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Public Participation in Health Policy:

A Case Study of the Region 4 Aboriginal Community Health Council

By

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ABSTRACT

The purpose of this project was to provide an in-depth description of a community participation initiative in Calgary's urban Aboriginal population: the Region 4 Aboriginal Community Health Council. This included a documentation of the history and development of the Council, as well as a description of the Council's strategies for increasing the participation of Aboriginal persons in health policy development.

Data for this investigation was elicited from three sources. The first of these was Council documentation, including minutes and other reports; the second was 13 interviews conducted with Council members, health care providers and members of the community, and; thirdly, participant observation of Council functions.

Over the course of a decade, the Council developed from an informal working group into a legislated community health council. The Council utilized a number of public participation strategies and initiatives including a number of projects such as an urban Community Health Representative program, a national conference and an Aboriginal Hospital Representative program. Issues that will continue to challenge the Council are discussed.

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CHAPTER 1: BACKGROUND

I. INTRODUCTION

Canada's indigenous peoples are currently suffering from one of the worst health status records in the Americas (Assembly of First Nations, 1996). Chronic diseases, social concerns, environmental hazards and infectious illnesses are all found at disproportionate levels in the Aboriginal population (MacMillan, MacMillan, Offord & Dingle, 1996; Tookenay, 1996). Over the past decade, these concerns have been well documented by both the research community and government inquiries. In 1996 the final report of the Royal Commission on Aboriginal Peoples (RCAP) reported the findings of countless research studies and months of public hearings into the status of Canada's Aboriginal population. The resounding message from this Commission was clear: the policy directions followed in this country for the last 150 years have had terrible consequences on the health of Canada's Aboriginal peoples (Royal Commission on Aboriginal Peoples, 1996). In the aftermath of the Commission's release, it was obvious that fundamental changes in policy were needed to improve the health of Canada's original peoples.

Within the Aboriginal population, one of the proposed strategies for obtaining these needed changes has been to increase the involvement of Aboriginal persons in their own affairs (Crichton, Robertson, Gordon & Farrant, 1997; RCAP, 1996). At its broadest level, the exemplar for these participatory efforts can be found in the increasing lobby for self-government by a number of the First Nations. This lobby has called for an increase in the involvement of Native persons in both the infrastructure and decision-making processes of their communities. Embodied within related initiatives has been the explicit

objective to increase the involvement of Aboriginal persons in the delivery of health care to their communities (Assembly of First Nations/First Nations Health Commission, 1994; Alberta Health, 1995). Since 1986, the primary focus for this objective has been the health transfer policy: a federal initiative which has seen the control of many health services turned over to individual First Nations communities. However, the effectiveness of this policy for increasing Aboriginal involvement in health care has yet to be determined. A source of conflict is the view held by some of the First Nations that this is "an attempt by the federal government to abrogate its responsibility for First Nations health care" (AFN/FNHC, 1994, p. 8).

Another proposed avenue for increasing the participation of Aboriginal persons in the delivery of health care is through either representation on, or the organization of, committees or health councils. It is proposed that this representation would enable First Nations persons to be directly involved in health care decision making processes, including the development of health policies (Alberta Health, 1995). The focus of the present research is a decade-old participatory initiative, the goal of which has been to increase the involvement of Aboriginal persons in the delivery of health services and the development of health policies in Calgary, Alberta, Canada. This initiative is currently found in the form of a provincially legislated community health council entitled the Region 4 Aboriginal Community Health Council. It is the objective of the present investigation to provide both an in-depth description of this Council, as well as to identify and describe the strategies used by the Council to involve Aboriginal persons in health policy development and implementation.

The following literature review will first discuss the need for initiatives such as the Health Council by way of an overview of the poor health status of Canada's Aboriginal peoples. This overview is supplemented by a discussion of the health needs of the urban Aboriginal population; a group whose health needs have often been identified in the literature as being unmet (RCAP, 1996; Alberta Health, 1995; Shah, 1998). Next, the background and role of public participation in health promotion is discussed. This will include an identification of the potential benefits from public participation, as well as the barriers often associated with public participation initiatives. The focus will then narrow to a discussion of public participation efforts within the Aboriginal population. A summary of past and current participatory initiative is provided. To conclude the chapter, gaps within the literature are identified and the place of this report in filling these gaps is described.

II. THE HEALTH STATUS OF CANADA'S ABORIGINAL POPULATION

A. Introduction

Throughout this proposal the term Aboriginal population will be used for the sake of simplifying communication. However, it should be kept in mind that, as with many populations, there are many key differences that distinguish the sub-populations of Canada's Aboriginal peoples. There are, in fact, many Aboriginal Nations in this country, and the researchers do not wish to over-generalize or to deny diversity. Despite this diversity, there are some general observations that can be made based on published research and reports. It is these observations that will be presented through the first section of this literature review.

The last half of this century has seen pronounced improvements to both morbidity and mortality rates in the Aboriginal population. Unfortunately, the overall health status of Canada's Aboriginal peoples continues to remain among the poorest in this country. This situation has only heightened the call by Aboriginal leaders and the health care field to address the unique health needs of this population. Epidemiological research has identified a number of health problems that are the major contributors to this poor health picture. In recognizing the holistic conceptualizations of health found among Canada's Aboriginal peoples, these issues will be detailed through the framework of the Medicine Wheel. The Medicine Wheel has been used as a metaphor by many of the First Nations of this country to explain and conceptualize many facets of life (Cunningham, 1996; McCormick, 1996; Ross & Ross, 1992). With regard to a definition of health (which includes both wellness and an absence of illness), many Aboriginal cultures view four different components or directions on the Medicine Wheel: spiritual, physical, psychological and emotional (Cunningham, 1996; McCormick, 1996). This review will provide a discussion of health issues within the context of each of these four components. Appendix A provides one example of the Medicine Wheel, which is utilized as a framework for the information presented here. Although for the sake of organization this review will provide a health summary of each of the four directions separately, it is important to recognize that the Medicine Wheel represents a continuous circle and thus most health problems would affect more than one of the four health components. Furthermore, many First Nations persons believe that complete well-being can only be achieved when all of these parts are in harmony.

B. Physical Health

The North corner of the Medicine Wheel corresponds to those aspects related to physical well-being. Within the Aboriginal population, this component of health has been most affected by the disproportionate burden of a number of chronic and infectious diseases. The most serious health impact has been the continued rise of Type II diabetes (RCAP, 1996; Waldram, Herring & Young, 1995; Ponting 1997). Overall, diabetes incidence rates among Aboriginal persons are up to four and a half times that of the general population, with certain sub-populations (i.e., urban) being at even higher risk (AFN, 1996; MacMillan, MacMillan, Offord & Dingle, 1996). The impact of this disease is only heightened by its association with both acute and long-term complications including blindness, coronary disease, nerve damage, vascular disease and renal failure (Waldram, Herring & Young, 1996; Vander, Sherman & Luciano, 1996). Unfortunately, current health care efforts to prevent and treat chronic illnesses such as diabetes may be largely ineffective because of a lack of integration and/or understanding of Aboriginal culture (Grams et al., 1996). In response to these circumstances, the past two decades have seen an increase in the call for the provision of culturally appropriate health services to the Aboriginal population (AFN/FNHC, 1994; RCAP, 1996; MacMillan, MacMillan, Offord & Dingle, 1996).

In spite of widespread public health efforts, infectious diseases also continue to be a major burden in the Aboriginal population. Aboriginal persons are at a higher risk for a number of infectious illnesses including tuberculosis, hepatitis A and B, gastroenteritis, meningitis and, of more recent concern, HIV/AIDS (Long & Fox, 1996; MacMillan, MacMillan, Offord & Dingle, 1996). Evidence also indicates that Aboriginal children

may be at particular risk for both respiratory infections and otitis media compared to their non-Aboriginal counterparts (MacMillan, MacMillan, Offord & Dingle, 1996). Poor living conditions such as nutritional problems, inadequate housing, and a lack of proper sanitation infrastructure have been identified as the major contributing factors to many chronic and infectious illnesses (RCAP, 1996). As long as these and other prevalent risk factors continue to exist, it is likely that the disproportionate burden of these illnesses will continue to plague the Aboriginal population.

C. Emotional Health

The East corner of the Medicine Wheel is associated with emotional health. Within this component, one of the most documented health concerns has been the high rate of suicide among Aboriginal persons (See RCAP, 1995; Kirmayer, 1994; Quantz, 1997). This issue is particularly pronounced among the youngest members of the Aboriginal population. In Canada today, an Aboriginal adolescent is nearly 6 times more likely to die of suicide than their non-Aboriginal counterpart; a problem which is further compounded by the growing proportion of adolescents in the Aboriginal population (RCAP, 1995). As this population bulge of young persons enters these vulnerable developmental periods, it is predicted that the number of suicides will rise dramatically (RCAP, 1995).

Substance abuse is another well-documented health concern from within the Aboriginal population. In the 1991 Aboriginal People's Survey, nearly three-quarters of reserve residents expressed that alcoholism was a problem in their community (Ponting, 1997). Alcohol is also associated with higher rates of injuries and suicide, both of which are major causes of mortality in the Aboriginal population (Waldram, Herring & Young,

1996). A number of other emotional disorders are believed to exist at higher levels among the Aboriginal population, with children being especially vulnerable to these problems (Gotoweic & Beiser, 1994; McCormick, 1996). Unfortunately, the treatment of emotional disorders may be hindered by the reluctance of Aboriginal individuals to seek out psychological care, especially from non-Aboriginal persons (McCormick, 1996; Garret & Garret, 1994).

D. Mental Health

The South corner on the Medicine Wheel corresponds to the psychological/mental components of health. Under this heading, it is poor socio-economic conditions which are the key burdens affecting the mental well-being of the Aboriginal population. The extent of poverty and unemployment in many Aboriginal communities has had a devastating effect and recent statistics indicate that one-quarter of the total First Nations population is forced to rely on social assistance (Ponting, 1997). Unemployment rates are reported to be up to three times higher than the total Canadian population and some communities experience near-universal unemployment (Ponting, 1997). Overall, Aboriginal persons also attain a lower level of education than Canadians as a whole. While 88% of the total Canadian population possesses at least a secondary diploma, it is estimated that only a quarter of the total Aboriginal population has attained this level of education (Kirmayer, 1994; Ponting, 1997). These conditions contribute to an overall lack of opportunity among Aboriginal persons by restricting employment, income and educational opportunities. These factors have all been identified in the health promotion framework as key determinants to the health of a population (National Forum on Health, 1997). In response to these issues, health policy initiatives must be able to

incorporate the improvement of economic conditions such as employment and income, as well as the promotion and development of educational opportunities.

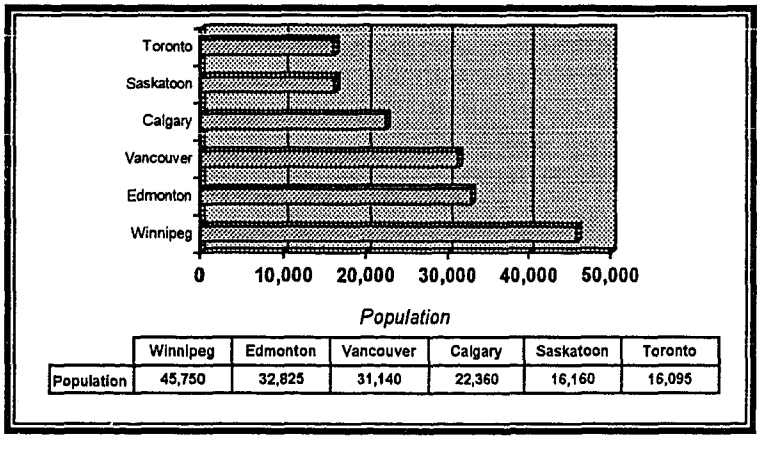
E. Spiritual Health

The West direction on the Medicine Wheel corresponds to the spiritual health of an individual or community. Health problems falling under this component can be linked to the disruption of traditional Aboriginal culture including family, language and religious beliefs (RCAP, 1996). Sociologist Emil Durkheim (1951) speculated on the negative societal impact created from such cultural disruption and termed the resulting situation *anomie.* In the Aboriginal community, anomie has been the result of both oppressive government policies and the residential school program, which hindered the language, religion and culture of Aboriginal persons (RCAP, 1996). The residential school program strictly forbade the speaking of Aboriginal languages and between 1887 and 1951, it was illegal for Aboriginal persons to participate in religious practices such as the Sun Dance and the Potlatch (RCAP, 1996; Cunningham, 1996). These barriers to their own culture, combined with the failure of government assimilation policies, have resulted in many Aboriginal persons finding themselves lost between two cultures. Today, efforts to begin healing some of the spiritual aspects found within the Medicine Wheel are evident in the attempts being made to recapture traditional beliefs and practices (RCAP, 1996).

III. A NEW CHALLENGE: URBANIZATION

The health picture of the Aboriginal population in this country is further complicated by a changing demographic profile. For example, the age distribution among Aboriginal persons has become considerably different from that found among the general population. It is estimated that 56% of the Aboriginal population is now under the age of 25, compared to a proportion of only 35% in the non-Aboriginal population (Statistics Canada, 1996). Furthermore, the birth rate among Aboriginal persons is currently twice the national average (Statistics Canada, 1996). Both of these statistics are indicative of a growing population of youth; a trend which contrasts that of the general population in this country.

Another demographic change has been the result of the increasing numbers of Aboriginal persons who live off reserve lands. According to the latest census data, a large proportion of persons of Aboriginal descent in this country now actually live off reserve lands (RCAP, 1996). Furthermore, the majority of the off-reserve population is concentrated within a handful of urban centres. As seen in Figure 1, the city of Calgary alone is home to over 22 000 people who identify themselves as being of Aboriginal



	Winnipeg	Edmonton	Vancouver	Calgary	Saskatoon	Toronto
Population	45,750	32,825	31,140	22,360	16,160	16,095

Figure 1:

Aboriginal Population by Metropolitan Areas

descent (Statistics Canada, 1996). This is the fourth largest urban Aboriginal population in the country and it also represents approximately 3% of the city's total population (Statistics Canada, 1996).

A number of factors have been speculated to explain the migration of Aboriginal persons to urban centres. First, housing availability in reserve communities is extremely limited, thus many Aboriginal persons move to the city in order to find adequate shelter (Alberta Health, 1995). A second motivation is the lack of opportunity on many reserves, either in employment or educational prospects. Many Aboriginal persons make the move to urban centres in hopes of improving their lives through better jobs or further education (AFN/FNHC, 1994). Finally, some Aboriginal persons may move in order to experience an urban environment (AFN/FNHC, 1994).

Unfortunately, many of the outcomes associated with this migration are negative and many Aboriginal persons do not find the improvements they were seeking in a move to the city. In recent years, research has begun to show that Aboriginal persons residing in urban areas actually have a poorer health status than those living on-reserve (Shah, 1998). The poorer health status of the urban Aboriginal population has been attributed to a number of factors. Of foremost concern is the fact that Aboriginal persons living in urban areas fare extremely poorly on any number of socio-economic indices. An adequate income, for example, is often hindered by a lack of suitable employment prospects for Aboriginal persons (RCAP, 1996). This situation is only exacerbated by the poor educational background that many Aboriginal persons possess (RCAP 1996; Shah & Dubeski, 1995). This inability to find suitable employment can lead to both poverty and homelessness.

Aboriginal persons' access to many health care services in the city may also prove to be inadequate because of a number of factors. First, there is often difficulty in adjusting to a provincial health care system, rather than the services provided by Medical Services Branch (Shah & Dubeski, 1995). As a result, many Aboriginal persons do not know what services are covered by health insurance and may thus be reluctant to access care (Alberta Health, 1995). Second, there are often communication difficulties in cases where an Aboriginal person does not speak English; a circumstance particularly common among the elderly (Shah, 1998). Discriminatory attitudes and a lack of culturally appropriate care from the health profession may further discourage First Nations persons from seeking health care in the Western system (Shah, 1998; RCAP, 1996). Finally, many Aboriginal persons who do not have official Status are ineligible for federal Aboriginal programs. Such programs provide at least some financial support for Status Indians and are especially important in increasing access to alcohol and drug rehabilitation programs. Overall, it is estimated that up to 70% of Aboriginal persons living off-reserve are ineligible for this type of funding (Shah, 1998).

Finally, Aboriginal persons moving to urban areas may also face a number of social challenges. For example, there may be pressure to socially integrate into their new setting. Aboriginal persons may also face stress from both discrimination and a lack of culturally appropriate services (Crichton, Robertson, Gordon & Farrant, 1997). To exacerbate the negative impact of these circumstances, a move to an urban setting often results in a decrease in the social support network for Aboriginal persons (Shah & Dubeski, 1995). This decline in support becomes even more of an issue for groups such

as the elderly, who must face numerous challenges in daily living without the support of friends or family.

IV. PUBLIC PARTICIPATION IN HEALTH PROMOTION

A. Background

With the introduction of Lalonde's (1974) *A New Perspective on the Health of Canadians*, a framework was set which began shifting the responsibility of health from the health care system to individuals. The identification of non-biological health determinants set out in this report would be an impetus for individuals to make informed lifestyle choices, and thus actively participate in caring for their own well-being (Lalonde, 1974). Since that time, the ideology of promoting health rather than curing illness has been supplemented by the identification of numerous other determinants of health beyond one's immediate and individual lifestyle choices. Among others, this list of health determinants includes education, income, culture and gender all factors which were included in the preceding discussion of Aboriginal health status. In addition to the identification of these determinants of health, the health promotion framework also outlines strategies to improve the health status of both individuals and communities. These strategies were first set out in both the Ottawa Charter and Epp's (1986) Achieving Health for All: A Framework for Health Promotion. Although a number of different strategies are outlined within these documents, there remains the common underlying principle of empowerment. This principle calls for the initial and continuing participation of the individual, family, group or community in any health promotion program.

Of specific relevance to this research is the health promotion strategy of fostering public participation. Public participation is considered to be axiomatic to both health and community development and has been continually emphasized in the policy documents of both government and international organizations (Woelk, 1992; Higgins, 1999). Epp (1986) states that the encouragement of public participation allows people to "assert control over the factors which affect their health" (Epp, 1986, p. 10). Furthermore, community participation also plays a key role in other health promotion strategies, including advocating healthy public policies and strengthening community health services (Epp, 1986). It is the purpose of the following section to provide an introduction to community participation including a review of the mechanisms for public participation; the potential benefits of public participation, and; some barriers that may exist within public participation initiatives.

B. Strategies for Public Participation

Many of the mechanisms or strategies for public participation are derivatives of those identified within Arnstein's ladder of participation. Arnstein (1969) identified 8 progressive levels which define the extent of public participation in any decision making process. These range from the lowest rung of the ladder *manipulation,* in which individuals are placed on token advisory boards or committees for the purpose of "educating them or engineering their support" (Arnstein, 1969, p. 218) to *citizen control,* in which the "public have obtained the right to govern a program or institution, to be in full charge of policy and managerial aspects, and to be able to negotiate the conditions under which others may change them" (Wiebe, MacKean & Thurston, 1999, p. 165). The choice of which level of public participation should be sought is often dependant on

the objectives for including the public in a decision making process, if they should be involved at all. Mackean and Thurston (2000, p. 18) note "any decision that will have a significant impact on a population should incorporate public values and perspectives". Thus, the first step that policy makers have to undertake in any type of public involvement would be determining if input is either desired or essential (MacKean & Thurston, 2000).

Weibe, MacKean & Thurston (1999) have identified a number of strategies for facilitating public participation. These include:

1. Informing – informing the public on the issue of interest through such mechanisms as open houses, printed materials and advertising.
2. Consultation – consulting with the public on the issue of interest through such mechanisms as public hearings, surveys and focus groups.
3. Advising – using the public in an advisory capacity on the issue of interest through such mechanisms as committees and task forces.
4. Partnership – equal power in determining the issue of interest through such mechanisms as review/regulatory/management boards, committees, and leadership councils.
5. Delegated Power – citizens hold significant power through such mechanisms as semi-autonomous community health boards, councils or coalitions.
6. Citizen Control – citizens hold the majority of decision-making power through such mechanisms as autonomous community health boards, councils or coalitions.

C. Benefits and Barriers

A number of potential benefits have been identified for involving the public in health decision-making. These benefits can be a result of both allowing the community to convey their concerns and facilitate the contribution of a wide range of expertise and opinions from the public. Ultimately, this has the potential to result in better quality decisions and, ideally, a better health care system (Praxis, 1997; MacDonald, 1993). Concurrent with this outcome can be an improved relationship with the public, resulting from an increased feeling of power and vested interest on the part of the community.

