
Anishinaabe Ik-We Mino-Aie-Win

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

SUMMARY REPORT

**by Kathy Bent
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The entire report including appendices can be found at URL:
<http://library.athabascau.ca/drr/viewdtr.php?course=dtpr&id=308>

Introduction

According to a recent study, Aboriginal women “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). Aboriginal women’s poor health status may be directly linked to discriminations arising from their female and Aboriginal status and from the difficulties associated with defining “health” and “wellness” in terms that make sense to them. 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 manner that adequately parallels their lived experiences especially when it comes to identifying “wellness” characteristics that make up a large portion of their over all being. 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 and economic and spiritual wellness of people is inconceivable in Aboriginal traditions. The widely accepted meaning of the term “well-being” however, usually relates to physical health, which limits understanding of “wellness” in other areas related to emotional, mental and spiritual dimensions. 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 main 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” (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” (CWHN 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 and highlights the need for research based on female experiences.

For Aboriginal women who are discriminated against because there are female and Aboriginal, the consequences of male bias 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, “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), 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 than Non-Aboriginal Canadian women. To add to their already low socio economic standing, Aboriginal women are also having more babies than Non-Aboriginal women and they are having them at younger more vulnerable ages. 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).

These are startling statistics that raise questions of legitimacy concerning a recent report based on the Aboriginal People's Survey (APS) that show some improvements have been achieved in urban Aboriginal women's health and wellness status in that their self-ratings shows that both themselves and their children have excellent or very good health (Statistic Canada, 2003). Regarding their children, a recent Statistic 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, Statistic 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.

Literature Review

The review conducted for this study was based on the topic of Aboriginal women's health but focused primarily on the topic of their wellness. Studies that discuss Aboriginal wellness as a whole were also included because of the lack of academic studies in this area specific to Aboriginal women. Focus group meetings reports and conference minutes and reports have also been reviewed because of this deficiency. Unfortunately, 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 (Bartlett, Hamilton, Joyal, Laborero, McCorriston, McKay, Shore, Sinclair, & Yadao, 2004; Deiter & Otway, 2001; Dion Stout, 1995; Dion Stout & Kipling, 1998; Dion Stout et al., 2001; Wilson, 2004).

When Aboriginal women were asked questions related to their health and wellness, an Aboriginal holistic worldview resonated through many of their responses. An Aboriginal worldview contains spiritual elements not common to other worldviews. Unfortunately, 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). A study conducted by Wilson (2004) on cultural identity and wellness, 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. In her study, 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” (p. 9).

Interconnectedness is an Aboriginal holistic value present in an Aboriginal worldview therefore it is not surprising that “interconnectedness” is mentioned in all the studies reviewed. Like the descriptions presented by Wilson (2004), Bartlett (2004) also put forth rich descriptions of what health and well-being mean to Métis women. In her study the four dimensions (e.g., Spiritual, Intellectual, Physical and Emotional) of health contained in an Aboriginal holistic worldview were described from Métis women’s perspectives. 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. 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. She reports “unemployment and the lack of employment equity were identified as factors contributing to poverty among Aboriginal women. In this study, it was noted that single mothers in particular face unemployment as an obstacle” (p. 26). The fact that a significant proportion of Aboriginal families are headed by single females is noteworthy. 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 lack of attention given to Aboriginal women's voices, along with limited employment opportunities for Aboriginal women, are equity issues that need to be addressed by everyone if Aboriginal women are ever to overcome the negative effects of ill health and wellness.

The development of health systems and programs based on an Aboriginal perspective were highly recommended in all of the studies reviewed. Dion Stout (2001) and her colleagues for example, support the integration of traditional medicines and the holistic understanding of health with mainstream practices. In their study, Aboriginal women's strength and resilience were mentioned as characteristics related to their wellness. Svenson and Lafontaine (1998) also have argued that 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 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 making the need for Aboriginal based health systems more apparent.

