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**SHARING OUR STORIES ON PROMOTING HEALTH AND COMMUNITY HEALING:
An Aboriginal Women's Health Project**

Connie Deiter and Linda Otway

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SHARING OUR STORIES ON PROMOTING HEALTH AND COMMUNITY HEALING: An Aboriginal Women's Health Project

1. INTRODUCTION

The mandate of the Centres of Excellence for Women's Health (CEWH) Program is to improve the health of Canadian women by understanding and responding to women's health issues. Aboriginal women's health is a priority for the CEWH centres across Canada. This report is commissioned to expand on the questions for research.

The authors of the study, Connie Deiter and Linda Otway, are both First Nations women. Both are educators and researchers of issues concerning their people and in particular, Aboriginal women. The Prairie Women's Health Centre of Excellence (PWHCE) contracted the authors to conduct the study "Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project". The study was conducted from February 1 to May 1, 2001.

The report is unique in that it presents and honours the perspectives and stories of Aboriginal women in describing what good health and healing means to them and their communities. A sample group of 98 included Aboriginal women from urban, reserve, and northern communities in Saskatchewan and Manitoba. Of the 98, 52 were from Manitoba and 46 from Saskatchewan. Oral history interviews were completed with five elderly women relating to cultural knowledge and health concerns of senior women. This study resulted in the formation of various recommendations for improvements to the health and well-being of Aboriginal women.

Purpose

The purpose of this study is to provide analysis and recommendations on the current situation of Aboriginal women's health. The specific research objectives include:

- ❖ To gather stories of Aboriginal women in Saskatchewan and Manitoba, documenting their experiences and strategies in promoting community health and healing;
- ❖ To highlight the cultural frameworks and worldviews that underpin the experiences and approaches that Aboriginal women use to promote health and well-being among individuals and communities;
- ❖ To conduct a literature review to highlight studies and reports that provide insight into the health of Aboriginal women and important strategies to promote health;
- ❖ To translate the stories and experiences obtained into policy recommendations; and
- ❖ To determine the ways that Aboriginal women's experiences in health and healing promote ownership and control among Aboriginal people over their well being.

Statement of the Research Problem

Aboriginal health is a complex issue. Separate federal departments address First Nations' health issues. Constitutionally, the federal government has exclusive jurisdiction for "Indians and lands reserved for Indians" (British North American Act, 1867, sec. 91.24), resulting in the establishment of the Indian Act, which is designed to administer the services and responsibilities of the federal government for registered Indians in Canada.

The Medical Services Branch (MSB) of Health and Welfare Canada is a federal health agency mandated to deliver health services to First Nations' people. It is separate from the Department of Indian Affairs and Northern Development. Criticism from some health researchers argues the MSB is not working in concert with other federal departments in the move towards the Population Health approach. Health researchers argue MSB continues to view health in medical and physical terms.

The Population Health Approach recognizes that health is influenced by a number of factors, or determinants. One determinant is gender; others include income and social status, social support networks, education, employment and working conditions, social environments, physical environment, biological and genetic factors, personal health practices and coping skills, healthy child development, healthier services and culture¹. This approach is similar to Aboriginal concepts of health and wellness.

Health researchers in Aboriginal communities agree that "social, economic, and political factors have profound effects on the relationship between lifestyles and

health of Native peoples in Canada" (Long and Fox: 241). In their article, David Long and Terry Fox include a report conducted on health in a First Nations community in Alberta. The definition of "health" by virtually all respondents in the study emphasized the holistic nature of self, based on the medicine wheel, as being a balance and harmony between the spirit, physical, emotional and mental components of the individual.

A two-fold approach was identified as being largely responsible for turning the health and healing focus of the community in a positive direction. These include the revitalization of Aboriginal spirituality and the rediscovery of some almost forgotten cultural traditions. Together, these have contributed to the strengthening of Aboriginal identities, the integrity of efforts to bring about social and political change, and their belief that change toward healing is possible (ibid. 256). Specifically, Long and Fox identified that the health needs of Aboriginal women have to be considered separately from those of Aboriginal men.

According to Long and Fox, "*federal government policies and initiatives continue to demonstrate the overly medicalized, bureaucratic approach to healing and health that has informed much of the history of Indian health services in Canada.*" (ibid). While a growing body of literature includes social and political causes for the poor health of Aboriginal people, the government continues to look at the problem from a fragmented approach. The article identifies the federal government's transferring of First Nations' programs and services to the provincial government as the most significant obstacle of health and healing in Aboriginal communities.

The research problem for this study is to define health, healing and well being from an Aboriginal women's perspectives and to provide recommendations toward achieving good health.

¹ Population Health Approach – Health Canada at www.hc-sc.gc.ca/hppb/phdd/approach/index.html

2. ABORIGINAL WOMEN IN CANADA: A HISTORY

Colonization has severely affected the health and well being of Canada's indigenous population, and in particular, the health of Aboriginal women. Colonialism has been described by James Frideres, a Sociology Professor at the University of Calgary, as a seven-step process, as follows:

1. The uninvited arrival of the colonizer into the territory
2. The destruction of indigenous social and cultural institutions
3. The creation of economic dependency by the indigenous people on the colonizer
4. The establishment of external political control
5. The provision of low level social services such as health, education and housing
6. The use of a colour line, i.e. racism, to justify the above
7. Weaken the resistance of the indigenous people (Frideres 2001: 4-12).

That is, the process begins with forced or uninvited entrance of the dominant on the colonized society which acts to constrain, transform or destroy indigenous culture; then, representatives of the dominant power administer the law and control government bureaucracies. There is a separation of labour status and an economic dependency encouraged between the colonizers and the colonized. As well, there is provision of low level social services such as health and education. Racism develops as a principle through which people are seen as biologically inferior in order to justify their domination and exploitation, and the colonizer seeks to weaken any resistance on the part of the colonized (Frideres 1983: 3-8).

In what is Canada today, the French were the initial colonizers. They implemented a strategy of colonization that included an effort to convert and civilize the Indians, in

the name of Christianity. The Jesuits were particularly effective in their colonizing efforts. The colonization focused on the fur trade and ensured a steady and profitable supply of furs from the Indian trappers. The Jesuits introduced a European male-dominated, nuclear family structure that undermined the traditional extended family structure of the First Nations. This had a devastating effect on the role of women within First Nation's society. (Bourgeault 1986, Anderson 1991: 164).

The English took a different approach. They expected the Indians to come to them with their furs. This approach left the Indians intact with respect to their mobility and their way of life, at least for the moment (Brizinski 1993: 96). Both the French and English colonizers took Indian women as country wives and had children with them. The mixed blood children of European fur traders and Indian women became known as Half-breeds or Metis.

Mona Etienne and Eleanor Leacock address the question of colonialism and its detrimental effects on Aboriginal women. They write:

In all parts of the world, a rising European bourgeoisie sought to make profits from different peoples and their lands, whether through extracting wealth, using native labour, or decimating indigenous populations in order to establish settlements in their territories. As with the origin of exploitation itself, the imposition of capitalist exploitation linked the subjugation of people generally with the special subjugation of women (Etienne and Leacock 1980: 16).

