. Several participants pointed out that mental health and, in particular, trauma counseling needed to be improved as, in the absence of such counseling, the health system is left treating symptoms, such as addictions. Recommendations in this area included the creation of trauma teams on reserves, an awareness of the need to help entire families cope with trauma and its effects, and a focus on youth. Participants also recommended that youth be the focus for addictions and violence treatment. In the area of addictions, participants recommended strengthened addictions counseling and the creation of "second-stage" housing and treatment for those recovering from addiction. Several participants noted that full recovery from addictions takes longer than most programs allow for. Diabetes treatment and prevention (see below for more on prevention) were repeatedly noted as priorities. Lastly, participants noted the need for long-term care facilities for the elderly and disabled on reserves, as First Nations people generally have to move off reserves to receive long-term care.

Four sets of cross-cutting issues were noted most often as barriers to receiving services. These were cultural and linguistic issues, a lack of knowledge about program availability, lack of services in rural and remote communities, and a lack of sustained commitment and funding for effective programs that are initiated on a pilot project basis. Participants noted that the lack of cultural sensitivity of institutions created mistrust and recommended a variety of responses. These included the training of foreign service providers in the cultural context they will be working in Saskatchewan, the use of Elders and healers in teams with doctors and other practitioners, the provision of language and spirituality support services on a 24/7 basis, and signage in Aboriginal languages. Participants also noted two effective programs. Native Counseling Services in Regina provide an interpreter and a prayer room right at the entrance to the hospital. As well, the two community clinics in Saskatoon which deal overwhelmingly with Aboriginal patients were identified for their provision of services in a trustworthy, culturally respectful way, especially in the spiritual and mental health areas. Participants also noted that these clinics have succeeded in attracting and retaining Aboriginal staff, who now account for about 14 percent of the staff complement, and have set the next goal at increasing Aboriginal people's participation in management. Increasing Aboriginal people's participation in the health care field was identified as an important means to address cultural barriers. Participants also noted that the division in the public provision of services between Métis and First Nations people created an unjust burden for Métis people.

A lack of knowledge about program availability and public or private coverage of services was repeatedly noted as a problem. Participants made several recommendations to address this issue. One suggestion was to have someone create a directory of available health care resources, as is apparently done in Alberta, and note which services are

publicly provided or publicly subsidized and to whom. Other participants identified the need to have patient advocates to represent patients with health care workers and make information available to Aboriginal patients.

Participants repeatedly expressed concerns about the lack of services in rural and remote areas, the length of time it takes to receive emergency services in rural and remote areas, and the cost of travel to urban areas to receive services. They noted that poverty creates a significant barrier to access to services, both in the case of services that are not publicly funded and where travel is necessary to receive services. Participants had several suggestions to address this issue. One of the most interesting suggestions was to create mobile clinics for isolated communities staffed by Aboriginal healthcare providers. Participants also recommended the creation of housing for Aboriginal people and their families who must travel to urban centers for treatment, and the need to make such housing welcoming for Aboriginal people. An example of this was Larga House in Edmonton. Participants also wanted to see more after-hours services, better linkages between reserve residents and urban service delivery agents so that people do not fall into service gaps if they move between reserves and urban centers, and equal funding of ambulance services both on and off reserves so that on-reserve ambulance services no longer either charge more than the provincial ambulance system or struggle to remain solvent.

The fourth area of concern was with the tendency for “pilot programs” to be established but not sustained, even if they prove beneficial. Participants noted that, too often, funding provided to programs is short-term and, when the funding program ceases, it is not replaced. As a consequence, even successful programs are forced to shut down.

2. Sharing in Improvements to Canadian Health Care

Achieving a representative workforce was generally seen as the key to sharing improvements in health care with Aboriginal peoples and increasing their involvement in the health system. Participants identified a wide variety of strategies to achieve a representative workforce. Participants linked the need for more Aboriginal students with the need for more job opportunities and job placements for them once they had completed their education. Part of this task was to improve Aboriginal student recruitment and make Aboriginal youth more aware of the possibilities that exist for them in the health care field if they seek an appropriate education, and job shadowing was also suggested as part of any strategy. Others recommended that Métis people receive assistance in paying for their education in the way First Nations people do. Union rules were also identified as a barrier to Aboriginal employee retention and advancement. A third significant issue that participants identified was the need to make workplaces more accommodating for Aboriginal employees through cultural awareness training for the existing workforce.

3. Promoting Health and Well-being

Health promotion was a major concern for participants. Indeed, it may have received the most attention of any issue. Many participants strongly identified the need to address socio-economic determinants of health status if the well-being of Aboriginal peoples is to be improved, as health is not solely about health care and the promotion of healthy

lifestyles, but about income, education, housing, and the environment. Simple factors, such as the cost of food on reserves, were noted as barriers to good health. Participants also noted the need to break down stereotypes and misunderstandings which arise out of a legacy of mistrust. One example of this was the need to develop understanding among Aboriginal people that a health worker visiting a home is not there to take a person's children, so they should be allowed into the home. To many participants, access to information and education was seen as the key to health promotion.

Participants were concerned that population health information is not getting to the people who need it, in part due to a lack of resources for education and training on population health issues and disease prevention. Many participants put a high priority on early education to promote good health practices among children. Youth education on diabetes, nutrition, and exercise, smoking, mental health, and addictions were all identified as needs. One participant described such educational initiatives as "break the cycle" strategies. Some participants noted that Aboriginal youth need role models and mentoring programs to make good lifestyle choices. Other participants recommended increased physical activity and health studies in the school curriculum and specifically noted the File Hills First Nation diabetes education program as an example. The Aboriginal HeadStart program, with its promotion of parental involvement, and the "Dream Project" in North Battleford, which focused on health risk factors for diabetes among children and involved a health worker to work with those whose diet put them at high risk, were also cited as examples of effective programs. At least one participant indicated that the benefits of the Dream Project for controlling diabetes were obvious. One participant noted that, outside the health sector, community schools were working effectively because they engage both children and their parents, and wondered whether this model could be adapted to the health sector. Participants also recommended that education programs be targeted to young mothers on such issues as nutrition and the effects of alcohol while pregnant, and to entire families on creating better home environments. A further suggestion was to reinforce such simple injury prevention strategies as requiring that new mothers have a car seat before leaving hospital with their newborns.