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). 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). Elias, Leader, Sanderson, and O'Neil (2000) 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 "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). Overall they found positive health behaviours tended to be associated with increased age, higher education and higher socioeconomic status. According to Elias and her colleagues, gender is a factor known to affect health status but "little is known as to how women differ from each other" (p. 3). More research is needed to explore these differences.

In general, the findings from the articles reviewed indicate that there are positive aspects of Aboriginal women's lives that largely go unnoticed due to the negative focus on their lives. 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 strategists 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 a culture's value system. The articles reviewed show that Aboriginal women live rich fulfilling lives despite the many drawbacks they face due to their female status and the effects of colonization on their Aboriginal identity.

Colonization and Acculturation

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 subsequent trauma associated with the near destruction of Aboriginal cultures along with the inter-generational transmission of unhealthy lifestyles all contribute largely to the plight of Aboriginal women.

Aboriginal cultural enrichment programs have been at the forefront of most Aboriginal initiatives intent on serving the Aboriginal population. 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" (Stout et al., 2001). 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. 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.

Acculturation relates to an individual's adaptation to a culture other than their own culture and "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). 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 is unknown which brings to light a complex issue that needs to be addressed. 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 term ethnic identity has 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 a way that makes it difficult to analyze their workings linearly. 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 that does not have the propensity to consider all aspects of the situation. 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 review on colonization and acculturation theory 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.

Aboriginal Traditional Knowledge

Aboriginal traditional knowledge is based on a holistic worldview that places value on all living and non living matter and that knowledge 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 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. She states historically the Medicine Wheel “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 3rd 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 because unfortunately, most of this knowledge is contained only in oral formats. This makes it difficult for Aboriginal women to access the knowledge. Aboriginal traditional knowledge plays a central role in addressing Aboriginal

issues. On a positive note, a number of Aboriginal groups have developed their own approaches to wellness based on a holistic perspective and 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 sought 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. 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.

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. 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?"

Procedures and Research Design

The research methods for Project I were deemed ethically appropriate by the Research Ethics Board at Athabasca University. Permission was obtained from the management of six Aboriginal organizations in the City of Winnipeg to conduct this study at their organization. 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. 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 and 85% of the sample lived in an urban setting (The City of Winnipeg). 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%), 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. Over 69% of the women also reported that they had dependent children and 28% of them reported single parent status.

