A Discussion Document

Knowledge translation to improve the health of Indigenous Peoples

"Inaugural Meeting to be held

3-6 October 2003

Townsville, Australia"

Finalised **March 2003**

Rationale

The continuing disparities between the health of indigenous people and the non-indigenous settlers of Australia, Canada, New Zealand and the United States of America is a matter of major concern. In each country the legacies of colonial dispossession, land alienation, forcible relocation, suppression of indigenous cultural practices, values and beliefs, loss of language, disruption of families, violations of indigenous inherent sovereignty and right to self-determination, treaties, international law and indigenous cultural law, 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, Maori, Canadian Aboriginal, Kanaka Maoli, American Indian and Alaska Native peoples. There are also some striking differences relating to these factors. In response to demands, each colonial government has initiated health programmes. The policies and strategies used to impact indigenous health have varied, as have the results. We believe that there is much to be learned from sharing each other's approaches, experiences and results. An International Network in Indigenous Health Knowledge and Development will provide this opportunity.

Knowledge translation will be promoted in the INIHKD through activities designed to build capacity, stimulate research, and strengthen and expand the international knowledge translation system. The aim is to translate new 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.

Statement of purpose

Leadership by indigenous peoples located within communities and in academic institutions in the planning and programming activities of the International indigenous Health Network (INIHKD) is fundamental.

Aims

The purpose of the INIHKD is to provide a network for people working to improve the health of indigenous peoples. For this purpose, indigenous peoples are defined as the original inhabitants of a country, now outnumbered by settlers, with a continuing legacy of colonialism. The international network will include university, community/indigenous health providers and policy-making representatives interested in contributing to the improvement of indigenous health.

The aims of the INIHKD are to provide a vehicle for indigenous communities and indigenous academics to:

- Development of standards that ensure Aboriginal leadership and participation at all levels of research including research priorities, methods, data collection, interpretation, dissemination of results and implementation of actions arising from the research findings
- Exchange of ideas, models and experiences about health services delivery, health determinants and health systems;
- Sharing approaches, knowledge and experiences and encouraging exchanges in the teaching of health staff involved in delivery of health care services for indigenous people;
- Fostering collaboration in, and exchange of information about, basic and applied research and workforce education and training, with a particular emphasis on models which facilitate enhancement in health care delivery and improved health gains;

- Sharing policy approaches to indigenous health that have been adopted in each country, identifying strengths and weaknesses in the various approaches, and providing information to policy makers, and;
- Fostering mentoring relationships and exchanges of researchers and students.

The INIHKD is proposed as a practical means of improving health through the exchange of ideas, models, and experience, in a network led by, and for the benefit of, indigenous people in Australia, Canada, New Zealand and the United States of America. This process of exchanging, models and experiences is formally known as knowledge translation, encompassing all steps between creation of new knowledge and its application to yield beneficial outcomes for society[i].

The network will foster knowledge translation in three key areas:
1. Education, training and workforce
2. Health services and
3. Research.

Within each country there should be broad representation from:
1. Indigenous community based health service organizations;
2. Indigenous academics from health and other relevant disciplines, and;
3. Academic institutions involved in indigenous health education and research, and policy development;
4. Policy makers

Training, education and workforce issues

The formally trained indigenous health workforces are small. In some countries there is a larger number of un-trained or minimally trained community health workers. Challenges within the training and education sector include:

