

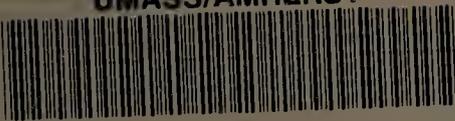


University of  
Massachusetts  
Amherst

**Collaborative community research and change  
in an aboriginal health system : a case study of  
participatory education and inquiry for introducing  
system change in a First Nation in northern Canada.**

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COLLABORATIVE COMMUNITY RESEARCH AND CHANGE  
IN AN ABORIGINAL HEALTH SYSTEM:  
A CASE STUDY OF PARTICIPATORY EDUCATION AND INQUIRY  
FOR INTRODUCING SYSTEM CHANGE IN A FIRST NATION  
IN NORTHERN CANADA

A Dissertation Presented

by

DONALD HUGH CASTLEDEN

Submitted to the Graduate School of the  
University of Massachusetts in partial fulfillment  
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1992

School of Education

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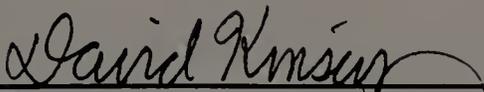
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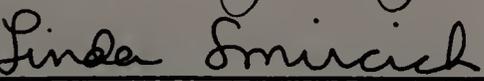
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## **DEDICATION**

I would like to dedicate this dissertation to the members of the Split Lake Health Task Force who worked with me on this inquiry. For reasons of confidentiality, they have not been individually identified but their participation, as reflected in their story, indicates their dedication to improving their community's health system and their contribution to this study. This work is very much a shared endeavour.

## ACKNOWLEDGEMENTS

I am indebted to many for their contribution to my learning and development in this research journey. Most immediately are the members of the Health Task Force in Split Lake who joined with me in this inquiry. I appreciate their willingness to take the risk of working with me in this endeavour. They have helped my learning. I hope I have helped them in their study of their health system.

I owe a special thanks to David Kinsey, who stepped in and became my Advisor after Horace Reed, my initial Advisor, died in the summer of 1989. David has given me the guidance I needed. Never more than I wanted but always enough to help me focus and integrate my effort. I have really appreciated his insights, observations and above all his commitment to my own development process and the collaborative research process in which I have been engaged. Although he was never able to meet personally with the members of the Health Task Force, he responded to their work as if he was personally there and supported me in the work I was attempting to do.

I especially want to recognize Horace Reed who welcomed me to the University of Massachusetts in 1985. He turned his home over to my two daughters and me for part of that first summer and became a friend and colleague during my year in Amherst. I shared with many a sadness when Horace died in July, 1989. Those of us involved in community change and development lost a friend.

I want to thank Linda Smircich and Bailey Jackson. Linda provided me with the intellectual high point of my year at Amherst. Her seminars on Research Methods and Advanced Organization Theory were demanding and stimulating and opened up the

philosophy of research to me. Bailey provided me an opportunity to both explore the multiple issues in oppression and integrate these issues into a greater understanding of how oppression manifests itself in the areas in which I work. He helped me understand the process that turns learning about oppression into action, moving from awareness to resistance.

When I think about how I got to where I am, I need to reflect back a long way. My parents somehow influenced how I got started. My first work in development owes much to the people of Moose Lake and Philip Umperville in particular, who allowed me to learn as I discovered what community development was all about in their community. My colleagues in a remarkable community development organization who challenged, helped and struggled to make a difference were also central to my learning. Farrel Toombs and Ed Moe were instrumental in helping me learn about my work and my self. My colleague for the last twenty years, Angus MacIntyre has been a major influence on my work and learning.

I want to thank those who have helped me put this dissertation together, typing transcripts, drafts and copy. They are my daughter, Jennifer and Elizabeth Bartlett, Michelle Benoit, Janice Kostelnyk and Kris Dubois. I am also indebted to Jim Wastasecoot who helped me design figures and scanned the necessary maps and documents, Bob Kayes and Angus MacIntyre who read my transcript and Rainey Jonasson who helped me understand traditional Aboriginal ways of inquiry.

There are other friends and colleagues at work who have lent their support and encouragement, offering assistance when I needed someone to do something extra for me at the office.

The most important help has come from my family. Jaye, my life long friend, confidant and spouse, encouraged me, supported me, made never ending allowances for the time I needed to devote to this work and also typed and critiqued sections of my work when I needed an extra hand. Jennifer and Heather, my two daughters, were there for me as well, accepting the disruption to their lives that occurred when the whole family accompanied me to Amherst in the fall of 1986, and helping with the typing and transcribing whenever they were home from their own busy schedules and when I needed that extra assistance. Most important has been their love which makes all the rest possible.

## ABSTRACT

COLLABORATIVE COMMUNITY RESEARCH AND CHANGE  
IN AN ABORIGINAL HEALTH SYSTEM:  
A CASE STUDY OF PARTICIPATORY EDUCATION AND INQUIRY  
FOR INTRODUCING SYSTEM CHANGE IN A FIRST NATION  
IN NORTHERN CANADA

MAY 1992

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This study describes and analyses a collaborative research process used to initiate inquiry and change in a health system in a First Nation, Aboriginal community in Canada. As background, the author reviews issues in transferring government health programs to local control, describes traditional and government health systems in the Split Lake Cree First Nation community and grounds the rationale for the research approach in the traditions of action research and participatory research.

The case presentation covers the first year and a half of participatory education and collaborative research activities. Initially it deals with the formation and development of a community research group, with the author serving as co-operating external researcher and training resource. This represents the first instance in Canada of an Aboriginal group doing its own study in preparation for taking over and transforming its health system

rather than employing an external consultant to do the study. Specific activities include the preparation of a proposal for funding a study to help with the transfer and the initial design and field work on a study of traditional health practices and resources in the community.

The account is based on audio recordings and transcriptions of fourteen meetings, each two to three days in length. In the meetings, the efforts, constraints, interactions, training and skill development of the research group as well as its analysis of systems and reflections on its own process are documented. The author intersperses his own observations in italics.

In conclusion, the author reflects on issues arising out of this innovative experiment and on insights it offers for specific problems in collaborative research. Finally, there are recommendations for the use of such an approach as a means for community empowerment and control over change in local health systems.

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## GLOSSARY

<b>Aboriginal</b>	Refers to the descendants of the original inhabitants of Canada. This is the preferred term used by Aboriginal people themselves.
<b>Band</b>	Term used by the Government of Canada to refer to local Aboriginal governments.
<b>Cree</b>	Classification employed by anthropologists to denote Aboriginal people who belong to the particular language group involved in this inquiry.
<b>Elder</b>	Respected spiritual leader, usually middle aged or older.
<b>First Nation</b>	Term used by Aboriginal people to refer to local Aboriginal governments.
<b>Indian</b>	Term used by non-Aboriginal Canadians to refer to Aboriginal people.
<b>Ininiwuk</b>	Name used by the Aboriginal people involved in this study in referring to themselves in their own language. In English, it means 'the people'.
<b>Medicine Man or Woman</b>	One who practices Aboriginal healing.
<b>Native</b>	Term used by non Aboriginal Canadians to refer to Aboriginal people.
<b>Reserves</b>	Land set aside for the sole use of Aboriginal First Nations.
<b>Shaman</b>	One who practices Aboriginal healing.
<b>Traditional Healer</b>	One who practices Aboriginal healing.
<b>Tribal Council</b>	A regional Aboriginal administrative organization formed by a number of First Nations.

## CHAPTER I

### INTRODUCTION

This dissertation is a case study of my experience as an external researcher working with a community research group in their study of the community's health system in anticipation of taking control of a government health service. The dissertation covers the initial phase of the collaborative research process. It examines the formation, development and work of the community research group together with my intervention as the external researcher. The setting is an Aboriginal community in northern Canada. I am of Euro-Canadian background. The inquiry is therefore a cross cultural experience for myself and the community research group.

#### Historical Context and Problem of Study

And with a view to show the satisfaction of Her Majesty [Queen Victoria] with the behaviour and good conduct of Her Indians, She hereby, through Her Commissioners, makes them a present of five dollars for each man, woman and child belonging to the bands here represented, in extinguishment of all claims [to the country] heretofore preferred. [Treaty No. 5, 1875]

Aboriginal people have inhabited the region now known as Canada since time immemorial. Their occupation of these lands was altered irrevocably some three hundred years ago with the arrival of the first European settlers on the east coast of what is now Canada and in the north by a mercantile trading company, The Hudson's Bay Company. The Hudson's Bay Company, operating under a Royal Charter issued by King Charles II

of England, obtained trading rights and administrative control from the British Crown over the vast region encompassed by the drainage basin of Hudson Bay. This region extended from Ungava in the east to the Rocky Mountains in the west and as far south as Minnesota. Early in its history, the Hudson's Bay Company established trading posts at the mouth of a number of major rivers flowing into the Bay and began a flourishing trade in fur with the Aboriginal inhabitants of the land. The trade continued well into this century. It relied on an extensive Aboriginal trade network for exchanging European manufactured goods for the valuable fur of the area. Aboriginal people turned their energy to harvesting and transporting the fur to the trading posts ringing the shores of the Bay. This trade pattern continued into the early eighteenth century at which point it shifted inland to strategically located trading posts established by the Company to head off competition coming from independent fur traders operating out of Montreal. The control over the region exercised by the "Hudson's Bay" represented European political and economic power in the region until 1870 at which time the Company surrendered its jurisdiction to the newly formed Dominion of Canada.

Britain, which emerged as the dominant colonial power in North America in the eighteenth century, succeeded in taking possession of New France in 1763. It proceeded to extend its authority over the settled regions of eastern Canada shortly after by issuing a Royal Proclamation in 1763. Under the terms of the Proclamation, colonial authorities in Canada were required to enter into formal agreements with local Aboriginal groups before territory could be acquired for settlement. Treaties between the Crown and the Aboriginal people became the vehicle for legitimizing these acquisitions. The first treaty had been negotiated a decade earlier between Britain and the Aboriginal people on the east coast. Following the Royal Proclamation, treaties signalled the westward and northward extension of European and later, Canadian authority. Many of the treaties in western Canada were signed in the period between 1870 and 1911 with the last treaty

being signed in 1921 between the Crown and the Dene Nation in the Northwest Territories. The treaty process established land reserves for the sole use of the Aboriginal people. Each treaty, besides providing for a grant of five dollars per person, granted Aboriginal people the right to a school on the reserve, a ban on alcoholic beverages, the right to hunt and fish on unencumbered lands and farming, fishing or hunting implements or equipment as might be required in the locale. In exchange, the Aboriginal people were to:

Transfer, surrender, and relinquish to His Majesty the King, His heirs and successors, to and for the use of the Government of the Dominion of Canada, all our right, title and interest whatsoever which we and the said Bands which we represent hold and enjoy, or have held and enjoyed, of, in and to the territory. [Adhesion to Treaty 5 by Split Lake and Nelson House, 1908]

In 1876, the Parliament of Canada furthered the process of extending its authority over the Aboriginal peoples by enacting the Indian Act which has governed relations between the Government of Canada and Aboriginal people to the present day. The Act made the Aboriginal people wards of the state, decreeing how they would govern themselves. It established the extent of their law making authority within Canada and ruled that the authority they did continue to have was subject to the approval and sanction of the Minister responsible for Indian Affairs. Under the Act, all reserve lands were to be held in trust by the Minister; formal elections for Chief and Council were to be held under the authority of the Minister; and all Council Resolutions passed by local Aboriginal Councils were to be subject to Ministerial approval. The Indian Act replaced the traditional form of leadership and governance within the Aboriginal communities, which had been located in the family, clan or totemic system [Johnson, 1976; Miller, 1955]. Where Aboriginal cultural practices were perceived as anathema to European

values, as in the Potlatch on the west coast or the Sun Dance on the prairies, they were made illegal. Aboriginal ceremonial and spiritual symbols were confiscated and destroyed. The Indian Act thus imposed political, economic, social, religious and cultural control over the affairs of the Aboriginal people.

By the 1960's, the federal department responsible for Indian affairs had become a large bureaucracy with regional offices in most provinces coordinating local district offices. The district offices oversaw the administration of community affairs including education, health and social assistance. The Department maintained formal membership lists for each Aboriginal community, designated as an Indian Band by the government, oversaw the election of each Chief and Council and approved or disallowed Band Council Resolutions passed by the Councils.

In 1969, the federal government attempted to eliminate the Aboriginal people as a political entity and power. They did this by issuing a 'white paper' outlining a policy designed to divest the federal government of responsibility for Aboriginal people by assimilating them into the 'mainstream' of Canadian society. Strong and vocal opposition by Aboriginal leaders saw this policy shelved but the intentions implied in the policy have served to keep Aboriginal leaders vigilant and cautious of subsequent initiatives to transfer federal government responsibility to other jurisdictions. The attempt to introduce the 1969 white paper served as a catalyst for increasing political awareness in the Aboriginal community and each new proposal by the federal government to change existing relations is now examined carefully as the spectre of assimilation haunts negotiations.

Aboriginal people in Canada are emerging from the oppression they have experienced for the past two to three hundred years by actively asserting their right to self determination and their right to govern themselves. They have established their own regional, provincial and national political and administrative organizations and have turned to both the courts and the political arena in the pursuit of their right to remain a self-governing people.

The demand for change and self determination has led to significant changes in relations between the federal government and Aboriginal communities, now referred to as First Nations. Constitutional talks have been held between First Nation leaders, Provincial Premiers and the Prime Minister of Canada and although these talks have not as yet produced a resolution of the right of First Nations to self determination and authority to govern nor established a formal protocol to govern relations between First Nations and the Government of Canada, they have put the issue on the national agenda.

First Nations are assuming control over many of the programs and services previously administered by the federal government. The first programs transferred from the government to First Nations were welfare, housing and local government services. Education followed and in 1988, the federal government instituted a policy which allows for the transfer of health programs and services currently administered by the Medical Services Branch of the federal Department of Health and Welfare to First Nations.

### **The Problem**

The transfer of health programs and services from Medical Services Branch is now being considered by the Split Lake Cree First Nation. This transfer raises a number of issues. The existing government health system, for instance, is almost entirely based on a

'western' concept of health. This model emphasises treatment and relies on western trained medical personnel and western models of service delivery. The personnel trained to work within this system have been educated in Euro-Canadian institutions to which Aboriginal people have only recently gained access. The government health system functions almost entirely as a separate system in Aboriginal communities, with the administration and health service directed from regional administrative centres across Canada. In the existing government run system, there is very little understanding of or contact with traditional health practices and the holistic view of health reflected in the practice of traditional Aboriginal healers in the communities.

In order to transfer health services, Medical Services Branch has established a policy which provides funding for a study of local health services prior to a decision by a First Nation to proceed with negotiations to transfer the programs and services to local control. This policy provides for the hiring of a consultant to prepare the study for the First Nation.

Employment of consultants to prepare transfer studies takes away from the community the opportunity to become fully involved in the study process as the consultant's report tends to be prepared in isolation from the community. There is usually minimum input from the community which leaves the community ill prepared for managing the implementation phase of health transfer.

In the case of the Split Lake Cree First Nation health services transfer, I proposed that a community research group conduct its own study. This involved a community research group developing a proposal to study health issues in the community, exploring the integration of traditional and western health practices, preparing a funding proposal to enable the group to study the issue of transfer and preparing a health development

plan. The goal was to develop the capacity within the community to manage and direct the health transfer process while reducing long term dependency on external technical resources.

### **Purpose and Rationale**

The purpose of this dissertation is to describe, analyse and assess the collaborative research process that developed between myself as the external researcher and the community research group in a study of the community's health system prior to changes being introduced in the system by the community. The dissertation documents both the community research process and the collaborative relationship between the external researcher and the community research group. The dissertation focuses on the early phases of the research process, including the period in which I as the external researcher attempt to determine what constitutes research in this experience, manage the uncertainty of not knowing the sequence of tasks to be followed in the research process and respond to the community research group as they begin the study of their health system.

There is very little in the literature on how an external researcher is to work with local researchers in applied research. Much of the literature on participatory research is philosophical in nature and ignores the role of the external researcher. The literature on action research is somewhat more developed in this regard with some writers exploring the clinical role of the consultant or researcher who is seen as a helper assisting organizations to change. This dissertation describes on the role of the external researcher. It also documents the community research process experienced by the community researchers. The literature relating to the research methodology is examined in greater depth in Chapter IV.

This collaborative research process is designed to involve a community research group in the conduct of an inquiry. The process involves shifting the onus for the inquiry from the external researcher, who might normally conduct the inquiry, to the community research group who are expected to take responsibility for the study. This process requires a commitment by members of the community research group to learn the skills necessary for doing the research. It also requires a commitment to carry out the work required for the study.

The research also provides an opportunity to investigate the role of the external researcher in collaborating in the inquiry process. To accomplish this, a critical subjectivity [Reason, 1988] is required by the external researcher in reflecting on his or her role. The nature of the collaboration between external researcher and community researchers is such that the community researchers also need to reflect on their work, their relationship with each other, their relationship with the external researcher and on the role of the external researcher.

### **Methods and Framework**

This case study extends over a period of a year and a half, beginning in October, 1989 and ending in July, 1991. It begins with the initiation of the inquiry and terminates with the completion of a Pre-Transfer Funding Proposal which was forwarded to the federal government for funding a Pre-Transfer Study. Fourteen meetings were held in Split Lake over the period in question. Each meeting was of two to three days duration. The meetings were recorded on audio tapes. The tapes were then transcribed and condensed into a narrative which recounts the experience. As I reviewed the data, I noted issues and topics which I later sorted and classified in order to identify issues that arose during the meetings. I also maintained a journal in which I kept a record of my thoughts,

feelings and reactions during the period of the study. This data was supplemented by interviews to obtain information on the government health system. Interviews conducted by members of the community research group provided information on the traditional health system. The attempt has been to achieve what Geertz would describe as a thick description of events which is descriptive and systemic [Reason, 1988].

In assuming the role of an external researcher, I have provided direction and training for members of the community research group. I have also provided encouragement and support to the community researchers as they have engaged in their inquiry.

I have proceeded on the basis of a number of assumptions. The first is that full participation of a community research group in the research process is essential if the values and beliefs of the community are to guide and direct the change effort. This is a fundamental requirement in any change process and even more so in a cross cultural context such as this where I, as the external researcher, am from a different culture than that of the community research group. I have also assumed that those seeking change, in this case change in the health system and the transfer of health services to community control, are confronting their own problem. If change is to occur, those responsible for introducing change will have to act to bring about the desired change. They will have to live with the result of their actions.

I have not conducted a health transfer study for the Split Lake Cree First Nation. Nor have I provided a set agenda with a preconceived set of tasks which were assigned the community research group. Rather, I have attempted to provide a framework for the community inquiry which I hope has helped the community research group focus on the task at hand.

In providing this framework, I have generally proposed a task or asked the community research group what they see as the task. This has been followed by the community research group working on the task. My interventions included proposing a procedure for the task, providing an outline of the research tasks that had to be performed, joining in tasks with the group and facilitating the interaction within the group.

A number of terms related to this study need to be clarified.

The current term used by indigenous people in Canada to refer to themselves is Aboriginal. The members of the community research group in this study and their community refer to themselves in their own language as Ininiwuk. In English, they use the term Cree, a designation given to the Aboriginal people in this region by anthropologists. The Ininiwuk are a sub group of the Algonkian language group.

Aboriginal people use the term First Nation when referring to their communities. The Government of Canada refers to these communities as Indian Bands.

## Organization

The introduction to this dissertation is followed by chapters which describe the education and research issues in the inquiry, the setting for the case study, the research methodology and the narrative of the case study. These are followed by concluding chapters which provide a recapitulation and reflection on the case and note the implications and recommendations for further study.

Chapter II examines the educational, research and implementing issues involved in developing a collaborative community study of a community health system with a

community research group in preparation for transferring a government health service to local control.

Chapter III examines the organization of the existing health system in the Split Lake Cree First Nation. This includes a description of both the traditional Aboriginal health system and the government run health system. The context as well as the policy for transferring health programs and services from government to local control are also described.

Chapter IV provides a rationale for using a collaborative research process in this inquiry. The roots of this approach in action research and participatory research are discussed and collaborative research is described as a strategy and approach for introducing change.

The case study is recounted in Chapters V and VI. The narrative begins in Chapter V with my initial approach to the Councillor responsible for health in Split Lake and my proposal to work with a local community research group in the study of the health system and the transfer of health programs and services. The Chapter traces the period during which negotiations take place, examines questions concerning the health system and recounts the preparation of a proposal for funding a Pre-Transfer Study. Chapter VI continues the narrative, focusing on the development of the community research group, the first attempts at conducting research within the community as the research group begins to gather data on traditional health and finally a discussion of concerns relating to the work of the community research group. This discussion includes reflection on the group's internal processes.

Chapter VII provides an opportunity for me to reflect on what I have learned from the experience. It examines what helped and hindered the community research group in conducting the inquiry. This includes issues relating to the establishment of health goals for the community, identifying the research question, awareness of the interpersonal processes within the community research group and an examination of the role of the external researcher.

Chapter VIII summarizes what has been learned from this dissertation, noting the implications for using a collaborative community research process for assisting a community research group in studying change in a social system within a community. Areas for further study are also identified.

## **CHAPTER II**

### **TRANSFERRING HEALTH PROGRAMS AND SERVICES TO LOCAL CONTROL: RESEARCH, IMPLEMENTATION AND EDUCATIONAL ISSUES**

A number of research, implementation and educational issues occur in a study designed to introduce broad social change in an existing social system. What triggers the need for change? What issues have to be examined? Who takes responsibility for introducing the change? How is that change to be introduced? What help or assistance is needed? Can research help those wanting to introduce the change?

The impetus for change in this case came from pressure exerted by the Aboriginal leadership on the Government of Canada to transfer control of health programs and services to First Nations in Canada. The Split Lake Cree First Nation responded to this opportunity and began the process of investigating the transfer of health services by collaborating with the writer on a community research project for changing the health system.

#### **Introduction to the Issue of Transferring Health Programs and Services from Government to a First Nation**

In 1988, the Government of Canada instituted a policy for transferring health programs and services from Medical Services Branch to Aboriginal control [Health Program Transfer Handbook, 1989]. The policy provides individual First Nations with the opportunity of applying for funds to conduct a Pre-Transfer Study for the purpose of investigating the feasibility of transferring control of specific health programs and services to the community. Although First Nations may choose to forgo this preliminary

study, the assumption is that most communities will take advantage of the opportunity to assess the health needs of their communities and the programs and services to be provided through transfer before embarking on negotiations to transfer control. Two years are allowed for the Pre-Transfer Study with provision for a consultant to be employed to conduct the study. A per diem rate for consulting services is established by Medical Services Branch.

In practice, most First Nations in northern Manitoba have retained a consultant or consulting firm to prepare a detailed Pre-Transfer Funding Proposal on their behalf. The consultant typically meets with the Chief and Council, a local health co-ordinator or health committee, discusses the areas to be investigated in the transfer of the government health program and then leaves the community to prepare the proposal following guidelines set out by Medical Services Branch. The proposal is then submitted to the community health committee, health coordinator or Chief and Council. The document, once approved by Chief and Council, is forwarded to the zone office of Medical Services Branch for review. Further changes may be required. Once approved at this level, the proposal is forwarded to the regional office and then to Ottawa for final approval. At this point, funds are released by Medical Services Branch for the Pre-Transfer Study. The consultant is normally contracted to conduct the study which will form the basis for negotiations between the government and the First Nation for transferring the health programs and services.

### **Rationale for Using a Collaborative Inquiry Approach**

In a typical case where a consultant is employed to develop a Pre-Transfer Funding Proposal and conduct the Pre-Transfer Study, the detailed work involved is performed by the consultant. This work is often done away from the community. In this approach,

local people are usually deprived of an opportunity to have significant input into the Pre-Transfer Funding Proposal or to determine the recommendations coming out of the Pre-Transfer Study. As a result, when a local health group is called upon to implement the recommendations of the study, the group is often at a loss as to how to proceed.

In order to circumvent these potential problems, a collaborative research approach has been used. In this approach a community research group has been encouraged to conduct its own inquiry into the community's health system. This provides the community research group with an opportunity to assess its own health system and establish desired health goals. It is also an opportunity to acquire knowledge about the system and the skills required for managing the transfer process and the health system once transfer has taken place. The process is designed to provide maximum participation in the inquiry and planning phases of the study, increase the capability of members of the community research group in implementing the inquiry and encourage members of a community research group in assuming ownership of the inquiry process. This collaborative research process is described in greater detail in Chapter IV.

### **Issues in Initiating a Collaborative Research Process**

Change in any system usually occurs when internal or external forces become strong enough to cause movement [Lippitt, Watson & Westley, 1958; Moe, 1972; Reading Book: Annual Laboratories in Community Leadership Training, 1969; Watson, 1967]. Change in the way the Government of Canada relates to Aboriginal First Nations has occurred as Aboriginal leaders have demanded the government respect their inherent right to govern themselves. The government's response to this political pressure has been to transfer administrative control of specific programs and services to First Nations.

Change under these circumstances can be planned. Collaborative research offers one means for investigating the issues involved in introducing change to a social system. When outside help is sought, the helper or researcher must determine how she or he will respond. Does the researcher conduct an inquiry and then provide a client with a set of recommendations or does the researcher engage members of the group seeking help in resolving their own problem? If the latter, how is this help offered? Schein [1987] suggests that the role of the researcher is to help a client group diagnose its problem, discovering beneath the layers of the problem the underlying issues that must be addressed. He describes this role as a clinical or helping role.

The relationship between the community research group and the external researcher raises a number of issues. The community research group and the external researcher need to clarify their roles in order to determine the expectations each has of the other in contributing to the inquiry process. What does the community research group expect the external researcher to do? Is this consistent with the external researcher's understanding of his or her role? What does the external researcher see as the role of the community research group? Is this consistent with the community research group's understanding? How are possible role conflicts to be resolved?

The term research conveys a number of interpretations coupled with certain expectations to most people. Does the community research group understand the nature of the collaborative research approach proposed by the external researcher? What is their understanding of research and what it involves? Are they prepared to engage in the demanding work required of community researchers in doing the research? Do members of the community research group have any previous experience in doing research? What research skills do members of the group have? Are members of the research group aware of the skills they possess?

An external researcher as an outsider must address the need to establish an effective relationship with the community research group. This means developing an atmosphere of trust if honest and open interaction are to occur. An external researcher, who is of a culture other than that of the members of the community research group, must also be sensitive to the cultural differences and aware of the issues that may separate the two cultures. In Canada, the Aboriginal community has experienced oppression and racism at the hands of Euro-Canadians. This may interfere with any effort to establish an open and genuine relationship if the researcher is a Euro-Canadian.

The issue of competence has to be addressed by the community research group. They are putting their trust in an external researcher whom they may not know. They may not have had any previous research experience with this individual. They need to ask if the researcher is competent to provide the leadership the research needs, especially in the early stages of an inquiry.

### **Issues in Implementation**

In a collaborative research process, it is important to clarify the approach that is being proposed. The external researcher and community leaders or researchers may differ in their understanding of research and how it is to be conducted. Collaborative research breaks with many of the assumptions of traditional research and those agreeing to participate in a collaborative inquiry need to understand how it is to be carried out and the role each person can be expected to take in the inquiry.

Another task is the formation of a community research group if this has not already occurred. The formation of any new group raises a number of issues. The first concerns membership and relates to those who are invited to become members of the group or

who seek to join the group. Individuals in the group need to decide if they want to belong. They must determine whether others want them to be there. Members will also need to test whether they can influence others.

A research group will go through a number of phases or stages as it comes together to work on the research task. Schutz [1966] identifies three issues that occur in any group which impact the relationships within the group and the productivity of the group: inclusion, control and affection. These issues relate to an individual's psychological and emotional needs. Bion [1961] suggests that there are three dimensions of group life which reoccur and impact the work of the group: dependence, pairing and fight or flight. Tuckman [1977] identifies four stages a group must go through in its development: forming, the period when members join the new group; storming, a period of conflict when members vie for power and influence within the group; norming, when accepted ways of relating and working are established; and performing, when the group is able to do productive work. Significantly, each stage as well as the interpersonal issues must be mastered if the group is to become a high performing group in which members support and encourage each other as they work on the task. The threat is that the commitment to the group may not be strong enough to hold members together while they work through the phase in which competition and conflict emerge to test members' commitment to the group and its task.

A community research group must also deal with the issue of authority. Where does the group derive its authority to do research? Is the group's authority self proclaimed or is it granted by an authorizing body?

A community research group must deal with these processes while also managing the insider-outsider dynamic introduced by the presence of the external researcher in the

group. Community researchers are insiders, with an indepth knowledge of the local system derived from living within it. The external researcher is normally the outsider, with much less knowledge of the local system but with specific skills or knowledge which are useful to the inquiry process. Both perspectives are important and need to be valued by both the community researchers and the external researcher. Members of the community research group may be unfamiliar with the technology required for conducting the research and will have to master this knowledge and the appropriate skills so that they are able to apply them in their inquiry. They need to be able to define the research problem, discover how data is to be collected and used to generate insight and knowledge and possess or acquire the skill needed in constructing instruments and conducting interviews where these are employed for gathering data.

The external researcher needs to provide support and training, if needed, for members of the community research group as they work to become an effective research group. This may take the form of formal training sessions, risking continued dependence on the external researcher or he or she may choose to model effective group skills, helping the group deal with its interpersonal and task issues as needed. Formal training assures early acquisition of the skills necessary for effective group functioning and if done well and at an appropriate time increases the capability of group members to participate in the decision-making processes of the group. Modelling effective group behaviour is less intrusive, taking place informally but may delay the acquisition of the skills necessary for effective group participation.

The dependence of the community research group on the external researcher occurs during the early stages of the group's development. The external researcher is generally seen as the most knowledgeable individual in terms of conducting the research. He or she is normally expected to provide direction. This gives the external researcher considerable

power and it requires skill and confidence in oneself as well as in the group members to encourage group members to take leadership and, if necessary, challenge the external researcher's position in the group.

The goal is to develop an independent research capability in the community research group. The external researcher has to provide sufficient direction for the research work to be carried out while working in such a way as to extricate him or herself from the dominant 'expert' role in the group. This requires treating each aspect of the research as a learning opportunity for group members, an opportunity which prepares the members to assume the overall management of the research process. The experiential 'laboratory' education process described by Benne, Bradford, and Lippitt [1964] is an effective learning model for encouraging group members to reflect on their own group processes. In this approach to learning, a group's own interaction is used to generate data which is analysed by participants during a period of reflection. Action then follows as the new knowledge and insight acquired from the learning are applied to the task to be performed. This research approach to learning condenses Lewin's [1946] action research model into a learning experience and fittingly becomes the third part of the research, training and action triangle he describes in advocating an action approach to research designed to bring about social change.

The external environment is a factor in any inquiry. Unforeseen events can have major implications for the inquiry and although they can not be planned for in the sense that they can be managed, they can be seen for what they are when they occur and a strategy developed to deal with their consequences. Emery and Trist [1965] describe this uncertain environment as a turbulent environment.

The inquiry process involves a certain fairly predictable sequence of activities: discussion of the research problem; planning the work; deciding on methods for data collection; gathering the data; assessing the data; and arriving at a conclusion. In reality, as Torbert [1981] points out, the process is never this straight forward and unexpected delays, changes in direction, new ideas and the need to act disrupt the process. Rowan [1981] describes the process from a dialectical perspective. He starts by being dissatisfied with the way things are and begins rethinking the problem. He describes this as a creative, inward movement in which he always wants more information while finding himself trying to manage the excess information he has already accumulated. At this stage, he finds he needs to act, to involve others. He moves outward, making plans and decisions, the contradiction being the need for better plans and having too many. At some point he needs to act and the plans become a distraction from the past as he and others interact, improvising and experimenting until he reaches the point where he must withdraw to reflect and discover what it all means, finally communicating the results of his analysis and contemplation to others. Reason [1988] suggests that Rowan's explanation of the research process illustrates how inquiry is an alive process of engaging in the world.

This dissertation attempts to address these concerns and issues as well as new issues that emerge as the research unfolds. The dissertation provides a description of the initiation of the collaborative community research process, paying special attention to the role of the external researcher, through the reflection of the external researcher on the processes experienced in the encounter with the community researchers. The dissertation also explores the phases involved in forming the research group, identifying the research problem, preparing a proposal for funding the research and initiating the first field work in a study on traditional health.

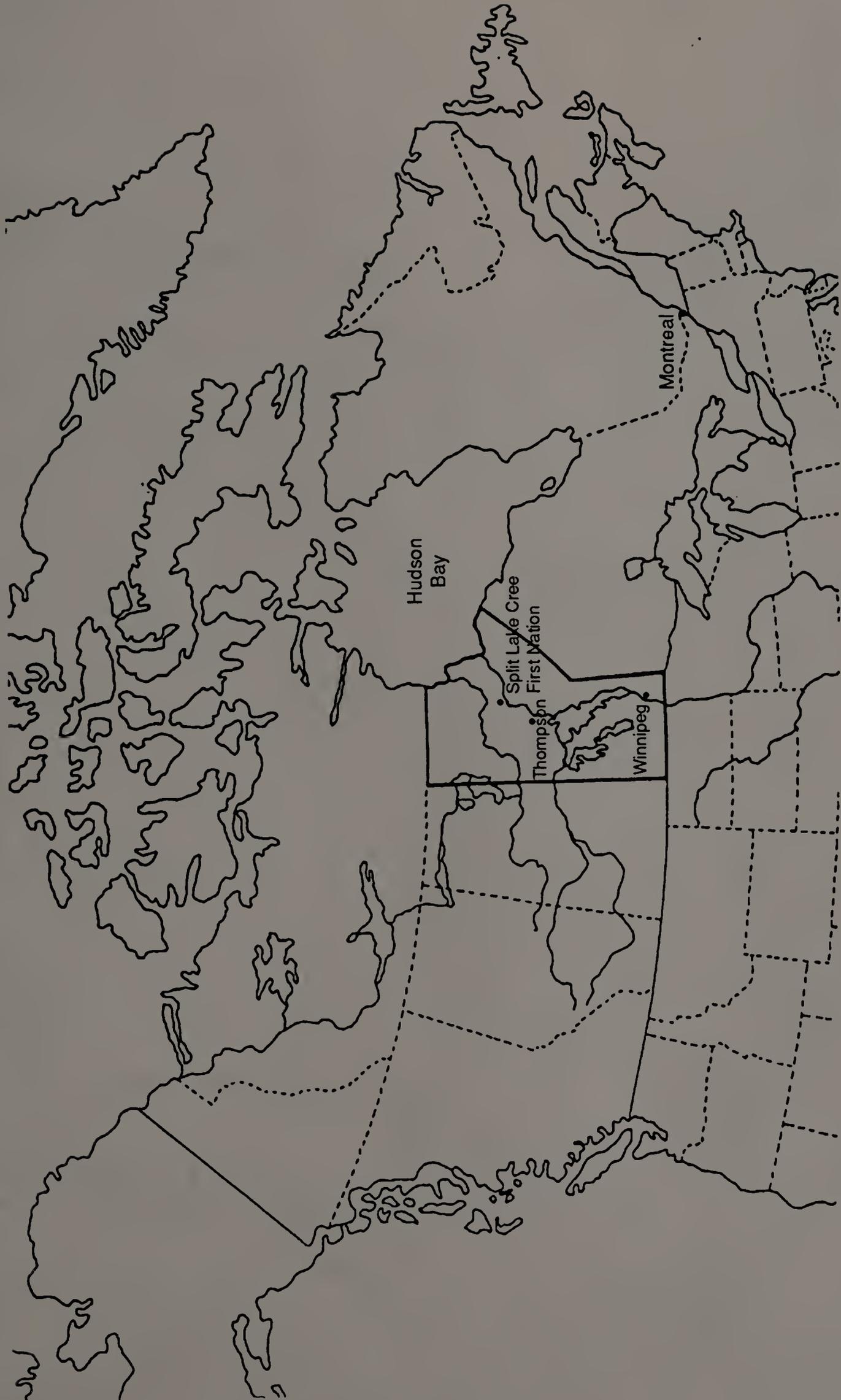
## CHAPTER III

### THE SPLIT LAKE CREE FIRST NATION: HEALTH SYSTEM AND CONTEXT OF TRANSFER

The Split Lake Cree First Nation is a relatively small community of fourteen hundred people located on an expanded portion of the Nelson River, approximately two hundred kilometres west of Hudson Bay. The location of the community is illustrated in Figure 3.1. The community was relatively isolated until 1970 when an all weather gravel road was built linking Split Lake to Thompson, Manitoba, 130 kilometres to the west. Thompson, an administrative centre with a population of 13,000, is the largest community in northern Manitoba. Through Thompson, Split Lake now has road access to Winnipeg, the capital city of the province of Manitoba. The road also connects Split Lake with Gillam, Manitoba, the site of a massive hydro electric dam on the Nelson River downstream from Split Lake.

Prior to the road being built, Split Lake's access to the larger Canadian economy was limited to intermittent river traffic, infrequent air service, freight hauls over winter roads and a rail line between southern Manitoba and Churchill on Hudson Bay. The railway, built in 1929, touches the far shore of the lake at the small Aboriginal community of York Landing, ten kilometres from Split Lake.

The Split Lake Cree First Nation has been relatively shielded from the destructive social forces that more immediate access to the Euro-Canadian society might have introduced. There is considerable social cohesion in Split Lake. The community has not, however, been sheltered from the health problems introduced by European settlement, whether from dietary changes or the successive epidemics that have devastated



Map of Canada Indicating Location of the Split Lake Cree First Nation  
Figure 3.1

Aboriginal communities since Europeans first arrived in North America. One estimate is that as a result of epidemics, the Aboriginal population in Canada was reduced to one fifth of its original size between 1700 and 1900 [Young, 1988].

Much of the isolation and relative autonomy of Split Lake changed with the building of the road. The community found itself caught up in the dislocation that a huge hydro project introduced in the north. Protracted negotiations to surrender parts of the reserve to allow for fluctuating water levels on the lake and changes in the water flow took place during the 1970's. The community received compensation from Manitoba Hydro as a result of this dislocation and these funds have provided the community with an infusion of capital for building the community's infrastructure. A sewer and water system now serves approximately half the homes and will eventually hook up with all the residences and public buildings in the community. The community has also initiated major new housing construction and has expanded serviced land in response to the need for housing.

There have been significant alterations to the land base upon which the people depend for their livelihood, notably in the trapping and hunting sectors. The fluctuating water levels have contributed to an increase in mercury levels in fish stocks which has negatively impacted the commercial fishery. In addition during the summer of 1989, forest fires devastated the region and depleted the fur bearing ecosystem. With both the trapping and fishing industries in decline, transfer payments from the federal government and compensation from the provincial hydro utility have become the economic mainstay of the economy.

The Split Lake Cree First Nation is governed by an elected Chief and Council who serve a two year term. The system of governance is legislated by the Government of

Canada with the terms and conditions of office set forth in the Indian Act. The Council is supported in its work by an administration organized into departments of education, community services, public works, northern flood agreement and finance. Individual departments co-ordinate a variety of programs. Community Services for instance co-ordinates programs in community health, social development, employment, native alcohol and drug awareness, social work, medical transportation and police. Each department is headed by a director or administrator. Elected Councillors have responsibility for program portfolios. For instance, one Councillor is responsible for the Health Portfolio. This portfolio carries responsibility for the Native Alcohol and Drug Awareness Program, social work provided through a regional Aboriginal child and family service agency, medical transportation and the Community Health Representative Program.

The local political system has no direct control over the health service provided by the Medical Services Branch.

### **Traditional Health**

A traditional health system exists parallel to a western health service within many Aboriginal communities. It is an informal loosely structured system in contrast to the western bureaucratic and hierarchical structure which characterizes Medical Services Branch. The traditional system is represented by medicine men and women, individuals within the communities who have acquired knowledge of traditional healing methods and plants. This knowledge which has been passed down through the centuries includes spiritual and psychic powers to support healing. Traditional healing is noted for its concern with the whole person, with the physical, social, mental and spiritual needs of those seeking help all attended to in the healing process.

Individuals will go to great lengths to seek out traditional healers, travelling to other communities, provinces and the United States. Healers are known by their reputation, which is passed on by word of mouth as well as by the reputation of the persons under whom they have trained. Traditional healers may be especially known for their healing abilities for specific illnesses.

Split Lake at one time had traditional healers. A number of elders do have the knowledge and skill but do not practice. Midwives have in the past been responsible for child birth and still practice in emergency situations in some communities. There are ten midwives in Split Lake who may be called on in an emergency. Members of the community also share common knowledge of local healing substances used to treat specific complaints, such as a seneca root which alleviates tooth ache.

Traditional healers do not charge a fee for their service. Those approaching a traditional healer are expected to offer a gift to the healer to honour him or her for the service. Traditionally, this is a gift of tobacco which has spiritual significance. Smoke is used to purify and cleanse one's spirit.

Traditional healers are not directly involved in the health system operated by the federal government, although two major teaching hospitals in Winnipeg do involve traditional healers in the care of Aboriginal patients who wish to have this service. A number of hospitals in Winnipeg also provide interpreters to improve communication between Aboriginal patients, their families and medical staff. Thompson General Hospital, the hospital nearest to Split Lake, does not involve traditional healers in the care they provide to Aboriginal patients.

## **Government of Canada Health Services for Aboriginal People**

The Government of Canada is “responsible for the direct provision of and ensuring access to health services for Indian and Inuit people in Canada.” [G. Godmaire, Personal Communication, January 1991]. This service is provided by the Medical Services Branch of the federal Department of National Health and Welfare. The Branch is mandated to provide four programs: Treatment; Public Health; Environmental Health; and Communicable Diseases.

Medical Services Branch, which delivers these programs, is organized on a regional basis. The province of Manitoba is considered a region, with a Regional Director situated in Winnipeg. A number of program directors who report to the Regional Director are also located in Winnipeg. These include the Director of Community Based Health Services who is responsible for the transfer of health programs to First Nations; the Assistant Regional Director of Operations; the Director of Finance; the Director of Administration; the Director of Programs; and a Regional Nursing Officer. A northern zone office is located in Thompson. The Director of the zone reports directly to the Regional Director in Winnipeg.

Western medical care in Split Lake began with the arrival of fur traders and the Anglican church. Clergy in particular were called on to provide medicines when illness struck. The first western trained physician to visit Split Lake arrived in the community with the treaty party in 1908.

A nursing station was built in Split Lake in 1950. A resident nurse arrived in the same year. The nursing station was expanded to its present size in 1982. The facility has two clinic rooms, one emergency room, two holding rooms, a public health room, X-ray

room, dental room, waiting room, three offices and various storage rooms. There are four residential suites incorporated into the facility. Two single rooms are also available for visiting staff. A general lounge area and a kitchenette are included in the living quarters. The nursing station is self contained with its own back up diesel electric power plant and its own water and sewage system.

Three registered nurses staff the nursing station. One of the nurses is designated the Nurse-in-Charge and reports for administrative purposes to the Director of the north zone office. The Nurse-in-Charge reports to the Regional Nursing Officer in the Winnipeg regional office regarding medical matters. Until very recently, the nursing staff also provided services for a satellite nursing station at a neighbouring community of York Landing.

