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BAR CODE

introduction

Welcome to the Fall 2001/Winter 2002 issue of *Network*, a special expanded issue on **Aboriginal Women's Health**. It's been a long wait we know, but I hope you'll find your patience rewarded. This issue follows up on two previous issues of *Network* which focused on "Women's Health and Diversity" by looking in even more depth at the research, policy development, community work and healing being done by Aboriginal women across Canada. It also contains some of the newest resources available on the subject—which illustrate that while there's good work being done, so much more is needed.

~ Connie Deiter, Guest Editor

WHAT'S INSIDE

our cover

Our cover painting, by Métis artist Bob Boyer, is entitled "Walks by the Water Woman." It remembers a young woman who was viciously attacked during an evening out. Her family called in an elder to pray for her during her stay in hospital. She was not expected to live from her injuries but she did. She changed her lifestyle, began to follow her traditional First Nations way and was given the name "Walks by the Water Woman." Bob Boyer is Head of the Department of Indian Fine Arts at the Saskatchewan Indian Federated College, an international recognized artist and a pow-wow dancer and teacher.

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PLS PLACE LOGOS AS PER LAST ISSUE

RESEARCH AS A SPIRITUAL CONTRACT: *an* Aboriginal Women's Health Project

BY LESLIE TIMMINS

This article is based on an interview with Connie Deiter

PHOTOGRAPHY: CONNIE DEITER

In the past, when an anthropologist approached a First Nations tribe to document, for example, a ceremony, it would sometimes happen that faulty information would be given. If the researcher failed to "pay" for the knowledge being offered, he risked putting himself and the giver of that knowledge in jeopardy. In Cree, *pastahow* refers to this spiritual harm or "debt" that can be visited upon the relatives or future generations of the giver or receiver of knowledge if proper payment is not made. If you take something from someone, you have to give something back: this keeps life in balance. In this way, all knowledge is spiritual knowledge.

Connie Deiter and Linda Otway, two researchers affiliated with the Prairie Women's Health Centre of Excellence, recently completed a study in which they put this principle into practice. "When Linda Otway and I approached First Nations women elders for our research on health and community healing," says Connie Deiter, "we brought them traditional gifts of pouch tobacco and cotton broadcloth, and an honorarium. In a way we were following a 'research method' we'd been taught as children. When we asked an elder to teach us something or pray for us, we paid them with a gift. The skill or benefit we gained would, in turn, accrue value to our family and community. When we asked for knowledge to be shared in our research study, we knew we were entering into a spiritual contract."

The completed study, *Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project*, indicates that definitions of health, healing and healthy communities, as articulated by the women Otway and Deiter interviewed and those who answered their survey, still carry remnants of these old teachings. "An enduring concern about 'balance' and *pastahow* is apparent," says Deiter. "What you do now, or is done to you, puts in place what will happen in the future; how we treat each other has a fundamental impact

on our health. Although elders expressed these views in explicitly spiritual terms and the (mostly younger) women in the survey in primarily secular terms, most of the women's responses indicate a broader understanding of health than is offered by a biomedical view alone."

A total of 98 women from Manitoba and Saskatchewan participated in the study, including five elders. "Because so much of First Nations history has not been recorded, we wanted to talk to older women who had experienced residential schools. Women who knew the old permit system, which required people to get a pass from an Indian Agent to receive medical care. With the elders," Deiter says, "we used an interview method that allows for an oral history to be given if the speaker wishes. We asked one question only, 'What do you think 'health' is?' The elders' responses commonly placed 'healing' and 'health' within both personal and historical contexts, linking colonization and illness."

Amy, a Sioux grandmother from Oak Lake, Manitoba, who is diabetic, said, "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 [abuse]. When I was taken out of my home and taken to a residential school—from that first day, that's when my illness started. Through healing I went back to … my Indian and Dakota way. Since I sobered up twenty years ago, the Creator has helped me and I help others." Inez, a Plains Cree elder in her late sixties, recalls, "For a long time at Onion Lake residential school, I had what was called a 'running ear'; nothing was done.… Today, I follow the Indian way. I always go back to my reserve for healing and rest."

The top health concerns identified by the elders were family violence, diabetes, and the need for better coverage of non-

If you take something from someone, you have to give something back: this keeps life in balance. In this way, all knowledge is spiritual knowledge.

insured medical expenses. Although prescription drugs are "free" to First Nations people under the Indian Act, Deiter points out that a number of the women said that they were usually only covered for "older" drugs. "If they wish to have the newer (and more effective) drugs, they have to pay for them themselves."

Although the majority of survey respondents were younger women, 70% concurred with the elders in identifying family violence as their number one health concern. They chose this over options including Fetal Alcohol Syndrome, hypertension, and cancer. Again, like the elders, they listed diabetes as a second priority, followed by substance abuse and mental health issues.

Most respondents said their communities were not healthy and their definitions of "healthy" showed a high degree of consensus. A common description was, "[a place] where everyone works together and watches out for one another." One woman wrote that a healthy community is "one that is free of ill-health [or] comprised of people who, despite ill-health, are intellectually, spiritually … and emotionally sound."

Confirming other research about the poverty of Aboriginal women in Canada (Statistics Canada, *Aboriginal Profile,* 1996) the data showed that 57% of the respondents live on incomes of less than $20,000 a year, only 40% are employed full or part-time, and 35% are single parents. Although some identified "good food" as part of good health and most of the women said their nutritional requirements were being met, some qualified this by stating that they regularly could not afford to buy fresh foods. "Can't afford the Canada Food Guide" was the cryptic comment of one woman. "Of the 28% who said their nutritional requirements were not being met," Deiter points out, "some stated that they have gone without food to ensure their children were fed."

"Our study reveals that Aboriginal women see health as a holistic condition, largely created by the community and for the community," Deiter says. "We used a variety of research tools to find this out, but it was essential, in our view, to include methods that were appropriate to the culture we were studying. And now it's essential for governments to embrace this view of health and empower Aboriginal women to realize it."

This article is reprinted from the Centres of Excellence in Women's Health Research Bulletin, *Vol. 2, No.3, Winter 2002. For a free subscription to the* Research Bulletin, *contact the CWHN.*

Leslie Timmins is Assistant Editor of the CEWH Research Bulletin. *Connie Dieter is a Plains Cree writer and researcher, soon to be defending a Master of Arts thesis on oral history at the University of Alberta.*

For a copy of Sharing Our Stories on Promoting Health and Community Healing: An Aboriginal Women's Health Project *contact: Prairie Women's Health Centre of Excellence, Tel: (204) 982-6630, Fax: (204) 982-6637, e-mail:* pwhce@uwinnipeg.ca *or download:* www.pwhce.ca/pdf/deiter.pdf.

PREGNANT ADDICTED WOMEN *in* Manitoba

BY CAROLINE TAIT

After the "Ms G" Supreme Court decision in September 1997, Manitoba Health commissioned the Prairie Women's Health Centre of Excellence (PWHCE) to manage a research study exploring the experiences of pregnant women who seek, participate with and complete addictions treatment, and of their recovery. It also examines current services and programs to determine if they meet the needs of the target population, and to define the characteristics of those that are effective.

Representatives from PWHCE and Manitoba Health (Addictions), a research consultant, a university professor and the principle investigator made up the PWHCE Project Working Group. Representatives from five addictions agencies, from Health Canada, Manitoba Health (Addictions and Aboriginal Health), and Manitoba Family Services and Housing formed the Project Advisory Committee. These two groups oversaw the research.

Taking a holistic view of variables affecting health and well-being, the study uses the Determinants of Health approach. A series of in-depth open-ended interviews were conducted with seventy-four service consumers with experiences of substance use during pregnancy. Data was also collected through consumer focus groups, community meetings, educational material from service providers and a questionnaire. First Nations on-reserve services were not included, nor were the experiences of First Nations women in accessing non-reserve services.

The report, *The Service Needs of Pregnant Addicted Women in Manitoba* (or the 'PAW study'), contains forty-nine recommendations, seven of which are key.

- That Manitoba Health support mentor programs like STOP FAS for high-risk women in regions of the province outside Winnipeg, and mentor programs that address other substance addictions, particularly the use of inhalants.
- That Manitoba Health, with addiction and outreach service providers, improve after-care services available to women, fostering increased communication among service providers and effective follow-up services to connect women with positive supports in their home communities.
- That Manitoba Health develop the service capacity of gender-sensitive outreach services that women identify as supportive and trustworthy, especially those for specific high-risk populations and in communities with widespread substance use, and that these services work with other agencies like addiction treatment

programs and Child and Family Services to support women to build healthy support networks, and decrease or cease their use of substances before, during and after pregnancy, creating stable home environments and expanding their education and employment options.