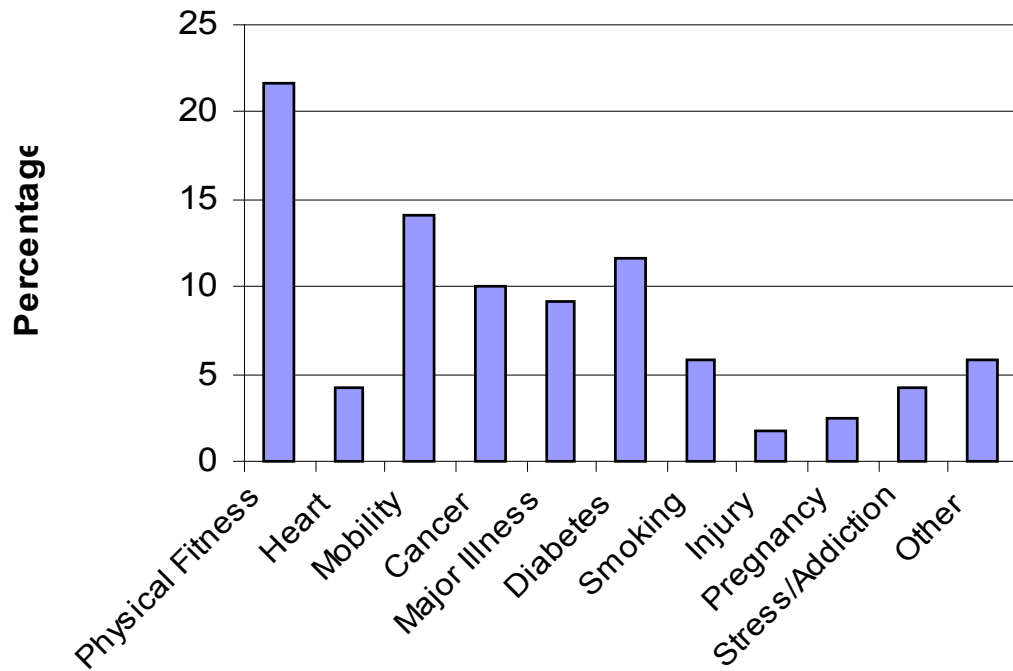
Health Issues

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. 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. Although 64% (N = 75) of the women felt their nutritional needs were being met, a large minority (36%; N = 42) did not. The majority of women smoked (69%; N = 83) and did not exercise on a regular basis (56 %; N = 66). 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, and 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

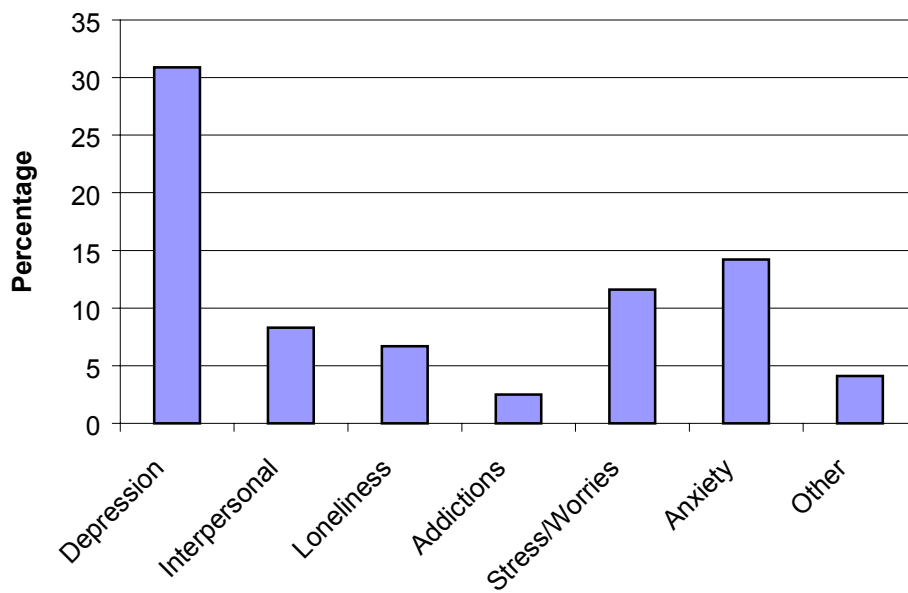
Figure 1: Physical Health Concerns



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. 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. 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.