Two local full time Community Health Representatives and one part time Community Health Representative are employed by the Split Lake Cree First Nation. They have offices in both the nursing station and in the community's administrative facility. Funding for these positions is provided by Medical Services Branch under a contribution agreement with the Chief and Council.

A clerk, caretaker, housekeeper and two relief staff are employed at the nursing station. These staff are local residents employed by Medical Services Branch. In most communities in the northern zone, these positions have been transferred to the local First Nation administration under the Chief and Council. In Split Lake, the clerk and caretaker have been maintained as employees of Medical Services Branch in order to protect their pension benefits built up over their years of service as employees of Medical Services Branch.

There is no resident doctor in Split Lake. A doctor visits Split Lake for three days every two weeks. Medical doctors are retained under independent contracts with Medical Services Branch. Most of these physicians have practices in Winnipeg or Thompson and live in one of these two communities. A few larger Aboriginal communities in the north have resident doctors. In one community, a resident doctor is of Aboriginal descent. A hospital administered by Medical Services Branch is located in Norway House, the largest Aboriginal community in northern Manitoba. The doctors attached to this hospital are resident in the community.

Medical specialists, in addition to physicians, visit Split Lake on a periodic basis and work out of the nursing station. Specialists include dentists, optometrists, mental health workers and nutritionists. The number of visits made by each varies depending on the need. Most of these itinerant health care personnel are retained under contract with Medical Services Branch. They are coordinated by the zone Program Medical Officer in consultation with the Regional Program Medical Officer in Winnipeg.

All medical staff, including contract staff, are recruited and hired by Medical Services Branch. In northern Manitoba, Medical Services Branch will request Chief and Council to appoint a delegate to sit on interview boards for all staff seeking resident employment at a nursing station. On occasion this requires interviews by conference call rather than in-person representation on the interview board. In preparation for interviews, the zone office prepares questions for the interview board, sends a copy of the questions to the community to critique and invites the community to add questions it feels are relevant to the interview. At times, individual communities or a Tribal Council will contribute names of candidates for consideration in the recruitment of medical staff. Aboriginal representation is also required on interview boards for staffing north zone Medical Services Branch office positions.

Decisions to move or re-assign nursing staff from the community may occur for a number of reasons. In some cases, the decision is made by the individual. A nurse, for instance, may decide to terminate employment for personal reasons. Nurses may also request a move because they find the work load too heavy in a particular community or they may simply want a change. At other times, Medical Services may decide to move a nurse for reasons of advancement to another position in the Branch. Medical Services Branch alone or in consultation with the Chief and Council may initiate the removal of a nurse from the community. For instance, Medical Services Branch requires that all nurses successfully complete a community health certificate within one year of being hired. If unsuccessful, a nurse cannot remain in a nursing station position but can be placed in a hospital within the zone. An example of the impact of this policy in the Split Lake Cree First Nation occurred when a nurse who did not complete the required community health certification within the one year time limit was moved out of the community. The nurse, who was married and had a family, had been provided with trailer accommodation by the Split Lake Cree Council as the nursing station offered only single accommodation. This removal was done over the objections of the Council who wanted to retain this Aboriginal nurse in the community.

Medical Services Branch together with Chief and Council act on any community initiated complaints concerning nursing staff. Written complaints must be submitted to the Chief and Council who in turn must contact the zone Director. A community designate is assigned by Chief and Council to work with the zone Nursing Officer. They will meet with those who have lodged the complaint and with the individual nurse involved in an attempt to resolve the complaint. If it cannot be resolved, the individual nurse will be located elsewhere. The Branch does not move a nurse to another community if this means passing on a problem to another community. The receiving community is told if a Chief and Council have passed a Band Council Resolution asking

that a nurse be removed. In this way, the receiving community can contact the original community regarding the circumstances of the nurse being asked to leave.

In 1984, the average length of stay of a resident nurse was twelve to fourteen months. Currently the average stay is two years. The northern zone Director attributes this in part to communities having a greater understanding of the pressures a nurse experiences working in a somewhat isolated setting. As a consequence there has been increased community support for the nurses.

Communities do not have input into the selection of doctors. A newly contracted doctor will be introduced to a local health committee, where nursing staff and the local health committee attempt to convey the community's expectations to the new physician.

Nurses have responsibilities generally associated with those of a registered nurse. They follow up on directions given by physicians to patients and give treatment to stabilize patients who need to be sent out for further care. Nurses are not allowed to prescribe drugs but can dispense drugs under the guidance of a physician. They do not perform operations nor do they deliver babies unless an emergency arises and then they usually do so under the guidance of a doctor who communicates by telephone.

In recent years, nurses have taken on a much stronger role in the area of public health. They conduct more home visits, prenatal and immunization clinics and educational workshops.

Patients can be referred to medical specialists in Thompson or Winnipeg by the attending physician in the community or, in emergencies, by the local Nurse-in-Charge, either on her own volition or through consultation by telephone with a doctor. Referrals

are handled by the co-ordinator of the Referral Unit now administered by the local Tribal Council.

Patients are normally sent to the closest hospital, in this case Thompson General Hospital. In the event that a needed specialist is not available, patients are sent to a Winnipeg hospital. Recently the number of patients sent to Winnipeg has diminished as more specialists have been employed in the Thompson Hospital. Approximately ninety percent of the referrals in the north are to Thompson. There is no First Nation representation on the Board of Directors of this hospital.

Physician services and hospital care are classed as insured benefits and are covered by Medical Services Branch. Non insured benefits are those not covered under the provincial medicare plan. They include dental services, optometrist services and medical transportation. Non-insured benefits are funded by Medical Services Branch.

Medical Services Branch funds travel expenses for community members to see a traditional healer if this is requested. The Nurse-in-Charge forwards the request to the zone Director for approval.

In Split Lake, a medical transportation system is in place to transport patients to the nursing station or to Thompson. This system is administered by the Split Lake Cree Council. Two vans were purchased by the Council to provide this service. Medical Services Branch funds this service through a contribution agreement with Chief and Council.

Mental health care is the responsibility of the provincial government, however the province claims it does not have the resources to serve First Nations in Manitoba. The

Medical Services Branch nurses may, under a physician's guidance, refer patients out of the community to seek psychological help. Medical Services Branch may also hire counsellors on a contract basis. Patients requiring mental health treatment or hospitalization often find they must travel to a southern community far removed from their families and support systems in order to obtain treatment.

The federal government has on occasion conducted training for local mental health workers in First Nation communities although this has not occurred in Split Lake. Discussions are taking place regarding more training as a result of the public revelations in the past year of physical and sexual abuse endured by many individuals who attended residential schools operated by churches and the government in years past. The federal government provides some funding for family violence projects through one of the Branches of the Department of National Health and Welfare.

Community Health Representatives are employed by First Nations. They are considered part of the health team. The Split Lake Cree First Nation employs two full time and one part time Community Health Representatives.

Community Health Representatives are expected to liaise with the nursing staff and function as interpreters for nursing staff when needed. Under the guidance of the nursing staff, they conduct follow up home visits, provide care for seniors, assist nurses in changing dressings and assist at well baby clinics and pre and post natal care clinics. They are often called upon in cases of accidents to be with the family, helping to keep things calm and to make sure medical materials are available as they are required. Community Health Representatives present public health workshops for students in the school and adult groups in the community. They may conduct these sessions on their own or team with a nurse. Community Health Representatives are responsible for taking

monthly water samples from the community's water supply. These samples are shipped to a provincial laboratory for testing in order to ensure the safety of the water supply. Community Health Representatives do not have medical training and may not dispense drugs or carry out medical procedures.

A Health Committee was established in Split Lake in 1986 by the Community Health Representatives. The Committee has been involved in a number of initiatives. One of these was the establishment of an elder hostel for seniors who require permanent accommodation. Funding for this hostel was provided by the Department of Indian and Northern Affairs. The Health Committee looks after the needs of the seniors in the hostel. The Health Committee also organizes an annual spring clean up of the community. The school participates in this campaign with school children using it as a fund raising project. The Health Committee funds the building of protected garbage stands to keep garbage out of the reach of dogs and ravens.

### **The Transfer of Health Programs and Services from the Government of Canada to First Nations**

In 1969, the federal government initiated a process of devolution of a number of government programs to First Nations. This policy meant that programs that had been organized and delivered by the federal government were to be transferred to local communities where communities indicated they were prepared to take over the administration of the program. In 1979, the federal government announced that health programs were to be included in the devolution process. A cabinet order authorizing this program to begin was signed in 1988.

The objectives of the federal government's policy for the transfer of health programs as stated in the Health Program Transfer Handbook are:

to enable Indian communities to design health programs; establish services and allocate funds according to community health priorities; strengthen and enhance the accountability of Chiefs and Councils to community members; and ensure public health and safety is maintained through adherence to mandatory programs. (pg. 2-1)

The government advises that its purpose is centered in the concept of self determination in health. The parameters within which transfer is to occur were spelled out by the federal Cabinet in March, 1988. Under this policy, Aboriginal control was to be realized through a process which:

operates within current legislation; is optional and open to all Indian communities within provincial boundaries; permits health program control to be assumed at a pace determined by the community; enables communities to design health programs to meet their needs; requires that certain mandatory public health and treatment programs be provided; strengthens the accountability of Chiefs and Councils to community members; gives communities the financial flexibility to allocate funds according to community health priorities and to retain unspent balances; gives communities the responsibility for eliminating deficits and for annual financial audits and evaluations at specified intervals; permits multi-year funding agreements; and does not prejudice treaty or aboriginal rights. (pg. 3-1)

There are a number of contradictions in this policy. The federal government indicates in the policy that its intention is to strengthen the accountability of Chiefs and Councils to community members. This contradicts the logic of accountability. Accountability is the concern of members of First Nations and not the prerogative of the federal government. Leadership after all receives its authority from its electors or members and must be held accountable by those electors or members.

The policy included in the Health Program Transfer Handbook further states that the transfer agreement “will vest primary responsibility and authority in Chiefs and Councils, or their designated health organization, for assessing needs, determining priorities, designing and operating programs and allocating resources”. The policy also states that “community members will hold community leaders responsible for the success of the health program in meeting community needs and for ensuring fair and equal access to service for all community members” (pg. 4-1). This reflects the continuing paternalism embodied in the Indian Act which holds Chief and Council responsible to the Minister of Indian and Northern Affairs. The contradiction inherent in the policy is illustrated further by the statement in the policy that “the accountability relationship between Chiefs and Councils and the Minister of National Health and Welfare will reflect an approach more like that of one government to another rather than of an agent administering federal government programs” (pg. 4-1). Later, the policy notes that “Chiefs and Councils will be accountable to the Minister for meeting the terms and condition of the [health] transfer agreement” (pg. 4-1), and that “the Minister will continue to be accountable to Parliament for prudent financial management of community health resources and for overall program results to protect the health and safety of Indian people” (pg. 4-2).

Split Lake is now considering the transfer of control of health services. They have the opportunity to submit a proposal to obtain funding to study their health system and on the basis of the study, decide whether they want to take over and administer the system. They have the option of taking over the total system, a part of the system or none of it. If they choose the latter option, Medical Services Branch will continue to deliver the health service. In preparation for making this decision, Split Lake has chosen to participate in a collaborative community research project to study their health system. The rationale and strategy for using a collaborative approach to the research is set forth in the following chapter.

## **CHAPTER IV**

### **USE OF A COLLABORATIVE COMMUNITY RESEARCH PROCESS: RATIONALE, STRATEGY AND APPROACH**

This dissertation describes the use of a collaborative community research process in studying and implementing organization and system change. Collaborative research draws from participatory research and action research as methods of inquiry for initiating social change. These methodologies have their roots in a radical change paradigm which views research as purposeful and directed toward change [Burrell and Morgan, 1979]. This dissertation also examines the change process from the perspective of the participants in the inquiry process. This is a radical humanist perspective which represents the subjective dimension within the radical change paradigm. The radical humanist perspective contrasts with the traditional positivist research perspective in which the researcher views the world as an objective stable reality. In positivist research, individuals who are the subject of inquiry are treated objectively, with the researcher attempting to minimize his or her interaction with the subjects under observation. In contrast, in this inquiry the external researcher has become fully involved with community researchers who become co-researchers in the inquiry process. Together they examine the interaction that occurs during the inquiry process, paying attention to both the overall research process as well as the relationships within the community research group and between the external researcher and the community research group.

#### **Contributions from Action Research**

Action research in North America developed out of the work of Kurt Lewin and his colleagues and their research on social problems in the United States in the 1940's

[Lewin, 1946; Peters and Robinson, 1984; Rapoport, 1970]. Lewin proposed using action research as a means for dealing with intractable social problems which he observed were not alleviated by the application of knowledge acquired through traditional positivist methods of inquiry.

Lewin and his colleagues had struggled for a decade to bring together social scientists concerned about the need to use social science for bringing about change in critical problem areas in society. In this effort, they encountered considerable resistance to their efforts in the professional associations to which they belonged. The resistance was based on an ideological belief that social science as a science should not be applied directly to bring about change [Lippitt 1946]. This belief advocated a position that held that science should be value neutral, a position that Burrell and Morgan [1979] have characterized as reflecting a view of science which values regulation and the maintenance of the status quo in society. This view subscribes to one state of affairs in the human condition and of necessity abrogates the possibility of the researcher studying change as a participant in the change process.

Positivist social scientists view the introduction of change during the research process as a contamination of the research process. The positivist ontology holds that every effort should be made to study social situations at a fixed point in time and to generalize the knowledge acquired in these circumstances to other situations where problems exist. This static perspective fails to take into account the processes that occur and impact a dynamic situation where the action itself influences the perceptions and the actions of the actors even as they are reflecting on the data that is being generated in inquiry. Where an actor's behaviour is goal oriented, it will critically influence an actor's perception and assessment of the world. Action researchers recognize this dilemma but believe that you need to change social conditions in order to study their dynamics

[Schein, 1987a]. Lewin, in proposing to collaborate with practitioners to find ways to bring about needed change, saw research and the generation of theory as an integrated process leading to social action.

In post-war Britain, Bion and his colleagues working with patients experiencing psychological problems due to their war time experiences also pursued an applied research strategy. Their work focused on the interpersonal processes occurring in therapy groups. Their research, subsequently carried on through the Tavistock Institute of Human Relations, evolved into applied research on social and organizational problems in Britain and overseas [Rapoport, 1970].

Action research has concentrated primarily on the improvement of organizations [French and Bell, 1984]. Susman and Evered [1978] describe how this process takes place. They begin with the assumption that organizations are artifacts created by human beings, with the means and ends guided by values and members' conception of the future. They state that organizations can be understood experientially, that is, through the interaction that occurs amongst the members of the organization. They note that organizations need to be studied as single cases, pointing out that the circumstances and dynamics of each case are unique and only the experience and understanding gained from the case are applicable in other settings. They describe the techniques or know-how a researcher acquires through the action research experience as being the knowledge one acquires from engaging in the research process. It is this knowledge which can be applied in other research settings. This includes discovering how to create an environment for learning, becoming comfortable with working in ambiguous situations, encouraging others to take responsibility for dealing with organizational problems and assessing the system of which one is a part through generating images of a possible future. They point out that action research is an enabling science, concerned with the development of others.

Schein [1987a] describes this process as a clinical or helping process where research data is generated by the interaction of the researcher-clinician in his or her helping role. The clinician gets involved with participants in a change process, the point of reference always being the client's defined need for help.

Susman and Evered [1978] state that action research is future oriented in that it is concerned with creating a more desirable future. It requires collaboration between the researcher and the client system and it implies system development. It is a cyclical process which needs to be maintained over time. It generates theory grounded in action which though influenced by previous studies and experience needs to be reformulated in each new case. The problem and goals need to be generated by the process itself, that is, the appropriate problem has to be determined for the unique circumstances of each case. Susman and Evered, in proposing a cyclical process for doing action research, describe how knowledge is to be generated through the act of identifying a problem, diagnosing the situation, considering alternative courses of action, planning and choosing a course of action, evaluating the consequences and identifying general findings.

Action research, in the years since Lewin, has focused on change in organizations with the researcher undertaking the research for an organization which then uses the findings to institute change. This is a formative process with change occurring as the inquiry proceeds.

Action research has tended to be less concerned than participatory research with the empowerment of those engaged in or impacted by the research. Brown and Tandon [1983] attribute this to the ideological stance of action researchers who they characterize as defining their research problem from the perspective of those who employ them, generally the managers of organizations contracting for the research. This perspective

assumes that the interests of the managers of the organization are shared by the employees and that the data analysis and knowledge that is generated from the inquiry will be perceived as beneficial to all parts of the system.

### **Contributions from Participatory Research**

The literature on participative research and participative action research explores the rationale and approach for using participative research with local people in studying and acting to bring about change, particularly in conditions of oppression [Brown, 1982, 1983, 1985; Castellano, 1986; Conchelos and Kassam, 1981; Fals-Borda, 1990, 1991; Hall, 1981; Hall, Gillette and Tandon, 1982; Maguire, 1987; Tandon, 1981, 1988; Vio Grossi, 1981].

Participatory research emerged in Central America and in Tanzania, east Africa, in the 1960's and 1970's. In each instance, researchers began their work believing that local people needed to be involved in the study of their own socio-political circumstances if they were to bring about fundamental change [Hall, 1981]. The emphasis is on empowering those seeking change. A basic tenant is that knowledge sought through research must be meaningful and useful to those who would use it to change their condition. Vio Grossi, [1981] in a critique on participatory research, states that participatory research must contribute to social transformation, that is, structural change in society. He argues that only fundamental change will alter the exploitation, poverty and dependence experienced by the oppressed.

Participatory researchers have stressed the need to address the fundamental social forces that determine power relationships in society. This socio-economic and political analysis and the increased awareness of the forces that impact one's existence that arises

from an analysis of these forces is central to the participatory research endeavour. Attention to these macro forces reflects a belief held by the researcher that knowledge and understanding of societal forces and how they impact the group are essential if participants are to understand the situation in which they exist. It is held that this knowledge is essential if those engaged in the research are to act to bring about change.

Brown [1982] has commented on some of the ambiguities in participatory research, noting that different participatory researchers advocate different objectives. These objectives include generalizable abstract knowledge, increased awareness of local issues and the relevance of action and social change. He points out that there is confusion concerning the definition of the roles of researchers and participants. In some cases, there is a blurring of roles which he notes works to the detriment of the inquiry. Brown states that there is no clear agreement on the methods and technologies to be used in conducting participatory research.

### **A Collaborative Research Process**

A collaborative or co-operative research process involves a researcher who is external to a group and members of a group collaborating to conduct research. They become co-researchers, each contributing his or her specialized knowledge, perspective and interests to the inquiry, intentionally influencing each other as they seek knowledge that can be applied to bring about change in the social condition under investigation. The process requires openness and trust as both external researcher and community researchers come together to pursue common purposes in the midst of unforeseen occurrences and events [Reason, 1988; Torbert, 1981].

Collaborative research is an educational process in which the external researcher and community researchers need to be open to reflecting on their own behaviour as they engage in the inquiry process. Openness to learning and to discovering the impact of one's behaviour, is essential in unlocking the knowledge about the inquiry process as well as about one's self as a participant in the research process. Each participant in this process contributes his or her own perception, insight and awareness and this becomes data for both the inquiry and the building of interpersonal relationships between the researchers. Science is thus treated as a reflective learning experience [Lewin, 1946; Brown, 1983, 1985; Reason, 1988; Tanden, 1981, 1988]. Torbert [1981] in pointing out the importance of developing collaboration and the requirements for achieving it, states that:

Each actor requires [an] others' best attention and sincere responses in order to learn whether his or her own purposes, theories, actions, and effects are mutually congruent. In other words, the aspiring action scientist requires [an] others' friendly collaboration. A second reason why collaborative inquiry is necessary for effective action is that the 'topology' of social situations is determined by the qualities of each actor's intuitive, theoretical, sensual and empirical knowledge and being. Consequently, each actor can gain increasingly valid knowledge of social situations only as other actors collaborate in inquiry, disclosing their being, testing their knowledge, discovering shared purposes, and producing preferred outcomes. As the actor-researcher increasingly appreciates these motives for collaborative inquiry, [she or he] increasingly wishes to approach situations in everyday life as real-time, mutual learning experiments, as experiments-in-practice [p. 147].

The collaborative research process is not a step by step process but rather one that responds to the forces that impact the inquiry as it proceeds. Nor is collaboration completely achieved in the first phase of inquiry. Torbert [1981] points out that participants, including the researcher, don't fully comprehend the situation. The purposes of the inquiry and action are not fully explicit. Participants invited to join in the inquiry are ambivalent about joining until they know what it is they are being asked to join and then determine whether it is in their interest to do so. The attention of participants to the task is constantly being interfered with by other claims on each person's time and energy.

The external researcher, as the one providing direction must contribute structure and control in this initial phase, creating an ordered environment in which participants can come to understand the inquiry process, determine how they can achieve their own purposes through the inquiry and work through their ambivalence about joining. The researcher, while providing stability must always be working to achieve increased collaboration as participants indicate a desire to engage in inquiry and assume ownership of the inquiry process.

Collaboration increases as participants gain the skill and confidence in their ability to conduct the inquiry. The technical skills and knowledge of the researcher are continually required but there is increasing input from the other participants as they engage in dialogue about the purposes of the inquiry, data collection, data analysis and decisions concerning the outcome of the research. The forceful and empowering exchange of views, experience, knowledge, insight and opinion are indicators that participants have joined in the inquiry process.

## Strategy and Approach

I have drawn on the research approaches represented by action research, participatory research and collaborative research to initiate and engage in this inquiry. Participatory research has highlighted the need for empowering community researchers. Aboriginal people in Canada have experienced years of oppression and racism and it is only through taking control of their own governing systems and in conducting their own research that they will be able to control the programs and services which are designed to meet their needs. Collaborative research is one means for an external researcher to join in this endeavour.

Action researchers have paid special attention to the role of the consultant and researcher as helper [Berg & Smith, 1985; Gray, 1989; Schein, 1987a, 1987b]. This attention has shed light on the dynamics of the helping or consulting relationship, an important learning for a collaborative researcher.

The external researcher must be able to provide direction for the research. He or she must also establish conditions that are conducive to learning. Collaborative research provides an opportune time for community researchers to acquire new research skills. The external researcher's task is to facilitate this learning, helping the community researchers learn from their experience doing the research. The experience provides the raw data for reflection and insight. This "process learning" may also be supplemented by training in specific research skills.

An important goal in collaborative research is the development of the research group as an independent group. This is a difficult task for the external researcher as he or she begins in a position of considerable power, providing both direction for the

research and the learning. The willingness and ability to see this power wane and re-emerge in a confident and knowledgeable community research group is not necessarily a smooth transition. It may involve confrontation. It may involve a renegotiation of roles and role expectations. It ultimately leads to disengagement and, if successful, an independent capacity on the part of the community research group to pursue their own research. The process has been documented in numerous interpersonal training groups in which group members go through a counter dependent stage in which the role of the 'trainer' is challenged and a struggle for group leadership takes place [Bennis, 1964]. A similar process may occur in collaborative research as local researchers ultimately gain control.

The external researcher must help the research group evolve into an effective team. This will involve providing feedback to the community research group on the groups internal processes which the group can then use for improving the way it works on its task. The external researcher may also be called on to provide training required to improve group functioning or for carrying out research tasks.

The external researcher needs to be clear about his or her role and be prepared to negotiate the responsibilities of the role with the community research group. This clarification serves to establish role boundaries, both for the external researcher and the community researchers and determines the areas of responsibility for both.

The external researcher is responsible for structuring the research process, a process which must enable the research group, including both the external researcher and community researchers, to determine the research goal, decide on information that has to be collected, analyse the information, choose the action they will take, act and evaluate the effectiveness of each aspect and phase of the inquiry process. Establishing the

structure goes a long way towards establishing a secure working environment for the research group. The initial experience of participants as they enter into the research group is one of confusion, ambiguity and uncertainty. The external researcher needs to provide stability, allowing the group to feel secure enough that they can focus on the task. The sense of security also allows trust to develop between community researchers and between the community researchers and the external researcher. The external researcher must establish a climate which is open, warm, responsive and informal and which invites participants to interact with each other and with the external researcher. Much of the climate setting is achieved by the external researcher modelling behaviour that is open and supportive.

The external researcher contributes an external perspective vital to the research process. It is the interplay between the internal perspective of the participants and the external perspective of the researcher that has the potential to stimulate new insights and discoveries in the analysis of the data. The external perspective is embedded in the value system of the external researcher. This perspective reflects the presuppositions of the external researcher, which Vio Grossi [1981] would argue should, in participatory research, require the disindoctrination of the elements in a people's culture which have been imposed and are functional to the status quo. Whatever the perspective, it influences the diagnostic process so that the external researcher has an obligation to be aware of his or her own biases and declare them to the community researchers.

Opposite this is the perspective of the community researchers who represent the values, beliefs, history and tradition of the community. Their perspective is critical in keeping the inquiry anchored in the reality of the community and its needs. The openness of the external researcher to the influence of the participants and vice versa determines to a great extent the potential for reformulating and transforming the awareness and

understanding of all engaged in the research process. To achieve this, the researcher must have a profound faith in the people with whom he or she is working, a faith that Alinsky [1969] claims is essential in working with people in social change. Anything less is transparent and will be readily perceived as such by community researchers.

## CHAPTER V

### INITIATION OF COMMUNITY RESEARCH AND THE PREPARATION OF A PRE-TRANSFER FUNDING PROPOSAL: CASE NARRATIVE

I became involved in this collaborative community research project with the Split Lake Cree First Nation as a result of a long history of working with Aboriginal communities in northern Manitoba. This involvement began in the early 1960's when I was hired by a provincial community development agency and assigned to an isolated northern Aboriginal community in response to that community's request for a community development worker. I worked closely with a newly formed commercial fishing co-operative, learning about the enterprise from the fishermen while engaging in a non directive, non formal educational role, asking questions, offering suggestions and providing support as the fishermen worked to establish their co-operative.

I left the community after four years to pursue graduate studies in adult education. Through my studies I had the opportunity to become involved as a trainer in experiential 'laboratory' education and have drawn on this experience to develop training programs for Aboriginal organizations in the areas of community leadership, organization and community development.

In 1981, I was approached by a tribal council in northern Manitoba and asked in my capacity as a program co-ordinator in Continuing Education at the provincial university to develop a university certificate program in management studies, designed specifically for First Nation managers. This program which utilizes experiential learning methodology now provides training for senior Aboriginal managers employed by First Nations throughout Manitoba and northwestern Ontario.

In 1988, the executive director of the tribal council asked me to develop a training program for health care administrators. It was felt that communities would need to have trained administrators in place once the transfer of health programs and services to local First Nations was completed. I agreed and together with Henry Mooswa, co-ordinator of health programs for a northern Chiefs' organization, formed a planning group to develop the training program. The northern Chiefs' organization was the political umbrella organization of twenty-four First Nations in northern Manitoba. The work on the health administrators certificate program progressed through the spring but came to an unexpected halt in late summer when a key member on the staff of the Chief's organization assigned to work with the planning group unexpectedly resigned. Other pressing priorities meant that the Chief's organization had insufficient staff to continue the project.

I had been aware for some time that the planning group would need to work closely with one of the First Nations planning to take over the government health system in order to obtain essential information related to the training needs of future health administrators. At the suggestion of Henry, I contacted a Councillor responsible for health for the Split Lake Cree First Nation and arranged to meet with him to discuss the possibility of a collaborative research project designed to study the health system in the community. I thought that the information obtained from such a study would be needed in developing a health administrator training program. I also believed that the research would be useful to the community in its preparations for taking over the health system.

This and the following chapter describe the case study of the research with the Split Lake Cree First Nation. Chapter V recounts the negotiations leading to the agreement to collaborate on the community research; the first meetings of the community research group; discussion of the Split Lake health system; and the preparation of a funding

proposal to study the transfer of government health programs and services to local control. Chapter VI continues the narrative, describing the establishment of the community research group as an entity separate from the Split Lake Health Committee; the initial design and field work for a study on traditional health; and reflection on the community research group's intra group issues and processes.

The events in these two chapters overlap to a certain extent although they are organized as discrete topics in the narrative in order to recount activities associated with specific tasks. The schedule of meetings and the topics dealt with in these meetings are illustrated in Figure 5.1.

I have incorporated verbatim dialogue taken from transcripts of the meetings in order to reflect the ideas and opinions of members of the community research group. I have inserted the word Cree in brackets whenever members spoke in their own language. The Cree dialogue may be as brief as one word or a lengthy exchange between members of the community research group. I have not attempted to transcribe nor translate the Cree. The dialogue in the narrative is the dialogue accessible to me as a unilingual English speaking external researcher. My inner reflections are denoted by italicized type in order to set them apart from the actual events and dialogue that tell the story of the community research group. They constitute a narrative within the narrative.

The community research group that formed to study the health system of the Split Lake Cree First Nation and I, the external researcher, met fourteen times in Split Lake during the year and a half covered in this case study. Each meeting was two to three days in length. As the external researcher, I also met with individuals a number of times to discuss the progress of the study.

Date	Meetings and Events
<b>1989</b>	
October 3	First meeting with John Knott, Councillor responsible for the Health Portfolio for the Split Lake Cree First Nation to discuss proposal to collaborate on a research project for introducing change in the local health system.
October 11	Second meeting with John. He advised me that Council had expressed interest in the research but no decision has been made.
November 2	John advised that the Chief has approved the research.
November 23-25	First meeting in Split Lake with the Health Committee. Shared information about ourselves, the goals of the Health Committee, a vision of the health system in the future and information on the traditional health system. Audio tape on aboriginal culture. Comparison of past and desired future health system. Comparison produced insight into the changes in life style and nutrition that have occurred and their impact on the health of people. Health Committee presented description of current health system. Identified questions concerning pre-transfer planning required for health development plan leading to the transfer of control of health services from government to the community.
December 6-7	Conducted team building and communication skills session for Health Committee, heard report by John on a health transfer conference he attended in Toronto and began work on a Pre-Transfer Funding Proposal to obtain funds from Medical Services Branch. Clarified the purpose and the goal of the Health Committee concerning pre-transfer and discussed my role as researcher. Discussed proposed research, research methods, and health concerns. Health Committee began work on the community profile for the Pre-Transfer Funding Proposal.
December 8	Met with Helen Wood, zone director for Medical Services Branch. Advised her I was working with Split Lake on research on their health system, including the Pre-Transfer Funding Proposal.
December 22	Met with John, later joined by George Maskwa, Medical Services Branch, to develop outline for the Pre-Transfer Funding Proposal.
<b>1990</b>	
January 15-17	Met with Split Lake Health Committee and George to review Medical Services Branch guidelines for Pre-Transfer Funding Proposal and develop Proposal outline.
February 1-2	George and I travelled to Split Lake where we met with the Health Committee and worked on the Pre-Transfer Funding Proposal.
February 7	Phoned John. Health Committee is meeting to review what has happened in our work to date and discuss the commitment members have to continuing with the process through the next two years.

**Chronology of Meetings and Events**

**Figure 5.1**

**Continued, next page**

Date	Meetings and Events
<b>1990</b>	
February 8-9	Met with the Health Committee. Discussed my commitment to the project and my research. Worked with the Health Committee on the Pre-Transfer Funding Proposal. Community research group adopts new name, Health Task Force.
February 13-15	Training session on Team Building including decision-making, group evaluation, model building, planning for a community workshop and identifying areas for inquiry.
April 10-11	Worked on Pre-Transfer Funding Proposal. Began work on Traditional Health Study.
April 18-19	Discussed experience of doing first interview on traditional health. Worked on translating and transcribing interviews.
May 22-24	Worked on Pre-Transfer Funding Proposal.
June 20	Meeting cut short due to conflicting commitments of Committee members. Discussed my role in the health transfer project, my available time and my commitment. Discussed the Pre-Transfer Funding Proposal. Established a preliminary time frame for the research project. Discussed problem of hiring a project coordinator. Discussed roles in conducting the first community workshop.
June 25-27	Group worked on the first two traditional health interviews. Translated and transcribed the interviews and categorized the information. Identified next four elders to be interviewed. Revised interview questions and schedule. Worked on revisions to the Pre-Transfer Funding Proposal.
October 31- November 1	Discussed intra group issues and revised Pre-Transfer Funding Proposal.
<b>1991</b>	
March 5-6	Final editing of the Pre-Transfer Funding Proposal. Reviewed narrative describing previous meeting.
July 23-24	Discussed intra group issues and delay in forwarding Pre-Transfer Funding Proposal to Chief and Council and Medical Services Branch.

Figure 5.1

The individuals who became involved in the community research group are listed below in the order in which they are mentioned in the narrative. Also included are individuals who were involved in a significant way with the health study. The role of each individual is noted. All individuals are Aboriginal except for the external researcher.

### List of Participants

- John:** Councillor responsible for the Health Portfolio  
Community Health Representative  
Member of the Health Committee
- Betty:** Community Health Representative  
Member of the Health Committee
- Mary:** Member of the Health Committee
- Karen:** Member of the Health Committee
- Joan:** Member of the Health Committee
- Margaret:** Member of the Health Committee
- David:** Member of the Health Committee
- Dolly:** Member of the Health Committee
- Irene:** Member of the Health Committee
- Ethel:** Part time Community Health Representative  
Member of the Health Committee
- June:** Councillor  
Former Transfer Coordinator, Medical Services Branch
- George:** Transfer Coordinator, Medical Services Branch, North Zone
- Don:** External Researcher

## Negotiating the Research Project

I arranged to meet John Knott, the Councillor responsible for the Health Portfolio for the Split Lake Cree First Nation in early October. I briefed John on my interest in change in a First Nation's health system stemming from my involvement in working on the health administrators certificate program and asked him if he and the community would be interested in working with me on a collaborative research project to study change in their health system. I advised him that I was interested in documenting the research project for my dissertation. He responded positively to my suggestion and agreed to meet me in Thompson, Manitoba to discuss the possibility of participating in the research project.

We met in Thompson on October 2, 1989. John began by telling me that he had not prepared anything in advance of our meeting as he was not sure what was wanted but that he did have a number of concerns regarding the existing health system. His first concern related to the restrictions Medical Services Branch placed on patients who wanted to visit a medicine man. The Branch's position was that patients were to see a "regular" doctor before seeing a medicine man and if the treatment provided by the medicine man did not work on the first visit, the patient was then to see a western trained doctor. I responded by sharing a personal experience I had had in obtaining a medical referral when I was required to see my regular doctor a number of times before being referred to a specialist. I had not been satisfied with the first specialist and had obtained a referral to a second specialist who identified the problem and provided me with the necessary treatment. John responded by telling me that the community needed to have control of the referral element in the system.

*In reflecting on my attempt to identify with John in this our first meeting, I became aware much later on reviewing my notes that I had missed the point that John had made. In Split Lake, people did not have the freedom to seek out the healer of their choice. They were subject to policies prescribed by Medical Services Branch, which limited their options. In my situation, I had the right under the provincial medicare system to seek the medical help I desired and when I was dissatisfied with the first referral, I was able to readily obtain a second referral to a specialist of my choice.*

John went on to tell me that at one time a researcher had visited the community to gather information on herbs that were used by traditional healers. He had personally been asked by the researcher to assist him in approaching an elder who was a medicine man. The medicine man had agreed to tell John about the plants and herbs but had then refused, saying the knowledge he was about to share was not going to be used in the right way. The medicine man believed that the researcher would take the plants away and analyse their properties. He considered this to be a misuse of the knowledge and showed a lack of respect for the plants and their healing qualities. John told me he was not sure how to deal with the belief that the analysis of the healing properties of the plants and telling others of the beliefs or stories that accompanied the use of plants would be disrespectful. He added that he was aware of the change that had taken place in the community over time concerning peoples' beliefs and recounted how as a child his grandfather had told him not to go near the water because a serpent had been seen in the water. At the time, this had kept all the kids away from the water but the same method did not work today. In another instance, as a child, when he had wanted to go outside to play after dark he had been told the story of Jahabess, the moon, and how if he went outside he risked looking at the face of the moon which would then draw him up. He was expected to go to bed so that he could get up early to help with the chores. Now the kids just stare at the moon. Today, his kids jokingly tell him, "Boy, you guys were abused!"

*John's story of a previous researcher's attempt to gather data on herbs and plants used for healing illustrated conflicting values and beliefs between traditional and Euro-Canadian health research and practice. It may reflect an accurate reading by the elder medicine man of the rejection of indigenous knowledge and the explanation of that knowledge. John's story suggests that conflicting values and beliefs are an issue that he had still not resolved in his own mind.*

I told John I had not expected him to have prepared anything for our meeting but that I had wanted a chance to meet him and explore the possibility of doing a research project with the Split Lake Cree First Nation. I recounted the background of my involvement with the tribal council and how those I had been working with had recommended that I contact him suggesting that he would be a good person to involve in research on change in a First Nations' health system.

John told me that he was concerned about his role as the Community Health Representative (C.H.R.) at Split Lake. He was expected on the one hand to provide care for people, telling diabetics for instance why it was important for them to wash their feet, while not being allowed to provide the medical reasons for the health care he was giving. He also had to keep track of medical records and while he had no qualifications for this, he remained liable for anything that went wrong. He had no liability insurance to cover this aspect of his work which left him feeling vulnerable.

John informed me that at the present time the Split Lake Cree First Nation had only two nurses in the community although the government's own policy authorized a compliment of three. One of the nurses was required to provide nursing care in a satellite nursing station at the community of York Landing located across the lake. When she was away and the other nurse was preoccupied, he, as the Community Health Representative,

was on the spot! He added that he felt that he could have been trained as a Registered Practical Nurse but no training had been provided.

I described the research project that I had in mind. I explained that I wanted to work with the community in studying what the community needed to know in order to change its health system. I saw the research as providing the community with the basis for negotiating a transfer of the health services. This meant implementing the findings from their research.

John told me the Split Lake Cree First Nation was moving ahead on devolution in health care. He indicated that he thought the research I was proposing could be part of that process. I asked him who else would have an interest in the research and he said he had organized a Health Committee which was made up of committed people. He thought they were an obvious group to involve in the study.

We ended the evening with John saying he would discuss the idea with the other Split Lake Cree First Nation Councillors the following day as the newly elected Council was meeting to assign portfolios. John expected to be reappointed as the Councillor responsible for the health portfolio. He told me that he would phone me the following afternoon to let me know the decision of Council. I told him I needed to know what the Council's intentions were one way or another, as I had to make a decision on where I would do the research for my dissertation. I advised him that I was currently on leave from my work at the university and that I had the next two months to work on the research, followed by four additional months leave later in the year.

*I sensed that John wanted to go ahead with the research, linking it to the health transfer process offered by Medical Services Branch. In our first meeting, it had been*

*essential that we each determine whether we shared a mutual interest in working together on researching the Split Lake Cree health system. Underlying this was the issue of trust. Did we trust each other enough to proceed with my proposal?*

*A key issue raised by John at this time was the issue of control. He pointed out that the community lacked control of the health services in Split Lake. There was also an oblique reference to control of the inquiry process itself and the use to which information might be put. The researcher studying healing substances in the community had been seen as potentially violating the traditional values and beliefs of the community, resulting in their loss of control of locally held knowledge.*

I phoned John later in the week and learned that Council had not met as the Chief had not returned to the community. John told me that he had talked to a number of Councillors and the Deputy Chief and they were supportive of my proposal to work with a community research group. He noted that he thought my research interests and the Health Pre-Transfer Project might compliment each other. John added that the Councillors wondered where they would obtain the funding for my travel expenses but he thought I could be used as a consultant on their health pre-transfer project.

I phoned John the following week. He asked me to send him a letter indicating what I proposed to do in my research, why I wanted to do the study and how the study would benefit the community. He suggested I indicate what I thought might be both the intermediate and long term benefits to the community. He noted the long term benefits might include administrative training. He also suggested I indicate why I thought Split Lake was the ideal community in which to do the research. A copy of the letter is included as Appendix A. John later advised me that the Council was interested in the long term goal of administrative training and the Chief told them that I could get that training for them.

John wanted to know how I would be able to work on my research along side a consultant who would be working on the health pre-transfer process. I told him I was not clear what he meant by this and he responded saying that he himself was not clear. I asked him if the Council had a consultant in mind. He told me they had not identified one but he wondered what would happen at the end of my six months leave. I said that on entering this project, I was committing myself to working with them until they were well on their way to implementing their own health program, whether it took two years or eighteen months and that my involvement would be terminated at a mutually agreed upon time. I told John that after six months I would have less time to devote to the project and asked him what his expectations were regarding the amount of time that would be needed for the study. John told me that current practice was for a consultant to come in for a few days, leave to write a report and return after three or four weeks to give the report. I told him I could see myself providing that amount of time and more but that they would probably have to compensate the university for my time after my six months leave ended. I added that I saw the Health Committee getting involved in the research, as co-researchers, and that I would not be doing all the research myself. John responded by saying that the Health Committee members didn't have the appropriate training.

John wondered if I could be labelled an advisor. I told him that advisor, consultant or researcher was all the same to me and that I had experience doing consulting work.

*I was not sure how he differentiated these roles nor whether he saw me as capable in one role and not in others. I did not ask him to clarify what he meant by the terms and so missed an important opportunity to clarify his understanding of my role. I was not familiar with the requirements in conducting a Pre-Transfer Study. I was to learn that the guidelines for the pre-transfer process published by Medical Services Branch assumed a consultant would be retained by First Nations to prepare a Pre-Transfer*

*Funding Proposal and the Study. In negotiating my relationship with the community Health Committee, I found this expectation to be a complicating factor which contributed to considerable confusion around my role and the community based research process that I was proposing. It took some time before this issue was worked through.*

*The weeks spent waiting for approval from the Council to proceed were ones mixed with anxiety and frustration. The need to get on with my dissertation combined with a limited time for my leave put severe pressure on me to get started on the field work. In reality the process in the community required time. My personal needs were not the number one priority in Split Lake even though it was an unexpected opportunity for them to obtain help in preparing for their Pre-Transfer Study at minimal cost.*

I met John in Winnipeg on Thursday, November 2, 1989. He said he had spoken to the Chief and that the Chief had given his approval to proceed with the research. He told me that he had asked the Chief for a letter confirming approval but had received no response. We agreed to meet in Thompson in mid November to begin the project.

During one of our discussions on the research project, John stated that he understood the research on the health system would be jointly owned. He emphasized this point by describing how previously a teacher had done research for an M.A. thesis while working in the community. He told me that nothing had ever been heard of that research. I told him that I saw the research as a joint undertaking and that I would ask them to approve whatever I wrote. If we disagreed on something, I said I would include both our views but that I expected we would be able to achieve consensus on anything I wrote. I told John that I would not write or include anything which was not acceptable to the Split Lake community research group. I added that I would maintain confidentiality in whatever I wrote.