- That Manitoba Health recognize Aboriginal agencies, such as Metis Child and Family Services, Friendship Centres and the Aboriginal Health and Wellness Centre in Winnipeg, are in key positions to work directly with high-risk pregnant women and with the communities they serve, and are in the best position to create meaningful programs and services for Aboriginal women, and to work with off-and on-reserve addiction services.
- That Manitoba Health develop services for pregnant women who present when intoxicated, including those who are detained by police under *The Intoxicated Persons Detention Act*.
- Recognizing the central role of Child and Family Services in the lives of women with substance use problems, whose children have been apprehended or will be apprehended at birth, that Manitoba Health work collaboratively with CFS and addiction treatment programs to find ways for them to provide meaningful service options for women when an order of apprehension is made.
- That Manitoba Health, together with a wide range of service providers and addictions treatment programs, ensure that women at risk of using substances while pregnant feel safe and secure to access services meaningful to them that can best support them in reducing or ceasing the use of substances.

Tim Sale, Manitoba Family Services and Housing Minister and Chair of the Healthy Child Committee of Cabinet, in December 2000 announced the expansion of the STOP FAS program to Thompson and The Pas, funded by $264,000 from Healthy Child

Who was "Ms G"?

"Ms G" was a 23-year-old First Nations woman from Winnipeg who was ordered into treatment by the court when five months pregnant with her fourth child.

Behind the legal action was Winnipeg Child and Family Services (CFS), with the charge that "G"'s unwillingness to stop sniffing glue was harming her fetus. Although the original ruling was overturned by Manitoba Court of Appeal, "Ms G" decided to get treatment of her own accord.

CFS still sought the power to order substance-using pregnant women into treatment, even against their will, and looked to the highest court in the land to authorize it.

The question before the Supreme Court was whether the state has the right to force pregnant substance users into treatment programs. If the Court agreed, declaring a woman legally owes a 'duty of care' to her fetus, the door could be opened to a wide range of actions to control the behaviour of expectant women.

Chances are such power would be used most harshly against the poorest and the most marginalized women among us. Giving legal rights to a fetus could also curtail the reproductive freedom of all women, including our hard-won access to abortion.

To protect women's right to autonomy, a strong campaign was mounted by health care providers, community groups and researchers to convince the Court that legal force is the wrong way to handle this complex social problem. The coalition argued that substance use is a health issue best addressed by services sensitive to women's needs, not by the law.

Intervening on behalf of "Ms G" were the Women's Health Rights Coalition—comprised of Women's Health Clinic, Métis Women of Manitoba, Native Women's Transition Centre and Manitoba Association of Rights and Liberties—along with the Women's Legal Education and Action Fund, Canadian Abortion Rights Action League and the Canadian Civil Liberties Association.

Taking a closer look at the dangers of simplistic and individualistic approaches, the coalition cited five reasons why the Court should rule against mandatory addictions treatment for pregnant women.

The ineffectiveness of forced treatment has been well documented. Women at risk tend to steer clear of services fearing they and their children will be apprehended, and thus are driven underground, deprived of necessary care.

Manitoba. The Minister noted this as one of the key recommendations of the PAW study, which is also posted on the Manitoba Health website.

The willingness of women to improve their quality of life, along with the positive momentum created by provincial service providers and a strong commitment from governmental ministries could well translate into practical health benefits for at-risk women and their families.

Moving the recommendations of the PAW study forward or indicating how they have been or are being addressed is the focus of the Strategy Development Committee, comprised of members of the PAW Project Advisory Committee, the Employment and Income Assistance Division of Family Services and Housing, and private child welfare agencies.

Caroline Tait is a Metis woman from Saskatchewan, a Fulbright Scholar currently completing her Ph.D. at McGill University. She is recognized as taking the lead in research into FAS and FAE in Aboriginal communities.

The Service Needs of Pregnant Addicted Women in Manitoba *is available on-line at:* www.gov.mb.ca/health/documents. *A print copy may be ordered from the Prairie Women's Health Centre of Excellence by calling (204) 982-6630 or by visiting their web site at* www.pwhce.ca.

Forced treatment laws may be applied unfairly. Studies from other countries show the majority of women confined against their will are poor and/or members of racial minorities.

A law and order response is a quick fix that fails to deal with the systemic and social causes of substance use including violence, sexual abuse, poverty, low self-esteem and lack of control. Racism and other forms of discrimination worsen the situation for women from marginalized groups.

Further, if fetuses are granted a legal right to care, the court could extend the power to institute control over any behaviour of all women of child-bearing age.

Finally, granting such authority to the child and family service system causes much concern, particularly over the conflict created by the competing priorities of doing prevention work with families as well as having the legal responsibility of supervising and apprehending children at risk.

In the end seven out of nine Supreme Court Judges said that the court does not have the right to force pregnant substance users into treatment programs.

While the Women's Health Rights Coalition was pleased with the decision of the Court, it would have preferred the financial resources spent on the case could have been used to meet the urgent needs of pregnant women who use substances. The coalition was also saddened that the court did not more strongly remind governments of their positive duties and responsibilities to provide them with appropriate care, ensuring women-friendly treatment and support programs are available to all who seek them.

This synopsis is excerpted by Lynnette D'anna from the Special Report in the Winter 1997 issue of Network, *which provides a thorough analysis of the potent mix of challenges posed by the "Ms G" case. Back issues of* Network *can be ordered from the Canadian Women's Health Network.*

Let's Talk about Aboriginal Women's Health Research

Would you like to exchange ideas, news, research plans or events information with other people working in the field of Aboriginal women's health research?

The Canadian Women's Health Network has recently established a listserv for an informal group called the Aboriginal Women's Health Research Interest Group (or AWHRIG). The listserv was set up following a recommendation from the National Workshop on Aboriginal Women's Health Research organized by the Centres of Excellence in Women's Health in March 2001. It's a forum to post announcements, discuss possible research projects and cooperate in research development.

To subscribe, send an e-mail to owner-awhrig-l@list.web.net asking to subscribe to the AWHRIG-L listserv. Please include a brief description of your areas of interest and work.

Mother launches campaign to recruit Aboriginal bone marrow donors

BY MICHELLE HÜGLI

Gloria Greyeyes forced her four-year-old daughter, Jasmine, to take a pill every day, and another one and a half pills twice a week. Three days a week Jasmine took liquid antibiotics.

In addition, every month Jasmine got a shot in the heart and took three pills twice a day for five days. Every three months, Jasmine went for a spinal tap and took six and a half pills every week to maintain that treatment. And every six months she had some of her bone marrow removed for examination.

"It's scary and confusing," says Greyeyes but she kept Jasmine on this routine from the age of two. It broke her heart to do this, but she had to; Jasmine has leukemia and needed chemotherapy to stay alive.

Jasmine was diagnosed with acute lymphocytic leukemia in September 1999. When her treatment was due to end in November 2001, ironically, her mother was even more afraid. Greyeyes said, "I'm scared again, in a different way because all through the treatment I've had the chemotherapy kind of as a guard against this cancer. Now, the door's open for the leukemia to return. She's not going to have the chemo to keep it at bay." However, Jasmine is now off cancer medication and chemotherapy treatment, and she and her family are thrilled.

Greyeyes is not only fighting hard for Jasmine but for other Aboriginal children with the disease. The Aboriginal community is in need of blood donations and bone marrow donors. Greyeyes is targeting Aboriginal people because ethnicity is important in finding eligible bone marrow donors. Proteins called antigens match marrow, and some combinations of antigens are specific to populations sharing close genetic relationships, such as Aboriginal people. She has designed posters and flyers with Jasmine's picture to create awareness of this need.

Although Jasmine doesn't need a bone marrow transplant right now, Greyeyes knows there's a possibility she could need one soon. And that's what motivates her.

"The chances of finding a bone marrow for someone who's Aboriginal are too slim. And it's just a scary thought because I know for a fact that my girl is not the only one in this world that's going to have cancer. I hope that if another child needs a bone marrow, an Aboriginal child, that I've done enough work that there's a match on the marrow for her or him," said Greyeyes.

Of the 215,000 registered donors on the Canadian Blood Services' Unrelated Bone Marrow Donor Registry, only 1771 are Aboriginal. That's less than one percent. Right now, there's a 1 in 750,000 chance to find a match in an unrelated bone marrow registry.

In 1998 Lance Relland, a Métis teenager, established the Aboriginal Bone Marrow Registries Association (ABMRA) after he was successful in finding a matching bone marrow donor. He realized that other Aboriginal children might not be as lucky. The ABMRA is dedicated to helping Aboriginal people find eligible donors in a culturally sensitive manner.

The ABMRA allows for directed donations where people can choose to whom they will donate. Canadian Blood Services provides only universal donations. They won't allow people to request they give only to Aboriginal people. Mary Lindsay, Director of the Donor Division at ABMRA, says it's a culturally sensitive issue because some Aboriginal people believe that when a person shares their blood, they become related to that person.

