

ANNOTATED BIBLIOGRAPHY



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Introduction

This annotated bibliography prepared for the Montreal Urban Aboriginal Health Needs Assessment aims to review health needs and gaps in access to and delivery of health care/healing in Canadian and North American Indigenous populations, as well as in urban Indigenous populations. This review also covered a search for culturally sensitive health needs and access to care/healing assessment instruments used in research with Indigenous peoples in Canada. Finally, this review helps to define a sampling strategy in order to respect the sociodemographic portrait of Montreal urban Aboriginal communities, and the distribution of services and community-based/civil-society organizations. A search was performed in scientific data bases (e.g. Medline, Pubmed, JSTOR, PsycNet), as well as on Canadian Aboriginal health/healing organizations/research groups websites in order to identify scientific and grey literature that would meet these initial goals.

ALLEN, K.E. 2000. Negotiating Health: The meanings and implications of 'building a healthy community' in Igloolik, Nunavut. M.A. Thesis, McGill University, 92 p.

Allen's Master's thesis explores the meaning of building a healthy community in the Canadian arctic hamlet of Igloolik, Nunavut. The researcher interviewed community members in order to collect narratives used in contextual semantic analysis to examine the health promotion values of community, participation and empowerment. The narratives collected reveal that these values are adopted and directed by personal and political perspectives, while taking into account historical and ethnographical realities. The results obtained show a variety of definitions for health community as well as a diversity of practices to maintain a healthy community. We can be inspired by the narratives of the community members in order to get a better idea of what may be the needs of Montreal's Inuit population.

ANDERSSON, N, Shea, B, Archibald, C, Wong, T, Barlow, K, Sioui, G. 2008. Building on the Resilience of Aboriginal People in Risk Reduction Initiatives Targeting Sexually Transmitted Infections and Blood-Borne Viruses: The Aboriginal Community Resilience to AIDS (ACRA). Pimatisiwin, A Journal of Aboriginal and Indigenous Community Health 6(2): 89-110

The objective of this project is to provide insights into the role of resilience and its impact on the health and well-being of Aboriginal youth, especially as it relates to sexual and injecting behavior. There is evidence that Aboriginal people may be at increased risk of HIV infection; they also experience higher rates of other blood-borne viral (BBV) and sexually transmitted infections (STI). The project is organized in the several phases, the first being the establishing of a framework with Aboriginal leadership and involvement at every level. Next, both qualitative and quantitative methodologies will be used to identify factors that protect Aboriginal youth against blood-borne viral and sexually transmitted infections and their transmission within local communities. Finally, results from this project will be used to develop interventions and appropriate frameworks for their evaluation in Aboriginal communities. An important component of this five-year project will involve the building of capacity within participating communities, with the goal of identifying strategies related to resilience that can be incorporated into public health and clinical practice.



ANDERSSON, N. 2008. Directions in Indigenous Resilience Research. CIET. Pimatisiwin, A Journal of Aboriginal and Indigenous Community Health 6(2): 201-208.

The last decade or so of Indigenous research in Canada, reflected in this special issue, has increased our understanding of the distinction between Indigenous resilience and the research into Indigenous resilience. Measurement offers glimpses of resilience, mostly from the potentially distorted view of how resilient youth face specific adversity that is set by the funding opportunity: tobacco, substance abuse, suicide, or HIV infection. The driving role of funding has obvious problems: the priorities of funders may not be the priorities of communities and results can tell more about the funding opportunity than about resilience itself. Even so, this problem-focused research has the very practical advantage of producing results geared to solutions. A major lesson of this body of work is that we should allow ourselves the space (and the modesty) to recognize that Aboriginal resilience is greater than we have been able to measure under specific funding opportunities. Even with this limitation, the results show a large degree of specificity - what strengthens youth resilience to one type of adversity in one setting might well not work in another. Five proposals emerge from the findings.

BAKER, F.W., Findlay, S., Isbister, L. and Peekeekoot, B. 1987. Native Health Care: an alternative approach. Canadian Medical Association Journal, 136: 695-696

In September 1983 the Mayor's Task Force on Indian and Métis initiatives recognized a role for Aboriginal peoples in the health care system and recommended the following: greater involvement in the health care process, encouragement and greater opportunities to pursue careers in health care, cross-cultural education for those who work with First Nations and Métis and prevention health care and education for the First Nations and Métis population. In this essay, the authors demonstrate the specific health care needs of Aboriginal peoples and how these can be better addressed. They acknowledge the work of Native Liaison workers, who are based at the hospital but spend most of their time in the community, acting as interpreters of the established health care system for the patients and their families. They are also available to the nurses, social workers and other staff at the hospital to explain Aboriginal issues. In another study, Shah and Farkas expressed an urgent need for medical schools, Aboriginal organizations, hospitals and various levels of government to cooperate and develop health care services for Aboriginal peoples in Canadian cities; a program in Regina has proved that this is feasible. This successful initiative is now funded by the hospital and the provincial government and has become an autonomous department of the hospital.

BATAL, M.A. 2002. Sociocultural determinants of traditional food intake across indigenous communities in the Yukon and Denendeh. Ph.D. Dissertation, McGill University, 222 p.

This study used food frequency and 24-hour recall questionnaires to quantify traditional food intake in 18 communities in Denendeh (Western Northwest Territories) and the Yukon. Chronic non-communicable diseases related to excessive or unbalanced dietary intakes are on the rise among some Indigenous populations in Canada, which is believed to be due to a transition from traditional to more westernized diets. In this study, individual, household and community levels of traditional food intake were assessed in order to construct a multivariate statistical model that describes the amount and



diversity of traditional food intake in the Western Canadian Arctic. This study described and used a tool to measure traditional food diversity, which may be an appropriate indicator of the process of dietary change experienced by Indigenous peoples in Denendeh and the Yukon. The tools used in this study could be useful in our Needs Assessment, which could include a component on nutrition.

