Achieving a Balance of Wellness for all British Columbians

Aboriginal People and Regionalization

Aboriginal Governors Working Group

Recommendations to the Ministry of Health

Aboriginal Governors Forum
Vancouver, British Columbia
December 13, 1999

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INTRODUCTION

In the early 1990's, the Ministry of Health explored ways to make health services more responsive and more effective in British Columbia. It was determined that the most appropriate way to do so was through direction from community and regional level boards and councils. To that end, the Ministry delegated a large degree of fiscal and decision-making responsibilities to community-level authorities. The make up of local health authorities was to contribute to the desired responsiveness by ensuring all sectors of the community would have a voice on partially-elected boards. At that time, the Ministry required each health authority to have a dedicated Aboriginal seat and an Aboriginal health plan.

A review of the delegated health initiative led to a reorganization in the mid-1990's. In that reorganization the Aboriginal-specific requirements were set aside. There is now a strong recommendation for at least one Aboriginal member on most health authorities; while there is no requirement for an Aboriginal health plan, planning guidelines do require health authorities to address Aboriginal health. The current system of appointed regional health boards, community health councils and community health service societies was initiated on April 1, 1997.

Throughout the process, Aboriginal people faced, and continue to face, a number of challenges related to how, or if, they should participate in the regionalized health system. As consumers, access, both physical and cultural, were at issue. There was little history of participation and cooperation to build upon. Finally, there were serious misunderstandings regarding what level of government should provide their health services.

As Aboriginal governors, issues continue to arise related to accountability to Aboriginal communities, health authority and Aboriginal perspectives on the role of Aboriginal governors, underdeveloped processes for bringing Aboriginal health issues to health authority agendas, the low priority Aboriginal health is given by many health authorities and the lack of support for relationship building efforts by Aboriginal governors and the Aboriginal community. In general, the regionalized approach to health appears to many Aboriginal British Columbians to be no more effective in meeting their needs than the previous Ministry-centred system.

In response, the Ministry of Health, through the Aboriginal Health Division in cooperation with the Aboriginal Health Association of BC hosted a forum of Aboriginal governors in 1998 to identify significant issues with respect to meaningful Aboriginal participation in health authorities. Thirty-one Aboriginal governors identified four areas needing special attention: representation, information needs, relationship building, and Aboriginal components to health plans. (See Appendix B for Forum recommendations; based on Forum proceedings produced by Sal'I'shan Institute)

Shortly after the forum, ten governors responded to a general invitation to form a working group to further develop actions to address the identified issues. The Aboriginal Governors Working Group (AGWG) was struck to expand upon and refine the issues and recommendations. Topics from the forum were organized into three broad categories: representation; retention; and education, information and training.

The AGWG was mandated to provide recommendations to the Ministry of Health for positive changes to Aboriginal community involvement in the health authority governance and planning process, within a framework to effective partnerships. This was to be achieved in one year, beginning with the 1998 forum and ending with an AGWG report at a forum to be held in 1999. AGWG membership represent communities throughout the province, with ex officio participation from the Aboriginal Health Association of BC (AHABC), the Health Association of BC (HABC) and the Ministry of Health's (MOH) Aboriginal Health Division (AHD).

The following recommendations represent our collective effort to achieve those tasks. Within the context of this discussion paper, the term "Aboriginal community" is an inclusive reference to all First Nations, Métis, off-reserve and/or non-status Aboriginal British Columbians.

The Aboriginal Governors Working Group wishes to acknowledge the assistance of all who assisted in this undertaking: current and past governors, health authorities and their chairs, the Aboriginal Health Association of BC, the Health Association of BC and the Ministry of Health.

Respectfully submitted,

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I. REPRESENTATION

Current approaches to governance have created considerable challenges for both Aboriginal governors and health authorities. The Ministry of Health has pursued a number of activities to ensure adequate Aboriginal involvement, including participation in Aboriginal Governors forums.

At the July 1998 Aboriginal Governors Forum in July 1998, attending Aboriginal Governors expressed concerns that representation was not consistent - that it was often felt or seen to be tokenism, and they were frequently confused about their role and the role of the board and council. There was also a lack of clarity about their accountability to, and relationship with, the Aboriginal community. Generally they did not feel their participation was significantly valued by health authorities or understood by Aboriginal communities.

Health authority chairs, at a workshop in September 1998, identified many of the same issues, from a different perspective (see Appendix C). They expressed concerns around sporadic attendance, lack of participation and a low level of awareness about the health authority process as factors. They were unsure about how to identify Aboriginal people for nominations, and acknowledged a relatively low level of knowledge about Aboriginal people and their communities.

The Aboriginal governors made a number of broad recommendations at the forum regarding representation, which the AGWG addressed with two goals: Aboriginal representation and greater accountably to Aboriginal communities.

Goal A: Ensure adequate Aboriginal representation

Aboriginal governors have expressed concern that a number of health authorities still did not have Aboriginal members, or that their numbers were and continue to be, inadequate. The Ministry currently recommends at least one Aboriginal member on each health authority. In areas with a large Aboriginal population, MOH recommends that the membership reflect the proportion of population. However, recommendations do not have the force of legislation or policy, and health authorities may choose not to act upon them.

In a number of cases, health authorities have expectations that an individual Aboriginal member to take on all aspects of consulting and building relationships with the Aboriginal community. While their knowledge and efforts may constitute a valuable resource for health authorities, this is an onerous task for one person; Fostering consultation and relationships is a responsibility shared by all members of a health authority. A governor may only be able to meet the needs of diverse and distant communities at the expense of family, community and work commitments. This has resulted in some health authorities not taking advantage of other appropriate community-based initiatives which promote Aboriginal involvement or fostering a greater appreciation of the role of health authorities.

AGWG members frequently spoke of the challenges of being the only Aboriginal member of a health authority - of being one vote in fifteen; of the need to share tasks

related to Aboriginal health; of not being able to miss a meeting for fear of missing an important discussion; and of being a member of one Aboriginal community struggling to articulate the needs of another community. To address these issues, the AGWG determined that health authorities should be required to have appropriate representation. The principle of appropriate representation should be applied to identifiable, non-Aboriginal populations as well (In an area with a 20 per cent Indo-Canadian population, one-fifth of the members of a health authority should be Indo-Canadian).

1. **Establish policy requirements to ensure Aboriginal representation reflects the proportion of aboriginal population in the health authority areas.**

2. **Amend legislation to require that a minimum of two Aboriginal people be nominated and appointed to health authorities by the Minister for each authority.**

There is also concern that the mechanisms to appoint Aboriginal members to regional health boards and community health councils do not exist for community health service societies. Given their important role in community health in over half of the province, this situation should be remedied.

3. **Establish policy that requires Aboriginal representation on Community Health Services Societies.**

The AGWG emphasized the need to involve and work with all Aboriginal communities. Aboriginal governors consistently pointed out that non-Aboriginal agencies often either do not recognize or allow for the diversity of Aboriginal communities in BC; there is no single approach to effective relationships that works with all communities. To varying degrees, Aboriginal governors have found that many health-related policies and practices are limited in scope, and are subject to uneven or restrictive interpretations. This is most evident in discussions about providing services to citizens living on reserves; and can be found both within the MOH and among health authorities.