*Control was an important issue. Who owned the research? I stressed the idea that we would be working together but did not at this time clarify or negotiate the degree of ownership or control each of us would exercise. I did not know what, if anything, would be exclusively my work and what would be exclusively theirs. As it has evolved I believe each of us has shared in planning and doing the research while at the same time each of us has had specific interests that are exclusively our own. I, for instance, am interested in my role and my relationship with the community research group. The research group is interested in specific health issues and how these will be studied and incorporated in the community health study. Significantly, these interests require the collaborative effort of each of us.*

*A secondary issue was the interplay between my proposal to work with the community in a collaborative community research project and the need to conduct a Pre-Transfer Study in order to negotiate the transfer of health services from Medical Services Branch to the community. I did not realize at this stage that they would in fact become one and the same piece of research. Nor did I see how my proposed collaborative research might be combined with the preparation of the Pre-Transfer Funding Proposal. The uncertainty around my time commitment to the project added to the confusion around my role and my potential involvement in the Pre-Transfer Study.*

### **The Community Research Group**

I wrote John on November fourteenth, confirming plans to meet with the Split Lake Health Committee the week of November twentieth. The letter outlined my understanding of the decision by the Health Committee to investigate the transfer of health programs from the federal government to the Split Lake Cree First Nation and indicated how I thought the research process would prepare the Committee for

investigating their health system and the management of the transfer process. The letter is reproduced in Appendix B.

The meeting was delayed one week. I arrived in Thompson Wednesday evening, November twenty-ninth and set out for Split Lake at eight the following morning. This was to be my first trip to Split Lake in many years. I had rented a half ton truck and now headed down the gravel highway. There had been a fresh two inch snowfall and the road had not been ploughed. The temperature was minus twenty degrees celsius and the sun was just lighting the eastern sky. Daylight comes late at fifty-four degrees north latitude in November. As I turned off the main road heading northeast to Split Lake, I quickly took in the sign that warned motorists to carry winter survival gear on the road as there were no services for the next two hundred and twenty kilometres. There was only one set of tracks down the centre of the road. I wondered how icy the road was under the snow. I knew the swirl from passing vehicles or from a slow moving truck I might want to pass would obliterate my vision. I also wondered how wide the shoulders of the road might be and how far over I could go to pass an oncoming vehicle.

I arrived in Split Lake two and a half hours later without incident and headed east past the Band Hall and the Northern Store looking for some sign of the nursing station where we were to meet. I remembered from a previous visit to Split Lake twelve years previously, the nursing station and the church being on a point of land at the east end of the community. I finally spotted the church at the end of the road and then, down a side road that angled off to the right, a building that looked like it might be the nursing station. There were four or five trucks and a van parked next to it.

I parked and went in the side door. John approached as I was taking off my goloshes. He welcomed me with something like, "You're here," and said he would call

the others and tell them to come on down. I followed him in, parked my bags and parka in his office and followed him into the community health room where we would meet.

I briefly reviewed with John the agenda I had prepared. He indicated that it looked straight forward.

Shortly after, members of the Health Committee entered the room and took their places around the table. John introduced each person. The group included Betty Hart, Mary Ross, Karen Green, Joan Sinclair, Margaret Daniels, June Ouskan and John. John and Betty are both Community Health Representatives. June is a Councillor and former employee of Medical Services Branch.

John then suggested I explain the purpose of the meeting and the agenda. I told the group that the meeting was an opportunity to discuss the feasibility of conducting a study of the community's health system and the transfer of control of health programs to the Split Lake Cree First Nation. I explained to the group how I had been approached by the Tribal Council to become involved in the issue of health in the Aboriginal community. I added that I was interested in working with a community research group in a study of change in a health system as a research project for my doctoral dissertation and added that I had contacted John and proposed working with their community. This had led to our meeting that morning.

I indicated that I would shortly tell them about myself but that I first wanted to hear something about the members of the group and the work of the Health Committee. I suggested that we would need to spend considerable time becoming clear about what they wanted to accomplish as a Committee. I added that John and Betty, the two Community Health Representatives (C.H.R.s) in the group, might tell us what they knew

about the health transfer process and proposed that later in the meeting we take time to identify questions that John Knott and June Ouskan, the two Councillors who were planning to attend a conference on health transfer, might attempt to answer while at the conference. I added that I would explain the research process, noting that research involved gathering information that the community needed in order to discover things one didn't know and needed to know. I added that I wanted to use a participative approach in the research and that this involved working together as a research team. I told the group that I would like to tape record the sessions and wondered if anyone felt uncomfortable with having the sessions recorded. I had set the tape recorder up but had not turned it on. I explained that the tapes would be used for my dissertation and anything I wrote would be shared with them and okayed by them before I used it. I also told the group I would be sharing my work with three faculty advisors whom I was working with in my graduate program. John said that the Council had approved my taping the sessions as long as I cleared what I wrote with them. I said that was okay but I wanted those present to agree as well. There were nods of agreement. No one said they were opposed.

I told the group a bit about myself, how I had previously lived in Moose Lake, a Cree community in northern Manitoba, where I had spent four years working as a community development worker. I also told the group that I had worked in adult education in the Northwest Territories and had directed a community development training program for Dene Aboriginal field staff in the western arctic. I then asked those present to tell me something about themselves and what they had been doing as a Health Committee. I turned on the tape recorder at this point.

John said a few words in Cree and then began. He told me that they had tried to form a Health Committee approximately five years ago but that the Committee members

at the time had not been that interested. Then three years ago they had brought together the present group. It was a very dedicated and helpful group. They had looked at the community as a whole and had wanted to address the concerns of the community and those of the nurses. Their main concern had been sanitation. During the past two years they have built garbage stands for each house. They have raised money for this project by running bingos, raffles and by selling Nevada tickets. The Committee also helps with the elders' group home. The home can accommodate ten elders. There are currently four residents in the home. For the past two years the Health Committee has participated in the running of the home. Committee members help elders by cashing the elders' cheques in order to pay the elders' store accounts. Members also participate in shopping for the group home and meet with the group home staff to address staff concerns. The Health Committee raises money for the community as a whole for anything that will benefit the community. The Health Committee also makes recommendations concerning health to Council. Committee members are paid twenty dollars for each half day they attend meetings, except for the Community Health Representatives who are salaried employees. The Committee meets once a month.

I asked the group if they had discussed the idea of transferring control of health services to the community. John said they had discussed my involvement in researching the health system as well as the health transfer project but the decision concerning these two tasks had not been finalized.

**John:** But again that's up to the Council.

**Don:** They haven't made that decision yet?

**John:** They haven't made that decision yet. Maybe they will form another group. I don't know but that's a Council decision.

**June:** There's just been general discussion yet.

**Don:** Okay, I guess I made some assumptions. One would be that the ... Health Committee would be involved in the pre-transfer [process].

**John:** Well most likely they will but again that's a Council [decision]. That's not decided.

John added that he saw my role in part as training members of the Health Committee so that they would be more confident in taking on major tasks in the area of health.

At this point I asked the group to tell me what they wanted to accomplish as a Health Committee. I listed their items on a flip chart. The list included training for Health Committee members and the preparation of a Pre-Transfer Funding Proposal.

*I had begun my first meeting with the Health Committee by explaining the purpose of the meeting, how I had become involved in studying change in the Aboriginal community's health system and my interest in studying my role in working with them in the research. I had introduced myself and asked them to tell me about the work of the Committee. These introductions and the explanation of the purpose for our meeting had been the first step in establishing a working relationship with the Committee. The positive response from John suggested that he was in agreement with my proposal to work with the Health Committee although there was confusion about the relationship between my proposed research and the health transfer process. Other members of the group seemed prepared to participate in the study of their health system.*

*John did not appear to be clear about my role and the role a consultant might play in preparing the Pre-Transfer Study. His confusion seemed to reflect uncertainty on Council as to the distinction between what I was proposing and what the pre-transfer process required. I was not clear myself as I was not familiar with the pre-transfer*

*process and the health transfer guidelines. I later discovered that the guidelines implied that a community was to hire a consultant to do a Pre-Transfer Funding Proposal and Study. The Study was expected to take two years to complete. My limited leave of six months and the need to immediately locate travel funds to enable me to work with the Health Committee in Split Lake seemed to rule out my working on the Pre-Transfer Study as far as John and the Chief and Council were concerned.*

*There was uncertainty as to the parameters around the authority Council had delegated to the Health Committee for studying the health system. John, as Councillor responsible for Health, was uncertain whether Council intended the Health Committee to conduct the Pre-Transfer Study. This ambiguity made it difficult for him to give clear direction to the Committee or resolve the confusion between the research I had proposed and the research required for the Pre-Transfer Study.*

### **Developing the Research Project: Comparing Past and Future Health Systems**

I now asked the Health Committee members to develop a list of the components of the health system they wanted in the future. They worked on this as a group, preparing a list on newsprint which they presented in general session. I reviewed the list with them and grouped each item under categories that seemed to encompass a general topic or area. I followed this by asking them to develop a second list indicating what the health system had been like in the past before 'white' people arrived. They again generated an extensive list which was written up on newsprint and presented. The lists are reproduced in Figure 5.2. This ended the afternoon session. We closed the meeting, as we would most meetings, with the Lord's prayer.

	<b>What We Want The Health System To Be Like In The Future</b>	<b>What The Traditional Health System Was Like In The Past</b>
<b>Health Care Providers</b>	Resident Doctor Traditional Healer Licensed Personal Care Home Resident Pharmacist Midwives (recognized) Dental Services Direct Referrals to Specialists Native Health Professionals Escort/Interpreter Service Mental Health Support Group Worker Drug/Alcohol/Solvent Abuse Centre Daycare Centre Cultural Awareness	Midwives Medicine man/woman
<b>Organization and Structure</b>	Band Run Facility Local Control Health Administration Health Board	
<b>Transportation</b>	Ambulance Airport	
<b>Resources</b>	Licensed Personal Care Home Local and Outside Resources Drug/Alcohol Abuse Centre Crisis Centre Diet Centre Health Education Programs	Indian Medicine
<b>Environment</b>	Proper Sanitation System Water and Sewage	No environmental contaminants Wood used for heating No junk food
<b>Qualifications/ Certification/ Authority to Provide Service</b>	Certification and Authorization	

**Comparison of a Desired Health System  
and the Traditional Health System**

**Figure 5.2**

**Continued, next page**

	<b>What We Want The Health System To Be Like In The Future</b>	<b>What The Traditional Health System Was Like In The Past</b>
<b>Funding</b>	Sufficient Funding Compensation	
<b>Health Education</b>	Community Awareness and Support Health Education Programs Cultural Awareness	
<b>Nutrition</b>		Traditional Foods No Pampers Family/Group Support Caribou milk Traditional food preparation
<b>Life style</b>		Outdoor life People were in better health All children were breast fed More exercise Dog teams (kept clean) Less disease Self-supporting/Self-reliant
<b>Programs</b>		
<b>Conditions</b>		
<b>Inter-organization Relations</b>	Inter-agency support	

**Figure 5.2**

We began the next morning with an opening prayer. I followed this with a review of the agenda and then played a tape in which Ray Fadden, a Mohawk who directs a Mohawk museum in Akwesasne, New York, describes the medicines, foods and technology that Aboriginal people have given to the world.

*I had hoped this tape would be thought provoking and would increase members awareness of their own traditions.*

After listening to the tape, I asked the group to compare the two lists they had developed the previous day describing the health system they would like to create and the traditional health system in Split Lake prior to European contact. The categories I had developed were used to group and compare items in each list. As members of the group reviewed the lists, I asked them to look for significant differences and to speculate as to why those differences might exist. The process generated considerable discussion and comment.

**John:** Well, one of the big differences is that we didn't have a doctor, we didn't have a nurse and there [was] no hospital. [As for] health care providers, we had medicine men and midwives. That's a big difference.

The group had identified the need for fourteen health care providers in a future health care system.

**John:** In the future that's what we want.

**Don:** Where as you only had two [health care providers] in the past.

**John:** But what's not represented [on the list are] the parents. Like [even today], a mother brings a child in [to the nursing station]. They get a medication but once they get home it's the mother that continues the dispensing. That was the case in the old days too.... Another big difference in the old days [was] ... life style and exercise. Nutrition too was a big factor ... even though they probably didn't have all the vegetables that we have, but they got their vitamins from their traditional diet.

**Don:** John is saying there is a major difference in [the] two charts in terms of nutrition and life style [which were] much more [a factor] in the past than ... [they are] today. What did that mean in terms of health?

**John:** I guess what that represents too is that [Cree] the people lived off the land. They were nomadic. They were trappers ... where as today ... [trapping] is done but not to that great an extent. [Cree] People still trap beaver, like Mary.

**Mary:** How do you know? [laughter] [Cree]

**John:** Organizational structure.

**Don:** That's another point. The structure is much more complex now than it was in the past where it was mainly the family that provided the structure and the organization.

**John:** Health education. The women especially were taught many things. Like one lady said last week there was an old lady here teaching the young mother, for the placenta. That was respected. They didn't just discard it like that. There was not a whole ceremony but there was a special way of disposing of it. That was taught to the mothers so that was health education. They were taught how to care for themselves. Like the mothers and the grannies, I guess it was up to them to teach young ladies how to be a mother.

I told the group that one thing that they would want to be thinking about at a later stage were the factors that kept the community healthy in the past. These factors needed to be included in plans for the future. I added that we would come back and compare the two lists again and look at the differences in order to determine why change occurred.

The group went on to identify some of the significant changes that had taken place in the health system, including increased specialization in the role of health care providers. I added that the organization of health was now much more complex. John drew attention to the fact that the environment had changed and he wondered how we might represent the change. I suggested that the group needed to ask themselves why the change had occurred, given their assessment that people had been healthier in the past even though they did not have as many health care providers.

John said he felt it was very important to consider how they could integrate traditional health with western medicine. He reflected on the difference in the health of people who now were susceptible to all the modern diseases even though they now had

western trained doctors and nurses. I suggested that if they were able to figure this out they might be able to make important changes in their future health system.

*The comparison of the desired future health system and the traditional health care system engaged the group in a critical review of the two systems. This was my first attempt at introducing a consciousness raising process that asked fundamental questions about health and health practice in the community. I had searched for a way to initiate this process without imposing my ideas and values on the group. The contrasts that emerged from the two health systems when they were compared had produced insights that I hoped would emerge. I had wanted something like this to happen but I had not known beforehand if anything significant would emerge from the lists nor whether members of the group would identify significant differences in the two systems and how the difference might have come about. I did point out during the exercise that control had shifted from the community to government during the period in which the comparison was made.*

The group had looked ahead to the future and back to the past. I now asked them to describe the current health system. I suggested that they discuss it and write up their points on the flip chart. John said that they had already done this and that they only needed to find the newsprint on which it was written. Betty located the material and the group reviewed the list of services provided by Medical Services Branch.

### **Introduction to Health Pre-Transfer**

We discussed pre-transfer that afternoon. We were at a disadvantage as John, who appeared to be the most knowledgeable about the transfer process, was absent.

Betty told us that funding was available for a community to research the problem of taking control of its health services. She explained that the pre-transfer process was an opportunity to prepare the community for making a decision as to whether a First Nation wanted to commit itself to transfer health services to local control. She added that the main concern appeared to be whether adequate funding would be provided to maintain the health service. The concern was that once a First Nation took over its health system, a ceiling would be placed on funds available for health in the community.

I asked Betty if she understood what John had in mind concerning the hiring of a consultant and what the consultant was supposed to do. I made the point that I believed the Health Committee was capable of doing their own study.

**Betty:** He [the consultant] just helps us I guess [on the] study, guides us and advises us on the study.

**Don:** But you can do a lot of that study yourself with a bit of guidance, eh?

**Betty:** Well, during the study you have to go to different resources to find out the information. Like all, most of the stuff is kept at M.S.B. [Medical Services Branch] and transportation, medicine, most of the other things [are] in their computers or wherever they keep them.

**Don:** Somebody from the community could go to M.S.B. and get that information if they wanted to, eh?

**Betty:** I'm sure they could.

*I had asked Betty if she knew what John had in mind as I was confused and hoped she could explain the Split Lake Cree Council's position. I had expected my work with the Health Committee would be an integral part of the research required for the Pre-Transfer Study. I am aware as I read the transcript that I was promoting the Health*

*Committee's involvement in the research rather than clarifying the expectations and understanding the group might have of my role.*

We switched to the topic of the upcoming conference on health transfer which was being held in Toronto. I asked the group to think about questions they had about the pre-transfer process and suggested that we ask John and June, who would be attending the conference, to obtain answers to these questions. There was no response to this suggestion so I proposed that the members of the group work on developing a list of questions. I then left the room.

When I returned, the group was ready with their questions. They wanted to know how many communities had gone through the pre-transfer process, how many communities had turned down transfer and for what reasons? They also wanted to know what cutbacks had been made in health services.

I suggested that it might be useful to know if there was a list of Pre-Transfer Studies that had been carried out by other First Nations and whether one could get copies of these studies. I suggested that the questions could be reviewed with John and June before they left for the conference.

*With John absent, the leadership had evolved to Betty, the other Community Health Representative, but there was little dialogue in the group until I assigned them the task of identifying questions to be asked at the Health Transfer Conference and then left the room. The group had little difficulty generating an extensive list on their own. This suggested to me that considerable work was needed on my relationship with the group if members were to feel free to engage in discussion with me present.*

Betty wondered if the questions they had identified were for my dissertation. I responded by explaining the purpose of my research. I began by suggesting that the pre-transfer process enabled them to study their own health system prior to taking control in order to know what they wanted in their system. I told them that they had started this process as they examined their past and future health system and that they were in essence a study group or a research team. I added that the Split Lake Cree Council had declared that they were the group that was to study transfer and added that I understood that I was their advisor.

I attempted to explain the nature of research, suggesting that the essential task was to decide what they wanted to study. I added that they needed to be clear about the problem requiring research. I told the group that it appeared to me that they were concerned primarily with acquiring control of their health system but my guess was that they first needed to consider what they wanted as a future health system. I explained that the research process required that they discuss and reflect on various ideas until they got a clear sense of where they were going. I added that they needed to move from a problem statement to a goal statement in order to be clear as to where they were headed. To accomplish this they needed information from others outside their group. The goals for health had to represent the interests and ideas of the community at large. I suggested that one of their tasks would be to talk to others, perhaps through interviews, and to bring this information together so that they could sort and organize it. As they gathered the information, they would need to make changes and rethink their goals. I stressed that it was important to consider why control was a problem in the first place and what had produced the current state of affairs. They would need to consider how traditional health practice and western health and medical practice could enhance each other. I pointed out that, in the last two days, they had identified a number of factors that had impacted their health. I concluded by telling the group that the process of analysis involved reworking

ideas and information until they came to a conclusion and were ready to make a decision. At that point they would be able to say, "You know, there are some ways we ... [can] change the health of this community and here's how we will do it." At that point, they would be able to make recommendations to the Chief and Council. I suggested that the recommendations could be in the form of a proposal which would need to include a plan of action.

I became aware at this point that I was doing all the talking and that the group was patiently waiting for me to finish. I ended my discourse and we adjourned.

*When Betty asked me if my interest in their questions concerning the pre-transfer process was related to my research, I responded by launching into a lengthy description of the research process and how research was conducted. When I later read the transcript, I was struck by my inability to provide a clear explanation of the research process. My explanation was garbled and unfocussed. This reflected my own uncertainty with the process at this stage in my dissertation. I talked about setting goals, doing an analysis of the data, restating the problem and the goal and eventually arriving at a conclusion. This rambling discourse was interspersed with an admonition that the group had to plan for the professional training of nurses from their community. I drew attention to an Aboriginal nursing education program that was to start in the north in the fall. I also included an explanation of the planning and evaluation process. I finally ended my monologue when I realized I was doing all the talking and was losing the attention of the group.*

The second meeting was to be a training session for the Health Committee. It was scheduled for December sixth. I arrived that morning at 10:00 a.m. to discover that there was to be a funeral that afternoon and that the Chief had cancelled all community

activities and meetings. He gave his approval for our meeting to take place after the funeral at 3:30 p.m. We met in the public health room at the Nursing Station. Only four members of the Health Committee were present. Karen joined us later.

With only four members present, I realized I needed to reorganize the training design. I began with a session on effective meetings. Later that evening with seven members present, I conducted experiential exercises on co-operative behaviour and interpersonal communication in a group.

The exercise on co-operative behaviour effectively identified the need for group members to understand the task or problem they were working on, to recognize the contribution each could make in solving the problem or completing the task, and to identify behaviours that helped or blocked the group from completing its task.

I asked two group members to demonstrate an interpersonal communication skill exercise I had prepared. They had difficulty getting started and both appeared uncomfortable being the centre of attention. I broke the impasse by asking group members to find partners and practice the communication skill in pairs. Working in their own language and in pairs greatly facilitated the process.

*I had not expected members to find it difficult to demonstrate the communication exercise to others in the group. In hindsight, I realize it would have been more effective to ask two members of the group to volunteer to demonstrate the communication skill or to have begun the exercise by having everyone work in pairs.*

We began our session the following morning by reviewing the minutes of our first meeting. We checked these minutes for accuracy with information contained on the

original flip chart papers and made a few minor corrections. I reviewed the research study process described in the minutes in considerable detail; the setting of goals, a look back at the past, and identifying information needed in order to achieve a goal. I suggested that gathering information could be done through interviews or community workshops. I pointed out that the next stage, analysis, would enable us to discover new knowledge about the situation. I explained that analysis involved figuring out what the information was telling us. I pointed out that the group's comparison of past experience and goals for the future had led to the observation that lifestyle and nutrition had changed over the years and impacted in a negative way the health of the community. Based on this analysis, the group would need to develop a plan of action which took this insight into account while answering the overall question about taking over their own health system.

I told the group that the minutes which had been written by Betty were some of the best minutes I had seen in that they reflected the intent and work from our first meeting. One task that we had agreed on and assigned to one of the members, the rewriting of the lists describing the past and future health system, was not included in the minutes. This was to have been written out on newsprint in preparation for this session.

*The review of the minutes indicated that as a group we had failed to assign responsibility for contacting the Tribal Council. I also discovered that I had failed to phone John at an agreed upon time to confirm our next meeting date. The review effectively provided the Committee with feedback on its decision-making and planning process.*

I suggested that John give a brief report on the conference on health transfer he had attended in Toronto. He had not been given the questions the Health Committee had prepared. John explained that this was the second national conference on the Transfer of Health Services to First Nations although it was the first one anyone from Split Lake had

attended. An address by the National Chief, George Erasmus, had cautioned delegates about accepting the pre-transfer process as prepared by Medical Services Branch. Chief Erasmus had pointed out that in accepting the process, the First Nations were accepting the colonial system practised by the federal government and that as sovereign nations they should be able to negotiate the process and not have it dumped on them. Chief Erasmus had stated that First Nations that signed a transfer agreement with the government were signing away their treaty rights. A counter argument expressed by a Chief at the conference suggested that First Nations could state in a Memorandum of Understanding that in signing any agreement on health, a First Nation was signing an agreement to enhance the health services for their community and that the agreement was in no way to impact the Treaty. John proposed that Split Lake follow this latter approach in signing any Memorandum of Agreement.

John reported that he and June had divided up the workshops they had attended. He had participated in a session on Community Health Needs Assessment. One community when asked what it would do differently in conducting a Pre-Transfer Study reported that it would not hire a consultant. When they had started, it had looked like they could not do the study on their own but once the consultant had completed the task, they had come to the conclusion that their Health Committee could have done the study with some professional help. They felt that they just needed to be pointed in the right direction and helped to ask the right questions. John expressed his belief that the Split Lake Health Committee could do their own study, especially a community health needs assessment, providing they first received the training they required.

John told us that those attending the Conference had been advised that a needs assessment could include anything the community wanted to study, including traditional medicine, medicine men and mental health. He added that there were a lot of models to

look at, that people think differently and that they need only contact those who have done studies elsewhere to learn from the experience of others. He told us what one community had done.

**John:** There were a lot of kids in the hospital, pneumonia, colds, scabies. A lot of women were getting sent out [Cree] to the hospital to give birth. Well they did their own community health plan. They implemented [the plan] and the money spent by Medical Services Branch while they were running it, they cut it down by half. What happened, they were using midwives again for deliveries. They were getting families to participate in the health plan. Less children were being hospitalized. What they meant by that, the community had to be involved.

John cautioned the group about how they deal with Medical Services Branch. He recounted a situation that had been described at the Conference on Health Transfer.

**John:** The Kahnawake Reserve ... They are part of the Six Nations and they have a hospital and the first thing they said was, 'We don't want to be part of the transfer process'. Well anyway, they went a few months later ... and asked for pre-transfer funding. Medical Services Branch said, 'No. You're not interested in the pre-transfer process. Why should we give you some money?' So they can't tap into it. That's another warning they gave us, you know, even if you just want to study [the health system, go ahead and] study it, but don't say you don't want to transfer cause they'll just cut it.

John suggested that the role of the Health Committee could change and as in other First Nations, it could take primary responsibility for health. This would mean that Health Committee members rather than Councillors would be attending health conferences in the future.

The next item on the agenda was the question of whether the group should prepare a Pre-Transfer Funding Proposal to enable them to conduct a Pre-Transfer Study. The planning guidelines provided by Medical Services Branch indicated topics that should

be addressed in the Proposal including training for members of a local health authority which, it was assumed, would exercise authority over the local health program.

I began by suggesting that we were moving into the planning stage when we looked at the pre-transfer process and that one way to plan was to envision their future. I proposed that the group determine their own objectives for health as the first step in preparing a Pre-Transfer Funding Proposal. I added that they would also need to consider what Medical Services Branch wanted in the Pre-Transfer Study as the Branch was funding the project. John corrected me. "The question is what does Medical Services Branch require, not want". He then voiced his expectations for the group.

**John:** I guess ... what I would [like to] see is this group be [oriented] ... towards the pre-transfer concept.... [This would mean] looking at the other programs, things like that [and], like how to produce a survey, a questionnaire,... how do you produce a questionnaire.

John further described the way the Health Committee needed to work.

**John:** If we are going to be the group that spearheads this transfer then we have to take it into the community with us, to inform the community and also if there is a meeting we have to be able to answer specific questions that arise as a group, not just as David or Betty, but as a group.

At this point, I asked whether a decision had been made as to whether the Health Committee was the group that was going to take responsibility for conducting the Pre-Transfer Study.

**Don:** Is this the group that will do the Pre-Transfer Study? It seems to me there is some question [as to] whether this is the group that is going to spear head this or not.

**John:** Well, that is what I've got to take back to Council. We had a Council meeting last Monday here. I just told them we were going to prepare a

[Pre-Transfer Funding] Proposal as a Committee to look at this and I didn't ask them if we were going to spearhead it so I'll have to take it to them next Monday.

**Don:** Is that a question that has come up, whether this is the group or not?

**John:** Well, originally it was the wish of the Council that the Health Committee spearhead it but again we really haven't voted on it as a [Health] Committee. But I would like to see it take that direction. But again, I need the blessing of the whole Council.

**Don:** Is that likely?

**John:** Yeah, if I push it that way, it will happen.

**Don:** How about in the [Health] Committee itself? Is that what people are expecting to be doing, wanting to do?

**John:** See in the long run, before I answer that, what I [would] like to see is [the Health Committee] gets this training, they go through the Pre-Transfer and at the end of the Pre-Transfer the Band says, 'Yes we are going to go ahead,' and at that time the Council says, 'Well, you guys have been working on this for two years. You're the Health Board. You're nominated.' But there are many ways you can select the Health Board. We can work towards that gradually. We, the Health Board start making decisions for the Band as to how the nursing station is going to be run, how it's going to be for the Band, hiring and firing, transport. The Council will be part of that process.

*John's digression indicated his concern that the Health Committee retain control of the health system. He saw the need for the Committee members to obtain the training that would make their position as Board members who governed the health system unassailable. This reflected his concern that the management of the health system remain separate from personal political interference in the community.*

I said that I understood the Health Committee wanted to study the health system and on the basis of their inquiry, make a number of recommendations as to what health programs and services would be included, who would control the health system and how

the health system would be organized. The Split Lake Cree Council would then need to make a decision for the community, based on the Health Committee's recommendations. My understanding was that Medical Services Branch, under their transfer process, would provide funding for up to two years to conduct a Pre-Transfer Study. I suggested that the group needed to work out what they had to do to get from where they were now to where they wanted to be two years hence and only after that look at the health transfer guidelines provided by Medical Services Branch. This approach would allow them to maintain control of their study by first establishing their own goals rather than limiting their response to the guidelines prepared by Medical Services Branch.

There was some discussion concerning the length of time it would take to do the Pre-Transfer Study. John told us that Medical Services Branch allowed twenty-four months for the Study which could be stretched to thirty months. He also told us that it could take up to eight months to get the Pre-Transfer Funding Proposal approved although this could be speeded up and done in two months if you "walked it through" the government's decision-making process.

We drew up a list of the tasks required to develop the Pre-Transfer Funding Proposal. This included a community profile, a community health needs assessment, a survey questionnaire, a description of existing health services, a health status report, a policy on medical transportation, a time frame for the research, a budget, an indication of who would be doing the research, a Memorandum of Understanding between the Split Lake Cree First Nation and Medical Services Branch, training for the Health Committee, community workshops to develop community awareness of health and overall project co-ordination and administration.

Concern was expressed as to where we would get the information that was needed. Betty asked if Medical Services Branch would provide information on the health status of members in the community. John responded with an example which he had heard at the Health Transfer Conference.

**John:** Another thing that was stressed at the workshop by these other communities that are under this [pre-transfer program]. They said that Medical Services Branch doesn't have a lot of information or they don't want to provide it. They said we have to go back and forth, phoning, [saying] we need this. There's one community that said that. She said that for her community, she made calls needing these statistics on the health status of the community, kept on phoning, phoning. [She] said about four months later ... [she] got a letter from [Medical Services Branch]. She said there was [information on] a community [and that the] health stats in that paper ... [were] from a United States native community about their size. What the hell are you going to do with that, eh? It's that M.S.B. didn't have it. That was [British Columbia]. So I said we need their full support.

John then raised his concern about the Pre-Transfer Funding Proposal we were discussing.

**John:** What we're doing right now is we are going through the whole [pre-transfer] thing. Really what I wanted [was to first provide training for] ... you know, the Health Committee, but it's okay. Like....

**Don:** I think we need to do this and then go back to the Health Committee. We've got to get the overall picture.

**John:** You want the overall first and then.

**Don:** Yeah, [if] you are going to train a Committee you have to know ... what it's going to be doing.

**John:** But that's another thing that has to, Don, you have to make clear with the Council.

**Don:** Hmm.

**John:** ... That's why I said I have to go back to the Council.

**Don:** Sure.

**John:** Your role at this time was to train the Health Committee.... I don't know if we are taking you away from your initial goal? I don't know if in discussing this we are taking a different direction?... What I mean by that is, your thesis.

**Don:** Yeah.

**John:** Your part in looking at the community here and then from there, you know, but with the Council too. The way I explained it to them ... your role was from here to April ... Now we're talking about twenty-four months down here. If you're gone by April, then you know, but I'm not. It's like I have to go back to Council. But again, we may not have any money by April. Maybe we will get funding by April but then you could be gone by then ... not that we want to get rid of you but it may take that long to get funding....

**Don:** I guess my understanding was ... I've free time until the end of April and after that I can take some time.

**John:** But, the thing is ... I'm talking to you and the Council is over here. I'm just going back and forth. I think if we're going to continue on for twenty-four months you have to meet with the Council.

**Don:** Sounds right.

*This was a missed opportunity to clarify my role as the external researcher and the expectations John and the Council had concerning my role as a trainer and my commitment to the research project. John pointed out that he was caught in the role of go-between, between myself and Council. He did not appear to have the authority to direct the pre-transfer process. The need to clarify the overall task and my role was critical.*

The momentum of the meeting seemed to dictate that we proceed as if the Committee was authorized to develop the Pre-Transfer Funding Proposal. John agreed with this action.

John identified traditional healing, including medicine men, traditional medicine and mental health as additional areas to study. Betty then questioned whether these items were allowed by Medical Services Branch in their pre-transfer funding. Much of the discussion took place in Cree.

There was concern about my role in training the Health Committee. The health transfer guidelines for preparing a Pre-Transfer Funding Proposal indicated that training should be provided for a future Health Board. I explained that I expected to include training as part of the ongoing study and that members of the Health Committee would learn from actually conducting the inquiry.

*The trainer role was a necessary adjunct to the research role. It was a required task in preparing the local research group to undertake pieces of the research and to equip them for exercising their role as co-researchers. My approach was to integrate the training with the ongoing work of the community research group. Betty had indicated that the training should be included in the Pre-Transfer Funding Proposal as a separate item as indicated in the guidelines provided by Medical Services Branch.*

*It later became clear that the training I was proposing for the Health Committee which would equip them with the skills needed for doing the research was quite different from the training for Board membership provided for by the health transfer guidelines. The confusion about the training reflected the subtle influence exerted by the guidelines*

*on the research process. This influence had to be constantly checked in order to maintain the integrity and local control of the community research process.*

John raised the question of the satellite nursing station at York Landing. There was agreement that York Landing needed to be consulted and that they would have to decide whether they wanted to be part of the Split Lake Pre-Transfer Funding Proposal or submit a proposal of their own for a Pre-Transfer Study. A third community, War Lake, which was currently served by the provincial health system was also identified as a possible community that might want to join the Split Lake Pre-Transfer Study.

We discussed the need to study mental health. There was concern that Medical Services Branch did not provide mental health services. It was felt that a separate study was needed but that there would be more likelihood of getting funds to conduct the mental health study if it was included in the Pre-Transfer Funding Proposal. John suggested that when the community research group hired a local co-ordinator, this individual could co-ordinate the mental health study as part of the larger project.

I used the example of mental health to emphasize the importance of thinking about a community's health needs rather than limiting oneself to the guidelines and assumptions established by Medical Services Branch. I wanted the group to realize that their inquiry needed to address their needs rather than the existing health services which in some cases were inadequate.

We discussed the need for a questionnaire to conduct a community survey on health concerns. John drew attention to the problem of dealing with sensitive topics, which had been raised at the conference on health transfer. He described what might happen and how another community had dealt with a sensitive issue.

**John:** There's one lady that talked about a questionnaire, okay. They asked, 'How much beer or liquor do you drink? Do you abuse your wife? Do you hit your wife?' All those questions to us, they are offensive, but to Medical Services Branch they are required. That's what she said. A lot of people were not honest. Like they don't want to answer that....

**Betty:** Why do they want to know that?

**John:** The way ... [the community spokesperson] explained it, it [is] all tied to the social problems, okay. Like people that drink a lot, what happens, the nutrition in the family goes down, you know. They are not eating well. Kids are not dressed. Kids are ending up in the hospital and the social structure of that family is not as strong. So to us, they are offensive but to that group, that community, it had to be answered. So they went back out again. She happened to know that these things [happened in the community].... Do we want that kind of question?

**Karen:** You mean go around to each [home]?

**John:** They said they go around but some people said they don't want to answer. So what one community did was they sent out a questionnaire but what they did, they put a number up here [in the top right hand corner of the questionnaire], something like a lottery ticket, eh. You put a number up here and you bring your questionnaire in. [The number] gets removed and put in the basket. They said they had over fifty percent return on that questionnaire. And they had a draw, and then, it was just for \$100.00, but just the little gimmick, they had more come in.

John stressed the need to gather critical data and how it would be used by the community.

**John:** In order to be helpful, in order to be better than Medical Services Branch or the present health system, we have to know the true picture, eh....

**Don:** Yeah.

**John:** You know, [Medical Services Branch is only concerned with the problem] if people come in for treatment. That's how far they go. They don't try to understand ... what is going on in that immediate family [that is causing the problem].... [Our objective is to] implement [a program] to contest that underlying issue. The hidden problems they call it.

John pointed out the need to network with other agencies such as the National Native Alcohol and Drug Awareness Program and a regional Aboriginal child and family service in the north, in dealing with these issues. He also stated that he did not want the Tribal Council taking over programs from Medical Services Branch without consultation with member First Nations. This was currently happening with the Tribal Council negotiating to take over the referral service provided by Medical Services Branch. The referral service controls all patient transportation, both emergency evacuations and referrals to specialists. Members of the Health Committee stated that they did not want the Tribal Council to have a monopoly on medical transportation, thereby dictating how people would have to travel. This had particular relevance in Split Lake as a number of people in the community, including one of the members of the Health Committee, had recently been in a medical van which had been hit by an aircraft owned by the Tribal Council during a crash landing on the highway. Although nobody had been killed or seriously injured, the emotional trauma was very real and present as members discussed this incident.

We finished the morning session and I summarized the topics and tasks that we had identified that needed to be included in the Pre-Transfer Funding Proposal. When we met after lunch, we began without John who had been called to a Council meeting. Margaret, who had not been present that morning, joined us so I asked that someone in the group tell her what we had done that morning. There was a short quiet discussion in Cree. I wasn't sure whether the material we had covered had been clearly explained and no one volunteered to tell me so I reviewed the items we had discussed.

I pointed out the tasks that had to be completed and stressed the need to develop a plan of action in which tasks were spelled out in detail. In this way members would know who was responsible to see that each task was completed. I told the group that I

had suggested using health goals rather than needs assessment as indicated in the health transfer guidelines in order to help the group establish the parameters of their health study. I explained that needs tended to focus on the present whereas goals drew one's attention to the future.

*I might have demonstrated greater confidence in the group if I had accepted the fact that they had reviewed the mornings activities for Margaret. This was one time my inability to communicate in their language left me at a disadvantage and tested my confidence in the group.*

I received very little response from the group to this review so I suggested that they break into two smaller groups with each sub group agreeing to discuss one of the topics we had identified that was to be included in the Pre-Transfer Funding Proposal. I suggested they might plan how to proceed with the Proposal, deciding who would work on the tasks and a time frame for doing the work. After a few minutes of discussion in Cree, they told me they all wanted to work as one group on the community profile. I agreed and told them I would work on a plan for training the Health Committee.

After some discussion, those working on the community profile advised me that they could get most of the information they needed from the most recent profile prepared by Split Lake Cree's community planner. I asked if everyone knew what was meant by a community profile. Betty said that she knew so I asked her to explain it to the others. I joined the group as they listed the items that should be included in the profile. When they had concluded this task, I suggested they identify the individuals who would be responsible for obtaining additional information from the planner. Karen and Margaret agreed to get the information.

We discussed the means by which the Health Committee could identify the health goals for the community. The members had suggested a questionnaire, a community workshop and the possibility of inviting resource people who would attend the workshop. I suggested that the group might want to include interviews as a way of getting information as questionnaires usually had a poor rate of return. As an example, I referred to the survey that was currently being done in the community by a researcher working for Medical Services Branch who was gathering information on heart disease. She was using a combination interview and questionnaire to gather data. We talked about video taping interviews and it was suggested that Mikesiu Morning, the Aboriginal morning T.V. show broadcast from Thompson, might be interested in taping interviews with elders.

The group thought that they could obtain health status data from Medical Services Branch through the new Transfer Coordinator in the Thompson zone office. I pointed out that the data might be incomplete and that they might want to approach the university's Northern Medical Research Unit to assess the data.

We developed an outline for items in the Pre-Transfer Study including investigation of other First Nation Pre-Transfer Studies, a review of the Northeast Demonstration Project conducted by the five First Nations in northeastern Manitoba, development of a strategy to increase community awareness of the Pre-Transfer Study, agreement to contact other communities such as York Landing and War Lake that might be included in the Split Lake Study and areas where training was needed.

We discussed the investigation of other First Nation Pre-Transfer Studies. I proposed that the Health Committee contact Medical Services Branch and the Assembly of First Nations, the national organization of Chiefs in Canada, to see if they might have a list of transfer projects that were underway. From this list the group would be able to

contact people to obtain copies of reports that they could review and from this review select one or two projects that they might want to visit.

We discussed how the Health Committee could increase the community's awareness of the Pre-Transfer Study by conducting community workshops; through informal discussion; by producing a newsletter such as the one that was put out by the students in the local school; by one of the Health Committee members being interviewed for the school newsletter; through posters, pamphlets and announcements at Bingo games and on the local community television station; by organizing an open house at the nursing station and by developing a play or drama to put across ideas about health issues.

Concern was expressed that when members joined the Health Committee they were told that they had to keep information confidential. I suggested we discuss confidentiality at our next meeting because the Committee needed to let people know that they were working on a Pre-Transfer Study.

We discussed the importance of networks and the need to keep others informed, including staff from the child and family services agency, school committee members, teachers and the school principal, workers with the National Native Alcohol and Drug Addiction Program and the nurse-in-charge at the nursing station. I told the group that I had briefly reviewed the meeting we had held in November with individual nurses as they had seen the newsprint and information on the walls in the community health room but did not know what it was all about.

We still needed to prioritize and organize the topics to be included in the Pre-Transfer Study but this was left to a follow up meeting. We agreed that John and I could take the

study outlines and try to pull them together in the form of a Pre-Transfer Funding Proposal.

The meeting ended with a prayer and a wish for a Merry Christmas.

### **Meeting the Zone Director for Medical Services Branch**

On my return through Thompson on Friday, I called on Helen Wood, the Director of the northern zone office for Medical Services Branch. I was acquainted with Helen from previous contacts and now told her that I was working with the Split Lake Cree First Nation on researching their health system and health transfer. She talked about her work and told me that she enjoyed the process of negotiating the health transfers, at times having to provide more than was asked for by First Nations when they underestimated their costs. She felt that some First Nations still had not grasped the change that was proposed and that they tended to remain fixed in their thinking. She said that she had really enjoyed the negotiations with one of the First Nations which had just opened a beautiful new health facility. She figured that negotiations with one of the next communities would be different as their style was much more confrontational but that was just part of the negotiating game.

*I had called on Helen in order to make contact with the Medical Services Branch zone office and to re-establish an old friendship. Helen's commitment to have the transfer process benefit the communities was confirmed. Our meeting was short and I did not have time to explore in depth any of the issues in the transfer of health services. My purpose had been to advise Helen that a Pre-Transfer Funding Proposal would be forthcoming from Split Lake and to assure myself that there would be support for the Split Lake Proposal when it was submitted.*

## **Developing a Pre-Transfer Funding Proposal for the Transfer of Health Programs**

John and I met in Thompson on December twenty-first to discuss the Pre-Transfer Funding Proposal. We reviewed the topics the Health Committee had identified for the Pre-Transfer Study and the health transfer guidelines provided by Medical Services Branch. We also developed a time frame for the topics to be included in the Pre-Transfer Study in the form of a bar graph to indicate when each topic would be studied during the next two years.

That afternoon, George Maskwa, the Health Transfer Co-ordinator for Medical Services Branch joined us. He provided us with a sample Pre-transfer Funding Proposal from Kelsey House and promised to provide us with a critique of the Kelsey House Proposal prepared by Medical Services Branch.

We finished reviewing the Split Lake Pre-Transfer Funding Proposal outline that afternoon. John said he thought I should rework the time frames to reflect the time I thought it would take to do each individual component in the Pre-Transfer Study. He pointed out that he would have preferred to have had the whole group present to develop the time frames but that had been impossible given the urgency to complete the Pre-Transfer Funding Proposal. We were under pressure to complete and submit the Proposal as John estimated that it would take six months to get funding approved.

