

INAUGURAL
BIENNIAL
MEETING

3-6 October 2003

Jupiters Hotel and Casino
TOWNSVILLE AUSTRALIA

Hosted by
JAMES COOK UNIVERSITY
Indigenous Health Unit



International Network Of
INDIGENOUS HEALTH
Knowledge and Development

CONFERENCE

REPORT

Edited by
Assoc Prof **JACINTA ELSTON**
and
Dr **BARRY LAVALLEE**

First Published in 2005

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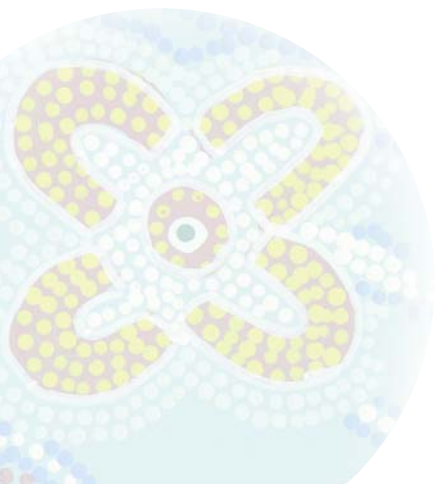


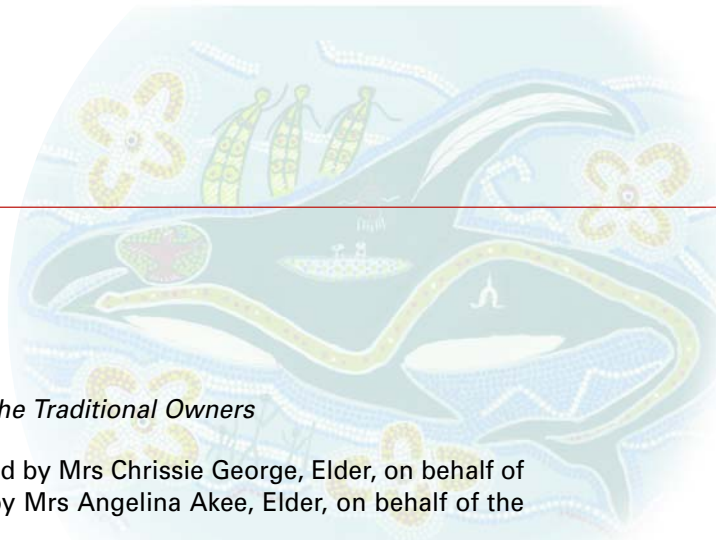
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International Network Of
INDIGENOUS HEALTH
Knowledge and Development

WELCOME



Welcome to Country on behalf of the Traditional Owners

Delegates were warmly welcomed by Mrs Chrissie George, Elder, on behalf of the Wulgurukaba people, and by Mrs Angelina Akee, Elder, on behalf of the Bindal people.

Greetings from Homelands

Members of the Aotearoa (New Zealand), United States of America, New Mexico and Canadian delegations extended traditional greetings to the conference.

Conference welcome

It is our pleasure to extend a warm welcome to all our guests, friends and their family members. Thank you for accepting our invitation to participate in the International Network of Indigenous Health Knowledge and Development meeting, and welcome to Jupiters Townsville, the forum venue.

We acknowledge the traditional owners of this country that we are on, the Wulgurukaba people and the Bindal people.

We would like to thank you for participating in the inaugural gathering of the International Network of Indigenous Health Knowledge and Development. The International Steering Committee has selected the meeting themes in order to help facilitate the sharing of experiences and to learn from each other.

The international Steering Committee acknowledges the support and contributions of the Indigenous communities of Australia, particularly the Queensland Aboriginal and Islander Health Forum, The Townsville Aboriginal and Islanders Health Service, Ms Rachel Atkinson and Mr Alec Illin.

We would like to acknowledge the support from the various government agencies, universities and community organizations from Australia, Canada, Aotearoa (New Zealand) and the United States of America.

Through the active participation of yourself and other delegates we anticipate a meeting which is challenging and rewarding; with time for sharing of, and reflection about, individual and collective knowledge and experiences.

We appreciate the invaluable contributions of the collective members of the International Steering Committee, and each country's specific working groups in planning for this meeting.

We do hope you find this meeting productive and valuable as a contribution to improving the health of International Indigenous peoples.

Professor JACINTA ELSTON

For and on behalf of the International Steering Committee
International Network of Indigenous Health Knowledge and Development

ACKNOWLEDGEMENTS

Sincere appreciation is extended to the sponsoring government agencies, universities and community organisations for their support, and to conference committee members for their personal commitment and contribution in planning for this inaugural conference.

CONFERENCE SPONSORS

AUSTRALIA



CANADA



AOTEAROA (NEW ZEALAND)



UNITED STATES OF AMERICA



CONFERENCE COMMITTEE

International Steering Committee

Associate Professor Jacinta Elston,
Australia

Mr Mick Adams,
Australia

Ms Rachel Atkinson,
Australia

Dr Sue Crengle,
Aotearoa New Zealand

Dr Gayle Dine Chacon,
United States of America

Dr Bonnie Duran,
United States of America

Mr Earl Nowgesic,
Canada

Dr Jeffrey Reading,
Canada

Dr Judith Bartlett,
Canada

Dr Barry Lavallee,
Canada

Australian Working Group

Associate Professor Jacinta Elston

Mr Mick Adams

Associate Professor Ian Anderson

Ms Rachel Atkinson

Dr Patricia Fagan

Dr Ian Ring



EXECUTIVE SUMMARY

The inaugural gathering of an International Network of Indigenous Health Knowledge and Development (INIHKD) was convened in October 2003, in Australia. This meeting sought to highlight and bring international attention to the continuing disparities between the health of Indigenous people and the non-Indigenous settlers of Australia, Canada, New Zealand (NZ) and the United States of America.

The basis for bringing together representatives from these four countries was to initiate an exploration of the challenges involved in reducing health disparities, and to formulate plans and strategies by working in partnership to develop knowledge that would analyze, assess critically and determine the impact of our shared legacies of colonization and the resulting dispossession of traditional lands, and the ongoing social, political and economic marginalization.

The information shared during the INIHKD meeting highlighted the similarities and differences in health status, epidemiology, key health issues, and trends in health and disease for Māori, Canadian Aboriginal, American Indian peoples and Australian Aboriginal people and Torres Strait Islanders. In response to the health disparities of Indigenous people each colonial government has initiated health policies and programs. The policies and strategies aimed at improving Indigenous health have varied, as have the results. The INIHKD meeting provided an opportunity for participants to learn from sharing each other's approaches, experiences and results.

Knowledge translation was promoted in the INIHKD meeting through activities that were designed to build capacity, stimulate discussion on research, and strengthen and expand on the international knowledge translation system. The aim of the meeting was to commence a process through which the INIHKD will provide opportunities for individuals to translate new knowledge from the research setting to real-world applications. We believe the improvement of the health of Indigenous peoples in Canada, Australia, New Zealand and the United States of America will result from more effective health services and

systems led by Indigenous communities, Indigenous researchers, Indigenous health service providers and Indigenous government policy makers.

The outcomes of the INIHKD meeting have reinforced the importance of having Indigenous peoples located within communities, academic institutions, and governments engaged in a network. Further, the meeting reinforced that the planning and programming of network activities must be led by Indigenous peoples.

The INIHKD meeting fostered knowledge translation across the three themes of

1. Workforce development,
2. Health service models, and
3. Research.

In planning for the inaugural meeting, the Steering Committee developed a time-limited structured program, which sought to facilitate the transfer of knowledge, the sharing of experiences and generation of discussion. The aim was to highlight the similarities and differences between the four countries across the network themes. The steering committee attempted to ensure that there should be broad representation from:

- Indigenous community representatives;
- Indigenous health service providers;
- Indigenous academics from health and other relevant disciplines, and
- Indigenous and non-Indigenous Indigenous health policy representatives from governments.

The meeting resulted in a number of key recommendations and initiated a process to develop the "Gullumbulburra, Declaration on the Health of Indigenous Peoples". This declaration, although under ongoing development, is included within this report (please refer to section reporting the discussions of Day Four on page 32 for further information).

EXECUTIVE SUMMARY

This report is based on the summaries by Dr Reid and the summary teams, and is structured to reflect the conference framework and outcomes.

The presentations during the showcasing and plenary sessions of days 1-3 are included in this report as highlights only, whereas more in-depth information has been provided on the resulting discussions and major issues arising following each of the presentations through breakout sessions. This has mostly been reported in dotpoint form as a conscious attempt to not reinterpret the words as they were recorded in the process.

Recommendations from participants (including Indigenous community, academics and researchers and government representatives) are reported as they arose from the meeting sessions, and are primarily centered on the structure and functions of the International Network of Indigenous Health Knowledge and Development (INIHKD).

This information is presented in the Executive Summary commencing with overall recommendations, followed by the recommendations which arose under each of the three central themes of the meeting.

INIHKD Inaugural Recommendations

Indigenous community representatives recommended that the INIHKD:

1. Needs to take time to develop the capacity to build the infrastructure.
2. Take control and be assertive, and
3. Maintains cognizance of the Indigenous community identified priorities and identified solutions.

Representatives at the INIHKD meeting, who were both Indigenous and non-Indigenous academics and researchers, recommended that the INIHKD:

1. Develop as a collaborative network (via e-mail research committee, website, chat rooms).

2. Advocate for the establishment of funding/proposal submission priorities and processes under the tri-country International Cooperation Agreement (Australian, New Zealand and Canada) - International Indigenous Health Research Cooperation.
3. Establish an ongoing process to discuss how we self-identify as Indigenous people, and
4. Foster discussion, experiential sharing and planning which aims to make research relevant for Indigenous communities.

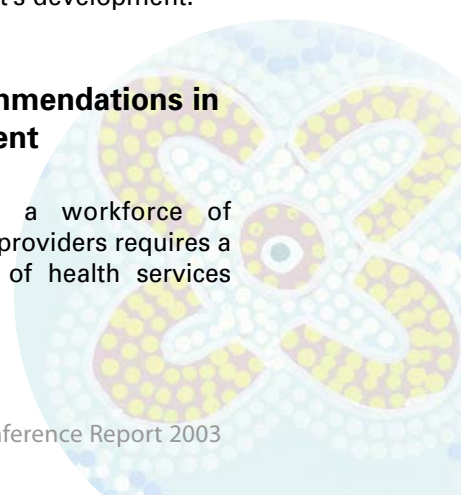
Indigenous and non-Indigenous government representatives who participated in the meeting recommended that:

1. A kanohi ki te kanohi (face-to-face) meeting be held every two years.
2. The host country provide secretariat support for the International Steering Committee, and associated Working Groups, and provide secretariat support for the planning and conduct of the meeting, as well as the production of a proceedings report.
3. Government sector to meet as a sub-caucus concurrent with INIHKD meetings, along with other representative groups, and
4. That intra-government agencies within each country collaborate to fund INIHKD meetings and, in so doing, ensure the continued formalization and capacity of the Network.

The recommendations above arose on day three of the INIHKD meeting and primarily relate to the establishment of the INIHKD and provide the foundation on which the International Steering Committee shall continue to work towards it's development.

Key Issues and Recommendations in Workforce Development

- The development of a workforce of Indigenous health care providers requires a supporting framework of health services



EXECUTIVE SUMMARY

and systems which is culturally competent and self-determining.

- The INIHKD participants acknowledge that a comprehensive Indigenous health workforce needs to encompass clinical services, community engagement, effective administrative and managerial systems, traditional practices and protocols, research activities which are based on best practice, Indigenous community priorities and culturally competent partnerships with research/academic institutions.
- The workforce development crisis has come about as a result of systematic underperformance of educational sectors and mal-distribution of socio-economic determinants. Redress will require the reversal of these mechanisms.
- Harmonization of the relationships between western and traditional health systems must be a priority.
- There is a need for acknowledgement that comprehensive long-term strategic approaches are being initiated by some governments.
- There is an ongoing need to strengthen the alliances and partnerships between Indigenous communities, academic institutions and government agencies.
- Workforce recruitment activities need be turned on their heads (or reoriented) so that communities shape recruitment strategies and measures of success or achievement are changed from a focus on input measures to an output (graduation) focus.
- Retention initiatives need to nurture and prevent burnout in students and graduates within our systems and provide support for ongoing training and professional development.
- Cultural safety of both Indigenous and non-Indigenous health care providers is essential.
- Adequate and long term resourcing commitments to workforce development is

fundamental to minimize the current health disparities between Indigenous and non-Indigenous peoples.

- Within workforce development strategies there is a strong focus on doctors at present but we need to strengthen the focus on nurses and community health workers (as well as other administrators, managers and academics) in strategies.

Key issues and Recommendations in Strengthening Research and Development of Research Priorities in Indigenous Health

- Acknowledgement by INIHKD participants that research has, in the past, been part of colonization (and there are risks that this may continue) whereby Indigenous resources (intellectual, material and process) have been appropriated for the benefit of non-Indigenous peoples and used against Indigenous people.
- We noted the underperformance of the research sector to date with respect to Indigenous workforce development and appropriate information outcomes. Not all of this underperformance is attributed to the failure of the education systems. It can also be attributed to:
 - racist theoretical positioning;
 - the lack of provision of safe cultural environments for Indigenous researchers; and
 - research paternalism.
- All of the factors listed above have contributed to the underperformance of the research sector to date and therefore need to be remedied through the development of strategic initiatives in partnership with Indigenous communities.
- Health inequalities exist; the INIHKD recognizes that research can create, maintain or eliminate inequalities e.g. poor quality of Indigenous data collection in national surveys. In this way, research remains a colonization risk:

EXECUTIVE SUMMARY

- through misrepresentation of our realities;
 - through inappropriate ways of doing and knowing;
 - through misappropriation of our traditional property, knowledge, and culture.
- Throughout the meeting there was a strong recurrent theme about the rights of Indigenous communities to engage with research through a spectrum of processes ranging from control, collaboration, and participation through to the right to understand. This discussion recognized the urgent need to resource Indigenous communities to build capacity to move through this spectrum in order to minimize damage and ongoing impacts of colonization; so as to not only control the research agenda but also to develop and manage our own Indigenous research agenda.

Key issues and Recommendations in Health Service Models

- Within the INIHKD meeting, participants envisioned a future that was premised on our Indigenous right to self-determination in health service delivery. This future is also underpinned by concepts of holistic wellbeing that are not defined, confined or restricted by non-Indigenous models of health, wellbeing or illness.
- Indigenous health services were celebrated as “sites of resistance” where Indigenous realities and ways of knowing were centralized and normalized, not marginalized and pathologized. This elements celebrated included: Indigenous ownership, cultural safety, restorative justice for healing, service and policy development, infrastructure development, comprehensiveness and Indigenous workforce development.
- There was widespread acknowledgement that good intentions, hard work and best practice need to be partnered with appropriate resourcing.

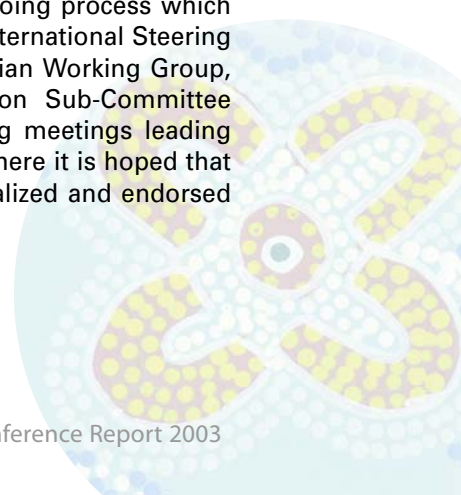
- There was also acknowledgement that Indigenous models of best practice could improve services (by Aboriginal people) for everyone. There is evidence that existing models of service “by non-Aboriginal for Aboriginal, or for everyone” create inequality, but no evidence that “by Indigenous people for everybody” does.

