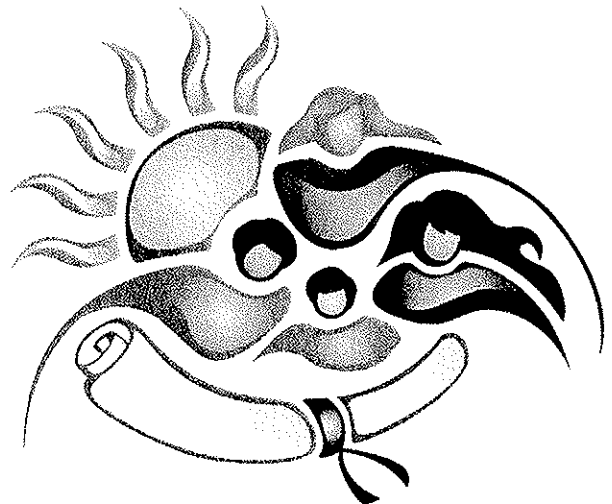

ABORIGINAL HEALTH HUMAN RESOURCES INITIATIVE
ROUND TABLE TWO

THE ALBERTA STRATEGY

Red Deer
September 22 & 23, 2008

Prepared by

Table of Contents

I. Context 1

II. In comes AHHRI … 2
(a) Strategic objectives 2
(b) Priorities 3

III. The Alberta AHHRI strategy 3

IV. The process 4

V. Round Table One 5

VI. Round Table Two 6

VI. Round Table Three 9

VII. A call to action 10

Appendices

A Round Table One Report
B Summary: Round Table One Report
C List of identified factors: Participation
D List of identified factors: Retention
E Tabulation: Factors impacting on participation
F Tabulation: Factors impacting on retention

I. Context

It is not racist to acknowledge that people, at their most vulnerable, prefer to be among their own – or at minimum work with people who understand the cultural barriers they face.

The introduction of Aboriginal people to Western medicine was awkward and the interaction between them and Western medical care givers continue to be uneasy.

Medical issues and care are by nature very personal, even intimate, and intersects with recipients' and patients' lives at the greatest point of vulnerability. To benefit from health care in any of its forms requires from the patient a high level of trust and in many instances even surrender. It calls for faith in the motives and abilities of caregivers and often demands that recipients suspend personal control over their lives and allow someone else to do things to and for them that materially affect their existence and lives.

Add to this the strong link that exists for Aboriginal people between medicine, healing, and spirituality; and the huge existing gap between that philosophy and the practice of 'science-based' Western medicine; and the reason for the challenges surrounding Aboriginal health care become glaringly obvious.

But, that is not the sum total of the challenges to Aboriginal health delivery.

There are also the societal attitudes that have been imprinted on us – with all the attendant stereotypes and preconceived notions that human beings carry with them on a two-way street.

Elderly Aboriginal people are especially affected – for not only are they more deeply rooted in tradition, but they also face a language barrier, let alone a terminology and conceptual chasm, when confronted by advanced medical equipment and treatments.

It has long been acknowledged that the Aboriginal community in general, for a multitude of reasons, experiences more health problems than the Canadian population as a whole.

In the absence of positive change, these challenges will be compounded given the changing demographics of Canadian society.

Against this backdrop it would seem self-evident that introducing more Aboriginal health care workers, while not offering a cure-all, would have considerable positive impact upon Aboriginal access to- and benefit from available health services.

II. In comes AHHRI ...

Aboriginal Health Human Resources Initiative (AHHRI) was formed with the vision and purpose of reducing health care inequities between Aboriginal people and other Canadians through locally administered health care services provided primarily by Aboriginal people, for Aboriginal people.

This initiative, spread across Canada with committees in each of the provinces, strives to meet its mandate through the committed participation of practicing Aboriginal health care workers who devote their time and energy to address the challenges of getting and retaining more Aboriginal health care workers into the system.

(a) Strategic objectives

The strategic objectives of AHHRI, specific to First Nations, are

(i) To increase the number of First Nations that are aware of health careers as viable career options for their members, focusing particularly on youth awareness.

(ii) To increase the number of First Nations students entering into- and succeeding in health career studies.

(iii) To increase the number of post secondary educational institutions which are supportive of- and conducive to First Nations students in health career studies (e.g. with culturally appropriate curricula; student support; programs, mentorship; and reduced barriers to admissions).

(iv) To identify the conditions that create supportive and conducive work environments that will increase the retention of First Nations health care workers and non-Aboriginal health care workers working in First Nations communities.

(v) To establish standards of practice and certification processes for First Nations community-based allied

health care workers, which will help to ensure a properly trained and mobile health work force, and help improve retention of community-based allied health care workers.

(vi) To establish the foundations for collaboration so that all partners accept the appropriate roles and responsibilities and are committed to act upon them.