BARLOW, K., Loppie, C. and Jackson, R. 2008. Culturally Competent Service Provision Issues Experienced By Aboriginal People Living With HIV/AIDS. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6(2): 154-180.

This study explores the cultural skills among service providers who see Aboriginal people living with HIV/AIDS (APHAs) and the perspectives of APHAs. The purpose is to better understand the wellness needs of APHAs and how culturally competent care affects health service access and use. The research methodology was based on the OCAP model (Aboriginal ownership, control, access, and possession) and community-based research (CBR). The data was collected using homemade semi-structured interviews and focus groups for quantitative and qualitative information. Each participant completed group surveys eliciting demographic, cultural, health status and occupational information. The first phase included 35 interviews and second phase included 11 focus group sessions and 8 interview sessions. In total, 52 people from 25 organizations participated in the survey. Ethical considerations were guided by the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (CIHR et al., 1998). The most reoccurring themes in the results indicated that active addictions are a major obstacle to adherence to HIV drug regimens and addictions and HIV must be treated together, reflecting the holistic worldview of Aboriginal people.

BARNEY, D.D. 1999. The relative influence of protective factors in quantitative models of American Indian and Alaska Native adolescent health. Ph.D. Dissertation, University of Kansas, 205 p.

This dissertation specifically studied if protective factors of “caring and connectedness” and “help seeking” influenced self-perceived health status for American Indian and Alaska Native youth. Barney used structural equation models with LISREL from a sample of 12,284 American Indian and Alaska Native adolescents from the ages of 12 to 19. The research covers four themes: alcohol use, delinquent behavior, depression and suicidal ideation. The results show that an adolescent’s increased perception of being ‘cared-for’ and ‘feeling connected’ also increased his or her health status. This shows that there appeared to be a protective factor involved in attaining positive health status. Help seeking, on the other hand, failed to serve as a protective function. A social work intervention that increases a sense of being cared-for and a high level of connection with parents and other adults may be beneficial for this high risk population. The approach used by this researcher is interesting and can be relevant when trying to understand the social networks of Montreal’s urban aboriginal community members. Having items related to social networks on the questionnaires will allow us to understand if community members’ primary sources of support are still primarily based in their communities, or they are now based in Montreal, such as from certain service providers.



BERNIER, S. 2003. Determinants of food choices in Arctic populations. M.Sc. Thesis, Université Laval, 155 p.

This article examines the importance of traditional food and the effects of imported food on the diets of Inuit living in Kuujjuaq, Nunavik. Triandis' theory of interpersonal behaviors guided the development and application of a questionnaire to measure the determinants of traditional Inuit food consumption. The results of the study showed the most important determinants of the intention to eat traditional food were the following, in order of decreasing importance: perceived behavioral control, affect, personal normative belief, habit and attitude. Other researchers have shown that eating imported food as opposed to traditional food can have negative health effects such as cardiovascular disease and diabetes. A better understanding of the motivation for Inuit of Kuujjuaq to eat traditional food will help health workers to devise programs that will promote these healthy choices. Once again, this study can help us understand the importance of diet in community health and the effects it can have on the levels of food-related diseases.

BLUM, R., Harmon, B., Harros, L.. 1992. American Indian-Alaska Native Youth Health. Journal of American Medical Associations, 267(12): 1637-1644.

The objective of this study was to revise the Adolescent Health Survey, a comprehensive, anonymous, self-report questionnaire with 162 items addressing 10 dimensions of health, to better gauge the health status of Native youth in Alaska. The results found high rates of health-compromising behaviors and risk factors related to unintentional injury, substance use, poor self-assessed health status, emotional distress and suicide. The author recommends that interventions must be culturally sensitive, acknowledge the heterogeneity of American Indian populations, be grounded in cultural traditions that promote health and be developed with full participation of the involved communities.

BOMBAY, A., Matheson, K. and Anisman, H. 2010. Decomposing Identity: Differential Relationships Between Several Aspects of Ethnic Identity and the Negative Effects of Perceived Discrimination. Cultural Diversity and Ethnic Minority Psychology, 16(4): 507-516

The present investigation examined the relationship between perceived discrimination and depressive symptoms among First Nation adults in Canada. It was considered that specific aspects of ethnic identity could serve as resilience and/or vulnerability factors. The data for the study was collected through surveys, which were sent out in the mail or filled out on line. A total of 220 respondents answered the questionnaire, which was developed with elements from the Beck Depression Inventory (BDI-SF), the Perceived Ethnic DECOMPOSING IDENTITY 509 Discrimination Questionnaire, and Cameron's 12-item social identification scale. The results of the study were consistent with research among other minority populations when the specific aspects of identity were considered. One predominant issue in the findings concerns the generalization of the findings across and within ethnic groups.



BREW, N.E. 1992. Life experiences in care, illness, and healing among Iñupiat practitioners of traditional healing in northwest Arctic Alaska: A qualitative exploration. M.S. Thesis, University of Alaska Anchorage, 124p.

This study explored the life experiences of six Iñupiat traditional healers in caring, health, illness and healing. The Iñupiat of northwest Alaska used to depend on themselves for staying healthy and treating illness in a harsh environment; now they have access to modern healthcare which is not always adapted to their culture and nurses are not very well culturally informed of their realities. Brew discusses ideas about different methods of caring and how it can be implemented to better adapt the services to the Iñupiat. This study may reveal methods for improving services in Montreal in the context of making health care providers more culturally sensitive to Montreal's urban-Aboriginal population.

BROWNS, AJ, Smye, V.L., Rodney, P., Tang, S.Y., Mussell, B., O'Neil, J. 2011. Access to primary care from the perspective of aboriginal patients at an urban emergency department; Qual Health Res, 21(3):333-48.