Finally, of particular interest to this investigation, public participation may also be a mechanism for providing power to disenfranchised groups (MacDonald, 1993).

Unfortunately, the widespread participation of the public in health care processes may be limited by several factors, aside from the actual desire to participate. Underlying many of these limitations are the real, and/or perceived, pre-requisites required for participation. These may include such characteristics as skills in public speaking, the ability to understand policy, professional status, education, time, income and previous experience (Woelk, 1992; Higgins, 1999). Often the very structures of participation techniques are a barrier to involvement (Higgins, 1999). Unfortunately, these factors may contribute to the exclusion of marginalized groups from these processes. To combat these barriers, Higgins (1999) recommends the development of participation techniques which reflect the daily lives, comfort level and experience of the target community.

D. Public Participation in the Aboriginal Population

In concurrence with the continued advocacy of public participation by the health promotion field, Aboriginal leaders, government officials and concerned academics have all called for a similar increase in health care delivery participation among Aboriginal persons (Young & Smith, 1992). The World Health Organization has affirmed this position, stating that increased Aboriginal involvement in health care is a fundamental prerequisite for improving the health of this population (Young & Smith, 1992). These calls for participation have partially arisen from the gross under representation of Aboriginal persons working in the Canadian health care system. Square (1996) notes that there is only one Aboriginal physician for every 33 333 Aboriginal persons. This lack of representation has been identified as one of the main reasons behind the seeming lack of

control Aboriginal persons find in our health care system (Kirkness, 1991). In response to such concerns, the Royal Commission has recommended the training of over 10 000 new Aboriginal health care workers (RCAP, 1996).

Over the past two decades, there have been a number of initiatives that have attempted to increase the participation of Aboriginal persons in their own health care (Young & Smith, 1992). These initiatives can generally be classified into three different categories. The first of these is the development and implementation of programs whose goal is to increase the number of Aboriginal health care workers. An example of this strategy can be found in the First Nations Health Careers programs, which currently operate at the Universities of British Columbia and Alberta. Such programs not only work to recruit Aboriginal Health Workers, but also provide support for First Nations students in the health care field (Kirkness, 1991). A second strategy has been the creation of the Community Health Representative (CHR). These are individuals who are hired by the federal government to provide both direct services, and health education. The goal of the CHR program is to improve the health status of Aboriginal communities by providing a referral and facilitative link for Aboriginal persons to existing health care services. These positions were originally initiated in reserve populations, but have since been expanded to include urban centres with large Aboriginal populations (Lentjes, Hasselback & Courchene, 1998).

The two strategies outlined above generally focus upon increasing the *involvement* of Aboriginal persons in health care delivery (i.e., through increasing the number of Aboriginal health workers). In contrast, another strategy has been to increase the participation of Aboriginal persons at the decision making level of health care. This

has been partly accomplished through the development of Aboriginal health authorities, boards and committees. On reserves, there are numerous manifestations of health related boards, many of which have resulted from the transfer of health programs from government to community. In Southern Alberta, for example, the Blood Tribe Board of Health (BTBH) is responsible for the delivery of health care services to the 7 000 member Blood Tribe (Young & Smith, 1992). This group includes appointed officials, a liaison person, and ordinary band members who may seek election to this board (Young & Smith, 1992). In addition to these formal health boards in reserves, a number of other informal community health committees have also served as a vehicle for increasing Aboriginal participation in health care delivery (Young & Smith, 1992). Often these are in response to a particular health concern in the community. In British Columbia, for example, the much-publicized Alkali Lake prohibition strategy began with an "informal volunteer planning committee", and in the province of Saskatchewan, there has been much use of health care dialogue action circles (Young & Smith, 1992, p. 28).

The past decade has also seen the development of a number of Aboriginal advisory committees working with government health planners at both a provincial and regional level. In many cases these advisory bodies have been a community driven response to a renewed emphasis on increasing public input into Aboriginal health policy issues. At a provincial level, for example, the British Columbia Aboriginal Health Councils provide an opportunity for Aboriginal persons from both on and off reserve to participate in reviewing and making decisions on health care intervention projects (Aboriginal Health Association of BC, 2000). These Councils provide representation across the province and their membership consists of both Aboriginal community and

government representatives. In Alberta, the development of a framework for providing mental health services to the Aboriginal population has been highlighted by the initiation of a Wisdom Committee (Alberta Mental Health Board, 2000). This committee was organized to help incorporate traditional healing practices and views into the work of the Alberta Mental Health Board.

At a regional level, the city of Edmonton has incorporated a Wisdom Council to provide vision and guidance to the Capital Health Authority on the delivery of services to Aboriginal persons (Capital Health Aboriginal Health Services, 1999). The Vancouver/Richmond Health Board also has an Aboriginal advisory committee in the form of one of the region's population health advisory committees (Vancouver/Richmond Health Board, 2000). Again, the function of this group is to advise and provide recommendations to the local health board on health issues, priorities and policies that address the health needs of the region's Aboriginal population. Finally, the city of Calgary is home to an advisory committee (and the topic of this study), the Region 4 Aboriginal Community Health Council.

V. RATIONALE

The present investigation addresses two major gaps in the knowledge surrounding public participation efforts among Canada's Aboriginal populations. The first of these shortcomings involves a lack of detailed documentation regarding community based participatory initiatives in the health sector. This study addresses this need by providing an in-depth description of a long-standing public participation initiative in Calgary's Aboriginal community: the Region 4 Aboriginal Community Health Council. This description encompasses the history and development of this group, the Council's

operations and the strategies utilized to involve the community. Such information may be of benefit to Aboriginal populations by being an example from which additional programs to involve the public in the decision making process can be developed.

The second knowledge gap this investigation addresses revolves around a lack of information regarding community participation efforts found within urban Aboriginal populations. Community participation efforts within the Aboriginal population have generally occurred within reserve settings where resources for such initiatives are more likely to be available. However, as detailed earlier in this chapter, there has been a marked population shift from reserve settings to urban centres. Furthermore, this growing urban population appears to be at a higher risk for a large number of health problems compared to those individuals living on reserves. As such, public participation efforts must respond to these demographic changes with increased initiatives for urban Aboriginals. The present research will provide important background information to advance this effort because of its detailed description of an urban-based Council's development and activities. In addition to advancing the knowledge regarding community participation efforts in the Aboriginal population, this study will also provide insight into available public participation frameworks.

VI. SUMMARY

The continuing poor health status of the Aboriginal peoples of this country has led to increasing calls for changes to improve the health of this population. Among these proposed changes have been an increase in the participation in health care delivery and health policy development by Aboriginal persons. This strategy is synonymous with one

of the key components of the health promotion framework which calls for the fostering of public participation to increase the well-being of a community. Benefits of public participation can include better quality decisions and an improved relationship with the public. A number of strategies have been used in the Aboriginal population for increasing public participation. These have ranged from an increased involvement of Aboriginal persons in health care delivery to the organization of health councils or committees, which often advise existing health authorities on Aboriginal policies. Such initiatives may provide a route through which the processes and outcomes of health policy planning could be directly influenced by the Aboriginal population.

CHAPTER 2: METHODS

I. INTRODUCTION

Chapter two first outlines the objectives and research questions for this investigation. This is followed by an overview of the study design including the methods of data collection, analysis strategies and issues of verification. The chapter is concluded with a discussion of ethical considerations and an outline for disseminating the results of this study. One of the research questions refers to the CRHA Public Participation Framework, which will be discussed in Chapter 3.

II. PURPOSE

A. Objectives

The purpose of this research project is to provide an in-depth description of an example of public participation in Calgary's Aboriginal population: the Region 4 Aboriginal Community Health Council. Three sub-objectives have been chosen to achieve this goal:

1) Document the history and development of the Aboriginal Health Council;
2) Provide a description of the strategies used by the Council to increase the participation of Native persons in the development and implementation of health policies related to their community, and;
3) Provide recommendations for increasing successful participation by assessing the perceptions of the strengths and weaknesses of different strategies for participation.

B. Research Questions

1) What are the issues and events in the history of the Aboriginal Health Council?
2) What role does the Aboriginal Health Council play in directing CRHA policies towards Aboriginal peoples? How has this role developed or changed throughout the Council's history?
3) What strategies for participation does the Aboriginal Health Council utilize to involve the city's Aboriginal population in its work? What are the perceived strengths and weaknesses of each of these strategies? What are stakeholders' opinions of these strategies?
4) How does the Council deal with the health needs of different groups in the Aboriginal population? Are Aboriginal persons from the different nations in this region well represented? Are both men's and women's health issues identified? Are special needs of different age groups considered? What are the Council's strengths and weaknesses in this regard?
5) How congruent is the Aboriginal Health Council with the CRHA's Public Participation Framework?

III. RESEARCH DESIGN

A. Qualitative Methods

The ultimate goal of a qualitative inquiry is a greater understanding of the experiences of any social or human problem (Denzing & Lincoln, 1994). To accomplish this, an emphasis is placed on capturing a rich and varied description of the opinions and experiences of those who are part of the inquiry of interest. With the overall goal of this

project being to provide a description of the experiences and opinions surrounding the Region 4 Aboriginal Community Health Council, these methods were deemed to be both appropriate and desirable for this study. Qualitative methods also hold strength for the present investigation by facilitating a direct voice for the Aboriginal population. In considering the historically uneven relationship that has existed between the Aboriginal population and the research community, studies that prioritize and incorporate Aboriginal opinions are essential to the ethical advancement of knowledge in Aboriginal health. As such, this investigation will employ a qualitative paradigm to gather a wide range of information and opinions on the development and activities of the Region 4 Aboriginal Community Health Council.

B. The Case Study

The case study has a long history across numerous disciplines and has been used extensively in both medicine and the social sciences. The use of case study methods involves systematically gathering enough information about a particular person, social setting, event or group to permit the researcher to effectively understand how it operates or functions (Berg, 1998). This method is also characterized by the placement of limitations around the case through either time and/or place. This case is thus referred to as a bounded system (Creswell, 1998). In the present research project, the bounded system refers to the development and activities of the Health Council from its origin to November 2000.

IV. METHODS

A. Data Collection

To ensure a rich and diverse collection of data, Creswell (1998) recommends the use of multiple sources of information. In following this recommendation, this study utilized a number of different methods to address each research question. The data collection methods used in this study were: document reviews; key informant interviews, and; participant observation notes.

1. Document Review

A review of documents concerning the operations, activities and policy directives of the Region 4 Aboriginal Community Health Council was undertaken. The majority of these documents consisted of the minutes kept at the Health Council's regular meetings and retreats occurring between September 1995 and November 2000. Documents from meetings taking place prior to the commencement of this research were obtained through the assistance of members from both the Council and the Calgary Regional Health Authority. A number of additional documents from both the Health Council and the CRHA were identified and provided by key informants. These additional documents included membership lists, project proposals and evaluations, correspondence and newsletters.

2. Interviews

a. Key Informant Selection

Data was collected via confidential interviews with key informants. Key informants are "individuals who provide useful insight into the group and can steer the researcher to information and contacts" (Creswell, 1998, p. 60). An initial list of key

informants was established at the beginning of the study via a review of Council documents. Those individuals who held key positions in the Health Council and/or who had served in a long-term capacity with the Council were identified for initial interviews. During these interviews, informants were asked to provide a list of contacts who they thought could also contribute to the study (Patton, 1990). A rationale for the choice of each contact was requested from the informant. Using this information, further interview candidates were identified and selected.

The selection process was guided by the desire to choose a range of informants who could best capture all points of view with regards to the Health Council; a strategy identified by Patton (1990) as maximum variation sampling. This strategy took into account the diversity of the individuals who participate in the Health Council's activities, and the diversity of the city's Aboriginal population.

b. Interview Strategy

i. Pre-Interview

Thirteen potential informants were approached either personally or by phone/email to request their participation in an interview. The initial conversation also served as an opportunity to develop rapport and inform the interview candidate about the research. All thirteen individuals contacted agreed to participate. At the time of the interview request, all candidates were also given the choice of having an Aboriginal person conduct his/her interview but none made this choice. Thus, all interviews were conducted by the same person. A convenient time and location was then arranged for the interview. All but one interview was conducted at the informant's place of employment, at which a quiet environment was provided. One informant requested the interview be

performed at a local restaurant. This location also provided a quiet environment to carry out the interview.

ii. The Interview Guide

At the beginning of each interview, a consent form was given to the informant to read and sign (See Appendix B). After consent was obtained, permission was sought to tape record the interview. All agreed to be audio-recorded. Before the interview began the informants were given the opportunity to ask questions regarding the research in general or their role within the research.

In order to ensure common data, an interview guide based on the research questions of this study was developed (See Appendix C). Topics or issues that the informant raised throughout the interview were also probed. The interview guide was adjusted as appropriate. Due to the diversity of informants' experiences with the Council, for instance, certain lines of questioning were not appropriate for particular interview candidates. New Council members were not queried regarding the early history of the Council and former Council members were not queried regarding current Council initiatives. In these cases, the interviewer may have omitted certain questions and replaced them with ones that were more appropriate for the informant.

The first line of questioning pursued the history and development of the Health Council, seeking information and opinions about the events of this process. Details regarding the informants' personal experience in becoming involved were also solicited. The informant was asked to discuss the accomplishments of the Council. The role of the Council within the Calgary Regional Health Authority was queried, including the Council's involvement in health policy development. If appropriate, the informant was

asked to comment on the region's public participation framework. The informant was asked a number of questions regarding the role of the Health Council both in the reserve population and in the urban Aboriginal population. This included a number of queries related to representation issues and strategies of the Council. Finally, to obtain reflections on the issue of the identity of the interviewer, participants were asked their opinions on the potential influences of an Aboriginal versus a non-Aboriginal interviewer.

Each interview lasted approximately one hour. No new interviews were sought after saturation was achieved (Creswell, 1998). Saturation was assessed to have occurred when no new information emerged from the interviews.

3. Participant Observation

Participant observation allows one to "observe the naturally unfolding worlds of the population under study" (Berg, 1998). In this case, the interviewer had the opportunity to observe the operations and activities of the Health Council through attendance at 9 monthly meetings and 1 retreat between November 1999 and November 2000. A conscious effort was made not to intervene or speak during the course of the Council meetings. Interactions with Council members occurred before and after meetings. Detailed field notes concerning these interactions were taken during and after these events. Prevalent issues in the Council's operations and initiatives, feelings, questions and ideas were generated by the experience.

V. ANALYSIS

A. Data Management

Interviews and field notes were transcribed verbatim into Microsoft WORD. The minutes from Council meetings and a number of other documents were scanned into Microsoft WORD using a text recognition program. All Microsoft WORD documents were checked for accuracy, formatted as needed and transferred into the qualitative software program NUD*IST 4 for storage and analysis.

B. Coding and Analysis

The author of this thesis and his supervisor were both integrally involved in data analysis. The first step in the analysis process was an extensive review of the data collected for this study. During this review, data sources were viewed individually and units of data were coded based on activities, themes, issues and events. This template provided a framework to categorize related topics in order to answer this' project's research questions. Codes are "tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study and are used to retrieve and organize data" (Miles & Huberman, 1984). Units of data ranged from phrases to paragraphs to entire documents, as appropriate. During this analysis process, regular discussions of data and results were held.

The second aspect of analysis involved the task of categorical aggregation (Creswell, 1998). In this process, the coded data are reviewed to collect similar instances in an effort to elicit common themes. This process was used to break down the data into units that could be subsequently categorized based on emerging themes (Maxwell, 1996). Emerging themes were explored between data sources in an effort to search for

relationships, consistencies and/or inconsistencies. To assist in the above processes, Maxwell recommends keeping similar codes and categories physically linked "in order not to lose the original context from which they developed" (Maxwell, 1996, p. 79). The use of the NUD*IST software program makes this possible by marking emerging themes and cross-referencing them in the various data sources. Through this process, a hierarchy of categories was continually created and in cases where codes were similar, these were merged.

As outlined in Creswell (1998), a case study analysis plan was also followed. The first step in this process was detailing a comprehensive description of the Health Council, including its history, accomplishments and activities. A chronology of events and issues in the history of the Health Council was created through the review of documents, field notes and interview data.

VI. VERIFICATION

The verification of data is an integral part of the analysis process, and was addressed through checks of the truthfulness, credibility, and transferability of all data sources (Creswell, 1998). In determining the truthfulness of data, the researcher must establish "confidence in the truth of the findings based on the research design, informants, and context" (Krefting, 1991, p.216). This was assessed using triangulation of data sources, a method of verification in which multiple and different sources of evidence are used to corroborate data and answer research questions (Creswell, 1998; Maxwell, 1996; Krefting, 1991). As previously outlined, in this study the multiple data sources consisted of documents, interview data, and field notes taken from the direct

observation of Council meetings. The triangulation of researchers was also used as a strategy for verification. The author of this thesis and his supervisor met several times to compare and contrast analysis results in order to ensure all themes, events and activities were captured.

The credibility of data refers to the accuracy with which data collected from informants is represented. Krefting (1991) describes the central issues of credibility as being "the ability of informants to recognize their experiences in the research findings (p. 219). In the present study, credibility was assessed through member checks, a technique in which the findings and interpretations of the researcher are taken to informants for verification (Creswell, 1998; Maxwell, 1996). In this case, a summary of results was presented to all informants. These individuals were asked to provide feedback on this summary and recommend any clarifications.

Transferability refers to the generalizability of information; in other words the extent to which information can be transferred to other settings (Creswell, 1998). To allow the reader to properly assess the transferability of any findings, it is recommended that rich, thick descriptions of the data be reported (Creswell, 1998; Maxwell, 1996).

VII. ETHICAL CONSIDERATIONS

Permission to conduct this research was first sought and obtained from the current Region 4 Aboriginal Community Health Council (See Appendix D). This research was also granted ethical review by the Conjoint Medical Ethics Review Board at the University of Calgary (See Appendix E). Key informants who agreed to be interviewed received a letter detailing their consent and the confidentiality of their participation.

To protect the confidentiality of informants, the sources of all quotations from interviews and field notes are not provided in this report. Other information or details that could be used to identify participants are also excluded. In the case of minutes, the names of people or organizations were replaced with an X. Both interview tapes and field notes were kept in a secure location. To further protect confidentiality, interviewees were assigned a numerical code which was used on all documents. A master list of names and codes was kept in a separate location from the interview tapes.

In light of concerns that previous research among Aboriginal populations has failed to contribute back to those communities, the researchers have a dissemination plan which will provide a direct contribution to the Health Council at the completion of this study. This includes providing a presentation of the final results of this investigation at a conference organized by the Health Council. The Health Council will also receive a report on the findings and any necessary clarification will be provided in a timely manner. Results will also be prepared for a peer-reviewed publication.

VIII. SUMMARY

A single-case study design using qualitative methods was employed for this study. To ensure a rich description of the case, data was collected from multiple sources. This included a review of documents from the Council's activities from September 1995 to November 2000; personal interviews with key informants; and field notes from participant observations of meetings the researcher attended from November 1999 to November 2000. All data was imported into NUD*IST 4 software for storage and analysis purposes. Data was categorized based on consistent themes, issues and events.

CHAPTER 3: RESULTS - HISTORY AND DEVELOPMENT

I. INTRODUCTION

There are three objectives to this chapter. The first of these is to provide an outline of the procedures that were followed by the researchers in gaining entry into the Region 4 Aboriginal Community Health Council. The second objective is to provide a summary of the data that was collected from key informant interviews and document reviews. The third objective is to provide an introduction to the Region 4 Aboriginal Community Health Council. This is accomplished through a description of the setting of the Health Council, a documentation of the history and development of this group, and a discussion of the Health Council's current role.

II. GAINING ENTRY

Kowalsky, Verhoef, Thurston and Rutherford (1996, p. 268) note that "cultural sensitivity is required when conducting research so that entry into a community will result in an effective working relationship with community members". In this case, the *community* to be accessed is the Health Council and those individuals associated with the Council. This includes past and present Council members, community representatives and CRHA employees. For this project, care was taken to ensure that the initiation of this research and the entry into this group was done in an acceptable manner to the Council. To accomplish this, information regarding the project development was presented to the Council on several occasions. The researchers made themselves available to address any questions or concerns that Council members had. A description of the steps taken in this process is presented below.