Leacock documents the Jesuits' efforts to introduce the European norms of sexual and conjugal behaviour, and the patriarchal nuclear family to the Montagnais-Naskapi. She states the Jesuits continued with systemic attacks on the individual autonomy of women and the egalitarian relations of a band society. The Jesuits wanted to introduce four changes to Montagnais-Naskapi society: discipline for children; the need for an autocratic

government; the subjugation of women to a patriarchal nuclear family and residential schools for children. They argued this would bring First Nations from "savagery" to "civilization".

All of the steps of colonization described by Frideres are evident in the experience of Aboriginal women. Women's roles in Aboriginal societies changed as the colonizers addressed the demands and technical innovations of men, favouring men's access to cash, encouraging economic dependency of women and, consequently, encouraging the emergence of the patriarchal nuclear family. These changes were compounded by the transition from group rights in land use to private property. The effects of individual land tenure on the position of women are well documented. Colonized peoples have often resisted these changes, especially changes in the institutions of the nuclear family and private property ownership in land. Colonialism is an ongoing process that continues to transform economic structures and relations between the sexes where political independence has been attained (ibid. 19-20).

Government policy at the time reflected the goal to make room for the influx of European settlers who were to be the future market for European manufactured goods, and producers of the new agricultural products (Adams 1989: 61, Carter 1992: 274). The problem was that Indian and Metis were the majority population and understood they had ownership to the land. As the Canadian government could not afford to fight expensive Indian wars like those taking place in the United States, they negotiated treaties with First Nations and recognized Metis claims to the land. Between 1871 and 1899, in Saskatchewan and Manitoba, the federal government negotiated treaty and assignment of reserve lands with the Saulteaux, Nakota and Plains Cree. The negotiations only took place after calls by the chiefs to begin the treaty process.

Pre-Treaty Health and Healing

Health and healing for First Nations and Metis was tied to the resources of the land. A holistic approach was taken that involved the mind, body, spirit and heart (feelings). Healers or shamans could be either men or women who were usually born with a natural gift for healing, but also studied under the guidance of Elders (Mendelbaum 1979: 146). The healer also learned through experience and spiritual development. Women were midwives. They possessed the knowledge of nutrition, herbology, gynaecology, counselling, and obstetrics (Malloch 1982: 105). Known herbal medicines and cures were often traded between tribes. For example, Mendelbaum documents the trade between Plains Cree and the Saulteaux. The Cree traded horses and clothes for herbal medicines and instructions on their uses from the Saulteaux (Mendelbaum 1979: 146).

The weakening of traditional Indian medicines and cures began with contact with missionaries and the dispossession of Indian peoples and their lands. Christian missionaries whose sole purpose was to eradicate the beliefs and customs pertaining to traditional health and healing viewed shamanism as demonic. For example, students at the church-run residential schools were admonished on the evils of Indian ceremonies and practices to do with maintaining spiritual purity and growth (Campbell 1991).

The surrender of land through treaty signing and the subsequent dispossession of the land through relocation onto Indian reserves prevented Plains Indians from following their nomadic way of life. This in turn prevented the people from gathering the herbal medicines they had used since time immemorial. The knowledge of the herbs and their medicinal uses was all but obliterated. Moreover, the introduction of diseases from Europe against which the Plains Indians had no immunity or cures,

annihilated thousands of people. Weatherford writes that:

Never in human history have so many new and virulent diseases hit any one people all at the same time. Smallpox, bubonic plague, tuberculosis, malaria, yellow fever, influenza, and the other major killers of the Old World had been totally unknown in America until the arrival of Columbus. These diseases swept rapidly through the people, who lacked all immunities against them. The Indians also lacked immunities to what are often called the childhood diseases of the Old World. Diseases such as measles, mumps and whooping cough that provoked only a minor illness among Europeans and Africans proved deadly to whole villages of Indians who had never before encountered any of those germs (Weatherford 1988: 195).

Population estimates of the Indigenous peoples of the Americas prior to contact are between 90 and 112 million people. In North America today, the total population is estimated at 1.5 million. This means that at least 90 to 110 million First Nations people were wiped out as a result of European diseases. The First Nations of the Americas were not only numerous, but they were also healthy. According to Nikiforuk, *"(t)hey suffered none of the ailments that wobbled the legs, loosened the teeth and rattled the lungs of Europeans. There was no smallpox, no measles, no plague, no leprosy and no influenza, no malaria and no yellow fever... the idea of living well and staying healthy formed an essential core of their religion"* (Nikiforuk 1991: 76). In the face of the holocaust, Indian practitioners found their cures impotent and this led to the disuse of many traditional medicines. Some English place names are a living memorial to the once powerful role of Indian medicine, places such as Medicine Lake, Montana, Medicine Bow Forest, and Medicine Hat, Alberta (Weatherford 1988: 196).

The Indian Act 1876

The Indian Act defined an Indian as male. A female obtained her Indian status as a daughter, or as a wife, of an Indian male. According to Sections 11 (1)(f) and 12 (1)(b)

of the Indian Act, if an Indian woman married a non-Indian male, she lost her Indian Status, as did her children. If an Indian male married a non-Indian female, she gained Indian status. One can imagine why the Indian Act discriminated against Indian women: when genocide is on the minds of legislators, the women and children become the targets. Ninety-five per cent of enfranchisements (the loss of Indian status) were involuntary enfranchisements of Indian women.

Indian women had no choice. They were no longer able to live on reserves, and lost benefits such as education rights, land rights, economic development provisions. They were not even allowed burial with their forebears on reserve land. This further dispossession of Indian women, now from reserve land, created poverty, culture loss and social pathologies among Aboriginal women (Sutherland [Otway] 1995: 60).

The Indian Act also undermined the traditional roles of Indian women in their families and communities. Ceremonies, such as the Sundance that provided a significant role for women, were banned. Indian children were forced into residential schools, deprived of their familiar, loving and nurturing homes and communities. Parents lost parenting skills. Over the generations, residential schools continued to care for thousands of Indian children across Canada. Recently residential school survivors have begun to disclose incidents of physical, emotional, and sexual abuses that were rampant. As well, a loss of culture and language resulted because children were severely punished if they spoke their Aboriginal language (Deiter 1999: 78-79). The multi-generational and socially pervasive impacts of the residential school system are so far-reaching, it is difficult to evaluate them. In her book, From Our Mothers' Arms, Connie Deiter writes:

Many First Nations people, and others, have blamed the high number of health and addiction disorders, the high suicide and overall mortality rates, the family and community disintegration on the effects of attending

residential schools. Some survivors and their communities have lost the skills needed to be healthy individuals. The loss of nurturing parents; loss of parenting skills; loss of identity, low self-esteem; the inability to think independently; the lack of unity within families and communities; the loss of language, culture, and respect for self; and finally, the loss of spiritual values have left communities in chaos (Deiter 1999: 78).

The high incidence of family violence among Aboriginal women is seen as one of the most tragic results of the residential schools. Further, the loss of traditional values, poverty, alcohol and drug abuse, overcrowded housing and low self-esteem play out in the lives of Aboriginal women. Eight out of ten Aboriginal women have indicated that they contend with violence in their homes. The profound effects this has on Aboriginal children is epidemic (Saskatchewan Women's Secretariat 1999: 40-41).

