

ACCESS TO HEALTH SERVICES FOR ELDERLY MÉTIS WOMEN IN BUFFALO NARROWS, SASKATCHEWAN

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Project #146



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Prairie Women's Health Centre of Excellence (PWHCE) is one of the Centres of Excellence for Women's Health, funded by the Women's Health Contribution Program of Health Canada. The PWHCE supports new knowledge and research on women's health issues; and provides policy advice, analysis and information to governments, health organizations and non-governmental organizations. The views expressed herein do not necessarily represent the official policy of the PWHCE or Health Canada.

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EXECUTIVE SUMMARY

The Northwest Métis Women's Health Research Project investigated the health care needs of elderly women and their caregivers in the Métis community of Buffalo Narrows, Saskatchewan. The research project looked at access to home care and long-term care services for elderly women in the particular demographic, social, cultural and economic context of northern Métis communities. The goal of the project was to recommend appropriate home care and long term care policies for northern Métis communities and to ensure that these policies will be responsive to women's needs as care recipients, care providers and caregivers. By looking at the specific needs of women, the research project hoped to raise awareness of gender as an important factor to consider in developing and implementing policies related to care of the elderly.

This project used Pechansky and Thomas' (1981) approach which describes the degree of fit between clients and health system service access in terms of accessibility, affordability, availability, acceptability and accommodation. However, it is important to note that many of the issues that influence one dimension of access may also influence another. With multiple, intersecting barriers to access for this population, addressing needs becomes a challenge in prioritizing these dimensions alongside the health and social issues unique to senior Métis women and their caregivers.

The project was led by a Métis Women's Research Committee from the community of Buffalo Narrows working in partnership with the Aboriginal women's health research coordinator of the Prairie Women's Health Centre of Excellence (PWHCE). The research used qualitative methods to gather information from Métis women about the need for and access to home care and long term care services for elderly women in the community. During individual interviews local Métis women were asked to describe the types of services available, types of services needed, the quality of services available and what was needed to improve the quality of services. They were asked to identify barriers which limit access to services and to suggest ways those barriers might be overcome. Based on the interviews, the Métis Women's Research Committee developed recommendations for ways to improve policies and programs to make them more responsive to women's health needs.

Responses from the Métis women in Buffalo Narrows identified many key recommendations for meeting the complex service needs of elderly women in the community and for improving access to health care and community services that would ease the burden on extended family members and give elderly patients more independence. Recommendations focused on addressing barriers to service access in terms of accessibility, affordability, availability, acceptability and accommodation.

INTRODUCTION

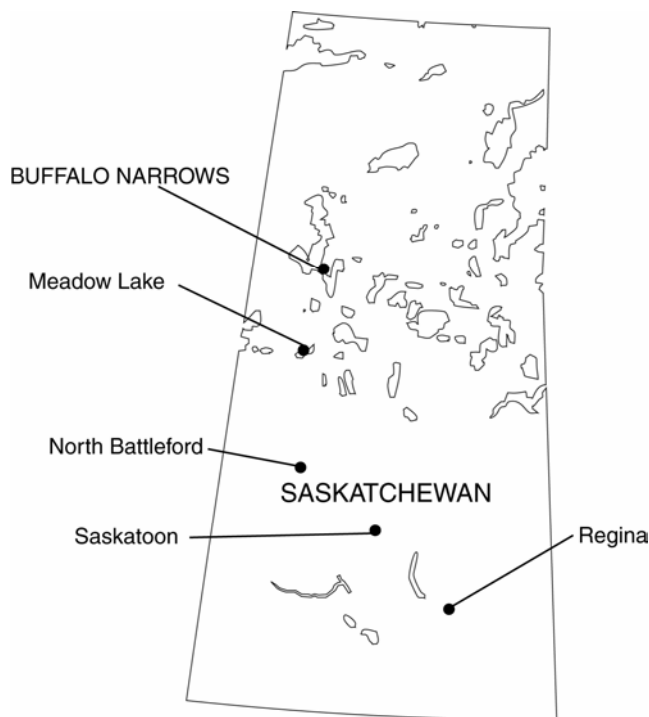
The Northwest Métis Women's Health Research Project investigated the health care needs of elderly women in the Métis community of Buffalo Narrows, Saskatchewan. These are important issues for women of *all* ages in rural and remote communities as women shoulder the primary responsibility for providing care to young and old, sick and disabled. Older women are both the recipients of care as well as care givers, while younger women are most often care givers. The goal of the project was to recommend appropriate home care and long term care policies for northern Métis communities and to ensure that these policies will be responsive to women's needs as care recipients, care providers (paid) and caregivers (unpaid). By looking at the specific needs of women, the research project hoped to raise awareness of gender as an important factor to consider in developing and implementing policies related to care of the elderly.

Aboriginal peoples are interested in research rationales and processes and want collaborative efforts that benefit the community and produce an accurate understanding of the community and its issues (Leeman, et al, 2002; Smylie, 2001). At the Métis Nation Health Policy Forum held in Saskatoon in April, 2002, one speaker commented on the need for Métis to be "researched to life" through research that was Métis generated and Métis controlled (Métis Centre, 2002). Research involving Aboriginal communities around identified community issues should be conducted cooperatively and collaboratively to ensure that the research needs of the community are indeed met.

The Buffalo Narrows Métis Women's Health Research Project was led by a Métis Women's Research Committee with members from the community of Buffalo Narrows working in partnership with the Aboriginal women's health research coordinator of the Prairie Women's Health Centre of Excellence (PWHCE). The Métis Women's Research Committee made a decision to focus on services to elderly women in Buffalo Narrows as an important issue for the community. In community discussions held in the spring of 2004, women identified the following components to the issues:

1. Fiscal restraint, health care restructuring and limited investment in home care infrastructure may save the health system money, but at the expense of both patients and caregivers;
2. Concerns that family members are expected to provide home care support as an extension of their domestic and family work;
3. A realization that when one member of a family requires care, the stress of caregiving affects everyone in the family, but that women and men recognize and respond to stress differently; and
4. There is a lack of good quality long-term care available in the community of Buffalo Narrows to take the place of existing informal care giving.

The Métis community of Buffalo Narrows and surrounding communities do not have long-term care facilities for the elderly. Therefore elderly people in need of care must move to a long term care facility outside of the community, taking them away from their home and family members. The closest long term care facility is in Meadow Lake, two and one-half-hours' drive from Buffalo Narrows. Not all families have transportation or the financial resources to visit their elderly family members who have been sent out of the community for remainder of their lives (see map).



Elderly residents who live in their homes in the community of Buffalo Narrows do have access to home care. Available services include home nursing, homemaking, *Meals on Wheels* and day programs. Homemaking and *Meals on Wheels* are offered to clients at a fee of \$2.50 per hour. People also have community access to outreach workers, mental health workers, addictions workers, nutrition programs, a dietitian and a diabetes educator through the Keewatin Yatthé Regional Health Authority (www.kyrha.ca, 2006).

Crosato and Leipert (2006) report that a lack of services and funding has resulted in informal care being more prevalent in rural and remote areas. While Statistics

Canada reports that over 18% of the Canadian population over the age of 15 years provided care for an elderly person, in the community of Buffalo Narrows 28.5% of the population reported they provided care for an elderly person. Sixty percent of those providing care for the elderly in Buffalo Narrows were women (Statistics Canada 2001b).

LITERATURE REVIEW

The Canadian Institute for Health Information report *Improving the Health of Canadians* states “there are few specific data, including health data, on the Métis population” (CIHI 2004; 78). The report goes on to comment that “given the divergent histories and experiences of Canada’s Aboriginal Peoples, First Nations data alone do not provide an adequate indicator of the health status of all three recognized Aboriginal groups” (CIHI 2004; 97). Although Métis people account for more than 26% of Aboriginal people in Canada, Young (2003), in a recent survey of the leading academic health journals, noted that less than 1% of health research on Aboriginal populations focused on Métis people. As a result, the health issues and concerns of Métis communities have not been well documented.