- Recruiting adequate numbers of suitably qualified applicants to apply for training programmes
- Providing 'bridging' or 'remedial' courses for people who do not currently meet entry requirements but would be suitable applicants once knowledge gaps are addressed
- Developing 'affirmative action' programmes within educational institutions that currently do not provide these programmes
- Supporting students who are engaged in educational training programmes
- Providing placement opportunities within indigenous health services for people in training courses. Supporting the health services that do provide placement opportunities to ensure that the service benefits from the experience as well.
- Providing appropriate post-basic training (medical specialities etc.) opportunities and support for people engaged in these programmes
- Support for indigenous students undertaking Masters and Doctoral level studies
- Training and education programmes should be provided in ways that maximises indigenous peoples access to these programmes. For example, teaching occurring at weekends or in block courses for people who continue to work or have to travel considerable distances; use of Internet and distance based learning resources.
- Translation of models of indigenous Participation and Support Programs from Medical faculties and schools to other health disciplines as appropriate.
- Developing Indigenous peoples capacity (researchers and community members) who participate in Indigenous health research projects
- Development of effective workforce development planning models and identification of current workforce and estimating future needs
- Supporting Indigenous students in high school to identify the health professions as a potential career pathway, and work with schools to improve educational standards in high schools
- Sharing models for early intervention in communities…
- Integration of informatics and computer / internet in courses

In addition to the issues surrounding indigenous participation in the health workforce, there is also an urgent need to enhance the capacity of the existing and future health workforce to ensure that they provide effective, high quality and appropriate health care to indigenous peoples. Issues of relevance here may include:

- Planning, recruitment and facilitating entry into the health workforce -
- Preparation of the health workforce. Ensuring that graduates from health training programmes have the knowledge and skills necessary to allow them to practice in a high quality, effective and appropriate manner. This preparation needs to occur at three levels: during undergraduate health care training, during vocational training (e.g. during training in the various health specialties) and during maintenance of professional standards (continuing medical education etc.) programmes.

- The content of this training can be considered to fall into three broad areas:
  - Legal, under western international law, indigenous cultural law, constitutional and historical issues e.g. the constitutional basis of the relationship between government and indigenous peoples (where such a relationship exists); the history of colonisation and the impacts that this had on indigenous peoples; the nature of the contemporary relationship between government and indigenous groups; current policy regarding indigenous issues.
  - Relevant clinical and epidemiological information; the types of indigenous health services and health workers that are available for collaboration and referral; clinical issues that are important within indigenous communities (but may not be common in non-indigenous populations).
  - Cultural safety and engaging with indigenous communities/groups/organisations. It is important that members of the health workforce are able to practice in a culturally safe manner with indigenous communities. Contemporary cultural safety teaching involves the individual developing an awareness of their own cultural practises, values and beliefs and the impact of these on how they see the world and interact with other people. Once this is understood the health worker understands that people from different cultures have different beliefs, values and practices, is able to identify areas where these may differ from their own, and can interact in a respectful and safe manner.

It is also important for the health workforce to know what indigenous groups and organisations are available for information and relationship building, and that practitioners are aware of protocols around approaching indigenous communities for collaboration and relationship building.

Specific issues surrounding the teaching of indigenous health within academic institutions and other training organisations are also identifiable. These include:

- Ensuring that curricula for the health workforce are comprehensive and include the elements outlined above.
- Ensuring that the delivery and content of teaching programmes is comprehensive and of high quality. This includes ensuring that, when the audience includes indigenous people, the teaching methods and content are not culturally insensitive or unsafe.
- Flexible models and mechanisms to enhance teaching of indigenous health should be explored. For example, Internet and online delivery, learning support via telemedicine, site visits, weekend and block mode courses.
- Involving indigenous peoples in the teaching and training about indigenous health. Teaching and training in indigenous health must include indigenous peoples. However, teaching and training must not be seen as the total responsibility of indigenous peoples. All health care providers must be cognisant of indigenous health issues and contribute effectively and safely to improving indigenous health. To achieve this, people involved in teaching and training must provide high quality education about indigenous health.

- The participation of indigenous peoples in all arenas within the health sector is a key requisite. Partnerships with indigenous communities are an important facet of participation in teaching and training. Institutions and individuals involved in teaching and training should foster these relationships and partnerships.
- The role of primary health care workers as an essential component of the Indigenous Health Workforce, and issues relation to career pathways and progression.

It is anticipated that an INIHKD would facilitate knowledge translation among those interested in training, education and workforce development in different countries. This could occur via meetings, electronic communication and exchange of personnel and curricula, on an ongoing basis.

