

Speaking From the Inside: Participation in Aboriginal Health Planning
in a Regional Health Authority

by

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Abstract

This case study explores participation in Aboriginal health planning as perceived by members of the Aboriginal Health and Wellness Advisory Committee of the Interior Health Authority, a regional health authority in British Columbia. By prominently featuring the voices of Committee members as recorded in personal interviews, this research identifies issues and tensions in participatory Aboriginal health planning. Document review and personal observations enrich and support the analysis.

The research findings convey that, although Committee members express a range of perceptions and beliefs about Aboriginal health planning, the Committee provides a foundation for meaningful participation. Strengthening accountability relationships and employing Aboriginal population health approaches are suggested means by which meaningful participation in Aboriginal health planning can be actualized. This study emphasizes the importance of genuine relationship building between the health authority and Aboriginal communities for achieving gains in Aboriginal health.

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Dedication

This thesis is dedicated to my mother, Preme Cheema, whose good humour and abundant love kept me going throughout this work. I cannot adequately express the depth of my gratitude and awe for all that she has given me.

Chapter 1 – Introduction and Context of the Study

Rationale for the Study

This case study of Interior Health's Aboriginal Health and Wellness Advisory Committee sheds light on meaningful participation in Aboriginal health planning. Meaningful participation is essential to improving Aboriginal health outcomes, and undoubtedly, improvements in Aboriginal health are necessary. Within British Columbia and Canada-wide, Aboriginal peoples consistently suffer poorer health than their non-Aboriginal counterparts (Canadian Institute for Health Information, 2004; Commission on the Future of Healthcare in Canada, 2002; Foster, Macdonald, Tuk, Uh, & Talbot, 1995; Ministry of Health Planning, 2002; Royal Commission on Aboriginal Peoples, 1996b). The gap in health status between Aboriginal and non-Aboriginal populations is an enduring legacy of colonialism, sustained by the continuing political, social and economic marginalization of Aboriginal peoples (Hackett, 2005; Kelm, 1998; Kirmayer, Simpson & Cargo, 2003). Given these broad determinants of Aboriginal health, the healthcare system is only one avenue to Aboriginal health improvement, but it remains a crucial one.

This study occurs amid a number of broad and deeply rooted trends that have strongly influenced the mainstream health system's interest in Aboriginal peoples' participation. Due to remarkable efforts by Aboriginal leaders and communities, Aboriginal issues are now commonly acknowledged within the political and legal arena in Canada. At the same time, and perhaps as a consequence of this greater visibility, Aboriginal health statistics (and other measures of human development) have become an

unceasing and internationally recognized source of shame for the Canadian government; recently, for instance, the United Nations Human Rights Commission determined that Canada's number eight ranking in the human development scale would drop to forty-eight if all Canadians assumed the health and socio-economic conditions of Aboriginal people registered under the Indian Act (United Nations Commission on Human Rights, 2004). Faced with such glaring 'policy problems,' the Canadian government has been impelled to respond, for example, with dedicated research institutions, resources, and policies that are more supportive of Aboriginal peoples' participation.

Both the federal and provincial governments have acknowledged that Aboriginal participation in healthcare contributes to Aboriginal health improvement. Federally, the 1979 Indian Health Policy's goal is to "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" (Health Canada, 2001). In their guidelines for Aboriginal health planning in regional health authorities, the BC Ministry of Health states: "Involving Aboriginal people at all levels of the [health] planning and development process is integral to successfully being able to create and implement service options that are required to meet Aboriginal community health needs" (Ministry of Health Planning, 2001, p. 2).

While regional health authorities in British Columbia have been tasked with Aboriginal engagement in health planning, they have little guidance as to how this is to be achieved. As relatively new organizational entities, regional health authorities do not have a long history of citizen or community engagement to draw on, particularly with respect to Aboriginal peoples. Providing for Aboriginal participation is clearly a

challenge for regional health authorities and must be supported by in-depth inquiries, such as this study.

The literature on public participation (or the currently favored iteration, ‘citizen engagement’) in healthcare is well developed. However an examination of this body of literature reveals that the implication of citizen engagement for Aboriginal peoples has not yet been explored. Studies that refer to Aboriginal participation in health are mostly limited to Aboriginal participation in health programming (e.g., Griffin, Gilliland, Perez, Upson, & Carter, 2000), and health research (e.g., Dickson, 2000; J. Kaufert et al., 1999; J. M. Kaufert & Kaufert, 1998). Even the application of the term “citizen” to Aboriginal peoples has different connotations than the mainstream literature on citizen participation (Wood, 2003).

Based on the colonial history of Aboriginal disenfranchisement and lagging health outcomes, it is apparent that Aboriginal people must be involved in health care decisions that affect them. But simply applying a mainstream model of citizen participation to Aboriginal participation in health planning is inappropriate. The literature in this area is thin, and the issue is complex. For these reasons, this research is exploratory.

Research Questions

The purpose of my research is to elicit and explicate the perceptions that members of the Aboriginal Health and Wellness Advisory Committee hold regarding their participation in Aboriginal health planning, using a case study method of inquiry. My research questions are:

- (1) *How is participation in Aboriginal health planning perceived by members of the Aboriginal Health and Wellness Advisory Committee?*

By thoroughly analyzing the perceptions of Committee members, I offer a response to the second research question:

(2) What constitutes meaningful participation in Aboriginal health planning for members of the Aboriginal Health and Wellness Advisory Committee?

The terms used in these research questions require immediate elucidation.

Canadian Aboriginal peoples are the descendents of the original inhabitants of North America. In this research, the term Aboriginal is inclusive of First Nations, Inuit and Métis people, regardless of legal status under the Indian Act. First Nations, variously known as ‘Indian’ or ‘Native,’ include many Nations, linguistic and cultural groups. The unique heritage of the Métis derives from mixed First Nation and European ancestry. The Aboriginal people who have historically resided in northern Canada are known as the Inuit. There is a great deal of diversity within the Canadian, and even BC interior population of Aboriginal peoples; not all Aboriginal people that reside within Interior Health’s administrative boundaries share the same culture, history or health issues.

The Aboriginal Health and Wellness Advisory Committee (AHAWAC) of Interior Health is most directly involved in Aboriginal health planning in the Interior Health region. The Committee is composed of Interior Health staff, Interior Health Board members and Aboriginal community members, and serves as an interface between the regional health authority and Aboriginal communities. Since the vast majority of AHAWAC members are Aboriginal, I sometimes interchange the phrases “participation in Aboriginal health planning” and “Aboriginal participation in health planning;” based on the demographics of the Committee, these mean nearly the same thing in the context of this case.

Health planning “essentially involves identifying problems or gaps within a specific [health] area and developing an action plan for implementing solutions” (Pivik, 2002, p. 2). This cyclical process includes identifying health needs, setting priorities, developing a plan, implementing the plan, and ongoing evaluation.

There are various modes of public participation noted in the literature, which may or may not imply participant input into decision-making. However, I use participation (interchangeably with engagement) to refer to direct input into the health planning decision-making process. In this usage, participation implies a link between the participatory process and the ultimate decisions and outcomes that arise from that participation.

According to the BC Provincial Health Officer (2002), Aboriginal health plans must demonstrate “increased Aboriginal involvement in decision-making and planning for their population, and...show establishment of a *meaningful* working relationship with the Aboriginal community” (Ministry of Health Planning, 2002, p. 87) [my emphasis added]. Similarly, several reports concerned with public participation in healthcare allude to meaningfulness, such as *Towards More Meaningful, Informed and Effective Public Consultation* (Abelson & Forest, 2004), and *Practical Strategies for Facilitating Meaningful Citizen Involvement in Health Planning* (Pivik, 2002). While the term ‘meaningful’ is often appended to the concept of public participation, it is generally left undefined. One aspect of this study is to explore meaningful participation according to participants’ perceptions of the value of their role in Aboriginal health planning.

Site of the Case Study: Interior Health’s AHAWAC

In December 2001, the Province of British Columbia created five regional health authorities (plus one provincial health services authority) by amalgamating the fifty-two authorities from the previous regionalization model. Geographically, the Interior Health region includes over 200,000 square kilometers (about the size of Washington State) in the southern interior of the province (see Figure 1). It serves approximately 700,000 residents, of which nearly 50% live in rural and remote settlements of less than 8,000 people (BC Stats, 2004b).

Figure 1. Geographic boundaries of the Interior Health Authority



The provincial restructuring of health regions in 2001 simultaneously created the Interior Health Authority and dissolved the Aboriginal Health Councils, which had previously held authority for Aboriginal health planning and funding in each of six

regions in the province (see Appendix A for a timeline of key events). Interior Health is currently responsible for managing health services for all of the region's residents, including particular obligations in Aboriginal health. In the absence of the Aboriginal Health Councils, Interior Health administers the Aboriginal Health Initiatives Program (AHIP), funding supplied by the province for Aboriginal community initiatives in mental health, addictions and chronic disease management. In addition, Interior Health is required to develop an Aboriginal health plan that identifies Aboriginal health priorities for the region and articulates strategies for Aboriginal health improvement.

The Aboriginal Health and Wellness Committee (AHAWAC) was created on May 6, 2002 when Aboriginal community members and Interior Health staff met to discuss the province's transfer of Aboriginal health responsibilities to the regional health authorities. There, the Committee was formed (then called the Aboriginal Health and Wellness Steering Committee). The AHAWAC is a concerted effort by involved parties to include Aboriginal peoples in health planning in Interior Health. The composition of the AHAWAC is further described Chapter Three.

Background: Aboriginal Peoples within the Interior Health Region

The service area of the Interior Health Authority is the traditional territory of many culturally distinct First Nations, and is now also home to many Aboriginal people from other parts of the province, country and continent. In 2001, there were 36,700 Aboriginal peoples residing in the Interior Health geographic region, comprising 5.7% of the overall population of the region (Aboriginal peoples comprise 4.4% of BC's population overall) (BC Stats, 2004b).

Aboriginal settlements in the Interior Health region include nine Nations:

Shuswap, Okanagan, Ktunaxa, T'silhoqot'in, Nlaka'pamux, St'Wixt, Carrier, Sl't'atl'imx and Métis (Interior Health Authority, Revised 2003). There are approximately fifty-four Aboriginal settlements within Interior Health's service boundaries (see Appendix B for a map of First Nations communities), yet, judging by the provincial situation, it is likely that less than half of the Aboriginal population in the area lives on-reserve (BC Stats, 2004a). The Aboriginal population is unevenly distributed across the region. As a percentage of the overall population, the Aboriginal population ranges from a high of 10% in the Thompson Cariboo Shuswap Health Service Area, to a low of 3.1% in the Kootenay Boundary Health Service Area (Interior Health Authority, Revised 2003).

In some health status indicators, Aboriginal peoples share more similarities with one another than with non-Aboriginal residents of the Interior Health region. For instance, deaths due to injury occur at a rate of 14 to 23.5 per 10,000 people among Status Indians (Aboriginal people with status under the Indian Act). For other residents in the region, the range is 5 to 7.5 per 10,000 (Interior Health Authority, Revised 2003).

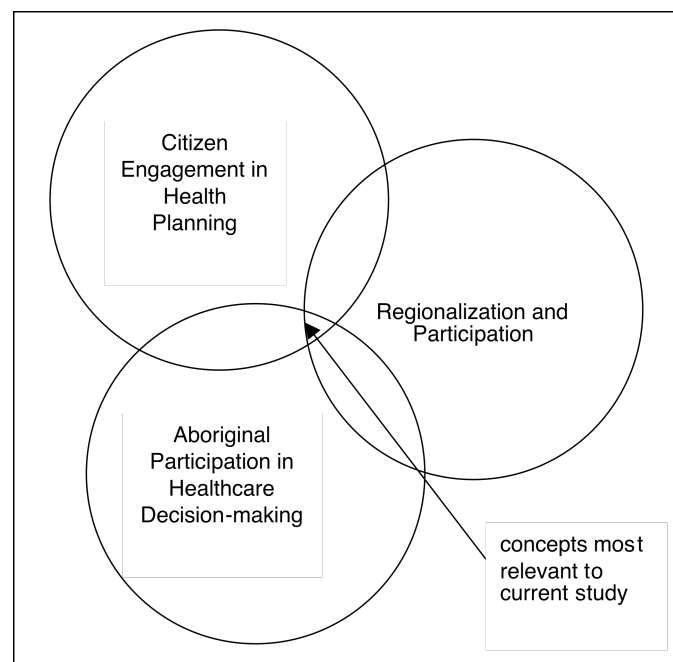
In other indicators, there are strong geographic differences among Aboriginal populations. The age standardized mortality rate for Status Indians residing in the Interior Health region is consistently higher than the rest of the population. However, the range is from approximately 23% greater than 'others' in Thompson & Cariboo, to 230% greater than 'others' in East/West Kootenay (Interior Health Authority, Revised 2003). Clearly, Aboriginal peoples across this vast region face different health challenges. While it is beyond the scope of this research to account for differences across Aboriginal Nations or

cultures, readers are well-advised to keep in mind the diversity masked by the term Aboriginal.

Chapter 2 – Conceptual Framework

A conceptual framework is “simply the current version of the researcher’s map of the territory being investigated” (Miles & Huberman, 1994, p. 20). The conceptual framework described here was formulated concurrent to the research questions, and has informed my interview questions and preliminary data analysis. Given the exploratory nature of this research, this conceptual framework does not intend to overly constrain or determine the inquiry; rather, it forms a matrix of interrelationships by which the case was approached.

Figure 2. Diagram of Conceptual Framework



The conceptual framework is based on three, somewhat overlapping conceptual areas: citizen engagement in health planning; regionalization and participation; and, Aboriginal participation in healthcare. These three framing concepts refer to historically informed trends that provide much-needed context and depth for this relatively unexplored research area. Alone, they provide only a fragmented base of knowledge for

this research topic, but together they illustrate the relevant intersections of this study.

Figure 2 illustrates the conceptual framework in graphic form, as a Venn diagram. The equal size of the ‘bubbles’ is not meant to imply equal depth of literature in each of these fields; in actuality, citizen engagement in health planning is the most researched area, while Aboriginal participation in healthcare decision-making is the least researched. I explore these three concepts in this chapter, drawing connections between them as I proceed.

Citizen Engagement in Health Planning

Citizen engagement requires active communication between government and stakeholders and direct connection from citizens to the policy process. Citizen engagement implies a quality of public participation that purportedly facilitates meaningful input into decision-making. Its central tenets include “greater emphasis on information and power sharing, and mutual respect and reciprocity between citizens and ...governors” (Abelson & Gauvin, 2004, p. 2). However, in the literature, the more generic term ‘public participation’ may also be used to describe the quality of participation implied by citizen engagement. For instance, public participation is “the process by which public concerns, needs and values are incorporated into governmental decision-making” (Maloff, Bilan, & Thurston, 2000, p. 72).

As illustrated in Arnstein’s (1969) well-known ‘ladder of citizen participation’ (see Appendix C), participation can take on a broad spectrum of meaning ranging from forms of non-participation at the lowest rungs, to token participation in the middle rungs, to degrees of citizen power and citizen control at the top of the ladder. Establishing a commonly understood definition for citizen engagement is plainly important. In this

study, I will use citizen engagement and public participation interchangeably, but with the caution that I am referring to active participation in decision-making.

Citizen engagement is a key aspect of the ‘new public management’ that has been widely adopted by governments of Western industrialized countries in the last twenty years. New public management is characterized by decentralization, devolution of responsibilities to other government jurisdictions or third parties, and restructured accountability relationships. This redesign of governance systems is intended to permit more participation, citizen control, democracy and responsiveness, as well as (perhaps paradoxically) a greater market orientation (Pal, 2001).

But despite the adopted rhetoric of new public management, citizen engagement appears to be in direct opposition to the centralizing trend in government decision-making seen at the federal government level and in the right-wing British Columbia government under Gordon Campbell (Wharf & McKenzie, 2004). Given this tension, the extent to which new public management actually translates into greater citizen involvement is much up to question.

While citizen engagement has recently become a buzzword in public administration, the conceptual idea of public participation in healthcare may be largely attributed to the World Health Organization, which, in the 1978 Alma-Ata declaration, forwarded community participation as a cornerstone of the strategy to achieve “Health For All by the Year 2000” (Zakus & Lysack, 1998). Public participation is also consistent with the health promotion and population health approach espoused by health researchers and Canadian healthcare organizations. According to Health Canada, the population health approach “ensures appropriate opportunities for Canadians to have meaningful

input into the development of health priorities, strategies and the review of outcomes” (Health Canada, 2001). Still, even with this apparent government backing, “the use of citizen engagement mechanisms in the Canadian health system is in its infancy” (Abelson & Gauvin, 2004, p. 3).

There is a voluminous body of literature on citizen participation in health planning. In framing this overview, it is useful to keep Labonte and Laverack’s (2001) suggestion in mind: “Whenever the term ‘participation’ is encountered, it should always be followed by the specifications, ‘by whom,’ ‘in what,’ ‘why’ and ‘for whose benefits’” (Labonte & Laverack, 2001, p. 127).

Rationale, Benefits & Costs of Public Participation.

The principle of affected interests states that everyone who is affected by the decision of a government should have a right to participate in that government (Wharf & McKenzie, 2004). Beyond this basic political right, there is a broad consensus that public involvement in health planning provides a multitude of benefits to both the healthcare organization and the public. One of the main stated goals of public participation is to include the concerns and desires of those who utilize the system in decision-making, thereby improving decisions and empowering individuals and communities (Perlstadt, Jackson-Elmoore, Freddolino, & Reed, 1998). Citizen participation in health planning is also purported to increase accountability and networking between health service providers and community members, to make more efficient use of scarce resources, and to encourage creative problem solving (Pivik, 2002).

However, several commentators have noted that there is little empirical evidence to support these professed benefits (Blue, Keyserlingk, Rodney, & Starzomski, 1999;

Zakus & Lysack, 1998). Public participation “in health system planning and decision making remains a largely untested concept” (MacKean & Thurston, 2000, p. 19). Some suggest that evidence gathering in this area has been thwarted by a lack of critical research analysis as well as conceptual ambiguity (Zakus & Lysack, 1998).

As suggested by Arnstein’s (1969) ladder of participation, government and public participants may have differing views of public participation, to the point where two extremes emerge. On one side, participatory strategies may be employed dishonorably, resulting in manipulation. On the other extreme, romanticized notions of public participation as complete community control disavow the necessary role of government structures completely (Labonte & Laverack, 2001).

Generally, the application of public participation lies somewhere between these two extremes. In the public sector, public participation may be applied to address the loss of faith in public institutions and professional decision makers. Participation plays a role in legitimizing policy, and can be employed by organizations to diffuse public criticism (Zakus & Lysack, 1998). In health planning, public participation may be used to increase community knowledge of a plan, and to gain understanding of difficult resource allocation decisions (Abelson & Forest, 2004; Pal, 2001).

For public participants, benefits of participation include the ability to influence a desired policy outcome (out of altruism or self-interest) and continuing learning opportunities and personal development (Abelson, 1999). Public participants may also view participation as an opportunity to direct power, even in opposition to the government system. Zakus and Lysack (1998) suggest that if participants and public

bodies do not share the same sense of purpose regarding participation, preexisting tensions between the groups may be exacerbated instead of ameliorated.

Public inclusion does not occur without costs. For an organization, public participation involves resources for organizing meetings, providing adequate leadership, staff and facilitation support, and significant time. Healthcare organizations may not have the human resource capacity to take on the task of citizen engagement. Public participation also implies a cost to the existing power relations that largely characterize health care decision-making in Canada, as “information exchange, power sharing and partnership [are] not easily embraced in a policy sector dominated by professional expertise in the clinical and management domain” (Abelson & Gauvin, 2004, p. 3). Sharing power may be “one of the main challenges associated with CP [citizen participation] in health planning” (Pivik, 2002, p. 15).

For public participants, time and effort are significant costs, both to attend meetings and for the necessarily continuous assimilation of information. Perlstadt et al. (1998) suggest that “the amount of time and effort that volunteer participants must invest to learn the background and technical details of a health planning process can be burdensome, if not overwhelming” (Perlstadt et al., 1998, np). Accordingly, organizational supports, skills, knowledge and information are key themes and requisite components of citizen participation in health planning.

Organizational Supports

Substantial organizational supports are required for successful public involvement processes. These supports imply organizational commitment and resources, and include leadership, staffing, external experts, and ongoing learning opportunities for public

participants. Empowering styles of leadership (including decision-making style, networking, visibility) result in more active and successful coalitions with the public (Perlstadt et al., 1998), while staffing support provides continuity and expertise to citizen-dominated participatory bodies. The use of external facilitators is thought to be essential to build trust among public and organizational decision makers (Abelson & Forest, 2004). However, the complexity of health planning places “an extraordinary burden on specialized personnel to support and guide, but not to dictate processes and products” (Perlstadt et al., 1998). This dilemma arises from the often limited knowledge possessed by public entrants to the highly technical field of healthcare planning.

Skill, Knowledge & Information Requirements

The requirements for adequate skill, knowledge and information for participation in health planning are pervasive themes in the literature. While there does not appear to be a consensus on the topic, it is suggested that public representatives ideally possess negotiating skills, analytic skills and leadership skills (Maloff, Bilan, & Thurston, 2000). The skill levels of participants may be subject to scrutiny by those opposed to a participatory process (Frankish et al., 2002).