Current literature on the health care needs of elderly Métis women residing in Northern and remote locations is even more limited. Examination of recent literature using the key words: health care; rural; remote and northern; Métis; Aboriginal; elderly; aged; informal care and health services highlighted the lack of research on these topics. A review of available journal articles and reports resulted in little current information on the issues surrounding access to health care services, the health needs of elderly Métis women, the health needs of rural and remote residents or the provision of informal care services. This lack of information exists despite acknowledgement of the health needs and the unique barriers to health care services in Canada’s rural and remote communities (Romanow, 2002).

The increase in elderly peoples in Canada and the inability of current health and social policy to meet their service needs and demands has placed this population in jeopardy (Buchignani & Armstrong-Esther, 1999). In Canada, 17% percent of seniors live below the poverty line (Saskatchewan Seniors Mechanism [SSM], 2003) and these numbers appear to be directly related to age, gender and geography. That is, the annual income for seniors residing in large urban centers was \$16,521 compared to \$16,407 in small urban centers, and \$13,311 in rural areas. Further among those aged 75+, 11% of females and 9% of males reported annual incomes less than \$10,000 and 75% of females and 58% of males reported incomes less than \$20,000 per annum (SSM, 2003). In Saskatchewan, women make up 50% of seniors aged 70-74. However, by ages 75-79, women comprise 57% of seniors and account for 64% of all Saskatchewan seniors 80 years and older (Statistics Canada, 2001a).

Aboriginal women experience far greater vulnerability than any other collective group in Canada. Aboriginal women have a lower life expectancy, elevated morbidity rates and are at greater risk of suicide than non-Aboriginal women (Leeman et al, 2002; Wilson, 2004; Thomlinson, et al, 2004). Rural Aboriginal populations are said to experience higher unemployment rates, lower levels of education, income and health status than the general Canadian population (Statistics Canada, 2000). Such disparities are thought to be

associated with low income, low social status and exposure to violence. Aboriginal women experience the highest rates of poverty and violence in Canada (Wilson, 2004). Statistics profiling the social conditions of Aboriginal peoples describe a population more likely to live in single-parent families, with higher rates of unemployment and lower rates of high school completion than non-Aboriginal populations (Statistics Canada, 2000). In Canada, the average annual income of Aboriginal women is \$13,000.00, compared to \$18,200.00 for Aboriginal men, and \$19,495.00 for non-Aboriginal women (Statistics Canada, 2000).

Statistics Canada reports that the number of Aboriginal seniors increased by 40% between 1996 and 2001 (Statistics Canada, 2001a). This is a dramatic change when compared to the 10% increase among non-Aboriginal seniors. Although the life expectancy of Aboriginal peoples has increased over time it is still lower than the Canadian average for both sexes. The life expectancy for Aboriginal females is 71 years, compared to 79 years for non-Aboriginal females (MacMillan, et al, 1996; Newbold, 1998). The life expectancy for Aboriginal males is 64 years compared to 73 years for non-Aboriginal males.

Statistical evidence has demonstrated a steady increase in social and health related risk factors for Aboriginal peoples, especially women. However, despite the continuing disparity between Aboriginal women and mainstream society, there exists little research that has effectively identified and addressed the issues of Canada's Aboriginal population.

A. MÉTIS IDENTITY

The Métis have been part of the cultural, historical, and political landscape of Canada since before Confederation. Métis identity is based on historical events; a history marked by ongoing struggles for recognition as a distinct Indigenous nation, rich in culture and tradition unique to those with mixed-blood ancestry (Lawrence, 2004; Leclair, et al., 2003). History and the cultural consequences of the *Indian Act* have muddied the waters around claims of Métis identity and the need for identity has created contention and a sense of ownership around who is and who is not Métis (Lawrence, 2004).

Métis identity currently speaks to not only the historical experiences of mixed-blood that existed under the fur trade but to the contemporary groups of Métis that include Non-Status Cree Métis who still live off the land, those who still reside in Métis settlements and urban Métis with ancestral ties to historic communities (Anderson, 2000; Lawrence, 2004). A sense of "otherness" is felt between those who claim historic ties to the Red River Settlement, who strongly assert their unique culture through language, music and dance, and those of mixed blood, who do not have historic ties to the Red River Settlement, but identify with Métis because they have lost their status due to the *Indian Act* (Lawrence, 2004; Leclair et al, 2003).

The issues that arise out of identifying as Métis have to do with the interrelated processes of loss of identity, reclaiming identity and the struggle to find identity. For some, identifying as Métis is done with pride, for others it is done out of necessity, trying to make a connection lost through the imposition of an identity that severed community ties (Lawrence, 2004; Leclair et al, 2003). For the purpose of Métis Nation membership, inclusion and exclusion is based on three criteria: mixed Aboriginal ancestry (although some Métis Nation locals require direct ancestral connection to Red River), self-declaration as Métis and community acceptance (Métis National Council, 2006; Newhouse & Peters, 2004).

Métis were accorded legal status as one of Canada's three Aboriginal Peoples, along with First Nations and Inuit, under section 35 of the *Constitution Act*, 1982. For Métis, recognition in the Constitution Act was a major victory. However, funding for programs and services and the overall provision of health care are not equally available to each or all constitutionally recognized Aboriginal Peoples' in Canada. Métis do not have access to the same level of health benefits as First Nations and Inuit, notably the Non-Insured Health Benefits administered by Health Canada's First Nations and Inuit Health Branch.

Métis have been, and continue to be, one of the most marginalized populations within Canadian society. This marginalization is especially evident when dealing with issues such as health.

“Irrespective of the excuse, the result of this is that even though Métis people represent close to 26% of the Aboriginal population in Canada (2001 Census), they receive minimal access to Aboriginal health supports or services provided by the federal or provincial governments. Moreover, Métis continue to encounter difficulties accessing or interfacing with provincial primary health service delivery models resulting in our people falling further and further behind other Canadians in most health status indicators” (Métis National Council, 2004, pg 13.).

In Canada, health is a provincial responsibility dependant on federal transfer funds. Thus, the provinces and territories are responsible for the delivery of health services to Métis, and in some jurisdictions, target health promotion programs to Métis. On the federal level, some Aboriginal health initiatives, such as programming for HIV/AIDS prevention, fetal alcohol syndrome, diabetes, and early childhood education are inclusive of Métis. With a variety of jurisdictions providing health services across Canada, the services available are not necessarily equitable or comparable from province to province. This appears to be the case for many Métis communities who are not afforded the same health services or benefits as other northern communities in Canada. Thus, future health policy must be developed that is reflective and respectful of Métis health issues, needs and concerns.

“For years, it has been understood that there is an Aboriginal health care crisis in Canada; meanwhile Métis citizens have suffered for decades because of jurisdictional wrangling between the federal and provincial governments with respect to responsibility for the Métis. Last month, President Charrier called on the Council of the Federation and the Prime Minister to end the resulting health care discrimination against the Métis Nation” (Métis National Council, 2004).

For many Métis, historical and cultural factors have affected both health care needs and access to available services. Recently, some of these issues have been identified and documented in the Government of Saskatchewan’s (2001) *Healthy People. A Healthy Province. The Action Plan for Saskatchewan Health Care*. This document not only acknowledges the unique issues and concerns of Northern and Aboriginal communities in regards to health care, but also recognizes the importance of self-determination in creating responses to the growing issues. The Saskatchewan Northern Health Strategy highlights access to services as a major challenge to Northern and Aboriginal health care due to geography, which in turn affects the delivery of services on multiple levels. It also advocates partnering with northern Métis and First Nations people in developing frameworks of health service delivery and health promotion, increasing capacity, ensuring diversity and achieving equitable resource allocation.