Funding and bureaucracy were, however, identified as barriers to effective education and prevention programs as well. Participants again noted the need to ensure that there was secure funding for programs that are working and commented that bureaucratic rules were interfering with the use of traditional knowledge and health promotion initiatives in schools, such as increasing the consumption of traditional, healthier wild game meats. One participant also noted, as an example of a funding and bureaucratic barrier, that a community lost the Métis pre-school that had been established under Aboriginal HeadStart when the program was renewed.

4. Monitoring Progress and Learning as We Go

Participants identified a number of issues related to monitoring and evaluation. One participant noted that successes exist but the challenge is to learn what makes a successful initiative successful and transfer this knowledge to others. Accountability was an important component of evaluation and participants were concerned that data collected

be used to improve performance, rather than simply "gathering dust". Participants noted the importance of generating a commitment among managers to results-based reporting and evaluation, and some suggested tying pay to performance. On the other hand, they noted that there currently existed an excess of program reporting, which occupied so much time of small organizations that it interfered with the actual delivery of services. As well, there were conflicting opinions on what timeframes should be used for evaluation, with some participants seeking to quickly determine whether a program was working and, if not, to implement another program and others noting the need for long-term evaluation of success.

What data to collect and how to collect it were also concerns. Participants commented on the need for a public health information system for Aboriginal peoples, at the regional level. They also recommended that communities and service providers be directly involved in evaluation and that Aboriginal people be involved, to create targets that they feel are important in making a real difference in people's lives. Métis participants noted the need for Métis-specific data and, on a related note, participants noted the need to think about how to encourage people to self-identify. Participants who live in the Heartland Health Region noted that the Aboriginal population in the region was essentially invisible and commented that the region needs to know more about the population and how to serve it. Participants also noted that results needed to be published in a respectful way, so that all can read and interpret them. Some participants noted, however, that privacy concerns were an issue in data collection.

5. Clarifying Roles and Responsibilities Between Governments and Organizations

While there were few specific suggestions for clarifying roles and responsibilities between governments and organizations, there was a general concern that bureaucratic rigidity and jurisdictional issues were a problem. Part of the problem identified was that jurisdictional issues led to confusion and misconceptions about public funding of services because of the way governments sub-divide the Aboriginal population, leaving Métis and off-reserve First Nations people at a disadvantage compared to on-reserve First Nations people. There are also misconceptions about the level of funding provided for on-reserve services. Some participants also suggested that First Nations should be provided jurisdiction over the provision of health care and that non-Aboriginal people needed to be educated about the differences among Aboriginal people to eliminate the misconceptions about Aboriginal peoples' access to publicly-subsidized services.

6. Developing On-going Collaborative Working Relationships

The need to create good partnerships, however, was a significant issue in the discussions, and cultural competence was an important component of this. Participants noted that, while collaborations and partnerships are important, mistrust of non-Aboriginal institutions and the bureaucratic cultures of those institutions were barriers to the establishment and sustainability of partnerships. As well, participants commented that current policies do not reflect grassroots perspectives on what is really needed in communities. Instead, partnerships need to engage seriously and empower Aboriginal peoples in decision-making processes, and need to be established at, and controlled by, the community level. People must feel listened to and respected and the commitment of

all partners to the partnership needs to be felt. Several participants commented on the importance of two-way communication, to allow people who may currently work in isolation to share their ideas and knowledge, and respectful listening. Participants also noted that partnerships take time and must be nurtured.

Participants commented that it is important in making partnerships work that Aboriginal peoples' beliefs are understood and respected. Some participants commented on the need to educate non-Aboriginal people about treaties and their relationship to the provision of health care as part of this effort. Participants also commented on the need for large numbers of Aboriginal groups to be involved in partnerships, to adequately reflect their ideas and traditions, and specifically for Aboriginal women to be involved, as some participants felt they were currently marginalized. Métis participants also noted that the Aboriginal Health Blueprint itself should have included Métis-specific consultations, to demonstrate a commitment to respect Métis as a distinct people in building and implementing the Blueprint.

Meeting 2: Educators and Researchers – Saskatoon, May 30, 2005

A separate session for health educators and researchers was held in Saskatoon on the morning of May 30 to solicit their views on the issues contained in the Aboriginal Health Blueprint. Numerous issues were raised about the education of Aboriginal people in the health field, what research is needed, and how to conduct research. Participants commented that more Aboriginal people were needed in the health care system, and therefore in health education programs, but health education received a number of positive comments. Participants noted that the College of Nursing at the University of Saskatchewan has over 100 Aboriginal students and, over time, a higher proportion of the students have been Métis and urban First Nation people. Aboriginal peoples' access to nursing education over the last 20 years has been a major success, due in part to innovations in the program such as increased cultural relevance and on-line training. The program is looked upon favourably across the country. Now, the College is trying to increase the number of students, especially northern students and students in graduate school, but effectively there is a cap as funds from the federal government are limited.