The depth of specialized knowledge that public participants must possess in order to effectively participate is also up to question. Some suggest that lay participants should not be expected to become technical experts (Frankish et al., 2002). Others maintain that in order to make policy and establish goals, objectives and priorities, public participants must be well attuned to the organizational structures, processes and mechanisms required to attain goals (Perlstadt et al., 1998). While the experiential knowledge of participants is recognized as an information source (Abelson & Forest, 2004; Wharf Higgins, 1999),

without facilitation, there is some danger that personal experience may become the basis of unproductive venting sessions (Perlstadt et al., 1998).

It is widely acknowledged that public participants must have access to the most complete and accurate information on which to base their decisions. But information can also “overwhelm and bias participants who may know little about a subject” (Abelson et al., 2004, p. 207). Information is critical for not only promoting understanding of the issues, but also for building trust and credibility between the organization and participants. Information must be perceived as unbiased, reliable and shared, and inclusive of participants’ experiential views (Abelson & Forest, 2004).

Selection, Representation & Inclusion/Exclusion

It is apparent that not all members of the public will be able or permitted to participate in a health planning process. Thus, the selection of participants, and whom they represent is a key issue in public participation. According to some authors, the process of selecting lay participants for involvement in healthcare planning should be publicly known and clear (Perlstadt et al., 1998). Public participants themselves should have a say in the method of selection, and delegates must be accountable to the group they were chosen by, or those they represent. There are generally four methods of selection: election, appointment, self-selection and organizational representation (Perlstadt et al., 1998).

It is widely suggested that public participants are only effective to the extent that they can draw upon a constituency for ideas and support (Frankish et al., 2002; Maloff et al., 2000; Perlstadt et al., 1998; Wharf Higgins, 1999). The extent to which public participants should be demographically representative of their constituencies is another

matter. Participants in health planning are likely to be characterized by high levels of wealth, education, confidence and skills (Wharf Higgins, 1999). People who are socially and economically marginalized in society are generally excluded from participation for a variety of reasons. Systemic barriers to participation include lack of access or trust (Maloff et al., 2000). Ironically, marginalized segments of the population may have some of the greatest health needs (Raphael, 2004b).

Wharf Higgins (1999) suggests that public participants in healthcare decision-making need not be demographically representative of their communities, as long as they understand the needs and experiences of those they represent. The basis of this understanding, experiential participation, involves an ongoing relationship between the lay participants and the community. This relationship is also integral to the accountability of representatives.

Accountability

Citizen engagement is “an emerging mechanism for achieving citizen-government accountability” (Abelson & Gauvin, 2004, p. 3). Accountability relationships between regional health authorities and citizens are not premised on electoral accountability, since, most often, a Minister appoints health authority board members (Flood & Archibald, 2005). Thus, regional health authorities must take special care to establish accountability for public participation processes, basing them on a clear purpose, with transparent links between the input provided and the final decision outcomes. The extent to which it is necessary to build in explicit accountability measures may depend on the organization’s past experiences in public participation (Abelson et al., 2004).

Public participants who represent constituencies are also accountable to those citizens. There is some danger that structured participatory bodies designed to provide community input (such as ‘advisory groups’) may “lead participants to view themselves as the community representatives, thus disconnecting them from ongoing relations with the community” (Frankish et al., 2002, p. 1476). If accountability is an objective, mechanisms for participants to gather information from constituents and disseminate feedback must exist.

Regionalization and Public Participation

Regionalization and public participation is the second major concept in this conceptual framework. Regional health authorities are uniquely positioned with respect to public participation (as well as Aboriginal health). The changes to healthcare organization implied by regionalization “arguably constitute the most radical restructuring of Medicare since its inception, with far-reaching implications for governments, citizens, physicians, hospitals and other interest groups” (Lomas, Woods & Veenstra, 1997, p. 372).

The regionalization of health services “generally means an organizational arrangement involving the creation of an intermediary administrative and governance structure to carry out functions or exercise authority previously assigned to either central or local structures” (Church & Barker, 1998, p. 467). While regional authorities are devolved from the provincial government, they may also be amalgamations of more localized control, such as hospital boards. Regional health authorities embody the tension inherent in new public management, between local participation and local accountability

(client-centered), and concerns with economies of scale in service delivery (market-driven).

The move towards regionalization in Canada began in the late 1980's, as a response to "system fragmentation, extensive duplication of services, excessive dependence on the medical model, and ...unresponsiveness to local needs" (Kouri, 2002, np). To date, nine of ten provinces (with the exception of Ontario) have taken up regional models based on sub-provincial authorities. Regionalization has not been implemented in the same manner across the country; governance models have been built according to decisions made by each province.

One characteristic that the provinces share is grappling with the optimal balance between consolidation and decentralization of regional authority. For instance, in 1997, British Columbia established eleven Regional Health Boards, thirty-four Community Health Councils, and seven Community Health Services Societies for a total of fifty-two health authorities (Lewis & Kouri, 2004). The 2001 restructuring reduced this number to five much larger regional health authorities plus one provincial health services authority. Restructuring followed a political change in government that characterized the old governance model as "one of the most complicated and expensive in the country," which "contributed to patient confusion and a variety of care problems" (Ministry of Health Services, 2002). British Columbia is not alone in revisiting regionalization. The general trend in Canada has been to decrease the number of sub-provincial health authorities, revealing an interest in recentralizing power and the pursuit of economies of scale.

Regionalization carries implications for public participation. In the regionalization literature, it is generally surmised, "decentralization of the system [has] opened up more

opportunities for public input because decision-making...occurs closer to the community” (Maloff et al., 2000, p. 68). Reviewers have found that “there has been a significant increase in the quantity of citizen participation...as a result of the regionalization process across Canada;” however, “this increase...may have been more than offset by the decline in citizen governance caused by the dismantlement of hospital boards across the country” (Flood & Archibald, 2005, p. v).

While “more meaningful public participation” is cited as one of the objectives of the original transition to the regional model (Kouri, 2002, np), the extent to which public participation appears a priority for regional bodies varies. More generous viewpoints describe a great deal of opportunity, political will and activity for involving citizens in regional-level decision-making (Kouri, 2002; Maloff, Bilan, & Thurston, 2000), while more critical views describe the regionalization model as moderately likely or unlikely to involve citizens in decision-making (Church & Barker, 1998; Lewis & Kouri, 2004). These critical views outline the various barriers that thwart the rhetoric of public participation in regional health authorities.

Potential barriers to increased public participation in regional authorities include weak leadership commitment, lack of public and media interest, and the exclusion of public participation in performance agreements made with the province (Lewis & Kouri, 2004). Church and Barker (1998) point out other structural barriers to public involvement in decision-making. Chief among these is the monopoly on highly specialized knowledge held by health care professionals and groups (such as physicians). Their greater resources and incentive to influence the policy process undermine the ability of healthcare consumers to participate in decision-making.

Regionalization must also be considered here for its impact on Aboriginal health.

It is apparent that regional health authorities have significant responsibilities in Aboriginal health. In British Columbia, these include health planning, service delivery, and meeting agreed-upon Aboriginal health priorities included in performance agreements with the provincial Ministry of Health Services. BC regional health authorities are tasked with providing acute care, continuing care, public health and some environmental health services to Aboriginal residents of British Columbia, regardless of their legal status or place of residence. However, some of these public services may be offered on reserve by Health Canada or by health transferred Aboriginal organizations, which naturally leads to some confusion over responsibility and jurisdiction. Despite these extensive responsibilities, the implications of regionalization for Aboriginal healthcare have not been significantly addressed in the literature.

A scan of the academic literature on Aboriginal peoples and participation in regional health authorities yields few documents. An unpublished MSc thesis from the University of Calgary, a descriptive case study of the Aboriginal Community Health Council within the Calgary Regional Health Authority, is the only identified academic research with some resemblance to this inquiry (Quantz, 2001). Within the BC context, one document from the ‘grey literature,’ a report from the Aboriginal Governors Working Group, is particularly relevant. *Aboriginal Peoples and Regionalization*, cites that “the regionalized approach to health appears to many Aboriginal British Columbians to be no more effective in meeting their needs than the previous Ministry-centered system” (Aboriginal Governors Working Group, 1999, p. 1). Given this assertion, it is apparent

that the relationship between regional health authorities and Aboriginal participation requires further exploration.

Aboriginal Participation in Healthcare Decision-making

In order to understand the participation of Aboriginal peoples in healthcare decision-making, it is first important to grasp the basic elements of Aboriginal health care. This involves tracing the complex system of funding relationships and multiple accountabilities (Abele, 2004) as they have evolved to the current scheme, where the government of Canada has responsibility for ensuring the provision of health care services to Status Indians and the Inuit, and the services are provided to Aboriginal peoples through a combination of federal, provincial and Aboriginal-run services. Here, I provide an apologetically abbreviated version of history that may, at the least, point to the political influences, competing assumptions, and fragmented service delivery that characterize Aboriginal healthcare (Commission on the Future of Healthcare in Canada, 2002). This context profoundly shapes the ability of Aboriginal peoples to participate in healthcare decision-making.

Prior to European contact, Aboriginal communities in what is now Canada had regionally specific, locally controlled and often sophisticated systems of health care (Kelm, 1998). Through European colonization, these systems were displaced, de-legitimated and challenged by new infectious and chronic diseases. The history of Aboriginal participation in Western healthcare has been marked largely by exclusion and paternalism on the side of government (Kelm, 1998) and the contemporary notion of participation cannot be divorced from this (O'Neil, Reading, & Leader, 1998).

When British Columbia joined Canadian Confederation in 1871, jurisdiction for Aboriginal peoples' health and welfare passed from the local to the federal government. In 1874, the Canadian government passed the Indian Act, effectively cementing federal trusteeship over Aboriginal peoples.

Several treaties were signed between First Nations and the Canadian government, but only one (Treaty No. 6 signed in 1876 with the Cree of central Alberta and Saskatchewan) contained any explicit provisions for healthcare. This treaty contains the infamous 'medicine chest' clause that has been subject to differing interpretations regarding the healthcare obligations of the Canadian state to Aboriginal peoples. Notwithstanding this, the Canadian government has been formally involved in health service delivery to Aboriginal people since establishing the first nursing stations on reserves in the early 1900's. Rather than viewing this relationship as one of Aboriginal right, the federal department of health has viewed its direct service provision to Aboriginal people as "a matter of custom and moral duty" (Elliot & Foster, 1995, p. 114).

In the early to mid-1900's, Aboriginal health policy was shaped by colonial notions of racial superiority and the 'white man's burden', assimilative goals, and the fear of the spread of 'localized' infectious diseases (e.g., tuberculosis due to the poor living conditions on reserve) (Kelm, 1998). Within this agenda, Aboriginal peoples 'participated' insofar as they were the recipients of this system of care, or were involved in resistance to colonial systems of medicine.

In 1969, Prime Minister Trudeau's White Paper called for repealing the Indian Act in order to encourage the greater assimilation of Aboriginal peoples into mainstream Canadian society (Indian and Northern Affairs Canada, 2004). Aboriginal peoples

resoundingly rejected this plan as an attack on their sovereignty. The plan was withdrawn, but these events marked the beginning of a new phase in Aboriginal/non-Aboriginal relations, and opened the door to discussions of Aboriginal self-government. This shifting policy orientation is reflected in Aboriginal health policies since this time.

In 1979, the federal government adopted the Indian Health Policy. The stated goal of the policy was "to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" (Health Canada, 2001a). Following the intention of this policy, in 1986, the federal government announced the opportunity for eligible Aboriginal communities south of the 60th parallel to take up administrative control of federal on-reserve health services. The federal cabinet approved the Indian Health Transfer policy in order to fulfill this commitment.

The Indian Health Policy and the Indian Health Transfer indicate a significant change in the delivery and control of health services to Aboriginal peoples. Many Aboriginal communities are currently involved in Health Transfer. In the Pacific Region (British Columbia) as of June 2004, forty-one transfer agreements had been signed, affecting fifty-five percent of on-reserve First Nations communities in the region (Health Canada, 2004).

While Health Transfer has significantly increased Aboriginal participation in health care decision-making by devolving administrative control to Aboriginal communities, the policy does not encompass all types of health services, and does not apply to all Aboriginal peoples; only Status, First Nations, on-reserve communities can even qualify. This is extremely significant, given the large urban/off-reserve and non-status Aboriginal population in British Columbia. Moreover, Health Transfer is not

necessarily a panacea for Aboriginal self-determination in health. Some Aboriginal communities view Health Transfer as a withdrawal of the federal government's historical commitment to protect Aboriginal peoples' health, and thus refuse to participate in Health Transfer (Culhane Speck, 1989). Other communities do not have the capacity to participate (Sommerfield & Payne, 2001). All of these factors mean that Aboriginal peoples and communities, both with Health Transfer arrangements and without, still rely to a great extent on services delivered by regional health authorities.

Each province has chosen its own policies and practices in Aboriginal healthcare, with varying resultant forms of Aboriginal participation. In British Columbia in 1991, the government formed six Aboriginal Health Councils across the province. The Health Councils were comprised of Aboriginal representatives from the community and included government health representatives as ex-officio members. The Health Councils engaged in strategic planning to determine how to best address the Aboriginal healthcare needs in the area and to set priorities for funding provided by the provincial government.

When the province of BC regionalized health services in 1997, it was mandated that all Regional Health Boards and Community Health Councils have one Aboriginal governor on their board or council. However, when the province restructured regionalization in 2001, the requirement for Aboriginal participation in health authority governance was eliminated, along with the entire Aboriginal Health Council structure. Interior Health and the four other newly restructured regional health authorities assumed the responsibilities for Aboriginal health planning and resource allocation.

Aboriginal health plans are a Ministry-mandated requirement of each BC health authority. According to the Ministry of Health, "involving Aboriginal people at all levels

of the planning and development process is integral to successfully being able to create and implement service options that are required to meet Aboriginal community health needs” (Ministry of Health Planning, 2001, p. 2). Not only must Aboriginal health plans address access to services, significantly, they must demonstrate “increased Aboriginal involvement in decision-making and planning for their population, and...show establishment of a meaningful working relationship with the Aboriginal community” (Ministry of Health Planning, 2002, p. 87). While the Ministry provides final approval of all Aboriginal health plans, to date, there has been no formal assessment of the extent to which Aboriginal people are meaningfully participating in health planning.

Summary

As I framed it, my research interest lies at the intersection of three concepts that involve Aboriginal health policy, the implications of regionalization, and the inclusion of citizen voices in decision-making. This grounded, contextual understanding provides a rich starting place for an exploration of Aboriginal participation in health planning. In discussing the research findings, I will return to the most relevant parts of this literature, and also delve into other literature in order to shed light on the case study.

Chapter 3 – Methodology and Method

Research Strategy: Case Study Inquiry

This research is based on qualitative methodology, using a single case study approach. Case studies are used when requiring a holistic understanding of an event or situation within a real-life context (Palmquist, 2004), where the boundaries between the phenomenon and the context are not clearly evident (Yin, 1989). These characteristics are eminently suited to this study. In this case, the phenomenon is participation in Aboriginal health planning, particularly as perceived by members of the Aboriginal Health and Wellness Advisory Committee. As explained in the conceptual framework for this study, the context for Aboriginal participation is a complex set of historical and contemporary relationships that have bearing on the dynamics operating in the case.

This case study can be considered intrinsic, in Stake's (1995) categorization of case studies. This case was not selected for study because it is representative of other cases of participation in Aboriginal health planning; rather, the case itself is of interest and was accessible for study. This is not to refute the utility of case studies for making generalizations. But rather than 'sample-to-population' generalizations, case studies are most useful for analytic generalizations that examine constructs and their relationships (Miles & Huberman, 1994). Case studies also offer particular generalizations (or what Stake calls 'petite generalizations') that are a small step toward grand generalization. However, Stake (1994) cautions against the preoccupation with making generalizations, stating that "damage occurs when the commitment to generalize or create theory runs so strong that the researcher's attention is drawn away from features important for understanding the case itself" (Stake, 1994, p. 238).

A single case study is justified, given the current state of academic knowledge regarding Aboriginal participation in regional health planning. This focus on the single case has allowed for greater depth of understanding by highlighting the views of the “actors” in the case. Utilizing a multiple case study within the constraints of this thesis project would not have done justice to the complexity of the phenomenon.

Researcher’s Point of Entry

I am a non-Aboriginal researcher who has entered this work with certain ideas, assumptions and biases. One such belief is that Aboriginal participation in health and healthcare – from health planning, to self-care to healthcare service delivery – is an integral aspect of improving Aboriginal peoples’ health outcomes. As a researcher, I have attempted to be objective to the extent possible; invariably, however, my worldview has consciously and unconsciously influenced my research approach and my interpretation of the data.

While my position as a non-Aboriginal researcher informs this study, my scope of thought and understanding is not reducible to a linear extrapolation of mainstream social mores and assumptions. My upbringing and experiences as a visible minority in Canadian society, as well as my undergraduate studies in critical sociology and anthropology have equipped me with the ability to understand multiple vantage points. I believe that these skills and experiences have served me well in this research project. Notwithstanding this, the construction of academically acceptable research, as well as my own assumptions and preferences have shaped this project significantly.

In this same vein, my past experiences working for Interior Health have likely influenced my interpretation of the data. On one hand, my familiarity with the

organization and with several of the staff have provided me with access to this case study, as well as with a practical view of how Aboriginal health might fit in with the organization's structure and operations. On the other hand, this previous experience may bias me towards an acceptance of established attitudes or administrative practices at Interior Health. But, generally, I believe that my knowledge of Interior Health, gained while working on a co-op term and as a subcontractor on projects, has enhanced my awareness, knowledge and sensitivity to many of the issues intrinsic to engaging with Aboriginal peoples in health planning. I have informed research participants about this relationship to Interior Health through the consent form; I have also emphasized that this research is an independent project, conducted under no obligation to Interior Health.

Interpretive Paradigm: Constructivism

A key aspect of transparent research is identifying the researchers interpretive paradigm, the basic set of beliefs that contain "the researcher's epistemological, ontological, and methodological premises" (Denzin & Lincoln, 1994, p. 13). The positivist paradigm is not compatible with this investigation of purpose, perception and meaning. In contrast, constructivism allows for the inclusion of multiple knowledges that are mediated by social, political, cultural, economic, ethnic and gender factors (Guba & Lincoln, 1994). The goal of constructivism is "understanding the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p. 118). This paradigm is well suited to my research questions, as well as my ethical approach to the research.

Ethical Considerations

Aboriginal peoples in Canada (and elsewhere) have been subject to research characterized by unequal power relationships between researchers and researched, with dubious benefits accorded to participants (Smith, 1999). According to an Aboriginal author, “‘Research’ is probably one of the dirtiest words in the indigenous world’s vocabulary” (Ten Fingers, 2005, p. S60). I am aware of the damage that research has inflicted on Aboriginal peoples and do not intend to add to this legacy. While a participatory methodology would have been preferable for this study, I ruled this out due to the time constraints of this project. However, there are several steps that I have taken in order to be mindful and respectful of the centrality of Aboriginal peoples in this research.

To start with, the conceptual framework for this study underscores the fact that mainstream literature on citizen participation cannot be uncritically applied to Aboriginal peoples. Understanding the Canadian history of Aboriginal marginalization and exclusion is a necessary base from which to study inclusion of Aboriginal people. In addition, my research questions place primary importance on understanding the lived experience of multiple actors within the case study. Moreover, I have emphasized member checks as a means for participants to have continuing input into the research; I will discuss member checks in depth later in this chapter.

I have made efforts to ensure that participants in this study gain some benefit from their participation. All participants have been offered an electronic copy or hardcopy of his or her own research transcript. Upon the completion of this project, I will be distributing a short summary of the research to all participants, as well as mailing a copy of the complete thesis to those participants who request this. In addition, I have offered to

provide a presentation of the results of the research to the Aboriginal Health and Wellness Advisory Committee, as well as other bodies (e.g. Board of Interior Health) at the request and with the consent of all participants. It is my hope that these efforts will lead to further engagement with the research findings.

Other ethical considerations in this research include recruiting responsibly, achieving informed consent, and ensuring confidentiality and anonymity. Responsible recruitment occurred through a ‘double consent’ process. At the request of Interior Health, I prepared a briefing note (see Appendix D) that was distributed by the Aboriginal Health administrative assistant to all members of the AHAWAC. The briefing was based on the letter of information and consent form that were provided for University of Victoria Ethics Review. The briefing included the request for recipients to inform the Committee’s administrative assistant if uninterested in participating in the study; no names were forwarded.

The next stage of recruitment involved an invitation for select Committee members to participate in the study (participant selection is fully described in ‘Recruitment’). I provided the invitation, where possible, via telephone contact and by emailing each potential participant (including an attached consent form with the email letter). Several prospective participants did not respond to my request to participate, and others were interested but unavailable during the period of data collection. This led me to contact alternate participants until I secured twelve interviews. A thirteenth interviewee was added to accommodate an interested member of the Committee.

I clarified the role of confidentiality and anonymity in my research to participants as an aspect of informed consent. Informed consent was established firstly through the e-

mailed briefing note, secondly through an electronic and hard copy of the consent form, and thirdly by ensuring that participants had read and understood the consent form prior to the beginning of the interview. Through the consent process, I informed participants that their anonymity is not possible in this study since I was conducting the interviews myself. The loss of anonymity has provided some benefit to the participants, in enabling me to share the interview transcripts for verification.