B. ACCESS TO HEALTH CARE SERVICES

The increasing number of seniors, and specifically seniors of Aboriginal ancestry, is alarming when considered in the context of the particular health needs and concerns of those living in rural or remote communities. These concerns are further compounded by the barriers this population faces in trying to get potential services. In this section, we review existing research on the health needs of elderly women and their caregivers living in rural and remote communities, identify the current barriers in access to services and discuss how these issues affect those responsible for filling in the gaps through the provision of informal support.

Aday and Anderson (1981) describe access as “the potential and actual entry of a given individual or population group into the health care delivery system.” Pechansky and Thomas (1981) move away from a utilization focus and instead describe access by defining the relationship or “fit” between the characteristics of the service provider and the user. They describe five dimensions of access, including availability, accessibility, affordability, acceptability and accommodation which provide a useful framework to more fully explore issues of access.

Availability speaks to the relationship between the volume and service provided and the users need. Accessibility addresses the location of services and patient mobility. Transportation resources and travel time required to attend medical appointments outside of the community further compound accessibility. Affordability examines the ability of

individuals to pay for direct and indirect costs of services including medications, independent living appliances and transportation to specialist appointments.

Acceptability refers to the shared understanding between the attitudes and beliefs of the users and the provider. Finally, accommodation is the relationship between how services are organized and a patient's perception of appropriateness, including issues such as hours of operation, waiting times, and office policies and protocols (Pechansky & Thomas, 1981).

Barriers to Access

Although Pechansky and Thomas (1981) examine barriers to service access in terms of each of the 5 components, it is important to note that many of the issues that influence one dimension of access may also influence another. For example, elderly Métis women living in remote locations in Northern Saskatchewan find that issues of access blur the boundaries on all five dimensions in terms of geography (accessibility), distance (affordability), limited services and personnel (availability), cultural and gender specific service (acceptability) and inconsistent office hours and locations (accommodation). Addressing needs for senior Métis women must make these multiple considerations as well as other health and social issues.

Leipert and Reutter (2005a & b) examined the role of geography and gender on the social and health determinants of women in remote and northern communities. They found that within the northern context, vulnerability to health risks was a result of marginalization characterized by physical and social isolation and limited options for services and education (Leipert & Reutter, 2005b). Gender and ethnicity were central characteristics of marginalized populations experiencing social and economic disadvantage (also Leeman et al, 2002). Dodgson and Struthers (2005:339) defined marginalization as “the notion of vulnerability due to genetic, social, cultural and/ or economic circumstances”. Health professionals and researchers have examined the implications of marginality on the determinants of health and the delivery of health and social services. Marginalization has been linked to the occurrence of chronic illness, poverty and victimization where racial minorities and women have been shown to experience greater health and social issues and lack of access to health care than the larger population (Leeman et al, 2002).

Many rural and urban Aboriginal communities have demonstrated elevated incidence of the related effects of marginalization (Benoit, et al, 2002; Bourassa, et al, 2004; Hanselmann, 2001). Aboriginal populations experience poorer health characterized by higher rates of chronic illnesses and disabilities and an increase in elderly populations (Thomas-Prokop, 2004). As a result Aboriginal communities are more directly affected by limited availability of home and health care services. Further, elderly or physically challenged women, who are geographically isolated, are particularly vulnerable to the limited availability and accessibility of necessary services (Leipert and Reutter, 2005a).

Marginalization through health, socioeconomic, and environmental variables experienced by many elderly peoples is further compounded by the aging process and geographical location which places them at higher risk for disease and disability (Magilvy & Congdon, 2000). Barriers such as distance, geography and poor distribution of services and health care providers restrict access to health care. As a result, elderly people may have lowered expectations of health and thus do not seek services until they are experiencing acute symptoms. Elders in remote and northern areas depend more on informal care, but in some cases because of the barriers outlined, these informal services may be accessed simply to compensate for the void of formal services. Further, many of the issues experienced by Aboriginal women are manageable or considered preventable through improved health education, assistance with the activities of daily living, home support services and home nursing care, as well as traditional healing practices (Thomas-Prokop, 2004).

Accessibility

Leipert and Reutter (2005b) reported that geographically isolated, physically challenged or elderly Aboriginal women were experiencing increasing vulnerability and multiple marginalizations when accessing health care. Barriers to service delivery that involve issues of accessibility include travel both to and from the community. This relates to both the ability of the medical personnel to get into a community and the feasibility of residents traveling outside of the community for appointments. Travel difficulties can lead to the postponement of needed appointments, delay of medical staff attending or visiting communities or local professionals unable to travel certain roads. Remote and rural communities that depend on fly-in medical personnel may experience disruption of services and patient care due to weather conditions. Timing of medical visits can inhibit the accessibility of medical care if they are not coordinated with community activities or are scheduled when residents are out of the community (Minore, et al, 2004).

Affordability

The cost of home care services is described as a deterrent to accessing services (Leipert & Reutter, 2005a; Morgan et al, 2002). This occurred even if the clients were able to access subsidized care, as most families live on fixed incomes. Even home care personnel recognize that the cost of home care services acted as a deterrent due to financial hardship (Morgan et al, 2002) and minimal costs applied to services such as housekeeping and home visits detracted from residents making use of the services. This is especially of concern for Métis communities that do not have the same health care coverage as First Nations' reserves. Women in all financial brackets whether or not they are employed, have limited finances, or are currently ill, are unable to access services because of limited finances, time and energy (Leipert & Reutter, 2005a). Many senior women receive limited pensions, due to women's lower levels of participation in the formal labour force and high levels of unemployment in many Métis communities.

Those living in remote or northern communities describe current housing as small and in need of maintenance and repair. Many Aboriginal seniors are ill-prepared for independent living in old age or lack the financial means to afford the luxury of private care. They report not having the financial resources to meet their basic needs, stating that they do not have money left at the end of the month for emergencies and often live in multigenerational homes (Buchignani & Armstrong-Esther, 1999).

Availability

The physical locations of health care services and facilities are an issue as not all health care services are available or offered in remote communities. As a result, many people must rely on medical personnel intermittently traveling into the community to deliver services (Newbold, 1998; McCann, et al, 2005; Morgan, et al, 2002).

Availability of care in remote areas is also affected by the difficulties in recruiting and retaining qualified medical personnel, and as a result medical personnel are either unavailable or constantly changing (Minore et al, 2004). Such conditions compromise the quality of care by increasing experiences of isolation, delaying diagnoses and prolonging treatment and recovery (Leipert & Reutter, 2005a). Inability to recruit stable and consistent medical staff in rural and remote areas means that services are often inadequate and inappropriate because of a lack of consistent, confidential and diverse health care (Leipert & Reutter, 2005b). These issues affect both diagnoses and follow up as patients may make initial appointments and not be followed up for extended periods of time. Further, during that time medical personnel may have changed and patients then have to retell their stories and many abandon treatment (Minore et al, 2004).

Acceptability

Approaches to the health of Aboriginal populations often do not include an holistic understanding incorporating aspects of spiritual, emotional, physical and mental well-being (Bartlett, 2005), but rather are based on western approaches to health and well-being. The literature demonstrates that the failure to include cultural and educational aspects that promote all areas of well being such as informational services and programs on exercise and diet act as deterrents to accessing services. Bartlett (2005) discussed the concerns that Métis women have with the lack of collective experience around diagnoses and treatment and identified feelings of isolation in a more individualized system and society as opposed to traditional Métis communities that valued the importance of community and collective well being. Current services are based on westernized models that do not take into account the unique value systems of Métis women around collective identity and communal support.