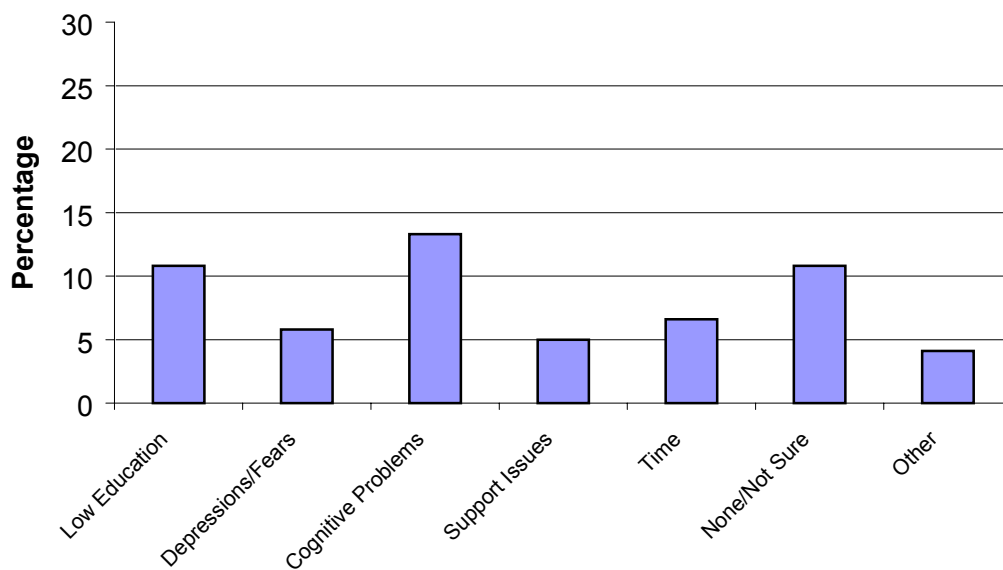
Figure 2: Emotional Health Concerns



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

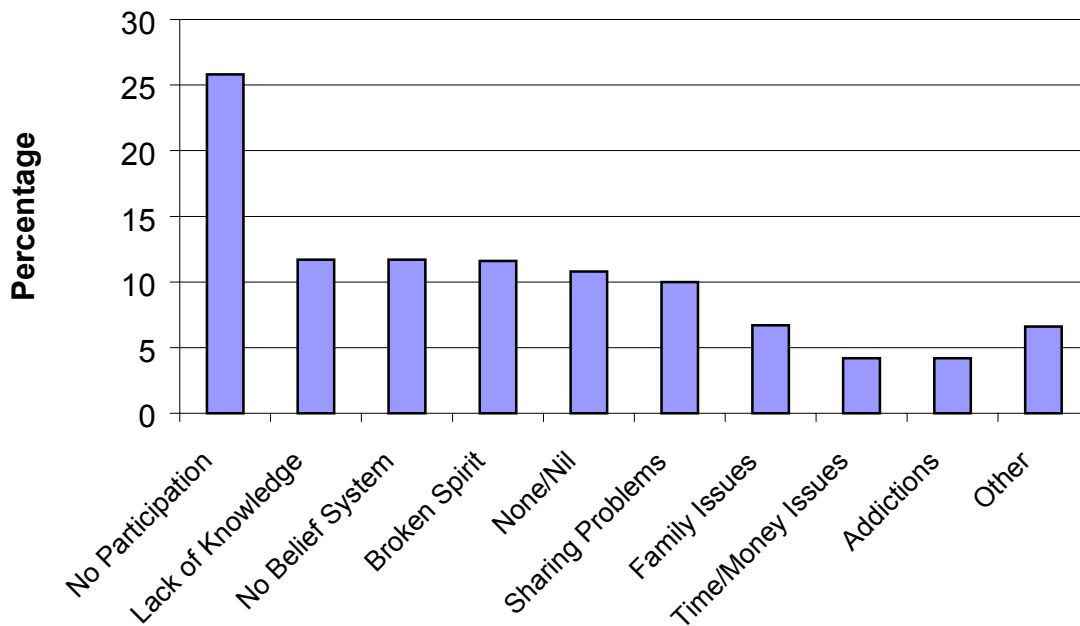


Spiritual Health Concerns

“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. 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 addiction 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.

