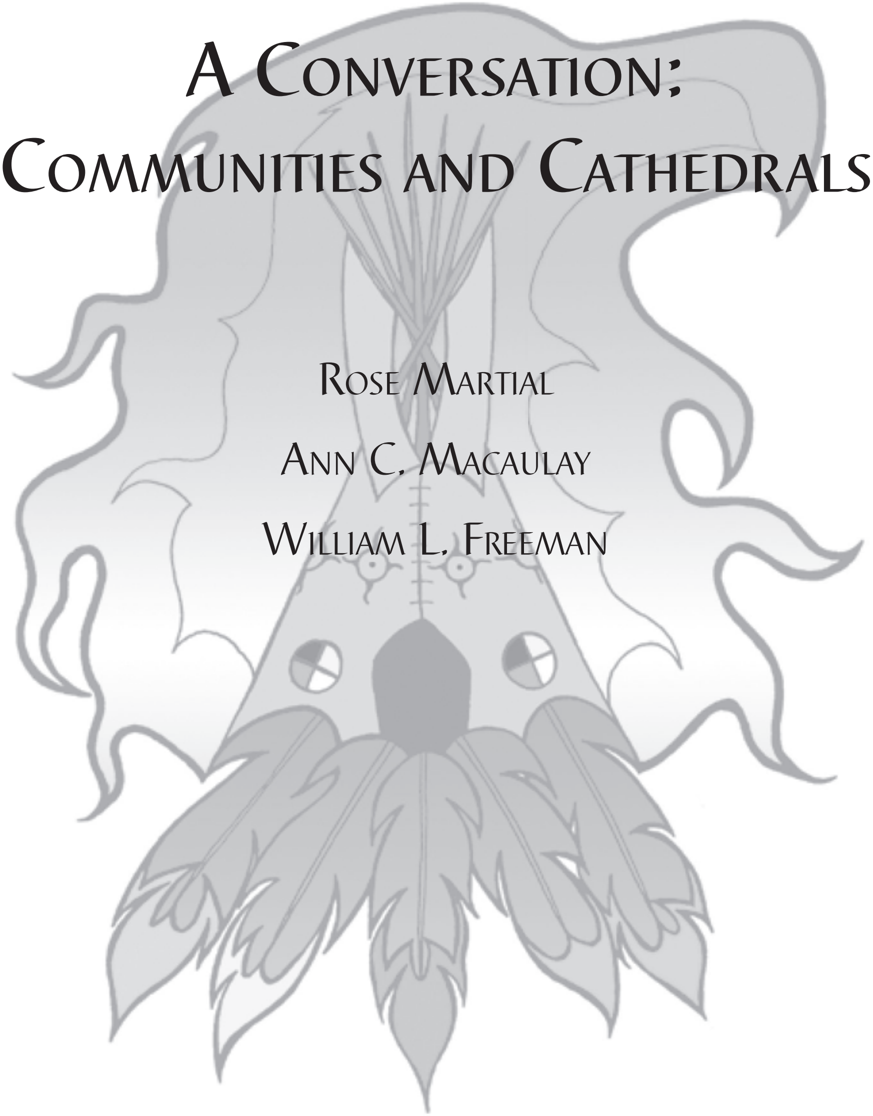
A CONVERSATION: COMMUNITIES AND CATHEDRALS

ROSE MARTIAL

ANN C. MACAULAY

WILLIAM L. FREEMAN



Since the focus of this first issue of Pimatziwin is research in its broadest sense, we invited three people to engage in a conversation on our theme. The following are the transcribed responses of Rose Martial, a community representative; Ann C. Macaulay, a family physician researching diabetes on the Kahnawake Territory in Quebec; and William Freeman, professor at North West Indian College and former Director of Research for the Indian Health Service in the United States. Their experiences are varied and their viewpoints often differ, presenting a cross-section of perspectives.

WHAT IS YOUR EXPERIENCE WITH ABORIGINAL COMMUNITIES?