Indian Health Care 1867-1970

The British North America Act (BNA Act) of 1867, Canada's first constitution, gave exclusive jurisdiction for "Indians and lands reserved for Indians" to the federal government in Section 91(24). To open the west for settlement and avoid expensive Indian wars, treaties were negotiated on the Plains from 1871 to 1876 between the federal government and the Indian nations. While earlier treaties did not acknowledge medical benefits, Treaty Number Six called for the medicine chest clause, which stated:

In the event hereafter of the Indians... being overtaken by any pestilence, or by general famine, the Queen... will grant to the Indians assistance... sufficient to relieve them from the calamity that shall have befallen them... A medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the discretion of such Agent.

Treaty Six and the Indian Act provisions outlined the federal responsibility of health for Indians. There were no provisions for

Metis or non-Status Indians, and consequently the federal government did not provide their health care. At present, the federal government maintains providing health care to status Indians and Inuit as a matter of policy and does not base its responsibility on either treaties or the Indian Act.

Until 1945, the federal Department of Indian Affairs administered Indian health services. In 1904, Dr. Peter Bryce was appointed Chief Medical Officer for the department. He was dismissed nine years later when he attempted to bring attention to the plight of disease in Indian residential schools. In 1922, Dr. Bryce published The Story of a National Crime, which chronicled the inadequate health care services provided by the department to Indians. It is unlikely the quality of health care improved. Between 1933 - 34, despite a separate division within the department, health care per capita expenditures for Indians was actually less than the amount spent for other Canadians by the Department of Health (Kue Young 1984: 260).

In 1943 there were 14 hospitals with 540 beds; half were occupied with tuberculosis patients (ibid.) After 1945, Indian health care was transferred to the new Department of National Health and Welfare. The federal government continued to assert that health care was not an Indian right, but built hospitals and provided a rudimentary type of health care to Indians.

In 1962, the Department underwent another restructuring with the result that all federal health services outside provincial jurisdictions were under Medical Services. Shortly afterward, national attitudes towards health were changing, culminating in the universal medical care insurance in Canada. With universal medical care, the Department of Indian Affairs paid insurance premiums for Indians, resulting in Indian hospitals and nursing stations being closed in the south, but maintained in the north.

Since the 1960's, the Medical Services Branch continues to provide services for uninsured benefits for Indians: eyeglasses, prescription drugs, dental care and medical transportation. However, guidelines restrict the amount spent on these services. Interview participants for this report complained of the inferior drugs and restricted level of services provided by the Medical Services Branch. Given that most of the participants live under the poverty line, these reductions in services create hardships, most often for women and children.

Medical Services Branch has recognized that current health problems of Indian people now stem from living in a lower socio-economic status. Over-crowded housing, environmental factors including poor water quality, poverty and lack of employment opportunities, and substance abuse are some of the contributors to poor health. As well, violence and accidents are the leading cause of death for status Indians in the western provinces. This is particularly true for women.

The Royal Commission on Aboriginal People

In 1990, the federal government established the Royal Commission on Aboriginal People (RCAP), a five-year project to examine the relationship between Canada's Aboriginal people and the rest of Canada. As part of its 16-point mandate (Brizinski 1993: 327), the Commission examined the state of health and healing among Canada's Aboriginal population. In 1993, the RCAP made public its report on the round table discussion on health and social issues entitled, The Path to Healing, Report of the National Round Table on Aboriginal Health and Social Issues. In 1996, the RCAP published its final report, Gathering Strength. Volume 3, Chapter 3 of the final report deals with health and healing issues.

The RCAP research reports are the most recent definitive works with respect to Aboriginal health in Canada. The report states:

Canada is widely thought to be one of the best countries in which to live. In 1994, the United Nations Development Programme measured the quality of life around the world, using a variety of social and economic indicators. Canada placed first.

Yet, within Canada's borders, there are two realities. Most Canadians enjoy adequate food and shelter, clean water, public safety, protection from abject poverty, access to responsive medical and social services, and the good health that results from these things. Aboriginal people are more likely to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death. The gap separating Aboriginal from non-Aboriginal people in terms of quality of life as defined by the World Health Organization remains stubbornly wide (RCAP 1996, Vol.3, Chap. 3: 107-108).

The mandate for the RCAP with respect to Aboriginal health stated:

The Commission may study and make concrete recommendations to improve the quality of life for Aboriginal peoples living on-reserve, in native settlements and communities, and in rural areas and cities. Issues of concern include, but are not limited to: poverty, unemployment and under-employment, access to health care and health concerns generally, alcohol and substance abuse, sub-standard housing, high suicide rate, child care, child welfare and family violence (ibid. 108).

The RCAP also defined what "health" means to Aboriginal people, that being a balance in the life support systems that promote mental, emotional, physical and spiritual well-being" (ibid. 109). "Healing" is viewed as:

Personal and societal recovery from the lasting effects of oppression and systematic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures,

languages, identities and self-respect. The idea of healing suggests that to reach 'whole health', Aboriginal people must confront the crippling injuries of the past. Yet, doing so is not their job alone. Only when the deep causes of Aboriginal ill health are remedied by Aboriginal and non-Aboriginal people working together will balance and harmony – or health and well-being be restored (ibid 109).

Hundreds of thousands sickened and died as a result of their encounters with Europeans. Famine and warfare contributed, but infectious diseases were the great killer. Influenza, measles, polio, diphtheria, smallpox and other diseases were transported from the slums of Europe to the unprotected villages of the Americas. The subsequent decline of the indigenous population is often described as genocide or a holocaust (ibid. 112).

On January 7, 1998, the Government of Canada announced its "Gathering Strength – Canada's Aboriginal Action Plan", a strategy to begin a process of reconciliation and renewal with Aboriginal Peoples. A cornerstone of Gathering Strength was the Government's commitment of \$350 million to support community-based healing initiative for Metis, Inuit and First Nations people on and off reserve who were affected by the legacy of physical and sexual abuse in residential schools. The Aboriginal Healing Foundation was created as the entity to design, manage and implement the healing strategy under the terms outline in a funding agreement with the Government of Canada. The Foundation is an Aboriginal-run, non-profit corporation that is independent of both government and the representative Aboriginal organizations.

3. REVIEW OF THE LITERATURE

A number of studies, journal articles and books about health and a renewal of traditional worldviews on Aboriginal health contributed to this study. These contributions cover a wide range of health issues and provide an overview with respect to Aboriginal women's health issues.

- ❖ 2000, 'Being Alive Well', Health and the Politics of Cree Well-being, Naomi Adelson, author. This study examines the essence of health among the Quebec Cree. This book recognizes the world view of the Cree in their definition of health, "being alive well", which means that one is able to hunt, to pursue traditional activities, to eat the right foods, and keep warm. This is above all a matter of quality of life. That quality is linked, in turn, to political and social phenomena that are as much a part of the contemporary Cree world as are the extingencies of "being alive well".
- ❖ 2000, A Second Diagnostic on the Health of First Nations and Inuit People in Canada, published by Medical Services Branch. The report provides demographic information, health information and socio-economic environment factors for First Nations and Inuit living on reserve. The report provides current statistical information on various health issues faced by Aboriginal people. The report is not specific to First Nation women's concerns.
- ❖ August 2000, Substance Use and Pregnancy: Conceiving Women in the Policy-Making Process, published by the Status of Women Canada. The report followed the Supreme Court of Canada decision of Winnipeg Child and Family Services and M.G. It provides a review of the literature, a case analysis, and comments from First Nation women and a case study of a Northern British Columbia community. Finally, there are recommendations for policy direction based on the research. The recommendations call for a "less polarizing and punitive approach toward women".

