Résumé

La recherche de modes de prestation des soins sensibles aux valeurs culturelles : les enseignements de deux communautés autochtones de la Saskatchewan

Pammla Petrucka, Sandra Bassendowski et Carrie Bourassa

La Southern Saskatchewan/Urban Aboriginal Health Coalition est une équipe interdisciplinaire et intersectorielle de chercheurs et de communautés voués à l'étude de modes de prestation des soins sensibles aux valeurs culturelles autochtones. Prenant appui sur un modèle de recherche communautaire, on a tenu des cercles de parole auxquels ont participé les membres de deux communautés autochtones de la Saskatchewan dans le but de déterminer les éléments qu'ils considèrent comme essentiels dans la prestation de soins bien adaptés à leur culture. La triangulation et l'analyse thématique ont permis de dégager neuf thèmes initiaux et quatre grandes thématiques. L'étude présente des enseignements susceptibles de guider de futurs travaux de recherche auprès des communautés concernées et d'autres groupes culturellement diversifiés, particulièrement en ce qui a trait au savoir-faire culturel aussi bien des prestataires de soins que des services de santé.

Mots clés : savoir-faire culturel, recherche communautaire

Seeking Paths to Culturally Competent Health Care: Lessons from Two Saskatchewan Aboriginal Communities

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The Southern Saskatchewan/Urban Aboriginal Health Coalition is an interdisciplinary, intersectoral team of researchers and communities dedicated to exploring culturally respectful care in Aboriginal communities. Through a community-based research approach, the communities and the Coalition used sharing circles to determine the key elements that 2 Saskatchewan Aboriginal communities see as requisite for culturally competent care. Through triangulation and thematic analysis, 9 initial themes and 4 broad thematic groupings were derived. The lessons from this study could inform further research with these communities and other culturally diverse groups with respect to cultural competency in terms of both health-care providers and health services.

Keywords: Aboriginal health, cultural competency, community-based research

The Southern Saskatchewan/Urban Aboriginal Health Coalition, a unique research team representing a range of health, educational, and Aboriginal sectors in the Canadian province of Saskatchewan, has been involved in a project spanning nearly 2 years. The Coalition comprises researchers from several organizations: First Nations University of Canada (Regina and Prince Albert), University of Saskatchewan College of Nursing (Regina and Saskatoon), Native Access Program to Nursing (Regina), Saskatchewan Institute of Applied Science and Technology Nursing Division (Regina and Saskatoon), Regina Qu'Appelle Health Region, Standing Buffalo First Nation, and Regina Métis Sports and Culture Centre.

The idea for this research project was initiated by individuals from three organizations who met in September 2002 at a meeting of a research consortium hosted by the University of Saskatchewan. Aboriginal health was a dominant topic at that meeting, and the three shared a mutual interest in establishing culturally respectful care for Aboriginal persons in both the education of health professionals and the health-care system. This common ground led to the formation of the Coalition and to the identification of communities of interest that pred-

icated the research. The composition of the Coalition is somewhat fluid but there is a core membership of between 16 and 20. In addition, an Advisory Committee comprising nine Aboriginal people has provided direction to the research team throughout the research process. This group was essential in forming the research team and bringing the communities together. Further, the Coalition has been supported at all stages by two Aboriginal elders working collaboratively as expert advisors to both the research team and the Advisory Committee.

The early meetings of the research team were spent in thoughtful discussion of what each member knew and understood about concepts such as culturally respectful care, Aboriginal knowing and healing, Aboriginal communities, education programs for health professionals, Aboriginal pedagogy, health-care delivery, and health. As the team began to explore and trust the process, the emphasis turned to developing health-care delivery systems and education programs that would incorporate indigenous knowledge and therefore be culturally appropriate for Aboriginal people. The research questions and methodologies were determined by the Aboriginal communities that served as partners and co-researchers in the project. The initial questions focused on Aboriginal healing, culture, and ways of knowing, in order to appropriately incorporate them into the health-care system and into the education of health professionals. These initial efforts led to the ongoing research and team-building efforts reflected herein.