In this article, the authors discuss findings from an ethnographic study that focuses on experiences of access to primary care services from the perspective of Aboriginal people seeking care at an emergency department (ED) located in a large Canadian city. Data was collected over 20 months of immersion in the ED, and included participant observation and in-depth interviews with 44 patients triaged as stable and non-urgent, most of whom were living in poverty and residing in the inner city. Three themes in the findings are discussed: first, anticipating providers' assumptions; second, seeking help for chronic pain; and third, use of the ED as a reflection of social suffering. The authors discuss the implications of these findings in relation to the role of the ED as well as the broader primary care sector in responding to the needs of patients affected by poverty, radicalization, and other forms of disadvantage.

BUCHWALD, D., Beals, J. and Manson, S.M. 2000. Use of traditional health practices among Native Americans in a primary care setting. Medical Care, 38: 1191-1199.

This study used a brief self-report survey of 869 adult American Indian and Alaska Native (AI/AN) patients randomly sampled over a 14-month period from a comprehensive urban primary care program. Home-made tools were used in construction of a 59-item self-report survey that took 30 minutes to complete, administered verbally for illiterate participants. The SF-6 (Medical Outcome Study 6-item General Health Survey) was used to assess physical, role and social functioning, psychological distress, current health perceptions and pain. The SF-6 has been found to have high reliability and validity with many populations and correlates highly with results from SF-36. Socio-demographic information included age, gender, blood quantum, tribal affiliation, marital and employment status, income, education, household membership and immigration patterns. Other questions included alcohol use, smoking, victimization and trauma. Traditional health practices were assessed by asking patients if they had used certain practices such as smudging, herbal medicine, and sweat lodges and how these practices helped them to be healthy. Two items asked to what extent participants follow the Native way of life and to what extent they follow the white/American way of life. Finally, the patients were asked if they were interested in great availability of traditional treatments, the cultural sensitivity of the clinic (if the care considered cultural identity and background) and the satisfaction with the care provided at the clinic.



BURACK, J, Blidner, A., Flores, H., Fitch, T. 2007. Constructions and deconstructions of risk, resilience and wellbeing: a model for understanding the development of Aboriginal adolescents; Australas Psychiatry, 15(Suppl 1):S18-23.

In this study, a developmental framework for understanding issues of risk, resilience and wellness among Aboriginal adolescents in Canada and elsewhere is presented. As these constructs are not monolithic, simplistic linear risk models of a specific predictor to a specific outcome are inadequate to conceptually capture the complexities of real-life patterns. The authors' focus is on ideal constructions of competence within the context of continually ongoing transactions in which adolescents affect and are affected by the various layers and components of the environment. However, the pragmatics of empirical research necessitates simpler approaches in which outcomes are predicted from specific factors. Nonetheless, in keeping with the notion of the complexity of all individuals, competence and wellness are viewed within the framework of the 'whole child' across domains of academic success, behavioral competence and appropriateness, social adaptation and emotional health within the context of the specific community. Although Aboriginal communities within Quebec, across Canada, the United States, and elsewhere differ considerably with regard to history, culture, language and priorities for youth, this approach allows for the universal application of a framework, for which specifics can be modified in relation to the unique and changing aspects of societies, communities and the individuals within.

BURHANSSTIPANOV, L., Gilbert, A., LaMarca, K., Krebs, L.U. 2001. An innovative path to improving cancer care in Indian country. Public Health Rep., 116(5):424-33

This article briefly describes the process that led to the formation of the Native American Cancer Survivors' Support Network, as well as preliminary findings, primarily for breast cancer survivors, of ongoing qualitative and quantitative research. The aforementioned network is an innovative public health program designed to improve survival from cancer and the quality of life after a cancer diagnosis for American Indians, Alaska Native and Canadian Aboriginal patients and their loved ones. The Network, initiated in 1999, now has more than 300 survivors enrolled as members. Network data show patterns of cancer care that are partially responsible for poor survivorship outcomes.

Canadian Aboriginal AIDS Network. 2005. Canadian Aboriginal People Living with HIV/AIDS: Care, Treatment and Support Issues. Vancouver: Canadian Aboriginal AIDS Network.

This is a review of the impacts and specific effects of HIV/AIDS on Canadian Aboriginal peoples and how they cope in ways specific to cultural beliefs. One contributing factor stems from the population who attended residential school, who suffer from poor mental health, including low self-esteem, because of psychological and sexual abuse, and the subsequent abuse of substances, and unhealthy sexuality. To cope with the ensuing difficulties, many Aboriginal people living with HIV or AIDS seek advice from Elders and participate in healing or sharing circles to receive social support. When Aboriginal people take the opportunity to connect or re-connect with their culture, they generally build stronger coping mechanisms for negative life experiences associated with disease. Cultural competence and health system delivery consideration are important when providing care to



Aboriginal peoples. In Saskatchewan, 83.3% percent noted a higher level of satisfaction when receiving traditional services as opposed to regular services. The study suggests that research should be done in Saskatchewan to understand its services and design of traditional services so that other regions that indicated lower rates of satisfaction, i.e. Quebec/Atlantic, Ontario and the North, can understand what made Saskatchewan services successful.

CARGO, M., Delormier, T. and Kirby, R. 2003. Activity Implementations as a Reflection of Living in Balance: The Kahnawake Schools Diabetes Prevention Project. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 1(1): 145-163.

This study of Kahnawake Schools Diabetes Prevention Project (KSDPP) program implementation is based on the retrospective analysis of diabetes prevention activities implemented over an 11-month period, from September 2000 to July 2001. The data collection relied on the analysis of documents, observations and in-depth interviews by the primary author with intervention staff. The Université de Montréal ethical review committee and the KSDPP Community Advisory Board granted ethical approval. Qualitative data analysis proceeded inductively through constant comparisons and theoretical sampling to construct categories and identify relationships between categories. Cargo and colleagues concluded that the implementation of diabetes prevention in Kahnawake is complex, encompassing elements of stability and adaptation and reflecting cultural values and practices.