I have protected confidentiality in this study by not disclosing individual identities in the thesis and securely storing records with individual identifiers. In order to disguise participants' identities while maintaining methodological transparency, I randomly assigned each participant with a number from 1 to 13; attribution of quoted passages was accomplished through the following notation: [Px], where x is the randomly assigned number. [Ux] indicates material attributed to a Committee member who was not interviewed, but who contributed data during observational analysis or email. I also ensured that the cumulative impact of this attribution system did not unreasonably compromise confidentiality. However, confidentiality in this study may be compromised by the fact that the composition of the AHAWAC is public information, and the participating individuals involved are known within Interior Health and their communities.

According to the constructivist paradigm, "The close personal interactions required by the methodology may produce special and often sticky problems of confidentiality and anonymity, as well as other interpersonal difficulties" (Guba & Lincoln, 1994, p. 115). The dilemmas of ethical research, particularly respecting confidentiality, were reinforced in data collection. During my data collection, I recorded

personal disclosures, as well as noted the other extreme, participants who obviously withheld candid answers. Based on this experience, it was apparent to me that I would need to be vigilant in preserving confidentiality in my presentation of the data in order to protect participants from (real or perceived) negative consequences of their candour. To this end, I limited my use of personal identifiers to only those instances where it had significant bearing on the findings, and similarly reserved the findings to themes that didn't require discussion of an identifiable individual. This concern with confidentiality has, unquestionably, led to some necessary omissions in the findings.

Having interviewed the majority of the committee members on the Aboriginal Health and Wellness Advisory Committee, I have established a strong sense of accountability to the whole group. Many participants have expressed their interest and even enthusiasm for seeing the results of this study. My concern for avoiding participant harm and for the validity of the findings has kept both ethics and rigor at the forefront of my research approach.

Recruitment and Participant Profile

The Aboriginal Health and Wellness Advisory Committee is comprised of fourteen Aboriginal community members, seven Interior Health staff (one by contract) and two Interior Health Board members. The breakdown of membership is per Table 1. While official membership on the Committee is inclusive of all of these categories, staff and Board members are ex-officio members, while other participants are “voting members.” With two exceptions, all members of the AHAWAC are Aboriginal.

Potential participants for this research were purposefully selected from a list of members of the Aboriginal Health and Wellness Committee, using quota selection:

“identifying the main subgroups and then taking an arbitrary number from each” (Miles & Huberman, 1994, p. 28). In order to include a spectrum of views in the research, I recruited seven community-based members and six individuals affiliated with Interior Health (Interior Health staff, Board Members and contractors). Within these sub-groupings, I also targeted my recruitment efforts to include geographical representation of the Interior Health region, as well as representation from urban Aboriginal groups and reserve communities. These efforts were largely successful; based on these criteria, the sample provides a reasonable reflection of the entire twenty-two member Committee.

Table 1. Membership of the AHAWAC, as of April 2005

Interior Health Staff (7)	Aboriginal Community Members, by Affiliation (14)	
<ul style="list-style-type: none"> • Senior Medical Health Officer • Aboriginal Strategies Coordinator • Aboriginal Liaison Okanagan Health Service Area • Aboriginal Liaison East Kootenay Health Service Area (on contract) • Aboriginal Liaison Kootenay Boundary Health Service Area • Aboriginal Liaison Thompson & Shuswap Service Areas • Aboriginal Liaison Cariboo Service Area 	<ul style="list-style-type: none"> • Ktunaxa Nation • Lillooet Tribal Council • South Secwepemc (Shuswap) • North Secwepemc (Shuswap) • Okanagan Nation Alliance • Nicola Tribal Association • N'laka'pamux Tribal Council 	<ul style="list-style-type: none"> • Tsilhqot'in National Government • Métis (Region 3) • Carrier Chilcotin Tribal Council • Urban Cariboo Region • Urban Okanagan Region • Urban Kootenay Boundary Region • Urban Thompson Region
Interior Health Board Members (2)		

Methods of Data Collection

Case studies are characterized by the use of multiple sources of evidence (Yin, 1989). For this study, I relied on interviews, direct observations and documents.

Interviews

Interviews are “one of the most important sources of case study information” (Yin, 1989, p. 88). Interviews are central to the methodology of this study, given the concern with presenting Aboriginal participation in health planning from the vantage of the AHAWAC members. Interviews were semi-structured and were based on open-ended questions (see Appendix E) that encouraged respondents to determine the focus and content of the interview. For instance, respondents were prompted to offer their own definition of Aboriginal approaches to health planning. Interviewees were informed in the informational briefing note that copies of the interview questions would be available by request prior to the interview; no such requests were made.

I interviewed thirteen of the twenty-two members of the Aboriginal Health and Wellness Advisory Committee. Eleven in-person interviews took place in eight geographically dispersed cities, towns and reserves in the Interior of British Columbia in March and April 2005, in addition to two interviews conducted by phone – in February 2005 (pilot interview) and April 2005. The duration of the interviews ranged from 0.75 hours to 1.75 hours.

In-person interviews were audio recorded and then transcribed for words. Transcription is described as “a technique that involves the selective preservation of elements of the research interview” (Sandelowski, 1995, p. 373). In this case, I preserved the words that were spoken, minus verbal idiosyncrasies (e.g., ‘you know’, ‘umm’ or repeated words). These transcripts were central to data analysis.

Direct Observations

My data collection included direct observations of two types of meetings: Aboriginal health planning community consultation meetings (four meetings of five total

conducted) and one meeting of the Aboriginal Health and Wellness Advisory Committee. While it would have been preferable to observe more than one AHAWAC meeting, only one meeting occurred during the period of data collection.

I observed the Aboriginal community consultation meetings in order to gain a broader, and more in-depth understanding of Aboriginal participation in health planning in forums that included non-AHAWAC community members. These consultations were the major focus of Interior Health's Aboriginal Health division at the time of data collection. During my interviews, research participants often commented on these consultations, and the consultations were also the chief item of discussion at AHAWAC meeting I attended. The community consultation meetings offered a significant look at the relationship between the organizations and Aboriginal communities, and were invaluable to data analysis.

Since the meetings were open to any interested public participants, I did not seek special permission to attend. However, during the introductions round at each meeting, I introduced myself as a graduate student researcher collecting data for my thesis.

I also attended a regular Aboriginal Health and Wellness Advisory Committee meeting as an observer in April 2005. Interior Health sought permission for my attendance at this meeting from Committee members prior to the meeting date. Interestingly, my previous interview contact with twelve of the nineteen attending Committee members may have influenced the events at this meeting. I found that many of the same views, and even anecdotal stories that interview respondents shared with me were reiterated in this group forum. It is possible that my interviews could have brought salience to some issues, made them top-of-mind, or reinforced convictions. This apparent

‘duplication’ of some issues served the purpose of data triangulation. In addition, the repetition of interview material revealed how comfortable many AHAWAC members were in voicing their thoughts in the group setting; this somewhat eased my concerns regarding confidentiality.

My observational notes from each of the meetings included descriptive notes (reconstruction of some dialogue and particular events) as well as reflective notes (personal thoughts and impressions and interpretations). These notes were subject to the final coding scheme as determined through analysis of interviews transcripts (described in ‘data analysis’).

Document Review

Numerous Interior Health documents were reviewed for this research. These include the Interior Health Aboriginal Health and Wellness Plan (Interior Health Authority, Revised 2003); organizational charts and job descriptions for IH Aboriginal Health staff; minutes of all (eighteen) meetings of the Aboriginal Health and Wellness Committee from June 2002 to present; Aboriginal Health Reports prepared by the Senior Medical Health Officer; and summaries of the Aboriginal community consultation meetings, among others. The Ministry of Health Aboriginal health planning guidelines were also an integral part of comprehending Interior Health’s explicit responsibilities in Aboriginal health.

Although some documents are referred to in the findings, documents were mainly used to understand the activities, goals and mandate for Aboriginal health in Interior Health. By contributing this additional vantage point, documents nicely complement my own meeting observations, and the perceptions of Committee members. Drawing from

these diverse sources of data, I formed an accurate overall picture of the phenomena being studied, while still allowing Committee members' views to drive the analysis.

Rigor

Many qualitative researchers have argued that the criteria for evaluating rigor must be appropriate to the research and the type of research methods used. In a general sense, rigor refers to the reliability and validity of research (Davies & Dodd, 2002), as well as objectivity. Qualitative researchers working in the constructivist paradigm have claimed that these positivist criteria are “regressive” and “counterintuitive” should be replaced with terms such as credibility, transferability, dependability and confirmability (Denzin & Lincoln, 1994). The essential elements of rigorous constructivist qualitative research will be presented here, as well as how rigor was ensured in this study.

Credibility is a term that parallels internal validity. Internal validity is “the extent to which a researcher’s observations and measurements are true descriptions of a particular reality” (Kincheloe & McLaren, 1994, p. 151). In this constructivist approach (and other approaches in the critical, postmodern tradition), credibility refers to the ‘trustworthiness’ or ‘truth value’ of the research. A qualitative study is credible “when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own” (Sandelowski, 1986, p. 30).

Critical postmodern researchers also reject the traditional notion of external validity; that is, “the degree to which descriptions can be accurately compared with other groups” (Kincheloe & McLaren, 1994, p. 151). This one-dimensional, cause-and-effect depiction of generalizability is not suited to my constructivist paradigm. Sandelowski

(1986) suggests the concept “fittingness” as an alternative to external validity. A study meets the criterion of fittingness when the “description, explanation, or theory ‘fit’ the data from which they are derived” and when the “audience views its findings as meaningful and applicable in terms of their own experiences” (Sandelowski, 1986, p. 32).

The quantitative, positivist notion of reliability in research refers to replicability over time and across contexts. But here, “reliability [of] data [is] based on consistency and care in the application of research practices, which are reflected in the visibility of research practices” and “reliability in... analysis and conclusions [is] reflected in an open account that remains mindful of the partiality and limits of [the] research findings” (Davies & Dodd, 2002, p. 280).

Each of the preceding elements of rigor was addressed in this study through a variety of checks, procedures and acknowledgements. Data triangulation, met through a variety of data collection methods, has served towards the assurance of rigor. In this study, I have used document review, interviews and direct observations to reduce the likelihood of misinterpretation and to identify different ways the phenomenon is being seen (Stake, 1994).

In addition, rigor was applied to the design of the interview questions. The interview schedule was designed to be semi-structured to allow for participants to themselves identify salient themes. In this way, I have avoided “premature analytic closure and a tenacious and (often unrecognized) commitment to some a priori view of the phenomena under investigation” (Sandelowski, 1995, p. 371). Interview questions were piloted with a member of the AHAWAC through a telephone interview and were revised for clarity.

In addition, member checks were an essential part of ensuring the rigor of my data collection, analysis and interpretation. All participants were offered a written transcript of their interview, an offer to which twelve of thirteen participants responded. In two cases, minor omissions, additions and clarifications were submitted as feedback, along with grammatical corrections.

A second round of member checks involved the review of the draft research findings chapter (Chapter Four). I invited three research participants, selected to be demographically diverse (two community based Committee members, and one Interior Health staff member), as well as an additional Interior Health staff member familiar with the AHAWAC to review the chapter. Reviewers were provided with the entire chapter (electronically, according to their preference), as well as some context regarding the placement of the chapter within the thesis, the research questions, and a statement regarding how I would consider any feedback; that is, noting my accountability as the final author of the document, while suggesting a place in the methodology chapter for suggested alterations that I did not accept.

Of the feedback I received (one reviewer did not submit comments), none contested the content of the findings or any aspect of my interpretation. Some comments I received indicated difficulty with following the connection between the themes (representation and reconciliation) and the three parts of the chapter; I have attempted to clarify this through the use of a diagram. Other feedback indicated that my portrayal of the Committee is balanced and realistic.

Finally, I have made this study rigorous through the transparency of my research methods. In keeping with my constructivist approach, I do not claim that my observations

and interpretations are perfectly repeatable; however, outlining my position as a researcher and detailing my research methods allows outside readers to critically analyze the connections between my methodology, data analysis and findings.

Data Analysis

Qualitative analysis is a means to knowledge production that involves the separation of elements of data according to some a priori or data-derived system (Sandelowski, 1995). According to Stake (1995), there are two strategic ways that case study researchers reach new meanings about cases: direct interpretation and categorical aggregation. Direct interpretation involves identifying significant meaning directly from an instance in the case. In categorical aggregation, the researcher finds meaning from reappearance of patterns in documents, observations and interviewing; that is, thematic coding. In my analysis, I relied on coding and direct interpretation from observations and interpretations informed by my data collection experiences and previously held knowledge of the case.

When embarking on data analysis, I followed Cresswell's (1994) commonsensical advice to first get a sense of the whole. I began this process by reviewing documents before the fieldwork, and transcribing interviews while in the field. Once data collection was complete, I carefully reviewed each transcription, writing preliminary interpretations beneath the transcribed text in a different colored font. Next, I reread the transcriptions and bolded passages that seemed to neatly capture the essence of what the informant was saying. At this time, I also reread my accumulated documents and gathered more documents based on information revealed from the initial data collection.

Following this, I made a list of all issues that arose in each interview. My initial synthesis of these issues took the form of a ‘mind map’ that attempted to define the links between the issues. Upon discussion of this map with my thesis committee, I began to organize the issues around the most glaring feature of the data: the existence of various competing interests and views, or what I call ‘tensions’. I explored the source of these tensions by examining the data for inconsistencies and contradictions. Originally, I categorized the tensions into five thematic areas, as per Table 2.

Table 2. Original Themes for Data Coding, with Associated Tensions

“Theme”	← Tensions →	
<i>Self-Concept: Membership, Role and Authority of the Committee</i>	Policy Advisory	Management Directive
<i>Implementation Gap</i>	Commitment to Aboriginal health goals	Administrative capacity, resources, knowledge, skills
<i>Conceptualization of Aboriginal Health division at IH</i>	Integration Central/Global	Separation Local
<i>Challenge of Community Representation: Participation, Accountability & Validity</i>	Direct consultation	Expert representatives Experiential knowledge
<i>Determinants of Health</i>	‘Western’ biomedical	Aboriginal holistic

Using a separate color for each ‘theme,’ I coded each of the interview transcripts according to this schema. This procedure revealed several things. These themes did not adequately capture some elements in the findings that I felt were significant. I also found that this coding structure was too rigidly determined for the fluid boundaries of the findings. I eventually collapsed the five original themes to four, and then three (which are now ‘parts’ I, II and III of the findings), and recoded the interview data. The final codes were applied to my observational notes, and to selected documents.

In order to define and distinguish the parts of the analysis, I found it helpful to ‘talk out’ my thoughts on recorded audiotape. When the sheer volume of data became overwhelming to me, I listened to the recordings in order to identify and trace a logical interpretive path through the data. These recordings document some of the iterative coding procedure in action. It was through this cyclical coding process that the overarching themes of the findings emerged: representation and reconciliation.

Representation and reconciliation identify the source of much of the tension that is evident in the data. While, admittedly, these themes do not capture the totality of the data, research is characterized by the fact that not all data collected is used in the final product. According to Stake (1994), “less will be reported than was learned” while the “criteria for selecting content [for analysis and presentation] are many” (Stake, 1994, p. 240). I determined that representation and reconciliation covered a significant amount of ground related to my research questions, offered substantial and important material for presentation, and helped me to organize the findings for the written thesis.

Reporting the Findings

The findings of this research are reported with concern for Stake and Trumbull’s (1982) “naturalistic generalizations” or intuitive understandings. These authors maintain that case studies can support program improvement through descriptions and assertions that provide “a maximum of vicarious experience to the readers who may then intuitively combine this with their previous experiences,” thus reaching new insight and understandings (Stake & Trumbull, 1982, p. 1). According to these authors, information presented in this way is more likely to be assimilated into the reader’s memory.

Through my presentation of the findings, I aim to provide this vicarious experience. Readers should find that the prominent participant voices in the findings offer an authentic view of the lived experience of AHAWA Committee members. My framing of these voices provides needed context and interpretive insight, while maintaining participant confidentiality.

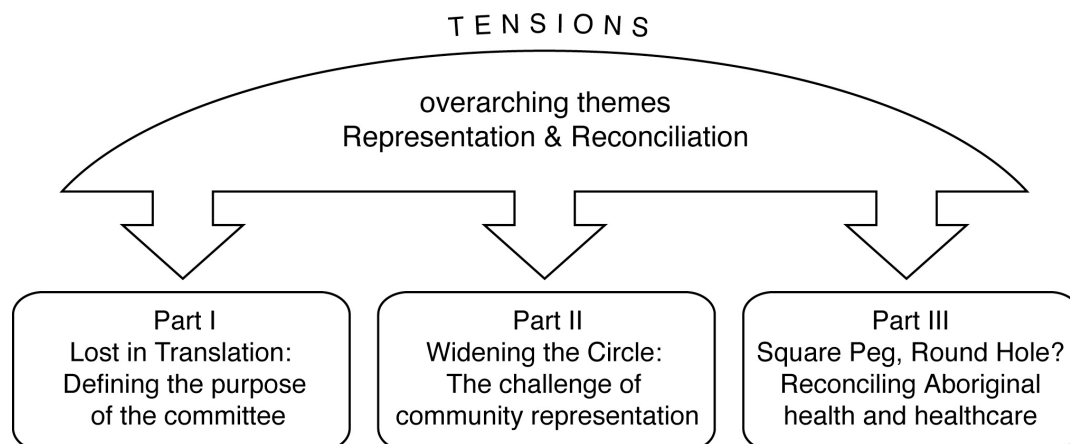
Chapter 4 – Participation in Aboriginal Health Planning:

Common Aim, Divergent Perspectives

This constructivist inquiry rests on understanding Aboriginal participation through the voices of members of the Aboriginal Health and Wellness Advisory Committee (AHAWAC) as recorded in personal interviews and observations. The findings are also supported and supplemented by documentary evidence. The constructivist approach relies on the researcher's interpretation, which I provide by "elucidat[ing] the process of meaning construction and clarify[ing] what and how meanings are embodied in the language and actions of social actors" (Schwandt, 1994, p. 118).

At the outset of the analysis, certain qualities of the data became evident. The data reveal a great deal of 'tension' – the interplay of opposing elements, manifested in contradictions, varying interpretations and divergent perspectives. As described in the methodology chapter, I have identified this tension as relating to two overarching themes, representation and reconciliation. Using these themes, I categorized the findings relevant to this inquiry into three parts. Part I concerns the role and purpose of the Committee, Part II explores community representation, and the Part III focuses on the improvement of Aboriginal health. Figure 3 diagrams the relationship between the formative influence of tension, the overarching themes, and three parts of this chapter. Before presenting the findings, it is important to understand how the themes of representation and reconciliation categorize the tension that radiates throughout this investigation of Aboriginal participation in health planning.

Figure 3. Relationship between Tension, Themes and the Three Parts of the Chapter



Representation and reconciliation both underscore the challenges that Committee members face in establishing meaningful working relationships between Interior Health – a bureaucratic organization couched in Western medicine – and local Aboriginal communities that are enduring the reverberations of historic disenfranchisement, continuing marginalization, and poor health status. In my usage, representation is a multifaceted concept. It points to the representational role that Committee members each play with respect to ‘the community’ and/or Interior Health. Representation implies the power to survey, define and categorize the represented. In this case, the represented could be the people in communities, the concept of Aboriginal health/care, or the agenda of the organization. The Committee itself is also a representation – not just a working body, but also a symbol of the relationship between Aboriginal peoples and ‘the government’. Representation is subject to the scrutiny and judgment of all involved parties; discerning true or false representation is a routine task in the building of relationships. It is my intention to show through the findings that representation offers dilemmas that Committee members must navigate in carrying out their work.

Reconciliation implies rebuilding damaged relationships. Integral to the concept of reconciliation is redefining a balance of power between parties. Reconciliation also refers to the difficult process that Committee members face in creating correspondence between sometimes competing agendas and conflicting worldviews. One example that I will explore in depth is how Committee members seek to reconcile the traditional, holistic Aboriginal conception of health with the reality of working for health improvement through a Euro-Western, biomedical healthcare system.

My identification of tension as a clear element of the findings bears some further explanation here. Tension weaves through the themes of representation and reconciliation, and across the findings I will be presenting. My focus on tension could be misconstrued as a preoccupation with the negative elements of the case, but is not my intent to place judgment on the Committee's work, functioning or accomplishments, nor on Interior Health or Aboriginal communities. Rather, I am using the concept of tension as a device through which to explore the nuances of the case. Through the analysis process, it has been useful for me to note where Committee members hold contradictory views, or how tension operates in Committee dynamics and beyond its boundaries. This analytical use of 'tension' does not exempt areas of concurrence, success and harmony from the findings; these elements, too, form part of the lively coexistence of oppositional forces.

The three parts of this chapter will demonstrate how representation and reconciliation provide the framework for the findings and how tension informs the reading of this framework. It will become evident that there are a variety of perspectives of how Aboriginal participation in health planning currently operates and how it 'should'

operate. Together, the findings inform the definition of meaningful participation in Aboriginal health planning at Interior Health, a notion that will be explored in the next chapter.

Part I. Lost in Translation: Defining the Purpose of the Committee

Unobjectionably, the impetus for the Committee's participation in health planning at Interior Health is to address the health inequities that face the Aboriginal population. But beyond this broad mandate, Committee members attribute various meanings to the purpose of the Aboriginal Health and Wellness Advisory Committee. In the first part of these findings, I will discuss the advisory nature of the Committee, and then continue this section with a closer look at two functions of the Committee as they have been articulated by Committee members: funding allocation and education. In shaping the relationship between Aboriginal communities and Interior Health, the Committee's activities suggest both reconciliation and representation.