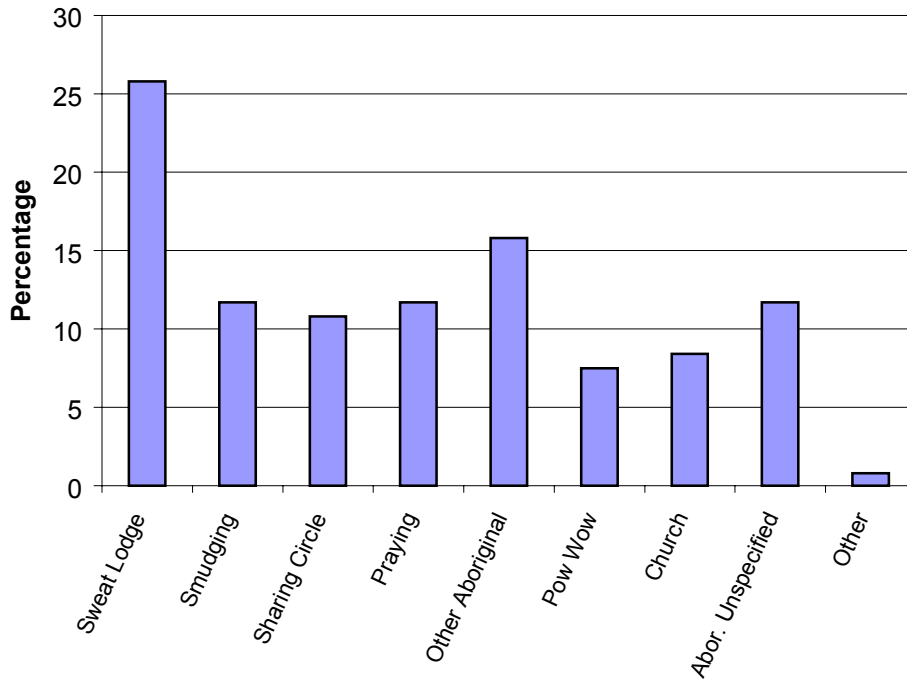
Figure 4: Spiritual Health Concerns



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 as depicted in Figure 5 on the next page.

Figure 5: Spiritual Activities

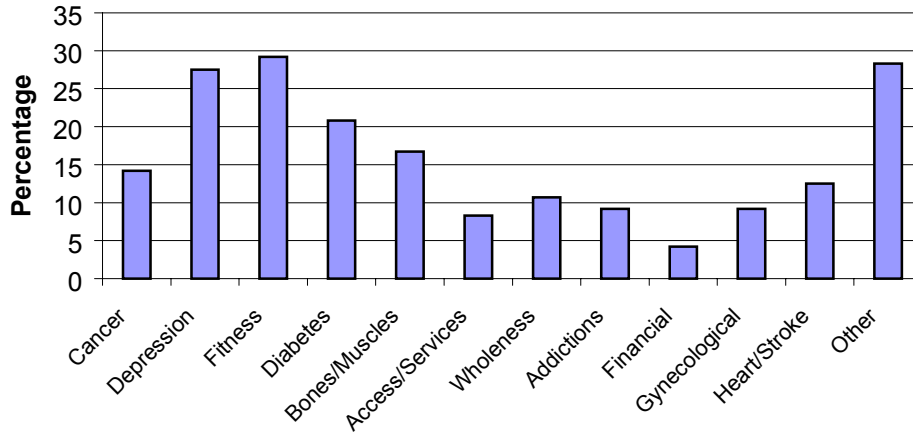


General Health and Wellness Issues

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.

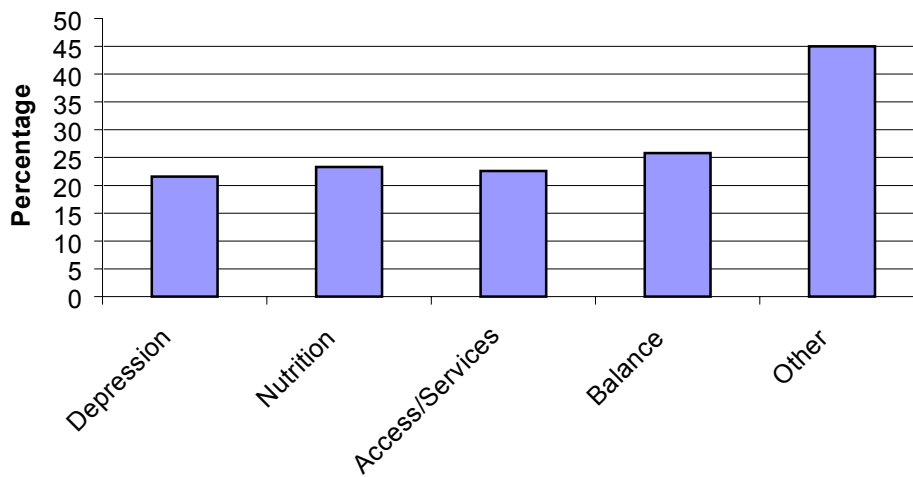
Figure 6: Top Health Concerns



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%). These results are recorded in Figure 7.

