UNIVERSITY OF CALGARY

Environmental Scan of Research and Services for Aboriginal Women in Alberta

by

Melissa Toby Hyman

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

DEPARTMENT OF COMMUNITY HEALTH SCIENCES

CALGARY, ALBERTA

MAY, 2005

UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Environmental Scan of Research and Services for Aboriginal Women in Alberta" submitted by Melissa Toby Hyman in partial fulfilment of the requirements of the degree of Master of Science.

SUPERVISOR, DR. WILFREDA E. THURSTON
DEPARTMENT OF COMMUNITY HEALTH SCIENCES

DR. LYNN M. MEADOWS
DEPARTMENTS OF COMMUNITY HEALTH SCIENCES
AND FAMILY MEDICINE

DR. JULIA MURPHY
DEPARTMENT OF ANTHROPOLOGY

DATE

Abstract

Aboriginal women have specific health concerns, and the lack of gendered analysis in research and planning often leaves these concerns unrecognized. The purpose of this project was to produce a scan of services specifically for Aboriginal women in Alberta within the context of provincial and national research regarding Aboriginal women's health. Data collection included interviews and an in-depth literature review. The majority of services identified included: parenting programs; talking and healing circles; support groups; and lifestyle programs. There was a failure by some organizations to understand gender based analysis. Capacity building, diversity of Aboriginal women and senior Aboriginal women are recent foci being addressed in the literature. Both the literature and data identified a lack of information regarding the underlying causes of the poor health status of Aboriginal women. The relevance of these findings is discussed, along with the gaps in services and gaps in the literature.

Acknowledgements

First, thank you to all of the organizations and interviewees that participated in this research. Many of the participants were overburdened and busy and still took the time to take part in my research project. It was much appreciated.

To Dr. Thurston- although this manuscript has my name on it, it wouldn't have been possible without your guidance. Thank you for answering my endless questions. Thank you for your time, your fantastic editing skills and most importantly your belief in me. I would also like to thank Dr. Meadows for being there when I needed assistance.

Thank you to the research assistants (Lauren, Meghan and Tabin) who helped with the interviews. I appreciated your questions and your thoughtful work.

I am extremely grateful to the wonderful research team that supported me throughout my degree. To Kathy Dirk, Laura Lagendyk and Amanda Eisener- thank you for being there for me, whether it was helping with my work or just listening to me rant.

To my fellow graduate students, especially Heidi, Catherine, Laura, Colleen, Kelsey and Lianne, thank you for making this degree that much more enjoyable.

I would also like to thank my employers at the Calgary Health Region for allowing me to take some much needed time off to finish my thesis, it was greatly needed and appreciated.

To all of my great friends, you are such an important part of my life. Thank you for being there when I needed you and even when I didn't.

Special thanks to Carly who took a week of her life to read and edit this entire thesis. To her and the rest of my family, who although they joked that I would never finish, have always provided me with so much love and support, I am truly lucky to have them.

Finally, I would like to thank the Canadian Institutes of Health Research- Institute of Gender and Health for providing partial funding for this project.

Table of Contents

List of Tables

List of Figures

CHAPTER ONE: BACKGROUND

1.1 Introduction

Aboriginal people suffer disproportionately from health problems compared to the general Canadian population. In addition, aboriginal people generally face challenges accessing the health care system. Aboriginal women have specific health concerns, and as several researchers have identified, the lack of a gendered analysis in research and planning often leaves these concerns unrecognized. The purpose of this project is to contribute to the growing body of research by producing a scan of services that are available specifically for Aboriginal women in Alberta and to compile provincial and national research to provide information on the status of the health of Aboriginal women living in Alberta and in Canada. This research will be available to Aboriginal organizations in Alberta and Canada to build upon for improvements in the health of Aboriginal women.

1.2 Aboriginal Peoples in Canada: Background

In Canada, the Aboriginal population consists of three major groups: North American Indian (First Nations), Métis and Inuit people (see Appendix I for definitions and notation on language). Collectively, these groups include a varied range of smaller groups who differ from each other in terms of their history, culture and traditions (Newbold, 1998). The 2001 Census (Statistics Canada, 2003) found that just over 1.3 million people reported having at least some Aboriginal ancestry, representing 4.4% of the total Canadian population. In 2001, people who identified themselves as Aboriginal accounted for 3.3% of the nation's total, compared with 2.8% five years earlier. Aboriginal birthrates have remained above the overall Canadian birth rate, although the

birth rate has declined from four times the Canadian rate in the 1960's to one-and-a-half times today (Statistics Canada, 2003). These statistics are not completely reliable because participation of Aboriginal people in the 2001 census was lower than other segments of the population.. In addition, enumeration was not permitted, or was interrupted before completion, on 30 Native reserves and settlements, contributing to the lack of participation. It is estimated that 30,000-35,000 Aboriginal people were incompletely enumerated.

It is well documented in the literature that Aboriginal people have poorer health than other Canadians and that they experience a disproportionate share of physical and mental illnesses (MacMillan, MacMillan, Offord, & Dingle, 1996; Tookenay, 1996). Prevalent health problems of Aboriginal people include mental illness, alcoholism and fetal alcohol syndrome, suicide, family violence, injuries, diabetes, tuberculosis, HIV infection, obesity and hypertension (Tookenay, 1996). This burden of illness is associated with "a complex web of physiological, psychological, spiritual, historical, sociological, cultural, economic and environmental factors" (Waldram, Herring, & Young, 1995, p. 3).

Despite progress in the last 20 years to combat inequalities, disparities in health, income, education and socio-economic status between the Aboriginal population and the general Canadian population remain. It is difficult to gather representative data regarding the health needs of Canadian Aboriginal people because of the diversity of the Aboriginal population. In understanding the health issues of Aboriginals, it is essential to understand the conditions within which they live (MacMillan et al., 1996). Available information often refers to specific groups of Aboriginal people, and therefore generalization is not always possible. Speaking specifically of women, Stout (1996) writes, "[I]t is important

to remember that Aboriginal women do not all suffer the vagaries of ill-health equally and always. In the final analysis, the diversity and ingenuity of Aboriginal women cannot be ignored" (p.12).

1.3 Aboriginal People in Alberta

The total number of people reporting Aboriginal identity living in Alberta in 2001 was 156,220 (or 16% of the total Aboriginal population in Canada). This was second only to Ontario at 188,315 (19.3%) (Statistics Canada, 2003). Out of the total number of Aboriginal people living in Alberta, 92,060 were registered Indians (individuals who are registered pursuant to the Indian Act). As of December 2003, 62.5% of the registered Indian's in Alberta lived on-reserve (see Appendix II for map of Alberta including reserves and treaty areas). Just over 50% of this population was female (N=46,712) {Strategic Services 2004).

1.4 History of Aboriginal Women in Canada

In order to understand Aboriginal women's health issues, it is imperative to look at the history of Aboriginal women in Canada. "It is becoming clear that history, too, has something to offer. Not only does it provide a much needed sense of perspective, an awareness that, indeed, great strides are possible, but it can also contribute substantively to our understanding of the origins of many of the present health concerns" (Hackett, 2005, p. S18). The purpose of colonialization was to conquer, take possession of the land, and to enlighten those who first inhabited the land (Moffitt, 2004). This "enlightenment" occurred through religious teachings, residential schools, and adherence to Western society's norms, rules, organization and ways of living (Moffitt, 2004; Kirmayer et al., 2000). The colonial legacy resulted in loss of cultural identity, stigmatization and

marginalization, and specifically for Aboriginal women, discrimination based on race, class and gender (Stout et al., 2001; Browne et al., 2001; Browne & Smye, 2002). Inequities in health and social indicators, therefore, are "manifestations of the complex interplay of historical, socioeconomic and political conditions that influence health status and access to equitable health care" (Browne & Fiske, 2001 as cited in Browne et al., 2002, p. 29).

"To fully understand the present social, political, and economic position of First Nations women in Canada, one must first look at Aboriginal women in a historical context. It is certain that past events laid the foundation for the current situation" (Voyageur, 2001, p. 83). Anderson (2000) described Aboriginal women as once being spiritually powerful and held status in their communities because of this power. As well, she described Aboriginal womanhood as once being a sacred identity that was upheld through a knowledge system of balance and harmony. The suppression of culture through government policies has blurred the identity of Aboriginal women (Anderson, 2000; Kirmayer et al., 2000).

The Indian Act, passed in Canada in 1876, defined Indian identity and had particularly severe consequences for Aboriginal women. All status Indian women who married non-Indian men lost their Indian status and their band membership under the Indian Act. Furthermore, if an Indian man married a non-Indian woman not only would he retain his status, but she gained status for herself and for their children. Even if this non-Indian woman were to divorce her husband or if he was to die, she and her children would retain their status (Voyageur, 2001). In addition, Indian women could not own property, and once a woman left the reserve to marry she could not return to her reserve

so she lost all property rights. This legacy of disenfranchisement was then passed on to her children (Wotherspoon & Satzewich, 2000, as cited in Bourassa et al., 2005). These are only a few of the effects of Federal government laws and policies on Indian women.

Persistent lobbying by Aboriginal women finally resulted in the Indian Act being amended by Bill C-31 in 1985 that allowed many Aboriginal women to regain their status. Despite the amendment, the Indian Act still has significant implications for Aboriginal women (Bourassa et al., 2005). Thousands of women lost their status and were forced to leave their communities and although some have since regained their status others have not (Bourassa et al., 2005). Many Indian women and their children have not been welcomed back to their communities. Since Indian bands have gained more control from the Federal government, band governments have been able to refuse band membership (Bourassa et al., 2005). Refusal to accept some women may be due to lack of resources and funding (Voyageur, 2001), and these women have received little other support from their bands and governments.

The Federal government is responsible for funding and organizing services for some groups of Aboriginal peoples, primarily those First Nations and Inuit people living on reserves. But, according to the Canadian government, there is no constitutional obligation or treaty that requires the government to offer health programs or services to Aboriginal peoples. As a result, the Federal government limits its responsibility to being the “payer of last resort” (Romanow, 2003, p. 212). For many years, the Federal government has been transferring the responsibility for managing and delivering health services to Aboriginal communities. As of 2001, 82% of eligible First Nations and Inuit communities had, or were in the process of transferring responsibility, with 46% having

signed transfer agreements (Romanow, 2003, p. 213 as cited in First Nations Inuit Health Branch 2001). The Federal government has not made women's equality an explicit goal of the transfer process.

If responsibility is being shifted to the communities, leadership in the Aboriginal communities must take gender into consideration in order to improve the health of Aboriginal women. It is important to note that not all Aboriginal peoples have equal access to programs and services offered by the Federal government. Benefits vary according to legal status (i.e., treaty or non treaty), identity (i.e., First Nations, Inuit or Métis) and according to where people live (i.e., on or off reserve). Therefore, special attention needs to be paid to the large number of Aboriginal women living in urban (and rural non-reserve areas) who are having a difficult time accessing the health system. “While those residing in urban areas may have access to a greater number of health care services, including access to traditional healers through native friendship centres, health services may not be utilized to their full benefit” (Newbold, 1998, p. 62).

Not surprisingly, the diversity of interests, needs and capacities among Aboriginal communities and organizations has led to differing views on the issue of transferring responsibility and delivering Aboriginal health services (Romanow, 2003). The Romanow commission heard many thoughts on the importance of federal, provincial and territorial collaboration with Aboriginal communities and opinion was not unanimous. One common sentiment was a call for more active participation of Aboriginal peoples, communities and organizations in deciding what services would be delivered and how (Romanow, 2003). How well Aboriginal women would be incorporated in participation is matter for continued research.

Colonialization affected the ability of Aboriginal women to maintain health and well being (Bourassa et al., 2005). Aboriginal women have been especially marginalized through the colonialization process and "their lower social status is reflected in diminished resources and poor health. Health consequences for women have been identified…. [but] the wounds that results from the cultural ambiguity imposed on Aboriginal women are harder to catalogue" (Bourassa et al., 2005, p. 27).

1.5 Aboriginal Women in Canada Today

In 1999, there were approximately 408,100 Aboriginal women in Canada, out of a total Aboriginal population of 799,000. The average life expectancy for Aboriginal females is 76.6 years (which has increased in recent years), compared with a Canadian average of 79 years (Health Canada, 2003a). Not only is there disparity between the health of Aboriginal women and non-Aboriginal women, but it has also been shown that within the Aboriginal population there are disparities between men and women (Stout, Kipling, & Stout, 2001; Benoit, Carroll, & Chaudhry, 2003). The 1999 crude death rate for First Nations men was 30% higher than for First Nations women (Probert & Poirier, 2003). As well, among First Nations females the leading cause of death was circulatory disease, while the leading cause of death for First Nation males was intentional and unintentional injury. The rates of suicides were much higher among First Nations males than females, although the females attempted suicide more often than males (Probert et al., 2003). New research shows that Aboriginal women may be at greater risk of diabetes and obesity than Aboriginal males. Approximately two thirds of all First Nations people diagnosed with diabetes were female (Probert et al., 2003). Another important issue for

Aboriginal women is their social environment, in which substance abuse and spousal violence are widespread. Aboriginal women have much higher rates of incarceration than their non-Aboriginal counterparts and increasing numbers of sexually transmitted diseases, including HIV/AIDS (Stout et al., 2001). These statistics just begin to show the unique picture of Aboriginal women in Canada and point to the necessity of continued research to improve the health of Aboriginal women.

While research with Aboriginal people has generally increased in the past 15 years, Aboriginal women have rarely benefited from continuous research attention that explores their lives, challenges and strengths (Stout et al., 2001). As well, much of the research remains narrowly focused and is often centred on the causes of Aboriginal women's marginalization and oppression without focusing on prevention and health promotion (Stout et al., 2001). Young (1994) points to a gap in knowledge regarding the impact of social factors on the health of Aboriginal women, such as social support, social networks and stressful life events. Many researchers have a tendency to focus on the negative aspects of Aboriginal women's lives, which creates a certain depiction of their lives (Bent & Ross, 2004). Bent and Ross (2004) write that, "there are many positive aspects of Aboriginal women's lives that largely go unnoticed due to the tendency of researchers to focus on negative aspects of their health and well-being" (p. 22). Studies that focus only on the negative aspects of Aboriginal women's lives will not succeed in identifying aspects of strength, wellness and resiliency that could help to enrich the lives of all Aboriginal women (Bent et al., 2004).

The work of more recent researchers reflects a growing concern for Aboriginal women's health (Bartlett, 2005; Benoit et al., 2003; Deiter & Otway, 2001; Stout et al.,

2001;Bent et al., 2004; Wilson, 2004; Meadows, Thurston & Lagendyk, 2004). Much of this recent research is focused on the positive aspects of Aboriginal women's lives. The research is also focused on culturally relevant and holistic aspects of Aboriginal women's lives that might help to improve their health.

In 2000, the five Centres of Excellence for Women's Health, the Canadian Women's Health Network and the Women's Health Bureau of Health Canada identified Aboriginal women's health research as a priority. In 2001, Madeline Dion Stout, Gregory Kipling and Roberta Stout produced the *Aboriginal Women's Health Research Synthesis Project* that emphasizes the importance of addressing Aboriginal women's health status particularly for those groups which have been underrepresented in past research, namely urban women, non-status Indian women and women in conflict with the law. The five principle theme areas that they identified in their report encompassed: Aboriginal women's health status; violence and sexual abuse; substance abuse and maternal health; health seeking behaviour; and access to services (Stout et al., 2001). The paper recognizes the importance of regional as well as community-based studies in order to understand the health-related challenges facing Aboriginal women across Canada.

Bent and Ross (2004) focus their research on how wellness is conceptualized by Aboriginal women and characteristics of wellness that may be unique to Aboriginal women. One hundred and twenty-five Aboriginal women completed a questionnaire designed to assess their health status, their health and wellness concerns, their access to services and their thoughts on what wellness means to them. When physical, emotional, intellectual and spiritual health concerns were considered in combination, the top concerns were fitness (29%), depression (28%) and diabetes (21%). The top health needs

of the women interviewed were: having balance in their lives (26%); treatment and services for depression (22%); having their nutritional needs met (23%); and improvement to access and services (23%). When the participants were asked to define good health in semi structured interviews, some of the themes that emerged were holistic balance, wellness, mentally feeling happy, self care, physical fitness, being free from poverty, and having their identity (Bent et al., 2004).

Another article looking at the health needs of Aboriginal women gathered information from people in nine focus groups and five interviews with Aboriginal women living in Saskatoon. The purpose of *A Community Based Research Project Examining the Health Needs of Aboriginal Women In Saskatoon* {Saskatoon Aboriginal Women's Health Research Committee, 2004) was to gain a better understanding of Aboriginal women's access to health services in the city, to identify gaps in services and to develop a shared vision of an Aboriginal women's health centre that would meet the needs of Aboriginal women. Aboriginal women wanted greater access to Aboriginal traditional healers and alternative therapies; Aboriginal women wanted greater control over their health and how their health needs are met; Aboriginal women envisioned a holistic health centre based on the medicine wheel and Aboriginal traditional principles and teachings, and finally, Aboriginal women were interested in a facility that would meet the needs of the family as women's health means the health of ones family and community (Saskatoon Aboriginal Women's Health Research Committee, 2004). This study found that Aboriginal women have many unmet needs (particularly lack of information and the lack of access to available services). "The range of unmet basic needs of women in the community is large and alarming. Meeting Aboriginal women's needs will require

creative, cooperative and culturally sensitive approaches to service delivery" (Saskatoon Aboriginal Women's Health Research Committee, 2004, p. 11).

Until recently, there has been very little research regarding the impact of cultural identity on health and wellness for Aboriginal women. *Living Well: Aboriginal Women, Cultural Identity and Wellness* (Wilson, 2004) tries to extend our understanding of the positive impact of cultural identity on the wellness of Aboriginal women in Manitoba and our understanding of the ways that Aboriginal women have retained and drawn upon cultural values, teachings and knowledge in their efforts to heal themselves, their families and their communities. The women in this project revealed identities that are inseparable from their connections with their family, history, community, place and spirituality. One woman interviewed responded that "[o]ur traditional roles have been given away or taken-doesn't matter how it happened, but we're not as strong in our communities anymore. Once we were both the life-givers and decision-makers in our communities-culturally, traditionally, we have to take back that role" (Wilson, 2004, p. 16).

Five studies were located regarding the health of Aboriginal women in Alberta. Two of these discuss Aboriginal women's perspectives on living with HIV (Mill, 2000; Mill, 1997). The third assesses the association of Aboriginal and socio-economic status with birth outcome and maternal morbidity in Alberta (Johnson, Jin, & Truman, 2002). One article looked at Aboriginal women at midlife, and suggests that Aboriginal women "who focus on the future for either themselves or their grandchildren may be changes agents that help improve health not only for themselves but for their families and communities as well" (Meadows, Thurston, & Lagendyk, 2004, p. 159). Finally, "Balancing Culture, Ethics, and Methods in Qualitative Health Research with Aboriginal

Peoples" (2003) (Meadows, Lagendyk, Thurston, & Eisener, 2003b) provides important considerations for researchers working with Aboriginal women. Although not specific to women, *Strengthening the Circle: What Aboriginal Albertan's Say About Their Health* centres on comments from Aboriginal Albertans speaking out on their health. This report did mention the health of Aboriginal women but it was mostly in the context of reproductive health. Gender was not mentioned as a determinant of Aboriginal people's health in this report (Alberta Health, 1996). Although this report contained some excellent recommendations (for example: Aboriginal community taking control of community health services, building trusting relationships between government and Aboriginal communities) as well as an Aboriginal Health Strategy for Alberta Health, Aboriginal women were not mentioned as a priority.

One study, conducted in Quebec, reports that:

> (T)he current challenge(s) of improving health of Aboriginal women, their children and their communities are manifold and can only be resolved if we first work on the problems at the heart of the matter- more specifically lack of prevention, education and health promotion programs, inadequacy of programs …., lack of coordination and consultation, lack of long-term programs and activities, problems with accessibility and availability of services and resources, lack of cultural sensitivity, lack of resources specific to women and complicated procedures for obtaining services due especially to a lack of skills (Strategic Services, 2003, p. 14).

Anecdotal reports suggest that the same conclusions will be made in Alberta; however, the political and economic environment is very different from other provinces and more specific recommendations are needed. It is important to identify the issues affecting the health of Aboriginal women in Alberta so that health and social service programs can be created that are appropriate and applicable.

1.6 Determinants of Health Framework

When doing research on Aboriginal women's health, it is fundamental to use the Determinants of Health (DOH) as a framework because this approach is similar to Aboriginal concepts of health and wellness such as the medicine wheel (Deiter et al., 2001). As well, the poor socio-economic and physical environments within which many Aboriginal people live contribute greatly to the difficulty in achieving healthy lifestyles and to the much poorer health status in the Aboriginal populations (Bourassa, McKay-McNabb, & Hampton, 2005; Benoit et al., 2003). The continued improvement of Aboriginal women's health requires that attention be paid to all the determinants of health. The Royal Commission on Aboriginal Peoples stated that health is about the individual as well as the harmony with social and environmental systems that are themselves functioning in a balanced and holistic way (Indian and Northern Affairs Canada, 1996). By using the DOH framework, we can look at the lives of Aboriginal women in full context as opposed to researching only certain aspects of their lives.

Health Canada has played a leading role in the development of the concepts of health promotion and the DOH since the early 1970's. The 1974 Lalonde report, *A New Perspective on the Health of Canadians*, was the earliest document that identified some of the key factors that contribute to the health of populations. This report identified human biology, environment, lifestyle, and health care organizations as the principle factors affecting health (Lalonde, 1974). The Lalonde report was the momentum for a sequence of National reports that were aimed at 'Achieving Health for All', a term coined by the Federal Minister of Health, Jake Epp, and the Ottawa Charter for Health Promotion (Wilson & Rosenberg, 2002). In 1986, Jake Epp's paper, *Achieving Health for*

All identified specific challenges faced in achieving health for all Canadians: 1) reducing inequalities; 2) increasing the prevention effort; and 3) enhancing people's capacity to cope (Epp, 1986). In 1986, *The Ottawa Charter for Health Promotion* (World Health Organization, 1986) along with *Achieving Health for All: A Framework for Health Promotion* (Epp, 1986) expanded on the Lalonde report by focusing on the broader social, economic and environmental factors that affect health. These factors, or DOH, include income, employment, social status, education, and the physical environment where one lives and works as important influences on health. Attention began to shift from factors that were in the immediate control of individuals, professionals and communities to the societal (population) level (Population Health Directorate, 2001).

In 1989, the Canadian Institute for Advanced Research (CIAR) introduced the Population Health concept, proposing that individual DOH do not act in isolation. It is the complex interaction among determinants that can have a far more significant effect on health. Together, these factors can then lead to poor health. In 1994, the population health approach was officially endorsed by the federal, provincial and territorial Ministers of Health in a report entitled *Strategies for Population Health: Investing in the Health of Canadians* (Federal Provincial and Territorial Advisory Committee on Population Health, 1994). The report, which summarizes what was known about the broad DOH, laid out a framework to guide the development of policies and strategies to improve population health. The Federal, Provincial, and Territorial Advisory Committee on Population Health (ACPH) produced a second document in 1996 entitled *Report on the Health of Canadians* (Federal Provincial and Territorial Advisory Committee on Population Health, 1996) which also identified similar key factors that influence the health of Canadians. In

January 1997, the ACPH defined population health as the health of a population that is measured by health status indicators and is influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life span and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations (Federal Provincial and Territorial Advisory Committee on Population Health, 1999) . The adoption of a population health framework in the 1990's set the stage for the development of policy initiatives that integrate economic, social and health policy at different levels (Strategic Policy Directorate, 2002).

The Royal Commission on Aboriginal Peoples (1996) felt the focus should be on paying attention to the whole person in their total environment, versus isolated aspects of their lives. In the chapter, "An Overview of Women's Health" in the report *Canada Health Action: Building on the Legacy*, it was suggested that gender be added to the evolving list of Determinants of Health (Health Canada, 2003a). Much of the recent research with Aboriginal women points to the importance of culture and gender roles in improving the health of Aboriginal peoples (Bent et al., 2004; Wilson, 2004; Stout et al., 2001).

1.7 Gender Analysis Background

Gender refers to the social construction of female and male identity. It is more than biological differences between men and women. It includes the ways in which those differences (whether real or perceived) have been valued, used and relied upon to classify

women and men and to assign roles and expectations to them. Gender roles are socially constructed and maintained by underlying beliefs about the way a society should be. Gender roles can also vary within and between cultures (Vlassoff & Moreno, 2002). While women generally live longer than men, they suffer greater burdens of morbidity, distress and disability (Doyal, 1998). Women have been historically excluded as subjects of research; therefore much of the data informing prevention and intervention has been incomplete and inaccurate for women as a whole, (Greaves, 2000) not only sub-populations such as Aboriginal women.

Until recently, sex differences in health and illness have been poorly understood (Vlassoff et al., 2002). Gender analysis recognizes that women's and men's lives, experiences, needs, issues and priorities are different. As well, gender analysis recognizes that women's lives are not all the same. Life experiences vary for different groups of women (depending on age, ethnicity, disability, income levels, employment status, marital status, sexual orientation and whether or not they have children). Gender analysis aims to achieve equity (not equality), which takes into consideration the differences in women's and men's lives and recognizes that different approaches may be needed to produce outcomes that are equitable (Horne, Donner, & Thurston, 1999).

Gender analysis necessarily addresses issues of power. Gender is one of the principle sources of power inequality in most societies. Women and men rarely have equal access to resources such as money, information, power and influence. Gender differences in men's and women's roles and responsibilities and gender inequities in access to resources, information and power are reflected in gender differences and inequalities in women's and men's health. Gender interacts with biological and social

factors and thus affects access to health care; health seeking behaviour; health status; and the way health policies and programmes are developed and implemented (Vlassoff et al., 2002; Horne et al., 1999).