Take My Advice...

According to the Committee's Terms of Reference, the Committee's purpose is to "provid[e] advice to Interior Health on matters pertinent to the improvement of health and health services for Aboriginal People" (Interior Health Authority, 2004b, p. 1). However, judging from remarks of Committee members, this advisory capacity is contentious:

"...there's that element of 'this is an Interior Health committee, and Interior Health has the last say,' that this is 'an advisory to'. So there's still a bit of that power struggle, still that tension." [P-9]

“...there’s been a lot of frustration as to clarity. Nobody was really clear as to what power, what kind of authority does this Committee really hold? And people are kind of, ‘well, we’re just an Advisory Committee, why are we here? There’s no real point. What can we do?’ But if you go back into the history of reading about the Committee, they chose to be an advisory committee.” [P-10]

“[The Committee’s] role isn’t to be in control, [its] role is to be an advisory committee; there’s a difference.” [P-3]

The apparent purpose of providing advice is not only a source of confusion and frustration within the Committee; it is potentially problematic in other ways. For instance, according to some Committee members, the advisory role carries the risk of providing the governmental organization with a consultative process, with little or no perceived benefit to the Aboriginal participants:

“I know that with government bodies, we make their job easier. They can say, ‘Yes, we’ve consulted.’ You need to be wary. [...] You have to ask the key questions so that everyone is up front.” [P-6]

“Because it’s a common occurrence – Aboriginal participation on committees. It’s always the ‘Oh, we want an Aboriginal committee.’ But it’s an Aboriginal committee to do the job that they want.” [P-13]

Tension around the Committee’s advisory role is linked to issues of power and authority. For instance, the scope of the Committee’s jurisdiction in Aboriginal health is subject to varied interpretation. The following Committee members’ assertions point to a broad interpretation of the Committee’s jurisdiction:

“If there is a decision to be made with respect to Aboriginal health, resources or programming, it’s to come to [the Committee] table.” [P-13]

“...anything that smacked of Aboriginal things, the Committee wanted it to come to them.” [P-1]

But the following statement demonstrates a lack of consensus regarding the Committee’s ambit of authority:

“There’s [sic] some people on the Committee who really believe that we should be the health authority for the Native people...and anything that happens in health, we should have the authority over it, which is ridiculous.” [P-3]

Given that advisory means, “having the power to make recommendations but not to enforce them” (Oxford Dictionaries, 2005), it is likely that some of the tension surrounding the Committee arises from a disjunction between providing advice and the implementation of that advice. One Committee member [P-2] expresses the belief that implementation should follow advice: “I think that because they are asking for our advice as an advisory committee, they should take our advice.” Similarly, another Committee member [P-9] provides a definition for success in health planning that indicates a direct link between advice and implementation: “Interior Health will say this is what the First Nations or Aboriginal people have done, this is what they recommend, and here is the budget to support them.”

In contrast, comments by other participants demonstrate a belief that the Committee’s advice is not equal to a directive:

“It’s not as if we can come and say ‘we want this and we want that, so give us that.’” [P-10]

“[The Committee] can’t rant and rave and say we want control of that money and we’ll decide where it has to go. There has to be a reasonableness about it.” [P-1]

Clearly, Committee members do not share the same perceptions of the authority vested in their role as advisory. As suggested in the last quotation, the tension surrounding the Committee’s authority is apparent with respect to funding allocation, one of the main roles of the Committee. This role is explored in depth next.

Slicing Up the Pie: The Funding Allocation Role

The AHAWAC is involved in both policy and management with respect to resources. At the broad policy level, the Committee sets the priorities for resource allocation through the Aboriginal Health and Wellness Plan and associated work plans. At the management level, the Committee is involved in allocating funds that are provided to the health authority by the BC Ministry of Health through the Aboriginal Health Initiatives Program (AHIP). Previous to the formation of Interior Health, these funds were administered by the regional Aboriginal Health Councils. While, according to Interior Health, these funds are not intended to comprise core funding for the Aboriginal health plan, they offer a vital source of revenue to Aboriginal community programs that promote health improvement.

In order to distribute these funds, Interior Health invites proposal submissions from interested community based organizations for short term (one-year) funding. A subcommittee of AHAWAC judges submitted proposals and decides on funding allocation. While AHIP funds are currently the main focus of the Committee’s funding distribution, Aboriginal projects funded through another ‘envelope’ of resources from the Ministry of Health (known as ‘targeted funds’) have been recently evaluated at the

impetus of the Committee, leaving potential room for further involvement in funding distribution.

Priority setting for resources is universally viewed as central to the Committee's work, but the emphasis on funding allocation is unsatisfactory to many Committee members, as seen in the following comments:

“Generally what’s been discussed over and over is these flippin’ AHIP dollars – the money. That’s been kind of a constant theme throughout these meetings, and we’re to the point sometimes that ‘is it answered this month?’” [P-10]

“I see [funding distribution] as a management function and not a policy function. [...] It’s pretty hard to separate yourself, to look at the big picture when you’re in the day to day needs.” [P-11]

“We are struggling at AHAWAC. [...] The main scope of reporting is AHIP funding. We haven’t gotten to the other levels.” [P-6]

It is clear that some Committee members believe that the Committee's preoccupation with AHIP funding allocation prevents it from attending to issues that are more significant. Accordingly, several members feel the allocation of AHIP funds is more appropriately conducted outside of the Committee structure. The following statements support this assertion:

“...if we weren’t worrying about these proposal calls and this money, and that was just being taken care of by the contract committee from the hospital or something, then we could maybe get down to better business.” [P-3]

“...I say let’s take the money away, and the Committee should really be looking at what direction to go, and then Interior Health should be using those dollars to make that direction happen.” [P-12]

Not only is funding allocation perceived as in competition with other work, it is also contentious because decision-making is conducted by a subcommittee rather than by the AHAWAC as a whole. Some Committee members are concerned with biased decision-making, both real and as perceived by community members.

“...I hear locally, as long as such and such sits on the [sub] committee, we’ll never get any money. So I know it’s a sore point.” [P-1]

“They have a small little subcommittee from our table making those decisions and going through those proposals while the people everywhere in this Nation are upset about that, and I don’t blame them. [...] The Native world is a small world. Everybody knows everybody from here to... So there’s always that chance of being biased or being favoured.” [P-3]

Along the same lines, funding allocation is perceived as divisive because it can become an opportunity for Committee members to funnel funds to the community that they represent, rather than focusing on the overall agenda for Aboriginal health. A Committee member expresses this concern here:

“I’m disappointed that even though we say at the table, we’re all working together to utilize what resources we have to the best we can, there’s still some politicking on the side, for those few dollars and whatever else.” [P-9]

Similarly, the following sentiment articulates the challenge inherent in balancing local community representation with the overall Aboriginal health agenda. It also points to the perceived contribution that ‘the government’ makes to this dilemma:

“The government always does this...I don’t know if it’s the government, but funding is always an issue. They throw money at the table and say ‘Okay, it’s up to you guys to split up this money and deal with it to meet these tons of health needs’. But because we all come from different areas, your area is priority, and it has to be because...You want the good of all people, but in your area, because you’re from there, it’s like your own family. You want them to get ahead and so you focus more on them. So I find each of the Committee members kind of do that.” [P-8]

Without question, funding allocation is a contentious role for the Committee due to the perception of resource scarcity relative to the goals of the Aboriginal Health and Wellness Plan. Committee members point to the connection between resource scarcity and the conflict that is generated by funding allocation:

“There’s only so many dollars and they’ve got us all fighting over them. It’s typical.” [P-3]

“Sad to say, I think that for Aboriginal people to come to a table and always be in the position where you’re trying to get as many resources as you can...[you see] a lot of that misbalance in relationships, kind of that oppressive factor. You really see it when you look at those that have been oppressed for so long become the oppressors.” [P-10]

A Committee member nicely summarizes the competing issues underlying the Committee's preoccupation with funding allocation:

“Throwing money on the table is always divisive. [...] But at the same time...See, that's what makes it confusing because it's a double standard. The money belongs to Aboriginal people so Aboriginal people should decide on how it's best spent and where it should go.” [P-8]

Funding allocation is currently a central role for the Committee, but one rife with tension. The application of funding for Aboriginal health will be explored further in Part III, *Reconciling Aboriginal Health and Healthcare*, where perceptions of resources reveal how Committee members variously construe the relationship with Interior Health and Aboriginal health improvement.

Teaching and Learning: The 'Education' Role

In addition to allocating funds, Committee members remark that a great deal of the work of the Committee is focused on an umbrella of activities that I term 'education'. This includes knowledge transmission, information sharing, and facilitating historical and cultural awareness of Aboriginal health. The emphasis that Committee members place on these activities underscores the importance of reconciliation; that is, overcoming misinformation, discrimination and other barriers to create effective relationships between Aboriginal communities and Interior Health.

One important aspect of this role is the Committee's contribution to educating Interior Health staff about Aboriginal healthcare. This includes elucidating the reasons for poor Aboriginal health, and correcting the widespread assumption that Aboriginal healthcare resources are sufficient. Conduits for this education are Committee meetings

that include invited Interior Health managers, as well as the cross-cultural training promoted by the Committee (delivered to Interior Health staff by Interior Health Liaisons). The following statements underscore the perceived importance of this education role:

“[The Committee is] putting that Aboriginal context into [the Interior Health] system. Making sure that we have voice...and educating those individuals within the organizational structure about what our needs are and why. [...] There’s...a great deal of misinformation within the system that is leading to some of the problems in decision-making, because they don’t understand that there’s isn’t a huge dollar out there.” [P-7]

“I think there is [sic] these myths and beliefs that the federal government just takes care of everything for [Aboriginal people] so they must be fine. I think it’s been very educational for [Interior Health staff] to find out, no, a lot of the benefits that they’ve had have been cut off and they do struggle with health care. So I think it’s been an eye-opener for IHA.” [P-3]

“There are very few people in healthcare from the top down that really understand our people and understand the reasons for being and [that] we can’t just be assimilated. [...] It’s good to know that we have cross-cultural training now.” [P-4]

These Committee members’ views are also reflected in the Aboriginal Health and Wellness Plan, which states, “Without a proper understanding of the Aboriginal culture, history and imposed legislation the existing health system cannot provide Aboriginal

people with the necessary continuum of services” (Interior Health Authority, Revised 2003, p. 40).

The education of ‘Interior Health’ also extends to how the organization should appropriately engage with Aboriginal people. According to a Committee member:

“[The] number one [role of the Committee] was to assist in the education of Interior Health as a new entity with very little history with respect to working with Aboriginal people. So there was a whole bunch of education that had to take place with respect to the corporate acknowledgement of the relationship with Aboriginal people.” [P-13]

Information sharing is also thought to be important as it flows in the other direction, from Interior Health to the AHAWAC table, and subsequently, into Aboriginal communities. As seen here, some Committee members identify this channel of information with capacity building:

“[A positive experience I’ve had with the Committee] has been having the opportunity to be at a table where I’m able to collect information that’s going to help us as a [community] organization run better.” [P-3]

“We’re learning a lot about Interior Health and about the system. In working on how to improve it, we are looking for how to change for ourselves.” [P-6]

A Committee member describes the process of education as necessarily occurring in both directions, between the healthcare organization and Aboriginal communities:

“There’s still assumptions on both sides, in the communities and with Interior Health facilities, about what goes on in each other’s back yards. Nobody really knew. [...] I think that informational exchange is really crucial to understanding

relationship building. And I think that's where probably a lot of frustration could be alleviated is at that point of learning." [P-10]

'Education,' then, is a crucial element of reconciliation and relationship building.

While many Committee members point to the need to educate 'Interior Health', some report benefiting from knowledge flowing in both directions. In this section, I have presented findings on how the Committee members view their purpose with respect to 'advising', funding distribution and education. In Part II, I will give significant attention to a major role of the Committee: representing the interests of the Aboriginal community.

Part II. Widening the Circle: The Challenge of Community Representation

According to the Committee's Terms of Reference accountability statement, "AHAWAC is the link between IH and Aboriginal communities. Committee members are accountable to the communities they represent and should ensure the provision of communication to Aboriginal people. IH acknowledges the Committee as representing the Aboriginal People within the First Nations territories served by IH" (Interior Health Authority, 2004b, p. 1).

In describing the challenge of community representation, it is first necessary to point out and give some attention to the fact that not all Committee members have identical roles to play with respect to community representation. The first section describes the delineation of roles between Interior Health staff and community-based members of the Committee. Grasping this distinction is necessary for understanding accountability and communication between Interior Health, representatives of Aboriginal communities, and Aboriginal peoples and communities themselves. Following this, I describe efforts and gaps in representation as identified by Committee members. Finally,

I provide Committee members' perspectives on the mechanisms of community engagement employed in Interior Health. Part II emphasizes that while community representation is couched within individual members, Interior Health also has an important role to play with respect to engaging Aboriginal communities.

Round Table, Different Seats

In this section, I examine the roles and challenges that Committee members face with respect to community representation, and focus particularly on the issues facing Aboriginal Liaison staff and community-based Committee members. Given the confidentiality issues inherent in presenting data from such a small group of participants, it is not my intention to focus on distinguishing the different 'types' of Committee members and the differences or similarities among their perspectives. The point here is to demonstrate that Committee members do not have uniform roles to play with respect to community representation.

As an amalgam of Interior Health staff, Interior Health Board members, and community-based participants, the AHAWAC's composition challenges the unitary notion of providing advice based on community representation. At the very least, it is clear that staff, community members and Board members have varying roles with respect to implementation. In fact, it is evident that many Committee members draw distinctions among themselves with respect to Committee membership, to the extent of redefining the basis of membership. This is exemplified in the following exchange I had with a participant [P-2]:

Interviewee: "How many Committee members have you interviewed so far?"

GC: "You're number [number stated here]."

Interviewee: “Are you going to do more? There’s only fourteen Committee members.”

Here, membership is inclusive only of the fourteen community-based members, not the entire Committee membership of twenty-two individuals. Despite the common occurrence of this delineation throughout my conversations with Committee members, it is significant to note that *all* of the Aboriginal Committee members (including staff and Board members) feel that they are in some measure representative of Aboriginal peoples and communities. This is in apparent opposition to the Committee’s Terms of Reference that identifies all ex-officio (staff and Board members) as “representatives of Interior Health.” It is perhaps not surprising, then, that Aboriginal Interior Health staff members, particularly the Aboriginal Liaisons, are faced with unique challenges in reconciling dual representation and dual accountability.

Without exception, the Aboriginal Liaisons participating in this study convey a great deal of allegiance to Aboriginal communities, grounding their work in their ties to community. At the same time, the Liaisons remark that they are representative of and accountable to Interior Health, and are concerned with providing a beneficial service to both the organization and communities. Liaisons state the challenge of the position in this way: “I’m being pulled in a lot of directions, I guess. [...] It’s hard to meet in the middle and be that one person for everybody” [P-8], and “It’s a balancing act” [P-10]. The Liaisons’ bridging role appears to involve conflicting allegiances, particularly given the Euro-Western notion of the ‘neutral public servant.’ This is described in the following remark: “As a Liaison for Interior Health I must be neutral...So sitting at the [AHAWAC] table is sometimes very painful for me.” [U-1, email]

The extent to which Liaisons are expected to represent the needs, concerns and wishes of Aboriginal people in their local health service area is ambiguous, leaving their position at the Committee table unclear. Until recently, Liaisons had been presenting operational reports from each health service area at the Committee table. Due to a decision made by the Committee, the Liaisons must now collectively generate issue papers in order to transmit community concerns. As a consequence, Liaisons express the concern that community representation has been compromised:

“[The Committee has] dropped the focus off the Liaisons so we don’t bring as many community issues unless it’s done through an issue paper, and...those things are time consuming.” [P-8]

“...Now we’ve since pulled back on giving reports. So now they’re not getting any input [from the Liaisons] into what’s going on at the community level. [...] I still remind [community members] of who their representative is on that Committee, and I would just strongly encourage them to contact them [if they want to provide their input to the Committee]. That’s all I can do.” [P-10]

Community-based Committee members do not face identical challenges, but there is tension evident in their role in community representation. Typically, community-based Committee members link their accountability back to the organizations that appointed them to the position. This appointment system is based on what a Committee member [P-4] describes as “Indian criteria.” According to this system, representatives for the AHAWA Committee (or any governmental advisory committee) are chosen by letter of appointment through a band council resolution, tribal council resolution, or through joint approval from urban Friendship Centres in an area.

Most often, community-based members describe their central role as being a representative for the Aboriginal people of their respective Bands, Nation, or urban area. Only one Committee member claims otherwise, stating:

“...I don’t represent anybody. [...] I have a certain knowledge of those communities identified, and I have the endorsement of the formal bodies that are recognized as those that work and are representative of the interests of those...Aboriginal peoples in those certain areas. But it would be very presumptuous of me to say I represent. Those individuals didn’t give me a mandate to represent them.” [P-11]

Some Committee members state that their input is not limited to the concerns of their local ‘constituents’. These Committee members express the belief that local representation must be balanced by the broader interests of Aboriginal peoples across the diverse region served by Interior Health. For instance:

“I bring a global perspective. I speak beyond just this region.” [P-7]

“I believe that it’s up to me to bring my knowledge of that [local] perspective in, but to ensure whatever advice and input I have is reflective of the overall needs.” [P-11]

“We have to represent the interests that we come to the table with, and that’s very important because we have such diverse interests. If we were not all representing those interests, IH could not represent that diverse population. [...] But at the end of the day when a decision is being made, the interests are for all Aboriginal people and the wellbeing of Aboriginal people as a collective.” [P-13]

From these findings, it is apparent that representation is not simply a linear extrapolation from local community to the AHAWAC table. Aboriginal Liaison staff must reconcile dual representation through their work, but at the same time, their role as representatives at the AHAWAC table appears to be marginalized. Community-based members are also challenged in their representational role with respect to balancing local representation with broader interests of Aboriginal people.

Efforts and Gaps in Representation

Representation, by its very nature, limits the direct involvement of all stakeholders in the health planning process. Here, I will present evidence of the extent to which the Committee members feel they adequately represent the Aboriginal peoples in the region for health planning.

The composition of the Committee is based on the categories of representation set out at the foundational meeting of May 6, 2002, but has since been modified to provide some additional positions for community based members and Interior Health staff. The Committee currently has one seat for each of the Nations indigenous to the region, as well as one Métis representative and urban Aboriginal representatives. Many Committee members feel that the Committee structure adequately represents the Aboriginal peoples of the region, provided that “everybody shows up” (many Committee members are concerned by lack of consistency in members’ attendance). Some members note that the Committee cannot adequately represent the great number of bands and Aboriginal organizations in the area, because “there isn’t dollars for every rep in the Interior Health area to be at the table” [P-2] and “you’d have to have this massive group of people if you really wanted to represent everyone” [P-3].