Conclusion

Overwhelmingly the participants at this inaugural meeting reiterated the value and benefits of coming together over the three and a half days of the meeting, and have expressed their ongoing support and commitment to participating in future INIHKD activities and meetings. In line with this support, the International Steering Committee has determined that the second meeting of the INIHKD will be held in 2005, in Vancouver, Canada. A Canadian Working Group was established out of the inaugural meeting in Townsville to work towards the development and conduct of the next meeting.

In the lead up to the second meeting, the International Steering Committee acknowledges that a very important task for the planning is to continue to develop and strengthen our relationships with other Indigenous peoples from within the four countries, eg the Kanaka Maoli (Native Hawaiians) and Alaskan Natives. The committee also acknowledges an ongoing commitment to broaden and strengthen national representation from within each country.

In addition, a Declaration Sub-Committee arising from the INIHKD meeting will continue to progress the ongoing development of the “Gullumbulburra, Declaration on the Health of Indigenous Peoples”. The development of the declaration will be an ongoing process which will be discussed by the International Steering Committee and the Canadian Working Group, along with the Declaration Sub-Committee members in their planning meetings leading up to the 2005 meeting, where it is hoped that the declaration will be finalized and endorsed by INIHKD participants.



OVERVIEW



During October 2003 Australia hosted the inaugural biennial meeting of a unique new international network established by Indigenous health workers, researchers and planners to improve the health of Indigenous populations around the world. This meeting was held in Townsville, north Queensland.

The International Network of Indigenous Health Knowledge and Development, INIHKD, is comprised of Indigenous researchers, academics and community representatives from Australia, Aotearoa (NZ), Canada and the United States and aims to address continuing disparities between the health of Indigenous people and the non-Indigenous populations of these four countries.

In each country the legacies of colonial dispossession, forcible relocation, suppression of Indigenous cultural practices, values and beliefs, and other factors, have resulted in Indigenous peoples experiencing a deplorable health status compared to non-Indigenous settlers. Remarkable similarities in health status, epidemiology, key health issues, trends in health and disease and the causal syndemic factors that underlie these findings are evident in Australian Aboriginal and Torres Strait Islander, Māori, Canadian Aboriginal, Kanaka Maoli, American Indian and Alaska Native peoples.

The policies and strategies designed by the governments in these countries to manage Indigenous health have varied, as have the results. Despite significant improvements in health in a number of Indigenous populations since the 1970s, considerable differentials remain. Current mortality rates for all causes combined remain substantially higher than non-Indigenous rates, with the rate for Native Americans being 1.6 times, Canadian Indians 1.4 times, New Zealand Māori 1.8 times and Australian Indigenous people 3.4 times the total Australian rate.

The INIHKD is based on the central tenet that leadership by Indigenous peoples is fundamental for effective management of Indigenous health. The Network was therefore established to open up an international dialogue that would allow Indigenous communities, academics, health care providers and policy makers from each country to share approaches, experiences and results.

The ultimate aim of the INIHKD is to translate this knowledge from the research setting to real-world applications in order to provide more effective health services and strengthen health care systems, thereby improving the health of Indigenous people.

The themes of the Townsville conference, hosted by the James Cook University Aboriginal and Torres Strait Islander Health Unit, were selected to help facilitate Indigenous leadership and international collaboration on workforce development, health services models and research processes. It also provided the opportunity for setting the scene, to identify commonalities and differences, priorities and challenges for partnerships in the future, and to strengthen existing networks.

CONFERENCE FRAMEWORK

This meeting was conducted as a four day conference and was structured to maximize the sharing of knowledge and experiences from the participating delegates, including Indigenous Elders. On commencement of the meeting, welcome to the participants was offered by Elders of the traditional owners, and throughout the meeting other Aboriginal and other Indigenous Elders assisted the process by providing guidance and advice.

The meeting sought to integrate experiences around three themes, within a framework of plenary sessions for each theme, with one speaker from each country providing a brief overview of the current situation regarding the theme in their country, a description of currently funded and planned strategies, and the emerging issues for that theme.

The three themes were:

- Workforce Development
- Research
- Health Service Models

After each plenary, the conference delegates worked in groups to construct a reflective critique of the issues for each theme in a way that aimed to integrate the unique experiences of each of the participating countries. These critiques were reported back to the larger conference group to facilitate wider conference discussion and consensus-forming on the outcomes. A small team of steering committee members and individuals were nominated to record and provide summaries of these feedback sessions, and Dr Papaarangi Reid provided a daily summary of the entire proceedings to the conference participants.

This report is based on the summaries by Dr Reid and the summary teams, and is structured to reflect the conference framework and outcomes.

During the proceedings of the meeting, nursing practitioners who were in attendance initiated an Indigenous Nursing and Midwifery

Caucus, whose first meeting was held during the INIHKD meeting to discuss issues relative to Indigenous health and nursing. A summary of the Caucus discussions is attached in Appendix H.

In brief the framework was:

→ DAY ONE:

Showcasing positive strategies/models of service from the non-government and government sectors of each country, including a site visit to the Townsville Aboriginal and Islanders Health Services. In addition, a presentation to the delegates at the welcome reception provided an overview of the health status of the Indigenous peoples of the four countries.

→ DAY TWO:

Plenary, groups and feedback sessions on Workforce Development, and Strengthening Research and Development of Research Priorities in Indigenous Health.

→ DAY THREE:

Day three was split into:

- 1 Plenary, groups and feedback sessions on Health Service Models - summary provided by P Reid
- 2 International Health Initiatives. This session involved focused group work around each theme, as well as the processes to progress the themes across the four countries.
- 3 Presentation of the Draft Declaration, for discussion on Day 4

→ DAY FOUR:

Dr Reid led discussion towards the development of a process to refine and adopt an International Indigenous Health Declaration, followed by the closing ceremony.

DAY ONE

Showing positive strategies/models of service from the non-government and government sectors of each country, including a site visit to the Townsville Aboriginal and Islanders Health Services. In addition, a presentation to the delegates at the welcome reception provided an overview of the health status of the Indigenous peoples of the four countries.

Non-Government Sector Showcase

Session Chair: Dr **Helen Milroy**, Australia

AUSTRALIA: Mr **Chris Bin Kali**

Director, National Aboriginal Community Controlled Health Organisation, NACCHO Chair, Kimberley Aboriginal Medical Service, KAMSC

National Aboriginal Community Controlled Health Organisation

AOTEAROA (NZ): Ms **Diane Gibson**

Kai Arataki (Chief Executive) Ngati Porou Hauora

Māori Health – Towards Tinorangatiratanga

CANADA: Dr **Barry Lavallee**

Senior Physician, Aboriginal Health and Wellness Centre of Winnipeg Inc.

Indigenous Community Based Health Program

UNITED STATES OF AMERICA: Ms **Nancy Miller Korth**

Great Lakes EpiCenter Coordinator, Great Lakes Inter-Tribal Council Epidemiology Center

Native American Research Initiatives

Government Sector Showcase

Session Chair: Dr **Barry Lavallee**, Canada

AUSTRALIA: Ms **Helen Evans**

First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, OATSIH

National Overview of Aboriginal and Torres Strait Islander Policy and Strategy in Australia

AOTEAROA (NZ): Ms **Rangi Pouwhare**

Manager, Ministry of Health

He Korowai Oranga / Māori Health Strategy

CANADA: Dr **Jay Wortman**

Regional Director, Health Canada

Overview of FNIHB Policy and Strategies

UNITED STATES OF AMERICA: Dr **Kathleen R Annette**, M.D.

Area Director, Indian Health Service

Overview of NIH Policy and Strategies for Native American and Alaskan Indigenous Health

Health Status Overview

Session Chair: Mr **Michael Adams**, Australia

Dr Ian Ring and Associate Professor Jacinta Elston, Australia

A comparative overview of the health status of the Indigenous peoples of Australia, Aotearoa (NZ), Canada and the United States of America.

International Comparisons of Indigenous Morality

Substantial reductions in mortality have occurred in the Indigenous populations of Canada, the USA and New Zealand since the 1970's. Notwithstanding these improvements, current mortality rates for all causes combined remain substantially higher than non-Indigenous rates, with the rate for Native Americans being 1.6 times, Canadian Indians 1.4 times, New Zealand Maoris 1.8 times and Australian Indigenous people 3.4 times the total Australian rate for example. Circulatory, respiratory and endocrine conditions, injury and poisoning and neoplasms are responsible for 78-88% of the total deaths and 66-92% of the excess deaths in the indigenous populations of these four countries. The major causes of excess mortality in US and Canadian Indian populations remains injuries and circulatory conditions although there have been substantial reductions in both conditions for both populations. The major causes of excess mortality in New Zealand Maoris are circulatory conditions, neoplasms and endocrine conditions, though there have been substantial reductions in mortality from circulatory conditions and neoplasms. The major causes of excess mortality in the Australian indigenous population are circulatory, respiratory and conditions, though there has been considerable reductions in respiratory mortality. Mortality from endocrine conditions and neoplasms is increasing in all indigenous populations other than New Zealand Maoris. These continuing similarities are differentials suggest the need for indigenous leadership and international collaboration on the Network themes of workforce development, health services models and research processes.

Summary of Day One

- The need for governments to protect the inherent sovereign rights of Indigenous people.
- Issues with the definition of Aboriginal peoples and their recognition by governments without acknowledgement of our Indigenous right to name ourselves and be counted.
- Problems with minoritisation of Indigenous people (democracies). Moana Jackson – even if only one Indigenous person remains she would have all the rights of Indigenous peoples – not marginalized by proportionality.
- Acknowledgement of disparities/ inequalities but the gaze was often on need not on the greed.
- (If we don't belong to the biological determinants school) then disparities represent systems where some people are privileged by the appropriation of an unfair share of health resources and benefit.
- Clear statements of government objectives and policies support and acknowledge the right of Indigenous people to monitor the performance of governments and their policies and practices.
- While disparities in health outcomes were acknowledged – little movement on the acknowledgement of disparities in resourcing both at an absolute level and then, more importantly, in proportion to need.



Plenary, groups and feedback sessions on Workforce Development, and Strengthening Research and Development of Research Priorities in Indigenous Health.

Workforce Development

Session Chair: Dr **Karina Walters**, United States of America

AOTEAROA (NZ): Dr **Sue Crengle**
Head of Discipline, Māori
University of Auckland, Department of Māori and Pacific Health

Training, education and workforce development in Aotearoa/New Zealand

CANADA: Ms **Bernice Downey**
Policy Analyst
National Aboriginal Health Organisation, NAHO

Aboriginal Health Human Resources: "A pillar for the future"

UNITED STATES OF AMERICA: Ms **Joyce Naseyowma-Chalan MPH**
Director, Public Health Division, New Mexico State Department of Health

The Challenges faced in State Health Departments

AUSTRALIA: Dr **Ngiare Brown**
The Australian Indigenous Doctors' Association
Member, Aboriginal and Torres Strait Islander Health Workforce Working Group

Indigenous Health: Moving from Rhetoric to Reality

Questions for Workforce Development breakout session

1. How do we Indigenise the health workforce?
 - a. Recruitment and retention?
 - b. What are the political and cultural tensions?
 - c. What challenges does this present to traditional health disciplines?
2. What's the relationship between Indigenous knowledge and culture, and Indigenous health workforce development?
3. Is there a link between self-determination and Indigenous health workforce development? What is it?

Breakout Session Outcomes

Questions for Workforce Development breakout session:

QUESTION 1.

How do we Indigenise the health workforce?

a. Recruitment and retention

- Recruitment:
 - Begin early, school, primary or elementary
 - Affirmative action/quotas
 - Bridging progress
- Retention:
 - In university, etc – develop our own training institutions e.g. Wananga
 - Needs commitment and financial support to retain

DAY TWO

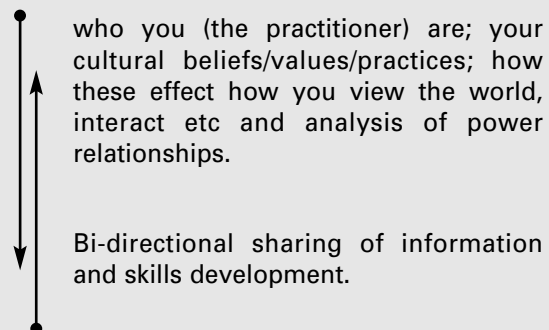
- Support programs for students/address poverty
- Needs of people from remote/distant regions
- Mentoring/role models
 - Nurturing and mentoring and role models – early school through to advanced training.
- Need career pathways, ongoing training and development.
- Community health workers – key features. Issues around training, competencies, regulation etc. Need career structure. Recognition prior learning.
- Gender issues in health workforce – men are small in number
- Health and wellbeing of Indigenous workers
 - How to ensure / protect
 - Multiple obligations
- Career pathways – recruit young and mature people. Career pathways at all levels of workforce.
- Broad focus on workforce, including:
 - Policy makers
 - Researchers
 - Managers
 - Community health workers
 - Doctors, nurses and other clinicians, midwives, etc
 - Public health
 - Academics

b. What are the political and cultural tensions?

- Medical paradigm dominance.

- In all countries focus on sickness and medical interventions rather than for health and healing e.g. health promotion.
- Struggles/issues associated with working in your own community.
- Health training doesn't reflect Indigenous values. Need to identify potential intersection between Indigenous views on health and medical paradigm. OR need to transform system.
- Indigenous people more likely to be able to integrate their western training and Indigenous culture and knowledge.
- Valuing who/how/what we are as Indigenous people.
- Need performance indicators for institutions.
- Cultural safety and cultural competence.

Cultural safety:



Cultural competence

Providing effective health care to a culturally diverse patient population.

c. What challenges does this present to traditional health disciplines?

Traditional healers – standards/quality

Has been done by them – should be done by them

Interface with western medicine / health paradigm

DAY TWO

QUESTION 2.

What's the relationship between Indigenous knowledge and culture, and Indigenous health workforce development?

- There needs to be acknowledgement of our Indigenous cultures at all levels including policy, planning and training.
- Our culture drives workforce development. Workforce development is the end result of what you want your community wants.
- Workforce development is the result of education and processes determined by the community.

QUESTION 3.

Is there a link between self-determination and Indigenous health workforce development? What is it?

- Is there a link between self-determination and Indigenous workforce development? YES! Can't have one without the other. Define our own health workforce needs and own strategies to meet them.
- Community to be involved in the identification of workforce needs and the potential trainees/workers
- Research to clarify workforce development opportunities and outcomes.
- Need to partner with other programs, tribes, Indigenous communities.
- We need to define self-determination for ourselves and not be declared from the outside.
- The government needs to embrace self-determination.

Summary of Workforce Development – Day Two

During the daily summary, Dr Reid reported on:

- The development of a workforce of Indigenous health care providers necessitates a supporting framework of health services and systems, which is culturally competent as part of self-determination.
- An acknowledgement that a comprehensive Indigenous health workforce needs to encompass clinical services, community engagement, effective administrative and managerial systems, traditional practices and protocols, research activities which are based on best practice, Indigenous community priorities and culturally competent partnerships with research/academic institutions.
- That the workforce development crisis has come about by systematic under-performance of educational sectors and maldistribution of socio-economic determinants. Redress will require the reversal of these mechanisms.
- Harmonisation of the relationships between western and traditional health systems is a priority.
- Comprehensive long-term strategic approaches are being initiated by some governments.
- There is a need to strengthen the alliances/ partnerships with communities and institutions (government/government, government/institution relationships) and non-Aboriginal colleagues.
- Recruitment issues:
 - Need to turn this on its head so that communities shape recruitment.
 - Input measures are changed to output (graduation) focus.