The focus of the research was on capacity-building and respecting cultural competency in the academic research community and two participating Aboriginal communities. The Coalition anticipated that the research would lead to a better understanding of the diversity and commonalities in the Aboriginal communities in Saskatchewan regarding culturally respectful care and its relationship to the education of health professionals. Accordingly, two distinct but related research questions were identified: 1. *How can the curricula of education programs for health professionals be made more culturally respectful for Aboriginal people?* 2. *How can health-care delivery be made more culturally respectful for Aboriginal people?*

Essentially, the research team believed that addressing the fundamental issue of culturally respectful health-professional education and health-care delivery would provide a sound foundation for research into Aboriginal health in Saskatchewan. Although all health professions are of interest to the research team, nursing programs and nursing care were an early focus. This article describes the nature of the research partnership and presents the findings of the initial phase of the partnership efforts to enhance research capacity related to cultural competence in health-professional education and health-care delivery.

Research Context

Since late 1996, following publication of the report of the Royal Commission on Aboriginal Peoples, the emerging paradigm for Aboriginal health has been developing. The 2002 document *Building on Values: The Future of Health Care in Canada* recommends "new initiatives to improve timely access to care, to enhance the quality of care the system provides, a more co-ordinated approach to health human resources planning, and a special focus on the health needs of Aboriginal peoples" (Romanow, 2002). It also cites the importance of addressing Aboriginal health-care needs and involving Aboriginal people in that process.

Health disparities between Aboriginal people and other Canadians are significant, persistent, and unacceptable. According to Romanow (2004), the disparities in life expectancy, prevalence of infectious diseases, rates of chronic disease (especially diabetes), and trends in mental health (i.e., suicide, substance abuse) require immediate and innovative interventions. Much of the research has addressed on-reserve Aboriginal people. The Canadian Community Health Survey found that approximately 800,000 Aboriginal people in Canada are living off reserve (Sibbald, 2002). Aboriginal people, both on and off reserve, have frequent interactions with the formal health-care system in relation to their self-care and informal caregiving roles, but little voice in articulating appropriate approaches to care, the incorporation of culture into the healing process, or approaches to teaching health-care practices that are consistent with Aboriginal ways of knowing (Sibbald).

Saskatchewan's health-care system has been undergoing reform as it attempts to respond to fiscal and human resources challenges and to meet the needs of the population. *The Action Plan for Saskatchewan Health Care* identifies the challenges of addressing the health-care needs of Aboriginal people in the province (Government of Saskatchewan, 2001).

Saskatchewan has the highest percentage of Aboriginal people of all Canadian provinces — 13.5% of the total population — trailing only the northern territories (Statistics Canada, 2001). Yet self-identified Aboriginal health professionals continue to be underrepresented in the work force. Within the Saskatchewan health-care sector, only 5% of employees (approximately 1,800) self-identify as Aboriginal, and, significantly, most of those are in entry-level positions (Saskatchewan Association of Health Organizations, 2004). According to the Saskatchewan Job Futures Web site (http://saskjobfutures.ca), the following percentages of health-care personnel self-identify as Aboriginal: support staff (i.e., orderlies, nurse's aides), 6.8; licensed practice nurses, 5.6; nurses and psychologists, 3.7; dental assistants, 3.1; family physicians, 0.9; occupational and physical therapists, 0.

The fall 2004 First Ministers' and Aboriginal Leaders' Special Meeting called for the development of a blueprint recognizing and respecting the unique, specific, and diverse needs of all Aboriginal peoples, including access to health care and health professionals (Office of the Prime Minister [OPM], 2004). The September 2004 federal budget included $100 million for an Aboriginal Health Human Resources Initiative to increase the number of Aboriginal people choosing health professions; adapt current health-professional curricula for a more culturally sensitive focus; and improve the retention of health-care workers serving all Aboriginal peoples, including First Nations, Inuit, and Métis (OPM; this expenditure was confirmed in February 2005).

Education programs for health professionals, including nursing programs, have made strategic efforts to recruit and retain Aboriginal students, to promote culturally respectful teaching and learning environments, and to develop research opportunities for Aboriginal nursing students and graduates. Aboriginal people in Saskatchewan have become the focus of formal health-professional education, as evidenced by the growing number of Aboriginal students enrolled in nursing (University of Saskatchewan/Saskatchewan Institute of Applied Science and Technology), targeted bursaries for Aboriginal people entering the health professions (Saskatchewan Health), and dedicated seats for Aboriginal students in selected programs (University of Saskatchewan). However, persistent gaps and the need for further development of the education programs have been identified; the programs have not sufficiently addressed the need for culturally respectful health and education systems for Aboriginal people and Aboriginal ways of knowing (Roberts & Nagy, 2002; University of Saskatchewan – Health Sciences Deans Committee, 2004).