"Some people are really touchy about that, they don't want their blood to go to strangers and they feel that other native people are not strangers to them and that's something that's a cultural issue that you have to be sensitive to."

Lindsay says that she would rather have people donate to a small group than not at all. The ABMRA goes out to First Nations reserves and rural communities to recruit potential donors. They do an in-cheek swab to collect DNA rather than draw blood, so the method is less intimidating to people who are interested in becoming a potential donor.

Greyeyes works closely with the AMBRA to promote awareness of the importance of Aboriginal bone marrow donors. She says they have been very supportive and believes they are doing extremely important work. She sees her daughter's pain and looks for something good in the life of a cancer patient.

"I honestly believe that everything happens for a reason, even bad things and this is definitely bad, and I got to believe and got to find out that there's something positive there and I believe that the Aboriginal Bone Marrow Registry is that positive thing."

With support from the ABMRA, Canadian Blood Services, the Muskeg Lake Tribal Council and the Federation of Saskatchewan Indian Nations (FSIN), Greyeyes is spreading as much information on leukemia, blood donations and bone marrow transplants as possible. She plans to deliver posters, flyers and leaflets to all First Nations reserves and communities in Canada, including through Friendship Centres in major cities.

Greyeyes has approached the FSIN for permission to use their mailroom to send out the information, because she can't afford the cost of the postage on her own. She always carries leaflets of information with her to hand out to people she meets and to leave in band offices and other places she visits. She feels a sense of urgency in getting the information out.

"It's a panic situation," Greyeyes says. "People need bone marrow transplants right now."

Greyeyes has no doubt that once people learn about her daughter's story and the need for more registered Aboriginal bone marrow donors, they will come forward to help.

"I know Indian people are givers and they're keepers. What I mean by that is they look after each other's kids. If you see some little Indian kid in distress, you go to their aid right away and check it out, try to help them out. This is the same thing, only it's bone marrow."

Michelle Hügli is a Journalism student at the University of Regina. She is a Cree-Saulteaux from the Yellow-Quill First Nation in Saskatchewan.

Inuit Women's Health:

A Call for Commitment

BY PAUKTUUTIT INUIT WOMEN'S ASSOCIATION OF CANADA

Pauktuutit has become internationally recognized and respected for its expertise in health promotion and prevention. At the root of our success is our commitment to ensuring Inuit ownership by using Inuit working groups and steering committees to guide and direct all our initiatives.

We seek meaningful involvement in the development of programs and policies affecting us. We need to regain control of our own health care, involved as true and active partners. Too often, our needs are incorporated into larger discussions about Aboriginal health. Most significantly, programs designed for First Nations are often implemented where Inuit-specific community-based initiatives are needed.

The imposition of non-Inuit health programming affects us in many ways. One is the loss of traditional midwifery as an integral part of our lives. Childbirth practices were inherent to our way of life and crucial to our social fabric. The bonds within family and community were reinforced and intensified much beyond the birth event, extending to a child's education and place in the community.

Now most Inuit women give birth in hospitals far from their home. While they appreciate the benefits of modern medicine, and the presence of doctors and nurses in case of complications, there is increased demand for us to be allowed to choose to give birth in our own communities, in a manner consistent with our culture and traditional expertise. While there is renewed hope for a revival of midwifery and community-based childbirth in the North, it is threatened by the imposition of standards and accreditation processes that would almost certainly exclude Inuit women and ignore the value of traditional practices.

Capacity building is a long process that requires substantial and sustained support. It is not sufficient to provide opportunities for Inuit to gain the education required to meet standards set by Southern Canada when, to take advantage of such programs, we must leave our families and communities for extended periods of time. Programs must reflect the reality of Arctic life and be delivered in the North in order for Inuit to build capacity.

Many health care needs of Inuit women are not being met. ▶

Mammograms, an important diagnostic tool for breast cancer, are only available in the South. Waits longer than six months for an appointment are common. A test that requires Southern women a few hours away from their jobs or families can mean a week or more for an Inuk woman. If she is diagnosed with breast cancer, she has little or no choice but to remain in the South, unable to participate in family life while undergoing potentially life-saving treatment. The value of family support for women facing breast cancer is well documented, yet it is most often unavailable to us.

The lack of accessible information and low literacy levels mean that many Inuit woman do not have basic health care knowledge. We need educational material in our own language, Inuktitut, and in plain English.

There is clearly a need for community-based health initiatives to augment health system programs. Two of the most successful are the Pauktuutit's tobacco cessation program and the Canadian Inuit HIV/AIDS Network. At the core of each is a commitment to heavily involve community members with respect for the expertise of Inuit in their delivery. Building sustainable capacity can only take place when the community is involved in the process.

Poverty, homelessness and the lack of information and services have a negative impact on women's overall health. Family violence also remains a major physical and mental health issue. Many Inuit women and children experience it in their own homes. Policy and decision makers should consider an investment in violence prevention as an investment in reducing the escalating costs of health care in the North.

For many years, Pauktuutit participated in national health policy discussions and design of initiatives through its limited health consultation funding. Its funding was lost in October 1999. Immediately following, the federal government announced several major health initiatives intended to benefit First Nations and Inuit. Because the organization no longer has sufficient financial resources to be an effective advocate, Inuit women have been left out of federal consultations where decisions concerning health policy and program development on matters affecting them are made.

As women, and as members of families and communities, we have great wisdom and expertise to share.

We strongly encourage the federal government to consult directly with Inuit women on health matters. As women, and as members of families and communities, we have great wisdom and expertise to share.

Governments must also provide financial and human resources for Inuit women to build their capacity to participate in health policy discussions and planning.

A version of this brief was presented to the Senate Standing Committee on Social Affairs, Science and Technology.

Pauktuutit is a national non-profit association representing Inuit women throughout Canada. Its mandate is to foster needs awareness and encourage Inuit women's participation in community, regional and national concerns in relation to social, cultural and economic development.

Pauktuutit has a number of publications listed on its web site www.pauktuutit.on.ca. Inuit Women's Health: Overview and Policy Issues, *for instance, is available for $10 plus postage. Contact Catherine Carry, Special Projects Coordinator, Pauktuutit Inuit Women's Association of Canada, 131 Bank Street, 3rd Floor Ottawa ON K1P 5N7.*
Tel.: 613) 238-3977
Fax: (613)238-1787
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Aboriginal Women's Health Research

BY MADELEINE DION STOUT, GREGORY D. KIPLING AND ROBERTA STOUT

In November 2000, the five Centres of Excellence for Women's Health, the Canadian Women's Health Network and the Women's Health Bureau of Health Canada identified Aboriginal women's health as an area for priority intervention. They asked us to capture the cumulative knowledge and experience generated through Centres of Excellence activities on Aboriginal women's health to help establish priorities for future work.

We set out to provide an overview of key health and health-related indicators for Aboriginal women in Canada and conduct a critical review and synthesis of research and other initiatives on Aboriginal women's health undertaken or funded by the Centres. Our *Aboriginal Women's Health Research Synthesis Project Final Report* also reports on the proceedings of the National Workshop on Aboriginal Women's Health Research held in Ottawa in March 2001, and presents recommendations for priority setting in future research.

The Research in Context

It has been long argued that policy makers and researchers show little interest in the challenges facing Aboriginal women in Canada. Doubly marginalized as both female and Aboriginal, these women have seldom benefited from sustained research attention that explores, in substantive fashion, their lives, challenges and strengths.

The situation has improved over the last 15 years, as Aboriginal women's organizations and their allies have forced decision makers to take notice of the appalling inequities in many Aboriginal women's lives. But much of the work being undertaken remains narrowly focused and is often tangential to the underlying causes of Aboriginal women's marginalization and oppression.

Research has begun to be more critical of existing policies and structures and we cite a number of examples in the report. Attention has increasingly focused on patterns of Aboriginal women and men's usage of the formal health care system, with particular emphasis on access barriers and means of overcoming them. There is increasing focus on emerging issues such as HIV/AIDS, diabetes and the implications of Bill C-31. A notable development is researchers and policy makers' growing interest in health determinants, along with the importance of capitalizing on knowledge already present within Aboriginal communities.

Nonetheless, additional resources need to be channeled into Aboriginal women's health, which remains under studied and poorly understood despite some innovative, action-oriented research work.

The Research of the Centres of Excellence in Women's Health

In reviewing the Centres projects, we identified five principal theme areas, encompassing Aboriginal women's health status, violence and sexual abuse, substance abuse and maternal health, health-seeking behaviour, and access to services.

While all of the initiatives undertaken or supported by the Centres probe questions of key concern to Aboriginal women, additional work is needed in a number of areas. In particular, steps must be taken to ensure that research methodologies are clearly articulated and respectful of Aboriginal women's multiple burdens, that attention be focussed on groups of Aboriginal women whose needs and concerns have been under-represented in previous research, and that research initiatives be reflective of Aboriginal women's linguistic and cultural diversity.