*I was concerned and uncertain about how much of the work I should be doing. I thought that John might be seeing me in the role of a consultant for the Pre-Transfer Funding Proposal and Study, as someone who would write up the Pre-Transfer Funding Proposal for the Committee. I did not want to be cast in this traditional consultant role in which the consultant does the work for the client. I eventually decided to develop time*

*frames for the Proposal in order to speed up the funding process but was aware that t his decision was short circuiting the work of the Health Committee. For the time being, I decided to treat the Proposal separately from the community research task. I was to discover in time that they were inseparable, the Pre-Transfer Funding Proposal ultimately shaping much of the research task and providing momentum throughout the planning stages. The transfer of health programs and services was after all what had motivated Split Lake to consider taking over their health system. It was also the reason why I had sought them out as a potential research partner.*

John and I agreed to meet with the Health Committee in Split Lake, in mid January to finalize the Pre-Transfer Funding Proposal. I was to prepare a guide and outline for that meeting.

*Later as I thought about the Pre-Transfer Funding Proposal, I realized that I was going to have to incorporate a considerable amount of the work that had to be done for the Proposal in the overall research plan for the inquiry into the health system if I was going to make any progress working with the community research group on their inquiry into their health system during the winter. I felt the need to have the community research group consider some of the important questions and issues concerning health and wondered how this was going to happen in the midst of developing the Pre-Transfer Funding Proposal. Up to now they had identified some of the areas that needed to be studied but they had not explored the underlying research issues and questions that I believed would be critical to the inquiry.*

*The meeting with George was the first examination of the health transfer guidelines for the Pre-Transfer Study. I had intentionally avoided reading the guidelines until now*

*as I wanted both myself and the Health Committee to focus on Split Lake's own health goals before responding to the directions and focus indicated by the guidelines.*

It was a fairly simple task of grouping the areas the Health Committee had identified for study under categories set out in the health transfer guidelines developed by Medical Services Branch for the Pre-Transfer Funding Proposal. The guidelines included a number of topics we had not identified and these were added to the list of studies identified by the Health Committee.

The copies of pre-transfer funding proposals prepared by other First Nations and the critiques prepared by Medical Services Branch proved helpful and reflected the support the zone office was prepared to provide.

I did little work on the Pre-Transfer Funding Proposal over the Christmas holidays other than to refine the time frames John and I had developed for the study. The Health Committee was to begin work on the Proposal in earnest at our next meeting in Split Lake, January 15, 1990.

George Maskwa agreed to join us in Split Lake for our next meeting. He picked me up at the Thompson airport on Monday morning and we drove to Split Lake, arriving at about 10:30 a.m. The meeting with the Split Lake Health Committee was held in the public health room at the Nursing Station. John introduced George to the Committee, noting in passing that three members of the Health Committee had withdrawn from the Committee. He mentioned later that one of them had been appointed by the Chief and Council to the School Board.

I presented an agenda for the next day and a half and suggested that we review our last meeting in December, have an update on the meeting between John, George and I in Thompson and then work on the Pre-Transfer Funding Proposal. I told the group that George was going to review the Health Transfer Guidelines and advise us about items that Medical Services Branch would expect us to include in the Proposal. I finished the introduction by reviewing the material on newsprint from the meeting of the Health Committee in December.

John began by asking George if health services which were not included in the Health Transfer Guidelines could be part of a Pre-Transfer Funding Proposal.

**John:** Looking at the proposals that other communities [have] submitted, they didn't really mention things like the Northern Health Unit and Health Science Centre [in Winnipeg]. Like I'm just asking George. We identified those [as areas that need to be investigated]. Looking at how they operate.... If Split Lake was to go into pre-transfer, how does that affect our relationship with the Health Sciences [Centre in Winnipeg]?

**George:** Well, Split Lake presently sends people out for treatment to [the] Health Science Centre or other hospitals in Winnipeg or Thompson. I'm not sure how that would....

**John:** Like if we put in the Proposal that the Committee wants to visit [the] Health Science Centre. We know it's not in the pre-transfer program guidelines but is that possible?

**George:** It's possible. You have to justify that visit. You have to tie it in to pre-transfer planning studies.

**John:** What would justify it?

**George:** I'm not sure.

I suggested that the Health Committee needed to establish a means for dealing with the extended health care system and that a support system was needed for Split Lake residents who were receiving health care in the hospitals in Winnipeg and Thompson.

George told us that he had spoken to the Chief in York Landing and the Chief and Council at War Lake and in both instances they had said they were not interested in joining with Split Lake in Split Lake's Pre-Transfer Study. York Landing wanted to obtain their own nurse and did not want to remain a satellite of the Split Lake nursing station. War Lake was currently meeting with both the provincial and federal governments concerning their health services.

I suggested that we needed a strategy for informing the community about the health study. I added that we also needed to develop a questionnaire to identify health goals as well as conduct interviews to obtain data on traditional health and the current health status of people in Split Lake. George noted that doctors usually did health status assessments. John asked if we could purchase equipment such as tape recorders for conducting the interviews and was advised by George that pre-transfer funds could not be used for the purchase of equipment.

I reviewed the training needs we had identified and proposed that we build some training into each meeting. I noted that communication, group dynamics, planning, skill in designing and facilitating workshops, organizing and writing a proposal and writing reports were areas where members might need training. I added that we were going to be working on writing the Pre-Transfer Funding Proposal during the next few days.

The group discussed their concern about the potential conflict of interest that might occur if Health Committee members paid themselves an honorarium for time they put

into the research project. The policy of Medical Services Branch on this issue was clarified by George. Medical Services Branch held the view that any funding agreement was with the Chief and Council and that it was up to the Council to determine how those working on the project should be compensated. Committee members could therefore be hired by the Chief and Council.

I reviewed aspects of health that we had identified that needed to be covered in the health study. George stressed that as far as Medical Services Branch was concerned, the Pre-Transfer Study had to result in a health development plan. He also stated that the manual on health transfer provided by Medical Services Branch was only a guideline and did not have to be the outline followed by Split Lake. The health transfer guidelines did however highlight areas that Medical Services Branch would be considering in assessing any health plan. I stressed the different perspectives of the community and the government, pointing out that the priorities of the community and the Health Committee were not necessarily the same as those of the federal government. John expressed concern about funding cutbacks in Medical Services Branch and wondered where personnel would be cut. George confirmed there were cuts and that field positions would be eliminated as health transfer proceeded. George wondered why the Health Committee needed training at this stage in the project and how this would contribute to the transfer of health services. John explained the purpose of the training.

**George:** What is this training you have?

**John:** What we're trying to do is ... develop the questionnaire, writing skills, interviewing skills, communication skills. That's what we're trying to do and not [the training for the Health Authority which is to be included in the] Proposal ....

George stated that the intent of the pre-transfer funding was to develop a community health plan and establish a Health Authority.

**George:** The funds are for [the] establishment and training of a health authority and activities leading to the incorporation of a health development plan. I want you to keep this in mind as you are working through [this Pre-Transfer Funding Proposal]. This is really important because this is what you see in all the literature, community health plans. This one word there is very important because everybody knows that the existing health care that is received by the people is not adequate. What any community health plan is going to need to better health care services. The Proposal establishes a schedule linking development activities in transfer. Are these [training] activities going to facilitate transfer?

*The interchange underscores the conflicting goals imposed by the health transfer guidelines and the need to train the community researchers in research skills. The intent of the guidelines was to provide training for a future health authority or board and did not take into account the need to train local researchers.*

George noted that funds could not be used for research on the original treaties and the provisions for health included in these treaties. The government's position was that funding for this research was covered under another program, Treaty and Aboriginal Rights Research. This limitation restricted First Nations from using pre-transfer funds to probe the underlying assumptions that governed federal government responsibility for health care in Aboriginal communities. George also noted that funding would only be provided for one Pre-Transfer Study and would not be available for a second study at a later date.

After these preliminary discussions, we began a detailed examination of the Health Transfer Guidelines. George led us through an outline he had prepared on newsprint, referring to sections in the Health Program Transfer Handbook which provided detailed explanations of each component to be included in a Pre-Transfer Funding Proposal.

Once George had completed the overview, John suggested that we begin identifying information that was needed for the community profile. The group discussed a few items but there seemed to be a lack of spontaneity. I struggled to draw out the members. When this did not work, I suggested that we split into two sub groups, with some moving to one corner of the room to work on the community profile and others joining me to begin work on the outlines for individual studies that were to be included in the Pre-Transfer Funding Proposal. Joan, Mary, Betty and George formed the group that worked on the community profile. John and I began work on the study outlines to be included in the Proposal. We were later joined by Karen.

John and I began by identifying issues that needed to be addressed including the management of the health facility, employment of health professionals, mental health, traditional health, first aid training, legal services, inadequate accommodation for health personnel and the funding for the programs. He described a number of problems in the health system including difficulty in obtaining desired health care and conflict that arose at times between health care professionals and Chief and Council.

George joined us later and we discussed the goals of the Split Lake health system and problems in the existing system. George again pointed out that the objective of the Pre-Transfer Study was the development of a community health development plan. John and I on the other hand focused on the overall goal of health in the community, a different perspective which was broader than that set out in the health transfer guidelines. John attempted to clarify for George the approach we were taking.

**John:** That's what I'm saying...I don't know if I'm making it clear, [laughter]

**Don:** Tell me that again. [laughter]

**John:** Okay.... Well, we say analyse and identify problems and gaps in the health care system.

**Don:** Right.

**John:** What we'll do is look at the health care system as [it exists] now.

**Don:** Yeah.

**John:** Right? And look at the problems.

**George:** Right.

**John:** And what are the gaps and then from there we go into ... [laughter] the goals. You know, the goal is to....

**George:** I don't know.

**John:** To correct the problem, okay? And then bang, you have ... [achieved the goal] ... and so you go into the next [goal], number two. We will ... conduct surveys, and all that.

George finally acknowledged the importance of establishing health goals for Split Lake while cautioning that it would take more than two years to achieve the ideal health system.

**George:** See that's why I said this here is very important.... Working over the next two years you're going to come up with a plan.

**John:** Yeah.

**George:** That will develop.

**John:** The ideal goals.

**George:** Right ... and I can guarantee that that ideal goal or that that ideal health care system is not going to be reached ... even within three years after the....

**John:** Umhm.

**George:** Assessment is done.

**John:** There will still be a lot of ongoing....

**George:** Yeah.

**John:** Negotiations.

George concluded by supporting the approach taken by John.

**George:** ... But it will be the communities plan.

**John:** Umhm.

**George:** It won't be somebody else's plan. That's the difference.

**John:** Umhm.

The other sub committee now advised us that they had completed an outline for the community profile. We joined them and discussed the outline, helping to classify some of the items in the profile and adding other items that had been overlooked. There was considerable humour in the debate as we discussed those who should be included in the population. The debate hinged on whether we should include those living off the reserve as well as new residents who were returning to the community now that the government had changed the legislation to allow former members of the First Nation to be reinstated as members of the First Nation. Under the previous federal legislation, Aboriginal women who married non Aboriginal men lost their status as members of First Nations.

*Although it did not occur to me or anyone else at the time, the total number of First Nation members included in the population would likely impact the per capita funding provided for future health care.*

We continued working on the profile through the remainder of the afternoon, adding and expanding on information that had been included in the draft outline.

When we adjourned at the end of the day, we had completed the initial profile and a general overview of the studies that would be included in the Pre-Transfer Funding Proposal.

Our next meeting was held in Split Lake on Monday, February the first. At this meeting, I asked George Maskwa to review an outline he had prepared on pre-transfer funding proposals and the criteria used by Medical Services Branch in assessing the submissions. He outlined the phases involved in a Pre-Transfer Study and added that he expected the negotiation of the transfer itself to take six months.

John pointed out that negotiations would only go ahead if a First Nation decided to proceed with transfer. George acknowledged this and explained that there were three options. One option was to transfer all services to the community. A second option was to decide not to proceed with the transfer of health services. A third option was to phase in the transfer of services over a number of years. George cautioned us at this point, stressing that it was important to know what was wanted once you began negotiations. He referred to Pipestone Lake which was in the midst of negotiating the transfer of health services although the options had not yet been presented to the community.

John was concerned that if a First Nation opted for total transfer, they would not have the professional staff in place to manage the health system.

**John:** If the Band at that time were to say total transfer.

**George:** Yeah.

**John:** The professional staff is not there.

**George:** The professional staff?

**John:** ... Well nurses and management, the people who are going to manage this and the system.... Like you're going to need administration.

**George:** Oh I see what you mean, yeah.

**John:** You know, okay, we can go ahead [with] ... total transfer but what's going to happen is we're going to have white guys like Don working for us. We won't have our local people there cause.... [laughter] Yeah, I'm using you as an example here. [laughter] [Cree]

**Betty:** [Cree]

**John:** So.

**George:** So what you're saying.

**John:** If the Band is going to look at total transfer ... [in three years] we won't have anybody there as an administrator.

John pointed out that the pre-transfer funds were to be used to establish and train a Health Authority and prepare a community health development plan. He equated this with the need to develop the community's management capability. He wondered if funds were available to employ an individual in the role of health administrator. George suggested that a Pre-Transfer Funding Proposal could include funds for a project co-ordinator who might be trained as a health care administrator but he advised the group that they would need to arrange separate funds to keep this individual employed during the negotiation stage of the transfer as Medical Services Branch would not provide funds to maintain the project co-ordinator during this period. He suggested that as an alternative, a First Nation could hire a trained health care administrator under a term contract for two or three years while a member of the community left to obtain training.

We continued the discussion on the preparation of the Pre-Transfer Funding Proposal. George advised us that the Proposal should be accompanied by a letter from the Chief and Council of York Landing indicating whether they wanted to be involved

in the Split Lake Study. Betty pointed out that adding York Landing to the health program for Split Lake would mean a significant increase in the number of people served by the health system. The group discussed inviting representatives from York Landing to attend their meeting the following afternoon and identified a number of people who might be invited including the Chief, the Councillor responsible for health and the Community Health Representative.

We began a detailed review of the draft Pre-Transfer Funding Proposal, beginning with the community profile. Each member of the group took turns reading a portion of the document as the group corrected factual errors, added or reworded the narrative and re-ordered components of the profile. The end result was a very detailed account of the services and facilities owned and operated by the Split Lake Cree First Nation, a report on the external services and agencies located in the community, a statement on changes in the economic, social and health conditions of the people since the flooding of the lake by Manitoba Hydro and comment on the capability of the community to administer its own programs and services.

We proceeded to flesh out the studies included in the Pre-Transfer Funding Proposal, indicating the purpose of each study and the method proposed for gathering the data. The studies were then organized into a logical sequence beginning with the definition of health, health goals for the community, a report on the history of health in the community, an assessment of the current health of people, a report on current health services and development of an organization to implement the health goals. I suggested that we consider both traditional health and western health practices in each study.

The following day we discussed some of the methods we might use for conducting the research, including community workshops to engage people in developing a

definition of health and field trips which would enable the Health Committee to become acquainted with health programs and services in other communities. I also suggested that we look at the socio-economic and political factors that impacted health in the community. I referred to the changes the members of the group had identified in their diet as well as the potential impact contamination of the local fisheries was having on the economy.

The Pre-Transfer Study was to include a financial analysis of existing health services and a projection of costs for future health programs. A review of health legislation was also required. The existing Canadian division of powers meant that the federal government provided health care for on reserve residents and the province provided care for First Nation members living off the reserve. Each province was also responsible for maintaining provincial health data as well as hospital and mental health services. Split Lake would need to negotiate access and services in these areas.

We discussed the components of each study. John and George both suggested that any definition of health needed to include the physical, spiritual and emotional well being of people. Environment was also identified as an item that needed to be included. Finally, we examined the need to develop an organization to provide health services in Split Lake. This organization would also need to establish linkage with other health agencies in the region in order to provide comprehensive health care.

We adjourned, agreeing to meet the following week.

The meeting on February the eighth was an opportunity to work on the detail required for the studies included in the Pre-Transfer Funding Proposal. I explained how the group could identify the health concerns in the community by developing a

questionnaire which the community researchers could then use in interviewing people. I explained that as a research group, we would need to compile the data from these interviews in a report and share it with members of the community in a community workshop. The workshop would provide an opportunity to both share the data and validate it by having it modified and approved by those attending the workshop. I recommended this approach in order to achieve broad community input and understanding of the health study and health issues in the community.

The group had included field trips to study other health projects in the Pre-Transfer Funding Proposal. I suggested that they would need to prepare reports on these visits to share with other community members in a community workshop.

I proposed developing training sessions for each of the research activities required for the Pre-Transfer Study, including training in conducting interviews, organizing workshops and promoting participation in the workshops. A team building workshop scheduled for the following week was designed to provide experience in organizing and conducting community workshops.

I explained that the next task was to review and rewrite each study we had sketched in outline form, adding more detail in order to explain the purpose of each individual study. I pointed out that we had just about completed the first phase of the inquiry, having formed a community research group and a draft outline of the Pre-Transfer Funding Proposal. The second phase would involve data collection and the preparation of reports for each component of the Pre-Transfer Study. The third phase would require the development of the community health development plan and an organization to deliver health programs. The final phase was the negotiation of the transfer. The four phases of the research project are illustrated in Figure 5.3.

Phase I	Phase II	Phase III	Phase IV
Resolution by Chief and Council to proceed with Pre-Transfer Funding Proposal  Formation of Community Research Group  Preparation of a Pre-Transfer Funding Proposal  Training for Community Research Group  Community Workshop	Conduct Studies <ul style="list-style-type: none"> <li>• Traditional Health</li> <li>• Health Concerns</li> <li>• Current Health Status</li> <li>• Health Services</li> <li>• Finance</li> <li>• Legislation</li> </ul>	Develop Health Organization  Health Development Plan <ul style="list-style-type: none"> <li>• Services</li> <li>• Facilities</li> </ul>	Negotiate Health Transfer  Memorandum of Understanding  Health Board

**Phases in the Research Process for Health Transfer**  
**Figure 5.3**

We now faced a delay in our schedule as we were entering Lent and all large public gatherings in the community were prohibited during this period.

By April tenth we were editing the Pre-Transfer Funding Proposal and the budgets for each component of the Proposal. At the conclusion of this working session, John expressed his concern that “Council needed to understand and support ... [the Pre-Transfer Funding Proposal] or else somewhere down the line they’ll just tell us, ‘Where did that come from?’ ... I keep telling them about it but they say, ‘We’ll table it.’ ” John told us that he thought that we might be criticised for not involving the community in preparing the Proposal. He added that the community input would come when we did the Pre-Transfer Study and once a decision had to be made as to whether Split Lake was going to go ahead with health transfer. He made the point that at this stage the Committee

was only preparing the Proposal. It would be up to Chief and Council to forward the Proposal to Medical Services Branch.

**John:** Correct me if I'm wrong. It's a proposal right now ... Split Lake wants to go into pre-transfer. What we've done is, we've come up with a [Pre-Transfer Funding] Proposal. We give it to Council. The Council approve it, not approve it, but sign it off. It has to come from the Chief and Council. It can't come from the [Health Committee]. Then we can work under [the Chief and Council] to make it, to implement it, the Proposal, okay? We can implement it but the thing is ... that's all it is right now. It's a proposal.

We agreed to meet again on April eighteenth. I told the group I would submit the draft Pre-Transfer Funding Proposal to the Northern Medical Research Unit of the Faculty of Medicine at the university for their comment. The research administrator with this Research Unit had volunteered to have staff peruse the document to make sure that we had covered all aspects that their medical staff believed should be included. The administrator also agreed to check items that should be included in the budget that we might have overlooked.

Following the meeting, the community research group forwarded the draft Pre-Transfer Funding Proposal to the northern zone office of Medical Services Branch in order to obtain a preliminary assessment of the document.

I met with George Maskwa Tuesday evening, May twenty-second. He briefed me on the critique he and Helen Wood had completed of Split Lake's Pre-Transfer Funding Proposal. The critique was useful in identifying a number of areas in the Proposal where the intent of the study was unclear. One suggestion was that we develop a more detailed health development plan as well as a work plan.

*The health development plan seemed to be a task that more properly belonged in the Pre-Transfer Study. I hoped we would be spared this added task. For one thing, we did not have the funds available to do this work.*

George told me that Pipestone Lake, another community engaged in health transfer, had spent all their pre-transfer funds but had still not finished the Pipestone Lake Health Development Plan. He pointed out that the Pipestone Lake Health Committee now faced the task of completing their plan but did not know how to do it. Their consultant, it seemed, had written the Pre-Transfer Funding Proposal for the community but had only consulted with the community project co-ordinator. As a result, George was of the view that no one was in a position to take over the project and do the needed work. The same scenario was taking place in Kelsey House with the same consultant. George made the point that the process in Split Lake was quite different with the Health Committee actually doing the work.

*I continued to be concerned that I was doing too much of the detailed work on the Pre-Transfer Funding Proposal. The need to get the task done seemed to leave me with no alternative. My intuition told me that the members of the community research group were at the end of their patience with the process and were not prepared to continue with the tedious work of writing and rewriting the Proposal. I was also feeling the pressure of time as my study leave would soon be finished and I had a dissertation to write. I was somewhat surprised that the zone director had approved the Pipestone Lake and Kelsey House projects in the first place as the projects appeared to have little community input in the actual research.*

George asked me if I would present the critique of the Pre-Transfer Funding Proposal to the community research group on his behalf the following day in Split Lake

and save him a trip in to the community. I declined and told him that the community research group needed to hear the views of Medical Services Branch directly from him.

### **Critique of the Pre-Transfer Funding Proposal**

I arrived in Split Lake the next morning. George arrived shortly after and members of the Task Force assembled within a few minutes. After an opening prayer, I did a quick check of our priorities. We decided to spend the full day reviewing the Pre-Transfer Funding Proposal. John expressed the hope that we would finalize the Proposal during this session.

I told the group that I had met with George the previous evening and that we had reviewed Medical Services Branch's critique of the Pre-Transfer Funding Proposal. George then began listing each item on the flip chart that he thought we should revise. He suggested that we include a map of the community and the province in the Proposal pointing out that those who would be reviewing the Proposal in Ottawa would not be familiar with Split Lake. He also recommended that we include an organizational chart for the Split Lake Cree First Nation. John responded saying the Council was having difficulty devising a chart. The problem stemmed from uncertainty around lines of authority.

George suggested that we add a work plan, a new Band Council Resolution supporting the Pre-Transfer Funding Proposal and a covering letter from the Chief.

John intervened at this point to ask who had reviewed the Pre-Transfer Funding Proposal. George advised us that he and Helen Wood, the zone director, had done the review. He said he had also attempted to meet with the Director of Community Based

Health Services in Winnipeg to discuss the Proposal but that he had been unsuccessful in arranging a meeting.

George supported the initiative of the community research group in preparing their own Pre-Transfer Funding Proposal and in planning to do their own research. He contrasted this with the other two communities, Pipestone Lake and Kelsey House, which had hired external consultants to do their Proposals and prepare their health development plans. In his view, the Health Committees and members of these communities were left out of the planning process and were not familiar with the issues and options when it came time to make a decision as to whether to proceed with the transfer of health programs. He noted that the Health Committees in these two communities had also missed out on the learning that would have occurred if they had been directly involved in the preparation of their health development plans.

George agreed that the proposed community workshops would be an effective way to inform people in the community about the study. John concurred but told us that he didn't want a community meeting to discuss the Pre-Transfer Funding Proposal until the final copy was ready.

**John:** The only reason I said that [we need a final package] was that ... there's been many instances in the past where we said, 'Oh, this [is] what's going to happen' and it doesn't really turn out that way, eh. So the people say, 'Well you said this. You're a liar now.' I don't want to face that. I don't want to lie about it.

We discussed the proposed field trips to investigate other health projects. George stressed the need to explain and justify why they wanted to send all the members of the community research group to study other health projects as he believed the Medical Services Branch committee that would review the Pre-Transfer Funding Proposal would

closely question this item. John pointed out that the trips were considered essential for the orientation and education of the community research group. He saw each visit as a planned learning activity, investigating the experience of others and the programs others had put in place. He also pointed out that the community research group needed to establish links with other health institutions in the province that provided health services and resources.

We moved to a discussion of the budget. The one item Helen Wood found high was the amount estimated for the community workshops. We debated the number of discussion leaders needed for a workshop. I pointed out that one was needed for each discussion group and that in doing the budget we had estimated the number of community members we thought might attend. George was sceptical. He recalled a time when he had attended a workshop in Split Lake and only two people had showed up. George eventually accepted the budget estimate and suggested we begin promoting the workshops in order to achieve the turn out we had projected.

We had scheduled a study of traditional health in the Pre-Transfer Funding Proposal and also planned to involve traditional healers in the study of current health in the community. George questioned this wondering why we would need to engage traditional healers in more than one study. I explained that in the second study, traditional healers would be retained as consultants. We would be asking them to provide an assessment of the current well being of people in the community. George accepted this idea and shared with us the fact that Kelsey House had retained a traditional healer in an advisory capacity for their Pre-Transfer Study.

We reviewed the proposed study of an organization to administer the health programs and services. George questioned whether this met the requirements of Medical

Services Branch for establishing a health authority. He wondered if the organization was to become the Health Authority envisioned by Medical Services Branch. John and Betty pointed out that we were interested in studying the total health system. It was only after the study was completed that we would be in a position to consider how health services were to be organized and delivered in Split Lake. George tried to relate the health system to the health authority. We did our best to explain the different concept and approach we had taken but George continued to emphasize the need to establish a Health Authority. We finally agreed that we would clarify the concept before submitting the Pre-Transfer Funding Proposal.

George explained the process through which the Pre-Transfer Funding Proposal would be reviewed by the zone office, regional office and department head office. At each stage the reviewing office would attach its comments to the submission. He felt that all questions should if possible be dealt with by the zone office before the Proposal was forwarded to the region. He had already scheduled a meeting with the Regional Director of Community Based Health Services in Winnipeg to go over the preliminary draft of the Proposal.

We adjourned at five o'clock. George left shortly after for the trip back to Thompson. The rest of us agreed to meet again that evening to continue working on the Proposal.

After a late evening revising the Pre-Transfer Funding Proposal, we met the next morning to discuss the time frame for completing the Proposal. John suggested that we set a deadline of June thirtieth for submitting it to Medical Services Branch. He felt any one of the group, particularly he or Betty, could make minor changes, consulting by phone where necessary with either myself or George. The members of the group all

agreed it should be done by the end of June. I recommended that the community research group complete a work plan on their own and then submit the Proposal. John wanted assurance that I would be available to discuss it with them by phone. I told him I would be available.

We discussed a date for our next meeting. I was anxious to meet in June while I still had some study leave remaining. John was anxious to complete the Pre-Transfer Funding Proposal but expressed concern over my availability once the Proposal was approved and funding was secured. He told me that the group had been accommodating my schedule up to now but that when the project got under way he wanted assurance that I would be available when emergencies arose. I told him I would be available whenever possible but that I did have other commitments which I had to meet. I told the group I had one month remaining in my study leave and that I would like to see the Proposal and initial work on the study on traditional health completed in the time remaining for my leave.

We concluded the morning with a discussion of the role of a local community research co-ordinator. This involved determining the authority to be delegated to a research co-ordinator, the procedure for reporting to the community research group and the Split Lake Cree First Nation Council and administrative responsibility for the budget and the expenditure of funds.

We closed our meeting and I left shortly after for Thompson and my flight home.

## CHAPTER VI

### THE COMMUNITY RESEARCH GROUP AND ITS STUDY OF TRADITIONAL HEALTH: CASE NARRATIVE CONTINUED

Chapter VI traces the formation of the Split Lake Health Task Force, describes in some detail the design and field work involved in a study on traditional health, recounts the difficulties experienced by the community research group when other events in the community disrupted their plans and records the assessment the group makes of its own process. The narrative concludes with the submission of the Pre-Transfer Funding Proposal to Medical Services Branch.

#### Formation of the Split Lake Health Task Force

We had met regularly since December, 1989 to work on the Pre-Transfer Funding Proposal. As in the life of any group, the agenda shifted from one topic to another as issues or tasks emerged that demanded the attention of the group. Formally establishing and naming the community research group was one such issue.

John had asked me in December if there was a suitable name for the community research group that might differentiate it from the Health Committee. Not all the Health Committee members were active in the community research group and the group was taking on a life of its own. Now during their meeting in the first week of February, the group named itself.

They began by asking me what the difference was between the meaning of the terms research and task force. I suggested they develop a list of words they associated with each term. The lists are illustrated in Figure 6.1.

Words Associated With Research	Words Associated With Task Force
Equal study time Money Material Correspondence Documents Statistics Books Writing Paperwork Reporting What does it mean to know Site Location Environment Costs Problems and solutions People Government Study Questions, lots of questions Interviews Questionnaires	A group with a mandate to study a specific thing A specific job Job Work Travel Money Meetings A group of people More authority than research groups Big Being out and doing the job Assignments More work Appointed Hired Force

**Word Association in Naming the  
Community Research Group  
Figure 6.1**

After considerable discussion, Mary suggested they call themselves a task force as it conveyed greater authority. John concurred.

**John:** What we're trying to do here, the process to us, is a major undertaking.

**Don:** Yeah. Sure it is.

**John:** A major undertaking. And, that's where I would attribute a task force. A major undertaking.... [The task force] would have decision capabilities

and the authority to make decisions, at the end, while the research group [on] finishing [its] work [is told]. "You did your part. You made recommendations, you know, and [now] you give it to this other group who make the decisions, whether to shelve it...."

**Don:** So.

**John:** So, a task force.

The group devoted the rest of the session to working on the Pre-Transfer Funding Proposal.

We met again on February eighth. The members of the Task Force had met the previous day to discuss their role and their concerns as to whether Medical Services Branch would accept the draft we were preparing for the Pre-Transfer Funding Proposal. A further concern was my continuing commitment to work with the group. John reported on their discussions.

**John:** We looked at this [research project] and ... one of the ... community members said, 'Can we do it?'

**Don:** Right.

**John:** Okay. I said 'Yeah.' The thing is [pause]. We talked about you too but ... I'll get to that. In relations to ... [the issue of] the consultant, okay. The other communities hired a consultant for two years. Period. And they had these consultants assist them in ... preparing this [Pre-Transfer Funding Proposal]. And also [there was concern about] the ... contents. Does this [Proposal] meet the M.S.B. criteria, the guidelines?

**Don:** Umhum.

**John:** Okay. Well the way I answered that was, 'Well there's three steps. We finish it. When we're satisfied with it we submit it to M.S.B. in Thompson. They have their screening board. And if it doesn't pass that, then they'll.

**Don:** Yeah.

**John:** They'll throw it right back at us.

**Don:** Right.

**John:** So that's [what will happen and] ... even if Thompson ... passes this document, they [will still] send it to Region [and if] Region [is] not satisfied, it will come back to us. [And so on] ... down the line, right down to Headquarters in Ottawa. If they're not satisfied it will come back to us. So, there's three phases ... three steps where it goes, where if it's not approved or it's unsatisfactory, then ... it'll come back to us ... to redo it. But I said if George's input [is] in here, you know, [and] if George [has input as] ... a member on the screening board.

**Don:** Umhum.

**John:** In Thompson. You know, I'm pretty sure that he won't mislead us but what I'm saying, like ... we're doing it on our own, eh, as a community. Well with your expertise and [with] ... George being involved in it too, [we should not have a problem]. That's how I addressed that concern.... We also discussed you. Well I'll get back to it. At [one] time in Winnipeg or even in Thompson we addressed that.

**Don:** Right.

**John:** Concerning, regarding ... your time.

John was concerned about my availability on short notice and whether I could get away from my office when I was needed. He said he would have to answer these questions when he presented the Pre-Transfer Funding Proposal to Council. I explained how I would need to arrange for additional leave or carry the research project as part of my work responsibility at the university. In the latter scenario, the university would need to be compensated for my time. I assured the group I would be available to discuss the work by phone and respond to inquiries sent to me by fax. John accepted the arrangement but expressed a note of caution concerning the fees that I might charge.

**John:** But that's another thing too. We have to watch ... Don. Like, we have to have a mutual understanding.... If we ask you as [a] Committee [to do some work] we don't want to get a bill unless it's covered through this program. Like it's a new thing for us.

**Don:** Right.

**John:** You'll have to respect that.

I assured John I would get prior approval to spend funds as I currently did with my travel expenses.

John also noted his concern about the Council. He did not want Council to make minor changes in the Pre-Transfer Funding Proposal nor did he want me discussing the Proposal directly with Council without going through the Task Force. I assured him that I would continue dealing with the Task Force.

John pointed out that it was also important for the Task Force to identify one person that I would contact by phone. He wanted to avoid having more than one member of the Task Force contacting me about the same topic. Betty suggested some of the discussions could be done using a speaker phone when the Task Force members were present.

We discussed the management of the funds once the Pre-Transfer Funding Proposal was approved. The group wanted to make sure that the Task Force maintained control of the funds for conducting the Pre-Transfer Study.

**John:** If we ... get funding, the funding has to go to Chief and Council. Okay, but what the Committee has to do is we have to say to Chief and Council, this money is strictly for this [Pre-Transfer Study]. We want it on account.

**Betty:** Cause what they're good at doing is borrowing.

**John:** Yeah.

**Don:** Against it.

**Betty:** Yeah.

John noted that there should be some sort of recognition given to members of the Task Force once the Pre-Transfer Funding Proposal was approved. He pointed out that preparing the Proposal had been a learning experience.

**John:** What we have learned in this process as a Committee ... the Committee don't see it, but you know ... this alternative [approach], they don't really notice this. But ... they have grown, you know along [with] this process.

We discussed the problem in arranging meetings and attendance of members. John told us that he had felt guilty about ducking in and out of the meeting the previous week in order to attend to Council business. I suggested that as a group, we needed to be able to say to each other that we need you here attending to the business of our meeting.

John wanted assurances that the audio tapes would be secure, especially the dialogue that was in Cree.

**John:** One more question. These tapes here. What do you do with them?

**Don:** Well I'm using them ... to write up our meetings, what happened at our meetings.

**John:** Umhum.

**Don:** And then I'll circulate that ... [amongst] this group. I haven't written any of them up yet....

**John:** In relation to like, there's about sixty per cent English on there and forty per cent Cree.

**Don:** Right.

- John:** In relation to Cree, what do you do with it?
- Don:** I haven't done anything yet. [laughter]
- John:** What about it?
- Betty:** ... Erase it.
- Don:** I can't imagine using it, unless it was interpreted.
- John:** Umhum.
- Don:** Cause I don't think I'll be able to master Cree [that] quick. [laughter]
- John:** No, it's just that if you're going to translate it, there's some things we said, that we shouldn't have said, [laughter] in Cree to each other ...
- Betty:** In other words, don't get it translated. [laughter]
- Don:** Well now, I'm really curious. [laughter] I'm going to have to work on my Cree. [laughter] Like that's an interesting boundary activity, eh?

I pointed out how language provided the group with a means for maintaining the boundary between themselves and me. John acknowledged how this allowed the group to control the discussion. Betty commented how this sometimes resulted in expressions of anger when members of the community spoke their own language in the nursing station.

- Don:** When you want to say [something] amongst yourselves and you don't want me part of it, you just [say it] in Cree. That sets up a boundary....
- John:** Umhum. It's a way of controlling the discussion.
- Betty:** We get the nurses mad when we do that. [chuckles]

The group returned to the task of editing the Pre-Transfer Funding Proposal, adjourning late that afternoon. The next meeting was to be a team building workshop scheduled for mid February.

## A Team Building Workshop

The team building workshop was a three day event. It was an opportunity for the members of the Task Force to increase their knowledge and skill in interpersonal and group relations. It was also an opportunity to discuss the research task.

The first activity was designed to establish a supportive learning environment, one that encouraged openness and trust in the group. I used a series of stem questions in which group members were asked to share with a partner their thoughts and feelings about being together in the group.

We followed this with exercises in interpersonal communication and group decision-making. These experiential exercises helped the group learn about their own interaction and provided an opportunity for them to try new behaviour in order to become more effective members in the group.

The latter half of the workshop explored the health system in Split Lake. As we discussed health, John reflected on traditional spiritualism and the power of the shaman. He said that elders warned them as young people that they did not know what they were getting into when they talked about wanting to know about the old ways. The elders told them that fearful spirits were used to frighten the kids and that the shaman could harm you. The shaman had almost dictatorial powers acquired through the fear he engendered. John added that he had learned most of this from what he had read. He pointed out that although elders had adopted Christian beliefs, they still turned to medicine men for healing. He added that people who had gone out to the mental hospital for mental disorders would come back and go to a medicine man who would heal them. He added that the competing belief systems resulted in stress for the individual.

I next asked members to list ideas about health. They were to follow this by developing a working definition of health. The definition and a diagram illustrating their definition are represented in Figure 6.2. John explained the diagram.

**John:** What is health? In a native perspective of health the spiritual, physical, mental, emotional [are connected]. We drew a diagram to represent that where the circles interchange and interact with each other,... mental meaning the mind, physical meaning the body and social meaning emotions [together with] the spiritual. In the western society they are separated. For mental health you go somewhere to be treated. Under the native circles we tried to treat them in all the same ways. The mental health and the mind. Some people assume that you are referring to a person who is going through psychiatry or therapy. Really what [we] are saying is that the mental health of the mind, people going through mental stress, could be over someone dying or [else] somebody is sick in their family and causing stress. The physical part again is the body, internal organs or the skin if you get it cut. A broken leg. The spiritual part is where the spirit of all denominations and beliefs impact a person's aggressiveness.

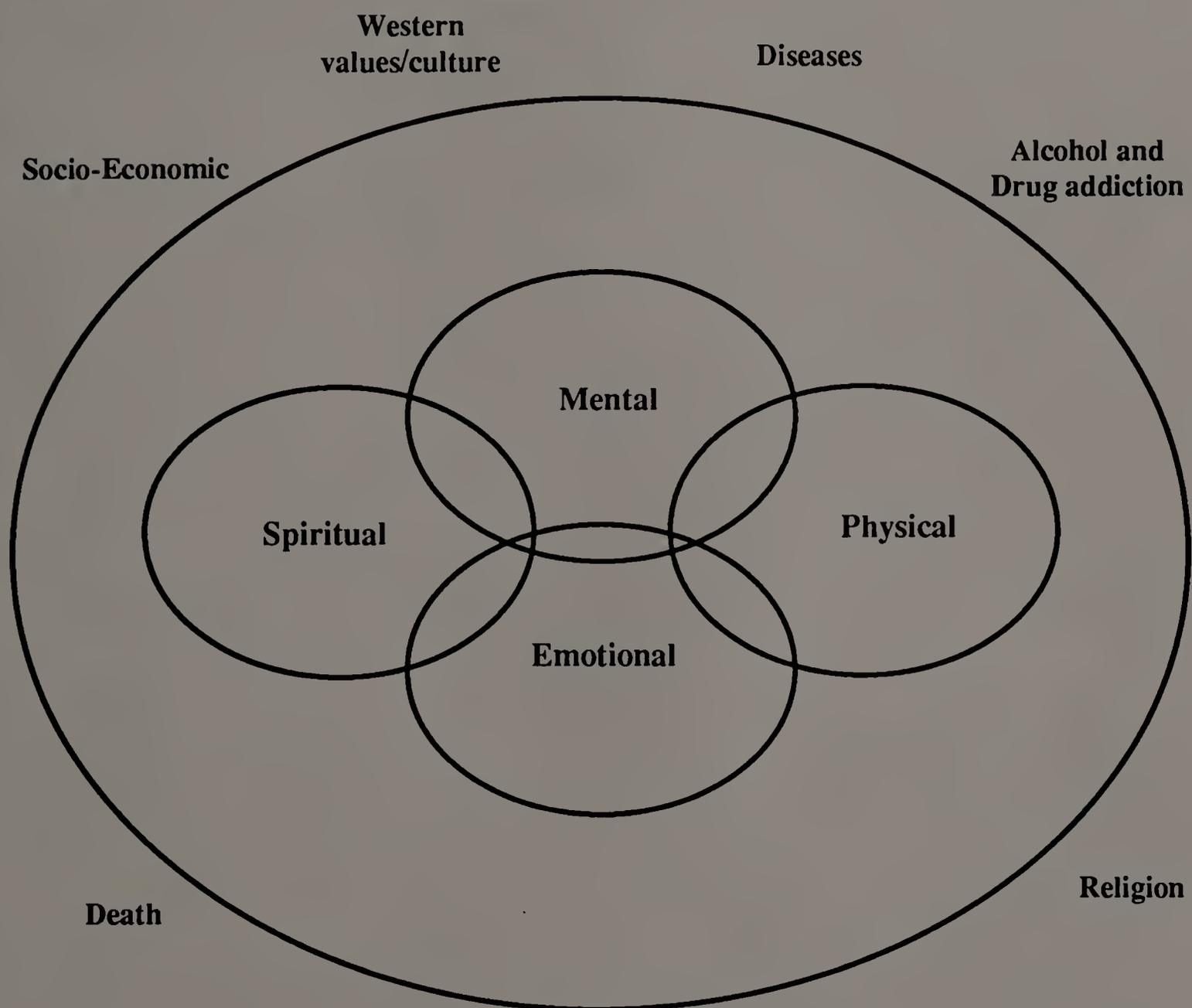
How does that bring about imbalance here? If you are aggressive and offend people and they are drawing away from you, the emotions or social part suffers. There is an imbalance. We drew a circle around that.... What would make a person unwell externally. We said the other people do that and then there [are] diseases and the western values and culture. Then there is alcohol and drug abuse and then there is environment. Then there is religion. If you are into native spirituality then you have the anglican faith, alcohol withdrawal or the R.C.'s [Roman Catholics] or United Church or other denominations that can help by attacking this part of you. Then there is the socioeconomic method that can impact a person. Basically that is what we think the health thing is. The mental, physical, spiritual, emotional part of an individual. Mental health is being of sound mind, physical health is well being of the body, emotional is the physical being or the emotions of the body, spiritual health is satisfying the spiritual needs of a person. When all these parts are in balance or harmony one is in good health.

**Don:** That is a very complete looking definition. I couldn't help thinking as you went through that you talked earlier about the fear of the shaman. He almost had a dictatorial power and I wonder how you deal with that in your model here?

Health is the mental, physical, emotional and spiritual wellbeing of an individual.

- Mental health is being of sound mind;
- Physical health is wellness of the body;
- Emotional health is the social, feelings, emotional wellbeing;
- Spiritual health is satisfying the spiritual needs of a person;

When all these parts of a person are in balance or in harmony, one is in good health.



**Definition of Health**  
**Figure 6.2**

**John:** One way to look at it... We would like to see a hospital here ten years from now and a doctor and a healer, all houses have water and sewer, recreation centre, a dietician, licensed personal care home, mental [health] care worker, crisis centre, elder advisory group, crisis line, [and no] unemployment. Ten years from now there will be different denominations in the community. The community right now is the anglican faith. You could have an elder advisory group to test that. You could say this person has a mental health problem and he also has a spiritual problem. We could refer him to a mental health institution or we could ... refer him to a different denomination.