The first step taken was arranging through a CRHA representative to attend a regular meeting of the Health Council in July 1999. During this meeting, the student and his supervisor were personally introduced to Council members and a summary of the proposed research project was presented. Questions regarding the project were answered both during and after the meeting. Following this contact, a formal letter was sent to the Chair of the Health Council briefly describing the study and formally requesting permission from the Council to proceed with the research. The Council then undertook their own discussion at a regular monthly meeting. At this time, members agreed that the Council would participate in the project. The researchers were notified of this decision in October 1999 via a letter from the Chair of the Health Council.

The student, who would conduct interviews and observe meetings, began his formal entry into the Council in November 1999 through attendance at a retreat. He was invited by a Council representative to attend this retreat. The retreat provided a chance to begin to get to know Council members on a personal basis. The informal setting of this event also provided an ideal opportunity to interact, answer questions, and feedback from Council members. A positive working relationship with the Council was further enhanced by attending regular Council meetings, beginning in December 1999.

III. SAMPLE

A. Document Review

As described in the preceding chapter, two sets of documents were reviewed for this project. The first set of documents consisted of the minutes of 54 meetings and 2 retreats that occurred between September 1995 and November 2000. To our knowledge, these documents were inclusive of all meetings taking place during this time period. The

second set of materials reviewed consisted of 24 miscellaneous documents. These included membership lists, project proposals, project evaluation reports, correspondence and community newsletters.

B. Key Informants

As was the goal of the selection process, the chosen informants represented a range of backgrounds and connections with the Health Council. A total of 13 individuals were interviewed. Seven of the 13 informants were female (54%), while 8 of the 13 indicated that they were of Aboriginal descent (62%). Both past and present members of the Council were selected, as well as individuals from the C.R.H.A. and community who had knowledge of and/or involvement in the Health Council's activities

IV. CASE SETTING

A. Regionalization

Within the past decade, there have been two major avenues of health reform in the province of Alberta. These two directions have been financial downsizing and regionalization. It is the latter process which is of primary interest for describing the setting of the topic of this research. In 1993, Alberta released its first recommendations for health care reform, among which the key recommendation was the establishment of regional health structures (HEALNet, 2000). Within two years, the province "had partially devolved their responsibility [for health care] to sub-provincial regions [with] the objective being to streamline the delivery system and make it less fragmented and more responsive to community needs" (HEALNet, 2000, p. 1). Today, there are 17 regional health authorities in the province of Alberta, each with a defined geographic

boundary. These regional health structures are responsible for hospitals, continuing care facilities, public health programs and service delivery within that geographic region. A regional board is responsible for the governance of each regional health authority.

B. The Calgary Regional Health Authority

The Calgary Regional Health Authority (CRHA) in Alberta, Canada was established on April 1, 1995. It encompasses a geographic area including the entire city of Calgary and the municipalities of Cochrane, Airdrie and Crossfield. The Health Authority is responsible for the governance, planning, management and delivery of health services and facilities that serve over 800,000 residents of the region. Of primary interest to this study, the Health Authority also provides services to a large number of Aboriginal persons. Within the city itself, there are over 22 000 persons of Aboriginal descent, including the Tsuu T'ina nation reserve which is included within the CRHA boundaries. In addition, Aboriginal people living outside the health authority boundaries often access a number of CRHA services not available outside the region. Service is regularly provided to residents of the Stoney Nation to the west, Siksika Nation to the east, and the Blackfoot Nation to the South.

C. CRHA's Public Participation Framework

As part of a commitment to promoting public and community support, the CRHA initiated a process to develop and implement a regional public participation framework in 1998 (CRHA Community Affairs Committee, 1999). The goal of this project was to explicitly outline the key areas in which the public could shape and influence CRHA policy decision-making (Maloff, Bilan & Thurston, 2000). As such, this framework provides an outline of many of the guiding principles and processes for public

participation within the health authority. This includes areas for participation, the levels at which participation may occur, and the expected outcomes from public participation (CRHA Community Affairs Committee, 1999). Ultimately, this framework is an "organizing tool to guide decisions on public participation activities" within the CRHA (CRHA Community Affairs Committee, 1999, p. 6).

Community health councils were created as a key strategy for involving the public in regional health authority decision-making in this province. As will be described further in this chapter, the topic of this research is currently the only community health council within the CRHA. It is likely that the development of this framework by the CRHA may have a subsequent impact on community health councils and, concurrently, the Health Council's activities. To examine this, the interviewer queried informants on their knowledge and opinions regarding the framework. With the exception of some informants who actually work within the CRHA, informants were not aware of this framework and those who were noted that it had not yet had any influence on the Council. However, one informant noted that the Council would likely see itself as providing the opportunities for participation outlined within the framework:

> I think fundamentally, though, I think the Council acknowledges ... or would acknowledge if they've had an opportunity to view the document that it sees itself as providing that whole spectrum of opportunity for participation. To this point, within that continuum on that framework the Council's role is to provide advice and I think that ultimately there will be a time when the Council will want to become more of a partner, to go down the other extreme on the continuum, or at least, you know, want delegated responsibilities to provide services.

V. HISTORY OF THE COUNCIL

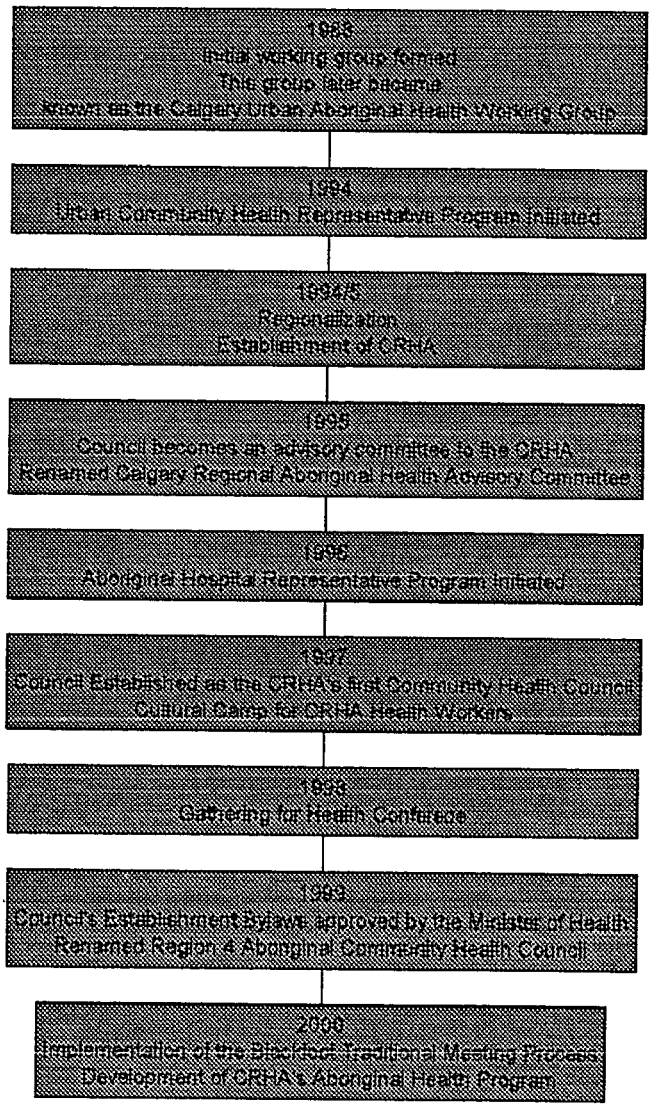
A. Origin

Figure 2 presents a timeline of the Council's history. These key events are presented within Chapters 3 and 4. The Council's beginnings can be traced back to 1988. At that time, a number of health professionals working with Calgary Health Services approached the Native Friendship Centre with the prospect of creating a group to begin addressing some of the health needs of the urban Aboriginal population. This initiative continued to grow through the increasing involvement of professionals working in Aboriginal health, as well as representatives from various Aboriginal agencies around the city of Calgary. This group eventually became known as the Calgary Urban Aboriginal Health Working Group, the first official identity for the Health Council. There was no formal membership for this group and all interested parties were encouraged to attend. Several informants provided a description of those individuals who attended the meetings of the Working Group:

> It consisted of a number of professional people who were in some form or other involved with the Aboriginal community providing service.

> It involved any Aboriginal agencies that we could entice to attend and the aim was really to try to improve the health of Aboriginals living in Calgary and the health services that were provided.

Figure 2: Council Timeline



B. Roles and Activities

Three roles and/or sets of activities in which this early working group engaged were identified. The first of these revolved around the sharing and discussion of information regarding Aboriginal health needs. One informant provided a description of this role:

> It was really an interest group, or a networking activity, to try and identify what were some of the health issues affecting Aboriginal people in the community.

The second set of activities this group pursued revolved around providing education and building awareness of urban Aboriginal health needs and cultural differences. To accomplish this, the Working Group began to contact multiple levels of government in an effort to raise these issues. Presentations were also made to hospital boards and the group provided cross-cultural awareness sessions for health care workers.

> We were pushing to have more awareness in the non-aboriginal community about Aboriginal issues. I mean that was one of the things I did, I said "what we've got to do is just collect a little bit of information about Aboriginal health in Calgary and make to the three or four different boards that existed in Calgary at the time, you know, boards of hospitals, General Hospital, Rockyview, the Foothills Hospital and then public health. And my idea was to make them more aware of the pressing issues and to get them to start to develop strategies on their own with our help, to address some of these things, some of these issues.

The third set of activities was a result of the development of a link with the former Calgary Health Services (CHS). The Working Group began to serve in an advisory capacity to the CHS with regards to Aboriginal health needs and services. Likely facilitating the development of this role was the fact that a number of early members of the Working Group were also employees of Calgary Health Services. The development of this link would also be a factor in the later stages of the Working Group's development.

C. Early Development

1. Introduction

Two events were identified that played key roles in influencing the evolution of the Working Group. The first of these was a research initiative, which was begun by the Working Group but which would eventually be completed by the Region 4 Aboriginal Health Council. The second influential factor was the regionalization of health services and the creation of the Calgary Regional Health Authority. Both of these are described below.

2. Community Health Representative Program

The Community Health Representative (CHR) Program was the first major initiative of the Calgary Urban Aboriginal Health Working Group. The driving force behind this program was a perceived lack of health services available for urban Aboriginals. An excerpt from the final evaluation of this initiative describes the sentiment that was felt by Working Group members:

> Members of the Calgary Urban Aboriginal Health Working Group had been continually frustrated by the lack of resources to effectively address the health needs of urban Aboriginals (Lentjes, Hasselback & Courchene, 1998).

Driven by this identified need, the Working Group proposed to implement and evaluate an urban Community Health Representative program within the Calgary region in the hopes of improving the availability of, access to and satisfaction with health services for urban Aboriginals. The project was developed as a research proposal that encompassed three stages:

> Phase I consisted of a pre-survey of urban Aboriginal persons to determine levels of awareness of, use of and satisfaction with urban health services; illness symptom experiences over a three month period; experience in adapting to urban life; and perceived health status.

> Phase II of the study involved employing a CHR to work with the Aboriginal community.
>
> Phase III of the study consisted of a post-survey of CHR users and non-users in order to assess changes in patterns of utilization, awareness of health services, satisfaction with health care provided and perceived health status (Lentjes, Hasselback & Courchene, 1998).

The project received funding from the Alberta Heritage Foundation for Medical Research and had the participation and support of numerous agencies, organizations and individuals. During the course of the project, the Working Group became the Advisory Committee. Before the end of the project, this Advisory Committee became the Region 4 Aboriginal Health Council. The results obtained in Phase III indicated that the program was effective for improving access for Aboriginal clients and clients also reported a high level of satisfaction with the services provided. The results of this project were detailed within two reports. The people who were responsible for the project and who authored these reports were members of the Working Group and some continued on to become Health Council members.

The undertaking of the CHR project had several points of significance for the development of the Health Council. First, it was the first major initiative that this group undertook and it provided those involved with a focus for their efforts. Informants noted how the CHR project was a rallying point for the Council:

> It was critical, I think, because it got the support of the Council in its early form, it was very much a community driven effort.
>
> That successful accessing of a resource certainly became a central point around which the Council could then focus its attention for a period of time. There was more energy and a greater willingness to do something.

Second, the research project was deemed to be a success by sources both inside and outside the Working Group and it gave the group experience in both organizational and administrative skills. Results of this project were disseminated around the province though presentations and the release of a public report. This success of the project allowed the Council to have an impact on how Aboriginal health needs were viewed both in and outside the region:

> It was a very well done research project by all accounts and it began to have an impact on how we in the region were providing or viewing Aboriginal health needs by coming up with innovative ways to begin to try and address the needs through an innovative approach...because we now have a couple of CHR individuals within the region providing services in a community based setting.

> The [CHR program] presentation to Alberta Vocational College will be reviewed by the college and considered for possible incorporation of the findings into their curriculum update for the CHR program.

Finally, the project was also identified as the focus of the transition from the Working Group to a more formalized Council:

> The CHR project would sort of stand as the transition from the advisory group to the Calgary Health Services to the region.

3. Regionalization

The process of regionalization and the resulting creation of the Calgary Regional Health Authority also had a significant impact on the future of the Working Group. Both members from the Working Group and a number of individuals from the newly formed CRHA saw an opportunity to develop a formal relationship. One informant gave his perspective regarding this setting:

> When the regionalization happened in 1994, there was an opportunity for the region to, I guess become involved with that advisory group. When the region was formed Calgary Health Services became a part of the region so with that

> came the advisory council so there was an opportunity to continue that link on a regional basis for that group.

Efforts to develop this relationship began with the invitation of CRHA board members to attend the meetings of the Working Group. This was also followed by a presentation from the Working Group to the CRHA board. Several informants described this process:

> We worked together with the health authority and got a couple of board members from the health authority to become involved with our Council. We....worked with the health authority to eventually consider and it did go ahead, for the health working group to become an actual Council.

> Gradually it evolved that it would be good for the CRHA to have more knowledge of Aboriginal people's health needs and we just kind of...they asked us if we would be interested in being a health council and that happened.

Continuing communication between these two bodies would lead to the development of a formal working relationship. In June 1995, the CRHA board unanimously passed a motion that designated the Working Group as an Advisory Committee to the CRHA. Terms of reference for the Advisory Committee were developed and unanimously approved by the Advisory Committee in September 1995 and the new identity of this group was the Calgary Regional Aboriginal Health Advisory Committee. The Terms of Reference outlined matters relating to the purpose of the Committee, duties and responsibilities, composition of the Committee and operational aspects. The Advisory Committee now officially fell under the auspices of the CRHA and its role as an advisory group would remain until it was converted into a community health council.

VI. CURRENT STATUS

A. Community Health Councils

The Ministry of Health and Wellness describes community health councils as an avenue for Albertans to provide input into the policies and services that affect their health care. Regulations were developed that allow individual health authorities to plan the role and function of community health councils within their business plans. In this way, regions can formally establish community councils through by-laws that are subsequently approved by the Minister of Health. Today, there are 64 community health councils across the province of Alberta. Within Region 4, the Calgary Regional Health Authority, there remains but one: the Region 4 Aboriginal Community Health Council. This section details the Advisory Committee became a community health council.

The process of converting the Advisory Committee into a community health council began in September 1996. At this time, the Chair reported that the region wished to have the Advisory Committee become the region's first community health council. Concurrently, the original Terms of Reference were forwarded to Alberta Health who advised that certain revisions were required in order for the advisory committee to become a community health council. Using the input received from Alberta Health, a revised version of the Terms of Reference was drafted and the Council voted to approve this revised document and forward this to the health authority. In January 1997, the Advisory Committee was notified that these revised Terms of Reference had been approved. An excerpt from the minutes of the February 1997 Committee meeting fully outlines this announcement:

> The Chair referenced the January 1997 letter from the Minister of Health in which he provided his approval for the development of the Region 4 Aboriginal Health

> Council and the Council's Terms of Reference. The Chair noted that the Region 4 Aboriginal Health Council is the first Community Health Council established by the CRHA, and it is possibly the first Aboriginal Health Council in Alberta.

The final stage of this process began in January 1998 as a result of the recently approved Provincial regulations on Community Health Councils. These regulations required that specific by-laws for each Community Health Council be approved by first the Region, and then the Minister of Health. The Council established a sub-committee to work with the Region in drafting the by-laws. Over the next several months, the sub-committee worked to develop the revised by-laws and then brought these forward to the Council. Over the course of three Council meetings, these by-laws were reviewed, revised and were finally approved by the Council to be forwarded to the CRHA and the Minister of Health in November 1998. In May 1998, the CRHA board approved these by-laws and on August 5, 1999 the Minister of Health gave his approval to the by-laws establishing the Region 4 Aboriginal Community Health Council.

B. Purpose

The purpose of the Aboriginal Health Council can be found in Article 3.1 of their establishment bylaws (See Appendix F). This mandate states:

> The primary purpose of the Council is to promote the provision of culturally appropriate health services to Aboriginal people of Region 4 and those from other regions utilizing the services of Region 4 that enhance the ability of the individual and family to achieve optimal spiritual, mental, emotional and physical health.

It is identical to that outlined in the Council's original Terms of Reference from 1995 and also mirrors the comments of informants regarding the purpose of the Council's predecessor, the Calgary Urban Aboriginal Health Working Group. Indeed, several informants noted that the guiding purpose of the Council, to improve the health of

Calgary's Aboriginal population, has remained steadfast throughout the group's development. The biggest change is in the Council's ability to accomplish that purpose:

> The goals of the Working Group were quite similar to the Council, actually, but we didn't have the status and the authority.
>
> I think we're still basically doing the same thing. We're promoting appropriate health care for Aboriginal people and I think that's the foundation of everything. The form that takes may have changed a little bit and the possibilities have expanded because of, a stamp of legitimacy that maybe wasn't there before. I think we were always legitimate but now we've got the stamp of it.

One informant noted that this focus has been a strength of the Council:

> It's really powerful to have a single vision...that vision is to improve the well being of Aboriginal persons. Once you've got a very set simple agenda, it's pretty easy to move forward.

C. Objectives and Goals

As described above, the global mandate of the Council is clear enough. To accomplish this mandate, the Council periodically sets a list of specific goals and objectives. This strategy has been a part of the Council from its time as a Working group to the present. An excerpt from the September 1997 minutes state:

> The Council's predecessor committee – the Working Committee, had set out goals and strategies for each year and this valuable practice should continue with the Health Council

Since 1997, the Council has set up retreats as planning sessions to set priorities for the coming year. Open discussion is encouraged at these retreats to facilitate ideas regarding objectives and strategies, which are recorded by a facilitator throughout the retreat. Final objectives are chosen through a rating process, during which each Council member provides a number for each goal, depending on how high a priority each goal is to them. Table 1 provides a list of the goals that were established during the 1997 and 1999 retreats. Initiatives which are a result of these goals will be discussed in Chapter four.

Table 1: Council Objectives (1997, 1999)

November 1997 Objectives	November 1999 Objectives
1. Community Needs Assessment	1. To Develop An Aboriginal Injury Prevention Program for the Calgary Region.
2. Promoting Health Careers and Increased Number of Aboriginals in Health Careers	2. To Support the Development of More Aboriginal Education & Awareness Programs in the Calgary Region.
3. Strengthening Linkages among Employment, Justice, Housing and all Aboriginal Agencies/Services	3. Promote the Development of a Centralized Aboriginal Health Center for the Calgary Region.
	4. Plan and Implement a "Bigger and Better" Health Conference for 2001.
	5. To Proactively Promote and Strategize Opportunities for Youth Involvement in Planning for the Health Needs of Calgary's Aboriginal Population.

VII. OPERATIONS

A. Membership

The Region 4 Aboriginal Community Health Council has 18 members including an executive committee consisting of a Chair, a Vice-Chair and a Secretary/Treasurer. Members are appointed to either one or two-year terms with half of the total memberships being appointed each year. Membership selection is done through a nomination and review process. The selection process is described in Article 7 of the establishment bylaws:

> (1) The Authority will seek nominations from the Aboriginal community for members identified under clause 6.3 (a) to (c). In January of each year. the Authority will advertise the Council positions available for the upcoming term and the eligibility criteria.
>
> (2) All nominations will be reviewed by a "Nomination Review Committee" established by the Authority. The Nomination Review Committee will be appointed by' the Authority and consist of two (2) members of the Aboriginal Community, two (2) members of the Council and two (2) members of the Authority. The Nomination Review Committee will put forward recommendations for Council membership to the Authority. All nominations will be considered by the Authority and the Authority will appoint the new Council members at its March meeting.