Other issues include the lack of sufficient funding to pursue Aboriginal women's health research, and the need to ensure adequate and appropriate follow-up. We also highlight the importance of giving Aboriginal women control over research that affects them and the need to enhance training and networking opportunities for Aboriginal women researchers,. We urge the fostering of partnerships

and collaboration with both Aboriginal and non-Aboriginal organizations.

Indigenizing the Research Process

We have a number of recommendations to promote the indigenization of the research process. The Centres of Excellence for Women's Health, in conjunction with Aboriginal women's health researchers and appropriate Aboriginal organizations, should outline a strategy for just, sustainable and inclusive collaborations and partnerships. The Centres should educate researchers and research participants about health research and Aboriginal women.

Aboriginal organizations also need to be part of developing a strategy for the incorporation of Aboriginal women's health stories, experiences and knowledge into an analytical framework that can be used as a "lens" when doing research with Aboriginal women. A dialogue is needed between academic and community researchers to address outstanding issues related to health research on Aboriginal women, particularly as these relate to identity, culture and key social categories.

Engaging Aboriginal Women in the Research Process

The Centres must recognize Aboriginal women's multiple burdens, including poor health status, poverty, violence, substance abuse, childcare and over-surveillance. Aboriginal women's health researchers and appropriate Aboriginal and non-Aboriginal organizations should work with Aboriginal women in communities to promote participation in research projects, share approaches to mobilize Aboriginal women, and identify means of strengthening community-driven research.

The Centres, in conjunction with the Canadian Women's Health Network, could coordinate research and develop policy that would support Aboriginal women's groups; involve researchers deemed to be personally suitable for work with Aboriginal women; protect the rights of both researchers and Aboriginal women; build upon Aboriginal women's strong leadership role in health-related matters at the community level; recognize the evolving capacity of Aboriginal women to conduct research; and show sensitivity to diverse audience groups.

The Centres could work with researchers to develop an analytical tool that would assist in establishing Aboriginal women's health research so as to weigh the consequences of acting or not acting on key health issues, and also examine the pain/health/healing paradigm that informs the provision of health care services to Aboriginal women.

We hope the Centres, the Women's Health Bureau and other relevant federal government departments will consider holding an annual meeting on Aboriginal women's health research.

Addressing Gaps and Weaknesses in Aboriginal Women's Health Research

We recommend that the Centres work with Aboriginal women's health researchers and appropriate Aboriginal and non-Aboriginal organizations to determine when, how and why academic and community methodologies should override, intersect or co-exist with one another; identify and track positive health indicators; facilitate networking by Aboriginal women's health researchers; exploit new information technologies to disseminate and share research findings; undertake analyses which compare and contrast local, regional and international trends, issues and solutions; and articulate both gender- and Aboriginal-based analyses.

The Centres should work with Aboriginal women's health researchers to develop culturally-appropriate methodologies; identify model communities such as Alkalai Lake and Hollow Water; develop a knowledge base of key Aboriginal concepts and principles (e.g., respect) which may be relevant in the pursuit of health research; situate research in larger social, economic, political, legal and cultural contexts; undertake research which is sensitive to Aboriginal women's diversity; understand the implications of the medicalization of Aboriginal women's health; and carry out research which supports Aboriginal women's programming needs.

There was a strong consensus among the participants at the National Workshop on Aboriginal Women's Health Research that research must be both action oriented and acted upon. In the words of one woman, "… once the research has [been] done, we have to do whatever it takes to act on this research." We must seek ways of promoting change.

The full text of the Aboriginal Women's Health Research Synthesis Project Final Report *may be downloaded at* www.cwhn.ca/resources/synthesis/synthesis-en.pdf. *Copies of the report, available in both English and French, can be ordered from the Canadian Women's Health Network.*

Madeleine Dion Stout is a Cree-speaking educator from the Kehewin First Nation. She is widely recognized for her work on women's health issues and has published for Status of Women Canada and others. A former faculty member at Carlton University, she now resides in British Columbia. Gregory D. Kipling is a health researcher currently working on immigration and refugee issues. Roberta Stout is a Cree woman from Kehewin Alberta, currently working on Aboriginal women, health and the environment.

The Health of Native Women in Quebec

BY PRUDENCE HANNIS

Quebec Native Women (QNW) is a non-profit organization representing over 3,000 women from Quebec First Nations, whether or not they live on reserves. Since it was founded in 1974, the QNW has worked extensively on the political and socio-economic fronts, focusing particularly on justice, the promotion of non-violence, employment, and, since January 2001, health.

From the very start, the QNW's main theme has been equality between the sexes—economically, socially, legally and politically—in addition to campaigning for more equilibrium between the living conditions of Aboriginal and non-Aboriginal peoples. According to reports on the healthcare situation of Aboriginal women, the importance of maintaining these objectives becomes even more obvious. An extensive examination of the documentation on the health of Aboriginal women, a project carried out with the support of the Centre of Excellence for Women's Health—Consortium Université de Montréal (CESAF), produced a number of findings attesting to the many problems that Aboriginal women in Quebec face to varying degrees. The document, entitled *Femmes autochtones et santé : un état de la situation* (Aboriginal Women and Health: An Assessment), has two specific objectives: to be a basic reference on the different aspects of Aboriginal women's health and to pique the interest of decision makers regarding issues affecting Aboriginal women. This document was based on the Health Determinants approach, as developed by Health Canada. This approach is especially interesting in that it allows us to consider the many factors that may contribute to or adversely affect the well-being of women and the maintenance of their health. From this perspective, this exercise in awareness falls within, by definition, a greater context and exceeds the very field of healthcare, extending to more general social issues, social inequalities, socio-economic conditions and, in particular, the quality of life of Aboriginal women.

The highlights emerging from this progress report showed the necessity of promoting an overall community and multidisciplinary approach for healthcare programs and services, of attacking head-on the real causes behind the physical, mental, emotional, spiritual, community and family health problems from a perspective of long-term action and of enhancing the status of Aboriginal culture and traditional practices while promoting

*…**we must** remove structural obstacles that hinder the recognition and implementation of services that are **culturally adapted**, specifically adapted to the **actual needs of the people** and coming from the communities…*

cultural sensitivity, a sound social environment through different support measures, approaches and services that specifically respond to the needs of women, as well as developing approaches that promote family integration. Mental health, putting an end to violence, promoting health, optimizing resources, cultural recovery and family health are among the priorities on which specific actions must be taken.

The current challenges of improving the health of Aboriginal women, their children and their communities are manifold and can only be resolved if we first work on the problems at the heart of the matter—more specifically lack of prevention, education and health promotion programs, inadequacy of programs and real requirements of the people, a work overload for all involved, lack of coordination and consultation, rigid rules for programs and services, lack of long-term programs and activities, problems with accessibility and availability of services and resources, lack of cultural sensitivity, lack of resources specific to women and complicated procedures for obtaining services due especially to a lack of skills.

Fifteen recommendations were made to present to the various decision makers regarding the health of the First Nations:

- that Aboriginal and non-Aboriginal governments implement policies, programs and plans of action aimed at fighting poverty among Aboriginal women by promoting access to education and decent working conditions, as well as ensuring pay equity, income security and access to decent housing;
- that the Federal and provincial governments continuously support the government programs and/or community initiatives set up to help families;
- that governments facilitate and support initiatives to inform people about the healthcare needs, concerns and priorities of Aboriginal women by reflecting them in the government and community policies and programs;
- that governments promote interdepartmental consultation by integrating Aboriginal groups;
- that governments remedy any administrative and legal impediments to service access;
- that governments promote and recognize alternative approaches to service provision. In order to do this, we must remove structural obstacles that hinder the recognition and implementation of services that are culturally adapted, specifically adapted to the actual needs of the people and coming from the communities, especially by ensuring more flexibility as to financing community initiatives;
- that we support the development of training programs aimed at the development of community expertise in healthcare;
- that the development of intercultural education be supported;
- that government subsidize research into the health of Aboriginal women based on their diversity;

- that funds be earmarked in on a recurrent basis to develop programs, tools and methods aimed at furthering and intensifying the promotion of health through prevention, awareness and education based on the requirements identified by the Aboriginal communities and organizations and on the diversity of women;
- that a truly holistic approach to health is developed, by studying the development of a work setting that allows consultation that would lead to remedying the compartmentalization of services;
- that governments and Aboriginal organizations support the development of the expertise of Quebec Native Women regarding health;
- that programs and services be designed based on a long-term perspective and that financing be granted accordingly;
- that governments be committed to eliminating shortcomings in terms of material, financial and human resources that hinder the quality of service provision;
- that the leadership of Aboriginal women be supported and promoted by including them in the decision making process.

Quebec Native Women is committed to defending the interests of Quebec's Aboriginal women regarding health and to continue increasing the awareness of the government decision makers and First Nations.