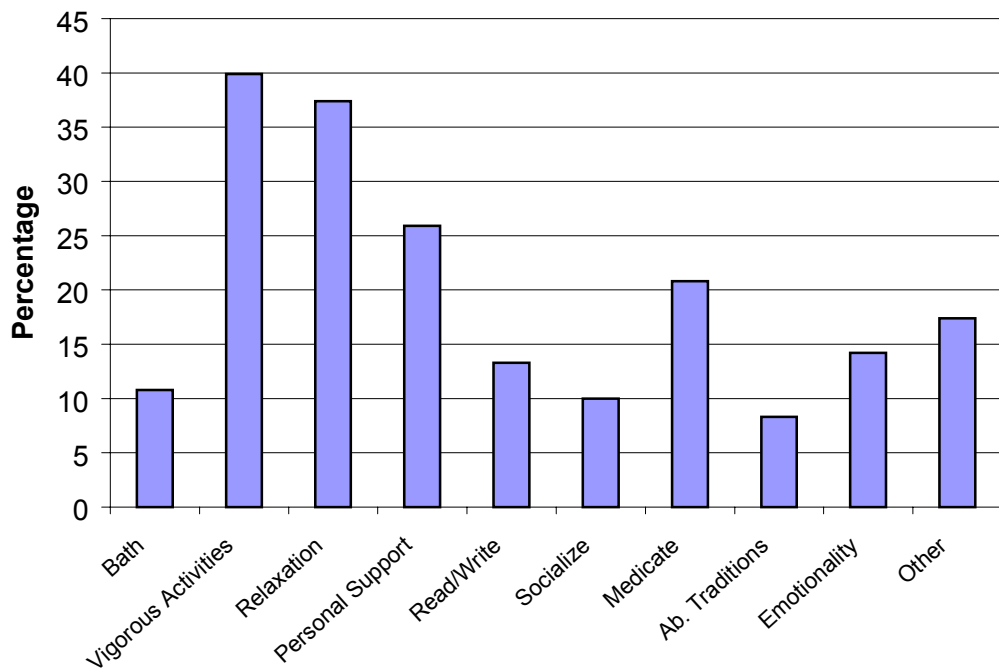
Figure 7: Top Health Needs



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. 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.