B. Meetings

The Health Council schedules regular meetings on the third Wednesday of every month, with the general exception of August. These meetings are, in most cases, held in public and both members and non-members may make announcements or presentations by a request to be added to the agenda. (See Appendix F for cases where meetings may not be held in public). Minutes are recorded during each meeting and are subsequently distributed to all members. Resolutions are voted on by Council members and either a quorum or consensus is required to pass a resolution. The Council also establishes working committees in support of its initiatives, or to seek further discussion on an issue. These working committees meet separately as required.

C. Resources

The Regional Health Authority is responsible for providing the Health Council with support in two areas: (1) Administrative support to assist with conducting meetings and normal business, and; (2) Funding to support the Council's meetings and some activities (i.e., retreats, Aboriginal Awareness day events). The direct costs associated with the latter of these two areas is approximately $10 000 annually. The costs of administrative support have been estimated by CRHA informants to be between 15 and 20 000 dollars. The CRHA also provides a location for most Council meetings. The Council is responsible for preparing and submitting an annual report of its activities for the previous year to the Health Authority by June 30.

VIII. SUMMARY

Care was taken in the initiation of this research to ensure the development of a positive working relationship. Document review, interviews and participant observation field notes were utilized for data collection in this project. The Council originated in 1988 as a Working Group consisting of both health professionals and representatives from community agencies. Two factors played key roles in the development of the Working Group: (1) The initiation of the Community Health Representative project, and; (2) The establishment of the CRHA. Both of these created a setting, which led to the creation of the formal Advisory Committee in 1995. This would subsequently become a Community Health Council in 1997, the present identity of the Health Council. Figure 2 provides a timeline of the Council.

The purpose of the Council is to improve the well-being of Calgary's urban Aboriginal population. Goals and objectives in support of that purpose are established annually by the Council. The establishment by-laws outline the operational aspects of the Council including meetings, administration and membership. The CRHA provides both administrative and financial support for the regular business of the Health Council.

CHAPTER 4: RESULTS – STRATEGIES AND ACTIVITIES

I. INTRODUCTION

The objective of this chapter is to document the strategies and activities that have been undertaken in the name of the Region 4 Aboriginal Community Health Council. For the sake of brevity and confidentiality, the specific members undertaking initiatives will not be named. Instead, the term Health Council will be used in a general sense to refer to members and their initiatives.

The chapter begins with a discussion of the methods and issues surrounding the task of representing Calgary's diverse Aboriginal population. The focus then turns to the activities of the Council by identifying the strategies and initiatives that the Health Council has utilized in its efforts to improve the well-being of Calgary's Aboriginal population. This is supplemented by a discussion of the Health Council's roles and actions within the CRHA. Next, a discussion of the elements and challenges that will likely play a role in the Health Council's future development is undertaken. Finally, the chapter concludes with an identification of the benefits that members receive from their participation in the Council.

II. REPRESENTATION

A. Calgary's Aboriginal Population

In Chapter 1, the point was made that Canada's Aboriginal peoples do not reflect a homogenous population. Rather, they are a diverse group of communities composed of many nations and backgrounds. This diversity is also characteristic of Calgary's Aboriginal population, which is comprised of Aboriginal peoples from around the

province and the country. Some of the groups represented in the city and the surrounding areas include the Blackfoot, Cree, Metis, Ojibway, Tsuu T'ina and Stoney nations. As will be discussed throughout this section, the Health Council is challenged with representing these communities through its operations and activities. During interviews, informants commented on this diversity and identified numerous elements that reflect the multifarious composition of Calgary's Aboriginal population. For example, this informant's response is typical of how the various sub-populations within the city are viewed:

> It's complex. There are those that move back and forth between the reserves that are near to Calgary and then there's people who live here all the time. There are people who don't belong to the reserve that are transient. And then there's the Metis group, the Inuit, there's the non-treaty, the treaty, the C-31 group. There's those who are of a higher socio-economic status who may tend to orient to the mainstream more. And then there's the groups that are very much outside of that mainstream and are isolated, and of course, poverty is a huge issue. And people come here for education too. So there's a real mixture.

Another informant noted the necessity for the Council to recognize the diversity within Calgary's Aboriginal population in order to avoid causing harm:

> When we use Aboriginal community, we use it with a lot of caution. We don't want people to forget that it's diverse because if you put everybody in one basket and not recognize the differences, you can do some harm.

B. Community Role

The Health Council has identified its role in the urban Aboriginal population as one of an advocate. Within this role, the Council sees itself as being responsible for attempting to represent the needs and opinions of the urban Aboriginal population in their operations and activities. Informants noted their opinions on this role:

> Well, I would say they play an advocacy role for the needs...to speak on the issues and the needs of Aboriginal people. And teaching them that we are different from the general population, we do have special needs.

> To be a voice for the Aboriginal people. To represent...to provide representation for the urban Aboriginal population. To address the issues in Aboriginal health and to try to make a difference in those areas and make change.
>
> I think their role is for us to go out into the community...really find out what it is the urban Aboriginal people want and then bring those to the Council.

In its efforts to effectively serve in this role and represent the needs of this dynamic and diverse population, the Health Council has employed a number of strategies. As described below, these strategies range from formal membership in the Council to efforts to identify the health needs of the various groups who comprise the city's Aboriginal population.

C. Strategies

1. Membership

One of the more direct approaches to representation can be seen in the Council's efforts to recruit a diverse membership group. This is partially accomplished through the requirements defined within the official establishment bylaws of the Health Council. In their discussion of representation, one informant described this strategy:

> One of the ways that we've tried to accomplish that kind of an objective is in the bylaws itself and that is, they tried to get a diverse membership on the Council. And the requirements that are in the bylaws were set up in such a way that it can hopefully accomplish that. So they're set out to encourage a diverse membership on the Council and it needs to maintain...to keep that going.

The bylaws outline three different categories of membership. There must be an equal number of members from each of these categories. The bylaws outline the 18 total membership positions as follows:

> (a) Six members from the Aboriginal community at large;
> (b) Six members from community service agencies/organizations providing services to the Region 4 Aboriginal community; an 'alternate' representative from

> the service agency/organization may attend Council meetings in place of the appointed member;
> (c) Six members who are CRHA Employees or Independent Service Providers.

In addition to the formal membership requirements outlined within the bylaws, there is also a conscious effort to recruit and select members that reflect the range of diversity within the urban Aboriginal population. One informant noted:

> When we appoint people or get people to apply to become a member of the Council, the effort is made to try to get a wide representation of various Aboriginal community elements.

Another informant noted the challenges that trying to capture this wide representation brings and the commitment required to make this task successful:

> There has to be a commitment. A commitment from the members so that they can include everybody as much as possible. That's not an easy thing to do because when you have a Council like that, they found that you can only have so many members part of the Council, otherwise it's difficult. It's difficult to be able to have too many members. So, you have to be really careful to try and include everybody and at the same time make sure it's not too big. If you get too many, then it becomes really cumbersome to try and get... make sure you accomplish a quorum.

An example of this commitment to capture the range of elements within the Aboriginal population can be found in recent efforts to increase the representation of youth on the Council. The Council recognized the importance of this growing population group within the Aboriginal community and the need for this group to become involved in the Council and in the health care system as a whole. One informant noted:

> We need to get more youth involvement so that they are knowledgeable about the kinds of services that are out there. I think they are going to be... unless we get youth involved they ah, might find that youth become isolated. And if they become isolated then more problems arise out of that isolation.

As a result of the identification of this need, the Council actively and successfully recruited a youth member. To facilitate youth involvement, the Council's minimum age

requirement for membership is only 16 years of age. The involvement of more Aboriginal youth does remain a current priority and the Council is utilizing community linkages and word of mouth to recruit more young people.

A final membership representation strategy for the Health Council is one that has been in place throughout its history. This is representation from agencies and organizations. Throughout the existence of the Council, a large number of Aboriginal agencies and organizations have had representatives participate in the Council's membership. Informants noted both positive and negative aspects to agencies and organizations playing such a key role in the Council. One informant noted that through this strategy, sub-populations can be represented on the Council through an agency member:

> Well, there are representatives on the Health Council from a lot of community agencies that work with subcultures like single parents, parenting kinds of things. Involvement with agencies that are involved with federal programs like Head Start and so on. People, I don't know if you call them that, subcultures, people with addictions are represented through agencies, people with mental health problems. There are certainly people who've been involved with advocacy for the disabled. I think the fact that most members of the council have worked with a lot of subcultures is kind of recognition that they're there and there are needs and what can we do about it.

Another informant noted that representation from agencies and organizations could actually be a limitation for the Council:

> I think one of the limitations is that the majority of the representation is probably agency representation which is limiting because it does mean that those in the general community who don't, aren't working in an agency at an administrative level or whatever, that they probably are underrepresented.

In spite of the potential benefits and/or limitations, agency and organization representation will likely continue to be a big part of the Council's membership composition. This skewed membership is not surprising for a number of reasons. First,

as described in the previous chapter, the Council originated with representatives from agencies and organizations; many of which continue to send representatives to the Health Council. Second, individuals working for agencies and organizations are more likely to be aware of the Health Council and thus become involved. The majority of informants noted that they themselves became involved with the Council through their employment with an agency or organization. Finally, some informants and Council members reported that being a member of the Health Council was a requirement of their position as an agency employee.

In conclusion, the question to be answered is how successful has the Council been in representing the range of groups who comprise Calgary's Aboriginal population within its membership. As described above, a number of strategies have been employed for this task. A breakdown of the Council's membership composition over the past year does, indeed, seem to indicate a group comprised of a wide range of Aboriginal groups, as well as non-Aboriginal persons. Table 2 provides a breakdown of membership by background.

Table 2: Membership by Background (1999, 2000)

	Blackfoot	Cree	Metis	Ojibway	Non-Aboriginal
September 1999	3	3	3	3	3
April 2000	6	3	3	3	3

The Council has also had representation from youth, Elders and a wide range of agencies and organizations. So it does appear that the Council has had success at recruiting individuals from at least some of the various sub-populations within the broader community. As informants discussed, however, capturing all facets of the

population within the Council's membership is a difficult task and it must be recognized that only a certain number of actual membership positions are available.

Four other points should also be recognized in a discussion of Council membership. First, no members are formally accountable to the population they represent as members of the Health Council. There is, of course, an obligation as a member to abide by the bylaws and mandate of the Health Council. However, only members who represent agencies have a medium for regular consultation with the constituency they represent. Second, a notable absence from the membership list is any representation from Calgary's nearest reserve populations, Tsuu T'ina and Stoney. This has been a particular challenge for the Council and is discussed in depth later in this chapter. Third, the Council's membership has and continues to include non-Aboriginal persons. This was identified as strength of the Council by a number of informants:

> Well, even the fact that we have a mixed group. I like that. Because we have not only Aboriginals in there, we have Caucasians in there.

Fourth, a final point of interest is the Council's disproportionate sex ratio. As seen in Table 3, in September 1999 women comprised 93% of the Council membership, while in April 2000 women comprised 72% of Council membership. The reason for this phenomenon is not clear, although the Council has often enjoyed a humourous comment regarding this sex disparity.

Table 3: Membership by Sex (1999, 2000)

	Female	Male
September 1999	14 (93%)	1 (7%)
April 2000	13 (72%)	5 (28%)

2. Operations

Community participation in the Council's activities is not limited to formal membership. The operations of the Council also allow for non-member participation. Council meetings are held in public and anyone may attend these meetings. One informant noted how this characteristic can facilitate non-member participation:

> It's by involving people, like the meetings are pretty well open. People can come in to listen to what's going on. We have guests come in.

Individuals attending these meetings may also make announcements and/or raise concerns by requesting to be placed on the meeting's agenda. One informant noted this is a continuation of oral traditions:

> And the fact that we have our meetings every third Wednesday of the month, it's standing, and we all know that, and many times we tell other people you know, if you want to present, ever. The oral tradition of my culture we're still using that, within that atmosphere.

As a result of this openness, many attendees at Council meetings are observers and there is regular participation in Council discussions by these individuals. In some cases, observers have even served on working committees for the Council's various initiatives. Many individuals who are observers also become formal Council members at later dates. One informant noted their experience in this regard:

> So I was going as an observer, going to sit and listen to the concerns of the people...what was happening...how the Council was helping the community at large. So then I became a voting member.

Finally, the role of an observer is also a method for former members to continue to participate in the Council activities.

The Council may also seek out the participation of specific groups in its activities. In particular, the Council has initiated a number of efforts to involve Elders within the

workings of the Council. Although a number of Elders have served in a formal membership role, the Council has also taken steps to facilitate the involvement of Elders in a non-membership role. For example, the Council will provide an honorarium for transportation costs for any Elder wishing to attend a Council meeting. The Council has previously organized an Elders sub-committee to plan activities and gather input from Elders. This excerpt from the minutes of a March 1997 meeting notes some of the efforts the Council has undertaken, including the planning for an Elders' Council:

> 7.2 Role of Elders
> The Chair briefly reviewed recent discussions and historical happenings relating to an Elders Council in the Calgary area. He then introduced X1 who has made some preliminary inquiries with a number of Elders regarding their perceptions of the need for an Elders Council. During the course of these discussions X1 learned Elders developed relatively specialized roles and each has specific skills and preferences. X1 reported that they, X2, X3 and X4 recently met to review and discuss the issues associated with the formation of an Elder's Council. They subsequently developed a questionnaire, which was prepared for the Council's review and consideration.
> The questionnaire was then distributed. It was designed to be given to the Elders to solicit their input on how they might be able to help the Aboriginal Health Council. The Council members were asked to identify any concerns or areas of inquiry which were missing from the questionnaire. In response, X5 noted that a number of issues relative to protocol and respect. The Chair suggested that one of the latest strategies coming forward would have the Aboriginal Health Council facilitate a meeting of local Elders and Elders from Southern Alberta First Nations. The purpose of this initial meeting would be to allow the Elders to meet and discuss the possibility of establishing an Elders Council.

Within the above excerpt, there is also an indication of the care taken with Elders to insure that these initiatives were undertaken in a culturally appropriate manner. In the researcher's experience with the Council, this respect for Elders was evident on numerous occasions. For example, many members called on Elders for advice on issues and, when possible, Elders were asked to say the opening prayer. The Council also

requested the guidance of an Elder in their efforts to bring a traditional process to the Council's meetings and operations.

3. Special Populations

The Council's efforts to represent the needs of different groups are not limited to the direct participation which was described in the above sections. Often this representation is accomplished through the Council's own initiative to identify and/or take action regarding the needs of a sub-population defined by either age, sex, or a health need. Formally, this role is outlined in the establishment bylaws as a function of the Council.

> Gathering information and Community input relating to the health and health needs of the Aboriginal Community served by Region 4.

One informant discussed a recent example of how the Council has functioned in this role. The informant described how the Council identified the Aboriginal HIV/AIDS population as having unmet needs in the community and, thus, the Council needed to take action to meet these needs:

> I think they've identified a number of priority areas in terms of service and the needs for Aboriginals, recognizing that Aboriginal needs are not being met. One that comes to mind immediately is the HIV population. So it was recognized as a need, so that's a group that has received special consideration and attention from the Council.

Throughout the Council's history, there are numerous other examples of the Council's efforts to identify the health needs of different populations. For example, with regards to the paediatric population, the Council has played a role in initiatives such as the Head Start Program and the development of a Children's Health Center. Information has also been presented during Council meetings on child health issues ranging from immunization to SIDS to employment. In recognizing the health needs of women, the

Council has supported a proposal for a Calgary Women's Homeless Shelter, participated in a Women's Planning Group and, again, regularly brings information on women's health issues and services around the city. As described earlier with regards to HIV/AIDS, the Council also recognizes the needs of populations based on health needs. The Council has initiated efforts to serve those with diabetes, renal patients, transplant, mental health and cardiac patients, the homeless and the disabled.

4. Consultation

The final strategy the Council utilizes to represent the health needs of Calgary's Aboriginal population is via community consultations. In most cases, these are external initiatives (i.e., CRHA, community, government) in which a Council member, or group of Council members, has participated. Table 4 provides a list of community input gathering initiatives in which the Council has previously participated.

Table 4: Participation in Consultation Initiatives

▫ City of Calgary's "Removing Barriers Listening Circle Initiative (Spring 2000)
▫ Future of Healthy Aging in Alberta — Community Consultation (Feb. 1999)
▫ Provincial Health Summit (Feb. 1999)
▫ Gathering Strength — Canada's Aboriginal Action Plan (Healing Foundation)
▫ Provincial Health Council Concerns Resolution Process Policy Framework (Aug. 1997)
▫ Provincial Health Council — "Citizens Evaluation for a Reformed Health System" (July 1997)
▫ Native Information Exchange Committee — Street People (Feb. 1997)
▫ Provincial Health Ethics Network (Jan. 1997)
▫ CRHA's Inner City Community Health Task Force (1996/97)

The Council becomes involved in these consultations through two routes. One is that the Council is approached by an outside entity to participate in a consultation initiative:

> When opportunities do come up within the region to sponsor various forums, for instance, there's been a couple of occasions in the last year when the Council was

> asked to bring people into a forum, or focus group, or what have you in making, I guess, direct inquiries and requests to members of the Council to come out.

The second avenue through which the Council becomes involved is through the initiative of its own members. Council members have brought forward numerous opportunities to participate in consultation initiatives. In some cases, members become aware of these consultations through their employment setting and feel that the Council should be a part of these efforts. For example, the recent Listening Circle was brought to the attention of the Council by a regular participant. This individual informed the Council about the initiative and suggested that the Council should become involved, as seen in this excerpt from a July 1999 meeting:

> It was also advised of an initiative underway through the City of Calgary's Community and Social Development Department, which is ultimately designed to provide opportunities to remove barriers to services provided by the City. The project involves forming a number of focus groups which will consist of community members, various service providers and municipal officials. X suggested that the Health Council needs to be aware of this initiative and further suggested that it may be appropriate for the Council to consider serving as a focus group specifically as it relates to health services for Aboriginal residents. In this way the Council will have an opportunity to contribute to a strategy and plan of action which would be designed to remove service barriers and which would contribute to improving community wellness through a partnership approach with the various stakeholders.

Through this participation, two objectives are achieved. The first is an opportunity for the Council to represent the Aboriginal population. The second is an avenue through which community needs can be identified and taken back to the Council to facilitate the planning of objectives and priorities.

D. Summary

In their efforts to effectively represent and address the health needs of Calgary's diverse Aboriginal population, the Health Council employs a number of strategies.

Through its membership, the Council attempts to select individuals who represent the range of diversity within the Aboriginal population. Explicit efforts are made to recruit members from under represented groups. The open structure of the meetings allows community members to participate in the Council without formal membership. The Council also works to address the needs of numerous sub-groups, whether identified by age, sex or a specific health issue. Finally, public input is obtained through the Council's participation in community consultation initiatives.

III. ACTIVITIES

A. Introduction

In Chapter 3, the Council's mandate for promoting the provision of culturally appropriate services among Calgary's Aboriginal peoples was described. In support of that purpose, the Health Council has utilized a number of strategies and undertaken a number of initiatives throughout its history. The purpose of this section is to provide a documentation of these activities. Three categories will be used to present these activities. The first will include a description of the strategies the Council has used to participate in initiatives originating within the community, including from agencies and organizations. The second category provides a documentation of the initiatives which have originated from the Health Council itself. The third and final category will include a description of the Council's roles and activities within the regional health authority will be described.

B. Strategies

1. External Participation

There are numerous examples of the Council's participation in community and agency/organization initiatives. Participation in community consultation efforts was previously described as one example. In addition, the Council has been a part of initiatives that have included steering committees, program proposals and research projects. As was the case with community consultation efforts, the Council becomes involved through either an invitation from the group leading the initiative, or a Council member who brings forward information about the initiative.

In participating in these external projects, one or more Council members will attend the meetings of the initiative and then provide reports back to the Council. In this way, a two-way information flow is established from the Council to the initiative's planners. This strategy has the advantage of allowing the Council to branch out in their efforts and be a part of an initiative that their own restraints (i.e., financial and human resources) may not allow. With this participation, though, there is often a substantial voluntary time commitment required for members.

In some cases, participation has been a strategy through which the Council can accomplish its' own objectives. For example, one of the Council's current goals is to support the development of an Aboriginal Health Centre. At this time, the Council is currently participating in the efforts of both a group of paediatricians and the Treaty 7 Tribal Council to develop a proposal for an Aboriginal Health Centre in the city of Calgary.