DAY TWO

- Retention issues
 - Nurture and prevent burnout.
 - Support ongoing training.
- Cultural safety of both Indigenous and non-Indigenous health care providers is essential.
- Adequate resourcing of workforce development is fundamental to minimize the current disparities.
- There is a strong focus on doctors at present but we need to acknowledge nurses and community health workers [as well as other administrators, managers and academics] in strategies.
- Recognition given to the role doctors often play in unlocking some of the gate keeping barriers for our communities, and remain cognizant of the dangers of that this gate keeping role plays in colonizing us.
- Acknowledgement of the medium to long-term moves to develop our own training organizations, curriculum and systems.

Strengthening research and development of research priorities in Indigenous Health

Session Chair: Dr **Jeff Reading**, Canada

UNITED STATES OF AMERICA: Dr **Francine C Romero**, PhD, MPH
Epidemiologist
Northwest Portland Area Indian Health Board

United States American Indian and Alaska Native Research Initiatives

AOTEAROA (NZ): Ms **Moe Milne**
Chair, Māori Health Committee, Health Research Council, and
Ms **Louisa Wall**
Kaiwhakahaere Rangahau Hauora, (Manager,

Māori Health Research) Health Research Council of New Zealand

Strengthening Indigenous Research and Priority Setting

CANADA: Dr **Judith G Bartlett**
Associate Director, Centre for Aboriginal Health Research

Indigenous Research Capacity in Canada: "Major recent gains – still some way to go"

AUSTRALIA: Dr **Sandy Eades**
Senior Research Fellow, Menzies School of Health Research

Strengthening research and development of research priorities in Indigenous research – The NHMRC Roadmap: A strategic framework for improving Aboriginal and Torres Strait Islander health through research

Questions for Strengthening Research breakout session:

1. What are the dangers and benefits of health research?
2. What is the relationship between Indigenous knowledge and research?
 - a. How do we make research appropriate for Indigenous communities?
 - b. How do we make Indigenous research appropriate for Indigenous communities?
 - c. What is appropriate?
3. How do we integrate Indigenous knowledge into health research?
 - a. Is the context in which research is conducted an issue (university-based, community-based, etc)?
 - b. What sorts of processes are important to enable Indigenous peoples to bring their knowledge to the research process (community involvement in priority

DAY TWO

setting, research implementation, what types of things help build collaborations, etc)?

- c. How might Indigenous values drive the ethics of research?

Breakout Session Outcomes

QUESTION 1.

What are the dangers and benefits of health research?

- Dangers:
 - Intellectual expropriation, exploitation and the legal costs of protection from that
 - Who owns information: No sharing of data with indigenous communities versus communities owning and not releasing important data/information
 - Communities stigmatized by results of data
 - Misinterpretation of data: lack of historical and social context of research outcomes
 - More dangers:
 - Some research may be motivated by a bad political agenda
 - Research done not necessary translated into program outcomes
 - Community not having input into setting own research agenda
 - Health information portabilities – accountability act in the USA recognizes the individual right of where info goes – it must have prior permission.
 - Danger of research compromising the country's privacy act.
 - Research funds wasted if don't have community input / partnership
 - Role of indigenous researches minimized
 - Exploiting junior native researchers in granting environment
- Competing with other minority/ethnic groups for the research dollar is hurtful, unhealthy and creates animosity
- Evidence-based research can restrict us in clinical practice
- People building research careers out of Indigenous research with no results/outcomes coming back to the community = profiteering
- Benefits
 - We need research in order to reduce disparities
 - Research can be a method to document and protect traditional rights medicine, intellectual property etc.
 - Reclaim and restore cultural knowledge and ways of knowing.
 - If done right can be empowering by increasing community capacity
 - We have the opportunity to do purpose-based research with benefits to the community
 - Research is definitely a tool for advocating for communities and seeking resources – it effects policy
 - Can explore the issue of community consent as well as individual consent
 - Can provide a platform for the development of Memorandums of Understandings and Partnerships
 - Contribute to quality improvement in health care services
 - Can help us identify the things we do well
 - Can reflect on treaty obligations to indigenous peoples
 - Can positively influence mainstream models, philosophy – native wellbeing = public wellbeing
 - Help us realize our dreams and aspirations, understand the impact of loss, trauma, and health i.e. colonization.

DAY TWO

- Stimulate protected funding specifically for indigenous health needs.
- Address issue of political poverty resulting in political balance
- Possibility to ensure that resilience research, traditional governance systems and elders' stories for setting direction/gets profiled

QUESTION 2.

What is the relationship between Indigenous knowledge and research?

a. How to make research more appropriate to Indigenous communities?

- In order to be appropriate research it must include:
 - Time
 - Consultation
 - Community driven
 - Explanation and understanding
 - Translation into outcomes
 - Participation
 - Indigenous Value driven and community ethics driven
 - Ownership
 - Needs to be transparent
 - If its not community driven, topic may not be of interest to community
 - Recognize the limits of indigenous researchers face within the academy, lack of funding, etc
 - Must recognize starting point of mistrust
 - Theorizing, exchange of information
 - Deep engagement
 - Code of ethics
 - Respect
 - Defined benefits for community

- Penalties for those who don't comply
- Emancipatory and empowering leadership

b. How do we make Indigenous research appropriate for Indigenous communities, and what is appropriate?

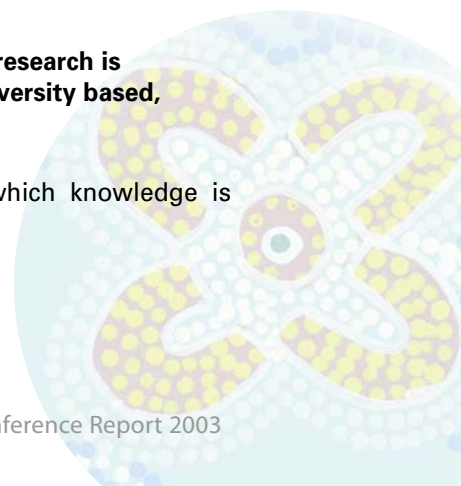
- Research needs to be defined for each community, what does this mean for community?
 - Increasing qualitative versus quantitative and other methodologies
 - Needs to be capacity building process
 - Community participation in research needs not to be a drain on community services and community staff and programs
 - Community as PI
 - Encompassing diversity
 - Illness VERSUS wellness
 - Definition of community may differ between research and community
 - Research is superficial and indigenous knowledge is deep engagement
 - Lived experience versus conceptualization
 - Communities may be more interested in healing than in researching
 - Esoteric questions versus community grounded healing or living processes
 - Focus on diversity of community and differences in health research needs

QUESTION 3.

How do we integrate Indigenous knowledge into research?

a. Is the context in which research is conducted an issue (university based, community based etc)?

- The process through which knowledge is power



DAY TWO

- Universities versus community organizations
- Process and context needs to be influenced by indigenous knowledge
- Reciprocity = needs to be part of process of research
- Production of knowledge development e.g.; research process determines what are the results and how results are used
- Integration is accomplished by having community models and world views
- By community initiated research
- By clearly developing community university partnerships
- By clearly setting out the ethics of research before starting research

b. What sorts of processes are important to enable Indigenous peoples to bring their knowledge to the research process (community involvement in priority setting, research implementation, what types of things help build collaborations, etc)?

- Focus on resiliency
- Interface between community, practice and policy
- Ensuring community is at beginning of process
- Controlling dissemination
- Recognizing urban communities
- Recognizing researchers as members of communities
- Recognizing research can uncover negative findings
- Bilingual publications

c. How might Indigenous values drive the ethics of research?

- Indigenous community partnerships with research institutions
 - Institutions are responsible for developing safe practices and structures
 - Tribes contract researchers; trust is crucial
 - Elders and community representatives to be involved as advisers in research projects
 - Validating the existence and inherent value of Indigenous knowledge sharing through oral traditions, ceremony and dance
- Community ownership over research question, data and results in order to maximize the synergy between research outcomes and community values.
- Indigenous researchers from Indigenous communities reflect community values enabling self determination for communities in research activities.

A presentation on the Canadian, New Zealand and Australian International Cooperation Agreement - International Indigenous Health Research Cooperation

Dr **Jeff Reading**, Scientific Director
Canadian Institute of Health Research –
Institute of Aboriginal Peoples' Health

*International Cooperation Agreement -
International Indigenous Health Research
Cooperation*

Dr Reading provided an overview of this initiative for participants. Further information is available at:

<http://www.cihr-irsc.gc.ca/e/25134.html>
or

DAY TWO

<http://www.nhmrc.gov.au/funding/si.htm>
or
<http://www.hrc.govt.nz/assets/pdfs/coopagreemement.pdf>

Summary of Research – Day Two

During the daily summary, Dr Reid reported on:

- There was an acknowledgement that research has in the past been part of colonization (and there are risks that this may continue) whereby Indigenous resources (intellectual, material and process) have been appropriated for the benefit of non-Indigenous peoples and used against Indigenous people.
- That colonization within some research paradigms presents deficit and victim blaming analyses of our current situations to the detriment of our communities.
- Most presenters noted that research is not a post colonial phenomenon. Indigenous peoples, like all people, have long traditions of research. Our survival and development was not due to a unique series of accidents but rather a reflection of a series of highly refined, socially moderated systems.
- As such, systems of research continue to be one of our Indigenous rights for development. In this setting it is also seen as a tool for development and health sector reform.
- We noted the underperformance of the research sector to date with respect of Indigenous workforce development and appropriate information out-comes. Not all of this was solely due to the failure of the education systems but can be attributed also to:
 - racist theoretical positioning
 - the lack of provision of safe cultural environments for Indigenous researchers and

- research paternalism

- All these factors have contributed to the underperformance of the research sector to date and therefore need to be remedied through the development of strategic initiatives in partnership with Indigenous communities.
- Government research bodies are in the process of preparing comprehensive strategic planning with shifts that include significant support for Indigenous workforce development and Indigenous community controlled and initiated research agendas. However while this step is applauded, one can't help but note that there is a continuing disparity in the allocation of research resources and power during research decision-making.
- Especially while health inequalities exist – recognize that research can create, maintain or eliminate inequalities e.g. national surveys.
- In this way, research remains a colonization risk
 - through misrepresentation of our realities
 - through inappropriate ways of doing and knowing
 - through misappropriation of our traditional property, knowledge, and culture
- There was a strong recurrent theme about the rights of Indigenous communities to engage with research through a spectrum from control, collaboration, participation through to the right to understand.
- This discussion recognized the urgent need to resource Indigenous communities to move through this spectrum in order to minimize damage and colonization... so as to not only control the research agenda but also to develop and manage our own Indigenous research agenda.

DAY THREE

Day three was split into:

1. Plenary, groups and feedback sessions on Health Service Models – summary provided by P Reid
2. International Health Initiatives. This session involved focused group work around each theme, as well as the processes to progress the themes across the four countries.
3. Presentation of the Draft Declaration, for discussion on Day 4

Health service models

Session Chair: Dr **Rhys Jones**, Aotearoa (NZ)

CANADA: Ms **Josée Lavoie**
Research Associate, Centre for Aboriginal Health Research, Winnipeg

First Nations in Canada: Self-government or governance by contract

UNITED STATES OF AMERICA: Dr **Gayle Dine'Chacon**, M.D.
Director, Center for Native American Health
University of New Mexico Health Sciences Centre

USA Health Care System

AUSTRALIA: **Rachel Atkinson**
Chief Executive Officer, Townsville Aboriginal and Islanders Health Services Limited
Health Service Models and Aboriginal and Torres Strait Islander People

AOTEAROA (NZ): Dr **Sue Crengle**
Head of Discipline: Māori, University of Auckland, Department of Māori and Pacific Health

Māori primary care services

Questions for Health Service Models breakout session:

1. What is an effective Indigenous health service model?
2. What are the accountabilities of government its agencies and Indigenous health services?
 - a. What are the accountabilities of services to government and community?
 - b. What are the tensions between being accountable to government and community?
 - c. What accountabilities do governments have to communities and services?
3. How do we ensure quality in Indigenous health care? What is quality in indigenous health care?
 - a. What is quality in indigenous health care?
 - b. How do we measure it?
 - c. What types of processes are required to build quality care?

Breakout Session Outcomes

QUESTION 1.

What is an effective Indigenous health service model?

- A service for and by Indigenous people
- Components include:
 - Lifelong: birth to old age,
 - Comprehensive (lifestyle, prevention, counselling and primary medical care, social support);
 - Inclusive of traditional healing practices

DAY THREE

- transport and financially free services to consumers
 - outreach services
 - training systems and supportive frameworks for health workforce
- A service with the following values and principles:
 - Indigenous language
 - Indigenous values, beliefs and protocols (dignity, self esteem and compassion built within a holistic approach)
 - Protocols/beliefs created by staff for (health service) with Management/Board approval
 - Non-profit organizations
 - Tribally driven (indigenous priorities) and Indigenous community control of governance – where all community members have equal opportunity to participate in the decision making processes of the service
 - Lead by indigenous policy makers and managers
 - Respectful of elders', their wisdom and counsel
 - A service that encompasses the following structures and processes:
 - Systematic planning, which included consultative processes with all staffing levels within the organization
 - Horizontal organization – emphasis on equality
 - Links to other services including hospitals to achieve aims
 - Provider and consumer representation on Management, Boards and regional council
 - Support from tribal and other lead indigenous agencies to advocate for health services and resources

- Acknowledgment that developing effective health service models is not easy and that long term planning and resourcing is required.

QUESTION 2.

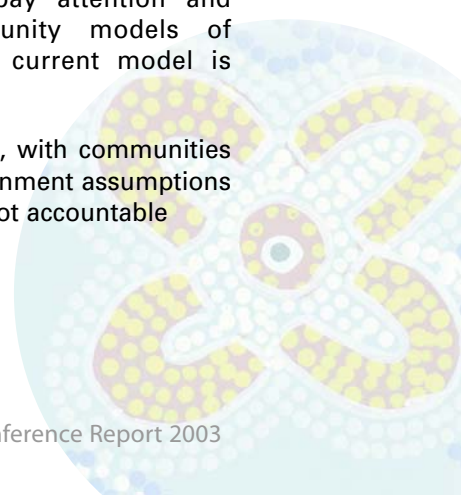
What are the accountabilities of government its agencies and Indigenous health services?

a. What are the accountabilities of services to government and community?

- Acknowledge that Australians do not have formal sovereignty by treaty status
 - Government has different values, and vested interests, it expects conformity, and provides no reciprocity
 - Labels, measures and processes associated with accountability can reinforce negative perceptions and need to be questioned e.g. high fertility and teenage pregnancy rates perpetuate the negative labeling for communities

b. What are the tensions between being accountable to government and community?

- Tensions exist within the indigenous community e.g. between service providers and academics; between community and service providers
- There are different concepts of accountability across indigenous and non-indigenous communities – a mismatch of values, ways and practices e.g. community people give 24/7 and accountability concepts can have different meanings to diverse indigenous groups, government people observe business hours; government should pay attention and resource the community models of accountability as the current model is colonial in it's nature
- There is a lack of trust, with communities often experience Government assumptions that communities are not accountable



DAY THREE

- Broad acceptance that accountability has its place but that the implications from the results of measures of accountability can have negative effects on services and communities (e.g. closing services)
- Who makes government accountable for their responsibilities and their promises???
- Government often provide no opportunity for Indigenous communities to monitor government performance
- Evaluation of performance with Ministers and political leaders pressing for budgetary and performance outcomes in service delivery lead to one way accountability. This highlights the importance of contractual arrangements and communities having sound understanding of “self administration” in all it’s implications as this can lead to governments distancing themselves from their accountability to communities
- Resources that flow from need as defined by government is never sufficient

c. What accountabilities do governments have to communities and services?