Health Services

The examination of health services is a multi-level activity; ranging from the health system adopted by a particular country to health service provision at a community level.

Each country has a unique health system. Similarly, the approaches to meeting the health needs of indigenous peoples vary in each country. Issues that could be addressed through the network include:

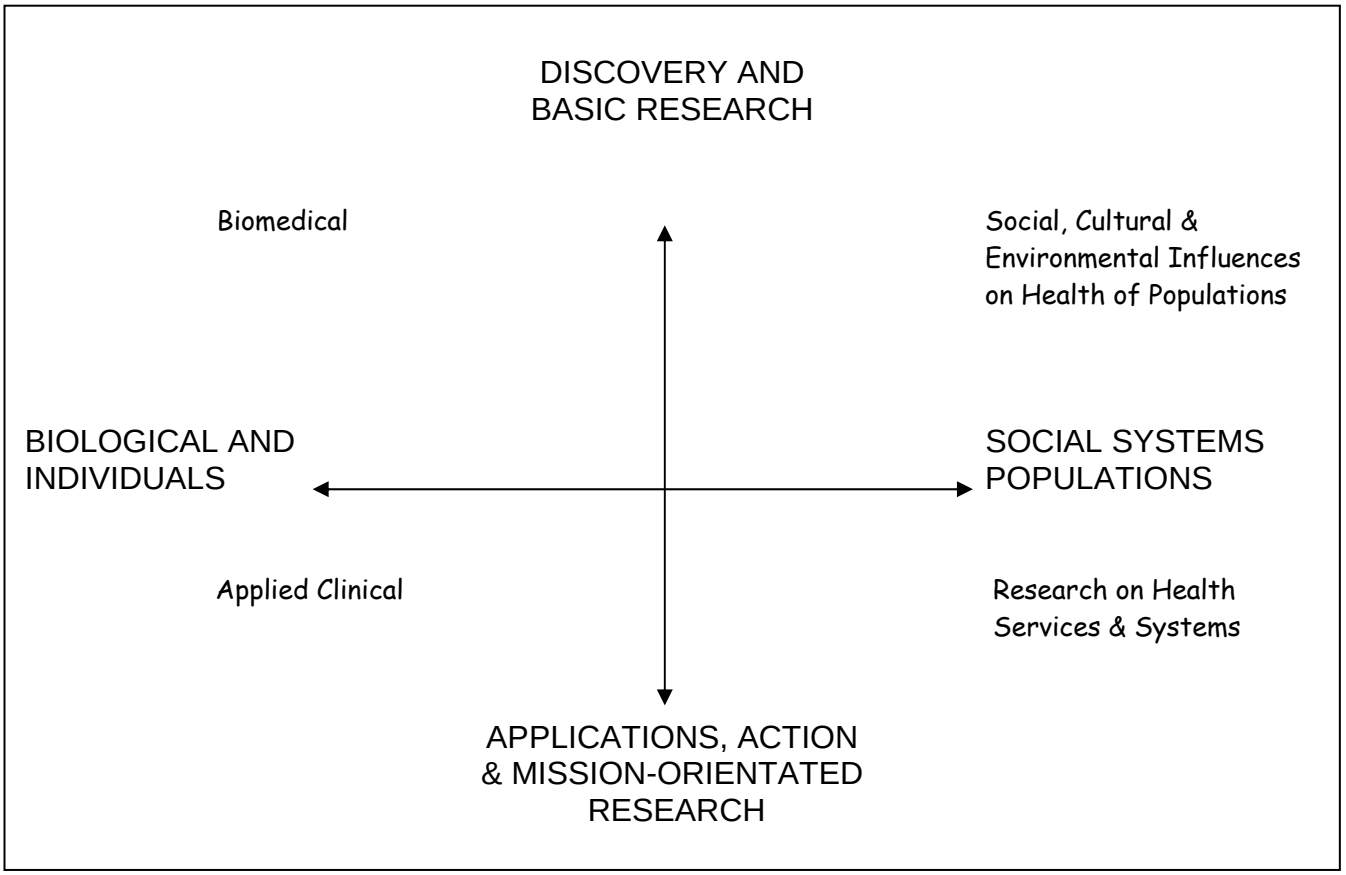
- Indigenous peoples governance and decision meetings through all levels of the health care system. For example, partnerships between indigenous peoples and those involved with the funding, planning and delivery of health care
- Indigenous peoples participation in the health workforce including strategies to increase indigenous participation in the workforce
- Models of health service delivery to indigenous people; including services provided by indigenous people, for indigenous people. For example,
  - Accountability to communities
  - Development of networks with local community health and other social service agencies
  - Innovative programmes and models
  - Flexibility to local health needs and priorities, including ability to respond to changes in circumstances in indigenous communities and populations
  - Reorientation of the organisational culture of health services including management and delivery
  - Planning monitoring and evaluation of health systems and services
  - Resource allocation for indigenous health needs and economic efficiency issues
  - Models of health service management within indigenous health services
- Quality and effectiveness of the health care system including
  - Accessibility to and utilisation of health services
  - Health information systems including ethnicity identification in data collection
  - Indigenous peoples access to standard medical care pathways and protocols
  - The use of evidence based and best practices in indigenous health settings
  - Performance indicators and reporting measures for health service delivery
  - Development of wellness standards
  - What are the key elements of provider /constituent (patient) relationships
- Relationships and collaborations between traditional healers and Western health practitioners

