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# Anishinaabe Ik-We Mino-Aie-Win

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**Aboriginal Women's Health Issues: A  
Holistic Perspective on Wellness**

**University of Athabasca  
MAIS 701- 702 Final Projects**

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## **Dedication**

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## **Abstract**

Aboriginal women suffer the effects of marginalization in every area of their lives. Profound effects have particularly been noted in their health and wellness status. Yet little research has been conducted to unravel the complex array of variables that affect their health and wellness. Research that has been conducted either medicalizes their experiences in a Western fashion, so that little is still known about the actual lived experience of health and wellness for Aboriginal women. This research study sought to answer questions that are important to Aboriginal women's health and wellness because it relates to identifying aspects of health and wellness that are unique to Aboriginal women. In Project I, 125 Aboriginal women completed a 49-item questionnaire designed to assess their health status across four dimensions (i.e., physical, mental, emotional, spiritual), their health and wellness concerns, their access to health care services in the mainstream and in the Aboriginal Community and most importantly their thoughts on what "wellness" means to them. In Project II, the primary focus was on identifying aspects of wellness, health concerns across the same four dimensions, and documenting Aboriginal women's stories about their experiences with the health care system. Ten Aboriginal women who did not complete the survey questionnaire were interviewed and asked questions relating to their health experiences, needs and concerns. The results indicate that Aboriginal women face health problems that are not common to non-Aboriginal women and current health care services do not adequately meet their needs. These results are discussed in terms of acculturation theory. Elder consultation also provided information for the inclusion of traditional knowledge in the analysis. The interview results were analyzed for relevant themes in relation to the survey data, current services and traditional knowledge.

## Introduction

Aboriginal<sup>1</sup> women fare the worst when it comes to health and wellness in Canada. According to a recent synthesis project they “bear the burden of ill-health, premature death and marginalization to a degree unimaginable to much of the country’s population” (Dion Stout, Kipling & Stout, 2001, p. 16). The dire state Aboriginal women occupy in Canada may be directly linked to the contention that they are doubly marginalized due to their female and Aboriginal status. Regarding the latter for example, an Aboriginal perspective has long been excluded from discussions and work related to health and wellness in Canada. As recent as 1997, a health survey of First Nations and Inuit People (FNIRLHS) living on reserve was conducted in response to the fact that First Nations and Inuit people had been left out of three major national health surveys - the National Population Health Survey (NPHS), the National Longitudinal Survey of Children and Youth (NLSCY), and the Survey of Income and Labour Dynamics (SLID), (Health Canada, 2001). A second wave of that survey has also been conducted and Statistics Canada (2003) has completed two Aboriginal Peoples Survey (APS) where both reserve and non-reserve populations were included. The latest version derived from the 2001 census contains a comprehensive analysis of off reserve Aboriginal people’s health status in Canada (Statistics Canada, 2003). The exclusion of Aboriginal people from their own affairs has led to serious shortcomings across all areas of their life as evidenced by the Royal Commission on Aboriginal people report (RCAP) that sought to address some of the shortcomings (1996). The main findings of the RCAP support the conclusion that Aboriginal traditional knowledge plays a key role in addressing the many concerns facing Aboriginal people.

It is the gap between Aboriginal traditional knowledge and mainstream Western epistemology that creates one of the biggest hurdles for Aboriginal women to overcome when dealing with health and wellness issues. The first step then is to comprehensively outline their issues and concerns in a way that

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<sup>1</sup> Throughout this document the term “Aboriginal” refers to First Nation Status, Non-Status, Métis and Inuit people.

makes sense to Aboriginal women and in a manner that adequately parallels their lived experiences especially when it comes to identifying “wellness” characteristics. The notion of “wellness” as it relates to human beings is a contentious concept because of the myriad of meanings associated with it and the linkages it shares with other concepts and factors that affect human life. Wellness may be thought of in economic terms where individuals are financially well if they have a lot, or at least adequate amounts, of money or other monetary possessions and resources to sustain them. It may also relate to social wellness or the position an individual creates and maintains with his or her family, friends, local community and the world community. If a person is very, or even moderately, socially isolated he or she would certainly not be considered socially well off.

In philosophical terms, the Stanford Encyclopedia of Philosophy refers to wellness or well-being in broad terms where it defines “how well a person’s life is going for that person” (Crisp, 2003, p. 1). Although this stance on wellness allows for the consideration of all aspects of a person’s life when it comes to thinking about their well-being or wellness status, it is person centered where well-being is attached solely to what is best for the individual and not other people, animals, things or objects. For Aboriginal people, “wellness is a community issue, a national issue, a women’s issue” (Svenson & Lafontaine, 1998, p. 2). The idea of separating the social, economic, and spiritual wellness of people is inconceivable in Aboriginal traditions. The widely accepted meaning of the term “well-being” however, usually relates to health. In its overview, The World Health Organizations (WHO), a United Nations agency that specializes in advancing the good health of the entire world population, defines health “as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2004 overview). The inclusion of the term “well-being” in the WHO’s definition of “health” speaks loudly about how health and wellness are linked together in the mainstream without giving much attention to the differences between these concepts and the ontological and epistemological assumptions that supported their creation, and also provides evidence of the ambiguity surrounding the term itself.

The Canadian Well-being Measurement Act (2004) provides a sound definition of wellness but lacks the spiritual dimension common to Aboriginal approaches to wellness. It is based on principles of well-being that provide a means to develop measures of well-being or wellness. Appearing comprehensive, these principles are related primarily to personal wellness, community wellness, the well-being of ecosystems and the wellness of other nations but no spiritual measures are mentioned. This Act promotes the basic necessities of life such as pure water, clear air and healthy food for the creation and maintenance of wellness, but also emphasizes the “the value in individual and collective activities, such as learning, relationships, appreciation, sports, music, dance, and other sorts of creativity” (Canadian Well-being 2004, p. 2). According to this Act, community well-being depends on such variables as cohesion, mutual respect, communication, freedom of belief, opportunity to participate in decision making on matters that affect one's life, opportunity to contribute economically and low levels of violence and other crime. The maintenance of biodiversity and protection of ecosystems is also inherently linked to wellness measures, as is the assessment of Canadian actions on the well-being of people in other countries. In line with Western traditions, the spiritual dimension of human life is diminished or ignored all together in this Act.

Goklany (2002) discusses the globalization of human well-being and examines five indicators that measure wellness including the popular United Nations Development Program's human development index (HDI). The other four indicators encompass food supply, infant mortality, prevalence of child labour and life expectancy at birth. Regarding the latter, Goklany (2002) thinks that life expectancy at birth is “probably the single most important indicator of human well-being” (p. 3). He also mentions what he considers “more important measures of well-being (such as freedom from hunger, health, mortality rate, child labour, educational levels, access to safe water and sanitation, and life expectancy) and that wellness is associated with other desirable outcomes (such as adherence to the rule of law, government transparency, economic freedom, and, to some extent, political freedom)” (pp. 2-3). On a positive note, he also states that these indicators generally improve with higher incomes but their relations are not linear and “human well-being is not synonymous with wealth” (p. 2). The HDI, which is based on

life expectancy of birth, educational attainment and per capita income, was also developed with this in mind. The acquisition of material wealth is a common Western value and belief that is not inline with non-materialistic Aboriginal traditions. Unfortunately Aboriginal women in particular and Aboriginal people in general do not fare well according to the HDI who liken Aboriginal people's health and living conditions with that of third world countries. However, even the MFNRHS found that income did not seem to be associated with health outcomes except for individuals with suicidal feelings. Contrary to other findings the MFNRHS study suggests "higher reported household income is associated with more people indicating suicidal feelings" (Centre for Aboriginal, 1998, p. 74).

The common linkage between health and wellness may be associated with ethnocentric ontological and epistemological assumptions that create problems when trying to understand Aboriginal health and wellness issues. The ontology of Aboriginal people is not congruent with the basic Western ontology and therefore should not be treated as such. Western ontology represents the existence and views of the mainstream population in Canada but does not necessarily delineate Aboriginal views. The disparities between the Aboriginal way of knowing, Aboriginal traditional knowledge, and mainstream knowledge also contribute to confusion concerning Aboriginal health and wellness. The assumption that wellness is inherently linked to health leads to inadequate definitions, misconceptions of both terms and misunderstandings. The Medical Model of health for example, is largely based on long held views of health that relate primarily to the absence of illness or disease rather than on other indicators of health such as those related to the social, mental and spiritual spheres.

The WHO's definition of health which includes factors other than those related to physical illness represents a deviation from the medical health model but still does not approximate the definition of health or wellness for Aboriginal people. How we define and conceptualize terms such as health and wellness influence the elements we focus on when we try to reach an understanding of a health and wellness issue and therefore highly reflects and shapes the knowledge we acquire in those areas. This knowledge in turn impacts greatly on the subsequent thinking, behaviour and actions of individuals, family members and governing officials who control funds that contribute to everybody's well-being.

The problem in trying to address the many wellness issues that affect Aboriginal people stem from ontological and epistemological assumptions that guided the creation and maintenance of health care systems in Canada for centuries and contributes greatly to the health disparities between Aboriginal people and the Euro Canadian population. For example, a Saskatoon Aboriginal Women's Health Research Committee recently completed a research project that was designed to explore Aboriginal women's health and wellness needs (Saskatoon Aboriginal, 2004). Information was gathered from nine focus groups and five interviews with Aboriginal women residing in the Saskatoon community. The findings show that "the questions of defining good health posed difficult for all groups; however, one particular group seemed unable to come up with a group option of defining health" (p. 5). The authors suggest that perhaps language barriers, articulation difficulties, or the lack of trust to freely express their feelings contributed to the challenge of defining health. A thorough understanding of health and wellness based on an Aboriginal perspective must be garnered if Aboriginal people are to ever gain the same standards of health and wellness that most other Canadians enjoy.

Aside from defining terminology adequately, another barrier for Aboriginal women is directly linked to their female status. The Canadian Women's Health Network's (CWHN) recent submission to the Commission on the Future of Health Care in Canada, for example, reported "traditionally, men's health needs have been the basis for health research and services delivery" (Canadian Women's 2001, p. 1). Like their main stream counterparts, Aboriginal women's health and wellness concerns have largely been grouped together with the concerns of white males in society which "has led to medical research being conducted on men and then generalized to women, with insufficient evidence" (Canadian Women's 2001, p. 1). The male bias in health and wellness research and services has held negative, life-threatening consequences for women in general. The news that only recently has the medical professional determined that heart attack symptoms are completely different for women than they are for men, supports this contention.

For Aboriginal women who are discriminated against because they are female and Aboriginal, the consequences are magnified to the extent that according to a Health Canada Fact Sheet (1999), as of 1995

and 1996 the life expectancy for Aboriginal women was 76.2 while the life expectancy for non-Aboriginal women was 81 years. This shorter life expectancy is not surprising considering the mortality rate due to violence is three times greater for Aboriginal women than it is for all other Canadian women. In addition, "hospital admissions for alcohol related accidents are three times higher among Aboriginal females than they are for the general Canadian population.... and over a five year span (1989 - 1993), and Aboriginal women were more than three times as likely to commit suicide than were non-Aboriginal women" (Health Canada, 1999, p. 1). Aboriginal women also experienced higher rates of circulatory problems, respiratory problems, diabetes, hypertension and cancer of the cervix and HIV/AIDS compared to Non-Aboriginal Canadian women. To add to their already low socio economic standings, Aboriginal women are also having more babies than Non-Aboriginal women and they are having them at younger more vulnerable ages (Health Canada, 1999). Sixty-five percent of the female and transgendered sex trade workers in the city of Winnipeg have also been reported to be of Aboriginal descent (Berry, 2003).

As well, the Aboriginal People's Survey (APS) derived from the 2001 census shows that some improvements have been achieved in urban Aboriginal women's health and wellness status. Self-ratings show that both the women and their children have excellent or very good health (Statistics Canada, 2003). Regarding their children, a recent Statistics Canada report indicated that in Winnipeg, 20,000 Aboriginal children were enumerated for the 2001 census and 96% "of them were described by their parents or caregivers as being in good or excellent health" (Sanders, 2004, p. B1). These types of statistics are valuable in that they provide a bird's eye view of Aboriginal women and their children in terms of certain health indicators but they do not reveal the whole picture which contributes to a lack of adequate resources and the perpetuation of negative conditions promoting poor health. Indeed, Statistics Canada (2001, 2003) asserts that "self-rated health status is considered a reliable indicator of health" (p. 1) but when it comes to Aboriginal people, consideration must be given to the prevalence of mistrust regarding mainstream initiatives, especially those relating to the federal government. This mistrust stems from the colonization process and may cause Aboriginal people to report more positively on their health, especially when it comes to their children, for fear of losing custody if poor health is reported. Nevertheless,

according to the APS, most of the urban Aboriginal populations reported good or excellent health with differences between men and women smallest among older individuals. Further, slightly more men reported better health compared to women (59% versus 54% respectively) and as in the total Canadian population, a clear and direct association between declining age and poor health was noted.

The findings from the articles reviewed in this section show that Aboriginal women's poor health status may be linked to discriminations arising from their female status and from the difficulties associated with defining "health" and "wellness" in terms that make sense to them. Further research is needed to explore aspects of Aboriginal women's health and wellness that may lead to more fruitful approaches to dealing with their issues. Excellent research has been conducted to date on this topic but it is too sparse to substantially influence policy makers. This assertion is supported by Aboriginal researcher, Dion Stout (2001) who states, "Aboriginal women have seldom benefited from sustained research that explores, in a substantive fashion, their lives, challenges and strengths" (p. 17). A review of the literature on the topic of Aboriginal Women's health and wellness provides further support for her statement and the previous contentions on wellness.

### **Literature Review: Aboriginal Women's Health and Wellness**

The work of Aboriginal and non-Aboriginal scholars reflects a growing concern for Aboriginal women's health and wellness (Bartlett et al., 2004; Benoit, Carroll, & Chaudhry, 2003; Deiter & Otway, 2002; Dion Stout et al., 2001; Dion Stout, 1995; Mallett, 1995; McEvoy & Daniluk, 1995; Svenson & Lafontaine, 1998; Wilson, 2004). This review presents literature on the topic of Aboriginal women's health but focuses primarily on the topic of their wellness. Studies that discuss Aboriginal wellness as a whole have also been included in this review because of the lack of academic studies in this area specific to Aboriginal women. Focus group meeting reports, conference minutes and non-academic reports have also been reviewed because of this deficiency. It should be noted however, there is no deficit when it comes to the amount of work conducted by people working on urban Aboriginal issues pertaining to Aboriginal women in the City of Winnipeg. Although the present study focuses on urban Aboriginal

women, some of the studies reviewed here have been conducted in First Nations reserve communities. However, generalization from studies completed with reserve populations to help understand urban health issues does not present a major concern. According to a recent mobility study coordinated by the Institute of Urban Studies in collaboration with the Assembly of Manitoba Chiefs and the Manitoba Métis Federation, the influx of Aboriginal people from reserve communities to the city of Winnipeg has always been great and is expected to increase in the future (Distasio & Sylvester, 2004). Their contention is supported in an Aboriginal Planning Program report initiated by the University of Manitoba that points out that Winnipeg has an Aboriginal population that is expected to increase substantially in the next few years which "heightens the need for health care related services" (Cruz, 2004, p. 61). A high portion of this increase can be attributed to the movement of First Nation reserve members to the city who bring with them an excess of emotional, physical, mental and spiritual problems in their migration. It is therefore important to examine the work done on reserve populations in conjunction with work on urban Aboriginal populations. As much as possible, Manitoba studies and the work of Aboriginal scholars are emphasized, but all research on Aboriginal women's wellness is vitally important and has therefore been considered.

Health and wellness are two distinct but closely related concepts that are often used interchangeably. A number of studies discuss the difficulties associated with this as well as conceptual problem related to the differences between Aboriginal and Western worldviews (Lane, Bopp, Bopp & Norris, 2002; Svenson & Lafontaine, 1998). Lane et al. for example, completed an extensive research report based on community-based consultations with six Canadian Aboriginal communities, two located in Manitoba, in order to develop a comprehensive Aboriginal healing map. Although the authors of this study give credit to the innovative work going on in relation to individual and societal healing in Aboriginal communities, they also discuss their concern for a lack of clarity regarding certain definitions, principles and processes that guide Aboriginal healing plans. Like the conceptualization problems associated with Aboriginal women's "wellness", the term "healing" is also fuzzy. The authors point to a caption in the RCAP (1996) "Gathering Strength" to illustrate the ambiguity surrounding the issue of

“healing”. This report states “healing in Aboriginal terms, refers to personal and societal recovery from the lasting effects of oppression and systematic racism experience over generations” (p. 11). The authors also assert “while this description tells us something about the origins of dislocation and disease in Aboriginal communities, it does not tell us a great deal about how to promote the recovery process” (p. 11).

In the same vein, 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. Lane and his colleagues call for a clear and comprehensive articulation of “how healing is related to the development of well-being and prosperity” (2002; p. 12). They also call for an “exploration of the role of both traditional and Western science based healing models” (p. 13). Taken from the RCAP, they put forth the following definition of health “good health is not simply the outcome of illness care and social welfare services. It is the outcome of living actively, productively and safely, with reasonable control over the forces affecting everyday life, with the means to nourish body and soul, in harmony with one's neighbour and oneself, and with the hope for the future of one's children and one's land. In short, good health is the outcome of living well” (Vol. 3: 34-35 as cited in Lane et al., 2002, p. 19)

Svenson and Lafontaine (1998) have also expressed a concern for the manner in which health, wellness and healing are defined in most studies. They mention that the questions put forth in most studies on Aboriginal healing and wellness do not allow for a complete definition of either what is meant by “traditional ways” or “community wellness” (p. 201). They further contend that more adequate definitions will not come from researchers but “will emerge from the First Nations and Inuit communities in their struggle to meet the challenges of their own health needs” (p. 204). In the study they conducted utilizing data from the 1997 First Nations and Inuit Regional Health Survey (FNIRHS) they found that over 80 percent of the 9,870 adult First Nations and Inuit living on reserve and Inuit communities who responded to the survey, advocated for a return to traditional ways for promoting wellness in their communities and “see the solution to their wellness issues in a very different kind of system than that

being delivered to the rest of the Canadians” (p. 185). The strength of their study rests in their holistic approach to the term “wellness” which is very loosely but broadly defined as relating to community aspects such as control of resources and programs, traditional approaches to healing and the use of Elders, native spirituality, traditional roles of men and women, renewed relationship to the land, reduction in alcohol and drug abuse, and traditional ceremonial activities.

