

# Exploring Diverse Ways of Knowing Cardiovascular Health among First Nations People in Manitoba

Collaborating on Development of a Mixed Methods Study to Advance the Base of Evidence

## Project Team Members

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## What is the CV Health among FNs people in Manitoba?

This collaborative project is a planning grant that will support development of a research project exploring Manitoba (MB) First Nations (FN) people cardiovascular health and health care services. This planning grant came out of eighteen months of discussions with AMC in 2012 where ideas were generated for membership on an Integrated Knowledge Translation (IKT) advisory board.

The objectives of the project are to:

- 1) Facilitate active and meaningful collaborations among MB First Nations health leaders, MB Cardiac Sciences Program leaders, MB Aboriginal and Northern Health Office, and the research team.
- 2) To further develop an operating grant proposal inclusive of cross-sectorial member input, which acknowledge identified priorities and relevance for the sectors.
- 3) To nurture and grow our social capital to support the success of the research study and related knowledge translation strategies.

## November 21, 2013 Meeting

At this inaugural meeting people from the Assembly of Manitoba Chiefs (AMC), MB Cardiovascular Health programs, others in the community involved with cardiovascular or FN Health, and the research team gathered together.

The morning discussion focused on the vision for cardiovascular health among FN people using Aboriginal Knowledge Translation (AKT) and Western research methods.

The afternoon component

participants worked together to provide critical feedback on drafted components of the research grant, and dialogued ideas regarding AKT processes.

Throughout the day various themes emerged around the challenges facing First Nations people and cardiovascular health. These topics ranged from access to colonialism to research. These themes will be discussed separately following the sources of data section



## Collaborative Partners for the November 21, 2013 meeting

- University of Manitoba
- St. Francois Xavier University
- Assembly of Manitoba Chiefs
- Manitoba Keewatinowi Okimakanak (MKO)
- Southern Chiefs Organization (SCO)
- Health Science Centre
- St. Boniface Hospital
- CancerCare Manitoba (CCMB)



## Background and Rationale CVD Health among FNs people in Manitoba?

Three sources of evidence provide support for the research topic and suggested planning activities. The data resources utilized were both from an Indigenous and a Western source.

material used the Western approach of quantitative data from epidemiological literature. Each data methods highlights unique insights and questions relevant to First Nation CV health.

was from a first person narrative based on a First Nation woman, daughter and internal cardiac residence experience. The final data is published reports and literature highlights.

The first two data sources utilized the Indigenous method of story. The stories were from two team member experiences. The final

The first source is first person reflections from an experienced health care provider at a large tertiary care center in Manitoba. The next source of story

Each data source will be discussed in-depth beginning with health care provider story.

## Health Care Providers Story

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*“I also have wondered why there are not more First Nations people receiving secondary prevention procedures.”*

Over the years, I have come to believe First Nation patients’ first presentation in the health care system at a later stage of CV disease, which then has implications for treatment options, complication rates, and health

outcomes. I also have wondered why there are not more First Nations people receiving secondary prevention procedures. This conundrum resulted in discusses with researchers and early stages of research

development. Next I initiated relations with the AMC by presenting early research ideas; here is where I was struck by the Chiefs experiences of cardiac care and health service delivery. My commitment to this research was cemented.



## First Nations woman, daughter and internal cardiac residence Story

I received a phone call letting me know my father had collapsed and was in emergency. When I arrived in emergency my dad was intubated (breathing tube down his throat into his lungs). He was clearly upset and scared and I asked the emergency physician, "Why is he not sedated?" Sedation is a standard of care for anyone intubated. The reply was, "We didn't know what he was on."

I was livid at the implied diagnosis of intoxication for my Dad, who is visibly a First Nations middle aged man. I said, "My father is not on anything. Sedate him now." So, after about 20 minutes of being

intubated and clearly distressed, my father received standard medical care.

Next I asked, "What did his EKG show?" a standard of care, is to first rule out a heart attack. The ER doctor replied, "We didn't do one because he was fighting too hard." I then said, "Well you better order one now." The EKG technician came very quickly; interestingly, the results strip was handed to me and showed my dad was having a massive anterior myocardial infarction. Showing the physician, I asked, "Who is going to call the cardiac cath lab?" He stood in silence, not answering. I

turned to my friend on call for the cardiac care, who quickly arranged for an angiographer. My dad's care from this point forward was excellent.

My Dad suffered through being denied an appropriate standard of care because of a health professional's racist assumption. While his death certificate might have identified myocardial infarction as cause of death, I suggest the real cause of death would have been racism; of which, there is no ICD code.

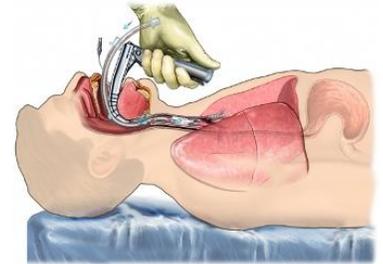


Illustration of Intubation

## CV rates for First Nations populations

Canadian CV mortality rates for First Nation populations are increasing, which includes disproportionately higher rate of CV mortality and morbidity when compared to non-First Nation Canadians (Higginson, 2008; Riediger et al., 2010; Statistic Canada, 2009). Riediger and associates noted that CV disease prevalence for First Nations peoples is 18% compared to 8% of Canadians of European descent. In the Canadian context, CV risk factors notably high within FN

communities include: smoking, obesity, increased waist to hip ratios, diabetes, and elevated plasma high density apolipoprotein levels (Anand et al., 2001; Bruce, Riediger, Zacharias & Young, 2010; Elias et al., 2011; Riediger et al.; Sarkar, Lix, Bruce, & Young, 2010). The ability to reduce one's risk is dependent on broad array of health determinants. According to the MB Tribal Nations Health Survey (N=2125), almost 50% of First Nations responders felt

their access to health services was less compared to other Canadians (Elias et al., 2011). Given the higher CV disease burden in First Nations communities, access limitation to health services for early screening and prevention of CV disease is concerning.