Gender analysis can improve health planning and programming in at least five ways: 1) improving detection and treatment of health problems in underreported groups; 2) improving understanding of the epidemiology of health problems; 3) elucidating psycho-social dimensions of disease for men and women; 4) improving relevance of public health services; and 5) increasing potential for greater public participation in health (Vlassoff et al., 2002). Equity suggests fairness, rather than equal treatment. When doing research with Aboriginal women it is important to use gender analysis since all women, including Aboriginal women, have a fundamental right to adequate health care and equal opportunity for better health.

1.8 Purpose

The purpose of this study was to assess the availability and nature of services for Aboriginal women's health in Alberta and to place the findings within a review of published literature regarding Aboriginal women's health in Canada. The goal is to provide a consolidated source of information for decision makers and others who will be able to use this information for continued research and program development. Using a Health Promotion Framework (Thurston, Vollman, Wilson, MacKean, Felix & Wright, 2003) and a Gender Analysis Framework (Horne et al., 1999) to help create the interview guide, this project identified available services specific to Aboriginal women's health. It also described the current state of health of Aboriginal women by using provincial and national research reports. This project used multiple methods, including quantitative and

qualitative data collection as well as an in depth literature review in order to provide a source of information that may contribute to a better understanding of the health of Aboriginal women living in Alberta and across Canada.

CHAPTER TWO: METHODS

2.1 Research Objectives

1) To describe existing programs specific to Aboriginal women in Alberta.

2) To determine what foci are currently reflected in published literature about Aboriginal women's health in relation to determinants of health in Canada and to identify gaps in research.

2.2 Research Questions

1) What is the nature of the programs that are currently available specifically for Aboriginal women in Alberta?

2) What substantive and methodological issues concerning determinants of health are identified in existing reports in National and/or Provincial health studies?

2.3 Conceptual Framework for Research Design

In order to analyze and evaluate the current knowledge and programs, we used a conceptual framework adapted from the *Women's Health in Alberta: An Environmental Scan (WHES)* (Appendix III). The resources necessary for the promotion of women's health at the population level in Alberta are research (both quantitative and qualitative); programs and services; and policies related to women's health (Meadows, Thurston, & Vollman, 2003a). This study considered Aboriginal women of all ages (age thirteen and over) as women at different ages have different health status and needs.

2.4 Research Design

This study used multiple methods and sources of data collection to answer the research questions. This project sought to gain multiple perspectives on the issue of

Aboriginal women's health. Data collection was triangulated, providing corroborating evidence supporting the description of Aboriginal women's health in Alberta (Creswell, 1998). "Typically this process [triangulation] involves corroborating evidence from different sources to shed light on a theme or perspective" (Creswell, 1998, p. 202). This study used both quantitative and qualitative methods in order to capture in-depth information regarding Aboriginal women's health.

2.5 Research Question 1: Programs for Aboriginal Women

2.5.1 Development of Interview Guide

An interview guide was developed specifically for this study in order to survey organizations that provide services for Aboriginal women (Appendix IV). To develop the interview guide, we adapted elements from the Health Promotion Framework (Thurston et al., 2003), the Framework for Gender Analysis (Horne et al., 1999), and the WHES template for project description (Meadows et al., 2003a) (Appendix V). We were seeking information concerning history, funding, and activities of the program. We sought information regarding the importance of the concepts of health promotion and women's health to the programs. We were interested in the official organization stance and the personal opinion of the interviewee regarding the implementation of the program. Copies of written reports and/or annual reports were requested where available. Original wording of questions was developed with the help of the thesis committee and two research associates within Community Health Sciences who have extensive background working with Aboriginal communities and research interview guides. Many questions were closed ended (with yes or no answers and checklists). The open-ended questions were meant to promote discussion and enhance the more structured answers.

2.5.2 Study Population

This study focused on all service providers in Alberta that provide services specifically for Aboriginal women. The service providers could have been health service providers or those that provide services that in any way indirectly impact Aboriginal women's health (for example: employment agencies that provide workshops for Aboriginal women entering the workforce). We first contacted organizations and then identified programs or services provided to Aboriginal women.

2.5.3 Recruitment Strategy

The main sources that were used, in addition to the thesis committee, to gather information on programs available specifically for Aboriginal women in Alberta were:

1) "A Guide to Aboriginal Organizations in Alberta" produced by the department of Aboriginal Affairs and Northern Development (Aboriginal Affairs and Northern Development, 2004);

2) A list of all the Aboriginal health centres in the Treaty regions in Alberta;

3) "Calgary Aboriginal Agencies and Services" produced by the City of Calgary (City of Calgary, 2004); and

4) Snowball sampling (where one interviewee recommends another source) (Tashakkori & Teddlie, 1998). This technique has been shown to assist in gaining access to people in communities, which may be guarded against researchers from outside the community.

Key informants who could speak about the organization and programs were identified and contacted for information by telephone. If there was no informant known to the researchers or one had not been recommended, the Chief Executive Officer of the organization was approached. A letter explaining the project and the purpose of gathering

the information was available for those who desired written communication. Interviews were conducted at a time that was convenient for the interviewee. Each organization was contacted at least three times in order to give them ample time to respond to our interview request. After contacting an organization three times without a response, we decided that the organization was either too busy or uninterested in conversing with us. If we contacted an organization and there was interest in taking part, we followed up with a maximum of six phone calls.

2.5.4 Data Collection

Data were collected during telephone interviews with the key informants using the interview guide. Telephone interviews were chosen, due to funding and time constraint issues. As well, we felt that we could capture the important information in a reasonably short telephone conversation. Written notes were taken during the interview. The interview was initially piloted among peers and modified slightly during each interview for ease of comprehension and clarity. Three research assistants were hired and trained on the study protocol and interview techniques in order to complete a comprehensive scan.

Each informant was asked about any programs they thought were specific to Aboriginal women. Once each interview began, each program identified as being for Aboriginal women was put through a specific set of inclusion criteria:

1) The program was specific for Aboriginal women; and
2) The program either directly or indirectly impacted Aboriginal women's health.

For those projects that met the inclusion criteria, the interview was completed. At the end of each interview, the interviewee was asked if he/she could be contacted again for

further information as well as if they would be interested in receiving a final report from the project.

2.5.5 Data Analysis

2.5.5.1 Quantitative Data

All quantitative data were entered into an Excel spreadsheet and inspected for missing data and outliers. Outliers were coded as 999 and missing values as 0. The data was then transferred to Stata where descriptive statistics were run.

2.5.5.2 Criteria Used For Classifying Programs:

The main outcome of Research Question I was the programs that organizations identified that are specific to Aboriginal women. We adapted a classification scheme to categorize the programs and organizations so that it would be possible to reproduce our results. The classification scheme used for this study was adapted from an existing classification scheme found in Febbraro, Hall and Parmegiani (1999), the International Classification of Non-Profit Organizations (p. 35-36). Although not all of the organizations in this project were non-profit, all organizations could be classified using this scheme. When thinking of a classification scheme, the following guidelines were used:

1. Economy: An effective classification system must organize the vast number of entities in the voluntary sector into a reasonable number of groupings, using a limited number of organizing criteria;

2. Significance: The system must organize its groupings according to significant and meaningful differences in the entities being studied;

3. Rigor: The system should be rigorous and reliable. The criteria should be clear and based on widely obtainable information so that different people will group the same organizations in the same way;

4. Combinatorial richness: the system should provide enough diversity within it to highlight interesting relationships, comparisons and contrasts;

5. Organizating power: the system should be flexible enough to fit circumstances other than those for which it was originally developed (Salamon and Anheier 1992, 1997, as cited in Febbraro, Hall, & Parmegiani, 1999).

Classification of organizations was based on the respondents' answers regarding the primary role of the organization. Classification of programs was based on the respondents' answers regarding description of program. The classification scheme consisted of:

1) Culture:

- Media and communications;
- Visual art;
- Performing arts;
- Ceramic art; and
- Other cultural programs

2) Education and Research: programs and activities that are administered, provided, promoted, conducted, supported and serviced around education and research

- Primary and secondary education;
- Higher education;
- Adult learning and continuing education and vocational/technical schools; and
- Programs involved in research (medical research, science and technology, and social sciences

3) Health issues (prevention and treatment):

- Chronic diseases (for example: diabetes, cancer, heart disease);
- Acute illness;
- Mental health;
- Violence;
- Alcohol and drug dependencies; and
- Sexual health

4) Social Services:

- Children, youth, families, handicapped, elderly;
- Self help;
- Injury prevention (suicide etc.); and
- Income support and maintenance

5) Development and Housing:

- Help to improve communities and promote communities;
- Economic, social and community development; and
- Housing

6) Law, advocacy and politics:

- Civil rights;
- Law and legal services; and
- Justice for women

7) Religion:

- Religious beliefs, services and rituals

8) Business:

- Employment;
- Leadership; and
- Training/skills

9) Wellness:

- Nutrition;
- Physical activity;
- Healthy lifestyles; and
- Recreation

2.5.5.3 Qualitative Data

A preliminary read-through of the interview transcripts allowed the researcher to gain an impression for the overall data (Creswell, 1998). As there was limited qualitative data, the interviews were coded manually. Manual coding was performed using different coloured markers for each theme identified. This allowed the researcher to examine data line-by-line, search for themes, categories and cross themes (Creswell, 1998). Simultaneously a spreadsheet was developed of all the emerging themes for each question. Once coding of all of the interviews was complete, data related to each question were organized and analyzed separately. The researcher and the thesis supervisor were involved in analyzing the data, which resulted in discussion of major themes throughout the data.

2.5.6 Research Rigor (standards of quality and verification)

Creswell (1998) discusses the procedures to verify qualitative research work and determine the standards of quality by which the research was produced. The researchers followed Creswell's guidelines to ensure the research was verifiable and produced with rigor including:

1. Clarifying Researcher Bias: Researchers discussed how their past experiences and assumptions might influence data analysis.

2. Triangulation: The use of multiple sources of data allowed for multiple perspectives on the issues.

3. Member checks: The final report was disseminated to all those who participated and who wished to receive a report.

4. Peer review or debriefing: The researcher had regular contact with the thesis supervisor to discuss any issues that arose during data collection and analysis.

2.6 Research Question 2: Literature Review

2.6.1 Data Collection

An in-depth literature review and synthesis of research and other initiatives on Aboriginal women's health was conducted throughout Alberta, as well as across Canada. The review used a systematic, explicit and reproducible method to identify, evaluate and interpret the existing body of recorded work regarding Aboriginal women's health produced by researchers, scholars, and practitioners (Fink, 1998). This method will enable others to reproduce our review and to make a rational determination of whether to accept the results of this review.

A search covering the time period from January 1, 2000 to March 1, 2005 was completed. Many different search terms were used (considering the diverse terms that are used to define Aboriginal). These included: Aboriginal, Métis, First Nations, Indian, Inuit, and Native. The search was limited to only research completed in Canada. Since the focus of the study was with Aboriginal women, the terms women, female and girls were also used in the search. The databases searched included: PubMed, Medline, Psych Info, and Sociological Collections. Articles were also identified from a review of article references. In addition to searching academic journal articles, it was felt there was

important information to be found in government and organization reports. An Internet search using the same search terms was also done. Certain well known sites that contain information regarding Aboriginal health in Canada were searched, including: Health Canada; Canadian Women's Health Network; National Aboriginal Health Organization; Native Women's Association of Canada; Centres of Excellence in Women's Health; Canadian Institutes of Health Research; and Aboriginal Nurses Association of Canada.

Papers were chosen that met the following criteria: 1) the population of interest was Aboriginal people of Canada; 2) the paper was a review or original research concerning, in some way, the health of Aboriginal women in Canada; and 3) the paper was written after January 1, 2000.

2.6.2 Data Analysis

Many researchers have pointed out that there has not been a lot of research that focuses specifically on Aboriginal women (Stout et al., 2001; Young, 2003). In the last 15 years researchers have identified Aboriginal women's health as a priority and more research that is specific to Aboriginal women has been conducted. One important review (Stout et al., 2001) provided an overview of key health issues and health related indicators for Aboriginal women in Canada and a review and synthesis of research and other initiatives on Aboriginal women's health undertaken or funded by the Centres of Excellence for Women's Health (CEWH). In reviewing all of the CEWH projects, five principle foci of research were identified: health status; violence and sexual abuse; substance abuse and maternal health; health seeking behaviours; and access to services. Finally, Stout et al. (2001) formulated recommendations that were meant to serve as the basis for priority setting in future Aboriginal women's health research activities.

Using the Determinants of Health (DOH) Framework (Strategic Policy Directorate, 2001) and beginning with the five foci above, this review aimed to continue where Stout et al. left off, reviewing all research regarding Aboriginal women's health in Canada from January 1, 2000 to March 1, 2005. This allowed us to:

a) Identify other foci of research and determine if the foci found in Stout et al. (2001) are continuing to be researched;

b) Determine which DOH are being researched and which are not; and

c) Identify existing gaps in research.

In order to analyze and synthesize the reports from the literature review, we used the DOH Framework (Strategic Policy Directorate, 2001) developed by Health Canada (see figure 2.1 below). The DOH Framework considers the entire range of individual and collective factors and conditions and their interconnectedness that have been correlated with health status (Strategic Policy Directorate, 2001). It was important to look at each DOH individually as well as in combination with each other in order to capture the cross cutting themes that much of the research contained.

Figure 2.1: Determinants of Health

1. Income and social status
2. Social support networks
3. Education
4. Employment/working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

The DOH Framework is an evolving framework and as we learn more about how interactions between determinants affect health, we will better understand why and how policies and different health approaches affect the health of a population. We will also better understand why some groups within populations are healthier than others.

The selected articles were organized in a matrix with the DOH along the Y-axis and the foci of research along the X-axis. Although the first five foci were taken from Stout et al. (2001), more themes were identified throughout the course of data collection. If a theme did not fit into the matrix at all, it was noted and discussed in detail.

A final report was then produced synthesizing the literature review and available programs. A final report was disseminated to Aboriginal organizations throughout the province as well as to the Canadian Institutes of Health Research's Institute of Gender and Health and the Institute of Aboriginal People's Health.

2.7 Ethical Considerations

This research received approval from the University of Calgary Conjoint Medical Research Ethics Board. Anonymity for all the organizations and interviewees that participated was ensured at all times by assignment of a code number that was used on all transcripts, data analysis and written material. Interviewers hired to work on the project signed confidentiality agreements. Any identifying information was removed from data used in reports and this thesis. Upon completion of this project, data will be secured for seven years by the supervisor as per University of Calgary policy.

By agreeing to participate in the interviews, the interviewees provided consent. All participants were informed that their names and/or organization names would not be mentioned in the final report. It is believed that no harm has come from these interviews, nor was there any benefit such as financial compensation or in-kind gratuities.

CHAPTER THREE: RESULTS

This chapter contains a description of the study results. Telephone interviews lasted between fifteen minutes and forty-five minutes. Interviews were completed from May 1, 2004 through to November 4, 2004.

3.1 Results of Research Question 1

3.1.1 Organizations

In total, 238 organizations were identified as eligible to take part in the scan. We obtained data from 167 (70%) of the organizations. We called each of the remaining 71 organizations three or more times in order to give them ample opportunity to participate (Table 3.1). Messages were left on the second and third phone calls. If we talked with someone at the organization and they thought someone from their organization would be able to participate, we followed up more thoroughly (with a maximum of six phone calls).

Table 3.1: Organizations

Organization	**Frequency**	**Percent**
Contacted	167	70.2
Not contacted	71	29.8
Total	238	100.00

Of those organizations contacted, 82 organizations (49.1%) had programs that we might want to include in this scan and 72 organizations (43.1%) had no programs to include in this scan (Table 3.2). The other thirteen (7.8%) of those organizations listened

to what our research was about and either did not want to participate or else wanted the interview guide faxed or emailed to them and did not return it. Thus, almost half of the participating organizations and one third of the 238 organizations originally identified had programs that we might want to include in this scan. Only one organization contacted did not want to participate in this scan. Five organizations agreed to participate, but only if the questionnaire was emailed to them (5.88%) and not one of those organizations replied once they received the email. As well, eight of the organizations wanted the questionnaire faxed to them and again only one replied once they received the fax.

Table 3.2: Result of phone call

Result of contact	**Frequency**	**Percent**
Refusal	13	7.8
No programs	72	43.1
Programs	82	49.1
Total	167	100

Forty-three organizations (52.4%) had only one program for Aboriginal women (Table 3.3). Twenty-four organizations had three or more programs.

Table 3.3: Number of programs per organization

Number of programs	Frequency	Percent
1	43	52.4
2	15	18.3
3	15	18.3
4	4	4.9
>4	5	6.1
Total	82	100

In total, 82 organizations took part in the scan of 143 programs. Many of the questions were asked in regards to the programs the organization offered. Thus, although 143 programs were scanned, there were only 82 responses. Therefore, throughout this chapter, when writing about the questions regarding the programs (from the 82 organization) the responses will reflect the “organizations” stance on their program(s).

The majority of the programs in this project were identified in the northern area of Alberta covered by area code 780 (62.2%) (Table 3.4). The smaller number of programs available in southern Alberta is an area identified for further research. One program was found in Llyodminster (the 306 area code).

Table 3.4: Area code of programs

Area code	Frequency	Percent
(780)	51	62.2
(403)	27	32.9
(306)	1	1.2
1-800	3	3.7
Total	82	100

3.1.2 Organization and Interviewee

The majority of the organizations with programs specific to Aboriginal women are non- government organizations (63.4%) (Table 3.5). Non-government organizations included for example, First Nations bands councils, non-profit organizations and for profit organizations.

Table 3.5: Type of organization

Organization type	Frequency	Percent
Government	24	29.3
Government & First Nations	5	6.1
Non- government	52	63.4
Missing	1	1.2
Total	82	100

The primary role of the majority of the organizations contacted (approximately 47.6%) was health services (Table 3.6). For seventeen (20.7%) of the organizations development and housing was their primary role. A majority of these organizations were friendship centres whose primary goal is improving the Aboriginal community by providing programs and services for Aboriginal populations.

Table 3.6: Primary role of organization

Primary role	**Frequency**	**Percent**
Health services	39	47.6
Development	17	20.7
Education & research	6	7.3
Law, advocacy & politics	3	3.7
Social services	4	4.9
Wellness	3	3.7
Culture	5	6.1
Total	82	100

One half (N=41) of those who participated in this scan worked at the upper management level (Table 3.7). Upper management level included:

- President;
- CEO;
- Executive director;
- Director;
- Health director;
- Interim director; and
- Acting director

Only 7.3% of the respondents were considered management level staff. Management level staff included assistant directors and regional/provincial coordinators.

Front line staff comprised approximately 40% of the respondents, and these included administrative staff, programs coordinators and those who delivered the programs.

Although our goal was to interview upper management, it was not always possible. This might have led to differing answers and types of information being shared in the interviews. It was thought that upper management would be more knowledgeable in regards to some of the workings of the programs. As well, upper management might have differing opinions regarding leadership and the importance of gender issues in programming.

Table 3.7: Role of interviewee

Role of interviewee	**Frequency**	**Percent**
Front line worker	32	39.0
Management	6	7.3
Upper management	41	50.0
Missing	3	3.7
Total	82	100

3.1.3 Program Specifics

Although all 82 organizations initially responded that they had programs to include in this scan that were specific to Aboriginal women, when probed deeper during the interview, it was found that not all programs were 1) specific to women and 2) specific to Aboriginal people. Fifty-seven organizations (69.5%) responded that the programs

identified were specific to women's health (Table 3.8). Fifteen respondents replied that the programs were not completely specific to women's health, and four responded that although not specific to women's health, the majority of the users are women.

Table 3.8: Frequency of programs specific to women's health

Specific to women's health	Frequency	Percent
Yes	57	69.5
No	15	18.3
No (majority women)	4	4.9
Missing	5	6.1
Total	82	100

The majority of the respondents replied that the programs discussed were indeed specific to Aboriginal women (N=56, 68.3%). Approximately 25% of the organizations replied that although the programs are not specifically for Aboriginal women, the majority of users are Aboriginal women (Table 3.9).

Table 3.9: Frequency of programs specific to Aboriginal women

Specific to Aboriginal women	Frequency	Percent
Yes	56	68.3
No (majority aboriginal)	21	25.6
Missing	5	6.1
Total	82	100

Most of the organizations (approximately 80%) had some type of funding to run the programs discussed in the interviews. Only 12% of the organizations had no funding (Table 3.10). Funding came from a variety of sources including for example, in-house funding, Health Canada, federal government initiatives, provincial government initiatives, and non-profit organizations such as the United Way. The programs that had no funding provided the space for programs, used volunteers to run programs, and had the clients bring snacks when necessary.

Table 3.10: Availability of funding for programs

Funding (yes/no)	**Frequency**	**Percent**
Yes	66	80.5
No	10	12.2
Not sure	1	1.2
Missing	5	6.1
Total	82	100

3.1.4 Evaluation Information

Less than half the organizations (43.9%) had completed evaluations of their programs (Table 3.11). Few respondents (19.5%) reported planning an evaluation of the program in the future (Table 3.12). Seven organizations were either not sure if they would be performing an evaluation in the future or were sure that it would not be a formal evaluation. Thus, formal evaluations of programs for Aboriginal women are few and according to the data there was no indication that this will change.

Table 3.11: Evaluations completed to date

Evaluation complete	Frequency	Percent
Yes	36	43.9
No	38	46.3
Not sure	1	1.2
Not formally	1	1.2
Missing	6	7.3
Total	82	100

Table 3.12: Evaluation planned

Evaluation planned	Frequency	Percent
Yes	16	19.5
No	15	18.3
Not formally	2	2.4
Maybe	5	6.1
Missing	7	8.5
Not applicable	37	45.1
Total	82	100

3.1.5 Reports

Few organizations (24.4%) had a written report on the programs that were discussed (Table 3.13) and only seventeen organizations (20.7%) had an annual report that had some relevance to the programs discussed (Table 3.14). Thus, printed reports are

not a common means for program documentation or dissemination of experience and expertise. A copy of the report was requested if the organization did indeed have a report that might be useful to this scan. Although nine organizations replied that there was either a written report or annual report that we could use for the purposes of this project, none were received. Seven interviewees were unsure if we could have the reports as they were housed elsewhere (i.e. regionally).

Table 3.13: Availability of written reports

Availability	**Frequency**	**Percent**
Yes	20	24.4
No	54	65.6
Maybe	1	1.2
Developing it	1	1.2
Missing	6	7.3
Total	82	100

Table 3.14: Availability of annual reports

Availability	**Frequency**	**Percent**
Yes	17	20.7
No	59	72.0
Missing	6	7.3
Total	82	100

3.1.6 Age Range

Each interviewee was asked about the age range served and specific populations for which programs were designed. If the organization had more than one program specific for Aboriginal women, they were asked to answer based on all the programs that we were discussing combined. All age ranges were well served by the programs, although childbearing women were most often the focus of programs (Table 3.15).

Table 3.15: Frequency of specific age groups

Age range	**Frequency**	**Percent**
≤ 18	53	64.6
19-39	69	84.2
40-64	51	62.2
≥65	51	62.2
Total	82	-

3.1.7 Target Populations

The majority of organizations (54 organizations) providing programs for Aboriginal women were focused on reserve areas (Table 3.16). It is important to note that 28 organizations focused on more than one area (i.e., 6 organizations offered services to urban areas as well as rural areas and 21 organizations offered services to urban, rural and reserve areas) (Table 3.17).

Table 3.16: Targeting specific areas (N=75)

Area served	**Frequency**	**Percent**
Urban	39	47.6
Rural	28	34.1
Reserve	54	65.9

Table 3.17: Individual versus multiple service areas

Area(s) served	Frequency	Percent
Urban (alone)	12	14.6
Rural (alone)	1	1.2
Reserve (alone)	33	40.2
Urban and rural	6	7.3
Urban, rural and reserve	21	25.6
Missing	9	11.0
Total	82	100

Just over 56% of the organizations felt that their programs targeted all women versus a specific population (i.e. abuse survivors etc). Over 13% of the organizations felt that their programs targeted any women who were at risk. It is interesting to note that only one organization's programs specifically targeted Inuit women and that no programs were designed to serve lesbian/ two spirited women (Table 3.18).

Table 3.18: Target populations (N=75)

Target population	Frequency	Percent
Single mothers	22	26.8
Lesbian/two spirited women	0	0
Abuse survivors	17	20.7
Women with disabilities	12	14.6
Women with low incomes	20	24.4
Women with low literacy	15	18.3
All women at risk	11	13.4
Expectant moms/new moms	3	3.7
Addicted/were addicted	1	1.2
Women in need of healing	1	1.2
Inuit women	1	1.2
All women	46	56.1

3.1.8 Determinants of Health Addressed in Programs

Personal health practices, health services and culture were addressed most often in the programs while biology, income, employment and physical environment were addressed least often (Table 3.19 or Figure 3.1). When asked if there were any other determinants of health that were addressed in their programs, almost 5% of the organizations responded that legal and civic issues were addressed (Table 3.20). As well, 3.7% of organizations responded that the medicine wheel/native spirituality was addressed in their programs.