CARGO, M., Peterson, L. and Lévesque, L. 2007. Perceived Holistic Health and Physical Activity in Kanien'keha :ka Youth. Pimatisiwin, 5(1):87-110.

The main purpose of this pilot study was to assess the relationship of perceived holistic health with self-reported physical activity and television-watching in a sample of 35 Kanien'kehá:ka youth living in the Mohawk community of Kahnawake. This research followed the Kahnawake Schools Diabetes Prevention Project (KSDPP) Code of Research Ethics (Macaulay et al., 1998) and was reviewed and approved by the KSDPP's Community Advisory Board, the Board of Directors of the community schools, and the Université de Montréal Research Ethics Board. A multi-dimensional measure of perceived holistic health was developed by using the Medicine Wheel to create a four-item index comprised of single indicators for each of perceived spiritual, social, emotional and physical health. Of all youth, 20% endorsed all four categories, while 66% endorsed one to three categories and 14% did not endorse any categories. Physical activity was assessed through self-reporting using previously validated indicators. Key findings suggest that Kanien'kehá:ka youth living in balance tended to be more physically active and watch less television than those youth experiencing disharmony.



CLARK, N. and Drolet, J. 2009. Melq'ilwiye" Coming Together in An Intersectional Research Team – Using Narrative and Cultural Safety to Transform Aboriginal Social Work and Human Service Field Education. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 7 (2): 291-316.

This article describes a unique community-based, participatory action research partnership between Elders, an urban Aboriginal community health and social services agency, Aboriginal university faculty, non-Aboriginal faculty and research participants working together to develop culturally safe best practices in social work and human service field education in Aboriginal community health settings. Methods of Cultural Safety (Irihapeti Ramsden and Diane Wepa, 2007) and community-based participatory action research were used. Principles and ethics to guide the research process were developed in partnership with community organizations and included ownership of data, ethics, issues of consent and evaluation. It was adapted from Brascoupe and Mann (2001); Duran and Duran (1999); Justice Institute of BC (2002); Macaulay et al. (1998); Smith (1999); Wallerstein and Duran (2006). This project contributed to a better understanding of the relationships between Aboriginal and non-Aboriginal peoples and between their respective intellectual and cultural traditions in field education partnerships. It increased knowledge and appreciation of the needs, values, knowledge, experiences, and contributions of Aboriginal peoples both in British Columbia and in Canada, in particular the needs of Aboriginal students in field education experiences in social work and human service.

DEGAGNÉ, M. 2007. Toward an Aboriginal paradigm of healing: addressing the legacy of residential schools. Australas Psychiatry, 15(Suppl 1):S49-53.

This article analyses key aspects of a report on the legacy of residential schools, sponsored by the Aboriginal Healing Foundation (AHF). The AHF commissioned quantitative and qualitative research on community projects and their impacts over the seven years of its first mandate, which begins to create an empirical base for healing approaches grounded in Indigenous knowledge. Degagné discovered that individuals and communities engaged in healing from the legacy of residential schools move through four stages that are both sequential and recurring.

Environics Research Group Limited. 2009. Urban Aboriginal Peoples Study: Main Survey. Ottawa: The Environics Institute.

The Urban Aboriginal Peoples Study (UAPS) was conducted by an independent firm in 2009 among the urban Aboriginal population of 11 Canadian urban centers. In Montreal, 250 residents, self-designated as Aboriginals, answered the survey; 67% First Nations, 30% Métis and 3% Inuit. Among this sample population, 10% claimed to be Non-Status. Almost half of that sample (47%) were 45 years and older and the respondents of both sexes were equally represented (50% in both group). A total of 41% had attained a college degree, while the amount of respondents with a high school degree or no degree was almost the same percentage as the sample (24% and 23% respectively), while 12% had a university diploma. The vast majority of the respondents (86%) were born and raised outside Montreal, while 14% mentioned that they lived in Montreal their whole lives. Among those who had grown up in a city (25 pers.), 53% of them declared that their parents were originally from a First Nation reserve, while 26% declared that their parents and grand-parents were from a settlement, a



town or a city but not a First Nation reserve. The survey aimed to discover more about a variety of points concerning the urban experience of Aboriginal people: their perception of the city, their plans for the future, their reasons for moving out of their communities and the different services they are using, or lack, in order to improve their quality of life. When consulting the statistics concerning the number of respondents, the age and sex ratio fit census statistics collected in 2006 by Statistics Canada, thus making the survey a reliable source on many topics not explored by the official national survey. The focus on the urban population underscores a growing reality among the Canadian Aboriginal population which is highlighted in this survey.

FARKAS, C.S. and Shah, C. 1986. Public Health Departments and Native Health Care in Urban Centers. Canadian Journal of Public Health, 77(4): 274-277

The sanitary needs of Canadian urban-Aboriginal peoples are not well known. In this study, the author examines the work done by Public Health services and the administering of their health programs.

First Nations Center. 2009. Health Information, Research and Planning: An Information Resource for First Nations Health Planners. Ottawa: National Aboriginal Health Organization

This resource, offered by the National Aboriginal Health Organization (NAHO), gives a compressive overview on important elements to consider when conducting health related research with Aboriginal peoples. The document includes the research requirements for health research in Canada, such as those used by the Canadian Health Needs Assessment (CHNA). The type of information sought after by CHNA include demographics of community members, elements that make up the community health system, the kinds and levels of health issues members of the community are experiencing (including physical, mental, social and environmental), the circumstances that are factors of these health issues, the resources that are available to address these health issues (current programs, community expertise, other strengths and assets), the best way to meet the needs of community members and the training needs of the health care personnel to help them meet the health goals and objectives. However, indicators developed for the Canadian population are not always effective for First Nations because Canadian indicators often miss issues that are important in First Nation communities. The Assembly of First Nations (AFN) places more emphasis on non-medical determinants of health, reflecting the belief that many of the factors influencing health lie in the complex social, economic and physical environments in which people live. The AFN health policy and planning model is unique in that it emphasizes the significance of self-government as the underpinning framework for First Nations health determinants.