Literature Review

The challenge of achieving cultural competence within the health-care sector is a multi-faceted challenge. According to Betancourt, Green, and Carrillo (2002), the complexity of cultural competence is evident in the actions of legislators who seek policies, administrators who strategize, academics who ask how to teach students in the health professions, and providers who struggle to deliver a culturally competent standard of care. What constitutes cultural competence remains unclear and is further confused by the interchange of the term with others, such as cultural sensitivity, cultural/transcultural awareness, and cultural knowledge (Adams, 1995; Texas Department of Health, National Maternal and Child Health Resource Center on Cultural Competency, 1997). This literature review looks at cultural competence as well as the knowns and

unknowns of cultural competence in terms of the delivery of health services and the education of health professionals.

Cultural Competence

According to Campinha-Bacote (1988), cultural competence is not an end in itself but an ongoing process of seeking cultural awareness, cultural knowledge, cultural skill, and cultural experiences. This definition has been extended to include behaviours, attitudes, and policies adopted by the system, agencies, or professionals so as to function effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989; Isaacs & Benjamin, 1991).

Cultural competence in health care is the ability of the system to provide care to clients with diverse values, beliefs, and behaviours, which means tailoring delivery to meet their specific social, cultural, ethnic, spiritual, and linguistic needs (Jecker, Carrese, & Pearlman, 1995). Applied to Aboriginal and other potentially vulnerable populations, culturally competent care has three attributes: cultural appropriateness (Jecker et al.; Lavizzo-Mourey & Mackenzie, 1995), cultural accessibility (Association for Older Americans, 2001), and cultural acceptability (Cross et al., 1989; Lavizzo-Mourey & Mackenzie).

Cultural competence is a developmental process that evolves over time. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum (Cross et al., 1989; Issacs & Benjamin, 1991). Cultural competency is "a set of academic and personal skills that allow (health professionals) to increase our understanding and appreciation of cultural differences between groups" (Cross et al., p. 18). It can be achieved only by integrating knowledge with respect to individuals and groups into specific practices and policies applied in appropriate cultural settings (Antone, n.d.; Taylor & Brown, 1997).

> The most common source of cross-cultural conflicts and problems is a lack of cultural education on the part of non-Aboriginal institutional staff and professionals. This is not to suggest that sincere efforts have not been made; rather, this realization points to the factors that have complicated otherwise well meaning program attempts and developments. (Ellerby, 2001, p. 6)

Health professionals must make a commitment to learn about cultural concepts, become aware of cultural values, and continually strive to develop and improve their cultural competence (Meleis, 1999; Swiggum, 1995; Wenger, 1999). A culturally competent professional establishes positive helping relationships, engages clients, and improves the quality of services that he or she provides (Antone, n.d.; Cross et al., 1989).

Summary

The literature review yielded several working definitions of cultural competence, nearly all touching on the need for health-care systems and providers to be aware of and responsive to the cultural perspectives of patients. It is evident that the achievement of cultural competence depends on fundamental individual, collective, and systemic change.

The Research Process

Methodology

The initial research challenge for the Coalition was to identify appropriate ways of undertaking research with Aboriginal communities and to explore ways of improving the delivery of health services and the education of health professionals through the use of inclusive and culturally respectful methodology. Such methodology is necessarily based on the application of practical knowledge to locally defined issues and problems such that it leads to long-term improvement in the quality of life for a group of people.

Community–Based Research

The Action Plan for Saskatchewan Health Care (Government of Saskatchewan, 2001) identifies the importance of community involvement in determining priorities and appropriate health-care approaches. Thus the study invoked community-based research rooted in the tradition of participatory action research. This model seeks to engage community members as equal and full participants in all phases of the research process. The two communities involved throughout the project were identified through previous relationships with members of the team, became full participants on the research team, and secured volunteers for the Advisory Committee. This strong linkage was imperative in establishing the long-term involvement anticipated for the project in light of the *Action Plan*'s emphasis on community-based, long-term health outcomes.

Site Selection

Two sites were selected based on the research team's mandate to include one First Nations community and one Métis community as well as one rural and one urban site. In addition, the participating communities had to be within driving distance of Regina and had to be part of the Regina Qu'Appelle Health Region (one of the research partners).