Femmes autochtones et santé : un état de la situation *will be translated into and published in English in the near future.*

Prudence Hannis is the Health Coordinator for Quebec Native Women.

New from Quebec Native Women (QNW)

"The four insights from Mali Pili Kizos" is a qualitative research project done with 12 Aboriginal women of Quebec who were students of residential schools. The emphasis is on moving beyond victimization and learning about successes in the women's healing journeys. The four major themes that guided the work are: resilience capacity, survival strategies, turning points, and steps they took to repair the trauma and to maintain balance. Phase two of the project intends to bring the women together again to help heal wounds that could have been opened by telling their stories. An article describing the project appears in the magazine of the Aboriginal Healing Foundation, *Healing Words*, Vol.3, No.2, Winter 2001. A report is available from QNW.

QNW has begun research on the Quebec midwifery legislation and its impact on Aboriginal midwifery practices. The research will also give an up-to-date picture of Aboriginal midwifery in Quebec. The long-term goal is to help create a working group to represent First Nations midwives. Results are expected to be available in June 2002.

A report is now available from QNW on their 'Apitendemowin' project, a seminar on the issue of sexual abuse in the Aboriginal milieu. 'Apitendemowin' is an Algonquin word meaning 'treat someone with much respect and consideration.' The report includes not only 41 recommendations to government and community services, but also extensive references and descriptions of existing programs and services. Contact QNW for a copy of the report.

In collaboration with l'Institut national de recherche scientifique – Urbanisation, culture et société, QNW has produced a research report on employment solutions for Aboriginal women. *Aboriginal Women and Jobs: Challenges and Issues for Employability Programs in Quebec* is available through Status of Women Canada and may be downloaded at www.swc-cfc.gc.ca/publish/research/010606-0662654889-e.html.

Quebec Native Women (QNW):

460 Ste-Catherine West, suite 503, Montreal (Quebec) H3B 1A7
Tel: (514) 954-9991, Fax: (514) 954-1899, E-mail: info@qnwafaq.com

POVERTY IS HAZARDOUS TO WOMEN'S HEALTH – AND WE CAN DO SOMETHING ABOUT IT

Governments planning health care reform need to include the recommendations of a new study from the Women's Health Clinic in Winnipeg. The study, called *Women, Income and Health in Manitoba*, shows that while women living in poverty may get sick and die sooner, Canada's income inequality means every income group is vulnerable to having poorer health and shorter lifespans.

"We want Manitobans to be aware of how low income not only affects the health of women living in poverty, but every income group up the economic ladder," says Barbara Wiktorowicz, the WHC's Executive Director. "We want them to know there are things that we can do now to change this, so we're releasing this study now because it's critical to the current debate. Preserving and enhancing medicare is a women's issue, but it affects everyone."

The study's launch in February, which received considerable media attention, is the first stage of a Manitoba-wide "Poverty is Hazardous to Women's Health" campaign. WHC wants to raise awareness in the general population and among policy-makers that "Reducing poverty improves health for everyone. Together we can do it."

Government and health researchers have known about the relationship between income and health for some time. However, research across developed nations shows that it is not just poverty that makes people sick; inequality is bad for everyone's health. In societies with greater inequality, even the wealthiest get sick and die sooner.

In Manitoba, as in the rest of Canada, poverty discriminates, striking women substantially more frequently and more severely than men. It hits women with disabilities and women of colour even harder, and Aboriginal women hardest of all. Aboriginal women have poorer health than Aboriginal men or any other Canadian women. The study makes a special effort to include the views, and needs, of Aboriginal women.

"Preserving and enhancing medicare is a women's issue, but it affects everyone."

The Women's Health Clinic wants to get the public involved in making change. Once it is understood that medical care is less important in ensuring the health of the entire population than economic security, social support and a more equitable distribution of wealth, the public can work with—or push—policy makers to take new approaches.

One priority is redesigning health care services to meet the needs of low-income women, and to start by including the women in planning and evaluation. A wider goal of the awareness campaign, however, is to help decision makers, both inside and beyond the health care sector, to consider the health consequences of their decisions and how these can assist low-income women's health.

Policy changes outside the health sector can be as, or more, important than changes within. Municipal politicians, for instance, should consider the impact on women's health when setting public recreation fees and transit fares. The CRTC should consider how lack of phone service can lead to social isolation and contribute to ill health when setting local phone rates.

The campaign lists a number of 'Ideas for Action', including: raising the minimum wage, increasing social assistance rates, broadening eligibility for Employment Insurance, increasing the number of subsidized child care spaces, providing non-insured health benefits such as dental care and prescription drugs to all those living in poverty, and others.

In addition to the study, there are an attractive full colour pamphlet, brochure and poster for the "Poverty is Hazardous to Women's Health" campaign. The study, brochure and poster can be downloaded at www.womenshealthclinic.org. Paper copies can be ordered from: Gail Watson, Project Coordinator, Women, Poverty and Health Project, Women's Health Clinic, 419 Graham Avenue, 2nd Floor, Winnipeg, MB, R3C 0M3. Phone (204) 947-2422, ext. 134, or e-mail: gailwatson@womenshealthclinic.org.

Cultural Competence *for Registered Nurses*

BY LAURIE DOKIS

Editor's Note: *Laurie Dokis is an Ojibwa woman and registered nurse who was transplanted to the Northern Alberta community of Westview. While there, she saw non-Aboriginal nurses struggling with differences between their own attitudes about health and those of their Aboriginal clients. Both needed to develop more understanding about each other's ideas about health and community. While not planning to become an expert, she found herself in the role of middle person between the two cultures.*

Laurie has come a long way. Now in the Master's program in the Health Sciences Department at the University of Alberta, she is working on her thesis examining the subject of cultural competency of the registered nurses in her district.

Last fall in Calgary, Laurie gave a workshop on the topic at the National Aboriginal Health Conference, well-attended by health practitioners, policy makers and Aboriginal people. Not following the usual lecture format, the workshop started as a sharing circle, in which each participant spoke about where they had come from and what they wanted to learn about cultural competence. Laurie answered their questions and then everyone listened as an Aboriginal elder talked about her own difficulties with the health system.

I asked Laurie about her study. The following is a summary of recommendations and findings.

CULTURAL COMPETENCE IS IMPORTANT FOR REGISTERED NURSES WORKING IN CULTURALLY DIVERSE POPULATIONS. AWARENESS AND UNDERSTANDING OF CULTURAL DIFFERENCES STRENGTHENS AND BROADENS THE MEASURABLE OUTCOMES OF NURSING SERVICES, CONTRIBUTES TO COST-EFFECTIVE PROGRAMMING AND ENHANCES THE BEST PRACTICES OF THE PROFESSION.

Experts in the field of Aboriginal health recognize the need for culturally competent nursing care as documented by the Inuit Regional Health Survey, the Royal Commission on Aboriginal Peoples, the Canadian Medical Association's *Bridging the Gap* and the Aboriginal Women's Health Report.

In the second phase, a Cultural Advisor would be hired to provide continued resources for ongoing professional development.

Increasing the cultural competence of registered nurses is a priority for Aboriginal organizations, practising nurses and nursing management of the Westview Regional Health Authority (WRHA) in Northern Alberta.

Evaluative criteria for this initiative include understanding how disparities between Aboriginal and non-Aboriginal health beliefs impact on the planning and delivery of nursing services, increasing Aboriginal access to mainstream health services, improving the quality of nursing service and health outcomes for Aboriginal people, and increasing financial resources to provide specialized health services to Aboriginal populations.

Achieving cultural competence for registered nurses, fostering increased understanding between Aboriginal and non-Aboriginal parties, and fulfilling the evaluative criteria are the goals of this four-phase policy recommendation.

The first two phases would take place over a three-to-five year period with funding provided by non-Aboriginal sources.

During the initial phase, a mandatory cultural training program for nurses would be planned and implemented. Because of the informal nature of their relationships to each other and the limited resources of the Aboriginal organizations in the district, the WRHA would fund this training. Such input of resources would signify its good will and begin the process of establishing a cooperative partnership.

In the second phase, a Cultural Advisor would be hired to provide continued resources for ongoing professional development.

During phase three, the cultural training program would continue as a mandatory employment requirement, and would be supported by regional education funding for nurses.

At this time, a transfer of the initiative to Aboriginal organizations would occur, with the formation of an Aboriginal Cultural Advisory Council. It would be responsible for the ongoing development, delivery and evaluation of the training program.

Developing and maintaining an effective partnership of Aboriginal and non-Aboriginal organizations throughout this initiative is critical. The experience gained from such a relationship could then be extended to include the Department of Advanced Education with the purpose of achieving a long-range goal to increase the number of Aboriginal nurses, making it possible to hire Aboriginal nurses proportional to the Aboriginal population.

The short-term benefits of cultural training and access to a Cultural Advisor would contribute to ensuring the long-term benefits of Aboriginal self-determination in the area of health, as well as increased representation of Aboriginal people in the field of nursing.