In response to local relationships and high-profile issues in local Aboriginal communities, health authorities will need to develop a continuum of relationships with those communities. Whatever process, or processes, are in place, will need to be developed in cooperation with those communities. The AGWG identified approaches that are already in place, or could be implemented, in some health authorities. The commonality in these approaches is that the process provides avenues for input that work for all stakeholders. Alternative venues and means of providing input contribute to a stronger sense of commitment and a better understanding for both communities and health authorities. These mechanisms, however formal or informal, are worthwhile only if they result in greater accountability and appropriate Aboriginal involvement.

While not yet widespread, some governors believed that advisory committees were effective in bringing Aboriginal health issues forward. Among the benefits of effective advisory committees are inclusiveness in areas with diverse Aboriginal populations, the

ability to draw on expertise outside of the health authority (including direct patient and consumer input) and their familiarity in the Aboriginal community as a component of many existing relationship models. Aboriginal governors realize that establishing such committees requires time, work and resourcing; as such they are unlikely to provide immediate solutions to Aboriginal health issues. A strong feeling was also evident that allowing alternate members would ensure the necessary Aboriginal knowledge and perspective were available at most health authority meetings.

4. **Recognize and develop other mechanisms and processes for ensuring Aboriginal involvement in the decision-making and planning for health services in the region that would support and enhance the role of Aboriginal governors:**
   a. **Establish Aboriginal Advisory Committees to health board/councils that could make specific recommendations to Health Authorities, and could even look at the development of an Aboriginal component to health plans.**
   b. **Establish government-to-government relationships between health board/councils and First Nation Councils with formal protocols and a mandate for regular meeting(s) to discuss and address relevant health issues.**
   c. **Establish models for relationship building, consultation, participation, and decision-making that recognize the diversity of, and take into account the distinctiveness of, First Nations, Métis and urban Aboriginal communities.**
   d. **Organize and resource regular regional health forums for health authorities and Aboriginal communities to exchange information, and for the identification of common issues, and the development of methods to address these issues.**
   e. **Encourage health authorities to meet with Aboriginal communities in the communities themselves.**
   f. **Bi-annual health meetings between the Aboriginal community and the health authority board and staff.**
   g. **Allowing for an alternate to attend meetings in the event that a governor is not able to attend a particular meeting.**
   h. **Consider video taping and public distribution of minutes of meetings to Aboriginal communities and organizations, and rotate meetings through Aboriginal communities as well as other communities in the health region.**

All protocols and processes must respect First Nations and Aboriginal community protocols regarding relationships and meetings.

Given a history of broad exclusions from most consultation and decision-making activities, the AGWG saw greater participation and commitment only where the Aboriginal community had input into both the nomination process and relationship Aboriginal governors would have with the communities. The current nomination process does not take cultural relevancy or community accountability into account, and thus does not foster the connection between governors and Aboriginal communities.

5. **Develop model(s) for a nomination process and procedures that are culturally appropriate and demonstrate support from the Aboriginal community.**
   a. **Boards and Councils have a responsibility for making the process work collectively and must involve the Aboriginal community in nomination and other board processes.**
   b. **Boards and Councils need to take the time to build relationships with Aboriginal communities – this will generate interest in Board/Council activities, including governance.**
   c. **Establish formal and informal relationships with Aboriginal health authorities and Aboriginal health organizations which could assist in the nomination and governance process.**

Individual Aboriginal governors identified cases where a health authority is more than willing to work with Aboriginal communities in a way that meets the needs of both. However, where mutually acceptable approaches for representation have been found in some areas, Ministry policy is either vague or not flexible enough to accommodate the community-based solution. Aboriginal governors recognize that structural consistency is important, but believe that flexibility in achieving the goals of health authorities and Aboriginal communities is necessary.

6. **Health authorities and Aboriginal communities must have the freedom to develop locally appropriate approaches to participation, consultation, nomination and alternative representation models that ensure an adequate voice and a partnership.**

Neither Aboriginal nor non-Aboriginal communities are homogeneous. Aboriginal people understand the extensive diversity of their communities in the province and the history of its development and its complexities. Although non-Aboriginal agencies acknowledge and work with the diverse nature of non-Aboriginal people, they often do not recognize a similar diversity in Aboriginal British Columbians. Both the MOH and health authorities need to seek a better understanding of Aboriginal diversity and develop practical ways to work with all segments of the community.

While the AGWG recognized that it may be easier to identify and work with formal First Nations governments, the reality is that half of all Aboriginal British Columbians live off-reserve and/or in urban centres. All Aboriginal communities and populations need to play a role in addressing Aboriginal health issues.

The governors also recognized the importance of developing partnerships with other initiatives, such as a Provincial Aboriginal Health Services Strategy, to ensure that every available avenue towards improved understanding and participation is pursued.

7. **All models that encourage broader representation must ensure that the diversity of the Aboriginal community is respected, and include: First Nations (on and off reserve), Métis, Status and non-Status, and Inuit, and should recognize different political affiliations.**

AGWG members share with the Ministry of Health the view that Aboriginal involvement is vital to making health services more responsive to community needs. However, both participants at the 1998 forum and AGWG members commented on the length of time between nomination and appointment. There was some concern that the lengthy process may be interpreted as a lack of commitment, or that Aboriginal communities might interpret this as a lack of interest or commitment on the part of health authorities to improvements in the health of Aboriginal people.

8. The Ministry must review the current appointment process to ensure that appointments are made in a timely fashion.

Goal B: Ensure accountability to the Aboriginal community.

While the AGWG understood that Governors are not appointed to represent any one community, the reality is that health authorities do have geographic representation. This is reinforced by the identification of the governor's town or district in the MOH appointment news releases and health authority lists. Given that reality, and the feeling that Aboriginal communities *"... can only function on the basis of ... community accountability"*, explicit consideration does need to be given to the relationship between communities and governors – both Aboriginal and non-Aboriginal.

One aspect of that relationship building is acknowledging that a two way communications process is essential to connecting Governors and communities and ensuring community accountability. There is also a need to ensure that health authorities fully understand the health needs of the Aboriginal citizens in their regions. Communicating and working directly with Aboriginal community members in their communities increases opportunities for Aboriginal involvement; as well as support Aboriginal Governors in providing relevant information to the health authority and creating community-supported change.

Consideration must also be given to the fact that First Nations work within the legislative requirements of the Indian Act, as well as community expectations of accountability. As governments, First Nations are legally accountable to their members. The sense of accountability extends to all who act on behalf of or represent a community. While expecting to be accountable to their communities, Aboriginal governors also recognize their broader responsibilities to all citizens.