These findings have been supported in studies which have shown that Aboriginal communities have concerns with diabetes being reflected as an individual issue that only affects the person diagnosed with it, thereby isolating the individual (Dickson, 2005).

Many persons diagnosed with diabetes were not referred by their physicians to proper resources for education and information which further isolated the individual (Dickson, 2005). Peer support was seen as crucial in minimizing these feelings of isolation, normalizing the experience and providing information and coping strategies (Daniel et al, 1999).

Accommodation

Geography and isolation create unique challenges in delivering health care to rural Canadians (Sutherns, 2004). Many services are unable to accommodate the diverse needs of remote and northern communities in terms of hours of operation, location and the specific needs of client services in rural and northern location. This leads to limited options or a complete lack of access to health care in addressing the specific health care needs of women and aging populations. Leipert & Reutter (2005a) note that women in rural communities have limited access to gender specific care and must therefore travel great distances to get the care they need.

As well, program funding for isolated communities is often short term and intermittent. Services are restricted, understaffed and only available during limited times, with no option for emergency services. Morgan et al (2002) demonstrated that many potential users of home care services felt that the limited hours of service was a deterrent and this was further compounded by the limited availability of homecare personnel. Further, episodic funding disrupted the continuity of care when enrolled patients chose to terminate the service or did not become involved in community programming because they assumed that the program was time limited (Minore et al, 2004).

Research on Aboriginal seniors identified the need and desire for activities, not only for addressing specific health needs but also for socializing, exercise and physical well-being. They reported not having the opportunity to participate in bingos, dancing, attending powwows or visiting at all or as often as they wished because of travel or reduced physical ability (Buchignani & Armstrong-Esther, 1999). Limited physical strength and ability also meant they required assistance for housecleaning, maintenance or volunteering in the community.

Social interaction with peers and family members is especially important for older people, and social isolation has been associated with loneliness and depression which affect physical well-being (McCann et al, 2005). Isolation is especially concerning for elderly populations in northern and remote communities as it increases the potential for boredom, loneliness and depression. Leipert & Reutter (2005a) found that limited opportunities for socialization also prevented sharing information, receiving support around diagnoses and treatment and networking for accessing services.

C. INFORMAL CAREGIVING

The extended family is very important in providing support and interaction for elderly people. Penning and Chappell (1987) argue that these relationships increase the well-being and adjustment of aging populations. Further literature on ethnicity and aging identify cultural factors as a significant feature in understanding the availability and use of informal supports among aging and elderly individuals (Buchignani & Armstrong-Ester, 1999; Penning & Chappell, 1987). The elderly in remote or northern communities were often dependent upon informal care from immediate and extended family members and friends to compensate for the lack of health care services. Magilvy and Congdon (2000) suggested that Aboriginal seniors were advantaged in the area of informal support due to community values and the importance placed on Elders in Aboriginal culture. Aboriginal seniors typically have a large familial and community based support pool to draw from and more often lived with others or lived in large extended families. Buchignani and Armstrong-Ester (1999) further suggested that Aboriginal seniors tend to have larger social circles to draw on for social and emotional support.

However, Leipert and Reutter (2005a) reported that elderly women who depended on personal and community resources as their primary source of support experienced threats to their well being because of limited personal and community resources to fill in the gaps in available service. Resources were limited not only in number and variety but also in the manner in which they were provided. Inadequate and inappropriate resources increased northern women's risks of inadequate care and affect accessibility. Elderly women did not have access to home care at all times to assist with monitoring their medications and meals on wheels were often not available in the community (Leipert & Reutter, 2005a).

Informal care compensates for disparities in economic support, assistance with daily activities and mental and social needs. However, it becomes an expectation that those providing informal care for elderly Aboriginal family and friends will compensate for gaps in health care services in remote and northern communities. This includes the expectation that because the elderly are Aboriginal, there will be informal safety net and as a result many seniors fall through the cracks (Buchignani & Armstrong-Ester, 1999). In many remote and northern communities families live in extreme poverty. This affects informal care as adult children have to work outside the home or move in search of employment, leaving elderly parents without immediate caregiving support (Magilvy & Congdon, 2000). In many communities, services to balance this reality are unavailable as there are no assisted living programs or alternative services to help elderly residents maintain their independence.

Informal caregivers remain an integral part of service delivery in northern and remote communities because they offer back up care and supervision for elderly residents who would otherwise need residential care. Crosato and Leipert (2006) note that rural women caregivers face many challenges in providing quality care for an elder. These included "limited access to adequate and appropriate healthcare services, culturally

incongruent health care, geographical distance from regionalized centres and health services, transportation challenges and social/geographical isolation” (Crosato and Leipter 2006:1). In addition, many of these women faced multiple demands of being a wife, mother, caregiver and employee, leaving them vulnerable to stress and burnout with limited resources to depend on. McCann et al (2005) demonstrated that family caregivers often experience heightened emotional and psychological stress as a direct result of their isolation and geographical distance from primary services. Women and relatives are predominantly in the roles of providing informal care (Fast et al., 2004). Women often take on the bulk of the domestic responsibilities to assist elderly residents remain independent, they do most of the visiting and often provide follow up care recommended by medical staff that would normally be included in the responsibilities of home care and specialized medical personnel (Buchignani & Armstrong-Esther, 1999).

Morgan et al (2002) comment that although rural locations rely heavily on informal care networks, it is uncertain whether this is because of values, inadequate formal services or the reluctance of elderly residents to use formal services. However, Bedard et al, (2004) found that fewer formal supports were available for rural caregivers and most rural caregivers (85%) received help predominantly from informal sources compared to only 33% for urban caregivers.

Limits on the quantity and quality of services available at any one time were also recognized as an issue. Health care services are now increasingly organized and delivered from a small number of centralized locations rather than in each small community. This may reduce the quality of care as home care workers who lived in the same community as the clients would be more likely to have information on the clients and knowledge about how the families were coping, and thus able to develop more proactive relationships with the caregivers (Morgan et al, 2002).

D. CONCLUSION

When discussing health services for Northern and Aboriginal communities it is difficult to rank the multiple barriers these communities face in accessing health care. Barriers to access, including service availability, transportation, financial needs, language (as we will see later) and isolation have led to increased dependence on informal caregiving to fill the gaps of necessary services. For many of these communities, issues associated with accessing services are interconnected and it is difficult to isolate one variable as being more important than the next. This in combination with underlying issues of marginalization in terms of poverty and isolation provide a basis for emergent response. The dimensions outlined by Pechansky and Thomas (1981) are helpful in identifying the many axes of service needs, but it could be argued that the issues northern and Métis women face would best be examined as multi-dimensional rather than existing within multiple dimensions.

METHODOLOGY

This project was led by a Métis Women's Research Committee from the community of Buffalo Narrows working in partnership with the Aboriginal women's health research coordinator of the Prairie Women's Health Centre of Excellence (PWHCE). The Métis Women's Research Committee established the research questions, assisted in developing the interview guidelines, advised on the methods used to recruit women to participate in the study, oversaw the appropriate protocols used in the community, received the research findings and advised on the production of the final document (See Appendix A). A local woman was hired as a community researcher to conduct interviews in Cree, Dene, Michif and English and to transcribe the interviews. The community researcher received training in research ethics, interview skills, and qualitative data analysis. The Committee also received some training in research methods (See Appendix B).

The Committee adopted the Ethical Guidelines for Aboriginal Women's Health Research (Saskatoon Aboriginal Women's Health Research Committee, 2004) to protect the rights of individuals and to ensure that the research provided benefits to the community. The research proposal was submitted to the Prairie Women's Health Centre of Excellence Research Advisory Committee for ethics approval.