The holistic approach Svenson and Lafontaine (1998) take to analyzing wellness issues is inclusive in nature, making it readily appropriate to apply their analysis to Aboriginal women. Like other Aboriginal women's health researchers (Bartlett, 2004; Benoit, Carroll, & Chaudhry, 2003; Deiter & Otway, 2003; Dion Stout, 1995; Dion Stout et al., 2001; Wilson, 2004), Svenson and Lafontaine (1998) also argue Aboriginal traditional views that define their relationship to the world, differ from that of Non-Aboriginal people's views. They believe that an Aboriginal perspective is missing from the present health care system in Canada. Svenson and Lafontaine quote F. Capra (1992) a writer deemed to provide one of the most in depth discussions of the worldview concept as it relates to health care. Capra states that, “the conclusion to be drawn from these studies of the relation between medicine and health seems to be that biomedical interventions, although extremely helpful in individual emergencies, have very little effect on the health of the entire population. The health of human beings is predominantly determined not by medical intervention but by their behaviour, their food, and the nature of their environment,” (p. 189). These variables of course differ from culture to culture.

Studies devoted exclusively to Aboriginal women's wellness are few but the ones that have been completed provide much insight into the lives of Aboriginal women, (Bartlette, 2004; Deiter & Otway, 2001; Dion Stout, 1995; Dion Stout & Kipling, 1998; Dion Stout et al., 2001; Wilson, 2004). Wilson (2004) for example, conducted a study about the relationship between “wellness” and Aboriginal women's cultural identity that yielded rich information on the topic of “wellness”. She garnered her data from focus group discussions, consisting of 4-6 Aboriginal women, and interviews held in four Manitoba communities (two were reserves and two urban communities). The women in this study were not asked directly to define what “wellness” meant to them. However, a good picture of the unique characteristic of

“wellness” for Aboriginal women came through their responses to indirect questions relating to their ideas on what contributes to the health and well-being of Aboriginal women in Manitoba, how they maintain their personal well-being in their daily life and how wellness is part of their community. The Aboriginal holistic worldview resonates through many of the women's responses. Their wellness characteristics have been identified mainly as an interconnectedness that ties their identity to all life experiences in a way that makes it clear that “their identities are deeply seated in family and their home community” (Wilson, 2004, p. 9).

For Wilson's (2004) participants “wellness is balance in your life, physical, mental, emotional, spiritual. You always try to balance those things in your life....wellness starts with yourself, in your interactions with either your family or your community or nation” (pp. 10 -11). This translates into putting appropriate things into your body whether it be food or drink, getting enough sleep, physical exercise, going to church, saying your prayers, and relating to people well. These particular characteristics of wellness are not that different from Western views on wellness. According to this study however, the unique aspects of wellness for Aboriginal women seems to rest in the spiritual aspects of their lives. However, it is hard to determine unequivocally if this is so because the sample for this study may not be representative of all Aboriginal women due to the assertion that “the women who participated in the research have rich spiritual lives” (p. 11). The generalizability of study results is a main concern for researchers who seek to understand diverse groups. Clearly, not all Aboriginal women are spiritual nor are they fortunate enough to live spiritually rich lives. Aboriginal spirituality and ceremonies have “only recently become shared knowledge outside of guarded memories of shared history of the lived wellness of Aboriginal women pre 1960. Before Aboriginal people had the right to vote all was common knowledge but at the same time even if there were differences, there were still similarities. Everyone's way to wellness was the right way, no one was doing it the wrong way. It was the way of the people, the way of the animal life, plant life and so on, but above all, it was the Indigenous way” (Cochrane 2004, personal communication)

Wilson (2004) has revealed a vast array of information on the Indigenous way and what wellness means to Aboriginal women. Praying, smudging, participating in Aboriginal ceremonies, following Medicine Wheel teachings, contributing to community wellness, reclaiming “the acknowledged importance of women” (p. 16) in traditional Aboriginal cultures, empowering each other, meditating and using breathing techniques would encompass some of the unique characteristics of wellness for Aboriginal women. Like Svenson and Lafontaine (1998) as well as others who advocate for the inclusion of an Aboriginal perspective as a means to ameliorate the negative conditions Aboriginal women live in, Wilson (2004) also asserts “traditional understandings of health and wellness in Manitoba’s Aboriginal communities are distinctly different from understandings that have conventionally prevailed in most of the province’s health care institutions” (p. 1). This distinction rests mainly in an Aboriginal approach to health that emphasizes balance where “wellness is prioritized over illness” (p. 3). A focus on lived wellness aspects is more proactive, less reactive, and more conducive to healing the intergenerational effects of the colonization process that plague Aboriginal women and their families than present healing practices that emphasize a program approach based on the medical model of health.

Dion Stout and her colleagues also put forth information related to the wellness of Aboriginal women in their final report on Aboriginal Women’s Health Research Synthesis Project (2001). The report largely consists of data from research on Aboriginal women’s health gathered from five centers of Excellence on women’s health, Aboriginal organizations working in the field and a National Workshop on Aboriginal Women’s Health Research (NWAHR) held at the Odawa Native Friendship Centre in Ottawa. The information on wellness that was derived from the Aboriginal women who participated in a NWAHR workshop reveals, “their health is inseparably related to that of their families and communities” (Dion Stout et al., 2001, p. 18). Five main themes relating to Aboriginal women’s health and wellness emerged from their review of the literature and included; “Aboriginal women’s health status; violence and sexual abuse; substance abuse and maternal health; health-seeking behaviour; and access to services” (p. 21). For the interest of this study, a focus will rest only on the theme related to “health-seeking behaviour” because that theme more closely approximates the concept of “wellness”

which, as previously stated, has been poorly defined but clearly has positive undertones that are not present in the other four themes. Dion Stout et al., (2001) call our attention to “longstanding tendency within the mainstream research and policy communities to portray Aboriginal women as victims and to pathologize their lives (Dion Stout and Kipling, Mar. 1998)” (p. 24), while overlooking and failing to promote health-seeking behaviours that enhance wellness. Indeed, one NAWAHR workshop participant is quoted as saying “we need to look at birth instead of death, wellness instead of illness, positive behaviours instead of guilt” (p. 25). Notwithstanding, wellness conference participants seemed to lean toward the negative as they identified “spousal violence, the cultural identity of adoptees, and the need to address the specific health and wellness concerns of older and younger Aboriginal women” as needing attention (p. 25). The authors of the synthesis project identified diabetes as a significant health issue, and Aboriginal women's strength and resilience were mentioned as characteristics related to their wellness. Dion Stout and her colleagues support the integration of traditional medicines and the holistic understanding of health with mainstream practices.

Bartlett (2004) conducted a study in 2003 to find out what Métis women in Manitoba thought about their health and well-being. In her study, the four dimensions of health contained in an Aboriginal holistic worldview were described from Métis women's perspectives. Like the descriptions presented by Wilson (2004), rich descriptions of what health and well-being mean to Métis women, are also presented in this study. Regarding spirituality, the women “described spiritually well individuals as having strength and resistance to adversity in difficult circumstances; being supportive; accepting; and non-judgmental; and caring for the spiritual needs of children” (Bartlett, 2004, p. 57). Emotionally well individuals were described as those individuals who “can identify feelings and understand their sources, accept emotions as part of the self, express feelings and keep others' feelings confidential, manage and control emotions in daily life, and understand that emotional well-being can only truly arise within one's self” (p. 59). The women in Bartlett's study also mention a connection between emotionality and spirituality stating “emotional well individuals are also spiritually well, free of drugs and alcohol, practice traditional activities, and act as positive emotional role models” (p. 59).

Interconnectedness is an Aboriginal holistic value present in an Aboriginal worldview therefore it is not surprising that “interconnectedness” is mentioned in all the studies discussed so far as well as the next studies reviewed. Unfortunately, the women in Bartlett’s study did not think of themselves as physically well but they described physically well women as individuals who “eat a proper diet, ensure that their children have adequate diets and nutrients, are physically active and work hard” (p. 62). The Aboriginal women in Wilson’s (2004) study felt their identities were inherently linked to their families and communities. The NAWAHR workshop participants’ thoughts mirrored Wilson’s findings indicating that “health is inseparably related to that of their families and their communities” (Dion Stout et al., 2001, p. 18). The “interconnectedness” theme also runs through the Métis women’s ideas of the physical side of being a human woman, as they state their physical wellness also involves taking care of their children. As for their intellectual wellness, according to the Métis women in Bartlett’s (2004) study, “intellectually well individuals learn from reading and reflecting each day, are open to new ideas or out-of-the box thinking, respect others’ views, are advanced and at ease in both their thinking and abilities, are rapidly adaptable to circumstances, respond with creative ideas, and attain higher education despite difficult life experiences” (p. 65).

Complementing Dion Stout and her colleagues (2001, 1998, 1995), Wilson’s (2004), and Bartlett’s (2004) research, Deiter and Otway (2001) completed a study on Aboriginal women’s health and healing in Saskatchewan and Manitoba in order to “define health, healing and well being from an Aboriginal women’s perspective” (p. 23). They administered a survey to ninety-three Aboriginal women and interviewed five Elder women. The women in their sample were reported to be largely poor, underemployed and undereducated with health concerns related to “family violence, diabetes and mental health issues” (p. 24). Health was defined by these women in much the same way as the mainstream regards health but their definitions also held an Aboriginal holistic view where balance and harmony with all that exists is promoted. For these women health was not only defined as “including a good diet, exercise, no substance abuse, adequate rest and food” (p. 19), but these women also noted “that health is not only physical, but includes emotional and spiritual” (p. 19). The authors put forth a number of

recommendations to address the concerns of Aboriginal women including encouraging various governments “to recognize and accept an Aboriginal concept of health and healing by working towards wellness through holistic healing approaches” (p. 24).

In the same vein as Svenson and Lafontaine's (1998) previous discussion on the need to more adequately define what is meant by “traditional ways” and “community wellness”, the concepts of health, healing and wellness must also be more clearly defined by members of the community and by researchers seeking to gain a better understanding of health and wellness issues. What is clear is that mainstream interventions have fallen short of addressing the social and economic problems experienced by Aboriginal people due to colonization and discriminations (Benoit, Carroll, & Chaudhry, 2003; Canadian Mental Health Association, 1994; Dion Stout et al., 2001). In a report entitled *A Second Diagnostic on the Health of First Nations and Inuit People in Canada* completed by Health Canada's First Nations and Inuit Health Branch (1999), it was stated that “despite improvements in many areas, First Nations and Inuit people continue to have a poorer health status than the general Canadian population due to wide spread inequities the Aboriginal population faces in the opportunities for health, notably in socioeconomic conditions” (p. 30). For example, the authors of this report state “the prevalence of self-reported chronic diseases in First Nations and Labrador Inuit people was higher than in the general Canadian population.” (p. 7). This finding applied to all age groups and both genders. The prevalence of chronic conditions was also higher than in the 1991 Aboriginal people's survey. Overall the authors of this report concluded that “the socioeconomic environment of a population, as expressed by education, employment, and income is a strong predictor of health status” (p. 11).

The Aboriginal components of Donner's (2000) comprehensive study on women, poverty and health in Manitoba shows that the Aboriginal women interviewed for the study also talk about their own health in relation to the health of their children and their families. Indeed the “women tended to think in terms of their children and families, more often than that of their own health” (p. 9). Although Donner's study is not geared specifically towards Aboriginal women's health, it provides ample evidence to support the research on the ill health of Aboriginal women. “Unemployment and the lack of employment equity

were identified as factors contributing to poverty among Aboriginal women. It was noted that single mothers in particular face unemployment as an obstacle” (p. 26). A very high percentage of Aboriginal families are headed by single females so the results of this study are significant and highly applicable. Another major issue put forth by one woman interviewed for Donner's study was “that nobody wants to listen to what an Aboriginal woman has to say about her own health” (p. 27). The latter issue is an equity issue common to Aboriginal women that renders them virtually voiceless. Indeed, a Status of Women Canada's (2000) report on First Nations, Métis and Inuit Women's equality concluded that “coming to terms with gender-based discrimination against First Nations, Métis and Inuit women must be done in tandem with stopping racism from non-Aboriginal Canadians and government institutions” (p. 4).

In addition to the concern of not being heard expressed by the women who were interviewed for Donner's (2000) study, “Inuit participants repeatedly stated that their history, identity and living conditions are distinct from those of other Aboriginal peoples, and as such they cannot accept the federal government position that they are a “supplementary Aboriginal race” (Status of Women Canada, 2000, p. 4). A forum on Aboriginal health that was conducted by the National Aboriginal Health Organization and the Commission of the Future of Health Care in Canada found similar concerns (National Aboriginal Health Organization, 2002). The forum was held so that Aboriginal people could share their viewpoints on the future of health care in Canada and the report of the draft proceeding indicates that both on reserve and urban Aboriginal communities face tremendous challenges in regards to improving their health status. Although the forum did not center on Aboriginal women's issues one Inuit woman who introduced herself as the President of the Inuit Women's organization, stated that the biggest challenge faced by Inuit women was “traditional knowledge on the midwifery issue” (p. 34). She further “suggested that it was time that the commission recognized Inuit people and used them in the communities because they held the knowledge and could save millions of dollars rather than bringing professionals to the communities” (p. 34). Apparently, “the midwife in Rankin Inlet was an Inuit Woman who was not recognized by Health Canada” (p. 34). Another woman who was a participant from the Akwesasne Traditional Medicine Program said there were “many success stories of natural births when hospitals had decided that a mother

needed a C-section" (p. 36). She also stated "that the answer was within the Aboriginal people, in how they talk to the baby, to the spirit of the baby, to have changes come about" (p. 36) which reflects the spiritual nature of Aboriginal and Inuit cultures.

Elias, Leader, Sanderson, and O'Neil (2000) conducted a study that sought to describe the health promoting behaviors of people living in Manitoba First Nations on reserve communities. Using data derived from the MFNRHS, they also examined characteristics that distinguish Manitoba First Nation women and men in relation to healthy behaviours such as engaging in more physical activity, positive dietary changes, quitting smoking, and stopping drinking for a time. They found that although women made more positive dietary changes than men (79% versus 66% respectively), "there were little or no differences between women and men for quitting smoking or practicing two or more positive health behaviours" (p. 1). However, "individuals making changes were more likely to be women, older, more educated, and to have history of drug, alcohol, or mental health problems" (Elias, et al., 2000, p. 2). As well, Elias and her colleagues found that "individuals who quit smoking were more likely to have higher education and income status, whereas individuals who made dietary changes were older, well educated, and women (p. 2). Overall they found positive health behaviours tended to be associated with increased age, higher education and higher socioeconomic status. According to these authors, First Nation people living on reserve are working toward a more balanced life but they also noted that while gender is also a factor, "little is known as to how women differ from each other" (p. 3). More research is needed to explore these differences.

In their project summary, Elias and her colleague's (2000) reported most of the participants stated their health was good or very good "in spite of multiple chronic illnesses and functional impairments. Being healthy meant being able to participate in their families, groups of friends, and communities, as well as being able to look after themselves" (p. 1). Elias and her colleague's focus on health promoting behaviors is a move away from the primarily negative approach taken when exploring Aboriginal women's health issues. Dion Stout (1998) has declared "with surprisingly few exceptions, work dealing with Aboriginal women has tended to be highly problem-focused, and it has pathologized these women's

agency and realities. This in turn has allowed little room for an understanding of the real complexities at work, and has provided little insight into the strategies that work” (p. 2). With the exception of Elias et al., (2000), Wilson (2004), Bartlett, (2004) and Deiter and Otway (2001), most researchers have a tendency to focus more on the negative aspects of Aboriginal women's lives which creates serious flaws in their general depiction and subsequent healing plans.

In summary, the findings from the articles reviewed in this section indicate 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. For example, their feelings of interconnectedness to all that exists around them rather than centering inward, sets them apart from mainstream Euro Canadian women who are more individually focused. This factor has implications for the direction health and wellness researchers and policy makers take to address Aboriginal women's wellness concerns. Strategies aimed at increasing self esteem may prove to be fruitless if self esteem is not an integral component of Aboriginal women's a cultural value system. The articles presented here show that Aboriginal women live rich fulfilling lives despite the many drawbacks they face as a function of both their female status and the effects of colonization on their Aboriginal identity. The next section will discuss colonization and acculturation in relation to Aboriginal women's health and wellness.

## **Colonization and Acculturation Theory**

In 2001 there were approximately 499,605 Aboriginal women in Canada out of a total Aboriginal population of 976,305 while in Winnipeg, there were 29,715 Aboriginal women out of a population of 55,760 Aboriginal people (Statistics Canada, Census, 2003). Most of these women live in a state of poverty that can be linked to the effects of government of Canada assimilation policies and practices that have evoked acts of cultural destruction on the Aboriginal population (Royal Commission, 1996). One act of paramount proportion occurred when Aboriginal children were separated from their families through the residential-school system from 1879-1986. During this period, the Canadian government “forcibly took Anishinabe children as young as six years old away from their parent's influence” (Nelson

1997, p. 8). Another act that may be seen as disruptive as the residential school experience occurred in the 1960s and thereafter when child-protection agencies took a large number of Aboriginal children out of their homes and arranged for them to be adopted into non-native families or placed in non-native foster homes (Bennett & Blackstock, 2002). In both incidents, Aboriginal children were isolated from their families and forbidden to speak their language and practice their cultural traditions. These events all but destroyed the Aboriginal way of life. The strength and resilience of Aboriginal people becomes evident in light of this knowledge and when considering the tremendous obstacles they have faced, and continue to face, in their efforts to survive and prosper. The strength and resilience of Aboriginal people is also reflected in the scholarly work that has been completed so far on the topic of Aboriginal women's health and wellness.

The subsequent trauma associated with the near destruction of Aboriginal cultures along with the inter-generational transmission of unhealthy lifestyles and the occupation of a marginalized status due to discrimination and prejudice, all contribute largely to the plight of Aboriginal women. It has been recognized that colonization in general and assimilation practices in particular may be directly related to the social and economic problems common to the Aboriginal population today (Dion Stout et al., 2001; Royal Commission, 1996). Aboriginal cultural enrichment programs have been at the forefront of most Aboriginal initiatives intent on serving the Aboriginal population because as Bill Lee (1992) concluded in his study on Colonization and Community development, "it is crucial that communities must become a source of pride and support for their members...this suggests that traditional cultural underpinnings must be reestablished" (p. 216).