Rose Martial

I was born in the Cold Lake First Nations Reserve. There were three reserves in total. When I was a child, there was lots of visiting back and forth. People made their livelihood on the trap lines. As a young child, I spent most of my time in the bush with my grandfather, grandmother, and parents. We took in sugar, tea and flour, baking powder, maybe cooking oil or lard, but otherwise we lived off the land. Winter we spent in the bush. In the spring, we came back to raise gardens and pick berries to dry for the next winter. We ate ducks, rabbits, deer and moose, fish — some we ate fresh and some we dried or smoked. There was no food from the store. It was a real treat to get oranges and fruit when we came out of the bush. I was taught how to sew and cook and I try to teach my grandchildren now. There was no welfare and people had pride and took pride in the way they lived, not from what they had. Family units were very strong then. Resources included a lot of respect for elders, who told us stories and legends by the campfire. History and story-telling doesn't happen now. There was lots of laughter then.

I was sent away to school at six or seven. Institutionalized. I understood English quite a bit, but spoke Chipewyan at home. My father spoke Cree as well but taught his children Chipewyan. He felt it wasn't right to teach too many languages at one time.

I came home for holidays, Christmas, and two months in the summer. I missed the nourishing of family very deeply. There were so many restrictions and rules at the school. For the first time in my life I was slapped, I was hit with a ruler and strapped: I learned violence. I was taught how to read and write. I try to remember only the good things about it. It wasn't all terrible. I was in residential school to Grade 8. By then I was close to 16 and at 16 schooling was stopped. I went back to my parents' home and helped with chores — haying, helping Dad put up hay for horses. I helped in the barn, worked at the fish plant in Cold Lake and did baby-sitting for the workers building the airport. I wanted to be a nurse, and at 16 I lied about my age and applied to a university nursing program. When my father found out, he forbade me to go. So I went to work and eventually got married and had a family.

Ann Macaulay

In 1970, I was hired as a family physician by the Mohawk Aboriginal community of Kahnawake to help achieve their goal of directing their own health services through transferring control from the Federal Government to the community. I undertook my first research project in 1980 and over the years I have gradually spent more time undertaking research with the same community, although I still see patients one day a week.

William Freeman

I started working with Aboriginal communities in my first summer at Medical School. I worked with the Swinomish on their reserve sixty miles north of Seattle doing a community-initiated survey of attitudes and concerns about health. I stayed in contact with the people there through my next six years of medical school and then residency in Seattle. The experience of working on the reserve completely changed my career plans. On graduating as an MD, I entered the Indian Health Service which provides medical care by hiring doctors for reserves or by directly funding tribal medical and health care. The IHS areas of concern include medical, psychosocial, environmental, and dental care. At this point, about half of the American Indians on reservations get their health care from doctors hired by the Indian Health Service, and half get their health care from tribal staff funded by the Indian Health Service.

As an employee of the Indian Health Service, I worked on the Lummi Reservation, west of Bellingham, Washington and just south of Vancouver, B.C. I was one of two doctors providing out-patient, clinic, and hospital care. The hospital care was through Bellingham hospitals, rather than a tribal hospital. I worked there for 13 years and then left to become the Director of Research for Indian Health Service. I worked in that position until January 2002. Now I am back at Lummi, working for the Northwest Indian College developing community health courses around specific health issues such as diabetes and environmental health.

As Director of Research, I had a research program which became progressively less funded. I began an Institutional Review Board to review research in which the Indian Health Service was involved. In the United States, almost all the regulations work for individual protection over community protection. This makes the protection of communities a lot harder than it is in Canada. A lot of my role was to help researchers and communities to talk to each other. In practice, that meant that I talked to researchers, encouraging them not to be discouraged, but to hang in there with the community. I could represent the community interests in language the researchers could relate to and therefore I had their trust. Toward the end of my time as Director, I began to develop the infrastructure for funding that would support research that promoted community and academic partnerships. In this, I had help from Dr. Cliff Poodry, a Seneca.

WHAT WAS YOUR FIRST EXPERIENCE WITH RESEARCH IN AN ABORIGINAL COMMUNITY?

Rose Martial

I wanted to be something more than a wife and mother. In 1970, I was given the opportunity to train as a Community Health Representative. I went first to Moose Factory, on James Bay in Ontario, which meant leaving my children behind in Cold Lake for four months. That was very hard. There were 38 other First Nations people from across Canada taking the same course. We had classes six days a week and learned about germ theory, communicable disease, dental care, prenatal and post-natal care. We lived and had classes in one wing of a big hospital with 500 beds that served all the people from the North. We had Sundays off, but there was no transportation to go anywhere except dog sled, helicopter, ski-doo, or boat. We were there for four months, then four of us finished the course with two months at the Charles Camsell Hospital in Edmonton.