**Don:** It seems that your definition and your model really addresses that interconnectedness. The issue you raised earlier about the traditional belief, [that] a shaman or a spiritual leader would be very strong, I am wondering and [it is] something that you might think about,... how does that person impact your model? [Does] it become out of balance if one person has too much influence? It is a question in my mind.

**John:** If it is one person then there are services around him. When you talk about a shaman or a priest, all this individual has with that person is a spiritual need or he can go to the hospital to address the mental issue or a marriage counsellor. We don't expect the shaman to be a mister know it all or a cure all. These support groups will have to take part in the well being spiritually.

**Don:** I guess if the care providers or helpers follow your model they are going to have a balance.

**John:** There should be a referral system. If a person gets sick with mental problems because of his mental problems all of his problems suffer in time. He gets help with his problems but he could get help with a priest or shaman and get back into society in the community....

There is another thing the elders used to say. People used to have mental health problems at one time. It is nothing new. People would be bothered by spirits. They would go to a person who could drive away spirits and sure enough that person would be well again in a little while but now we have to send these people to [the mental hospital] ... back and forth. After a while they become so unbalanced that they [do not] have spiritual balance. It doesn't help them to be well. Other times it does but there is always cases where it doesn't. They become unbalanced.

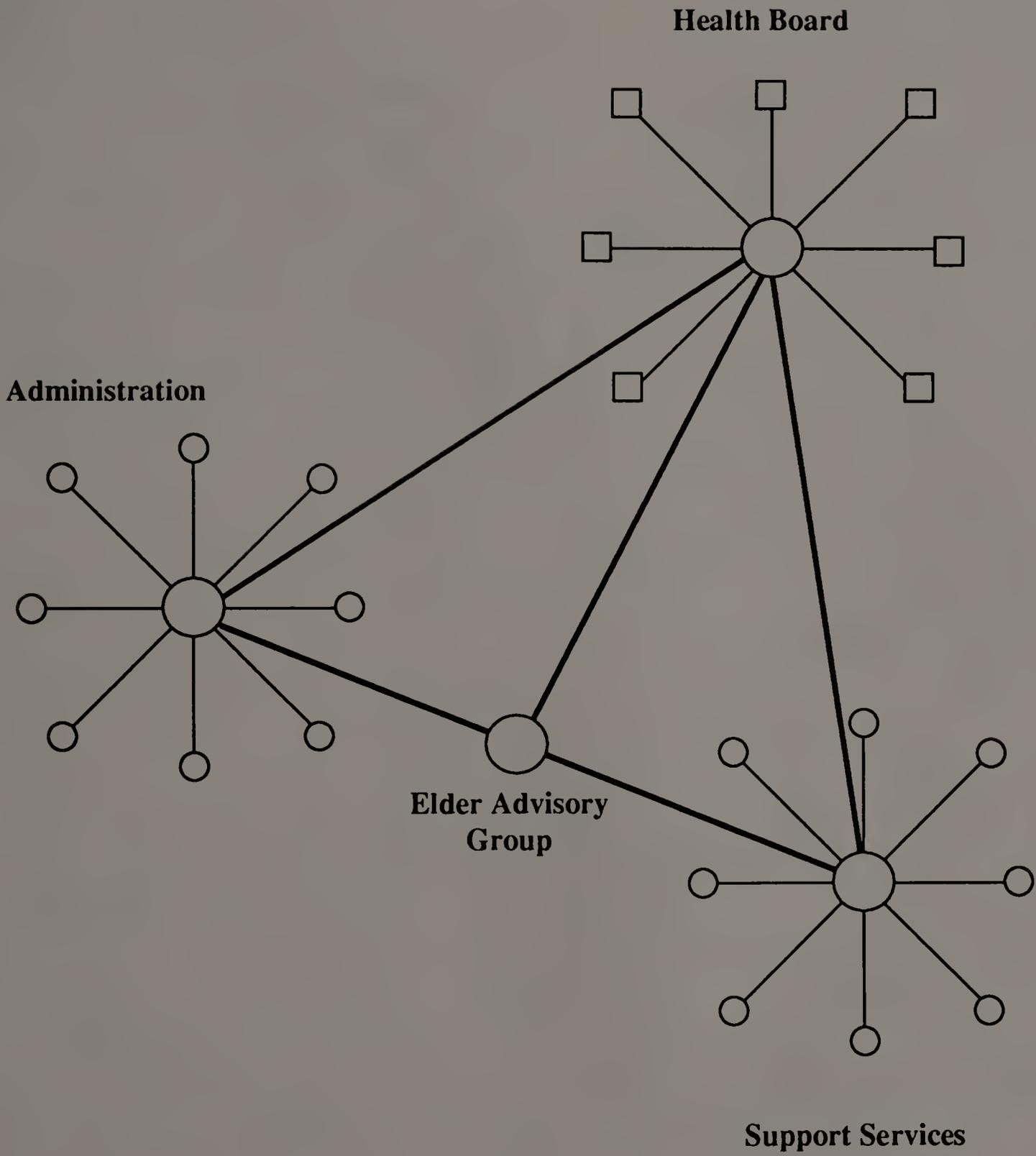
Once the group had completed the definition I asked them to build a three dimensional model of the Split Lake health system. The model was to reflect their definition of health. I provided them with tinker toys for constructing the model. The group began by sketching their model and then proceeded to build it. [See Figure 6.3.]

*The model appeared to me to reflect two separate systems, one system representing the administration of health and another system representing support services, the two linked by a community Health Board. The model seemed to treat western health as a separate system with a support system controlled by the community rather than incorporating the ideas contained in the group's definition. I did not share this observation with the group at the time as I was concerned that it might seem that I was negating their effort.*

On the final day of the workshop, I worked with the group to prepare a preliminary plan for the first community workshop. I followed this by asking the group to brainstorm reasons why the Split Lake Cree First Nation might want to take control of the health system. The brainstorming was a slow process with most of the ideas coming from John.

The last activity in the workshop was a session to identify aspects of the health system where members felt they lacked information. I asked the group to work on their own and withdrew. Karen became the recorder. The group generated much more energy, enthusiasm and ideas. I intervened at one point to provide a framework for analysing the health system. Once the members developed the list, I asked them to identify those areas of the health system which they personally wanted to study.

*I thought it was significant that individuals generally picked entirely new areas to study rather than those they had identified where further information and knowledge*



**Split Lake Health Task Force's  
Model for the Health System  
Figure 6.3**

*was needed. My knowledge of systems and organizations proved helpful as it provided categories for analysing the health system. Members of the group were able to relate to these categories and identify additional knowledge that was needed.*

### **My Relationship with the Task Force**

I attempted to reach John a number of times after the workshop to arrange the next meeting. When I finally reached him he told me he was unavailable until April ninth as he and Betty were each going to be away for consecutive weeks during the spring school break.

*I was disappointed as we had planned to meet the first week of April and hold a community workshop on April nineteenth. I realized everybody had worked hard in February but there had been no meetings during March. I was anxious to get on with the work but I did not sense any urgency on the part of the group. I did not know what to do about it.*

*Financial arrangements were an additional concern. I had not received payment on my last three expense accounts which had left me somewhat short of funds. John advised me he would check into this and call me back but I did not hear from him. It was upsetting to have finances interfering with the project and I was left wondering what was happening to the inquiry. I felt dependent on the group and I did not know what was going on. I was worried that the shortage of funds to cover my expenses and my questioning as to when these would be paid might mess up my relationship with John.*

We finally met on April tenth. The first task was to complete work that needed to be done on the Pre-Transfer Funding Proposal. The next item was a discussion of my relationship with the Task Force.

John was concerned about my availability during the next twenty-four months to work on the project. I told the group that I had one month remaining in my leave in addition to one month of holidays. I added that I hoped that the members of the group would take on more of the leadership and work of the project. The members discussed this last suggestion amongst themselves in Cree. There was considerable laughter.

**John:** All I asked them was if they feel confident enough to do it, take the leadership I guess. She laughed. She said she's not sure, said she's quitting. [laughter]

**Betty:** John's going to do it all by himself.

**John:** I said we can do it ... I feel confident that the Committee can do it.

John proposed we start with the review of how we were working as a team. He thought we had made considerable progress. He noted that when we had started, the Health Committee had been sceptical about their ability to carry out the research project. He stated that there was always an attitude that a white man, either a lawyer or consultant had to do this type of work but as he noted from the conference he had attended in December, speakers for First Nations who had completed their Pre-Transfer Studies had attested to the fact that in hindsight they felt their communities could have done the Pre-Transfer Studies themselves with a bit of assistance.

**John:** I think we've come a long ways from just an idea that was there. When we started ... some of the members weren't sure where we were going and why we were together. Like personally, I have some idea, like when I went to Toronto, that workshop, that gave me a lot of insight into this. Especially with this attitude that it always has to be a white man that has to do everything, like the consultants, you know, and the lawyers that have

to be involved in this. Some of the other communities, First Nations communities, ... especially in Ontario and the ... William Charles Band in Saskatchewan, when they did their presentation, they said that one of the questions asked was "[with] what you know now, what would you do different in relation to the development of the project" and they said "well, I'd let the Band do it from their own perspective and the way the Band wants it done. To do it [ourselves]." And [the] same [thing] with [the] William Charles Band. [They] said that "it should be a community development [process]. It doesn't have to be a consultant. You shouldn't have to pay ... all this money to this consultant firm." And they were quite confident at that, if they were to do it again, ... that they would be able to do it and that's what I thought this group could do with your direction.... I think they can do it but a lot of times we have this mentality that ... we have to be ... it's grade twelve and all that, to be in university, before you are able to do these kind of proposals but ... anybody can come up with a proposal.... The only thing is that the proposal we're trying to come up with, it's [in] relation to health.... It has to do with Medical Services Branch preconceived guidelines. I don't know how flexible they [Medical Services Branch] are in relation to that. Like the money is there.

John pointed out that my connection to sources of expertise at the university which they might utilize was important. He was concerned that if I was not involved, the Chief and Council might move in and assign others to the pre-transfer project.

**John:** In relation to our working together, one of the fears that we have in relation to you is [that] after April ... [we are not sure] how much can we use of your time.... It's not that we're trying to lean on you too much, it's just that it's a new thing for this community.

**Don:** Right.

**John:** What could happen is this. If we don't ... utilize your expertise and this is your level, with your outside contacts that you tap into, ... what's going to happen is that we're going to go into the Band, we go into the Band, ... like the Chief and Council.

**Don:** Hmm.

**John:** Then once we get into that and once there's too many people [who] start ... giving directions, this whole program [will] not be lost but they [the Chief and Council] could take it away from us.... It won't be a Health Committee [project] any more. It'll be the Council. [They will decide] who they [will] appoint to the group. And I don't really like to see it go in that direction.

**Don:** Are they likely to appoint more people to the Task Force?

**John:** ... They could try. I don't know if I'll let them.

John was concerned about the amount of time I would have available to work with them after April. He thought it was important that I remain involved as I provided direction for the group. In response to these concerns, I shared my own fears about their commitment and expressed my frustration around the difficulty I experienced in arranging meetings. I told them that after April, I would be available to work with the Task Force from mid June through to mid July. I added that I had an additional month of holidays available for work on the study but advised them that I would need to negotiate time off for trips to Split Lake in the fall after I was back at work.

John explained that he had to obtain approval for my travel expenses, especially now that they were into a new fiscal year and that it was not always easy to locate the Chief or Deputy Chief to obtain that approval. He acknowledged that he had forgotten to phone me the previous week to tell me the Task Force had decided to change the date for that week's meeting. Betty had told me she had been surprised when I had showed up for the meeting. There was considerable laughter when I told the group that when I had walked in the door Betty had greeted me with "That guy is here!" I told John I appreciated his honesty.

I explained to the group that I was interested in studying how we were working together as part of my dissertation and that I was particularly interested in exploring my

relationship with the Task Force. John responded. He observed that I was a white man and an outsider but as an expert I provided needed assistance. He was aware that my approach was to encourage the Task Force to move on issues. He said he was not sure how I had begun talking with them about my dissertation and had ended up working with them on the Pre-Transfer Funding Proposal. He added that initially in his mind, he thought I was only doing this work for my dissertation but he had changed his mind as I had continued with the work on the Pre-Transfer Funding Proposal.

**John:** How we see you?

**Don:** Yeah.

**John:** Well we see you as a white man.

**Don:** That's obvious.

**John:** An outsider.

**Don:** Yeah.

**John:** I think. In relation to us, like I guess in a way we tap in to you, we see you as an expert and I know that a lot of times you turn to us, like you want us to work the problems out more or less. Like you give directions but you want the Committee to, not necessarily solve it but to move on an issue.... Again, in regards to that thesis you're doing, I don't know where you are at [on] that or ... but the thing is also ... like when you talked about the thesis and then we some how ended up with this project with you in it ... it was almost like ... the thing that came to mind was that ... you were more in this for your thesis than for this project but the more I see your commitment towards this process, the more or less you erase that I guess from your [my] mind.

John told me the group had not really discussed their relationship with me but that he personally found that I took an interest in them and in that I was different from other whites or non natives who were only interested in their job. He thought this was best illustrated in my friendship with Mary and her family where I had my meals. I told Mary

that I appreciated being able to spend time at her home and that I certainly preferred having my meals together with her family rather than being left to eat alone.

John noted that some of the Task Force members had left the group and that both he and Betty did not know how much time they would have available to work with the group in the fall. There was a possibility that they would both be participants in training programs being organized by Medical Services Branch. John added that some of the other members of the Task Force needed to become more assertive and realize that the project belonged to them.

The group discussed a number of potential new members, identifying reasons why individuals might not be available. In one instance, an individual lacked support from her spouse and would not likely be able to join the group. Another individual had just obtained a full time job at the Northern Store, formerly the Hudson's Bay Store. John commented, "[She] started working in The Bay once we brought up her confidence!" His comment was met with laughter. John added that quite a few Health Committee members had been recruited by other committees and that the Health Committee was a training ground for the community. This was met with more laughter. The group did not decide on a specific plan of recruitment. John's final comment was that he thought the group would be able to establish a more regular work schedule once the Pre-Transfer Funding Proposal had been reviewed by the university's Northern Medical Research Unit and Medical Services Branch.

I told the group the status of my dissertation. It was at the stage where my faculty committee had been asked to approve my dissertation proposal. Once the approval was given I told them I would share it with them.

John wondered what I had thought of the community research group when I had first met them. I told him that I was quite impressed by their commitment and the effort they had put into the research project and the Pre-Transfer Funding Proposal. I told the group I hoped we would soon reach a point where each of us might have different points of view on an issue but that we would be able to debate the issue before we came to a decision.

**Don:** So at some point you're going to be saying to me, I don't agree with you, I don't think we should do that. We should be doing this. And we'll argue, debate it and make some decisions but the decisions will be the [decisions of the] group.

John responded explaining how decisions were made in the community.

**John:** I think we're tied here, I don't know but in ... our culture it's always the group that makes a decision. It's not really an individual. It has to be agreed upon.... But we have to think too that the person who has done it more often is right, you know, which is not necessarily right, correct. I'm glad we're opening up here.... I'm pretty sure Karen here has some concerns and Mary here but I'm pretty sure they'll come around.

John suggested that our interaction in the group was an area the members of the group needed to discuss amongst themselves.

**John:** Maybe [at] your next meeting we'll have something.

**Don:** I think one of the important things as a team, as a group here, is [to get to the point where] ... we all feel comfortable saying what we [think].

John suggested that there was a degree of uncertainty in the group because they did not know what the next step would be in the research project. I acknowledged this and said that I had intended to provide them with an overview of the phases in the Pre-Transfer Study that afternoon.

I began that afternoon by presenting an overview of four phases in the Pre-Transfer Study, explaining that the first phase involved the decision by the Chief and Council to approve the research project and to proceed with the Pre-Transfer Study. This phase included the formation of the health Task Force and the preparation of the Pre-Transfer Funding Proposal. The second phase was the actual research involving seven studies, beginning with one on traditional health. Further studies were to be conducted on health goals, health concerns in the community, current health services, the health status of members of the community and reviews of health legislation and finance. These studies were to be the basis of a community health development plan to be developed in phase three. The Task Force also needed to design an organization to deliver health programs and services during this phase. The fourth and final phase of the project involved a decision by Chief and Council as to whether the community was going to proceed with the transfer of the health programs to the community. The phases are illustrated in Figure 6.4.

John drew attention to the apparent overlap in the studies, noting that the study on traditional health and the study on current health both involved medicine men. I acknowledged this was the case but explained that while each study had its own particular focus, the information gained from one study could be applied in another. I noted that while the research project might seem somewhat overwhelming, it would be manageable if it was done piece by piece. I pointed out that the Task Force had almost completed the first phase and were now beginning work on their first study in phase two. John commented that while it was a challenge, the diagram was helpful in laying out the process.

Phase I	Phase II	Phase III	Phase IV
<p>Form Health Task Force Prepare Pre-Transfer Funding Proposal</p>	<p>Pre-Transfer Study</p> <ol style="list-style-type: none"> <li>1. Definition of Health and Health Goals</li> <li>2. Traditional Health Study</li> <li>3. Current Health System (western and traditional perspective)</li> <li>4. Current Health Status (western and traditional)</li> <li>5. Program Planning <ul style="list-style-type: none"> <li>• Health Facilities</li> <li>• Health Services</li> </ul> </li> <li>6. Financial Analysis</li> <li>7. Analysis of Health Legislation</li> </ol>	<p>Pre-Transfer Study</p> <ol style="list-style-type: none"> <li>8. Organization <ul style="list-style-type: none"> <li>• Structure</li> <li>• Roles</li> </ul> </li> <li>9. Inter Organization <ul style="list-style-type: none"> <li>• Regional First Nations Health Services</li> <li>• Non Aboriginal Regional Health Services</li> </ul> </li> </ol>	<p>Decision</p> <p>Proceed or not proceed with Health Transfer</p>

**Phases in the Development of the Split Lake Cree First Nation Pre-Transfer Study**  
**Figure 6.4**

## The Study of Traditional Health

We now began the study of traditional health. We discussed data collection and the use of questionnaires. I explained two approaches we might use in gathering data. One approach was to use a set of questions accompanied by an interview. A second approach was to use an open ended interview in which the person being interviewed talked without any direction provided by the interviewer except the introduction to the topic. John told me he had assumed that we would need to develop a questionnaire. I explained the difference between an open ended and a closed question and the advantages and disadvantages in using each for gathering data. This led to a discussion about the approach to take in gathering data for the study of traditional health in Split Lake.

**John:** I guess when I thought of a questionnaire, automatically I thought [about] a set of questions.

**Don:** Yeah.

**John:** Now you are more or less saying we should go in with an open ended [question].

**Don:** Well we need to look at that because [it] depends [on] what information we want. In some cases it makes sense to develop a questionnaire and get specific information and other times it might make more sense to have an open ended one.

**John:** Well along with the questionnaire you can also have [an] open ended question.

**Don:** Yeah, yeah.

I suggested the group use an open ended question to initiate the interviews. I explained that it was important to capture the ideas and understanding of elders on

traditional health as the life experience of the elders was very different from the experience of the group members. Betty expressed concern, suggesting that the elders would use this invitation to tell lengthy stories. I explained that this was one reason why we might want to use this approach as it provided the elders with an opportunity to explain to us in detail through their stories the significance of traditional health. I added that specific questions could be used to follow up on the initial open ended question in order to illicit information that might not have been addressed in the first part of the interview.

The group proceeded to identify various complaints and illnesses that would have been treated by traditional healers. Out of this discussion they developed a list of questions which were to be used as an interview guide for the first interviews, adding a question to determine how traditional health had changed over time and another question to determine which traditional health practices were still practised and by whom. I suggested that the interviewers also ask elders their views about the current health of people in the community as this information would be needed for the study on the current health status of people in Split Lake. John stated that it might be too late to obtain information about health problems that might have been prevalent in the past as there were very few surviving elders although he still thought it was important to gather as much information as possible.

A lengthy discussion in Cree followed as members discussed how they might word the open ended questions in Cree. Once they were satisfied with the phrasing, we proceeded to identify elders who should be interviewed as well as a time when the first interviews could be conducted. Two interview teams were formed. Betty and John agreed to work together and Mary and Karen formed a second team. The plan was to complete two initial interviews in the coming week.

We finalized our arrangements for the interviews and agreed to meet again on April eighteenth. We adjourned shortly after this and I left for Thompson and my flight home.

### First Interviews

There was excitement after the first interview had been completed. John and Betty had interviewed Elizabeth, an elder from Key Lake, who was now living in the Elder Hostel in Split Lake. John began by telling us that he had found the tape fascinating and that he had played it for his children. His children had found the information captured in the interview to be "out of this world". He told us that he had not known what to expect but that the interviewee, Elizabeth, had been very willing to discuss health although she had used terminology that he and Betty had not understood. He referred to the words she had used to describe various plants as high Cree.

John commented on the fact that neither he nor Betty had interrupted Elizabeth to get an explanation of the terms she was using as they had not wanted to interfere with her once she got started. The first question had been about the old days.

**John:** Tell us about how, in the old days, before, more or less before the white man.

**Don:** Yeah.

**John:** And she kept referring to ... when she was a child. How what her father told her in regards to what happened. It wasn't all glory.... It was a lot of hardship. She tried to stress that by telling how ... native people lived, like saying almost as if there was no god.... I couldn't really translate beliefs.... I just said, how did you believe but I didn't want to lead her and say superstitions.

**Don:** You didn't want to what?

**John:** Lead her.

**Don:** What do you mean by that?

**John:** Well I didn't want her to respond to a specific question, like either yes or no, or just to lead her, in regards to superstition. Like, how can I explain that? Like beliefs. Why did they do it the way they did it.

**Don:** Right.

**John:** Okay.... Why did they live the way they did or why ... certain things were done the way they were done. Was it superstition? Was it because it was [the] traditional way of doing [things], culture? We didn't want to lead her that way.

I drew attention to John's point that it was important not to lead the interviewee. I commended John and Betty on their approach which encouraged the interviewee to put her thoughts in her own words. I also supported John in being careful not to use a term like superstition as it implied that a person's belief was not acceptable.

John and Betty had missed taping some of the interview as they had forgotten to turn on the tape recorder at the beginning and later they were unaware that the tape had run out part way through the interview.

John suggested that he should have edited the tape before we listened to it but I told him that the group needed to work with the unedited tape. The editing would come later in the writing phase.

John told us that he and Betty had tried to make Elizabeth, the interviewee, feel comfortable and that she had made it easy by making wise cracks when they started. However, he said that once she got going 'it was straight business.'

John and Betty discussed the difficulty in explaining the interview questions to Elizabeth.

**Betty:** She couldn't really understand the question that was being asked.

**John:** Hmm.

**Betty:** Especially that part there.

**John:** Especially on beliefs too.

**Betty:** Hmm.

**John:** I didn't like ... the way I [Cree] [introduced the question about] the old beliefs.... To her it's not a question. I don't think that's the kind of question you ask.

**Betty:** Hmm.

**John:** I don't know how we can rephrase that.

**Betty:** Even ... living conditions.

**John:** Living conditions. Like I tried to direct her, like how did the people live, what was their home like. She talked about that.

John indicated his enthusiasm for the experience.

**John:** It was good. It was a good session and when Betty and I walked out of there we were, I guess we were stunned and surprised by [what she told us]. There were some words we didn't know ... but you can sense it, the feeling that she was very sincere, eh, She was talking from her heart, experience. It's too bad you [Don] don't understand Cree.

The group proceeded to listen to the tape and discuss the experience. One of the first things that John noted was that he had difficulty with the opening question in the interview and he thought it should be revised. It had been difficult to explain in Cree just what he meant when he had asked Elizabeth to tell him about health in the community as far back as she could remember.

**John:** Like when I said beliefs, right away she talked about religion. In the old days before the white man there was no.... They didn't really believe that there was a god. They felt that ... the people were under each other's care so they had to provide for each other. There was no god to help them as individuals but they had to function as a group in order to survive. They were under each other's....

**Don:** Care.

**John:** Care.

**Don:** That's a pretty remarkable idea.

**John:** Hmm....

John noted the difficulty in asking about her beliefs.

**John:** So they didn't have this divine, divine assistance or whatever you want to call it. But I couldn't get her to talk about mother earth and things like that, different beliefs like that. I tried to say, well I heard that some people prayed to the moon or something like that. She didn't dwell on that.

**Don:** Right.

**John:** And I didn't bother pursuing it.

This discussion led into a description of the shaking tent, important in the practice of many traditional healers.

**John:** But she said that, she kept referring to the southern tribes doing things differently eh, something like that. I don't know if we've got it on tape but she said they live differently. She said, the real Indians or something like that. I don't know what she meant by that. That's when she was talking about lodgings, she referred to [the] teepee as being a southern thing.

**Don:** Yeah.

**John:** And they adapted to using logs themselves, here.... What else. We didn't really dwell ... on treatments here.

**Betty:** Medicine lodge. [Cree]

**John:** She kept saying about medicine lodge. That's an interesting story.

**Betty:** She said there are some still there.

**John:** ... The site is still there where just recently this old man passed away. He was still ... [practising] that in Key Lake.

**Karen:** How do you say that in Cree, medicine lodge?

**Betty:** Did she say meegwap or something?

**John:** Meegwamis, meegwamis.

**Mary:** Meegwamis.

**John:** Meegwamis.... But like there's another term she used. That's the way we say it here.

**Betty:** Megam.

**John:** But I forgot, its in there, [on the tape] meegwamis. It's a shaking tent.

**Don:** Hmm.

**John:** That was a last resort they used. First they tried the herbs [to] try and cure somebody. If that didn't work they took them to the shaking tent.... They took it out of the community. Like it wasn't done right on the community, with[in] the settlement. They went about a mile away or so and that's where they took this sick person and the medicine man and they do it. They did the ritual in the evenings, eh, and [she] said you can hear all this, just like lightning she said. You can see all these different sparks, right through the trees, just like lightning, just like thunder was inside that. They could see, phew, just like thunder inside that shaking tent and then the next day, the man would be cured. Walking around. But I didn't ask her why it had stopped and I didn't ask her whether she thinks it could ... still work. I think I did at the end and she believed it could still work.

**Betty:** Could we go back to that? She said yeah, to do some healing.

**John:** Hmm.

**Don:** It isn't practised now?

**John:** It's not.

**Betty:** Not really.

**John:** It's not a common practice.

We briefly discussed the interview questions. Betty said she found them helpful but that we needed to organize them into some kind of order. Betty wondered whether they should use the medicine wheel as a conceptual model in inquiring about traditional health. John explained that the medicine wheel addressed the physical, spiritual and emotional wellbeing which should be included in a discussion on health. I agreed that it might be a useful conceptual model but cautioned about introducing a model which might not be indigenous to the community.

John wondered what Elizabeth's status might have been in her community and how that might have impacted her knowledge and perception of health. He related this to her lack of response to his question about her beliefs. He suggested that a leader in the community would have seen spirituality in life.

I asked John why they chose to interview Elizabeth as she had not been a member of the community. It turned out that she had been sitting in the lounge and they had decided to go ahead with the interview thinking that she would provide an interesting perspective that would be different from somebody who had spent all his or her life in Split Lake.

When the tape ended the group began discussing what they had heard. Elizabeth had told them about peoples' dwellings, catching and preparing food, making tea from one of the local plants, boiling the roots of a local plant to make a poultice and using the bark from the tamarack for treating cuts and bruises. She confirmed that medicine men were the healers.

**John:** Yes, there were medicine men. They used herbs. They used plants. Not just the plant itself, [but] the roots themselves too and they boiled them to make it into a liquid and then with one specific plant that she mentioned ... they scraped it off and it [became] soft and then they would apply it to where a person is injured or sick.

**Don:** Like a poultice?

**John:** Yep. But she named different plants ... and if that didn't work they'd build this shaking tent....Before the white man came, it was all done by medicine men. Everything was done by medicine men.

**Don:** Right.

John emphasised the strength of Elizabeth's convictions.

**John:** Yes it was all native medicine before white man's medicine and they had the knowledge, I guess ... and she's one witness to say that it worked.... I asked her if it was possible to revive that and she said yes. Before it's too late she said, eh. But I don't know how....

So she's one supporter of traditional healing but she kept saying to us "See this, I've witnessed this." She kept saying that. Maybe she was trying to get us to believe her but we did believe her. Reinforce what she's saying. Anyway, a really good interview.

The discussion prompted members of the group to share some of their own knowledge about traditional medicines. John described seneca root that is used in Split Lake for treating tooth aches and ear aches. The root is gathered throughout the north for commercial purposes and sold to pharmaceutical companies.

**John:** But there's a few terms we didn't understand. Maybe one of those is that seneca root.

**Mary:** [Cree].

**Karen:** That's how they use that here. Tooth aches, ear aches. [Cree]. Something like that anyway.

**Don:** What do they use?

**John:** Seneca root.

**Don:** Seneca root?

**John:** They still do that. There's one guy who does that a lot. You have a tooth ache, you go see him. Just burns you. [Cree] Then a few weeks later your tooth just falls out. Kills the pain, kills the root. They do something and [indecipherable] that's it and a few weeks later your tooth falls off. But I never go see him but a few of my friends do.

John recalled his earlier experience that he had previously recounted about the misuse of information and the need to respect knowledge that is shared with them.

**John:** Like I told you, one time there's this old man. I asked if I could send out some of these things to be analyzed in Ottawa and he told me he didn't want me to do that. If you do that, that medicine's properties, the spirit of the medicine will attack you and [that] scared me so I didn't bother. [laughter] That was my belief, eh.

**Don:** Yeah.

**John:** I didn't want to push it.

John reflected on how the interview had been a learning experience for him, especially the terminology that Elizabeth had used.

**John:** Personally I could do [interviews] for a whole week. Interview these people. They just, I don't know, I think, this terminology that I heard was so eye opening to me. I always hear there is this high Cree but I've never really.... I hear old people say when they talk about trapping, they use a lot of high Cree. I don't understand, but this one, this lady, she talked about plants, berries. I thought I knew everything about names about berries and bark and whatever. You know she's showing me.

John again expressed concern about the wording for the open ended question. I suggested they work at revising it until they felt comfortable with the phrasing. I proposed they form two interview teams and take turns practising the introduction to the

interview until they felt comfortable with it. Two teams were formed and the members worked on the introductory question. John pointed out that there were many ways to say what they wanted to say in the introduction. I suggested that he put it in his own words in whatever way was comfortable for him.

They discussed how to handle the issue of acknowledging a person's standing or status as a healer, recognizing that western concepts of accreditation and certification were inadequate terms. Betty suggested that they ask how healers learned to practice healing and how they came to be accepted as healers.

Once they had reworded the interview questions, John added that they would likely have to change the interview questions again after the next set of interviews.

*John and Betty had interviewed Elizabeth by chance. They had gone to the care home expecting to interview Louise Ross but Elizabeth had been sitting in the lounge so they had gone ahead and interviewed her. This raised the issue of selection. We had not established criteria for choosing individuals to be interviewed other than to assume that all elders were appropriate informants. In Elizabeth's case she was a recent resident of Split Lake, having spent most of her life in another community.*

That evening, Betty and Mary interviewed Arnold Sakakeep. Arnold proved a difficult choice. At ninety-three, he had difficulty remembering the past and was unable to provide information on many traditional healing practices. Before we began reviewing the tape the next morning, we spent considerable time discussing the experience and the difficulty of getting the information that was wanted from the interview. There was a sense that Arnold had not told them much about traditional health. This led to a debate over whether the interviewee had information he was unwilling to share, had paid little

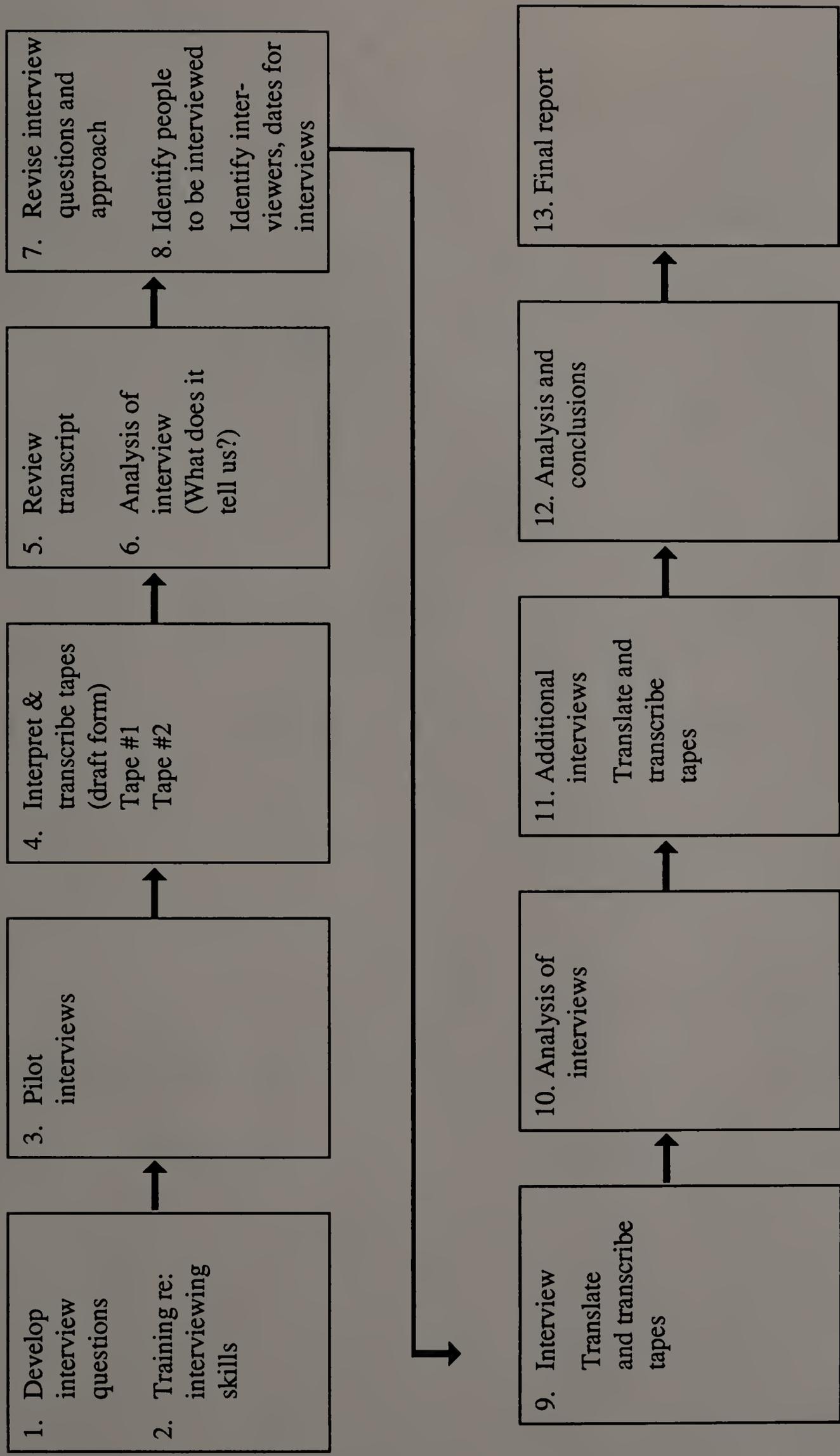
attention to the way health care was provided as a youth, was experiencing a loss of memory or had been raised in an environment where traditional healing practices were taboo. I stressed that we had to accept that Arnold was drawing from his own experience and that we had to learn what we could from the experience. Betty observed that Arnold seemed at times to be clear and at other times to be forgetful. She thought it might have helped to have asked him specific questions in order to prompt or remind him about the past. Mary pointed out that Arnold was very old and this seemed to affect his memory.

*I suggested Arnold may not have known much about traditional health even though others practised traditional medicine during his life time. This might have been the result of little interest in healing or a strong taboo against traditional healing learned in the Christian home in which he had been raised. It appeared that members of the Task Force needed to be more selective in choosing those whom they interviewed. The problem was compounded by the fact that there were only a few elders left in the community. The Task Force was going to have to work within this limitation.*

We discussed some of the technical aspects in doing the interviews. John pointed out that he had wanted to avoid drawing attention to the tape recorder, actually a hand held dictaphone and that as a result he had failed to check on the amount of tape left to run and had missed reversing the tape when it ran out. The dictaphone he was using had too little capacity for the type of interview he and Betty had been conducting. Betty and Mary commented on the discomfort they had felt when listening to themselves on the tape recording. It seemed to interfere with Betty's participation during the discussion of the interview. John and I encouraged them to keep practising with the tape recorder, telling them that they would get used to it in time.

*The interviews were the first experience in data collecting for the group. It had been an exciting process and I sensed considerable enthusiasm, both from those who had done the interviews and from those who were hearing the recordings for the first time. I was impressed by the discussion and the insight members had demonstrated as they weighed the quality of the information they had gathered, the effectiveness of their own interview technique and the changes they wanted to make in the interview schedule. They took this on with little direction from me. I think the differences between the two interviewees also contributed to significant learning for everyone as we became aware of the importance of establishing criteria for selecting the elders who were to be interviewed. There was also a need to provide members with some practice time listening to themselves on tape until they felt comfortable with the process.*

We met May twenty-second to review the critique on the Pre-Transfer Funding Proposal. Our next meeting to work on the traditional health study was scheduled for June twentieth. This turned out to be a short meeting but did give us time to establish a time frame for the study. I presented an outline of the steps involved in the study. The outline, illustrated in Figure 6.5, provided the group with a sense of direction and a visual sense of the work involved in the study. I also listed the activities and a time schedule required for the study on the flip chart and indicated the work they had already completed. The Task Force had developed the question format, conducted two pilot interviews and now needed to translate and transcribe the interviews. We would then need to do a preliminary analysis to discover what the interviews told us about traditional health and then revise the interview schedule or questions prior to conducting additional interviews. I explained that we needed to continue with this process until we felt we had as much information as we needed. The group still had to identify elders that they wanted to interview, set times for the interviews and complete the translation and transcription of the interviews.



Outline of Steps Involved in the Study of Traditional Health  
Figure 6.5

The outline helped identify the work involved in the study and did much to alleviate concerns about where we were headed. John expressed strong support for the task ahead and the capability of the Task Force members to undertake it.

**John:** Let me explain something to Karen and Irene. Like Karen, like Irene, in your own right or in this process you are learning something...[Cree] like with that [Pre-Transfer Funding] Proposal when we started... [Cree] I remember those words, okay. We struggled through about ninety-five percent of it. [Cree] Once we have finished this in two years [Cree] this whole thing.

**Karen:** I hope so.

**John:** No, you will. [Cree]. But the thing is [Cree] ... you guys can do it and learn from it and then it will just make the Task Force stronger. Hopefully in the long run ... the Task Force can become the Health Board. That's what I'd like to see and [in] the Health Board, you [will] have different responsibilities, but this is the ground work and you'll know more about ... [the health system] than the Chief and Council that come on board in two years. And in the fourth year, five years from now, you'll know more about this thing [indecipherable], but that's it, that's ... why I'd like to see the Committee take more responsibility, especially into ... [the] interviews. That [in] itself is a great experience, [a] training experience. And once you've finished that, bang... What do you think? [Cree] Like, you don't have to feel one hundred percent comfortable with it... If you feel, if you think you can do it, you can do it.

I suggested that the research process was giving the Task Force ownership of the health transfer process.

**Don:** What this process does is give you ownership of the whole process.... You create the knowledge. It's your study. You are in a position to know what to do with it. If you have somebody else do it, a consultant, they give you a report. What do you do with it?... You start cold. In this process, as you create the knowledge, you begin thinking how you're going to use it. It's quite a different process.

**John:** [Cree] This is not just a small thing. It is a major undertaking.

John added that, at a meeting he had recently attended in Thompson, Medical Services Branch staff had been very supportive of the process.

We discussed further work to be done with the two initial interviews. John said that he found it difficult to translate by himself and thought it would be more effective to work on the translation in the group. The different structure of the language, with nouns occurring at the end of a sentence in Cree and at the beginning in English, made it difficult to capture the meaning in the translation. I suggested they form two teams to do the translation and transcribing and complete a rough draft in time for a meeting we had scheduled for the following week. If a draft was ready, we would be able to work on the analysis of the interviews.

We mapped out a time frame schedule for the study on traditional health. I suggested we meet in two weeks to assess our progress on the interviews and again in another four weeks to wrap up the translations and transcribing. Although John suggested leaving the dates open for the time being I insisted that I needed to know the specific dates we would be meeting so that I could request a leave of absence.

I listed the steps or tasks to be completed while members discussed target dates, agreeing in some cases to meet during their summer holidays. The schedule was tight but everyone indicated they thought we could complete the work within the time frame we had developed. It would mean that the traditional health study would be completed by the end of the year.

The process for establishing the time lines was quite effective. The time frame and plan for the study on traditional health helped everyone feel more confident with the direction we were taking. This together with an outline of the tasks helped reduce the

anxiety of members of the group. I sensed members of the group were more confident in their ability to do the work.

I arrived back in Split Lake Monday morning, June twenty-fifth and found Betty and Mary in Betty's office hard at work translating and transcribing their interview tapes. They were later joined by Karen. I phoned John. He was at home translating his tape. He proposed that we meet at 1:00 p.m. I spent the time working on the Pre-Transfer Funding Proposal budget. Betty and Mary worked until 12:40 p.m. It meant we all had a late lunch.

That afternoon we finished translating and transcribing the work done by Betty and Mary. When we had finished, we started on the tape John had been transcribing. This was the interview he and Betty had completed in early April. John, began by saying that transcribing the tapes had been very hard. He had torn up a number of attempts. He found that when he tried to translate the interview he ended up doing a lot of condensing. Betty also mentioned that it was very difficult translating word for word and that the interviewee was quite repetitive. We began reviewing the handwritten transcript John had prepared, members listening to the tape as they revised the initial draft. Medicines were identified, including red willow and tamarack root. John had not questioned Elizabeth, the interviewee about the use of these medicines so I suggested that the next time he ask specific questions in order to discover the healing properties of the medicine. At one point, John explained that Elizabeth had not described the berry that she had used in her treatment. I asked him why and he explained that he had just asked her how it had been used.

We worked until 4:30 p.m. and closed with a prayer.

We began the next morning with John saying that he was at the point where he would rather start the meeting with traditional drums instead of the Lord's prayer. He added that that was his own internal fight. He asked if I was chairing the session or if I wanted him to chair it. I suggested that he or somebody else take on the role. John then began the session saying that we would review the interview done by Betty and Mary. We were then to look at the budget for the Pre-Transfer Funding Proposal or possibly a questionnaire for the next interview. I suggested that we proceed with the translation and transcription as John had proposed and then if the material was typed, do a preliminary analysis of the first interview to see what it told us about traditional health adding we might also want to revise the questions for future interviews. We also needed to develop a list of elders to interview and determine who would conduct each interview.