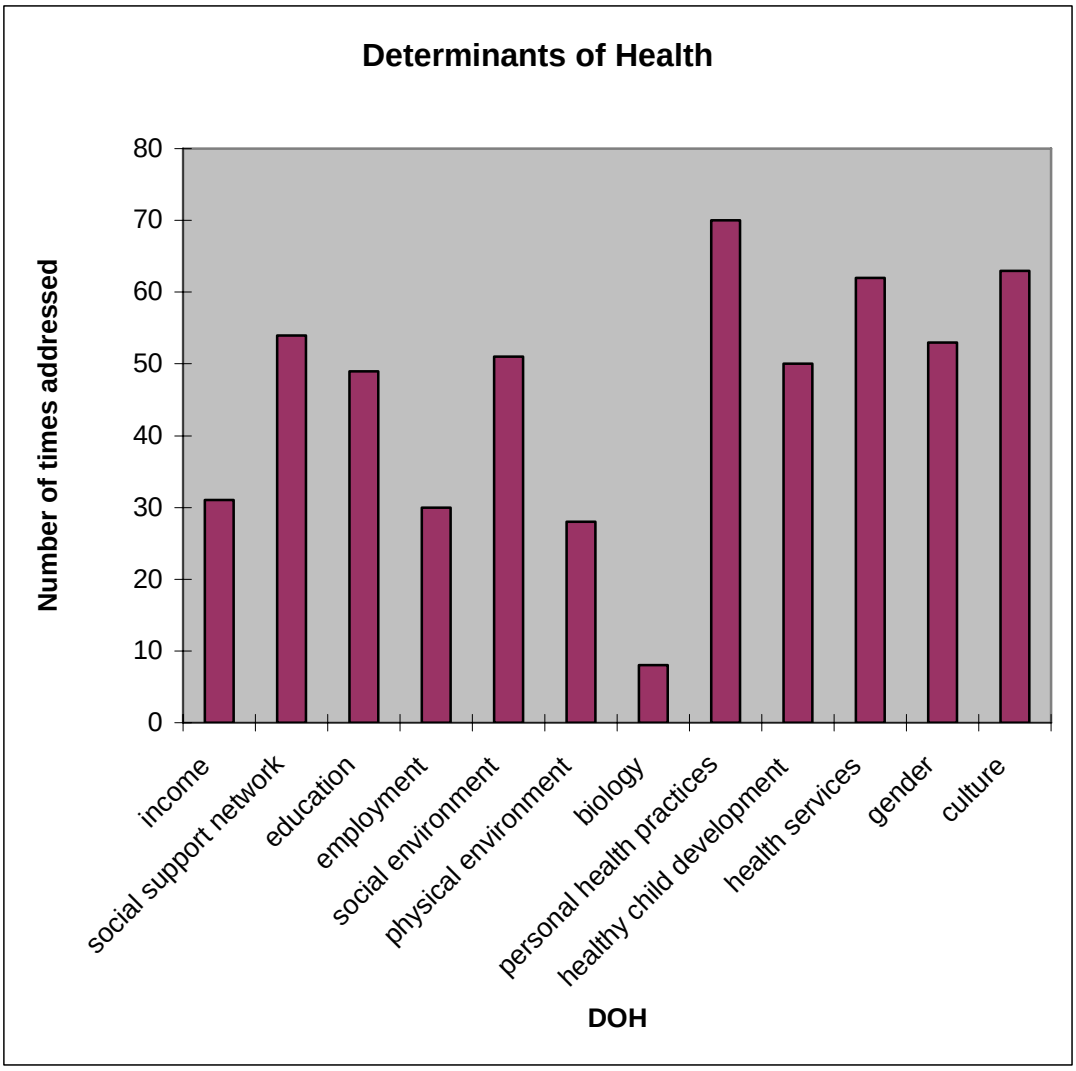
Table 3.19: Frequency of determinants of health addressed (N=75)

Determinant of health	Frequency	Percent
Income	31	37.8
Social support networks	54	65.9
Education	49	59.8
Employment	30	36.6
Social environment	51	62.2
Physical environment	28	34.2
Biology	8	9.7
Personal health practices	70	85.4
Healthy child development	50	61.0
Health services	62	75.6
Gender	53	64.6
Culture	63	76.8

Table 3.20: Other determinants of health

DOH: Others	Frequency	Percent
Legal/civic issues	4	4.9
Medicine wheel/ native spirituality	3	3.7
Others (fit into one of the 12 DOH above)	9	11.0
No others	59	72.0
Missing	7	8.5
Total	82	100

Figure 3.1: Determinants of Health



3.1.9 Official Organization Policies

Just over 80% of the organizations surveyed indicated that their programs were officially health promotion programs. Tables 3.21 to 3.25 display the frequency of the responses to questions concerning incorporation of the five strategies described in the Ottawa Charter for Health Promotion. The strategies incorporated most often into the programs were creating supportive environments and developing personal skills (61 programs and 63 programs respectively). The strategies incorporated least often were

building healthy public policy, strengthening community action and reorienting health services (15 programs, 39 programs, 38 programs respectively).

Table 3.21: Building healthy public policy

Healthy public policy	**Frequency**	**Percent**
Yes	15	18.3
No	51	62.2
Not sure	1	1.2
Not applicable	7	8.5
Missing	8	9.8
Total	82	100

Table 3.22: Creating supportive environment

Supportive environments	**Frequency**	**Percent**
Yes	61	74.4
No	6	7.3
Not sure	1	1.2
Not applicable	6	7.3
Missing	8	9.8
Total	82	100

Table 3.23: Strengthening community action

Community action	Frequency	Percent
Yes	39	47.6
No	29	35.4
Not sure	1	1.2
Not applicable	5	6.1
Missing	8	9.8
Total	82	100

Table 3.24: Developing personal skills

Personal skills	Frequency	Percent
Yes	63	76.8
No	4	4.9
Not sure	1	1.2
Not applicable	6	7.3
Missing	8	9.8
Total	82	100

Table 3.25: Reorienting health services

Health services	Frequency	Percent
Yes	38	46.3
No	28	34.2
Not sure	1	1.2
Not applicable	7	8.5
Missing	8	9.8
Total	82	100

Some organizations indicated that other health promotion strategies were incorporated into their programs, such as: building courage (1.22%), education (1.22%), empowerment (1.22%) and the medicine wheel (1.22%) (Table 3.26). When asked if the program was officially considered a health promotion program, we did not ask for further elaboration. Several respondents discussed in more detail what health promotion programming meant to them. One theme that was common was that the intent of health promotion was healthy families and healthy communities. Many of the respondents indicated that when talking about health, Aboriginal women are not just thinking in terms of their own health, but the health of their children, their families and their communities. Other themes that were identified were: healthy lifestyles, a holistic view of health promotion based on the medicine wheel (i.e. physical, mental, emotional and spiritual), and empowerment. One respondent replied, “the goal is for women to gain control and power over themselves, to regain their own individual identities as women” (Interview 40).

Table 3.26: Other health promotion strategies

Others	Frequency	Percent
Building courage	1	1.2
Education	1	1.2
Empowerment	1	1.2
Medicine wheel	1	1.2
Not applicable	7	8.5
Missing	8	9.8
No others	63	76.8
Total	82	100

Fifty-five of the organizations (67.1%) replied that women's health was an official priority in their programs (Table 3.27). One respondent felt very passionately about women's health being a priority as she responded, "women's health/well being is the priority of everything we do. Indeed, women's health (especially Aboriginal women's health) is not often enough identified as a priority" (Interview 69). When discussing whether women's health was considered an official priority, the focus was on the holistic view of women's health and the importance of looking at the physical, mental, emotional, and spiritual health of women. One interviewee added a cultural component into women's health by responding that, "the philosophy of indigenous women is if healing one woman, she can heal her significant other. She can heal her family and can heal her community" (Interview 43). Although many organizations felt that women's health was officially identified as a priority, so was the health of men, families, and children. One

respondent replied that “Its not just women anymore….trying to incorporate both….dividing the two just doesn’t work” (Interview 22). One respondent felt that her organization could not justify saying that women’s health was officially a priority as “urban Aboriginal women are falling between the cracks” (Interview 59). The theme of maternal health also was common when people talked about women’s health.

Table 3.27: Women’s health as an official priority

Priority	**Frequency**	**Percent**
Yes	55	67.1
No	17	20.7
Yes and no	2	2.4
Not sure	1	1.2
Missing	7	8.6
Total	82	100

Although gender was addressed in over 64% of the organizations (in terms of determinants of health), only 11 of the organizations (13.4%) have a statement of commitment to gender equity for their programs. Two organizations were not sure if there was a statement of commitment to gender equity (Table 3.28).

One theme that emerged from numerous interviews was that there was no official statement of commitment to gender equity, but that it was implied or there was a general understanding. Unfortunately, we did not explore in more depth what exactly was implied or what the understanding was in these organizations with respect to gender equity. One respondent replied that they wished there was a statement of commitment “because then

more men would be served. Because of the strength of women women's movement, [there are] some gaps in other areas" (Interview 19). One other theme that emerged from the data was that men and women should be equal.

Table 3.28: Programs with a statement of commitment to gender equity

Statement of commitment	Frequency	Percent
Yes	11	13.4
No	62	75.6
Not sure	2	2.4
Missing	7	8.6
Total	82	100

Approximately 73% of the organizations recognize that there are certain barriers that are specific to Aboriginal women accessing their programs (Table 3.29) and the majority of these organizations indicated that they are trying to overcome these barriers. Many of the organizations provide transportation to and from the programs, childcare or babysitting, programming free of cost, as well as meals or snacks. Perhaps more importantly, many of the organizations provide a safe and comfortable place for women to come and a sense of comfort in sharing with the other women. Frequently there was a cultural component added to the program, often by having female elders come and share their experiences with the women. Organizations identified that they provide services based on the needs of the women who access their program. For example, they provided advocacy, referrals, and resources to address any issue that was brought up by the women (for example, violence was mentioned quite often). As well, organizations indicated that

through talking circles and support groups, they are able to discuss the barriers that women are facing and ways the women could address these barriers themselves. Lastly, many organizations indicated that they try to empower women with knowledge of what is available to them in terms of services, confidence in accessing services and awareness of other issues that are affecting other women.

Some organizations expressed that inadequate funding limited their ability to address some of the barriers that exist and therefore some of these issues were only addressed on a case-by-case basis. One organization commented that, "[t]here are virtually no programs other than our own who address the issues of Aboriginal women in this city [Calgary] and surrounding areas" (Interview 43). Another comment made once was that "men have more barriers than women" (Interview 30).

Table 3.29: Barriers to accessing programs

Recognizes barriers	**Frequency**	**Percent**
Yes	60	73.2
No	11	13.4
Not sure	3	3.7
Missing	8	9.8
Total	82	100

Just over 62% of the organizations indicated that those running their programs were qualified to address issues related to gender inequality that affect women's health (Table 3.30). Just over 17% of the organizations surveyed were not sure whether their staff were qualified to address issues related to gender inequality.

The qualifications necessary to address issues related to gender inequality that affects women's health included: educational experience and training; life experience; the life experience and cultural dimension that elders brought to the programs; as well as the actual sex and ethnicity of the workers. It was important to many organizations that their workers were trained and they had many highly qualified staff (most common examples included social work degrees, counselling certificates, psychologists, trained facilitators). One respondent replied that, "this [type of] experience increases positive interventions" (Interview 17). Many organizations felt that life experience and life skills were just as important as educational experience. When talking about life experience, organizations mentioned the importance of having elders take part in the programs to bring their life experience to the programs. One respondent replied that, "elders are central to [the program's] effectiveness" (Interview 70). As well, respondents identified the importance of growing up in the communities they are serving as well as going through the groups themselves. Many organizations brought in qualified professionals to run certain programs that they felt they were not qualified to provide. For example, professionals were brought in to do presentations regarding issues such as diabetes education or HIV prevention. In some communities, professionals were brought in to perform breast screening and pap tests. Finally, many organizations indicated that the sex of those running the programs was important in dealing with gender issues. Many organizations felt that the programs ran much better if there were women running the programs as they could relate to the participants much better than men could. One respondent relayed that their reserve had a male nurse and that this led to some gender related problems and that many of the women did not feel as comfortable talking to him about certain issues.

Table 3.30: Qualifications of those running the programs

Qualifications	Frequency	Percent
Yes	51	62.2
No	9	11.0
Not sure	14	17.1
Missing	8	9.8
Total	82	100

In almost 90% of the organizations, women were reported to be involved in the planning and implementation of programs that are directed at women (Table 3.31). In fact, there was only one organization where women weren't involved in the planning and implementation of the programs and the interviewee responded that they would like women to be involved. While this is a very promising number of women involved in programming, we did not look at whether the upper management was male or female.

Table 3.31: Involvement of women in planning and implementation of programs

Involvement	Frequency	Percent
Yes	72	87.8
Yes (only in implementation)	1	1.2
Would like them to be	1	1.2
Missing	8	9.8
Total	82	100

3.1.10 Personal Opinions of Those Interviewed

It is important to note that the previous questions were focussed on the "official" organizational policies on issues related to health promotion, women's health and gender issues. The following questions were more concerned with the respondent's personal opinions on the same issues.

Almost 72% of the respondents felt that women's health has been well incorporated into the program (Table 3.32), with many reporting that the programs had a holistic view of women's health with a emphasis on healthy lifestyles. Many of the programs provided the women with a support that was needed and a sense of comfort and belonging. Many of the programs were designed to empower the women with the knowledge, skills and confidence they needed to overcome whatever barriers they were facing. Many of the programs, particularly the healing/talking circles, had no one focus and addressed whatever issues the women wanted to discuss. Therefore, the respondents felt that these programs focused on the women's needs.

Some of the organizations that felt their programs did a good job of incorporating women's health issues had a particular focus. For example, the programs focused on young Aboriginal women, on maternal health, on older Aboriginal women or on the community. Some respondents indicated that women's health was well incorporated into their program because the majority of the users in the community-focused programs are women. "Women's health has been well incorporated as "it brings Aboriginal women's health to the forefront of the community's awareness" (Interview 69).

On the other hand, some respondents felt that women's health issues were not well incorporated into the programs and that there is much more they could be doing to

better address women's health issues. "I can use immigrant women who have countless agencies and duplication of services…..[for example], but ABSOLUTELY nothing for Aboriginal women but system barriers" (Interview 69). A few respondents mentioned that there is not enough funding to really delve into women's health issues. "Yes from a community point of view; no from a financial perspective….it is a band aid approach by Health Canada- that they don't provide enough funding to complete tasks to contribute to women's enhanced healthy lifestyles" (Interview 37). Others felt that it was not fair to just focus on women's health and that men's health and community health needed to be the focus. Women's health "competes with other priorities. It is core, as well as men's health etc. [I] don't segment it out; [I] have a community focus" (Interview 19). The main themes that arose from those that did not think women's health was well incorporated into the programs was that there is more that needs to be done, more money is needed and more health care workers are needed in order to make a difference.

Table 3.32: Women's health (as a topic) incorporated into the programs

Women's health	Frequency	Percent
Yes	59	72.0
No	10	12.2
Yes and no	3	3.7
Not sure	1	1.2
Missing	9	11.0
Total	82	100

Almost 90% of the organizations felt that the programs had a positive impact on women's health (Table 3.33). One respondent was not sure of the impact because their program was just beginning and they could not assess the impacts on the women using the program.

The feedback was very positive in terms of the programming having a positive impact on Aboriginal women's lives. Many respondents felt that the programs helped to empower the women by giving them awareness, education and information, which builds knowledge, confidence and skills to overcome barriers and to help find their identity. As well, respondents indicated that the programs provided the women with a sense of comfort and belonging. Some of the programs gave the women a sense of community that they had not felt before. For example, in many cases the women learned and felt more comfortable accessing certain health services when learning together as a group. As well, the programs provided the women with the ability to ask more questions (and get more answers), improved their self-esteem and improved the way they handled stress.

Many respondents felt that the programs were having positive effects on women's health and the testament to this was the success stories coming out of the programs. For example, cooking styles changed, women were taking care of themselves and choosing more healthy lifestyles. One respondent mentioned that, "many women would remember us when they saw us on the street, and tell us how much the program has affected their lives" (Interview 73).

Some respondents felt that positive effects are occurring as a result of the programs, but it is still not enough. More programs, more funding, more prevention and more female staff are still needed to make a difference. A few respondents felt that positive things were happening, but that it will take time to see real change, in light of the years of negative history that women have faced and the loss of their cultural identity, "slowly, but eventually women's habits will be changed (for example: eating, exercising, esteem)" (Interview 63). One respondent felt there was only so much that programming could do to affect women's health. "Any education is a positive effect, but you can lead a horse to water, but you can't always make them drink it" (Interview 47).

Table 3.33: Positive effects of the program on women's health

Positive effects	**Frequency**	**Percent**
Yes	72	87.8
Yes and no	1	1.2
Not sure yet	1	1.2
Missing	8	9.8
Total	82	100

Less than 50% of the organizations felt that the leaders are taking gender into consideration when running the program (Table 3.34). Only 13.4% of the organizations felt that the leaders were not taking gender into consideration while just over 25% of those were not sure if the leaders were taking gender into consideration or not.

Many respondents were unsure if the leaders were taking gender into consideration when running the programs. Some respondents felt that the leaders were trying, and doing the best they could, while others felt that gender is not an issue that is addressed at all by the leaders. For those that did feel that the leaders were taking gender into consideration, they felt that the leaders were being sensitive to women's specific needs and they were aware of gender issues. The respondents felt that the leaders understood the importance of having same sex facilitators to address sensitive issues. Some respondents indicated that the leaders of their organizations realize that women must come to terms with a sense of loss of cultural identity and the leaders want to help women regain their identity. The respondents indicated that the leaders are providing funding and leading with their experience, and that they are doing the best they can for women. Some respondents believed that it was very important for the leaders to be women in order for gender issues to be taken into consideration.

Other people surveyed felt that the leaders were not taking gender into consideration. One interviewee responded, "I was once a leader, I saw for myself that it's not a priority" (Interview 66). Another interviewee felt that the leaders supported gender issues verbally, but they were not seeing any action-based support. One interviewee was quite passionate when answering this question. She replied, "ABSOLUTELY NOT. The government has failed Aboriginal [women] consistently for many years. The Amnesty

report on cases of assault/abuse and the missing women are all proof of the utter failure of leaders to address the needs of Aboriginal women" (Interview 69). It is interesting to note that some answered this question in terms of their organization leadership, and some took it to mean political leadership.

Table 3.34: Consideration of gender by leaders

Consideration of gender	Frequency	Percent
Yes	38	46.3
No	11	13.4
Not sure	21	25.6
Doing the best they can	1	1.2
Only if leaders include women	1	1.2
No comment	1	1.2
Missing	9	11.0
Total	82	100

3.1.11 Programs

In total, 143 programs were identified in the organizations contacted. The programs were categorized into nine different categories:

1) Culture (media, arts, cultural programs);
2) Education & Research;
3) Health issues (prevention & treatment);
4) Social services;
5) Development;
6) Law, advocacy & politics;
7) Religion;
8) Business & employment; and
9) Wellness

Although there were 143 total programs, some of the programs fit into more than one service category. Therefore this study assessed the number of times service categories were identified in the programs instead of assessing total number of programs in each category. Health issues were identified most often, approximately 31% of all services described fell under health issues (Table 3.35). Social services were identified approximately 24% of the time while wellness programs were identified over 21% of the time. Culture was identified over 16% of the time. Religion was not identified once in any of the programs and education and research was only identified on one occasion.

Table 3.35: Number of times service categories addressed in programs

Service categories	Frequency	Percent
Culture	35	16.2
Education & research	1	0.5
Health issues (prevention & treatment)	67	31.0
Social services	52	24.0
Development & Housing	1	0.5
Law/advocacy/politics	3	1.4
Religion	0	0
Business/employment	11	5.1
Wellness	46	21.3
Total	216	100

Out of the total number of programs 66% fell under a single service category. Almost 19% fell under two categories (Table 3.36) and just over 16% fell under three categories (Table 3.37).

Table 3.36: Frequency of two service categories being addressed

Culture/ health	2	7.7
Culture/social services	5	19.2
Culture/development	1	3.9
Culture/wellness	2	7.7
Health/social services	9	34.6
Health/wellness	4	15.4
Social services/wellness	2	7.7
Law/advocacy/ politics &business/ employment	1	3.9
Total	26	100

Table 3.37: frequency of three service categories being addressed

Service categories	Frequency	Percent
Culture/health/wellness	22	95.7
Health/social services/education & research	1	4.3
Total	23	100

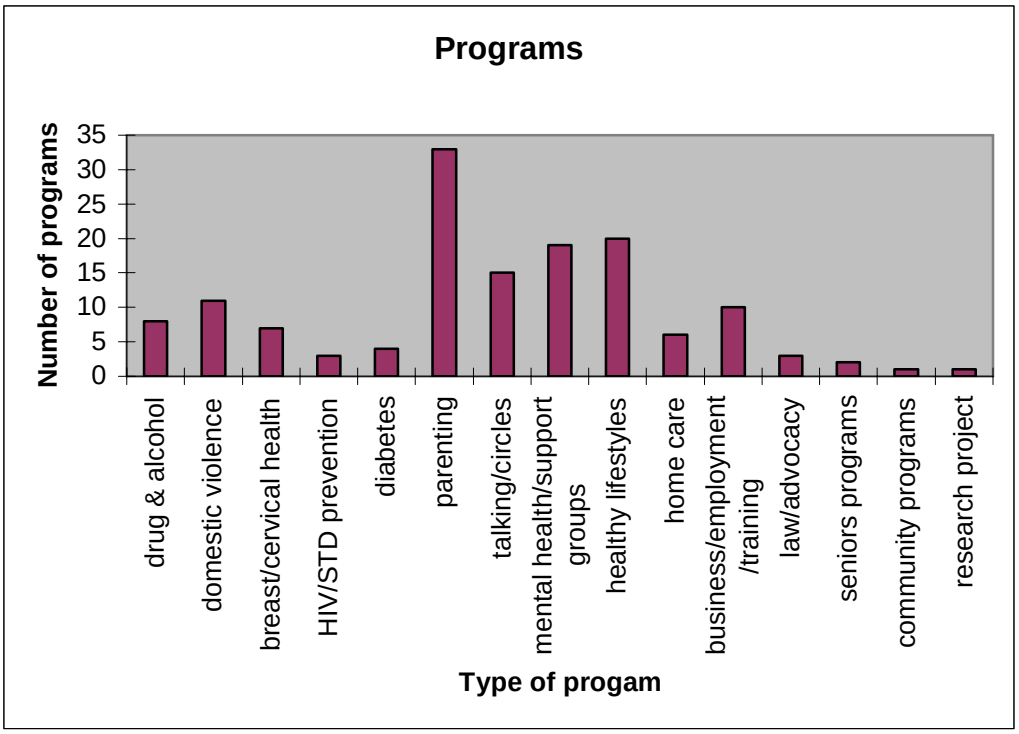
Just over 23% of the programs identified were related to parenting (Table 3.38). Other frequent programs were healthy lifestyle programs (14.0%), mental health and support groups (13.3%) and talking and healing circles (10.5%). Only 2% of the programs dealt with HIV and only 5.0% dealt with breast and cervical health. Seven percent of the programs involved employment and business and one program dealt with justice for women.

Table 3.38: Types of programs

Programs	Frequency	Percent
Drug & alcohol	8	5.6
Domestic violence	11	7.7
Breast/cervical health	7	4.9
HIV/STD prevention	3	2.1
Diabetes	4	2.8
Parenting	33	23.1
Talking/healing circles	15	10.5
Mental health/support groups	19	13.3
Healthy lifestyles	20	14.0
Home care	6	4.2
Business/employment/training	10	7.0
Law/advocacy	3	2.1
Senior programs	2	1.4
Research project	1	0.7
Community programming	1	0.7
Total	143	100

The preponderance of programs devoted to parenting is even more striking when the data are displayed as a figure (Figure 3.2). When one considers that the drug and alcohol category includes prevention and treatment of FAS/FAE, the focus on parenting is even greater.

Figure 3.2: Types of programs



Almost 30% of the programs assessed were initiated between 2000 and 2003 (Table 3.39). A number of the organizations surveyed did not identify start and end dates for a number of programs because if an organization had more than one program they only answered based on the first program they discussed.

Table 3.39: Date program began

Begin date	Frequency	Percent
2004	12	8.4
2000-2003	40	28.0
1995-1999	33	23.1
1991-1994	15	10.5
1981-1990	11	7.7
$\leq$ 1980	1	0.7
Missing	31	21.7
Total	143	100

Very encouraging is that almost 70% of the current programs are going to continue indefinitely (Table 3.40). For some programs, the end date will depend on need for the program (2.1%) as well as funding (2.1%). Therefore, existing programs do not appear to be in danger of ending.

Table 3.40: Date program will end

End date	Frequency	Percent
Indefinitely	99	69.2
Indefinitely based on need	3	2.1
Indefinitely based on funding	3	2.1
2004 (2 would like to continue)	4	2.8
2005 (2 would like to continue)	3	2.1
2009	1	0.7
Not sure	4	2.8
One time only	2	1.4
Missing	24	16.8
Total	143	100

3.2 Results of Research Question 2 (literature review)

3.2.1 Summary of Results

In total, we identified 48 articles and reports focusing specifically on Aboriginal women's health in Canada. Many other articles were identified that were not specific to Aboriginal women's health. See Appendix VI for a complete bibliography of search of the literature published in Canada completed from January 1, 2000 to March 1, 2005. Some of these articles had sex-disaggregated data but paid virtually no attention to the circumstances that may be different for women and men. Only articles that were specific to women or those that discussed gender related issues are included in the discussion below.

The foci identified in the recent literature are the same as the foci identified by Stout et al. (2001) (i.e. horizontal access of matrix) that included: health status; violence and sexual abuse; maternal issues (including substance abuse); health seeking behaviour; and access to health services. New foci that were identified in the present research included: mental health; senior Aboriginal women; and diversity of women (i.e., projects for First Nations, Inuit and Métis women). In addition to the foci mentioned above, a theme of capacity building was identified in the literature. Health status, health seeking behaviours and access to services were addressed most often in the articles identified, while violence, substance abuse and maternal health, and Aboriginal senior women were addressed less frequently.