First Nations of Quebec and Labrador Health and Social Services Commission. 2007. Quebec First Nations Health and Social Services: Blueprint 2007-2017. Wendake: FHQLHSSC

This document offers an updated overview of the many health concerns existing in Aboriginal communities and how their needs differ from those of other Canadians. Through studies that have been conducted, it was revealed that the rates of obesity are twice as high in Aboriginal people as in the general population. Infant mortality is 15% higher in First Nation communities, Fetal Alcohol Spectrum Disorder may affect one in five children and there are lower than average levels of breastfeeding, because hospitals where Aboriginal people give birth do little or nothing to promote breastfeeding. Aboriginal people are twice as susceptible to injury as the general population, 15% of new cases of HIV/AIDS in Canada are found in Aboriginal peoples and the rates of Hepatitis C are 7 times higher than in the general population. It was also found that blood-borne and sexually transmitted infections (BBSTI) are on the rise. First Nation peoples are four times more likely to encounter problems accessing health care, especially for isolated rural communities, while inaccessibility to adequate care in the first six years of Aboriginal children's life, on top of weak parenting skills, has led to serious problems including the inability to identify the special needs of their children. Only 7 out of 33 communities have long-term care centers, and many services are lacking. Half of First Nations people have used traditional medicines, but in Quebec communities, almost half have encountered difficulties in accessing such medicines. The increase in funding to health care in these communities has been minimal; it has only risen 1.6% from 1999 to 2004, which does not add up to the increase in population: 11.2%. There are also challenges when trying to assess the challenges in these communities: the empirical, quantitative and qualitative data on health care and social services programs delivered to First Nations is stored in various government systems and is not always available to the First Nations themselves. Data that has been made public is too limited, partial and incomplete to be used to shed light on the overall performance of the health care system that is available to First Nations.

Among the solutions, the document suggests mapping out existing health care and filling in the missing services in order to develop a clear picture of the services offered in the various communities. The authors also suggest mapping out the services in the communities and identifying the disparities between providers, filling in the missing services in the community to assure continuum of care. They also mention the need for human resources support by research and development. It was noted that one in two Aboriginal people would prefer seeing an Aboriginal care provider and that several people deprive themselves of care because of this need. Finally, it was found that the communities had difficulty in attaining statistics which makes it hard to understand the needs of each community.

First Nations Regional Longitudinal Health Survey (RHS). 2005. Results for Adults, Youth and Children Living in First Nations Communities. Ottawa: First Nation Centre



The Regional Longitudinal Health Survey (RHS) is an extensive research project that covered various issues concerning specific health problems, and their possible sources, among a large number of Canadian Aboriginal communities. According to the respondents, over 11% of the Aboriginal population of Quebec had answered the survey. The results cover some very specific points regarding



physical and mental health issues but also include suggestions for further research on possible causes for several diseases afflicting the Canadian Aboriginal communities. The results are equally divided among specific realities facing children, adults and Elders. These results are particularly telling for the health situation of the Aboriginal people living in their home reserves/communities, where the survey had been distributed. The survey does not reflect the specific reality of the urban Aboriginals. Also, the goal of the research was to represent the most general health issues and needs of the whole Aboriginal population of Canada, not the specific needs for each province, with the exception of extreme cases, such as the negative impacts of overcrowded houses in Quebec's Nunavik.

FLEMING J, Ledogar, R.J. 2008. Resilience, an Evolving Concept: A Review of Literature Relevant to Aboriginal Research. Pimatisiwin, 6(2):7-23.

This literature review covers topics surrounding resilience, which has gone through several stages over that past 40 years. Resilience has been most frequently defined as positive adaptation despite adversity. Psychologists began to recognize that the source came from within the individual, which led to a search for resilience factors at the individual, family, community - and, most recently, cultural - levels. In addition to the effects that community and culture have on resilience in individuals, there is growing interest in resilience as a feature of entire communities and cultural groups. Contemporary researchers have found that resilience factors vary in different risk contexts and this has contributed to the notion that resilience is a process. In order to characterize the resilience process in a particular context, it is necessary to identify and measure the risk involved and, in this regard, perceived discrimination and historical trauma are part of the context in many Aboriginal communities.

Fleming and Ledogar's review suggests five areas for future research with an emphasis on youth: first, studies to improve understanding of what makes some Aboriginal youth respond positively to risk and adversity, and others not; second, case studies providing empirical confirmation of the theory of resilient reintegration among Aboriginal youth; third, more comparative studies on the role of culture as a resource for resilience; fourth, studies to improve understanding of how Aboriginal youth, especially urban youth, who do not live in self-governed communities with strong cultural continuity can be helped to become, or remain, resilient; and, fifth, greater involvement of Aboriginal researchers, who can bring a nonlinear world view to resilience research.

FLEMING, J, Ledogar, R.J. 2008. Social Capital and Resilience: A Review of Concepts and Selected Literature Relevant to Aboriginal Youth Resilience Research. Pimatisiwin, 6(2):25-46.

The authors of this review highlight the ability of resilience research to link evidence on community social capital with individual data and the recognition that individuals can be resilient even if the communities they live in have low or even negative social capital. They see social capital as an asset or a resource for resilience that can be a characteristic of the community or the individual. As an individual asset, social capital consists of a person's relationships to available social resources. As a characteristic of communities, it consists of attributes such as trust, reciprocity, collective action and participation. Fleming and Ledogar recommend future research with attention to the social capital potential of Aboriginal spirituality, more comparison of urban-rural differences in social capital, and a better understanding of the factors that underlie Aboriginal youth resilience where social capital is defective.



FRIEDERICHS-FITZWATER, M.M., Navarro, L. and Taylor, S.L. 2010. A Value-Based Approach to Increase Breast Cancer Screening and Health-Directed Behaviors among American Indian Women. *Journal of Cancer Education*, 2(4): 582-587.