But despite this initially straightforward equation of representation with Committee composition, many Committee members problematize representation with reference to communication and accountability. In the words of a Committee member [P-13]: “...to be truly representing, you have to hear what people are saying, if you’re going to be at the table speaking on people’s behalf.” One Committee member points to the connection between representation, communication and accountability in the following comment, and shows concern about the efficacy of some Committee members’ representation:

“So, have we got the representation? Yes. Do we have all of the issues on the table? No. I don’t believe that all of the Committee members are as diligent in performing their functions of representing and reporting back to their constituencies.” [P-12]

Other Committee members indicate similar concern:

“There’s not a clear enough process for how we report back [to the community]. Not everyone is doing that.” [P-6]

“There needs to be, I think, tightening up of the accountability back to the general population with reporting...having a proper conduit for that information flow to go through.” [P-5]

Committee members note a variety of channels through which they choose to accomplish representation. Some Committee members report relying somewhat on their experiential knowledge as an Aboriginal person, as well as informal contacts to inform their contributions at the Committee table. For instance:

“I have a lifetime of experience as a First Nations person... And I choose to live with and be around First Nations people for the most part. And through my experience and knowledge and past and current contact with First Nations people and reading and that kind of thing, I believe I have a good solid knowledge about what the wishes [of the First Nations people] would be.” [P-9]

All of the community-based Committee members are actively working and volunteering in health and social services, and report using these organizational links to transmit information back and forth from the Committee table. As such, these Committee members report that their contributions are informed by some combination of the following: organizational statistics (“looking at the statistics of the services that are provided” [P-11]); speaking with organizational staff (“I contact the health directors of the bands” [P-6]); speaking with clients (informally or at regular meetings such as an Annual General Meeting); and, participating in needs assessments. One Committee member describes the route employed for sharing information:

“I guess I can’t communicate one on one with everyone. But it’s important to communicate with the organizations that I represent so that they should be totally aware of what’s happening with the Committee, what is being discussed at the table, then they can disseminate it out to the population that they provide service to.” [P-4]

A reliance on constituency organizations as information hubs appears to apply equally to representatives of urban Friendship Centres and First Nation and Tribal Association representatives. One Committee member [P-13] reports an additional

political level of reporting: “I have to report to the Chiefs of those communities through a tribal structure.” Another Committee member notes:

“I should be reporting to the Chiefs but they aren’t interested. You can ask them to report to them all you want to. As health, we usually get the last five minutes of their meeting and usually we get bumped anyway.” [P-3]

Despite the various, often informal means Committee members use for accountable representation, some members express concern about the Committee’s ability to represent all Aboriginal peoples for Aboriginal health planning. They identify specific representation that should be included in Committee membership: “[On] the Committee, I would include people from the communities, some young people from the communities, at least a couple of elders from the communities” [P-9]. One Committee member contends that Aboriginal health planning would be better served by including Aboriginal health experts from the community in ongoing Interior Health planning processes:

“I think it would be really important to have knowledgeable Aboriginal input into the planning, to actually sit at that table. It may not necessarily have to be an AHAWAC Committee member because there might not be a member there with that expertise, but they could recommend someone from the Aboriginal community that had that area of expertise.” [P-4]

In addition, several Committee members express that it is important to have broader community input into Aboriginal health planning, as exemplified in the following comments:

“I always think that it’s really good not just to include the service providers [in planning] but to include those that are receiving the service, because they often have a good insight, probably better than I do.” [P-4]

“Engagement of the population that’s going to be a recipient of the service, I think that’s an indicator of success in planning in Aboriginal communities. [...] If we’re planning for elders, then we should have elders at the table, so if we’re planning for youth, we should have youth at the table... we’re actually engaging those people so that we get their interests first hand.” [P-13]

While some Committee members express interest in employing inclusive processes for health planning, Committee members identify certain barriers to involving community members, such as community disinterest:

“We tried a couple of different things, but getting people excited about health and that kind of thing is not that easy, even though its important.” [P-9]

“...even though we put the questions out there, or we give them the information, you don’t get a lot of feedback back. The basic kind of feeling I get from the people is just take care of it. That kind of apathy thing. ‘You guys worry about all that stuff, about money, funding, proposals and whatever else.’” [P-3]

Community engagement in regional health planning is further challenged by the complexity of the Aboriginal healthcare system. As explained here, community members may not understand the role that Interior Health plays in healthcare for Aboriginal people:

“You hear the complaint [from Aboriginal community members], ‘Well, we don’t get services from the province’. It’s almost like they don’t understand what the

provincial services are that they're getting. [...] They're so confused; they don't know who's paying for what or who should be giving them what. It's too complicated." [P-3]

Furthermore, one Committee member describes the challenge of reaching more marginalized segments of the Aboriginal population:

"To get information out from here to the average person, it takes more than posting it at the Band Office, at the Friendship Centre, emailing folks, whatever. Not everybody uses computers or the Internet or anything. Not all do. Most of our people live at or below the poverty line, so going online somewhere is not a priority. They're worried about the rent or how to feed the kids in the last week of the month... It's that group of people that we need to reach, but that means getting out there and basically going door-to-door. And who has time to do that? Who's willing to do that?" [P-9]

According to some Committee members, "[It is important] that [Aboriginal] people are aware that they are being represented" [P-4]. Relating to this issue, one member stresses the responsibility of Committee members:

"I really think that representatives like this on the Committee, if they're serious about their position and their role and making plans, they would make it a priority to set up consultations within their areas. You'd think that they would start there, and that information would start to be free-flowing because it seems to me that everybody's in limbo, nobody knows what's going on. Communities don't know. They don't even know who their rep is sometimes, so I think that that's one of the big problem areas." [P-10]

Consultation and detailed representation themselves, however, pose challenges to timely decision-making and progress with the Committee's work, as Committee members note:

"There's still a tendency, I think, embedded in our people that even though you're representative or you're chosen to sit on a committee, you're still unsure because you're one person and you're speaking on behalf of this area ... People, I don't think, are comfortable making decisions because they have to go back to the community. But you know what? The community put you there, so they're saying make the decision, move us forward." [P-10]

"There's a lot of people who would say there should be many more people on [the Committee], there should be much more detailed representation. The more people you have, the less you accomplish, the less ability you have to make a statement, because you have to get consensus from everybody." [P-7]

Community representation provides a variety of challenges to Committee members. Many Committee members would like the health planning process to be inclusive of other community members, while at the same time, there appears to be some dysfunction with respect to the current accountability scheme between Committee members and the community. As well, Committee members have identified several barriers to involving the community in health planning, including the inherent complexity of the Aboriginal health system, and other barriers to participation (lack of time, access).

Mechanisms for Aboriginal Community Engagement

Since the creation of Interior Health in December 2001, the health authority has employed various mechanisms to engage with Aboriginal peoples. Chief among these is

the Aboriginal Health and Wellness Advisory Committee itself. But engagement strategies also include Aboriginal Health Improvement Committees, the Aboriginal health conference, human resources and community consultation meetings. Committee members do not uniformly endorse each of these mechanisms as they have been carried out.

The Aboriginal Health Improvement Committees (AHICs) exist in two of Interior Health's four health service areas. AHICs are described by one Committee member [P-10] as "a networking, educating, empowering kind of group" that is composed mainly of health service workers from Aboriginal organizations, although the monthly meetings are open to all interested parties including clients. Meetings are facilitated by Interior Health Aboriginal Liaisons and focus on service delivery issues and information sharing between the community and Interior Health.

The authority and utility of the AHICs to provide added value to Aboriginal health planning in Interior Health appears to be contestable. One Committee member [P-4] relates that AHICs are very useful as a venue to gather advice to bring to AHAWAC: "...when...it's really important to communicate...I also to go to the Aboriginal Health Improvement Committee." AHICs are also perceived as a useful means of familiarizing Committee members with local Aboriginal health issues, specifically the ramifications of AHAWAC's decisions. The value of this link is explained here:

I recognize that I need that connection [to AHIC] and they do too [to AHAWAC]. So even though I may not be able to bring their specific issues forward [to AHAWAC], at least I can look at 'okay, how is this going to work effectively here?'" [P-11]

However, another Committee member contends that because there are only AHICs in two of the health service areas (where the Aboriginal Liaisons are employed full-time), it is not ‘fair’ to rely on the AHICs to provide systematic advice to AHAWAC. This is captured in the following comment:

“I know that at the last meeting there was a lot of emphasis on AHIC and asking them for advice, which I thought was grossly unfair. [...] If [the Aboriginal Liaisons] only work two days a week, how are they supposed to come up with this thing [an AHIC committee]?” [P-1]

Some AHAWAC members report regular or periodic attendance at AHIC meetings, but more often, Committee members report that they have little or no involvement with the AHICs. Interior Health has done some preliminary work to expand the AHICs into the remaining two health service areas, and to encourage the AHAWAC members to attend AHIC meetings. This is despite the fact that many Committee members feel that they are too busy to attend further meetings or are uninterested in having an AHIC in their area. As yet, there does not appear to be a systematic use for the AHICs at the AHAWAC table.

Another mechanism used for Aboriginal community engagement in Interior Health was an Aboriginal health conference hosted in the Fall of 2003. A response to “feedback...that some [community] people are not informed,” the conference provided “a vehicle to distribute information on Aboriginal health in IH” (Interior Health Authority, 2003a, p. 1). This stated function is in keeping with the perception of some Committee members who reiterate that the conference was mainly a mechanism to report to the communities, rather than to solicit feedback or input into health planning. The

Committee's meeting minutes suggest further drawbacks of the conference as a means to involve Aboriginal people in planning; here, it notes that Committee members were concerned that the bulk of resources for the conference went to facilities, and suggested that smaller, locally based gatherings might be preferable in order to increase participant access and discuss locally relevant concerns (Interior Health Authority, 2004a, p. 4).

Other Committee members, though, have more favorable impressions of the conference as a means to engage in health planning with the Aboriginal community. One Committee member [P-2] states that the conference should occur annually or every alternate year, in order "to get feedback from community members and [provide an opportunity where people in the communities] get to know who the committee members are." This Committee member adds:

"At the conference [community members] came away with a good feeling about Interior Health. They knew who Committee members were; we all introduced ourselves, who we are and who we represent. We [had the opportunity] to communicate with each other as First Nations." [P-2]

Several Committee members emphasize Aboriginal human resources as an essential element of Aboriginal participation in health planning. When asked about the main purpose of the Committee, one Committee member said:

"To find that place within the organization for us that will best meet our needs and improve our health status. So that means at every level – the Committee level, the Board level, everywhere in-between, and employment-wise from to custodians, receptionists to nurses to doctors, administrators. [...] Getting our people employed right from the front door is imperative." [P-9]

Other Committee members contend that Aboriginal human resources are capable of shifting the organization's response to Aboriginal health. This is particularly thought to be the case if Aboriginal representation is present at the senior leadership level:

“You’ll never see diversity at the Senior Executive level. It’s just not there; it’s never been there. But what would it look like if we had lots of diversity at that level? Don’t you think that would change policy and the ways that [Interior Health is] working with people? I think that it would.” [P-10]

The connection between Aboriginal human resources and Aboriginal health is mirrored in documentary evidence. The following statement refers to the Interior Health

Aboriginal Human Resources Collaborative (a committee composed of Aboriginal Liaisons, Aboriginal Strategies Coordinator and Interior Health human resource staff):

“the [AHRC] is tasked with working to improve the health of Aboriginal peoples through employment opportunities that increase Aboriginal representation in a diverse range of roles.” (Interior Health Authority, 2005, p. 2).

Community consultation health planning meetings are another mechanism Interior Health has used to engage with Aboriginal people. These meetings were being conducted at the time of data collection for this project. According to Interior Health, the purpose of the meetings was for community members: “to hear about our progress to date, to learn about our planning process, and to give us [Interior Health representatives] your feedback on [2006-9] plan priorities and suggestions for action steps.” Local Aboriginal community health services staff and Interior Health staff participated to varying degrees at each of the five consultation meetings. Besides Interior Health staff members of

AHAWAC, three AHAWA Committee members each attended one community consultation meeting.

As was made apparent at the AHAWA Committee meeting I observed, these community consultations were, generally, badly received by community-based Committee members. Various reasons were given for this, although there was a general consensus that the meetings were conducted with little notice to participants. Other issues include the impression that the consultations were conducted with no acknowledgement of previous consultations and work done in the communities. For instance: “We just did this a year and a half ago. We should be working from that, not from something that was thrown together in a week.” [U-2, observational].

In addition, the original intention for the meetings as it was conceived at the AHAWAC table appears to be different than what was carried out. A Committee member [P-3, observational] explains that the gatherings were to be used to establish and strengthen relationships: “I wanted to see a large room with our Native people. I heard the meeting here was thirty people with twenty-eight Interior Health staff. [...] You [Interior Health staff] haven’t even met our Chiefs.” The relatively low numbers of community members at some of the meetings struck some Committee members as inadequate representation for a consultation:

“If there was less than thirty people there, it wasn’t representative.” [P-11, observational]

“The validity is up to question, because there were not enough community reps at the meeting.” [P-4, observational]

Furthermore, the responsibility for invitations being sent to communities by the Aboriginal Liaisons was not thought to be appropriate by one Committee member, revealing tension regarding the power to define community representation. The Committee member [U-2, observational] states, “Leaving it to the Liaison who’s out of touch with the community, working for Interior Health, was totally inappropriate.” Other Committee members note that the community consultation meetings actually damaged relationships between communities and Interior Health. One member [P-6, observational] who attended a consultation explains why: “[The meetings] really brought the mistrust back. The questions that were asked by the communities weren’t responded to with back-up and supporting documents.” Another Committee member [P-3, observational] characterizes the hastily organized community consultation meetings in the following way: “Let’s chuck them [Aboriginal people] a bone and they’ll shut up about it. I don’t want to be thrown a bone. I’d rather not be thrown anything at all.”

By way of contrast, some Committee members who attended the community consultation meetings felt that they were useful for linking Interior Health staff with community members, and informing community members about current planning processes in Interior Health. Despite the drawbacks of the employed consultation process, a Committee member reinforces the importance of community participation:

“Building the plan is only a part of it. I don’t care so much about the document.

It’s to let people know that they’ve got a place to voice their concerns, even if it’s only once in three years.” [P-3, observational]

It is apparent that community representation is a key aspect of the Committee’s operation as a representative body. But it is also clear that community representation is

not achieved linearly from each representative to the AHAWAC table: organizational and community affiliations add complexity to local and regional representation. At the same time, Committee members are aware of areas of under representation, lack of accountability, and barriers to fuller community representation. While Committee members may be individually accountable for representation, Interior Health is also implicated in representation; the organization is involved in community consultation and representing itself to the community. Therefore, ensuring adequate, appropriate community representation is a challenge for all participants in AHAWAC.

Part III. Square Peg, Round Hole? Reconciling Aboriginal Health and Healthcare

Parts I and II have dealt largely with how Committee members perceive their purpose with respect to advising, distributing funds, educating, and representing the community. In Part III, I continue to elucidate the themes of representation and reconciliation with respect to Aboriginal health and healthcare. Here, too, tensions arise and abound. Committee members must reconcile a latent tension between their conception of Aboriginal health and the mainstream healthcare approach to health planning. Related to this is a tension regarding how the Aboriginal health plan is carried out relative to the other functions of Interior Health.

Part III begins by presenting Committee members' views on the determinants of Aboriginal health, and holistic healthcare. Next, I discuss the variously construed pathways to Aboriginal health improvement, and I conclude with an examination of Committee members' perspectives on progress and success in Aboriginal health planning.

Aboriginal Determinants of Health and Holistic Healthcare

Committee members identify various determinants of Aboriginal health that can largely be traced to the impact of colonization. One Committee member [P-9] states, “How did we get this way? It didn’t happen overnight. [We are] still feeling the impact of two hundred-some years of colonization.” In keeping with this, Committee members point to Aboriginal determinants of health outside of the healthcare system. For example:

“...we recognize that health is just a response to or a reaction to lack of opportunity in all the other areas.” [P-13]

“Health is interconnected and linked with socioeconomic status, education, general wellbeing.” [P-9]

“...of course the determinants of health are everything but the healthcare system.” [P-10]

Historic colonization and continuing marginalization also impact the ability of Aboriginal people to access mainstream healthcare services. A Committee member explains:

“Well, you program a people for a hundred years to do something one way, you put social systems of support around them and take away their will to do things, you create [an] artificial environment for them to live in, then you pull it all away and say ‘why aren’t they coming into town?’ or ‘why aren’t they joining the normal stream of life?’ Well, there’s [sic] reasons for that. Understand them. [...] The culture within the health environment...still does not recognize that there’s an issue there.” [P-7]

The determinants of health identified by Committee members are in keeping with the traditional, ‘holistic’ approach to Aboriginal health. Committee members commonly

describe holistic health as encompassing mental, physical, emotional and spiritual health. As stated in the Terms of Reference, a part of the Committee's mission is to "support the development of a holistic health and wellness system which is responsive to the needs of the Aboriginal Community" (Interior Health Authority, 2004b, p. 1).

How do Committee members explain the 'Aboriginal approach' to health planning? And how do they see this approach being employed in Interior Health Aboriginal health planning?

Committee members, as noted earlier, place great value on cross-cultural education of healthcare providers and administrators as a means to increase understanding of Aboriginal health and thus improve Aboriginal access to healthcare. The majority of Committee members identify such education as an essential part of the 'Aboriginal approach' to health planning. But Committee members also note "it's not [enough] just to lay a one-day workshop on people" [P-1]. As one Committee member [P-7] states, "We started a process of cultural education, cross cultural training. I think that has to go a lot deeper in order to get this thing resolved." True reconciliation, as expressed by this Committee member, involves frank discussion and recognition of the issues underlying the poorer health status of Aboriginal peoples, in a venue involving government officials and Aboriginal peoples.

Some Committee members report that the Committee's 'Aboriginal approach' to health planning is reflected in the criteria for AHIP funding, which targets broader determinants of health than healthcare. A Committee member explains the connection:

"I think the characteristic of [an Aboriginal approach to health planning]...is just looking at some of the [AHIP] projects that have been supported and the reason

why...We look at things in a more holistic manner and I think there could have been a danger of what other groups see as strictly social needs not happening [if the Committee wasn't setting the criteria for funding]. People have to be in the right frame of mind to change lifestyle and look at alternate ways of living and eating and behaving.” [P-11]

To be sure, not all Committee members are convinced that the Committee is employing an Aboriginal approach, or developing a holistic health system. For instance:

“...When we're doing health planning, we're looking at the absence of disease, that's the medical model. That does not meet with an Aboriginal perspective.” [P-13]

“I look at the Aboriginal Health and Wellness Plan and to me it's not an Aboriginal approach.” [P-8]

“We may be looking at this from too much from a western medicine perspective and trying to 'Aboriginalize' western medicine rather than trying to build on the benefits of western medicine within the Aboriginal health structure.” [P-12]

Some Committee members express their skepticism about the ability to reconcile an Aboriginal approach with the medical model of Euro-western medicine. The following comments demonstrate the view that holistic health is in conflict with the premise and structure of the mainstream healthcare system:

“[Aboriginal people] look at mental, physical, emotional and spiritual wellness at the same time...If we're going to be effective in how the system does planning and the way we respond, it has to become more holistic and integrated. That

won't happen because Interior Health has that mandate, MCFD [Ministry of Child and Family Development] has that mandate..." [P-13]

"In the Aboriginal world, our approach to health wasn't anywhere near the medical model. We were smudging and it was all more natural. So how we can even talk about incorporating the Native way into the medical model is beyond me. [...] Spiritually, I mean again, how are you going to have that spiritual part of health care in a facility like [the local hospital]? I don't see how it would work." [P-3]

Other Committee members are more hopeful that a holistic model can be pursued within Interior Health planning, for example, with respect to the use of traditional medicines. One Committee member indicates a need for traditional medicines to be incorporated into the Aboriginal health planning process:

"Holistic healing needs to be incorporated into Interior Health; give us that flexibility to incorporate holistic health. I think we need to start looking at our traditional medicines and using elders. We can never go back there, but we can still practice it to a certain extent." [P-2]

Committee members evidently adhere to varying views with respect to the 'Aboriginal approach' to health planning. Some feel the Committee has been successful in using such an approach, others hinge this approach on the roles of resource allocation and education, while still others are more skeptical of the Committee's alignment with an 'Aboriginal approach.'

Unity, Separation or Distinct?

Most Committee members define successful Aboriginal health planning with reference to health improvement of the Aboriginal population, most definitively captured by improved health statistics. The following (partial) responses of Committee members to the interview question, ‘How do you define success in Aboriginal health planning?’ attest to this:

“Probably the way I define success is what are we able to achieve in terms of reducing the inequities that exist between Aboriginal and non-Aboriginal peoples.” [P-12]

“Better health stats, basically.” [P-3]

“When statistics show that we’re meeting the goal. And it is going to be statistic driven in order to prove that.” [P-1]

“I believe that we are totally successful [when] the general Aboriginal population will not be in the state that it currently is in with respect to the health determinants and the health conditions.” [P-5]

“Long-term success would see the statistics change.” [P-4]

“Getting the diabetes issues under control, getting the obesity issues under control. Those metrics are definitive of a success.” [P-7]

“When everybody is healthy. Lower stats of FAS/FAE, alcohol, drugs.” [P-2]

However, not all Committee members share this same conception of success, and predictably, not all share the same idea of how to achieve success. Committee members express beliefs about Aboriginal health improvement that reveal the type of relationship they would like to see between the Committee, Interior Health and Aboriginal communities. These beliefs can be arrayed along a spectrum. At one end, Aboriginal

healthcare is idealized as a fully integrated part of Interior Health's service delivery. At the other, some members relate that Aboriginal healthcare should exist, to some degree, separate from this structure. In between, Committee members attempt to define a space for the distinctness of Aboriginal health.

Several Committee members argue that Aboriginal health must be approached as an integrated part of Interior Health. That is, Aboriginal people's health needs are responded to through established channels of operation within Interior Health. Relating that Interior Health should provide health services similarly to Aboriginal and non-Aboriginal clients, one Committee member stated:

"I don't see a whole lot different in a lot of ways, other than magnitude between Aboriginal and non-Aboriginal patrons of the health system. [...] I don't care whether its Aboriginal or non-Aboriginal, remote or local. Services have to be provided." [P-7].

Other Committee members also adhere to an integrative approach to Aboriginal health, but place special consideration on Aboriginal culture. Stressing the importance of integration, while acknowledging the uniqueness of the Aboriginal population, one participant emphasizes:

"I really think that [Aboriginal health] is something that has to be taken on together. I don't believe that Aboriginal health should ever be stand-alone within an organization. To stand alone is to be alone, and to be alone is isolation. And we know that isolation is oppression, because we've been there. We've been on the outside in our communities for the last hundred years or more. We know that if there's going to be any kinds of improvements, it's going to come within a system

and we're going to have to be integrated, yet retaining our distinct identity and culture." [P-10]

Other Committee members suggest that Aboriginal health should be funded as a distinct entity, separate from the rest of the population residing within Interior Health's service area. One member expresses this viewpoint here:

"What some of us have been saying on the Committee, well, let's go per capita. Seven hundred seventy thousand people reside in our territories [within the service delivery area of Interior Health], so out of that seven hundred seventy thousand, how many are First Nations, Métis or Inuit? We'll take our cut, along with those few dollars that are tagged [specially allocated for Aboriginal health by the Ministry]." [P-9].