The group began reviewing the second interview. Betty and Mary had prepared a first draft. I left to work on changes that had to be made to the Pre-Transfer Funding Proposal. When I returned, I sat in as an observer while the group worked on the transcript. I eventually checked to see if there had been any changes and if they had checked the transcript for accuracy. I complimented Betty and Mary on the layout of their draft as they had left space for writing in changes and notes that would be required during the analysis stage.

John made the observation that the two interviews were not comparable. He said that the questions were different in each interview. When I asked him what he saw that was different, he reflected on my question for a minute and then replied that it was actually the responses that were different.

We discussed the second interviewee's background and the taboo against medicine men and women in Arnold's Christian upbringing even though his grandmother had been

a medicine woman. One member of the group pointed out that the knowledge of the traditional healer was only passed on to a select few, suggesting that not all elders would be aware of traditional healing knowledge. I responded saying that I found the interview quite fascinating and that when the interviewee began the interview by discussing the church and its role in the community, as interviewers, they had to go with the direction he chose to take. Mary interjected with her understanding of the purpose of the interview.

**Mary:** We [are] trying to find out ... how these people lived in regards to health. Were they healthier? How were they healthier?

I agreed and suggested that they had discovered that the interviewee appeared to have interpreted health as being the prerogative of western medicine. He had stated that the first doctor had arrived with the treaty party in 1908. The interviewee had also identified traders and the church minister as individuals who had dispensed medicine. He later identified traditional healers in the community when he had been asked about 'Indian' medicine men. This was important information as it gave the Task Force additional leads in identifying traditional healers in the community. I added that although the interview was more difficult to transcribe than the first, it may have given them important information concerning past health practices.

I asked the group what they were learning from the interviews. John responded by wondering what we were looking for in the interviews. He pointed out that we had obtained information on medicine men and diet but he was not sure about his own probing in his interview when he had asked Elizabeth how they used to catch fish. I asked him what he thought we were looking for and agreed with him when he responded by summarizing the purpose of the study as being a record of traditional health including diet, life style, the role of the medicine men and women and the use of herbs or healing substances. John then said that he thought something was missing. After a pause he

suggested that midwifery and pre and post natal care had to be included. Alcohol and drug abuse were also added as health issues to be investigated. John jokingly asked, "Was there a secret recipe for the most potent home brew?" This was typical of the humour that accompanied the work of the group.

John added that the historical record, especially the onslaught of the epidemics, flu and tuberculosis were important to document. He felt we also needed to document the role of the church in "killing our culture."

I suggested that they might want to continue their research into healing substances once they had taken control of their health system. This was knowledge that was not being used in the nursing station and which was being lost. They might do this on their own or in co-operation with the university's Northern Health Research Unit.

Members identified information they had obtained from the interview with Arnold, information about the history of the people of Split Lake, the Christian church, treaties, the nomadic way of life, shelter, diet, transportation, including travel by foot, boat and dog team, medicines and the names of healers still living in the community. The group added that from their own knowledge they knew that meat and fish were smoked and dried, that the broth from boiled fish was given to infants as a calcium supplement, moss was used as an absorbent in diapers and rabbit wraparounds were used to keep infants warm in their cradle boards or tiekanawgans. John suggested that in future interviews, we might ask people to describe a typical day in one's life during the period we were studying.

I told the group that we would need to establish categories into which we could group the information: diet, lifestyle, infant care, healers, medicine and historical background. I pointed out that when we had started with the second interview, they had

said that it did not provide much information. In fact, we had learned quite a bit. We had also identified areas where we lacked data. I noted that each interview would vary in this way.

That afternoon we did further work on the first interview that Betty and John had conducted. The interviewee had described the role of the traditional healer, comparing it to modern health providers. Her recollections of traditional health practices were from her childhood and from the stories told to her by elders. She had described a diet of smoked, boiled and roasted meat and berries, the use of young tamarack roots which were boiled and scraped and used as a poultice and the use of the megwamish by the healer as a place to treat those who were sick. During the period when their tape had run out, the interviewee had talked about women's health. From these initial interviews, we were able to begin constructing the role of the traditional healer, develop a description of the facilities that were in use at that time and identify some of the medicines and diet.

When we had finished transcribing the tapes, I advised the group that we needed to organize the data we were collecting. I suggested that we number each interview and include the name of the person being interviewed as well as the names of the interviewers and the date of the interview. I added that someone needed to take responsibility for looking after the files and the tapes. John suggested that Mary take on this task, suggesting she use a file drawer in the C.H.R. office in which to store the materials.

John wanted to know who we were going to interview next. We discussed the time available, the loss of much of the next week due to Indian Days celebrations and the work it took to transcribe the interviews. The group finally selected four elders to interview and made up two interview teams.

We discussed the interview questions. John thought that the questions needed to be the same or similar in each case in order to have a good report. I suggested that we continue with the open ended question followed by probes to get at detailed information. John wanted to know what to do if the interviewee talked about items other than health. This was an important question. After some discussion, we agreed to continue with the open ended question followed by questions to elicit specific information. We proceeded to list questions that needed to be asked about diet, herbs and medicines, other healers, injuries, specific health concerns such as women's health including pre and post natal health, healing practices and the role of the healer.

The opening interview question was now modified. The interviewer was to begin with the question: "Tell me about the traditional health care in the community and how it was maintained before the arrival of the white man."

John wanted clarification as to what was meant by healing practice. I explained that this meant asking the healer what he or she actually did to heal the patient.

We organized the questions, starting with those that we felt people would readily respond to, such as questions about medicines and history. We followed with questions that might be more difficult, questions that related to life style, role, and other healers. The interview questions are reproduced in Figure 6.6.

*The group had worked well on translating and transcribing the interview tapes. The two initial tapes provided fascinating information but there were gaps in the information, indicating that the interviewers needed to follow up with probes to obtain more data. It was impossible for me to pick up what might have been missed in transcribing the tape as I do not speak Cree but the group seemed to identify the gaps, noting information that*

**Opening Question:**

Tell me about the traditional health care in the community and how health was maintained in the community before the arrival of the white man.

**Follow-up Questions:**

1. What did people eat? How did they prepare it? (Diet)
2. How did they live? What were the living conditions like? (Life style)
3. What were the herbs or medicines that were used?
4. What beliefs did people have?
5. Who were the care givers? Were they both male and female?
6. How did they learn to be healers? How did they get accepted?  
(Training and qualifications)
7. What was the treatment for?

- |                   |              |
|-------------------|--------------|
| fever             | colds        |
| broken limbs      | S.T.D.       |
| stomach ache      | boils        |
| pre natal illness | constipation |
| seizures          | diarrhoea    |
| mental illness    | hypothermia  |
| appendicitis      | cuts         |
| still born births | lice         |
| heart attack      | skin rashes  |
| headache          | abortion     |
| burns             | ear aches    |
| toothaches        |              |

8. How was health organized?
9. What facilities were used?
10. How did people deal with death?
11. How was health care changed over time?
12. What traditional health practices are still practised?
13. Who still practices traditional health?
14. How would you describe the health of people of Split Lake now?

**Interview Questions**  
**Figure 6.6**

*was missing. The discussion helped identify areas where additional questions needed to be asked, resulting in a revision of the interview schedule in order to cover areas where specific information was needed. My task in this was to help the group organize and revise the questions so that the members were satisfied with the intent of each question.*

There was a high level of participation amongst all members in translating the tapes. As a nonparticipant observer, I was aware of the cohesiveness of the group as it worked on the task. Members seemed more natural and spontaneous than they had in earlier sessions. I had little to say except to tell the group to include the questions they had asked in the transcript and to advise John not to edit the tapes before he transcribed them. There was considerable laughter as the group worked on its task.

*John had questioned who would chair the session on the second afternoon. I had said that it was up to the group to select a chairperson and John had then assumed the role but I undermined his position by proposing a slightly altered agenda. John later noted that by the end of the afternoon, I had taken over the role of chairperson. I was unaware of my need to control the process until he drew it to my attention. My desire to complete this initial phase of the project in order to have sufficient data for my dissertation has impacted the way I am working with the group.*

### **The Community Research Group: Issues, Concerns and a Time to Reflect**

It is necessary to pause here and review a number of issues related to the work of the Task Force during the previous month. I had had difficulty reaching John to confirm arrangements for the meeting on June twentieth and twenty-first. When I finally did

reach him at a Medical Services Branch workshop that he was attending in Thompson, he advised me that the meeting was to go ahead as scheduled.

I set out for Split Lake Tuesday evening, June nineteenth, and by chance met the Executive Director for the Split Lake administration as I was boarding the plane at the Winnipeg airport. He told me there was an important community meeting in Split Lake the next day to discuss a major compensation package by the government concerning the Northern Flood Agreement. This was my first indication that the meeting with the Task Force was in jeopardy. I boarded the plane wondering what I might encounter once I arrived at Split Lake. After overnighting in Thompson, I set out for Split Lake.

When I arrived in Split Lake, John met me at the main office. He asked Betty to join us and explained the Task Force meeting was going to have to be cancelled. He apologized, explaining that he had to go to the community meeting that afternoon. John told me that he had intended to call me on Tuesday to tell me the meeting was cancelled but he had become caught up in a meeting and it was four thirty by the time he remembered to phone. By then it was too late as I was at the airport heading north. He suggested we meet until one o'clock after which time he would have to leave to attend the community meeting. Betty indicated she also wanted to attend the community meeting. We agreed to go ahead with a short meeting.

Karen and Irene arrived shortly after we started. They had not known the meeting was to be cancelled.

*I felt encouraged to see them. It indicated their commitment.*

The meeting was short but productive. In three hours we were able to review the schedule I had prepared for the study on traditional health, plan a community workshop and begin the preliminary planning for the community health survey.

During this meeting, John again raised the issue of my commitment, pointing out that there was no contract or agreement between myself and the Task Force. I acknowledged that this was the case. He was still concerned that I would abandon them when I finished my dissertation.

I tried to reassure John that I was committed to continue working with the Task Force until the Pre-Transfer Study was finished. I re-stated my position concerning the time I had available until mid July and I told the group that I was requesting an additional six to eight weeks leave for the fall. I pointed out that I did not know what the decision would be on my request. I added that I would also be asking for three to five days a month to continue working on the project in the new year but that I had no guarantee that I would be granted the time I would need for the research.

Betty was concerned about the need to consult with York Landing and raised the issue of the satellite nursing station. We discussed what that might involve, including the number of meetings, travel costs and the need to include representatives from York Landing in the Task Force. It became apparent that it could become a major undertaking. John finally reacted to this dilemma. "They can really kill us, those guys". I challenged him. "Well, you have to decide whether you're going to allow that or not." Finally he said, "All that is required with them is consultation. That's all and that's the end. I think it is up to us whether we want them or not." Betty added that the provision of medical services to York Landing was a problem that Medical Services Branch would have to resolve.

John expressed concern about hiring a local community research co-ordinator and the problems this might create.

**John:** Then the [community research] co-ordinator, I don't know. Shit. That co-ordinator always gets in the way. That's another thing that's scary too. You know the Committee here, you've seen them come up, like Mary and Karen, start participating and then if we get a jerk for a co-ordinator, starts trying to run the show.

**Don:** Why would you do that?... Who's the co-ordinator working for?

**John:** Nobody right now.

**Don:** No, if you hire a co-ordinator, who's the co-ordinator reporting to?

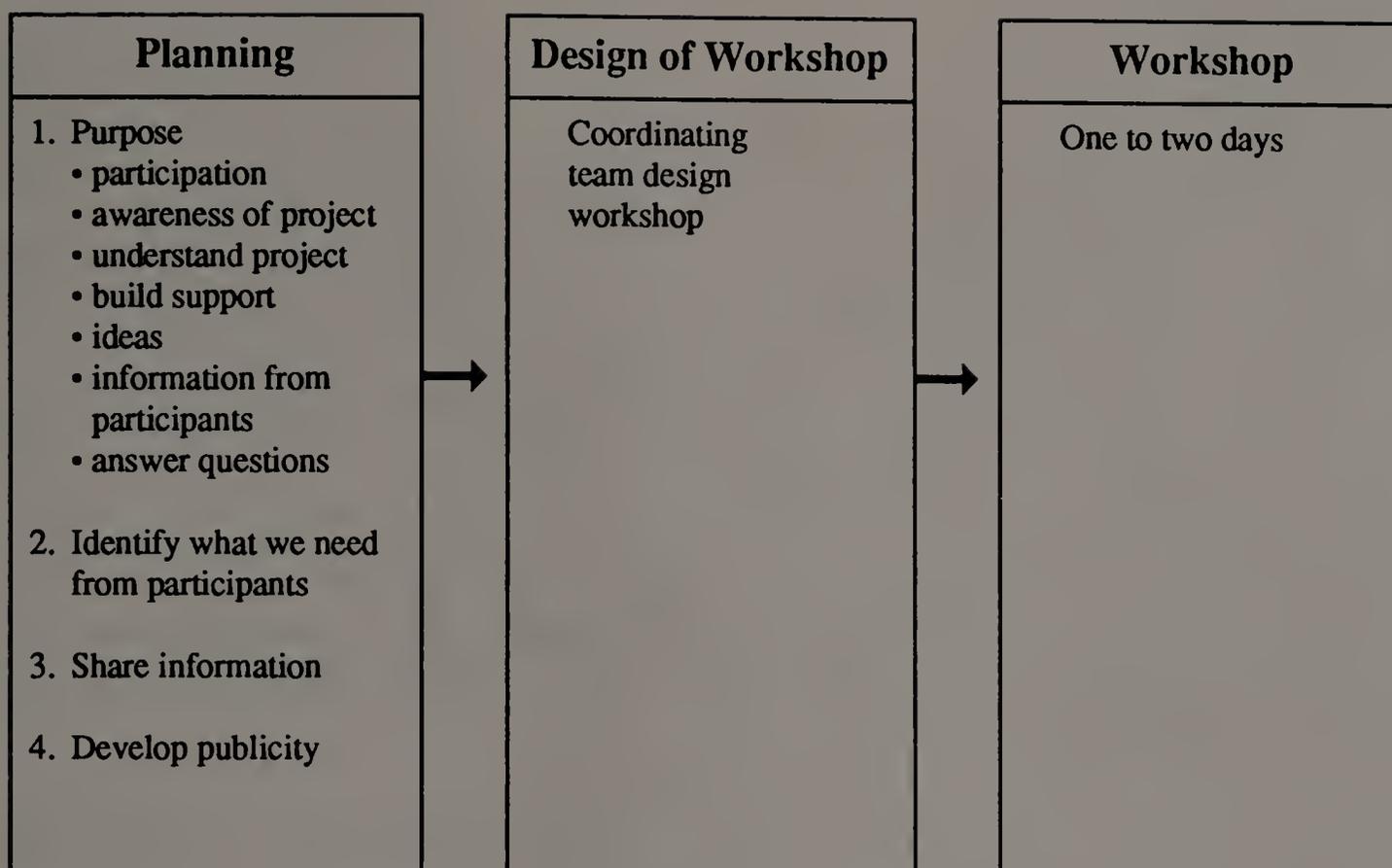
**John:** To the Chief and Council or we can make it so that he addresses [his concerns] to us and we in turn bring it to the structure. It can be set up that way. I never really thought about this.

**Don:** That's pretty critical, eh. Number one you don't want a jerk. Number two, whoever you get has to recognize the work that this Committee has done.

**Betty:** Job description [indecipherable].

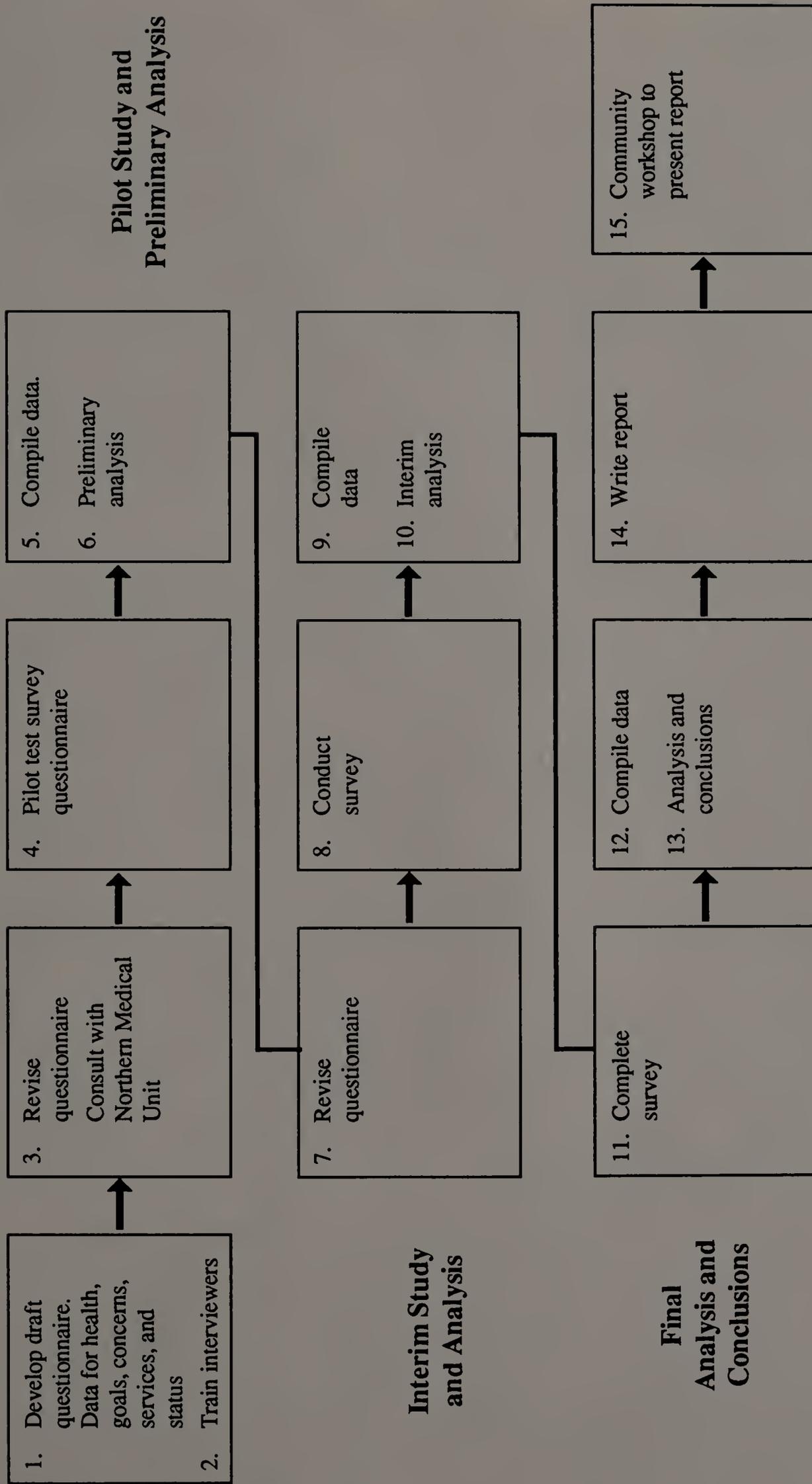
**Don:** So that's the Task Force's responsibility to decide, you know, who they want and what the reporting relationship is. What they want this person to do, eh.

We discussed the organization of the first community workshop. There was some concern about co-ordinating the event. I explained how this could be managed using group facilitators and discussion recorders. I also presented the steps we would have to go through to plan and deliver the workshop. [See Figure 6.7.] The explanations of the process appeared to ease the anxiety of the members. We agreed to schedule the workshop for August twenty-second.



**Community Workshop**  
**Figure 6.7**

I referred to the items that were to be included in studies for the Pre-Transfer Study and suggested that information on health goals, health issues, concerns and services and the current health status of members could be gathered in a community wide survey. I added that we could follow the same procedure we were using in the study on traditional health, although in this case utilizing a questionnaire instead of an open ended interview. I proposed that we also consult with researchers at the Northern Medical Research Unit concerning some of the questions which they might recommend we include in the health status report. I added that in order to undertake this study, we would need to develop the questionnaire, train interviewers, test the survey question, do a preliminary analysis of the data we collected from a pilot test, revise the questionnaire and finally carry out the survey. I suggested that we plan to meet half way through the data gathering phase and again at the conclusion of the field work to analyze the information and prepare the report. The schedule is set forth in Figure 6.8.



Community Health Study  
Figure 6.8

We agreed that this study should only get underway once the study on traditional health was complete. We set September fourth as our target date to begin the study, hoping to complete it by the end of November. All agreed that we needed to hold meetings throughout this period even if John and Betty were unable to be present due to other commitments. The results were to be presented at a community workshop the first week of December.

The work of the Task Force now came to an abrupt halt and the plans we had developed to complete the study on traditional health and organize a community workshop were postponed indefinitely. I became aware that a problem existed Sunday evening, July eighth, when John phoned to cancel the meeting we had scheduled for that week. He told me that the Split Lake administration was experiencing difficulties in one of its program areas and that the Council had called an emergency meeting the next day to deal with the problem. The Council was to hold a number of meetings with the community during the next few weeks in an attempt to present the problem to the community and obtain support in their effort to rectify the situation. The plan they eventually adopted meant repriorizing programs and postponing a number of programs for a year. The Chief did authorize the expenditure of \$3,000.00 to enable the Task Force to complete the Pre-Transfer Funding Proposal but there was no money available for non essential work. I was in contact with John off and on throughout the summer in an attempt to arrange a meeting with the Task Force and John remained optimistic that funds would become available for a meeting but we did not meet again that summer.

I phoned Betty Thursday afternoon, September sixth. She jokingly asked, "Who are you?" The Task Force had met the day before and decided they should go over the Pre-Transfer Funding Proposal with Medical Services Branch and then meet one more time to finalize the Proposal. She suggested I call John the next day to find out when this might happen.

I was tied up with my work at the university for the next three weeks and did not reach John until late September. When I finally contacted him, he greeted me with "old friend" and expressed his concern about the long delay and lack of funds. He said the lack of funds was an embarrassment to him. We agreed to meet in late October.

*John's response greatly reduced the anxiety I was feeling about our lack of contact and progress on the research. I had spent the summer working on my dissertation but I was concerned about the uncertainty of the project and the need to bring the current phase to some kind of closure in writing my dissertation.*

### **The Task Force Reconvenes**

We finally met on October thirty-first. I discovered that we were limited to a one hour meeting as all of us had overlooked that October thirty-first was halloween and members had to leave by 3:30 p.m. in order to prepare for the evening's activities. Trick or treating was to be followed by a costume party at the community hall.

*It was good to meet with the group again but disappointing that only three members, Betty, John and Mary, were present the first afternoon.*

We got started, listing agenda items on a flip chart. This included finalizing the Pre-Transfer Funding Proposal, preparing a draft for a Band Council Resolution in support of the Proposal; preparing a formal letter concerning my involvement and commitment in the research; reviewing the progress that had been made on interviews for the study on traditional health; reviewing our experience together as a Task Force; and agreeing on a schedule for future meetings.

We began with the Pre-Transfer Funding Proposal. John had sent Helen Wood a draft of the Proposal in August. She had provided a critique which strongly supported the work that had been done and asked only a few questions where clarification was needed.

John told us that he was still concerned about the limitations imposed by the transfer guidelines which stated that pre-transfer was for existing health programs. He stated that the Task Force knew the community would need new programs in the future and yet the guidelines did not make provision for this eventuality. I recommended that we proceed with the research in order to identify health services that would be needed, suggesting that there was no need to limit the study at this stage.

John wondered how we might increase awareness of the Pre-Transfer Study in the community. He saw the need for people to become informed about health but recognized that we could not provide training for everyone. He suggested that the community workshops would be an opportunity to obtain information from those who attended but was concerned that people would still not know what the health study was about. I suggested that we could use the workshops to both inform people and gather information.

We adjourned shortly after this discussion in order to prepare for the evenings festivities. It turned out to be quite a show with multiple Ninja Turtles, various costumed characters and some talented jiggling.

We reconvened Thursday morning to finish our work on the Pre-Transfer Funding Proposal. I stressed the need to forward it to Medical Services Branch by the following week if the Proposal was to be reviewed by the Department before the new year. I had by chance met Helen Wood, the zone director, on the plane the week before and she had told me she would give the Proposal special attention if she received it before she had to leave

for meetings and a conference in Toronto in early December. This special attention would be needed if the Branch's review committee was to consider it at their final meeting in Ottawa before the Christmas holidays.

John questioned how I was going to share the research I was doing with the group. He wondered if I was revising my dissertation as we progressed. I told him that I was constantly revising it and that I had planned to review my dissertation proposal with them during the summer once it had been approved by my research committee. Unfortunately we had not been able to meet. John wondered whether I had received a research grant to conduct the study. I told him I had not received a grant. We discussed the purpose of my dissertation and I explained that the focus of my study was the work of the Task Force including my involvement with them.

### **The Task Force Reflects on Its Own Process**

The discussion of my dissertation led into a discussion of the community research project and the participation of group members in the Task Force. Members had been clear about the purpose of the Health Committee and their role when the Health Committee had been formed but they were uncertain about their roles in the Task Force and in conducting the Pre-Transfer Study. Community research was a new experience for them and they shared their concerns.

**John:** You probably recognize by now, like when we were a Health Committee we were just talking about certain issues we thought were, I guess, problem issues more or less, how do we resolve them, like dog [control], sanitation.

**Don:** Hmm.

**John:** Basically these, but when we come to this [research] which we weren't as, some of the members were not [as clear as to our purpose], it was a new step for them.

**Don:** Right.

**John:** A whole new involvement which they didn't really know, the roles and you know, they were quite hesitant to step into it.

**Don:** Right.

**John:** But now we [have] come this far, they're saying, "Well, here, we finished this. Now there's the field work to be done." They're still hesitant to go into it, that one too, but I'm sure if they really go into it they will feel more comfortable with themselves, but I have, I think that's okay.

**Don:** Yeah and like I mean that's natural, eh. When I first started this [research project] I was hesitant and I had to ... do a lot of reading and talk to my advisors about how to do it. So as you get more confident, then you are ready to go and try it. So that's what I'm interested in. How does this group get the confidence to go and do it....

**John:** Like I also know the Committee has this perception that you're to be the leader and I don't think that's necessarily the case.

**Don:** Right.

**John:** ... But the thing is it's only as a group that we can be strong.

**Don:** Yeah, I agree with all of that.

John had to leave the room so I took the opportunity to ask Mary what she thought about the work that had been accomplished by the Task Force.

**Mary:** Well, it took me a while ... [pause] to understand it.... I really, you know, [pause] I just listen and try to listen and understand what's going on.

**Don:** How does it feel at this point?

**Mary:** Well, we came this far, so it's more like looking for ...

**Don:** Looking for what?

**Mary:** Looking forward to going [pause] [ahead with the] transfer.

Betty expressed concern that the transfer process might not get the support it needed in the community given the difficulties the administration was currently experiencing. She thought the administration's problems might reflect badly on the Task Force and affect the reception the Task Force would receive when it presented the Pre-Transfer Funding Proposal to the community.

**Betty:** Like when you say pre-transfer, it has to be really explained I guess. They might really shoot us down, eh. Why do you want to take over health when you can't even [manage]!

**John:** [The] Band administration.

**Betty:** Administrate your [programs], that kind of thing.

**Don:** Who would you hear that from?

**John:** The general [membership of the Split Lake Cree First Nation].

**Betty:** General [membership].

**Don:** In the community?

**Betty  
& John:** Hmm.

**Don:** How do you see answering that?

**Betty:** That's what I mean. Like we have to really explain what this is, what we're doing. Like it's only pre-transfer. It would be up to the people to decide if they want to go into [the full transfer of health programs to the community].

**Don:** Right.

**Betty:** Transfer. Like they may think that we're already going right in to it, eh. That's just my feelings about it. The way people will think. It has to be really explained.

Betty stated that she would like to see more of the Health Committee members participating on the Task Force, pointing out that she and John were not always available due to their work commitments. John agreed noting that members did not always get the support they needed from their spouses for the time they put into the work of the Task Force. He added that he didn't think that health received the support it needed in the community.

Finally, we began the review of our work together as a Task Force. I provided the group with a short summary of events as they had occurred during the year.

John recounted his involvement as the Councillor responsible for the Health Portfolio. He had carried on in this role through the transition onto the new Council in September, 1989. He said that the Council had discussed the transfer program shortly after the new Chief and Council had taken office. At about the same time, I had approached him about working with the community. He told the group that he had thought that the community was going to have to hire a consulting firm to prepare the Pre-Transfer Funding Proposal but that the Chief had okayed my involvement in the project. I had also been endorsed by members of the community and the Tribal Council.

We identified issues we needed to discuss. I recorded the points on a flip chart. They included group cohesion; understanding the pre-transfer project; tasks that members had to undertake; training required by members in order to carry out the work of the Task Force, including keeping minutes of meetings, maintaining a record of the work of the Task Force and recruiting additional members; attendance at meetings; participation; completion of assignments; commitment to the two years needed to complete the Pre-Transfer Study; and ownership of the research project. I added the

issue of my relationship to the Task Force and the possibility that the members' perspective on health might have changed over the year. John stated that he felt we had to get everyone together in order to discuss these issues.

We adjourned for lunch with members agreeing to contact Joan, Irene and Karen in order to have everyone present that afternoon.

We reconvened after lunch with everyone present. Joan stated that she had not known about the meeting. John protested saying that he had mentioned it at the Health Committee meeting the previous Friday and pointed out that the lack of minutes left him with nothing to back up his claim that he had announced the meeting. This led to a renewed discussion later in the session of the need for someone to keep minutes.

I asked that someone review our morning discussion for the benefit of those who had not been present. Mary volunteered for this task.

I followed Mary's report with a review of the issues we had listed on the newsprint. I suggested we consider what was working well and what was holding us back in each case.

John began pointing out that Betty, he and I did most of the talking and that the discussion seemed to be inhibited when I was present. Others said that they feared making mistakes, felt shy and stated that they didn't always understand what was being said. Betty noted that the group only seemed to work at the research task when I was present. This was confirmed by Joan. John emphasised that they had almost finished the Pre-Transfer Funding Proposal. He felt that the study that was to follow would prepare them to take on the role of a health authority for Split Lake.

I commented on how I had observed members of the group working together.

**Don:** When I think of [our work] ... back in June when we were doing these tapes, listening to the tapes, like people were participating then, ... and there was lots of laughing, joking. [We] sort of reached a point ... where I thought the group was really coming together and then unfortunately the group sort of fell apart over the [long summer break].

Betty responded making an important observation on the group's process and a key norm in the group.

**Betty:** What is working well. [laughter] Everyone in the culture wants to laugh.

**John:** Means we had a good meeting.

**Betty:** We're able to work as a group I guess and we want to.

Betty pointed out the influence I had on the group and their apparent inability to accomplish their work unless I was present.

**John:** Well, you also made a reference to Don [this morning]. [His] presence.

**Betty:** The only time we seem to do work on this is when, I don't know, you [Don] seem to push us or how you say.

**John:** We're almost, like this morning... what I understood you [to say], we're almost depending on him.

**Don:** Hmm. Yeah, I'm aware of that.

**Betty:** The only time we do anything [laughter] [is] when we know you're coming, we try to. [laughter]

**Don:** Get the work done.

**Betty:** It's like day and night. For me the only time ... we're doing this [study] is when Don is coming cause we have other things [to do].

**Joan:** We never do this when Don is not here.

**Betty:** I know.

**Joan:** We should get together on our own and discuss it.

**John:** Hmm, like, ah.

**Joan:** We should inform [people about our meetings],... like me for instance.

**Betty:** That's what I mean. We need more, like a chairman to call meetings.

**John:** You're [Joan] the chairman now!

John drew attention to the newness of the experience while expressing his confidence in the group and their commitment to completing the task.

**John:** But I'll be honest to myself too. I don't fully visualize this. Like this is new to me too.

**Don:** Yeah....

**John:** Like when we started, I didn't know what it was going to look like, but we got ... [the] package together. Not one person. I believe [we did it] together.

**Don:** That's right.

**John:** And it will take [us working] together to finish it but I think it's getting to the stage [where].... Things are pointing here [to where we will finish it]. I think as a Committee we [are] ... able to do this, but like I said, we are counting on you [the group members]. Like we said that already, depending on you.

About pre-transfer? Like what I said this morning. ... This is ours. We're doing it, but this is Split Lake Cree's.

**Betty:** Task Force.

**John:** This is Split Lake Cree's.... We developed it together as a Task Force. But this belongs to Split Lake Cree.... Yeah, we made this. But this document belongs to the Band. We prepared it and we can work under it ... but this morning, what I said ... we can give this to somebody else very easily. We can contract it out. We can do that. We can give it to some consultant.... He'll work it out. But what happens is this. We can lose control over it.

**Betty:** Somebody did that for them [the other communities who have gone through pre-transfer planning]... But what we did, we [prepared the Pre-Transfer Funding Proposal] ... instead of getting someone to do it for us.

**Joan:** Yeah.

**Betty:** What did George say that time. Some of the communities are running into problems?

**Don:** Yeah, in Pipestone Lake ... they contracted with a consultant to do it. The consultant went away, wrote it and then gave it back to them. [He] had a meeting and presented it and then the consultant was gone and ... they didn't know what to do with it. How do you take the ideas the consultant put in and do something with it?

**Joan:** So this way we're doing this on our own.

**Don:** Yeah.

**John:** And that's why we should. That's why, I feel very strongly that the tasks in here should be done by the members. We don't lose that [experience].

John explained the concept of devolution, the transfer of government programs to tribal councils and First Nations. He recounted how Medical Services Branch had begun the process of devolution for health programs in 1984 at the same time that government programs were being downsized. The Chief and Council in Split Lake had decided not to enter into negotiations to transfer programs until 1989 due to their heavy involvement in implementing programs within the Northern Flood Agreement. He noted that I had been recommended as someone to work with the Health Committee. John added that as a Task

Force, they would have to analyze the services provided by Medical Services Branch, determine what was missing and then decide whether they wanted to proceed with transfer. I added that First Nations were expressing their desire to establish their independence and run their own affairs, creating in the process their own programs to meet their needs and that health was one of the program areas where this opportunity presented itself.

John referred to the second item on the list of topics that we were to review; understanding the objectives of the Task Force.

**John:** Our primary objective ... is to, I don't know if that is the correct word, analyse, but we have to look at what Medical Services ... [provides the] community. What does the community have now in terms of health services? What did it have a long time ago? And we work along that line and then if we were to run the risk [of taking] over the services, what is missing? What is needed? And then build from there. That is our objective. To look at the health services now.... Is Split Lake ready to ... take over the [health] services in two years?... That's the objective I see and all this Proposal will be [is] a guideline to [doing] that. Investigation of [the] health project [and the] budget.

Betty responded by asking why they had had difficulty completing the task.

**Betty:** What is holding us back?

**John:** I think that what was holding us back was [that] we were depending on Don. I don't know if that is right or wrong.

**Don:** I certainly feel that.

**John:** Okay. Another thing holding us was this was new to us. Like, we were never exposed to this kind of thing. Like to some extent, I was through other little [experiences similar to this], but not to this great detail. Like Betty has been exposed to it through asking for funding through... C.E.I.C. [Canada Employment and Immigration] or other programs, or other little [projects], but not to this great extent. And I think Joan's very honest when she said, ... I don't understand this....

**Betty:** I think another thing ... [which] I said this morning, ...[is] this kind of thing is new.

**Don:** Sure.

**Betty:** [It may] write some of us off, overwhelming....

**Don:** I think having to do a Proposal which has to be complete is kind of intimidating at the very beginning because you can't ... develop it as you get into it, eh. You have to ... think it all through ahead of time in order to get the....

**John:** Like even the M.S. [Medical Services] guidelines that they had. We ... have never sat down and looked at that.

**Don:** No

**John:** We just went ahead and did [it].

**Don:** I've looked at them and I guess you have and George presented them at the first meeting but after that we just went ahead with what was needed here.

**John:** Hmm.... That was the community perspective that we wanted.

**Don:** Yeah.

**John:** Which is good. I think that is good. But that is our objective.

The group discussed assigning responsibility for leadership and the tasks that had to be done by various members of the group. Betty stated that she wanted to see the group work on its own without direction from me. Joan also expressed a desire for the group to take the initiative to work on its own. This earned her a nomination for chairperson of the group. She protested but then asked what a chairperson would do. John responded, explaining that a chairperson would be expected to chair meetings, organize the agenda, keep the discussion focused on the topic under discussion and see that members were notified when meetings were to be held. Joan intimated that she would be interested after she became more involved in the Task Force. John responded by telling her that the members would help her.

The group discussed the problems associated with a changing membership and the need for a commitment from members for the two years required to complete the Pre-Transfer Study.

I was interested to know whether the group members' perception or concept of health had changed over the year. The response of everyone was that each person's perception had not changed. John expressed his views on the right of Aboriginal people to health care as guaranteed under treaty.

**John:** Health to us as natives is a right, an obligation. The government is obligated to provide that [health care] to the natives ... [as agreed to in ] the treaties. That is our understanding of it.... But to the government, they say we are doing this through the goodness of our heart.... We, under the Memorandum of Understanding [which will accompany any proposal to transfer health programs to the community] ... have to make that clear.... But my perspective on health hasn't changed for me. In terms of health care ... it's still the same. And it [health] will only improve if we have some control into it.

John expanded on his definition of health.

**John:** We know [that] health ... has to do with water and sewer, housing, everything, eh? So the government says we'll increase this, we'll do more of this, more houses, better quality water and sewer. Now if we could look forward to that, that would change our perspective on health. [The] government is trying to do something for our people instead of fighting them while we work with them....

**Don:** Your perspective is a very broad one. You see health as related to all, housing and water.

**John:** Land,... the environment.

**Don:** The environment, yeah.

**John:** Even.

**Mary:** [Cree]

**John:** Like health is food too, eh?

I asked the members to discuss my relationship with the group, identifying what was working well and what was holding us back.

**Betty:** Well, like we said before. We feel dependent.

**Don:** Yeah, yeah. I feel that and I've been trying to think, how do I get out of that, eh.... Part of it makes sense. People, any group, I ... or anybody works with, if it's new, then you are dependent on the [resource] person. But there's stuff that ... I don't have to be in charge of or ... [where I don't have to give] direction. [For instance], if we think of those interviews. We got to the point last spring, last June, where you were doing the interviews. You were doing the translations and writing them up. I didn't need to be part of that. After that point people could have carried on.

I asked if there were any other issue besides dependency. This was followed by silence so I shared my thoughts.

**Don:** Well, I guess I feel pretty good about working with the Task Force. I've enjoyed coming out here and I guess I get a little discouraged when everybody isn't here or there's long delays, like this past summer, over funding problems and that. I get anxious because I want to get on with it too but on the other part when I get here I really enjoy working with you.

*In reviewing the transcript I realized I was commenting on my relationship when I should have waited for group members to assess it. I can only imagine it was my own unease at being the focus of scrutiny and I, uncharacteristically I believe, responded when I should have waited for others to speak. I will need to be aware of this defensiveness on my part and try to check myself the next time. I wonder if I have to back off and wait for the group to take the initiative in order to break the dependency. My*

*problem is that I need to finish my dissertation and I don't know how long I will have to wait.*

The last issue we reviewed was our administration. I pointed out that I had not received a copy of the Pre-Transfer Funding Proposal that we had prepared in June. Betty and John acknowledged that both of them had brought copies of the Proposal to Winnipeg on successive trips but had been unable to reach me by phone and had returned to Split Lake with it still in their possession. Nobody had made sure that it had been mailed to me. I told them I thought that the failure to get these tasks completed was holding us back. Joan agreed and proposed holding a meeting within the next three weeks to appoint members to take responsibility for various tasks.

I suggested that we complete the work on the Pre-Transfer Funding Proposal that afternoon. This meant members would have to read the document over the weekend and be prepared to meet the following week to finalize the Proposal. The members agreed to meet Friday. We proceeded to deal with the questions raised by the zone director in her critique of the draft Proposal and I took the opportunity to lay out an action plan on the flip chart identifying tasks that had to be done, who was going to do them and when each task should be done. This process clearly identified those who would be responsible and the time frame for completing each task. The task assignments are illustrated in Figure 6.9.

John, who had been absent when we had discussed my role with the Task Force earlier in the afternoon, pointed out that we needed something in writing to formally establish my relationship to the Task Force. I read a draft letter that I had prepared which I thought might form the basis of a letter of agreement between myself and the Task Force. John wanted to clarify the extent to which I would be responsible for training the

What	Who	When
1. Review Proposal and make final changes	All Members of the Task Force	Friday, November 2
2. Phone Zone Director re Proposal	John	Friday, November 2
3. Phone/Fax comments	Don	Friday, November 2 1:30 p.m.
4. Prepare Letter of Intent and Band Council Resolution	John	Monday, November 5
5. Check on the use of education authority's printer and have Proposal printed if possible	Betty	Monday, November 5
6. Present Pre-Transfer Funding Proposal to Chief and Council including draft Letter of Intent and Band Council Resolution	All Members of the Task Force Presenter: John	Try for Monday, November 5
7. Mail formal copy to Don	Mary	Tuesday, November 6
8. Deliver Proposal to Zone Director for MSB in Thompson	Joan	Tuesday, November 6 or Wednesday, November 7

**Action Plans for Completing Pre-Transfer Funding Proposal  
Figure 6.9**

Task Force. I said that I did not plan to do all the training as I did not have the necessary knowledge to provide instruction in areas such as health policy and accounting. John wondered whether the agreement was between him and me or between the Task Force and me. I explained that I thought that the agreement should be between the Task Force and me and that the Task Force had to be responsible for carrying out the actual study in the community. John agreed.

Our meeting ended with a brief discussion concerning when we should meet again. John wanted to set a tentative date in late November or early December as the community was still in the midst of negotiations with the Province and Manitoba Hydro concerning the Northern Flood Agreement. The negotiations involved numerous planning sessions and community meetings. I suggested members work as teams on transcribing the traditional health interviews that had been completed so that we could begin work on them at our next meeting. I drew up a brief action plan for these tasks but we did not finish assigning tasks and deadlines before we had to adjourn. John suggested the group deal with this task at their next regular meeting as a Health Committee the following Wednesday. The meeting then closed with a prayer.

Lack of funds and a busy schedule meant that we did not meet again until March. That session was devoted to finalizing the Pre-Transfer Funding Proposal, a discussion of my dissertation proposal and a review of the report and analysis I had done of our previous meeting in late October.

We did not meet again until July 23, 1992. During this meeting we discussed our work as a research group, examining with considerable frankness the failure of members of the Task Force to follow through on a number of tasks, most notably the submission of the Pre-Transfer Funding Proposal to Chief and Council and Medical Services Branch. The detailed planning and assignment of tasks during the meeting the previous October had not resulted in a significant change in the way the group worked. This time, the frankness of the discussion, the airing of feelings and the ownership of the failure to follow through with commitments resulted in action being taken. John took the Pre-Transfer Funding Proposal in hand along with a covering letter and a Band Council Resolution supporting the Proposal and obtained the necessary signatures from Chief and Council. The documents are reproduced in Appendix C and Appendix D. Ethel, a new

part-time Community Health Representative who had joined the Task Force in March, took it upon herself to gather up the documents and mailed them to Medical Services Branch. A milestone had been achieved.