The theoretical framework guiding the formation of these initiatives operates on the premise that if Aboriginal people regain their cultural identity and restore their cultural traditions, then they will be better able to deal with their problems. However, no significant research exists to prove or disprove this theory and despite the progress that has been made in relation to Aboriginal programming and service initiatives, it has been reported that, "Aboriginal women and men are characterized by a health profile one would normally associate with the developing world" (Dion Stout et al., 2001, p. 12). This is devastating

news given the fact that Canada has one of the highest standards of living in the world and has a health care system that is the envy of a lot of other countries. Furthermore, restoring Aboriginal identity through participation in long held cultural traditions is a lengthy process that does not seem to address the immediate concerns of Aboriginal women that are taxing the health care system and reaping havoc on the lives of Aboriginal women, their families and their communities. Fresh new approaches stemming from new ways of theorizing about Aboriginal women's health and wellness may alleviate the problem. Acculturation and Feminist theories may prove to be an apt starting point for developing a new approach but the possibilities are endless. Regarding the former "one popular approach to acculturation research presumes that a person can appreciate, practice, or identify with two different cultures independently of one another" with little or no negative effects (Rudim, 2003, p. 3). Aboriginal cultural enrichment theory is similar to acculturation theories because it too involves adapting to a culture, albeit to one's own lost culture. It also does not exclude other aspects of other cultures, but it hardly acknowledges them either, except in negative terms.

Rudim (2003) examined the history of acculturation theories focusing on those that defined different types of acculturation. He states that the "first psychological theory of acculturation was proposed in 1918 by social psychologists Thomas and Znaniecki" (pp. 10- 11). According to Thomas and Znaniecki, acculturation goes hand in hand with the ways in which individuals adapt to his or her surroundings. If a person is low in fear and high in curiosity they adapt more easily (high acculturation) than individuals who are high in fear and low in curiosity. In this way, adaptability is akin to maintaining and modifying "the schemas of the minority culture to adapt to the dominating pressures of modernity" (p. 11). This view most closely approximates Aboriginal cultural enrichment theory and the present day living conditions of Aboriginal women. According to British psychologist, Bartlett (1923/1970) psychological dimensions are determinants of acculturation and "unresolved acculturative tensions could lead to pathological developments of social life" (as cited on p. 11). For Aboriginal women this would mean that they have a great deal of unresolved acculturative tensions.

More recently the idea that there are four types of acculturation - assimilation, separation, integration, and marginalization has become more appealing. In short, assimilation relates to the dominant culture being favoured, separation relates to favouring a minority culture, integration involves favouring both cultures equally, while marginalization refers to adhering to neither the mainstream or minority culture. This model does not allow for varying degrees of thinking and behaving. For example, Aboriginal women have been deemed to be both assimilated and marginalized, some more or less than others. The extent and the degree to which they vary are unknown, bringing to light a complex issue that needs to be addressed. Rudim (2003) asserts that "all humans, everywhere, are subject to acculturation processes, whether they know it or not and whether they like it or not" (p. 6). He also goes on to say that "to suggest that minorities are psychologically reactive to intercultural contact and the dominant groups are not almost implies that minority people are a different species of psychological being, one distinct from the majority" (p. 6) is one step away from racism. Of course this is not so. Aboriginal Enrichment theory does not assume the dominant culture in Canada has not been affected by Aboriginal cultures. Quite contrarily, the contributions of Aboriginal cultures to the development of Canada have been emphasized by Aboriginal people. However, the theory also proposes that the dominant cultures have alienated and continue to alienate Aboriginal people to the extent that Aboriginal cultures have nearly been destroyed.

Rudim (1993) also argues against the conclusion "that integration has a substantial relationship to adaptation, evident in virtually every study regardless of acculturation contexts, and that integration is the most successful type of acculturation" (p. 6), because "never once was a significant negative correlation between integration and one measure of maladaptation replicated with the other measure of maladaptation" (p. 7) where maladaptation was measured as marginality and stress. In support of Rudim's contention regarding acculturation and maladaptive behaviours such as illicit drug use, the findings in one study showed "that moderately acculturated Hispanic Americans, not the unacculturated or highly acculturated, were the most susceptible to drug use" (Ramirez, Crano, Quist, Burgoon, Eusebio, Grandpre, & Gandpre, 2004, p. 3). As well, low acculturated and moderately acculturated Hispanic

Americans reported significantly higher 30-day drug use than highly acculturated Hispanic Americans and Anglo Americans and “usage of highly acculturated Hispanic Americans and Anglo Americans did not differ” (p. 6). Overall, the authors of this study found that their “analyses show that acculturation does not consistently predict drug use across all types of drugs” (p. 9) They go on to say that “past discrepancies may have arisen because researchers combined findings across drugs, without considering possible differences in patterns of usage.....parental monitoring, familism and knowledge of the negative effects of using drugs contributed to a strong and consistent negative association with marijuana and inhalant use” (p. 9).

Another important issue illustrated by Rudim (2003) relates to the problem of a convergence of ideas on acculturation in that researchers in the field are “particularly weak in citing similar research” (p. 16). He quotes Triandis (1977, p. 10), who contends that “at least two presidents of the International Association for cross-cultural psychology have pointed out the field’s failure to cite and build on prior research” (as cited in Rudim, 2003, p. 17) and that “predictions of acculturation correlating with psychopathology or with well-being have rarely been empirically demonstrated in a rigorous way” (p. 19). To add to this problem, Jean Phinney (1998) who has contributed a great deal to the understanding of acculturation, has declared “the study of attitudes about one’s own ethnicity has been of little interest to members of the dominant group, and little attention has been paid by mainstream, generally White researchers to the psychological aspects of being a minority group member in a diverse society” (p. 73).

Phinney (1998) also presents further terminology issues because the terms ethnic identity have been used virtually synonymously with acculturation despite the fact the two terms are different. An individual’s ethnic identity certainly plays a central role in their acculturation but there is more to acculturation than ethnic identity. Acculturation involves a complex array of variables that result from contact between two and perhaps more, distinct cultures. These variables are meshed together in such a way that it makes it difficult to analyze how they might work together in a linear fashion. Like Rudim (2003), Phinney discusses the linear model of acculturation whereby acculturation is defined loosely as a concept that deals “with changes in cultural attitudes, values, and behaviours that result from contact

between two distinct cultures” (p. 77). The linear approach is limited because it operates on the assumption “that a strengthening of one requires a weakening of the other; that is, a strong ethnic identity is not possible among those who become involved in the mainstream society, and acculturation is inevitably accompanied by a weakening of ethnic identity” (p. 78). The survival of Aboriginal cultural traditions, despite mass assimilation policies that forbade their practice, indicates that there is more to acculturation than can be explained through a linear process. The resilience of Aboriginal people has been proven by their ability to withstand the devastations inflicted upon them through the colonization process. This resilience may be directly linked to a strong identification with their own culture in light of outward displays of adherence to the mainstream cultural traditions. This less linear approach to acculturation is supported by Phinney who calls for a view of acculturation as “a two-dimensional process, in which both the relationship with the traditional or ethnic culture and the relationship with the new dominant culture must be considered, and these two relationships may be independent” where “minority group members can have either strong or weak identifications with both their own and the mainstream cultures, and a strong ethnic identity does not necessarily imply a weak relationship or low involvement with the dominant culture” (p. 78).

In short, the previous review of colonization and acculturation theories shows that very little theoretical work has been done with respect to Aboriginal culture specifically. An understanding of how assimilation, integration, separation or marginalization is manifested by Aboriginal women in their everyday lives is needed in order to describe their health and wellness holistically. This understanding must be based on Aboriginal traditional knowledge and framed holistically. These issues will be covered in the next section.

## **Aboriginal Traditional Knowledge**

Aboriginal traditional knowledge is based on a holistic worldview that places value on all living and non-living matter. Knowledge, from this perspective, also differs from group to group. “The Creator is considered to be at the centre of all that exists (Mallett, Bent & Josephson, 2000, p. 72). The

integration of seven sacred teachings into everyday thinking and behaviour make up the philosophy of most Aboriginal cultures in Manitoba. There is much diversity among the Aboriginal groups in Manitoba. This diversity is reflected in the slight differences between these seven sacred teachings. According to an elder from the Ebb and Flow First Nation in Manitoba, love, humility, courage, respect, honesty, wisdom and truth are the principles underlying Aboriginal traditions (Mallett et al., 2000). Bartlett (2004) asserts however, "the underlying philosophy is that of seven sacred teachings, which are principles of living that include sharing, caring, kindness, honesty, respect, trust and humility" (p. 68). In his book *Seeking Mino-Pimatisiwin*, Michael Hart of the Fisher River Cree Nation in Manitoba describes the Aboriginal approach as coming "from the common concepts of the symbolic model of the medicine wheel and includes wholeness, balance, connection, harmony growth, and healing" (Flett, 2004, p. 45).

Bartlett (2004) has developed an Aboriginal Life Promotion Framework that is based on the concept of the Medicine Wheel, that she states historically "were stone structures constructed on the plains of the North America and consisting of a large, central cairn from which spoke-like lines radiated" (p. 68). Medicine wheels are integral to the creation of Aboriginal traditional knowledge in the health and wellness field. The medicine wheel fits into the circle concept which "is symbolic of a holistic philosophy; it is a tool used to illustrate Aboriginal people's belief in the circularity of life, and helps to convey the connections and relationships with the Creator and all creations" (Mallett et al, 2000, p. 70). Like talking, sharing, teaching and healing circles, medicine wheels are used in teachings to organize information and to aid the conception of ideas. Elder Linda Bloom of the Circle of Life Thunderbird House uses her teachings to help people and has much to offer regarding traditional knowledge on Aboriginal women's health. According to Bloom,

*Aboriginal women's health is very important because women were very well respected years ago. They were life givers, the life carriers, the water carriers and those three things make a woman....it was very unthought of to hit a woman. It was very unthought-of to think that a woman should do her own work and her health. For her health she was provided for. In the mean time she did a lot of things to make sure her family was healthy, that her partner was treated very well because he was sure she was provided for. If she got sick there was the other*

woman to look after her. Nobody was ever left to be on their own not like today if a woman gets sick and has to go to the hospital Child and Family Services say oh the mother isn't here lets take the kids. It's sad for a woman to be ill, if a woman wanted to quit drinking and she goes to a group or addictions or what ever, right away they are there taking the children....Long ago there were medicines for every illness especially to do with the woman. The woman's uterus and fallopian tubes, you know, there were medicines for that. There was always an elderly lady that had all those medicines. If a woman didn't want to be pregnant there was a medicine for that. If she says me and my husband are going away for a long ways and we have to walk I don't want to get pregnant while I'm on this journey, there was medicine for that. If the winter was coming and they say okay I want to get pregnant, then she would get pregnant and have her baby in the spring. It was all planned; women didn't have 4, 5, or 6 kids like they do today. The woman only had maybe 2. They were spread out. If a woman got married and had a partner the baby would be born 2-3 years after she would be with her partner. Maybe after that another baby would be born 6 or 7 years later because the first one would be brought up already then the grandmother would take care of that child while the mother was pregnant. They were very well looked after. There was nothing that ah...surely they worked hard, it was a hard living for them. Today there is none of them. Women don't help each other. We don't help each other. We don't help each other enough. Once you get pregnant, oh well you're on your own, you know, it's your fault. No child is ever a fault, but they could prevent it. Today they give you the pill. There was medicine like that long ago...we had the pill. There was a medicine women took not to get pregnant and if she got pregnant and they are going on a long trip she goes and talks to the elderly lady and says I don't want to be pregnant right now, I can't be pregnant right now she would give her something to drink to abort the baby. So it's not like this is all new, it's just that they know how to regulate it you know. Like I could only afford to have 2 children, maybe I'll have a 3<sup>rd</sup> child I'm still young enough, you know, my husband is a good provider. Always the first child goes to the grandparent... We're not that barbaric (laughing) as they would like to think. The medicines that they had... there was a lot of that. They did ceremonies because when you're ill there is a lot of spirits that they need to talk to sort of a thing you know. There were a lot of ceremonies, smudges; some people went to Sundances. It was all connected the spirit world that was the biggest thing.....Our traditions nearly died in 1957 when they went underground for many years. All of a sudden in the 60's they started coming out again. Today we have a sweat lodge right in the middle of Winnipeg and its going good. It's a place where people come to learn and experience, you know. Everybody that comes through that place had good experiences, there was nothing negative. People were saying this is so different than a sauna and I said of course when

*you come here you come to pray it's just like going to church, like being reborn.* (Extrapolated from an interview conducted May 19, 2004).

Traditional knowledge of this sort is important to the health and wellness of Aboriginal women for it has the potential to ground their lived experiences in knowledge that is relevant to their cultural identity. The preservation of traditional knowledge in a written format is vitally important. Unfortunately, most of this knowledge is contained only in oral formats which makes it difficult for Aboriginal women to access. Aboriginal traditional knowledge plays a central role in addressing Aboriginal issues. The placement of Aboriginal issues at the top of the Canadian federal government's agenda in the first Speech from the Throne is a positive move but a definite aberration from past government actions (Ponting, 2000). On a more positive note, a number of Aboriginal groups have developed their own approaches to wellness based on a wholistic perspective (Mallett, Bent & Josephson, 2000; Poonwassie & Charter, 2001; Proulx & Perrault, 2000). As well, in Manitoba, most Health Care facilities have some Aboriginal component to their programming since the implementation of the Winnipeg Regional Health Authorities Aboriginal Initiative (2004). Yet Dion Stout's (2001) synthesis project provides evidence that Aboriginal women still suffer the effects of poor health at rates considerably greater than the rest of the Canadian population.

## **Project Overview**

This research project seeks to answer questions that are vitally important to the study of Aboriginal women's health and wellness. Firstly, how is wellness conceptualized by Aboriginal women? And, are there characteristics of wellness that are unique to Aboriginal women? No research exists on aspects of wellness as it relates specifically to Aboriginal women. Another more fundamental question that has been answered to some extent by a few researchers, (e.g., Dion Stout, et al., 2001) relates to identifying and then prioritizing Aboriginal women's health issues. This research attempts to address these concerns and may be of special interest to other women's health researchers and theorists, health care providers, policy makers, non-government and government funders and most importantly Aboriginal

women. These questions will be answered through two projects. Project one involved administering a survey questionnaire containing questions related to Aboriginal women's health and wellness to Aboriginal women residing in the city of Winnipeg. In project two, ten Aboriginal women were interviewed in order to more fully capture the lived experiences of Aboriginal women.

## Project I

### Survey Methods

#### Participants

125 Aboriginal women were recruited from six Aboriginal organizations in the City of Winnipeg to take part in this study. The sample includes both staff and clientele of all the organizations except for the staff of the Aboriginal Health and Wellness Centre. Demographic information on the participants is included in the results section of this report. Information about the study was posted at the various sites inviting women to participate in the study. Please see Appendix 1 for the poster and overview of the study. The researcher also visited the various sites, described the study to the women participating in the various programs and asked them to voluntarily fill out a questionnaire. Please see Appendix 2 for the recruitment script.

#### Materials

A 49 item questionnaire was developed to explore and assess four areas of the women's lives; demographic information, health issues across four domains (e.g., physical health, emotional health, intellectual health and spiritual health), access and availability to health services in both the mainstream and Aboriginal community and general health and wellness issues. A variety of closed and opened ended questions were used. Regarding health issues, the participants were asked to describe their health in four areas. Sample questions included, "Do you consider yourself physically well?" "What would you say is your biggest physical health concern?" and "What would you say is your biggest emotional health concern?" and so on. Examples of questions contained in the access and availability section include, "In

the past 6 months, how often have you visited a doctor for your health concerns?" and "In the past 6 months, were there times that you wanted to visit a doctor for your own health concerns, but were unable to?" The final section of the questionnaire consisted of six opened ended questions that asked the participants to share their opinions about general health and wellness concerns. An example of one of the questions is "What does wellness mean to you?" Please see Appendix 3 to view the questionnaire.

### **Procedures and Research Design**

The research methods for Project I were deemed ethically appropriate by the research ethics committee at Athabasca University. Please see Appendix 4 for the memorandum of ethical approval from the university. Permission was obtained from the management of six Aboriginal organizations in the City of Winnipeg to conduct this study at their organization. Please see Appendix 5 for the letters of permission. Questionnaires, posters and an overview of the project were dropped off at all six sites. Some of the women picked up the questionnaires at these sites, filled them out individually and then returned them to the contact person at each site. Some of the women also completed the questionnaires in a group. The study was presented to women who participated in various programs at the Ma Mawi Wi Chi Itata Centre, Native Women's Transition Centre and Aboriginal Health and Wellness Centre. Students attending a Family Support Training program at Urban Circle Training Centre and Ka Ni Kanichihk Inc. a program of Mother of Red Nations Women's Council of Manitoba, were also asked to fill out the questionnaire. Smudging took place before the presentation of the study and administering of the questionnaire in all the sites except for the Ka Ni Kanichihk program. The intent of the study was explained and the participants were informed about the voluntary nature of the study and the fact that they had the right to withdraw from the study at any time without repercussions. All of the participants were told that a copy of the final report would be made available to them through their respective agency or by calling the contact numbers listed on the overview they received. The participants did not receive

compensation for taking part in this study. Their agreement to complete the questionnaire was taken as voluntary consent to participate in the study. Participation required approximately 30 minutes.

## **Results**

### **Demographics**

A total of 120 (N=120) women completed the questionnaire. Sixty-two percent reported that they were First Nations, 30 % Métis, and 5% Non Status. The remaining 3% either reported 'other', a combination status, or chose not to declare her status. The majority of the participants (52%) were between the ages of 31 and 50. The majority of women (85%) lived in an urban setting (The City of Winnipeg), 12 % reported that they lived in a rural setting and 3% on reserve. Regarding their degree of assimilation, the majority (58 %) of the participants reported moderate assimilation, 26 % reported low assimilation and spoke an Aboriginal language, 9% reported that they were not assimilated at all and spoke an Aboriginal language, and 7% of the women reported that they were fully assimilated and did not participate in Aboriginal cultural events and activities on a regular basis. Eighty three percent of the women reported that English was their primary language, 14% reported a combination (usually Aboriginal and English), and only 3% of the participants reported an Aboriginal language as their primary language. The majority of women were unemployed (63 %), single (55%) and not supported by a spouse (75%), had less than Grade 12 education (31%) and had dependent children (69%).