Then I worked on my reserve at the Health Centre with nurses who came and went. We had summer student nurses who came and made rude comments about our life style. They would say things like “Why are these people playing cards at 2 in the afternoon when there are dirty dishes to be washed?”

One of the nurses who came for a time was particularly hard to work with. She treated people as if they were little children and she was a terrible driver. I finally got permission and mileage to use my own car instead of travelling with her. I was the only one willing to stand up to her. The other nurses were great. There were no Aboriginal nurses in the 1970s in the northeast area of Alberta, but the CHRs were all Native women from other bands.

Ann Macaulay

As a family physician in the late 1970s, I was concerned that many of my prenatal patients were choosing to bottle feed, and so came the first research project. I thought that if I interviewed all the mothers who had given birth the previous year that perhaps I could learn from the mothers why they had chosen to breast feed or bottle feed. My hope was to be able to incorporate this knowledge into the pre-natal programs and thus encourage more mothers to breast feed. I went back to university part-time to learn some research skills, did the study, discussed the results with the nurse and the nutritionist in the pre-natal team, wrote a one-page summary that I gave to all the pregnant mothers, and published the findings in a family medicine journal. In the early 1980s, the nutritionist and I repeated the study, which showed increasing rates of breast feeding — but we never know if it was due to our efforts or not, as breast feeding rates had also increased in the surrounding dominant society!

At the same time, it was the clinical impression of the family physicians working in the community hospital that there were high numbers of patients with diabetes and hypertension (at that time the only published data of diabetes among Aboriginal populations were from the USA). In the early 1980s, I mentioned the potential high rates to Louis Montour, a Mohawk from Kahnawake, who was then a medical student at the nearby McGill University. The next year, he decided to survey the rates of diabetes in the community as his research project for his family medicine residency training program. So, I collaborated with him to undertake a simple chart survey that documented a high prevalence of diabetes type 2 and hypertension. By the mid eighties, Louis Montour was on staff as a family physician in Kahnawake, and our second survey (again based on clinical impressions) documented high rates of complications in those people with diabetes. In 1987 we took the results of both surveys, with detailed explanations, back to the community. Our goal was to inform community leaders through formal presentations and the community at large by speaking on the local radio. We ended the presentations by stating that the high rates of obesity, diabetes, and the diabetic complications could be reduced through increased physical activity such as walking and changing eating habits. This information, combined with the teachers' concerns of new obesity among the elementary school children, resulted in elders from the community asking us to "do something" to prevent the children and grandchildren from carrying the same burden of disease. (Through qualitative research, we have since discovered that sharing these results with the community shifted the perception of diabetes from being viewed as an individual disease to being a disease that concerned the whole community.)

So we changed the plans we had to undertake a prospective study of the complications of diabetes and agreed with the elders that preventing diabetes was much more important. Then, to meet this big goal of preventing diabetes, we invited academic researchers with the needed research expertise to join what until then had been a team of health and education professionals together with community members. Seven years later we were successful in accessing national research grant money to start a community-based diabetes prevention project. From the beginning, this was based on a community-researcher partnership using the principles of community-based participatory research.

William Freeman My first real experience with research in an Aboriginal community was my first job as the Clinical Director at Lummi. However, because our research was practice-based, it didn't involve the community directly. I ran a number of small projects, one a year, which I funded myself, about issues such as ways to improve the care we gave, basic epidemiology and so on. My very first project was a comparison of PAP rates between Lummi and the Swinomish. It turned out to be a natural experiment as well, since Lummi picked it up just as Swinomish abandoned it. I reported all the results of these little projects to various professional gathering, rather than the community.

IF YOU COULD GO BACK AND CHANGE THAT EXPERIENCE, WHAT WOULD YOU CHANGE?

Rose Martial I'd make them understand more that our ways are different. We live at a slower pace. We're not in the rat race. Everything is slower on the reserve. I would do more to educate the non-Aboriginal people about our ways and the value of them. So what if you don't get up until 9 a.m.? So what if you don't go to bed until 2 a.m.?

My mother went to a residential school, but my father didn't. My mother frequently used to read to father, especially in the evening. They were always talking and sharing. They had an open communication with one another. Mother was very strong in her faith; she taught us Bible stories, to pray and to go to church every Sunday. It was a way of living. Religion was very strong in our family life. My mother was brought up a Catholic. Before Christianity, we had medicine people and spiritual leaders in our family. My grandparents talked about their families having to conceal the places for sweats when priests were around. I heard about the old ways in bits and pieces because the priests were dead set against traditional ways of praying.