## CHAPTER VII

### RECAPITULATION AND EXTERNAL RESEARCHER'S REFLECTION ON THE INQUIRY PROCESS

This chapter recapitulates the community research process and reflects on the experience of the external researcher in working with community researchers. The reflection focuses on two research processes which occur simultaneously. One is the community research process which describes the formation of the community research group in a First Nation and the experience of the community researchers as they begin the inquiry into changing their health system. A second research process, the collaborative research process, focuses on the interaction between the external researcher and the community research group. In the collaborative process, I, as the external researcher, have examined my interventions, noting what helped the process as well as what I might have done differently to support the community research process. A third research process, the research for this dissertation is noted whenever it impacts the two primary research processes under investigation.

#### The Community Research Process

The community research process in this case began with the initial contact between myself as the external researcher and John, the Councillor responsible for the health portfolio in the Split Lake Cree First Nation. Negotiations followed that led to an agreement to undertake the research. This was followed by a comparative assessment of the community's health system, formation and development of the community research group, preparation of a Pre-Transfer Funding Proposal, initial research on traditional health and reflection by the community research group on its own process and interaction

with me as the external researcher. The community research process as it developed with the Split Lake Cree First Nation is illustrated in Figure 7.1.

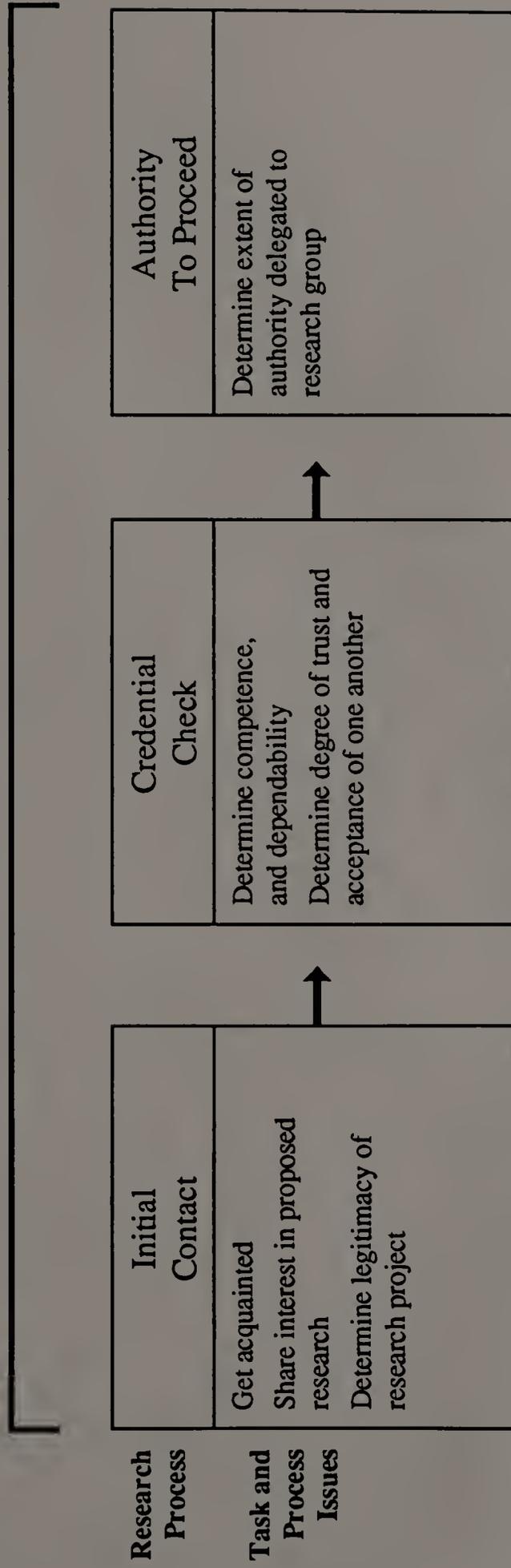
The negotiation phase began when I approached John to see if he was interested in participating in a collaborative inquiry to study change in the community's health system. He responded favourably. Our first meeting provided a time for getting acquainted, for John to share some of his concerns about the existing health system and for both of us to discuss the idea of a collaborative inquiry into the community's health system.

We came together out of a shared interest in change in the community's health system. I was interested in change and how that might occur through a collaborative research process. John, was interested in the transfer of control of health services from the federal government to the community and how this could best be accomplished.

Following the initial meeting, it took some time for John to obtain approval from the Chief and Council to proceed with the proposed research. He first had to check with the Tribal Council staff who knew and had worked with me concerning my ability to do the work and then obtain Council approval. The underlying issue here was of trust and competence. Was I competent to do the work and could I be trusted to work for the benefit of the community? I also contacted colleagues who had worked in Split Lake to determine whether John was a person I could work with, whether he would be committed to the process once it began and whether he would be open to working with me in a collaborative research process.

The negotiating phase led to a tentative decision by Split Lake's Health Committee to participate in the research. They did not make a final decision until the fourth month when the community research group met independently of me to discuss whether they

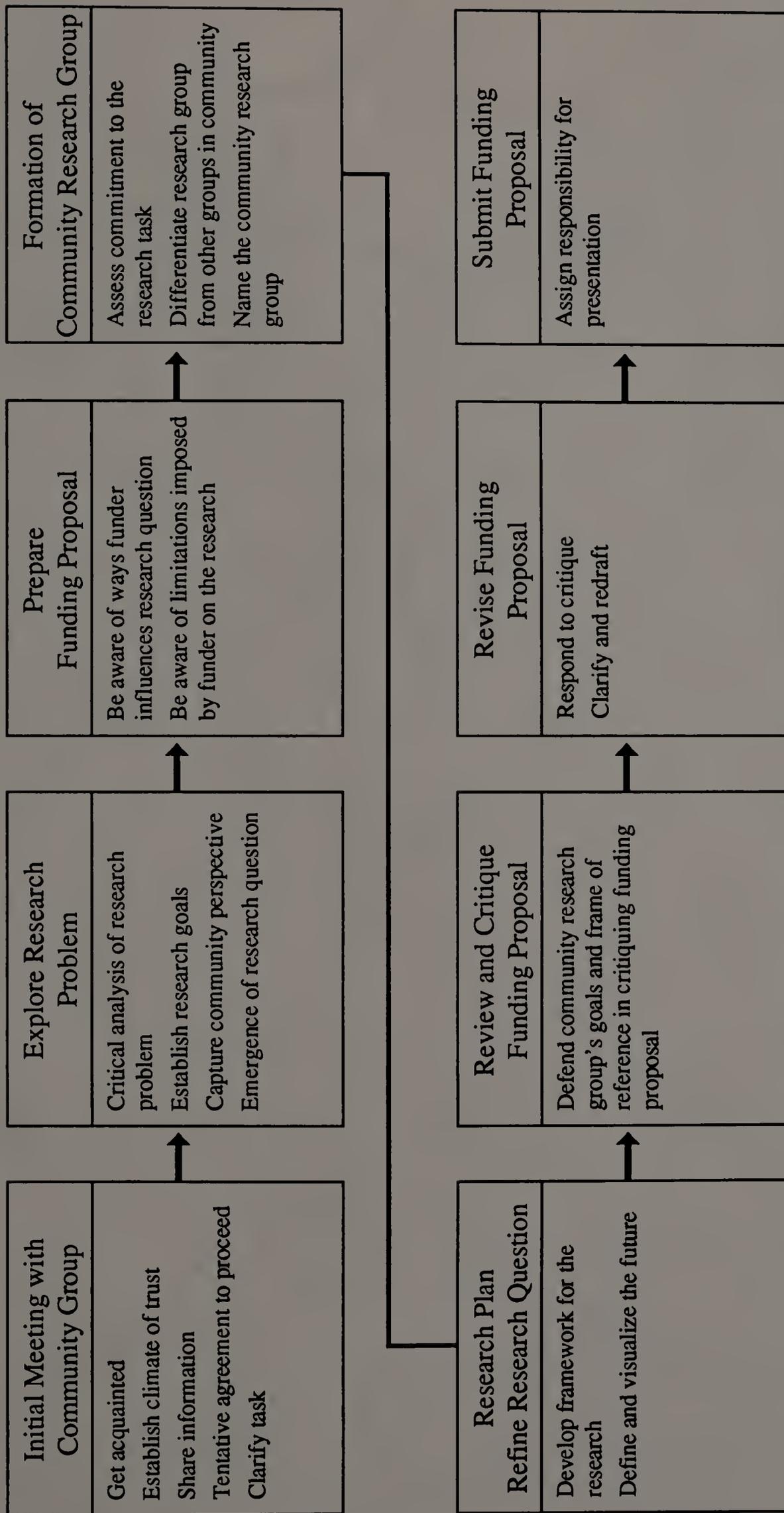
**Phase I: Negotiations Between External Researcher and Community**



**Community Research Process  
Figure 7.1**

Continued, next page

**Phase II: Formation of the Community Research Group, Preparation of a Funding Proposal and Development of the Research Question**



**Figure 7.1**

**Continued**

Phase III: Conduct Research

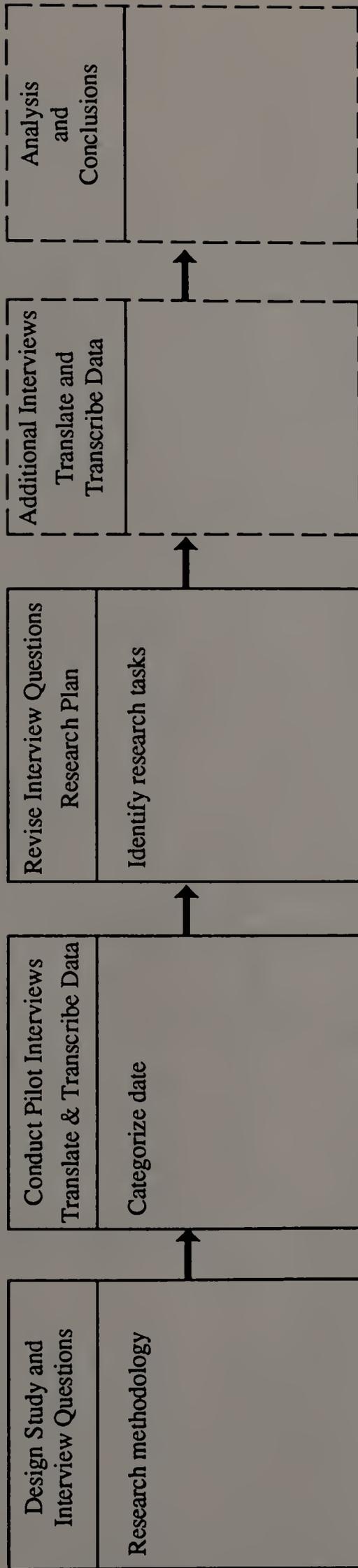


Figure 7.1

Continued

**Phase II & III: Reflection on Community Research Group's Process**

<p><b>Clarify Relationship of External Researcher To Community Research Group</b></p>	<p>Determine commitment of external researcher to the total research task Move from dependency to interdependency</p>
<p><b>Identify Intra Personal and Intra Group Issues</b></p>	<p>Respond to issues of:</p> <ul style="list-style-type: none"> <li>• confidence</li> <li>• competence</li> <li>• leadership</li> <li>• role conflict</li> <li>• asymmetrical power</li> <li>• authority of group</li> <li>• commitment</li> <li>• dependence</li> <li>• interdependence</li> <li>• responsibility</li> </ul>
<p><b>Manage Impact of External Forces</b></p>	<p>Respond to:</p> <ul style="list-style-type: none"> <li>• unforeseen events</li> <li>• uncertain community support</li> <li>• uncertain authority</li> </ul>

**Figure 7.1**

felt confident enough to proceed with the inquiry. Torbert [1981] notes this ambivalence in a research group when it first forms and the uncertainty in members as to whether the proposed research is something in which they want to invest their time and effort. As noted in this case, some members of the Health Committee chose not to become members of the research group.

The legitimacy of conducting research in the community was discussed. John recounted the story of a previous researcher's attempt to gather data on herbs and plants used for healing. A traditional healer had refused to share this knowledge with an external researcher, as the Euro-Canadian values and beliefs intrinsic to the proposed research conflicted with the values and beliefs of the traditional healer. Later, John recounted the story of an external researcher who had taken a document from the community for research purposes, a document which was never returned. The results of the research in this latter instance were never shared with the community. In each of these examples, the community's lack of control of the research and concern over the use of the knowledge underscore the concern over research that has been conducted in the past which has not been seen as beneficial to the community. It suggests that people have been used rather than involved in research. It also suggests that the research may not have been undertaken with the interests of the community in mind. The significance of this to an external researcher embarking on a collaborative research process is that the external researcher needs to check out with the group their previous experience with research and researchers. Their past experience will impact their understanding and definition of the research process. It is important to clarify the difference between a collaborative research approach as described in this case and other approaches community researchers may have encountered in the past in order to clarify expectations.

I had told John that I wanted to work with a community research group interested in studying its own health system in an inquiry that would be a shared undertaking. He later confirmed his understanding of this arrangement when he stated that any research we did on the health system would be jointly owned. At the time I had stressed that we would be working together on the research but did not clarify or examine the degree of ownership or control each of us would exercise, except to say that I would submit my work for my dissertation to the community research group for approval. I did not know at the time what, if anything, would be exclusively my own work and what might exclusively belong to the community research group. As the research has evolved, we have shared in planning and conducting the community research while at the same time each of us has had varied interests in the research which we have pursued. I, for instance, have been interested in my role and my relationship with the community research group. My attention to the collaborative research process reflects my special interest in this aspect of our work. This has involved tape recording our meetings in order to gather data for this dissertation. The research group has been interested in specific health issues and how these are to be examined and incorporated in the study designed to change the community's health system. Significantly, our interests have required collaborative effort from both of us.

A number of issues remained to be resolved once we had moved past the initial negotiation phase. They reappeared throughout the project, requiring further negotiation and resolution. I began the research project believing that the community research on the health system would provide information that was essential in considering the transfer of health services from the government to the community. John had indicated at the outset that I might be used as the community's consultant for their health transfer. The Split Lake Cree First Nation Council had met and discussed my interest in the research and had given their approval to proceed but the Council also appeared to be committed to

hiring a consultant to develop a Pre-Transfer Funding Proposal. The Council seemed to consider my research initiative as separate from the planned study for health transfer. I suspect that this was based to a large extent on the health transfer guidelines provided by Medical Services Branch for preparing a Pre-Transfer Funding Proposal and conducting a Pre-Transfer Study. The guidelines implied that a consultant should be retained to prepare the Proposal and conduct the Study. This approach had been taken by other First Nations in northern Manitoba, a fact which probably also raised the expectations that the Split Lake Cree Council needed to hire a consultant to prepare the Pre-Transfer Funding Proposal.

The Pre-Transfer Study was expected to take two years to complete. As described in the narrative, my limited leave time resulted in John making the assumption that I would not continue working with the community once my leave was finished. I did my best to let him know I was committed to the total research process, from the outset, but the uncertainty of my time commitment haunted our relationship throughout the year and led to numerous discussions around my role and my commitment to the Pre-Transfer Study. Once we were well into preparing the Pre-Transfer Funding Proposal, John was to wonder aloud how I had become immersed with the Health Committee in developing the Pre-Transfer Funding Proposal. For my part, I had come to see the preparation of the Proposal as a necessary task for obtaining research funds for the community research group and had worked with the group on this task. I had hoped to finish this task as quickly as possible and get on with the community research but I eventually realized it was a necessary component of the community research process.

The confusion over my role in preparing the Pre-Transfer Funding Proposal may have derived from a somewhat different understanding of research and our somewhat different objectives. I wanted to inquire into the research processes involved in working with a community group in bringing about system change. John and the Council would

likely have seen my dissertation as complimentary to their initiative which was to take control of the existing health system. Although the two objectives were complimentary, they were different and represented different expectations on the part of the Council and myself.

The situation might have been clarified if I had met with the Council and discussed my research interests and how I thought the research would contribute to the development of Split Lake's Pre-Transfer Funding Proposal and Study. As it was, I left it to John to present my proposal for collaborative research outlined in my letter of October 6, 1989 to Council. A meeting with the Council should have been one of the first things I arranged when I arrived in Split Lake. It would have also been helpful to have asked the Health Committee to identify questions they might have had about my research interests. This would have brought to the fore some of the uncertainties around my involvement and commitment and would have provided an opportunity to clarify our expectations and understanding of the research task.

During the first meeting with the Health Committee, I had explained my interest in working with the Committee in studying their health system. I had asked the group to develop two frameworks, one representing their traditional health system and the other representing a desired future health system. The frameworks established categories for comparing the two systems and this intervention enabled the group to identify changes that had occurred in their health system over time. The exercise also enabled the group to develop a vision of a future health system. I had hoped that this exercise would increase members' awareness of the fundamental questions about health and health practice in the community and had searched for a way to initiate this process without imposing my ideas and values regarding a health system on the group. I thought it was important that the community research group consider the underlying issues before they became locked into

a predetermined health model implied in the health transfer guidelines provided by Medical Services Branch.

The contrasts that emerged from the comparison of the two systems produced insights into changes that had occurred over time. John made a number of key observations when he noted that life style, nutrition and education had played an important part in the traditional health of the people. He also pointed out that parents played an important role in maintaining good health and that it was not solely the professionals in the system who were responsible for the health of the community. I also drew attention to the shift in control of health from the community to government with the introduction of the government health system. I wanted to draw attention to the impact this had had on traditional health and illustrate how the present government run system continues to undermine local participation and control of health in the community.

The development of a definition of health by the community research group during an early training session was an additional step in establishing the community research group's perspective on health and its goal in taking control of the government run health system. The definition reflected the cultural beliefs and values of the group. At the time, I felt that a three dimensional model of their future health system, which the group constructed, did not seem to reflect the definition they had developed but rather seemed to link the existing government run health system to a new and separate referral system. The referral system co-ordinated travel for patients requiring transportation to hospitals or for trips to see specialists in Thompson or Winnipeg. In reviewing the transcript for this dissertation, John wondered why I had not pointed out the inconsistency in the model when the group had presented it. I told him that I had not questioned the model at the time as I did not want to appear critical of their effort. I was not sure how my critique

would have been received at that stage in our relationship. This is both an issue of trust and an issue related to the appropriateness of feedback. I might have avoided this dilemma if I had begun the model building exercise by asking the group to consider what they wanted in their future health system as well as what they did not want, thus creating a dichotomy which might have helped them break free from the framework and services of the current health system which seemed to limit their model building effort. The exercise is an activity that could be repeated now that the group has had additional time to reflect on the changes needed in the health system. It would also be useful to repeat the exercise at a later date, involving more members of the community.

The definition of health, the comparison of past and future health systems and, to some extent, the model were important factors in identifying the research question and the knowledge the group needed to acquire in order to achieve their desired future. The research question unfolded as questions for further inquiry were identified by the group as it moved from an initial concern with the transfer of the existing government health program and information they needed about the current government health system to concerns about the need to uncover local knowledge of traditional health practice and healing substances. Later, local knowledge of traditional ways of organizing to provide health services to the community would be needed. The process of discovering further knowledge involved peeling away layers of accepted ways of perceiving reality that obscured both the past and the future. The process is not unlike that involved in excavating an archeological site in which layers of rubble are removed in order to reveal artifacts and clues about people and how they lived in the past. At the same time, it is important to assume the stance of a strategic planner, asking questions about the desired future. The archeologist-planner needs to imagine the future in which knowledge from the past is used to construct the future. The evolution of this expanding

and evolving process for discovering the research questions in this case is illustrated in Figure 7.2.

In the early stages of the project, I was somewhat tentative in providing direction for the overall research task as I was attempting to discover how to do research with the community research group myself. The question was not so much how to work with the group as it was understanding what constitutes research and what we had to do to be doing research. What in fact were we trying to discover? I was also engaged at the same time in establishing a number of research questions for my own dissertation and had not considered the research question or questions which might be of importance to the community research group. As a result I did not ask the group to focus on the research question but had asked them to consider the past, present and anticipated future health system. Fortunately, the comparison of the systems indicated where inquiry was needed and the community research group had its research question. The preparation of the Pre-Transfer Funding Proposal added questions that needed to be investigated.

One shortcoming in the development of the research goals and research question has been the failure to obtain broader input from the community in the early stages of the community research process. Part of this was due to the initial urgency to complete the Pre-Transfer Funding Proposal. Part was later due to John's reluctance to present the Proposal to the community until he was assured it would be approved by Chief and Council and Medical Services Branch. He pointed out that people in the community had had their hopes raised in the past when they had been told a community initiative was going ahead only to be let down when it did not proceed. He did not want to be caught in the position of "lying" to the community by presenting a proposal which might not receive approval from Medical Services Branch. His concern may reflect past experience in which proposals have been presented to the community which were

Area of Inquiry	Research Problem
Transfer of government health program to community	Problem of uncovering relevant knowledge
Traditional health knowledge and practice	Problem of uncovering local knowledge
Western health practices	Problem of uncovering relevant knowledge
Integration of traditional health and western health systems	Problem of creating knowledge for an anticipated future
Traditional organization	Problem of uncovering local knowledge
Development of a culturally appropriate health organization	Problem of creating knowledge for an anticipated future
Linking local health system with external health system	Problem of creating knowledge for an anticipated future

**An Expanding Research Question**  
**Figure 7.2**

subsequently dropped or which failed to get funded. This is the price that is paid when a community is dependent on external agencies for funding their initiatives. Whatever the reason for his decision, it meant the community was denied an opportunity to be involved in the health study in the earliest stages of the project.

The community research group had planned to present the Pre-Transfer Funding Proposal to Chief and Council as early as February, 1990. This did not take place. If the presentation had been made, it would have provided the group with an opportunity to explain the intent of the Proposal and build support for the Pre-Transfer Study to come. John later commented on the fact that he might be criticized by other Councillors for not keeping them informed although he had brought the subject up at a number of Council meetings. It is fair to note that the Split Lake Cree Council was distracted throughout the year by ongoing negotiations concerning the Northern Flood Agreement, an agreement which will have a major impact on the community. They may have had little time to give serious consideration to the work of the community research group.

As the community research group neared completion of the Pre-Transfer Funding Proposal, both Betty and John spoke of their fear that the Proposal might be rejected by the community. This occurred at a time when the Council was being criticized for problems in one of their programs. Betty and John indicated that these problems might reflect badly on the leadership in the community and indirectly on the work of the community research group. The impact of the Northern Flood negotiations and the concern that other incidents might reflect on their work illustrate how external events can disrupt the community research process.

The health transfer guidelines provided by Medical Services Branch for preparing the Pre-Transfer Funding Proposal both helped the group focus on their task and served as a constraint. I had intentionally avoided reading the guidelines prior to the initial discussion of health goals with the community research group as I was concerned that the guidelines might exert undue influence on the direction taken by the group and myself. I wanted the community research group to arrive at its own goals for health and then determine what needed to be studied in order to achieve these goals before either they or I considered the guidelines. This was important if the community research group was to manage the institutional interface between the community and the government health system. The fact that the Pre-Transfer Funding Proposal had eventually to be tailored to the guidelines nevertheless did influence the preparation of the inquiry topics. For instance, the assumptions upon which the guidelines are based directed the community research group to develop a plan for administrating the existing health system rather than undertaking an inquiry into the health system itself. This was illustrated in the debate between George, representing Medical Services Branch, and the community research group over the question as to whether health goals had to be determined before a health development plan was prepared. John, speaking for the community research group, insisted that determining the health goals of the community had to proceed development of the health development plan. George argued that the community research group should follow the guidelines which required the preparation of a health development plan, the assumption being that the goals were already set by the government in providing the existing health service. George eventually accepted John's point that the community's health goals had to be the first step in developing a community-owned health development plan.

A second example of the influence of the guidelines relates to the establishment and training of a local health authority. The community research group planned a study to

determine the appropriate organizational structure for their health system, a decision that would normally come after they had examined the existing health system and the needs of a future system. The guidelines assume that the existing organization of health services will suffice once control has passed to a local health authority and provide no direction for inquiry into the development of a culturally appropriate system for delivering health services. The guidelines also provide for the training of members of a health authority and make no provisions for the training of members of a research group so that they are able to obtain the skills required for doing the research.

The guidelines introduced the idea of hiring a consultant to prepare the Pre-Transfer Funding Proposal and conduct the Pre-Transfer Study, ignoring the possibility that a community research group might undertake an inquiry into their health system, either on their own or in collaboration with an external researcher. Research is important, particularly if a community is to investigate the issues involved in transferring a social system located in one culture into an entirely different culture. A social system conveys within it the values, beliefs, practices and structure intrinsic to the culture of which it is a part. Any attempt to transfer a program, service or technology of one culture to another requires careful study by the receiving culture if they are to reshape and reorganize the system so that it conforms to their own cultural imperatives. A fundamental transformation has to take place.

The guidelines imposed limitations on the community research group in considering program areas not currently funded by Medical Services Branch. This was illustrated a number of times when members of the research group questioned whether it was legitimate to include traditional health in their inquiry. The guidelines also explicitly prohibited funding any investigation of the obligations of the federal government to

honour health provisions enshrined in the treaty that governed the Split Lake Cree First Nation's relationship with Canada.

There are a number of shortcomings in the funding policy for health transfer. There is a lack of funding available at the outset for the preparation of the Pre-Transfer Funding Proposal. There is also a lack of funding available for training a local administrator to manage the health system once transfer takes place. This need was identified in the North East Health Study in 1986. John reiterated this need during our discussion of the Pre-Transfer Funding Proposal with George. He pointed out that a trained local administrator was necessary for a locally controlled health system, noting that an external non Aboriginal administrator did not constitute local control and was not acceptable.

The guidelines reflect the policy of the government, prescribing areas that must be studied prior to the transfer of health services to local control. They need to be addressed in preparing Pre-Transfer Funding Proposals but the restrictions and the impact of the guidelines must be kept in mind by those desiring to formulate their own research goals and fundamentally transform local health systems.

The community research group paused at one point to reassess their commitment to the research task. Once they decided that they would continue, they established their identity as a separate entity distinct from the Health Committee which had been the temporary home of the research group. Some members of the Health Committee chose not to participate in the community research group. In naming themselves a Health Task Force, the group took an important step in accepting ownership of the research project.

Throughout the year, the group needed to reflect on intra group processes and the relationship of the group to the external researcher. In the early stages, trust,

commitment, ownership of the task, clarity of the task, confidence in one's ability to do the work, leadership, dependency and direction were issues that had to be worked through. Lack of familiarity with the research process tended to inhibit group members in the early stages of the project. Some members initially lacked confidence in their ability to do the research and this lack of confidence interfered with their participation in the work of the group. This was accentuated on the one hand by the strong leadership role taken by John and on the other hand by the unease some members felt with the presence of the external researcher in the group. As the external researcher, my inability to communicate with members of the group in their own language restricted my ability to interact with those who tended to remain quiet or were less comfortable conversing in English. I also found that I tended to respond to John's leadership rather than working to draw other members into the discussion. This was a period of trust building and as in any new group, it took time to establish the trust and confidence that were necessary for full participation in the group.

Later, there was a high level of participation amongst members of the group as they worked on translating and transcribing the pilot interview tapes for the study on traditional health. It is important to note that most of these discussions took place in Cree. The group seemed more natural and spontaneous at this stage than it had in earlier sessions. The two initial interviews provided fascinating information about traditional health but there were instances where clarification was needed in order to fully understand what was being said. This was to be expected in interviews where the interviewers were trying out a new skill for the first time. I pointed out that the interviewers would need to follow up their questions with probes to clarify what was meant or to elicit more information but it was impossible for me as the external researcher to pick up what might have been missed in transcribing the tapes. Members of

the group identified these gaps, noting information that was missing and identifying areas where additional questions were needed.

There was considerable laughter as the group worked on its task. Betty was to observe that laughter was part of the culture and was an indicator that they were working well on the task. As an observer, I was aware of the cohesiveness, openness and involvement of all the members in this activity. The work the group accomplished in translating and transcribing the interview tapes and in revising the interview protocol demonstrated its growing confidence and ability to conduct the study.

Later the community research group was confronted by intra group issues including member participation, acceptance of responsibility for administrative tasks, asymmetrical power within the group, authority of the group to engage in the research and dependence and interdependence. The group's growing ability to openly discuss these issues helped it immeasurably in resolving problems that had the potential to block or interfere with its work. It was also important that I help them work through these issues.

The community research group discussed recruiting new members while speculating on the possibility that potential members would be unable to commit the time necessary for participation on the Task Force. They pointed out the possibility that potential members might not have the support of their spouses and acknowledged that health appeared to have a low priority in the community. In reflecting on this issue, I am aware that it might have been useful at this point to have had the group explore approaches to recruiting volunteers as part of a recruitment strategy. This would have helped them resolve the issue to the extent that it was possible to respond to the constraints faced by potential new members.

The authority of the community research group to conduct the research was an issue that the group had to resolve. John, as Councillor responsible for the Health Portfolio, had the authority to discuss with me my initial proposal to work with the Health Committee in the study of the health system in Split Lake. He had taken my proposal to the Chief and Council and obtained their approval. What was unclear were the parameters that delineated the authority the Split Lake Cree Council had delegated to the Health Committee. John, for instance, was uncertain as to whether Council intended the Health Committee to develop the Pre-Transfer Funding Proposal and Study. He was doubly uncertain as to whether I should be involved in preparing the Pre-Transfer Funding Proposal and at one stage said I needed to bring this issue to Council. This lack of clarity about the task and the authority to proceed made it difficult for him to give clear direction to the community research group or resolve the confusion between the research I had proposed and the research required for the Pre-Transfer Funding Proposal and Study. I had assumed the two would go hand in hand. Clarification of this issue would have allowed the community research group to take ownership for the research on the health system and the pre-transfer process early in the project. The failure to clearly delegate authority resulted in a somewhat tentative beginning and a re-occurring questioning of the group's authority to proceed with the Proposal.

In authorizing the Health Committee to proceed with the research, the Council did not provide the Committee with the necessary budget allocation required in preparing the Pre-Transfer Funding Proposal. This left the Committee dependent on the administration whenever they wanted to spend money, a factor in arranging travel for me to attend meetings in Split Lake.

The uncertainty inserted into the project by the lack of clear authority was illustrated as late as the fall of 1990, one year into the project, when John wondered whether a

written agreement stating my commitment to work with the Task Force should be between him and me or between the Task Force and me. In my letter setting forth my proposal to work with the Split Lake Cree First Nation in the fall of 1989, I had indicated I would like a formal letter from the Chief and Council authorizing me to proceed. When the issue was raised at the end of the first year, I indicated that I wanted the agreement to be between the Task Force and me in order to make sure that the Task Force remained responsible for the research. In fact, two separate agreements were needed, one with the Chief and Council authorizing my involvement in the research and one between the Task Force and me setting forth the agreement between us to work together on the research. The Task Force's involvement in preparing the Pre-Transfer Funding Proposal was resolved to some extent by the momentum of the moment, which, when the issue arose seemed to dictate that we proceed as if the Health Committee was authorized to develop the Proposal. John had concurred with this action. This was an example of authority being seized by taking action.

The question of the authority of the community research group surfaced again when members wondered whether they had the right to call themselves a Task Force and whether Medical Services Branch would accept the decision they made in naming themselves. The uncertainty appeared again when members of the Task Force claimed ownership of the Pre-Transfer Funding Proposal. John reacted, stating that the Task Force had prepared the Proposal on behalf of the Chief and Council and the Split Lake Cree First Nation, clearly illustrating on this occasion that the authority of the group had been delegated to them by Chief and Council. The Task Force was concerned at another time over what they perceived would be a loss of control and authority if a local co-ordinator was hired to administer the research project. It was unclear to the Task Force whether they would have the authority to hire and direct the co-ordinator or whether a co-ordinator would be hired by Chief and Council and be responsible to the Council.

Uncertainty as to the authority of the Task Force, as well as uncertainty within the Council as to where authority lay, was further illustrated in the difficulty Council had in preparing an organization chart. The difficulty in clearly delegating authority likely constrained the Task Force as low authority reduces the energy and power of a group to work on its task and contributes to a climate of uncertainty and tentativeness. This in turn may have contributed to the delays and missed opportunities to complete the Pre-Transfer Funding Proposal within the time frame developed by the Task Force.

The long delay in presenting the Pre-Transfer Funding Proposal to Council and in forwarding it to Medical Services Branch for funding is difficult to comprehend. One factor was the heavy emphasis in the community on the renegotiation of the Northern Flood Agreement which was the focus of Council's attention and energy throughout the fall and winter of 1990-91 and on into the spring. As it turned out the Proposal was not approved by Chief and Council and forwarded to Medical Services Branch until July, 1991. John acknowledged that he, as Councillor responsible for the Health Portfolio, was responsible for the delay but if the Task Force had had a broader, shared leadership, it might have acted sooner to request that the Proposal be put on the Council's agenda.

The multiple roles John carried as elected Councillor responsible for the Health Portfolio, as Community Health Representative and as leader of the Task Force combined to frustrate the initiative of the Task Force. While John was instrumental in giving leadership and support to the group, his concern with the political process, a legitimate concern of a political leader, inhibited the Task Force in its efforts to have the Proposal approved. His very dominance in both his personality and his multiple roles made it difficult for others to emerge as significant players in the group. Role conflict, the power that accompanied the role of Councillor and the role of Community Health Representative and John's own not insignificant personal power combined to inhibit

others from challenging him for leadership within the group at a time when leadership was needed to get the Proposal approved. This asymmetrical power relationship among the members of the group impacted the group's ability to work on its task. It was not until the second summer that members of the Task Force were able to share their frustration with the long delay. John, who joined the meeting after the group had aired their frustrations, accepted the criticism. He proceeded to act expeditiously, obtaining the necessary signatures of approval from the Councillors and the Chief. Ethel, a new part-time Community Health Representative who had joined the Task Force that spring, took it upon herself to gather together the completed Proposal and necessary documents and mail them to Medical Services Branch within the week. This was a sign that new leadership was emerging.

I sense that my presence in the group during the meeting in which members expressed their frustration made it safe for members of the group to speak out but I might have helped the group deal with this issue much earlier if I had asked them to discuss the leadership role in the group and the necessity of group members sharing responsibility for the leadership. I might have done this by asking members of the group to consider how their dependence on John inhibited the group's work.

The dependence - interdependency issue was a continuing factor in the relationship between the group and myself. Dependence is natural in a group when an external resource person, in this case a researcher, introduces a new concept or project. Dependence is determined to a large extent by the past experience of members of the group and their knowledge and skill in performing the tasks that are necessary for carrying out an inquiry. As the external researcher, I too was dependent on John for continued leadership in the community research group. The goal of an external researcher in this situation is to support and encourage a community research group, helping it to

move as quickly as possible from a dependent relationship to one of independence and interdependence. This can be achieved relatively quickly once the task is understood by all and the requisite knowledge and skills have been acquired by all participants. This was demonstrated by the Task Force members when they engaged first in developing the questions for the traditional health study and then as they revised the questions and interview format. It was also demonstrated by the group as they learned to share their feelings of frustration and act to change the way they were working as a team.

I had hoped that the Task Force would proceed on their own with the interviews once we had completed the pilot interviews but the interviews, translations and transcriptions were a demanding task and may have required the prompting and discipline imposed by a designated leader. Betty observed at one point that the group only worked on the task when they knew I would be arriving for a meeting. Independent action is much more likely to happen now that the group has recognized and voiced their concern about this problem. The discipline required for acting independently and for completing the work may also be reinforced in the future when the Task Force obtains funds to employ a local community research co-ordinator to organize and co-ordinate the work.

The Task Force's review of their own performance was effective in highlighting issues on which the group needed to act although members did not always take the required action. For instance, the group failed to maintain regular minutes of meetings. This meant that we often had to repeat work previously done, if for no other reason than to bring all members up to date with what had been done at previous meetings. At one point John noted that the lack of minutes meant that he could not back up his claim that he had announced the times when the Task Force would meet. This occurred when a number of members stated that they were not aware of a meeting. Even in these circumstances no one volunteered to keep the minutes. On occasion, commitments made

to complete tasks were not completed on time. Minutes could have served as a reminder and held members accountable.

The review sessions were effective in allowing group members to identify and reflect upon issues that impacted the group. They were able to identify and share their lack of confidence, feelings of intimidation, dependency and frustration when commitments were not kept. In the future it would be useful to build this review process into the end of each session rather than deal with these issues on a periodic basis.

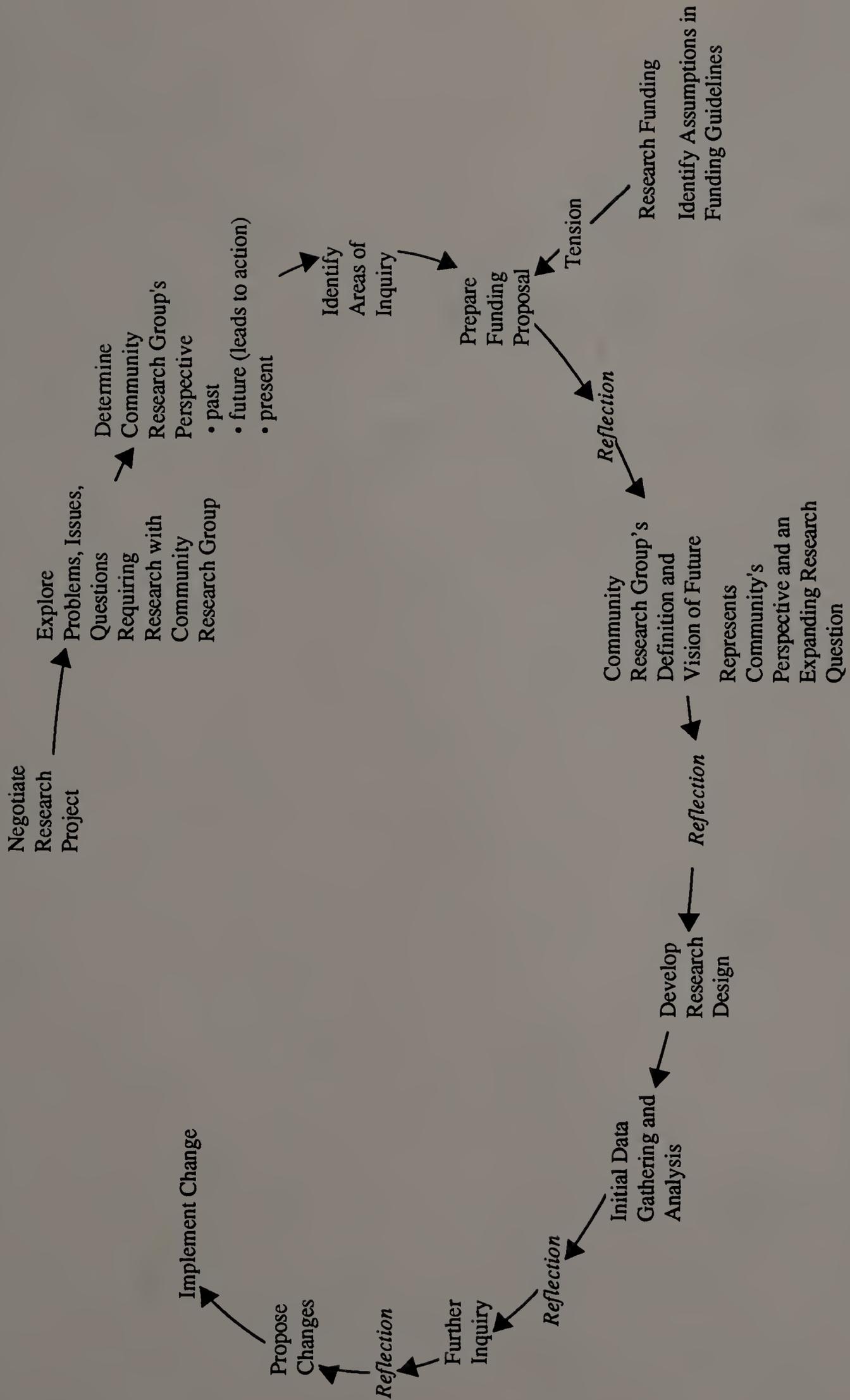
My commitment, as the external researcher, to the research and more particularly my availability to work with the community research group during the two years required for the Pre-Transfer Study was a continuing concern to John and the Task Force. This concern was real enough as I was only able to make a commitment to be available for extended periods of time during the period of my leave which was due to end in July of the first summer of the project. My availability after my leave hinged on the time I could negotiate to be away from my work at the university. In the early phases of the research, John had assumed that I would concentrate primarily on my dissertation. This appeared to mean to him that my commitment to complete the Pre-Transfer Study would be secondary at best and that I might abandon the Task Force once my dissertation was completed. This issue did not get aired until members of the group felt confident enough to raise their concern with me and have me assure them that I was committed to continue working with the community research group until their research was completed.

### **The Collaborative Research Process and the Role of the External Researcher**

As the external researcher, I saw myself as responsible for providing a framework for the research process . I assumed that the community research group did not have

previous experience conducting research. I also began with the assumption that most members would not have the research skills necessary for conducting the inquiry. I accepted responsibility for providing the training required by members of the community research group, training that was identified by members of the group as one of the tasks they expected me to perform. I also took responsibility for helping the community research group diagnose and work through internal problems that interfered with the group's ability to carry out its task. These are issues that need to be considered and discussed at the outset of a collaborative research process as they introduce and can perpetuate dependency in the relationship.