Overall, the demographic information suggest that the education level of Aboriginal women is improving because more than 50% of the sample reported having completed Grade 12, college or university education. Unfortunately, the majority of the sample was unemployed (64%) and when they were employed (36%) the income level reported most often was less than \$20,000/year. Education and employment factors have been known to seriously affect health status but as mentioned in the introduction, the relationship between these variables is not linear and they may not hold as many implications for the total well-being of an individual as one would think given the connections between

health and wellness (Goklany, 2002). Detailed summaries of the demographic information are provided in Table 1 as follows.

**Table 1. Education, Employment Status, Income Level, Living Arrangements, Marital Status, Number of Dependent Children, Age, Assimilation, Aboriginal Status**

<b>Education</b>	Gr. 8 or <	Grade 12	> Gr. 12	University	College	Other
	14 (11.7%)	23 (19.2%)	35 (29.2)	18 (15%)	23 (19.2%)	7 (5.8%)
<b>Employment</b>	Full-time	Part-time	Casual	Unempl	Self Emp	No Ans.
	29 (24.6%)	5 (4.2)	6 (5.1%)	75 (63.6%)	3 (2.5%)	2 (1.7%)
<b>Income Level</b>	> \$20 K	\$21-39 K	\$40-59K	\$60 –79 K	Other	No Ans.
	75 (67%)	30 (26.8%)	6 (5.4%)	1 (.9%)	0 (0%)	8 (6.7%)
<b>Marital Status</b>	Single	Widowed	Divorced	Separated	Married/Eq	Other
	66 (55%)	3 (2.5%)	9 (7.5%)	17 (14.2%)	25 (20.8%)	0 (0%)
<b>Living Arrangement</b>	Alone	With Parents/rel.	With Partner	Single Parent	With Friends	Other
	31 (25.8%)	2 – 4 (1.7 & 3.3)	32 (26.7%)	34 (28.3%)	2 (1.7%)	15 (12.5%)
<b># of Children</b>	Yes	No	One	Two	< Three	No Ans.
	83 (69.2%)	37 (30.8%)	16 (20%)	22 (27.5%)	52 (19.2%)	40 (33.3%)
<b>Aboriginal Status</b>	First Natio	Metis	Inuit	Non Status	Other/Comb	No Ans.
	74 (62.2%)	36 (30.3%)	0 0%	6 (5%)	3 (2.5%)	1 (.8%)
<b>Assimilation</b>	Fully	Moderate	Low	None	Other	No Ans.
	8 (7.1%)	66 (58.4%)	29 (25.7%)	10 (8.8%)	0 (0%)	7 (5.8%)
<b>Age</b>	18-25	26-30	31-40	41-50	51-60	No Ans.
	22 (18.5%)	24 (20.2%)	36 (30.3%)	26 (21.8%)	11 (9.2%)	1 (.8%)

Over 69% of the women also reported that they had dependent children and 28% of them reported single parent status which may cause strain and negatively affect the well-being of all members of a given household.

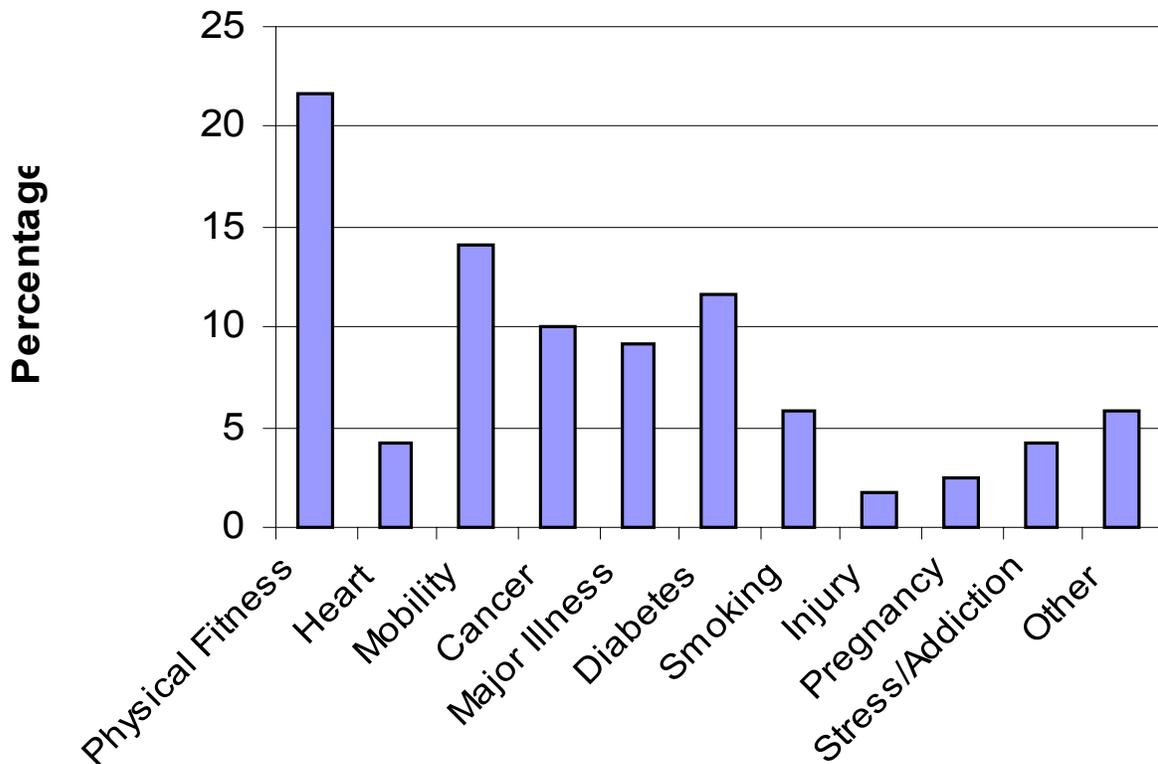
## **Health Issues**

### *Physical Health Concerns*

“Physical health” refers to anything “involving the body as distinguished from the mind or spirit” (Webster, 1913). Sixty-one percent (N = 72) of the women reported that they considered themselves to be physically well, while 38% (N = 46) felt they were not physically well. Two percent of the women did not respond to this question. Seventy-two percent (N = 86) of the women had not been diagnosed with a major physical illness in the last three years, although just under half of the women (N = 59) reported having minor physical health problems in the last three years. These minor physical ailments included: flu, colds, sore legs, knees, back, shoulders, joint pain, carpal tunnel, gall stones, bronchitis, bells palsy, bladder infections, anemia, and gynecological problems such as benign ovarian cysts and yeast infections. Although 64% (N = 75) of the women felt their nutritional needs were being met, a large minority (36%; N = 42) did not. Three of the women did not respond to the question on nutrition.

The majority of women smoked (69%; N = 83) and did not exercise on a regular basis (56 %; N = 66). One woman did not respond to the question on exercise. Collapsed data showed that physical fitness was the biggest physical health concern reported by the women (32%) followed by mobility issues (14%) and then diabetes (12%). Cancer and other major physical illness (i.e., asthma, lung infections, kidney problems, hepatitis c) were each reported by approximately 10% of the women and at rates quite close to that of diabetes. Smoking, injury, pregnancy, stress/addiction and ‘other’ health concerns were all reported at lower frequencies than those already mentioned. These results are presented in Figure 1 on the next page.

Figure 1: Physical Health Concerns



**Note:**

“Fitness” includes weight, overweight, poor nutrition and exercise concerns.

“Mobility” includes arthritis, joint pains, carpal tunnel.

“Cancer” includes ovarian, cervical, lung, uterus, abnormal cells, family history of cancer.

“Major Illness” includes asthma, lung infections, anemia, stomach problems, kidney problems, liver problems and hepatitis c.

“Stress/Addiction” includes anxiety, crack cocaine use and anger.

“Heart” includes high blood pressure, heart problems, strokes and chest pains.

“Pregnancy” includes pregnancy issues such as worrying about having a healthy baby.

“Injury” includes job injuries and accidents.

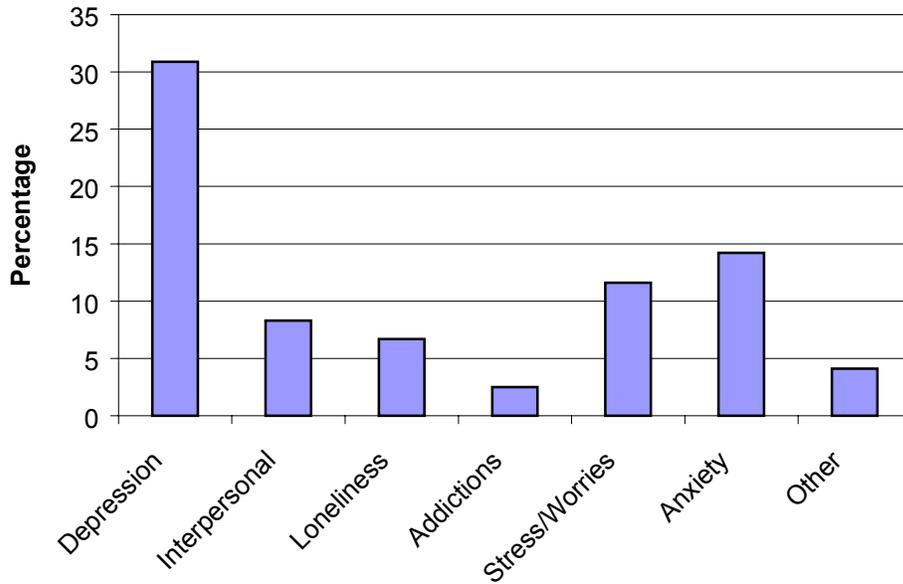
“Other” includes doctors not spending enough time with you, inadequate referrals for testing, finding a doctor, cosmetic, allergies and dental problems.

*Emotional Health Concerns*

“Emotional health refers to “a moving of the mind or soul; excitement of the feelings, whether pleasing or painful; disturbance or agitation of mind caused by a specific exciting cause and manifested by some sensible effect on the body” or “any strong feeling determined or actuated by emotion rather than reason” (Webster, 1913). Sixty-two percent of the women (N = 72) considered themselves to be emotionally well despite the fact that 49% (N = 59) reported having had a mental health illness such as depression and anxiety in the last three years. Collapsed results indicate that depression (31%), anxiety (12%) and stress/worries (12%) are major emotional health concerns for these women. To a lesser degree, the women also reported loneliness, interpersonal relationships and emotional health factors relating to hormonal imbalance and FAS effects as areas of concerns.

Regarding addictions, which have been known to have a serious impact on all aspects of an individual's life especially emotional health, the findings from this study do not appear to support previous statistics indicating addictions as a major concern for Aboriginal women. Although a significant minority of women (26%; N = 31) did report addiction to drugs, alcohol or other substances such as nicotine or cocaine, in all likelihood for many of the women, these addictions were nicotine related. Participants were not asked to indicate what their addiction was, but some of the women qualified their yes/no response by writing “smoking” next to their answer. It is important to note that over 69% (N = 83) of the women in this group reported that they were smokers which has negative implications for all areas of their health and wellness. However, less than 3% of the women reported addictions to be an emotional health concern as reported in Figure 2 on the next page.

**Figure 2: Emotional Health Concerns**



**Note:**

“Depression” includes becoming depressed again, co-dependency, emotional pain, hurt, depression relapse, grieving.

Interpersonal” includes relationships problems, dealing with abusive relationships, abuse, sexual abuse issues, dealing with people on the job, dealing with grandkids, dealing with daughter calling me down, worrying about what people think, worrying about children, dealing with family unwellness and their addictions.

“Loneliness” includes isolation and being alone, being with my kids, loneliness, no support, isolating myself, no self confidence hard to trust.

“Addiction Problems” includes recovering alcoholic, smoking addiction, ability to quit smoking.

“Stress/Worries” includes stress, stress relieve, feeling stressed, stressed out, worrying about weight, worrying about not having enough money, dealing with anger.

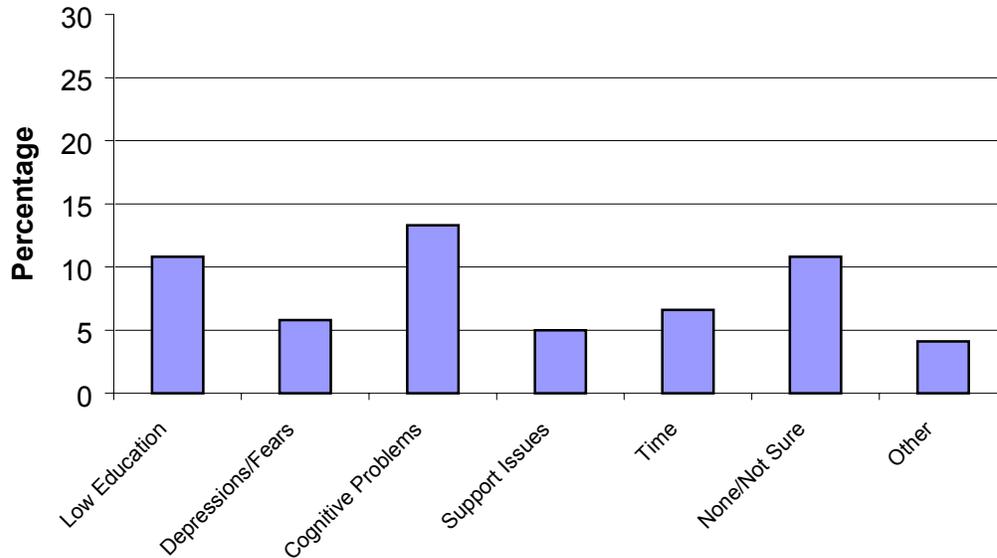
“Other” includes no emotional concerns (3 women), FAS (1 woman) and hormonal imbalance due to pregnancy (1).

*Intellectual Health Concerns*

“Intellectual health” refers to “belonging to, or performed by, the intellect; mental” or mind (Webster, 1913). The majority of women (79%; N = 95) considered themselves to be intellectually well. The majority of women (76%; N = 93) also read on a regular basis and half (N = 60) possessed a library card. Only 14% (N = 17) felt they were not intellectually well. Seven percent of the women did not respond to the question, “Do you consider yourself intellectually well?” Cognitive problems were cited most frequently by the women as an intellectual concern (13%; N = 16). These problems included

forgetfulness, confusion, lack of concentration, lack of energy and no motivation. Low education was also a concern for 11% of the sample, while another 11% of the women were not sure where they stood in relation to their intellectual health. Figure 3 summarizes the data on intellectual health concerns.

**Figure 3: Intellectual Health Concerns**



**Note:**

- “Low Education” includes lack of education, need grade 12, need higher education, need to finish school, difficulty reading, difficulty using key words, difficulty with math.
- “Depression/Fears” includes FAS, anxiety, depression, seizures, inner fears, and fear of rejection, fears regarding my health (e.g. diabetes, cancer).
- “Cognitive Problems” includes forgetfulness, confusion, lack of concentration, distracted, memory loss, not having the common sense I should have, lack of energy, no motivation, hard time trying to keep up, not able to keep up.
- “Support Issues” includes lack of support, costs high, no financial support, no education counseling, stressed over debts.
- “Time Issues” includes lack of study time due to parenting and work demands, lack of childcare knowledge.
- “None/Not sure” includes don’t know and no intellectual concerns.
- “Other” includes sexist attitudes, goals to high, and inability to complete a course because of unspecified reason, street life, smoking and drinking.

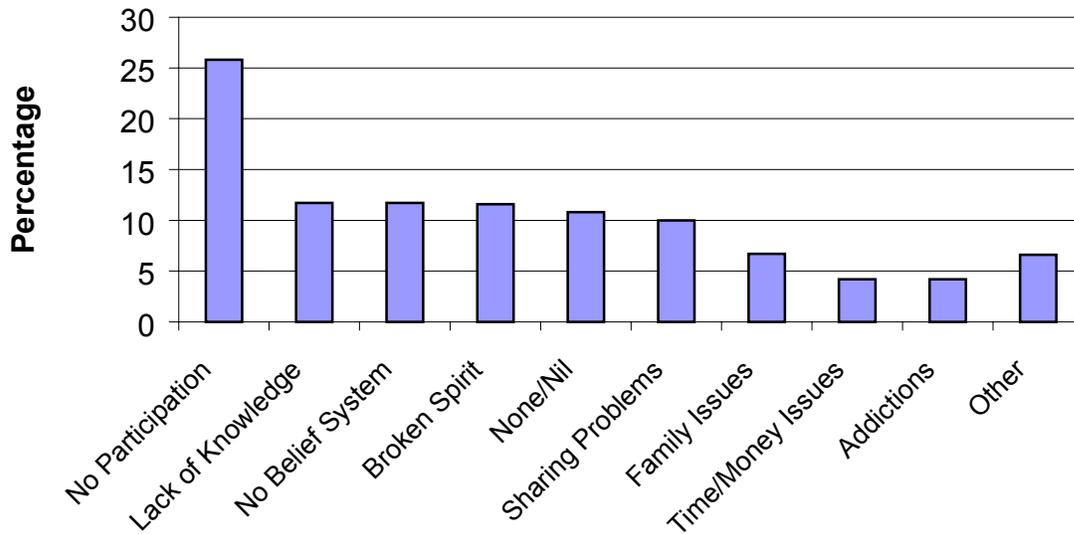
### *Spiritual Health Concerns*

“Spiritual” refers to “the vital principle or animated force within living things” (Webster, 1913). It should be noted that Aboriginal traditions hold that this vital principle is also contained within inanimate objects. Over 68% (N = 80) of the women reported that they considered themselves spiritually well, while 32% (N = 37) indicated they were not. Three women did not respond to the question relating to their spiritual wellness. The collapsed data shows just over a quarter of the women (N = 31) reported that no participation in spiritual activities was their major spiritual health concern. Lack of knowledge regarding spirituality (12%; N = 14), no belief system (12%; N = 14) and a broken spirit (12%; N = 14) were also mentioned as spiritual concerns. Ten percent of the women reported that they had concerns regarding not sharing enough with Aboriginal people. Only 4% (N = 5) of the women reported that addictions was a spiritual health concern. Addictions were however, mentioned in each health issue category which indicates that Aboriginal women are aware of addiction issues related to their health and wellness. The spiritual health concern results are presented in Figure 4 on the next page.