9. **Health authorities must recognize that many Aboriginal governors are directly accountable to their communities – accountability is an expectation in First Nations communities when someone is representing their interests. Certain policies and expectations of health authorities may be culturally contradictory; it is important to develop an understanding of how an Aboriginal governor sees themselves in relation to their community, and this must be respected.**

10. **Recognition that all governors represent all citizens in the health region, requires that non-Aboriginal governors accept responsibility for addressing the needs of Aboriginal citizens. The entire board/council is accountable to the community as a whole; no one board/council member should be expected to take responsibility for a segment of the population; Aboriginal members views should be consulted and considered on all health issues.**

Many historic and contemporary relationships between the Aboriginal community and public agencies can be characterized as power imbalances; Aboriginal people receive services in the manner the agency chooses to deliver them, with only limited input or appeal. In efforts to develop functional and fair interactions, the AGWG sees a need for the Ministry to play a part in balancing the relationship between Aboriginal communities and the provincial health system.

11. **Ensure, through policy and funding mechanisms, that Aboriginal communities are involved in the planning, delivery, and evaluation of appropriate health services.**

The AGWG recognized the need for a higher profile for health in Aboriginal communities, both on- and off-reserve. Many community agendas are focussed on resource and infrastructure development as a means of improving the lives of their members. While such issues are important, the longer-term impacts of health issues need to be given a higher priority.

12. **Cooperate in raising the profile of health in Aboriginal communities through open health meetings, through regularly rotated meetings in Aboriginal communities, and at joint health meetings between Aboriginal community health board and staff, and health authority board and staff, respecting the protocols of the Aboriginal community(ies).**

II. RETENTION OF ABORIGINAL GOVERNORS

Acknowledging the health needs and the widespread lack of relationships, health authority chairs and Aboriginal governors have identified the necessity for greater Aboriginal involvement in health authority services and governance. However, participants at the 1998 Forum spoke candidly about the personal costs of being a governor in terms of family, community and professional lives. Many Aboriginal governors express reservations about seeking reappointment.

In general, the demands of being a governor must be balanced against work, family and community commitments. As most Aboriginal governors still work, have young families and engage in cultural and community activities, balancing all the needs is more difficult than for other governors.

The sense of achievement essential to the retention of any volunteer is often challenged by inconsistencies between expectations and training, the magnitude of necessary improvements in Aboriginal health, the lack of support in building relationships, misunderstandings about Aboriginal health and a perception that there is little commitment to addressing Aboriginal health at the health authority level. Aboriginal governors have stated that the best demonstration of interest and commitment is in seeing Aboriginal health as an integral part of the health authority health plan; and that component must have been developed with Aboriginal people, not just for them.

The forum made a number of recommendations related to improving retention, and identified: orientation and education, the need for community endorsement for mandatory Aboriginal health plans. The AGWG expressed the forum discussions in four goals with regard to improving the retention rate of Aboriginal governors: appropriate orientation and training; resourcing Aboriginal involvement in health authority processes; support for Aboriginal governors; and the need for participatory Aboriginal health planning.

To improve the retention of Aboriginal governors, the AGWG recommended action regarding standards for governor orientation and training; Health Authority support of Aboriginal involvement; addressing issues that lead to a sense of isolation of Aboriginal governors; and the need for Aboriginal health plans.

Goal C: All Governors, Aboriginal and non-Aboriginal, need an appropriate orientation to be effective.

There was consistent concern voiced at both the 1998 forum and by AGWG members during working group meetings that the level of training for new governors was usually inadequate. Further concern was expressed regarding the lack of consistency in orientations and training between health authorities.

AGWG members shared their own experiences in terms of being ".. handed a large binder and being welcomed aboard" or of receiving a minimal orientation as much as three months after they joined a health authority. The quality of initial exposure to the health authority usually sets the tone for the balance of a governor's term.

AGWG members also identified a substantial lack of understanding on the part of non-Aboriginal governors. In addition to providing an Aboriginal perspective to health authorities, Aboriginal governors often struggle to educate other governors and staff so that they may provide services in an appropriate manner. Many identified such education as "taking place with unwilling learners".

13. A full orientation should take place within three months of being appointed to a board or council.

14. An appropriate orientation would inform new governors in a number of areas.

To better inform and prepare all governors, include:

- **a. the roles, responsibilities and expectations of a governor**
- **b. the programs and services that the HA is responsible for managing**
- **c. how decisions are made regarding planning, services, and funding**
- **d. presentations by programs, services, departments explaining what they do**
- **e. 'snapshot' community profile of the health authority (region, boundaries, services, First Nations, population profiles, etc.)**
- **f. historical health structures and dynamics**
- **g. a briefing book on significant health issues in the region, including aboriginal health issues, and their priority within the communities**
- **h. available Aboriginal resources (resource directories, handbooks); community, political and service organizations; and information regarding the relationships between organizations and processes**

As well, all governors would benefit from mandatory training in:

- **i. Aboriginal history, health issues and traditional practices**
- j. **anti-racism and cross cultural awareness training.**

Aboriginal governors believe the separation of communities has been so great, for so long, that many non-Aboriginal governors may have driven through, but never visited, an Aboriginal community. Both forum participants and AGWG members felt strongly that an orientation in an Aboriginal community puts a human face on what is often viewed as an academic or statistical problem by non-Aboriginal people.

15. Orientations should take place in conjunction with Aboriginal communities where possible; providing an introduction to community protocols.

Aboriginal governors understand that individual learning styles contribute to the success of all education processes. Orientations need to work with understandable language and concepts. In all cases, orientations must take into account varying personal schedules, levels of academic experience, abilities to conceptualize holistic and organizational approaches to health, as well as individual learning styles.

16. Orientations need to accommodate differences in individual learning styles.

A number of Aboriginal governors felt confined in their health authority work to Aboriginal-specific issues. This seems to stem from a belief that they were appointed only to fulfil an Aboriginal requirement, or were interested only in Aboriginal issues. While each stressed the importance of bringing an Aboriginal perspective to health authorities, most expressed a desire to contribute to other initiatives and activities.

17. Ongoing training opportunities need to be available to all governors, as does participation in regional and provincial boards, councils and advisory committees, as a learning opportunity and for professional development.

GOAL D: Health authorities need to provide the necessary resources, human and financial, to support Aboriginal involvement in the governance and planning process.

Although many health authorities are aware of the need to build relationships with Aboriginal communities and are willing to designate an Aboriginal governor to lead that development, AGWG members see most efforts as under-resourced. The geographic remoteness of many Aboriginal communities, combined with a widespread need to establish basic relationships, suggest that initial relationship building efforts will be resource-intensive. Individual Aboriginal governors can not be expected to underwrite such efforts from their own resources.

Even where health authorities encouraged building relationships with Aboriginal communities, AGWG members identified a number of frustrations related to their work in building those relationships. Examples include the inability to access a photocopier; lack of funds for community mailouts; loss of income; cost of travel; and difficulty around child care arrangements. There was also a feeling that the level of commitment to Aboriginal health usually did not extend to hiring Aboriginal programs and services personnel.