More detailed discussion and translation of knowledge about these issues will occur through the INIHKD.

Research

The dimensions of indigenous health research have not been fully explored. This evolving discipline is interdisciplinary by its very nature and has the potential to demonstrate how collaboration can add value to health research. Issues that are currently being explored include the role of spirituality, self-determination and cultural practices in health and well being. The dimensions of non-indigenous health research models usually include biomedical, clinical, health systems and services, and social, cultural and environmental influences on the health of populations. For example the model used by CIHR[ii] (see Figure 1) describes two continuums: from basic to applied research, and from individuals to communities for the unit of analysis

FIGURE 1: Dimensions For Health Research



Note: The four pillars or domains of health research include biomedical, applied clinical, health services and systems and social, cultural and environmental influences on population health. The key to the model is the integration of researchers in collaborative interdisciplinary health research teams. These relationships are important to achieving the knowledge translation objectives especially when they include meaningful involvement and integration of indigenous 'ways of knowing'.

In the area of research, knowledge translation includes

- Knowledge dissemination,
- Communication,
- Technology transfer,
- Ethical context,
- Knowledge management,
- Knowledge utilization,
- Two-way exchange between producers and users of knowledge,
- Implementation research,
- Technology assessment,
- Synthesis of results within a global context,
- Development of consensus guidelines, and more.

Knowledge translation can be defined as follows:

> *Knowledge translation is the exchange, synthesis and ethically - sound application of knowledge – Within a complex system of interactions among* producers and users of knowledge – *to accelerate the capture of the benefits of research through improved health, more effective services and products, and a strengthened health care system.*

Partnerships are at the heart of effective knowledge translation. Ongoing relationships based on trust between the producers and users of knowledge have been found to be the strongest predictors of success in achieving evidence based decision-making. Knowledge users include Researchers, Policy makers and administrators, health care providers, in both the formal and informal systems of care, general public and patient groups and the private sector.

Within the research community it is increasingly recognised that the active exchange of information between the producers and users of knowledge is an integral part of research[iii]. Researchers and funding bodies must create more opportunities for interaction between themselves and potential users of the research.