### *Spiritual Activities*

Spiritual Activities refers to Aboriginal and mainstream activities as well as private and public activities. Sixty-four percent (N = 75) of the women reported participating in spiritual activities on a regular basis, with the remaining 36% (N = 43) reporting no spiritual activity. Two women did not respond to the question. The graph in Figure 5 on page 41 shows the spiritual activities the women participated in most often. The results indicate that over 25% of the women participated in a sweat lodge ceremony on a regular basis.

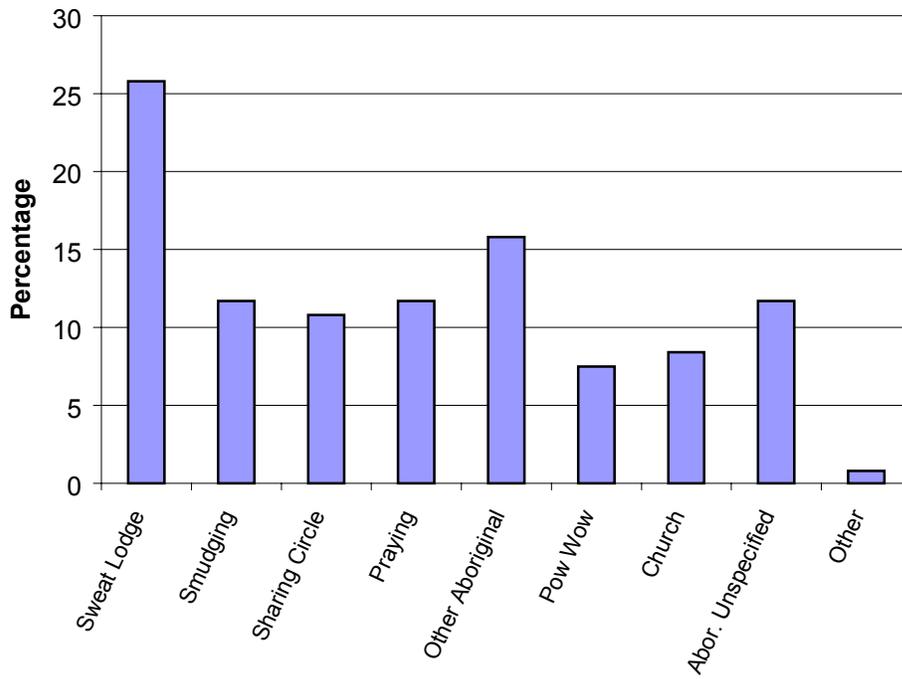
**Figure 4: Spiritual Health Concerns**



**Note:**

- “No Participation” includes lack of participation/neglecting my culture, don’t care about my spiritual needs, not involved, don’t stay in contact with elder, don’t pray often enough, don’t feed my spirit as often as I should, can’t seem to do it on a regular basis, keeping balanced lifestyle.
- “Lack of Knowledge” includes not being aware of spiritual events/activities, not knowing what is best for me/not knowing enough/need to know more because want to do more/wanting to learn/want to become more spiritual, confused between religions, don’t know how to access an elder, trying to understand it, where to connect with elder.
- “No Belief System” includes no goals and need something to believe.
- “Broken Spirit” includes lost identity, keeping spirit alive, inner self-healing, spirit dead, because of past events, past hurts, spiritual emptiness, healing wounded spirit, back sliding into the dark side, finding the right way and path through healing, healing within myself, losing identity/language, seeking my Aboriginal identity, not knowing who I am as an Aboriginal women, learning culture not ready yet/not being able, to pass on Aboriginal traditions to my children, feeling better about self.
- “Sharing Problems” includes not sharing enough with Aboriginal people.
- “Family Issues” includes family using bad medicine.
- “Time/Money Issues” includes lack of time and money to do things/finding the time.
- “Addictions” includes drug use, marijuana use, alcohol use and addictions.
- “Other” includes difficulty accessing true, real spiritual leaders, choosing an elder that’s true and good can’t stay in sweat lodge because it’s too dark and hot, sweats, people not taking our spirituality seriously enough, wellness of other people, dreams.

**Figure 5: Spiritual Activities**



**Note:**

“Sharing Circle” includes healing circles

“Praying” includes meditation and solitary reflection

“Abor. Unspecified” means attended aboriginal ceremonies but not specified

“Other Aboriginal” means other Aboriginal Ceremonies including Feasts, Sundance, pipe ceremonies, full moon ceremony, medicine picking, medicine wheel, healing programs, four directions, letting go ceremony, helping out, teachings, elder teachings

“Church” includes watching church programs on television, attending church, listen to spiritual music, attending Bible studies in group, attend Roman Catholic church, celebrating Christmas, Easter and attending church weddings, funerals and baptism

## **General Health And Wellness Issues**

### *Top Health Concerns*

When the women considered their physical, emotional, intellectual and spiritual health concerns in combination, they reported that fitness (29%) was their major health concern followed by depression (28%) and diabetes (21%). Almost one third of the women reported health concerns that were entirely different from the top three health concerns reported in the earlier part of the questionnaire. These concerns along with bone and muscle problems (17%), cancer (14%), heart/stroke (13%) were also significant concerns but to a lesser degree than fitness, depression and diabetes. Figure 6 on the next page provides a summary of these results.

### *Top Health Needs*

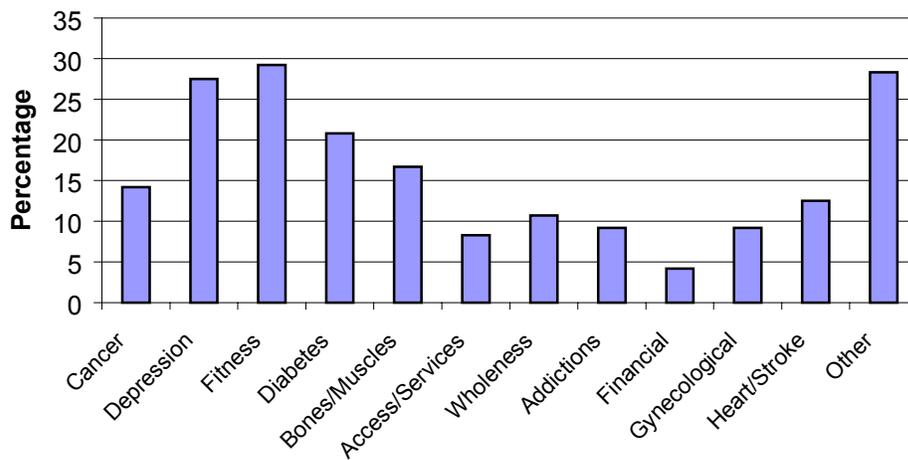
A lot of the women could not differentiate between their health concerns and their health needs as the two concepts are closely related. When the women considered their physical, emotional, intellectual and spiritual health concerns in combination, they reported balance in their life (26%) as their top health need followed by treatment and services for depression (22%), having their nutritional needs met (23%) and improvement to access and services (23%). Almost half of the women reported other health needs that were significantly different from the top three health needs reported earlier in the questionnaire. These results are recorded in Figure 7 on page 45.

### *Stress Relief*

The women were also asked "What do you do to relieve stress?" Stress relief is an important component of health and wellness as it has the propensity to alter the physical, emotional, intellectual and spiritual aspects of an individual's life. The vast majority of women (93%; N = 112) reported participating in activities to reduce their stress levels. Eight women either did not respond to the question on stress relief or did not participate in stress reducing activities. The majority of women (79%; N = 88) reported using positive stress relief strategies such as engaging in vigorous activities, relaxation

techniques and personal support. One fifth of the sample reported activities that might be considered negative such as smoking cigarettes, getting high, drinking alcohol, smoking a joint, taking medication such as sleeping pills, tranquilizers and antidepressants. These results are presented in Figure 8 on page 46.

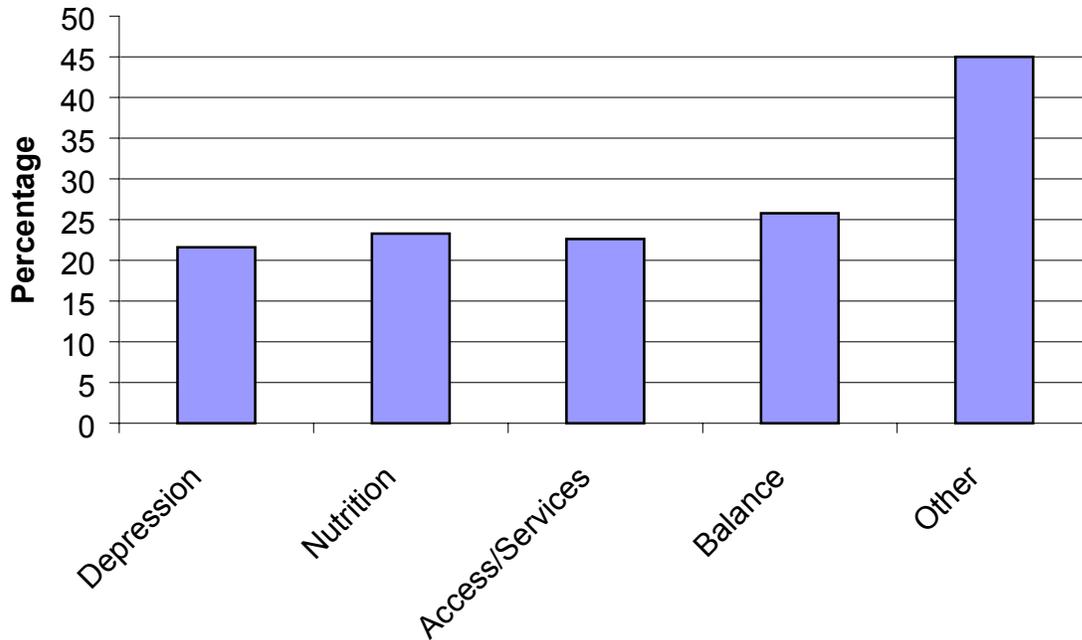
**Figure 6: Top Health Concerns**



**Note:**

- “Cancer” includes breast, ovarian, family history, lung, and cervical cancer.
  - “Depression” includes mental problems, anxiety, emotional pain, panic attacks, grieving insomnia, stress and bipolar
  - “Fitness” includes increasing physical activity, lack of exercise, over weight, heavy appetite, and nutritional concerns.
  - “Bone/Muscles” includes joint, feet, leg, back, shoulder, wrists and hip pains, carpal tunnel, osteoporosis and arthritis
  - “Access/Services” includes availability of qualified doctors who understands Native women, availability of traditional healers, lack of access to physician, lack of supports in the health, profession, doctor rushed, too much prescriptions and not enough talk.
  - “Wholeness” includes wholeness of self, health well being, lifestyle concerns regarding the body, mind, spirit, losing touch with spiritual needs, spiritual, mental, physical and spiritual disconnection, lack of education.
  - “Financial” includes not enough money, stress on social assistance, stress in general, medications too expensive.
  - “Addictions” includes smoke addictions (only 2 women reported drug/alcohol addictions)
  - “Gynecological” includes birth control needle, having a health of baby, gynecological problems, infertility possibility, yeast infection, abortions, pregnancy issues, dental, root canal while pregnant, menopause, aging and accepting it.
  - “Heart/Stroke” includes high blood pressure.
  - “Other” includes five responses or less to such conditions as stomach problems, intestines, headaches, dizziness, lung problems, high cholesterol, decline in sexual appetite, anemia, vision problems, primary biliary cylorais, hyper thyroid, thyroid condition, hepatitis c, allergies, hemorrhoids
- Only one person reported that she did not have any health concerns.

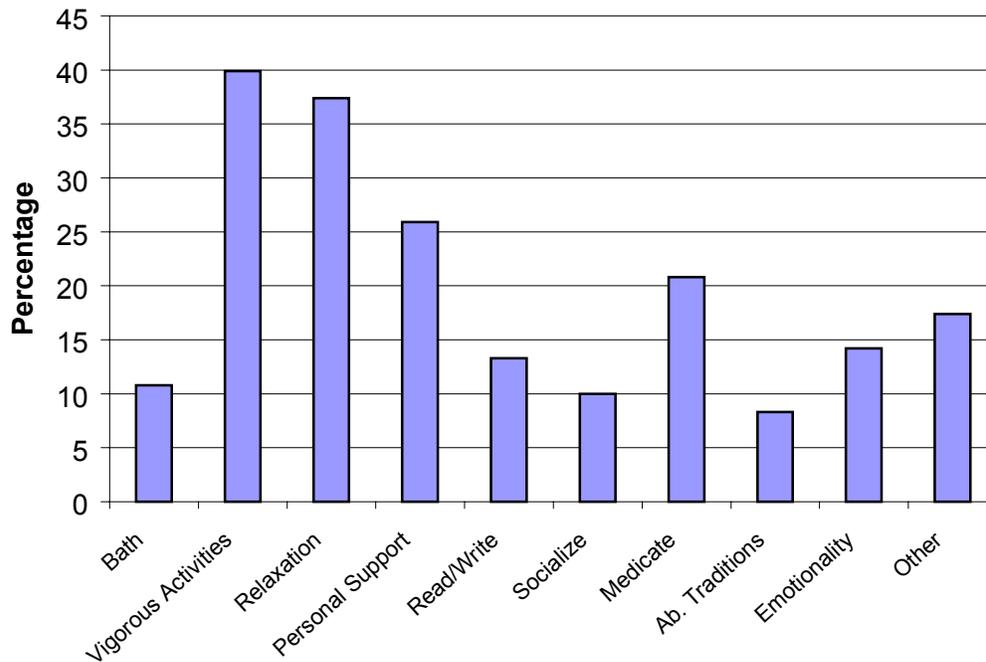
**Figure 7: Top Health Needs**



**Note**

- “Depression” includes emotional help, having a counselor available when needed, peace of mind, someone to listen to problems, affordable emotional care, anxiety, aggression, lack of coping mechanisms
- “Nutrition” includes better access to fresh food, nutrition, good food, more money for healthier food, dietician, diet, nutritional diet, more money for better food, clean water, weigh control, need to lose weight
- “Access/Services” includes having my Dr. listen, caring doctors/nurses, good doctor, having doctor available when needed, understands me, regular access to doctor, no long waits to see Dr., getting proper care, doctor’s willing to do paper work, health programs for native women in all areas, stop smoking programs, liaison between patient and system, access to cultural programs, addiction programs, access to better complete screening, taking proper tests, more women doctors, gynecologist and midwives.
- “Balance” includes more exercise, overall physical well-being, medical balance, spirit, mental, physical access to gyms, physically being well, staying in touch with my spiritual.
- “Other” includes five responses or less covering such things as cancer (ovarian, cervical, breast), anemia, iron injections, dental care, head pains (MRI), taking care of diabetes, heart attacks and stroke/heart problems, pain killers/medications/proper prescriptions, more education/literature, more rest/less stress/proper sleep/rest, quit smoking/breathing problems/lungs, lower cholesterol, glasses/eye sight problems, child doctor/support with family/children/pregnancy issues, don’t know/don’t have any, better housing/living in safe environment, hepatitis c, back problems, walking problems, joints, feet, wrists, allergies, better hygiene, clean house, making time for checkups.

**Figure 8: Stress Relief**



**Note:**

“Vigorous Activities” includes long walks, vigorous exercise, house cleaning, keep busy, house renovations, play with kids, bike ride, swim.

“Relaxation” includes refocus attention, meditate, breathing exercises, relax in a dark room, self talk, stretching, concentrate, forget about problems, don’t let no one bother me, walk away from stressful situation, except it, time out, breaks sleep, rest, lay around, get enough sleep, count to ten.

“Personal Support” includes talking to a friend, family support system, vent to someone close, get angry at strangers arguing with friends and family.

“Read/Write” includes writing in a journal.

“Socialize” includes getting a massage, going to galas, concerts, bingo, church, movies, take time for self, just going out and out with friends.

“Medicate” includes smoking, getting high, drinking alcohol, smoking a joint, taking medication such sleeping pills, tranquilizers and antidepressants such as Paxil.

“Ab.Traditional Activities” includes talking to an elder, attending healing programs, counseling, sweats, sacred teachings, smudge ceremonies, and taking traditional medicines.

“Emotionality” includes yelling as loud as possible, screaming, crying and laughing.

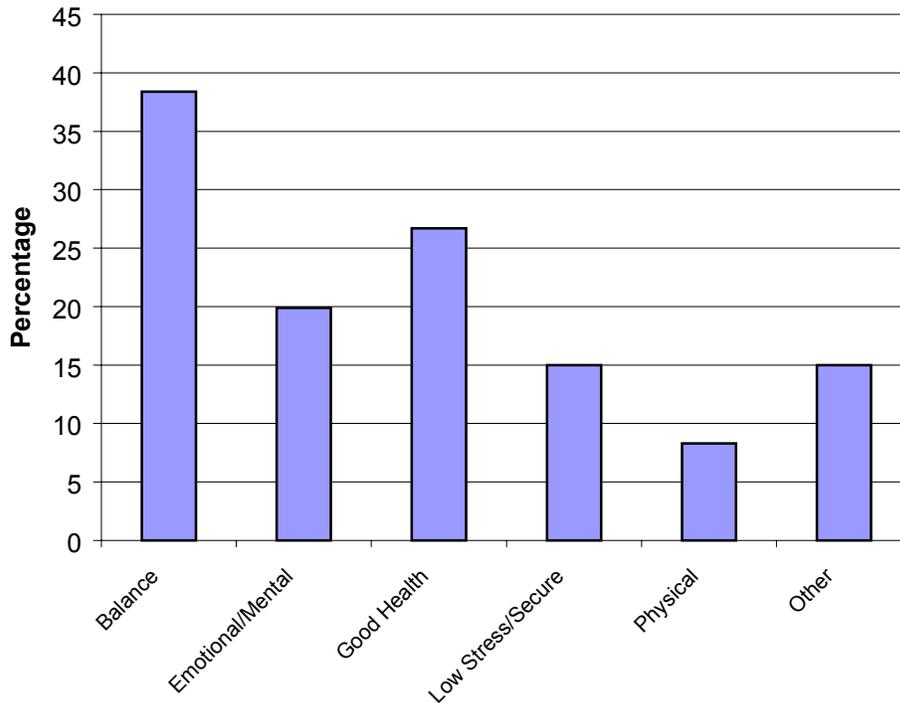
“Other” includes those answers with less than a 10% response rates combined (i.e., gardening, listen to music, have sex, eat, buy beauty products to make myself feel better, nothing, hit/, play cards, watch television, knit, crochet).