Ann Macaulay Even greater involvement of community members in the earlier stages of the research. For myself, I would have taken a year off to improve my research skills sooner.

William Freeman

I now have a greater appreciation of the need to involve community in research right from the beginning and to report results back to them. At the time, I did nothing with factors such as attitudes and beliefs and they are important.

Do you believe that academic health research has helped Aboriginal communities? Can you give an example?

Rose Martial

No, none whatsoever. The Royal Commission, for example, only resulted in a bunch of money being made available to bands and other Aboriginal organizations to spend as they saw fit. It was in place of residential schools, but it didn't always do the job. People may want to help but money isn't enough. We need trained Aboriginal people who understand the communities and the culture to help us.

Ann Macaulay

I think that some academic research has benefited communities, especially when the use of participatory research has provided a true partnership between the researchers and the community members, with real sharing of decision-making and power. For type 2 diabetes there are examples in Canada where participatory research methods have been beneficial. There are good examples of researching the understanding and perceptions of type 2 diabetes, type 2 diabetes in children, and the primary prevention of diabetes in Sandy Lake Health and Diabetes Project in northern Ontario and in the Kahnawake Schools Diabetes Prevention Project, in Quebec.

William Freeman

I would say yes and no. Some research has benefitted communities and some hasn't. Some research hasn't helped communities as much as it might have had it been approached differently. I can give you an excellent example, however, of research which has benefitted many Aboriginal communities.

In the early 1950s a research project was set up at Many Farms, Arizona, which is a Navajo Reservation. The Medical School there started up programs on how to set up community-led, community-relevant programs in Native health. They worked with traditional healers as equals and developed the concept of Community Health Representatives. It was a pilot project to see if how community care was developed would make a difference in the results. They didn't involve the community in their research directly, but let the Community Health Representatives develop the projects.

The impetus for the project was a tuberculosis epidemic on the Navajo reservation. They were looking for better models to deal with an almost 100% infection rate. Their approach of working with the community and the traditional healers to develop the project brought the problem under control very quickly.

In the end, the researchers published a book about the project, *The People's Health: Medicine and Anthropology in a Navajo Community,* by John Adair and Kurt W. Deuschle. John Adair was an anthropologist and Kurt Deuschle was an MD. There were a couple of other people involved as well and they all went on to become very prominent in the field of social medicine.

That was almost 50 years ago: they made some changes, but government and university bureaucracies have been slow to respond. They were well ahead of their time.

DO YOU BELIEVE THAT ACADEMIC HEALTH RESEARCH HAS HARMED ABORIGINAL COMMUNITIES? CAN YOU GIVE AN EXAMPLE?

Rose Martial Yes, but it is hard to think of specific examples now. I took life-skills coaching training, on the reserve, where I worked two weeks, learned two weeks, worked two weeks and so on. Then I quit my job as a CHR on the reserve to become a student counselor for reserve and off-reserve kids. It was very stressful because families had so many problems. I came to Edmonton to live in 1976. I worked with the City of Edmonton as a social service liaison worker. That was a joint appointment between the Social Planning Department and the Public Health Department. My role with the Department of Public Health was Health Centre work and home visits and follow-up with the clients. My Social Planning Department role was working with tenants in public housing, dealing with issues of discrimination, and social difficulties. Often I would do a home visit after a complaint of fighting and discover that everything was fine. I told my supervisor to talk less and listen more. After ten months, I quit and told my boss to hire ten Indians instead of just one.

I was also involved in collecting the Census for Statistics Canada in the city of Edmonton. Listening to the stories of Aboriginal people living in the city and seeing where they lived was a real experience. I found people living in cubicles with a small table for a bed and a hotplate for cooking. One person had a bad eye infection and no health coverage. He weighed about 300 lbs. I took him to the Royal Alexandra Hospital to get his eye treated and his wife came along. I offered to take him home on release. He was admitted and the eye was removed. Situations are surfacing now that were hidden then.

Collecting census reports was hard. I did it as part of a STEP program. I felt conflict between the job expectation of getting information written down and the cultural expectation of helping people in need whenever possible. Taking census is important for First Nations people, but it should be handled from the band. Statistics Canada doesn't ask the right questions; they don't get to the nitty-gritty of issues being faced at the personal level. They talk about economic issues in terms of "Where do you shop?" Ask me if I am able to shop first! Can I keep a roof over my head?