2. Links and Partnerships

Another strategy the Council has employed is the development of links or partnerships. The Council has developed links with numerous community agencies and organizations. One informant described this strategy:

> They've provided a lot of support to community members through community projects. That's when members would go and support other efforts, like the Calgary urban Aboriginal outreach project was also a partnership. They would partner with other agencies, like in Calgary the CRHA, and then there's a partnership with the HAS coalition. They would provide support to the community, depending on what the issues were and I see that happening now with the injury prevention program now that they've taken on that initiative.

3. Endorsement

The Health Council is often approached to provide their endorsement for a project. This may be either a function of the Council's role to review proposals for the CRHA that affect Aboriginal persons, or it may be an independent individual/group seeking support from the Council for various purposes (e.g., funding, partnerships). This endorsement is often provided via a letter of support from the Council. The following excerpt from the minutes of the December 1995 meeting provides an example of a organization presenting to the Council in an effort to seek their support.

> Presentation - The Calgary's Homeless Women's Centre
> X1 from Connection Housing introduced the X2 initiative to develop a Calgary Homeless Women's Centre. She distributed a copy of the Calgary's Homeless Women's Centre proposal to each of the members present. She then explained the necessity for a centre of this calibre in Calgary. She explained that it would be an emergency facility which would provide assistance for up to 25 women, and women with children. She noted that this centre would provide accommodation, meals, health and counselling services to homeless women who are in need. The purpose for her presentation was to obtain the support from the CRAHAC. It was therefore decided that the Chair would draft an appropriate letter of support to be submitted to the X2.

4. Networking

Through its members and contacts, the Council also plays a key role in a networking activity consisting of the Council, the health authority, community members and agencies. One informant noted that the Council uses this strategy to identify issues and events:

> In beginning to identify an activity or an event that might be of interest.... I guess another way of considering it would be I guess a network, a community network that would pass the word along by word of mouth.

As seen in the excerpts from Council meetings presented below, there are many examples of this network being utilized in the Council's regular activities. In these examples, this network is used to pass information on about services and to encourage community members to participate in activities.

> The Chair encouraged members to circulate this material within their organizations.
>
> X suggested that anyone interested or anyone who serves clients who may be interested should phone him for more details.
>
> X asked that the committee members use this information and encourage them to check with their colleagues in order to identify individuals who could be invited to sit on the focus groups.

5. Information Centre

Finally, the Council also stands as a centre through which information on Aboriginal health can be presented and passed on to the Aboriginal community. All of the strategies outlined above play a role in this information exchange, whether as a method for communication or the result of information. One informant described the Council as a conduit for a range of information:

> I think the Health Council is the conduit from which wellness and health will be understood interpreted, researched, where the issues will come forward. It will provide the ground from where the voices of the people will come through.

C. Initiatives

1. Education and Awareness

As a strategy for trying to improve the well being of Calgary's Aboriginal population, the Health Council has initiated a number of projects with the goal of increasing the awareness of Aboriginal health and cultural topics. Generally, these educational initiatives have been directed towards health providers. In this case, another example can be seen of the Council acting to fulfil its functions outlined within the bylaws:

> Acting to facilitate cross-cultural exchanges between Aboriginal and non-Aboriginal service providers.

Council members view these efforts as a key role for the Council:

> One of the objectives is acting to facilitate cross-cultural standards between Aboriginal and non-Aboriginal service providers. And that's a key factor that's viewed as being detrimental, or can be detrimental to Aboriginal health when clients come into the system...how they are viewed by providers because there are certainly stereotypes and lots of negative perceptions and the Council sees this as a major role in sort of bridging the gaps in understanding by trying to provide providers with a sense of Aboriginals being individuals, and health needs that need to be addressed and view them in a different mind perhaps.

One informant noted that the Council can serve as a cultural bridge between Aboriginal persons and non-Aboriginal services providers:

> It also helps, I think it's a two-way thing that it also helps the non-Aboriginal health care providers to understand what Aboriginal culture is, how the Aboriginal culture impacts on health. There has to be an understanding in both directions. And so, basically there needs to be some form of a bridge and I think the Health Council serves as a bridge, a very practical one and an informational one, as well.

a. Aboriginal Cultural Awareness Camp

In September 1997, the Council organized a Cultural Awareness Camp for CRHA employees. The camp was a three-day event and was held at the Peigan Reserve. The project was viewed as an opportunity to affect change in light of the concerns of Aboriginal patients who face stereotypes, racism and cultural misunderstandings while in the health system. One informant noted an example of why it is necessary for health providers to be aware of the issues that many Aboriginal patients may face:

> The Camp was an accomplishment because within the hospital setting, there's a lot of misunderstanding. You look at a family who have been in the residential schools; they've got their own barriers. They don't want to come in here.

Twenty-one individuals were selected to attend based on both an interest in Aboriginal health and their willingness to take back the knowledge they acquired to the setting in which they worked. The CRHA provided the funding for the project. Attendees included physicians, nurses, management and support staff. The objectives for the camp as outlined within the project proposal were:

1) The participant will gain an understanding of Aboriginal prospective and ceremony as compared to the western perspective.
2) The participant will understand the different roles and responsibilities of Elders in the Native community.
3) The participant will have an understanding of health care issues in the Aboriginal community today.
4) The participants will demonstrate an understanding of how contemporary Peigan/Blackfoot and Cree are affected by women's roles.
5) The participants will understand and identify a typical Aboriginal community as it exists today.
6) The participant will have an understanding of how the intangible existence and tangible existence are integrated.
7) The participant will have an understanding of the circle structure.

At the end of the event, participants were asked to complete an evaluation form. The Council later noted the positive feedback that was received regarding the experience and how information about this initiative would be disseminated:

> In general, X noted that the responses have been very positive and indicated a very successful Camp experience. It was then agreed that the Council would send a letter to the Region's Community Health Council Committee with a report on the Cultural Camp and would share the evaluations with the Regional Committee.

Many informants also spoke of this event as one of the key accomplishments for the Council. Not surprisingly, interest for a second camp was expressed a number of times during the course of Council meetings and in 2000, the Council initiated the planning process for a second cultural awareness camp.

b. Gathering for Aboriginal Health Conference

During the Council's planning retreat in 1997, the idea of hosting an Aboriginal health conference was put forward as one of the Council's objectives. The purpose of this conference was to bring interested parties in Aboriginal health together to open a dialogue surrounding Aboriginal health issues. As recorded in the minutes presented below, the Council described their motivations and views on holding the conference and how it could affect change:

> The council basically saw a need to bring people together to talk about Aboriginal health issues.
>
> The successful outcome of this Conference will be the creation of a more in-depth understanding and respect of the unique cultural significance as it applies to our Aboriginal peoples and the health care services that health care workers provide to them. Health care providers will also receive concrete and useful information about traditional Aboriginal views of healing and how these views might relate to contemporary medical care.

The process for this conference began with the establishment of a planning sub-committee in late 1997. Initial start up costs for the conference were acquired via a loan

from CRHA management while funding was acquired through both conference fees and sponsorships. A coordinator was hired to work with the Council sub-committee to organize the details of the conference, however, all members were encouraged to participate:

> The Chair encouraged all Council members to assist in the conference planning and to certainly participate when the Conference is held.

The conference was held in Calgary the weekend of October 19-21, 1998. Presenters and providers from a wide variety of disciplines and from across the country participated in this event. Based on the high attendance, interest and positive responses from all parties involved, the Conference was judged to be a success. The impact of holding this successful event was not lost on the Council and informants identified several areas in which the conference affected the Council. First, the conference accomplished its purpose of bringing people together to discuss and identify the main issues in Aboriginal Health. One informant noted:

> So, anyways, the initiatives that probably became the major...I thought one of the major issues and a valuable one was actually putting on that conference. Because that conference, it served a lot of very valuable results and outcomes for the Aboriginal community. It served as a way for people to come together, both Aboriginal and non-Aboriginal people, to look at health issues. To identify, to give an idea of how to identify what are the main issues that are most important for Aboriginal people.

Second, the conference served an excellent opportunity to publicize the Health Council and their activities. In addition to the high attendance, the conference was broadly covered by both local and national media sources. Some examples of the media coverage included the Sweetgrass newspaper, the Sharing Circle television program and an opportunity for the chair and vice-chair to speak on a national CBC radio program. Third, the conference was financially successful and the money made from the

conference provided the Council with funding to pursue other initiatives. Fourth, the conference also provided an opportunity to develop organizational skills among Council members. The range of planning required for this event was significant and included acquiring funding and organizing venues, speakers and events. As one informant noted, this knowledge would ultimately be a benefit for the Council in organizing further events:

> Well, one of the things we learned from doing a conference is you need a lot of good, solid planning. But after having done the conference, I hope that there will be enough members from the original conference to be part of that because those people would know what things they could have done in addition to what was done at the conference. We needed to have more time to do more work to do recording of the conference. All that was done in the original conference was a follow up documenting. A good recording the first time would really help to catch all the valuable things that came out of it. There are a number of things, a number of ideas things that members had for the conference, but it was a very, very good conference so it would be really good if they did something to follow that up.

The conference was also an example of the Council setting priorities, taking a risk and persevering against challenges. One informant noted:

> There are other weaknesses too...when we put on the Health Council conference we took a very big risk with that because we didn't have a budget. To put on a conference on a national scale was very expensive. We didn't have any money to start off, we had zero dollars and so there was a lot of risk involved. But people thought that the value of accomplishing this was so great that we should give it a try. And so there's risk involved and I guess in a sense that's sort of the weakness, if you don't have the resources, that can be a weakness. But, you know, the fact that it looks very difficult to accomplish, that's something that Council members haven't really let stand in the way. They've still gone after and moved forward with the challenges, they went ahead and tried anyways. And I think that as long as people can do that, that's gonna be...that'll keep the effort going and its worthwhile. It's so easy to not try something if it's too scary and it's too difficult.

Finally, the success of the conference has also led to the development of a second such event. Holding a second conference was identified as an objective at the Council's retreat in November 1999 and planning for this event began shortly after. This second gathering is scheduled for October 2001.

c. Aboriginal Injury Prevention Program

As part of the objectives outlined during the Council's retreat in November 1999, the Council formed a sub-committee to initiate the development of an injury prevention initiative within the Calgary region. The sub-committee has thus far pursued this initiative on two fronts. The first of these is through the undertaking of educational activities on this issue to Council members. This has included providing information about the problem through research reports, testing Council members' knowledge about injury prevention issues, inviting speakers and circulating documents on existing injury prevention efforts both inside and outside the region. The second strategy the sub-committee is utilizing is their participation in existing regional injury prevention efforts. Two sub-committee members volunteered to serve on the Calgary Injury Prevention Coalition Steering Committee. The future of this initiative will largely result from the primary mandate of these efforts which was recently identified by the Council:

> Injury prevention initiatives are an integral part of the Aboriginal Health Council's role and the Council actively engages the urban Aboriginal community in urban injury prevention efforts.

d. Education and Awareness Sessions

As another strategy, the Council also organizes and conducts educational sessions. Among these efforts have been several Aboriginal health orientation sessions to CRHA board members. These were viewed as a valuable resource by both the Council and the CRHA board:

> It was suggested that it would be valuable to provide the CRHA with an orientation to Aboriginal health issues. The orientation that Board members were provided in the Fall of 1994 was recalled and it was suggested that a similar program would be extremely valuable. It would provide the current Board members with an orientation to the health issues facing Aboriginals in the Calgary region.

> I think that that relationship is really just beginning to receive a little bit of wellness and also a little bit of respect in that relationship. And that relationship is in an evolving process and a whole lot of it depends upon education, education of ourselves and education of the Regional Health Authority. BOTH, both of us need to need to be educated in Aboriginal practice, Aboriginal values and principles.

The Council also participates in the planning and coordinating of staff cultural awareness sessions. In June 2000, the Council coordinated these efforts with National Aboriginal Day. The celebration included several presentations at the Foothills Medical Centre and an appearance by the former National Chief of the Assembly of First Nations.

2. Services

As described earlier, the Council has worked to promote an increase of Aboriginal persons working within the health system. Two initiatives of the Council reflect this objective by either directly creating positions or supporting those who are already working within the system. These initiatives are presented below.

a. Aboriginal Hospital Representative (AHR) Program

i. Development

One of the more extensive projects of the Health Council has been the implementation of the Aboriginal Hospital Representative program. The development of this initiative began in February 1996 with the establishment of the Aboriginal Health Liaison Working Group. This group was composed of both Council members and representatives from the Acute Care, Continuing Care and Public Health Branches of the CRHA. It was established for the purpose of developing a proposal for a CRHA Aboriginal Health Liaison Worker program. One informant noted the motivation behind developing this program:

> It started off with an identification of a need by the Council about Aboriginal patients who are coming into hospital, the main hospitals, and some of the difficulties that are experienced by those individuals while in hospital and in leaving hospital in terms of their follow up and, you know, going back to their community and then the links that the hospital needs to make with their respective health providers whether on the First Nations reserve or back in the community in an urban setting.

The proposal for this project was prepared and submitted to the Aboriginal Health Strategies Project Fund in March 1996, where it was subsequently turned down in September of that year. However, the group was invited to resubmit the proposal and in November 1996, the Council received word that the program had been approved for three years of funding at $50 000 per annum; an amount which the CRHA matched. The acquisition of this funding was noted as a successful element of the program's development:

> We took the opportunity to take advantage of provincial health funding programs for people wanting to get various Aboriginal health projects going and this was going on in the backdrop of limited funding and priority setting, so I think that in itself has been successful.

The program officially began with the formation of a Steering Committee in December 1996. This committee included Council members, Elders, and representatives from both the CRHA and Medical Services Branch. By March 1997, three hospital representative positions had been filled for the Foothills Medical Centre, the Peter Lougheed Centre and the Rockyview Hospital.

ii. Program Description

The AHR worker provides services within two general areas. First, they act to provide support and information to hospital patients and their families. This includes providing education about services and protocols, providing translation services if necessary, acting as a liaison between hospital staff and patients, establishing links

between hospital staff and the patient, and facilitating traditional healing. Second, they also provide in services to any group of CRHA staff members about Aboriginal culture and how culture affects health care delivery. The final evaluation of this program noted seven specific goals that the program had accomplished:

1. Increased accessibility to hospital services.
2. Increased cultural awareness of staff.
3. Increased comfort level of families using hospital staff.
4. Increased quality of health care.
5. Social action – identifying and addressing gaps in service.
6. Caregiver growth and education.
7. Increase in compliance of Native clients to health care regimes.

In addition to the hospital representatives themselves, the program also provides further opportunities to facilitate the involvement of the greater community. These have ranged from the supervision of practicum students to the piloting of a volunteer program. The program has also initiated an Elders project, through which hospital visits from Elders can be provided.

Informants noted the importance of this accomplishment for the Council and the community. For example, one informant noted the need that this program fills in providing traditional healing practices:

> Well, the other thing is, see what this does is there is a person there like, for example, at Peter Lougheed and she has done things that were more meaningful for the patients like traditional medicine, traditional ceremony. I know I went to one. Although so many of us went through residential school where we lost our Native spiritual gifts. And some would prefer Christian, a lot of them would. For those that want traditional, like Sweetgrass, it is able to do something about that.

Another informant noted that the program provides a role model for others to become involved in service delivery:

> I think the fact even that we have hospital reps shows that Aboriginal people can get employment in the field and so it's an encouragement for others out there who might be interested, or somewhat interested.

The initial funding received supported the program for three years. At the end of that period a final evaluation was undertaken and this report was submitted to the Aboriginal Health Strategy Project Fund at Alberta Health. The Health Authority has subsequently converted the project into a permanent program for serving the needs of Aboriginal patients accessing acute care health services.

b. Aboriginal Employees Forum

Another strategy among the Council's human resources efforts has been the formation of an Aboriginal Employees Forum. The purpose of this group was to support those Aboriginal employees already working within the CRHA and to support the recruitment of further Aboriginal employees. The idea for this initiative was suggested during both regular Council meetings and meetings of the AHR Steering Committee. In March 2000, a sub-committee initiated these efforts and planned a meeting with Aboriginal employees to gauge the need for a staff forum and to solicit input for the role and activities of such a group. The Council noted that strong support for such an initiative was evident at this meeting and four objectives for the forum were identified:

1. The Forum is to serve as a support group for the CRHA's Aboriginal employees.
2. To establish and provide resources for the continuation of the CRHA's Aboriginal Employees' Forum.
3. To bridge the gap between non-Aboriginal staff and Aboriginal staff by creating cultural awareness and giving recognition to those who contribute to Aboriginal health.
4. Create awareness of Aboriginal Employees' Forum internally within the CRHA and to enhance recruitment of other Aboriginal employees for membership in the forum.

D. The Council's Role in the CRHA

This documentation of the Council's activities will be concluded with a discussion of the Council's roles and activities within the Regional Health Authority. As described previously, the Health Council is the CRHA's first and only Community Health Council to date. Formally, the Council's functions in this role are outlined within the establishment bylaws:

> 1) Providing advice and recommendations to the Calgary Regional Health Authority about Aboriginal health issues, health needs and priorities, access to health services, the promotion of health, policies and practices related to the provision of health services and any other matters impacting Aboriginal Health.
>
> 2) Acting as a liaison between the Calgary Regional Health Authority and Aboriginal people served by Region 4.
>
> 3) Reviewing all proposals related to the health and health needs of Aboriginal people served by Region 4 and providing advice and recommendations to the Calgary Regional Health Authority on such proposals.

These functions outline the Council's capacity as both a liaison to the CRHA and an advisory body, through its activities of policy review and recommendations. Informants provided their own opinions on these roles and emphasized the importance and positive nature of this connection:

> It's a voice to, to the health system, the Calgary Regional Health Authority. We're an Advisory Committee, so from there we, we have a voice. You know? And I think that's really important.
>
> Well, I think it's sort of a practical role for information and a very available and direct offshoot for the connection where the people on the Council can actually come together with the people from the regional health authority. There is a definite link and connection there. It also makes a practical contact option available because of the Health Council and this contact with the different systems, the administration, the service providers, the hospitals and so on...all of the people that are working in the field. And that's important because the Aboriginal people who need the health services need to know and need to have a real recourse there for them when sometimes, perhaps, they're not receiving the services they need. And so the Health Council is there to help them...help people,

> many So, the Health Council sort of serves as an advocacy for these people.
>
> I think it plays quite a strong role, as I said that anyone who wants to start an initiative of health in the Aboriginal community, it must gain our support, whether it's for research or programs. Which means that, you know, that's a pretty strong role for the Council to play.

Informants noted that a positive relationship between the CRHA board and the Health Council has been a result of both the support and participation of several CRHA members, as well as the fact that a former Council member has been a CRHA board member for several years:

> Another thing that the working group did too, they lobbied to have an Aboriginal member on the board. And that's how X got on the board. And that was the initiative of the working group and then the advisory committee. So, you know that gains, again, more support within the board for Aboriginal issues. But I think it's because of the good working relationship too.
>
> I think the fact that one of the original members of the Aboriginal Health Council eventually went on to be a board member of the CRHA has been an ongoing boon to the community.

Lastly, informants also conveyed that they felt the Council was a way of keeping the Aboriginal issue alive with the CRHA:

> I think we're kind of a little thorn under the skin to sort of remind them that some of the things that they do on the CRHA just can't in a blanket way be applied to all people and that any health program needs to respect other cultures. That's the main thing.
>
> It's about keeping the Aboriginal issue ALIVE. I mean without some kind of a group there, I think it would be very difficult for the decision makers to realize that Aboriginal Health needs are you know, something that needs to be addressed.

E. Summary

The Health Council has pursued a number of activities in its efforts to promote the provision of culturally appropriate services for Calgary's Aboriginal population. This has included strategies for participation in initiatives from both the community and

organizations. The Council has also undertaken their own initiatives including the development of an Aboriginal Hospital Representative Program, a national conference and a CRHA Employees Forum. The Council serves as a liaison and an advisor to the CRHA. Informants noted the importance of this relationship and indicated that the Council is an avenue for keeping Aboriginal issues alive within the health authority.

IV. FUTURE INFLUENCES

A. Introduction

The Health Council and its predecessor working group have been a dynamic influence in Calgary's Aboriginal population for over a decade. As described throughout this report, a number of factors have contributed to the development of this group since its inception and there is little reason to doubt that the Council will continue to develop. The purpose of this section is to identify and describe some of the influences and issues that will affect how the Council functions and operates in the future. This includes an account of the implementation of the traditional meeting process and a description of the CRHA's Aboriginal Health Program. In concluding the results portion of this report, informants' opinions and suggestions regarding the benefits and challenges that the Council faces will be presented.