Data Collection

On the advice of the Advisory Committee, the study used sharing circles in each community. The sharing circle, a traditional Aboriginal oral means

of sharing information and stories, was proposed as a culturally appropriate alternative to the focus group (Berthelette, Raftis, & Henderson, 2001). Smith (1999) describes the need to reclaim the authority of the oral tradition:

> Indigenous peoples want to tell our own stories, write our own versions in our own ways, for our own purposes…a need to give testimony to and restore a spirit, to bring back into existence a world fragmented and dying. (pp. 28–29)

According to the Coalition for the Advancement of Aboriginal Studies (CAAS) (2002), the sharing circle symbolically and functionally reinforces, for all involved, the notion that "every issue has many aspects that can be viewed from both the inside and the outside and, at the same time, everything is connected" (p. 17). Central to the sharing circle is the respectful and equitable environment that it creates and perpetuates. Nabigon, Hagey, Webster, and MacKay (1998) view the sharing circle as a process that enables information-sharing and connecting and that seeks balance and harmony. Every individual decides whether and when to contribute, recognizing that active listening is an important feature of the sharing circle (CAAS, 2002). Further, all participants endeavour to stick to the matter under discussion, thus honouring the time and commitment of the other people present (CAAS).

The sharing circles served to affirm the communities as co-researchers. A total of seven sharing circles were held, either within the Standing Buffalo First Nations community or at the Regina Métis Sports and Culture Centre, between February and April 2004. Membership and participation were voluntary at each site. The groupings were subdivided according to gender and age to allow for the inclusion of a gender perspective and a youth perspective. The result was two sessions for men, three for women, one for boys, and one for girls, each with between six and nine participants. The gender/age segregation was undertaken on the advice of the elders, who stressed the variance among the groups and the likelihood of achieving optimal sharing with homogeneous groups.

Each session was guided by an elder and included a facilitator and a professional transcriptionist (note-taker/recorder) from outside the community. Each session opened with a prayer and included the sharing of food. The sharing circles followed a semi-structured instrument that was endorsed by the Advisory Committee. The instrument was used as a guide rather than as a script, enabling the facilitators to promote the openness and connectedness of a sharing circle environment. The questions were open-ended — for example, What makes you healthy? What makes your community healthy? The sessions lasted from 60 to 90 minutes and were audiotaped. Confidentiality was ensured in the tran-

scripts and recorded notes, with no names or personal identifying information being used.

Data Analysis

The choice of research questions, interview guide, research sites, and research participants is an essential aspect of data analysis (Miles & Huberman, 1994; Patton, 1990). Simultaneous collection and analysis of data was an important feature of this study, enabling the research team to focus and direct the data-collection process more effectively.

Thematic analysis. The individual transcripts were analyzed using an iterative process: each transcript and associated recorded notes were reviewed as received. Themes were derived using the 13 strategies for extracting meaning as described by Miles and Huberman (1994). Thematic analysis of the first two transcripts and recorded notes yielded a tentative list of themes. This preliminary list was taken to the research team for process, content review, and resonance with the research experience. It was considered a "straw man approach" in order to begin the dialogue on the analysis phase and to provide an opportunity to develop research capacity with students and other research neophytes within the team. This initial list of themes was fairly detailed and was acknowledged as representing only the two transcripts reviewed. As the list was reviewed, all transcripts (including the two original ones) were considered in subsequent iterations and in the triangulation process used in this study.

Data triangulation, a means of enhancing credibility, serves to deepen and broaden the understanding of the phenomena of interest. The use of multiple sources of data in evaluating a phenomenon strengthens the rigour of the investigation. The transcripts and field notes from the seven sharing circles, minutes of meetings of the research and advisory teams, and literature-based evidence were triangulated in this study.

Member checking is an essential strategy for critical observation and interpretation of research data. In this study, member checking served to strengthen the inclusiveness requirement, hone the research skills of team members, and ensure cultural respectfulness in the interpretation phase of the study.

Upon completion of the analysis and receipt of the Advisory Committee's endorsement, a subset of the research team (four members) reviewed the transcripts using the thematic template. This process led to a consolidation of the initial themes. The level of agreement with the coding and the indication of inclusiveness of the themes by the reviewers consistently led to increased trustworthiness of the final coding. The final thematic list was endorsed by the Advisory Committee.