The collaborative research process in this case is illustrated in Figure 7.3. From the perspective of the external researcher, the process begins with negotiations to work with the community on a specific research problem, in this case the transfer of a government health service to the community. This transfer was to take place across a cultural boundary. As the external researcher, I was looking beyond the immediate problems associated with the transfer to the question of change in the total health system in the community. I began with the assumption that this change implied more than the transfer of control of an existing health program from one jurisdiction to another. It also meant exploring issues related to cultural beliefs and values in each system and a determination as to how conflicting beliefs, values and practices would be addressed in the change process. These were also concerns raised by John during our first meeting. He had stated that the present government health system did not take into account traditional health and that this was needed in their health program. I sensed that John and members of the Health Committee recognized that some of the community's health needs were being met through the current health system but that a community controlled health system needed to reflect the community's definition of health and incorporate traditional health practice along with the western health care provided by the government



Collaborative Research Process

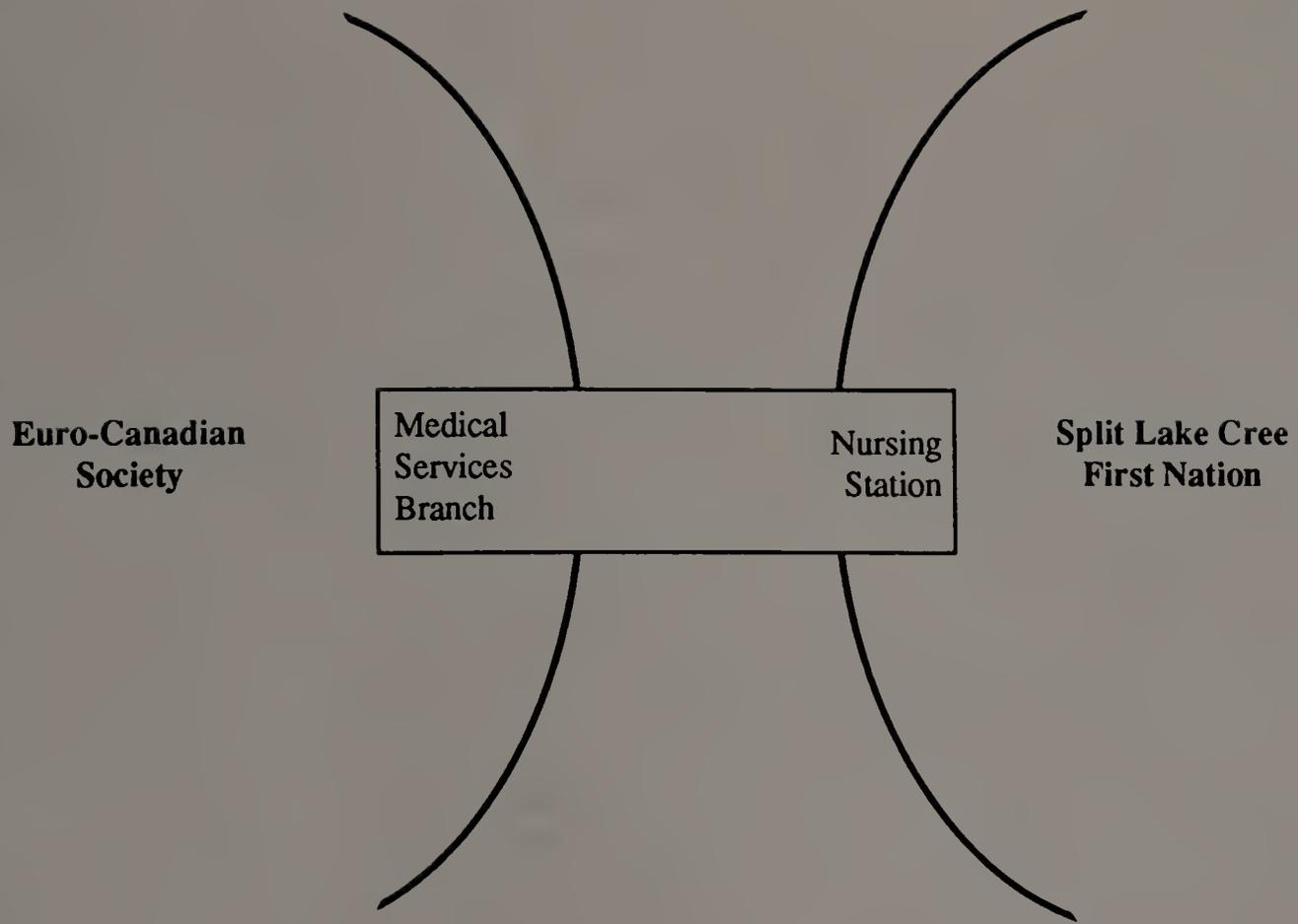
Figure 7.3

system. The two health systems, located within two distinct cultural boundaries, are illustrated in Figure 7.4. A culturally congruent health system is illustrated in Figure 7.5.

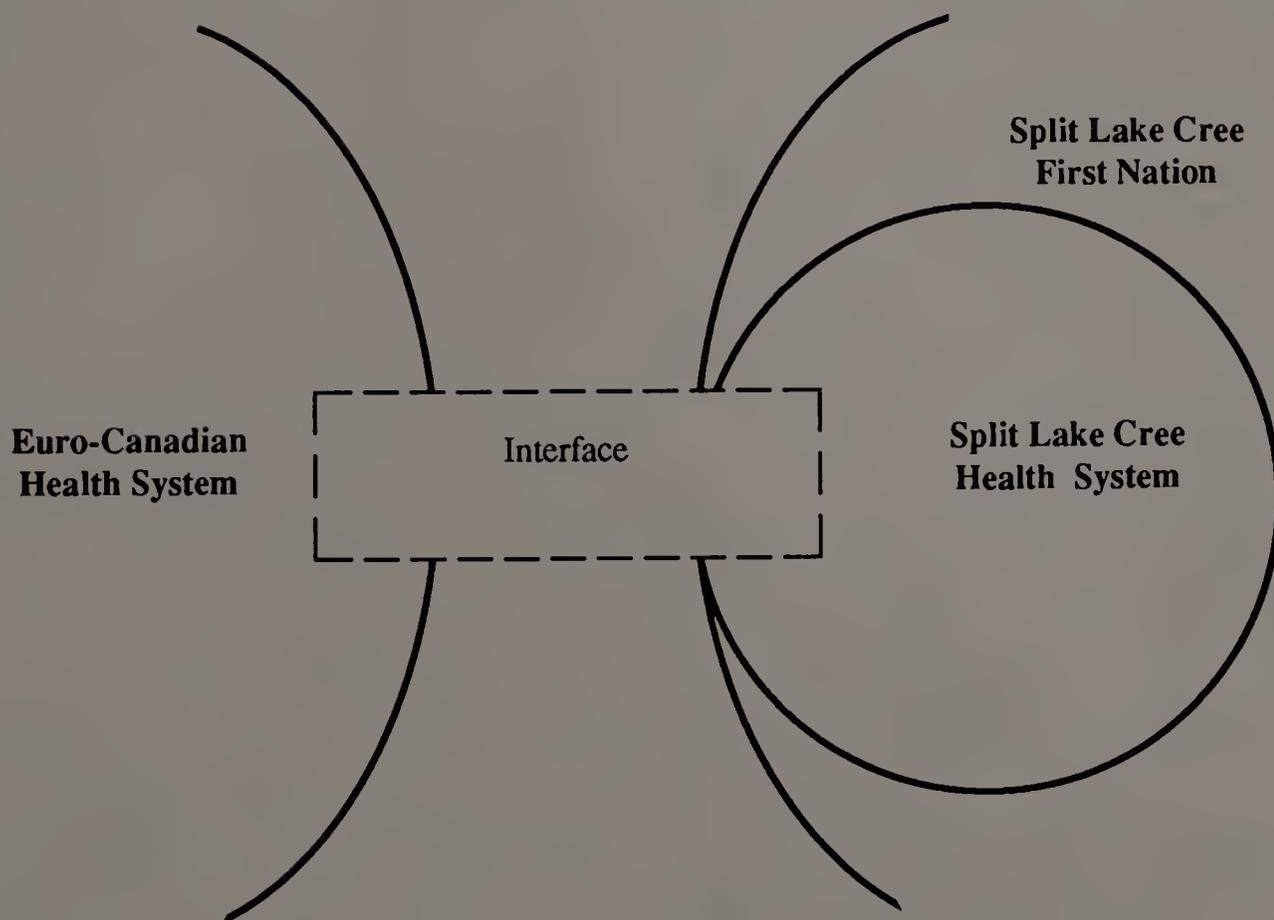
In providing a research framework for the community research, I was concerned that the process within the framework maximize the community research group's participation in and ownership of the overall research and change process. This meant providing a framework and initiating a process in which the community research group determined the direction and focus of each activity including the exploration of the research problem, preparation of the Pre-Transfer Funding Proposal, initiation of the research on traditional health and review of the group's own intra group processes. Inevitably, my taking responsibility for providing direction set up expectations on the part of group members that I would continue to provide direction and leadership. It also meant that I would determine to some extent what was included in the research.

The tension between this influence and the control of the research by the community research group parallels the influence exerted by the health transfer guidelines provided by Medical Services Branch. In each case, the influence can be managed to some extent if the influence and bias is acknowledged by the external researcher and in the case of the guidelines, written into the document so that community researchers are made aware of the these influences as they explore their research questions.

Designing the overall research process meant designing a process whereby the community research group could determine the questions that needed to be considered and the tasks that needed to be carried out in each phase of the research. In the beginning, I took full responsibility for the design, asking the group for instance to develop a description of their anticipated future health system and later to construct a model and develop a definition of health. The community research group worked on



**Existing Health System  
Figure 7.4**



**Community Controlled Health System  
Figure 7.5**

these tasks and later shared their work with me. The process maximized the community researchers' participation in the task. Later, as the research design took shape and areas of inquiry were identified, members of the community research group collaborated in discussing the design issues. This occurred when they began identifying studies and research methodologies to be included in the Pre-Transfer Funding Proposal. The influence of the health transfer guidelines was apparent at this stage as the group noted information that needed to be included in the Pre-Transfer Study. The research became very much a collaborative process in planning the study on traditional health as members of the community research group questioned the research method and redesigned and reordered the interview questions.

In asking the community research group to describe and compare the traditional, present and anticipated future health systems of the community, I was attempting to develop an awareness of the conflict between the traditional and western health systems. The comparison heightened awareness of the changes that had taken place in the health system in the community over time. The activity also helped the group envision their future health system. This led to a strategic planning activity in which I asked the community research group to develop a definition of health, construct a model of a future health system which embodied their definition and identify areas where they needed knowledge. The exercise enabled the group to employ their creativity in constructing the model and helped them identify issues, concerns and problems where further study was needed. Through this activity, the community research group discovered problems they did not know existed and identified research questions which needed to be studied.

The Pre-Transfer Funding Proposal introduced an element of tension between the community's objectives in launching their inquiry, the purpose of which was to change their health system, and the primary objective of the government, as reflected in the

health transfer guidelines, which was to transfer the existing health system to the community. The analogy that comes to mind in considering the existing government health system in relation to the community is that of a human transplant where the host body receiving the transplant calls forth its immunization resources to protect the body from the foreign transplant. As in human transplants, where there is a mismatch in the tissue, so to is there a mismatch in technical and cultural transplants where world views, frames of reference, values, beliefs and patterns and ways of relating differ. It was critical in this case to think about how the community research group might control the cultural invasiveness inherent in transferring the existing health system which is integral to one culture into their own entirely different culture. The task for the community research group is to reframe and reorganize the system being transferred so that the technical and system components would conform to the their community's social system to which it was to be grafted.

The inquiry into traditional health was the first attempt by the Task Force to collect data on the health system. My major contribution at this stage was to explain the advantages and disadvantages of using open ended and closed questions in interviews, suggesting the benefits and drawbacks in using interviews and questionnaires for obtaining data. I also proposed a skill practice session in which members practiced interviewing each other prior to conducting the pilot interviews. The members of the Task Force developed the questions to guide the interviews, conducted the interviews, translated and transcribed the tapes and later reworded and reordered their interview schedule in order to provide a more comprehensible and logical flow to the interview. Much of this work was done in Cree with the group pausing now and then to explain to me what they were doing, to ask questions or ask for direction. My role was largely one of participant observer.

As the external researcher, I saw my task as designing a process that enabled the community research group to determine the purpose of their inquiry and identify questions that needed to be investigated. There was tension between my role in designing this process and in providing overall direction and the need for the community research group to determine their own direction. For instance, the community research group at one point wondered what it was trying to achieve with the interviews on traditional health. This indicated that the community research group had not clearly determined the need for this study before it had been included in the Pre-Transfer Funding Proposal. I responded at the time by explaining how the information might be used in their overall study of the health system. A more effective response might have been to have asked the community research group to discuss among themselves why they felt it was important to study traditional health and determine how the information from the study might be used in changing their health system. This might have helped them clarify the purpose of this aspect of the research. They might have realized that the information they would gather would reveal knowledge about healing and healing substances. They might also have determined that it was important to document the extent of current traditional health practice and the possible need for an ongoing research program to maintain this knowledge. They might have decided that the information they obtained would be essential in building a case for incorporating traditional health in their future health system. As it was, the group launched the inquiry into traditional health with enthusiasm but with no clear understanding of the purpose of the study.

I had assumed that the data on traditional health would provide useful information, the purpose of which would become clear as we proceeded with the interviews and analysis. This approach made it more difficult for the interviewers to focus on the task and the information they were seeking. I realized later that my reliance on the data to

inform the study was too ambiguous. It stemmed largely from my own uncertainty and my search for an appropriate research method.

It was important to encourage members to assume a mode of inquiry. I missed an opportunity to do this on one occasion when Betty at one point proposed introducing the medicine wheel as a conceptual model that might help elders explain traditional beliefs about health during interviews. We had been discussing the use of open ended questions for gathering data and the importance of not leading the interviewee. I cautioned Betty about introducing a concept that might not be indigenous to the community when the purpose of the interviews was to discover local knowledge of health. It would have been more effective to have had her and the group consider how they might discover local theories or concepts of health in use in the community. Discovering how to obtain this information would have been a significant learning in how to do research. Her idea was an important one as she was suggesting the use of an Aboriginal theory of health and although it might not have been indigenous to the community or area, it would have countered the western model of health so prevalent in the current health system.

The community research group's concerns about my research and how it related to health transfer and the expectations we had about each others' roles in the community research project were important issues that needed to be clarified at the beginning of the study. These concerns might have been resolved by including a session in the first or second meeting in which members of the Health Committee and I identified questions and concerns we each had about working with each other in a collaborative relationship. This would have enabled us to clarify our roles and expectations and share our understanding of the research process. It might have led to an early airing of our understanding of the agreement between us and to putting in writing our commitment to the research task. We might have arrived at a clearer understanding of our task. As it

was, the issues were only resolved over time as concerns were raised and dealt with or as the natural process of working together on the research task gave us an opportunity to understand the contribution each of us was making to the inquiry.

An early meeting with Chief and Council to share with them the proposed research project and discuss my relationship with the community research group would have helped clarify the role of the community research group and my role as the external researcher. This in turn might have offset the lengthy delays that were to follow in bringing the Pre-Transfer Funding Proposal before Council for approval.

There was confusion concerning my role as a trainer. John and Betty initially saw my role as preparing Health Committee members to assume greater responsibility in the health transfer process, providing them with the training they would need to eventually assume the role of health authority or board. This was the training role specified in the health transfer guidelines. I saw myself, at least initially, training the local research group in the skills necessary for doing their own research, for their role as co-researchers. My approach was to integrate this training with the ongoing work of the Task Force, addressing training needs as they surfaced. The confusion in this instance was a reflection of the subtle influence exerted by the guidelines on the research process.

This collaborative research was conducted in a cross cultural setting. The community research group was most comfortable using Cree. This was due in a large part to the ease with which they were able to discuss ideas and concepts which were not always easy to translate into English. There may also have been times when they wanted to discuss concerns or ideas amongst themselves without involving me. This is an important reality for an external researcher working in a cross cultural setting where the language is different. In a cross cultural setting, it is necessary that an external researcher

feel comfortable when community researchers work in their own language. It is an important means by which they maintain control of the interaction and the work.

Asking a group to work in its own language is an important strategy for obtaining participation in a group. For instance, when I found that the community research group did not respond to a question, I would ask them to discuss it among themselves, expecting them to discuss it in Cree. I often left the room or busied myself with other work while they discussed the item. In these situations, there would inevitably be input from most members. This was most notable when the group worked at translating and transcribing the interview tapes on traditional health. The community research group's power is in their language. They, in translating their thoughts, become the bridge between their world and the world of the external researcher. This counters the tendency for the external researcher to view him or herself as the bridge between the two cultures.

Language can also be a defense against the invasiveness of the dominant or oppressing culture. John and Sally illustrated this in the anecdote they told of nurses who would get angry in the nursing station if people spoke Cree in front of them.

My role as external researcher was complicated by my work on my doctoral dissertation. I needed to collect data for my dissertation, documenting the community and collaborative research processes while taking an active part in the research work. This introduced confusion and ambiguity into my role in the community research undertaking. Some members for instance asked if the tape recordings I was making of our meetings were for the community research. They were not directly related to the community research yet the insight I obtained in transcribing the tapes, insight into the group and research processes and the impact of my interventions, was insight that I relayed to the community research group which in turn contributed to their intra group processes.

I found that transcribing the interview tapes and writing this dissertation gave me insight into issues I missed at the time they were occurring. This was data I would have lost if I had not tape recorded the meetings. I generally transcribed the tapes long after a meeting had taken place. In the future, I would recommend recording sessions, if agreeable to the community research group, and transcribing or reviewing the data immediately after a session so that the information is available for immediate reflection and feedback to the community research group. I also found it helpful to have others, including colleagues, my dissertation advisors and the community researchers read the transcripts and my dissertation. They gave me the benefit of a third party perspective on the dynamic processes occurring in the group. These insights were important learnings for those of us who have participated in the research and can be a valuable tool in conducting collaborative inquiry.

## CHAPTER VIII

### IMPLICATIONS AND RECOMMENDATIONS

This chapter examines the implications for using a collaborative research approach in working with a community research group. It explores the research process from the perspective of both the external researcher and community researchers and notes in particular the issues that must be addressed by the external researcher and the community. Areas where further research is required are also identified.

#### Community Research Processes

Collaborative community research is one means for assisting communities in conducting research for the purpose of changing organizations and social systems. The research process enables a local community research group to work with an external researcher in identifying its own research question, establishing its own change goals, gathering and analysing data and discovering knowledge that is needed to make informed decisions concerning changes that are to be made. The collaborative community research process also prepares community researchers for utilizing the knowledge they have acquired through the research.

Community groups embarking on a collaborative community research process must first determine the purpose of their intended research. In this case, the Split Lake Cree First Nation wanted to study their health system before making a decision on whether to take over the government run health program in their community. Once the decision is made to proceed with the research, it is important to consider the methods that are to be used to investigate the problems associated with introducing change. In the Split Lake

Cree First Nation, after discussing the idea with an external researcher, they agreed to employ a collaborative research approach for their inquiry into their health system.

The collaborative research process involves a number of phases. The first phase begins with a discussion about research and what people hope to achieve through research. This phase includes negotiations with an external researcher who is prepared to work in a collaborative manner with the community research group. The second phase focuses on the problem to be studied. When change is being introduced, it is essential that time be taken to assess changes that have occurred in the past. This historical perspective, when compared with the present and desired future, increases participants' awareness of the impact change has had on the community. It is also important to create a vision of a desired future. This vision establishes the goals for the research. Out of this process will emerge a number of research questions. Later phases in the research process involve gathering and analyzing data. From constant reflection on the data, new questions, insights and knowledge emerge. Action can then be taken to introduce desired changes in the system based on the knowledge gained from the inquiry.

A number of critical tasks need to be performed in implementing a collaborative research process. In the case study recounted here, failure to clearly establish the parameters of the authority delegated by Chief and Council to the research group, led to confusion as to whether the research on the health system was to include research on the transfer of health services, including preparation of the Pre-Transfer Funding Proposal and Study. It also led to uncertainty as to whether the work of the research group would be accepted by the Chief and Council and the community at large.

It is important to establish the goals of the research early in the research process. This provides the research group with a target and helps them remain focused in the face

of competing goals that may be introduced by external agencies. The funding agency in this case, Medical Services Branch, had its own goals in transferring health services to the community, the underlying assumption being that communities would take over and administer an existing health system. This assumption became a constraint that the community research group had to circumvent in its quest to study its own health system. The Split Lake Task Force's study needed to define health, determine the services required to achieve health and health care and ultimately create an appropriate organization for delivering health care in the community.

The external researcher can be expected to provide an important function, structuring the research process in such a way as to enable the community research group to establish future goals, assess indigenous knowledge, values and customs and acquire the knowledge and skills needed for doing the research. The process should focus on questions of concern to the community as opposed to the concerns of either the external researcher or the funder of the research. Inevitably, the external researcher's biases and assumptions come into play much as do those of the funder. One way to deal with this dilemma is to articulate the external researcher's biases and assumptions at the outset, perhaps working with the community research group to identify both those that are readily acknowledged as well as those that remain hidden to the external researcher. Community researchers and the external researcher can then take these into account as they proceed with the inquiry. This is even more crucial in the event that the external researcher is of a different cultural group than the community researchers.

It takes time for new researchers to grasp the idea of research, to gain confidence and to develop as a cohesive research group. In this case, individual members of the group had to overcome doubts about their own ability to do the research. John for instance had remarked that, "They, the members of the Health Committee, don't have the

[appropriate] education. They are not sure they can do it.” The Split Lake Task Force demonstrated that they were capable of doing the research, developing a comprehensive funding proposal, conducting, translating and transcribing interviews and redesigning the interview questions and schedule, a considerable achievement when compared with the experience of other First Nations in the region who had relied on external consultants to prepare their Pre-Transfer Funding Proposals and Pre-Transfer Studies.

Every group, no matter what its task, must go through a number of stages as they develop into an effective work group. In this case, the community research group needed to deal with its own leadership and the roles of its members, including responsibility for tasks that had to be performed. The group experienced problems with the imbalance of power in the group, with the defacto leader bringing his multiple roles into the Task Force, as Councillor with responsibility for the health portfolio, professional in the field of health, primary go-between with the external researcher and member of the group. This placed an unfair demand on him to perform many of the tasks that needed to be shared by others. The power imbalance associated with a number of these roles meant members were reluctant to challenge him for leadership or assume leadership roles.

Members of a community research group need to share the leadership and membership tasks of the group and work to achieve a balance in the power and leadership. They also need to share responsibility for work that must be completed within the group. They may need the help of an external researcher, trainer or consultant skilled in helping a group diagnose its internal processes in order to deal with these issues. This process requires a high degree of trust and openness to feedback from members of the group, a condition that can only develop over time. Self assessment by group members also requires considerable interpersonal skill and experience. Again, this skill takes time to develop.

The transfer of government health programs to local control is an important step in re-asserting First Nations' inherent right to govern themselves. The transformation of health systems is critical in re-asserting cultural autonomy. It shifts the struggle from one of resistance to one of assertion of one's cultural power. This dynamic is the underlying motivator for a community research group as it considers the possibility of conducting its own research. In Split Lake, the Health Committee and later the Task Force saw the opportunity to engage in the research as a way to become involved in this issue. They also saw it as an opportunity for improving the health of the community. There was satisfaction in doing their own research and personal reward for individuals in learning new skills and gaining new knowledge.

Administrative tasks need to be dealt with and action taken to assign responsibility and accountability. In this case, tasks were sometimes left undone, most notably the keeping of minutes. It is important to have administrative support available for major undertakings such as an inquiry into health transfer. Fortunately in this case the secretarial staff of the Split Lake Cree administration prepared the many drafts and revisions required in preparing the Pre-Transfer Funding Proposal.

The community research process is a lengthy undertaking and may require a longer time frame than initially expected, particularly if unforeseen events alter the time frames that have been established. Community researchers will need to adjust to interruptions and changing demands on their time and do what they can to accommodate the changes that need to be made in the work schedule. These demands may be as simple as rearranging cancelled meetings to coping with major disruptions which are beyond the control of the research group. Some unforeseen events, such as political interference or financial problems, may disrupt the research process and even lead to termination of the research.

This study has only begun to document the local knowledge of traditional health. It suggests that this knowledge is not being passed on in any systematic way and is quickly being lost. The collaborative community research process offers a way of validating this knowledge and experience. It is knowledge and practice that cannot survive unless it remains part of a larger cultural whole and can only be preserved as a legitimate part of the culture if those in the culture act to maintain and use that knowledge.

### **Collaborative Research Processes**

The collaborative research process which utilizes an external researcher requires a researcher who is committed to a process which both values and validates local knowledge and local inquiry. The external researcher must engage community researchers as co-researchers in the research enterprise. The external researcher must be able to provide a framework or structure for the research and appropriate methods for gathering and analysing the data but the content of the research, beginning with the goals of the research and including the determination of the research problem and the gathering and analysis of the data must come from the community researchers themselves.

The external researcher needs to be an active participant and contributor in the collaborative research process, providing suggestions, opinions and information but the community researchers must make the critical decisions which determine the direction, processes and findings that emerge from the inquiry. This is not necessarily an easy task for the external researcher as there is tension between providing overall direction for the research and research methodologies while remaining responsive to the initiatives and direction offered by members of the community research group. The tension is important even if it exists solely within the external researcher, for without the tension there is a

high propensity for a state of dependency to set in, leaving the external researcher controlling the input from the community researchers. Community researchers generally begin in a state of dependency. Otherwise they would proceed on their own without turning to an external researcher for assistance. The task of the external researcher is to extricate him or herself from this state of dependency and foster independent and interdependent action on the part of the community researchers. How this will be accomplished will vary from researcher to researcher but it must be achieved if the community research group is to take ownership of the research and ultimately use the findings for introducing change.

The external researcher will in all likelihood provide a framework for the research process which he or she offers to the community research group. This framework will emerge out of discussions about the purpose of the research. Again there is tension here as it is important to remain responsive to the direction taken by the community research group and not impose a preplanned framework which limits or restricts the group. In this case, I struggled to discover a framework as I worked with the community research group, a struggle which was part of my inquiry for my dissertation. As a result, I tended to work out the framework as I became aware of my own need and the need of the group. This resulted in a lack of direction at times but did avoid prescribing a rigid structure. The framework when it was presented provided a conceptual road map which helped the community research group understand where they were headed. In reflecting on this, I am aware that the framework might have been developed in a more collaborative vein, with discussion around local indigenous methods of inquiry.

Involvement of the community at large and the leadership, normally the Chief and Council in Aboriginal communities, in the formative stages of developing a research project is essential in order to obtain the community's understanding of and support for the

inquiry process. This support is needed if action to implement the outcome of the inquiry is to occur in the final phase of the inquiry process.

The community research process requires adequate time and resources. It will take two to three years to complete a comprehensive study of a local health system if a community is going to rely on local volunteer effort rather than contract with an external consultant to conduct a study. Time is needed to develop the research and funding proposals. In this case, the preparation of the Pre-Transfer Funding Proposal took nine months. Funds are needed at the beginning to underwrite the costs of this process as inexperienced researchers will need considerable assistance from an external researcher in the early stages of a research project.

Unforeseen forces can be expected to derail the process. In the uncertain environment in which many First Nations exist, dependent on federal funding for most programs, the chance of unexpected problems impacting the research process is very real. In Split Lake, the negotiations over the Northern Flood Agreement, the administrative difficulties experienced by the central administration in one of their programs and the lack of funds to continue paying the travel expenses of the external researcher disrupted the time frames for the research and caused considerable delay.

Roles need to be clarified. Both the role of the external researcher and the role of the community research group need to be discussed so that each participant understands his or her role as well as the role of others. The discussion of the roles should clarify the expectations that are associated with each role. It is an exercise that needs to be repeated whenever there is confusion as to who is responsible for carrying out required tasks.

The dependence-interdependence dilemma must be recognized and managed. The initial phase of collaborative research begins in dependency as community researchers generally rely on the external researcher for direction and his or her knowledge of research methods. An educational process is needed whereby community researchers acquire an understanding of the research process and gain the skills necessary for conducting the research. The task of the external researcher is to provide this instruction while working towards interdependency as well as independent action as the community researchers gain the skills and experience to do the research.

The external researcher is expected to provide the training required for performing the research tasks. When needed, the external researcher must also provide training in group and interpersonal skills. These skills are essential for leadership and participation in the life and development of the community research group. The external researcher should also help the group diagnose problems when intra group problems prevent the group from functioning effectively.

The collaborative research process is an alternative approach to traditional consultation in which the consultant prepares studies on behalf of a community. It demonstrates that researchers and consultants can collaborate with community researchers on research and consulting projects. Collaborative research in this way provides community researchers with an educational opportunity which can equip them with the knowledge and skills to do their own studies. The process is initially more time consuming and costly than employing an external consultant to prepare a study on behalf of a community but the benefits in the long run outweigh these initial costs as community researchers increase their capacity to do this work and acquire the knowledge for eventually implementing the results of the research. If such a policy is adopted, First

Nations will do their own research, utilizing where needed researchers committed to the development of local community researchers.

It is essential that the external researcher be aware of and sensitive to cultural differences. While the collaborative research process is designed to capture local knowledge and the cultural world view of the members of the research group, the process of cultural oppression is extremely difficult to counter and it needs the combined efforts of all those involved to counter the intrusion of the dominant belief system in the inquiry. The objective must be to assist the community research group to institute and manage change without violating indigenous values, beliefs and norms.

The collaborative research methodology is designed to maximize the participation of members of the community research group in defining the research question, assembling and analysing data, determining the significance of the research findings and in determining the action to be taken. In many ways the methodology is compatible with Aboriginal culture in that it emphasizes group discussion and consensus decision making in deciding on and carrying out the research task. It must be stated, however, that it is a methodology introduced from western culture and represents a western perspective and understanding of the world.

Collaborative research, located as it is in the subjective radical change paradigm, is less likely to violate indigenous values, beliefs and experience than other more invasive research methodologies such as positivist research which views people as objects to be studied at a distance rather than as participants and co-researchers engaged in inquiry but collaborative inquiry needs to move beyond its own paradigm and elicit indigenous ways of knowing and of making sense of the world. This may lead to either a synthesis or

alternatively to two parallel ways for conducting inquiry, for understanding and knowing the world.

The assumption that all that is needed for the successful transfer of an existing health system from the government to a First Nation is a study to determine the adequacy of existing health care and the organization of a body to administer and control the system once transfer has taken place is unacceptable. It does not take into account the profound differences between the two cultures in question and the need of the Aboriginal community to pursue an inquiry into their understanding of health and the means for organizing and providing for the health needs of their community. Aboriginal communities need to transform the existing health system so that it can be culturally integrated into the community. If Medical Services Branch acknowledges the need to provide support for an Aboriginal research effort, they will need to modify their health transfer guidelines and provide funding and guidelines that recognize the necessity of First Nations developing research proposals based on their own research goals. The advantage in supporting this approach is that First Nations will acquire the knowledge that will enable them to design health systems that are congruent with their culture and that express their own way of being and of being healthy.

### **Recommendations for Additional Research**

This case study documents the research processes entered into by a community research group and an external researcher investigating change in the community's health system. The research process in this case is ongoing. It provides a description of important initial stages in a collaborative research process and although these processes are unique in some ways to this case study, many will occur in other collaborative

research projects. The experience and the observations should therefore provide both a guide and a stimulus for other collaborative research efforts.

The continued documentation of the community research process in this case is important in providing other researchers with a comprehensive case study of one community's collaborative research effort. The role of the external researcher should also continue to be documented in order to gain insight into the processes involved in working with a community research group in collaborative research.

This research covers the initial phase involved in the development of a collaborative community inquiry for introducing change in an Aboriginal community's health system. A major recommendation is that the community research begun here continue in order to provide the Split Lake Cree First Nation with the knowledge they require to make an informed decision as to whether they should assume control of the health system and how they should transform it.

The inquiry should continue to study the intra group process of the community research group, discovering the dynamics experienced within the group and their impact on the research process.

Research is needed on the impact of potential role conflicts that may occur in communities where individuals assume a number of key roles. This is particularly significant when political and administrative roles are exercised by the same individual.

A study of the delegation of authority from community leaders to a community research group would provide insight into how the delegation of authority helps or constrains a group in its ability to carry out its work.

Support, encouragement and funding for initiatives by Aboriginal researchers to pursue Aboriginal methods of inquiry is needed so that Aboriginal knowledge and ways of knowing the world can inform Aboriginal decisions. This knowledge is essential for strengthening the Aboriginal struggle to manage their cultural boundary with western society.

Additional research is needed on the traditional health system to discover the knowledge and practice of healers. It is important to recognize, empower and legitimize this knowledge and the traditional healing arts so that as in John's words, "western and traditional healing can provide an integrated health service to the people."

Research is needed on how two health systems, traditional and western, can be integrated or managed in order to maximize the health of Aboriginal people in Canada.

Further research is needed on the impact of government program guidelines and funding policies and how they curtail and limit Aboriginal initiatives and the exercise of self government. The underlying assumptions of these policies must be declared as to their intent and expected impact if open negotiation is to take place between the Government of Canada and Aboriginal governments. John drove this point home when he reported, on returning from the conference on health transfer, that George Erasmus, the Grand Chief of the Assembly of First Nations, had declared that federal government programs developed by the government for the Aboriginal community rather than with Aboriginal people was a form of colonization.

Finally, collaborative research represents a radical humanist approach to inquiry located in the western way of perceiving the world. Based on the experience of this researcher, it is a research methodology that offers one way of working with a group across a cultural boundary, enabling that group to deal with the western world on their

own terms, using the tools of the western world to make their case for the way they will manage western systems that are impacting their community. For the Aboriginal community, collaborative research offers one method for communities to transform cultural systems which have been imposed upon them.

**APPENDIX A**

**LETTER TO JOHN KNOTT OUTLINING PROPOSAL  
TO WORK WITH SPLIT LAKE CREE FIRST NATION  
ON STUDYING CHANGE IN A FIRST NATION HEALTH SYSTEM**

19 Fallbrook Bay  
Winnipeg, Manitoba  
R2J 2P5  
October 6, 1989

John Knott  
Split Lake Band  
Split Lake, Manitoba

Dear John,

I appreciated meeting you on Tuesday to discuss my proposal to involve Split Lake in studying change in the health system of First Nations in northern Manitoba. I have been discussing the idea of a study of the health system as a first step in developing training for health administrators with Joe Nasikapow and Henry Woenusk for some time now. I believe a study is necessary if we are going to design an effective training program. I also believe a study is important in preparing a community health plan prior to negotiating health transfer.

I became involved with this proposal when I was asked by Joe and Henry to develop the health administrator training program. Recent staff changes at the Chief's organization has resulted in staff not having time to proceed with the study but Joe has said that the Tribal Council is prepared to proceed with the project. We [Joe, David and myself] realized that we needed to involve a community in the study and it was suggested that Split Lake would be an ideal community as the Band is preparing to enter into pre-transfer negotiations. You also have a health committee in place.

The study would be a participatory research project involving community researchers from Split Lake and a research team from the Tribal Council. This would provide the study with both a community and regional perspective. The research team and community would work together to identify the questions that need to be studied, carry out the study, analyse the data, and propose a plan of action. The research should provide us with an assessment of the existing health system as well as a plan for Split Lake's health system designed to meet the needs of the community as determined by people in Split Lake.

The goal of participatory research is to discover the knowledge people need to have in order to bring about desired change. Much of this knowledge concerning the health system is held by people in the community; the elders, health workers and those who use the health system. But an additional goal in participatory research is to act on that knowledge, working to bring about the change that is desired. This commitment to follow through is what makes participatory research different from traditional research which generally serves only the interest of the researcher who wants to do the study.

In the study I am proposing, I would expect the Health Committee and the Band Council to use what they learn in the study to establish a plan of action for achieving control of their health system. This would likely include the development of a negotiating position for entering into the health transfer process. Similarly, I would expect the Tribal Council to use the study as the basis for establishing regional services and support for community health services. The development of a training program for health administrators would also utilize the results of the study.

I would expect the project to proceed through a number of phases.

#### Phase I

Establishment of a research group in Split Lake to study the health system. I am assuming that the Health Committee would form this research group. An important task to be included in the project would be the training of this Committee. A joint research group would also be established involving both Split Lake and the Tribal Council which would be concerned with studying the regional health system. These two research groups would have overlapping membership. They would need to discuss and agree on the research problem, determine the information that needs to be gathered, work on analysis of the data and prepare a report. A plan of action should also be developed.

#### Phase II

This phase will likely involve negotiation of health transfer, development of appropriate training programs, continued study of health issues and planning for regional health services and support. I expect the Tribal Council to continue the process by involving other Bands in the study of the health system in their communities as a first step in instituting change leading to health transfer.

I want to do this study for a number of reasons. I am interested in the study of change in social systems. The transfer of health to the First Nations represents significant change. I have also been asked by the Chief's organization and the Tribal Council to develop a training program for Health Administrators. This requires working with a community to determine the specific role a health administrator will be required to perform. Finally I need to undertake research for my doctoral program this winter and I see the opportunity to work with the Tribal Council and Split Lake in a health study as an ideal opportunity to combine my thesis work with the practical need to implement change in a First Nations health system. I have six months leave from the University this winter to work on my thesis and this research project. I would not charge any fee for my time during this period but would appreciate assistance in meeting my travel expenses. Once my leave is over I would hope to continue my involvement in the project on a part time basis as an advisor/resource person. I expect that I will be working on the development of the health administrator program and so will be officially connected to First Nations health programs in the north through my work at the University.

I have attached a schedule of work that needs to be done this winter together with a budget indicating my travel costs and the expenses that will be incurred in tape recording and transcribing discussions from our research meetings and workshops. As I indicated to you, I will use my own resources where I can to keep the costs to a minimum. I would expect that as a research group we would develop a more comprehensive plan and budget which will be needed in following through with the implementation of the health transfer process.

I hope this brief outline is enough to get us started. If Council approves the study, we will need a Band Council Resolution authorizing us to begin the project.

Let me know if you need further information.

Regards,

Don Castleden

<b>Tentative Schedule</b>	<b>Proposed Dates</b>
Initial Research Planning Meeting Split Lake	Oct 16/17, 1989
Research Design Workshop The Tribal Council & Split Lake	Nov 6-8, 1989
Research Design Workshop Split Lake	Dec. 1989
Community Workshop Split Lake	Dec. 1989
The Tribal Council -Split Lake Workshop	Jan. 1990
Research Group Meetings	Feb./Mar. 1990
Community Workshop	Mar. 1990
Planning and Implementation	Apr. 1990

**APPENDIX B**

**LETTER TO JOHN KNOTT CONFIRMING ARRANGEMENTS  
TO MEET WITH THE HEALTH COMMITTEE**

19 Fallbrook Bay  
Winnipeg, Manitoba  
November 14, 1989  
R2J 2P5

John Knott  
Community Health Representative  
Split Lake Cree First Nation  
Split Lake, Manitoba

Dear John,

I have been doing quite a bit of background reading and thinking about how we might begin the research project. It has taken longer than I expected but I think it will pay off in the long run.

I have kept the week of November 20th open for meeting with the health committee. I would prefer meeting during the middle of the week if it all possible.

As I understand it, the Health Committee is responsible for the transfer of health programs to the Split Lake Cree First Nation. To do this the Committee will need to study the health system prior to negotiations for the transfer of health programs. The first task of the Committee will be to discuss what they want to achieve in transferring the health system. They will then need to develop a plan of action for accomplishing this goal. I see the first meeting as the beginning of a planning and learning process for accomplishing this task. It also needs to be the first step in a team building process.

The first phase in preparing for the transfer of health programs is the research phase. As it progresses, the research team should develop the management skills they will need for managing the transfer process and establishing a health system managed and controlled by the Split Lake Cree First Nation.

I have attached a tentative agenda for the two day workshop which should get us started on the research and transfer process. Please call me if you have any questions.

I am assuming that you will arrange the meeting space at Split Lake. Could you also arrange a place for me to stay overnight?

I'm looking forward to meeting with the Health Committee.

Sincerely,

Don Castleden

Split Lake Cree First Nation Health Committee  
Research Group  
Agenda  
November 23-24, 1989

**Day 1**

- 9:30            Introductions and get acquainted
- 10:15          How we will work together
- 10:30          Coffee
- 10:45          Discussion of the transfer process
- 12:00          Lunch
- 1:15            The research process
- 2:30            What the Health Committee wants to achieve
- 4:30            Review of the days activity
- 5:00            Adjourn

**Day 2**

- 9:30            Model building
- 12:00          Lunch
- 1:15            Identifying information to be gathered
- 2:15            Methods for collecting information
- 3:00            Plan of action
- 4:30            Review of the days activity
- 5:00            Adjourn

**APPENDIX C**

**LETTER TO ZONE DIRECTOR CONFIRMING INTENT TO  
IMPLEMENT STUDY ON HEALTH TRANSFER**



**SPLIT LAKE CREE FIRST NATION**

SPLIT LAKE, MANITOBA R0B 1P0

TEL: (204) 342-2045 FAX: (204) 342-2270

July 23, 1991

Ms. Grace Godmaire  
Zone Director  
Medical Services Branch  
Health & Welfare Canada  
83 Churchill Drive  
Thompson, Manitoba  
R8N 0L6

Dear Grace:

**Re: Split Lake Cree First Nation  
Pre-Transfer Proposal**

We, the Chief and Council of Split Lake Cree First Nation, intend to implement a study on the transfer of health services from Medical Services Branch to the Split Lake Cree First Nation.

In order to conduct this study, we are submitting the enclosed Pre-Transfer Proposal, which has been prepared by the local Health Task Force, for your approval and funding.

We trust our Proposal meets the criteria as outlined by the Department of Health and Welfare Canada.

We look forward to hearing for your reply.

Respectfully,

Chief Norman Flett

**APPENDIX D**

**BAND COUNCIL RESOLUTION SUPPORTING  
PRE-TRANSFER FUNDING PROPOSAL**



BAND COUNCIL RESOLUTION  
RÉSOLUTION DE CONSEIL DE BANDE


NOTE: The words "From our Band Funds" "Capital" or "Revenue", whichever is the case, must appear in all resolutions requesting expenditures from Band Funds.  
 NOTA: Les Mots "des fonds de notre bande" "capital" ou "Revenu" selon le cas doivent paraître dans toutes les résolutions portant sur des dépenses à même les fonds des bandes

The council of the Le conseil de la bande indienne	SPLIT LAKE CREE FIRST NATION	Current Capital Balance Solde de capital	\$ _____
Agency District	THOMPSON	Committed Engagé	\$ _____
Province	MANITOBA	Current Revenue Balance Solde de revenu	\$ _____
Place Nom de l'endroit	SPLIT LAKE	Committed Engagé	\$ _____
Date	23rd July AD 19 91 Day - Jour Month - Mois Year - Année		

DO HEREBY RESOLVE:  
DÉCIDE. PAR LES PRÉSENTES:

- WHEREAS: Health Services are presently provided to the Split Lake Cree First Nation by the Medical Services Branch of Health and Welfare Canada; and
- WHEREAS: the Band has reviewed the process described by Health and Welfare Canada to initiate and implement the transfer of Health Services; and
- WHEREAS: it is the intention of the Split Lake Cree First Nation to begin the process of the transfer of responsibility and authority of the community's Health Services to the Split Lake Cree First Nation; and
- WHEREAS: the Chief and Council have considered the work necessary to undertake the planning required to transfer the responsibility and authority for the Health Services to the Split Lake Cree First Nation.
- THEREFORE BE IT RESOLVED: that the Split Lake Cree First Nation support the attached proposal to Health and Welfare Canada seeking the funds necessary to conduct a Community Health Needs Assessment and develop a Community Health Plan for the purpose of assuming responsibility and authority for Health Services for the Split Lake Cree First Nation.

A quorum for this Band Pour cette bande le quorum est	
consists of fixé à	SIX (6)
Council Members. Membres du Conseil.	

*Allesaukitchewank*  
(Councillor - Conseiller)

*Daniel Kihler*  
(Councillor - Conseiller)

*Joseph Morris*  
(Councillor - Conseiller)

*Vito Spener*  
(Councillor - Conseiller)

*Norman Dhu*  
(Chief - Chef)

*JAM GARRON*  
(Councillor - Conseiller)

*Charlotte Westwood*  
(Councillor - Conseiller)

*1996 Pearson*  
(Councillor - Conseiller)

\_\_\_\_\_  
(Councillor - Conseiller)

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