Health is not the outcome of services alone. The ability of Aboriginal people to participate equally in decisions affecting them translates into their political and economic renewal, with benefits to the whole society.

Talking about weight with Aboriginal women

BY GAIL MARCHESSAULT

It is a commonly held belief among health professionals that weight preoccupation is not prevalent in Aboriginal communities. Yet my research shows that it may be more of a problem than most people suspect. In 1996-1997 I did a study with 80 Grade 8 girls and their mothers from Winnipeg and southern Manitoba. Half of the families were Aboriginal with half of those living in a First Nations community. More Aboriginal than non-Aboriginal girls and mothers reported dissatisfaction with their bodies. Using a scale showing pictures of body shapes, 83% of Aboriginal women indicated they would like to be smaller than their current shape, compared to 62% of non-Aboriginal women. Almost twice as many Aboriginal girls (66%) as non-Aboriginal girls (36%) indicated unhappiness with their size.

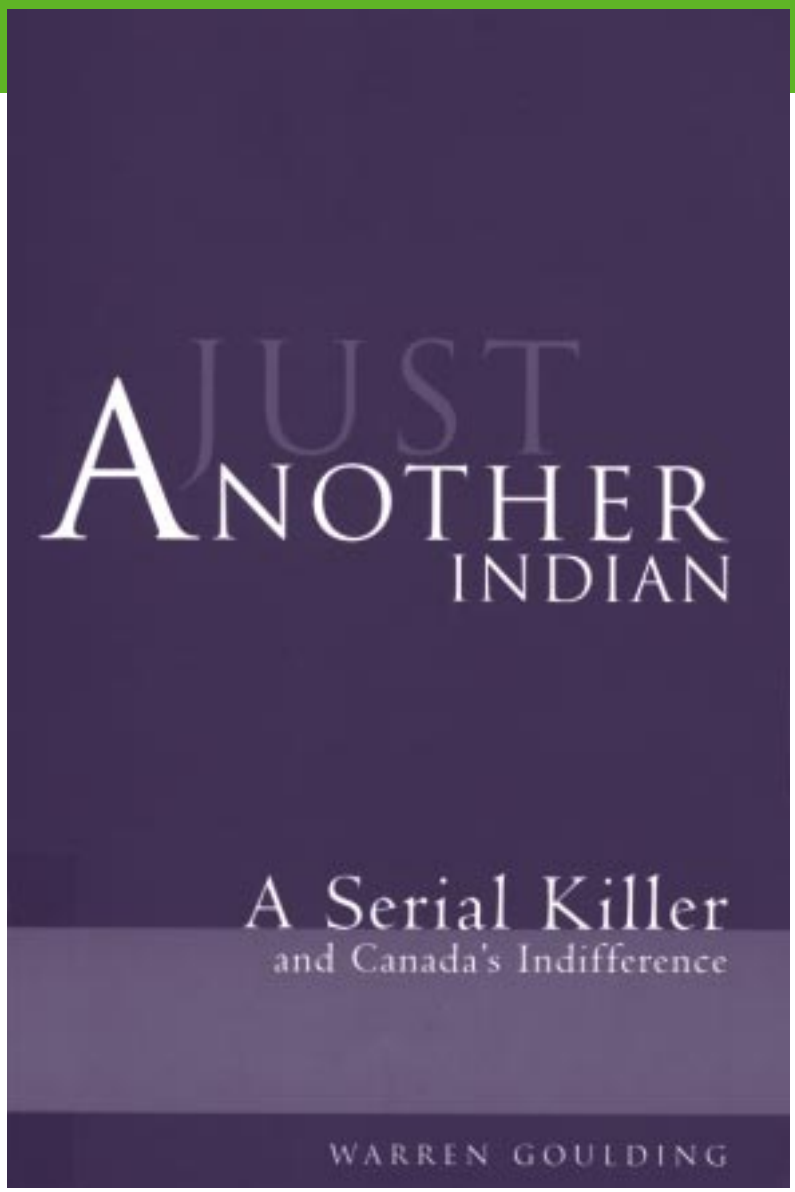
About one quarter of the girls and a third of the women reported they were currently dieting. Rates of dieting were highest for the families living in the First Nations community. Using the Eating Attitudes Test-26, 17.5% of Aboriginal girls (and 2.5% of non-Aboriginal girls) had scores suggestive of risk for an eating disorder. One in four of the girls from the First Nations community reported having vomited for weight loss. In addition, some Aboriginal women recalled a history of risky eating behaviours, indicating these concerns have existed for at least a generation.

There is growing attention to the high incidence of diabetes in Aboriginal communities and maintenance of a healthy weight is often a focus of health promotion activities. However, those doing this health education work need to consider that some Aboriginal girls and women living in or close to an urban centre may be preoccupied with their weight and may already be using risky methods to control their weight.

Gail Marchessault, R.D., PHEc, Ph.D is Assistant Professor in the Department of Foods and Nutrition at the University of Manitoba. This research was done for her Ph.D. thesis for the University of Manitoba.

Just Another Indian
by Warren Goulding
Fifth House Ltd.
Calgary, Canada
2001

BY CONNIE DEITER



His name is John Martin Crawford, and he is one of Canada's most deadly serial killers. He callously raped and murdered four women and possibly more. His crimes have placed him in the company of David Berkowitz, Ted Bundy, and Paul Bernardo, but most people would not have heard of him. Why? Because his victims were Aboriginal women, argue Warren Goulding and others.

I don't know which is more shocking to me, the fact that the Canadian public knows more about the birthday parties Karla Homolka attends while in prison, or that they don't know the name John Martin Crawford.

Goulding is a long time journalist in Saskatchewan. With this book he takes on a subject no one was interested in during the trial proceedings. Yet he writes a compelling chronicle of the killings, the investigation and the trials.

The 220-page book begins with asking questions of the media. Why were the murder investigation and subsequent trials not front-page news, carried with he same righteousness as the Paul Bernardo case?

One local Saskatoon columnist answered that it was because of geography, and the lack of drama. If this were Toronto, he argued, it would have been front-page news. According to him, racism was not one of the reasons.

As a First Nations woman raised in southern Saskatchewan, I find this response typical of the male white status quo in Saskatchewan. His attempts at justifying the silence around the killings is typical of those who don't want changes to a system that keeps First Nations women marginalized, underemployed and living in poverty.

This book is a good read. It challenges you to examine racism, sexism, and power imbalances in our society. Justice Wright, in his final remarks of the trial, nailed all of this:

"It seems Mr. Crawford was attracted to his victims for four reasons: one, they were young; second, they were women; third, they were native; and fourth, they were prostitutes. They were persons separated from the community and their families. The accused treated them with contempt, brutality; he terrorized them and ultimately he killed them. He seemed determined to destroy every vestige of their humanity."

Goulding's book gives back some of this humanity to Eva Taysup, Calinda Waterhen, Shelly Napape and Mary Jane Serion. He also challenges us to look inside ourselves, our families, and our communities for those elements that created John Martin Crawford.

Connie Deiter is a legal consultant, researcher, and lecturer at the University of Regina's School of Journalism.

These two pages are dedicated to Aboriginal women who have made a difference in health care in their community and across Canada.

Women OF NOTE

The Honourable Ethel Blondin-Andrew, P.C., M.P., L.L.D. was the first Aboriginal woman to be elected to the House of Commons in 1988, as Member of Parliament for the Western Arctic. Re-elected in 1993, Ms. Blondin-Andrew was appointed Secretary of State for Training and Youth, making her the first Aboriginal woman to become a member of the Privy Council and Cabinet. In June 1997, Ms. Blondin-Andrew was re-elected and re-appointed as Secretary of State (Children and Youth) where she continues today.

Throughout her political career, Ms. Blondin-Andrew has been a strong advocate for Aboriginal people, children, youth and persons with disabilities. She has raised awareness and worked actively on many initiatives and issues, including: the inclusion of Aboriginal communities in the development of national, regional and local labour market programs; Canada's Youth Employment Strategy (YES); Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE); youth at risk; homeless youth, children with special needs; and tobacco-abuse, particularly in her integral role on the Youth Advisory Committee on Tobacco Use. A Treaty Dene from the Dene Nation, Ms. Blondin-Andrew's mother tongue is Dene-Slavey. She is married to Leon Andrew and has three children—Troy, Tanya and Tim.