Ethics

One critical challenge in this research relates to the ethics of seeking information from the Aboriginal communities about Aboriginal ways of knowing, healing, and culture. Members of the research team expressed concern about whether "sacred knowledge" can be shared — a perplexity that continually challenged the adherence of research decisions to culturally respectful ethical principles. The project received ethics approval from three partnering agencies: the Regina Qu'Appelle Health Region, the University of Regina, and the University of Saskatchewan. Each participant was asked to complete and sign a consent form that also delineated the opportunity to withdraw one's participation without penalty. Consent in this context was heavily rooted in trust, which is achievable only through prolonged engagement with the community. The issue of confidentiality was addressed with the participants both in terms of the researchers' commitment to present findings in a non–identifiable format and in terms of the participants' commitment to refrain from sharing comments or confidences outside of the sharing circle environment.

The ethics approval process was a unique challenge, as the partners adopted the Ownership, Control, Access, and Possession (OCAP) principles (Schnarch, 2004) as a framework for ethical research with Aboriginal communities. These principles configure a self-determination approach to research involvement by Aboriginal communities. This approach was essential in negotiating elements of ethics with the communities and the participants. However, the requirement to adhere to academic ethics approval was also imperative, and at times this second mechanism was confusing to the community stakeholders. This experience highlighted the lack of a culturally appropriate ethics approval mechanism.

Findings

The initial analysis of two transcripts yielded nine tentative themes with a wide array of exemplars (see Table 1). These themes were rooted in three assumptions: (1) the determinants of health are foundational aspects of working with Aboriginal communities; (2) institutional racism must be acknowledged and addressed; and (3) vulnerability (i.e., over-use of Aboriginal communities for research purposes) and potential misuse (culturally disrespectful use) of information must be recognized and targeted as a part of capacity-building. These assumptions were articulated by members of the community and members of the research team.

The initial themes elicited challenging reflections within the analysis process. For example, the transcendence of time was described as an orientation and re-orientation embracing the recognition of time as

Table 1 *Initial Themes and Exemplars*

Theme	Exemplar
Transcendence of time	(Aboriginal people) have lived a long life in a very short time (male participant)
Experience of choice, loss, and consequences	We lost our understanding of our old morals and values…loss of language, loss of identity; need to understand we are a proud people — proud of being Indian and of being Dakota (male participant)
Invoking of tradition	Can't take medicines into public places, have to keep them private; there is a lot of teaching behind this (elder)
Teacher must be taught/ caregiver must receive care	The family had an elder come in and pray…nurse would not allow it…doctor allowed family and elder to do it (elder)
Value of respect	I think it's good that they get to know the culture so they won't do nothing to offend other people, I guess, so they will show respect for those cultures (youth participant)
Non-hierarchical relationships	We are not going to the health system and seeing ourselves there — that needs to change (female participant)
Sacredness of water	Water is the first medicine (elder)
Way of life/living	Everyone is looking for spirituality… they need to take the time to understand it, can't learn these things out of a book — it is a way of life (elder)
Value of truth	In the old days we didn't have to sign anything because we told the truth; now we lie so we have to sign [a consent form]? (elder)

simultaneously reflecting past, present, and future. Participants emphasized the cyclical nature of life and the interconnectedness of generations that somehow transcend time. Much discussion about the experience of choice, loss, and consequences was rooted in the legacy of colonization. This theme evoked extensive discussion of control, self-image, and self-worth. The invoking of tradition highlighted the difference between what is public and what is private in traditional practices, such as issues related to spirituality. The elders were pivotal in the consideration of the appropriateness and parameters of sharing traditional practices and knowledge. A theme encapsulated in the phrase "the teacher must be taught/the caregiver must receive care" intimated that there is reciprocity in all aspects of the relationship such that those providing knowledge must also be receiving knowledge. The participants expressed the view that although professionals are recognized as knowledgeable, they have a unique opportunity to experience complementarity with Aboriginal/traditional ways of knowing. The value of respect was highly regarded by the participants in terms of mutual understanding, valuing, listening, and cultural openness. Non-hierarchical relationships within the research project were viewed as culturally desirable and requisite to moving forward. Participants indicated that power distinctions and devaluing of certain groups is a significant barrier to culturally competent care. A discussion of the meaning of water was replete with symbolism related to medicine, life-giving and life-sustaining attributes, and environmental responsibilities. The sacredness of water for individual, community, and global peoples is fundamental to the Aboriginal context of health. According to participants, health is holistic and is achieved as a way of life/living. The theme highlighted the individual and communal paths to wellness. Finally, the value of truth was a recurrent theme relating to openness, transparency, honesty, and trust. Participants perceived a high level of distrust and misinformation by both Aboriginal and non-Aboriginal partners in the current health-care environment.