The researcher of this study favored the use of focus groups/interviews with American Indian and Alaska Native (AI/AN) women to learn more about beliefs and knowledge of breast cancer, and to test a prototype of the resulting Mother's Wisdom Breast Health Program delivered via a multimedia, interactive DVD. FRIEDERICHS-FITZWATER and colleagues used a Knowledge, Attitudes, and Beliefs (KAB) multiple-choice survey in pre- and post-test design. The instrument is adapted from the National Behavioral Risk Factor Surveillance System (Department of Health and Human Services (USDHHS) (1999) Behavioral Risk Factor Surveillance System Summary. She also used the Indian specific health risk appraisal for data collection and analysis. Besides items on knowledge and attitudes, other items inquire about demographics (age, marital status, children, education, income, and insurance type) and includes questions about the length of time since the woman's last clinical breast examination and last mammogram.

GONE, J. 2009. A Community-Based Treatment for Native American Historical Trauma: Prospects for Evidence-Based Practice. *Journal of Consulting and Clinical Psychology*, 77(4): 751-762.

Nineteen staff and clients in a Native American healing lodge were interviewed for this study regarding the therapeutic approach used to address the legacy of Native American historical trauma. Semi-structured, open-ended interviews were administered, as well as life narratives and an additional question about therapeutic matters. The questionnaire had 40 items pertaining to therapeutic training and practice and 45 items pertaining to therapist qualities and treatment experiences. All interviews focused on ascertaining the meaning of healing for staff and clients, on the basis of conversational give and take. The study showed that counselors saw pain in their clients that led to adult dysfunction, including substance abuse. These counselors believed that such pain had to be talked about to overthrow its effects and that this release would lead to lifelong habits of introspection and self-improvement. Finally, this healing journey would allow reclamation of Indigenous heritage, identity and spirituality that the staff thought would neutralize the negative effects of colonization.

GONE, J. P. 2010. The Red Road to Wellness: Cultural Reclamation in a Native First Nations Community Treatment Center. *American Journal of Community Psychology*, 47(1-2): 187-202.

This research study was undertaken as one of five empirical case studies commissioned by the Aboriginal Healing Foundation (AHF). This study was completed under the auspices of the Canadian National Network for Aboriginal Mental Health Research and the overall project was funded by the Canadian Institutes for Health Research. In order to portray cultural reclamation within a community treatment centre, open ended semi-structure interviews were conducted with 19 service providers and patients. Interview protocols were designed by Waldram (2008) for the mutual adoption in the five AHF case studies. One protocol was designed for program counselors, and one for clients using life narratives, followed by 40 items: meaning and facilitation of healing (26 items), training in therapeutic practices (4 items), therapeutic activities and client interactions (10 items). The client protocol included demographic information (15 items), the



meaning of healing (7 items), treatment experiences (6 items) and qualities of an effective therapist or healer (17 items). The length of each interview varied from thirty minutes to three hours. In order to draw more thorough conclusions, the researchers also gathered data through participant observation, from program documents and records, and extant ethnographical materials.

HERBERT, E., & McCannell, K. 1997. Talking back: Six First Nations women's stories of recovery from childhood sexual abuse and addictions. Canadian Journal of Community Mental Health, 16(2): 51-67.

This article explores interpersonal violence and the addiction experiences of First Nations women in a time of renaissance for First Nations cultural movements. The authors also sought to create a discourse about recovery that embodied and reflected the life experience of First Nations women who had experienced childhood sexual abuse and addictions. Data was collected through interactive audio-taped interviews with six women (aged 25–53 yrs) using an exploratory, emancipatory, feminist qualitative research design. The six stories uncovered four emergent themes, alcohol abuse and addictions, sexual abuse, recovery process and gender issues, with 10 subtexts. A third contact was made with four of the six women in order to obtain feedback on the themes used to summarize the data. The results found that gender and culture were central considerations in the women's recovery.

Institut National de Santé publique du Québec & First Nation of Quebec and Labrador Health and Social Services Commission. 2009. Research on the Health of Québec First Nations and Inuit: An Overview. 20 years of research at glance. Ottawa: Institut National de Santé publique du Québec & First Nation of Quebec and Labrador Health and Social Services Commission.

A report from the Institut National de Santé Public du Québec which collected from around 40 000 research projects issued from the Banque sur la recherche sociale et en santé (BRSS) and the ministère de la Santé et des Services Sociaux du Québec (MSSS) on a period covering 20 years of research. The research highlights precise and various points relating the needs and health issues and realities faced by specific segment of the Quebec Aboriginal population; according to different age groups, sex, regions, but this research did not specifically target the realities of an urban population.



IWASAKI, Y., Bartlett, J. and O'Neil, J. 2005. Coping with stress among Aboriginal women and men with diabetes in Winnipeg, Canada. Soc. Sci. Med., 60(5):977-88.

The purpose of the study was to gain a better understanding of the ways in which Aboriginal peoples with diabetes cope with stress. The study used a series of focus groups among First Nations and Métis women and men with diabetes in Winnipeg, Manitoba. Based on cross-thematic analyses of the data, three overarching themes were identified: first, individual and collective strengths of Aboriginal peoples with diabetes must be recognized and used to facilitate healing from or coping with the experience of stress and trauma; second, healing must be accomplished holistically by maintaining balance or harmony among mind, body, and spirit; and third, effective ways of coping with stress and healing from trauma potentially promote positive transformations for Aboriginal peoples and communities at both individual and collective levels. The researchers also identified many sub-themes: interdependence/connectedness, spirituality/transcendence, enculturation/facilitation of Aboriginal cultural identity, self-control/self-determination/self-expression, and the role of leisure as a means of coping with stress and healing from trauma.