Métis women expressed a desire for research that reflected Métis culture, values and languages. Métis women who spoke Cree, Dene, and Michif wanted to be able to discuss their health issues in their own languages and wanted the interviews conducted by local Métis women from northern Saskatchewan. The research methods adopted allowed participants to work towards a vision of accessible, high quality health care that meets the needs of elderly Métis women care recipients and caregivers. Thus, the research employed community-based qualitative methods to gather information from Métis women about the need for and access to home care and long term care services for elderly women in the community.

The interview guide (Appendix C) was developed in consultation with the local Committee and the literature review further informed the formulation of questions for individual interviews. Questions were included on the following themes: access to home care; access to long term care; quality of care services for the elderly; needs of elderly women and caregivers; distance caregiving; planning caregiving; coordination of care/care management; community services; transportation; alternative housing; isolation; cultural sensitivity; cultural safety; language; and possible solutions for the future of elder care within the community of Buffalo Narrows.

In individual interviews, women were asked to describe the types of services needed and their availability, the quality of services available and what was needed for improvement. They were asked to identify barriers limiting access to services and to suggest ways those barriers might be overcome.

PARTICIPANTS

Participants interviewed for this project included elderly Métis women who were users of health services, Métis women who provided informal care to family members, and Métis women who were service providers. The participants were recruited based on their experience and knowledge of elder care with the assistance of a key informant, followed by snowball sampling. Eight in-person semi-structured interviews were conducted with 12 women: three interviews with individual service users, four group interviews consisting of a service user and a family member and one interview with a health care provider. Six of the women were elderly Métis women using health care services themselves; one was an older Métis woman accessing health care services for herself and for her disabled daughter; four were Métis women who were providing informal care to family members; and one was a Métis woman who was a service provider in the community of Buffalo Narrows. Each interview was conducted in the home of the participant and lasted approximately one hour.

The interviews were taped and transcribed verbatim to provide an accurate record of the women's voices. The material from the transcripts were analyzed using a computer assisted qualitative data analysis program, Atlas-ti, and organized by important themes that addressed the questions and concerns outlined by the community advisory committee.

A draft of the report was presented to community members for further discussion, verification and/or revision.

LIMITATIONS

The small sample size (n=12) may create potential limitations for the outcome of the study. Potential participants were easily accessible through the use of a key informant who had already established strong, trusting relationships with the participants. All participants contacted were agreeable to being interviewed, however reliance on key informant interviews may have limited the interviews to those with personal connections to the research committee.

RESULTS

The objective of the interview process was to discuss with the research participants the strengths and weaknesses of the current health care situation that directly affects the elderly Métis women of Buffalo Narrows and the extended family members acting as informal caregivers. The aim was to develop a thorough picture of not only the existing services available but also to identify service needs that could influence government policy for health services for elderly Métis women in rural or remote areas.

Through the process of data collection and analysis, four themes emerged from the data outlining a continuum of care:

1. existing services
2. client issues
3. recognizing current barriers to services
4. identifying potential service needs to better serve rural and remote communities

Each theme is interrelated with the next in what could be described as a continuum for care based on the identified service availability and service gaps of this population of elderly Métis women. The identified availability and gaps in service spoke directly to the barriers to services outlined by Pechansky and Thomas' (1981) model. These in turn lead to recommendations for addressing existing barriers. Each theme is presented and discussed here using direct quotes from the interviews conducted in the Northwest Saskatchewan Métis Women's Health Research Project.

A. EXISTING SERVICES

The current services available for elderly residents are a mixture of imported health care services and community based programs. These services consist of home care, diabetic nurses, *Meals on Wheels* and organized community social programs offered through the local Friendship Centre. Existing health care programs are managed through the local home care office and nursing staff is available to address health issues:

"They have a Home care nurse and she does everything that is expected of a nurse. If you need any help with anything you just phone and she makes an appointment for you to come in and see her. She (the participant) said if the nurse is needed to go out to make a house call she will go and do it."

"And homecare's, and there's the nurses that come and check on seniors and do their toenails, check their blood pressure and they do that once a week, plus you have your diabetic nurse"

The home care office also offers supportive living programs that enable the residents to continue to live independently. These programs include services such as *Meals on Wheels* and house cleaning, as well as respite for extended family who take primary care

of their parents. However some of these services come at a cost. Although the cost is minimal for clients on a fixed income, this additional support is often not an affordable option.

"[Home Care] provides cleaning services to the ones that want it or to the ones that need it. [Home Care] gets recommendations from the Health Centre and the Doctors. [Home Care] don't only do services for the elderly, they also help out if a patient has just had surgery and can't do their cleaning, [Home Care] goes in once or twice a week to help keep their house clean."

"Some of the other things that Home Care is doing is providing meals on wheels for the elderly that want it, but it does cost them \$2.50 per meal."

"[Home Care] also does respite care if the mother needs time to go shopping or just needs some well needed rest."

The local friendship centre provides some of the additional services available to the elderly women of this Northwest Saskatchewan community. These services included community activities and gatherings as well as “pick ups when they have gatherings”, recognizing that many elderly residents require transportation to get to activities and gatherings.

B. CLIENT ISSUES

During the interviews, the participants identified two main areas of concern that appeared to be a consequence of location and economic position. The isolation of living in a remote location was a concern for the elderly women in terms of opportunities for social interaction and feeling dependant on others for assistance. The need for social interaction was highlighted in one woman’s desire to have ...

"gatherings at other ladies' houses to just have coffee and visit each other, because it gets quite lonesome being home alone and nobody to talk with. Nobody visits anymore, they just phone and see how you are."

In relation to the feelings of dependence on extended family members to assist them in household duties or to provide transportation to and from various activities, one woman talked about feeling as if “you’re forgotten people when you turn 65”. She reflected on this, stating that it was “pretty sad, because to me the elders are forgotten people, when you turn 65 you get a good kick in the butt and you stay there”.

These concerns also speak to the availability and affordability of current services in Buffalo Narrows, as well as the need to rely on extended family members to fill in the service gaps in the community.

"I need to take her myself because I get no help from anyone in the community. They know she is getting older and it gets harder for me to take her out in public because she tends to act up once in awhile, but

they don't make any attempt to come to my home and see how she is doing."

"And their travel, if you don't have family taking you and like most of the time, you still have to help out a little bit with gas even if family takes you."

"There again, I depend on the family to do and which sometimes maybe the family gets tired of me to but I still holler for them to come and do it."

The women recognized the difficult position they would be in if they did not have family to rely on to assist them with transportation. They spoke of the possibility of not having extended family, stating that...

"yeah it is just her family that takes her, if she had no kids no one would, no one would take her, she would just have to stay home."

Women rely on their families to get to social activities, to necessary appointments within the community and to local city centres for special medical attention.

"Yeah the transportation: for you to go to the hospital or go to the city you can't go by taxi or ambulance, your kids have to take you, right? So you have trouble with that. Cause if you didn't have kids, who would take you? Nobody!"

The ability to rely on family for social interaction, as well as easing some of the financial burden of unexpected medical needs was critical. The women spoke of the challenges of living on a fixed income and the insufficient amounts provided through pension allotments (Old Age Security) to meet basic needs. The women said that even without added medical expenses, the monthly pension amount was often not enough to cover basic expenses.

"And they think you are getting such a big cheque at the end of the month because you're not, if that's what it comes down to most of these people don't even have enough to last till the fifteenth of the month, even the ones that don't smoke, that don't drink, they still have to eat."