- There is a lack of adequate consultation that must be responsible and respect the diversity of indigenous peoples
- Governments need to resource indigenous people to define own health need and be accountable to deliver on those needs as defined by indigenous peoples, not by governments
- Government funding formulas need to be equitably reformulated to take account of the burden of illness and costs of service provision in the various Indigenous communities by means that are flexible and responsive
- Indigenous people have the right to gain access to health services which are cultural competence irrespective of political border and geographic locations
- Indigenous people need to be there to change these issues at every level of the system
- Governments need to demonstrate their accountability to both the Indigenous communities and the broader populations in their countries, by reporting on government performance and health outcomes for Indigenous people (report outcome)

QUESTION 3.

How do we ensure quality in Indigenous health care?

a. What is quality in indigenous health care?

- Those who define quality and set the vision need to be culturally appropriate, culturally safe and engender cultural ownership and participation by Indigenous people
- Quality in Indigenous health care includes technical and clinical processes, which must be about eliminating health disparities through the engagement of dynamic concepts with universal values such as appropriateness, access, control, participation, effectiveness, and ownership; it’s important to define these from an indigenous perspective
- Adequate and appropriate funding is required to achieve quality services
- The provision of quality Indigenous health service demands a shift from crisis management modes, through to one more reflective with continuous and planned management processes and strategies which are embedded in service delivery
- Quality requires holistic health care values and must reflect community and community diversity
- Aspects include: accessibility (financial, cultural, geographical), efficient, cost effective, safety, evidence based practice and practice based evidence,

DAY THREE

- Value based
 - Quality is not static and engages in an iterative process of learning and informing the health care system
- b. How do we measure it?**
- See above for aspects of measurement – but relies on careful definition
 - Avoid health status indicators, use process indicators
 - Qualitative and quantitative measures e.g. participation/engagement (retention)
 - Consumer feedback – including comfort, easiness
 - Services need a systematic approach to measure intermediate outcomes
 - Advocacy for an indigenous process with critical analysis of service and elements, processes
 - Within a community framework, community focused, broader than individual e.g. healthy individual linked to healthy family to healthy community
 - Need continuous quality improvement processes e.g. health disparities collaboratives that incorporate plan/do/study/act cycles
 - Indigenous accreditation processes
- c. What types of processes are required to build quality care?**
- Broader impacts on quality – e.g. resource allocation decisions – emphasis on acute care vs prevention
 - Indigenisation of workforce
- Balance with traditional
 - Dependent on appropriate underlying structures i.e. service model; client community and workforce participation in governance; indigenous leadership at all levels
 - Requires harmony i.e. good communication and relationships at all levels between agencies and government (indigenous and non-indigenous)
 - Challenging structures and processes that impede quality
 - Community monitoring and development
 - Include non-indigenous input by people deemed appropriate by community
 - Community relationship input on-going
 - Long term focus necessary
 - Quality development crucial
 - Governance and control of services is crucial, balanced by government resourcing and taking responsibility for ensuring on-going viability
 - Community governance depends on capacity within community
 - Integrity and ability of key people in management is crucial
 - Alternative processes of governance may need to be considered – alternative to the often tokenistic processes offered to Indigenous people.



DAY THREE

Summary of Health Service Models – Day Three

During the daily summary, Dr Reid reported on:

- Acknowledge our common experience of comprehensive disparities (including in health) as a result of our colonial histories, and present circumstances.
- Our determination and commitment is necessary to ensure our future is not envisioned as a colonial future.
- Providers envisioned a future:
 - that was premised on our Indigenous right to self-determination;
 - on holistic wellbeing not defined, confined and restricted by non-Indigenous models of health, wellbeing or illness.
- Indigenous health services were seen to be “sites of resistance” where Indigenous realities and ways of knowing were centralized and normalized (and celebrated) not marginalized and pathologised. This included: Aboriginal ownership, cultural safety, restorative justice for healing, service and policy development, infrastructure development, comprehensiveness and Indigenous workforce development.
- There was an acknowledgement that good intentions, hard work and best practice need to be partnered with appropriate resourcing.
- That Indigenous models of best practice could provide services (by Aboriginal people) for everyone. There was plenty of evidence that by non-Aboriginal for Aboriginal or for everyone creates inequalities, but no evidence that by Indigenous people for everybody does.

International Indigenous health initiatives

Session Chair: **Marie Allen**, United States of America

Delegates were grouped into community, academics and government to facilitate focused group discussions on the following areas, with the intention of utilizing outcomes to set future goals prior to the end of the conference:

- Health services
- Workforce development
- Research
- Processes

Breakout Session Outcomes

Government Session

Key recommendations:

1. A *kanohi ki te kanohi* (face-to-face) meeting every two years.
2. Host to provide secretariat support and an output of meetings to be a coherent proceedings booklet.
3. Government sector to meet in association with Network meetings.
4. That intro government agencies within each country collaborate to fund Network meetings and in so doing ensure the formalization of the Network.

Key challenges:

- Negative community perception of government agents.
- Indigenous peoples in key Indigenous specific and generic leadership and decision-making roles.

DAY THREE

- Inter-country agency collaboration as a prerequisite to inter-country collaboration.
- What is the role of Indigenous bureaucratic change agents – to change government policies to fit into community practices and processes.
- Importance of management and governance support to institute change.
- Consultation should be factored into a relationship between communities and agencies on an annual cyclic basis not as and when the agencies determine.
- We need to engage with our non-Indigenous counterparts and facilitate a space for mutual interaction within the Kaupapa/remit of Indigenous health.
- We need to develop frameworks that ensure policies that benefit Indigenous peoples are system reliant not individual reliant or change with political changes.
- Government agency processes and procedures must enable Indigenous communities to fully participate as providers of services to meet the needs of communities, and ensure a diversity of Indigenous community participation.

Conclusion

The participating government agents commit to:

- Operationalising translated research findings into policy.
- Working together to develop international Indigenous benchmarks in areas such as:
 - Workforce (set targets)
 - Funding models
 - Outcome and accountability indicators re performance.

An agency committee will be formed as a central point for information dissemination within each country via an e-mail network.

We need an inclusive Network to enable other Indigenous peoples to participate in collaborating to improve Indigenous health outcomes globally.

Community Perspective

What can we learn from each other?

- Nations sharing thoughts, ideas, training initiatives and service models.
- Language preservation and community exchange programs.
- Self-help initiatives.
- International networking to share/develop strategies.

Health Services

- By Indigenous, FOR Indigenous in governance, management and service delivery
 - Appropriate infrastructure to deliver services.
 - Focus on workforce, recruitment and retention.
 - Needs based service provision
 - Increase Indigenous community capacity to provide services from own planning
 - Appropriate remunerations and systems resourcing are required to enable workers in the community to have an improved capacity to respond to community needs
 - Community health workers are always placed on any new initiatives but get very little money to provide training; they are the lowest paid and will get burnt out quickly.

DAY THREE

- Diversity of needs to be considered
 - Isolated versus urban areas.
 - Processes for delivery
 - Adequacy of access to resources, comprehensive services, medication and traditional medicine and healing
- What works in our community
 - Resources exist in our community, the people, and the health workers come from the community.
 - Promoting our community successes, our values and principles, and demonstrating our diversity.

Problem

- Adequate funding affected by many issues including racism, lack of political will, competing international and national agendas such as education, housing, welfare, and the international wars.
- Indigenous providers are forced to be like mainstream providers by not being adequately resourced with workers to implement programs
- The conference has talked only about recruiting and retaining doctors, what about the Community Health Representatives/Workers, nurses, health administrators, social workers, mental health workers, etc?

Political advocacy

- Community needs to strategize/organize
- Need to step up the action by lobbying across sectors and use evidence as a rationale to increase resources
- Resources and research need to be used to meet community needs through appropriate interventions, by:

- Putting community on the government agency
- Accountability of government to communities
- Equitable partnership as consultation is mutually beneficial e.g. annual consultation meetings
- People being allowed to be people.

Workforce development

- Indigenous participation in all roles and at all levels in the delivery of health services
- Developing an Indigenous workforce at the Indigenous community level that focuses on the importance of retaining language essential to wellbeing.

Research

- Emphasis on intervention research versus descriptive research
- Appropriate and timely dissemination of research findings

Key recommendations

1. Need time and capacity to build the infrastructure.
2. Take control – be assertive.
3. Community identified priorities and community identified solutions.

Academics/Researchers (2 groups)

- Community and Researcher Relations
 - Climate in academic institutions is so different from community
 - There is a need to regain the trust of community relative to research

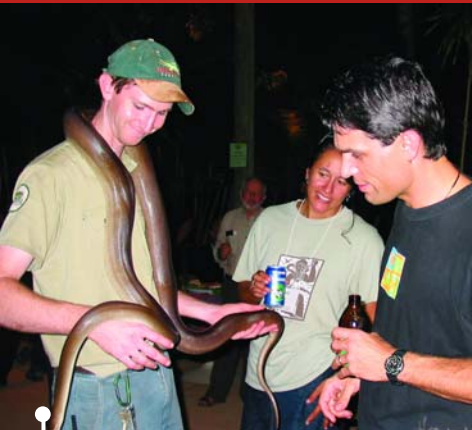
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DAY THREE

environment through stepping back to start new relationships

- Some tribal/Indigenous research groups (including IRBs) hesitate to share information
- Need to rethink the structure of partnership arrangements and how to engage community in a respectful process
- A lack of standardized data collected across communities affects research outcomes, policy planning, priority setting and health outcomes. These are the challenges of doing research with communities in which the research/government systems does not provide equity in adequate data collection systems and implementation and training resources
- In the situation of urban Indians being punished for moving away from reservations/reserves by disentanglement to on reserve health and social benefits. Poverty and low socioeconomic status are key reasons for health disparities. Some tribes question what difference research will make to their health outcomes?
- Institutional Issues
 - The guidelines of research funding agencies need to be restructured at national and international levels in order to ensure consultation time pre and post project in order to enable proper discussion and consultation on project aims and methodologies, in order to foster ownership by communities
 - What is rewarded in an academic level is not what is useful at a community level, this requires early negotiation pre-commencement of research to enable synergy between Indigenous community aspirations and research community goals
 - Researchers, Indigenous and non-Indigenous need to be culturally sensitive and competent
 - Conflicting and competing demands between institutions to continually acquire research grants before completion of existing research reduces the opportunities for knowledge translation and dissemination in meaningful ways
- There is a need to have long term strategic initiatives to foster the development of a critical mass of Indigenous health researchers
- Government and research bodies demand that researchers determine and write into grant proposals how information will be disseminated, problems can occur if this is in conflict with Indigenous community protocols
- Indigenous researchers often struggle with the competing demands of community needs in research and the research community needs to publish or perish
- Non-indigenous researchers are seen by community as being driven by publication, conference presentation and academic progression pressures
- Within the research community there is a strong need to develop new paradigms which foster indigenous community driven research priorities and transformative processes over the academic research pressures (research impact or research perish)
- Methodology
 - Normalizing Indigenous contextual methodologies and processes including holistic investigations and oral histories
- Knowledge Mobilization
 - Need to think how we build, develop and validate our own Indigenous health as a discipline (Indigenous workforce, systems and processes)
- Challenges
 - Recognizing similarities and differences between Indigenous and non Indigenous ways of knowing
 - Validating Indigenous knowledge



DAY THREE

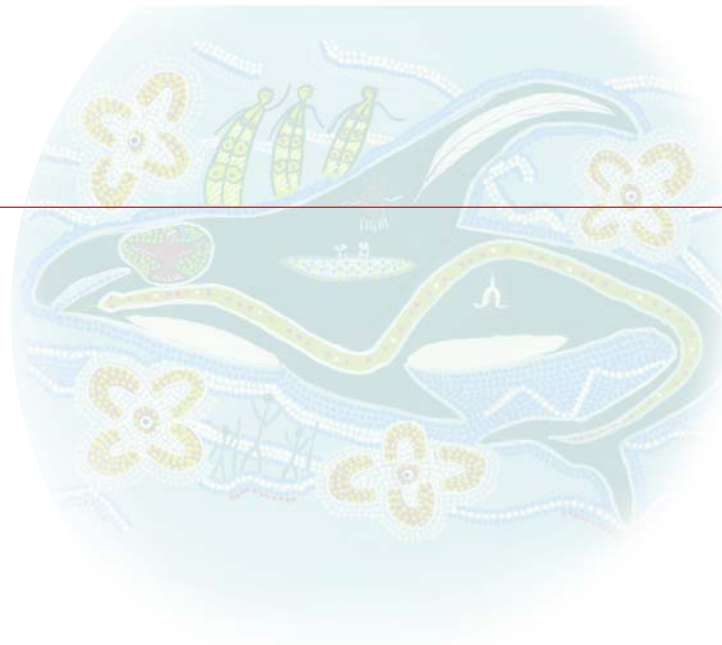
Key recommendations:

1. Collaborative network (via e-mail research committee, website, chat rooms).
2. Advocate for establishment of request for funding/proposal under Tripartite Agreement.
3. Agree to dialogue on how we identify Indigenous people.
4. Making research relevant for communities.

Development of an International Indigenous Health Declaration

Session Chair: Dr **Papaarangi Reid**, Aotearoa (NZ)

Over the course of the INIHKD meeting, a working group developed a draft declaration that was intended to convey to a wider audience the focus and outcomes of the Townsville INIHKD meeting. The draft declaration, titled "*Gullumbulburra, Declaration on the Health of Indigenous Peoples*" was presented to the participants, with further discussion to held on Day four.



DAY FOUR

Dr Reid led discussion towards the development of a process to refine and adopt an International Indigenous Health Declaration, followed by the closing ceremony.

Development of an International Indigenous Health Declaration

Session Chair: **Dr Papaarangi Reid**, Aotearoa (NZ)

The program on the final morning consisted of the discussion surrounding of the draft declaration, titled "Gullumbuliburra, Declaration on the Health of Indigenous Peoples" Gullumbuliburra is word given for

the Townsville area by the Bindal, and Wulgurukaba traditional owners. Discussion of this draft Declaration was undertaken by delegates breaking into four groups by country to workshop the draft declaration, and report back.

During the reporting back discussions delegates determined more work was needed to refine the draft Declaration which should be re-presented during the next INIHKD meeting. Subsequently a small working group which arose from the meeting has continued to progress the "Gullumbuliburra Declaration on the Health of Indigenous Peoples".

The draft Declaration below is current as at the time of printing:

DRAFT DECLARATION

The Gullumbuliburra Declaration on the Health of Indigenous Peoples

In recognition that following two years of dialogue, Indigenous people from four countries (Australia, Canada, New Zealand and United States of America) gathered at Gullumbuliburra (Townsville) Australia on 2–6 October 2003 for the inaugural meeting of the International Network of Indigenous Health Knowledge and Development.

The meeting was held in the spirit of peace and collaboration, acknowledging the inherited and inalienable sovereignty of the traditional owners of this land, locally the Wulgurukaba and Bindal peoples of Gullumbuliburra region, as part of the nations of Aboriginal and Torres Strait people of Australia.

A range of issues pertaining to indigenous health was discussed, in particular, shared models of health service provision, research, workforce development and policy. On the final day, the following declaration was developed by the Plenary.

Preamble

In keeping with the Draft United Nations Declaration of Indigenous Peoples, we reaffirm the rights of Indigenous peoples, including the right to self determination.

We acknowledge our collective histories of colonisation that continue today as racism and oppression that limit the full expression of our humanity.

We draw attention to our common experience of comprehensive inequalities and the structural issues that underpin them, and recognise the inequalities in health and the determinants of health experienced by the Indigenous peoples in all of our lands.