Participants commented that the way forward in health education was to build on past initiatives. Education of non-Aboriginal people about Aboriginal peoples is also an important aspect of strategies to increase Aboriginal peoples' participation in the health field. One participant suggested that Saskatchewan does a good job of educating high school students about Aboriginal peoples, but not adults. An Indigenous Health Studies course would be a key component of adult education, especially for future health care professionals such as doctors and nurses. Other ideas proposed were to provide scholarships to increase interest in health sciences, create career counselor positions, increase teacher education programs for Aboriginal people interested in becoming teachers so that there are more role models in math, science and health-related education courses, and create math and science enrichment programs in universities. Some participants noted that all educational institutions are building programs in these areas, but career counselors need to be the core. Participants also noted that Saskatchewan has

diabetes educators, which are not common in other provinces. With the difficulties the province is facing replacing retiring health care workers, incentives for young people to get further training to become part of the system are increasingly important. One participant noted that the income disparities among health care workers on and off reserve also create a barrier to access to health service providers on reserves.

Health research among Aboriginal peoples was the subject of both positive and negative comments. An over-riding concern was ownership of, control over, and access to research, because control over research defines the balance of power between the researcher and the subject of the research. Diabetes research in Kahnawake was noted as an interesting example, as the research was both managed and conducted by community members themselves. As participants agreed there was room for more research on diabetes, this model may be a good example to refer to. Other participants commented that Saskatchewan has benefited from a spirit of ingenuity and innovation, with models such as the Indigenous Peoples Health Research Centre being founded on the principle of collaboration and designed to create and use more evidence.

There was some question whether people even know what the term “Aboriginal” means, including concern that even the Aboriginal Health Blueprint was inappropriately putting all Aboriginal peoples together. Participants noted that Métis issues, for example, differ. While there is community-based Métis research being done, it is more difficult for Métis communities, as they have limited funds and human resources; many people are stretched too thin to be part of further research collaborations. Participants also expressed concern that the media often portrays Aboriginal people as collectively sick and needing to heal, yet if one goes to communities, one can find a lot of goodness, happiness and health. Others made the point that the whole system needs to heal, not just Aboriginal peoples.

Other comments on research were more directly related to the Aboriginal Health Blueprint. Participants questioned to need for additional consultation with Aboriginal communities when seminal reports such as the Report of the Royal Commission on Aboriginal Peoples, which involved broad-based consultation with Aboriginal communities across Canada and provided hundreds of recommendations, were available. It was unclear to participant how the Commission’s work was being used in the Blueprint process and whether the Blueprint was, in effect, a duplication of some of the work done by researchers and Aboriginal communities which participated in the Commission. They also recommended that the language of the Blueprint change from linear, “upstream/ downstream” language to more cyclical language. Participants noted that language is important, because the model that is reflected in terminology drives how one thinks about an issue.

Meeting 3 – Regina, May 31, 2005

1. Delivery and Access

As was the case with the meeting in Saskatoon, the discussion of delivery and access issues in Regina addressed both particular areas in which there were felt to be unmet

needs and cross-cutting issues. The first category included a number of issues. Participants expressed concern about the limited availability of emergency services for Aboriginal peoples in rural areas and on reserves. One suggestion to address this issue was to increase the number of EMTs. Participants also commented that there are not enough home care services on reserves and if individuals leave the reserve to seek services they have to pay for them, though they may not be able to afford it. They were also concerned about the length of time it takes to make an assessment of children's health status, which is a particular concern given the mobility of the Aboriginal population. Mental health was another concern, with participants commenting that it seems as though funds get reduced each year. At least one participant connected addictions, another major concern, to inadequate mental health services.

Participants commented on the need for after-hours services, drop-in services, outreach, and home visitation, to allow people to receive care when they are able or when they need it. One participant from the Regina-Qu'Appelle Health Region commented that the Region would like to expand its drop-in program hours but that this requires more staff and adequate security, neither of which they can currently afford. A lack of access to follow-up services, such as physiotherapy and rehabilitation, was also raised by participants. Jurisdictional barriers were highlighted in this area, with one participant commenting that occupational therapists could not come on reserves, as they are under provincial jurisdiction, even though they are needed on reserve.

Addictions services were subject to a great deal of comment. Participants noted that addictions require long-term treatment, which is not currently being provided, and criticized the tendency to separate addicted couples for treatment. As an addicted couple shares a problem, participants felt that treating them together and addressing their co-dependency would likely be more successful. One particular concern was with the lack of treatment for pregnant women who are addicted. There are no beds available for them to be cared for and treated in hospitals, yet addiction treatment centers cannot take them either, as they lack the health care capacity to take care of any pregnancy complications. Thus, pregnant women who are addicted suffer directly from a service gap.

The five most significant cross-cutting issues for the participants in the Regina meeting were transportation issues, the cultural appropriateness of health service delivery, jurisdictional barriers to service availability, a lack of knowledge of what services are available and inadequate funding. The need for individuals and, often, their families to travel long distances to receive services received much criticism for the cost, the lack of ancillary services such as affordable accommodation, and the disruption to rehabilitation that comes with forcing people into urban areas, and away from their home communities, to receive services. The general desire was to have services provided to people where they live instead but, as one participant from the Broadview area noted, they only see a nurse once every three months and thus feel as though they are being ignored. Two ideas were proposed for consideration. The first was to have specialists travel to different communities, both on and off reserve, on a regular basis and the second was to increase the use of Telehealth, which was seen by the participants as a positive development. One suggestion for Telehealth was to create a local "hub" with a doctor and nurse on site and videoconference facilities linked to specialist services in urban centers. Both of these ideas were proposed as ways to save money and improve service provision

simultaneously. Increasing the use of midwives to provide pre- and post-natal care in communities was also raised as an idea worth pursuing.