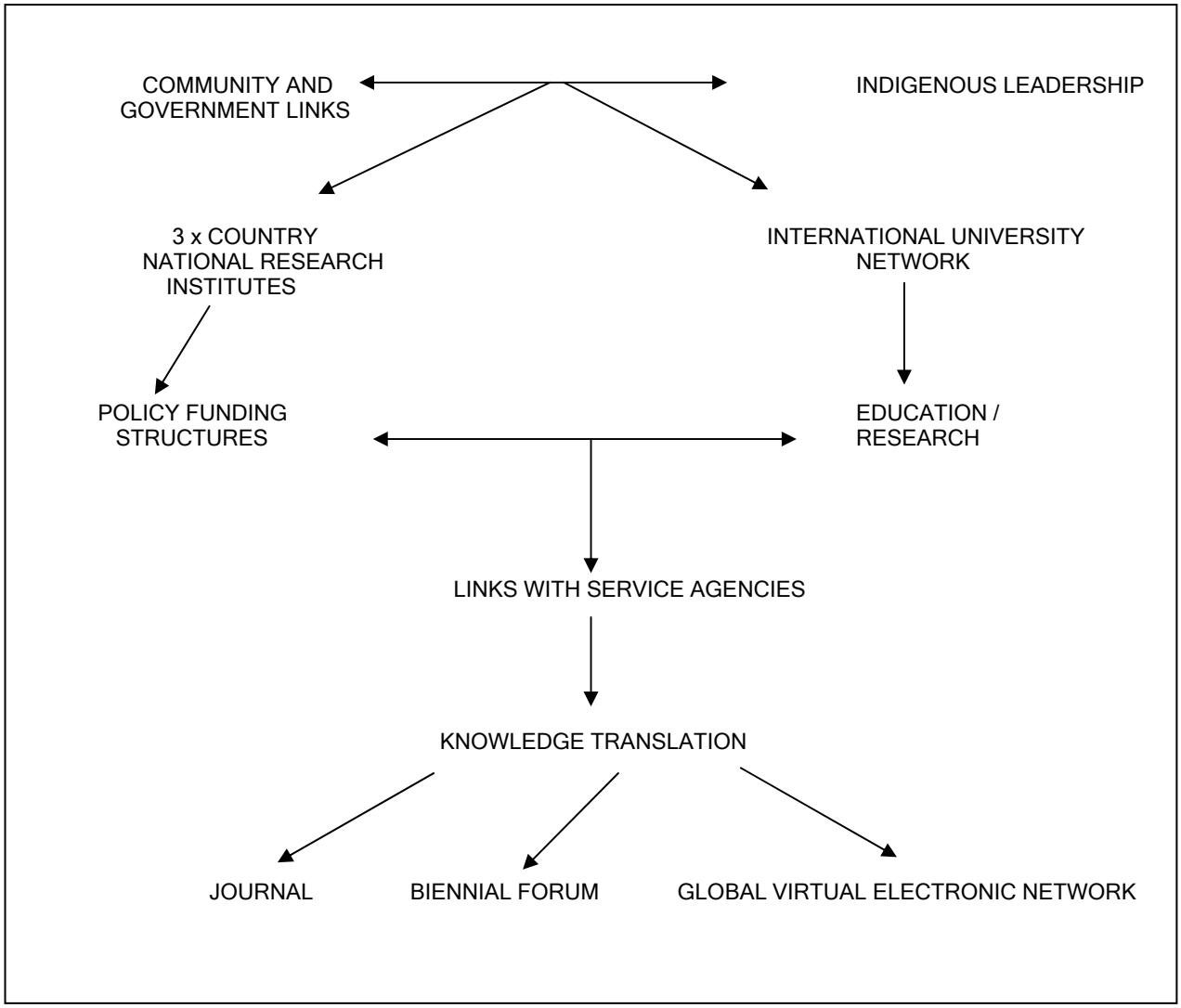
Decision makers must catalyse the translation of research into action across all sectors of public policy. These sectors have profound impacts on health, far outweighing the influence of the health care system alone. Knowledge exchange has to go beyond health researchers to achieve optimum results.

The INIHKD will provide a forum to:
1. Encourage researchers to engage in Indigenous health research
2. Foster collaboration in research
3. Promote dissemination of research protocols & ethics, and current research & findings
4. Share models for building Indigenous health research infrastructure and capacity

Network Structure

Figure 2 identifies the structure of the INIHKD and related core business activities as a means of achieving knowledge translation.