Principles

We believe in the resilience of the Indigenous spirit to endure and transmit to future generations our world views, cultural and spiritual beliefs and practices.

We are united in our vision of health and the right to health that:

- ☛ Is premised on the indigenous right to self determination.*
- ☛ Is shaped by indigenous ways of knowing.*
- ☛ Is controlled and governed by indigenous communities.*
- ☛ Has cultural safety and respect embedded in all aspects of practice.*
- ☛ Harmonises the relationship between Indigenous healing traditions and western medicine.*
- ☛ Is adequately resourced on the basis of health need.*
- ☛ Is interwoven with other social and community services.*
- ☛ Is supported by fully resourced infrastructure.*
- ☛ Interfaces with relevant policy agendas.*
- ☛ Recognises research as a vital tool for health sector development and reform.*
- ☛ Insists that Indigenous communities have the right to mandate and/or veto research about their communities.*
- ☛ Gives due recognition to the contribution of all staff, both voluntary and paid.*
- ☛ Fully values the contributions of our communities.*
- ☛ Is supported by a comprehensive indigenous workforce development strategy and system.*
- ☛ Is based on an indigenous framework of ethics for research, training, practice and policy.*

DAY FOUR

We confirm the benefits of meeting together to share ideas, experiences, wisdom and inspiration.

We propose the continued development of this network to:

- Develop respectful, ethical and excellent research and the translation of that research to improve the health of Indigenous peoples.*
- Develop international agendas for Indigenous health research*
- Promote and monitor research activities relating to Indigenous health, and to share the knowledge gained.*
- Develop communication tools to assist in this sharing of knowledge and promotion of activities.*
- Involve and engage all sectors in these activities - community, academic and governments.*

We acknowledge the limitations of our processes to date, especially with respect to comprehensive consultation and widespread involvement of other groups.

We commit as a next step in the development of this network to be as inclusive as possible

Where to from here? Future planning for a network

In concluding the meeting participants resolved that the proposed international network is a valuable initiative to progress Indigenous health knowledge and development. The participants supported the International Steering Committee to continue its work to formally establish the INIHKD and to reconvene in Canada in 2005 for a second meeting.

Once these discussions concluded, the representatives from each group participated in a formal exchange of gifts and bade each other farewell.



APPENDIX A

SUMMARY PROGRAM

	Friday 3rd October 2003	Saturday 4th October 2003	Sunday 5th October 2003	Monday 6th October 2003
Morning	<p>Commencement: MC: Mr Alec Illin</p> <ul style="list-style-type: none"> Elders Welcome Conference Welcome: Dr Sue Crengle (NZ) <p>Chair: Dr Helen Milroy (AUS)</p> <p>Non-Government Sector Showcase Presentations:</p> <ul style="list-style-type: none"> AUS: Mr Chris Bin Kali NZ: Ms Diane Gibson CAN: Dr Barry Lavallee USA: Ms Nancy Miller-Korth <p>Chair: Dr Barry Lavallee (CAN)</p> <p>Government Sector Showcase Presentations:</p> <ul style="list-style-type: none"> AUS: Ms Helen Evans NZ: Ms Rangī Pouwhare CAN: Dr Jay Wortman USA: Dr Kathleen Annette 	<p>MC: Mr Alec Illin: Welcome & Announcements</p> <p>Chair: Dr Karina Walters (USA)</p> <p>Workforce Development</p> <ul style="list-style-type: none"> NZ: Dr Sue Crengle CAN: Ms Bernice Downey USA: Ms Joyce Naeyowma AUS: Dr Ngjare Brown 	<p>MC: Mr Alec Illin: Welcome & Announcements</p> <p>Chair: Dr Rhys Jones (NZ)</p> <p>Health Service Models</p> <ul style="list-style-type: none"> CAN: Ms Josée Lavoie USA: Dr Gayle Dine Chacon AUS: Ms Rachel Atkinson NZ: Dr Sue Crengle 	<p>Mr Alec Illin: Welcome & Announcements</p> <p>Chair: Dr Papaarangi Reid (NZ)</p> <ul style="list-style-type: none"> Development of an International Indigenous Health Declaration Where to from here, future planning for a network <p>Closing Ceremony</p> <ul style="list-style-type: none"> Traditional Dancers Closing Remarks by A/Prof. Jacinta Elston
Afternoon	<p>Site visit at Townsville Aboriginal and Islander Health Service</p>	<p>MC: Mr Alec Illin: Housekeeping</p> <p>Chair: Dr Jeff Reading (CAN)</p> <p>Strengthening Research and development of research priorities in Indigenous Health</p> <ul style="list-style-type: none"> USA: To be confirmed AUS: Dr Sandy Eades NZ: Ms Louisa Wall & Ms Moe Milne CAN: Dr Judy Bartlett <p>Dr Papaarangi Reid: Daily Summary</p>	<p>MC: Mr Alec Illin: Housekeeping</p> <p>Chair: Dr Ted Wilkes (AUS)</p> <p>International Indigenous Health Initiatives. Four focused group discussions on:</p> <ul style="list-style-type: none"> Health Services Workforce Development Research Processes <p>Dr Papaarangi Reid: Daily Summary</p>	
Evening	<p>Welcome Function: Reef HQ</p> <ul style="list-style-type: none"> Traditional dancers <p>Health Status Overview</p> <ul style="list-style-type: none"> Dr Ian Ring/ A/Prof. Jacinta Elston 	<p>Free Evening</p>	<p>Chair: A/Prof Jacinta Elston & Ms Rachel Atkinson</p> <p>Conference Dinner: Southbank Convention Centre</p> <p>Welcome: Professor Ian Wronski</p> <p>Presentations: A/Prof. Jacinta Elston</p>	

APPENDIX B

EVALUATION SUMMARY

Question	Question Title	Rating 1 (Poor)	Rating 2	Rating 3 (Good)	Rating 4	Rating 5 (Excellent)	Comment
1 A	Pre-conference information	4	16	10	6	2	Unclear about the purpose of the conference, insufficient information. <i>Little information of accommodation & airport transfers.</i>
1 B	Social programs	0	0	4	14	22	Fantastic opportunities. <i>Enjoy the visit to Reef HQ.</i>
1 C	Showcase Presentation: <i>Non-Governmental</i>	0	1	3	22	13	Good to see community present. <i>Many presentations were repetitive - some sessions were quite long.</i>
1 D	Showcase Presentations: Governmental	1	2	3	21	10	Too many statistics that we already know; really enjoyed the NZ presentation. <i>Presentations lacked at times the voice of the consumer/grass roots.</i>
1 E	Showcase Presentations: Health Status	0	0	8	21	9	
1 F	Presentations: Workforce Development	0	0	10	22	9	
1 G	Presentations: Research	0	1	6	20	11	
1 H	Presentations: Health Service Models	0	0	7	19	10	Some more useful than others.
1 I	TAIHS Visit	0	0	0	7	29	Fantastic - great facilities and wonderful to see Indigenous peoples in the whole area. <i>Excellent.</i> Awesome hospitality and a wonderful initiative.
1 J	Plenary Group discussions	0	2	6	22	7	Difficult to follow - repetitive
1 K	Breakout Group discussion	0	1	11	13	16	Good opportunity to share ideas, information. <i>Would like electronically copies of group discussions.</i>
1 L	Accommodations	0	0	8	13	17	Great place to stay. <i>Breakfast was expensive - need more affordable option.</i> Would like to see the \$146p/n go to an Aboriginal centre, I could sleep on the floor. <i>Accommodation great - but rude staff.</i>
1 M	Conference facilities	0	0	9	15	14	Room was cold. <i>Prefer table conference setting.</i> Prefer tables to write on. <i>Prefer to be outside, rather than inside.</i>

Question	Question Title	Rating 1 (Poor)	Rating 2	Rating 3 (Good)	Rating 4	Rating 5 (Excellent)	Comment
2	What did you like best about the network meeting?	0	0	0	0	0	Meeting new people/resources. <i>Learn - research, programs & info from different countries.</i> Balance of showcase/discussion. <i>Meeting all the different Indigenous peoples - expanding my networks.</i> Meeting new people and sharing information. <i>Break out into group to discuss individual issues.</i> Communities. <i>4 countries participated contributed & gave insightful input.</i> Opportunity to shape the nations future.
3	What would you change?	0	0	0	0	0	Less presentations unless relevant - do not try to cover all countries. <i>The declarations should have been discussed on the first day and allowed 1hr ea day.</i> More community focus including health issues, programs and culture. <i>Presentations of community control organisations.</i> Make 3 days only - encourage social interaction earlier in conference. <i>Involve all Indigenous health disciplines.</i> Have prayer to start & close meeting ea day. <i>No fire alarm testing.</i> Non-smoking venue. <i>Have more crafts for sale.</i> Longer breaks. <i>Involve more people.</i> Presentation shorter. <i>Put politeness aside and answer questions.</i>
4	Were the conference aims met to your expectations?	0	0	0	0	0	Yes - met other colleagues with some concrete future plans. <i>Unsure as I wasn't sure what my expectations were.</i> Somewhat - actually the last two days. <i>Very well.</i> Need a chance to have a look at the bigger picture.
5	What are your suggestions for future meetings?	0	0	0	0	0	Share new research in health, programs, workforce development. <i>Meeting every 2yrs in different countries.</i> Have community members present their perspectives, experiences related to research, health services. <i>What challenges, strengths are working in community.</i> 18mths frequency to ensure momentum. <i>Excellent conference - idea of developing a community work exchange.</i> Discussing individual issues. <i>Allow for presentations at night.</i> Involvement & participations from youth/post-grad students. <i>Yes & No - were all relevant people involved from Australia?</i> That we benchmark our starting points from this meeting - develop indicators - health, funding, hr etc. to track progress. <i>Develop sub-committees.</i> Need of community health workers ensure that they are integrated into the academic & government levels. <i>Political strategies - develop & sustain INHKD networks.</i>

APPENDIX C

PARTICIPANT ALLOCATION TO BREAKOUT GROUPS

EAGLE

Robert Holt
Kathleen Annette
Alison Ball
Judith Bartlett
Treena Delormier
Suzanne Northcott
Adrian Miller
Brooke Arlidge
Dianne Kay Gibson
Alan Aldridge
Ian Anderson
Yael Cass
Harriet Yepa Waquie

POSSUM

L. Stephine Poston
Gail Valaskakis
Gail Garvey
Ian Ring
Cindy Shannon
Maggie Walters
Caroline Milne
Sheryl Lawton
Latisha Petterson
Marie Allen
Laura Commanda
Chris Cunningham

BEAR

Carol Nez
Anthony Ortiz
Barry Lavallee
Josée Lavoie
Fiona Pimm
Papaarangi Reid
Dennis McDermott
Kate Panaretto
Yvette Roe
Ian Wronski
Jacinta Elston
James Cheek
Judy Black

BUFFALO

Bonnie Duran
Bruce Garcia
Elizabeth Adams
Trudy Jacobs
Jay Wortman
Jill Guthrie
Rhys Jones
Lisa Ramanui
Patricia Fagan
Natalie Harkin
Cheryl Mundy
Elizabeth Naseyowma-Chalan
Deborah Schwartz
Sheryl Lawton

KIWI

Julie Lucero
Nancy Miller-Korth
Richard Jenkins
Malcolm King
Tungane Mei Kani
Caroline Audrey McKinney
Vicki O'Donnell
Mark Wenitong
Chris Bin Kali
Barbara Bond
Samantha Faulkner
Kath Howey
Ngairi Whata

ALLIGATOR

Ray Daw
Helen Milroy
Jon Perez
Jeff Reading
Bernice Downey
Roger Neufeld
Rangi Pouwhare
Mick Adams
Odette Best
Helen Evens
Raymond Dennison
Louisa Wall
Cindy Kiro
Sandy Eades

TURTLE

Madan Poudel
Caroline Tait
Terry Dunbar
Eva Kennedy
Rachel Atkinson
Judith Lee Black
Margaret Horne
Matire Harwood
Gayle Dine Chacon
Heather McCormack
Richard Vedan
Stephanie Poston
Francine Romero

GECKO

Erima Henare Johnson
Francine Eades
Joy Savage
Lila Pigilafori
Beryl Meiklejohn
Alayna Watene
Paul James Robertson
Indigo Sweetwater
John O'Neil
Gwen Packard
Ngiare Brown
Karina walthers
Gloria Teague

NOTES: **Indicates Facilitator** (bold),
Indicates Scribe (italics)

APPENDIX D

BIOGRAPHIES OF CONFERENCE CHAIRS

Dr Kathleen R. Annette, M.D., a member of the White Earth Band of Chippewa and a Minnesota native, began her career with the Indian Health Service (IHS), an agency within the Department of Health and Human Services, in 1986 as a medical officer at the Leech Lake Service Unit at Cass Lake, Minn. She subsequently held various positions of increasing responsibility, including Clinical Director of the Leech Lake Service Unit and later as the Chief Medical Officer for Bemidji Area of the HIS. Selected as the Director of the HIS Bemidji Area in 1990, Dr. Annette manages a varied health care program. The Bemidji Area provides health services for more than 60,000 American Indians from 33 federally recognized tribes in the states of Minnesota, Michigan, and Wisconsin. Health care is provided through direct care, contract care, or tribally operated facilities. Health facilities range from Urban health clinics, community health nursing stations, and walk-in first aid centres to fully staffed hospitals and clinics with lab, pharmaceutical, and X-Ray facilities. As part of a national Indian health system of federal, tribal, and urban Indian health programs, the Bemidji Area also contributes to the support of five urban health programs located in the cities of Minneapolis, Minn.; Detroit, Mich.; Green Bay and Milwaukee, Wis; and Chicago, Ill. Dr Annette is involved with the development and implementation of an annual Health Care Providers conference that focuses on health issues impacting American Indians, serves on an advisory committee for a joint Centers for Disease Control and Prevention and State "Emerging Infectious Disease" project, and is a frequent speaker on Indian health at medical schools and other institutions. As an Area Director, she also is a member of the Executive Leadership Council, a decision-making body of the agency that examines health care policy issues as they pertain to the HIS. A graduate of the University of Minnesota, Dr Annette holds a bachelor or arts degree in chemistry and a doctor of medicine. She obtained her residency at the Duluth Family Practice Center, receiving board certification in 1986. Professional affiliations include the Association of American Indian Physicians

In FY 2000, Dr Annette was selected as a recipient of the Presidential Rank Award. These prestigious awards are presented annually to top federal managers for extended, exceptional performance in the federal government. Dr Annette's other honors, awards and recognitions include: the U.S Public Health Service Outstanding Service Award; the American Indian Service Awards; the HIS Group Award for the National IHS Quality Management Health Professionals Workgroup on Recruitment and Retention; the Mead Johnson Award from the American College of Family Practice; and the Association of American Indian Physicians Recognition Award for Endeavors in American Indian Education on AIDS November 2000.

Ms Rachel Atkinson, BSW Ass.CW is a proud Yorta Yorta woman from Victoria. She has been Chief Executive Officer of the Townsville Aboriginal and Islanders Health Services (TAIHS) Limited for the past seven years. Her professional background is in social work and before joining TAIHS, she worked with the Queensland Child Protection Agency. Ms Atkinson is Chair of the Queensland Aboriginal and Torres Strait Islander Health Forum, QAIHF, is a member of the national executive of the National Aboriginal Community Controlled Health Organisation, NACCHO, and sits on a number of national health advisory committees that set national health priorities. Rachel is a valuable contributor to community affairs, to improving the status of Aboriginal and Torres Strait Islander health, and is an active advocate for equal rights.