Researchers need to book an appointment with First Nations people and keep doing it until contact is made. They must do the interviews with respect — don't come looking and acting like an "enemy." People who are too dressed up, have an attitude of disrespect, and are insensitive to atmosphere won't get very far. Let people talk.

Ann Macaulay

Definitely, some academic research has harmed Aboriginal communities. This is especially true of "helicopter research" where academic researchers make decisions without involving community members. As the late Louis Montour so eloquently stated in 1987: "Outside research teams swooped down from the skies, swarmed all over town, asked nosy questions that were none of their business, and then disappeared, never to be heard of again." There are many examples of negative results being published about Aboriginal communities in chronic disease, addictions, and mental health, without any background explanation about why these rates are high, how the community is approaching the issue or some of the balancing positive aspects of the same community. These endless negative results — because research until now has not focused on the positive or the resilience of communities — all adds to the collective stigmatization of Aboriginal communities.

William Freeman

There has certainly been academic research that harmed Aboriginal communities. One example was written up in the *American Indian and Alaska Native Mental Health Journal.* A group of researchers in an eastern US university travelled to a far western Native community to study their problems of alcohol. They were so impressed with the severity of the problem that they felt intervention was called for. Their method was to call a press conference back at their home university. They didn't ask the permission of the community; indeed, no one in the community even knew how much information they had gathered. The community was trying to get credit on Wall Street, to improve conditions; once the news broke, its credibility was gone. It was devastating for people in that community to be told they were in serious trouble by total strangers; worse that their "problem" was broadcast to other strangers by these same people.

Another example is research done on the hantavirus by the Center for Disease Control and Prevention. Their people came onto the Navajo reservation, where the problem was most severe, and spent seven days investigating. They identified the deer mouse as the problem, discussed with the community ways to avoid contact with deer mice, and left. The Navajo Nation, knowing that their results would be published, specifically asked them not to use any Navajo place names. Despite that request, the first two studies did just that. It was an entire year before the Navajo Nation was willing to permit research of any kind anywhere on their land.

What is the biggest challenge to effective partnerships between Aboriginal communities and health researchers?

Rose Martial The biggest challenge is programs and services designed and delivered by non-Aboriginal people who are only interested in making money. We hear the term "partnership" all the time, with oil companies for instance. Fine and dandy if you understand what you are getting into and if the other partner understands that you have rights that they don't and those rights need to be respected. The biggest challenge really is accurate, mutual cultural understanding and respect which leads to equal economic benefit.

For instance, someone told me that in BC, people come and try to lease First Nations land to grow ginseng. They are willing to pay $1000 an acre. But after five years the ground is destroyed and nothing can be grown.

Ann Macaulay Time, time, and more time!!! Time is essential to build and maintain effective partnerships and to understand all the different perspectives of people in a partnership. Good partnerships are further strengthened by ethical agreements and guidelines, which clearly outline the obligations of both the community and the researchers and how decisions will be made. Previous guidelines have been developed by universities, Aboriginal organizations and individual communities and projects. However each partnership should take the time to carefully discuss and write their own agreement for it is the process of discussing and developing understanding of different perspectives that promotes understanding and trust. Also, it is important for academic researchers to realize that, for them, a few years may be a long time to spend on one project, but the same time frame in community terms can be a drop in the bucket.

William Freeman

There are several challenges, I think, but a big one is the mind set of some researchers. There is an arrogance in some of them that makes it hard to truly form partnerships with people they too easily dismiss for "having less academic skill."

A second major challenge is the amount of time required in planning and execution for truly collaborative community partnered research.

A third challenge is dealing with the inevitable conflicts that arise in the process. Any community research is truly a cross-cultural situation and that goes beyond Aboriginal–non-Aboriginal partnerships. Conducting collaborative research in any community by any group of researchers always involves different perspectives and values expressed in different language. A researcher who is genuinely interested in conducting community participation must be able to deal with these conflicts in a productive way, rather than choosing the extreme of giving up or the easy out of blaming the other side. This, of course, applies equally to the community.

HOW DO YOU THINK THE ACADEMIC APPROACH TO HEALTH RESEARCH CAN BE BLENDED WITH TRADITIONAL ABORIGINAL KNOWLEDGE FOR USE IN COMMUNITY RESEARCH?