References

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*"CV disease prevalence for First Nations peoples is 18% compared to 8% of Canadians of European descent."*

## THEMES

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*...listening to what participants know are the challenges facing First Nations people and cardiovascular health*

Throughout the meeting, especially the morning, was spent listening to what participants know are the challenges facing First Nations people and cardiovascular health. There were initially over twelve themes generated from the morning discussion with some of the themes falling into more than one category.

For example with the issue of access had the theme of relocation and emotion imbedded in the discussion. In addition, some themes were collapsed into other areas for example the discussion around Indigenous Knowledge was collapsed into cultural barriers. There were in the end five specific themes

developed from the initial twelve themes.

A table of the themes were made and sent to the participants for further comments. Several people indicated verbally to the principle investigator they felt the themes generated did not need any changes.

### Theme 1: Access, Relocation and Emotional

For both North and South First Nations communities' participants indicated that access to health facilities was a problem. They would like to see more facilities closer to their home communities. The result of access meant many people had to relocate from their home community to, in many cases, an urban area. This relocation creates a high

degree of stress for the affected individual and eventually to the family.

Besides stress there is an emotional impact on first the individual and the family when someone is diagnosed with a chronic disease. The patients feel fear, stress and pressure from their family especially if they have to relocate to an urban area for health

care.

One of the Elders explained how First Nations people, when they go to a health center either in their home community or an urban area, they feel as if they are being "abused". Their emotional or mental health is not being addressed when they are diagnosed

### Theme 2: Bureaucracy

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*"Many patients are afraid to even enter into the hospital because they never know where they will end up."*

Participants expressed their concern about the policy with First Nations Inuit Health (FNIH). There were many policies made without consultation with First Nations. The same concern was expressed with the drug formulary made decided by Ottawa. They felt without consultation a lot of drugs are wasted since they are not as effective.

They feel the system of bureaucracy does not add value to patient health.

They also spoke about the bureaucracy patients have to face when they go to a hospital. Many patients are afraid to even enter into the hospital because they never know where they will end up.

They voiced their concern

how bureaucratic colonial thinking in the present century is evident in not only direct services to First Nations peoples but structural policy that does not include a First Nations voice or Indigenous knowledge.

## Theme 3: Cultural Barriers

Participants gave insights into how First Nations culture is very diverse and there is not one solution to addressing the culture of First Nations peoples.

They also spoke about the culture of the hospitals

and how the current health care system still thinks “like an institution” where First Nations values are still not being integrated into the policy of the various health care systems. For example one participant spoke about

how health institutions do not address poverty when they are asking First Nations people to change their diets.



## Theme 4: Colonialism/Historical/Present

Several voices spoke about how European historical colonialism, especially in the last two generations, has affected First Nations peoples' health.

Participants also spoke about the loss of land during the colonial process and it is this loss that is still evident with First Nations communities. Without a land base First

First Nations cannot be self-sufficient, they cannot continue to teach the younger generation about hunting, fishing and other food gathering methods.

They felt many health care professional do not have this knowledge of the colonial loss. Instead patients are made to feel they are at fault with their disease. Patients are not always treated with respect.

Because of this lack of understanding of past colonial history First Nations Health professionals indicated they felt this 'structural resistance' when they are employed in agencies that won't, for example, include traditional Medicines or Elders as part of the patient consultation process even when the patient is making a request

## Theme 5: Prevention and Education

There was frequent discussion about the lack of education around prevention. The current data indicates obesity, stress, diet, tobacco and alcohol are preventable yet information specific to First Nations people is limited.

Secondly, the health information that is developed for First Nations may not be appropriate. For example heart disease

may be seen differently from, for an example a Dakota versus an Ojibway perspective.

Although some information is translated in various First Nations language the translation may not be in a specific education level. For example an English pamphlet may have been written for a grade 12 level and then this grade 12 level translated into a First

Nations language. Instead the English pamphlet needs to be first made at an appropriate grade level then translated into a First Nations language.

Prevention information must cover ages children to adults not just adults. Also the verbal information given to patients by physicians is structured using a medical model not a holistic model.

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*“Secondly, the health information that is developed for First Nations may not be appropriate..”*

## Research Components generated from themes

### Next Steps

- AMC to set up meeting with Health Technicians
- Submit research grant

Thank you to all those that have participated in this collaborative project.

Using the five themes generated from the morning discussion overall the projects selected must follow the OCAP principles, benefit both the community and the researcher, application of Indigenous knowledge into the research.

The following research components were developed where research should be:

#### 1) Community Based

Given there is such cultural diversity the research must be community specific or local solutions where the emphasis is on communities or community needs rather than searching for all-encompassing solutions.

#### 2) CV Board

Projects will be selected through a "Cardiovascular advice board" comprised of community people, youth and health professionals. This advice board will work also work with the Communities to

help develop proposals and once proposals accepted the board will work with the Community Communities continue to assist them to achieve what they are proposing to research.

#### 3) Policy Develop

The research generated must have a policy component developed that will present protocols for health institutions to have working relationships with First Nations communities.

#### 4) Preventative

Preventative research must not only look at factors that will reduce CVD but the solutions must be available in the community. For example if you they are asking to change diet then that food must be made available or alternative foods. Also, the tools developed must utilize language that is understandable for that community. Finally the preventative model must begin with the understanding that it will

be holistic where the whole person will be viewed rather than just components of a person.

#### 4) Collaborative

The research should work with community members

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