*Wellness*

The women were asked “what does wellness mean to you?” Eighty four percent (N = 101) of the women responded to the question. The majority (38%) of the women’s responses reflected the holistic nature of Aboriginal traditions as balance across the physical, mental, emotional and spiritual dimensions, being well in your wheel and life, connected, feeling good inside and out, holistically, and wellness in all

aspects of life were mentioned most often. It was evident that the women also felt that good health (27%), emotional/mental health (20%), low stress and feelings of security (15%) were all related to their wellness. Findings are presented in Figure 9.

**Figure 9: Wellness**



**Note:**

“Balance” includes being balanced, well in your wheel and life, mental, physical, emotional, and spiritually balances, feeling good inside and out, holistically, wellness in all aspects of life, being at all levels of the wheel, complete sense of balance, /being aware of all aspects of self/taking care of your whole being

“Emotional/Mental” includes feeling good emotionally and mentally, feeling good about self, being happy, feeling well, a state of being well, enjoying life, how we feel in order to deal with day to day situations, being able to live life to fullest without any obstacles/happiness, being satisfied with my life/emotional health, feeling confident, being able to stayed focused on goals, being able to control diabetes

“Good Health” includes getting health concerns met, getting better, being healthy, seeking professional, help, to better yourself, being healthy mentally, spiritually, emotionally, seeing your doctor for diagnosis, health in all areas,

“Low Stress/Secure” includes minimal stress, free from worries, calm, relaxed, peace of mind, having enough money to get by so no worry, feeling secure, overall contentness. coping with it all, being comfortable at home and living well.

“Physical” includes eating healthy, being physically active, well, energetic, feeling well physically

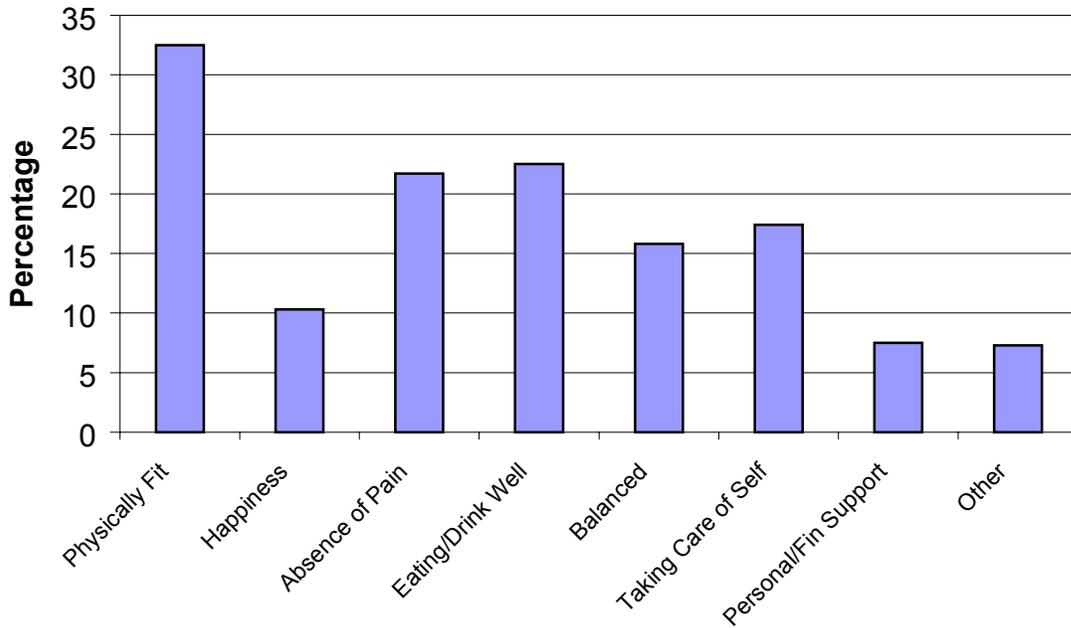
“Other” includes responses made by less than five women (i.e., dealing with past/present abuse history, to heal, to be fully accepted, lack of physical and mental pain, to help others, to be loving, honest and respectful, live long, being clean, don’t know but it means a lot to me).

*Good Health*

The women were also asked to define good health. The majority (33%) of women felt that good health was related to physical fitness. Over 21 % of the women reported absence of pain as defining good

health, eating/drinking well (23%), and taking care of self (17%). These results are not surprising considering the medical profession’s and the media’s emphasis on the physical aspects of human beings. In line with Aboriginal traditions, a significant minority (16%) of the women mentioned being balanced in their definitions of good health. Figure 10 provides a summary of these findings.

**Figure 10: Health**



**Note:**

- “Physical Fitness” includes physically feeling good /fitness/feeling, well, healthy, healthy body, being fit, feel better, good physical health, in shape, feeling of well being even through difficult times, keeping yourself emotional, spiritual and physically fit/feeling well on daily having energy to move freely/being active/ability to work and to do what you want to do/ability to function well/ability to talk about problems/health concerns and issues controlled, exercising regularly, walk a lot/walking
- “Happiness” includes being content, feeling great, laughter, feeling good about self
- “Absence of Pain” includes free from pain and sickness, no mental pain, no illness/no problems with the body, no health concerns
- “Eating/Drinking Well” eating healthy foods and clean water intake/eating, well, 3 meals a day/food from all good, groups/balanced diet/eating well/eating properly maintaining decent body weight/watching fat intake/being right weight.
- “Balanced” includes balanced physically, emotionally, mentally and Spiritually/looking after all parts of yourself is a sign of health living/perfect balance/well balanced life, all your being in balance.
- “Taking care of self” includes thinking about one’s self, staying in touch with your self, feeling good about self, good hygiene, having wellness plan focused on prevention/pap test, awareness of health issues, less visits to doctor, seeing doctor weekly, proper medication, paying special attention to any concerns, going to the doctor regularly so the doctor can help you being spiritual, having faith/, spiritual well
- “Personal/Fin. Supports” includes have adequate resources (financial, etc.), personal support system, stress free, no worries, feeling loved
- “Addiction Free” not abusing alcohol/drugs, alcohol free, no medications, no tobacco, no smoking
- “Other” includes having basic needs met, good eyesight, strong mind, respecting other people, giving positive feedback, being successful, proper rest, fresh air, looking good, healthy skin.

## Project II

### **Methods**

#### **Participants**

Ten Aboriginal women agreed to be interviewed for this study. The sample was drawn from the Aboriginal community in the City of Winnipeg using a snow-ball sampling procedure. The demographic information on the participants indicates that all but one of the women was employed and all but one of the women either had completed Grade 12, college or a university education.

#### **Materials**

A semi-structured interview protocol was created and used to compile interview data for this study. The protocol consisted of two parts. The first part was designed to gather demographic information and included questions such as "What is your age" and "What is your Aboriginal Status?" The second part consisted of 16 open ended questions designed to explore women's health and wellness experiences. Examples of some of the questions include: "What does wellness mean to you? How would you define good health? Do you consider yourself to be a well person?" and "What do you perceive as your biggest barrier to obtaining and maintaining optimum health and wellness?" Please see Appendix 6 for a copy of the Interview Protocol. An informed consent form was also used in this component of the study. Please see Appendix 7 for a copy of the consent form.

#### **Procedures and Research Design:**

The research methods for project II were deemed ethically appropriate by the research ethics committee at Athabasca University. Please see Appendix 4 for the letter of ethical approval. Once the women agreed to participate a time and place was established to conduct the interviews. The interviews were tape-recorded and took place in either the woman's home (N = 2) or at her work place (N = 8). Because one of the women interviewed was an elder and medicine woman, tobacco was presented to her before the interview. The other women did not receive compensation for participating in the study. All

women read and signed the informed consent form prior to beginning. Each of the interviews lasted approximately one hour.

**Results**

The first two questions of the second part of the interview protocol were analyzed for this report. These questions relate to the primary research question on defining the unique characteristics of well being for Aboriginal women and to assessing what health means to them. The remainder of the research questions focus on prioritizing Aboriginal women’s health needs and concerns and exploring their experiences with health care services. A thorough content analysis of the entire interview data will be conducted at a later date. Due to technical difficulties the first part (questions 1-3) of one of the interviews was lost. Therefore the analysis presented here includes data from nine interviews. The results, including some direct quotations of the respondents follow. The dominant key terms extrapolated from the responses to Question 1, “What does wellness means to you” are summarized in Table 2 along with associated response rates.

**Table 2. Wellness Themes and Response Rate**

<b>RESPONSE</b>	<b>RESPONSE RATE</b>
Balanced holistically (physically, mentally and spiritually)	55 %
Physical Health/Freedom from pain and sickness	44 %
Awareness/realization/understanding	11 %
Connection	22 %
Comfortable	11 %
Overall well-being	11 %
Self-care	33 %

Note:  
N = 9

### Holistic Balance

An Aboriginal traditional worldview, as evidenced in the summary Table 2, was represented in most of the women's responses either directly or indirectly. For example, most of the participants thought wellness related to the holistic balance of all aspects of their being. Some of the women's responses included:

*Physical wellness, mental wellness, emotional wellness, all those thing;*

*My emotional well-being, spiritual well-being, physical and mental. It's all of those areas that make me..if one of those is out of kilter, I'm not well;*

*It could be..physical wellness, mental wellness, emotional wellness, all those things. I guess if one isn't well it could be I don't know, mental, there is a lot of our people that are not mentally well;*

*being a human being.....being aware of their body, mind and their spirit all at once; and*

*Living comfortably in mind, body and spirit. It took me a long time to get well from the way I was. I'm an alcoholic and a drug addict...I use to get all that from boarding school stuff. A lot of crying a lot of talking and workshops.*

### Physical Health, Freedom from Pain and Sickness

Four of the participants thought that wellness related more to the physical side of being human. They stated,

*It means not being sick, not being sore and just being in good health;*

*Freedom from pain;*

*That you are capable of performing everyday things; and*

*What ever the community or medical plans can give you to make you healthy.*

### Awareness

Two women thought wellness related to the mental/intellectual aspects of being human. They stated,

*being aware of their body, mind and their spirit all at once and coming to a realization that in their life those are the three areas that gives them life and provides them life as they need have an understanding that they need to look at those parts of themselves and that doesn't happen when*

*you got poverty issues and are just trying to food to the table for your child and those kinds of things are usually not considered by people that live in poverty;*

*Living comfortably....to deal with life you need a good sense of humour; and.*

*being aware of who you are, how you heal and being comfortable with who you are.*

### Connection

In line with Aboriginal traditional values, two of the nine women mentioned that wellness was related to various sorts of connection in their life. One woman stated,

*A big aspect of wellness is that connection to the creator of their beauty and Wonderfulness; and*

another woman reported the connection between her home and work life and the connection between herself and her children. She stated,

*If you don't have good health at home how can you have it anywhere else? If your home environment isn't good how could you have a good relationship with other people anywhere else? If you're not happy at home and you're miserable at home, how could you go to work everyday and pretend to be happy?; and*

*My children are grown up an doing well, You know their not sick, they all have good jobs, they are all into something. My grandchildren are all happy.*

### Self-care

A few the women also thought wellness coincided with self-care. They stated,

*It means be able to take care of yourself and support myself. Being able to dress, being able to get groceries, clean my house and have a bath and being able to be positive in life;*

*To me it means to look after yourself and if you have a doctor's appointment make sure you attend to the appointment; and*

*It's a person's own responsibility for their wellness, they have to own up to them, they have to explain to the doctor what is wrong with them.*

### Overall Well-being

One woman felt wellness related to well-being. She stated,

*Wellness is overall well-being.*

It seemed difficult for the women to articulate their thoughts on wellness and they often used the terms “wellness” and “health” interchangeably. The results indicate the women felt health and wellness were inherently related but it was evident that the women were also aware that there was more to the concept of “wellness” then readily meets the eye as an Aboriginal worldview resonates through much of their responses.

The key terms found in the responses to Question 2, “How would you define good health?” are presented in table 3.

**Table 3.**

RESPONSE	RESPONSE RATE
Holistic balance	77 %
Mentally Feeling/good/happy	11 %
Self care	22 %
Physically fit/pain free/exercise/ability	55 %
Free from Poverty	11 %
Awareness	22 %
Identity	22 %
Wellness	11 %

Note:  
N = 9

Holistic Balance

The discussions on defining good health were lengthier and resulted in a greater number of responses related to holistic balance than did the discussions on “wellness”. This finding might indicate that women are more familiar with thinking about their “health” rather than thinking in terms of their “wellness”.

Some of the women’s responses to this question included,

*Your body is in balance....When I think about it, it is like a degree or range, you know, 0 probably being poor health and 10 being optimum health and when your optimum your body may be 9. The scale being your body, your mind, your mental being and your spiritual;*

*Not only physically good health, but emotional good health;*

*Addressing all four areas, requires me to start digging a little deeper. What have I not dealt with? What am I not eating right? What am I taking too much of? If your emotional*

*being is not right and you are carrying a lot of burdens... when you don't address certain areas it affects other areas in your life and your health starts failing miserably;*

*I think that health can be had by anyone no matter what his or her situation, again to me it's being aware of your mind, body and spirit....If you can awaken the spirit within you and live from that you could begin to think in a different way;*

*Good health is physical or good health is mental. Good mental health is a totally different field I find because even though my body may not be able to do all those things my mental health is good but my physical health is really the pits but I keep my mental health going;*

*I guess there are different aspects of good health like to physically have good health, mentally have good health. There is a balance there. Ideally good health is to be physically fit, have a sound mind and having an idea of who you are; and*

*I would define good health like physically, emotionally, spiritually well.*

### Mentally Feeling Good

One participant focused on the mental aspect of health. She stated,

*Well, I think you have good health when you feel good. If you feel good yourself, people around you know it. You're happy with who you are.*

### Physically fit/Pain Free/Exercise

Most women also focused on the physical nature of health. They stated,

*Good health is important; doctor has to specify that you are in good health, ....feeling good health, no heart pains, since my mother passed away knowing that I could pass my bowels properly;*

*Physically it would be pain free;*

*Good health means to get things done its part of being human;*

*being able to exercise, to be able to move to be able to do things that are constructive for yourself and your children; and*

*Being able to forgive yourself as a person, being able to eat what is healthy for you, being able to exercise.*

### Self care

Two women felt that health was related to self-care. They stated,

*For me good health means .....you take good care of yourself; and*

*Be good to yourself and be good to others.*

### Free from Poverty

One woman mentioned the connection between health and poverty. Her statements epitomize the struggle Aboriginal women face as they try to achieve good health and wellness in their lives. She stated good health,

*means being able to live your life free of poverty. Money doesn't buy you happiness. You could still have a pretty miserable life with your money and not be able to enjoy your life; and*

*I've always struggled all my life trying to be okay, trying to live this life and get off welfare and have a job. (Is this second quote from the same woman?)*

### Awareness

Two women mentioned the relationship between health and the mental/intellectual faculties.

They stated that health means

*Being aware of your mind, body and spirit; and*

*But to me good health was waking up in the morning and knowing what you did the night Before. Dealing with the day, how you dealt with it and what you leave behind when you go to bed at night.*

### Identity

Two women also mentioned the relationship between an individual's identity and health. They stated, health was being,

*happy with who you are; and*

*having an idea of who you are. I guess that's it is hard to find out who you are as an Aboriginal person because of white man's society.*

### Wellness

One woman discussed the link between health and wellness. She stated,

*Health and wellness going hand in hand, without your health you don't have wellness.*

## Discussion

Overall, both the qualitative and quantitative results of this study are encouraging. Findings from the survey, for example, indicate that the majority of Aboriginal women considered themselves to be physically (61%), emotionally (62%), intellectually (79%), and spiritually well (68%). This is surprising given that the majority of women also reported that they were unemployed (63%), single (55%) not supported by a spouse (75%), and had dependent children (69%). And, of the 36% of the women who reported working either full-time, part-time casual or self-employed, 67% reported that their annual earnings were less than \$20,000/year. According to the United Nations HDI discussed earlier, the poverty line for single parent families with two or more children is less than \$22,000/year. Much controversy exists concerning poverty measures but Statistics Canada (2003) low income cut-offs (LICO) have been reported to be the measure used most often in Canada as a measure of poverty because other official measures do not exist (Donner, 2000). According to LICO, in 2003 the poverty line after tax for four persons living in a city the size of Winnipeg was \$ 25,755 (Statistics Canada, 2003). The majority of women in the current study live well below the poverty line which is consistent with other studies that found "poverty is endemic in Aboriginal communities" (Donner, 2000, p. 8). The Social Planning Council of Winnipeg (SPC) also uses the LICO to determine its poverty statistics and has noted the connection between child poverty and single female parents. One issue of the Poverty Barometer, a SPC newsletter, stated that "seventy percent of poor children live with a single mother" and "the child poverty rate in Manitoba is 22.5%, almost 7% higher than the national rate" (Social Planning Council, 2004, p. 2)

Accordingly, 69% of the women participating in this study reported that they had dependent children and 47% of these women stated that they had two or more children. These findings suggest that these women would be placed below the poverty line according to the HDI index and the LICO. The literature reviewed for this study indicates that poverty is a serious concern in Aboriginal communities, particularly for Aboriginal women (Bartlett et al, 2004; Deiter & Otway, 2003; Dion Stout, et al., 2001; Donner, 2000; Statistics Canada, 2003; Wilson, 2004). Donner (2000) and her colleagues found a

definite connection between income, social status and health even though they “may not have a detailed understanding of the mechanisms by which income and social status affect health” (p. 4). The disparities resulting from low income and social economic status are worse for Aboriginal women who are more likely than Non-Aboriginal women and Aboriginal men to live in poverty (Statistics Canada, 2003). In fact, Dion Stout and her colleagues (1995, 2001) found definite connections between socio-economic status, education and employment condition. Furthermore, although the majority of women in this study reported that their nutritional needs were being met, the results of other studies indicate that these results do not apply to all Aboriginal women. The women in one study (Deiter & Otway, 2003) reported that “their nutritional needs were not being met and some stated when food supplies were low, they would go without food to ensure their children were well fed” (p. 18). That the women in this study reported overall wellness across their physical, emotional, intellectual and spiritual beings despite their low socio economic conditions points to at least two possibilities. Firstly, unknown factors are contributing to their well-being or secondly, they are not reporting exactly how they feel due to wanting to please the researcher or wanting to be colored in a positive light.