Figure 8: Stress Relief

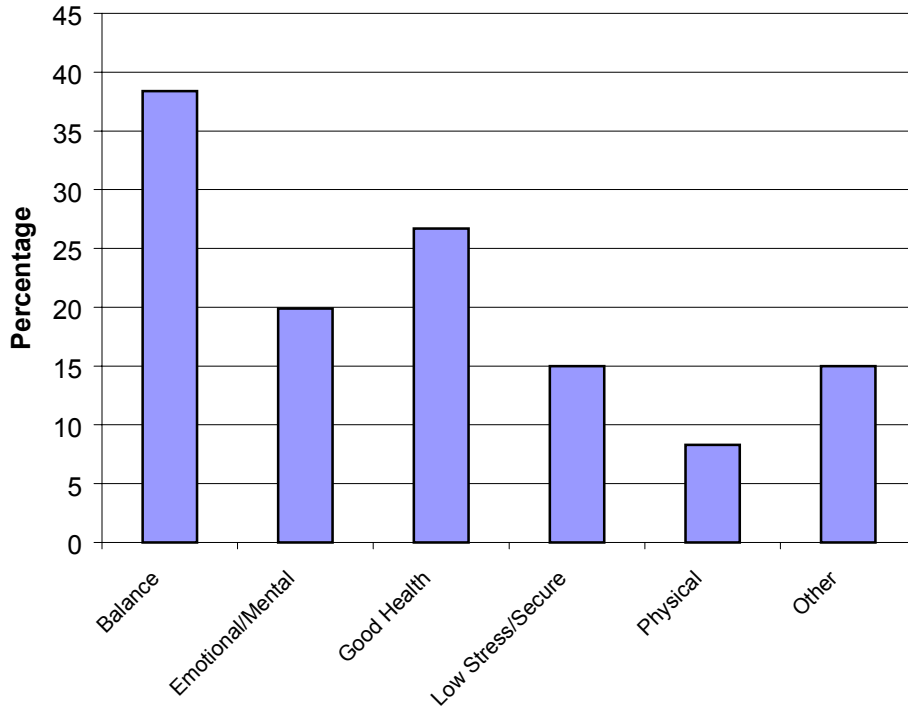


Wellness

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

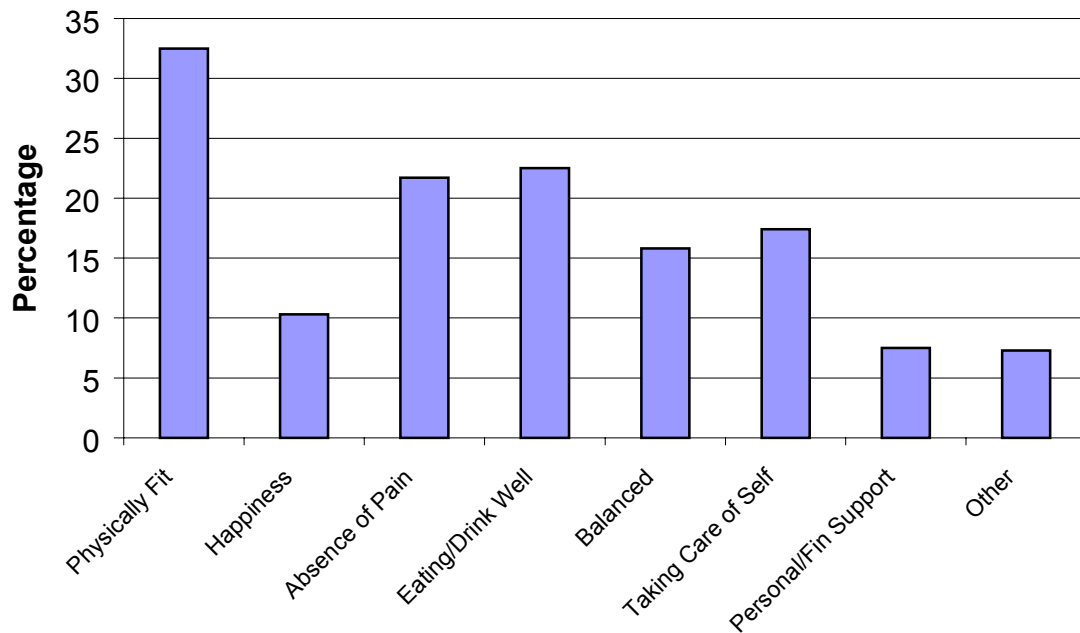
good health (27%), emotional/mental health (20%), low stress and feelings of security (15%) were all related to their wellness. Findings are presented in Figure 9.

Figure 9: Wellness



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 on the next page provides a summary of these findings.

Figure 10: Health

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?” An informed consent form was also used in this component of the study.

Procedures and Research Design:

The research methods for project II were deemed ethically appropriate by the Research Ethics Board at Athabasca University. 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 1 along with associated response rates.

Table 1. Wellness Themes and Response Rate

RESPONSE	RESPONSE RATE
Holistic balance (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 %

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; and

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 and 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" than 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 2 on the next page.

Table 2.

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 %

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 about 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 meansyou 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.

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.

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 Deitler and Otway (2003; p. 19) study reported that they were healthy. 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 (Deitler & 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 (Deitler & 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 of 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 woman, 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 grouped 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. 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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