The lack of culturally appropriate services and welcoming environments was also frequently criticized. It was felt that, generally, services are not responsive to Aboriginal peoples' needs, so people are not using the services available to them. One part of a response to this issue is to hire more Aboriginal staff, both in "healthcare fields" and as part of teams that combine traditional healing and traditional ceremonies with European-style health care to create a more holistic, welcoming environment for Aboriginal patients. One participant noted that, at Pasqua First Nation, the leaders have frequently heard concerns about the lack of Aboriginal people delivering services within the provincial health care system, so the First Nation wants to increase its capacity to deliver services to its members. Another approach advocated by several participants was more education for the existing workforce, so Aboriginal people are treated with greater respect. Other ideas to make Aboriginal people more comfortable with healthcare institutions, and therefore to increase their access to needed services, were to create an advocacy position within the hospital staff to help ensure that people understand their options and can deal effectively with decisions about their care, hospital tours as part of pre-natal programs, food vouchers, culturally relevant art in facilities, and a free telephone to allow people to remain connected with their families when they are at a facility.

Jurisdictional barriers and the related issue of lack of knowledge of what services are available were also raised by participants as issues. Métis and off-reserve First Nations members are particularly affected by these problems, as they know they are not treated the same as on-reserve First Nations members but often do not know what services are actually available to them or where to go to receive services. A participant from Carry the Kettle First Nation noted that they have created integrated service provision for their members and are now contracting with other First Nations to provide services to their members as well, in spite of the jurisdictional barriers. This participant pointed out that good services exist on First Nations and, in many cases, they are ahead of cities in developing integrated services, due to their commitment to serving their members. Other participants identified All Nations Health hospital in Fort Qu'Appelle as a successful example of parties cooperating to overcome jurisdictional barriers in the name of effective health service delivery.

The last issue in service delivery and access was funding. Generally, funding is felt to be inadequate and participants were of the view that more money needs to get to the community level, where effective programs are run. Participants were also concerned that people do not use services available to them because they lack the money to pay for them. One example of this raised was that people sometime do not take the medicine prescribed for them to save money for other priorities. A further funding concern was with the tendency of governments to create pilot programs, rather than sustained programming. This creates uncertainty for delivery agents and the recipients of services. Participants felt that sustained programming is essential.

2. Sharing in Improvements to Canadian Health Care

Education was seen by the participants as the key to sharing improvements in health care with Aboriginal peoples, and this was seen as an increasingly important task as the Aboriginal population grows. On one side, Aboriginal people need to be given an education that gives them access to positions in the health care field, so that there can be a representative workforce in health care institutions. This effort needs to begin early, with the promotion of education in math, sciences and English in high school, and the promotion of the idea that careers in the sciences and healthcare fields are real options available to Aboriginal students if they stay in school, educate themselves, and build the appropriate skills. Students also need access to stable funding to complete post-secondary education.

On the other side, the mainstream population also needs to be better educated, so that society is more aware of Aboriginal cultures and open to accommodating the cultural differences that exist within society. Again, this should begin early, in schools, and should be ongoing. One challenge is to reassure non-Aboriginal people that cultural awareness is not a threat but a benefit to them. A related concern is with the unwillingness of unions to accommodate the desire for a representative workforce in bargaining mandates and collective agreements, though this is beginning to change as unions become more sensitive to the importance of promoting a representative workforce.

3. Promoting Health and Well-being

As was the case in the Saskatoon meeting, participants in the Regina meeting focused on health determinants, education, and prevention as the keys to health promotion, and noted particular needs in the areas of parenting skills and immunization. Participants frequently noted the need to address the concept of health holistically, and connected such issues as access to nutritious food, employment, adequate housing, and community economic development to improving individuals' well-being. In the case of food, one participant summed up the importance of nutrition to good health by commenting that the traditional perspective of Aboriginal peoples is that food is life.

A number of suggestions were made for education programs that either exists as examples of good programs or that could be implemented. One suggestion was that governments target key populations, such as parents and babies, and work with whole families within those target populations on a variety of relevant health promotion issues. Participants were concerned that young parents do not know how to raise their own children, as they are often too young and unprepared for parenting themselves, but that they also do not know where to go for advice. Other participants suggested targeting youth and their families to educate and promote lifestyle changes, and to raise awareness of such issues as HIV, while others were concerned about a lack of programs for seniors.

Participants identified several good existing programs to promote healthy lifestyles, including the Focus on Fathers group run by the Regina-Qu'Appelle Health Region in the evenings, the Cooking to Live program, the Métis Nation's Little Tots program, the pre- and post-natal nutrition program done in partnership between Health Canada and the Regina-Qu'Appelle Health Region, and the multi-disciplinary diabetes team in the

Sunrise Health Region which includes First Nation and Métis team members and provides a part-time wellness nurse educator. One participant also noted that the Sunrise Health Region has held educational sessions for on-reserve as well as in off-reserve communities, and has discovered that the on-reserve sessions are much more successful in attracting people. Participants noted that, ultimately, the purpose of any education strategy is to empower people to make their own choices, and one way to supplement educational programs to assist them in making the right choices is to provide them with positive role models.

4. Monitoring Progress and Learning as We Go

Participants had several suggestions for effectively monitoring progress and learning from results. The most important of these was that evaluation focus on outcomes, not on the quantity of services provided, and that the essential condition for success is that health outcomes statistics for Aboriginal peoples be the same as for the non-Aboriginal population. Participants recognized that to get to that point requires a long-term effort and recommended that interim goals also be adopted, as a way to judge success over shorter timeframes. They also noted that people have to see actions being taken in response to the results of the monitoring and evaluation, or mistrust of the evaluation process will grow.

Part of monitoring and evaluation is also sharing information on effective practices that may exist in some communities. To do this effectively and to ensure that evaluations are relevant to communities, monitoring should be done at the community level, with extensive community involvement, though the data being collected should be standardized across communities, to ensure comparability of results. Métis participants also stressed the importance of collecting Métis-specific data, as none currently exists and this situation impedes the identification of any Métis-specific health challenges that may exist.