Dr Judy Bartlett graduated from the Faculty of Medicine of the University of Manitoba 1987 and specialised in family practice in 1989. She is currently a 2003 Masters of Sciences in Community Health candidate as well as a mother and grandmother. For two and half years, Dr. Bartlett has been practicing in First Nation communities as a flying doctor. For 5 years, Dr. Bartlett has been a senior program administrator and the director of Health Programs for the Canadian federal government. In the last 6 years, she has been involved in research and addictions medicine at the Health Services Center of Winnipeg. Dr. Bartlett is the board chairperson for the National Aboriginal Health Organization and a board member for the Institute on Aboriginal People Health. Previously, Dr. Bartlett has been the immediate past chair for United Way of Winnipeg and the female co-chair for the Aboriginal Health and Wellness Center.

Mr Chris Bin Kali was born in Derby, Western Australia. He graduated from Mt Lawley University with a diploma in education in 1986. He has worked for the Community Development Employment Program (CDEP) for 5 years. He has been involved in education for 7 years and decided to shift his focus to health in the last 5 years. Currently, Chris is a member and the current chair for the board of KAMSC and presently a board member for NACCHO.

Dr Ngiare Brown is an Aboriginal woman from the South Coast of New South Wales, of the Wadi-Wadi tribal group. She is a medical graduate from the University of Newcastle. Numerous adventures, including stints in the Navy and as ED Registrar; Indigenous Health Advisor to the Australian Medical Association; Manager of Preventative Health of World Vision Australia Indigenous Programs. Ngiare is currently advanced trainee with RACP Faculty of Public Health and until early October 2003 was CEO for the Australian Indigenous Doctors' Association. Ngiare is due to move to take up a new job in Darwin.

Dr Sue Crengle, BHB, MBChB, MPH (Hons), FRNZCGP, FAFPHM is from the Waitaha, Kati Mamoe and Kai Tahu tribes in Aotearoa/New Zealand. She graduated with her medical and Master of Public Health degrees from the Faculty of Medicine and Health Sciences at Auckland University. She holds specialty qualifications in both general and public health medicine. She was a recipient of the Harkness Fellowship in Health Policy 1999-2000, spending time at Johns Hopkins School of Public Health. On her return from the U.S. she spent a year working as a Senior Advisor in the Ministry of Health. She is currently Head of Discipline: Maori at the Department of Maori and Pacific Health, Faculty of Medicine and Health Sciences, University of Auckland and Director of Tomaioara Maori Health Research Centre. Her current research interests included a number of health services research and quality of care projects and surveys about youth and Maori men's health.

Dr Gayle Dine' Chacon, M.D. is Dine' from Chinle, Arizona, Navajo Nation. She is married and has three children. Dr. Dine' Chacon is an Assistant Professor in the Department of Family and Community Medicine at the University of New Mexico School of Medicine (UNMSOM). She is medical director of the Pueblo of Sandia Health Center, medical director of the Bernalillo County Juvenile Detention Center, and serves on the UNMSOM Admissions Committee. Her most current activity includes developing and directing the Center for Native American Health (CNAH) at the UNM Health Sciences Center. The CNAH was established to address the health priority needs of the 24 Native American tribal and urban Indian communities in New Mexico. She also is engaged in research in two Pueblo communities. The research is to investigate the prevalence of adolescent asthma and its associated symptoms.

Ms Bernice Downey is of Cree/Metis descent and the mother of three daughters. She is registered nurse, a life-long student and an advocate of Aboriginal health advancement. Her work with the Aboriginal people has encompassed addictions, health promotion, family violence and sexual abuse. She was formally the Executive Director of the Aboriginal Nurses Association of Canada and is currently working with the NAHO in their policy research unit with the Health Careers and Midwifery files.

Dr Sandra Eades is a medical graduate of the University of New Castle, 1989. A Ngoongar woman, she has worked both in community practice at Derbil Yerrigon, the Aboriginal Medical Service of Perth, and in health research. She is very close to completing her PhD in child health. Dr. Eades is currently a member of the NHMRC Research Council Research Committee, and has played a chief role in leading the National Indigenous Health Research Reform Agenda.

Associate Professor Jacinta Elston is an Aboriginal woman from the Kalkadoon people of Australia. She graduated with her Masters and Diploma in Public Health and Tropical Medicine, within the Faculty of Medicine, Health and Molecular Sciences at James Cook University. Jacinta chairs the James Cook University Medical School's Aboriginal and Torres Strait Islander Student Selection Committee, and is a current member of the Research Committee of the National Health and Medical Research Council (Australia), having previously served on the NHMRC's Research Agenda Working Group for Aboriginal and Torres Strait Islander people during the last triennium. She is currently the Assistant Dean: Indigenous Health, at the Faculty of Medicine, Health and Molecular Sciences at James Cook University. Her current research interests include health service models of care and Breast Cancer in Aboriginal and Torres Strait Islander women.

Ms Helen Evans has been First Assistant Secretary responsible for the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Australian Government Department of Health and Ageing since September 1997. Helen has an Arts Degree from the University of Adelaide where she majored in psychology and history, and a graduate degree in Social Administration from the Flinders University of South Australia. Since completing her tertiary education in 1971 she has worked in a wide range of positions largely within the public sector in the health, welfare and income security area. Her work in these positions has included senior management, policy development, planning and program implementation and review at both the ACT and the Federal level. Almost all her appointments have involved liaising and negotiating with a wide range of often quite diverse stakeholders. She very much enjoys this way of working.

APPENDIX D

Dr Rhys Jones is a Public Health Medicine Specialist and has a senior lecturer position at the Department of Maori Health, University of Auckland. He also has a part-time appointment at He Kamaka Oranga (Māori Health), Auckland District Health Board.

Dr Barry Lavallee from Canada is a member of the Metis and Saulteaux nations of Manitoba and belongs to the Bear clan. Barry is Senior Physician at the Aboriginal Health and Wellness Centre in Winnipeg, and is the Immediate Past President of the Native Physicians Association in Canada.

Ms Josée G. Lavoie is a PhD candidate at the Health Policy Unit of the London School of Hygiene & Tropical Medicine. Her PhD research focuses on the policies and financing mechanisms set in place in Canada, Australia and Aotearoa (NZ) to support the continued development of indigenous primary health providers. Josée is currently a Research Associate with the Centre for Aboriginal Health, located in Winnipeg, Canada. The Centre is affiliated with the University of Manitoba, and operated in partnership with the Assembly of Manitoba Chiefs.

Dr Helen Milroy is a descendant of the Palyku people of the Pilbara Region of Western Australia but was born and educated in Perth. Helen worked as a General Practitioner and Consultant in Childhood Sexual Abuse at Princess Margaret Hospital for children for several years before qualifying as a Consultant Child and Adolescent Psychiatrist in 2000. She is President Elect of the Australian Indigenous Doctors Association that was founded in 1999 and is also a member of the RANZCP (Royal Australian and New Zealand College of Psychiatry) committee for Aboriginal and Torres Strait Islander Mental Health. At present Helen works as a Consultant Psychiatrist at the Bentley Family Clinic, is the Director for the Centre for Aboriginal Medical and Dental Health at UWA (University of Western Australia) and is also a research fellow at the Telethon Institute for Child Health Research. Interests include holistic medicine, child mental health and developing the Aboriginal medical workforce.

Ms Moe Milne (Ngati Hine Puhī nui tonu) in addition to being a member of the Health Research Council of New Zealand (HRC) Council, is the chair of the HRC's Maori Health Committee. She is also a member of the HRC's Research Policy Advisory and Grant Approval Committees. A trained Psychiatric nurse, and a former teacher, Moe has a wide-ranging interest in health and education, and social services for Maori. She has a strong health management background, including senior management with the Northland Area Health Board, RHA Locality Projects Manager-Needs Assessment and, more recently, as Kaiwhakahaere (Maori Manager) for the Health and Disability Commissioner.

Ms Joyce Naseyowma-Chalan (Na-see-yeow-ma-Cha-lawn) is a Native American person whose tribal affiliation is the Hopi and Taos. She makes her home in New Mexico in Cochiti Pueblo, Tribal Community with a population of about 1200 residents. She married with 3 children and one grandchild. The governor of State of New Mexico, Bill Richardson, recently appointed Ms. Naseyowma to an Executive Director position in the New Mexico State Department of Health, Public Health Division. She is the first Native American person in the history of New Mexico to serve in this capacity. She received her graduate degree in Public Health from the University of Hawaii, and has worked on a variety of public health issues including alcohol and substance use prevention, HIV/AIDS education and prevention, intimate partner violence prevention, teen pregnancy prevention. Prior to her appointment she was employed by a non-profit community based Indian Health organization as the Executive Director. Some of her accomplishments include, National Award from the Assistant Secretary of Health for innovative culturally appropriate HIV/AIDS prevention education outreach program, Vice Chair of the National Indian Woman's Health Research committee, National Taskforce for Indian Health Services Disparity Index Work Committee, National Indian Health Service Alcohol and Substance work plan committee.

Dr Jeff Reading, a Mohawk from Southern Ontario in Canada, obtained his PhD and Master of Science degrees from the Department of Public Health Sciences at the University of Toronto. Jeff is the Scientific Director of the Canadian Institutes of Health Research - Institute of Aboriginal Peoples Health, based at the University of Toronto. Dr. Reading was recently appointed as full professor in the Faculty of Human and Social Development at the University of Victoria in British Columbia, Canada. Jeff retains academic cross-appointments to numerous university departments including the Institute of Medical Sciences and the Department of Public Health Sciences at the University of Toronto; and the department of Community Health at the University of Manitoba. Trained as an epidemiologist and physiologist, Dr. Reading is well known nationally and internationally for his research on indigenous health, policy and social determinants with particular expertise in participatory research and survey research methods, along with a substantive focus on diabetes, tobacco use and heart disease.

Dr Papaarangi Reid (Te Rarawa Te Aupouri) is a specialist in public health medicine. She is the director of the Eru Pomare Maori Health Research Centre at the Wellington School of Medicine and Health Sciences. Her research interests include the analysis and monitoring of disparities between Maori and non-Maori citizens of Aotearoa/New Zealand, the construction of ethnicity and indigeneity, colonisation, racism and privilege as determinants of health, and the options for progressing equity.

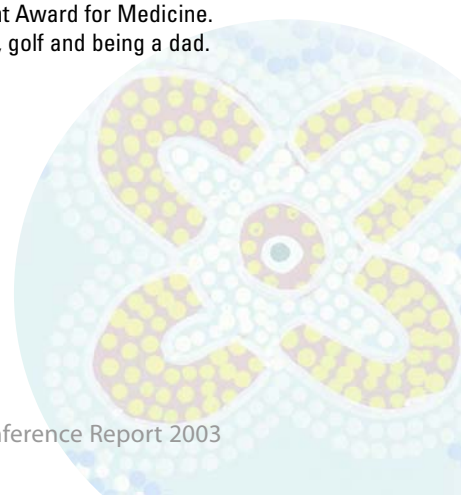
Dr Ian Ring is Adjunct Professor of Public Health and Tropical Medicine at James Cook University and has recently completed a four year term as Head of the School of Public Health at JCU. At various times he has been a Lecturer/Senior Lecturer at the University on PNG, A/Director (Epidemiology) NSW Health, Principal Medical Epidemiologist and Manager of the Health Information Centre, Queensland Health, consultant to WHO on information systems and Foundation Director of the Australian Primary Health Care Research Institute at the Australian National University. He has been a Member of the Board of the Australian Institute of Health, Member of the Council of the Public Health Association and the Australian Epidemiological Association. He was the Elkington Orator for the Qld Branch of PHA in 1992, and was awarded the Sidney Sax medal by JCU in 2001. His current interests include public health aspects of cardiovascular disease and Aboriginal and Torres Strait Islander Health.

Dr. Francine Romero is from Damez Pueblo, New Mexico. She has a PhD in population genetics from the University of New Mexico and a MPH in epidemiology from the University of Washington. Currently, Dr. Romero is the principle investigator for the Native American Research Center for Health and is also the co-chair for the Indian Health Service - Institutional Review Board. Dr. Romero is also a member of the Canadian Institute of Human Research - Institute of Aboriginal People's Health Institutional Advisory Board.

Ms Louisa Wall (Ngati Tuwharetoa me Waikato) has completed an MPhil in Social Policy, focusing on the motivation of Maori women MPs at Massey University. She came to the HRC from a position as a care co-ordinator with Moko Services, which provides Maori mental health services in the Waitemata area and has been Kaiwhakahaere Rangahau Hauora for 2 years. Louisa has worked on a child health nutrition survey, and is committed to ensuring Maori have opportunities to participation within the health research sector.

Dr Karina Walters is from Choctaw Nation of Oklahoma. She is an associate professor at the University of Washington and the co-director for the Native Wellness Research Centre in the School of social work. In addition to newly becoming a mother, Karina is a researcher who is studying the impact of traumatic stress on Indigenous wellness outcomes with an emphasis on identifying culturally protective factors.

Dr Jay Wortman BSc M.D. was born in Fort Vermilion, a small Metis settlement in northern Alberta. After graduation from high school he worked for ten years on heavy construction projects in northern Alberta as a surveyor and heavy equipment operator. In 1977 he returned to school to pursue a career in medicine. He completed a BSc in Biology and Chemistry at the University of Alberta in 1980 and received his MD from the University of Calgary in 1984. He went to Vancouver for Family Medicine residency at the University of British Columbia and practised there before becoming the Associate Director of Sexually Transmitted Disease Control for British Columbia in 1988. In that capacity he developed the first HIV prevention program in Canada to target the Aboriginal population. In 1990 he joined the Medical Services Branch of Health Canada to lead the national effort to prevent the spread of HIV in the First Nations and Inuit populations. In 1994 he returned to the British Columbia Ministry of Health as Medical Consultant to the Aboriginal Health Policy Unit where he led negotiations between the Nisga'a, the provincial government and Health Canada which yielded a tri-partite health transfer agreement in the Nass Valley. In 1996 he rejoined Health Canada in Ottawa as Director-General of Non-Insured Health Benefits, the program that provides dental care, drugs, vision care, and medical transportation benefits to First Nations and Inuit people across the country. In 1999, he returned to British Columbia as the Regional Director of the First Nations and Inuit Health Branch, Pacific Region, the position he currently holds. He maintains a clinical teaching appointment at the University of British Columbia Faculty of Medicine. He was the 2003 recipient of the national Aboriginal Achievement Award for Medicine. He lives in West Vancouver with his wife, son and two cats. He enjoys snowboarding, golf and being a dad.



APPENDIX E

ABSTRACTS

Only those abstracts that were available at the time of printing have been included.

Non-Government Sector Showcase Presentations:

AUSTRALIA: Mr **Chris Bin Kali** (not available)

Director, National Aboriginal Community Controlled Health Organisation, NACCHO

Chair, Kimberley Aboriginal Medical Service, KAMSC

National Aboriginal Community Controlled Health Organisation

AOTEAROA (NZ): Ms **Diane Gibson** (not available)

Kai Arataki (Chief Executive) Ngati Porou Hauora

Māori Health - Towards Tinorangatiratanga

CANADA: Dr **Barry Lavallee** (not available)

Senior Physician, Aboriginal Health and Wellness Centre of Winnipeg Inc.