On a positive note, the demographic information shows that more than 50% of the sample completed Grade 12, college or a university education. If level of education is related to intellectual well-being then the demographic information corresponds to the data on intellectual well-being. Most of the women (79%) considered themselves to be intellectually well, read on a regular basis and stated that they possessed a library card. Only a few intellectual health concerns were mentioned and only 11% of the participants reported low education as an intellectual concern. These positive findings might be a result of society's emphasis on increased education and training in the Aboriginal community. Unfortunately, 43% of the sample still reported having less than Grade 12 education and 12% reported having less than a Grade 8 education which points to the need for continued attention in these areas. Education, employment and income are important determinants of health but unfortunately a recent study that compared visible minorities, Aboriginal people and Non-Aboriginal found that “of all groups, Aboriginal

peoples are the most disadvantaged in education, employment and income” (Kunz, Milan & Schetagne, 2000, p. 13).

Although many (61%) of the participants reported that they considered themselves to be physically well and had not been diagnosed with a major physical illness in the last the last three years (72%), the majority of women also smoked (69%) and over half of the women reported that they did not exercise on regular basis. Given the link between lack of exercise, obesity, smoking and major illnesses such as heart disease, stroke and all sorts of cancers this news is disturbing. As well, half of the women reported having minor physical health problems such as the cold and flu and gynecological problems (e.g., benign ovarian cysts, yeast infections) in the last three years. It appears however, that the women are aware of the link between lack of exercise and physical health, in particular, and overall health problems in general. Physical fitness and mobility issues were the top two physical health concerns for this group of Aboriginal women. Diabetes which was reported by Health Canada (2001) and the MFNRHS (Centre for Aboriginal, 1998) to be a major health concern for Aboriginal women, ranked third in health concerns in this sample and was reported just slightly more times than cancer and other major physical illnesses (e.g., asthma, lung infections, kidney problems, hepatitis c). Of course overall physical fitness is related to diabetes, but it is still significant that the women mentioned their concern for issues related to their weight, poor nutrition and lack of exercise. The results of this study closely approximate the results of the APS which reported that diabetes was a major concern for older urban Aboriginal women and “the six most prevalent chronic conditions for the North American Indian, Métis, and Inuit populations were; arthritis or rheumatism; high blood pressure; asthma; stomach problems or intestinal ulcers; diabetes; and heart problems” (Statistics Canada, 2003, p. 4).

Unfortunately, only 6% of the sample in this study mentioned that they were concerned with their smoking habit and only 4% of the sample were concerned with stress and addiction issues. The latter statistic coincides with these addiction responses. Only 26% of the women reported they were addicted to drugs, alcohol or other substances which explains why this did not appear to be a concern for them. However, no explanation exists as to why smoking was not more of a concern to these women given the

great amount of anti-smoking publicity in Manitoba. As well, research indicates that the prevalence of smoking declined overall for both sexes and in all age groups except those ages 15-24, between 1985-2001 (Gilmore, 2002). Given the findings from the current study, a closer look at Aboriginal women's smoking habits is warranted.

On another positive note, a striking majority of women (93%) stated that they participated in activities geared toward stress reduction. This factor might also contribute to their sense of physical and overall wellness. Unlike this sample of Aboriginal women and the participants in Wilson's (2004) study who tended to report more positive physical and overall health, the women in other studies reported that they "felt discouraged and had a general dissatisfaction with their body image due to obesity and loss of their youthful vitality" (Bartlett, 2004, p. 62) and "very few respondents" in Deitier and Otway (2003) study reported that they were healthy (p. 19). These conflicting findings point to the need for more research in these areas.

There appears to be a serious lack of concern for Aboriginal women's emotional well-being. Most of the research conducted to date on Aboriginal women's health does not go into any great detail on the topic of emotionality, including issues related to depression and anxiety, even though depression seems to be a major concern for Aboriginal women. Kirmayer, Brass and Tait (2000) found a high prevalence of mental health problems in Aboriginal communities that "can be related to the effects of rapid culture change, cultural oppression, and marginalization (p. 614). They concluded that "local cultural concepts of the person, self, and family that vary across Aboriginal communities" must be adopted to address the high rates of depression and that "there is evidence that local control of community institutions and cultural continuity may contribute to better mental health" (p. 614). Although the majority of women (60%) in this study also considered themselves to be emotionally well, almost half of the sample reported suffering from a mental health illness such as depression or anxiety in the last three years. As with their physical health, the women are very aware of their emotional health issues. Depression (31%), anxiety (12%) and stress/worries (126%) were reported to be their top three emotional health concerns. As well, when asked to state their top three health concerns and needs when considering

all aspects (e.g., physical, emotional, intellectual and spiritual) of themselves together, depression (27%) ranked second to fitness (29%) as a major health concern. Diabetes (21%) was the women's third major health concern when considering all aspects of their being. When they were asked to state their top three health needs, all things considered, treatment and services for depression (22%) were reported just slightly less than their top three health needs. Achieving balance in their life (26%) was their top health concern followed by having their nutritional needs met (23%) and improvements to access and health and wellness services (23%).

The results of this study pertaining to emotional health support the general consensus of other studies where depression is expressed by Aboriginal women as a serious concern (Deiter & Otway, 2003; Donner, 2000). Indeed the majority of participants in one study "saw depression, low self-esteem and feelings of low self-esteem and feelings of low self worth to be attributed to poverty" (Donner, 2000, p. 10) and "depression was mentioned many times" in another study (Deiter & Otway, 2000, p. 20). Unfortunately poor emotional health is a common theme that runs through the literature on Aboriginal women's health. The effects of colonization, residential schools, poverty, gender inequities and discrimination are the leading contributors to these devastating statistics. Lane and his colleagues (2002) for example, completed an extensive research report based on community-based consultations with two Aboriginal communities located in Manitoba (i.e., Hollow Water and Waywayseecappo First Nations) and four other Canadian Aboriginal communities. Although gender differences were not accounted for, they mention that trauma associated with colonization is manifested in the behaviour of Aboriginal individuals who indicate they "can't maintain intimate relationships, can't trust or be trusted, can't work in teams with others, can't persevere when difficulties arise, can't function as parents, can't hold a job and can't leave behind harmful habits such as alcohol and drug abuse or family violence" (p. 9). All of these negative behaviours can seriously affect an individual's emotional and overall health. On the topic of negative behaviours associated with colonization, the participants in Wilson's (2004) study mention the destructive force of "jealousy" that seems to persist in Aboriginal communities. One woman stated,

*"we're not happy for someone's success – we're jealous! That stems from our historical*

*treatment – now we're doing it each other, as Aboriginal people. The Metis against First Nations, First Nations against each other, family against family" (p. 18)*

Jealousy and other negative thoughts and behaviours have created unhealthy Aboriginal communities. The findings from the current study, in addition to findings from other studies, indicate that more work needs to be carried out in areas concerning Aboriginal women's health in the emotional realm if they are ever to achieve a suitable level of well-being.

Like the women in Wilson's (2004) study who reported having rich spiritual lives, most (68%) of the women who participated in the current study also considered themselves to be spiritually well. The majority of them (64%) stated that they participate in spiritual activities on a regular basis. This is good news and is a clear reflection of the work and dedication put forth by members of the Aboriginal community in the City of Winnipeg as they create, develop and enhance the opportunities to participate in Aboriginal cultural activities for these women and the entire community. That being said, the top three spiritual health concerns reported by the women relate primarily to their lack of knowledge about their spirituality and Aboriginal cultural activities. A lack of participation in spiritual activities was the first major spiritual concern mentioned by the women. The primary reason for this concern is not the absence of desire to participate; it is that they are unaware of where to go to find information on their spirituality, culture and Aboriginal traditional activities. Some of their written comments reflect these findings:

*"not being aware of spiritual events and activities, not knowing what is best for me, not knowing enough, I need to know more because I want to do more, I want to learn, I want to become more spiritual, I don't know how to access an elder, I'm trying to understand it.*

Some the women's written comments also indicate the concerns they wanted addressed through

Aboriginal spiritual activities:

*keeping my spirit alive, healing my inner self, healing a dead spirit that is dead because of past events, recovering from past hurts, spiritual emptiness, healing wounded spirit, back sliding into the dark side, finding the right way and path through healing, healing within myself, losing my identity, losing my language, seeking my Aboriginal identity, not knowing who I am as an Aboriginal women, learning culture, not being able to pass on Aboriginal traditions to my children.*

Addictions were mentioned in this category as well but were not a spiritual concern for most of the women.

Regarding theoretical implications, acculturation theory would predict that the women who were more assimilated or acculturated would have better health and would experience higher levels of wellness compared to those less assimilated. In this study, the majority of participants were Status First Nation (62%) and Métis (30 %) individuals who were fully or moderately assimilated (66%). It is impossible to tell if the assimilated women were the women who reported wellness across all dimensions or reported less physical health concerns than the women who were not as assimilated (35%) without doing further analysis. A comparative analysis of other health and wellness data would be required to determine whether Aboriginal women's overall level of health and wellness and their top three health concerns and needs are similar to that of men and mainstream Non-Aboriginal women. Regarding the former, feminist's theory would predict that Aboriginal men's health would be better than Aboriginal women's health. Few studies have been done that account for gender differences between Aboriginal men and women's health experiences. Therefore, the concerns and health and wellness needs of Aboriginal women have largely been lumped together with Aboriginal men's issues and concerns. For example, the MFNRHS final report was based on a sample that consisted of nearly 60% women. However, as Alex Wilson (2004) declared "the final report on the survey analyzes gender only with respect to four health indicators (self-reported health status, high blood pressure, diabetes and suicidal feelings" (p. 2). It is important to note then, that although the MFNRHS (Center for Aboriginal, 1998) found that Aboriginal "men generally report better health than women" (p. 73) differences were noted in limited areas and did not represent the holistic nature of being human.

The results of this study do not coincide with the results of the MFNRHS (Center for Aboriginal, 1998) indicating "approximately half of the people interviewed reported their health as poor to fair" (p. 27). As previously stated, a majority of women in this study reported they were well across all dimensions. The MFNRHS was based on both reserve and urban Aboriginal groups while most of the women participating in this study lived in an urban setting. This factor probably accounts for differences

in ratings. The results of this present study however, are more in line with the APS that found a high percentage of urban Aboriginal women reported a health status that was good or excellent. In any case, more research is needed in the area of Aboriginal women's health and wellness. In particular, research that can cut through the conceptualization problems associated with thinking about wellness as it relates only to health matters is needed.

## **Conclusion**

The primary intent of this research was to identify how Aboriginal women characterize wellness and to prioritize their health and wellness concerns. Basically, the Aboriginal women's health concerns and needs were not that much different than their ideas on wellness. The Aboriginal women who participated in this study indicated that their concerns centered on overall fitness, especially weight and nutritional concerns. In terms of their top three health concerns, fitness (29 %) was their major health concern followed by depression (28%) and then diabetes (21%). Their top three health needs were balance in their life (26%), having their nutritional needs met (23%), improvements to access and services (23%), followed by treatment and services for depression (22%).

Unique characteristics of wellness were hard to identify in this study because the women had problems differentiating between the terms "health" and "wellness" and as previously stated they often used the words interchangeably which was evident upon reviewing the survey data. This data shows an overlap among the responses to questions asking the participants to state what "wellness" means to them and when asked to define "good health". This same overlap is present in the qualitative data, gathered from ten educated, articulate women. Balance, free from physical pain, self-care, overall well-being and wellness were key terms found in the responses to both questions on health and wellness. No unique characteristic of wellness were identified. The women reported that their wellness was related to good health (27%), emotional/mental health (20%), low stress and feelings of security (15%) and clearly, the majority of women seemed to feel that their good health and wellness were related more to their physical side of being human than their spiritual, emotional and intellectual sides. It is important to note however,

that the holistic nature of Aboriginal traditions and worldviews were represented in all the response. The women were keenly aware of the need for balance across these spheres. The women's responses, however, seemed heavily influenced by the commonly held views on health and wellness that prevail in society. Many aspects of the social, economic, political, cultural and historical climate are determinants of health and wellness for Aboriginal women. A closer examination of the lived experiences of Aboriginal women is still needed in order to get a clearer vision of where they came from in the past, where they are presently and where they hope to be in the future. This examination must come from the Aboriginal community, free of bias and stereotypes that so often color what is focused on in research to the detriment of the issue at hand.

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## ***Appendix 1 – Overview, Poster, Letters of Intent***

### Letter of Intent/Recruitment and Overview (Mail out version)

April 12, 2004

Dear Survey Participant:

Research indicates that Aboriginal women suffer the effects of ill health at levels considerably higher than the rest of the population. Much of the research conducted on Aboriginal women's health relates to revealing the reasons for this discrepancy, but little or no research exists on aspects of wellness as it relates to Aboriginal women. This study seeks to answer questions that are very important to Aboriginal women's health and wellness. To this end, attached you will find a survey questionnaire, a stamped addressed envelope to return the completed questionnaire, and an overview of the project.

The survey contains questions related to the health and wellness of Aboriginal women and will take you approximately 30 minutes to complete. Through this survey, we hope to identify any unique characteristics of wellness and we also hope to identify and prioritize Aboriginal women's health needs and concerns.

Your participation in this study is completely voluntary and should you wish to decline, you are free to do so without consequence. The information you provide on the survey questionnaire will be kept confidential and individual responses will not be used in any way that can publicly identify you as a respondent. The data will be stored securely in a locked filing cabinet and/or on a password protected computer hard drive. All data will be destroyed five years after the completion of the study.

This research is being conducted for a Master of Arts project and that the results from this study will be contained in a report that will be submitted to Athabasca University's Master of Arts (Integrated Studies) Program. The findings may also be published in scholarly journals and presented at conferences. If you require more information please contact information is listed at the end of the attached overview document.

Warm regards,

Kathy Bent

Letter of Intent/Recruitment and Overview (In person script)

April 12, 2004

Dear Survey Participant:

Research indicates that Aboriginal women suffer the effects of ill health at levels considerably higher than the rest of the population. Much of the research conducted on Aboriginal women's health relates to revealing the reasons for this discrepancy, but little or no research exists on aspects of wellness as it relates to Aboriginal women. This study seeks to answer questions that are very important to Aboriginal women's health and wellness. To this end, attached you will find a survey questionnaire and an overview of the project.

The survey contains questions related to the health and wellness of Aboriginal women and will take you approximately 30 minutes to complete. Through this survey, we hope to identify any unique characteristics of wellness and we also hope to identify and prioritize Aboriginal women's health needs and concerns.

Your participation in this study is completely voluntary and should you wish to decline, you are free to do so without consequence. The information you provide on the survey questionnaire will be kept confidential and individual responses will not be used in any way that can publicly identify you as a respondent. The data will be stored securely in a locked filing cabinet and/or on a password protected computer hard drive. All data will be destroyed five years after the completion of the study.

This research is being conducted for a Master of Arts project and that the results from this study will be contained in a report that will be submitted to Athabasca University's Master of Arts (Integrated Studies) Program. The findings may also be published in scholarly journals and presented at conferences. If you require more information please contact information is listed at the end of the attached overview document.

Warm regards,

Kathy Bent

Attach.

## INVITATION TO PARTICIPATE IN A STUDY ON ABORIGINAL WOMEN'S HEALTH

Project Title: Aboriginal Women's Health: Mainstream And Alternative Approaches to Well-Being

### Overview:

A recent (2001) synthesis project on Aboriginal women's health provides evidence that shows Aboriginal women still "bear the burden of ill-health, premature death and marginalization to a degree unimaginable to much of the country's population" (Aboriginal Women's Health Research: Synthesis Project, 2001, p. 16).

This study seeks to answer questions that are vitally important to Aboriginal women's health and wellness. Firstly, is wellness the same for Aboriginal and Non-Aboriginal women? If not, what are the unique characteristics of wellness for Aboriginal women? No research exists on aspects of wellness as it relates to Aboriginal women. Another more fundamental question that has been answered to some extent by a few researchers, relates to identifying and then prioritizing Aboriginal women's health issues. This research attempts to address these concerns and may be of special interest to other women's health researchers and theorists, community developers, health care providers, policy makers, non-government and government funders and most importantly Aboriginal women. These questions will be answered through two projects.

In the first project, a short survey will be mailed and handed out to at least 200 Aboriginal women in order to identify and prioritize their health issues. The survey data will be coded to ensure confidentiality and statistical analysis will be conducted utilizing SPSS. Descriptive statistics and frequency counts will be the primary focus of analysis but relationships between some of the variables will also be noted.

Interview questions will be designed for use in project II that will capture Aboriginal women's life experiences and qualify the survey results. A non-random, snowball sample of 10 Aboriginal women who have utilized the services of Aboriginal Health and Wellness organizations as well as mainstream health organization such as Health Clinics and hospitals will be drawn and in-depth interviews will be conducted. Smudging ceremonies will take place before each interview to make discussion of intimate details of the women's lives more comfortable and to establish trust. The results will be analyzed for relevant themes in relation to the survey data, current services and traditional knowledge.

This research is being conducted for a Master of Arts project and will be completed under the supervision of Dr. Lynda Ross from Athabasca University. A final report will be submitted to Athabasca University's Master of Arts (Integrated Studies) Program, research participants if they desire a copy, and any other interested parties that will use the information in a manner deemed ethically competent. If you require more information or would like to review the entire project proposal, please contact me at the numbers listed below.

### Contact Information:

Lynda Ross, PhD  
Manager Special Projects

Kathy Bent, BA (Hons.)  
993 Kimberly Avenue

Office of the Vice President Academic  
Athabasca University  
1 University Drive  
Athabasca, Alberta, Canada, T9S 3A3  
Telephone: (780) 675-6824  
Email: [lyndar@athabascau.ca](mailto:lyndar@athabascau.ca)  
Fax: (780) 675-6186

Winnipeg, Manitoba  
R2K 3V7  
Telephone: 1 (204) 669-3214  
Email: [kbent@mts.net](mailto:kbent@mts.net)

## Agency Recruitment Letter Template

Date

Address

Re: Aboriginal Women's Health: Mainstream and Alternative Approaches to well-being Research Study

Dear:

My name is Kathy Bent and I am an Aboriginal woman from Little Black River First Nations, Manitoba. I am currently working on my final MA research project and wish to invite the staff and clientele of the Native Women's Transition Centre to participate in a study on Aboriginal women's health.

If you agree to have your organization participate in this study, I would like to distribute a survey on women's health to the staff and clientele of Native Women's Transition Centre by the end of April, 2004. Before this distribution takes place, I would need to post an invitation to participate in the study at your centre and consult with some of your staff members on how best to acquire data from your clientele. For an ethics review application, a hard copy and an electronic copy of a letter of support that states you agree to let me conduct this study at your organization is also needed as soon as possible.