In terms of the DOH's addressed in the literature (vertical access of Matrix), health services, personal health practices and coping skills, and culture were addressed most often while biology, healthy child development, physical environment, social

support networks, education, employment and social environment were addressed less often. If looking at the matrix, the theme and DOH addressed together most were health status and health services; followed closely by:

- Health status and personal health practices;
- Access to services and health services;
- Health seeking behaviour and health services;
- Health seeking behaviour and culture; and
- Health status and culture

3.2.2 Health Status

The poor health status of Aboriginal women in Canada is well documented in the literature, prior to 2000 (Stout & Kipling, 1998; MacMillan, MacMillan, Offord, & Dingle, 1996). Unfortunately, the Canadian research from 2000 to the present also indicates that the general health status of Aboriginal women in Canada is poor. (Grace, 2003; Stout et al., 2001). Examples of the health related issues Aboriginal women are facing include increased risk of acquiring HIV (Mill, 2000), and increased prevalence of gestational diabetes, which leads to increased risk of type II diabetes (Dyck, Klomp, Tan, Turnell, & Boctor, 2002). In addition, estimates of the prevalence of violence against Aboriginal women range from 25% to 100%, and Aboriginal women are slightly more than three times as likely as non-Aboriginal women to report violence by a current or former spouse (Brownridge, 2003). Although these indicators continue to portray Aboriginal women's poor health, a few of the studies concluded that Aboriginal women self reported their health as relatively good (Grace, 2003; Bent et al., 2004). In the Bent and Ross study, the majority of Aboriginal women considered themselves to be

physically (61%), emotionally (62%), intellectually (79%) and spiritually (68%) well. The majority of these women also reported unemployment (63%), annual earnings less than $20,000 (67%) and that they were supporting dependent children (69%) (Bent et al., 2004). According to the DOH Framework, good health status is associated with positive indicators of the various DOH, particularly economic and social status (strategic policy directorate 2001), therefore, these results are somewhat surprising.

In much of the literature Aboriginal women identified that they have a holistic view of health encompassing physical, mental, emotional and spiritual health (Bartlett, 2005; Saskatoon Aboriginal Women's Health Research Committee, 2004; Bent et al., 2004; Deiter et al., 2001; Stout et al., 2001; Struthers, 2003). The participants in Bartlett's study *Health and Well-Being for Métis Women in Manitoba* reported that health was most often reflective of physical issues, while well-being was broader encompassing the spiritual, physical, mental and emotional aspects (Bartlett, 2005). In addition, Aboriginal women often measure their health status in terms of their family, their history, their community, their place in the community and their spirituality (Bent et al., 2004; Wilson, 2004).

One study focused on the health status of Métis women in northwestern Saskatchewan. The women noted that many of the factors that impact their health fall outside the health sector. The socio-economic conditions in their communities, the lack of employment opportunities, the limited access to services and the quality of housing and transportation were all seen as affecting overall health (McCallum-McLeod & Wilson, 2004). The Métis women who participated in the study felt that Métis identity is an important part of women's sense of self, and their connections to their communities.

They wanted access to services that reflect and respect their culture and values. The women also indicated that because of jurisdictional boundaries and eligibility criteria, Métis people are excluded from certain government programs available to other Aboriginal populations, which is a barrier to accessing services (McCallum-McLeod et al., 2004).

When Aboriginal women considered their physical, intellectual and spiritual health concerns in combination (Bent et al., 2004), they reported that fitness (29%) was their major health concern, followed by depression (28%) and diabetes (21%). Their top health needs were balance in their lives (26%), having their nutritional needs met (23%), improved access to services (23%), treatment and services for depression (22%), bone and muscle problems (17%), cancer (14%), and heart and stroke (13%). In another study conducted by Deiter & Otway in Manitoba and Saskatchewan, Aboriginal women were surveyed in regards to their health. Ninety-three Aboriginal women participated in the survey and the top three health concerns in this study were family violence, diabetes and mental health issues, followed closely by cancer and hypertension (Deiter et al., 2001).

Various health issues identified in the recent literature included: HIV (Mill, 2000), cancer (Young, Kliewer, Blanchard, & Mayer, 2000; Alberta Cervical Cancer Screening Program, 2002), diabetes (Dyck et al., 2002) , mental health (Grace, 2003; Maritime Centre of Excellence in Women's Health, 2001), and menopause (Webster, 2002). Many of the publications on the health status of Aboriginal women do not focus on a specific health issue, but discuss health in more general terms, particularly in terms of health services. (Bartlett, 2005; Benoit et al., 2003; Benoit & Carroll, 2001; Stout et

al., 2001; Pauktuutit Inuit Women's Association of Canada, 2002; Sutherns, McPhedran, & Haworth-Brockman, 2004; Hannis, 2002).

3.2.3 Health Services and Access to Services

Stout et al. (2001) states that, “numerous studies have highlighted the difficulties Aboriginal face in gaining access to the mainstream health and social services system. Moreover, even when they do make use of such services, they must often contend with racism, cultural insensitivity and lack of Aboriginal personnel” (p. 26). For the most part, Aboriginal women feel like health care services are not meeting their needs {Stout, Kipling, et al. 2001). In one study, in depth interviews with 10 First Nations women were conducted regarding their encounters with mainstream health services (Browne & Fiske, 2001). These narratives revealed that Aboriginal women faced racism, discrimination, and structural inequities that continue to marginalize and disadvantage them. Although some women in the study had positive experiences in the health care system, the invalidating experiences in this study included: dismissal by care by health care providers; negative stereotypes; marginalization from the mainstream; disregard for personal circumstances; situations of vulnerability (such as physical exams); and transforming themselves to gain credibility (Browne et al., 2001). As well, women in two different studies felt that there was a lack of integration between service providers, which impacted care for Aboriginal women (Benoit et al., 2003; Saskatoon Aboriginal Women's Health Research Committee, 2004). Women thought that service delivery was fragmented. They felt that agencies worked independently of each other rather than working together to improve the health of Aboriginal women. Aboriginal women thought that some agencies actually worked against each other, which made addressing health

issues more difficult (Saskatoon Aboriginal Women's Health Research Committee, 2004). It is important to note that the issue of fragmented health care is not unique to Aboriginal women (MacKean, G.L., Thurston, W.E. & Scott, C.M., 2005; Thurston, W.E. & Meadows, L.M., 2003).

A study done in Saskatoon identified lack of information and the lack of access to available services as the main barriers to health care for this population. (Saskatoon Aboriginal Women's Health Research Committee, 2004). Aboriginal women's needs that were not met and services that were not meeting their needs included a range of issues incorporating the DOH:

- Aboriginal people with disabilities;
- Adequate housing for elders, single moms, young moms;
- Residential school support and counselling;
- Access to information on aboriginal resources;
- Aboriginal traditional methods more accessible;
- Transportation to access services;
- Older women's services particularly adequate low income housing and subsidized health coverage;
- Services to mothers and children (low cost or free fitness, respite care, more daycare);
- Explanations of procedures in understandable language;
- Support programs to promote healthy lifestyles;
- Traditional Aboriginal counselling;
- Traditional aboriginal parenting program;
- Safety, health and community support services for children and youth;
- Family services that connect the whole family in healing;
- Bands not providing coverage for space in women's shelters; and
- Programs to address community safety and gang violence.

"The range of unmet basic needs of women in the community is large and alarming. Meeting Aboriginal women's needs will require creative, cooperative and culturally sensitive approaches to service delivery" (Saskatoon Aboriginal Women's Health

Research Committee, 2004, p. 11). The number one health need for Aboriginal women in Deiter and Otway's survey of Aboriginal women is for increased funding for non-insured benefits. Many of the women live in poverty and do not have the financial means for eyeglasses, dental care and prescription drugs. As well, the women in this study felt that mental health services were non-existent in many communities. Other needs identified included lack of resources for proper nutritional diet, adequate medical care on reserve, inadequate access to medical facilities, and long waiting lists to see doctors (Deiter et al., 2001). The most notable gaps and concerns in regards to services in Métis communities in north western Saskatchewan were: eye care, dental services, weekly programs relating to specific health issues, more diagnostic equipment, programs for diabetics and cancer patients, women doctors, home care, women's group therapy and programs dealing with depression (McCallum-McLeod et al., 2004). Specific populations of Aboriginal women and those living in different geographic locations may have different health concerns and different concerns accessing services.

3.2.4 Health Seeking Behaviour

Mainstream research and policy development has often portrayed Aboriginal women as victims and tended to pathologize their lives (Stout et al., 1998). "Studies that focus mainly on the negative aspects of Aboriginal women's lives, will always fall short of identifying aspects of 'wellness' that are fruitful for aiding the healing and enrichment of Aboriginal women's lives" (Bent et al., 2004, p.13). More recent research is focusing on the positive aspects of Aboriginal women's health. "Aboriginal women….are calling for re-orientation of research activities so as to focus attention on forward-looking strategies and the many positive developments in Aboriginal women's lives" (Stout et al.,

2001, p. 25). This is important because as Bent and Ross (2004) outline the positive aspects of Aboriginal women's lives and health and wellness are related to the development of their well-being.

The Aboriginal women who participated in Alex Wilson's *Living Well: Aboriginal Women, Cultural Identity and Wellness*, indicated that their health and wellness are connected to maintaining balance in all aspects of their lives, including physical, mental, emotional and spiritual aspects. The women's identities are inseparable from their family, history, community and spirituality. The women emphasized the importance of spirituality, manifested in cultural practices such as prayer, smudging, and with an ongoing commitment to extend honour and respect to others. "They are conscious of the importance of their roles as life givers, care givers and decision makers in their immediate families, extended families, communities and Nations" (Wilson, 2004, p. 21).

Although the project *Living in Balance: Gender, Structural Inequalities, and Health Promoting Behaviours* in Manitoba First Nation communities was not specific to women, it did consider the positive health changes made differently by men and women. Individuals that were making changes (e.g. engaging in more physical activity, positive dietary changes) were more likely to be women, older, more educated and to have a history of drug, alcohol or mental health problems (Elias, Leader, Sanderson, & O'Neil, 2004). More women made positive dietary changes (79% versus 66%), but significantly more men than women stopped drinking (80% versus 76%) and were more likely to be physically active (27% versus 16%). There were little to no differences between men and women for quitting smoking (Elias et al., 2004). This study concludes that structural inequalities are a major barrier to healthy living. As well, it demonstrates that First

Nations people of Manitoba are trying to empower themselves and bring balance to their lives by making healthier lifestyle choices.

The idea of empowerment was connected to health seeking behaviours. “By placing emphasis on the sharing of stories and experiences and the development of innate skills and strength of spirit…..provided participants with an opportunity to empower themselves and to build relationships with other Aboriginal women” (Stout et al., 2001, p.25). Geraldine Dickson (2000) used this concept in her case study involving Aboriginal Grandmothers. This study examines the effects of participating in a health promotion project (including a health assessment) using participatory action research. (Dickson, 2000). Participation in the project contributed to a number of gradual changes in the grandmothers, which were categorized as:

- Cleansing and healing (self-healing, self-care);
- Connecting with self (self understanding, well-being, self-esteem, and self respect; identification of strengths and needs (although this was a gradual process in which the building of trust was very important); as well as cultural and spiritual identity;
- Acquiring knowledge and skills (health education, assertiveness, articulation of strengths and needs, and learning about gaining access to resources);
- Connecting with the group (group identification, mutual understanding and respect, mutual learning and inspiration); and
- External exposure and engagement (willingness to influence the system, speaking up, community honouring).

One participant commented, “[s]ince I’ve been hearing the information at the grandmothers’ group, I’ve learned how to take care of myself…better…and I know what to do, and if I do need help, I know who to turn to” (Dickson, 2000, p. 197). Therefore, groups and social support networks may be important in learning positive health practices.

3.2.5 Violence and Sexual Abuse

Stout et al. (2001) addressed the relationship between violence and health. One of the conclusions of that research is that there was a general lack of research addressing the "inter-relationship between violence and health" (p.23 regarding Jauvin, Clement & Damaunt's research). They also noted that, with respect to Aboriginal women, the most recent work in this area has emphasized health related consequences of violence, including mental health problems, substance abuse and suicidal thoughts. The authors conclude that violence is an obstacle to good health, interacting with other determinants of health in complex and multivariate ways.

Only one paper was identified for this review that specifically focused on violence against Aboriginal women in Canada since Dion Stout's synthesis in 2001. This study by Douglas Brownridge focused on male partner violence against Aboriginal women in Canada. "[V]iolence against Aboriginal women is a pressing social problem that requires immediate attention by researchers, service providers, and policy makers" (Brownridge, 2003, p. 65). It has previously been reported that Aboriginal women have slightly more than three times the prevalence of reporting violence by a current or former partner than do non-Aboriginal women (General Social Survey; Statistics Canada 2003, as cited in Brownridge, 2003).

Brownridge's study (2003) fills a gap in the existent literature through an empirical analysis investigation of male partner violence. It uses a large-scale representative sample of Canadian women and the analysis shows that Aboriginal women have a significantly higher prevalence of violence by their partner compared to non-Aboriginal women. Not only are Aboriginal women more likely to experience violence,

but they are more likely to experience all forms of violence by their current partner, with the greatest differences manifesting in some of the most severe forms of violence. As well, comparing the 5-year and 1-year prevalence rates of violence directed at Aboriginal and non-Aboriginal women suggests that partners of non-Aboriginal women are more likely to stop their violent behaviour. Violence against Aboriginal women appears more likely to be ongoing (Brownridge, 2003).

Established risk markers (i.e. young age, low education, unemployment –both the women and her partner, living common law, having a previous marriage, residing in rural areas, having a larger family size, and having a partner who consumes alcohol heavily) are helpful in understanding violence against Aboriginal women. Risk markers generally operate in the same direction for Aboriginal women and non-Aboriginal women, but Aboriginal women possess greater representation on risk of violence. Differences between Aboriginal women and non-Aboriginal women on risk markers do not account for Aboriginal women's significantly higher prevalence of violence (Brownridge, 2003). The author felt that these results indirectly lend support to idea that the larger cultural experience of colonization might account for the higher prevalence of violence against Aboriginal women. It is interesting to note that not a lot of recent literature that addresses the relationship between the occurrence of violence and health of Aboriginal women was identified. Existing literature demonstrates that violence is a primary health concern of Aboriginal women (Deiter et al., 2001) that requires more research.

3.2.6 Mental Health

Research that addresses the mental and emotional health of Aboriginal women is increasingly required as "there appears to be a serious lack of concern for Aboriginal

women's emotional well-being" (Bent et al., 2004, p. 59). In Bent et al. (2004), 22% of the women surveyed felt that treatment and services for depression was one of their top health concerns. One theme that came out of research conducted in Vancouver's Downtown Eastside was that there is a lack of availability of mental health services for children, youth, and homeless urban women who suffer from severe and often long-term mental illness (Benoit et al., 2003). In a review to determine if research has adequately examined the health needs of Aboriginal populations of Canada, although not specific to Aboriginal women, Young (2003) identified only seven papers in total that dealt with mental health of Aboriginal peoples.

Two studies were conducted that considered the effects of diabetes and stress on Aboriginal men and women. (Iwasaki, Bartlett, & O'Neil, 2004; Iwasaki, Bartlett, & O'Neil, 2005). Both of these studies discussed the importance of recognizing gender issues within a multicultural context in Aboriginal research. "It is crucial to recognize gender differences in the sources of causes of stress in women's and men's lives" (Iwasaki et al., 2004, p.979). Unlike First Nations men, First Nations and Métis women described parenting or motherhood and household work as major sources of stress in their lives. "One source of stress unique to Aboriginal women in comparison to males may be that these women must fulfill multiple social roles, including responsibility for child and elder care and household work" (Iwasaki et al., 2005, p. 192). Common stress coping themes for women were: interdependence and the importance of social support networks; spirituality; realization of Aboriginal cultural identity; and self-control and determination (Iwasaki et al., 2004).

Another study that considered stress faced by Aboriginal youth in Nova Scotia was conducted in 2001. This study was not specific to Aboriginal girls, but did mention the different ways that girls and boys dealt with stress. The young women described stress as an internal emotional response (i.e. frustration or sadness), but when individual girls spoke of stress, they often mentioned externalizing feelings that were directed outside of the self (i.e. anger) (Maritime Centre of Excellence in Women's Health, 2001). As well, the young women in comparison to the young men reported experiencing a broad array of stressors.

A study looking at the effect of traditional healing circles for First Nations women in group counselling found that ceremony and beliefs established a spiritual component which contributed positively to the group (Heilbron & Guttman, 2000). This is a very significant finding in terms of the importance of a cultural component as a part of women's health and identity.

3.2.7 Maternal Health

Manitoba Health commissioned the Prairie Women's Health Centre of Excellence to study the issue of substance abuse and maternal health. In 2000, Caroline Tait explored the experiences of pregnant women who were substance users as well services available and whether the services are meeting the needs of the women (Tait, 2002). Tait found that the participants were quite realistic when deciding which services to access, although service providers often misconstrued this as non-compliance or lack of motivation. One of the recommendations that came from this research was that Manitoba Health (together with the appropriate service providers and addictions treatment programs) should take steps to ensure that women at risk of using substances while pregnant feel safe and secure

to access services that can support them in reducing or ceasing the use of substances. In another study identified by Stout et al. (2001), poverty and victimization by one's partner were shown to be closely associated with women's abuse of substances while pregnant. No recent studies were found in regards to substance abuse and maternal health, but Stout et al. (2001) emphasized that prevention must occur through understanding of why people abuse substances while pregnant. Another maternal health issue that is addressed in the literature is a study regarding gestational diabetes (Dyck et al., 2002). This study compared prevalence rates, risk factors and outcomes of gestational diabetes between Aboriginal and non-Aboriginal women. Analysis showed that Aboriginal ethnicity, most notably when combined with obesity, was an independent predictor of gestational diabetes. Body Mass Index greater or equal to 27 kg/m^2 and maternal age greater or equal to 33 years were the most important risk factors for Aboriginal women while previous gestational diabetes, family history of diabetes and maternal age greater of equal to 38 years were the strongest predictors in non-Aboriginal women (Dyck et al., 2002).

Three articles were found looking at the maternal and child relationship. Two of these articles were in regards to breastfeeding beliefs, attitudes (Martens, 2001), and traditions (Banks, 2003). Martens (2001) found that breastfeeding education increased breastfeeding beliefs, but not attitudes in a randomized school intervention. A third article described the utilization patterns of antenatal services for First Nations women in northern Manitoba (Hiebert, 2001). This research found that women were receiving an optimal level of services.

An interesting article regarding the relationship between colonialization and maternal health concludes that colonialization should be considered a determinant of

health for pregnant women. Colonialization is defined as “the act of bringing into subjection or subjugation by colonialism,” and colonialism is defined as “the aggregrate of various economic, political and social policies by which an imperial power maintains or extends its control over areas or people” {Webster's third new international dictionary 1993 2816 /id}. Moffitt (2004) describes colonialization as having “far-reaching effects into the very essence of a person’s being, a wound of great intensity and depth” (p. 324). The colonialization of childbirth, for many Aboriginal women living in remote communities includes separation from their community for weeks at a time, has been enforced for decades. “Colonialization of childbirth produces serious social consequences on the everyday lives of pregnant Aboriginal women, which results in lower health outcomes” (Moffitt, 2004, p. 323). By highlighting the concept of colonialization and establishing this concept as a determinant of health, nurses and midwives will identify disparities created through stressors of power and control.

3.2.8 Diversity of Aboriginal Women

The recent research is beginning to reflect the diversity of Aboriginal women in Canada. There are specific studies looking separately at Inuit women (Archibald, 2004; Lavallee & Bourgault, 2000; Pauktuutit Inuit Women's Association of Canada, 2002; Kenny, 2002), First Nations women (Lavallee et al., 2000; Moffitt, 2004; Maritime Centre of Excellence in Women's Health, 2001; Tarrant & Gregory, 2003; Kenny, 2002; Sayers et al., 2001), and Métis women (Bartlett, 2005; Kenny, 2002; McCallum-McLeod et al., 2004; Culjak, 2001). Research that looks at individual populations of Aboriginal women is extremely important, as Aboriginal women are a very heterogeneous population (Stout et al., 2001). Most research still focuses on First Nations women, while

research specific to Métis women is lacking. The research shows that more work with urban Aboriginal women has been conducted over the last few years (which used to be an area where research was lacking) (Bent et al., 2004; Benoit et al., 2003; Benoit et al., 2001; Saskatoon Aboriginal Women's Health Research Committee, 2004). This research is also reflective of Aboriginal women throughout the lifespan. There were three studies that looked at older Aboriginal women. One focusing on menopause (Webster, 2002), one on Grandmothers' experiences with health promotion and participatory action research (Dickson, 2000), and the last in regards to midlife Aboriginal women as agents of change (Meadows et al., 2004). One other article was found regarding older Aboriginal people focusing on death and dying in northern communities. Unfortunately, there was no mention of gender differences in respect to the issues of culture and remote service delivery in palliative care that was discussed (Hotson, Macdonald, & Martin, 2004). Two studies were found that focused on younger Aboriginal women. In particular, these articles focused on teenage pregnancy in Inuit communities (Archibald, 2004) and the home environment of adolescent mothers (Secco & Moffatt, 2003).

3.2.9 Capacity Building

Many mainstream interventions are falling short of addressing the social and economic problems faced by Aboriginal women (Benoit et al., 2003; Stout et al., 2001). "[E]pidemiological works measure health status by quantifiable indicators such as mortality rate, cause of death, and incidence and prevalence of some conditions (i.e. diabetes, cancers). However, they do little to increase our understanding of underlying factors such as social context or social determinants of health" (Meadows et al., 2003b, p.2). Much of this recent research concluded that more culturally appropriate research is

necessary. Aboriginal people in Canada are more vocally rejecting western paradigms of research and policy development. Instead, Aboriginal populations are reclaiming their right to be who they are, and are revitalizing their cultures through promotion and utilization of indigenous research methods and development of culturally rooted policy (Ten Fingers, 2005). Bartlett (2005) began to explore whether an Aboriginal Life Promotion Framework may increase culturally pertinent planning, collection and analysis of health survey data. The framework is a tool for reflecting on life by organizing beliefs that already exists. It is "grounded within an Aboriginal construct of holism and connectedness" (Bartlett, 2005, p. S23). By developing a culturally specific tool, the results of this study showed that this framework is useful as an organizing tool for systematically exploring the elements of living. It is becoming necessary to make the research process more culturally appropriate, "both to make it more reflective of Aboriginal women's own life experiences, as well as more grounded in traditional or grass-roots approaches to knowledge and learning" (Stout et al., 2001, p. 30).

Researchers are beginning to listen to the needs of Aboriginal women in regards to research. Researchers are becoming much more aware of cultural sensitivities and research methods that are culturally appropriate. Much of the recent research is using (at least in part) qualitative research methodologies in order to learn about the lived experiences of Aboriginal women, not only epidemiological information (Bent et al., 2004; Wilson, 2004; Deiter et al., 2001; Maritime Centre of Excellence in Women's Health, 2001; Archibald, 2004; Browne et al., 2001; Meadows et al., 2005). Meadows et al. (2003b) discuss the importance of involving Aboriginal women in the research process and the difficulties that ensue. The authors conclude that "[c]ontinuing to find

and share successful ways of practicing qualitative health research is essential if we are to effectively change health outcomes" (Meadows et al., 2003b, p.23)

One innovative research methodology that is being used within Aboriginal populations is photovoice (Moffitt & Robinson Vollman 2004). These researchers used photovoice to enable Tlicho women to talk about and reflect on their health beliefs and health promotion practices in the context of their individual and collective lives in their community. Photovoice is a technique "based on participation, empowerment, and self documentation, [which] is a culturally appropriate method…..capturing images in the context of one's life, thus allowing others to gain an insider's view of everyday life in one's community." (Moffitt & Robinson Vollman, 2004, p. 189). Health planners must think holistically, considering traditional and westernized medicine, First Nations' values, priorities and government systems, as well as evolving health systems (MacKinnon, 2005, p. S13).

Another research methodology being used with Aboriginal women is Participatory Action Research (PAR). PAR highlights empowerment of research participants through their participation in the research process, focusing on power relations within problems and educating participants regarding the problems studied. Dickson defines PAR for the purpose of her study as "inquiry by ordinary people acting as researchers to explore questions in their daily lives, recognize their own resources, and produce knowledge and take action to overcome inequities, often in solidarity with external supporters" (Dickson, 2000, p. 189). As discussed earlier, the "grandmothers study" (as it became known) used PAR as a method of engaging the grandmothers in the research in order to promote health and emphasize empowerment (Dickson, 2000).

Innovative research methods such as the ones discussed above are needed when thinking holistically.

3.2.10 Summary

Madeline Dion Stout argues that a "population health approach" needs to be utilized which considers the "total environment within which Aboriginal women's health is realized. Income, social support networks, education, physical surroundings, biological and genetic makeup, child development and health services are key elements to this approach" (Native Women's Association of Canada, 2002, p.3). In the research identified that was published in the last five years, there is more of a focus on culture (and the importance of culture in research) and gender (the importance of looking at the conditions that make life different for Aboriginal men and women). There has been a continued focus on personal health practices and health services (including access to services). There was very little focus on the underlying reasons for poor health of Aboriginal women. Many of the studies focused on individual responses (i.e., diet and exercise) versus poverty and unemployment, for example. Very few papers focused on biology, healthy child development, physical environment, social support networks, education, employment, and social environment. This is not to say that these issues have not been addressed in the research. Rather, when looking at these determinants and how they affect Aboriginal women's health specifically, there seems to be a gap.

Strides have been made in terms of research with Aboriginal women in Canada in the past five years. Much of the research is using in depth interviews and qualitative methodologies to look at the lived experiences of Aboriginal women. Much of the research is focusing on the strengths of Aboriginal women and positive health indicators

(rather than always looking at the negative). Much of the research is including Aboriginal women in some way in the research process. As well, there are some new, important areas of focus in the research, such as mental health, older Aboriginal women and research with various different populations. If we look back to the recommendations of Madeleine Dion Stout's Synthesis paper recommendations, some of them have been realized while others have not. As discussed, research methodologies are becoming more respectful of the complexity of the lives of Aboriginal women. Some of the recent literature has focused on those normally under represented in research (i.e., urban Aboriginal women), while little to no focus has been paid to Aboriginal women in conflict with the law, for example. Diversity is considered by some researchers, culturally as well as throughout the life span of Aboriginal women. The next important steps are to give Aboriginal women increasing voice and participation in research that affects them as well as opportunities to plan, implement and run services and programs that will enhance the health of their populations.