Indigenous Community Based Health Program

UNITED STATES OF AMERICA: Ms **Nancy Miller Korth** (not available)

Great Lakes EpiCenter Coordinator, Great Lakes Inter-Tribal Council Epidemiology Center

Native American Research Initiatives

Government Sector Showcase

AUSTRALIA: Ms **Helen Evans** (not available)

First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, OATSIH

National Overview of Aboriginal and Torres Strait Islander Policy and Strategy in Australia

AOTEAROA (NZ): Ms **Rangi Pouwhare** (not available)

Manager, Ministry of Health

He Korowai Oranga / Māori Health Strategy

CANADA: Dr **Jay Wortman** (not available)

Regional Director, Health Canada

Overview of FNIHB Policy and Strategies

UNITED STATES OF AMERICA: Dr **Kathleen R Annette**, M.D. (not available)

Area Director, Indian Health Service

Overview of NIH Policy and Strategies for Native American and Alaskan Indigenous Health

International Comparisons of Indigenous Mortality

AUSTRALIA: Dr **Ian Ring** and Associate Professor **Jacinta Elston**

Substantial reductions in mortality have occurred in the Indigenous populations of Canada, the USA and New Zealand since the 1970's. Notwithstanding these improvements, current mortality rates for all causes combined remain substantially higher than non-Indigenous rates, with the rate for Native Americans being 1.6 times, Canadian Indians 1.4 times, New Zealand Maoris 1.8 times and Australian Indigenous people 3.4 times the total Australian rate for example. Circulatory, respiratory and endocrine conditions, injury and poisoning and neoplasms are responsible for 78-88% of the total deaths and 66-92% of the excess deaths in the indigenous populations of these four countries.

The major causes of excess mortality in US and Canadian Indian populations remains injuries and circulatory conditions although there have been substantial reductions in both conditions for both populations. The major causes of excess mortality in New Zealand Maoris are circulatory conditions, neoplasms and endocrine conditions, though there have been substantial reductions in mortality from circulatory conditions and neoplasms. The major causes of excess mortality in the Australian indigenous population are circulatory, respiratory and conditions, though there has been considerable reductions in respiratory mortality. Mortality from endocrine conditions and neoplasms is increasing in all indigenous populations other than New Zealand Maoris.

These continuing similarities are differentials suggest the need for indigenous leadership and international collaboration on the Network themes of workforce development, health services models and research processes.

Workforce development

AOTEAROA (NZ): Dr **Sue Crengle**

Head of Discipline, Māori

University of Auckland, Department of Māori and Pacific Health

Training, education and workforce development in Aotearoa/New Zealand

Dr Crengle presented an overview of strategies in Aotearoa/New Zealand to increase the Maori health workforce. More information on several strategies was also presented to highlight some of the approaches currently being undertaken.

CANADA: Ms **Bernice Downey** (not available)

Policy Analyst

National Aboriginal Health Organisation, NAHO

Aboriginal Health Human Resources: "A pillar for the future"

USA: Ms **Joyce Naseyowma-Chalan** MPH, Director, Public Health Division, New Mexico State Department of Health

The Challenges faced in State Health Departments

Ms Naseyowma-Chalan provided an overview of workforce in USA specifically from the State of New Mexico. New Mexico's population has undergone tremendous change in the last decade where the majority population will be the Hispanic population primarily immigrants from Mexico. This poses major challenges for the Indigenous groups, the American Indian Tribes. It is anticipated that the health workforce will become representative of the new majority. Also discussed were some of the specific health needs of the Indigenous groups of New Mexico and Ms Naseyowma-Chalan outlined how she will utilize her position in State government to advocate for developing a workforce that is inclusive of the Indigenous groups.

AUSTRALIA: Dr **Ngiare Brown** (not available)

The Australian Indigenous Doctors' Association

Member, Aboriginal and Torres Strait Islander Health Workforce Working Group

Indigenous Health: Moving from Rhetoric to Reality

Strengthening research and development of research priorities in Indigenous health

UNITED STATES OF AMERICA: Dr **Francine C Romero**, PhD, MPH (not available)

Epidemiologist

Northwest Portland Area Indian Health Board

United States American Indian and Alaska Native Research Initiatives

AOTEAROA (New Zealand): Ms **Moe Milne**,

Chair, Māori Health Committee, Health Research Council

Ms **Louisa Wall**,

Kaiwhakahaere Rangahau Hauora, (Manager, Māori Health Research) Health Research Council of New Zealand

Strengthening Indigenous Research and Priority Setting

The Health Research Council of New Zealand (HRC) is the primary investor in public good health research in New Zealand. The HRC seeks to invest in Māori specific research to generate an evidence base for improving Māori health outcomes, and thus reducing disparities in health outcomes.

In 1990 the HRC undertook to invest in capability development by providing core funding to establish Māori health research centres and invested in capacity building initiatives via career development awards at masters, PhD and post-doctoral level.

In 2001 there was a formal recognition that hapu, iwi and Māori organisations had not been successful in accessing research funding and the challenge for the HRC was to modify and create a framework of investment that provided an inclusive opportunity of Māori participation.

The annual HRC investigator-initiated funding round provides competition between established Māori health research centres, Māori academics, new and emerging researchers, and Māori communities. This had led to very few hapu, iwi and Māori organisation led initiatives.

The HRC and the Foundation of Research, Science and Technology have collaborates since 2001 to co-invest in Māori health, social, economic and environmental research. This funding has become dedicated to ensuring research initiatives must be led by hapu, iwi and Māori organisations who identify and own their own research questions, who may have the capacity and capability to undertake the research or work in collaboration with research providers (Māori and non-Māori) who can help them answer the research question.

This has led to a more inclusive representation of research providers and the implications for evidence-based public policy and health services management development are immense.

Correspondingly, the HRC Māori Health Committee has via the current Rangahau Hauora Māori Portfolio Strategy ensured hapu, iwi and Māori community participation by clarifying the context of research must be into issues identified “by Māori for Māori” in areas of relevance to Māori and moves the agenda from describing problems to developing interventions.

CANADA: Dr Judith G Bartlett,

Associate Director, Centre for Aboriginal Health Research

Indigenous Research Capacity in Canada: “Major recent gains - still some way to go”

The paper showcased major Canadian initiatives in First Nations, Inuit and Métis health research, described identified research priorities, commented on the strengths and challenges in Canadian Indigenous health research, and suggested possible directions for International Indigenous research. A bibliography and Internet sources also are provided. Funding for research and writing of the paper was provided by Health Canada (the federal government department of health).

In the past ten years, persistent and striking gaps in health status, rising health care costs and continual pressure by Aboriginal organizations have raised the priority of Aboriginal health as a research and policy issue in Canada. Not only is there considerable new activity in the field, there is also a substantial shift in thinking about Aboriginal research. Aboriginal organizations and communities are reclaiming Indigenous approaches to research and taking a strong stand for the right to control or direct research that affects their communities.

Canada’s national Inuit, First Nations and Métis representative organizations - Inuit Tapiriit Kanatami, Assembly of First Nations, Métis National Council, Native Women’s Association of Canada and Congress of Aboriginal Peoples also have been active in advancing the Aboriginal research agenda. Recognition must also be given to the Royal Commission on Aboriginal Peoples (a national seven-member commission established in 1991 to investigate and make recommendations concerning a renewed relationship between Aboriginal Peoples and Canada), many of whose recommendations continue to influence programs and initiatives today.

The paper also covered:

- Aboriginal Directed or Controlled Initiatives
- Increased Federal Support and Improvements in Aboriginal Health Information
- Advances in University-based Research

- Meaningful Involvement in Research Affecting Aboriginal Peoples

AUSTRALIA: Dr Sandy Eades (not available)

Senior Research Fellow, Menzies School of Health Research

Strengthening research and development of research priorities in Indigenous research - The NHMRC Roadmap: A strategic framework for improving Aboriginal and Torres Strait Islander health through research

Dr Jeff Reading,

Scientific Director

Canadian Institute of Health Research - Institute of Aboriginal Peoples’ Health

International Cooperation Agreement

International Indigenous Health Research Cooperation

Australia, Canada and New Zealand recognize health disparities between Indigenous people and the general population.

These three countries realize Indigenous people want research undertaken on their terms:

- Protect cultural knowledge and values
- Participate in all phases of research
- Promote Indigenous research

Health service models

CANADA: Ms Josée Lavoie (see appendix I for summary)

Research Associate, Centre for Aboriginal Health Research, Winnipeg

First Nations in Canada: Self-government or governance by contract

United States of America: Dr Gayle Dine’Chacon, M.D. (not available)

Director, Center for Native American Health

University of New Mexico Health Sciences Centre

USA Health Care System

AUSTRALIA: Rachel Atkinson (not available)

Chief Executive Officer, Townsville Aboriginal and Islanders Health Services Limited

APPENDIX E

Health Service Models and Aboriginal and Torres Strait Islander People

AOTEAROA (NZ): Dr **Sue Crengle**

Head of Discipline: Māori, University of Auckland,
Department of Māori and Pacific Health

Māori primary care services

Dr Crengle presented an overview of Maori health providers in Aotearoa/New Zealand, highlighting the similarities and differences across the range of providers, the challenges they face and indicators of their success.



APPENDIX F

PRESS COVERAGE / PRESS STATEMENT

Townsville Bulletin 04-10-03

Global network aims to improve indigenous health



EXCHANGE ... Townsville's Marlene Griffiths checks the eyes of Mexican delegate Raymond Daw
Photo: EVAN MORGAN EM14023

JAMES Cook University's Indigenous Health Unit is hosting the first meeting of a new international network established by indigenous health professionals, researchers and planners to improve the health of indigenous people around the world.

The International Network in Indigenous Health Knowledge and Development (INIHKD) is comprised of researchers, academics and community representatives from Australia, New Zealand,

Canada and the United States.

The network is holding its first conference in Townsville. The conference started yesterday and finishes on Monday.

The event has attracted 110 delegates from all over the world.

The group aims to address disparities between the health of indigenous people and the non-indigenous populations of Australia, Canada, New Zealand

and the United States, says organiser Associate Professor Jacinta Elston, who is the Assistant Dean (Indigenous Health Unit) of JCU's Faculty of Medicine, Health and Molecular Sciences.

Focus

Seeking answers

An international network working towards improved indigenous health in New Zealand, Canada, the US and Australia suggests standards of Aboriginal and Islander health remain poor. LESLENE WOODWARD probes whether or not progress is being made

A NEWLY formed organisation concerned with indigenous health problems in four countries has turned a spotlight on the Australian situation, calling its indigenous mortality rates "unacceptable" and urging the Federal Government to act.

But the criticism has gone beyond health issues and focused on the need for improvement in Australian indigenous lifestyles.

The comments were made during a meeting in Townsville of the International Network of Indigenous Health Knowledge and Development, when figures were presented showing the mortality rate for indigenous Australians was 3.3 times the level of the total Australian population.

The network originated in an idea from James Cook University in Townsville, took two years to set up and comprises representatives from Australia, New Zealand, Canada and the United States.

Its purpose is to improve the health of indigenous peoples in the four countries, in a statement released at the end of the conference in Townsville last month, network spokesman Dr Barry Lavallee said.

"The Australian situation shocked participants. The mortality rates (in Australia) are the worst in comparison to all other indigenous groups and the general Australian population," he said.

"The Australian Government must recognise effective policies, improve their implementation and continue policy development that reflects indigenous communities' aspirations."

At a news conference after the meeting, Australian representative Rachel Atkinson said indigenous health would never improve unless handed in a



SOLUTIONS ... Dr Sue Crengle with Stephine Poston, Rachel Atkinson and Dr Barry Lavallee
Photo: EVAN MORGAN EM14023

holistic manner. "Indigenous people in New Zealand, the United States and Canada (Eskimos)."

"New data suggest little improvement in health status in the four countries over the past 20 years; the gap between indigenous and non-indigenous health is widening," Dr Lavallee said.

He said there was a

DATA suggest little improvement in health status in the four countries over the past 20 years; the gap between indigenous and non-indigenous health is widening

lack of improvement in the overall mortality rates in that period and this was a clear sign of the need to improve health delivery by addressing social, economic and political barriers.

But is the Australian situation really as straightforward as the network suggests?

The figures made available to the conference show a serious statistical imbalance between the health situation of indigenous and non-indigenous Australians, yet on-the-ground information suggests positive progress is being made.

A sub-committee of

the National Health and Medical Research Council, which compiled the Aboriginal and Torres Strait Islander Research Agenda Working Group Road Map, said the 2001 census showed indigenous Australians comprised about 2.4 per cent of the population.

However their poorer health standards relative to other Australians showed up as a significantly shorter life expectancy, higher rates of death, illness, injury and compromised quality of life.

According to the report, indigenous Australians have a life expectancy at birth 20 years lower than other Australians, 45 per cent of the male population die before age 40, and about 35 per cent of the female population will die by that age as well.

But the report also went on to detail initiatives by both the Research Council and the Working Group to improve health standards, including both early diagnostic services and education on long-term healthy lifestyle issues.

Federal Member for Herbert Peter Lindsay said he did not believe the challenges facing indigenous health were insurmountable.

"The problems are difficult, but it is important to remember progress has been made over the past decade," he said.

"Where indigenous leaders have the determination to take action to improve the health of their people and where the community is prepared to follow that leadership, significant improvements are being achieved."

"Palm Island is a good example - since the Aboriginal council banned wine and spirits on the island, public drunkenness has fallen, with a corresponding fall in violence and increased self-worth."

"There is evidence of early health gains child mortality rates have reduced and so has the rate of communicable diseases in some communities."



CONFERENCE ... Celestino Ross, 8, of Bindal Dancers with delegates Stephine Poston, Rachel Atkinson and Dr Sue Crengle
Photo: EVAN MORGAN EM151023

Lagging on indigenous health

AUSTRALIA lagged behind other developed countries on indigenous health and had by far the highest mortality levels, new research has found.

The unpublished findings were presented in Townsville to the inaugural conference of the International Network in Indigenous Health Knowledge and Development.

The weekend conference expressed serious concern at the state of health among Aborigines and Islanders, Maoris, US Indians

and Canadian Indians and Inuits (Eskimos).

Its greatest concern was for the indigenous Australian population, with mortality rates 3.3 times the level of the total Australian population.

"Health is much worse for the Australian Aboriginal population," said James Cook University public health professor Ian Ring, who led the research.

"On the evidence available we don't think there has been much headway at all (on mortality)."

At a news conference after the meeting, Australian representative Rachel Atkinson said indigenous health would never improve unless handed in a

holistic manner. "Indigenous people in New Zealand, the United States and Canada (Eskimos)."

"New data suggest little improvement in health status in the four countries over the past 20 years; the gap between indigenous and non-indigenous health is widening," Dr Lavallee said.