AGWG members share the view that sincerity of commitment is an ongoing process, rather than a one-off effort. In committing to Aboriginal health, health authorities need to encourage Aboriginal people to participate in, and work with, health authorities. This must be done at both the consultative and the governance level. At both levels, involvement must be substantive, and result in positive changes to the health of Aboriginal people.

18. Many Aboriginal people face significant economic disadvantages. While many Aboriginal governors are often working full time, they also have young or extended families. Participating in health governance should not create a hardship, and thus, financial resources/expenses should be covered for out of pocket expenses such as:

- **a. Reimbursement for lost wages**
- **b. Child care**
- **c. travel expenses including mileage or transportation, meals and accommodation if necessary**
- **d. where it is appropriate, financial support for Aboriginal members to meet with Aboriginal organizations and communities.**

Some governors felt their health authority viewed their role as being limited to Aboriginal health, without encouragement to speak to other issues. In other cases, non-Aboriginal members were discouraged from being more involved in Aboriginal health because the Aboriginal governor would deal with the issue. Such compartmentalizing does not meet the needs of either community or health authority. AGWG members also saw a need for consistent treatment around meetings, training and other activities.

Aboriginal governors reiterate the need for a clear, authoritative message from MOH regarding the need for all governors to be responsible for, and responsive to, all citizens in their area.

Aboriginal health and community issues impact relationships at all levels. To ensure that health issues identified by patients are dealt with in a substantive way, health authorities need to engage in serious discussions to address racism and discrimination that hinder understanding and taking appropriate action.

19. All governors are responsible for the governance, planning and service delivery in the region. Aboriginal governors are not solely responsible for the relationship with the Aboriginal community – all members must take responsibility to educate themselves, be aware of and speak to issues, and encourage relationship building.

20. **Provide human and office resources to support relationship building and consultation in the Aboriginal community. This would include staff time, access to office equipment (e.g. work spaces, file storage, photocopiers, fax machines, e-mail) and office supplies.**

GOAL E: Provide meaningful support for Aboriginal governors within the health authority process to ensure isolation does not occur, and sharing of ideas is nurtured.

A major consideration in relationship building with Aboriginal communities is that the extent of the outreach tasks involved are too great for one or two people. Engaging other governors in this would serve three purposes: to provide assistance in the process; to demonstrate that the health authority as a whole is committed to working with the Aboriginal community; and to broaden the understanding of non-Aboriginal governors of Aboriginal health issues.

A common issue identified by many Aboriginal governors was the difficulty in bringing Aboriginal health into health authority discussions. In some cases, there was a feeling that health authorities perceived that their obligation was fulfilled by having an Aboriginal member, and that those members could work Aboriginal issues into the existing framework for discussion and service.

As Aboriginal traditional territories rarely coincide with ministry or service agency boundaries, many cultural communities deal with two or more health authorities. Forums based on cultural communities or on regional groupings would provide information and allow for joint problem solving and strategizing.

Aboriginal people indicate that their involvement as governors results in a sense of isolation, both personally and professionally, from other governors and from the health authority process. As well, there was a strong desire for regional and provincial gatherings of Aboriginal governors as a means to share experiences and address common issues.

Most Aboriginal governors join a health authority with minimal exposure to the organizational process or personal dynamics; an already formidable learning curve becomes steeper. Opportunities, both formal and social, to learn about the people and the processes would enable new members to develop a sense of belonging and to begin taking part as fully functional governors.

21. **Provide opportunities for mentorship for new members by Aboriginal and non-Aboriginal governors.**

22. **Health authorities should ensure there are informal opportunities for governors to network with each other, prior to or outside of meetings.**

23. **Bring potential new board/council members on early to observe the process and ask questions.**

24. **Support Aboriginal Governors Forums and/or Retreats by planning for and providing necessary support and resources to attend annually.**

Many Aboriginal governors have found difficulties in bringing Aboriginal health issues forward at meetings. While most health authorities recognize the urgency of Aboriginal health, crowded agendas frequently focus on higher profile issues such as facilities, physicians and geriatric care. When Aboriginal health is on an agenda, governors see a need for greater time allocations, for placement at other than the end of agendas, and for greater respect for all governors and the issues they bring forward.

25. Support Aboriginal governors in bringing forward Aboriginal health issues – make Aboriginal health a standing agenda item on the board/council meetings.

Networking opportunities meet the needs of Aboriginal governors on both a personal and organizational level. While forums and other gatherings provide perspective to Aboriginal governors, information and ideas arising from such events would prove useful to health authorities in addressing health issues.

26. Establish a networking system for Aboriginal governors, provincially and regionally; ensure that health authorities are invited to participate.

27. **Consider regional Aboriginal health forums that bring together Aboriginal governors and community members to discuss and make recommendations for improving Aboriginal health.**

GOAL F: Require all health authority to develop Aboriginal health plans, or at least have an Aboriginal component to their health plans.

The AGWG identified that Aboriginal health plans or components can not be developed by health authorities without Aboriginal involvement. The cooperative development of components or plans lead to better working partnerships, which in turn support the most effective use of health resources.

28. **Aboriginal health planning must involve Aboriginal people throughout the process (goalsetting, planning, delivery and evaluation); and must allow for a more holistic approach to health that recognizes and respects both traditional and complimentary health practices.**

The AGWG sees a number of challenges to developing partnerships between Aboriginal communities and health authorities. Often the first element in any relationship is sharing perspectives and information. Aboriginal governors cite examples of the incomplete distribution of important information. They also believe that improvements need to be identified and publicized as a demonstration to all communities that progress is being made.

One visible improvement involves culturally sensitive services being offered by health authorities. Initial improvements may be as simple as facilities accommodating traditional foods or traditional practices, or hiring Aboriginal liaisons to address language and cultural needs. An understanding and acknowledgement of traditional healing practices would also improve the level of cross-cultural sensitivity.

AGWG members indicated that, while there is widespread interest in joint initiatives, many health stakeholders continue to view services to Aboriginal people as irreconcilably separate from those provided by health authorities. The governors believe that the Ministry of Health can take a lead role in coordinating such services.

29. **Hire Aboriginal staff to support the relationship building between the Aboriginal community and health authorities and their staff, and to support the development of an Aboriginal health plan/component.**

The AGWG members firmly believe that commitment is best demonstrated by action that leads to positive results. Health authorities are encouraged to engage in discussions with communities and to follow through with decisions and appropriate initiatives. Further, it is important to have examples of positive actions as models for others; a collation of best practices is one practical way of doing so. Best practices may incorporate working with or accommodating traditional practices; an example is setting aside an area as a grieving room or ensuring that facilities make allowances for extended-family size visitor groups. Given their first-hand knowledge of what works effectively, the identification of best practices should be carried out in conjunction with Aboriginal communities.

30. **Commit to relevant discussions with Aboriginal communities that lead to actions that measurably improve Aboriginal health.**

31. **Identify and publicize best practices in Aboriginal health locally, regionally and provincially.**

AGWG members acknowledged that many health authorities seek guidance in their planning processes. The AGWG felt that each health authority needs to address its local issues in a locally appropriate manner; this would mean that each health plan would be in some way unique. However, there are some common attributes that should be found in each plan.