The analysis of all seven transcripts led to a regrouping of thematic findings into four areas: trust, respect, communication, and understanding. The final broad thematic groupings were derived and viewed as conveying meaning and facilitating knowledge transfer to the community participants. Throughout this process there was consensus that these four thematic groupings fully encapsulated findings from the various data sources. In fact, the research team felt that the preliminary themes were subsumed under these broader thematic groupings, as reflected in Table 2. Some preliminary themes (i.e., way of life) were seen as fitting into more than one thematic grouping; however, this relationship was beyond the scope of this study and will be explored in subsequent projects.

Table 2 *Relationships of Final Thematic Groupings and Preliminary Themes*

Thematic Grouping	Representative Preliminary Themes
Trust	Experience of choice, loss, and consequences Non-hierarchical relationships Value of truth
Respect	Value of respect Sacredness of water
Communication	Teacher must be taught/caregiver must receive care
Understanding	Transcendence of time Invoking of tradition

These initial findings provide significant insights with regard to the two study questions. The final themes were seen as guiding principles for the establishment of culturally competent curricula and health services. For example, respect as a theme encompassed cultural aspects of respect, holistic understanding, cultural symbolism, and shared meaning. These elements are seen as critical to achieving individual and collective cultural competence in health care. The research team continues to review the data for community-, gender-, and age-related trends. The research team and the community are currently seeking ways of interpreting and applying these themes in terms of the research questions and future research directions.

Lessons Learned

This research process is a journey that has taken many paths and included many co-travellers. We have learned the importance of involving the community from the beginning, in all aspects of the research. The advice and guidance of elders are critical to the development of partnerships and the research process. Members of the community provide direction with respect to process and structures (i.e., sharing circles). The Coalition found that working in partnership takes additional time and resources, which must be considered in setting timelines and in organizing the research. For example, obtaining ethics approval from three organizations was time-intensive but critical to the success of the project. The use of a community-based approach to research was found to be appropriate and

facilitative. It highlighted the strengths of each subset of the research team and elicited potential areas for skills-acquisition with regard to all members of the team. This strategy explicated a need to work towards the identification and utilization of Aboriginal research methods that are rooted in traditional ways of knowing.

The dissemination strategy was critical to the learning process. Essentially, we learned that the findings of this research must be managed and circulated in a culturally appropriate manner, as the OCAP principles dictate that they ultimately belong to the communities. The community participants, the research team, and the Advisory Committee all had distinct information and communication requirements that needed to be addressed throughout the study. The research team, with the assistance of a summer student, developed a communiqué highlighting the findings and the next steps and disseminated it to the communities concerned.

A number of possible limitations of the study were identified. The findings are applicable to the specific communities and the participants from those communities and should not be considered generalizable. The presence of elders in the sharing circles may have influenced the viewpoints expressed by participants. The research did not accommodate dialogue in traditional languages, which may have limited the sharing and/or altered the meaning of the content.

The research team is committed to continuing its involvement with the two communities, working to develop research capacity and to more fully understand cultural competency in terms of both health-care providers and health services. At Standing Buffalo First Nations, the intention is to proceed with an integrated research and clinical project that will introduce students in nursing and allied health programs to culturally competent initiatives. The Regina Métis Sports and Culture Centre will be involved in a project aimed at building community research capacity and developing strategic priorities for the community related to individual, family, and community health. The research team continues to seek paths to an enhanced understanding of cultural competency and remains open to working with other culturally diverse groups towards the ultimate goal of culturally appropriate health care.

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The Advisory Committee consisted of the following members: Elder Ken Goodwill, Standing Buffalo First Nation; Elder Betty McKenna, Moose Jaw; Ken Akan, Regina; Bev Cardinal, Regina; Gail Starr, Starblanket First Nation; Nora Weber, student, Nursing Education Program of Saskatchewan; Rozella McKay, Standing Buffalo First Nation; Lea Beige, Regina Métis Sports and Culture Centre; Chief Rodger Redman, Standing Buffalo First Nation.

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