JACOBS, K. and Gill, K. 2007. The lives of Urban Women: A Survey of Help-Seeking Aboriginal and Non-Aboriginal Women in Montreal; McGill University Health Center and Psychiatry Department; McGill University; Montreal

In this study, Jacobs has reviewed existing literature and conducted a survey on help-seeking Aboriginal and non-Aboriginal women in Montreal. In her review, she found that, in 2002, one third of the 202 Aboriginal peoples interviewed reported having a substance abuse problem and that there were high levels of drug and alcohol abuse in their families. According to Health Canada, alcohol and other substance abuse are considered to be major contributing factors to the high death rate due to injuries, either intentional or unintentional. The results from Jacobs's survey found that more than one third of the women interviewed had a pregnancy before the age of 18 and Aboriginal women had reported more pregnancies in their lifetime than Non-Aboriginal Women. Non-Aboriginal women were more likely to have looked for care from a general practitioner than Aboriginal women as the later have more tendency to look to hospitals and clinics, while 46 participants reported not having sought any medical care. The reasons for not seeking medical attention were: wanting to solve the problem themselves (66.7%), believing the problem would cure itself (52.2%); they sought care in the past but it did not help (37%), they thought help would not do any good (33.3%), they were unsure where to go for help (26.1%).

The results of the survey showed that 77.3% of the participants had a social insurance card, 85.5% had a medical card, and 69.2% had a copy of their birth certificate. Overall, 61.2% of Aboriginal people had a Status card, or document of a beneficiary number for Inuit, which are necessary for services such as Aboriginal drug/alcohol treatment centers and federal non-insured health benefits, and 70.3% of Aboriginal women responded yes to having access to a medical centre that would provide exclusive access to Aboriginal peoples. Most women interviewed suffered from psychological distress and over two thirds had received treatment for a psychological problem in their lifetime. Aboriginal women reported lower rates of recent depression and were less likely to have been prescribed medication.



Aboriginal Women were more likely to be current cigarette smokers, to have used cannabis in the past month and to have spent more money on alcohol in the last month. Aboriginal women also used cannabis for more years and were more likely to have been treated for a drug or alcohol problem in the past. Three out of four women reported lifetime histories of physical, sexual abuse and emotional abuse. The study revealed that those with a history of sexual abuse were of the same age range, marital history and education level, as well as the same likelihood to be unemployed and have the same usual living arrangements in the past three years. Aboriginal people having suffered from childhood sexual abuse had significantly higher rates of suicide attempts. Finally, it was revealed that more than half of respondents had a chronic medical problem and most had sought help for a medical problem in the past year. The results of this survey reveal a dire need for access to services whether from increased education in awareness or more adequate service provision to meet the specific needs of these populations.

JEFFREY, B.L. 1999. Social determinants of self-rated health: The interaction of gender with socioeconomic status and social relationships in the Yukon. Ph.D. Dissertation, University of British Columbia, 258 p.

This study addressed the social determinants of health with a specific focus on three factors in the social environment that either individually or collectively have an influence on health status: gender, socioeconomic status (SES) and people's social relationships. The purpose of the study was to examine whether people's social relationships mediate the effects of SES on self-rated health status and to assess whether these effects differ for women and men. The research questions were examined by formulating a theoretical model and evaluating the hypothesized relationships through the use of structural equation modeling. The analyses were conducted using LISREL on data from 1,239 non-First Nations Yukon residents who participated in the territory's 1993 Health Promotion Survey. The results of this study suggest that household income significantly affected women's and men's health by influencing aspects of their social relationships. Jeffrey believes that this attention given to determinants of health presents an opportunity to contribute to a reform presently underway in the provincial and federal government's health-care systems. The findings of this study contribute to our understanding of the effects of SES on health by providing support for gender interactions in a set of relationships where aspects of people's social relationships mediate the effects of income on health status. These findings provide support for gender-specific mechanisms by which income level influences perceived health status by shaping people's social relationships, the quality of those relationships and the support they offer. The tools used in this study can be applied to our Needs Assessment and the results could be useful in identifying the realities that can very well reflect those found here in Montreal.



JOHNER, R., Gingrich, P. and Jeffrey, B. 2008. Does Aboriginal Identity Make a Difference? Single Mothers and Exclusion in Health. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 6(1): 137-160.

This paper examines the relationships between health, social exclusion and receiving social assistance from a holistic perspective in Saskatchewan Aboriginal and non-Aboriginal single mothers. The cross-sectional data for this paper was taken from a mail survey conducted in the summer of 2007 using randomly selected single-mother respondents in Saskatchewan (Canada). The Questionnaire included the outcome variable of self-rated health, the social exclusion factors of education, social supports and networks, and personal sense of control, and the socio-demographic characteristics of disability, age, having children 5 years and under, monthly income, and receiving social assistance. A total of 68 item questionnaires were administered with 12 items for personal information such as Aboriginal identity, education, income levels, and self-rated health. Instrumental Support Evaluation List (ISELF-SF) (Cohen and Christie, 1983) was used to assess perceived support; Spheres of Control, third edition (SOC-3) (Paulhus and Christie, 1981) was used to assess one's personal control; Social Network Index (SNI) (Cohen, 1991) was used for network density. Research ethics approval was received for this study, as well as for the pretest of the survey questionnaire (Johner et al., 2007) from the University of Regina, Research Ethics Board. From a Cross-sectional analysis, the researchers were able to recommend interventions in social assistance policies that prioritize education, education for mothers to be peer supports, and the offering of life skills to build self-confidence for single mothers in Saskatchewan.

Rowan, C. 2006. Needs Assessment Concerning Montreal Inuit and Aboriginal Head Start. Kativik Regional Government.

The objective of this needs assessment was to inform decision makers on the need for an Aboriginal Head Start Project in Montreal. This report helps identify an approximate number of Aboriginal children under 5 years old in Montreal, their current activities, their parents' need for a preschool program, access the transportation and other considerations concerning the development of a Head Start program. The results show a need for a home visitor program for parents that go to school as well as a biweekly drop-in for parents and their children on the weekend.