Dr. Valerie Assinewe has completed a doctoral thesis at the University of Ottawa on the medicinal use of American ginseng by Indigenous peoples. She looked at the phytochemical and immunopharmacological properties of this widely used natural health product. Her research showed that American ginseng stimulates the immune system. Her research included extractions and quantitative analyses of ginseng for natural health products manufacturers and diabetes research at St. Michael's Hospital, Toronto. Prior to her doctoral research, Dr. Assinewe was a consultant and career civil servant. As a consultant, she has worked primarily with the federal government on environmental issues and the participation of Aboriginal peoples on environmental protection issues. During her sixteen years as a manager and program officer with the Government of Canada in Edmonton, Yellowknife, Winnipeg and Ottawa, Dr. Assinewe coordinated the planning, implementation and fiscal management of a wide range of social development programs including Multiculturalism, Human Rights, Women, Disabled Persons Participation and Native Citizens. Dr. Assinewe was born and raised at Sagamok First Nation, Ontario. She resides in Ottawa with her husband, Terry Rudden, where they work as consultants.

Madeleine Dion Stout is a Cree speaker who was born and raised on the Kehewin First Nation in Alberta. Beginning as a Registered Nurse in Edmonton she went on to get a Bachelor's Degree in Nursing from the University of Lethbridge and a Master's Degree in International Affairs from the School of International Affairs at Carleton University. She is Past-President of the Aboriginal Nurses Association of Canada and has served as a member of the National Forum on Health. She has been Director of the Centre for Aboriginal Education, Research and Culture at Carleton (CAERC) and was awarded a lifetime honorary membership to the Canadian Research Institute for the Advancement of Women (CRIAW). "My work is as much community and social activism as it is academic," she says. "I've devoted a lot of my life to helping Aboriginal people and women to recognize their own power. I believe change comes about in the smallest of ways. These need not be fancy or high profile, but more everyday. And obviously I've contributed something meaningful in people's lives."

Lillian Dyck, Ph.D. is a member of the Gordon's First Nation in Saskatchewan. She is a neurochemist who is a full Professor in the Neuropsychiatry Research Unit, Department of Psychiatry, University of Saskatchewan. She has done research on how drugs, particularly antidepressants, affect neurotransmission. She is a member of a research team who developed and patented new drugs that may prevent neuro-degeneration in diseases such as Parkinson's and schizophrenia. She has done research on alcohol metabolism in Canadian Indians and other populations. Lillian received awards for Science and Technology from the National Aboriginal Achievement Foundation [1999] and Saskatchewan First Nations, Women of the Dawn [2000].

The Nuu-Cha-nulth Community and Human Services Community Health Nurses on Vancouver Island have been awarded the Health Advocacy Award of the Registered Nurses Association of B.C. For the first time it was awarded to a group of nurses for their culturally sensitive nursing care to the Nuu-cha-nulth First Nation. This island community and the nurses developed a framework for the nurses' relationship with their clients. Basic to it is respect for First Nations traditions and individual responsibility for health. The outcome is a partnership between the nurses and the community where the nurses provide care but the clients take responsibility for their health decisions. The most positive outcome of the nurses' advocacy is the increase in breast feeding among new mothers. "The challenges for this type of nursing are great and the successes are small," says Penny Cowan, community nurse specialist. The dedication of the nurses is unwavering. They know their work is empowering to the people in this small island community. The hope is that this community will not suffer the same preventable health problems that currently affect First Nations populations elsewhere.

Ophelia Kamenawatamin completed the Walk for Life, on October 2, 2001, to raise funds to buy dialysis machines for the new Sioux Lookout hospital and to lobby for suitable housing for kidney treatment patients. She walked from the Manitoba/Ontario border to Parliament Hill starting her walk on August 6. Ophelia contemplated this walk for nearly 10 years and in the year 2000 shared her dream with her family and friends who supported and encouraged her. As a mother of eight from Bearskin Lake First Nation she understands the needs of patients on dialysis. Ophelia's daughter was on dialysis for 11 years. "People rely on dialysis for life support—it's their life." Ophelia encourages others to support the walk by sponsoring, donating or participating in the Walk for Life.

Gail McDonald, a resident of the Akwesasne Mohawk Territory, has held positions at the national, regional and community level in an active career spanning 25 years in advocating First Nations health, research, policy, community development and self-governance. Gail is the Director of the National Aboriginal Health Organization's First Nations Centre. She has served in a number of national positions including National Coordinator for the First Nations and Inuit Regional Longitudinal Health Survey and the First Nations Information Governance Committee, both of which are initiatives mandated through the Assembly of First Nations. Her ongoing activities promoting the development of the First Nations health info structure—which will impact research, information, health technologies and access issues—coupled with her work advocating ethical research in First Nations communities, stand as a testament of Gail's commitment and dedication to improving Aboriginal health conditions.

Caroline Tait is a doctoral student in the departments of Anthropology and Social Studies of Medicine at McGill University. She has a BA from McGill University in Anthropology and a Master's degree from the University of California at Berkeley. Caroline was a Fulbright Scholar and Visiting Fellow at Harvard University in the departments of Anthropology and Social Medicine during the 1995-1996 academic year. Caroline's research is based mainly in Canada, particularly in Quebec and Manitoba. However, her research spans across North America, contrasting the Canadian and American public health responses to substance abuse by pregnant women. Caroline's doctoral dissertation is tentatively entitled, "Fetal Alcohol Syndrome and Fetal Alcohol Effects: The 'Making' of a Canadian Aboriginal Health and Social Problem" and will be completed in 2002. She is also the author of *A Study of the Service Needs of Pregnant Addicted Women in Manitoba*, and co-author of "The Mental Health of Aboriginal People: Transformations of Identity and Community" published in a recent volume of *Canadian Journal of Psychiatry*. Caroline is Métis from MacDowall, Saskatchewan She is a past advisory member to the Board of Directors of the Native Friendship Center of Montreal . Caroline has one son, Skender.

Women's Health Q&A

COMPILED BY BARBARA BOURRIER-LACROIX

Why is diabetes a concern for Aboriginal women? What are the health risks?

Until the 1940s, diabetes was virtually unknown in Canada's Aboriginal communities. However, in the last decades, it has reached epidemic proportions. The prevalence of diabetes among First Nations is now at least three times the national average, and rates appear to be higher on-reserve than off-reserve. Aboriginal women in particular are believed to be prone to diabetes. Approximately two-thirds of the First Nations people diagnosed with diabetes are women. This means that Aboriginal women are contracting the disease at a rate roughly twice that of Aboriginal men. This gender difference is not observed in the wider Canadian population, where diabetes strikes men more often than women. First Nations women have over 5 times the rate of diabetes compared to women in the general population. Not only is there a higher rate of type 2 diabetes in First Nations women of most age categories, many of these women were also diagnosed with gestational diabetes mellitus (GDM). While there has been little research conducted on diabetes rates in Inuit and Métis populations, recent studies indicate that these populations are beginning to show signs of risk factors and more cases of diabetes.

There are many theories about why diabetes has become an epidemic in First Nations populations. Colonization ensured that the Europeans displaced many, if not most, Aboriginal peoples. First Nations people were forced into a sedentary western lifestyle, with diets high in fat, sugar, and processed foods. Combined with the effects of displacement, colonization continues to force many Aboriginal people into a subsistence standard of living and a dependence on the state. Women who live in poverty have limited funds to provide the necessities of life. In some remote reserves, the availability and affordability of healthy food choices are severely limited. Many families live with what is commonly referred to as the "macaroni diet," a high-fat, low nutrient diet. There are also unique considerations in providing the education, care and support necessary to enable research and to prevent diabetes in First Nations communities. Health care services, including diabetes education and early screening, may be unavailable or inconsistent. Other factors include the higher percentage of chronic drug and alcohol abuse within Aboriginal communities, and increasing numbers of people relocating to urban centres leading to family disruption or breakdown, and placing high levels of stress on women in particular.

The toll of unmanaged diabetes in Aboriginal populations can be devastating. Having diabetes means a woman is at an increased risk of heart disease, high blood pressure, stroke, more lower limb amputations, kidney disease and dialysis, and eye disease.

Resources

■ **Diabetes Among Aboriginal People in Canada: The Evidence**
Aboriginal Diabetes Initiative, Health Canada
March 10, 2000
Available online at:
www.hc-sc.gc.ca/fnihb/chp/adi/the_evidence.pdf

■ **The Health of Aboriginal Women**
Women's Health Bureau, Health Canada
July 22, 2000
Available online at:
www.hcsc.gc.ca/english/women/facts_issues/facts_aborig.htm

■ **As an Aboriginal person, I understand I am at great risk of getting diabetes. What should I know about looking after myself?**
R. K. Abram, Canadian Health Network
March 2000
Available online at:
www.canadian-health-network.ca/faq-faq/aboriginal_peoples-autochtones/3e.html

■ **Empowering Words of First Nations Women: Manual for Speaking Out About Life, Health and… Diabetes**
First Nations of Quebec and Labrador, Health Services Commission
250, Place Chef Michel-Laveau
Wendake (Québec) G0A 4V0
Tel.: (418) 842 1540
Fax: (418) 842 7045

■ **Aboriginal Women's Health Research Synthesis Project Final Report**
Centres of Excellence for Women's Health
May 2001
Available online at:
www.cwhn.ca/resources/synthesis/index.html

Do You Have a Women's Health Question?