CHAPTER FOUR: DISCUSSION

4.1 Summary of Findings

The purpose of this project was to determine what services are available in Alberta specifically for Aboriginal women as well as to ascertain the foci of recent literature on Aboriginal women and Determinants of Health (DOH). As this was an environmental scan, there was no hypothesis posed in terms of what the programs would encompass. The majority of the programs identified were: parenting programs; talking and healing circles; support groups; and healthy lifestyle programs. There were smaller numbers of programs dealing with: violence, HIV, diabetes, alcohol and drug abuse, and cancer. Populations that were targeted for the programs included: single mothers; women with low incomes; abuse survivors; and women with disabilities. Lesbian and two spirited women were not targeted at all in the programming. As well, Aboriginal women living on reserves were targeted more often than those living in rural areas or in urban centres. Social support networks, social environment, education, personal health practices, healthy child development, health services, gender, and culture were the DOH addressed most often in the scan. Biology, physical environment, employment and income were addressed least often. With respect to the organizations that participated in the scan, almost 50% considered health services to be their primary service. Almost 50% of those that participated in the scan were upper management and less than 50% of the organizations had evaluated the programs included in the scan. Other important themes that emerged from the scan included a focus by organizations on a holistic view of health, a focus by organizations on the promotion of women's health and a failure by some organizations to understand Gender Based Analysis (GBA).

The foci of the recent literature on Aboriginal women's health included: health status, health seeking behaviours, access to health services, maternal health, violence, mental health, senior Aboriginal women, the diversity of women and capacity building. The foci on mental health, Aboriginal seniors and capacity building within Aboriginal communities are relatively new in the literature for Aboriginal women. Another focus in the recent literature has been on the positive aspects of Aboriginal women's lives, instead of only looking at the negative. As well, much of the recent literature is looking at Aboriginal women's health with a cultural perspective using a holistic view of health and incorporating the importance of the medicine wheel. The DOH addressed most often in the literature were: health services, personal health practices, and culture. Less frequently, papers focused on social support networks, socioeconomic status, education, employment and social environment. With respect to specific issues affecting the health of Aboriginal women, we identified a lack of research in the following areas: violence, Aboriginal women in conflict with the law, diabetes, cancer and the underlying causes of the poor health status of Aboriginal women.

4.2 Programs

4.2.1 Foci of Programs

4.2.1.1 Parenting

The majority of the programs identified were parenting programs (N=33 or 25%). This is particularly interesting because when asked about women's issues, the focus of service providers was on reproductive issues although it is widely known that there are many issues affecting the health of women. (Health Canada, 2002). There has been a tendency in the literature to frame women's health solely in terms of reproductive issues

(Greaves, 2000; Horne et al., 1999). This issue has been identified and criticized by health researchers in the past (Horne et al., 1999) and yet in marginalized populations such as Aboriginal women, it continues to be a focus of health services. It often appears that children's health is a priority over women's health, and that women and mothers are often actually overlooked as key to the health of the children; for instance, when discussions of children in poverty occur. This is in keeping with a failure to implement gender based analysis in which the important role of women as parents over the life cycle would be considered along with the impact on their health and well-being. .

4.2.1.2 Talking and Healing Circles

Some of the programs surveyed offered talking and healing circles for women (N=15). The organizations that offered these programs indicated that the talking and healing circles had a positive effect on women's health because the programs provided the women with a comfortable safe environment where they could share their life experiences with each other, learn from each other and gain empowerment, confidence and knowledge to access services. Geraldine Dickson (2000) concluded that healing circles contributed to a number of positive changes in the participants of her research project, including: healing, empowerment, connecting with self, connecting with group, and acquiring knowledge and skills. Heilbron and Guttman (2000) also found that ceremony and beliefs established a spiritual component that contributed positively to the group. Another interesting aspect of the talking and healing circles is that they provide a venue to address many different issues, as is directed by the needs of the participants. Many organizations offered mental health programs, particularly support groups (N=19), which lacked the cultural component of the talking and healing circles. The cultural

component of the talking circles and healing circles is important to understand because women are enabled to learn and share in a way that is culturally familiar and acceptable to them.

4.2.1.3 Healthy Lifestyles

A large number of the programs surveyed focused on healthy lifestyles (N=20). The services offered by the programs included physical activity groups, nutrition lessons and healthy cooking classes as a couple of examples. Physical fitness was the most common physical health concern reported by Aboriginal women in Winnipeg (Bent et al., 2004). Therefore, this emphasis on healthy lifestyles is very encouraging considering the high risk of diabetes, particularly in overweight Aboriginal women (Aboriginal Diabetes Initiative, 2000). As well, this health seeking behaviour might have positive effects on the health of the families and communities of these women who are trying to improve their own health.

4.2.2 Gaps in Programming

As mentioned earlier, there were few programs in HIV prevention (N=3), diabetes education or treatment (N=4), drug and alcohol addiction (N=8) and breast and cervical health (N=7) and yet the literature shows that these are some of the health issues that are important to Aboriginal women. Eleven programs were identified that offered violence related services. Considering the alarming statistics regarding the occurrence of violence directed at Aboriginal women (Stout et al., 2001), the number of organizations offering services is inadequate. Although there were several programs dealing with employment, business and training (N=8), there were no programs dealing with socioeconomic status and education. Many of the programs identified did not focus on these specific health

issues. This is not to say that these important issues are not being addressed in many communities throughout the province. For example, a talking circle might bring up HIV prevention as an issue of discussion, or a reserve may bring in a professional to do a presentation on diabetes prevention. Unfortunately, it was beyond the scope of this project to determine why there are gaps in programming in these important areas. Funding and resources might be potential reasons for these gaps in programming as well as a lack of understanding of gender-based issues. One positive commitment to change comes from the Alberta Cancer Board who have been trying to understand cervical cancer screening issues for Aboriginal women by conducting focus groups with Aboriginal women (Alberta Cervical Cancer Screening Program, 2002). The Alberta Cancer Board is formulating a screening strategy in order to capture as many Aboriginal women in the province as possible (Personal communication, Lengyel May 2004).

4.2.3 Target Areas

4.2.3.1 Urban, Rural or Reserve Focus

Traditionally, the focus of the research on Aboriginal people in Canada was on Aboriginal people living on reserve. Some researchers took notice of this gap (Stout et al., 2001) and much more recently, research has been conducted with urban Aboriginal women (Benoit, Carroll, & Chaudhry, 2003; Bent et al., 2004). More research regarding urban Aboriginal women is needed, as there is larger number of Aboriginal people living in urban areas than ever before. As of December 2003, 34.5% of registered Indians (i.e., a record of the individuals who are registered pursuant to the Indian Act) in Alberta were living off reserve (Strategic Services, 2004). With a high percentage of Aboriginal people living off reserve comes a need for increased services in urban and rural (non reserve)

areas. It is interesting to note that the migration from Canadian cities to reserves is seen as the result of a failure to adapt to urban life (Cooke, 2002). The lack of culturally appropriate programming and services and difficulty in accessing these services may contribute to the migration to reserves. The majority of the programs specific for Aboriginal women in Alberta were geared towards those living on reserves. Therefore, the recent research that has focused on urban Aboriginal women has not yet been reflected in the programming in Alberta. It is important to note that not all those living off reserve are living in urban areas. Therefore, it is also important to include women living in rural areas in research as they too are in need of health services.

Over 60% of the programs identified in this project were located in the (780) telephone area code. By looking at the map of Alberta (Appendix II) it seems that the area code (780) encompasses the majority of Treaties 8 and 6 lands or traditional territories, while the (403) area code encompasses only Treaty 7 lands or traditional territories. Of the registered Indians, 73% reside in the traditional territory covered by Treaties 8 and 6 (Strategic Services, 2004). There may also be more programs offered in the Edmonton area than the Calgary area because Edmonton is the provincial centre of government and organizations may have more access to government and therefore to funding.

4.2.3.2 Population Targets

One of the questions posed to interviewees was, “does the program target Aboriginal women who are: single mothers, lesbian/two spirited, abuse survivors, women with disabilities, women living on low incomes, and women with low literacy skills?” They were asked to name all of the above that apply as well as any others that were

targeted. No organizations specified that they targeted lesbian and two spirited women while 20 organizations targeted women with low incomes, 17 targeted abuse survivors and 12 targeted women with disabilities. As well, forty-six organizations answered that their programs were for all women (even though they had said yes to some of the above target populations). Although the interviewees easily understood this question, there may have been some misunderstanding as to what targeting a population means. For example, although 12 organizations indicated that they targeted women with disabilities, none of these organizations offered programs specifically for women with disabilities. It is interesting that not one organization surveyed targeted lesbian and two spirited women in their programming and that there was no information in the literature regarding lesbian and two spirited women, other than mention that this population is under researched. It is not unreasonable to conclude that Aboriginal lesbian and two spirited women in Alberta may be particularly marginalized. This may stem from, for example, Alberta's conservative government being the only provincial government in Canada to openly oppose homosexual marriage.

4.3 Integration Between the Literature and the Survey Data

4.3.1 Determinants of Health

The DOH that the organizations focused on included health services, personal health practices, culture, social support networks, gender and social environment. It was interesting that many organizations claimed that their programs had a gender focus, but when asked about gender equity, most organizations had no statement of gender equity and felt that some of the leaders were not taking gender into account when planning and running programs. If more organizations considered gender the result may be increased

programming for lesbian and two spirited women, as well as women in conflict with the law, for example. The organizations in this scan tended to focus on the more individualistic DOH which is demonstrated by the fact that personal health practices was the DOH addressed most often. This focus on personal health practices was not surprising as there was also a tendency in the literature to focus on personal health practices. Horne et al. (1999) discuss the importance of a comprehensive approach including upstream (more collective issues such as income distributions) as well as downstream (more individual behaviours) when addressing health determinants. A focus on the underlying upstream issues such as poverty, unemployment and lack of education, is necessary in order to improve Aboriginal women's health. One noticeable gap between the data and the literature is in terms of poverty as very few programs focused on poverty issues and yet the literature shows that poverty is a serious concern for Aboriginal women (Stout et al., 2001; Bartlett, 2005; Deiter et al., 2001). One positive indicator from the survey data is that there were eight programs focusing on employment and business specifically for women. Gaining knowledge and training in regards to the work force will help Aboriginal women increase their employment rates, which will subsequently impact their socioeconomic status.

4.3.2 Importance of Holistic View of Health

In the survey, when the participants were asked about health promotion, many answered that the programs they offered were health promotion programs, and that health was thought of in a holistic manner. The same theme emerged in the literature, concerning the importance of a holistic view of health and the importance of physical, mental, emotional and spiritual health of women, their families and communities. This

idea is similar to the concept of gender based analysis which recognizes that women's and men's lives are different in terms of their experiences, their needs, their priorities and their roles and responsibilities (Vlassoff et al., 2002; Horne et al., 1999). The concept of women's health is not only individual, but also related to the community and the family. (Meadows et al., 2004; Wilson, 2004). Other concepts that arose in the literature that are tied with this holistic view of health are the importance of cultural identity to the health of Aboriginal women and looking at the strengths of Aboriginal women and the positive aspects of their lives rather than the negative (Wilson, 2004). These concepts should be central when planning services and programs specific to Aboriginal women, particularly when using health promotion approaches (Bartlett, 2005).

4.3.3 Mental and Emotional Health

There were only a few reports and articles in the literature that addressed the mental health of Aboriginal women. The reports concluded that mental health is a very important issue for Aboriginal women (Bent et al., 2004; Kirmayer, Brass, & Tait, 2000). Although few programs addressed clinical depression, for example, many of the programs tried to address the mental and emotional health needs of Aboriginal women, through talking and healing circles. Service providers indicated that these types of culturally sensitive programs have enormous potential to positively increase women's health. As well, many organizations had mental health or support groups for women (N=19). These differed from the talking and healing circles by the lack of a cultural component in most cases.

Although the literature reviewed did not provide a lot of detail about the mental health of Aboriginal women related to depression and anxiety, depression is an important

issue for many Aboriginal women (Bent et al., 2004). Bent and Ross (2004) identified that when women considered their physical, emotional, intellectual and spiritual health concerns in combination, depression was the second greatest health concern and the second greatest health need was treatment and services for depression. “A compelling need exists to evaluate the current mental health care system to identify barriers aboriginal people face when seeking treatment. Barriers could include fear of being stigmatized, systemic racism, isolation from family and friends, and lack of consideration for traditional healing practices. Once identified, this knowledge must be used to improve existing mental health care for Aboriginal people” (Canadian Institutes of Health Research, 2003, p. 30). Improving mental health care for Aboriginal women may help to decrease the large number of attempted suicides, for example. The literature has shown that although Aboriginal men commit suicide more often, it is Aboriginal women who attempt suicide more often (Probert et al., 2003) and yet only a few articles were found in regards to Aboriginal women attempting suicide.

4.3.4 Gender Based Analysis (GBA)

The recent literature focused to a small extent on gender and using GBA. Although this is promising, much of this research came from a specific group of organizations, the Centres of Excellence in Women’s Health. Although most researchers are not using GBA, a small positive step forward is that a lot of the data was sex desegregated. Although looking at data separately for males and females is an important aspect of research, it does not help readers to understand the circumstances that led to the differences between males and females. This lack of GBA in the literature is reflected in the programs and the level of importance organizations put on gender-based issues.

Although many organizations responded that their programs addressed gender issues, very few organizations had an official statement of commitment to gender equity. As well, there were a lot of mixed responses as to whether leadership was taking gender into account. Leadership is widely recognized as a fundamental determinant of organizational performance (Fulop & Linstead, 1999). Therefore, for GBA to become more mainstream in Aboriginal organizations, leadership needs to play a large role. Fulop and Linstead go on to say that "[t]o change the leadership practices in an organization usually requires leadership from somewhere at the top levels" (p. 203). Thus, the leaders at the Federal, Provincial, and Territorial levels need to do their part to make the use of GBA more mainstream so that organizations can follow their lead.

To be included in the present research, potential interviewees were asked if they had any programs or services that directly or indirectly impacted Aboriginal women's health. If they answered yes to this question (N=82), the interview was continued. Later in the interview they were asked if the programs were indeed specific to women's health and specific to Aboriginal women. Surprisingly, only 68.3% of organizations identified the program being specific to Aboriginal women and only 69.5% identified the program being specific to women's health. Therefore, in the beginning of the interview did the interviewee feel compelled to say they were providing services to Aboriginal women? It may be that some interviewers have never thought about this question and that subsequent questions clarified that they were assuming they had programs specific for Aboriginal women. It is also possible that the idea of gender analysis and designing programs specifically for men and women has not been taken up. The latter has been found in other studies. Another possible explanation for this discrepancy is the large

number of parenting programs and that, although fathers were not using most of the programs, they were unlikely to attend and the program seemed therefore to be for women.

One positive result from the survey data in regards to gender analysis, is that many of the organizations claimed to understand the differences between men and women and tried to address these differences in their programs. For example, many of the programs provided childcare while the women attended the programs. As well, many of the programs ran at times when they knew women would be able to make it. These practices are significant when developing policies and programs because if the programs are not convenient for women and are not meeting their needs, they will not help to improve women's health (Vlassoff et al., 2002).

4.3.5 Importance of Evaluation

In Alberta less than half of the programs for Aboriginal women have been evaluated and there are few plans to evaluate programs in the future. This may in part be a resource issue. Particularly for smaller organizations, there may be a lack of funding and or personnel to conduct formal evaluations of programs. As well, some organizations might feel more comfortable spending the money they have on providing much needed services instead of on evaluating services already in place. In addition, many previously developed surveys and tools used to evaluate programs may not be culturally relevant or sensitive. Corin (1994) discusses that "[c]oncepts and methods attuned to this social and cultural heterogeneity must be developed for epidemiological and health research, along with more sophisticated methodological and analytical designs. Otherwise, strategies for action derived from epidemiological studies will remain disconnected from the reality

that are intended to influence" (p.119-121). Corin also discusses the dangers of inappropriate transfer of intellectual constructs from one culture to another. Bartlett (2005) writes that most health survey questions have not been validated within Aboriginal cultures. This would require further resources to develop tools for this purpose. Although more resources may be necessary to develop research and evaluation tools that are culturally appropriate for Aboriginal populations, this may increase the amount of evaluation that occurs in Aboriginal programming. It is important to note that Aboriginal organizations are not the only ones struggling with program evaluation and are not the only ones where capacity and resources for evaluation are limited. For example, locally, the Calgary Health Region is developing an evaluation framework for the region so as to increase their own capacity for evaluation.

With respect to evaluating programs, it is crucial that Aboriginal women as the users of these programs are included in the entire evaluation process. Patton (1997) discusses the importance of including key stakeholders, including the users of the program and those implementing the programs in the evaluation process. Involving primary intended users enables them to establish the direction of the evaluation, and provides them with a commitment to and ownership of the evaluation throughout the entire process.

An interesting finding from the survey data related to the infrequent evaluations found, is the lack of written reports or annual reports available regarding the programs. This might be as a result of lack of funding and necessary resources, or it may reflect organizational culture that does not see these as necessary public accountability

documents. This might be one area in terms of capacity building that could be strengthened in the future.

4.3.6 Capacity Building

One theme that arose frequently in the survey is that not enough is being done to improve the health of Aboriginal women. Although Aboriginal women's health was often viewed as a priority, many of those surveyed indicated that they did not have enough resources or funding to do as much as they would have liked to be doing. Building capacity, which is also a fairly recent focus in the literature, might give programmers and other stakeholders the opportunity to improve the health of Aboriginal women.

4.3.6.1 Role of the CIHR-IAPH

Capacity building has emerged as an important topic in Aboriginal health research. The Canadian Institute of Health Research (CIHR) created the Institute for Aboriginal People's Health (IAPH) in 2000 (Canadian Institutes of Health Research, 2003). The CIHR-IAPH supports and promotes health research that has a positive impact on the mental, physical, emotional and spiritual health of Aboriginal people at all life stages. The strategic research priorities for the CIHR-IAPH (for its first five years of conception) include: forging partnerships and sharing knowledge; respecting Aboriginal values and cultures; building capacity; and resolving critical health issues. One of the implementation strategies involved the creation of the Aboriginal Capacity and Developmental Research Environments (ACADRE), which consists of a network of national and regional research centres. Their purpose is: to create Aboriginal friendly research environments; to undertake Aboriginal health research in an ethical manner; and to encourage Aboriginal students to pursue careers in Aboriginal health research

(Canadian Institutes of Health Research, 2003). CIHR-IAPH and ACADRE are examples of concerted efforts to build the capacity of Aboriginal health research in Canada. These could have a major impact in the future.

4.3.6.2 Research Directions

When looking at the literature and the survey data that both show a lack of focus on employment and socio-economic status, it is clear that many mainstream interventions are falling short of addressing the social and economic problems of Aboriginal women (Benoit et al., 2003; Stout et al., 2001). Much of the recent research concluded that more culturally appropriate research is necessary. . "First Nations are *rejecting* colonial frameworks, and instead, are *working within our own indigenous frameworks,* from research to policy development. The latter approach inherently includes *revitalizing* our languages and traditional knowledge, and *reclaiming* our right to be who we are as Lakota/Dakota/Nakota, Ojibway, Cree, Dene, and other numerous and diverse First Nations cultures" (Ten Fingers, 2005, p. S60). Ten Fingers goes on to discuss the necessity of using culturally appropriate research methodologies:

> Whether researchers choose to utilize indigenous methodologies in upcoming research projects will soon become less and less of a choice, as First Nations increasingly develop our own research ethics and protocols that will apply to all research conducted in our territories and with our people. As First Nations continue to empower ourselves through rejecting colonialism, and embracing and building upon our cultures in policy development, so, too, will its direction change.(Ten Fingers, 2005, p. S63).

4.3.6.3 Participation

As we already mentioned in this report, the unique health needs of urban Aboriginal women have been largely neglected and under researched (Young, 2003). In a consultation with Aboriginal women in 2000, participants were very clear that their input

should be sought on all matters that affect them and that they want to "play a meaningful role in all aspects of consultation design to implementation. This ranges from participant selection to approval of the contents of the final report" (Status of Women Canada, 2000, p. 10). Aboriginal women want their voices heard (Voyageur, 2001). They want those who are presently planning programs and developing policies to listen to their needs and their priorities. This highlights the importance of the role Aboriginal women need to take to build capacity in order to shape policies and develop programs themselves. It is therefore significant to consider Aboriginal women's important future roles in research and their engagement in community building as well as participatory action research.

4.3.6.4 Aboriginal Capacity

Deiter and Otway (2001) recognize the importance of acknowledging the underlying causes and determinants of the poor health status of Aboriginal women. They recommend that "Aboriginal, Federal, Provincial and Municipal governments maintain and increase funding for Aboriginal women to achieve higher education, better paying employment, adequate housing and affordable day-care and family support services, all of which will contribute to improving their health and well-being" (p. 24). This is an important point, as one aspect of building capacity needs to stem from having more Aboriginal women involved in doing research. In order for this to happen, many of the above issues must be addressed and the number of Aboriginal women who receive post secondary education must increase, but there must also be attention to this need for mentoring female research assistants and hiring in the field. Although education, employment, and secure incomes are fundamental to improving the health of Aboriginal women, our research showed that there was very little focus on employment, education

and socio-economic status in the programs being offered. While some band councils and the federal and provincial governments are paying attention to these issues, it is not clear that gender analysis is included in these initiatives.

4.3.6.5 Collaboration

Collaboration of efforts and research are key to continuing to make improvements to the health of Aboriginal women. Those working to improve the health of Aboriginal women in Alberta and throughout Canada are burdened by heavy client workloads and many complex and interconnected social problems. Research capacity within Aboriginal communities is low, therefore, collaboration between Aboriginal and non-Aboriginal researchers is necessary. The CIHR-IAPH discusses the importance of forging partnerships between Aboriginal and non-Aboriginal organizations (Canadian Institutes of Health Research, 2003). The current research project recognized the importance of this type of collaboration and thus sent a short version of the results to the Ad hoc Spirit Advisory Committee in order to gain the perspectives of key stakeholders working in the area of Aboriginal women's health, including Aboriginal women. This advisory committee was set up to provide guidance to various women's health research projects. It was interesting to note that during a couple of the interviews, I was asked if I was Aboriginal myself, but the fact that I was not did not seem to affect the length or quality of the interview. To interpret such a question as the desire to have an Aboriginal researcher may therefore be incorrect. Quantz (2001) found the same in his research project.

4.3.7 Findings in Context

4.3.7.1 Cultural Identity

"Cultural identity is conceptually a larger construct than either racial or ethnic identity. It refers to the total experience of a group of people and encompasses spirituality, language, norms of behavior and social organization, traditions and rituals, elements of a group's history, and values and beliefs that are passed from one generation to another" (Green, 1999; Lum, 1996, as cited in Barrios & Egan, 2002, p. 208). Culture was an important theme identified in the survey data and the literature. The Royal Commission on Aboriginal Peoples (1996) discussed the notion that Aboriginal concepts of health and healing stem from the elements of life and living being interdependent. Extending from this concept, well being flows from balance and harmony among all elements of personal and collective life. Health care providers are becoming increasingly aware of the importance of cultural identity to health and wellness for Aboriginal people as well as the importance of incorporating cultural awareness into programs and policies (Wilson, 2004). Bourassa et al. (2005) suggests that Aboriginal women can look to cultural identity as a foundation on which they can build healthy lives. But, for many Aboriginal women who cannot draw on a firm sense of cultural identity, maintaining and promoting health might be more of a challenge. The loss of cultural identity (among other impacts of colonialization) has contributed to the poor health and well-being of many Aboriginal women (Bourassa et al., 2005).

4.3.7.2 Political Context

Aboriginal women continue to face discrimination based on race, class and gender

(Stout et al., 2001; Browne et al., 2001; Browne & Smye, 2002). Inequities in women's health do not appear to be addressed in the programs described. Other studies have found an emphasis on the reproductive roles of women to the neglect of other issues (Thurston, Horne, Donner, In press). If the sacred identity of Aboriginal womanhood (Anderson, 2000) becomes centred around reproduction, women will not receive the attention they deserve from all parts of the health sector. Given the legacy of disenfranchisement resulting from the Indian Act (Voyageur, 2001; Wotherspoon & Satzewich, 2000, as cited in Bourassa et al., 2005), Aboriginal women deserve programs and policies that create equity in health for them. This should include programs in urban areas and off reserve for those women and children who never regained their status (Bourassa et al., 2005). Special programs for Aboriginal women are not enough, however, and mainstream health services need to develop cultural competence in order to improve access for both Aboriginal women and men.

The transfer of responsibility for managing and delivering health services to Aboriginal communities by the Federal government should be subject to gender analysis. The Canadian International Development Agency, for instance, requires gender analysis in development projects overseas and Health Canada has a gender analysis policy. It is time that the concerns and hopes of Aboriginal women be considered in transfer agreements. The results of the present research project suggest that most of the time leadership is not taking gender into consideration when running programs. If responsibility is being shifted to the communities, leadership in the Aboriginal communities must take gender into consideration in order to improve the health of Aboriginal women in their communities. It is important to note that not all Aboriginal

peoples have equal access to programs and services offered by the Federal government. Benefits vary according to legal status (i.e., treaty or non treaty), how they are identified (i.e., First Nations, Inuit or Métis) and according to where people live (i.e., on or off reserve). Therefore, special attention needs to be paid to the large number of Aboriginal women living in urban (and rural non-reserve areas) who are having a difficult time accessing the health system. "While those residing in urban areas may have access to a greater number of health care services, including access to traditional healers through native friendship centres, health services may not be utilized to their full benefit" (Newbold, 1998, p. 62).