5. Clarifying Roles and Responsibilities Between Governments and Organizations

There is an inherent tension in the task of clarifying roles and responsibilities between the desire for better integrated, more efficient and more effective services for the entire population, and the desire of First Nations and Métis people to have greater autonomy and control over managing health care for their people. Participants agreed, however, that the current situation is overly complex and that people need to better understand the roles and responsibilities of governments and organizations. As well, for First Nations, it is important that the provision of health services respect their treaty rights and the treaty relationship between First Nations and the Crown. As at least one participant noted, however, there will always be jurisdictional issues, as jurisdictional conflict is really about the responsibility for the raising and spending of funds to provide healthcare.

6. Developing On-going Collaborative Working Relationships

The most extensive discussion in the Regina meeting was about the challenges facing collaborative working relationships, how to build effective collaborations, and examples of effective collaborations that already exist, as well as how the Blueprint process itself

could best serve the task of building a collaborative culture. Likely the single most important, and frequently made, point in the discussion was that partnerships require communication and the creation of trust among the participants. Effective communications and the building of trust are on-going challenges that will require the long-term commitment of governments, in particular. Participants also pointed out that building trust is that much more challenging a task in light of a history of racism and the frustration of community members that, despite numerous previous consultations and studies, little has changed for Aboriginal peoples. Trust between organizations, governments, clients and professionals may well be the biggest barrier to overcome in creating effective partnerships. Participants also expressed concern about the lack of coordination among departments in the same government and among regional health authorities; better communication and greater trust even needs to be built within bureaucracies so that limited mandates of organizations do not become barriers to effective and efficient service provision.

Part of the solution to improving communication and trust is to involve Aboriginal peoples and their communities more thoroughly and actively in discussions at all levels. Participants spoke often of the need to talk to grassroots community members, to let Aboriginal peoples make choices and take responsibility, and to focus on building on individual communities' strengths and addressing their greatest needs. One particular recommendation to improve the input of Aboriginal peoples that was raised was increasing the numbers of Aboriginal people on Regional Health Authority boards. Participants also noted that it was important to keep workers involved in decision-making, as they have to be able to act on the decisions made. Participants commented on the importance of having partnerships respect First Nations treaty rights, but also on their frustration with jurisdictional barriers and their desire to work together as service providers, both on and off-reserve, to create an integrated, coordinated system instead of the current fragmented system. One participant noted that pooling resources will mean losing some control, but that it will make people better off by joining together the strengths of all partners.

Several comments were made in this context about the Blueprint engagement process itself. There were positive comments that the Blueprint discussions were bringing people together to learn from one another and would allow people to bring ideas back to their communities, but there were also comments about the importance of the Blueprint process being connected to communities on an ongoing basis. One participant commented that the Blueprint must be a "living document" and be part of an ongoing process of discussion and refinement within communities. Another participant recommended that the governments hold some further meetings about the Blueprint on reserves to more thoroughly engage community members, better understand the realities of reserve life, and strengthen the trust of the communities in the commitment of governments to addressing their concerns.

Participants also commented on the relationships that were being built or that were already established and working. Participants noted that there was a lot of collaboration already in north-central Regina and that the Regina-Qu'Appelle Health Region, in particular, is part of a number of networks, including Together Now and the FAS Network. Similarly, some participants noted that the Sunrise Health Region has some

good partnerships, such as one to provide a First Nations home care nurse. One concern that was expressed with the environment for creating such partnerships is that there are currently too many small organizations that spend too much time reporting to funding agencies rather than providing services. This is a common frustration among community organizations to which governments need to pay attention.

Meeting 4: Educators and Researchers – Regina, May 31, 2005

The researchers and educators who met separately on the morning of May 31 in Regina focused on four key themes: the importance of their research being relevant; how to undertake effective monitoring and evaluation; opportunities and challenges to improving the provision of health services; and the importance of building a representative workforce. On the first issue, participants were concerned that there is too big a gap between the research being conducted and its application in the provision of health services. On the one hand, there was concern about effectively bringing research to policy-makers, so that research results in action, while, on the other hand, participants were concerned to ensure that communities had greater involvement in research. Participants noted that "research" is an unpleasant word in Aboriginal communities and that community-driven research yields better cooperation from the participants. This requires a number of changes in research methodologies, from having communities help researchers choose relevant research projects to undertake, to involving people who receive services in research, to reporting research in a way that is accessible to communities, even if that is not a traditional academic publication. It will also require granting agencies to become more accepting of community-based research. Participants pointed out that such forms of research raise questions of who owns indigenous knowledge and under what circumstances Aboriginal peoples are prepared to share their knowledge. This may require a significant shift in the attitudes of the health system to better apply holistic healing processes within the medical community. Participants wondered if the Blueprint process might provide an opportunity to begin to make these changes in the attitudes and biases of the medical establishment.

On the matter of monitoring and evaluation, the participants noted that there needs to be some common goals set for evaluation to be meaningful. As one participant commented, if we do not share a common definition of the desired destination, we will lack a common conception of what is effective and efficient. One suggestion was to start from the perspective that all people share the right to good health. Participants also recommended that it is important to get down to the community level and measure community health. Part of the reason for this is the significant differences between communities in northern Saskatchewan and, for example Toronto, which make community-level information important, and the other is that people exist within communities, so a community's health status can be as important to planning as individuals' health status. The other important point about evaluation that participants made was that one has to identify both effective and ineffective practices, and attempt to understand what makes those practices effective or ineffective if evaluation is to be useful to policy-making.