B. CRHA's Aboriginal Health Program

Throughout its history, the Health Council has faced many challenges in operationalizing objectives. These challenges are primarily a result of meeting the demands for the human and financial resources required to carry out many initiatives. As a group that is defined as both voluntary and advisory, the need for these resources

inevitably places a limit on the scope of the Council's activities, and ultimately the Council's role. In fact, several informants noted the desire for the Council to have a greater role within the community; one that would be better equipped to meet the health needs of the Aboriginal population. One informant described the challenges and solutions in achieving this expanded role:

> I guess one of the difficulties that I would see right now is that we don't have a formal operational arm within the CRHA that could actually carry out, from the operational perspective, the initiatives as recommended by the Council. If there was an operational arm with the mandate to carry out the initiatives and to coordinate Aboriginal health initiatives in the region and had a budget, we wouldn't be looking for the board to say, perhaps, give us money for this or that but it would be an ongoing operational budget, which would cover things like staff orientation to Aboriginal health, Aboriginal culture.

Over the past year, a new development within the health authority may indeed provide an opportunity for this expanded role. At the July 2000 Council meeting, it was announced that the CRHA was developing an Aboriginal Health Program:

> It was noted that planning is underway to propose a structure and process for establishing an "Aboriginal Health Program" under the Healthy Communities portfolio within the CRHA operations division. This planning activity should continue over the summer and into the fall and it is expected that by next April a program structure will be in place. Wayne noted that there is a commitment to hire senior administration personnel for the Aboriginal program and have dedicated money assigned by the Region to these programs. There will also be a more formalized process for implementing the Health Council recommendations within the Region as these recommendations will be addressed by the service portfolio.

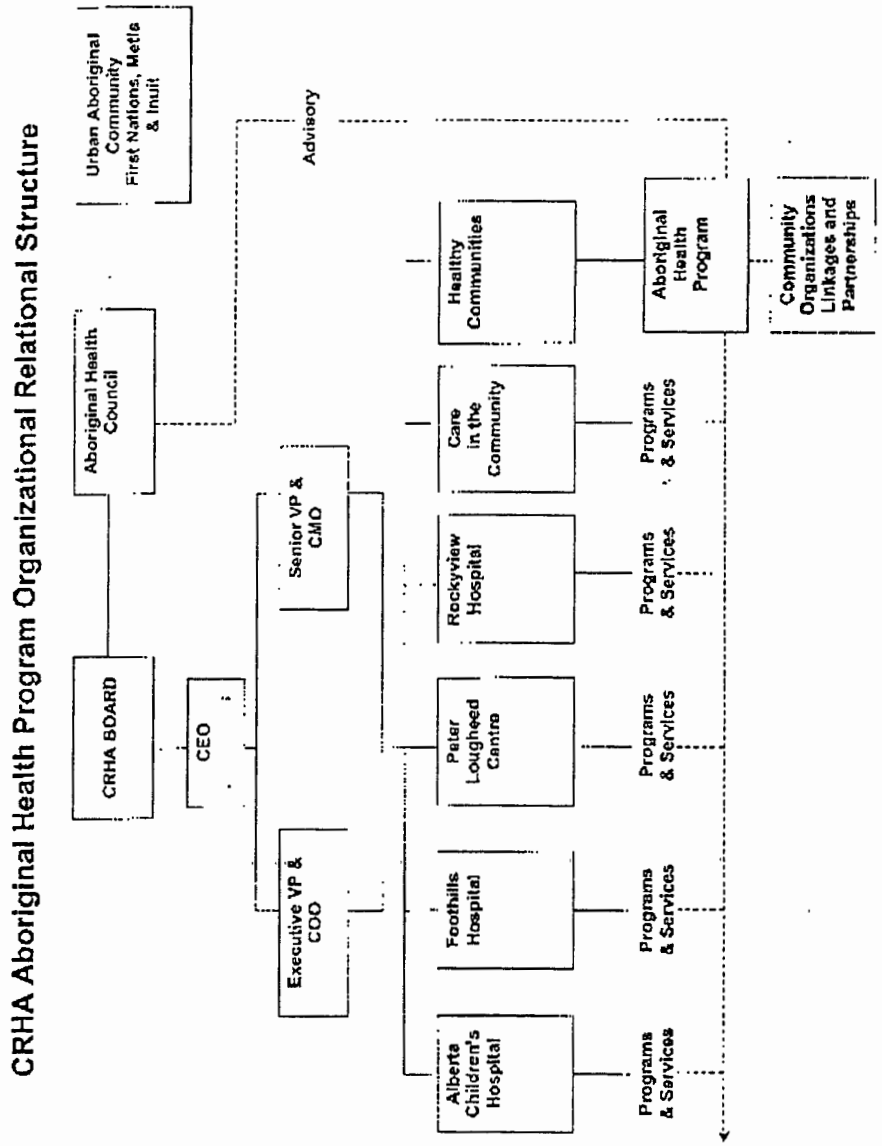
As of the present date, the Aboriginal Health Program is in its initial stages. The potential impact of such a program, however, can be speculated. Most importantly, this program represents a commitment from the health authority to take action to improve the well being of Calgary's Aboriginal population. This commitment is reflected in the CRHA's proposal for the Aboriginal Health Program:

> The Calgary Regional Health Authority recognizes the unique status of Aboriginal peoples as founding or first peoples and is committed to the development and implementation of a dedicated regional program that maximizes the health and wellness capacity of Aboriginal people who live in and/or access services within Region 4. Our commitment is based on both the recognition of the potential contribution of such a program and the specific health needs of the Aboriginal community.

As described earlier in this chapter, the relationship between the Council and the CRHA has numerous positive elements. This program has the potential to be a further step in strengthening that relationship. The program also creates the opportunity for the Health Council to expand their role within the community and may alleviate some of the challenges faced in operationalizing the Council's objectives and recommendations. Perhaps the primary issue surrounding this initiative, though, is delineating the relationship between the Council and this program.

Several organizational steps taken to date provide a partial answer to the question of this relationship. As outlined in Figure 3, the Council will now be an advisory body to both the CRHA Board and the Aboriginal Health Program. Furthermore, a planning group for the program has been assembled consisting of a CRHA advisory committee and representatives from the Council, community groups and agencies, Elders, the CRHA and the Treaty 7 Tribal Council. In spite of this organizational structure, several questions still remain and these have been voiced during recent Council meetings. For example, will these structures effectively facilitate the input of the Council? What will be the Council's expectations of this initiative? There is little doubt the Aboriginal Health program will have an impact on the Council's future development. The extent and results of this impact, however, will be determined in the coming years.

Figure 3: CRHA Aboriginal Health Program Organizational Structure



C. Traditional Meeting Process

At the Health Council's planning retreat in November 1999, the Council began down a path towards change; change that will inevitably affect how the Council operates

and functions in the future. This change encompasses an incorporation of the past teachings and practices of one of this province's First Nations into the Council's meeting structure and process. Informants viewed this process as an opportunity to become a truly Aboriginal Council:

> One of the greatest challenges of the Council, I think, is going to be how to incorporate itself so that it is truly Aboriginal which means they have to incorporate the Aboriginal culture into what they're doing.

Until now, the extent of Aboriginal cultural practices seen in the Health Council's operations have been limited to the prayers at every meeting, which are often spoken in one of the Aboriginal languages. Informants expressed frustration with this limitation and the need to incorporate further cultural elements into the meetings:

> Well one of the changes that I think would make this more effective is the direction that we're taking there about trying to change the way we were having our monthly meetings. We're trying to improve our, we're trying to instil the cultural elements into our meetings. Like in the past I wasn't very satisfied with the way meetings were going in terms of using the European style way of running meetings and saying that we had a, you know, cultural components of it. We weren't very satisfied with that, with just having a prayer beginning it, you know start the meeting and then ran the meeting in the usual way.

In response to this desire, the Council initiated a plan to implement the traditional Blackfoot process into its meetings. This began with the invitation of an Elder to guide the Council in these activities. Over the next several months, the Council began implementing various elements of this traditional process. Elements of this process have included the implementation of a traditional circle structure, the assignment of traditional roles to Council members and the use of a consensual decision making process. The Elder who was asked to guide this process attended several meetings and continues to provide feedback and instruction to the Council.

The potential impact of this change is of great interest to Council members. As one informant noted this is a challenge and a new path for the Council and the outcomes are yet to be seen:

> It's, it's, difficult because when you're used to doing something a particular way and you're very good at and it's working, it's hard to understand why we're doing something different. And on the one hand, part of the, part of peoples minds are saying, "I know, I know how to work this, I know how the Board works, I know how the process goes, and I'm comfortable, very comfortable with that. Now we're doing something else, and I'm not comfortable with that. But I am, I am getting teachings and I'm getting an understanding and it feels right, but you always want to go back to what, what is more comfortable and so I think people are, are wavering in that right now. And, and not really understanding or seeing the whole picture and the benefits of it, and it's because it's, it's something new, it's something new and something old. And so people are, are feeling a little bit of discomfort. It's hard to know or to predict exactly what's going to happen except that we have examples where this process has been initiated with health administrations. And what happened there um, I hope is what will happen with the Health Council. And what happened is an effectiveness to deal with everything it ah, efficiently and um, it keeps everything in balance, that's um, what are the issues and what do we want to accomplish? And things get built very quickly. So, when we finish this process and we become active in it, and understanding it, and comfortable with it, I think we will find the same as the Pegan Nation is that things roll through very, very easily, with much more ease than the current model that we're, that we're using. So it's effectiveness and it's ability to be able to get to the heart of the matter will just become automatic.

D. Challenges

The existence of the Council has not been without its challenges. A number of issues have affected the Council since its inception, and many of these have been the impetus for changes which have inspired the growth and development of this group. In this section, a number of issues are presented that informants have identified as being the Council's challenges in fulfilling its role within Calgary's Aboriginal population.

1. Attendance

Several informants expressed that membership attendance at Health Council meetings is a concern. One informant noted that attendance has always been a challenge for the Council:

> There's certainly one big problem with the Health Council and that is attendance. Like we really wonder sometimes if everybody is really committed to being on the Council and what their reasons are for being there because there is poor attendance. And that's always been the case. I mean even back when we were back in a working group...the number of people who attended on a really regular basis.

In some cases, individuals have joined the Health Council and attended meetings on an irregular basis, or have even stopped coming altogether. One informant noted a lack of commitment to attending meetings among some members in attending Council meetings:

> There's been kind of a core group but other people seem to view it as being optional.

During the researcher's attendance at Council meetings, he had the opportunity to observe the impact that attendance can have on the operations of this group. For example, achieving a quorum was not possible on several occasions and in one case, the low attendance at a sub-committee meeting hindered the planning of a Council initiative. At some meetings, observers actually outnumbered members and concern over attendance was voiced and discussed during several Council meetings. While the majority of members do attend meetings on a regular basis, this issue continues to remain a challenge for the Council.

2. Identifying Community Needs

Identifying the health needs of Calgary's diverse Aboriginal population was also noted as a challenge that the Council continues to face. Informants identified several

reasons behind this difficulty. One informant noted that the heterogeneity of the population can make identifying needs difficult:

> It's that ability to be able to express which is important and working with First-nations groups, often times...we run into problems getting a clear expression of what it is that they really want. From an internal perspective, they often have conflicting agendas as a population, and you...we shouldn't be expecting the various different tribes to be in agreement with each other let alone registered Indians agreeing with status Bill C-31 Indians, let alone agreement with the Metis population.

Another informant identified a lack of demographic information as an issue and the need for the Council to have this information:

> I think the weakness is that we don't have a really good handle on the number of Aboriginal people out there. We don't know who we're targeting as far as passing information on to them. If we as a Council knew more about who's out there and who needs services, I'm sure that they could develop. What I think we have to do as a Council is sort of keep a certain kind of information coming in to the Council so that we know what is happening out there. But I think generally, and this is another reason why we need to have some demographics, we need to know just what the social economic status of the Aboriginal Community is.

Informants expressed the importance of capturing the needs of the community. The Council's identified role as an advocate only heightens the importance of this task. One informant emphasized that the Council needs to ensure it continues to serve its purpose of representing the needs of the Aboriginal population:

> That's always going to be a challenge for the Health Council to make sure that it is serving its original purpose. So it needs to re-evaluate itself from time to time. One of the difficulties that can happen with the Health Council is how do you make it fit in with a major political structure that already exists so that you don't get hampered by the political structure. That's always a challenge and that's a challenge for any Council. And that's just something that can always happen in any kind of a council...the objective there is going to be to try and get around those difficulties. It's hard for a council because there's a certain amount of...when you're expressing, when you're serving a voice for the community, for the Native community, the challenge in having to voice those is always there.

3. Community Awareness

Earlier in this chapter, the strategies that the Council employs to try and involve the Aboriginal community in the Health Council and its activities were described. These ranged from direct membership to obtaining input through community consultations. Several informants noted that in spite of these efforts, many in the broader community may not be aware of the Health Council activities, or even its existence. Informants noted this as a challenge for the Council:

> If you go walking down the street and ask questions regular people there would be limited knowledge of it. I'd venture that when I say that the more organizations are more aware of it.
>
> The weakness I think would be a level of knowledge of the Health Council in the Aboriginal community.

Council members noted that word of mouth and face-to- face type efforts are indicative of those used to spread the news of the Council:

> I think its basically word of mouth a lot of it, like you know, and them getting touch with individual people. I think its basically individuals...like everybody's sort of word of mouth. They just let people know and getting people involved.

Strengths of this strategy were viewed as the personal aspects of reaching individual community members, as well as continuing the oral tradition. However, informants also noted that there needs to be an increased effort to create awareness of both the Council and culturally appropriate health services (i.e., Aboriginal Hospital Representative):

> I think the word of mouth is a good one but I think they need to improve some on creating more awareness of the Health Council. There's a lack of services too a lot of the time...a lack of culturally appropriate services in the city of Calgary, so that in itself people aren't really aware of what are the health services, like that kind of thing.

Informants made several suggestions as to how to increase the awareness of the Council in the community. These included better use of the media, including

announcements made through press conferences; a newsletter to reach the community, brochures, workshops and more educational efforts.

4. Reserve Representation

Informants also identified the task of involving the residents of Calgary's surrounding reserves as a challenge for the Council. Described in Chapter 3, the Council's mandate does include those Aboriginal persons from outside the region who utilize its services. This refers to the residents of several reserves, including the Stoney Siksika and Tsuu T'ina, which actually lies within the CRHA boundaries. While some reserves do have representation on the Council, linkages to many of these groups are noticeably absent.

> Morley...from that reserve. I find that there's no representation and yet we have a large influx of Aboriginal people coming from Morley. I think there needs to be more representation. There's a large amount of Blackfoot representation and that's good but...and then also representation from Tsuu T'ina because Tsuu T'ina is in the Region 4.

Informants felt that including the reserve population in the Council's activities was important and would make the Council more effective.

> We feel that it is very important because so many of their people come here for some services, particularly acute care services. So we need to meet their needs and we need to share.

> I think the Council would be more effective if there was representation from reserves around the city that used Calgary services in one form or another. I think that would make it much stronger.

The jurisdictional differences found in the reserve setting were noted as some the potential barriers to reaching this group:

> Unfortunately, that's an area where I don't know that the Aboriginal Health Council has really official recognition. The reserves around the city are still quite autonomous and haven't been particularly interested in being connected with the Health Council. I'm never sure of all the reasons for that. I think some of them

> are political. I think some of the reasons are that maybe they don't quite understand how they would fit in well enough. I think there's a lot of political reasons between the bands that make it difficult sometimes for them to come together under a health umbrella like the Health Council.
>
> We've tried, that is one of the things we have tried very much to improve. The jurisdiction problem, and who speaks for who, and the fact that they are a nation, and that their level of authority is at a higher level than the Regional Health Authority, has always created some issues and so we've had limited success.

Along with the Council's desire to include this group, there was also the recognition that this task must be pursued in an appropriate manner. Informants suggested that these efforts be pursued slowly and that the Council simply needs to continue to involve this population:

> I think that's something that the council realizes they have to go really slowly with... it may evolve at some point in time, but, you know, pushing for it to be speeded up could in many ways cause irreparable harm so it just has to happen eventually.

5. Time

Finally, it was noted that the voluntary nature of the group can also present a challenge for the Council. This is a result of the time limitations placed on members in their role with their Council:

> I would say that probably the biggest, not necessary an obstacle...but it does hold them back at times and I think that with any Community Health Council, if you look at the nature of the group, it's a voluntary group. They're unpaid positions so they are strictly there because they want to be but because they have lives and jobs to work at, it's difficult...to make large gains in small periods of time. Because there are ... there are only so many hours in anybody's day so it's going to be difficult, right, to concentrate totally on the job. They do meet monthly and they've established just recently and actually over time they've had a number of subgroups, sub-committees, which can easily take ten to twelve hours a month of an individual's time... and that is significant and substantial and can start adding up. Everyone has got lives of their own, work of their own ... you know, their own commitments in their other lives, if you like.

E. Benefits

In spite of any challenges, informants emphasized that interest and commitment to the Health Council remains strong:

> The Council has acted in a professional manner and is made up of members who are truly committed to improving the health of Aboriginal peoples within the region. The Council has been very successful in bringing people together from a broad section of the community and having them work together in a very committed and passionate manner to address the health care issues.

The personal experience for members was also expressed in a positive light. Informants conveyed the benefits they received as a result of their participation in the Council, both on a professional and personal basis:

> It has a very positive effect on the Aboriginal people that are actually able to be directly involved...a good feeling of confidence, accomplishment and it actually serves as a positive example of outcomes...something being done to deal with health issues

Informants noted that the Council can also provide members with educational benefits. Several noted that the Council allowed them to learn more about health services:

> I think people who participated on the Health Working Groups and so on and so forth were people that that became more aware of the needs around Health Services.

> Each group will learn more about what services are out there and available, and I think that's an important thing for the Aboriginal Community. Once you get a group of people who know a little bit more about the kind of services that are available to them, they can pass that on to other people in the community, like you know, you should be aware of these kind of service.

Another noted that the Council allows members to become familiar in working with an organization and its operations:

> I think becoming more sophisticated in dealing with a large organization as well. I mean with the people there that are involved with the Health Council and they get exposure to how an organization operates. And I think they also learn in changes, you learn to be more patient because you're dealing with a large complex organization.

Finally, one informant stated that their status as a Council member brings them recognition in other venues:

> Oh yeah. In negotiations with Health Canada, I'm recognized as a Council member. It's that kind of role that health council members play.

F. Summary

Two current initiatives were described in terms of their potential to impact on the Council's future operations and activities. These are the implementation of the Traditional Meeting Process and the development of the CRHA's Aboriginal Health Program. A number of challenges for the Council were also identified. These include inconsistent member attendance, increasing community awareness, identifying community needs and involving the reserve population and time restraints. Finally, the benefits of being a Council member were presented. These included an increase in confidence, an opportunity to increase their knowledge about health services and working with a large organization and the recognition that comes with the role of a Council member.

V. STRATEGY OVERVIEW

Within this chapter, multiple strategies and activities from the Health Council were discussed and described. Each of these elements appears to hold both positive and negative aspects. Informants' provided their opinions on these strategies and activities by noting the strengths and weaknesses they felt that each of these possessed. These opinions were presented throughout this chapter. Table 5 provides a summary of this information.