- ❖ July 2000, Women, Poverty and Health in Manitoba, An Overview and Ideas for Action, prepared for the Women's Health Clinic in Winnipeg, Manitoba. The study examines poverty and its relationship to health for women in Manitoba. Methodology includes a literature review of health and income distribution studies. The study found that poverty among Aboriginal women is gendered, and the combined effects of racism and sexism are clearly evident in the income levels of Aboriginal women. Seven Aboriginal women were interviewed for the study. The study recommends collective action between health services and others should be made to reduce the socio-economic inequalities between women and men.
- ❖ July 2000, The University of Regina's Social Policy Research Unit and the YWCA released Supportive Housing Needs of Women with Mental Health Issues. Housing is identified as a determinant for health. People who lack adequate housing will likely suffer from both physical and mental problems. The study did not identify Aboriginal women specifically but found that women who were at risk of being homeless or living in inadequate housing were on social assistance. However, given that the majority of Aboriginal people in Regina live in poverty it is likely that Aboriginal women would be represented in this study. Crisis housing units need to be created for those women with mental health issues.
- ❖ June 2000, A Study of the Service Needs of Pregnant Addicted Women in Manitoba by Caroline L. Tait and published by the Prairie Women's Health Centre of Excellence in cooperation with Manitoba Health. The study examines the service needs and experiences of pregnant women who have problems of substance abuse in Manitoba. Tait collected surveys and open-ended interview from 74 women. From this information she prepared a list of 49 recommendations. The recommendations include encouraging linkages with various mental health agencies and substance abuse programs, and culturally sensitive programming for Aboriginal women. Overall, the study is an excellent guide to programmers and researchers working with pregnant women who are involved in substance abuse.
- ❖ November 1999, the Saskatchewan Women's Secretariat released a report titled Profile of Aboriginal Women in Saskatchewan. The 48-page report provides information on various social determinants: age, income, education, employment, residence, marital status, housing, violence and health. The health information includes life expectancy, hospitalization rates, injuries and level of diabetes, smoking, alcohol use and others. The document is useful for health providers, policy makers, and others.
- ❖ 1998, Women, Gender and Health, published by the Prairie Women's Health Centre of Excellence provides an overview of the psycho-social influences on women's health. The report examines diversity among women using these categories: employment, marital status, parental status, age, and Aboriginal women. According to this study, Aboriginal women have higher mortality and morbidity rates than non-Aboriginal women.. They are more likely to die of injuries or violence and there is an increased risk of many diseases

- associate with smoking. They have higher rates of disability; one third of women of Aboriginal ancestry reported some type of disability. Suicide rates are three times the national rate.
- ❖ April 1998, Aboriginal Women and Maternity: Fetal Alcohol Syndrome, published for the Centre of Excellence, University of Montreal completed by Caroline Tait. The research outlines the current debate over substance abuse and pregnancy but focuses on the situation of Aboriginal women in Quebec. The report provides a summary of the interviews with 50 Aboriginal women in Quebec and Saskatchewan. One finding was that the treatment services for substance abuse address only the addiction and not the factors that lead the women into addictions. Recommendations included a gender specific treatment program and easier access to these programs for pregnant Aboriginal women.
 - ❖ March 1998, Aboriginal Women in Canada: Strategic Research Directions for Program Development was released by the Status of Women Canada's Policy Research Fund. The report, written by Madeline Dion Stout and Gregory D. Kipling provides a profile of Aboriginal women in Canada, and an analysis of literature on Aboriginal women on the topics of education, health, and residence. The report provides suggestions for future areas of study. These include research into the living circumstances of Metis and off-reserve women and Aboriginal women with disabilities, Aboriginal women and justice, and Aboriginal women and economic development.
 - ❖ 1996, "Circles of Healing: Illness, Healing and Health among Aboriginal People in Canada" by Alan Long and Terry Fox, summarizes past Indian health policies since Confederation. It also examines the differences in allopathic and holistic attitudes toward health and healing. In addition, the SITE Program of the Stony First Nation's attitudes toward health and healing is explained. The Self-Improvement through Empowerment program is a four step program: 1) healing, 2) life skills, 3) upgrading, 4) work placement and employment. The program according to Chief Wesley is successful with many of the participants having an improvement in their personal well being. Perspectives on healing and programs currently operating across Canada are discussed. Fourteen recommendations complete the article found in the book, Visions of the Heart, Canadian Aboriginal Issues.
 - ❖ Fall 1989: The Canadian Woman Studies published a journal devoted to native women. The volume contains ten health-related articles, but all thirty-nine articles are relevant to Aboriginal women's health given the Aboriginal holistic perspective to health. They are as follows:
 - ❖ "Our World according to Osenmiontion and Skonaganleh", provides the context for Aboriginal women's health issues within a discussion on the traditional roles of women within their tribal group. They discussed the spiritual roles of women within her community arising out of her relationship with Mother Earth, Grandmother Moon and her life-giving role. Women were the "keepers of the fire" which is the centre of their beliefs and

women are the keepers of the culture. The authors write:

We need to encourage our own women when they are trying to look at getting healthy in their communities, when they are trying to attack the issues of alcohol and drugs, lack of employment opportunities, lack of real and appropriate education opportunities and lack of community support mechanisms that had existed prior to us adopting this modern approach to living that has resulted (19).

- ❖ “Women in Huron and Ojibwa Societies”, by Marlene Brant Castellano discusses the role of women within her tribal group both historically and traditionally. She reports how the role has changed since the arrival of the Europeans.
- ❖ In the same journal, “Entrenched Social Catastrophe”, by Fran Sugar, an inmate at Kingston Prison for Women writes about life within the institution. She reports the current statistics for inmates, the reasons for incarceration and the lack of programming available to inmates.
- ❖ “Child Sexual Abuse”, a report prepared by the Aboriginal Women’s Council of Saskatchewan tells of the shame and inter-generational sexual and physical abuse that many Aboriginal women and children suffer in Aboriginal communities. A case management profile and its outcome are provided.
- ❖ “The Nechi Institute on Alcohol and Drug Education”, by Maggie Hodgson provides an overview of the services provided by the Nechi Institute. The centre operates in Edmonton, Alberta and provides counselling and training for people working with alcohol and drug addiction programs.

- ❖ “Indian Medicine, Indian Health” is a comparison between Indian and contemporary health practices. Lesley Malloch does not provide information on specific medicines used by First Nations healers but rather provides those First Nations values related to health. The article is the composite of discussions from various elders within the Anishnabe community. It is organized into four headings:

Traditional Indian Principles of Health

- ❖ *“Anishnabe teaching states good health is a gift from the Creator and it comes with responsibility to care for it. Respect for ourselves and others is the foundation of this teaching. Good health is a balance of the physical, mental, emotional and spiritual elements. If we neglect one we are out of balance and our health suffers. Because of this negative thought, poor eating habits, lack of exercise and not having a peaceful and harmonious relations with other people and the spiritual world will make us sick.”*

Traditional Roles of Men and Women in Health and Healing;

Traditional Indian Understanding of Medicine and Healers;

Traditional Indian Medicine and Western Medicine a Comparison of Values

Also included is a section on traditional midwifery.