Similarly, another Committee member's comments reveal doubt in the ability of Interior Health Aboriginal health planning to affect Aboriginal health improvement. Rather than a centralized approach based on integration, a localized community-led approach is sought, with Interior Health's role as a resource provider:

"How is that Committee or Interior Health ever going to reduce the number of low-birth weight babies? They'll never be able to have any impact on that. [...] Government [must] understand...that their role is not social planning, their role is not to be down on the ground trying to make decisions on behalf of the constituents, but more to liberate the resources to those [local] development plans. [...] We expect IH's resource to become available to us to come down to support the activities of that [local] plan." [P-13]

But some Committee members express hesitation in this purely localized approach:

“From the Aboriginals perspective, they’ve only been involved in the European health delivery process for fifteen to twenty years in British Columbia. We’ve been involved in holistic health, Aboriginal health, for hundreds of years. So to mix the norms...we’re still going to need a lot of support. And to say that ‘Here you are, you’ve got all this money, go at it, fly at it, is to me, a very haphazard approach to ensuring that the determinants of health are going to be bettered in the long run. Sometimes money, it doesn’t matter how much you have, it won’t help anything. So sometimes it has to be, resource-wise, the opportunity to meld, to integrate with each other in that process.” [P-5]

There are, then, a range of views on the extent of integration Aboriginal health should have relative to the organization of Interior Health. For many, success in Aboriginal health planning is marked by better health statistics. For others, success is not the outcome-gear, but rather the process of working with the communities. Reflecting a moderate approach, the following statement highlights the importance of sensitivity to local conditions in carrying out centralized health planning: “I define success [in Aboriginal health planning] by Interior Health knowing where our communities are at and our unique situations and taking that into consideration.” [P-6]

Measuring Progress

The Aboriginal Health and Wellness Plan states that the success of the Plan: “Will be measured by the extent to which there is follow through with proposed strategies, action taken on what has been planned, and results documented.” (Interior Health

Authority, Revised 2003, p. 4). On their sense of the Committee's progress and accomplishments, members often related aspects of the Committee's work that concern them, but also those that buoy their confidence in the ability to affect positive change for Aboriginal health. Here, Committee members describe how planning and implementation interact with resources, organizational structure, inter-Committee conflict, racism, and the time needed to create improvement.

Committee members commonly communicated a sense of frustration relative to the progress of the Committee. Some members attribute low group morale to a perceived lack of progress:

"...when you don't see changes, then you sort of lose faith too. And then you get to the point where instead of being enthusiastic and gung ho, you get lackadaisical and you don't put your effort forth. ...I know when the table was first formed, a lot of the people I represent were excited about it. And I don't think that excitement is there now." [P-4]

"I don't know if I'd call [my participation on this Committee] meaningful. I've been very frustrated mostly for two years because I just felt like we weren't doing anything, that nothing was changing. I felt like we were going to these meetings every two months and sitting there listening to a lot of presentations, but we weren't really doing anything, like what is our purpose now?" [P-3]

Elements identified as slowing the progress of the Committee, include "lack of consistency with [Interior Health] staff" [P-2] and Interior Health not "delivering...on some of the things that [it] should have been delivering on" [P-12], as well as conflict

within the Committee environment. One Committee member describes conflict in this way:

“There’s been some pretty heated discussions, some pretty nasty things said. A lot of racial slurs made. The people on our Committee, some of them have some strong feelings about non-Native people and White people and they’ll say things, and its gotten ugly at a couple of meetings.” [P-3]

Racism is also implicated within the healthcare organization; one Committee member associates racism with the inadequate resources Interior Health allocated for the Aboriginal health plan:

“Interior Health said, ‘Oh my god, a million and a half dollars over three years? Oh my god! That’s far too much money for those Indians, so cut it back.’ So to me it’s like trinkets again; ‘give those Indians a few trinkets and they’ll be quiet and happy for awhile and fight amongst themselves and we’re okay, we can carry on with business as usual.’” [P-9]

Despite the challenges to progress, Committee members consistently stress the positive aspects of the Committee, including its roles in funding distribution and education, as noted earlier. Most Committee members are, to some degree, hopeful of the ability of the Committee to affect positive change in healthcare for Aboriginal peoples. Commonly, it is the very existence of the Committee as a vehicle for Aboriginal health planning, and the structure of the Committee that engenders this conviction. Several Committee members noted that the inclusion of representatives of the Senior Executive Team and the Board of Interior Health on the Committee provides leverage to influence

the top levels of the organization. A Committee member describes the benefits of this relationship:

“We’re a very narrow tip into that organization, but we do have fairly good representation on the Committee. The Chief Medical Officer... that is definitely a commitment by IHA to this Committee. We have a Board [member] there. That is definitely a commitment. I think it has the potential to be very, very functional. [...] I definitely think I’ve found an opening into the system. There is an ear there.” [P-7]

But while Committee members are convinced of the importance of the Committee’s work, many note that Aboriginal health improvement will be a long process:

“...this is going to take a long time, this is going to be a process; this is going to be a work in progress in years to come.” [P-10]

“ [In order to achieve success, we must] be aware of the time it will take to get the whole system to work.” [P-6]

“...us, as the Indians, we didn’t get this way overnight. We’re not going to be fixed overnight.” [P-9]

Some Committee members note that significant improvement might not occur for some time, and will necessarily involve change outside of the healthcare system, such as in community attitudes, and socioeconomic circumstances. Some Committee members noted the limitations of their work:

“I think there’s a lot of potential there for a lot of impact [from the Committee’s work]. But making huge changes? We’re not going to see it in our lifetime, I

think. I don't think we're going to see huge changes with the Native people for probably three or four decades. Because that whole attitude and the whole dependency thing, that's so unhealthy, and it's so ingrained." [P-3]

"...it's not just the service provided by Interior Health. We have to look at our own families holistically, and there's so much poverty. Interior Health can't just hire everybody and much sure they have a wage and money to live on. So it plays a part, but the poverty issue, food security is critical. And if you don't have that, how are you going to improve your health status?" [P-4]

Summary

As a focal point for Aboriginal participation in health planning, AHAWAC faces challenges in representation and reconciliation. The Committee's various roles are not viewed with unanimity. Both individual and organizational functions in community representation and consultation are strained by unclear reporting mechanisms and inappropriate consultation approaches. Moreover, holistic health appears at odds with the basis of the healthcare organization.

But despite these tensions, it is exceedingly clear that Committee members value the AHAWAC forum, and are investing their time with the hope and expectation that this Committee will yield tangible benefits for Aboriginal health. A Committee member sums up the importance of the Committee in this way, and provides a reminder of the recent establishment of this working relationship:

"Can we really affect change? I think so, and I think that is more evident in some areas as opposed to others, but we have to remind ourselves that just because the process is flawed at times, the outcome is worth the challenges, and that

Aboriginal voice speaks, maybe too loud at times, maybe not loud enough at others, maybe in the wrong context or the wrong venue – how come no one from AHAWAC has invited the meeting to be on the Rez? – but speaks nonetheless, and somebody is listening and for a long, long time nobody heard us at all. So both sides will learn.” [U-1, email]

Chapter 5 – Meaningful Participation: Accountability, Power, and Validation

Viewed through the themes of representation and reconciliation, tensions reveal how Committee members variously perceive the AHAWAC's participation in Aboriginal health planning in Interior Health. Tensions are manifested in opposing views, competing vested interests and splintered subgroups. Despite this contestation, it is evident that the shared goal of Aboriginal health improvement is a strong binding force that urges Committee members to manage these tensions. Nearly all members view the AHAWAC as a valuable and necessary vehicle for Aboriginal participation in health planning.

In keeping with the exploratory nature of this research, the purpose of this chapter is to interpret the research findings based on my own observations and knowledge, as well as in relation to the research questions and the guiding direction of relevant literature. Most particularly, I explore the composition of meaningful participation through meaningful representation and meaningful reconciliation, concepts that inform the three parts of this chapter. In this chapter, Part I examines meaningful participation through multi-directional accountability relationships, while Part II categorizes AHAWAC's participation in health planning according to the extent of power sharing. Part III considers how shared concepts from population health and Aboriginal health create a 'common ground' for the organization and Aboriginal community members, where meaningful participation can be fostered. This discussion aims to both illuminate the importance of relationships to Aboriginal participation, as well as suggest points of entry for meaningful participation in health planning.

Part I. Multi-Directional Accountability

The AHAWAC Terms of Reference identifies community-based Committee members as representatives of their respective Nation, band(s) or urban constituencies, and most Committee members adhere to this definition of representation. However, meaningful representation is not simply a matter of identifying a member from each community. Given the Committee's position as an intermediary body between Aboriginal communities and Interior Health, meaningful representation implies multi-directional accountability relationships. This includes accountability between Interior Health and Aboriginal communities (vertical accountability), and between the community-based Committee members and Aboriginal peoples in the region (horizontal accountability). In addition, intersecting accountability highlights converging responsibility for meaningful participation, and conflicting accountability refers to the contestation latent in multidirectional accountability relationships.

Vertical Accountability

Broadly, Interior Health is accountable for Aboriginal health in the region through achieving the Aboriginal health goals detailed in the Interior Health Aboriginal Health and Wellness Plan. With respect to participation, the BC Ministry of Health's guidelines clearly identify regional health authorities as responsible for Aboriginal participation towards "collaborative development of locally relevant plans" (Ministry of Health Planning, 2001, p. 4). Despite this duty, I found no documented evidence that articulated Interior Health's accountability to the Committee. Accountability as defined in the Committee's Terms of Reference appears to refer solely to accountability between community-based Committee members and communities. Yet, it is evident that if the Committee's participation in health planning is to be more than token, Interior Health is

accountable to the Committee for employing a meaningful participatory process.

From the perspective of community-based Committee members in particular, meaningful participation requires that Interior Health support the health planning process with consistent staffing support, sufficient information, and adequate resources applied towards the implementation of the Aboriginal Health and Wellness Plan. Together, these elements inform many Committee members' sense of advancement of the Aboriginal health goals and group morale. When deficiencies in these areas are coupled with poor communication, community-based Committee members are left with the impression that the health authority is unresponsive to their input. From this perspective, meaningful representation requires clear articulation and expectations about the link between the Committee's advice and the health authority's actions.

Answerability is a key component in this link. Answerability "requires justification or a rationale for decisions through information provision either in advance (i.e., *ex ante*) or following (i.e., *ex post*) a specified decision or set of actions" (Abelson & Gauvin, 2004, p. 13). For Interior Health, answerability implies substantiating and communicating how contributions from the Committee inform the organization's actions, or as one Committee member states, "my understanding was that if the Interior Health Authority didn't take our advice, then they'd explain to us why not" [P-11].

Abelson and Gauvin (2004) contend that regional health authorities can sidestep answerability if the participatory process is not premised on trusting relationships. They explain:

RHA [regional health authority] decision-making can find superficial, non-binding ways to demonstrate through their business plans that they have

responded to community health committee advice. Without the key elements of relationship-building that include a trusting, open exchange between the RHA and community health advisory committee, the answerability criterion [of vertical accountability] may be easily undermined (Abelson & Gauvin, 2004, p. 26).

Accountability depends on relationships “built upon trust, openness and responsiveness between citizens and government or public institutions” (Abelson & Gauvin, 2004, p. 15). Trust is an essential component of social capital, which determines the extent to which participants act together to effectively pursue shared objectives (Arai, 2000). The centrality of trust and accountability confirm the importance of reconciliation and representation in relationship building between Aboriginal communities and Interior Health.

Committee members are also accountable to Interior Health for their role in participatory health planning. As many Committee members pointed out, this includes responsibility for maintaining the continuity of the Committee’s work through consistent meeting attendance, responding to email communications, following up on assigned action items, and staying current and clear as to decisions previously made in meetings.

Community-based Committee members are also accountable to Interior Health and Aboriginal communities for providing accurate community representation for Aboriginal health planning. Interior Health staff members have emphasized this aspect of meaningful representation more so than community-based members. Meaningful representation implies active engagement between Committee members and the communities that they represent, and the conscientious and consistent representation of these community interests at the Committee table – that is, horizontal accountability.

Horizontal Accountability

It appears that the 'Indian criteria' for selecting committee representatives is a widely accepted means of composing valid Aboriginal community representation. But according to Committee members, this structural representation does not forfeit the necessity of ongoing relationships between representatives and the community. Many Committee members rely on constituency organizations, generally Aboriginal health service organizations and/or Tribal Councils or Nations to maintain a link to communities. According to Pivik (2002), close relationships to constituency organizations may suggest that representatives have a broader base of support than otherwise unaffiliated individuals.

Despite the existence of these connections, several Committee members have expressed concern that not all members place appropriate emphasis on accountability to constituents. This implies that it is not the mere link to constituency organizations that creates appropriate accountability; rather, accountability refers to the quality of the interactions between representatives, constituent organizations and the Aboriginal population. Viewed in this way, meaningful representation implies that community members are aware that they are being represented, and that the representation is credible and responsive (Frankish et al., 2002; Maloff et al., 2000; Perlstadt et al., 1998). Thurston et al. (2005) confirm, "unless there [are] available communication channels to readily connect the chosen representative with everyone they [are] supposed to be representing, there [is] tension associated with representation" (Thurston et al., 2005, p. 247).

According to Wharf Higgins (1999), full representation requires that health planners reach marginalized people in their own settings in order to proactively engage

individuals in discussing their needs and concerns. While I have not delved into the research participant profile in great detail, it is evident to me that the AHAWAC members are highly educated compared to the general population; the Committee membership is not inclusive of unemployed and less educated members of Aboriginal communities. Only some Committee members appeared concerned about personally engaging with marginalized members, or other demographics (youth, elders) of the community in order to provide full representation. Possibly, most Committee members feel that they have an intimate familiarity with the entire scope of the community through familial or other informal relationships, as some Committee members suggested.

One issue of particular interest in horizontal accountability is the representation of the off-reserve Aboriginal population. More than half (57%) of British Columbia's Registered Indian population lives off-reserve (BC Stats, 2004a). This percentage is significantly higher for all self-identified Aboriginal people; according to 2001 census data, 73% of the entire BC Aboriginal population lives off-reserve (BC Stats, 2004a). Despite the fact that only five of the fourteen community-based Committee members are urban representatives, no Committee members expressed concern that off-reserve Aboriginal peoples may be underrepresented in Aboriginal health planning. One possible explanation for this surprising consensus may be the largely rural and remote character of the region; members may feel that the health priorities of many rural and remotely located off-reserve residents are akin to reserve dwellers.

Intersecting Accountability

For nearly all Committee members, relying solely on the Committee for Aboriginal health planning is not adequate representation. Evidently, the broader

Aboriginal community must be supported to perform a role in planning. Meaningful representation of communities implies health planning that is informed by knowledge and appreciation of the unique character, needs and abilities of individual Aboriginal communities, in turn supported by channels of communication and accountability to and from the Committee setting. According to the findings, both community-based members and Interior Health have responsibility for gathering this knowledge and cultivating these relationships.

While, in some respects, community representation is ongoing, Interior Health has also been involved in episodic community engagement. These efforts have not met with undisputed success. From the findings, it appears that success in community engagement involves open, reciprocal information exchange as a basis of relationship building between communities, representatives, and Interior Health. For instance, some Committee members appreciated the Aboriginal health conference for the opportunity to connect Aboriginal peoples with one another over shared interests in health. Based on some members' depictions, the conference foregrounded the roles of the AHAWAC members, thus underscoring and encouraging Interior Health's links to communities.

On the other hand, several Committee members felt that the more recent community consultation meetings held by Interior Health actually damaged relationships. While the impetus for these meetings apparently came from the Committee, AHAWAC was not involved in the planning or presentation of the meetings. Aboriginal Liaisons, too, expressed dissatisfaction with the short planning timelines in which to invite participants and the limited information they were provided about the meetings. At the

consultation meetings themselves, the Liaisons' role as speakers and facilitators generally appeared marginal, and other Committee members were scarcely present.

At these meetings the approach to consultation conflicted with the premise of reconciliation. Reconciliation implies restoring relationships gone awry, and takes a considerable amount of devoted time and effort. In contrast, a one-day consultation with the aim of informing the health plan, unaccompanied by an ongoing presence and link to the community, may appear to be a token attempt at participation.

Unfortunately, the centrality of AHAWAC members in the ongoing relationship with Interior Health and communities appears to have been overlooked during this recent consultation. Although some of the meetings were held in a circle, there was a clear 'stage' area that was unoccupied by AHAWAC community representatives or Liaisons. Despite professing a strong AHAWAC "team" at these meetings, Interior Health could not demonstrate the establishment of authentic, trusting, and power-sharing relationships within this team. Low Aboriginal participant turnout in some areas made some AHAWAC members question the authenticity of consultation. Moreover, by not providing a feedback form to participants by which to evaluate each session, Interior Health lost the opportunity to improve community consultation based on direct participant feedback. Thus, these meetings fell short of their potential with respect to meaningful participation.

Conflicting Accountability

Both community-based Committee members and Aboriginal Liaisons are confronted with conflicting accountability, which challenges meaningful participation. For community-based Committee members, the structure of representation requires them

to be accountable to their constituents by supporting the community's interests at the Committee table. While these Committee members are explicitly identified as community representatives, they must also balance the wishes of their constituents with an overall agenda for Aboriginal health that may or may not meet with their community's vision. In interviews, many participants alluded to the tendency of Committee members to protect their own community's interests, often at the expense of other communities. It is evident that the expectation of accountability to all Aboriginal peoples may be in competition with local accountability. Thus, tension is rooted in the very structure of representation. For some members, this tension fixes meaningful participation in a perpetual struggle. For others, reconciling this duality appears to require little effort. Whether this conflict was explicitly alluded to or not, all participants referred to the importance of the Committee's work on behalf of all Aboriginal people across the Interior Health service region.

As noted in the findings, Aboriginal Liaisons identify dual accountability to Interior Health and to Aboriginal communities. Similar to their minor role at the recent community consultation meetings, the Liaisons' role is not fully articulated or acknowledged within the Committee. Yet, despite not being a part of the community representation as stipulated in 'Indian criteria,' the Liaisons are instrumental in bringing community representation to Interior Health, and vice versa, on a daily basis. Meaningful community representation, then, would likely be strengthened by greater acknowledgement and support of the role of Aboriginal Liaisons both within the Committee and in their ongoing work on behalf of Aboriginal communities.

Though not a significant theme in the interview findings, Interior Health also faces potential dilemmas with respect to accountability. Interior Health is accountable to the Ministry of Health for meeting performance targets across all of the health authority's portfolios; the organization must balance its human and fiscal resources appropriately to carry out its full mandate. While regional health authorities are granted some discretion in how they achieve provincial government objectives, there are undoubtedly administrative constraints, such as resource shortages, that inform Interior Health's capacity to respond to the Committee's advice. These constraints, too, shape meaningful participation.

Part II. Defining the Relationship: Placation, Partnership or Citizen Power?

Reconciliation is a process by which trusting relationships are built through ongoing engagement and perceptible improvements. Some Committee members suggested that reconciliation is not limited to a staff encounter at an educational workshop, although this may be a pragmatic and necessary place to begin. Reconciliation can also be built by engaging with different community constituents, including chiefs, health service workers, and citizens, while creating connections to managers, Board members and staff in the health authority. Engaging in such relationships implies negotiating a distribution of power.

Sharing Power

Redistribution of power is a particular challenge in health planning, as “information exchange, power sharing and partnership [are] not easily embraced in a policy sector dominated by professional expertise in the clinical and management domain” (Abelson & Gauvin, 2004, p. 3). According to Arnstein's (1969) seminal article on citizen participation, “participation without redistribution of power is an empty and

frustrating process for the powerless” (Arnstein, 1969, p. 216). Some Committee members expressed concern about how Aboriginal participation could potentially be manipulated to provide authorization for decision-making without real gain, running the risk of tokenism, rather than meaningful participation. Keeping this in mind, it is useful to categorize this case study according to Arnstein’s (1969) ladder of citizen participation (see Appendix C), as well as the International Association for Public Participation’s (2004) public participation spectrum.

In reference to Arnstein’s (1969) ladder of citizen participation, AHAWAC’s participation in health planning is clearly beyond the lowest rungs, forms of non-participation whose “real objective is not to enable people to participate in planning or conducting programs, but to enable powerholders to ‘educate’ or ‘cure’ the participants” (Arnstein, 1969, p. 217). The Committee’s participation is largely beyond ‘informing’ (third rung) and ‘consultation’ (fourth rung), forms of tokenism that lack real power. In consultation, public participants are provided with a narrow window of opportunity to provide input (commonly through attitude surveys, neighbourhood meetings and public hearings), and the structure of consultation alienates dissenting or alternate constructions of the issue. While not indicative of the Committee’s work, some members likely conceive of the community consultation meetings as belonging to this category of participation.

‘Placation’ is the fifth rung up the ladder of participation. According to Arnstein’s scheme, placation is where “citizens begin to have some degree of influence though tokenism is still apparent” (Arnstein, 1969, p. 220). Here, mechanisms such as advisory and planning committees “allow citizens to advise or plan ad infinitum but retain for

powerholders the right to judge the legitimacy or feasibility of the advice” (Arnstein, 1969, p. 220). If the rights and responsibilities of such committees are ambiguous, considerable conflict and dissatisfaction regarding the benefits of participation will ultimately result.

This characterization has some salience when applied to the AHAWA Committee. Committee members hold contesting views on the roles and authority of the Committee, and the translation of advice to implementation is similarly unresolved. The reporting relationship of the Committee to the Senior Executive Team and the Board of Directors of Interior Health points to the ultimate seat of power in Interior Health. However, the Committee clearly has some authority in Aboriginal health planning (e.g., funding allocation and priority setting), so members’ participation is not restricted to this rung of the ladder alone.