Participants also made several comments on opportunities to improve the provision of health services. They made the point, however, that determinants of health are extremely important so that health service improvements alone will not create good health. Thus, a holistic approach to health is important. One comment was that food banks and diabetes prevention do not mix. They also pointed out the importance of community participation and control of health services in the community through partnerships. They highlighted the Northern Health Strategy Working Group and the Regina-Qu'Appelle Health Region's partnerships as good examples of functioning partnerships. Dialogue between providers and community members is an essential component of such partnerships.
Two specific areas were the subject of comments as well. To address issues of access to services, participants recommended that vans be equipped with some standard equipment, such as x-ray machines, and that these be taken into communities to provide basic diagnostic and health services, as had been done for isolated communities in the 1950s. Participants also stressed the importance of asking Elders what kind of care they wanted and needed for the end of their lives.

The other topic of discussion was the importance of creating a representative workforce. Participants stressed the need for education of both Aboriginal and non-Aboriginal people if a representative workforce was to become a reality. Participants commented that Aboriginal students need to participate in post-secondary education in greater numbers. This will require a greater focus on math and science education in high school and may require incentives, such as scholarships and targeted recruitment, and the creation of distinct programs for Aboriginal peoples in universities, for example by involving Elders as mentors and role models. The Indian Social Work degree and the Nursing degree program available in Prince Albert were identified as examples of innovative programs. Participants pointed that that how, where, and by whom a program is delivered matters. As well, there need to be opportunities for educated and trained Aboriginal people to work in their communities, as they are more likely to stay in those communities than foreign doctors. On the other side, participants commented that health regions should be seeking to become employers of choice, which will require that health providers and educators within the health system also be better educated about Aboriginal traditions and worldviews. This would allow Aboriginal and non-Aboriginal perspectives to become better integrated into the health system and workplaces to become more accommodating of Aboriginal peoples.

Meeting 5 – Prince Albert, June 6, 2005

1. Delivery and Access

As was the case in the meetings in Saskatoon and Regina, both cross-cutting issues and issues with particular types of services were raised in Prince Albert. Transportation, language and culture barriers, the jurisdictional barriers to adequate funding of services were the principle cross-cutting concerns; with the need for information on how to gain access to health services such as sending information packages about hospitals to communities, and the need for gender-specific programs also being identified. Among the specific issues raised, addictions was prominent, with participants commenting on the

need for treatment programs and creative strategies to motivate people to seek help for their addictions. One participant commented that, in the absence of treatment, people addicted end up in jail. Diabetes was also a major issue, with participants noting concerns both with a lack of access to such professionals as podiatrists and nutritionists in communities and the way in which a previous Métis diabetes program was ended after only one year. The third issue raised was with the stress placed on mental health services in the wake of growing problems with depression and addictions.

As noted above, participants frequently commented on the remoteness of northern communities and the ensuing transportation and accommodation issues. Participants noted that northern Saskatchewan is a big area with a small population and small, relatively isolated communities, and were concerned that decision-makers did not understand this reality. Because of the size of communities and the distances between them, as well as the poor quality of roads, numerous transportation challenges arise for people who need to get to larger centres to receive medical services. Participants were concerned that many people lack coverage for transportation and accommodation costs and that the costs of sometimes-necessary escorts are not covered. As well, meals can sometimes be an issue because of bureaucratic failure to validate meal vouchers. Participants also noted that if people are transported to Saskatoon or Prince Albert for a morning appointment, they are left in the city for the entire day because of a lack of flexibility in the transportation schedule and that, if a person is evacuated to Fort MacMurray in an emergency, they can often be left in the position of having to pay for their own transportation home when they are discharged. Participants were also concerned that the lack of facilities in small communities to manage chronic diseases were forcing people to relocate to urban centres, away for family supports. While the First Nations in the Athabasca region have been trying to assist people with their transportation issues, for example by providing empty seats to non-reserve residents who need transportation, there are bureaucratic impediments to improving service.

Participants suggested several options for improving this situation, largely by bringing professional services into communities. Some participants recommended that more opportunities be created for Licensed Practical Nurses to be used in communities to improve access to services, while others noted that northern communities are already attempting to recruit midwives and dental hygenists, and expressed the desire to place speech and physical rehabilitation staff in communities. Other participants noted that telecommunications technology provided an opportunity to provide services to northerners from locations farther south. Ultimately, though, participants sought, in the words of one participant, a “revolution” in service delivery and expressed a desire to return to a situation in which community members were able to help one another in the community, rather than relying on experts in the south.

The second most prominent issue was the existence of language and cultural barriers. Participants were concerned that doctors from other countries do not understand Aboriginal peoples and, because doctors tend to stay in northern Saskatchewan only for short periods, there is no time for trust to build up between doctors and their patients. Participants also felt that when Aboriginal people enter hospitals, their lifestyles are judged and they are the victims of demeaning attitudes towards Aboriginal peoples. Language was also identified as a barrier, especially for elderly patients. While culturally

sensitive approaches do exist in Saskatchewan, they are only available in larger centres, which again raises the issue of transportation difficulties. Some advances are being made, such as in La Ronge which has a palliative care team, and in Manitoba where the University of Manitoba worked with a northern community to create a delivery model based on their needs, and these may provide examples for other Saskatchewan communities. Lastly, participants recommended liaison worker positions be created in hospitals to act as translators and advocates for patients.

Funding of services was the third major issue raised, with participants being particularly concerned that funding become more flexible and sustained, to allow for planning, and that the chronic funding shortage be addressed. Some participants noted that First Nations health clinics in the north also provide services to members of the adjacent communities but they are only funded for services to the on-reserve population, which creates chronic shortfalls. Participants also noted that an inability to receive funds for services for the physically and mentally disabled on reserve was creating a barrier to addressing a real need. Further, some participants noted that people are going without medication because they cannot afford to pay for it and do not have it covered. Métis participants noted that funding was a significant issue for Métis because they are not provided with funding for core services equivalent to that provided to First Nations. Participants commented that the delivery framework needs to be changed to serve communities, rather than fragmenting services according to an individual's residency and status.