- ❖ “Pregnancies and Mohawk Tradition”, presents the traditional Mohawk attitudes toward pregnancy and childbirth. For example, when a woman is pregnant her husband is considered pregnant as well. During the 9 months gestation period the couple receives extra protection and spiritual strength. Sakokwenonkwas is the writer of this article.

- ❖ “Indian and Inuit Nurses of Canada”, by Jean Goodwill, contributes to the journal with an article about the nurses’ association. It includes the background and current services and plans for the future. She provides recommendations for the association and for communities where the nurses are working.
- ❖ “Native Community Care, Counselling and Development”, Mary Deleary interviews three health community workers who are graduates of the Native Community Care, Counselling and Development program offered in Ontario.
- ❖ Also in 1989, the Native Studies Review journal devoted an entire issue to Aboriginal health in Canada. “Native Health Research in Canada: Anthropological and Related Approaches” by John O’Neil and James Waldram provides an introduction to the journal and addresses health issues in Aboriginal communities. The following articles were printed within the journal.
 - ❖ “Dakota Perceptions of Clinical Encounters with Western Health Care Providers” by Sandra K. Sherey-Spiers describes the interaction between Dakota individuals and health care providers. The study provided qualitative research answers from members of the Oak Lake Dakota Band in Manitoba. (Native Studies Review, 1989)
 - ❖ “Native People and Health Care in Saskatoon” by James Waldram provides a summary of viewpoints and research on urban health care services. It provides a case study of Saskatoon and focuses on the Westside Clinic, a poverty health clinic that deals primarily with Aboriginal clients. The overall picture is that Aboriginal clients are utilizing the health care system at a higher rate than non-Aboriginals within this study group. (Native Studies Review, 1989)
- ❖ “Iskwew: Empowering Victims of Wife Abuse” by Gerri Dickson provides an overview of a program to break the cycle of violence in Prince Albert, Saskatchewan. The article provides reasons why Aboriginal men abuse women and some obstacles that prevent women from achieving a better state of health. The program is designed to have self-sustaining help groups for women in this community. (Native Studies Review, 1989)
- ❖ “Traditional Indian Healers in Northern Manitoba: An Emerging Relationship with the Health Care System” by David Gregory describes a study of traditional First Nations healers and Medical Services nurses. The study revealed the two groups work cooperatively with each other. The nurses assess when a traditional healer would be appropriate and contact the healer to work with the patient. Medical Health Services (MSB) has recognized traditional healers are helpful. MSB has made financial contributions for patients to see traditional healers and traditional healers have been taken into a community when needed. (Native Studies Review, 1989)
- ❖ “Physicians’ Attitudes toward Collaboration with Traditional Healers”, by Yvon Gagnon provides an overview of the use of traditional healers in Canada. Currently, it is estimated that thirty per cent of Manitoba natives still use traditional healers. The research completed includes a literature review, sample

surveys of physicians in Manitoba. Some findings included 73 per cent of physicians, while not discouraging a collaboration between the two, felt that in a hospital setting, traditional healers should not interfere with medical staff. (Native Studies Review, 1989)

- ❖ “Indian Health Transfer Policy: A Step in the Right Direction or Revenge of the Hidden Agenda” by Dara Culhane Speck provides argument for and against health transfers from the federal government to First Nations self-government structures. (Native Studies Review, 1989)

- ❖ “Culturally Appropriate Healing and Counselling: One Woman’s Path Toward Healing” by Brenda Isabel Wastasecoot, found in Voice of the Drum, Indigenous Education and Culture, Roger Neil, ed. provides a narrative of healing by the writer. She advocates a strategy for healing that incorporates traditional ceremonies, talking about the memories and pain from the past, Alcoholics Anonymous and drama as helpful to her on the path to healing. She contrasts western and traditional approaches to healing.

4. METHOD

The data collection process used for this study was completed in two parts. The first was a collection of open-ended interviews with Aboriginal women who were elders in their community. We approached Aboriginal women from Manitoba and Saskatchewan who were accessible and willing to participate in the study. We followed the traditional protocol of offering tobacco and a small honorarium for their stories.

The second data collection was a survey developed to address questions surrounding health and to provide some profile of the women interviewed as to their socio-economic status. The survey interviews were collected in Saskatchewan and Manitoba. The Manitoba interviews were completed during a visit to the “Gathering Place”. The “Gathering Place” has an adult education centre where with the assistance of the education director we collected the majority of the surveys. Surveys for Saskatchewan were completed in First Nations’ and northern communities. There was no selection process other than a willingness to complete the questionnaire by the Aboriginal women.

5. INTERVIEWS WITH ELDERS

The five Elder women who participated in this project were Sioux, Plains Cree and Metis from Saskatchewan and Manitoba. They were between the ages of fifty-three and seventy-eight. Following traditional protocol, tobacco and a small honorarium of twenty dollars was presented for the information they were going to share. The interviews were open-ended with no formal questions asked. We told them who was funding the project and that we wanted them to share their thoughts regarding health.

The most prevalent theme found in these interviews was the connection between childhood trauma incidents and health problems later in life. Most of the childhood trauma began in residential school. The women also mentioned the connections of the spiritual, emotional, to the physical problems they encountered. Two Elders described the spiritual moment that led them to a life-style change to a healthier future. They both explained that until they reached that moment, all other efforts to change destructive patterns were futile.

Amy, Sioux grandmother in her late sixties, raised in Oak Lake, Manitoba:

"My health problems, I believe began when I was eight years old. Now, I'm sixty-seven. In between there I went through a lot of mental, physical, sexual...(pause) I think what happened at residential school when I was taken out of my home and taken to residential school from that first day that's when my illness started. I was confused, hurt and lonely. I don't believe there ever was a doctor that came to our school. I figured my parents didn't want me [so] that's why they put me in that residential school.

"I married the first man who gave me a hug. I suffered lots of abuse in that marriage. My kids were taken from me. I turned to alcohol, roamed around the country. That went on for a long time. I lost my Indian heritage. I struggled long with this addiction (alcohol), keeping all this garbage inside of me has made me a very sick person. I don't know where this Lupus or Diabetes comes from. There is some medication I can't get for some diabetes medicine. I need help for my teeth, glasses I've had to pay for myself.

"Through healing I went back to my traditional ways. I turned back to my Indian and Dakota way. Since I sobered up twenty years ago, the Creator has helped me and I help others.

"My grandchildren's medicines are not covered, I don't know why we're treated so differently when we live off the reserve. There are a lot of elders who don't live on the reserve who are in need. Medications are quite expensive and they are not covered.

"Healing myself, Lupus, one doctor did tell me that I must have gone through a lot of abuse. We need to go through healing in a

spiritual way. Our chiefs and councillors need healing. Through my Dakota ways, I have forgiven people. Sometimes I think the illness comes from all the abuse we went through".

Inez, Plains Cree elder in her late sixties:

"The women are the ones who have to bring all these things out because we are the keepers of the sacred fires, by that I mean our stoves, where we stay home and guard our fireplaces. The meaning of health for me is healing. Fortunately, I'm still healing, because you never get healed. It's a lifetime process. I was a very negative person, that stemmed from the teachings of the residential school. We don't like to talk about residential school. Others can't speak about it because it was too painful. We have to talk about it. Before I was in the school, I had an infected ear. My stepfather didn't know what to do. For a long time at Onion Lake residential school, I had what was called a running ear; nothing was done. My path was made easier through the use of prayer. I always stress there are all different types of praying or healing. Today, I follow the Indian way. After I lost my child I lost my mind. I went back to my people for healing. I had to deal with a lot of negativity and couldn't believe until I went back to my traditional Indian church for healing.