Toll-free (in Canada): 1-888-818-9172
In Winnipeg: 942-5500
TTY (toll-free): 1-866-694-6367
TTY in Winnipeg: 942-2806
Fax: (204) 989-2355
E-mail: questions@cwhn.ca

Seen but Not Heard: Aboriginal Women and Women of Colour in the Academy

***Feminist Voices/ Voix féministes* No. 11**
Rashmi Luther, Elizabeth Whitmore and Bernice Moreau
This issue of *Feminist Voices* presents the proceedings of a Symposium, held in March 1999, describing the experiences of women of colour and Aboriginal women scholars with issues of equality in the academy. It includes a summary of the editors' research on the experiences of faculty in Canadian universities, as well as presentations of four speakers from the Symposium.
2001. Cost: $13.95 (non-members); $10.95 (members). English.
Published by: Canadian Research Institute for the Advancement of Women
151 Slater Street, Suite 408
Ottawa, ON K1P 5H3
Tel: (613) 563-0681
Fax: (613) 563-0682
E-mail: info@criaw-icref.ca
www.criaw-icref.ca

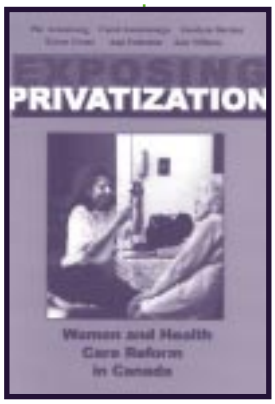
A Guide for Health Professionals Working with Aboriginal Peoples, SOGC Policy Statement

Executive Summary: The Sociocultural Context of Aboriginal Peoples in Canada

***Journal SOGC*, December 2000, Vol. 22, No. 12**
Health Issues Affecting Aboriginal Peoples
***Journal SOGC*, January 2001, Vol. 23, No. 1**
Cross Cultural Understanding
***Journal SOGC*, February 2001, Vol. 23, No. 2**
This series of articles is addressed to health professionals who wish to understand the perspectives from which Aboriginal individuals and communities may enter the therapeutic dialogue. It aims to supply health professionals with a toolkit to use when working with Aboriginal individuals and communities. Topics include: social, historic and political contexts, relevant health issues, how to mediate cultural differences, and ideas and examples regarding the development of health resources directed by and for Aboriginal peoples.
2000/01. Cost $12.00 (back issues). English/French.
Published by: Journal SOGC
Rogers Media
777 Bay Street, 5th Floor
Toronto, ON M5W 1A7
Tel: (416) 596-5000
Fax: (416) 596-5892

First Nations Women, Governance and the Indian Act: A Collection of Policy Research Reports

Judith F. Sayers, Kelly A. MacDonald, Jo-Anne Fiske, Melonie Newell, Evelyn George and Wendy Cornet
A collection of three policy research reports that provides a gender perspective in the public debate surrounding First Nations governance issues. It is hoped that this collection will support First Nations women and contribute to the ability of individuals and organizations to participate more effectively in the federal government's initiative to amend the *Indian Act*.
2001. Cost: Free. English
Published by: Status of Women Canada
123 Slater Street, 10th Floor
Ottawa, ON K1P 1H9
Tel: (613) 995-7835
Fax: (613) 957-3359
TTD: (613) 996-1322
E-mail: research@swc-cfc.gc.ca
Download :
www.swccfc.gc.ca/publish/research/011129-066231140X-e.html



Gender Dimensions of Racial Discrimination

UN Office of the High Commissioner for Human Rights
The report was prepared for the International Racism Conference in Durban, South Africa. It details how intolerance, prejudice and racism are deep-rooted, complex forces, and highlights how a gender-based analysis recognizes that racial discrimination does not affect men and women equally, or in the same way.
2001. Cost: Free. English.
Published by: United Nation Office of the High Commissioner for Human Rights
8-14, avenue de la Paix
1211 Geneva 10
Switzerland
Download :
www.unhchr.ch/pdf/wcargender.pdf

Exposing Privatization: Women and Health Care Reform in Canada

Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson and Kay Willson
This book exposes the many faces of health care privatization and its impact on women, as providers and patients. It also highlights the impact of health care reform on women's participation in the decision-making process, never losing sight of the significant differences among women related to their physical, social, economic, cultural/racial locations and their age and sexual orientation.
2002. Cost: $24.95. English.
Published by: Garamond Press
63 Mahogany Court
Aurora, ON L4G 6M8
Tel: (905) 841-1460
Fax: (905) 841-3031
E-mail: Garamond@web.ca
www.garamond.ca

Telling It Like It Is: Realities of Parenting in Poverty

Kathryn L. Green and participants of "We Did It Together:" Low-Income Mothers Working Toward a Healthier Community

This book came out of a project, funded by the Prairie Women's Health Centre of Excellence, which brought together fifteen low-income mothers in Saskatoon of preschool-aged children, who had taken part in programs like collective kitchens and parenting groups. It documents the barriers faced by low-income mothers and challenges the negative stereotypes too often associated with "welfare mothers."
2001. Cost: $7. English.
Published by: Prairie Women's Health Centre of Excellence
56 The Promenade
Winnipeg, MB R3B 3H9
Tel.: (204) 982-6630
Fax: (204) 982-6637
E-mail: pwhce@uwinnipeg.ca
www.pwhce.ca

Femmes et santé—suivez le guide

Conseil du statut de la femme—Québec

What physiological changes do women go through throughout their lives? How important are diet and exercise for women? What diseases do they have to watch out for? This guide tries to answer these questions as well as provide information on many other subjects.
2001. Cost: $12.95. French.
To order: Les Publications du Québec
Phone: (418) 643-5150
Toll-free: 1-800-463-2100 (in Quebec)
E-mail :
service.clientele@mrci.gouv.qc.ca

A Framework for Women-centred Health

The Vancouver/Richmond Health Board

This guide is a tool to help with the planning and implementation of policies, procedures, and initiatives across the continuum of care. Its 12 interconnected elements provide strategies to improve responses to the health needs of both individual women and specific populations of women.
2001. Cost: download free. English.
To order:
Vancouver Coastal Health Authority
Phone : (604) 709-6402
Download: www.vcn.bc.ca/vrhb

Maternités lesbiennes

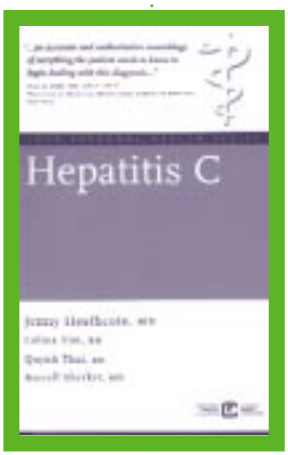
Nathalie Ricard

This book explores the ideas of motherhood and family among thirty lesbian mothers, looking at the family networks they form, their values and their relationships with the socio-political environment. As well, it discusses the ethical issues regarding the desire to have children and form a family, how the father fits in, reproductive technologies and international adoption.
French.
Published by: Les Éditions du remue-ménage
110 Sainte-Thérèse Street, suite 501
Montreal (QC) H2Y 1E6
Phone: (514) 876-0097
Fax: (514) 876-7951
E-mail:
info@editions-remuemenage.qc.ca

Vers un monde sans sexisme : guide pédagogique de réflexion et d'action pour le personnel enseignant de l'élémentaire et du secondaire

Réseau-Femmes Colombie-Britannique

Promoting non-sexist education, this guide deals with many topics, subdivided into sections such as purpose, general or specific strategies (depending on the case), several ready-to-use or adaptable activities, and a list of print, video and Web resources so that you can learn more about a given topic. The topics discussed include language, and linguistic interactions; a math, science and technology section; physical education; career choices; the media and the Internet; and gender and sexual harassment.
2000. Cost: $16.00. French.
To order:
Réseau-Femmes Colombie-Britannique
1752 Fir Street
Prince George (CB) V2L 1E7
Phone: (250) 960-1155
Fax: (250) 960-1144
E-mail: rfcb@telus.net
www.reseaufemmes.bc.ca



Hepatitis C: Everything You Need to Know

Jenny Heathcote, Colina Yim, Quynh Thai and Averell Sherker

A comprehensive and authoritative guide that explains what hepatitis C does, and how it can be prevented and treated. It discusses the medical aspects of the problem, and the practical concerns of living with the disease.
2001. Cost: $19.95. English.
Published by: Key Porter Books
70 The Esplanade
Toronto, ON M5E 1R2
Tel: (416) 862-7777
Fax: (416) 862-2304
www.keyporter.com

Note: We do our best to list the current cost of items reviewed before we publish, but prices do change. Costs listed do not always include shipping charges. We suggest you confirm the price with suppliers before you order.

Resources compiled by Barbara Bourrier-LaCroix