FIGURE 2: Structure of INIHKD



The key stakeholders in the INIHKD meeting are shown in Table 1 and encompass the participants of health related knowledge translation.

TABLE 1: Key Stakeholders in Network Meeting*

INSTITUTION		COUNTRY			
		AUSTRALIA	**CANADA**	**N.Z.**	**U.S.A**
POLICY and FUNDING	**Indigenous Community Agencies**	NACCHO	NAHO	Maori development Organisations, Nga Ngaru Hauora o Aotearoa and other Maori providers not covered by MDOs or Nga Ngaru Hauora o Aotearoa Te Ora and National Council of Maori Nurses	To be advised
	Government and Community Health Agencies	OATSIH	HEALTH CANADA	MINISTRY OF HEALTH and Te Puni Kokiri (Ministry of Maori development)	Indian Health Service
	Research Council	RAWG and NHMRC	CIHR/IAPH	HRC	NIH

** Includes but isn't limited to…*

The activities of the INIHKD is strengthened through the signing of a Cooperation Agreement between the Canadian Institute of Health Research (CIHR), the Australian National Health and Medical Research Council (NHMRC), and the New Zealand Health Research Council (HRC) and the Memorandum of Understanding between Health Canada and the Indian Health Service (USA). This agreement will provide a basis for future collaboration and priorities for indigenous health research and will be an important linkage in the future work and activities of the INIHKD, as the INIHKD will need to be responsive to the undertakings in the Cooperative Agreement. The Cooperation Agreement will reinforce knowledge translation within the research agencies and institutions, in partnership with the indigenous community, and relevant government agencies. The Cooperative Agreement also provides a framework for the future development of indigenous health research infrastructure, ongoing sponsorship of research, and translation to policy and health service development.

Proposed Core Business Activities of INIHKD

The network will undertake the following activities:

1. Meetings

Meetings of the INIHKD will be held to facilitate the bringing together of indigenous communities, indigenous and non-indigenous academics, and government representatives.

The key objectives of the meetings are:

- Link knowledge development, research priorities and strategies to the needs and benefits of communities and other end-users of research. ;
- Promote models of education and training for the indigenous health workforce;
- Provide a foundation for the dissemination of research knowledge to health services, indigenous communities, other researchers and policy formulators
- Establish a formal publication of the meeting proceedings

Representatives of the host country would convene the activities of the planning committee for the Network meetings. The first meeting will be held in Townsville, Australia, in October 2003. The host will alternate on a biennial basis between member countries at a university or research-intensive institutions in partnership with indigenous communities.

2. Activities between meetings

Sustained activity between the meetings of the Network is required to achieve maximum benefit. A secretariat may be required to achieve continuity for the network. An interim network committee will be implemented to develop sustainability options, governance, constitutional and operational issues for presentation to the inaugural network meeting. The committee will also consider activities that the network might undertake, including but not limited to:

- Student and academic exchanges;
- Newsletters;
- Collaborative research;
- Initiatives to enhance the Indigenous health workforce, and;
- Teleconferences and ongoing planning meetings;
- International journal of indigenous health
- Arrange publication of the proceedings of the meeting.

Development of the INIHKD

A. Preparation to date

An initial steering committee with representatives from universities in Canada, New Zealand, the United States of America and Australia has been established to begin planning the first network meeting. The working group met via teleconferences since February 2001, and face-to-face meetings to discuss these ideas and to develop this discussion paper have been held in Townsville, Australia (November 2001), Toronto, Canada (March 2002) and Hawaii (June 2002). Key supporting organisations have been identified as:

- Australia (NACCHO, RAWG, DHAC, and SCATSIH)
- New Zealand (HRC and various community agencies, MoH and TPK)
- Canada (ACADREs, CIHR, and NAHO).