Rose Martial

Our people believe in the Great Spirit and they rely on Him and their faith is in Him only to know that He is going to take care of them and that He loves them. Our spirits are strong. Children and adults need structure. I had a job with no structure, expectations, or supervision at the Glenrose Hospital, talking to Native people. It was very hard because nothing concrete could be done.

Researchers should try first to get people in the community to do the questionnaire or go and talk to these people. That's better than a bunch of strangers coming in, collecting information, and leaving. Ask, "What would you like changed out of this research?" Try to fill that wish list if you can within budget, of course, rather than the preconceived "academic" idea of what would be best. Answer the questions asked by Native people too. Treat research as a visit, rather than an interview.

We need to bring humanness back into families. See the beauty in others.

Ann Macaulay This requires both researchers and community members to truly respect each other's knowledge and expertise. Combining both academic skills and Aboriginal traditional knowledge will strengthen the research, increase community knowledge and capacity building, and promote continuity after the research funding ends.

William Freeman There are really two kinds of knowledge in Traditional Aboriginal Knowledge. One is community knowledge, the other is scientific knowledge. Often these two can seem to be in conflict. For instance, a researcher in diabetes may be interested in basic science while the community struggling with diabetes is more interested in practical solutions.

In addition, the community explanations for a condition or disease may overlap or be very distinct from a medical explanation. Western medicine sees diabetes as a body process gone wrong, often correctable by diet. For a Native community, the explanation may be expressed as bad spirits. The point is that researchers need to be able to hear more than the mere words. There is a message underlying the words which may be expressive of an imbalance in the society or in the way of life. Even when the explanations are truly different, a necessary humility is often lacking in the researcher.

A psychology professor at the University of British Columbia Medical School wrote a book about the Coast Salish culture and its way of dealing with alcohol and substance abuse. He noted that the traditional ways, which included drumming, could be very helpful to people who needed to turn their lives around. But he didn't leave it there. He went on to give a Western medicine reason for this effect, The drumming, he claimed, is effective because it is exactly the same frequency as theta waves in the brain. He didn't produce any evidence that theta waves have any effect on addiction, didn't notice that not all drumming is the same frequency. But he couldn't report the effect without providing an explanation that was stated in the language of Western science. He couldn't say, "Traditional medicine works, but in a way we don't understand."

IN WHAT WAYS MIGHT THOSE CHANGES BENEFIT ACADEMIC RESEARCH GENERALLY?

Rose Martial A resource person in any particular community would be good. Get to know that particular person and give them a role in the research. Always have someone who knows the community and then oversee the research in action. Get that person to help with the research questionnaire as well. Get them involved. Tackle the worst issues, whatever they are: water, environment, noise, pollution. Researchers can't go in and say we're going to fix this or that. They have to be well prepared to explain what they are doing and what the outcome might look like. Up to now, First Nations communities have felt that it is all about the money the researchers will make from their jobs and from the results. At the same time, we need to have the backing of university research people to do a better community job.

Ann Macaulay The validity of academic research is strengthened through partnerships with community, because the research is no longer based on theory, and because the findings have direct meaning for the community. The research findings are interpreted by the community, become part of community knowledge and can be used to improve health promotion. This so-called knowledge translation is the process of making research results directly available to any population. At a personal level many academic researchers are enriched through the partnership experiences for their personal learning and growth. For non-Aboriginal researchers, this also includes the privilege of working in a cross-cultural environment.

William Freeman Almost all health research occurs in a cross-cultural situation. It involves small groups of people (academics or health professionals) with relatively unique sets of values working with another group of people who do not have those values. The danger is that academics may not appreciate the differences, or even recognize that they exist. The question they don't ask is, "Should I force this round peg into that square hole, or should I note the shape of the peg and find a hole that fits?" They need to be far more attuned to the participants in their studies.

IF YOU COULD CHOOSE ONE THING TO IMPRESS UPON ALL RESEARCHERS, WHAT WOULD THAT ONE THING BE?

Rose Martial Show respect for everyone, all ages. Most Elders, when you approach them, you are supposed to give tobacco. I don't like giving smoke and yet they do use it in their ceremonies and sweat lodges. You make the offering the right way. Before you go into any given community, there is a protocol to make a tobacco offering to an Elder and ask permission to go into territory to do research. That is part of the respect.