4.4 Reflections and Reactions of Key Stakeholders

Stakeholders showed a lot of interest in this project. All those who had programs specific to Aboriginal women requested a copy of the results of the project. There were a couple of participants who were quite passionate about the issue of improving women's health. The passion and concern of these "champions" was obvious through the course of the interview. Connecting with these people might lead to some opportunity for development and future participation in research projects. As well, many individuals commented that this project was relevant, interesting and important.

Unfortunately, there were many organizations that did not participate in the survey. Of those that were reached, lack of participation was mostly due to the fact that they did not have any programs that were specific to Aboriginal women. There was only one instance where the interviewee was not interested at all in hearing what the research was about. This, as well as the many organizations that did not return our calls, may in part be due to limited time and resources. Along similar lines, some of those that were

interviewed rushed through the interviews or did not complete the interviews. Again, it was felt that their time was in such high demand, as approximately half of those interviewed were upper management of their organization.

Originally, there was to be an Advisory Committee of those with experience working in the field of Aboriginal health. According to Dr. Jeff Reading, Scientific Director of the CIHR-IAPH, involving Aboriginal people in the development of research regarding Aboriginal health is vital to finding long-term solutions that address the severe problems in the community. As well, the CIHR-IAPH annual report highlights the importance of making research relevant to Aboriginal people (Reading & Nowgesic, 2002). We tried to develop an advisory committee consisting of approximately four key stakeholders who have experience in Aboriginal women's health from a health determinants perspective. The role of the Advisory committee was to help us identify programs and key stakeholders to participate in the second participatory component of the project. As the thesis committee has extensive experience working with Aboriginal women's health in Alberta, we choose the members of the advisory committee on the basis of their experience in this field. Participation was sought by personal contact followed by a formal email of invitation.

Unfortunately, we had a hard time garnering support for this advisory committee. This was not all that surprising as many Aboriginal women who are heavily involved in health care are continuously asked to participate on such committees. Again, those who are trying to make a difference in the health of Aboriginal women are often involved in many initiatives and activities. In the academic department in which this research took place in, there were other projects that required the support of Aboriginal women and key

stakeholders throughout the province. Therefore, we decided not to add to the burden of these persons and decided that if we needed extra input we would contact people on an individual basis.

4.5 Personal Reflections

As a researcher, this project had many high points and low points. It was very encouraging to interview champions of Aboriginal women's health. It was very obvious who these people were; displayed in the passion they exuded when speaking about their work. It was also particularly encouraging when interviewees invited me out to their community to observe their programs for women. It was clear that they were very open and proud of what they were doing. I was also particularly excited to hear that the Calgary Health Region is planning an urban Aboriginal Health Centre in the city of Calgary. We contacted the planners and let them know about this project, and they were interested in meeting to discuss where the gaps in services are for Aboriginal women in the province. A meeting is scheduled in the near future to discuss services that are needed for urban Aboriginal women in Calgary. For a researcher, there is nothing more satisfying than being able to see your data go from research to the community. It is this translation of knowledge that makes research worthwhile.

The low points of the project were when participants did not call back or were not able to identify programs specific for Aboriginal women. This was discouraging as we were not getting the data we wanted, but more so because it opened my eyes to the many organizations that do not take women's health into account. Luckily, speaking with the champions who are passionate about improving Aboriginal women's health did not keep me discouraged for long.

4.6 Strengths of Study

Conducting an environmental scan is seen as a strength in this research, as it had the aim of locating all of the programs that are specific to Aboriginal women in the province, versus finding a sample of programs. The mixed methodologies was also a strength as it allowed us to synthesize survey results with what was currently occurring in the literature in terms of Aboriginal women in Canada. We had a high response rate and contacted many organizations. We made a genuine effort to contact as many organizations as possible, although we acknowledge that some organizations were undoubtingly missed (particularly those that are small or isolated).

The qualitative aspect of the survey was a strength as this allowed us to delve slightly deeper into information regarding the organizations' official policies in terms of health promotion and women's health as well as the personal opinions of those being interviewed. This gave us a better perspective on how Aboriginal women's health was being taken into account. Finally, another strength of this study is the context of the program of research of the student. The research team that the student is involved with is doing other important work with Aboriginal women in Alberta. This provided the student with needed resources and opinions in terms of the subject matter.

4.7 Limitations of Study

Although this was not the goal of the project, one limitation was that there was no opportunity for in-depth discussion of the programs. As well, some of the respondents, although taking the time to participate, were in such high demand that they tended to rush through the interview, thus not allowing us to us to finish data collection. Another limitation of the study was that different research assistants were hired to do the

interviews. While the interviewers were trained in regards to the interview guide having more than one interviewer might have led to some inconsistency in the way questions were asked and the depth of data that was collected. As well, some of the common language contained in the questions in the survey was problematic. Although it was not difficult for respondents to answer the question pertaining to type of organization (e.g., government, non-government, etc.) when it came to data analysis we realized it was not always clear what the answers meant because of the complexity of government. Finally, a limitation in our data collection process was that if we contacted an organization that had no programs, we did not ask them if they knew of any other organizations that might have programs (although this often happened without asking).

4.8 Conclusion

Using multiple methods of data collection, this research project has described programs available specifically for Aboriginal women in Alberta and put them in context with recent Canadian literature. There were very interesting and important findings from the programs, such as the abundance of programs relating to parenting as well as the lack of programming for lesbian and two spirited women and Aboriginal women in conflict with the law. Although there is a lot of work to be done to improve the health of Aboriginal women in Canada, this research project showed that there have been and continue to be a lot of positive strides. The literature is beginning to look at the positive aspects of Aboriginal women's lives and how this will help to improve the holistic health of Aboriginal women. As well, this project showed that there are champions and leaders working in this area who have invested themselves in helping to improve the current health status of Aboriginal women. "As Native peoples entering a new millennium, we

have much to celebrate. The fact that we still exist, that we are living and working within our own communities is in and of itself an achievement. We have many strong women and men who are capably leading us as we rebuild our families, communities and nations. We have elders who will guide us, and children who give us our motivation" (Anderson, 2000, p. 55). As Aboriginal women identify themselves in terms of their families, their communities and their nations, taking steps to improve their health will not only help themselves, but will also enable them to help improve the health of those they identify with.

REFERENCES

Aboriginal Affairs and Northern Development (2004). A guide to Aboriginal organizations in Alberta. Retrieved March 3, 2004, from Alberta Aboriginal Affairs and Northern Development: http://www.aand.gov.ab.ca/?lid=41

Aboriginal Affairs and Northern Development (2005). Indian Reserve Map. Retrieved May 31, 2005, from Alberta Aboriginal Affairs and Northern Development: http://www.aand.gov.ab.ca/AAND.asp?lid=54

Aboriginal Diabetes Initiative (2000). Diabetes among Aboriginal (First Nations, Inuit, Métis) people in Canada: The evidence. Retrieved March 3, 2004, from Health Canada:http://www.hc-sc.gc.ca/fnihb/cp/adi/publications/the_evidence.pdf

Alberta Cervical Cancer Screening Program (2002). Focus groups with Aboriginal women: Executive summary, September, 2002. Alberta Cancer Board.

Alberta Health (1996). Strengthening the circle: what Aboriginal Albertans say about their health Edmonton, Alberta: Alberta Health, Aboriginal Health Unit.

Anderson, K. (2000). A recognition of being: Reconstructing native womanhood. Toronto, Ontario: Second Story Press.

Archibald, L. (2004). Teenage pregnancy in Inuit communities: Issues and perspectives. Retrieved March 1, 2005, from Pauktuutit Inuit Women's Association: http://www.pauktuutit.ca/pdf/publications/pauktuutit/TeenPregnancy_e.pdf

Banks, J.W. (2003). Ka'nistenhsera. Teiakotihsnie's. A Native community rekindles the tradition of breastfeeding. AWHONN. Lifelines, 7, 340-3470

Barrios, P. G. & Egan, M. (2002). Living in a bicultural world and finding the way home: Native women's stories. Affilia, 17, 206-228.

Bartlett, J. G. (2005). Health and well-being for Métis women in Manitoba. Canadian Journal of Public Health, 96, S22-S27.

Benoit, C., Carroll, D., & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. Social Science & Medicine, 56, 821-833.

Benoit, C. & Carroll, D. (2001). Marginalized voices from the downtown eastside: Aboriginal women speak about their health experiences (Rep. No. NNEWH Working Paper Series #12). Toronto, Ontario: National Network on Environments and Women's Health (NNEWH).

Bent, K. & Ross, L. (2004). Aboriginal women's health issues: A holistic perspective on wellness. Retrieved March 2, 2005, from the Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/pdf/abWoHealthBentFull.pdf

Bourassa, C., McKay-McNabb, K., & Hampton, M. (2005). Racism, sexism, and colonialism: The impact on the health of Aboriginal women in Canada. Canadian Woman Studies, 24, 23-29.

Browne, A. J. & Fiske, J.A. (2001). First Nations women's encounters with mainstream health care services. Western Journal of Nursing Research, 23, 126-147.

Browne, A. J. & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing aboriginal women. Nurse Researcher, 9, 28-41.

Brownridge, D. A. (2003). Male partner violence against aboriginal women in Canada: An empirical analysis. Journal of Interpersonal Violence, 18, 65-83.

Canadian Institutes of Health Research (2003). Institute of Aboriginal Peoples' Health (IAPH): Five-year strategic plan: 2002-2007. Retrieved April 18, 2005, from the Canadian Institutes of Health Research:http://www.cihr-irsc.gc.ca/e/9188.html

City of Calgary (2004). Calgary Aboriginal agencies and services. Retrieved May 9, 2004, from the City of Calgary Website: http://content.calgary.ca/CCA/City+Hall/Business+Units/Community+and+Neighbourhood+Services/Information+Services+and+Directories/Aboriginal+Programs+and+Services+Guide/Aboriginal+Programs+and+Services+Guide.htm

Cooke, M. (2002). The effects of personal characteristics on migration from prairie cities to First Nations. Canadian Ethnic Studies, 34, 40-62.

Corin, E. (1994). The social and cultural matrix of health and disease. In R.G.Evans, M. L. Barer, & T. R. Marmor (Eds.), Why are some people healthy and others not? The determinants of health of populations, (pp. 93-132). Hawthorne New York: Walter de Gruyter Inc.

Creswell, J. W. (1998). Qualitative inquiry and research design: Choosing from among five traditions. Thousand Oaks, California: Sage Publications.

Culjak, T. A. (2001). Searching for a place in between: The autobiographies of three Canadian Métis women. American Review of Canadian Studies, 31(1/2),137-158.

Deiter, C. & Otway, L. (2001). Sharing our stories on promoting health and community healing: an Aboriginal women's health project. Retrieved May 3, 2004, from the Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/sharingOurStories.htm

Dickson, G. (2000). Aboriginal grandmothers' experience with health promotion and participatory action research. Qualitative Health Research, 10, 188-213.

Doyal, L. (1998). What makes women sick? Promoting women's health: The changing agenda for health promotion. Australian Journal of Primary Health-Interchange 4.2, 8-19.

Dyck, R., Klomp, H., Tan, L. K., Turnell, R. W., & Boctor, M. A. (2002). A comparison of rates, risk factors, and outcomes of gestational diabetes between Aboriginal and non-Aboriginal women in the Saskatoon health district. Diabetes Care, 25, 487-493.

Elias, B., Leader, A., Sanderson, D., & O'Neil, J. D. (2004). Living in balance: gender, structural inequalities, and health promoting behaviors in Manitoba First Nation communities. Abstract Retrieved February 28, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/livingInBalance.htm.

Epp, J. (1986). Achieving health for all: a framework for health promotion. Retrieved July 15, 2003, fromHealth Canada: http://www.hc-sc.gc.ca/english/care/achieving_health.html.

Febbraro, A. R., Hall, M. H., & Parmegiani, M. (1999). Developing a typology of the voluntary health sector in Canada: Definition and classification issues. Prepared for the Voluntary Health Sector Project, Health Canada

Federal Provincial and Territorial Advisory Committee on Population Health (1994). Strategies for population health: investing in the health of Canadians. Retrieved April 15, 2003 from Health Canada: http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/e_strateg.pdf.

Federal Provincial and Territorial Advisory Committee on Population Health (1996). First report on the health of Canadians. Retrieved April 15, 2003 from Health Canada:.

Federal Provincial and Territorial Advisory Committee on Population Health (1999). Toward a healthy future: second report on the health of Canadians. Retrieved April 15, 2003, from Health Canada: http://www.phac-aspc.gc.ca/ph-sp/phdd/report/toward/index.html.

Fink, A. (1998). Conducting research literature reviews: From paper to the Internet. Thousand Oaks, California: Sage Publications.

Fulop, L. & Linstead, S. (1999). Management: A critical text. South Yarra, Australia: MacMillan Education Australia PTY LTD.

Grace, S. L. (2003). A review of Aboriginal women's physical and mental health status in Ontario. Canadian Journal of Public Health, 94, 173-175.

Greaves, L. (2000). CIHR 2000: Sex, gender and women's health Vancouver, BC: Canadian Institutes of Health Research.

Hackett, P. (2005). From past to present: Understanding First Nations health patterns in a historical context. Canadian Journal of Public Health, 96, S17-S21.

Hannis, P. (2002). The health of Native women in Quebec. Canadian Women's Health Network, 4/5, 13-15.

Health Canada (2002). Women's health strategy. Retrieved May 8, 2004, from Health Canada: Women's Health Bureau:http://www.hc-sc.gc.ca/english/women/womenstrat.htm

Health Canada (2003a). Canada health action: building on the legacy Volume II: An overview of women's health. Retrieved May 8, 2004, from Health Canada : http://www.hc-sc.gc.ca/english/care/health_forum/publications/finvol2/womens/index.html

Health Canada (2003b). Closing the gaps in Aboriginal health. Health Policy Research Bulletin [5].

Heilbron, C. L. & Guttman, M. A. J. (2000). Traditional healing methods with First Nations women in group counselling. Canadian Journal of Counselling, 34(1), 3-13.

Hiebert, S. (2001). The utilization of antenatal services in remote Manitoba First Nations communities. International Journal of Circumpolar Health, 60 (1), 64-71.

Horne, T., Donner, L., & Thurston, W. E. (1999). Invisible women: Gender and health planning in Manitoba and Saskatchewan and models for progress. Retrieved May 3, 2004 from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/invisibleWomen.htm .

Hotson, K. E., Macdonald, S. M., & Martin, B. D. (2004). Understanding death and dying in select First Nations communities in northern Manitoba: Issues of culture and remote service delivery in palliative care. International Journal of Circumpolar Health, 63, 25-38.

Indian and Northern Affairs Canada (1996). Report of the Royal Commission on Aboriginal Peoples. Retrieved April 10, 2003 from Health Canada: http://www.ainc-inac.gc.ca/ch/rcap/index_e.html

Iwasaki, Y., Bartlett, J., & O'Neil, J. D. (2004). An examination of stress among Aboriginal women and men with diabetes in Manitoba, Canada. Ethnicity & Health, 9, 189-212.

Iwasaki, Y., Bartlett, J., & O'Neil, J. D. (2005). Coping with stress among Aboriginal women and men with diabetes in Winnipeg, Canada. Social Science & Medicine, 60, 977-988.

Johnson, D., Jin, Y., & Truman, C. (2002). Influence of Aboriginal and socioeconomic status on birth outcome and maternal morbidity. Journal of Obstetrics and Gynaecology Canada, 24, 633-640.

Kenny, C. (2002). North American Indian, Métis and Inuit women speak about culture, education and work (Rep. No. Cat. No. SW21-90/2001E-IN). Ottawa: Status of Women Canada.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The mental health of Aboriginal peoples: transformations of identity and community. Canadian Journal of Psychiatry, 45, 607-616.

Lalonde, M. (1974). A new perspective on the health of Canadians: a working document. Retrieved April 15, 2003 from Health Canada: http://www.phac-aspc.gc.ca/ph-sp/phdd/pube/perintrod.htm.

Lavallee, C. & Bourgault, C. (2000). The health of Cree, Inuit and southern Quebec women: similarities and differences. Canadian Journal of Public Health, 91, 212-216.

MacKean, G.L., Thurston, W.E. & Scott, C.M. (2005). Bridging the divide between families and health professionals' perspectives on family-centred care. Health Expectations, 8(1), 74-85

MacKinnon, M. (2005). A First Nations voice in the present creates healing in the future. Canadian Journal of Public Health, 96, S13-S16.

MacMillan, H. L., MacMillan, A. B., Offord, D. R., & Dingle, J. L. (1996). Aboriginal health. Canadian Medical Association Journal, 155, 1569-1578.

Maritime Centre of Excellence in Women's Health (2001). An exploration of the stress experience of Mi'kmaq female youth in Nova Scotia. Retrieved April 26, 2004 from Maritime Centre of Excellence in Women's Health: http://www.acewh.dal.ca/eng/reports/Wien%20Finalreport.pdf.

Martens, P. J. (2001). The effect of breastfeeding education on adolescent beliefs and attitudes: A randomized school intervention in the Canadian Ojibwa community of Sagkeeng. Journal of Human Lactation, 17 (3), 245-255.

McCallum-McLeod, L. & Wilson, K. (2004). Northwest Saskatchewan Métis women's health: Research discussion paper for the Northwest Métis Women's Health

Research Committee. Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/northwestSKMetis.htm.

Meadows, L., Thurston, W. E., & Vollman, A. R. (2003a). Women's health in Alberta: An environmental scan Calgary, Alberta: Women's Health Research Group; University of Calgary.

Meadows, L. M., Lagendyk, L. E., Thurston, W. E., & Eisener, A. C. (2003b). Balancing culture, ethics, and methods in qualitative health research with Aboriginal peoples. International Journal of Qualitative Methods, 2 (4). Article 1. Retrieved March 1, 2005 from http://www.ualberta.ca/~iiqm/backissues/2_4/pdf/meadows.pdf

Meadows, L. M., Thurston, W. E., & Lagendyk, L. E. (2004). Aboriginal women at midlife: Grandmothers as agents of change. Canadian Woman Studies, 24, 159-165.

Miles, M. B. & Huberman, A. M. (1994). An expanded sourcebook: Qualitative data analysis. (Second edition) Thousand Oaks, California: Sage Publications.

Mill, J. E. (1997). HIV risk behaviors become survival techniques for aboriginal women. Western Journal of Nursing Research, 19, 466-489.

Mill, J. E. (2000). Describing an Explanatory Model of HIV Illness among Aboriginal Women. Holistic Nursing Practice, 15, 42-56.

Moffitt, P. (2004). Colonialization: A health determinant for pregnant Dogrib women. Journal of Transcultural Nursing, 15, 323-330.

Moffitt, P. & Robinson Vollman, A. (2004). Photovoice: Picturing the health of Aboriginal women in a remote northern community. Canadian Journal of Nursing Research, 36, 189-201.

Native Women's Association of Canada (2002). Aboriginal women & health care in Canada. Retrieved April 2, 2005, from Native Women’s Association of Canada: http://www.nwac-hq.org/AboriginalWomenandHealthCareinCanada.pdf.

Newbold, K. B. (1998). Problems in search of solutions: Health and Canadian Aboriginals. Journal of Community Health, 23, 59-74.

Patton, M. Q. (1997). Utilization-focused evaluation: The new century text. (3rd Edition) Thousand Oaks, California: SAGE Publications.

Pauktuutit Inuit Women's Association of Canada. Inuit women's health: a call for commitment. Canadian Women's Health Network 4/5[4/1], 9-10. 2002.

Population Health Directorate (2001). Taking action on population health: A position paper for health promotion and programs branch staff Ottawa, Ontario: Health Promotion and Programs Branch, Health Canada.

Probert, A. & Poirier, R. (2003). The health status of First Nations people in Canada. Health Policy Research Bulletin 5, 6-10.

Quantz, D. (2001). Public Participation in Health Policy: A Case Study of the Region 4 Aboriginal Health Council. Unpublished masters thesis, University of Calgary, Calgary, Alberta, Canada.

Reading, J. & Nowgesic, E. (2002). Improving the health of future generations: the Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health. American Journal of Public Health, 92, 1396-1400.

Romanow, R. J. (2003). Building on values: The future of Canadian health care: final report. Retrieved May 14, 2004, from Health Canada.: http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf

Saskatoon Aboriginal Women's Health Research Committee (2004). Naspici Miyomahcihowin: Continuous good health. Final report: A community-based research project examining the health needs of Aboriginal women in Saskatoon. Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/continuousGoodHealth.htm.

Sayers, J. F., MacDonald, K. A., Fiske, J.A., Newell, M., George, E., & Cornet, W. (2001). First Nations women, governance and the Indian Act: A collection of policy research reports (Rep. No. Cat. No. SW21-85/2001). Ottawa: Status of Women Canada.

Secco, M. L. & Moffatt, M. E. (2003). The home environment of Métis, First Nations, and Caucasian adolescent mothers: An examination of quality and influences. Canadian Journal of Nursing Research, 35, 106-126.

Statistics Canada (2003). 2001 census: analysis series- Aboriginal peoples of Canada: A demographic profile Ottawa, Ontario: Minister of Industry.

Status of Women Canada (2000). Aboriginal women's roundtable on gender equality: Roundtable report. Ottawa, Ontario: Status of Women Canada.

Stout, M. D. (1996). Aboriginal Canada: Women and health. Canada-U.S.A. Women's Health Forum: Health issues relevant to Indigenous women. Retrieved January 8, 2005 from Health Canada: http://www.hc-sc.gc.ca/canusa/papers/canada/english/indigen.htm

Stout, M. D. & Kipling, G. D. (1998). Aboriginal women in Canada: Strategic research directions for policy development (Rep. No. Cat. no. SW21-20/1998). Ottawa: Status of Women Canada.

Stout, M. D., Kipling, G. D., & Stout, R. (2001). Aboriginal women's health research synthesis Project final report. Retrieved on April 28, 2004 from the Centres of

Excellence for Women's Health: http://www.cewh-cesf.ca/PDF/cross_cex/synthesisEN.pdf.

Strategic Policy Directorate (2001). The population health template: Key elements and actions that define a population health approach Ottawa, Ontario: Health Canada: Population and Public Health Branch.

Strategic Policy Directorate (2002). Promoting health in Canada: An overview of recent developments & initiatives Ottawa, Ontario: Health Canada: Population and Public Health Branch.

Strategic Services (2003). A guide to Aboriginal organizations in Alberta Edmonton, AB: Alberta Aboriginal Affairs and Northern Development.

Strategic Services, Aboriginal Affairs and Northern Development. (2004). Alberta: First Nations population summary (December, 2003). Strategic Services: Alberta Aboriginal Affairs and Northern Development [On-line]. Available: http://www.aand.gov.ab.ca/PDFs/FNPopFull_03.pdf

Struthers, R. (2003). The artistry and ability of traditional women healers. Health Care Women International, 24, 340-354.

Sutherns, R., McPhedran, M., & Haworth-Brockman, M. (2004). Rural, remote and northern women's health: Policy and research directions Ottawa, Ontario: Centres of Excellence for Women's Health.

Tait, C. (2002). Pregnant addicted women in Manitoba. Canadian Women's Health Network, 4\5, 5-7.

Tarrant, M. & Gregory, D. (2003). Exploring childhood immunization uptake with First Nations mothers in north-western Ontario, Canada. Journal of Advanced Nursing, 41, 63-72.

Tashakkori, A. & Teddlie, C. (1998). Mixed methodology: Combining qualitative and quantitative approaches. Thousand Oaks, CA: Sage Publications.

Ten Fingers, K. (2005). Rejecting, revitalizing, and reclaiming. Canadian Journal of Public Health, 96, S60-S63.

Thurston, W.E., Horne, T. & Donner, L. (in press). Understanding and acting on women's health: Is gender-based analysis mainstream? Women & Health.

Thurston, W.E. & Meadows, L.M. Rurality and health: Perspectives of mid-life women. Rural and Remote Health, 3(3), Article 219 (12 pages). Retrieved on May 30, 2005. On-line journal available from: http://rrh.deakin.edu.au

Thurston, W. E., Vollman, A.R., Wilson, D.R., Mackean, G., Feliz, R. & Wright, M.F. (2003). Development and testing of a framework for assessing the effectiveness of health promotion. Social and Preventive Medicine. 48(5), 301-316

Tookenay, V. F. (1996). Improving the health status of aboriginal people in Canada: New directions, new responsibilities. Canadian Medical Association Journal. 155, 1581-1583.

Vlassoff, C. & Moreno, C. G. (2002). Placing gender at the centre of health programming: challenges and limitations. Social Science & Medicine, 54, 1713-1723.

Voyageur, C. J. (2001). Contemporary Aboriginal women in Canada. In D.Long & O. P. Dickason (Eds.), Visions of the heart: Canadian Aboriginal issues (2nd ed., pp. 81-106). Toronto, Ontario: Harcourt Canada.

Waldram, J. B., Herring, D. A., & Young, T. K. (1995). Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives. Toronto, Ontario: University of Toronto Press.

Webster, R. W. (2002). Aboriginal women and menopause. Journal of Obstetrics and Gynaecology Canada, 24, 938-940.

Wilson, A. (2004). Living well: Aboriginal women, cultural identity and wellness. Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/livingWell.htm.

Wilson, K. & Rosenberg, M. W. (2002). Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? Social Science & Medicine, 55, 2017-2031.

World Health Organization (1986). Ottawa charter on health promotion Copenhagen: World health Organizational Regional Office for Europe.

Young, T. K. (1994). The health of Native Americans: Toward a biocultural epidemiology. New York: Oxford University Press.

Young, T. K. (2003). Review of research on aboriginal populations in Canada: Relevance to their health needs. British Medical Journal, 327, 419-422.