32. Aboriginal health plans/components should initially include:

- **a. An Aboriginal community profile (First Nations, off reserve Aboriginal pop; and include history of the region)**
- **b. An inventory of services**
- **c. A consultation plan with the Aboriginal community**
- **d. An identification of all Aboriginal service providers**
- **e. Where an Aboriginal specific service does not exist, identification of the services that are accessible**
- **f. Health statistics for Aboriginal people**
- **g. Identification of significant health issues**
- **h. Recommended actions to address these issues**

33. Recommended actions could/should include:

- **a. Coordination of federal/provincial/local health services in communities**
- **b. Identification of a sharing of resources, including a budget allocation, to improve a specific health issue**
- **c. Identification and recognition of traditional medicine and practices**
- **d. A review of current services and facilities in order to identify potential opportunities to make services/facilities more culturally relevant and appropriate**
- e. **Opportunities for partnerships, and for Aboriginal delivered health services.**

Given that new health partnerships will be developed, locally-appropriate approaches need to be explored. In considering program and service options, pilots need to be developed with full community and health authority participation in order to build on local commitment or knowledge.

34. **Identify opportunities for "made in BC" pilots which are developed in the region as alternatives to primary health care (and other kinds of health care) to Aboriginal communities - e.g. community health centers, travelling clinics.**

The AGWG identified a need for health services staff who are familiar with the cultural needs of consumers and who can communicate medical concepts without depending on medical jargon. Such staff would link Community Health Representatives, hospitals, medical specialists, patients and their families.

There is a need for such links in a broader manner at the health authority or regional level. Aboriginal governors identify the potential for regional liaison/development workers to provide links, identify community needs, further develop community capacity and contribute to the necessary ongoing dialogue that should take place between health authority and Aboriginal communities.

Generally, there is a need to reflect community diversity in health authority staff profiles, with attention to under represented populations. Aboriginal governors believe that, like other publicly-funded bodies, health authorities should strive to improve employment equity among their own staff. Aboriginal staff can both support and inform Aboriginal health initiatives and ensure a better understanding of community issues. Aboriginal staff can also link communities and health authority staff in the same way that Aboriginal governors can link communities and health authorities.

35. **Employment equity should be a priority among health authorities. All health authorities should employ Aboriginal liaison/development workers. At a facility level, such workers would assist hospitals health centers with intake, interpretation, and discharge planning. On a health authority or regional level, such workers would provide a local strategic link between health authorities and Aboriginal communities.**

The need to avoid medical/technical jargon was raised with regard to health plans. Given the diversity of stakeholders, and the need to reference health authority health plans, Aboriginal governors believed that a common understanding of language and terms would make any plan more accessible to Aboriginal communities; accessibility is essential to a sense of ownership and commitment and trust.

36. Health plans should use common language, should include definitions, and should provide a context for statistics to ensure further stereotyping does not occur.

III. EDUCATION, INFORMATION AND TRAINING

GOAL G: Address information gaps and needs to ensure that all governors have the same information in order to make informed decisions.

Aboriginal governors have consistently identified lack of information or inadequate information as a hindrance to addressing Aboriginal health. Frequently, health authorities or their staff make erroneous assumptions regarding what provincially-funded services should be provided to reserve communities. As well, many Aboriginal people remain unclear as to which services they may access.

37. To address jurisdictional confusion, the Ministry must develop clear policy statements with respect to providing services to First Nations on reserve. Such development must include First Nations involvement.

Aboriginal governors are very aware of the detrimental effect that incomplete information has when addressing complex community issues. Believing that fully informed partners make practical and fair decisions, the AGWG recommends that a single collation of Aboriginal health information should be available to health authorities, all areas of the Ministry of Health, First Nations, Aboriginal organizations and other health stakeholders.

38. The Ministry and health authorities need to collect accurate information regarding:

- **a. Federally funded services, on and off reserve**
- **b. Identification of which First Nations are involved in the health transfer process and what stage, what services will be provided**
- **c. Clarity on the role of the Ministry and of the Aboriginal Health Division funding**
- **d. Clarity on the responsibilities of health authorities with respect to services, particularly on reserve**
- **e. Description of non-insured health benefits covered by the Medical Services Branch, Health Canada**
- f. **Others, as identified in the regions**

In addition, Aboriginal governors believed that most materials regarding programs and services do not reach Aboriginal communities; where they are circulated, timeliness, relevancy and understandability are issues. Beyond recognizing a responsibility to provide services, health authorities need to inform all communities about what services are provided and what input processes are available.

39. **Health authorities need to provide very clearly what services they are responsible for, how decisions have been made in the past, what mechanisms there are in place to address health funding issues; this needs to be more**

transparent.

Aboriginal governors and many non-Aboriginal stakeholders believe that a handbook providing historical perspective and current realities would broaden the understanding of Aboriginal health, as well as serve as the basis for further non-Aboriginal governor training. The usefulness of any handbook would be extended if geographically-specific information regarding local First Nations and communities were included for distinct areas of the province.

Complimentary to such a handbook, a resource directory that cross-references Aboriginal communities, organizations, Ministry of Health, health authorities and service providers would enable all parties to make appropriate consultations with other stakeholders.

In both cases, such resources should be updated to ensure their accuracy and usability. Such resources would be a logical foundation in the development of modules for use in Aboriginal health training for governors and Aboriginal communities.

40. Develop an Aboriginal Health Handbook that provides accurate information about history, policies, politics, and health services.

41. Develop a Resource Directory that identifies Aboriginal and non-Aboriginal health service providers.

The economic, educational and social conditions for Aboriginal people are important factors in how well the role and services of health authorities are, or are not, understood. The AGWG members understand the importance of community outreach for health authorities; they also know that it is only effective if it is understandable to the community.

On a practical level, ensuring that the information reaches communities is a shared responsibility. Health authorities and Aboriginal governors need to distribute relevant information to communities, e.g. faxing health authority meeting summaries to local First Nations and Aboriginal organizations; Aboriginal communities need to identify how to distribute information within their own communities. There is also a need for all parties to openly inform and ask for information from other stakeholders.

42. Develop tools for information sharing such as pamphlets, videos, publications regarding rights to services, types of services available, and health promotion information for Aboriginal communities that is culturally relevant and appropriate.

Aboriginal stakeholders and health authorities have consistently identified the need for local health data that is accessible to all parties. Such data would provide for more accurate planning, service delivery and evaluation of health services.

43. Development of a utilization database that captures local, regional and provincial data, accessible to all health planners, that would ensure relevant and accurate information is utilized in the planning, service delivery and evaluation of health services. Ideally this database would identify information specific to First Nations, on reserve and off reserve, and non-status and Métis populations.

GOAL H: Relevant and accessible education and training opportunities for all governors.