Supporting organisations for the United States of America are to be determined. The members of the steering committee include:

- Dr Jeff Reading (Canada)
- Dr Barry Lavallee (Canada)
- Dr Judy Bartlett (Canada)
- Dr Earl Nowgesic (Canada)
- Dr Sue Crengle (New Zealand)
- Dr Tassy Parker (New Mexico)
- Dr Gayle Dine Chacon (New Mexico)
- Dr Bonnie Duran (New Mexico)
- Dr Michael Bird (USA)
- Mr Mick Adams (Australia)
- Ms Rachel Atkinson (Australia)
- Mr Henry Counsellor (Australia)
- Assoc. Prof. Jacinta Elston (Australia)

TABLE 2: Organising Committee for Network Meeting on Knowledge Translation*

INSTITUTION	COUNTRY			
	AUSTRALIA	CANADA	N.Z.	U.S.A
Community	NACCHO and QAIHF	NAHO	Maori development Organisations, Nga Ngaru Hauora o Aotearoa and other Maori providers not covered by MDOs or Nga Ngaru Hauora o Aotearoa Te Ora and National Council of Maori Nurses	To be advised
Universities	James Cook University	University of Toronto and The University of Manitoba	The University of Auckland	University of New Mexico

** Includes but isn't limited to…*

B. INIHKD meeting in 2003

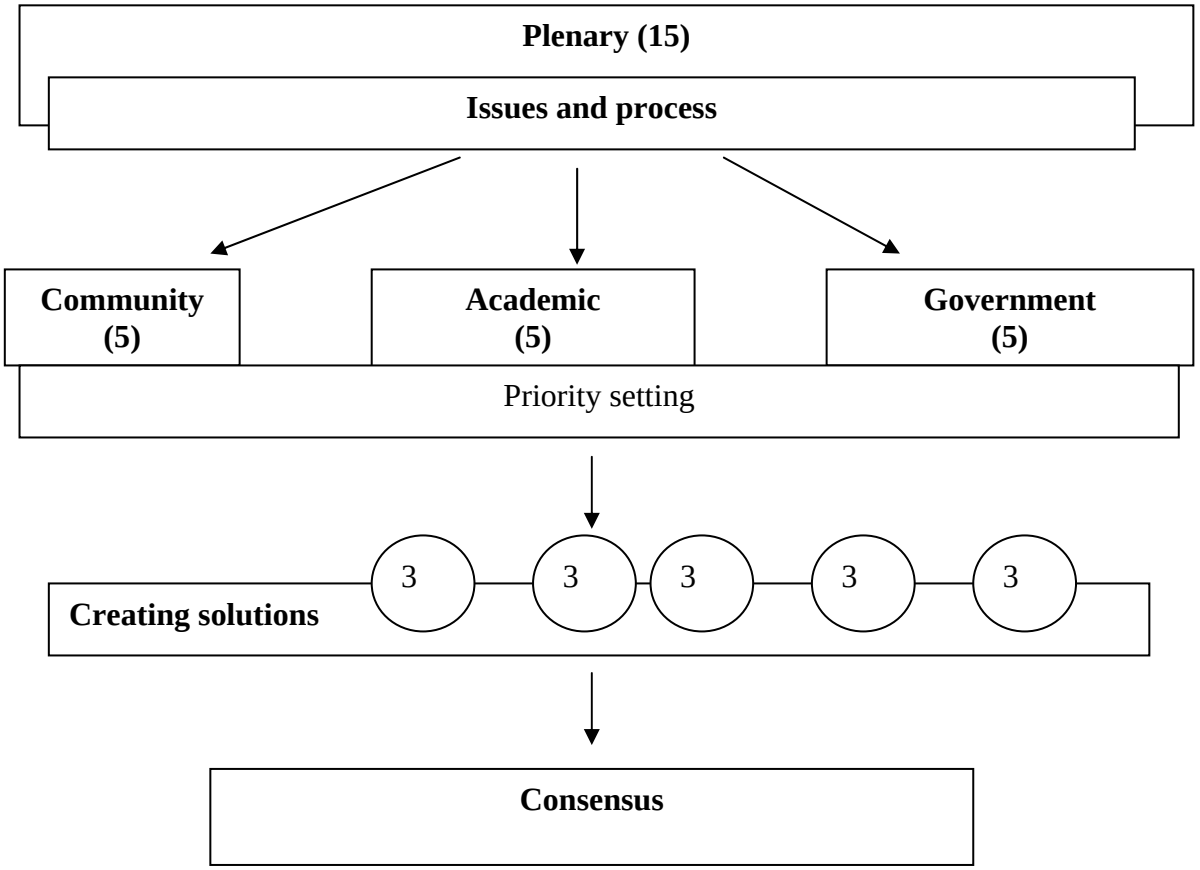
i) Meeting Structure

- Domains will provide an overall focus for each day's proceedings, and will draw upon a matrix of different perspectives, with all stakeholders and countries, community, health care services, etc., involved. For example, gaps in funding for health care → cannot support health care services → health care provision suffering; identify and inform how knowledge translation can assist.
- Breakout sessions to be informal and qualitative; invite group to talk on allocated theme, relaying and translating information, including community, research and health care perspectives.
- Invite targeted community groups to participate in breakout sessions to make content 'real'.
- Panel members will be allocated a theme/domain, to compile a brief overview/report and report on this during Synthesis and Feedback on final afternoon session. Alternately, organisers could dedicate one session to presentations and use breakout sessions for the remainder of the meeting, to generate as much knowledge translation as possible.
- Poster Section will be included to present and share different approaches and models of indigenous health service delivery, health education and research strategies.

ii) Forum Framework

The forum could utilise a matrix framework to draw together discussion and sharing of models around domains, within disease/illness-specific categories, whilst drawing on several themes of the program:

Proposed framework for meeting