Ann Macaulay Research must meet the community's needs, and not be driven by the researchers' agenda. The research process should build on community strengths and promote capacity building so that the benefits can remain in the community after the research funding ends. Research should not be for research's sake, but to benefit the community.

William Freeman In many ways, given the incredible amounts of money poured into medical research, health centres are becoming our new cathedrals. Despite that, research tends to be done without reference to the needs and wants of the public, which in turn reduces the effectiveness of the research results. Complete research requires that views other than those of the researcher's be accommodated and heard. This means that the researcher has less control over the direction and outcome of the research and bureaucracies supporting research do not support giving up control. My point would be that one has much greater influence in partnership with people than by being a dictator.

IF YOU COULD MAKE ONE KEY SUGGESTION TO COMMUNITY RESEARCH PARTNERS, WHAT WOULD THAT BE?

Rose Martial Be patient. Observe protocols. People may not respond as quickly as you think they should. Be respectful. Ask individuals in the community for permission to do your research as well as asking the community at large.

Ann Macaulay I think that community-researcher partnerships are clearer when there are written agreements to guide the research process to ensure that community needs are met. This includes how the community- researcher team will jointly develop the research question, undertake the data collection, interpret the data and disseminate the results in both lay terms and scientific publications.

William Freeman My first suggestion, to myself and researchers, is one word: humility. In answering this question, I am concerned about making suggestions to communities as a non-community person. I haven't lived a life of being stigmatized, so how can I make "key" suggestions? Nevertheless, I do believe, in spite of all the problems that have occurred, that communities can benefit from health research, if they are ready to take that step and if they have the patience and the will to work with researchers who are of good intent. This will require as much effort on the part of the community as it does of the researcher. Having said that, it isn't hard to understand why some communities may, at any given time, decide they are not interested in cooperating with research, whether the researcher is of good intent or not. A researcher can offer, but acceptance is up to the community.

IF YOU COULD MAKE ONE KEY SUGGESTION TO FUNDERS OF RESEARCH IN ABORIGINAL COMMUNITIES, WHAT WOULD THAT BE?

Rose Martial Specify funds to be used to make the research findings available to people who participate and ask for their feedback, before it goes into the large print. Make sure that you have verbal understanding from the research participants. Allow for changes in attitude and answers. Sometimes people respond in the moment in ways that are not a true reflection of their thoughts.

Ann Macaulay Funders need to understand that community research requires more time. Granting agencies should allow more time to discuss and develop the proposals with communities, build the partnerships and write the grant proposal. Funders need to provide grants for longer periods of time to facilitate community mobilization, and they should also provide funds to be used for hiring and training community members as research assistants for increased capacity building.

William Freeman Funders have to understand the realities of community-based research. The amount of time and effort required is much greater and the structure of community partnerships is very different from the traditional research models. Funding agencies need to think through the organization and structure of funding requirements which will encourage a community-based approach. Letters of support from communities are not enough. One idea might be to fund the communities for the required research, rather than the researcher. Then the researcher must approach the community for permission to be part of the project. There are a number of questions which need to be asked as well: Who are the researchers? What evidence can be provided showing that the funding is being requested for a project which differs from what the researcher originally thought of and what the community originally thought of? That track of change in focus must be documented. There must be clear evidence that both sides were listened to and opinions were altered accordingly.

content must be
accompanied by a letter form the appropriate authorities in the community

CALL FOR PAPERS

Pimatziwin is a quarterly, peer-reviewed journal, with an audience of Aboriginal community members, health professionals dealing with Aboriginal community health issues and academic researchers working with Aboriginal communities to address their health issues. We are looking for papers for our next two issues in the following areas. Papers may be submitted in writing or given orally and transcribed through the *Pimatziwin* office.

VOLUME 1, NUMBER 2

Theme: Health Research with Aboriginal /Indigenous Communities
Deadline for submissions: **March 31, 2003**

We welcome articles, preferably from original research, on topics such as the following:

Methods

Theoretical perspectives

Critical literature reviews

Case studies from various perspectives (e.g. health professionals, community researchers, academics)

Models for training in research skills

Collaborative articles that are in a discussion format are also welcome, as well as photo essays. All articles are reviewed by both academic and community peers. Articles reflecting community perspectives and content must be accompanied by a letter from the appropriate authorities in the community confirming agreement to publish.