(vii) To initiate the establishment of baseline information, initiate targeted research and analysis on the supply and demand for First Nations health care workers, and identify best practices and approaches in order to support policy, planning and program decisions.

(viii) To establish standards of practice and certification processes for First Nations community-based allied health care workers.
(Ensuring a properly trained and mobile health work force and helping improve retention of community-based allied health care workers, including the development of continuous learning opportunities to ensure health care providers keep pace with the changing health field.)

(b) Priorities

(i) Increase in health care providers
(Create awareness of health careers, increase the number of students in health careers and establish the necessary supports.)

(ii) Improve retention
(Lay the foundation for the development of retention strategies.)

(iii) Provide Supportive Elements
(Increase Aboriginal capacity to meaningfully participate in the implementation of AHHRI.)

III. The Alberta AHHRI strategy

The AHHRI Executive in Alberta took on the challenge in earnest by initiating a series of Round Table discussions aimed at developing a strategic approach backed by focused action plans.

A cornerstone element of the approach was the decision to build the strategy from the ground up. The 'builders' have to be from the communities – both recipients and providers.

Early on the decision was made not to take anything for granted; not to assume that the problems were as everybody 'knew' them to be; but to ask recipients and providers to zero in not only on the problems, but to go well beyond in pursuit of the root causes. For it is only when we fix what ails the roots that we can hope to heal the plant.

IV. The process

It was recognized that any strategies and action plans aimed at resolving wide-spread and deep-rooted problems would have to be guided, focused, and yet flexible. Human concerns cannot be addressed by the application of fixed mechanical formulae.

Health services are, ultimately, delivered to individuals. Where better to start then than by asking those individuals to identify problems, trace the root causes of those problems, and offer their solutions to correct them?

Although the process must remain flexible, plans were made for three Round Table discussions.

Round Table #1 would gather a variety of community members and health delivery staff and endeavour, over the course of two days in January 2008, to collect their thoughts on issues, barriers, and potential solutions to the challenges facing First Nations in their aim to have health care delivered by First Nations members.

Round Table #2 would involve, by and large, the original participants plus any other representative groups identified at Round Table #1 as essential contributors to the process (such as Elders and youth). The purpose of the second Round Table would be to revisit and reaffirm the challenges and root causes identified – after the lapse of time and the opportunity for contemplation.

Given the very long list of issues and causes identified, the second Round Table would

i. attempt to assess the level of impact attached to each challenge in order to formulate a set of priorities

– since 'fixing' everything at once is clearly not a realistic proposition;

ii. develop action plans;

iii. look at long-term strategies; and

iv. identify partners and stakeholders to be involved in the process and invite them to the third Round Table.

Round Table #3 would provide an opportunity to engage stakeholders and potential partners in developing individual and collective action plans and entering into commitments for results.

Ideally, AHHRI would like to coordinate an ongoing process with stakeholders involving regular measurement of progress and results and periodic adjustment of plans as required.

The importance of collaboration on terms that are acceptable to the Aboriginal community cannot be over-emphasized.

V. Round Table One

Round Table One, held in Edmonton on January 22 and 23, 2008, produced what, to some, may have appeared an overwhelming list of challenges to the ideal of recruiting and retaining Aboriginal health care workers.

In a number of breakaway sessions the participants, representing health care practitioners and elected representatives, undertook an exhaustive examination of the factors hampering Aboriginal access to- and retention within the health services delivery field. The main factors identified included:

BARRIERS TO ACCESS/PARTICIPATION	BARRIERS TO RETENTION
Inadequate promotion of health careers & a lack of role models.	*Lack of human resources across the board.*
A school system that fails First Nations students & does not prepare them adequately, especially in mathematics & science.	*Lack of support mechanisms.*
Lack of parental involvement & encouragement, compounded by lack of support from community leaders.	*The challenge of blending western & traditional views – and the need for support for First Nation health care workers.*
Cultural norms are not adequately incorporated	*Problems surrounding salary parity – First Nations*

– contributing to lack of identity, self-esteem, and confidence.	*cannot compete with other health delivery agencies and the government.*
Socio-economic barriers, social dependency, and negative lifestyles.	*Lack of housing & amenities in remote areas, & the quality of education available to the children of First Nation professional health care workers.*
Lack of awareness of the benefits that the holistic approach of First Nations professionals can provide.	*The critical local scrutiny given by communities to First Nation workers – the 'crab syndrome'.*
Shortage of resources – funding & child care services.	*Administrative barriers – such as the absence of collaboration with other departments, or even within departments.*
The challenges faced by First Nations students who have to leave their communities for education and training.	

Participants also spent considerable time identifying opportunities to promote and facilitate increased access to the workforce as well as supportive steps that could be taken to improve the success rate for retaining Aboriginal workers in the health field.

Full details of Round Table One findings are available in ***Appendix A***.
Appendix B provides a summary of the salient points in PowerPoint format.