‘Partnership,’ the sixth rung on the ladder, is where citizens share planning and decision making responsibilities with the organization, and thus have some measure of power. Arnstein notes that partnership works most effectively when citizen leaders are accountable to an organized power base in the community, and where they can, with sufficient resources, organize the communities to have bargaining influence. AHAWAC members’ participation has some features of partnership, and even ‘delegated power,’ the seventh rung. Community-based Committee members have responsibilities for significant policy and managerial decisions, particularly with respect to funds, and have exclusive voting rights for decision-making. However, the extent of Aboriginal community organization is uncertain, and the delineation of actual power in the partnership is ambiguous. While community-based members have the dominant decision-making

authority within the confines of a Committee meeting, they cannot be assured that their decisions will be translated to timely action by the health authority. Thus, without accountability and communication, this decision-making model runs some risk of slipping into tokenism.

‘Citizen control,’ the highest rung on the ladder of citizen participation, is akin to self-determination. In citizen control, participants are direct governors and managers of the program or institution. Full citizen control appears to be out of the reach of the AHAWA Committee. This volunteer structure, with its infrequent meetings and designated advisory function, is incapable of full management of the Aboriginal health portfolio.

The Committee most aptly fits in the category of ‘collaboration’ in the International Association for Public Participation’s spectrum of participation. Within this category, the organization makes the following “promise” to public participants: “We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible” (International Association for Public Participation, 2004, np).

Unfortunately, it is difficult to discern from this characterization what “the maximum extent possible” means with respect to power sharing, particularly when the organization decides what is “possible.” Again, this points to the necessity for clearly articulated expectations about how the health authority responds to Committee advice. Committee members must have a shared understanding of the organizational constraints and processes involved beyond the Committee table, and Interior Health must be answerable for action or inaction in relation to Committee decisions. Certainly, sharing

power for decision-making implies sharing a great deal of information, both to inform decision-making and to follow up on the provision of advice. It is also evident that while partnership and collaboration do not necessarily imply ‘equal’ sharing of power, the Committee structure still affords significant opportunity for meaningful participation.

Mutual Engagement

Citizen engagement typically refers to processes where governments take the initiative to involve citizens in policy development; a broader view of engagement includes ‘mutual engagement,’ an ongoing, cyclical exchange process. Abelson & Gauvin (2004) contend that mutual engagement is the most robust form of participation, as it implies both strong accountability relationships and community empowerment. This type of relationship requires all of the elements of meaningful participation described so far – accountability, power sharing, organizational support, trust, long-term investments, and tangible improvements. All actors in public participation have important parts to play here, but not identical roles.

As Interior Health receives funds for Aboriginal health planning and holds the final place of authority in the advisory relationship, the organization is responsible for providing support (resources, staff, supportive environment) for meaningful participation within the Committee. But meaningful participation implies much more. Interior Health plays an important role in community engagement through periodic and ongoing engagement efforts. While informing planning, successful community work pays dividends in relationship building. Strong ties founded on meaningful participation form the basis for substantive, community-based responses to Aboriginal health needs.

Initiating these relationships is clearly challenging for the organization, as this work goes well beyond the boundaries of service provision.

Yet, as argued already in this chapter, it is not Interior Health alone that determines meaningful participation. Mutual engagement respects Aboriginal self-determination and agency by highlighting the power of proactive community representation and leadership. Community-based Committee members are far from passive in shaping the relationship between Interior Health and Aboriginal communities – in fact, the impetus for the Committee formation itself came from organization within Aboriginal communities. Through their bridging role as community representatives, community-based Committee members can encourage and facilitate, or alternatively, inhibit engagement. As a small example, one Committee member suggested that inviting an AHAWAC meeting to be held on-reserve would be a gesture towards reconciliation. This fits with Wharf Higgins (1990) contention that participation that is “closer to home” – not only in the spatial sense, but also aligned with the experientially based contributions of community members – is more likely to engender active, representative participation.

In identifying elements of meaningful participation, the preceding discussion suggests that meaningful participation may be supported and developed. It is also clear from the findings that surmounting some barriers to meaningful participation will be more difficult than others, such as low community capacity, lack of implementation and inadequate resources. Seemingly more immutable than these is reconciling the conflict between Aboriginal conceptions of health, the biomedical foundation of the healthcare organization, and the statistics-driven approach to success.

Based on the research findings and on the literature, I have identified a place to achieve some resolution of this latter tension, and in this way, to facilitate more meaningful participation. Population health and Aboriginal conceptions of health provide bridging concepts that inform a vision of Aboriginal health improvement through the health authority.

Part III. A Meeting Place: Population Health and Aboriginal Health Planning

While population health might not at first appear central to this study of participation, the research findings have illustrated that Aboriginal participation in health planning cannot be divorced from Aboriginal health improvement. Both the motivation for participation and the gauge of successful participatory planning are based on improving Aboriginal health status. The population health approach itself similarly endorses the relationship between public participation and health. By exploring these concepts, this broad ranging discussion approaches Aboriginal participation in a more sophisticated way than the mainstream literature on citizen participation in health planning.

Applying the population health approach to Aboriginal health is not an entirely novel concept. It seems reasonable to apply a population-based approach to health to a distinct population group. However, despite the possible correspondence between the population health approach and Aboriginal health concepts, there is a dearth of literature that explores the link. This knowledge gap can be attributed to a number of factors.

Due to a lack of political response, population health has not yet enjoyed great success in implementation (Evans & Stoddart, 1994; Lindbladh, Lyttkens, Hanson, & Ostergren, 1998; Raphael, 2003; Raphael, 2000). As such, the population health

framework has not benefited from revisions and elaborations that could have extended its application to particular groups. In addition, given the immense range and diversity of Aboriginal peoples in Canada, it is unreasonable to posit a single Aboriginal approach to health. Aboriginal peoples “do not see themselves as a pan-Aboriginal population because they come from diverse Nations, heterogeneous cultures, linguistic groups and geographies where there is no ‘One Perspective’” (National Aboriginal Health Organization, 2001, p. 7). There are, however, some shared philosophies regarding health across Aboriginal cultures that could be termed ‘Aboriginal approaches’ (Kinnon, 2002).

Notwithstanding the clear limitations of knowledge from which to build the connection between Aboriginal health and population health, it would be more negligent to ignore the intriguing potential of this vein of exploration than to approach it cautiously, as I do here. At the risk of gross generality, I will be invoking the concept of ‘Aboriginal approaches to health’ in order to respectfully suggest aspects of an Aboriginal population health framework. Naturally, this discussion is limited to basic concepts that are, in practice, much more diverse, sophisticated and nuanced than what this limited discussion can suggest. My aim is neither to oversimplify or appropriate Aboriginal knowledge, nor to fully articulate a model for Aboriginal health planning; rather, this discussion suggests elements of an Aboriginal population health framework for health planning that could support meaningful Aboriginal participation.

The Population Health Approach

Population health is “an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups” (Health Canada, 2001b). As mentioned previously in the conceptual framework, the population

health approach requires citizen participation in health planning. Population health purportedly:

...engages citizens through the public involvement process which recognizes the role, contribution and shared accountability of stakeholders, citizens and governments in the development of public policies for health improvement (Health Canada, 2001).

This is an institutionally legitimated framework that is espoused in population health divisions at the federal, provincial and regional health authority levels. However, the necessity of such 'special' divisions points to the difficulty in reorienting the entire health care system towards the population health approach.

Population health stresses the importance of broad social, environmental and biological determinants of health on health status. These factors include income inequalities, social cohesion, material deprivation, education, poverty, genetics, lifestyle risks, and environmental hazards. While not intended to be definitive, Appendix F provides a duplicate of Evans, Barer and Marmor's (1994) framework for population health as an example of a well-recognized population health model. Here, healthcare comprises only one aspect of individual health. According to this approach, health improvement will be the result of multiple interventions across a range of contexts (e.g., from public policy to individual behaviour change) that address the various determinants of health.

Applying a population health perspective to health planning involves the following five planning principles: holistic view of health; evidence based decision-making; focus on equity; use of partnerships; and, empowerment and public participation

(Canadian Institute for Health Information, 2005). Like citizen engagement, population health expands the health organization's role beyond service delivery. By acting as an educator, resource broker, community developer, partnership developer and advocate, the health authority can support community empowerment, participation and inter-sectoral approaches to addressing the determinants of health (Labonte, 2002).

Despite the agreeableness of these principles, population health is subject to criticism. Some commentators argue that since population health is rooted in epidemiology, the quantitative, evidence-based approach elevates scientific understanding over the lived experience of people and health promotion action (Raphael & Bryant, 2002). The socially constructed nature of 'evidence' as a basis of decision-making is particularly contentious, given the power relations inherent in legitimating evidence (National Aboriginal Health Organization, 2001). Even when supportive (and 'credible') research and information is available, "health officials...seem unable to apply recent developments in social epidemiological theory and population health research findings" (Raphael, 2004a, slide 99). This 'inability,' as Raphael puts it, stems from the difficulty of implementing policies that require intersectoral action and a longer time frame to assess effectiveness, as well as political ideologies and medical culture that favour individual, biomedical approaches to health. Thus, while implying a sea change in health policy, population health has, as of yet, been limited to a marginal movement within health care.

Interior Health has acknowledged the value of the population health approach by creating the Population Health Planning and Support Unit, which aims to align the organization with a population health approach. The Interior Health Population Health

Plan (2003-2006) refers to the need for AHAWAC's participation in population health planning:

For the Population Health Plan to be useful to aboriginal [sic] communities in IH, it is important for the Population Health Planning & Support Unit to work collaboratively with the Aboriginal Health and Wellness Advisory Committee (Interior Health Authority, 2003b, p. 8).

To date, the most significant involvement by the Population Health Unit with AHAWAC is support for the community consultation meetings. However, a relatively recent (October 2004) administrative shift may allow for greater allegiance between population health and Aboriginal health; a single Medical Health Officer now oversees both of these portfolios.

Aboriginal Approaches to Population Health

Many commentators have emphasized the need for healthcare organizations to use approaches to Aboriginal health that are suited to local Aboriginal community values (Adelson, 2005; Armstrong, 2005; Kirmayer, Simpson, & Cargo, 2003; National Aboriginal Health Organization, 2001). As the provincial government has acknowledged, "addressing Aboriginal health needs calls for Aboriginal-specific processes to inform and guide health authorities in planning" (Ministry of Health and Ministry Responsible for Seniors, 2000, p. 23). This aligns with Warry's (1998) contention that "accepting the Aboriginal world-view of health and mental health as valid is a critical first step to the legitimization of Aboriginal cultures in Canada" (Warry, 1998, p. 161).

As noted in the findings, Aboriginal approaches to health acknowledge mental, physical, emotional and spiritual determinants of health. The causes and impacts of health

and disease, as many Committee members expressed to me, extend beyond individuals and reverberate throughout families and communities. Accordingly, “individual behaviours are [recognized as] important, but they are related to a much broader community health approach” (Armstrong, 2005, p. 5).

This community-based approach to wellbeing has led some commentators to characterize Aboriginal health improvement as an aspect of overall community healing (Warry, 1998). Like meaningful public participation, community healing implies a quality of community engagement consistent with the higher rungs of Arnstein’s (1969) ladder. Mignone and O’Neil (2005) identify community participation (through consultation and collective action) as likely contributors to Aboriginal social capital and health. That is, the community itself must identify and be engaged in the strategies to improve its own wellbeing. Accordingly, community healing implies that a health authority take on supportive roles consistent with the population health approach. In addition to adopting policies that reflect Aboriginal community values, the health authority would appropriately play important facilitative, training and advocacy roles in Aboriginal health (Labonte, 2002).

Commentators on Aboriginal health have suggested that “population health, health promotion, disease prevention, and health protection, are principles and approaches that are compatible with an Aboriginal world view” (Kinnon, 2002, p. 4). In fact, Ball (2005) refers to “Aboriginal ways” as “the original population health conceptual framework,” stating, “It would seem that Aboriginal ideas about how to support the survival, healthy growth, and optimal development of their own peoples have

long embodied the assumptions, aims, and approaches that society is now calling population health” (Ball, 2005. p. 37).

While there are clear commonalities between these two health frameworks, the population health approach as it is known in mainstream healthcare must be adapted for its application to Aboriginal health. For instance, the spiritual aspect of health integral to Aboriginal understandings is seriously lacking in the population health approach. Scott (2005) discusses both the commonalities and the divergence in the two perspectives, but emphasizes the relevance of population health to Aboriginal health:

Both Aboriginal views and population health frameworks recognize that well-being is the result of a complex interplay between environment and person. Both agree that a variety of players not previously thought part of the health web are part of the health solution. [...] However, there are key areas where subtle differences between western notions of human need and Aboriginal ideas (traditional and contemporary) exist. From an Aboriginal perspective, human needs cannot be prioritized. In other words, spiritual expression is as essential as water. However, soulful dimensions are only ever incidentally recognized within more fundamentally emotional or mental factors in the health determinants discussion. Secondly, as a natural response to assimilation, culture is important in the restoration of balance and harmony from a contemporary Aboriginal perspective. After all, culture is what influences all decisions that create ways of life. [...] Nonetheless, with its focus on the reduction of social inequities, environmental integrity, and self-determination, the population health approach has particular relevance for Aboriginal people in Canada (Scott, 2005, p. 2).

In its population health framework, Health Canada (2004) recognizes a connection between ‘culture’ and health, but provides a limited conceptualization of the relationship. The department states:

Some persons or groups may face additional health risks due to a socio-economic environment which [sic] is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services (Public Health Agency of Canada, 2004).

Unfortunately, while this accurately identifies marginalization as influencing health, it does not recognize the centrality of culture in community resilience to the effects of marginalization, nor does it question the privileged position of western science in the population health framework. The very understanding of what health means is subject to culturally-dependent interpretation, a fact not addressed by Health Canada.

The National Aboriginal Health Organization (2001) constructively critiques the relevance of Health Canada’s population health model for Aboriginal people, and suggests additional Aboriginal determinants of health:

The ‘determinants of health’ as recognized by Health Canada, are useful and pertinent to Aboriginal Peoples but they do not illuminate fully the poor health status and prospects this group finds itself in. For this reason, colonization, globalization, migration, cultural continuity, territory, access, poverty, and Self-determination [sic] need special attention and analysis (National Aboriginal Health Organization, 2001, p. 13).

By acknowledging and incorporating these elements, a respectful and effective Aboriginal population health framework would honour Aboriginal history, culture and ways of knowing.

Despite the affinity between population health and Aboriginal health, there are additional challenges to their acceptance in administration. While population health and Aboriginal health both challenge a purely biomedical approach to health, population health still struggles for legitimacy in a field obsessed with evidence-based decision making – where ‘evidence’ is most often equated with statistics, particularly disease morbidity and mortality. For instance, both the Ministry of Health and the Committee have expectations for Interior Health to improve Aboriginal health statistics (for which two performance measures are “reduced infant mortality and increased life expectancy among Status Indians”) within a three year period (Ministry of Health Services, 2003, p. 7). This is the only performance measure specific to Aboriginal health in the performance agreement between the Ministry and Interior Health; no measures are accorded to the requirement for meaningful Aboriginal participation in health planning.

Yet, population health and Aboriginal approaches are emphatic that the health system alone cannot improve the health status of a population. This apparent conflict also reflected in participant perspectives. Participants underscored the importance of meaningful representation and reconciliation, and yet, at the same time, many referred to improved health statistics to define success in Aboriginal health planning. Moreover, this health statistics driven approach to success cannot capture the quality of activities implied in meaningful participation, such as relationship building. Using only health status statistics, the Committee will have difficulty identifying its impact in Aboriginal health.

Leung, Yen and Minkler (2004) suggest the use of community-based participatory research (CBPR) as a remedy for the narrow concern with morbidity and mortality statistics that appears to afflict much of modern epidemiology and by extension, decision making in health organizations. As a participatory approach to creating scientific knowledge, CBPR implies broadening methodologies to include participation, qualitative research, and the integration of lay knowledge. But the public policy evidence base is not limited to research alone; the health authority's ongoing engagement with Aboriginal people and communities offers many opportunities to measure success in Aboriginal health planning. The use of evaluation forms at community consultation meetings is one simple way to invite feedback regarding success.

The application of Aboriginal population health approaches will require validation within Interior Health, especially through leadership support; this, in turn, will determine access to resources. The health authority will also need to build skills and capacity to employ Aboriginal population health approaches. Applying such a framework to health planning is an important point from which to build the shared understandings necessary for trust and true engagement.

Through the preceding discussion, I have merely indicated the potential to modify the population health approach to Aboriginal health planning; a fully articulated Aboriginal population health framework is clearly beyond the scope of this research. However, based on the interconnections between participation, population health and Aboriginal community-based healing, an Aboriginal population health framework would be grounded in the elements of meaningful participation elucidated in this research.

Chapter 6 – Conclusions

Readers of this case study research will have found that the discourse of participation has shifted to emphasize the findings of the research. Within this exploratory study, data analysis revealed an intricate understanding of participation featuring representation and reconciliation as key themes. This conceptual shift – from participation to meaningful representation and reconciliation – was consciously followed as a route to understand participation as a meaningful activity. But this reading of participation is not just a highly localized construct; representation and reconciliation have some parallels in the mainstream participation literature through concepts such as accountability, power sharing and trusting relationships. It is also evident, though, that Aboriginal participation in health planning cannot be fully understood with sole reference to mainstream citizen participation studies.

Certainly, there are strong connections between elements of this case and themes from other citizen participation research, but in addition to this, Committee members have articulated the vital connection between participation and Aboriginal health improvement. Aboriginal participation in health planning is inextricably linked to Aboriginal health itself, and both are fundamentally grounded in the socio-political context of Aboriginal people and culture as marginalized segments of Canadian society. This basis for understanding participation is not featured in the mainstream literature on citizen participation in health planning.

Similarly, the mainstream population health framework offers promising concepts applicable to Aboriginal health, such as participation and social determinants of health, but like the mainstream citizen participation literature, population health is not

sufficiently inclusive of Aboriginal approaches to health. Based on the research findings, I have suggested that the mainstream population health approach, while valuable in many respects, should be elaborated, stretched and challenged by Aboriginal population health approaches. I contend that such approaches are a means through which to build the responsive, trusting relationships integral to meaningful participation in Aboriginal health planning.

Further research in this area would contribute to developing a framework for meaningful participation in Aboriginal health planning. Evaluation research would be useful to assess the application of Aboriginal population health planning approaches, as well as to determine how meaningful participation contributes to policy development and the accomplishment of Aboriginal health goals. This research points out that additional inquiry is required to investigate the challenges that Aboriginal Liaisons face in their important work, and the implications that meaningful participation has for different demographics of the Aboriginal population (e.g., on- and off-reserve people, youth, elders). It would also be useful to study the impact of cross-cultural education and hiring of Aboriginal staff on the Committee's goals. Given the qualitative nature of meaningful participation, qualitative research should figure prominently in such research.

The results of this research parallel the Aboriginal health priorities identified by AHAWAC in the Aboriginal Health and Wellness Plan (2003-2006). The similarities are remarkable, considering this study's intended preoccupation with participation rather than health per se, and the initial impression of 'tension' as a significant feature of the data (suggestive of a fragmented, rather than cohesive vision). The top four health priorities in

the Plan are summarized with related issues in Table 3 (Interior Health Authority, Revised 2003, pp. 38-41):

Table 3. Priorities from the Aboriginal Health and Wellness Plan, 2003-2006

Holistic System	Community Need	Relationships & Partnerships	Other
<ul style="list-style-type: none"> • Increase awareness & information of Aboriginal people in the health system • Incorporate traditional medicine • Take holistic approach to services • Improve connection between Aboriginal communities and Aboriginal people in health system 	<ul style="list-style-type: none"> • Improve mental health [references effects of colonization, residential schools, poverty] • Improve early childhood development [including collaboration with other Ministries] • Create community-specific plans • Inform leaders in Aboriginal communities and government about Aboriginal health 	<ul style="list-style-type: none"> • Close gaps in programs and services for Aboriginal peoples • Improve cultural awareness of Aboriginal peoples • Improve equity in resourcing for Aboriginal health • Ensure accountability [including vertical and horizontal] 	<ul style="list-style-type: none"> • Create youth and elderly specific services • Improve access to health care • Increase number of Aboriginal health service providers • Ensure sustainable long-term funding for Aboriginal health services and programs

Many issues indicated here parallel with elements in the findings. This correspondence confirms the importance of these issues for Committee members, and again, draws a connection between participation (process) and the goal of health improvement (product).

But despite the emphasis placed on these priority areas, progress is slow. While this is perhaps unsurprising given the relatively recent concerted efforts in Aboriginal health, communities are already frustrated with repeatedly articulating their health needs to rounds of surveyors and administrators without any significant impact. If meaningful participation is to be a realize outcome in Aboriginal health planning (as is implied by the

Ministry of Health's directive for Aboriginal involvement at all levels of the health planning process), then participation must be supported by a whole range of attitudes, opportunities, policies, practices, and resources. These supports will facilitate perceptible advancement of the health goals identified by Aboriginal people.