Young, T. K., Kliewer, E., Blanchard, J., & Mayer, T. (2000). Monitoring disease burden and preventive behavior with data linkage: Cervical cancer among aboriginal people in Manitoba, Canada. American Journal of Public Health, 90, 1466-1468.

APPENDIX I: DEFINITIONS

Aboriginal: A collective name for the original peoples of North America and their descendants. The Canadian Constitution recognizes three groups of Aboriginal peoples: Indians (First Nations), Métis and Inuit

Indian: A term that collectively describes all the Indigenous people in Canada who are not Métis or Inuit. In Canada, the term Indian has generally been replaced with the term First Nation.

First Nation: A term that came into common usage in the 1970's to replace the word Indian, which some people found offensive. Although the term is widely used, no legal definition exists.

Inuit: An Aboriginal people of Arctic Canada who live primarily in Nunavut, the Northwest Territories and northern parts of Quebec and Labrador.

Métis: An Aboriginal people of mixed First Nations and European ancestry, distinct from First Nations people, Inuit and non-Aboriginal people.

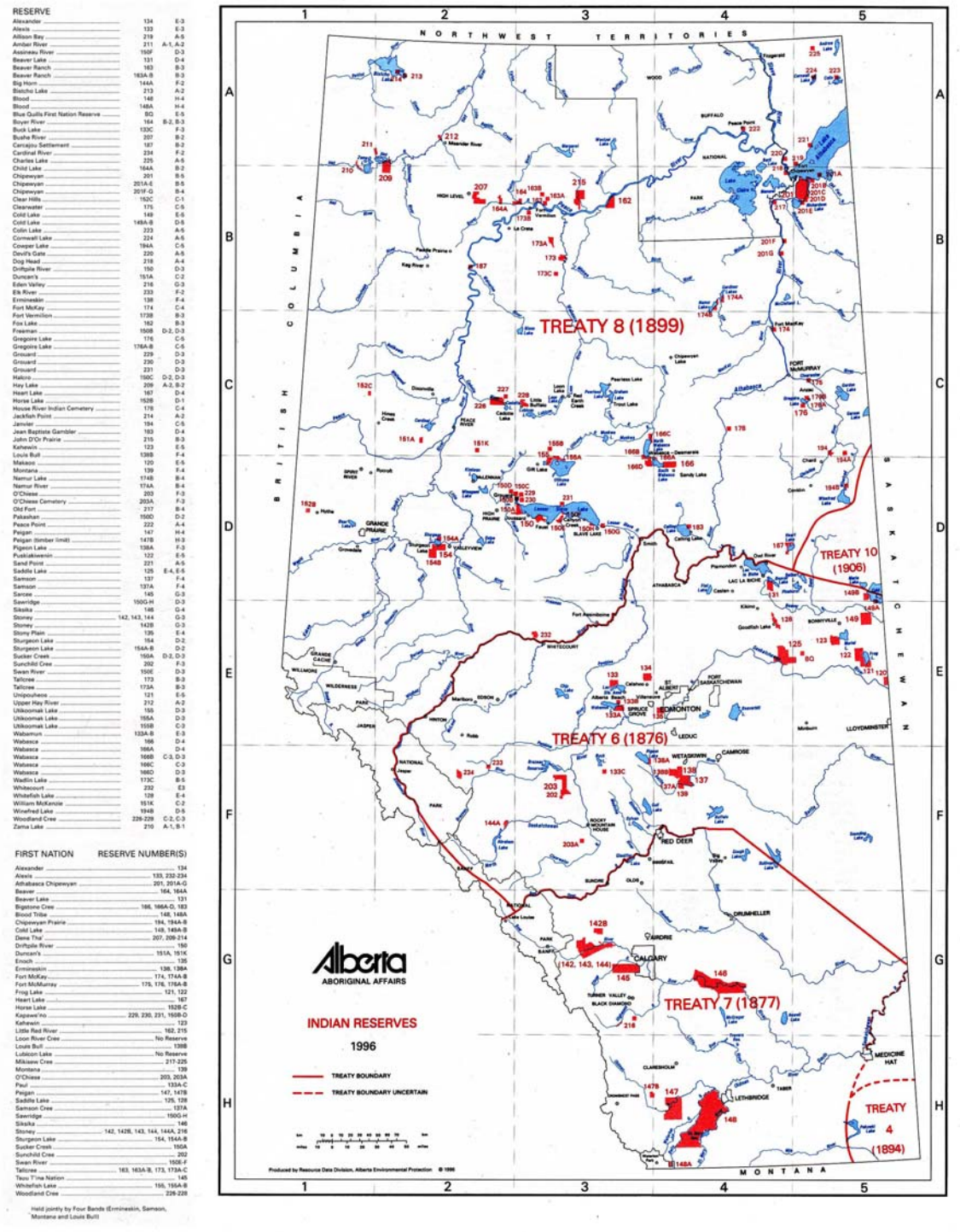
Status Indians: Aboriginal people who are registered or entitled to be registered as "Indians" with the federal government, as determined by certain criteria in the Indian Act.

Non-Status Indians: people who consider themselves Indians or members of a First Nation but whom the federal government does not recognize as Status Indians. In 1985, the federal government amended the Indian Act. Since then, thousands of people who had previously lost their status have been added to the Indian Register.

(Indian & Northern Affairs Canada, 2002)

Note: In this project the term Aboriginal will be used as a general term to refer to people whose ancestors were indigenous to Canada (see definition above). But, other terms may be used to describe information from an original source accurately.

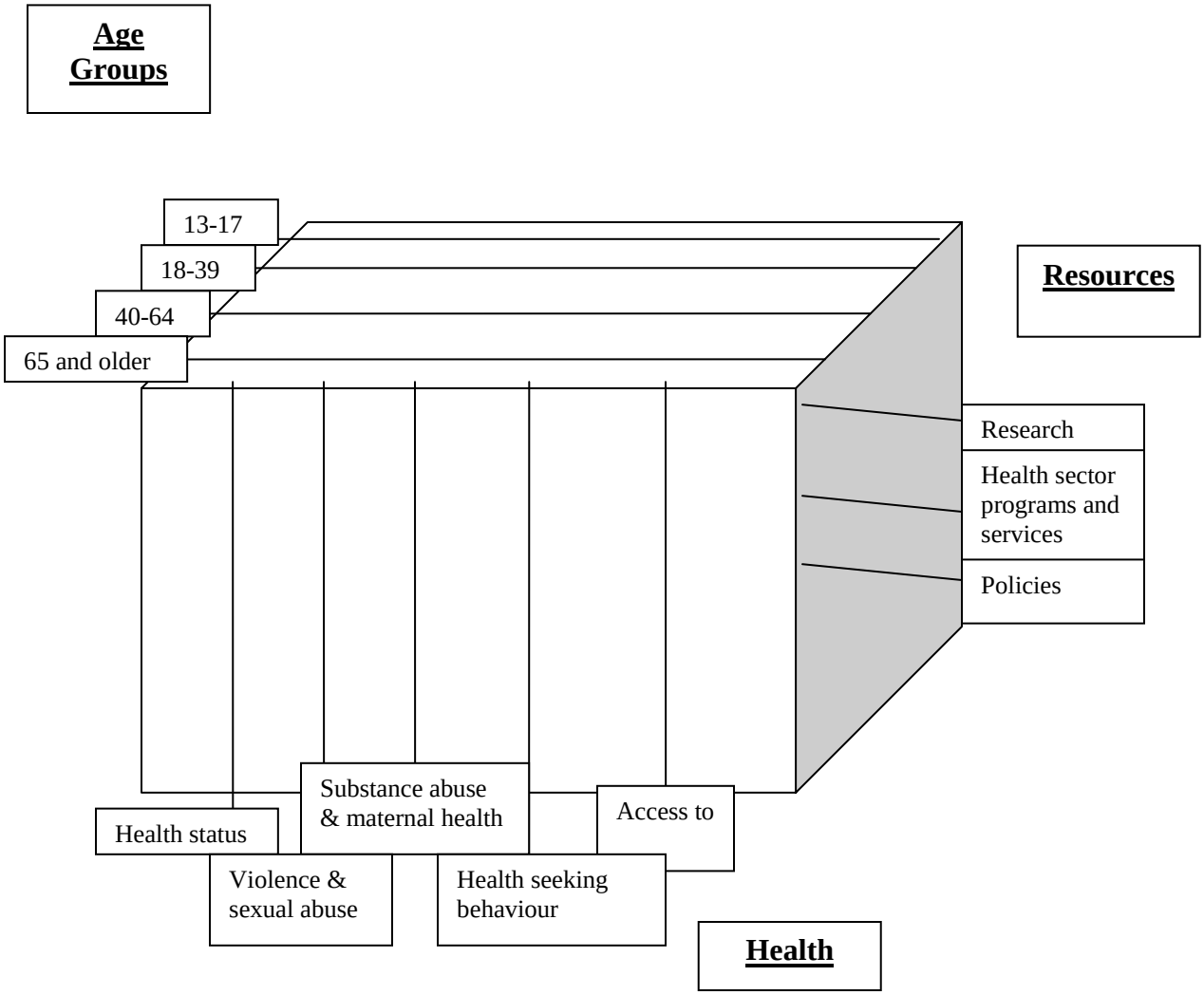
APPENDIX II: MAP OF RESERVE AREAS IN ALBERTA



(Aboriginal Affairs and Northern Development, 2001)

APPENDIX III: CONCEPTUAL FRAMEWORK FOR SCAN

Adapted from Women's Health Environmental Scan (WHES) with only one population (Aboriginal women)



(Meadows et al., 2003a)

APPENDIX IV: INTERVIEW GUIDE

Code number: _____

Date of call: _____

Organization/agency name: _____

An environmental scan of women's health research was completed in Alberta in 2003. In the provincial scan, service providers consistently identified the need for more research on Aboriginal women. This study will build upon the original environmental scan to ensure that the needs of Aboriginal women receive the attention required. This project aims to describe existing programs specific to Aboriginal women in

We hope to include all programs that:

- Directly or indirectly impact Aboriginal women's health
- Are Specific to Aboriginal women

Do you have any potential programs/services to include in project: YES ___ NO ____

Do you do anything in particular to attract Aboriginal women or provide any special services to meet their needs? YES ___ NO ____

_____

_____

_____

_____

_____

_____

I would like to let you know that no comments or personal opinions given here will be used without your permission.

Contact name: _____

Contact phone: _____

Contact email: _____

Before I ask you more specific questions regarding the program, I'd like to ask you a few brief questions about your organization.

Organization

1. Type of organization providing the service: (please check which applies)
- ❑ A. Government (Federal, provincial or city) (e.g., regional health authority; dept. social services)
- ❑ B. Non-governmental
    - o I. Administrative (e.g., band council)
    - o II. Self-help or mutual aid (e.g., Positive Women)
    - o III Not-for-profit
- ❑ C. For profit (e.g., business)
- ❑ D. Other (specify): _____

2. What is the **primary** role of your agency? Are there other roles? (Put P by primary and check others).

I. Culture and Recreation
- ❑ A. Culture and arts
- ❑ B. Sports
- ❑ C. Recreation and social clubs

II. Education and Research
- ❑ A. Primary and secondary education
- ❑ B. Higher education
- ❑ C. Other education
- ❑ D. Research

III. Health
- ❑ A. Mental health
- ❑ B. Crisis intervention
- ❑ C. Other health services (please specify: _____)

IV. Social Services
- ❑ A. Social services
- ❑ B. Emergency and relief
- ❑ C. Income support and maintenance

V. Environment
- ❑ A. Environment

- ❑ B. Animal protection

VI. Development and Housing
- ❑ A. Economic social and community development
- ❑ B. Housing
- ❑ C. Employment and training

VII. Law, Advocacy, and Politics
- ❑ A. Civic and advocacy organizations
- ❑ B. Law and legal services
- ❑ C. Political organizations

VIII. Religion
- ❑ A. Religion

IX. Philanthropic Intermediaries
- ❑ A. Fundraising
- ❑ B. Granting
- ❑ C. Promoting volunteerism

X. Business, Professional, Labour
- ❑ A. Business,
- ❑ B. Professional
- ❑ C. Labour interests

XI. International
- ❑ A. promoting between countries

XII. Other
Other **(Please specify**) _____

3. What is your role in the organization? _____

Now, if it is alright, I'd like to ask you some more specific questions regarding the _____ program we discussed

Program/project/service

4. Program/project/service name:

_____

5. Can you please give me a short description of the program/project/service:

_____

_____

_____

_____

6. When did the program/project/service begin (provide date if possible)?
_____

7. When did the program/project/service end, or when is the anticipated end date?
_____

8. Is the project:
   a) One time only YES _____ NO _____
   b) One time and continuing YES _____ NO _____
   c) Expected to continue indefinitely YES_____ NO _____

9. Is the program/project/service specific to women's health?
   YES _____ NO _____

10. Is it specific to Aboriginal women? YES _____ NO _____

11. Was funding received for the project? YES _____ NO _____

    If so, was it received from:
    a) Competitive government funding agency YES _____ NO _____
    b) Industry or business YES _____ NO _____
    c) In house YES _____ NO _____
    d) Philanthropic organization or charity YES _____ NO _____
    e) Other (please specify: _____)

12. If the program/project/service is completed, have you performed an evaluation* of this program/project/service? YES _____ NO _____

***NOTE: For the purpose of this study, evaluation is defined as: "the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness" (WHO Working Group on Health Promotion Evaluation).**

13. If not completed, is your organization planning on performing an evaluation of this program/project/service? YES _____ NO _____

14. Has your organization disseminated the results (i.e. outcomes) or are you planning to upon completion? YES _____ NO _____

15. If so, how are results being disseminated (check all that apply)?

I) Feedback to community YES _____ NO _____

- A. Public forum
- B. Workshop
- C. Community consultation
- D. Other (please specify: _____)

II) Academic journal or conference presentation YES ___ NO _____
III) Other articles or presentations YES _____ NO _____
IV) Report to funding agency YES _____ NO _____
V) Report to government YES _____ NO _____
VI) Report to Regional Health Authority YES _____ NO _____
VII) To better the program YES _____ NO _____
VIII) Other _____ YES _____ NO _____

16. Is there a written report available for this project?YES _____ NO _____

17. If there is no written report, is there an annual report for your organization or for the project, which might be useful?

YES _____ NO _____

If yes, can we get a hold of a copy of this/these report(s) to use in our analysis?

YES _____ NO _____

18. If yes, what method is best for you?

a) electronic copy? YES _____ NO _____
if so, please send to mthyman@ucalgary.ca

b) fax copy? YES _____ NO _____
if so, please fax to (403) 270-7307

c) mail copy? YES _____ NO _____
if so, please send to:
c/o Wilfreda Thurston
Department of Community Health Sciences
Faculty of Medicine
University of Calgary
3330 Hospital Drive N.W.
Calgary, Alberta T2N 4N1

d) pick up? (in the city of Calgary)

- fill in mailing address below

If a written report is available,
Can we contact you if we need more information regarding this program/project/service?
YES ____ NO _____

Would you like a copy of the results of this survey when they are available?
❑ Yes ❑ No **(If yes, please complete the following.)**

Name of person to whom the results should be sent: _____

Email address:_____

Mailing address:

_____

_____

_____

Do you have any questions or comments for me regarding this interview and what we've discussed?

_____
_____
_____
_____
_____
_____
_____

Thank you again for your time!!

Proceed to next page of interview questions, if no written report is available.

Now I'd like to ask you some more specific questions about the program.

Target population/issues:

19. What is the age range served (check all that apply)?

a) Girls (<18)	YES _____	NO _____
b) Young women (18-39)	YES _____	NO _____
c) Mid-life women (40-64)	YES _____	NO _____
d) Senior women (65+)	YES _____	NO _____

20. Does the program/project/service target Aboriginal women who are (check all those that apply):

- ❑ A. Living in urban areas
- ❑ B. Living in rural areas
- ❑ C. Living on Reserve
- ❑ D. Single mothers
- ❑ E. Lesbians/two spirited
- ❑ F. Abuse survivors
- ❑ G. Women with disabilities
- ❑ H. Women living on low incomes
- ❑ I. Women with low literacy skills
- ❑ J. Other (please specify:_____)

21. Please check off which of the following are/were addressed in this program/project/service:

- ❑ A. Income and social status
- ❑ B. Social support networks
- ❑ C. Education
- ❑ D. Employment and working conditions
- ❑ E. Social environments
- ❑ F. Physical environments
- ❑ G. Biology and genetic endowment
- ❑ H. Personal health practices and coping skills
- ❑ I. Healthy child development
- ❑ J. Health services
- ❑ K. Gender
- ❑ L. Culture
- ❑ M. Other (please specify: _____)

Health Promotion:

22. Does your organization **officially** consider this a health promotion program/project/service: YES _____ NO _____

(For the purpose of this study, **health promotion** is defined as: "The process of enabling people to increase control over, and to improve their health.")

23. If it is a health promotion program/project/service, which health promotion strategies does it incorporate? (check all that apply)

- ❑ A. Building healthy public policy
- ❑ B. Creating supportive environments
- ❑ C. Strengthening community action
- ❑ D. Developing personal skills
- ❑ E. Reorienting health services
- ❑ F. None of the above
- ❑ G.Other (please specify: _____)

Women's Health:

24. Has women's health been **officially** identified as a priority in this program/project/service? YES _____ NO _____

25. Does the project include a statement of commitment to gender equity? YES _____ NO _____

26. Does the program recognize that some barriers to access may be more prevalent for women than men (i.e., lack of childcare, transportation, fear of violence, out of pocket costs)? YES _____ NO _____

27. If the program/project/service recognizes that some barriers to access may be more prevalent for women than men, how does the program/project/service address these barriers?

28. Does the person/people running the program have particular qualifications to address issues related to gender inequality that affect women's health (i.e. abuse; low income; discrimination; economic dependency; power imbalances in relationships; cultural norms about male authority)? YES _____ NO _____

29. Are women (i.e. employees and/or volunteers) involved in the development and implementation of the program/project/service?

YES ____ NO ____

30. In which ways do women contribute to the development and implementation of the program/project/service? (check all that apply)

a) Development of the program, policy, etc. YES _____ NO ____
b) Delivery of program/project/service YES _____ NO ____
c) Evaluation YES _____ NO ____
d) Reporting strategies YES _____ NO ____
e) Decisions whether program continues or not YES _____ NO ____
f) Other? Please specify: _____)

<u>Your perceptions of project:</u>
(In this last few questions I am going to ask for your personal opinions. We will not reveal your identity in any report without your permission

31. Do you personally think that 'women's health' as a topic has been well incorporated into this program/project/service?

YES _____ NO _____

Can you explain how?

32. Do you think that this program/project/service has positive effects on women's health?

YES _____ NO _____

Can you please explain how?

33. Do you personally get the sense that the leaders are taking gender into consideration with regard to running this program? Can you tell me in which ways?

Thank you very much for answering our questions.

Do you have any questions/comments for me regarding this interview or what we've discussed?

Other Comments:

Thank you again for your time

Can we contact you if we need more information regarding this program?
YES ____ NO _____

Would you like a copy of the results of this survey when they are available?
❑ Yes ❑ No **(If yes, please complete the following.)**

Name of person to whom the results should be sent: _____

Email address:_____

Mailing address:

APPENDIX V: TEMPLATE FOR PROJECT DESCRIPTION

Program/Project Name:
Agency:

1. It is a women's health project or service.	Yes θ No θ
2. The project is active in January 2003.	Yes θ No θ
3. The project/service mission/goals/objectives are clear and appropriate to the scope of women's health.	Yes θ No θ
4. Health promotion principles are incorporated:	
a) Participation of women	Yes θ No θ
b) Capacity building of women	Yes θ No θ
c) Interdisciplinarity	Yes θ No θ
d) Appropriateness	Yes θ No θ
5. Project/service targets women's:	
e) SES status (e.g., poverty)	Yes θ No θ
f) Safety (e.g., violence, abuse)	Yes θ No θ
g) Citizenship (e.g., immigration status)	Yes θ No θ
h) Sexual orientation (e.g., lesbian)	Yes θ No θ
i) Living arrangements (e.g., communal)	Yes θ No θ
j) Setting (e.g., rural)	Yes θ No θ
k) Race/ethnicity (e.g., Aboriginal)	Yes θ No
6. Age range(s) served:	
l) Girls (<15)	Yes θ No θ
m) Young women (15 - 44)	Yes θ No θ
n) Mid-life women (45 – 64)	Yes θ No θ
o) Senior women (65+)	
7. Type of organization providing the service:	
p) Government (e.g., Regional Health Authority; Social Services)	Yes θ No θ
q) Non-governmental (e.g., Band Council)	Yes θ No θ
r) Self-help (e.g., Positive Women)	Yes θ No θ
s) Charity (e.g., Church)	Yes θ No θ
t) Other (specify) _____	Yes θ No θ
8. Dissemination of results has/will be through:	
u) Feedback to community	Yes θ No θ
❑ Public forum	
❑ Workshop	
❑ Community Consultation	
❑ Other? Please specify:	
v) Peer reviewed publication/conference presentation	Yes θ No θ
w) Report to funding agency	Yes θ No θ
x) Report to Government	Yes θ No θ
y) Report to Regional Health Authority	

	Yes θ No θ
9. Project is: z) One time only and finished aa) One time and continuing bb) Part of a program of research/development/whatever	 Yes θ No θ Yes θ No θ Yes θ No θ
10. Funding was received from: cc) Competitive government funding agency dd) Industry ee) In-kind ff) Philanthropic organization gg) Other? Please specify:	 Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ
11. Women (past/present consumers and/or the 'female public') are involved in. They have a (check as many as are applicable) ❑ Leadership role ❑ Advisory role ❑ Provide input into: hh) Development of the services/program/research/policy ii) Delivery of service/program jj) Evaluation kk) Reporting strategies ll) Decisions to continue mm) Other? Please specify:	 Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ Yes θ No θ

Template used in the WHES project (Meadows et al., 2003a)

APPENDIX VI: BIBLIOGRAPHY

In Celebration of Aboriginal Women's Gathering (2002). In Calgary: Aboriginal Women's Community Support Network.

Acting on what we know: Preventing youth suicide in First Nations (2003). Ottawa: Health Canada.

Markers of access to and quality of primary care for Aboriginal people in Ontario, Canada. (2003). American Journal of Public Health, 93, 798-802.

Aboriginal Diabetes Initiative (2000). Diabetes among Aboriginal (First Nations, Inuit, Métis) People in Canada: The evidence. Retrieved March 3, 2004, from Health Canada: http://www.hc-sc.gc.ca/fnihb/cp/adi/publications/the_evidence.pdf

Alberta Aboriginal Affairs and Northern Development (2001). First Nations of Alberta Research and Analysis Branch; Strategic Services, Aboriginal Affairs; Alberta Aboriginal Affairs and Northern Development.

Alberta Cervical Cancer Screening Program (2002). Focus groups with Aboriginal women: executive summary, September, 2002 Alberta Cancer Board.

Anand, S. S., Yusuf, S., Jacobs, R., Davis, A. D., Yi, Q., Gerstein, H., Montague, P. A., & Lonn, E. (2001). Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: the Study of Health Assessment and Risk Evaluation in Aboriginal Peoples (SHARE-AP). Lancet, 358, 1147-1153.

Anderson, K. (2000). A recognition of being: reconstructing native womanhood. Toronto, Ontario: Second Story Press.

Archibald, L. (2004). Teenage pregnancy in Inuit communities: Issues and perspectives. Retrieved March 1, 2005, from Pauktuutit Inuit Women's Association: http://www.pauktuutit.ca/pdf/publications/pauktuutit/TeenPregnancy_e.pdf

Auer, A. M. & Andersson, R. (2001). Canadian Aboriginal communities and medical service patterns for the management of injured patients: a basis for surveillance. Public Health, 115, 44-50.

Auer, A. M. & Andersson, R. (2001). Canadian Aboriginal communities: A framework for injury surveillance. Health Promotion International, 16, 169-177.

Banks, J. W. (2003). Ka'nistenhsera. Teiakotihsnie's. A Native community rekindles the tradition of breastfeeding. AWHONN. Lifelines, 7 (4), 340-347.

Bartlett, J. G. (2005). Health and well-being for Métis women in Manitoba. Canadian Journal of Public Health, 96, S22-S27.

Benoit, C. & Carroll, D. (2001). Marginalized voices from the downtown eastside: Aboriginal women speak about their health experiences (Rep. No. NNEWH Working Paper Series #12). Toronto: National Network on Environments and Women's Health (NNEWH).

Benoit, C., Carroll, D., & Chaudhry ,M. (2003). In search of a healing place: Aboriginal women in Vancouver's downtown eastside. Social Science & Medicine, 56, 821-833.

Bent, K. & Ross, L. (2004). Aboriginal women's health issues: A holistic perspective on wellness. Retrieved March 2, 2005, from the Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/pdf/abWoHealthBentFull.pdf

Boothroyd, L. J., Kirmayer, L. J., Spreng, S., Malus, M., & Hodgins, S. (2001). Completed suicides among the Inuit of northern Quebec, 1982-1996: A case-control study. Canadian Medical Association Journal, 165, 749-755.

Bourassa, C., McKay-McNabb, K., & Hampton, M. (2005). Racism, sexism, and colonialism: the impact on the health of Aboriginal women in Canada. Canadian Woman Studies, 24, 23-29.

Browne, A. J. & Fiske, J.A. (2001). First Nations women's encounters with mainstream health care services. Western Journal of Nursing Research, 23, 126-147.

Browne, A. J. & Smye, V. (2002). A post-colonial analysis of healthcare discourses addressing aboriginal women. Nurse Researcher, 9, 28-41.

Brownridge, D. A. (2003). Male partner violence against aboriginal women in Canada: An empirical analysis. Journal of Interpersonal Violence, 18, 65-83.