The AGWG believes that race relations training would benefit all communities, inasmuch as it provides tools to avoid and/or address culturally inappropriate behaviours. A further approach to improving cross-cultural relations would be to institute cross-cultural mentorships for governors and senior staff.

44. Race Relations and cross cultural training should be mandatory for all governors.

The AGWG strongly feel that individual Aboriginal governors can play a role in building better relationships within health authorities. This can be achieved by developing personal understandings of the functions and needs of local programs and services. AGWG members also felt that additional training would improve their effectiveness as governors. The development of programs or courses in Aboriginal health governance, provided by Aboriginal institutions, may better prepare Aboriginal people to participate in health authorities.

45. All governors should have an opportunity to tour all the health authority facilities, meet with senior staff, and discuss what the services are that are provided, and what the issues are in providing these services.

46. All governors should be able to improve their knowledge by identifying education and training needs that would assist in their governance role.

The governors identified the need for information and health models for communities and individuals to build upon. While many stakeholders speak to the importance of prevention and education, pressing needs within acute care, union relations and other programs consume many agendas. Aboriginal health status requires action to manage both immediate needs and potential demands on health services. Commitment to any prevention initiative is largely based on the relevancy to, and comprehension by, the community.

47. **Relevant health information needs to be readily accessible to communities so that everyone can take personal responsibility for their health. This needs to provided in culturally relevant formats.**

Comprehensive orientations affect how well any governor will perform within the health authority; comprehensive orientations may be made up of a number of sessions in a number of venues. In an era that is increasingly recognizing the value of competency-based training, orientations should be acknowledged for their contribution to health authorities.

48. Orientation should be seen as education and training, and be validated.

Like other British Columbians, Aboriginal people recognize the value in what an individual contributes to their community in terms of both economics and social values. The life investment of people living and teaching those values, while not formally credentialed requires acknowledgement; local issues are more than academic exercises to community members. Traditionally, Aboriginal teachers share all that they can with their pupils, then suggest where the next learning step would be.

49. Recognize that Aboriginal people have considerable expertise with regard to Aboriginal issues. Information regarding history, health issues and impacts, political structures and population information is both relevant and necessary; and compensation should be provided for the individual time and efforts of community members who provide it.

50. **Recognize Aboriginal governors as professionals, and seek their recommendations for appropriate Aboriginal trainers and training.**

CONCLUSION

The ten members of the Aboriginal Governors Working Group (AGWG) drew on both their personal commitments to improving Aboriginal health and their own experiences as governors to provide the preceding recommendations. While focused on three general issues, the AGWG entered the process with an awareness that these constitute one component of a broader, holistic approach to health, rather than a whole strategy in themselves.

The recommendations are practical suggestions that support the Ministry and health authorities commitments to improved health services for Aboriginal citizens. Acting on these recommendations is a beginning; a foundations for more effective and responsive health services for all British Columbians. The AGWG had a responsibility to develop the recommendations; but it is the Ministry and health authorities that have the authority and responsibility to act. The Ministry can make the best use of the AGWG's efforts when it will:

Acknowledge
Formally acknowledge the discussion paper, recommendations and action plan.

Adopt and adapt
Adopt the recommendations. Where wording in recommendations can not be reconciled with Ministry terminology or processes, the Ministry must adapt the recommendation to ensure their spirit is fulfilled.

Affirm
Affirm to Aboriginal citizens, the Ministry's commitment to improving their health status. This affirmation should be clearly stated, and be circulated within the Ministry and Provincial agencies, among health authorities; and to other service providers. A wide distribution of the AGWG documents, with a firm endorsement from the Ministry of Health, would improve the understanding of both Aboriginal health issues and the Ministry's intent to address them.

Act
Health authorities and other agencies look to the Ministry of Health for leadership and direction in making gains in Aboriginal health a reality. Improvement in Aboriginal health begins with the involvement of Aboriginal people in those organizations primarily responsible for health services, the health authorities; the recommendations identify ways to foster effective involvement. Effective involvement depends on relationships and health services that are inclusive, responsive, respectful and culturally appropriate - attributes that every British Columbians hopes to find in their health services.

A common adage says that the true measure of a society is in how it works to improve the lives of its most disadvantaged members. Acting on these recommendations is an opportunity to improve that measure in the British Columbia, to the benefit of all citizens.

APPENDIX A
Aboriginal Governors' Working Group Recommendations
December 1999

I. REPRESENTATION

Goal A: Ensure adequate Aboriginal representation

Recommendations:

51. Establish policy requirements to ensure Aboriginal representation reflects the proportion of aboriginal population in the health authority areas.

52. Amend legislation to require that a minimum of two Aboriginal people be nominated and appointed to health authorities by the Minister for each authority.

53. Establish policy that requires Aboriginal representation on Community Health Services Societies.

54. Recognize and develop other mechanisms and processes for ensuring Aboriginal involvement in the decision-making and planning for health services in the region that would support and enhance the role of Aboriginal governors:
    i. Establish Aboriginal Advisory Committees to health board/councils that could make specific recommendations to Health Authorities, and could even look at the development of an Aboriginal component to health plans.
    j. Establish government-to-government relationships between health board/councils and First Nation Councils with formal protocols and a mandate for regular meeting(s) to discuss and address relevant health issues.
    k. Establish models for relationship building, consultation, participation, and decision-making that recognize the diversity of, and take into account the distinctiveness of, First Nations, Métis and urban Aboriginal communities.
    l. Organize and resource regular regional health forums for health authorities and Aboriginal communities to exchange information, and for the identification of common issues, and the development of methods to address these issues.
    m. Encourage health authorities to meet with Aboriginal communities in the communities themselves.
    n. Bi-annual health meetings between the Aboriginal community and the health authority board and staff.
    o. Allowing for an alternate to attend meetings in the event that a governor is not able to attend a particular meeting.
    p. Consider video taping and public distribution of minutes of meetings to Aboriginal communities and organizations, and rotate meetings through Aboriginal communities as well as other communities in the health region.

All protocols and processes must respecting the First Nations and Aboriginal community protocols regarding relationships and meetings.

55. Develop model(s) for a nomination process and procedures that are culturally appropriate and demonstrate support from the Aboriginal community.
    d. Boards and Councils have a responsibility for making the process work collectively and must involve the Aboriginal community in nomination and other board processes.
    e. Boards and Councils need to take the time to build relationships with Aboriginal communities – this will generate interest in Board/Council activities, including governance.
    f. Establish formal and informal relationships with Aboriginal health authorities and Aboriginal health organizations which could assist in the nomination and governance process.

56. Health authorities and Aboriginal communities must have the freedom to develop locally appropriate approaches to participation, consultation, nomination and alternative representation models that ensure an adequate voice and a partnership.

57. All models that encourage broader representation must ensure that the diversity of the Aboriginal community is respected, and include: First Nations (on and off reserve), Métis, Status and non-Status, and Inuit, and should recognize different political affiliations.

58. The Ministry must review the current appointment process to ensure that appointments are made in a timely fashion.

Goal B: Ensure accountability to the Aboriginal community.