2. Sharing in Improvements to Canadian Health Care

Participants recommended several strategies to better share improvements in Canadian health care with Aboriginal peoples. They recognized the need to change both Aboriginal and non-Aboriginal perceptions of one another through education. Participants recommended cultural awareness training for non-Aboriginal people in the health professions and in schools as a way to end negative stereotypes and suggested that health regions become more familiar with the Aboriginal populations they serve. They also commented on the need to change Aboriginal perceptions of the health system by providing print and video resources with Aboriginal faces and voices. One participant also noted that Aboriginal people need to have opportunities to celebrate their successes as a way to motivate people to continue the effort to share improvements.

Participants felt that the key to sharing improvements, however, is creating a representative workforce and that this goal requires a commitment to education, recruitment of Aboriginal people, and their retention. Currently, too few Aboriginal people are working in institutions and, most notably, in management, in part because there are not enough qualified Aboriginal people applying for positions. Participants commented that more training funds are required and Métis participants noted that Métis, in particular, have limited access to education and training because they lack the funds available to First Nations to support the education of their members. Participants also suggested that educational institutions develop programs to encourage learning traditional medicine. NORTEP was identified as a program that works for teacher education, and participants wished to see similar programs in the health field, particularly in dental and mental health education. Participants also noted that the First Nations University of

Canada can play a role in providing distinctive programs for Aboriginal students. Lastly, participants noted that unions and collective agreements can sometimes create barriers to building a representative workforce, especially in the north, where recruitment and retention is that much greater a challenge.

3. Promoting Health and Well-being

Education and addressing the determinants of health were participants' key strategies for promoting health and well-being among Aboriginal peoples. They also identified the specific issues of the need for immunization programs, support services for addicted people and their families, FASD education, abuse prevention and treatment, and access to services for Métis as specific needs.

Participants repeatedly expressed the need to address such determinants of health as poverty, education, housing quality, water quality, affordable access to nutritious food, employment, social capital, and community development. One participant noted that, in the absence of progress in these areas, the best health care system in the world will not make people healthy. Thus, participants stressed the need for an integrated approach to individual and community health, rather than simply disconnected programs. Participants also identified the need for sports, recreation and physical activities, noting that young people were leaving communities because of a lack of these services. One initiative that was promoted was the KidsFirst North community garden; the community will harvest vegetables from the garden in the fall to increase access to healthy food. The Northern Diabetes Coalition was also identified as an effective partnership to address diabetes prevention holistically.

The other major issue participants discussed was the need for better education about healthy lifestyles. On participant noted that an Elder had recently described education as the buffalo now; in other words, education has become the key to survival for Aboriginal peoples. Public education is important as a way to motivate people to take an active role in protecting their own health. One participant noted that 97 to 98 percent of parents are now coming to parent-teacher interviews because they feel a sense of ownership and responsibility for their children's education; the challenge is to make people feel that same sense of ownership about their and their family's health, but current programs are not achieving this. Participants recommended several strategies, such as parenting skills education, providing parents with more information on communicable diseases, discussing sexually-transmitted diseases with youth, having the school system provide nutrition education to young students, and having a wellness officer in junior high schools. They also noted that a number of good initiatives already exist. These included the Northern School Board strategy for diabetes prevention, Missinnippi Broadcasting Corporation's healthy living broadcasts, walking programs for seniors and diabetics, and Ahtahkakoop First Nation's HeadStart pre-natal and women's wellness programs, though participants also noted that HeadStart always seems to have a challenge getting parents engaged.

4. Monitoring Progress and Learning as We Go

Participants made a number of comments about both what should be measured to monitor progress and how evaluations should be conducted so that they contribute to improved outcomes. On measures, participants pointed out that measures were still poor, largely because they do not provide statistics at the regional or community level, where the responses must come from. They also noted that where statistics such as the Health Indicators Report already exist, they should be used. Participants also commented that statistics are also often out of date, and therefore not useful for planning and evaluation. Another problem pointed out was that information that did exist was not getting to people in northern communities who need information to improve programs. Participants also discussed how to establish appropriate measures. One piece of advice was that communities need to define what constitutes a healthy person and healthy community, so part of designing measures should be to ask people how they feel about their own health status. Participants recommended not taking on too many measures at once, as that could reduce a community's focus on its critical issues. There was some debate among participants about the timeframe for measurement, with some arguing that one should not set objectives too far into the future, as they may not provide sufficient motivation. Others argued that, as health promotion is a long-term effort, objectives and measures should be long-term as well. Participants also provided some suggestions for specific objectives, such as reduced treatment costs and health status equal to the non-Aboriginal population.

Participants supported the idea of transparent evaluation and recommended that there be annual, or even quarterly, assessments done of what programs and initiatives were and were not working in communities. They did note, however, that it is important for the community to know why data was being collected and how it was being collected; community support for data collection as part of a community-driven process to improve programs and outcomes, rather than as part of a federal government-driven process, was important to the success of evaluations. As well, good evaluations require funding. Participants from the regional health authority commented that they want to do more consultation with community members about how their feel about the health services they are receiving so their program evaluations include a better client feedback component. Participants also noted the need for evaluations to tell success stories and allow people to see that solutions to problems do exist, as well as correcting failures.