Bruce, S. G. (2000). The impact of diabetes mellitus among the Métis of western Canada. Ethnicity & Health, 5, 47-57.

Callaghan, R. C. (2003). Risk factors associated with dropout and readmission among First Nations individuals admitted to an inpatient alcohol and drug detoxification program. Canadian Medical Association Journal, 169, 23-27.

Campbell, J. C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry, M. A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S. A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study. American Journal of Public Health, 93, 1089-1097.

Canadian Institutes of Health Research (2003). Institute of Aboriginal Peoples' Health (IAPH): five-year strategic plan: 2002-2007. Retrieved April 18, 2005, from the Canadian Institutes of Health Research: http://www.cihr-irsc.gc.ca/e/9188.html

Canadian Population Health Initiative (2003). Initial directions: Proceedings of a meeting on Aboriginal peoples' health. Wednesday, November 20, 2002. In Ottawa: Canadian Institute for Health Information.

Cardinal, J. C., Schopflocher, D. P., Svenson, L. W., Morrison, K. B., & Laing, L. (2004). First Nations in Alberta: A focus on health service use Edmonton, Alberta: Alberta Health and wellness.

Cargo, M., Levesque, L., Macaulay, A. C., McComber, A., Desrosiers, S., Delormier, T., & Potvin, L. (2003). Community governance of the Kahnawake Schools Diabetes Prevention Project, Kahnawake Territory, Mohawk Nation, Canada. Health Promotion International, 18, 177-187.

Cattarinich, X., Gibson, N., & Cave, A. J. (2001). Assessing mental capacity in Canadian Aboriginal seniors. Social Science & Medicine, 53, 1469-1479.

Clark, M., Riben, P., & Nowgesic, E. (2002). The association of housing density, isolation and tuberculosis in Canadian First Nations communities. International Journal of Epidemiology, 31, 940-945.

Colomeda, L. A. & Wenzel, E. R. (2000). Medicine Keepers: Issues in Indigenous Health. Critical Public Health, 10, 243-256.

Cooke, M. (2002). The effects of personal characteristics on migration from prairie cities to First Nations. Canadian Ethnic Studies, 34, 40-62.

Cornet, W. (2001). First Nations governance, the *Indian Act* and women's equality rights. In J.F.Sayers, K. A. MacDonald, J.A Fiske, M. Newell, E. George, & W. Cornet (Eds.), First Nations women, governance and the Indian Act: A collection of policy research reports (pp. 118-166). Ottawa: Status of Women Canada.

Culjak, T. A. (2001). Searching for a place in between: The autobiographies of three Canadian Métis women. American Review of Canadian Studies, 31(1/2), 137-158.

Daaleman, T. P., Cobb, A. K., & Frey, B. B. (2001). Spirituality and well-being: an exploratory study of the patient perspective. Social Science & Medicine, 53, 1503.

Daniel, M. & Cargo, M. D. (2004). Association between smoking, insulin resistance and beta-cell function in a north-western First Nation. Diabetic Medicine, 21, 188-193.

De Costa, C. (2001). Flora's legacy. The Lancet, 358, 2162-2163.

Deiter, C. & Otway, L. (2001). Sharing our stories on promoting health and community healing: An Aboriginal women's health project. Retrieved May 3, 2004, from the Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/sharingOurStories.htm

Deiter, C. (2002). Research as a spiritual contract: An Aboriginal women's health project. Centres of Excellence for Women's Health Research Bulletin, 2, 14-15.

Deiter, C. (2002). Just Another Indian (Book Review). Canadian Women's Health Network, 4/5, 19.

Dickson, G. (2002). Aboriginal grandmothers' experience with health promotion and participatory action research. Qualitative Health Research, 10, 188-213.

Dokis, L. (2002). Cultural competence for registered nurses. Canadian Women's Health Network, 4/5, 17-18.

Dyck, R., Klomp, H., Tan, L. K., Turnell, R. W., & Boctor, M. A. (2002). A comparison of rates, risk factors, and outcomes of gestational diabetes between Aboriginal and non-Aboriginal women in the Saskatoon health district. Diabetes Care, 25, 487-493.

Elgersma, S. (2001). Aboriginal women: A profile from the 1996 census Indian and Northern Affairs.

Elias, B., Leader, A., Sanderson, D., & O'Neil, J. D. (2004). Living in balance: gender, structural inequalities, and health promoting behaviors in Manitoba First Nation Communities. Abstract Retrieved February 28, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/livingInBalance.htm.

Ellerby, J. H., McKenzie, J., McKay, S., Gariépy, G. J., & Kaufert, J. M. (2000). Bioethics for clinicians: 18. Aboriginal cultures. Canadian Medical Association Journal, 163, 845-850.

Ferry, J. (2000). No easy answer to high native suicide rates. Lancet, 355, 906.

Fiske, J.A. (2000). By, for, or about? Shifting directions in the representations of Aboriginal women. Atlantis, 25, 11-27.

Fiske, J.A., Newell, M., & George, E. (2001). First Nations women and governance: A study of custom and innovation among Lake Babine Nation women. In J.F.Sayers, K. A. MacDonald, J.A. Fiske, M. Newell, E. George, & W. Cornet (Eds.), First Nations women, governance and the Indian Act: A collection of policy research reports (pp. 55-116). Ottawa: Status of Women Canada.

FitzGerald, J. M., Wang, L., & Elwood, R. K. (2000). Tuberculosis: 13. Control of the disease among aboriginal people in Canada. Canadian Medical Association Journal, 162, 351-355.

Fox, T. & Long, D. (2001). Struggles within the circle: Violence, healing, and health on a First Nations reserve. In D. Long & O. P. Dickason (Eds.), Visions of the heart: Canadian Aboriginal issues (2nd ed., pp. 271-301). Toronto: Harcourt Canada.

Grace, S. L. (2003). A review of Aboriginal women's physical and mental health status in Ontario. Canadian Journal of Public Health, 94, 173-175.

Gray-Donald, K., Robinson, E., Collier, A., David, K., Renaud, L., & Rodrigues, S. (2000). Intervening to reduce weight gain in pregnancy and gestational diabetes mellitus in Cree communities: an evaluation. Canadian Medical Association Journal, 163, 1247-1251.

Hackett, P. (2005). From past to present: understanding First Nations health patterns in a historical context. Canadian Journal of Public Health, 96, S17-S21.

Hanley, A. J., Harris, S. B., Gittelsohn, J., Wolever, T. M., Saksvig, B., & Zinman, B. (2000). Overweight among children and adolescents in a Native Canadian community: prevalence and associated factors. American Journal of Clinical Nutrition, 71, 693-700.

Hannis, P. (2002). The health of Native women in Quebec. Canadian Women's Health Network, 4/5, 13-15.

Hanrahan, M. C. (2002). Identifying the needs of Innu and Inuit patients in urban health settings in Newfoundland and Labrador. Canadian Journal of Public Health, 93, 149-152.

Hanselmann, C. (2001). Urban aboriginal people in western Canada Calgary, Alberta: Canada West Foundation.

Hanson, I. & Hampton, M. R. (2000). Being Indian: strengths sustaining First Nations peoples in Saskatchewan residential schools. Canadian Journal of Community Mental Health, 19, 127-142.

Harris, S. B., Zinman, B., Hanley, A., Gittelsohn, J., Hegele, R., Connelly, P. W., Shah, B., & Hux, J. E. (2002). The impact of diabetes on cardiovascular risk factors and outcomes in a native Canadian population. Diabetes Research and Clinical Practice, 55, 165-173.

Health Canada (2003). Closing the Gaps in Aboriginal Health. Health Policy Research Bulletin [5].

Health Canada (2004). A statistical profile on the health of First Nations in Canada First Nations and Inuit Health Branch.

Heilbron, C. L. & Guttman, M. A. J. (2000). Traditional healing methods with First Nations women in group counselling. Canadian Journal of Counselling, 34 (1), 3-13.

Hiebert, S. (2001). The utilization of antenatal services in remote Manitoba First Nations communities. International Journal of Circumpolar Health, 60 1), 64-71.

Holmes, W., Stewart, P., Garrowc, A., Anderson, I., & Thorpe, L. (2002). Researching Aboriginal health: Experience from a study of urban young people's health and well-being. Social Science & Medicine, 54, 1267-1279.

Hotson, K. E., Macdonald, S. M., & Martin, B. D. (2004). Understanding death and dying in select First Nations communities in northern Manitoba: issues of culture and remote service delivery in palliative care. International Journal of Circumpolar Health, 63, 25-38.

Hügli, M. (2002). Mother launches campaign to recruit Aboriginal bone marrow donors. Canadian Women's Health Network, 4/5, 8-9.

Iwasaki, Y., Bartlett, J. G., & O'Neil, J. D. (2005). Coping with stress among Aboriginal women and men with diabetes in Winnipeg, Canada. Social Science & Medicine, 60, 977-988.

Jacobs, K. & Gill, K. (2002). Determinants of the risk and timing of alcohol and illicit drug onset among natives and non-natives: similarities and differences in family attachment processes. Journal of Ethnicity in Substance Abuse, 1, 7-25.

Jacobs, K. J. & Gill, K. J. (2002). Substance abuse among urban Aboriginals: Association with a history of physical/sexual Abuse. Journal of Ethnicity in Substance Abuse, 1, 19-39.

Jacobs, P., Blanchard, J. F., James, R. C., & Depew, N. (2000). Excess costs of diabetes in the Aboriginal population of Manitoba, Canada. Canadian Journal of Public Health, 91, 298-301.

Jin, A., Martin, J. D., & Sarin, C. (2002). Diabetes mellitus in the First Nations population of British Columbia, Canada. Part 2. Hospital morbidity. International Journal of Circumpolar Health, 61, 254-259.

Jin, A. & Martin, J. D. (2003). Hepatitis A among residents of First Nations reserves in British Columbia, 1991-1996. Canadian Journal of Public Health, 94, 176-179.

Johnson, D., Jin, Y., & Truman, C. (2002). Influence of Aboriginal and socioeconomic status on birth outcome and maternal morbidity. Journal of Obstetrics and Gynaecology Canada, 24, 633-640.

Kelly, L. & Brown, J. B. (2002). Listening to Native patients - Changes in physicians' understanding and behaviour. Canadian Family Physician, 48,1645-1652.

Kendall, J. (2001). Circles of disadvantage: Aboriginal poverty and underdevelopment in Canada. American Review of Canadian Studies, 31, 43-59.

Kenny, C. (2002). North American Indian, Métis and Inuit women speak about culture, education and work (Rep. No. Cat. No. SW21-90/2001E-IN). Ottawa: Status of Women Canada.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2000). The mental health of Aboriginal peoples: Transformations of identity and community. Canadian Journal of Psychiatry, 45, 607-616.

Kriska, A., Hanley, A. J., Harris Stewart B., & Zinman, B. (2001). Physical activity, physical fitness, and insulin and glucose concentrations in an isolated Native Canadian population experiencing rapid lifestyle change. Diabetes Care, 24, 1787-1792.

Lavallee, C. & Bourgault, C. (2000). The health of Cree, Inuit and southern Quebec women: Similarities and differences. Canadian Journal of Public Health, 91, 212-216.

Leslie, W., Metge, C., Salamon, E., & Steinman, P. (2000). Determining the burden of osteoporosis in the Aboriginal population. In J.R.R.Oakes, W. Koolage, L. R. Simpson, & N. Schuster (Eds.), Aboriginal Health, Identity and Resources (Winnipeg: Department of Native Studies, University of Manitoba.

Leslie, W., Derksen, S., Metge, C., Lix, L., Salamon, E., Wood Steiman, P., & Roos, L. (2005). Demographic risk factors for fracture in First Nations people. Canadian Journal of Public Health, 96, S45-S50.

Long, D. & Dickason, O. P. (2000). Visions of the Heart: Canadian Aboriginal Issues. (2nd Ed.) Toronto: Harcourt Canada.

Luo, Z. C., Wilkins, R., Platt, R. W., & Kramer, M. S. (2004). Risks of adverse pregnancy outcomes among Inuit and North American Indian women in Quebec, 1985-97. Paediatric and Perinatal Epidemiology, 18, 40-50.

Maberley, D. A., King, W., & Cruess, A. F. (2000). The prevalence of diabetes in the Cree of western James Bay. Chronic Disease Canada, 21, 128-133.

MacKinnon, M. (2005). A First Nations voice in the present creates healing in the future. Canadian Journal of Public Health, 96, S13-S16.

MacMillan, H., Walsh, C. A., Jamieson, E., Wong, M. Y.Y., Faries, E. J., McCue, H., MacMillan, A. B., & Offord, D. R. (2003). The health of Ontario First Nations People: Results from the Ontario First Nations Regional Health Survey. Canadian Journal of Public Health, 94, 168-172.

Majumdar, B. B., Chambers, T. L., & Roberts, J. (2004). Community-based, culturally sensitive HIV/AIDS education for Aboriginal adolescents: implications for nursing practice. Journal of Transcultural Nursing, 15, 69-73.

Marchessault, G. (2002). Talking about weight with Aboriginal women. Canadian Women's Health Network, 4/5, 18.

Maritime Centre of Excellence in Women's Health (2001). An exploration of the stress experience of Mi'kmaq female youth in Nova Scotia. Retrieved April 26, 2004, from Maritime Centre of Excellence in Women's Health: http://www.acewh.dal.ca/eng/reports/Wien%20Finalreport.pdf.

Marrett, L. D. & Chaudhry, M. (2003). Cancer incidence and mortality in Ontario First Nations, 1968-1991 (Canada). Cancer Causes Control, 14, 259-268.

Martens, P. J. (2001). The effect of breastfeeding education on adolescent beliefs and attitudes: A randomized school intervention in the Canadian Ojibwa community of Sagkeeng. Journal of Human Lactation, 17 (3), 245-255.

Martin, J. D., Mathias, R. G., Sarin, C., & Byrne, S. E. (2002). HIV and hepatitis B surveillance in First Nations alcohol and drug treatment centres in British Columbia, Canada, 1992-2000. International Journal of Circumpolar Health, 61, 104-109.

Martin, J. D. & Uh, S. H. (2002). A vital statistics system for determining births and mortality in the First Nations population of British Columbia, Canada. International Journal of Circumpolar Health, 61, 92-97.

McCallum-McLeod, L. & Wilson, K. (2004). Northwest Saskatchewan Métis women's health: Research discussion paper for the Northwest Métis Women's Health Research Committee. Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/northwestSKMetis.htm.

Meadows, L.M., Lagendyk, L.E., Thurston, W.E., & Eisener, A.C. (2003). Balancing culture, ethics, and methods in qualitative health research with Aboriginal peoples. International Journal of Qualitative Methods, 2(4). Article 1. Retrieved March 1, 2005 from http://www.ualberta.ca/~iiqm/backissues/2_4/pdf/meadows.pdf

Meadows, L. M., Thurston, W. E., & Lagendyk, L. E. (2005). Aboriginal women at midlife: Grandmothers as agents of change. Canadian Woman Studies, 24, 159-165.

Mill, J. E. (2000). Describing an explanatory model of HIV illness among Aboriginal women. Holistic Nursing Practice, 15, 42-56.

Minuk, G. Y., Zhang, M., Wong, S. G., Uhanova, J., Bernstein, C. N., Martin, B., Dawood, M. R., Vardy, L., & Giulvi, A. (2003). Viral hepatitis in a Canadian First Nations community. Canadian Journal of Gastroenterology, 17, 593-596.

Moffit, P. & Robinson Vollman, A. (2004). Photovoice: Picturing the health of Aboriginal women in a remote northern community. Canadian Journal of Nursing Research, 36, 189-201.

Moffitt, P. (2004). Colonialization: A health determinant for pregnant Dogrib women. Journal of Transcultural Nursing, 15, 323-330.

Myers, K. A. (2002). Cardiovascular disease and risk in the Aboriginal population. Canadian Medical Association Journal, 166, 355.

Native Women's Association of Canada (2002). Aboriginal women & health care in Canada. Retrieved April 2, 2005, from Native Women's Association of Canada: http://www.nwac-hq.org/AboriginalWomenandHealthCareinCanada.pdf.

Osedowski, M. (2001). Risk perceptions and First Nations communities. International Journal of Circumpolar Health, 60, 180-183.

Pauktuutit Inuit Women's Association of Canada (2002). Inuit women's health: A call for commitment. Canadian Women's Health Network 4/5[4/1], 9-10.

Peressini, S., Leake, J. L., Mayhall, J. T., Maar, M., & Trudeau, R. (2004). Prevalence of early childhood caries among First Nations children, District of Manitoulin, Ontario. International Journal of Paediatric Dentistry, 14, 101-110.

Piquemal, N. (2000). Four principles to guide research With Aboriginals. Policy Options, December, 49-50.

Pohl, A. (2000). Building international awareness on Aboriginal issues Toronto: Citizens for Public Justice (CPJ).

Potvin, L., Cargo, M., McComber, A. M., Delormiera, T., & Macaulay, A. C. (2003). Implementing participatory intervention and research in communities: lessons from the Kahnawake Schools Diabetes Prevention Project in Canada. Social Science & Medicine, 56, 1295-1305.

Probert, A. & Poirier, R. (2003). The health status of First Nations people in Canada. Health Policy Research Bulletin 5, 6-10.

Prodan-Bhalla, N. (2001). Understanding the broader context: The health of the urban native Canadian. Canadian Journal of Nursing Research, 14, 20-25.

Quantz, D. (2001). Public participation in health policy: A case study of the Region 4 Aboriginal Health Council. Unpublished masters thesis, University of Calgary, Calgary, Alberta.

Ray, J. C., Vermeulen, M. J., Meier, C., Cole, D. E. C., & Wyatt, P. R. (2004). Maternal ethnicity and risk of neural tube defects: a population-based study. Canadian Medical Association Journal, 171, 343-345.

Reading, J. & Nowgesic, E. (2002). Improving the health of future generations: the Canadian Institutes of Health Research Institute of Aboriginal Peoples' Health. American Journal of Public Health, 92, 1396-1400.

Reading, J. (2003). A global model and national network for aboriginal health research excellence. Canadian Journal of Public Health, 94, 185-189.

Riben, P., Bailey, G., Hudson, S., McCulloch, K., Dignan, T., & Martin, D. (2000). Hepatitis C in Canada's First Nations and Inuit populations: An unknown burden. Canadian Journal of Public Health, 91 Suppl 1, S16-S18.

Rodrigues, S., Robinson, E. J., Kramer, M. S., & Gray-Donald, K. (2000). High rates of infant macrosomia: a comparison of a Canadian native and a non-native population. Journal of Nutrition, 130, 806-812.

Romanow, R. J. (2003). Building on values: The future of Canadian health care: Final report. Health Canada [On-line]. Available: http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.pdf

Rothe, P. (2001). Why First Nations communities should not be subsumed in a rural framework: Seat belt wearing rates in three Alberta First Nations communities. International Journal of Circumpolar Health, 60, 495-498.

Saskatoon Aboriginal Women's Health Research Committee (2004). Naspici Miyomahcihowin: Continuous good health. Final report: A community-based research project examining the health needs of Aboriginal women in Saskatoon. Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/continuousGoodHealth.htm.

Savoca, M. & Miller, C. (2001). Food selection and eating patterns: Themes found among people with Type 2 Diabetes Mellitus. Journal of Nutrition Education, 33, 224-233.

Sayers, J. F. & MacDonald, K. A. (2001). A strong and Meaningful role for First Nations women in governance. In J.F.Sayers, K. A. MacDonald, J.A. Fiske, M. Newell,

E. George, & W. Cornet (Eds.), First Nations women, governance and the Indian Act: A collection of policy research papers (pp. 1-54). Ottawa: Status of Women Canada.

Sayers, J. F., MacDonald, K. A., Fiske, J.A., Newell, M., George, E., & Cornet, W. (2001). First Nations women, governance and the Indian Act: A collection of policy research reports (Rep. No. Cat. No. SW21-85/2001). Ottawa: Status of Women Canada.

Secco, M. L. & Moffatt, M. E. (2003). The home environment of Métis, First Nations, and Caucasian adolescent mothers: an examination of quality and influences. Canadian Journal of Nursing Research, 35, 106-126.

Shah, B. R., Gunraj, N., & Hux, J. E. (2003). Markers of access to and quality of primary care for Aboriginal People in Ontario, Canada. American Journal of Public Health, 93, 798-802.

Sin, D. D., Wells, H., Svenson, L. W., & Paul Man S.F. (2002). Asthma and COPD among Aboriginals in Alberta, Canada. Chest, 121, 1841-1846.

Smylie, J. (2001). A Guide for health professionals working with Aboriginal peoples: Cross cultural understanding. Journal of the Society of Obstetricians and Gynaecologists of Canada, 100, 157-200.

Statistics Canada (2003). 2001 census: analysis series. Aboriginal peoples of Canada: A demographic profile Ottawa, Ontario: Ministry of Industry.

Status of Women Canada (2000). Aboriginal women's roundtable on gender equality: Roundtable report. Ottawa, Ontario: Status of Women Canada.

Steenbeek, A. (2004). A holistic approach in preventing sexually transmitted infections among First Nations and Inuit adolescents in Canada. Journal of Holistic Nursing, 22, 254-266.

Stout, M. D., Kipling, G. D., & Stout, R. (2001). Aboriginal women's health research synthesis Project final report. Retrieved on April 28, 2004 from the Centres of Excellence for Women's Health: http://www.cewh-cesf.ca/PDF/cross_cex/synthesisEN.pdf.

Stout, M. D., Kipling, G. D., & Stout, R. (2002). Aboriginal women's health research. Canadian Women's Health Network, 4/5, 11-12.

Stout, M. D. & Kipling, G. D. (2002). The health transition fund synthesis series: Aboriginal Health (Rep. No. Cat. H13-6/2002-5). Ottawa: Health Canada.

Strategic Services, AAAND. (2004). Alberta: First Nations population summary (December, 2003). Retrieved on March 1, 2005 from: Strategic Services: Alberta Aboriginal Affairs and Northern Development: http://www.aand.gov.ab.ca/PDFs/FNPopFull_03.pdf

Struthers, R. (2000). The lived experience of Ojibwa and Cree women healers. Journal of Holistic Nursing, 18, 261-279.

Sunday, J. & Eyles, J. (2001). Managing and treating risk and uncertainty for health: a case study of diabetes among First Nation's people in Ontario, Canada. Social Science & Medicine, 52, 635-650.

Tagornnak, D. (2003). There is a need so we help: services for Inuit survivors of child sexual abuse. Retrieved March 9, 2005, from Pauktuutit Inuit Women's Association: http://www.pauktuutit.ca/pdf/publications/abuse/ChildSexualAbuseReport_e.pdf .

Tait, C. (2002). Pregnant addicted women in Manitoba. Canadian Women's Health Network, 4\5, 5-7.

Tarlier, D. S., Johnson, J. L., & Whyte, N. B. (2003). Voices from the wilderness: An interpretive study describing the role and practice of outpost nurses. Canadian Journal of Public Health, 94, 180-184.

Tarrant, M. & Gregory, D. (2001). Mothers' perceptions of childhood immunizations in First Nations communities of the Sioux Lookout Zone. Canadian Journal of Public Health, 92, 42-45.

Tarrant, M. & Gregory, D. (2003). Exploring childhood immunization with First Nations mothers in north-western Ontario, Canada. Journal of Advanced Nursing, 41, 63-72.

Ten Fingers, K. (2005). Rejecting, revitalizing, and reclaiming. Canadian Journal of Public Health, 96, S60-S63.

Thompson, S. J., Gifford, S. M., & Thorpe, L. (2000). The social and cultural context of risk and prevention: Food and physical activity in an urban Aboriginal community. Health Education and Behavior, 27, 725-743.

Thompson, S. J. & Gifford, S. M. (2000). Trying to keep a balance: The meaning of health and diabetes in an urban aboriginal community. Social Science & Medicine, 51, 1457-1472.

Timmins, L. (2002). Research as a spiritual contract: An Aboriginal women's health project. Canadian Women's Health Network, 4/5, 3-4.

Tjepkema, M. (2002). The health of the off-reserve Aboriginal population. Health Reports, 13, 1-17.

Trovato, F. (2000). Canadian Indian mortality during the 1980s. Social Biology, 47, 135-145.

Twohig, P. L. (2002). Aboriginal health in Canada. Acadiensis, 32, 140-148.

Voyageur, C. J. (2001). Contemporary Aboriginal women in Canada. In D. Long & O. P. Dickason (Eds.), Visions of the heart: Canadian Aboriginal issues (2nd ed., pp. 81-106). Toronto: Harcourt Canada.

Webster, R. W. (2002). Aboriginal women and menopause. Journal of Obstetrics and Gynaecology Canada, 24, 938-940.

Willows, N. D., Morel, J., & Gray-Donald, K. (2000). Prevalence of anemia among James Bay Cree infants of northern Quebec. Canadian Medical Association Journal, 162, 323-326.

Wilson, A. (2004). Living well: Aboriginal women, cultural identity and wellness Retrieved March 9, 2005, from Prairie Women's Health Centre of Excellence: http://www.pwhce.ca/linvingWell.htm.

Wilson, C. E. (2000). Cree infant care practices and sudden infant death syndrome. Canadian Journal of Public Health, 91, 133-136.

Wilson, K. & Rosenberg, M. W. (2002). Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? Social Science & Medicine, 55, 2017-2031.

Young, T. K., O'Neil, J. D., Elias, B., Leader, A., Reading, J. R., & McDonald, G. (2002). First Nation and Inuit regional health surveys: Chapter 3 chronic diseases First Nations and Inuit Regional Health Survey National Steering Committee.

Young, T. K. (2003). Review of research on Aboriginal populations in Canada: Relevance to their health needs. British Medical Journal, 327, 419-422.

Ziebland, S., Robertson, J., Jay, J., & Neil, A. (2002). Body image and weight change in middle age: A qualitative study. International Journal of Obesity and Related Metabolic Disorders, 26, 1083-1091.