This research emphasizes that not all participation is necessarily meaningful, and meaningful participation is not the entire responsibility of any one party. Mutual engagement stresses the combined responsibilities of the health authority, the AHAWA Committee, and Aboriginal communities in engaging in effective relationships for Aboriginal health improvement. Thus, meaningful participation will be built from all sides, with importance placed on accountability relationships and respect accorded to Aboriginal approaches to health. As relevant today as ten years ago, the Royal Commission on Aboriginal Peoples (1996) reinforces the need for a comprehensive approach to Aboriginal health that includes mutual engagement, policy, practice and participation:

[Aboriginal people] need to work with non-Aboriginal health and social services agencies to transform relations with them. Mainstream services and agencies need to become more welcoming and more sensitive to cultural difference. They need to ensure that all traces of racism are eliminated from policy and practice. And they need to start seeing Aboriginal people as partners in the design, development and delivery of services. (Royal Commission on Aboriginal Peoples, 1996a, np).

The Royal Commission further emphasizes, "mainstream institutions and professionals can learn from Aboriginal ways of promoting whole health" by engaging with Aboriginal service organizations through shared training opportunities, building

mentoring opportunities, and providing access to other resources (Royal Commission on Aboriginal Peoples, 1996a, np). Clearly, relationship building through special projects, as well as ongoing, formal and informal connections offers benefits to both Interior Health and Aboriginal community organizations – some benefits for the health authority are summarized in Table 4. AHAWAC members and their constituency organizations provide ample opportunity for developing these relationships, and Aboriginal Liaisons are crucial links in ensuring equity of opportunity for other Aboriginal organizations (for example, through AHICs).

Table 4. Benefits of relationship-building between Interior Health and Aboriginal communities

<ul style="list-style-type: none"> • Build awareness, understanding, trust, interpersonal relationships • Improve clients' access to services by improving awareness and referrals • Improve suitability of services for Aboriginal client group • Establish channels for information flow between the community and IH • Increase knowledge of local communities' health issues & of Aboriginal health approaches 	<ul style="list-style-type: none"> • Establish basis for vertical accountability • Gain community input for evidence-based decision-making • Develop partnerships for addressing social/political/environmental determinants of health • Build capacity of Aboriginal health policy community • Support community-based efforts for community healing
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True commitment to Aboriginal health will require stretching the boundaries of comfort for the organization. Aboriginal health provides Interior Health with an ideal opportunity to test its commitment to the population health approach, particularly one that respects Aboriginal ways of understanding health. In order to be successful, the health authority must relinquish its complete devotion to the bio-medical, scientific-rational approach to health in order to incorporate the beliefs and values of its Aboriginal

client population. Interior Health also needs to become expert in building relationships with Aboriginal communities, as well as other sectors and organizations in order to make significant impacts in Aboriginal health.

The Royal Commission similarly underscores the need to work beyond the traditional boundaries of the Euro-Western healthcare system to improve Aboriginal health. The Commission's report states:

...the pattern of causality for a specific illness includes factors outside the boundaries of ordinary medicine – social, emotional and economic conditions that in turn lead back to the complex, destabilizing and demoralizing legacy of colonialism. Obviously, then, more of the same – more illness care services – will not turn the tide. What is needed is a new strategy for Aboriginal health and healing (Royal Commission on Aboriginal Peoples, 1996a, np).

According to the Royal Commission, this new strategy involves Aboriginal self-determination in an integrated system of health and social services. But the Commission acknowledges the critical importance of supportive mainstream organizations in facilitating the progression towards Aboriginal control. Interior Health can contribute to this vision by supporting meaningful participation in Aboriginal health planning.

Afterword – Post Script to AHAWAC’s Funding Allocation Role

Since the writing of this thesis, the funding allocation role of the Committee, described in the research as a significant focus of the Committee’s work in Aboriginal health planning, has been altered for at least the current funding cycle. Rather than being judged by a sub-committee of the AHAWAC, applications for AHIP (Aboriginal Health Initiatives Program) funds have been recently reviewed by an ad hoc committee composed mainly of Interior Health staff unassociated with AHAWAC. This committee also includes two AHAWAC members: the Interior Health Aboriginal Strategies Coordinator and an invited community-based AHAWAC member (not a previous member of the AHAWAC sub-committee).

Interior Health formed this arrangement as a response to concerns from an Aboriginal Health Improvement Committee (AHIC) that the AHAWAC sub-committee was biased in its awarding of funds. This is despite the fact that an AHIC in another health service area felt that the Committee’s involvement in AHIP funding was valuable, given their intimate knowledge of Aboriginal organizations, communities, cultures and traditions. As far as I am aware, AHICs in the remaining health service areas are not yet operational, and so have not contributed to this debate. While aware of the concerns regarding bias, it is not clear whether the AHAWAC as a whole reached consensus on the management of the AHIP funding process prior to the establishment of the ad hoc committee.

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Appendix A – Timeline of Key Events in Aboriginal Health Planning in Interior Health*

*includes events within the current geographic region of Interior Health, prior to the formation of IH

1991		The BC Ministry of Health forms six Aboriginal Health Councils across the province, including the Thompson Okanagan Kootenay Aboriginal Health Council.
1997		BC government regionalizes health services. Province-wide, the model consists of 11 Regional Health Boards (RHBs), 34 Community Health Councils (CHCs) and 7 community health service societies. All RHBs and CHCs must be mandated to have one Aboriginal governor on their board or council.
1999	Dec	Aboriginal Governors Working Group submits recommendations to the BC Ministry of Health on improving Aboriginal community involvement in the health authority governance and planning process.
2000	Mar	Ministry of Health stipulates requirements for Aboriginal health planning that include “meaningful Aboriginal participation.”
	Fall	Aboriginal Health Improvement Committee established in the Thompson Health Region. This Committee initiates a consultative health planning strategy in 2002.
2001	Apr	Memorandum of Understanding signed between Ktunaxa Kinbasket Tribal Council and East Kootenay Health Authorities.
	Sept	North Okanagan Health Region completes a draft Aboriginal Health and Wellness Plan.
	Dec	Aboriginal Health Working Group of the Okanagan Similkameen Health Region develop draft goals and strategies for Aboriginal health.
		BC government restructures regionalization model: - Dissolves Aboriginal Health Council of BC and regional Aboriginal Health Councils (including Thompson Okanagan Kootenay Aboriginal Health Council). - Creates Interior Health as one of 5 regional health authorities.
2002	Mar	One Aboriginal member appointed to the Interior Health Board of Directors.
	May 6 th	Interior Health holds community meeting with Aboriginal peoples. Interior Health Aboriginal Health and Wellness Steering Committee

		formed (name changed to Aboriginal Health and Wellness Advisory Committee later in same year).
	Sept	Interior Health Aboriginal Health and Wellness Plan submitted to the Ministry of Health.
2003	Apr	Thompson Cariboo Shuswap Aboriginal Liaison position commences (full-time).
	Summer	Aboriginal Community Needs Assessments conducted throughout Interior Health.
	Jun	First Nations Health Liaison Program Coordinator position commences (position upgraded to Aboriginal Health Liaison, Cariboo, in Dec 2004 – full-time).
	July	Okanagan Aboriginal Liaison position commences (full-time).
	Sept	Aboriginal Strategies Coordinator position commences (full-time).
	Nov	Aboriginal Health and Wellness Conference hosted by Interior Health in Kelowna.
2004	May	Okanagan Aboriginal Health Improvement Committee (AHIC) established.
	Jun	East Kootenay Aboriginal Liaison position commences (on contract; part-time).
	Sept	Kootenay Boundary Aboriginal Liaison position commences (part-time).
2005	Mar	Aboriginal Health Strategic Planning Community Consultations conducted in Kelowna, Cranbrook, Nelson, Kamloops, Williams Lake.

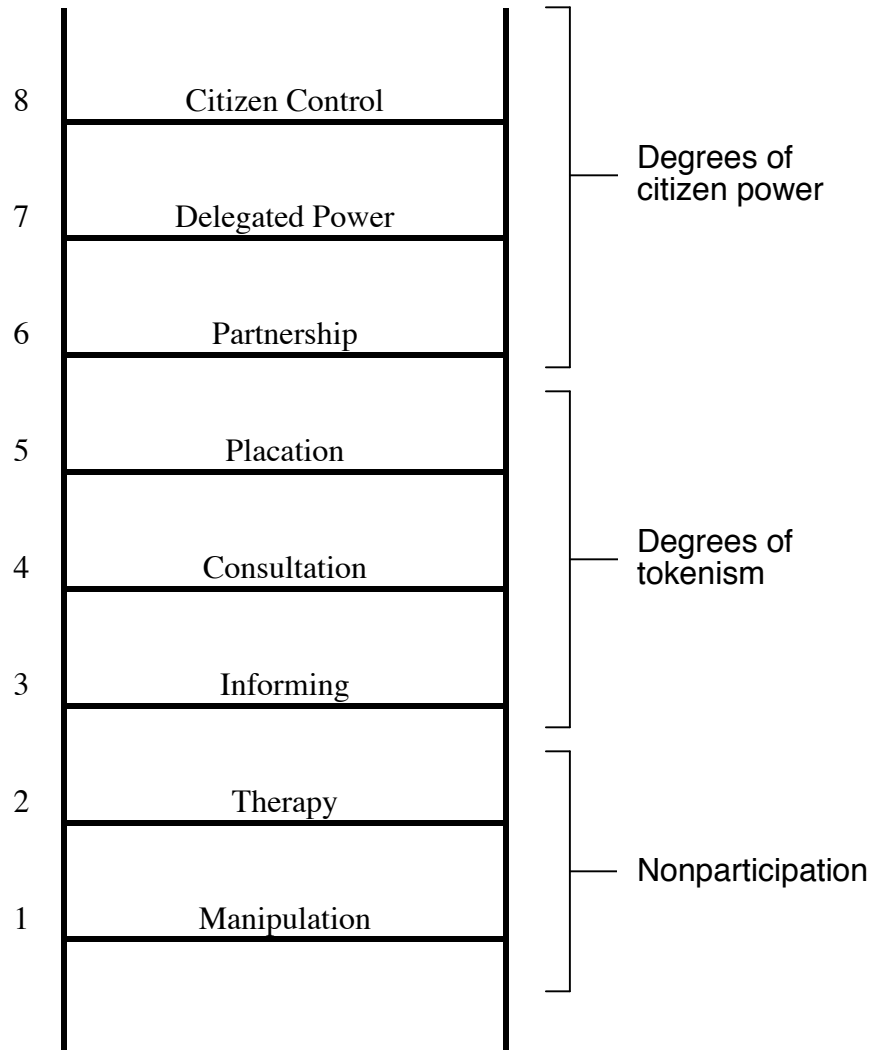
Appendix B – First Nations Communities within IH Service Area



Identifier	First Nation Name	Identifier	First Nation Name
591	Cayoose Creek	693	Coldwater
592	Xaxli'p	694	Cook's Ferry
593	T'it'q'et	695	Lower Nicola
594	Ts'kw'aylaxw	696	Nicomen
595	Seton Lake	697	Upper Nicola
596	Osoyoos	698	Shackan
597	Penticton	699	Nooaitch
598	Lower Similkameen	700	Boothroyd
599	Upper Similkameen	701	Boston Bar
600	Spallumcheen	702	Whispering Pines/Clinton
601	Westbank	703	High Bar
602	St. Mary's	704	Kanaka Bar
603	Tobacco Plains	705	Lytton
604	?Akisq'nuk	706	Siska
605	Shuswap	707	Skuppah
606	Lower Kootenay	708	Spuzzum
616	Okanagan	710	Alexis Creek
684	Adams Lake	711	Esketemc
685	Ashcroft	712	Tl'etinqox-t'in Government
686	Bonaparte	713	Canim Lake
687	Skeetchestn	714	Xeni Gwet'in Government
688	Kamloops	716	Soda Creek
689	Little Shuswap Lake	717	Stone
690	Neskonlith	718	Toosey
691	Simpcw	719	Williams Lake
692	Oregon Jack Creek	723	Skin Tyee

Based on information from (GIS Group, 2004) and (Statistics Canada, 2003).

Appendix C – Arnstein’s Ladder of Citizen Participation



Reproduced from: (Arnstein, 1969).

Appendix D – Briefing Note for AHAWAC

DATE: February 8, 2005

TO: Members of the Aboriginal Health and Wellness Advisory Committee
Interior Health

FROM: Geeta Cheema
Graduate Student, School of Public Administration
University of Victoria

RE: **Thesis Research Project on Aboriginal Health Planning in Interior Health**

The purpose of this note is to inform the members of the Aboriginal Health and Wellness Committee about a research project I will be conducting on Aboriginal participation in health planning. This is an independent research project affiliated with the University of Victoria, which will be applied towards the requirements for the Master of Public Administration degree.

Purpose of the Research

The research is an exploration of Aboriginal participation in health planning in the context of a regional health authority - namely Interior Health. There has been little academic research done in this specific area, despite the large role that regional health authorities play in planning and delivering health services to Aboriginal peoples. Through this research, I intend to shed light on the use of participatory mechanisms in Aboriginal health planning. In particular, I am interested in the perspectives of people who are involved in Aboriginal health planning at Interior Health.

Description of the Research

The research has three parts. Through this research, I endeavour to:

- (1) Document the policies and practices by which Interior Health is engaging with Aboriginal peoples for Aboriginal health planning
- (2) Present Aboriginal participation in health planning through the views of members of the IH Aboriginal Health and Wellness Advisory Committee
- (3) Explore the extent to which Aboriginal participation in health planning in IH is meaningful

This research will be conducted through a review of relevant documents (e.g., the IH Aboriginal Health and Wellness Plan), and through first-hand interviews. I would like to interview approximately 12 members of the AHAWAC. I will be contacting selected members of AHAWAC with an invitation to participate in this research. **Participation in this research is appreciated, and is completely voluntary.**

Participation in the Research

I will travel to interview participants at a mutually convenient time and location. The interview could last approximately 1.5 hours, and will be audiotaped for accuracy of data collection. Copies of the interview questions will be available by request prior to the interview.

Possible Risks to Participation in the Research

Possible risks to participation in this research are lack of anonymity, and possible loss of confidentiality. Anonymity means that the researcher cannot link the information a participant provides to her/his identity. Since I will be conducting face-to-face interviews, participants in this study are not anonymous.

I will protect participant confidentiality by not identifying individuals by name in the thesis document. However, since participants will be selected from a small group, there is a risk that individuals could be identified by other members of the committee (or other close associates) by the opinions and perspectives they provide.

It may be the case that participants wish to be identified in the thesis document, either by name, title, or nation/tribal affiliation. I would be pleased to honor the wishes of the participant in this matter.

Use of the Interview Data

I am the only person who will have access to the data I will collect from participants. The data will be stored securely at my place of residence during and after the completion of the research study. If I am no longer able to store the data securely, I will destroy the data.

I will write a thesis document based on my analysis of the interview data. I will minimize the risk of misinterpreting the data by providing interested participants the opportunity to comment on elements of the thesis as it develops.

Once I have defended the thesis in front of an academic committee at the University of Victoria, the document will be made publicly available through university libraries in Canada.

A summary of the completed research will be distributed by email to all participants. If requested by participants, I would be pleased to make a presentation of the results of the research to the AHAWAC and/or other groups. I may also use the findings to publish articles in journals or newsletters, and make presentations at conferences. The thesis will not be used for commercial purposes.

Ethics Approval and Contact Information

This study has received ethics approval from the University of Victoria. You may verify the ethical approval of this study by contacting the Associate Vice-President of Research at (250) 472-4545 or ovprhe@uvic.ca. This study has also received ethics approval from Interior Health.

I am available to answer any questions or concerns that you might have about the study. You can contact me any time at (250) 382-7652 or gcheema@uvic.ca.

If you do not wish to be contacted by me regarding this study, please notify Monica Wilson at (250) 851-7305 or monica.wilson@interiorhealth.ca by February 14, 2005.

Thank you in advance for your interest in this project. I'm sure that all participants will find the process and product of this research interesting and useful.

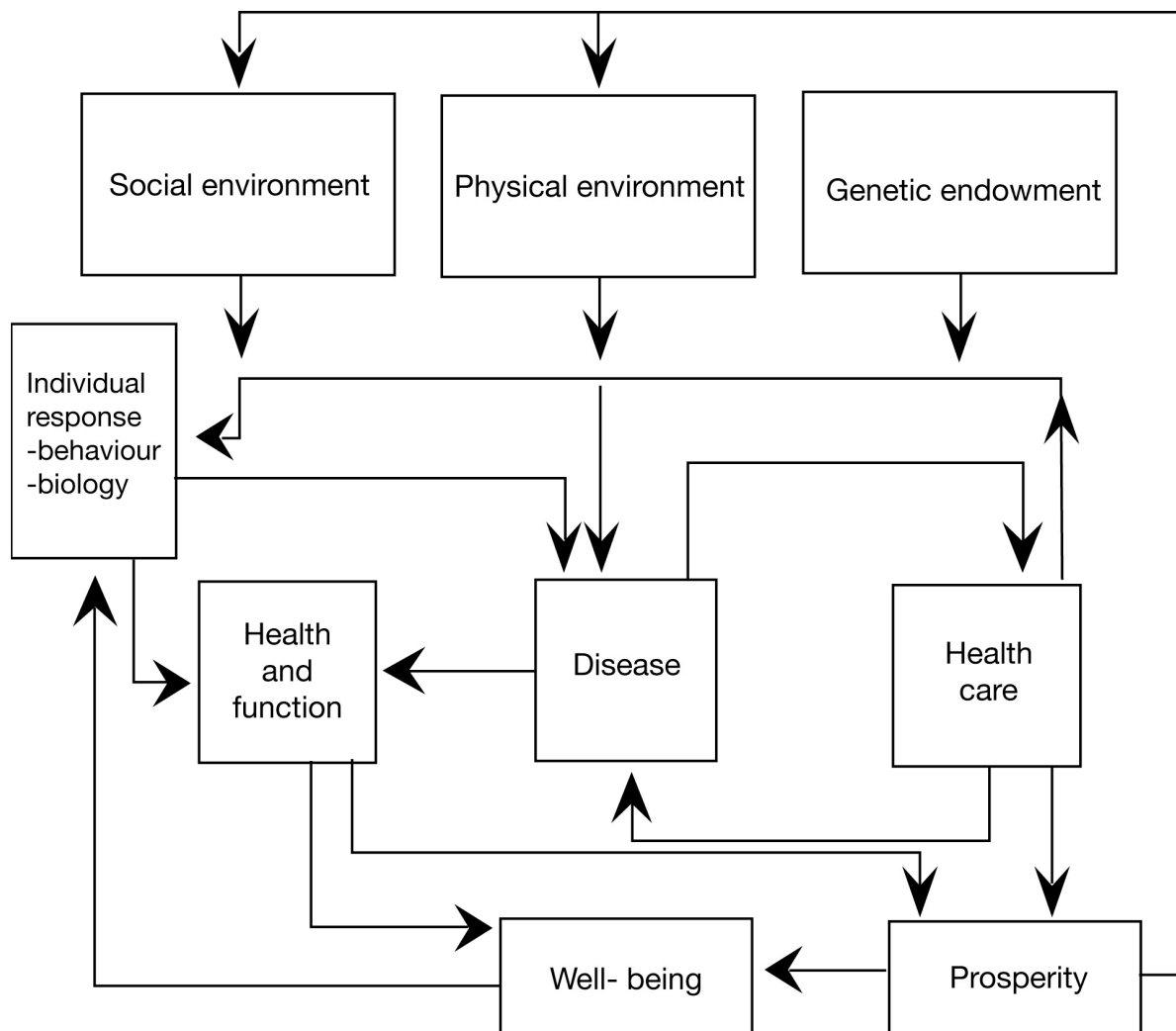
Sincerely,

Geeta Cheema

Appendix E – Interview Questions

1. As a member of this Committee, what do you see as your role?
2. In your role as a Committee member, who (if anyone) do you feel you represent?
3. In your role as a Committee member, who do you feel accountable to?
4. How do you make sure that your decisions as a Committee member reflect the wishes of [those represented, those feel responsible to].
5. a) In your view, does the Committee adequately represent the Aboriginal peoples that reside in the geographic region of Interior Health?
b) [If so, or, if not] what reasons would you give?
6. What do you see as the main purpose of the Committee?
7. a) What were your expectations of the Committee's work, when you joined?
b) Has this been your experience?
c) What are some positive experiences you've had while on the Committee?
d) What are some disappointing experiences you've had with the Committee?
8. Based on your experience, does the Committee incorporate Aboriginal approaches to health into its health planning?
9. How does the work of the Committee contribute to the broader goal for Aboriginal self-determination in health?
10. Based on your experience, has your participation on this Committee been meaningful to you? Why or why not? And in what ways?
11. a) How do you define success in Aboriginal health planning?
b) In your view, how can this success be achieved?
12. How would Aboriginal health planning be different if the Committee worked in the way you would like to see?

Appendix F – A Population Health Model



Reproduced from: (Evans, Barer & Marmot, 1994).

Vita

Surname: Cheema

Given Name: Geeta

Place of Birth: Kamloops, British Columbia, Canada

Educational Institutions Attended:

University of Victoria	2003 to 2005
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Simon Fraser University	1993 to 1999
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Degrees Awarded:

Bachelor of Arts	Simon Fraser University	1999
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Honours and Awards:

British Columbia Medical Services Foundation	2005
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Summer Research Scholarship

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Title of Thesis:

Speaking From the Inside: Participation in Aboriginal Health Planning in a Regional Health Authority

Author: _____

Geeta Cheema

Date: _____