❖ 3-4 country panels on selected **domains**, e.g.;

- Health care services
- Non-communicable and communicable diseases
- Research
- Traditional healing practice
- Life stages
- Health promotion
- Innovative solutions/best practices for common problems
- Policy implementations
- Teaching
- Community health
- Prevention

❖ 3-4 country panels on selected **topics**, e.g.;

- Diabetes,
- Cardiovascular disease,
- Obesity
- Well-being.

❖ 3-4 country panels on selected **themes**, e.g.;

- Improving indigenous health by sharing outcomes, experiences and solutions;
- Information and knowledge translation - using knowledge to transform and improve health;
- Putting knowledge into practice (linking research to teaching and policy applications);
- Approaches to medicine and healing (traditional practices) – collaboration with primary health care;
- Changing behaviour through indigenous/Aboriginal identity, knowledge, holistic medicine and dietary research/knowledge,
- Implications for teaching practices.

C. Funding

Ongoing funding is required to support the INIHKD infrastructure and the proposed activities of the network. Specific issues include:

- Each country to secure financial support to participate in the network and it's activities;
- Funding to be sought to enable International Indigenous communities and health service providers to participate in the INIHKD Meetings;
- Secure publication agreements for the proceedings of the inaugural network meeting;
- Host country/institution responsible for securing core funds for the biennial meeting;
- Potential funding sources may include: World Bank, Gates Foundation and WHO, and;

Each organising committee member to approach local contacts and internal funding bodies (including seeding grants), particularly for long-term funding/sponsorship. Requests for funding to commercial interests such as pharmaceutical companies will be made co-operatively between network members.

Comments and feedback on this document are welcomed. Please forward comments to the INIHKD Steering Committee by email at IIHNoc@jcu.edu.au.

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References:

[i] CIHR Act. Bill C-13, Assented to 13th April 2000 - http://www.parl.gc.ca/36/2/parlbus/chambus/house/bills/government/C-13/C-13_4/C-13_cover-E.html

[ii] Jeff Reading, Presentation to INIHKD Planning Meeting held 15-16 November 2001, Townsville Australia.

iii Lavis, J., Ross, S., Hurley, J., Hohenadel, J., Stoddart, G., Woodward, C., Abelson, J. Reflections on the Role of Health-Services Research in Public Policy-Making. Paper 01-06.