He said there was a

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APPENDIX G

ATTENDEES

Country	Surname	First Name	Salutation	Organisation	Title
Australia	Adams	Elizabeth	Ms	Charleville Western Areas Aboriginal & Torres Strait Islander Corp for Health	Chairperson
Australia	Adams	Mick	Mr	AICHS Brisbane	Chairperson
Australia	Ahmat	Maudesta	Ms	Townsville Aboriginal and Islanders Health Services Limited	Volunteer
Australia	Anderson	Ian	Assoc. Professor	Center for the study of Health and Society/school of Population and Health	Director
Australia	Atkinson	Rachel	Ms	Townsville Aboriginal and Islander Health Services Limited	Chief Executive Officer
Australia	Best	Odette	Ms	University of Southern Queensland, Dept of Nursing	Lecturer
Australia	Bin Kali	Chris	Mr	National Aboriginal Community Controlled Health Organisation	Director
Australia	Black	Judith Lee	Professor	University of Sydney	NH&MRC SPRF
Australia	Bond	Barbara	Ms	University of New England, Armidale NSW	Lecturer
Australia	Brown	Ngiare J	Dr	AIDA	
Australia	Cass	Yael	Ms	Dept of Health and Ageing	Assistant Secretary
Australia	Dennison	Raymond	Mr	National Aboriginal Community Controlled Health Organisation	Director
Australia	Dunbar	Terry	Ms	CRC for Aboriginal Health	Deputy CEO, Director of Development
Australia	Eades	Francine	Ms	Telethon Institute for Child Health Research	Post Graduate Student
Australia	Eades	Sandra	Dr	Menzies School of Health Research	Senior Research Fellow
Australia	Eldridge	Alan	Mr	Australian Indigenous Doctors Association Inc	Chief Executive Officer
Australia	Elston	Jacinta	Assoc. Professor	James Cook University	Assistant Dean
Australia	Erichsen	Dorothy Rose	Ms	Townsville Aboriginal and Islander Health Services Limited	Volunteer
Australia	Evans	Helen	Ms	Office for Aboriginal and Torres Strait Islander Health- DHA	First Assistant Secretary
Australia	Fagan	Patricia	Dr.	Office for Aboriginal and Torres Strait Islander Health- DHA	Senior Medical Advisor
Australia	Faulkner	Samantha	Mrs	Dept of Health and Ageing	A/g Assistant Director research and data
Australia	Garvey	Gail	Ms	University of Newcastle	Assistant Dean, Indigenous Health and Education

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Country	Surname	First Name	Salutation	Organisation	Title
Australia	Guthrie	Jill	Ms	National Centre for Epidemiology and Population Health, Australian National University	Lecturer
Australia	Harkin	Natalie	Ms	Department of General Practice- The University of Adelaide	Coordinator, Yaiya Purruna
Australia	Holt	Robert	Mr	National Aboriginal Community Controlled Health Organisation	Director
Australia	Howey	Kath	Ms	Faculty of nursing (MD2), University of Sydney	Indigenous Lecturer
Australia	Illin	Alec	Mr	Townsville Aboriginal and Islander Health Services Limited	Chairperson
Australia	Illin	Theresa	Ms	Townsville Aboriginal and Islander Health Services Limited	Volunteer
Australia	Kennedy	Eva	Ms	QAIHF	Board of Director
Australia	Kennedy	Kim Leonie	Miss	Townsville Aboriginal and Islander Health Services Limited	Volunteer
Australia	Lawton	Sheryl	Miss	Charleville Western Areas Aboriginal & Torres Strait Islander Corp for Health	Manager
Australia	Lee	Ryun	Ms	Indigenous Unit, School of Public Health & Tropical Medicine	Volunteer
Australia	McDermott	Dennis	Mr	School of Public Health & Community Medicine, UNSW	Senior Lecturer - Indigenous Health
Australia	Meiklejohn	Beryl	Ms	Queensland Uni of Tech (QUT)	Lecturer
Australia	Miller	Adrian	Mr	School of Public Health & Tropical Medicine	Senior Lecturer
Australia	Milroy	Helen	Assoc. Professor	Faculty of Medicine & Dentistry, Uni Western Australia	Director, Centre for Aboriginal Medical & Dental Health
Australia	Mundy	Cheryl	Ms	National Aboriginal Community Controlled Health Organisation	Director
Australia	Norling	Faye	Ms	Townsville Aboriginal and Islanders Health Services Limited	Volunteer
Australia	Northcott	Suzanne	Ms	Management & Policy, NH&MRC	Executive Director
Australia	O'Donnell	Vicki	Ms	National Aboriginal Community Controlled Health Organisation	Board of Director
Australia	Panaretto	Katie	Dr	QAIHF	Senior Medical Officer
Australia	Pigliafori	Lila	Mrs	Yapatjarra Health Service	CEO
Australia	Relly	Erin	Ms	Indigenous Unit, School of Public Health & Tropical Medicine	Volunteer
Australia	Ring	Ian	Dr	Queensland Health	Manager - Health Information Centre
Australia	Roe	Yvette	Ms	National Aboriginal Community Controlled Health Organisation	Director
Australia	Savage	Joy	Ms	Dept of Health and Ageing	Director

APPENDIX G

Country	Surname	First Name	Salutation	Organisation	Title
Australia	Walters	Maggie	Ms	University of Tasmania	Academic Director, Riawanna
Australia	Wenitong	Mark	Dr	Australian Indigenous Doctors Association	Executive
Australia	Wronski	Ian	Dr	James Cook University	Executive Dean
Canada	Bartlett	Judith G	Dr.	Centre for Aboriginal Health Research	Associate Director
Canada	Commanda	Laura	Ms	Institute of Aboriginal Peoples' Health	Research Projects Manager
Canada	Delormier	Treena	Ms	KAHNAWAKE Schools Diabetes Prevention Project	PhD. Candidate (Public Health) - Nutritionist
Canada	Downey	Bernice	RN	National Aboriginal Health Organisation	Policy Analyst
Canada	Horne	Margaret	MA	National Indian & Inuit Community Health Representatives Organisation	Executive Director
Canada	Jacobs	Trudy	Ms	Canadian Institute of Health Research- Institute of Aboriginal Peoples' Health	Administrative Assistant
Canada	King	Malcolm	Professor	Alberta Acadre Network	Principal Investigator
Canada	Lavallee	Barry	Dr	Aboriginal Health and Wellness Centre of Winnipeg	Senior Physician
Canada	Lavoie	Josée	Ms	Centre in Aboriginal Health Research	Research Associate
Canada	McCormack	Heather	Ms	Health Canada	Senior Policy Analyst
Canada	Neufeld	Roger	Mr	Health Canada-First Nations& Inuit Health Branch	Senior Policy Analyst
Canada	O'Neil	John	Professor	Centre for Aboriginal Health research	Director
Canada	Reading	Jeffery L.	Dr.	Canadian Institute of Health Research- Institute of Aboriginal Peoples' Health	Scientific Director
Canada	Sweetwater	Indigo	Ms	Aboriginal Nurses Association of Canada BC andNative and Inuit Nurses Association of British Columbia	President
Canada	Tait	Caroline	Doctor	National Network for Aboriginal Mental Health Research	Postdoctoral Fellow/Coordinator
Canada	Vedan	Richard W.	Assoc. Professor	University of British Columbia	Director, First Nations House of Learning
Canada	Wortman	Jay	Dr.	Health Canada	Regional Director

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Country	Surname	First Name	Salutation	Organisation	Title
New Zealand	Arlidge	Brooke	Miss	Tomaioa	Researcher
New Zealand	Crengle	Sue	Dr	University of Auckland, Dept of Maori & Pacific Health	Head of Discipline: Maori
New Zealand	Gibson	Dianne Kay	Miss	Ngati Porou Hauora	Kai Arataki
New Zealand	Harwood	Matire	Dr	Rehabilitation Training & Research Unit, Welling School of Medicine	HRC Research Fellow
New Zealand	Henare	Erima	Mr	Hauora Whanui	General Manager
New Zealand	Jones	Rhys	Dr	Te Ohu Rata O Aotearoa	Chairperson
New Zealand	Kani	Tungane Mei	Mrs	Nga Maia O Aotearoa Me te Waipounamu	Midwife
New Zealand	McKinney	Caroline	Ms	University of Auckland	Post-Graduate Student
New Zealand	Milne	Moe	Ms	Health Research Council	Chair Maori Health Committee
New Zealand	Pimm	Fiona	Ms	Ho Oranga Pounamu	CEO
New Zealand	Pouwhare	Rangi	Ms	Ministry of Health	Manager
New Zealand	Ramanui	Lisa	Mrs	Ministry of Health	Senior Analyst
New Zealand	Reid	Papaarangi	Dr	Eru Pomare Maori Health Research Centre	Director
New Zealand	Robertson	Paul James	Mr	National Addiction Centre, Christchurch School of Medicine & Health Sciences	Lecturer/Clinical
New Zealand	Wall	Louisa	Ms	Maori Health Research, Health Research Council	Manager
New Zealand	Watene	Alayna	Ms	Healthcare Aotearoa	Chairperson
New Zealand	Whata	Ngaire	Ms	National Council of Maori Nurses	
United States	Allen	Marie	Ms	Navajo Division of Health-Special Diabetes Project Program	Area Director
United States	Annette	Kathleen R.	Ms	Indian Health Services	Research Associate
United States	Ball	Alison J.	Ms	Child and Family Center	Co-Director
United States	Cheek	James	Dr	National Epidemiology program, Indian Health Service	Director
United States	Daw	Ray	Mr	Na' nizhoozhi Center, Inc	Director, UNM Center for Native American Health
United States	Dine Chacon	Gayle	MS	University of New Mexico	



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Country	Surname	First Name	Salutation	Organisation	Title
United States	Duran	Bonnie	Ms	University of New Mexico	Co-Director, UNM Center for Native American Health Tribal Administrator
United States	Garcia	Bruce	Mr	Pueblo of San Felipe Office of the Governor	
United States	Lucero	Julie	Ms	University of New Mexico	
United States	Miller-Korth	Nancy	Ms	Great Lakes Inter-Tribal Council	Great Lakes EipCenter Coordinator
United States	Naseyowma-Chalan	Elizabeth Joyce	Ms	New Mexico Department of Health	Director, NM Dept of Health Public Health Division
United States	Nez	Carol	Ms	University of New Mexico	Program Manager, UNM Center for Native American Health
United States	Oritz	Anthony	Governor	Pueblo of San Felipe Office of the Governor	Governor
United States	Packard	Gwen	Ms	Morning Star House	Director
United States	Perez, PhD	Jon	Mr	Indian Health Service	Director, Behavioral Health Services
United States	Poston	L. Stephine	Ms	Pueblo of Sandia	Public Relations Analyst
United States	Poudel	Madan	Dr	Navajo Division of Health	Health Service Administrator
United States	Romero, PhD, MPH	Francine	Dr	Northwest Portland Area Indian Health Board	Epidemiologist
United States	Schwartz	Deborah	Ms	Office of the Special Advisor for Aboriginal Health	Special Advisor
United States	Teague	Gloria	Ms	Cherokee Nation	Medical Director
United States	Verney Ph.D	Steven P	Assistant Professor	University of New Mexico	Assistant Professor
United States	Walters	Karina Lynn	Assoc. Professor	University of Washington, School of Social Work	Associate Professor
United States	Yepa-Waquie	Harriet Louise	Ms	Pueblo of Jemez - Health Clinic	Medical Social Worker



APPENDIX H

INDIGENOUS NURSING AND MIDWIFERY CAUCUS

Present:

Australia: **Odette Best, Kath Howey**

Canada: **Bernice Downey,
Indigo Sweetwater**

New Zealand: **Tungane Kani, Caroline McKinney,
Ngairi Whata**

United States: **Marie Allen**

An inaugural Indigenous nursing and midwifery caucus was held at the INIHKD meeting to discuss issues relative to Indigenous health and nursing.

In recognition that Indigenous nurses are the largest professional Indigenous workforce group and that Indigenous midwives hold traditional knowledge regarding birthing, the following priorities in Indigenous Health reform were identified:

Cultural Safety

That cultural safety must be evident in all levels of nursing/midwifery services for Indigenous Peoples.

Education

That Indigenous Health and cultural safety must be evident in core Nursing/Midwifery education curriculum.

Protection of Indigenous Knowledge

That Indigenous women and families have a birthright to the access of traditional Indigenous birthing practices and breastfeeding. Further, that Indigenous knowledge needs to be protected against misappropriation.

Self determination

That nursing and midwifery health care should be 'by Indigenous People for Indigenous People and through Indigenous Institutions'.

Indigenous Health Reform

That Indigenous Health Reform and development needs to be a multi-disciplinary and community led process.

That Indigenous Community Health Workers are often the first point of contact in Indigenous communities and that they make a valuable contribution in the delivery of healthcare for Indigenous Peoples.

Nursing Research Priorities

That nursing research should be for Indigenous nurses/people by Indigenous nurses and people.

That nursing research agendas should be developed within the overall aim to advance the health of Indigenous Peoples.

Nursing Workforce Priorities

That Indigenous nurses and midwives are critical to advancing the health of Indigenous Peoples.

That the current shortage of these workforce groups requires Indigenous specific solutions and strategies in order to address them.

That we need to increase the numbers of nursing academics.

That Indigenous Nurses and midwives need to be supported and nurtured in their work to address workplace, professional and cultural isolation within the context of developing sustainable nursing retention frameworks.

Health Initiative Priorities

That nursing and midwifery supports and advocates for the development of health initiatives that are based on an Indigenous wellness model.

That Indigenous nursing and midwifery services historically were provided in an Indigenous way to address the physical, emotional, spiritual and mental needs of Indigenous Peoples. Further, that in contemporary health care approaches, this is recognized as Primary Health Care.

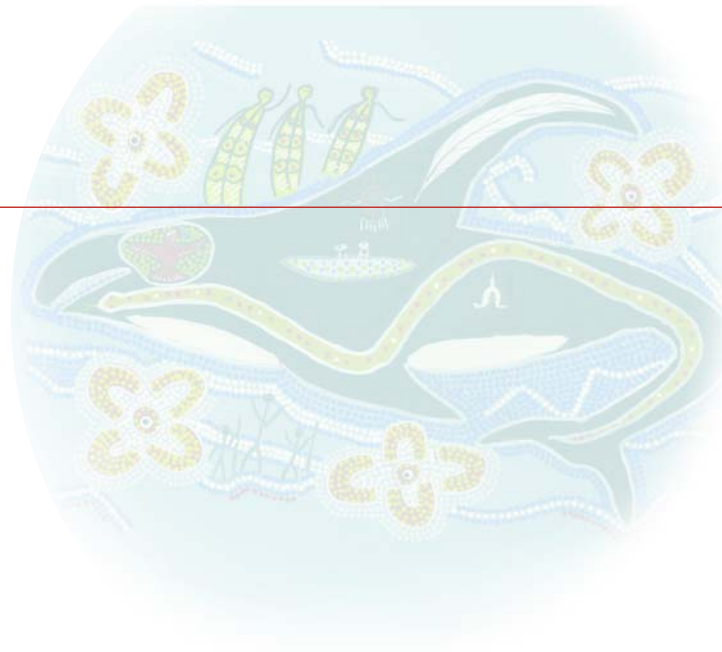
APPENDIX I

INTERNATIONAL COMPARISON

Presented by: Ms Josée Lavoie

	NEW ZEALAND	AUSTRALIA	CANADA	AUSTRALIA
Case study	Raukawa Hauora	Dilba Danila TRHHI	Health Transfer Policy	Katherine West
Basis for Financing	<ul style="list-style-type: none"> No core funding \$ accessed on a competitive basis. 	<ul style="list-style-type: none"> Core funding historical + other \$ on a competitive basis 	<ul style="list-style-type: none"> Historical, +indexation at 3%, no population increase from transfer 	<ul style="list-style-type: none"> Mix mode: capitation with remoteness and needs + mobility + indexation + increase population
Contracts	<ul style="list-style-type: none"> Yearly 	<ul style="list-style-type: none"> Funding yearly to 3 years 	<ul style="list-style-type: none"> 3-5 years 	<ul style="list-style-type: none"> 3 years
Clear definitions of what is being transferred	<ul style="list-style-type: none"> Each contract defines a clearset of output for a different population 	<ul style="list-style-type: none"> Demand driven Ambiguous boundaries 	<ul style="list-style-type: none"> On-reserve population Extension of Canadian Health Care System 	<ul style="list-style-type: none"> Population in zone Extension of the Australian Health Care System Residual role to be defined
Comprehensive primary health care	<ul style="list-style-type: none"> No, the contractual environment is too fragmented Vulnerable to constant reforms 	<ul style="list-style-type: none"> No, services depend on the ability to secure funding. Vulnerability to funding changes and vertical strategies 	<ul style="list-style-type: none"> Yes, with nurses as the centre of the health care team 	<ul style="list-style-type: none"> Yes









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INDIGENOUS HEALTH
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Symbolism:
Serpent/snake
is identified as part of,
and represents, Aboriginal
dreamtime

Ladies
represent Aboriginal people

Green circle
is a New Zealand representation
of new life

Durri
Torres Strait Island headdress

Inukshuk
Inuit land marker
for direction finding

Other represents
Native American and
Canadian Aboriginal people
with medicine wheel

Dotted lines
are borders in our lands to cross

Artist: Mick Adams