C. CURRENT BARRIERS

Although there may be services may be available in the community, they can be essentially inaccessible. The women identified two major barriers to service, availability and accessibility. Within accessibility, the participants further identified barriers of language (acceptability), transportation, financial resources (affordability) and social supports that limit their ability get the resources they need.

Availability

Barriers to the availability of services were based on the physical location of the community and the lack of, or proximity to, needed resources which spoke to the inability of existing services to meet the needs of the community. The women noted that some services were completely unavailable in the community:

"It would be nice to have one [Pharmacy] in our own community, instead of them being away in another community."

"Oh yeah it would be great to have something like that [a long-term care facility] here, because she is right at home and she doesn't have to go out of town like she knows everyone here and it's not hard on her emotionally you know ..., she knows people will come to visit her, she's closer to home."

"We don't have dentists or optometrists here, we got to take her to the city, these would be good to have here - something for seniors because it is too much for them to have to travel you know."

The women also reported difficulty in getting health services within the community for immediate health concerns. Many found it difficult to make an appointment and go to the clinic when medical personnel were available, leading to further feelings of isolation.

"If I don't make an appointment to go and see a doctor I just have to try and figure it out myself."

"I remember one time I asked her if she done home visits. She said no we don't, you have to come to the clinic and make an appointment to see me when you have something about, if something is not going right for you."

"As I was saying I am a diabetic myself and I don't think I have ever seen the nurse, the diabetic nurse for the last year. I've seen my doctor but not the nurse and when you have a question about a something about being a diabetic [it would be helpful to speak to a nurse]."

"I don't think there's one day in any time, any given time that I feel good in one day. I don't know if it's my diet or my exercise it's something that I'm not doing right, but who can I ask about it."

Further, if the services were available in the community they were in such great demand that the providers were unable to dedicate sufficient time to the clients and could only provide minimal services needed to maintain independence.

"There's a lot of things she can get help with that they don't have here because with homecare we only have two workers and they have to go all through the whole community, the same with our physical therapist she can't come in cause there's not enough physical therapists, there is only one, so she can't get her therapy."

Accessibility

The interview participants recognized that outside of the availability of the services offered in their community, accessing these and other services also presented a challenge due to a multitude of factors including transportation, financial resources, external supports and language barriers. Although the issues identified are interrelated, each factor independently creates a significant barrier to accessing services when those in need of the service experience difficulty with mobility.

Transportation was presented as a major issue to accessing services because many of the necessary services were based in another community and the residents had to travel great distances to acquire the health services they needed. Some were fortunate to have extended family and social supports in the community to help them not only with transportation but also with some of the home care services that would be available in urban centers. Further, those with family within the community depended on them to provide not only home care services but also to follow through on medical recommendations, such as basic physiotherapy. As a result, extended family members were often the ones responsible for ensuring a continuum of service that would normally be assigned to health care specialists.

"I am the one that has to do it for her and if I don't do it and she doesn't do it, so we need more physical therapists, even physical therapists assistants. We need more homecare cause she's not getting the full care that she needs."

Affordability

There is a need for services that promote independence but they are not available for free.

"Especially for spring cleaning like you cannot depend on your family alone to do all your cleaning for you, especially in the spring when they have their own homes, they have their own kids to look after and then you have to pay the [homecare] so much an hour and I don't think that they're that busy. Everything should be done for the elders, not at \$2.50, maybe a little lower or even not at all."

Even though the residents appreciated the option of meal and housekeeping programs, the program charge presented a barrier. For many women, their fixed income rates did not provide for the benefit of additional assisted living programs. Participants stated, "they [homecare] charge \$2.50 an hour, you can't really complain. It gets to be expensive when you don't even know what you are being charged for". The women recognized that "more would use it if it was less".

Residents of this community are also expected to cover the costs to travel to obtain services not available in their home community.

"I think what her and I would agree with is the traveling. She don't have the money, I don't have the money, if [the hospital] was in our community we wouldn't have to travel. That's the big issue, that's the biggest issue of all. Because when she has an emergency or if she has a check up, we got to take her the day before, we got to get a room, we got to get her to the hospital. See that's already three days of travel, when she's done her check up in Saskatoon, we have to spend a night again because it's too late to come home."

"If she was to go to the clinic here, if I didn't have a vehicle would there be someone to pick her up? Because here at the clinic they're not allowed to come and pick her up with their vehicle, the nurses can't do that. When they have an emergency they can't come and pick her up and take her to the clinic. They can't do that, it's something in their insurance policy. I don't know what it is. See if she had no way to get there, I guess they would make a house call."

The pension allotments of the residents were insufficient to meet the financial burdens of unexpected health needs or in acquiring health care to maintain their current health status.

"They can't afford to go on a taxi. They are all on a fixed income every one of them."

"Even if they have a y card ... for a medical and the ambulance most of them have to pay for the ambulance hey."

"On some certain pills, like some prescriptions when the doctor gives the pharmacy, hmmm I don't know some kind of permission for that month ... or for a couple of months to lower the price, they do but only under the doctor's consent."

In addition to travel, those residents who did not have family to rely on for assistance would have to pay to have an escort from the community to take them to appointments in other communities. These services were not covered by their health plan and thus became an out of pocket expense.

"There again you have to go to the welfare for them to pay for that escort, if they are going. So who pays for that escort is it you or the welfare who pays for that escort that goes with you on that taxi?"

"On top of it, they have to pay for the escort too, they have to get a room if they don't know anybody that lives in Saskatoon, that's really expensive. You pay for your gas, pay for your room, then if you have to be there for two days. That's two rooms, the gas home, it's really expensive for seniors."

"Because, there's a lot of times the doctors are coming here that day and no nurses are coming or going, so we have to drive to Ile a la Crosse to pick up the prescription, so we need our pharmacy back here."

Acceptability

The elderly residents in the community also relied on their families for translation to clearly express their needs to medical personnel recognizing that:

"It would be good if they had someone who could talk to them in Cree about mental problems like say psychology, because there's a lot of things they don't know, how to cope. Like myself I understand Cree, but she don't understand English. Some have communication problems. When I'm mad at her she misunderstands and takes it the wrong way, see because I can't talk Cree."

"And then when we get there she, say she was there all day - like six hours. And then we got there and we visit for 2 hours, within those two hours we would be running around doing all this because she didn't ask [the medical staff to help her] within those six hours."

The participants identified language as a barrier not only in terms of doctor-patient relationships but also in terms of expressing symptoms and understanding diagnoses.

"Especially if they can't talk [English] if they don't understand too good when somebody is telling them something, like maybe, just like me I'm deaf most of the time, half anyway ... I understand pretty good what they're trying to telling me, but there's some people that don't understand, some of them that only speak maybe Cree or a little bit of English, not much, so they have to take an escort accordingly. An escort would do that for them."

"Yeah, so even in the mental health field or in at the clinic [it would be good to have] somebody who talked Cree and come to talk to her about problems we're having at home and how to get through to her."

"Well for myself it is okay because I can speak English, but I imagine someone that only speaks Cree would have a hard time trying to get their message out to the doctors or else for them to understand what the doctors are trying to tell them."

Accommodation

The women recognized the limited staffing of home care personnel in the community, noting that office hours and appointment times could not be flexible because the office was always understaffed, restricting the time and space for accommodating for their needs.

"She [the home care worker] also said they are short of workers, so they only have two workers that go around and do the cleaning."

"But they need more care givers. I think they should have some for night time too."

D. SERVICE NEEDS

Participants made many suggestions for additional health services in the community that would best meet the diverse needs of the elderly population. Their suggestions were based on discussions about the unique issues and needs of this community. Recommendations were divided into three categories intended to address the needs on an individual, community and program level.