Table 5: Summary of Strategy/Activity Strengths and Weaknesses

Strategy/Activity	Strengths	Weaknesses
Membership	• Bylaws outline several categories of membership • Efforts are made to recruit under-represented groups • Agency and Organization employees provide representation for numerous sub-populations • Provides a number of benefits for participants, including skill building	• Limited number of membership positions • Some groups are not represented • Agency and Organization representation may limit participation by the general community • Significant time commitment • Member attendance can be an issue
Operations	• Open/regular meetings provide an opportunity for non-member participation	• Community members may not be aware of meetings
Consultation	• Provides an opportunity to provide input on a variety of initiatives • Allows the Council to become informed regarding issues and events affecting the Aboriginal population	• Substantial time commitment for members • Input may or may not be used by decision makers
External Initiatives	• Provides an opportunity for the Council to provide representation on activities affecting the Aboriginal population • Allows the Council to pursue objectives that may be limited by time and financial constraints	• Substantial time commitment for members
Links/Partnerships	• Allows the Council to affect and support community efforts	
Networking	• Provides a two-way flow of information between the Council and the community	• Network is limited by the range of membership

Education/Awareness Initiatives	• Provides an opportunity to educate health providers/professionals on Aboriginal health and cultural issues	• Difficulties in reaching a range of health professionals
Conferences	• Provides exposure for the Council • Allows the Council to provide an educational forum on Aboriginal health and cultural issues	• Professional involvement and structure may limit the participation of the general community
Aboriginal Hospital Representative Program	• Provides employment opportunities for Aboriginal persons • Provides a front line advocate for Aboriginal patients in the health system • Provides education to staff on Aboriginal health issues • Provides a role model for Aboriginal individuals interested in health careers	• Initial difficulties in obtaining funding
Aboriginal Employees Forum	• Provides a support network for Aboriginal employees • Promotes interest for Aboriginal persons interested in pursuing a health career	
Aboriginal Health Program	• Provides an operational arm for the Health Council • Reflects commitment of CRHA to the Health Council	• Members are unclear of the role of the Health Council within the program
Traditional Meeting Process	• Incorporates traditional Aboriginal beliefs and practices	• Challenge in effectively managing the changes associated with this initiative

CHAPTER 5: DISCUSSION

I. INTRODUCTION

This research was motivated by a lack of published literature on the public participation efforts of Canada's Aboriginal population in the health sector. It was the goal of this study to contribute to this literature through an in-depth documentation of a long-standing public participation initiative in Calgary's urban Aboriginal community: the Region 4 Aboriginal Community Health Council. Chapter 3 of this report outlined the history of this Council, as well as the key events and issues that affected its development. In Chapter 4, the roles and activities of the Council were identified and described. The final chapter has three objectives. The first is to provide a discussion of the significance of this research. The second is to provide a discussion around the results of this project and note the strengths and limitations of this strategy for public participation. Finally, the strengths and weaknesses of this research are reviewed, along with the potential for future research around public participation in the Aboriginal population.

II. CONTRIBUTION AND SIGNIFICANCE

The results of this study will help understand the history and function of the Region 4 Aboriginal Community Health Council. Detailed within this report were the key events and contextual elements that were an integral part of the Council's creation and development. This report also provided a description of the Council's strategies and activities for increasing the participation of Calgary's Aboriginal population in health policy development and implementation.

At a broader level, these results will also contribute to two other bodies of knowledge. First, the contents of this study will add to the overall picture of public participation among Canada's Aboriginal population. In addition to the Health Council, within this report are identified a number of Aboriginal public participation initiatives across Western Canada. Second, this research will contribute to an increased understanding of public participation frameworks. This study is also part of a larger investigation of public participation initiatives within the Calgary Regional Health Authority.

The results of this report hold significance for a number of reasons. First, the timing of this study corresponds with an environment of change among Canada's Aboriginal peoples. This change encompasses a desire for greater self-determination, including the areas of health policy and service delivery. As described in the background of this report, this environment has been accompanied by a number of efforts to increase the participation and control of Aboriginal peoples in their own health care. Second, this report provides a documentation of a unique organization. The Health Council is the first and only current Community Health Council within the CRHA. It is also the only known urban Aboriginal Health Council in the country. Finally, this study also holds significance by providing a discussion of representation strategies and challenges within a diverse Aboriginal population.

III. PUBLIC PARTICIPATION STRATEGIES

The Aboriginal Health Council utilizes a number of approaches for facilitating the participation of the Aboriginal community. First, there is an extensive effort within the

Council to provide information to the community. This includes keeping the Council informed regarding community initiatives, health services, etc. and subsequently passing this knowledge on to the wider community through Council members. This information strategy is accomplished through the Council's regular meetings and a network of contacts that exists through those individuals associated with the Council. The edict that knowledge is power does not seem to be lost on this group. Second, the Council utilizes community consultation as an approach for gathering public input. As described in this report, this is primarily accomplished through the Council's participation in external or government public consultation initiatives. Finally, as a whole the Council also serves as an advisory body through its role in the review and recommendation of all health policies affecting Aboriginal persons in the Calgary Region.

Some of the challenges reported within this study reflect the limitations of public participation previously identified within the literature. For example, if the perception of requiring skills, status or knowledge to participate in an initiative is a hindrance for community members to become a part of the Council, some individuals may be excluded. In considering the professional background of the majority of Council members, this perception may only be exacerbated. One of the Council's identified challenges is reaching out to and involving the wider public in the Council's activities. To accomplish this task, the Council may need to employ appropriate techniques to facilitate the participation of those who do not have experience. These techniques need to reflect the daily lives, comfort level and experience of the target community (Higgins, 1999). A recent approach to this challenge is the Council's implementation of the traditional

Blackfoot meeting process. However, caution must be taken to ensure that non-Blackfoot participants feel comfortable.

IV. IMPACT

This study identified and described the processes and outcomes associated with the activities of the Aboriginal Health Council. The impact of these activities within the Calgary Region can be seen in three groups: 1) direct participants in the Council; 2) the broader Aboriginal community, and; 3) the CRHA. The impact on each of these groups is discussed within this section.

For those who are direct participants in the Council (i.e., members, observers), the impact is primarily one of capacity building. This is a result of the skills acquired through members' participation in the multifarious list of activities that the Council undertakes. This lengthy list includes proposal writing and review, research, planning processes for a wide range of activities and programs, funding applications and the organizational skills required to operate a group like the Health Council. Working with the Council, and consequently the CRHA, also provides participants with an opportunity to become more knowledgeable with the health system and gain first hand experience with the operations of a large organization. The experience and skills acquired through this participation can enhance potential employment opportunities or provide skills that can be used in different settings.

The Council's impact on the broader Aboriginal community (i.e., those not directly associated with the Council) can also be noted in a number of areas. As described in the background of this chapter, the health status of the Aboriginal population

is considerably poorer than that of the general population in this country. Furthermore, the urban Aboriginal population may be at an even higher risk for many health problems. The vision of the Council has been to improve the health of Calgary's Aboriginal population and their activities have reflected this objective. Within the region, for example, a number of initiatives of the Council have had a direct impact on the services that Aboriginal persons access in the CRHA. Both the Aboriginal Hospital Representative program and the cross-cultural training provided for CRHA employees have a direct impact on Aboriginal persons within the system.

The Council continuously strives to capture the health needs of Calgary's Aboriginal community and the Council has undertaken or participated in numerous efforts to address these needs. For example, the objective of the Council's injury prevention initiative is to reduce the mortality and morbidity related to one of the Aboriginal community's leading health concerns. The Aboriginal community's need for a health centre motivated the Council to be part of two efforts to create these centres in the Calgary region. Finally, the Council can also have an impact by providing a link for Aboriginal persons to the health system. This link can create an opportunity for Aboriginal persons to express their concerns, gather information or even acquire employment.

Finally, the Council has had an impact on the CRHA itself. One of the Council's roles has been to create a bridge between the Aboriginal community and the health authority. This has been accomplished through a number of strategies. This has included ongoing efforts to provide education on Aboriginal cultural and health topics to CRHA

employees. This impact can also be seen through the appointment of a former Council member to the CRHA board.

V. CONCLUSION

One of the most intriguing aspects of the Health Council has been its ongoing development and growth. Since its inception, the Council has seen an increase in its membership, activities, community interest and access to resources. This is an initiative that began as an informal working group and has since evolved into the first and only Community Health Council of one of the largest health regions in Canada. It is also the first recognized urban Aboriginal Council in the country and its accomplishments include a national conference, the implementation of an Aboriginal Hospital Representative Program and the role of a liaise and adviser to the CRHA. How did this group manage to achieve this status?

There are two primary reasons behind the success of this group. Foremost of these is not surprisingly, the people who have been a part of the Council. From the beginning of this initiative, there has been a dedicated group of individuals who have provided the Council with a sense of continuity and commitment. Although some members have come and gone, this continuity has remained through the numerous developments that have occurred within this group. These people have been committed to making a change in the urban Aboriginal community and have maintained the single vision of improving the health of Calgary's urban Aboriginal population. Many of these individuals have also brought with them a set of skills and knowledge from their

professional lives. This has likely provided direction for both the Working Group and its subsequent iterations.

The second reason behind this success can be attributed to the Council's affiliation with the CRHA. This relationship has provided the Council with a number of benefits. In addition to the direct resources the Council receives from the CRHA, the Council may also benefit from a sense of credibility in its official status as a community health council to the region. The Council also benefits from the support of a number of individuals within the CRHA, some of whom played a role in the appointment of a former Council member to the CRHA board. Overall, the Council's role within the CRHA allows for a direct link to the body they are trying to influence; a circumstance which has likely facilitated the Council's changes to the region's services for Aboriginal persons. Conversely, the CRHA also benefits from the existence of the Council. The Council provides a significant investment in human resources through its members' time and expertise and continually initiates projects to improve the well being of Calgary's Aboriginal population. This arrangement does have the potential to deflect the responsibility of the region towards its Aboriginal population.

VI. STRENGTHS AND WEAKNESSES

This purpose of this section is to outline the strengths and weaknesses of this project. These are described in three categories: 1) data collection and analysis; 2) sample, and; 3) bias.

A. Data Collection and Analysis

A major strength of this project was its utilization of multiple information sources. This triangulation of data was one of the verification strategies used in this project. The minutes of every Council meeting for 6 years were used to document the operations and activities of the Health Council. Supplementing and clarifying the information from this source, was the use of additional documents and the information obtained from interviews. In capturing the experiences and opinions of the Council, the above data sources again complemented each other and allowed the researcher to verify informants' comments. Also contributing to this project was the researcher's participant observation reports. Attendance at Council meetings allowed a front line experience and allowed the researcher to supplement the meeting's minutes by identifying key issues and discussion points.

The interview strategy used by the author (i.e., the interviewer) was another strength of this study. This strategy attempted to capture common data, while allowing the interviewer to pursue additional topics. To accomplish this, a structured list of questions was utilized during each interview to ensure that data was obtained on the project's primary research questions. However, the interviewer was free to pursue additional questioning as guided by the informant during the interview process. For example, if the interviewer sensed that informants felt strongly about a particular issue or event, additional questioning regarding that topic was pursued. Many informants' were also well informed regarding some questions but not others. Again, the researcher adjusted the questioning to facilitate each interview. This strategy ultimately allowed the

interviewer to actively pursue the line of questioning which could be best answered by each informant.

Another strength of this investigation was the researchers' efforts to ensure that Council members were informed throughout the research process and that feedback and questions from the Council were answered in a timely manner. This was accomplished through several strategies. First, as outlined in Chapter 3, the researchers used care in their initial entrance to the Council. Second, one of the researchers regularly attended Council meetings and was readily available to address any questions or concerns. Finally, the researcher also used member checks by providing a summary of the case to informants and requesting any feedback. A potential weakness of this investigation may have resulted from limiting these member checks to informants. Additional Council members may have been able to further contribute by providing their own thoughts and opinions on the results of this report.

Finally, the analysis process of this project also contributed to its strengths and weaknesses. A strength of this project was the triangulation of investigators throughout the analysis stage. The researcher and his supervisor each coded the data set separately before meeting to discuss and compare the results. Most of the coding was comparable and the researchers discussed any differences. This collaborative process resulted in one coded data set. Prior to this collaboration, thesis committee members and members of a public participation research project were also provided with preliminary results. Feedback and questions from these sources regarding the preliminary results were duly noted and used to guide the student researcher during the analysis stage.

B. Sample

The objective of the sampling procedure used for this project was to capture the range of experiences and opinions of the individuals who have been, and currently are, associated with the Health Council. This objective was achieved on several fronts. First, there were opportunities to hear from individuals who had been involved with the Council for a long period, as well as those who were relatively new to the Council. This allowed the researcher to capture the opinions on the Council's past and current issues. Second, the sample of informants represented many of the agencies and organizations that play a key role in the Health Council. These included representatives from community agencies, Medical Services Branch and the Regional Health Authority. Third, the sample included a range of roles that one could have with the Council. These included past and present members, executive committee members, support personnel and observers. Finally, the sample also reflected the range of Aboriginal groups within Calgary's Aboriginal community. This included individuals who were Blackfoot, Cree, Ojibway and Metis.

There are two potential limitations to the sample obtained in this project. The first of these is with regards to ensuring that the entire range of opinions surrounding the Health Council is captured, whether these opinions are positive or negative. All of the informants in this sample had been involved with the Council for at least some period of time. It stands to reason that their continued involvement would be a result of at least some positive aspect(s) of their experience with the Council. As a result, the sample may have only reflected the opinions of those who have had a positive experience with the Council. Consequently, this sample may have omitted two groups: 1) individuals who

chose not to become members of the Council, and; 2) individuals who have joined the Council for only a very brief period before resigning their position. The experience of these individuals, whether positive or negative, remains unknown. Second, the sampling procedure did not capture the opinions of community members at large (i.e. those not associated with the Council). As described in Chapter 4, the Council has noted that the general community may not be aware of the Council. Including representatives from this group within the sample may have allowed the researcher to further delineate the Council's role within the community.

C. Bias

The potential role of bias as a weakness for this investigation should also be reported. Neither of the researchers were Aboriginal and this created the potential for them to be viewed as outsiders. This may be especially true considering the often one-sided relationship that has existed between the research community and the Aboriginal population. This context had the potential to create bias in informants' responses because of a reluctance to share sensitive information with the researchers. Two steps were taken to alleviate this potential for biased responses. First, one of the researchers had the opportunity to attend Council meetings on a regular basis and thus, was able to get to know most of the informants on a personal basis before the interview. This had the effect of increasing the comfort level of both the informant and the interviewer. Second, the researcher also offered all of the informants the opportunity to have an Aboriginal person conduct their interview. Although all agreed to have one of the researchers conduct the interview, many expressed that some informants, including themselves, may be reluctant to provide a complete interview. This project may be at least partially protected from this

bias through the use of multiple information sources to verify and supplement interview information.

Finally, the potential for bias from one of the researchers must also be noted as a potential weakness. First, in having the opportunity to become actively engaged with the Council, the researcher became friends with one of the key informants and later had another colleague and friend who became a member of the Health Council. Overall, the researcher had a very positive experience with the Council and grew to know many of its members and respect both these individuals and their work. In delineating the challenges of the Council, the researcher's close relationship with the Council may have biased his analysis and subsequent reporting Thus, this report may be biased towards the positive aspects of the Council. The triangulation of researchers in the analysis and writing stage, however, should provide a barrier against obvious omissions in reporting the Council experience.

VII. FUTURE RESEARCH

This report provided substantive documentation on a topic that had not previously been studied in depth. This investigation also generates a number of issues and questions for further consideration. One of these issues is a question of the effectiveness of community health councils in this province for obtaining public input, and subsequently influencing public policy. For a number of reasons, the Community Health Council presented in this report has been successful in this role. However, is this success a common scenario among the additional 63 community health councils in this province? What strategies have proven to be most successful for this type of community

participation? Do other community health councils face the same challenges as the Aboriginal Health Council? An evaluation and documentation of additional community health councils in this province would provide answers to such questions.

Within this document, a number of public participation initiatives within Canada's Aboriginal population were also reported. These initiatives reflected a range of strategies and structures for gathering public input and influencing policy. These examples also reflected a range of power. Some groups were able to directly operationalize their policy recommendations, while others were a strictly advisory group with little real influence. Many of these efforts are in their genesis, however, and like the Aboriginal Health Council, may face a period of growth and development. As such, all of these efforts may face similar challenges in their operations. An evaluation and comparison of these initiatives could be useful knowledge for Aboriginal groups in developing community participation efforts.

References

Aboriginal Health Association of British Columbia (2000). An overview of Aboriginal Health Council program delivery in British Columbia. Vancouver, BC: Aboriginal Health Association of B.C.

Alberta Health (1995). Strengthening the circle: what Aboriginal Albertans say about their health. Edmonton, AB: Alberta Health.

Alberta Mental Health Board (2000). Mental health establishes a relationship with Aboriginal Elders. Available: www.amhb.ab.ca/media_releases/aboriginal_news.html.

Arnstein, S.R. (1969). A ladder of participation. American Institute of Planners Journal, 35, 216-224.

Assembly of First Nations/First Nations Health Commission (1994). A discussion paper on the development of a First Nations Health Policy for consultation with First Nations. Unpublished Manuscript.

Assembly of First Nations (1996). First Nations Health Bulletin, 5, December.

Berg, B.L. (1998). Qualitative research methods for the social sciences. Toronto, ON: Allyn & Bacon.

Capital Health Aboriginal Health Services (1999). Aboriginal health services guide. Edmonton, AB: Capital Health Aboriginal Health Services.

Creswell, J.W. (1998). Qualitative inquiry and research design: choosing among five traditions. Thousand Oaks, CA: Sage Publications.

Calgary Regional Health Authority Public Participation Advisory Committee (1999). Public Participation Framework. Calgary, AB: Calgary Regional Health Authority Community Affairs Committee.

Crichton, A., Robertson, A., Gordon, C. & Farrant, W. (1997). Health care: a community concern? Calgary, AB: University of Calgary Press.

Cunningham, R. (1996). First Nations beliefs and practices related to health and illness. Vancouver, BC: Key an ow Consulting.

Denzing & Lincoln (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage.

Durkheim, E. (1951). Suicide. New York, NY: The Free Press.

Epp, J. (1986). Achieving health for all: a framework for health promotion. Ottawa, ON: Minister of Supply and Services.

Garret, J.T. & Garret, M. (1994). The path of good medicine: understanding and counseling Native American Indians. Journal of Multicultural Counselling and Development, 22, 134-144.

Gotowiec, A. & Beiser, M. (1994). Aboriginal children's mental health: unique challenges. Canada's Mental Health, Winter, 7-11.

Grams, G.D., Herbert, C., Heffernan, C., Calam, B.,Wilson, M.A.,Grzybowski, S., Brown, D. (1996). Haida perspectives on living with non-insulin-dependent diabetes. Canadian Medical Association Journal, 155, 1563-1568.

HEALNet (2000). About regionalization in Alberta. Available: www.regionalization.org

Higgins, J.W. (1999). Closer to home: the case for experiential participation in health reform. Canadian Journal of Public Health, 90, 30-34.

Kowalsky, L.O. & Verhoef, M.J., Thurston, W.E. & Rutherford, G.E. (1996). Guidelines for entry into an Aboriginal community. Canadian Journal of Native Studies, 16, 267-282.

Krefting, L (1991). Rigor in qualitative research: the assessment of trustworthiness. The American Journal of Occupational Therapy, 45, 214 – 221.

Kirkness, V. (1991). Preparing health care professionals: First Nations action agenda for the nineties. Unpublished Manuscript, University of British Columbia.

Kirmayer, L. (1994) Suicide among Canadian Aboriginal peoples. Transcultural Psychiatric Review, 31, 3-45.

Lalonde, M. (1974). A new perspective on the health of Canadians. Ottawa, ON: Ministry of Supply and Services.

Lentjes, D., Hasselback, P. & Courchene, W. (1998). Evaluation of the impact of a community health representative (CHR) program on access to and utilization of health services by Aboriginal persons in an urban setting. Unpublished manuscript.

Long, D.A. & Fox, T. (1996). Circles of healing: illness, healing and health among Aboriginal people in Canada. In D.A. Long & O.P. Dickason (Eds.) Visions of the Heart (pp. 239-267). Toronto: Harcourt Brace Canada, 1996.

MacDonald, C. (1993). Justifying public participation in health care policy making: an evaluation of individual and community based approaches. Available: www.ethics.ubc/chrismac/publications/particip.txt.

MacKean, G. & Thurston, W.E. (2000). The impact of public input: defining participation in health system decisions. Health Policy Forum, Spring, 16-19.

MacMillan, H.L., MacMillan, A.B., Offord, D.R. & Dingle, J.L. (1996). Aboriginal health. Canadian Medical Association Journal, 155, 1569-1626.

Maloff, B., Bilan, D. & Thurston, W. (2000). Enhancing public input into decision making: development of the Calgary Regional Health Authority public participation framework. Community Health, 23, 66-78.

Maxwell, J.A. (1996). Qualitative research designs: an interactive approach. Thousand Oaks: Sage Publications.

McCormick, R. (1996). Culturally appropriate means and ends of counselling as described by the First Nations people of British Columbia. International Journal for the Advancement of Counselling, 18, 163-172.

Miles, M.B. & Huberman, A.M. (1994). Qualitative data analysis: a sourcebook of new methods. Thousand Oaks, CA: Sage.

National Forum on Health (1997). Canada Health Action: Building on the Legacy. Ottawa, ON: Minister of Public Works and Government Services.

Patton, M.Q. (1990). Qualitative evaluation and research methods. Newbury Park, CA: Sage.

Ponting, J. R. (1997). First Nations in Canada: Perspectives on opportunity, empowerment, and self-determination. Montreal, PQ: McGraw-Hill Ryerson Limited.