Recommendations:

59. Health authorities must recognize that many Aboriginal governors are directly accountable to their communities – accountability is an expectation in First Nations communities when someone is representing their interests. Certain policies and expectations of health authorities may be culturally contradictory; it is important to develop an understanding of how an Aboriginal governor sees themselves in relation to their community, and this must be respected.

60. Recognition that all governors represent all citizens in the health region, requires that non-Aboriginal governors accept responsibility for addressing the needs of Aboriginal citizens. The entire board/council is accountable to the community as a whole; no one board/council member should be expected to take responsibility for a segment of the population; Aboriginal members views should be consulted and considered on all health issues.

61. Ensure, through policy and funding mechanisms, that Aboriginal communities are involved in the planning, delivery, and evaluation of appropriate health services.

62. Cooperate in raising the profile of health in Aboriginal communities through open health meetings, through regularly rotated meetings in Aboriginal communities, and at joint health meetings between Aboriginal community health board and staff, and health authority board and staff, respecting the protocols of the Aboriginal community(ies).

II. RETENTION OF ABORIGINAL GOVERNORS

Goal C: All Governors, Aboriginal and non-Aboriginal, need an appropriate orientation to be effective.

Recommendations:

63. A full orientation should take place within three months of being appointed to a board or council.

64. An appropriate orientation would inform new governors in a number of areas.
To better Inform and prepare all governors, include:

k. the roles, responsibilities and expectations of a governor
l. the programs and services that the HA is responsible for managing
m. how decisions are made regarding planning, services, and funding
n. presentations by programs, services, departments explaining what they do
o. 'snapshot' community profile of the health authority (region, boundaries, services, First Nations, population profiles, etc.)
p. historical health structures and dynamics
q. briefing book on significant health issues in the region, including aboriginal health issues, and their priority within the communities
r. available Aboriginal resources (resource directories, handbooks); community, political and service organizations; and information regarding the relationships between organizations and processes

As well, all governors would benefit from mandatory training in:

s. Aboriginal history, health issues and traditional practices
t. anti-racism and cross cultural awareness training.

65. Orientations should take place in conjunction with Aboriginal communities where possible; providing an introduction to community protocols.

66. Orientation needs to accommodate differences in individual learning styles.

67. Ongoing training opportunities need to be available to all governors, as do participation in regional and provincial boards, councils and advisory committees, as a learning opportunity and for professional development.

GOAL D: Health authorities need to provide the necessary resources, human and financial, to support Aboriginal involvement in the governance and planning process.

Recommendations:

68. Many Aboriginal people face significant economic disadvantages. While many Aboriginal governors are often working full time, they also have young or extended families. Participating in health governance should not create a hardship, and thus, financial resources/expenses should be covered for out of pocket expenses such as:
    e. Reimbursement for lost wages
    f. Child care
    g. Travel expenses including mileage or transportation, meals and accommodation if necessary
    h. Where it is appropriate, financial support for Aboriginal members to meet with Aboriginal organizations and communities.

69. All governors are responsible for the governance, planning and service delivery in the region. Aboriginal governors are not solely responsible for the relationship with the Aboriginal community – all members must take responsibility to educate themselves, be aware of and speak to issues, and encourage relationship building.

70. Provide human and office resources to support relationship building and consultation in the Aboriginal community. This would include staff time, access to office equipment (e.g. work space, file storage, photocopiers, fax machines, e-mail) and office supplies.

GOAL E: Provide meaningful support for Aboriginal governors within the health authority process to ensure isolation does not occur, and sharing of ideas is nurtured.

Recommendations:

71. Provide opportunities for mentorship for new members by Aboriginal and non-Aboriginal governors.

72. Health authorities should ensure there are informal opportunities for governors to network with each other, prior to or outside of meetings.

73. Bring potential new board/council members on early to observe the process and ask questions.

74. Support Aboriginal Governors Forums and/or Retreats by planning for and providing necessary support and resources to attend annually.

75. Support Aboriginal Governors in bringing forward Aboriginal health issues – make Aboriginal health a standing agenda item on the board/council meetings.

76. Establish a networking system and for Aboriginal governors provincially and regionally; ensure that health authorities are invited to participate.

77. Consider regional Aboriginal health forums that bring together Aboriginal governors and community members to discuss and make recommendations for improving Aboriginal health.

GOAL F: Require all health authorities to develop Aboriginal health plans, or at least have an Aboriginal component to their health plans.

Recommendations:

78. Aboriginal health planning must involve Aboriginal people throughout the process (goalsetting, planning, delivery and evaluation); and must allow for a more holistic approach to health that recognizes and respects both traditional and complimentary health practices.

79. Hire Aboriginal staff to support the relationship building between the Aboriginal community and health authorities and their staff, and to support the development of an Aboriginal health plan/component.

80. Commit to relevant discussions with Aboriginal communities that lead to actions that measurably improve Aboriginal health.

81. Identify and publicize best practices in Aboriginal health locally, regionally and provincially.

82. Aboriginal health plans/components should initially include:
    i. An Aboriginal community profile(First Nations, off reserve Aboriginal pop. Includes history of the region)
    j. An inventory of services
    k. a consultation plan with the Aboriginal community
    l. An identification of all Aboriginal service providers
    m. where an Aboriginal specific service does not exist, identification of the services that are accessible
    n. Health statistics for Aboriginal people
    o. Identification of significant health issues
    p. Recommended actions to address these issues

83. Recommended actions could/should include:
    f. Coordination of federal/provincial/local health services in communities
    g. Identification of a sharing of resources, including a budget allocation, to improve a specific health issue
    h. Identification and recognition of traditional medicine and practices
    i. A review of current services and facilities in order to identify potential opportunities to make services/facilities more culturally relevant and appropriate
    j. Opportunities for partnerships, and for Aboriginal delivered health services.

84. Identify opportunities for "made in BC" pilots which are developed in the region as alternatives to primary health care (and other kinds of health care) to Aboriginal communities - e.g. community health centers, travelling clinics.

85. Employment equity should be a priority among health authorities. All health authorities should employ Aboriginal liaison/development workers. At a facility level, such workers would assist hospitals health centers with intake, interpretation, and discharge planning. On a health authority or regional level, such workers would provide a local strategic link between health authorities and Aboriginal communities.

86. Health plans should use common language, should include definitions, and should provide a context for statistics to ensure further stereotyping does not occur.

III. EDUCATION, INFORMATION AND TRAINING

GOAL G: Address information gaps and needs to ensure that all governors have the same information in order to make informed decisions.

Recommendations:

87. To address jurisdictional confusion, the Ministry must develop clear policy statements with respect to providing services to First Nations on reserve. Such development must include First Nations involvement.