"I always go back to my reserve for healing and for rest. Elders are not used very much; they are not used in the right way. They could be used for counselling. They could be used for mothers; some of our people haven't got mothers.

"I have a thyroid problem which I think stems from a lot of stress. It makes me nervous and emotional. I am at risk of having high cholesterol, lots of time I eat stuff I'm not supposed to, but I love eating.

"On alcoholism, as Elders, my home is my church. I am very fortunate my children don't bring alcohol into my home. This is good because I keep medicines in here. The old elders say to keep your house clean, to keep it clean from abuse, from negativity, also gossip affects your health. We don't realize how much harm we do with gossip, especially children, we label them. We have to be careful what we say to young people. I do a lot of praying, for individuals for their drugs and alcohol (problems).

"I hope we never lose our reserves, I hope there is always a place for us to go near the city, where we can have our sweats, like a retreat. There are a lot of healers. We need to treat everyone good. They heal in different ways, music. Everyone has to find their own path, their own way. We need to get together as elders and get a list together with who has what gifts cause they all have different gifts.

"A lot of our young people that are coming in to the city, they have to do things in a quiet way. We need to show them where to get health things. There are lots of organizations to help people".

Alma, Metis mother in her early fifties; she now relies on a wheelchair:

"I need someone to look after my toenails, my friend will come in, but now I have infection in my legs and she afraid to do this. It makes me mad when I see hospitals closing, and doctors leaving, yet, they can build on to the casino".

Beatrice, Plains Cree in her early seventies:

"We had our own medicines before the Europeans arrived. My mother and grandmother knew all the medicines. My brothers now follow these ways. I too was diagnosed with diabetes but I quit taking

my medicine and take what my brothers told me too.

"I stayed in the Fort San, (tuberculosis hospital) when I was a young girl. The doctors said I would need an operation to take out three of my ribs and collapse my lung on this side. My parents and grandparents would come to visit me every week in the wagon. It was a long ride by wagon from the reserve to the Fort. They would bring me bottles of water to drink that my grandmother had prepared. I drank that mixture every day. Then one day the doctor came to me and told me I could go home, my lungs were fine and I didn't need to go and have my ribs taken out. My grandmother had something in that drink that they brought to me every week.

"We are having the medicine camp again, where the scientists are talking to our healers and asking them for information on which plants to use. This is a good thing and my brothers are participating."

Emma, Plains Cree in her late seventies:

"I am now a dialysis patient because I was taking too strong of a medicine for my blood pressure and I lost the use of both my kidneys about a year ago. I just listened to the doctor because you think that doctors know what they are doing. I didn't think taking medicine to stay healthy would hurt me more. Now I have to travel from the reserve to the dialysis clinic in the city twice a week. It is very hard to do this because now I am weakened by the treatment. You see a lot of Indian people at the dialysis clinic because of diabetes and many of them are amputees. It is really sad but it is the only way for me to keep alive so I keep going. Now I have to take about 12 pills a day which really bothers me because it just seems so many."

6. SURVEY FINDINGS

Ninety-three Aboriginal women participated in the study. The following information indicates the women's ages, type of community, income levels, employment, marital status, dependent children, education, Aboriginal group, living arrangements, whether they are supporting a spouse and whether nutritional needs are being met. The answers to the open-ended questions are presented following the demographic information.

Demographic Information of the Respondents:

The study involved 93 Aboriginal women in Saskatchewan and Manitoba who responded to the questionnaire.

Women's Ages:

	Number	Percentage
15 - 20	8	8.6
20 - 25	17	18.3
25 - 35	34	36.6
35 - 50	24	25.8
50 - 65	7	7.5
65 +	2	2.2
*NR	1	1
Total	93	100

A majority of the respondents, 63.5% were under the age of 35, and 25.8% were between 35 and 50. Ten per cent of the respondents were over the age of 50 (*NR=no response).

Type of Community:

	Number	Percentage
Urban	56	60.2
Rural	3	3
Small Town	3	3
Reserve	23	24.7

Northern	6	6.5
NR	2	2.2
Total	93	100

Approximately 60% of the respondents were living in urban areas, with the remainder living in rural, small towns, reserves and northern communities.

Income Levels:

	Number	Percentage
Less than \$20,000	53	57
\$20,000 - 39,999	24	26
40,000 - 59,999	5	5
60,000 - 79,999	2	2
\$80,000 - \$99,999	4	4
NR	5	5.4
Total	93	99.4

Fifty-seven per cent of the respondents earn less than \$20,000 per year, and another 26 per cent earn between \$20,000 and \$40,000 per year. Eleven per cent of the respondents earn over \$40,000 per year.

Employment:

	Number	Percentage
Full Time	19	20.4
Part Time	18	19.3
Unemployed	47	50.5
Self Employed	2	2.2
NR	7	7.5
Total	93	99.9

Of the 93 participants in the study, 40 per cent were employed full or part time. Approximately 51% were unemployed and only 2% were self-employed.

Marital Status:

	Number	Percentage
Single	38	41
Married/Equiv.	30	32
Divorced	13	14
Separated	6	5.4

Widowed	5	5.4
NR	1	1
Total	93	99

Forty-one per cent of the participants were single; thirty-two per cent were married or living common law. Almost 20% of the women were either divorced or separated and approximately 5 per cent had been widowed.

Support Spouse:

Support Spouse	Number	Percentage
Yes	11	11.8
No	44	47.3
NR	38	41
Total	93	100.1

Only 12 per cent of the respondents indicated that they were supporting a dependent spouse. There were a large number of the respondents who did not answer the question and this is attributed to the large number of single women who did not consider the question.

Dependent Children:

Dependent Children	Number	Percentage
Yes	30	32.3
No	59	63.4
NR	4	4.3
Total	93	100

Thirty-two per cent of the respondents had dependent children and approximately 63% did not have children in their care.

Education:

	Number	Percentage
Grade 8 or less	12	12.9
Less Grade 12	36	38.7
Grade 12	7	7.5
University	31	33.3
Technical	5	5

Other	2	2.2
Total	93	99.6

Approximately 52 per cent of the participants did not possess a grade 12 education, 7.5% indicated that they had a grade 12, and 33% indicated they had some university level education. Seven per cent indicated they had technical or other education. For example, life skills training was one example of the "other" type of education.

Aboriginal Group:

	Number	Percentage
Metis	20	21.5
Status	64	69
Inuit	1	1
Other	8	8.6
Total	93	100.1

Sixty-nine per cent of the respondents indicated they were status Indians and 31% indicated they were Metis or other (for example, non-Status Indian).

Living Arrangements:

	Number	Percentage
Live Alone	11	11.8
Live with Parents	9	9.7
Live with Relatives	7	7.5
Live with Partner	30	32.3
Single Parent	32	34.4
Live with Friends	3	3.2
Other	1	1
Total	93	99.9

A wide variety of living arrangements were identified by the respondents with approximately thirty-two per cent indicating that they lived with their husbands or partners. Almost 35 per cent indicated that they were single parents living alone with their children. Approximately 20% of the women lived with parents, relatives or friends.