It became evident throughout the group discussions that AHHRI's best hope for success lies in capitalizing on the lessons learnt elsewhere and connecting with other sources where people have found answers. Marshalling all available resources through partnerships and collaborative action would offer the best opportunity to improve the situation.

VI. Round Table Two

Round Table Two, held in Red Deer on September 22 and 23, 2008, set out to achieve three objectives:

i. Verify challenges and rate them according to impact.
ii. Select a number of achievable short-term goals.
iii. Set long-term strategies.

As it happened the enormity and sheer scope of the challenges, once again, hit home. Most important, though, was the renewed

recognition that AHHRI cannot bring about change through direct action itself.

Once the need to address root causes was acknowledged and accepted it became abundantly clear that *the scope of the challenge extended far beyond involving Aboriginal health staff or health delivery concerns in general, and called for cooperative planning and action by a range of governments, departments, industries, and programs* in Alberta and across Canada.

Round Table Two confirmed the list of challenges and root causes and set about rating those on the basis of their impact on access to- and retention of Aboriginal workers in the health delivery workforce.

In a series of breakaway sessions participants were asked to *collectively analyze* the impact of identified factors, *but individually rate* them in terms of the severity of their influence on access and retention efforts. The AHHRI Executive wanted to secure the benefits of group/team discussion, and yet avoid group thinking when it came to the final determination of the importance of specific root causes. The goal was to keep participants as fully engaged as possible.

The *process* called for every individual participant to identify the top five contributory factors and rate them in order of the severity of their impact.

The *method* involved presenting participants with a list of all the major factors identified at Round Table #1 as barriers to access. Each group was provided with two posters (***Appendices C** and **D***) displaying the identified factors in random order. Every participant was given a selection of colored stickers[1] and invited to identify the most critical factors, in order of decreasing importance, by attaching the stickers next to the listed factors. As there were more options than stickers, participants were not forced to rate the same five factors.

A numerical analysis of participant choices (for each breakaway group and for Round Table participants in total) produced the following results:

[1] The color green represented 1st choice (most critical); orange = 2nd; red = 3rd; blue = 4th; yellow = 5th.

(a) Factors impacting on participation – rated for severity of impact (1 being the highest impact):

1. Lack of parental involvement & lack of support from community leaders.
2. Schools failing First Nations students – inadequate math and science resources and support.
3. Socio-economic barriers; social dependency; negative lifestyles.
4. Failure to incorporate cultural norms; lack of identity, self-esteem & confidence.
5. Funding (subsistence support & education allowances).
6. Inadequate promotion & lack of role models.
7. Lack of child care.
8. Leaving the community.

(b) Factors impacting on retention – rated for severity of impact (1 being the highest impact):

1. Lack of support mechanisms for existing health care workers.
2. Absence of salary parity with health care workers outside communities.
3. Administrative barriers – lack of collaboration.
4. Lack of adequate housing, amenities, & education for health care workers in communities.
5. Failure to blend traditional & western views.
6. Local scrutiny – community members tend to be quite critical of their own.
7. Pursuit of personal agendas by health care workers.

Copies of the tabulation sheets are attached as ***Appendices E*** and ***F***.

Although the choices exercised by participants at first glance appeared to vary considerably, the results revealed a broad underlying consensus about which factors have the most severe impact.

Reaffirmation of the causes and the grassroots prioritizing of impacting factors provided the Executive with valuable information and validation of its strategic initiative.

Despite a persistent, valiant effort by participants and breakaway group facilitators, part 2 of the agenda – calling for the development of action items – came apart at the seams as it dawned on participants that the scope and breadth of the challenges inherent in AHHRI's mandate extended far beyond its capacity to effect change by itself.

It had been hoped and planned for that Round Table Two would produce a clear list of action steps for AHHRI. It soon became evident, though, that AHHRI could not introduce changes without the cooperation and commitment of delivery agents with program responsibilities. In fact, communities face a set of challenges so interlinked that no one agency or program can fix it alone.

AHHRI does not have the resources to provide sustainable program funding, but it can be the catalyst. The most appropriate role for AHHRI would be interaction with- and coordination between the partners, programs, and jurisdictions that hold the tools to address parts of the challenge.

The steps AHHRI can take on its own – such as raising awareness and influencing decision makers – are, by definition, limited to addressing symptoms and not root causes. While necessary, and by no means without value, the benefit of such efforts nevertheless would be superficial compared to the requirement and obligation, for governments (federal, provincial, and Aboriginal) and their delivery agencies to, once and for all, address systemic and root causes. Anything less would be activity for activity's sake and, at best, window dressing.

AHHRI strategy, therefore, must hinge upon playing a central coordinating and persuasive role – acting as catalyst to get all stakeholder governments, departments, and organizations involved in addressing the root causes.

VI. Round Table Three

In many ways, Round Table Three would be the 'make or break' event.

AHHRI will identify all significant stakeholders and potential partners, each of whom will be invited to have senior representation at Round Table Three.