88. The Ministry, and health authorities need to collect accurate information regarding:
    g. Federally funded services, on and off reserve
    h. Identification of which First Nations are involved in the health transfer process and what stage, what services will be provided
    i. Clarity on the role of the Ministry and of the Aboriginal Health Division funding
    j. clarity on the responsibilities of health authorities with respect to services, particularly on reserve
    k. description of non-insured health benefits covered by the Medical Services Branch, Health Canada
    l. Others, as identified in the regions

89. Health authorities need to provide very clearly what services they are responsible for, how decisions have been made in the past, what mechanisms there are in place to address health funding issues; this needs to be more transparent.

90. Develop an Aboriginal Health Handbook that provides accurate information about history, policies, politics, and health services.

91. Develop a Resource Directory that identifies Aboriginal and non-Aboriginal health service providers.

92. Develop tools for information sharing such as pamphlets, videos, publications regarding rights to services, types of services available, and health promotion information for Aboriginal communities that is culturally relevant and appropriate.

93. Development of a utilization database that captures local, regional and provincial data, accessible to all health planners, that would ensure relevant and accurate information is utilized in the planning, service delivery and evaluation of health services. Ideally this database would identify information specific to First Nations, on reserve and off reserve, and non-status and Métis populations.

GOAL H: Relevant and accessible education and training opportunities for all governors.

Recommendations:

94. Race Relations and cross cultural training should be mandatory for all governors.

95. All governors should have an opportunity to tour all the health authority facilities, meet with senior staff, and discuss what the services are that are provided, and what the issues are in providing these services.

96. All governors should be able to improve their knowledge by identifying education and training needs that would assist in their governance role.

97. Relevant health information needs to be readily accessible to communities so that everyone can take personal responsibility for their health. This needs to provided in culturally relevant formats.

98. Orientation should be seen as education and training, and be validated.

99. Recognize that Aboriginal people have considerable expertise with regard to Aboriginal issues. Information regarding history, health issues and impacts, political structures and population information is both relevant and necessary; and compensation should be provided for the individual time and efforts of community members who provide it.

100. Recognize Aboriginal governors as professionals, and seek their recommendations for appropriate Aboriginal trainers and training.

APPENDIX B
RECOMMENDATIONS OF THE JULY 1998
ABORIGINAL GOVERNORS FORUM

ABORIGINAL REPRESENTATION ON REGIONAL HEALTH AUTHORITIES

RECOMMENDATIONS:

1. There is need for a strong orientation for board/council members, and a process for ensuring transmission of knowledge from out-going to incoming members.

2. Education of non-Aboriginal board/council members and service providers is an important need.

3. We need to define clearly whom we, as members, are accountable to.

4. We need to define what will ensure that we do not have high turnover of board/council members and the supports we need to sustain our commitment.

INFORMATION GAPS AND NEEDS

RECOMMENDATIONS:

1. We need a means to communicate best practice materials to our CHC/RHB members and a system for access to current information. Evidence-based education materials are unassailable and invaluable in substantiating problems and workable strategies. We have to be relentless in emphasizing the issues. We should never give up, including the time it is necessary to move on. We should mentor the incoming person for a year at least.

2. The AHABC convene not less than two meetings a year of Aboriginal members of CHC/RHB groups.

3. The AHABC consider sending a small team (2 or 3 members) to the regional areas to give support, education and so on when indicated.

4. A reference that contains names, addresses, phone, fax and e-mail for all Aboriginal agencies, organizations, etc., that deal with Aboriginal health matters be created. This is being considered an appendix for the handbook.

Recommendations of the July 1998 Aboriginal Governors Forum, continued

RELATIONSHIP BUILDING WITH ABORIGINAL PARTNERS

RECOMMENDATIONS:

1. Repeatedly, people here have suggested a working group responsible for on-going communication and specific tasks.

2. If we believe in what it is that needs to be done, we must convey our conviction and beliefs, and not give up. It is important that we continue to pioneer, rally people with us to accomplish what needs to be accomplished. We need to mentor people so our knowledge is passed on and the incoming people do not need to struggle as much as many of us to understand the situation. We have to work in collaboration with other people; we cannot do the work alone.

THE DEVELOPMENT OF AN ABORIGINAL HEALTH COMPONENT TO HEALTH PLANS

RECOMMENDATIONS:

1. It is clear that every region needs an Aboriginal health plan, one that fits the particular needs of its groups.

2. One member noted that an Aboriginal health plan has to be brought into by the people, endorsed by them, implemented by them, and not be co-opted by the RHB.

APPENDIX C
HEALTH AUTHORITY CHAIRS MEETING RECOMMENDATIONS
September 1998

ABORIGINAL REPRESENTATION ON REGIONAL HEALTH AUTHORITIES

- Need to provide training and orientation to Aboriginal representatives on Board and Council process, role and expectations.
- Need to provide culturally specific and relevant training to Boards and Councils on Aboriginal health issues – this training needs to include anti-racism and cross-cultural awareness training.
- Where the Aboriginal population is significant, the representation should be similar to their population of the region.
- Ministry should look at developing models for nominating Aboriginal representatives that are inclusive and involve the Aboriginal community.
- Need to emphasize that Boards and Councils have responsibility to educate and orientate themselves on Aboriginal issues; this is not solely the responsibility of Aboriginal representative.
- Boards and Councils are expected to be accountable to the community; individual members do not carry this responsibility solely for a segment of the population they belong to.
- Aboriginal Advisory Committees could address some issues of representation and involvement – these could be community advisory committees inclusive of other under-represented groups.
- Ministry needs to respond to appointments more quickly
- Recognize Aboriginal people are volunteers as well; they cannot represent Aboriginal interests alone.

INFORMATION GAPS AND NEEDS

- Ensure relevant material and statistics on Aboriginal people in BC is made available to RHAs.
- Cross-cultural awareness and anti-racism education.
- Information on services provided on reserve by the Federal government.
- Clarity on Ministry policy with respect to providing services on reserve.
- Need to understand Provincial/Federal/First Nations jurisdictions.
- Need to resource directory that identifies Aboriginal organizations, First Nation communities, and Aboriginal health service providers.
- Need local statistics on Aboriginal health.
- Would like some tools to assist in information sharing and gatherings.

Health Authority Chairs Meeting Recommendations, September 1998, continued

RELATIONSHIP BUILDING WITH ABORIGINAL PARTNERS

- Accountability for making the process work – the Boards and Councils have a responsibility to involve the Aboriginal community in health planning and to deliver appropriate services and programs.
- Boards and Councils need to take the time necessary to build relationships – go to the community, don't expect community to come to them.
- Explore potential for partnerships in delivery of services and shares services.
- Provide options within current facilities for traditional practices which would support relationship building.
- Need to look at the integration of services by coordinating federal, provincial and Aboriginal health service in order to identify gaps.
- Need to establish relationships with Aboriginal health authorities and Aboriginal health organizations.

THE DEVELOPMENT OF AN ABORIGINAL HEALTH COMPONENT TO HEALTH PLANS

- Need to integrate services
- Need to look at sharing resources to deliver shared services
- Need to look at traditional practices – options in facilities
- Need to develop an inventory of Aboriginal service providers, organizations, and band contracts in order to begin the process
- Go to the community to develop relationships first and involve the community in the development of the plan