Attached you will find an overview of the project and contact information. Any comments or suggestions you may have regarding this study would also be appreciated. If you require more information, please contact me at your convenience.

Warm regards,  
Kathy Bent  
Attach.



## ATTENTION ALL ABORIGINAL WOMEN INVITATION TO PARTICIPATE IN A RESEARCH STUDY ON ABORIGINAL WOMEN'S HEALTH

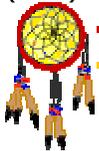
Project Title: Aboriginal Women's Health: Mainstream And  
Alternative Approaches to Well-Being

Aboriginal women bear the burden of ill-health,  
premature death and marginalization to a degree  
unimaginable to much of the country's population. This  
research study seeks to answer questions that are  
important to Aboriginal women's health and wellness.

Please help us to identify the health issues that affect  
Aboriginal women's lives by filling out a survey  
questionnaire. You can pick up a copy of the survey  
questionnaire at the following organizations:

Aboriginal Health and Wellness Centre  
Centre for Aboriginal Human Resource Development  
Mother of Red Nations Women's Council  
Urban Circle Training Centre  
Ma Mawi Wi Chi Itata Centre  
Native Women's Transition Centre

This research is being conducted for a Master of Arts project and is supported by grants  
from Athabasca University and the Prairie Women's Health Centre of Excellence. If you  
would like more information about this project please contact Kathy Bent by telephone at  
(204) 669-3214 or by email at [kbent@mts.net](mailto:kbent@mts.net)



## **Appendix 2 – Recruitment Script – Interview (the same script was used for the survey component but the information about the interviews was left out)**

My name is Kathy Bent and I am an Aboriginal woman from Little Black River First Nations, Manitoba. I am currently working on my final MA research project and was wondering if I could interview you for a study on women's health issues.

Research indicates that Aboriginal women suffer the effects of ill health at levels considerably higher than the rest of the population. Much of the research conducted on Aboriginal women's health relates to revealing the reasons for this discrepancy, but little or no research exists on aspects of wellness as it relates to Aboriginal women. This study seeks to answer questions that are very important to Aboriginal women's health and wellness.

The interview will be tape-recorded and will take about 1 hour to complete. Through this interview, we hope to identify any unique characteristics of wellness and we also hope to identify and prioritize Aboriginal women's health needs and concerns.

Your participation in this study is completely voluntary and should you wish to decline at any time during the interview, you are free to do so without consequence. The information you provide will be kept confidential and individual responses will not be used in any way that can publicly identify you as a respondent. The data will be stored securely in a locked filing cabinet and/or on a password protected computer hard drive. All data will be destroyed five years after the completion of the study. This research is being conducted for a Master of Arts project and that the results from this study will be contained in a report that will be submitted to Athabasca University's Master of Arts (Integrated Studies) Program. The findings may also be published in scholarly journals and presented at conferences. If you require more information please contact information is listed at the end of the attached overview document.

## Appendix 3 - Survey Questionnaire

### *Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-Being*

#### SURVEY QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Agency: \_\_\_\_\_

**Please check only one box.**

#### **Section I. Demographic Information**

The questions in this section are asking you to tell us a little bit about yourself.

What is your Aboriginal Status?

- First Nations       Metis       Inuit       Non Status       Other

What age group do you belong to?

- 18-25       26-30       31-40       41-50       51-60  
 61-70       71-80       81-90       Over 90

What is your marital Status?

- Single       Widowed       Divorced  
 Separated       Married Equivalent

What is your primary language?

- English       French       Aboriginal       Other

What is your degree of assimilation?

Fully = no contact with Aboriginal culture

Moderate = some, but very little contact with Aboriginal culture

Low = 50% or more of your time spent with Aboriginal culture including speaking the language

None = 100% of your time spend living with Aboriginal culture including speaking the language

- Fully  
 Moderate  
 Low  
 None

Are you currently supported by a spouse?

- Yes  
 No

Do you have dependent children?

- Yes  
 No

If yes, how many? \_\_\_\_

What type of community do you live in?

- Urban                       Rural                       Reserve                       Northern

What are your living arrangements?

- Alone                       With Parents                       With Relatives  
 With Partner                       Single Parent                       Live with Friends                       Other

What is your education?

- Grade 8 or less                       Less than grade 12                       Grade 12  
 University                       College                       Other

What is your employment status?

- Full Time     Part-time     Casual                       Unemployed                       Self Employed

What is your income level?

- Less than \$20,000     \$21,000 – 39,999     40,000 – 59,999  
 60,000 – 79,999     other

**Section II. Health Issues**

These next questions are going to ask you to describe your health. The questions have been divided into four sections asking about physical, emotional, intellectual and spiritual health.

a) Physical health

Do you consider yourself physically well?

- Yes  
 No

Have you been diagnosed with a major illness in the last 3 years?

- Yes  
 No

If yes, please check the appropriate box:

- |   |   |
|---|---|
| <input type="checkbox"/> Heart attack/disease | <input type="checkbox"/> Kidney problems                        |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Lung problems                          |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Bone and joint problems                |
| <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Eyes, nose, throat problems            |
| <input type="checkbox"/> Liver problems       | <input type="checkbox"/> Accident that required hospitalization |

Have you had any other physical health problems in the last 3 years?

- Yes  
 No    If yes, what kind? \_\_\_\_\_

Do you smoke?

- Yes  
 No

Do you exercise on a regular basis?

- Yes
- No

Are your nutritional requirements being met?

- Yes
- No

What would you say is your biggest physical health concern?

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b) Emotional Health

Do you consider yourself emotionally well?

- Yes
- No

Have you had a mental health illness in the last 3 years?

- Yes
- No

If yes please check the appropriate box:

- Depression
- Anxiety

Are you addicted to drugs, alcohol, or other substances?

- Yes
- No

What would you say is your biggest emotional health concern?

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c) Intellectual Health

Do you consider yourself intellectually well?

- Yes
- No

Do you read on a regular basis?

- Yes
- No

Do you possess a library card?

- Yes
- No

Do you participate in academic activities and events?

- Yes

No

What would you say is your biggest intellectual health concern?

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d) Spiritual Health

Do you consider yourself spiritually well?

- Yes  
 No

Do you attend church on a regular basis?

- Yes  
 No

If yes, what one? \_\_\_\_\_

Do you participate in spiritual activities?

- Yes  
 No

If yes, which ones? \_\_\_\_\_

Do you speak with an elder on a regular basis?

- Yes  
 No

Do you participate in Aboriginal cultural traditions?

- Yes  
 No

What would you say is your biggest spiritual health concern?

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### Section III. Access and Availability

The next set of questions ask you about how often you have used the services of various health care professional in the past 6 months. These questions also ask you to explain, if you needed or wanted more access, why you feel that these services weren't available to you and to describe what you did instead.

1. In the past 6 months how often have you visited a **doctor** for your own health concerns?

- Never  
 Once  
 Twice  
 Three – Four times  
 More than four times

2. In the past 6 months, were there times that you wanted to visit a doctor for your own health

concerns, but were unable to?

- Yes
- No

If you answered yes to this question, please explain why you were unable to visit a doctor.

---

---

What did you do instead of visiting the doctor?

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3. In the past 6 months how often have you visited a dentist's office for your own dental concerns?

- Never
- Once
- Twice
- Three – Four times
- More than four times

4. In the past 6 months, were there times that you wanted to visit a **dentist** for you own health concerns, but were unable to?

- Yes
- No

If you answered yes to this question, please explain why you were unable to visit a dentist.

---

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What did you do instead of visiting a dentist?

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5. In the past 6 months how often have you visited a **mental health professional** (e.g., counselor, psychologist, psychiatrist) for your own emotional concerns?

- Never
- Once
- Twice
- Three – Four times
- More than four times

6. In the past 6 months, were there times that you wanted to visit a mental health professional for your own health concerns, but were unable to?

- Yes
- No

If you answered yes to this question, please explain why you were unable to visit a mental health professional.

---

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What did you do instead of visiting a mental health professional?

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---

7. In the past 6 months how often have you visited an **Aboriginal healer** for your own health concerns?

- Never
- Once
- Twice
- Three – Four times
- More than four times

8. In the past 6 months, were there times that you wanted to visit an Aboriginal healer for your own health concerns, but were unable to?

- Yes
- No

If you answered yes to this question, please explain why you were unable to visit an Aboriginal healer.

---

---

What did you do instead of visiting an Aboriginal healer?

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10. In the past 6 months have you used any **other health care services** (not including doctors, dentists, mental health professionals and Aboriginal healers) for your own health concerns?

- Yes
- No

If you have used other health care services, could you please say what they were (e.g., nutritionist, nurse practitioner)?

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If you have used other health care services in the past 6 months how often have you used them?

- Never
- Once
- Twice
- Three – Four times
- More than four times

If you have used other health care services in the past 6 months, were there times that you wanted to use them, but were unable to?

- Yes
- No

If you answered yes to this question, please explain why you were unable to use the health care services you required.

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What did you do instead of visiting the health care services you required?

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#### **Section IV. General Health and Wellness Issues**

This next set of questions are asking your opinions about general health and wellness.

Overall, what would you say are your top three health concerns?

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What would you say are your top three health needs?

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What do you do to relieve stress?

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What does wellness mean to you?

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How would you define good health?

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Is there anything else you would like to tell us about your health and wellness or your experiences with the health care system?

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***Thank you for taking the time to fill out this survey. Your participation in this project is very much appreciated!***

## Appendix 4 – Ethics Memorandum of Approval



### MEMORANDUM

---

**DATE:** April 23, 2004  
**TO:** Kathy Bent  
**COPY:** Dr. Lynda Ross (Supervisor)

**FROM:** **Janice Green, Secretary, Research Ethics Board**  
**SUBJECT:** Ethics Proposal #04-01 “Aboriginal Women’s Health: Mainstream  
And Alternative Approaches”

---

The Athabasca University Research Ethics Board reviewed the above-noted proposal and supporting documentation, and I am pleased to advise that it has been awarded **FULL APPROVAL** on ethical grounds.

**Please provide the following clarification items and any revised documents arising, for file purposes only:**

Appendix 1 – Recruitment Script for Interview Component

- Revise fourth paragraph to add “at any time prior to the interview, or” so that Appendix 1 reads the same as Appendix 2 with regard to freedom to withdraw

The approval for the study “as presented ” is valid for a period of one year. If required, an extension must be sought in writing prior to the expiry of the existing approval. A Final Report is to be submitted when this research project is completed. The report form is located online at <http://www.athabascau.ca/research/ethics/index.html> .

As you progress with implementation of the proposal, if you need to make any changes or modifications please forward this information to the Research Ethics Board Chair via Janice Green, the REB Secretary.

If you have any questions, please do not hesitate to contact [janiceg@athabascau.ca](mailto:janiceg@athabascau.ca).

## **Appendix 5 – Agency Letters of Support**

April 2, 2004

Ms. Kathy Bent  
993 Kimberly Avenue  
Winnipeg, Manitoba  
R2K 3V7

Dear Ms. Bent

Re: Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-being  
Research Study

Thank you for the invitation you extended to the staff and students at Urban Circle Training  
Centre to participate in your study on Aboriginal women's health.

We are well aware of the benefits this study may offer Aboriginal women and would be pleased  
to participate. Please contact me when you are ready to make arrangements for data collection.

Sincerely,

Ruth Murdock

April 2, 2004

Ms. Kathy Bent  
993 Kimberly Avenue  
Winnipeg, Manitoba  
R2K 3V7

Dear Ms. Bent:

Please consider this letter as approval from the Ma Mawi Wi Chi Itata Centre for you to conduct a survey with our staff and community members for your research project.

We welcome you to post your poster in our 3 community sites at 94 McGregor, 318 Anderson Avenue and 743 Ellice Avenue.

Should you have any questions please contact me at 925-0502.

Sincerely,

Josie Hill  
Executive Director

April 2, 2004

Ms. Kathy Bent  
993 Kimberly Avenue  
Winnipeg, Manitoba  
R2K 3V7

Dear Ms. Bent:

Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-being Research Study

Thank you for the invitation to participant in a study on Aboriginal women's health that you extended to the staff and clientele of the Native Women's Transition Centre. We are aware of the benefits this study may offer Aboriginal women and would be pleased to participate. Please contact me or Lucille Bruce to make arrangements for your data collection.

Sincerely,

Vanessa Wilson for Lucille Bruce (Executive Director)

March 31, 2004

RE: Ethics Review Application  
Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-being  
Research Study

I have read the overview of the above project that is being undertaken by Kathy Bent as part of her Master of Arts project. I believe that this is a worthy research and give authorization for Ms. Bent to post information at (CAHRD) Centre for Aboriginal Human Resource Development and the Aboriginal Centre inviting women to participate in this study. She is also authorized to consult with our Central Employment Services employment counselors and supervisor regarding the study.

If you require further information I can be reached at 989-7112.

Sincerely,  
(CAHRD) Centre for Aboriginal Human Resource Development

PER:  
Marileen McCormick  
Executive Director

April 13, 2004

Kathy Bent  
993 Kimberly Avenue  
Winnipeg, Manitoba  
R2K 3V7

Re: Ethics Review Application for Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-being Research Study

Dear Ms. Bent:

Thank you for the invitation to participate in a study on Aboriginal women's health that you extended to the membership of Mother of Red Nations Women's Council of Manitoba, Inc. I have read the overview of the above project and I believe that this is worthy research. I am also aware of the benefits this study may offer Aboriginal women and would be pleased to post information on the project at our office and distribute surveys to the women who utilize our services.

If I can be of further assistance, please contact me.

Sincerely,

Leslie Spillett, Provincial Speaker  
MOTHER OF RED NATIONS  
26 Edmonton Street  
Winnipeg, MB  
R3C 1P7  
Ph: (204) 942-6676  
Fax: (204) 942-7639  
Email: [morn@morn.ca](mailto:morn@morn.ca)

April 14, 2004

Kathy Bent  
993 Kimberly Avenue  
Winnipeg, Manitoba  
R2K 3V7

RE: Aboriginal Women's Health: Mainstream and Alternative Approaches to Well-being  
Research Study

Dear Kathy,

Please be advised that the Aboriginal Health and Wellness Centre of Winnipeg Inc.'s two women's program will be happy to participate in this study. As per our conversation, your contact will be Ms. Anita Ducharme, Director of Operations. You can reach her at 925-1201 or by email at [aducharme@ahwc.ca](mailto:aducharme@ahwc.ca).

Sincerely,

Darlene Hall  
Executive Director

**Appendix 6 - Interview Protocol**

**SEMI-STRUCTURED INTERVIEW PROTOCOL**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Demographic Information:**

The questions in this section are asking you to tell us a little bit about yourself.

What is your Aboriginal Status?

- First Nations       Metis       Inuit       Non Status       Other

What age group do you belong to?

- 18-25       26-30       31-40       41-50       51-60  
 61-70       71-80       81-90       Over 90

What is your marital Status?

- Single       Widowed       Divorced  
 Separated       Married Equivalent

What is your primary language?

- English       French       Aboriginal       Other

What is your degree of assimilation?

Fully = no contact with Aboriginal culture

Moderate = some, but very little contact with Aboriginal culture

Low = 50% or more of your time spent with Aboriginal culture including speaking the language

None = 100% of your time spend living with Aboriginal culture including speaking the language

- Fully  
 Moderate  
 Low  
 None

Are you currently supported by a spouse?

- Yes  
 No

Do you have dependent children?

- Yes  
 No

If yes, how many? \_\_\_\_

What type of community do you live in?

- Urban       Rural       Reserve       Northern

What are your living arrangements?

- Alone                       With Parents                       With Relatives  
 With Partner                       Single Parent                       Live with Friends                       Other

What is your education?

- Grade 8 or less                       Less than grade 12                       Grade 12  
 University                       College                       Other

What is your employment status?

- Full Time     Part-time     Casual                       Unemployed                       Self Employed

What is your income level?

- Less than \$20,000     \$21,000 – 39,999     40,000 – 59,999  
 60,000 – 79,999     other

**Interview questions: (Open and closed ended)**

1. What does wellness mean to you?
2. How would you define good health?
3. Do you consider yourself to be a well person? Probe: physically, emotionally and spiritually?
4. What do you perceive as your biggest barrier to obtaining and maintaining optimum health and wellness?
5. Are your nutritional requirements being met? If not, why do you think this is so? And, What do you think can be done about this problem?
6. Have you had a major illness in the last 3 years? If yes, what illness did you have?
7. Have you had any minor physical health problems in the last three years? If yes, what kind of illness? Please describe this experience.
8. Do you visit a doctor on a regular basis? If no, why is this so? If yes, what was that experience like for you?
9. Do you visit dentists on a regular basis? If no, why is this so? If yes, what was that experience like for you?
10. Have you been to a hospital emergency ward or have you been admitted to the hospital in the last three years? If yes, what was that experience like for you?
10. Do you visit a traditional Aboriginal healer on a regular basis? If yes, please describe this experience. If not, would you consider seeing a traditional healer?
11. Have you ever taken traditional medicines? If yes, what has been your experience with traditional medicines? If no, what do you know about traditional medicines and would you ever try them?
12. Have you ever discussed taking traditional medicines with a mainstream doctor? If yes, please describe that experience.
13. Do you participate in Aboriginal events and traditional events? If yes, please describe. If no, why not?
14. Do you think you live in a healthy community? Please describe your situation?
15. What would you say are your top three health concerns?

## Appendix 7 - Interview Consent Form

### Interview Consent Form

I understand that I am being asked to participate in a study concerning Aboriginal women's health.

I understand that my participation in this project is completely voluntary and that should I wish to decline, at any time prior to the interview, or at any time during the interview, I am free to do so without consequence. I understand that the interview will be tape-recorded and that any information I provide during the interview will be kept confidential and that individual responses will not be used in any way that can publicly identify me as a respondent. I also understand that the data will be stored securely in a locked filing cabinet and/or on a password protected computer hard drive. All raw data (i.e., tapes, transcripts) will be destroyed five years after the completion of the study.

I understand that this research is being conducted for a Master of Arts project and that the results from this study will be contained in a report that will be submitted to Athabasca University's Master of Arts (Integrated Studies) Program. The findings may also be published in scholarly journals and presented at conferences.

I have read the information above. In signing and providing the information below and in returning this form, I am giving my consent to participate in this research project.

Name: (please print) \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_