Individual Needs

The women recognized that with additional supports they would be better able to live independently. Included in the vision of independent living were the resources needed to make them less reliant on their families for transportation, household activities and social contact. Transportation was a reoccurring issue throughout the interviews and respondents identified not only the need for reliable transportation to and from appointments, but also transportation services that were affordable (and preferably free), including travel subsidies for out-of-town appointments.

"Just to your rooms, where that guy stops that's were you're supposed to stay, I guess. From there on you need to take a taxi to your appointments everywhere, take a taxi back to the hotel, doesn't take you anywhere and that's wrong, when you , when they take you on a medical trip, you should be taken to your appointments in the mornings and picked up again."

"Another thing would be nice if the elderly had some kind of coverage for their drugs and for travel. For example when we need to go to, lets say, Saskatoon for a doctors appointment, we need to pay for gas and hotel rooms, meals and it gets costly. It would be nice if we could have a taxi take us and we had coverage like the Social Assistance Clients do."

The women recognized the need for personal assistance for those who did not have family support to escort them to appointments outside of the community. They thought this person could also act as the mediator between clients and medical personal by addressing language barriers and ensuring clear and accurate communication.

"Yes it would be good to have a escort that would help the patients, so they can understand what is going on and not be left in the dark."

"In [a Saskatoon] hospital, nobody [no translator] was there, Family was always with her, there was family. Yeah there was none [translators] there, but there was in [another Saskatoon hospital]. It would be good for the seniors if they did have that because a lot of them don't ask for well they can't, they don't know how to ask for it, they don't even know what the name of it is, until the interpreter gets the information from them and tells the doctor this is what she needs, she's has this kind of pain, this is where it hurts and then they know what medication to administer hey."

Language was a major issue for the participants. Access to health care workers with shared language or having a translator in the community was recognized as a personal need for those who access health services and other independent living tasks in the community.

"It would be good if, hmmm, on emergencies if she were going on ambulance if someone was in there who spoke her language to assist her and to make her comfortable, give her medications and what not."

"And it would be nice to have that translator too for telling them about the up to date banking, you know, how to get a card, to get a cheque book so they can, for finances how to do all that."

"Someone in Cree to even tell them about their will, to get it all set up. Everything"

Women noted the individual needs of the elderly clients within a household such as requiring someone to "cut their grass and snow removal and all that", as well as having the supported living tools needed to safely live independently.

"If you're having a bath and want to pull yourself up, they're handy for that. Or even if you're having a shower if you know in case, just like that, say I just about fell and I hung onto that pole."

The participants identified the need for consistent and available social supports. Issues of loneliness and isolation could be best addressed by having additional support so that the client did not feel they had to "chase the nurse", that she should be there to answer questions and concerns.

Community Needs

Due to the remoteness of the community, the need for more home visiting and community support of the elderly residents was identified.

"And with the school grade 11 and 12 maybe they could be candy strippers; Or you know where they come and say that we're having a bingo, we're selling tickets or doing this where you can order, you know they sell cookies and all that other stuff. Yeah if they come here and bring it to them because they can't go out."

"Nobody visits anymore they just phone and see how you are. Gather a few ladies together and maybe do some crafts together while we visit, that would be nice."

These social activities were identified as a means of addressing the feelings of loneliness and isolation on a community level. The women spoke of other communities that had organized social activities for the elderly residents and expressed a desire to have similar programming in their community. This would be done by increasing community awareness and ensuring that "the public should be aware, like everyone knows where the seniors are". Addressing the isolation of the elderly was identified as a community

issue and the lack of available social resources was a major concern to elderly women regardless of existing social supports.

"Yeah, the ones who don't go out very much, at least once a week there should be somebody going into these homes to visit you know, or make it a whole week, but choose different people, and they should even meet once a week somewhere and have these crafts or story telling, anything to get together."

"There's nothing much for the seniors in our town, to tell the truth, and if they say well seniors can go and gamble, what do they expect them to do, sit at home and rot away. They have got to have something to entertain themselves."

"It would be nice if the complex, or the recreation would set up some kind of what would they call that, where they come in and do a walk thing. They did that at the friendship center but maybe they didn't have enough interest, where they pick them up, or you drop them off and they just walk around the gym, but it would be nice to have medical people."

"And I wish they had what would I say. I don't know something more, a facility where they can gather you know and get together because they are at home too much alone, they don't know how to socialize."

"So they need something where they can gather to socialize. More events happening, like even if we had, I don't know, a big swimming pool for the seniors with that salt water where they don't sink, so they don't drown, Watrous has that. Something like that, we have the lakes but they are not going to go outside there's too much bugs."

"Even if the library could come here to bring them books from the library like they should have access to Cree books, I'd like my mother to know about Social studies, how the world's changing cause she has no idea, if they ordered Cree books ... she could read that because she reads Cree bibles. So why can't the library have those kinds of books."

"It would be nice if we could have gatherings at other ladies houses to just have coffee and visit each other, because it gets quite lonesome being home alone and nobody to talk with."

"I think they should have something even a exercise program, where someone comes in because well, they're older and they haven't done exercise."

Participants also recognized the absence of available medical services in the community, stating that they had to leave the community for services ranging from medical appointments to picking up medications at the nearest pharmacy. In response to this the participants felt the community should have a free medical van that would assist them in emergency needs, attending appointments and picking up prescriptions or groceries.

"Yup if I didn't have a vehicle, so it would be nice even if they had a, I don't know someone had a vehicle or medical for little medical emergencies like that, with a stand by medical or something."

"Because, there's a lot of times the doctors are coming here that day and no nurses are coming or going, so we have to drive to Ile a la Crosse to pick up the prescription, so we need our pharmacy back here."

"Well it would be nice to have our pharmacy back, since we lost the pharmacy we need to go to Ile a la Crosse for our medication if there is no doctor coming to Buffalo and it gets costly for gas to go back and forth."

"If she wanted to live independently by herself, it would be nice if our stores offered free delivery for the seniors, you know like they would phone them and say do you need groceries today, like if they did it once or twice a week and then they would deliver it and she would pay."

Programming Needs

In addition to the community response in supporting the elderly residents of this remote community, participants felt that programming brought into the community should be funded to fully support the elderly residents in a more comprehensive and affordable way. The major service needs recognized both the need for subsidized programming and increased personnel support to provide care to the community. A distinction was made for additional costs for elderly residents to be eliminated for additional services such as meal and home services stating that the ...

"Homecare services I think should be free for the elders, they are being charged now I guess what is it \$ 2.50/hour."

"I understand if ..., a younger person went out for an operation and came back and couldn't do their work, sure maybe then homecare could go in there and do their work and then charge them. But not elders, I don't think elders should be charged for homecare services maybe more of them would use it if ... they weren't charged."

The respondents also recognized the need for homecare to become more involved with the community in developing and implementing services to best meet the unique needs of each community.

"There's nothing in our town for homecare. There should be more involvement with the community, with the elders anyways. Some people sit at home, I think to me lots of people are lonely in our town."

In addition, the participants recognized the need for increased home care personnel in the community:

"Its okay, but they are short of workers. I find it hard to do the work, so Homecare comes in and does the rest of the work that I can't do."

"There is lots left to be seen if they do implement more programs for the elderly, but I guess only time will tell and they do need more staff."

As well as extended their services to include overnight care

"Homecare would be good if they had someone where they stayed overnight, say what if I got sick and there was no other family members... someone here to take care of her while I'm gone."

DISCUSSION

Aboriginal populations continue to be overrepresented in Canada's statistics on poverty, and social and health concerns. Aboriginal seniors often experience much poorer health than others of similar age and with similar physical, emotional and medical needs. These issues are further compounded by limited personal resources including financial resources, poorer housing conditions, fewer household conveniences and limited transportation. These conditions will become more problematic through the years as the elderly Aboriginal population continues to increase.