Meeting Own Nutritional Needs:

Nutrition Needs Met	Number	Percentage
Yes	63	67.7
No	26	28
NR	4	4.3
Total	93	100

Most of the women, almost 68%, stated their nutritional requirements were being met, although some qualified this by stating that they ran out of perishables before their next income arrived. Twenty-eight per cent of the women stated that their nutrition needs were not being met and some stated that when food supplies were low, they would go without to ensure their children were fed.

Sharings on Health

The following is a summary of the comments made by the individuals surveyed for this study. The Aboriginal women who completed the surveys are from Manitoba and Saskatchewan. The material was organized based on the

number of similar responses indicating dominant issues. The comments are included to give individual voice to these women concerns. These issues are as follows:

Definition of Health

From the survey, we found the women defined health as including a good diet, exercise, no substance abuse, adequate rest and food. The majority added a First Nations' perspective which is holistic. They answered that health is not only physical, but includes emotional and spiritual. Some related the medicine wheel analogy that states that if one is out of balance with any of the domains, then she is unhealthy. Sickness, illness results from an imbalance.

Many mentioned being healthy means having the financial resources to feed your family nutritious meals. Some of the women said they forego their meals for their family when groceries are low.

Interestingly enough, many mentioned that exercise is important to maintain good health, as is a positive attitude, and some included happiness in their definition of health.

"Good Health to me is an overall wellness, physically, spiritually and emotionally. These are all related to wellness, lacking in one area negatively impacts on all other areas."

"Positive attitudes towards everything. Good Health in physical sense, ensure family has the basic needs; food, clothing shelter."

" Exercise, eat 3 times a day, take long walks, eat vegetables and fruits, take care of yourself"

" Good nutritional food, have a hobby, go out with friends. "

" Eating 3 times a day, plus go to the gym and drink lots of water"

" Being healthy inside and out. Physically and mentally, being able to live a productive and happy life."

Definition of a Healthy Community

Very few respondents are healthy. The major response given for a healthy community was a community where everyone worked together and took care of one another. Many mentioned a community free of addictions and violence.

Some mentioned a clean environment and people being active,

Others mentioned the need for adequate services in health and recreation.

" A healthy community is one that is free of ill health and comprised of people who despite ill-health are intellectually, spiritually, physically, and emotionally sound."

" Having people not always in the hospital and in a nice clean living environment."

"helps one another, everyone cares"

" everyone works together and watches out for one another"

" a community that cares for its own"

" When everyone gets along, help one another out, looks out for one another."

Aboriginal Perspective on Health

Many of the respondents said the Aboriginal perspective is holistic and involves a balance between the mental, physical, emotional and spiritual.

They mention a harmony between self and the land.

Some wrote about the need to have adequate financial resources to live well and how sometimes Aboriginal people are not treated well.

" Harmony with self and the land"

" Healthy in all domains, physically, mentally, emotionally and spiritually."

" A Treaty Right"

" Can't afford the Canada Food Guide"

"Four parts of the medicine wheel is one is lacking than you are sick."

<p>Health Concerns</p> <p>The top three concerns were family violence, diabetes, and mental health issues; followed closely by cancer and hypertension.</p> <p>Depression was mentioned many times.</p> <p>Many mentioned substance abuse as being a cause for health problems. These include alcohol, drugs and solvent inhalants. Other concerns less prevalent included environmental issues, liver disease, sexual transmitted diseases, HIV and HEP C.</p>	<p><i>"My sister has hypertension, I've seen a lot of family violence, my auntie has diabetes, my niece has FAS, my mom has mental health problems and I don't want any STD's"</i></p> <p><i>" My mother is diabetic, and all my aunts had cancer, a lot of my relatives had either cancer or diabetes."</i></p> <p><i>" Too much family violence in society how does a person grow to be healthy and safe with that type of life."</i></p>
<p>Health Needs</p> <p>The number one need is for increased funding for non-insured benefits. Many of the women live under the poverty line and do not have the financial resources for eyeglasses, dentures, dental care and prescription drugs. Mental health resources are practically non-existent in most communities. It was the second concern for health needs.</p> <p>Other needs included lack of resources for proper nutritional diet, adequate medical care on reserve, inadequate access to medical facilities, long waiting lists to see doctors.</p>	
<p>Traditional Healers in the Community</p> <p>At least one of the respondents living in each of the various communities listed was aware of community members using traditional healers. The most use was found on reserve, with urban, northern communities, rural and small towns following, in that order.</p> <p>Some of the respondents felt the influence of the church was the reason that more Community members did not use traditional healers. Others felt that information of use of traditional healers was personal and not likely shared outside the family circle.</p>	<p><i>" Very few, my community is Anglican and afraid of past beliefs."</i></p> <p><i>" Family members do, this is not something made public."</i></p> <p><i>" No, not in the north."</i></p> <p><i>" No, Jesus is my healer"</i></p> <p><i>" No, not to my knowledge but could have access to one if necessary."</i></p>

<p>When asked if they knew of traditional healers living in their community?</p> <p>The respondents were split evenly between knowing traditional healers living in their community and not. The majority of those who said traditional healers live in their community lived on reserve. Many from the northern communities were not aware if traditional healers lived in their community. Two evangelical respondents claimed Jesus as their healers.</p>	<p>" Yes, but not enough"</p> <p>" No, but some come in from time to time."</p>
<p>Stress Relief</p> <p>Overall, the respondents identified that it was necessary to deal with stress. The most common stress reliever was smoking, followed by talking to friends, sports and recreation, and consuming alcohol. Other solutions included watching television, recreational drugs, and being with family. Some mentioned talking to Elders, maintaining a relationship with God, and attending cultural activities.</p>	<p><i>"Sports, smoke, consume alcohol, walk, talk to family member about problem."</i></p> <p><i>" Oddly enough hard work and focusing on the task at hand makes for stress relief lots of rest helps too."</i></p>
<p>Do you live in a healthy community?</p> <p>Most women felt they did not live in a healthy community, regardless of their place of residence. The major reason was violence and substance abuse. Some mentioned that there seems to be a higher rate of diseases where they live.</p>	<p><i>"No, alcohol plays an important role in destroying family life."</i></p> <p><i>" My home is healthy but my reserve is not"</i></p> <p><i>" Not really, some of my neighbours are involved with illegal activity."</i></p>
<p>Community Health Consultations</p> <p>The responses were equally divided between whether they felt the community was consulted or not. Some felt depending on the issues, they were consulted. Others complained they expect the community to go to the consultations and not the other way around</p>	<p><i>"Regina has band-aid programs t hat don't meet needs"</i></p> <p><i>" They try but no one wants to get involved."</i></p> <p><i>" Yes, all the time"</i></p> <p><i>" No, rarely or not at all,</i></p>