Praxis (1997). Moving toward a framework of public involvement for the Calgary Regional Health Authority. Calgary, AB: Praxis, Inc.

Quantz, D. (1997). Cultural and self disruption: suicide among Native adolescents. Available: www.thesupportnetwork.com/CASP/cultural.htm

Ross, J. & Ross, J. (1992). Keep the circle strong: Native health promotion. Journal of Speech Language Pathology and Audiology, 16, 291-302.

Royal Commission on Aboriginal Peoples (1995). Choosing life: special report on suicide among Aboriginal people. Ottawa, ON: Minister of Supply and Services.

Royal Commission on Aboriginal Peoples (1996). People to people: nation to nation. Ottawa, ON: Minister of Supply and Services.

Shah, C.P. (1998). Public Health and Preventative Medicine in Canada. Toronto: University of Toronto Press.

Shah, C.P. & Dubeski, G. (1995). In R. Masi; L. Mensah & K.A. McLeod (Eds) Health and cultures: exploring the relationships. Oakville, ON: Mosaic Press.

Square, D. (1996). U of Manitoba delivers care to Natives, hope to Aboriginal students. Canadian Medical Association Journal, 155, 1609-1611.

Statistics Canada (1996). Population by Aboriginal group, 1996 Census, metropolitan areas. Available: www.statcan.ca/english/Pgdb/People/Population/demo39b.txt

Tookenay, V.F. (1996). Improving the health status of aboriginal people in Canada: new directions, new responsibilities. Canadian Medical Association Journal, 155, 1581-1583.

Vander, A.J., Sherman, J.H. & Luciano, D.S. (1994). Human Physiology. Toronto, ON: McGraw-Hill, Inc.

Waldram, Herring & Young, T.K. (1996). Aboriginal Health. Toronto, ON: University of Toronto Press.

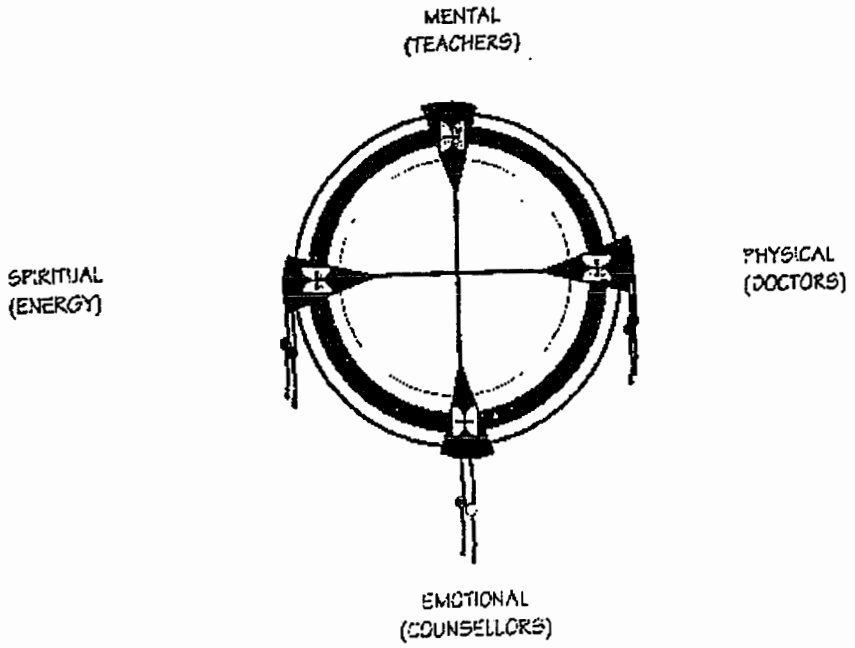
Wiebe, V.J., MacKean, G. & Thurston, W.E. (1998). Public participation in health promoting planning: a conceptual model. In W.E. Thurston, J.D. Sieppert & V.J. Wiebe (Eds.) Doing health promotion research: the science of action (161-176). Calgary, AB: University of Calgary.

Woelk, G.B. (1992). Cultural and structural influences in the creation of and participation in community health programmes. Social Sciences in Medicine, 35(4), 419-424.

World Health Organization (1986). Ottawa charter for health promotion. Ottawa: World Health Organization, Health and Welfare Canada & Canadian Public Health Association.

Young, D.E. & Smith, L.L. (1992). The involvement of Canadian Native communities in their health care programs: a review of the literature since the 1970's.: Edmonton, AB: Canadian Circumpolar Institute.

APPENDIX A: THE MEDICINE WHEEL



(From: Cunningham, 1995)

APPENDIX B: SAMPLE CONSENT FORM

Research Project Title: Public Participation in Health Policy: A case study of the Region 4 Aboriginal Community Health Council

Investigators: Darryl H. Quantz, Dr. Wilfreda E. Thurston
Sponsor: Department of Community Health Sciences, University of Calgary

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The primary purpose of this study is to provide an in-depth description of an example of public participation in Calgary's Aboriginal Community, the Region 4 Aboriginal Health Council. Specifically, this research carries three objectives. The first of these is to document the history and development of the Region 4 Aboriginal Health Council. The second is to provide a description of the strategies used by the Council to increase the participation of Native persons in the development and implementation of health policies. The third objective is to provide recommendations for increasing successful participation by assessing the strengths and weaknesses of different strategies of participation.

Your participation in this study will entail an approximately one-hour interview session. Interviews will be tape recorded and then transcribed at a later date. You are under no obligation to answer any question.

There should be no physical or emotional risk to participants of this investigation. Participation in any portion of this study is optional and may be terminated at any time. The names of any interview candidates who decline to participate will not be released. There is not likely to be any immediate direct benefit to the participant. The indirect benefits for yourself or others from this study may result from its use in the planning of community public participation initiatives.

Research reports will not identify individuals (e.g. in quotations) unless written consent is obtained. Only the principal investigators and research assistants will have access to documents, transcriptions and tapes collected in this study. They will be kept secure for 7 years and then destroyed. The identity of all key informants and Council members observed during meetings will be protected and their input kept confidential. To ensure the accuracy of data collected from interviews, member checks will be done in which the key informant will have the opportunity to review and comment on the information, which they have provided.

In the event that you suffer injury as a result of participating in this research, no compensation will be provided for you by either the University or the researchers. You still have all your legal rights. Nothing said here about compensation in any way alters your right to recover damages.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have further questions concerning matters related to this research, please contact:

Darryl Quantz
220-8285
or
Dr. Wilfreda E. Thurston
(Please call 220-4289 to contact Dr. Thurston)

If you have any questions concerning your rights as a possible participant in this research, please contact the Office of Medical Bioethics, Faculty of Medicine, University of Calgary, at 220-7990.

_____

Participant's Signature Date

_____

Investigator and/or Delegate's Signature Date

_____

Witness' Signature Date

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX C: INTERVIEW GUIDE

History and Development

1. Tell me about the history and development of the Aboriginal Health Council?
2. a) Who was involved in the events and issues which arose during the development of the Health Council? b) Can you tell me about their roles and how they participated?
3. What are the most important accomplishments of the Council?
4. a) Can you describe what the Council has done since its inception?

   b) What do you feel have been the greatest challenges?

Participation and Policy Direction

5. a) What role do you feel the Aboriginal Health Council plays in advising the CRHA's policies about Aboriginal peoples? b) Can you tell me about any difficulties or successes you have seen as a result of the role the Health Council plays in this regard?
6. Can you tell me how the Council's role has developed or changed throughout the Council's history?
7. a) What do you feel is the role of the Council in the Aboriginal population in Calgary? b) How do you see this role in the reserve population?
8. a) Can you tell me about any changes you see the Health Council undergoing? b) Are there any changes that you feel would make the Council more effective?
9. a) What strategies does the Aboriginal Health Council use to increase the involvement of Aboriginal persons in health care delivery in the city of Calgary?

b) What are your perceptions of the strengths and weaknesses of these strategies?

c) Are there any groups of Aboriginal persons you would like to reach more?

10. a) How does the Council deal with the health needs of different groups in the Aboriginal community? b) Are Aboriginal persons from different nations well represented? c) Are both men's and women's health issues identified? d) Are special needs of different age groups considered?

e) What are the Council's strengths and weaknesses in this regard?

11. a) Has the C.R.H.A. public participation framework had any influence on the work of the Council? b) If so, can you tell me about it?

Interviewer Follow-Up

12. a) Can you tell me if your choice of interviewer (i.e. Aboriginal vs. non-Aboriginal) has made any impact on your responses? b) Do you think it would make a difference in interviews with other participants?

APPENDIX D: COUNCIL APPROVAL LETTER

REGION 4 ABORIGINAL HEALTH COUNCIL

October 27, 1999

Dr. W.E. Thurston
Associate Professor
Department of Community Health Sciences
University of Calgary
3330 Hospital Drive NW
Calgary, Alberta T2N 4N1

Dear Dr. Thurston:

Thank you for your letter of October 1, 1999, in which you provided additional details on the proposed study of the Region 4 Aboriginal Community Health Council by Darryl Quantz.

Your letter was reviewed by our Council at the October 20, 1999 meeting. At that time, it was agreed, in principle, that the Council would support the proposed study and the study process as detailed to date. We look forward to working with you and Darryl in studying our Council's role in health policy development and implementation.

Please feel free to call me at your convenience (229-7934) to review the next steps of the project and the specific input you require from our Council.

Thank you.

Yours sincerely,

Sally Goodfellow
Chair
Region 4 Aboriginal Community
Health Council

/dlo

cc: D. Blain, CRHA
D. Quantz, UofC

CRHA

[illegible]

APPENDIX E: ETHICS APPROVAL

UNIVERSITY OF CALGARY

FACULTY OF MEDICINE

Office of Medical Bioethics
Heritage Medical Research Building/Rm 93
Telephone: (403) 220-7990
Fax: (403) 283-8524

2000-02-17

Dr. W. Thurston
Department of Community Health Sciences
University of Calgary
Calgary, Alberta.

Dear Dr. Thurston:

Re: Public Participation in Health Policy: A Case Study of the Region 4 Aboriginal Health Council
Student : Mr. Darryl Quantz Degree: MSc

The above-noted thesis proposal has been submitted for Committee review and found to be ethically acceptable. Please note that this approval is subject to the following conditions:

(1) a copy of the informed consent form must have been given to each research subject, if required for this study;
(2) a Progress Report must be submitted by 2001-02-17, containing the following information:
  (i) the number of subjects recruited;
  (ii) a description of any protocol modification;
  (iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
  (iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
  (v) a copy of the current informed consent form;
  (vi) the expected date of termination of this project;
(3) a Final Report must be submitted at the termination of the project.

Please note that you have been named as a principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Ian Mitchell, MB, FRCPC
Chair, Conjoint Health Research Ethics Board

c.c. Dr. L.R. Sutherland (information)
Mr. Darryl Quantz

APPENDIX F: BYLAWS OF THE CALGARY REGIONAL HEALTH AUTHORITY ESTABLISHING THE REGION 4 ABORIGINAL COMMUNITY HEALTH COUNCIL

APPROVED BY THE OFFICE OF THE DEPUTY MINISTER: AUG 5 1999

1.1 Statutory Basis of Bylaw
The Calgary Regional Health Authority, a corporation established under the Regional Health Authorities Act, hereby enacts the following bylaw governing the organization and functioning of the Region 4 Aboriginal Community Health Council in accordance with the Regional Health Authorities Act and the regulations made there under.

1.2 Binding Effect
These Bylaws bind the Council and all present and future members of the Council to the same extent as if each had signed, sealed and delivered to each of the others a promise to comply with and be bound by these Bylaws and all acts, decisions, proceedings and things done and taken under
these Bylaws.

1.3 Conflict with Act or Regulations
(1) These Bylaws are subordinate to the Act and the Regulations and are not intended to conflict with the Act or the Regulations.
(2) In the case of possible conflict, these Bylaws are to be interpreted to the extent possible so as to eliminate the conflict.
(3) If it is not possible to interpret these Bylaws to eliminate a conflict, the conflicting provision of these Bylaws shall be considered as separate and several from these Bylaws, the balance of which shall remain in force and be binding as if conflicting provision had not been included.

Article 2 - Definitions

2.1 Definitions
In these Bylaws:
-Aboriginal peoples means. as defined in the Constitution Act 1982, "The Indian, Inuit and Métis peoples of Canada
-'Act' means the Regional Health Authorities Act. S.A. c R-9.07 as amended from time to time
-'Authority' means the Calgary Regional Health Authority
-'Council' means the Region 4 Aboriginal Community Health Council
-'Council Year' means the fiscal year April to the following March 31
-'Member' means a member of the Region 4 Aboriginal Community Health Council appointed by the Calgary Regional Health Authority
-'Minister' means a member of Executive Council of the Province of Alberta who is charged with the administration of the Act
-'Ministerial Regulation' means the Community Health Council (Ministerial) Regulation
'Regulation' means the Community Health Councils Regulation

Article 3 - Purpose

3.1 Purpose of the Region 4 Aboriginal Community Health Council
The primary purpose of the Council is to promote the provision of culturally appropriate health services to Aboriginal people of Region 4 and those from other regions utilizing the services of Region 4 that enhance the ability of the individual and family to achieve optimal spiritual, mental, emotional and physical health.

Article 4 - Functions and Duties

4.1 Functions and Duties
The functions and duties of the Council may include the following:
(i) gathering information and Community input relating to the health and health needs of the Aboriginal Community served by Region 4
(ii) providing advice and recommendations to the Calgary Regional Health Authority about Aboriginal health issues, health needs and priorities, access to health services,
the promotion of health, policies and practices related to the provision of health services and any other matters impacting Aboriginal Health
(iii) acting as a liaison between the Calgary Regional Health Authority and Aboriginal people served by Region 4
(iv) reviewing all proposals related to the health and health needs of Aboriginal people served by Region 4 and providing advice and recommendations to the Calgary Regional Health Authority on such proposals
(v) acting to facilitate cross cultural exchanges between Aboriginal and non Aboriginal service providers

Article 5 - Community Served

5.1 The Council will serve as a forum for the Aboriginal community who access health services provided by the Authority.

Article 6 - Council Membership and Composition

6.1 Number of Council Members
The Council will have 18 members appointed by the Authority.

6.2 Eligibility
Persons must reside within the Calgary Regional Health Authority's geographic boundaries in order to be eligible for membership on the Council.
Persons not eligible to be a member of the Council include:
(a) members of the Authority
(b) the CEO of the Authority
(c) all Authority management personnel who report directly to members of the Authority or the CEO

(d) all other management personnel who report to management personnel referred to in (c) above
(e) all persons who are engaged on a fee for service basis in a management capacity referred to in (b), (c) and (d) above

6.3 Council Composition
The Region 4 Aboriginal Community Health Council membership will be appointed as follows:
(a) 6 members from the Aboriginal community at large;
(b) 6 members from community service agencies/organizations providing services to the Region 4 Aboriginal community; an 'Alternate' representative from the service agency/organization may attend Council meetings in place of the appointed member;
(c) 6 members whose eligibility is defined within the terms of clause 5(3) of the Regulation.

6.4 Term of Appointment
For the initial Council membership the Authority will appoint one-half of the members to a two (2) year term, and one-half of the members to a one (1) year term.
Following the initial appointments members shall be appointed by the Authority to a two year term.
One half of the total membership will be appointed each year. This process will allow for replacement of one half of the Council positions each year.

6.5 Termination and Resignation
A member's appointment may be terminated for cause, by notice in writing by the Authority. A member may resign, by notice in writing to the Authority. The Resignation will be effective upon receipt by the Authority.

Article 7 - Membership Selection Process

7.1 Nominations
(I) The Authority will seek nominations from the Aboriginal community for members identified under clause 6.3 (a) to (c). In January of each year the Authority will advertise the Council positions available for the upcoming term and the eligibility criteria.
(2) All nominations will be reviewed by a "Nomination Review Committee" established by' the Authority. The Nomination Review Committee will be appointed by' the Authority and
consist of two (2) members of the Aboriginal Community, two (2) members of the Council and two (2) members of the Authority. The Nomination Review Committee will put forward recommendations for Council membership to the Authority. All nominations will be considered by the Authority and the Authority will appoint the new Council members at its March meeting.

7.2 Filling Vacancies
In the event a member position is vacated during the course of the first 18 months of a two year term, the Authority will initiate a nomination process, as per 7.1, to fill the

vacancy. If the position is vacated during the last 6 months of a term, the Council shall continue to function with one or more vacancies.

Article 8 - Council Executive Committee

8.1 The Council's Executive Committee will consist of the Chair, Vice Chair and Secretary/Treasurer.

Article 9 - Elections

9.1 The Chair shall be an Aboriginal voting member of the Council and shall be elected by the members for a one (1) year period. The Vice Chair and Secretary/Treasurer shall be voting members of the Council and shall be elected by the members for a one (1) year period. Elections of Chair, Vice Chair, and Secretary/Treasurer will occur during the first monthly meeting of the Council year.

Article 10 - Council Meetings

10.1 Opening Prayer
Council Meetings shall commence with a prayer.

10.2 Elders
Aboriginal Elders from the community shall be invited to attend Council meetings and provide advice.

10.3 Meetings in Public
All meetings of the Council will be held in public except for those circumstances outlined below in

10.4 The Council may schedule regular times and places for meetings to be held throughout the Council's year.

10.4 Closed Meetings
When determining whether to hold a meeting or part of a meeting in private, the Council shall take the following considerations into account:
(a) whether holding the meeting or part of the meeting in public could result in the release of information that would prejudice measures protecting health, safety, security or the maintenance of the law;
(b) whether holding the meeting or part of the meeting in private is justified in order to permit the Council to carry out its responsibilities in an effective and efficient manner;
(c) whether holding the meeting or part of the meeting in private is justified in order to prevent the release of information relating to personal interest, reputation or privacy of any person,
(d) any other relevant consideration.

10.5 Recording Reason for Closed Meetings

If the Council decides to hold a meeting or part of a meeting in private, the Council will ensure that the minutes of the meeting record:
(a) the nature of the subject matter to be discussed in private, and
(b) the reasons why the Council considered it necessary to hold the meeting or part of the meeting in private

10.6 Quorum
(1) A majority of the members shall constitute a quorum for any meeting of the Council.
(2) If a quorum is present at the opening of a meeting, the business of the meeting may proceed notwithstanding that a quorum is not present throughout the meeting, provided that no vote may be taken on any resolution unless at the time the vote is called a quorum is present.

10.7 Voting and Resolutions
(1) A majority of Council members must be present to achieve a quorum and pass a resolution: however, decisions may be by consensus where possible and by majority vote otherwise.
(2) Each member, including the Chair, shall have one vote at a meeting of the Council; however, the Chair shall only vote in the event of a tie.
(3) Where a meeting, or part of a meeting is held in private, no resolution may be passed unless the meeting reverts to being held in public.

10.8 Minutes
(1) The Council shall record the minutes of its meetings.
(2) At each meeting the Council shall adopt the minutes of the previous meeting.
(3) The Council shall forward a copy of the adopted minutes to the Authority within 7 days after the meeting at which the minutes were adopted. Copies of the adopted minutes shall also be kept by the Council.
(4) Copies of the minutes of a Council's meeting will be forwarded to all Council members prior to the next meeting, along with an agenda for the next Council meeting.

10.9 Administrative Support
The Authority will be responsible for providing administrative support to assist the Council in conducting its meetings and normal business.

Article 11 - Annual Report

11.1 Annual Report
The Council will prepare an annual report of its activities for the previous year and submit the report to the Authority by June 30. The report will be prepared using the format and content guidelines developed by the Authority.

Article 12 - Additional Bylaws

12.1 Additional Bylaws

(1) All motions to adopt additional bylaws will require written notice given at least two (2) meetings prior to the resolution being voted on.
(2) The Council may, by an affirmative vote of at least two-thirds of the members present for the vote, pass a motion to adopt additional bylaws.
(3) Any additional bylaw shall not be effective unless and until it is approved by the Authority and the Minister.

Article 13 - Amendments

13.1 Amendments
(1) All motions to amend these Bylaws will require at least two (2) months written notice prior to the resolution being voted on.
(2) The Council may, by an affirmative vote of at least two-thirds of the members present for the vote, pass a motion to amend these bylaws.
(3) Any amendment shall not be effective unless and until it is approved by the Authority and the Minister.

Article 14 - Effective Date

These Bylaws are effective from and after the date they are approved by the Minister. This Bylaw is passed by the Board of the Calgary Regional Health Authority, the 31st day of May, 1999.