Most existing research does not adequately examine the health care needs of Aboriginal communities because it is rooted in a western perspective that sees Aboriginal communities through a pathologizing lens (Ermine, Sinclair & Jeffery, 2004). Many health care services, including health and social service research are charged with being neither culturally sensitive nor inclusive of the unique aspects of Aboriginal beliefs. Further, research focuses on individualistic approaches that do not include Métis women's collectivist focus on health and well-being (Bartlett, 2005). Métis women describe health and well being on a continuum, and are mindful of a holistic perspective that includes spiritual, emotional, physical and mental considerations incorporated into health care responses.

The literature identifies the need for more available and comprehensive services in existing Aboriginal communities where the elderly population is identifiable and the service needs known. These programs should mimic the services currently provided by informal care providers; including housecleaning, home maintenance and repair, transportation services and opportunities for physical activity and socializing (Buchignani & Armstrong-Esther, 1999). Further, interventions need to take into account the unique characteristics of Aboriginal communities and education strategies are needed to facilitate awareness, provide information conducive to prevention and control (Daniel et al, 1999; Newbold, 1998).

Currently, gaps in the formal and informal service provision for elderly residents cause many people to fall through the cracks. This occurs because of missed or inadequate referrals; lack of knowledge about community resources on the part of health professionals and patients; recruitment and retention of health professionals; funding cuts and closures of necessary services (Magilvy & Congdon, 2000). Therefore, a recommendation has been made for health professionals to reside in the communities that they service. This would give health care professionals the opportunity to become familiar with the community and develop positive and trusting relationships. It is essential that professionals are recruited and maintained in the communities where the patients reside in order to support elderly residents in their home community (Thomlinson et al, 2004).

The Métis women in Buffalo Narrows have informed many key recommendations for meeting the complex service needs of their elderly clients and create a northern health system that would ease the tension on extended family members and give elderly patients more independence.

Accessibility

- Reliable transportation to and from appointments
- Transportation services with escorts for out of town appointments
- Medical/ community van to support independent lifestyle ie., grocery delivery, prescription delivery

Availability

- Increased on-site health personnel
- Increased on-site services including respite or a long term care facility so that elderly family members can stay in the community
- Pharmacy in the community

Affordability

- Travel subsidies for out-of-town appointments
- Free transportation services in community or neighbouring communities for health needs
- Drug coverage for necessary medications

Acceptability

- Mediator for appointments for translation
- Holistic medical response with community focus to health needs
- Social activities/ recreational activities for elderly residents

Accommodation

- Emergency services
- Longer hours, after hours or 24 hour care
- Increase range of services provided by home care/ health care

Although the Saskatchewan Northern Health Strategy (2001) has recognized the importance of a holistic response that incorporates the unique aspects of Northern and Aboriginal communities, the reality, as demonstrated through the voices of the Métis women of Buffalo Narrows, falls short of its mark. Due to historical and cultural factors there is some danger in incorporating both Northern and Aboriginal communities into the same framework as funding for health care is different for Métis peoples. Thus, while dimensions relating to location, such as accessibility and availability, may share similarities with Aboriginal experience, all other dimensions must look at the unique aspects of Métis communities and culture in creating a response to the specific health care needs of this diverse population.

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APPENDIX A

Research Project Timeline:

1. Literature Review and Research Proposal Development

The Research Team Leader and the Métis Women's Research Committee of Buffalo Narrows will conduct a literature review, develop a research proposal and submit it for ethics approval.

The Committee will assist in selecting local women to be hired as community researchers and receive training in community-based research methods.

2. Training of Community Researchers

The Community-based Research Training Workshop will be held in Buffalo Narrows. The workshop will build upon participants' existing skills and identify areas where improving knowledge and skills would be beneficial.

Workshop participants will learn:

- How to conduct community-based research
- How to involve the community women
- Ethics of community-based research, including issues of community consent, community control, and confidentiality of information.
- Interviewing skills
- Focus group techniques
- Basic steps in qualitative data analysis
- Taking the material back to the community

PWHCE will develop a Community-Based Research Training Kit that will be used to train community researchers and will be provided as a guide for the women at a community level.

3. Data Collection

Elderly Métis women, Métis women who provide care to elderly relatives, and Métis women who are service providers will be recruited to participate in the research project. They will be invited to participate in either individual interviews or small focus group discussions. There will be three focus groups and each focus group will have six-eight participants. Individual interviews will also be conducted to hear from women unable to participate in focus groups.

4. Data Analysis

The Research Team will analyze the findings from the focus groups and individual interviews and prepare a report which identifies important themes and illustrates them

with quotations from the women themselves. The data will also be used to develop a critique of existing government policies and programs which affect access to elder care services in Métis communities.

5. Sharing Research Results with the Community.

The research team will prepare a draft report of the research findings and take this back to the Métis Women's Research Committee and to the community for review, verification and revision. This will also provide an opportunity to develop policy recommendations for improvements to health services for elderly Métis women.

6. Prepare a Final Research Report

Prepare a final research report that includes the major findings and policy recommendations. Have the report reviewed and approved by the Métis Women's Research Committee.

APPENDIX B

Research Training Workshop

Buffalo Narrows

January 21, 2006

1. Facilitators' Notes
2. Introductions
3. Purpose of the Day
4. Goals of the Research Project
5. Committee Members' Roles
6. Roles of the Researcher and Research Assistants
7. Overview of the Research Process
8. Research Design – Goals, Research Questions, Research Methodology, Workplan,
 - a. Data Collection - Gathering Information
 - b. Data Analysis – Looking for Patterns and Important Themes
 - c. Reporting the Results
 - d. Taking Action
9. Doing Research in a Good Way – Ethical Research Guidelines
 - a. Distribute handout and go over basic points covered.
 - b. Facilitate group discussion of risks and benefits in this project and situations that might arise where they will have to apply these ethical principles.
 - c. Saskatoon Aboriginal Women's Committee Ethical Guidelines - Go over basic points.
 - d. Go over the Consent Form to be used in this Project. Read it out loud. Ask if there are any questions.
10. Selection of Participants
11. How to Conduct Focus Groups/Interviews
12. Review of the Focus Group/Interview Guide
13. Practical tips (using equipment, taking notes, keeping organized)

APPENDIX C

Interview Guidelines For Groups And Individuals

1. Let's begin with introductions. This project is to learn about the health care needs of older Métis women in Buffalo Narrows.
2. Can you briefly describe why this topic is important to you?
 - i. Are you an older woman with health care needs?
 - ii. A service provider?
 - iii. Are you looking after the health needs of any older women in your family or community?
3. What kind of health care services are available to older Métis women in Buffalo Narrows? Which agencies are delivering these services?
4. How well are the services in the community meeting older women's needs for home care? for long-term care?
5. Are there any barriers to older women accessing health care services? (Cost, language, cultural sensitivity, transportation?)
6. What kind of services do you believe elderly Métis women in Buffalo Narrows need to live independently? (Prompt with questions about bathroom up-dates, housing maintenance, other?)
7. Do you or older women travel outside the community for medical treatment or health care? Can you describe this experience? What works well for you and older women and what does not?
8. What supports are needed for medical trips outside the community? (Prompt with questions about escorts, cultural sensitivity, language.)
9. What type of programs should be provided for elderly Métis women in the community of Buffalo Narrows? (Prompt with questions about visiting with elders, new services, more culturally appropriate services)
10. What about the women who are providing services or providing care to older women in the community – how well is the health care system working for them? What changes would service providers and caregivers like to see?
11. Do you have anything else you would like to say about health care services for older Métis women in Buffalo Narrows? If you could advise the health region on how to improve services for older Métis women, what would you say?