<p>Most Important Health Issue for Aboriginal Communities</p> <p>The major answer given was family violence with diabetes and substance abuse close seconds. Mental Health was the third most frequent answer with STD's, cancer, high blood Pressure following.</p>	<p><i>" Diabetes, cancer, high blood pressure" " Diabetes; we should eat the way we did when we were removed from our traditional lands"</i></p> <p><i>" AIDS, STD, diabetes"</i></p> <p><i>" Alcohol, Drugs and Mental Health"</i></p>
<p>Health Issues for Aboriginal Women</p> <p>The most important issue for Aboriginal women is violence. Followed closely by mental health issues, and diabetes. Other concerns included HIV, obesity, FAS and cancer.</p>	<p><i>" Family violence, diabetes, depression"</i></p> <p><i>" To stop violence and abuse, as well as respecting our bodies."</i></p> <p><i>" Mental health - having to bear the responsibilities of caring for others and putting others well being ahead of self"</i></p> <p><i>" Violence and being able to heal from past traumas."</i></p>
<p>Present State of Health</p> <p>The respondents were evenly split on whether or not their present state of Health affects their quality of life. Most of the respondents, whether they Answered yes or no, mentioned that stress was a factor in their lives.</p>	<p><i>" No, A little stress"</i></p> <p><i>" Yes, having no social or emotional support affects my parenting and school marks"</i></p> <p><i>" No, I'm much healthier today than I was as a child (physically)"</i></p>
<p>Contrast Traditional Healers with Medical Practitioners</p> <p>The majority of respondents said Aboriginal healer's focus is holistic. They heal spiritually as well as emotionally. They mention the use of Plants and medicines in its natural form. Many felt that medical practitioners focus on the physical ailment and are too Dependent on chemical solutions.</p>	<p><i>" Holistic for Aboriginal but mainstream is more 'tecky' and uses prescriptions."</i></p> <p><i>" More holistic; sweatlodge support for people getting off addictions, spiritual support."</i></p> <p><i>" Traditional methods focus on everything while mainstream focuses only on the body."</i></p>

<p>Indigenous Speakers</p> <p>Unfortunately, most of the respondents did not speak an Indigenous language, However; the majority was able to understand.</p>	<p>"Yes. Cree/Sioux"</p> <p>" Yes, Ojibway, Cree mixed."</p> <p>" Yes, a little Cree."</p>
<p>Health - Individual or Community Responsibility</p> <p>The majority said health is both a community and individual responsibility. Some reasons include one person's health affects others in the community; and health services are tied to budgets. Many mentioned individual responsibility for health as being the start to a healthy community</p>	<p>"It is a community, and national responsibility"</p> <p>" Individuals need to take control over their own health."</p> <p>" It's a community responsibility to have services available for its members, and it's an individual responsibility to access those services."</p> <p>" It's a community responsibility to try and help one another"</p>
<p>Health Care Givers at Home</p> <p>Few of the respondents were caregivers at home; those that were took care of ailing parents.</p>	<p>" yes, my mother and my elderly aunt"</p> <p>" Yes, Dad (4 yr.), uncle (6 mos.)"</p>

7. Conclusions and Recommendations

The research problem for this study is to define health, healing and well being from an Aboriginal women's perspectives and to provide recommendations toward achieving good health. Based on the information gathered in the study, some general conclusions and recommendations can be reached.

The denigration of First Nations' women and their health began with contact between traditional First Nation societies and the Europeans. The First Nations' practice of women being interdependent, autonomous individuals equal to the men in their society challenged the European ideal of femininity and womanhood. For example, at first contact the French missionaries or Jesuits set about to systematically change Indian

society to make it a reflection of French society, which included the male-dominated nuclear family.

Added to the denigration of women's roles was the introduction of European diseases within their environment. The loss of life as a result of diseases has been said to be of holocaust proportions. Dispossession of the land and its resources and its medicines furthered compounded the health of First Nations; these include the introduction of the Indian Act, residential schools, religious suppression and the result is Aboriginal women with many health concerns. Unfortunately, the health issues are not just related to physical ailments but to mental health issues.

Recommendation

- 1.0 That the federal, provincial and municipal governments of Canada recognize and accept an Aboriginal concept of health and healing by working towards wellness through holistic health approaches. This includes:
- ❖ Working towards an improvement in the socio-economic and political status of Aboriginal women in Canada.
 - ❖ Recognition for the intellectual property of Aboriginal healers and their medicines.
 - ❖ Acknowledgement of the destruction of traditional First Nations women's roles by missionaries and government; and encouraging research to rediscover those female icons which were important to First Nations spirituality.

From the survey questionnaires, we found similar patterns with other researchers regarding residency, age and income levels. Aboriginal women are poor, underemployed, undereducated, and young. There were high incidences of single-female-headed households with many of women stating their nutritional needs are being met, but mention that they occasionally ran out of food before the next cheque arrived.

Many mentioned being healthy means having the financial resources to feed your family nutritious meals. Some of the women said they forego their meals for their family when groceries are low.

Recommendation

- 2.0 That Aboriginal, federal, provincial and municipal governments maintain and increase funding for Aboriginal women to achieve:
- ❖ higher education;
 - ❖ better paying employment;
 - ❖ adequate housing;
 - ❖ affordable day-care and family support services;
- all of which will contribute to improving their health and well-being

The top three health concerns in this order were family violence, diabetes and mental health issues. The most common stress relievers were smoking, followed by talking to friends and consuming alcohol. Others told about speaking to elders, maintaining a relationship with God and attending cultural activities.

Recommendation

- 3.0 That more research and funding for services be provided for mental health issues.
- ❖ Information on positive stress relievers should be developed which target Aboriginal women e.g. anti-smoking campaigns, exercise programs
 - ❖ Encourage the use of traditional teachers on dealing with stress
 - ❖ Encourage women's support groups, talking circles, addiction support groups, and other avenues to provide support and help to Aboriginal women..

The majority of the respondents said they did not live in a healthy community. Their definitions of a healthy community included safety, a clean environment free of addictions; a place with health and recreational programs and a place where people worked together and took care of one another. The last comment regarding working together was the comment made most often. It could be said to be a First Nations value reminiscent of a band society where getting along with each other ensured sharing of resources and harmony in the band.

Recommendation

4.0 That Aboriginal, federal, provincial and municipal governments research First Nations, Metis and Inuit values that may assist in developing effective health community programming, and promote the empowerment of Aboriginal women.

The number one health concern was the lack of funding for uninsured benefits. Many of the women live under the poverty line and do not have the resources to purchase glasses, dentures, and prescription care. They also felt that mental health resources were non-existent. These concerns were also confirmed in the literature review by a number of researchers.

Recommendation

5.0 That Aboriginal, federal, provincial and other agencies work towards increasing the funding for uninsured benefits for Aboriginal women. This includes increased funding for glasses, dentures, prescription care and mental health practitioners.

The most important issue for Aboriginal women was violence

Recommendations

6.0 That Aboriginal, federal, provincial and municipal governments acknowledge the high level of family violence within Aboriginal families and communities.

- ❖ This acknowledgement would include further funding for community-based family violence programming.
- ❖ That community-based programming include women as full participants.

7.0 That research and programming be provided to address violence against Aboriginal women. This includes:

- ❖ Compiling and maintaining a database of Aboriginal women victims of homicide, assaults and other types of violence.
- ❖ Research money provided to rediscover the traditional roles of First Nations, Metis and Inuit women
- ❖ Workshops be delivered to deal with family violence within Aboriginal communities

Recommendation

8.0 That partnerships between Aboriginal, federal, provincial and municipal governments be developed for community-based health care delivery.

- ❖ That health boards and hospital boards include Aboriginal women as members
- ❖ That employment equity programs ensure that Aboriginal women are full and equal participants in health care delivery.

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