5. Clarifying Roles and Responsibilities Between Governments and Organizations

Overall, clarifying roles and responsibilities was the subject of less comment from participants than were issues about creating effective collaborations, but there were some comments. The biggest concern among participants was with the way jurisdictional divisions create divisions among people because different people receive different benefits. As one participant commented, health should have no boundaries. Indeed, some participants noted that some First Nations and non-First Nations communities were sharing services in spite of the jurisdictional barriers where there was insufficient demand either on or off reserve to justify a particular service but where the combined demand was sufficient to justify providing the service in the community. Participants also noted that First Nations are now frequently covering the costs of services off-loaded by

governments but that this increases those First Nations' debts. They also suggested that many innovative ideas exist but that they do not get adequately supported because of jurisdictional conflicts. Métis participants recommended that the First Nations and Inuit Health Branch in Health Canada also becomes a health provider for Métis, in recognition that Métis are an Aboriginal people, though other participants commented that First Nations, Inuit and Métis should still be treated as distinct peoples. Other participants cautioned that there was a danger of duplicating services if too many organizations were involved in service delivery.

One issue that came up several times was the relationship among treaty rights, self-determination and healthcare. Several participants wanted to see self-government implemented and saw self-determination as a health issue. Participants were curious about how the Blueprint would affect treaty rights and jurisdictional responsibilities. They also noted that people will not let go of their jurisdiction easily but that they can work together; they must have autonomy and respect, however, before joint ventures can occur.

6. Developing On-going Collaborative Working Relationships

As was the case in the other meetings, participants in the Prince Albert meeting identified effective communications as the key to good collaborative working relationships. Participants stressed the importance of getting more input into the planning process, especially from residents in communities, as changes need to come from the community level. Several participants recommended that officials travel into the north to see and hear first hand what is really happening there. Participants also noted that there is a level of mistrust of consultations, as there have been many previous consultations that have not led to meaningful, beneficial changes. In the face of this mistrust, transparency and long-term commitment to dialogue becomes important to building the ongoing relationships that allow groups to plan and work together across boundaries. One participant noted that health region staff hear about issues through anecdotes, but they recognize the need to make linkages regular and systematic so that information flows regularly and changes can be made in response to feedback. Other participants noted that Chiefs within the tribal councils already discuss their best practices with one another so they are not acting in isolation. One other important point that participants made was that accountability has to work both ways. Currently, First Nations are held to high standards of accountability to the federal government for their expenditures but the federal government is not accountable to First Nations, which causes suspicion and mistrust.

Participants also provided both numerous comments on how to foster a cooperative environment and examples of existing cooperative relationships that are proving effective. One point made was on the importance of establishing principles to which all parties would adhere in developing their relationships. Participants commented on the importance of taking a cooperative, rather than competitive, approach to service provision to meet the needs of small, rural communities, and suggested that communities develop integrated plans for service provision for all community members. One participant also commented that partners do not pick one another's pockets, making the point that partners' commitment to cooperation needs to be genuine; lack of trust is an issue that partners have to overcome. Several participants commented that bureaucracies

are often obstacles to cooperation and integration, and that this affects relationships among departments within a single government as well as between governments. Participants noted that front-line workers often learn how to work together on their own, even in the absence of support, and that inter-agency approaches to service delivery and problem-solving that have been established within First Nations need to be replicated within government bureaucracies. As well, participants noted that health regions need to have better relationships with First Nations, to create the kind of reciprocal awareness of issues and people that can foster cooperation.

Participants also commented on the effect of funding and reporting on cooperation. They indicated that funding has to be ongoing and based on research and long-term planning that takes place within communities for community partnerships to get established and function, and they noted that it was difficult to run a truly integrated program when faced with multiple reporting requirements. Lastly, Métis participants noted that it was difficult for Métis to form partnerships, even if they have excellent ideas, because they lack funds to bring to a partnership to help make it work.

The participants shared numerous examples of effective partnerships that exist across northern Saskatchewan. These included such initiatives as KidsFirst North, the Northern Human Services Partnership, the Northern Intersectoral Council, the Northern Labour Market Committee, the Health Northern Communities Coalition, and the Northern Diabetes Prevention Initiative. Participants also noted that Meadow Lake has a model in which Indian and Northern Affairs Canada, the schools and families are partners in a youth program called the Family Learning Model. Other participants suggested that Kelsey Trail has a number of partnerships, many of which include Métis members. These include a KidsFirst program, an Aboriginal Directors Group, the Cumberland House Reference Panel, and a Kids Health North program. As well, one participant indicated that the Athabasca has an integrated health authority which is recognized by the federal government as a First Nations controlled entity and which is funded by the provincial government as though it was a regular health region, though it was not created through the *Regional Health Authorities Act*.

Part of building effective partnerships is representation of different communities, and participants had a number of comments on representation. Participants commented that First Nations and Métis should be better represented on health region Boards and that Aboriginal women need better representation. Métis participants commented as well that non-recognition of Métis communities as distinct communities needs to be recognized as a barrier to Métis representation. In response, participants from the health region indicated that progress is being made on this front; each community has a representative on the health region Board and the region invites community leaders to quarterly meetings.

Participants also provided governments with some advice on the Blueprint process itself and related intergovernmental issues. They stressed the importance of having the Blueprint process complement existing community-level plans, rather than supplanting what already exists, as there are good partnerships already in the north. The Northern Health Strategy was frequently identified as a good example of something to build on, as the partners have already developed a level of trust in one another and they are focused

on community-based solutions. Participants also commented that the Blueprint needs to be concerned with the historic relationships that exist between Aboriginal peoples and the Crown and, in particular, treaty rights. Related to this was an anxiety over the provincial government's involvement in the Blueprint process; participants felt it would be important to define clearly the provincial government's role and wanted the provincial government to indicate what funding it was prepared to commit to Aboriginal health, in answer to the federal government's commitment to $700M over 5 years nationally.