KING, J. 1999. Access to health care for American Indians and Alaska Natives: A comparative approach. Ph.D. Dissertation, University of Wisconsin – Madison, 235 p.

King uses the Survey of American Indians and Alaska Natives (SAIAN) supplement to the 1987 National Medical Expenditure Survey (NMES), to study the access to health care services American Indians and Alaska Natives living in reservation communities. Specifically, the study asks whether access to health care among American Indians and Alaska Natives living in reservation areas differs from that of other economically-disadvantaged populations, and if so, how it differs. Drawing upon the well-known framework developed by Aday and Andersen, the research examines the use of health services among American Indians and Alaska Natives living in reservation communities, and the potential barriers they may face in obtaining care. The results show that there are barriers and the implications of this reality are discussed in this study. This study could give us more ideas as to the barriers that Montreal's Aboriginal population might face in accessing health care.



KIRMAYER, L. J., Simpson, C., & Cargo, M. 2003. Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, 11(Supplement): 15-23.

This article describes how traditional Aboriginal practices and world views have been used as tools for individual and collective healing by many First Nation communities. It explains how many traditional subsistence activities have been deeply integrated with religious and spiritual beliefs as well as with networks of family and community relationships. Because of the Canadian government's colonial policies, many Aboriginal peoples have encountered a loss of individual and collective self-esteem, leading to individual and collective disempowerment and, often, the destruction of communities. By returning to the land and taking part in cultural activities, these troubled individuals and communities have been able to reconnect with their pre-contact cultural practices. The authors argue that the establishment of legal claims to traditional lands and self-government may also be viewed as examples of cultural strengthening and re-appropriation, even when these new forms of government reflect contemporary political styles. They see the merging of traditional and modern health services as an effective model that will benefit Aboriginal people seeking care for both physical and mental health problems.

LANG, C., Macdonald, M.E. and Lévesque, M.J. 2010. Kadiminekak Kiwabigonem: Barriers and Facilitators to Fostering Community Involvement in a Prenatal Program in an Algonquin Community. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health*, 8(1): 55-82.

The objective of this study was to understand the barriers and facilitators to fostering community involvement in the development and implementation of a prenatal program in the Rapid Lake Algonquin community. The researchers looked to find the needs of prenatal and postnatal women in Rapid Lake and how these needs could best be met. They used a focused ethnography methodology, which is commonly used in community-oriented health sciences for the purposes of program development in health services. It focuses on actions, interactions, and social situations through focus groups, interviews, and participant-observation. The CIHR Guidelines for Health Research Involving Aboriginal People (2007) were used to guide this study and the McGill University Institutional Review Board approved the study. Two focus groups were held, one for nurses and one for community health workers, and lasted 60–90 minutes. The interviews were done individually or with friends or family members and lasted 20–60 minutes. Observations included characteristics and conditions of individuals, activities and interactions, verbal and nonverbal communication, and environmental characteristics. This method is particularly relevant to working with First Nation populations because it has been shown that nonverbal communication can be equally or even more important than verbal communication in these communities. The results found that there are barriers to community involvement because of political tensions, historical relationships with government institutions, cultural knowledge, language and literacy, and lack of health promotion events in the setting.



LASSETTER; J.H. 2011. The Integral Role of Food in Native Hawaiian Migrants' Perceptions of Health and Well-Being. *Journal of Transcultural Nursing*, 22(1): 63-70.

This study used a qualitative description design with semi-structured interviews through interpretive constructionist philosophy to gather data. As opposed to responding to a predetermined set of choices with assumed uniform meaning, as in a quantitative descriptive study, participants were able to explore the topic fully and share personal insights without predetermined conclusions.

LAVOIE, J.G. 1993. Public health politics in Nunavik health care: Shared concepts, divergent meanings. M.A. Thesis, McGill University, 97 p.

This thesis provides a background on health services provision in Nunavik, where many urban Inuit in Montreal originate from. It provides an overview of the development of Nunavik health services since the James Bay agreement, while focusing on the use of health discourses to promote, shape and limit regional and community health discourse. It would be interesting to read the findings of this study in order to be prepared for the challenges we may be facing in dealing with the provincial government in the development of our proposed health center.

LEHAVOT, K., Walters, K.L., and Simoni, J.M. 2010. Abuse, Mastery, and Health Among Lesbian, Bisexual, and Two-Spirit American Indian and Alaska Native Women. *Psychology of Violence*, 1(8): 53-67.

In this study, 152 American Indian/Alaska Native (AI/AN) women were interviewed as part of an investigation addressing the health concerns of two-spirit peoples. Tools used included the Childhood Trauma Questionnaire (CTQ; Bernstein, Fink, Handelsman, & Foote, 1994), the Index of Spouse Abuse-Physical Scale (ISA-P), Coker and colleague's modified version of the ISA-P, the Posttraumatic Diagnostic Scale (PDS; Foa, 1995), Pearlin and Schooler's (1978) mastery scale and the Medical Outcomes Study HIV Health Survey (MOS-HIV). The latter has 35 items and assesses 10 dimensions of functioning and well-being, including physical functioning, social and role function, cognitive functioning, pain, mental health, energy, distress about health, quality of life and overall health. The participants reported very high levels of both sexual (85%) and physical (78%) assault, both of which were associated with a worse overall mental and physical health. These relationships generally were linked to a diminished sense of control or mastery. The need to indigenize the concept of mastery is discussed, as is the urgency of interventions to work toward decreasing levels of abuse and increasing mastery among sexual minority AI/AN women.



MACAULAY, A. G. 1994. Ethics of research in Native Communities. Canadian Family Physician, 40: 1888-1890.

In this dissertation, Macaulay describes specific requirements when conducting research in Aboriginal communities. First, the researchers should ask themselves whether the research will produce results of value to the community, whether the subjects will participate freely and understand fully what is to be done, and whether they have freedom to leave the project without jeopardizing their ongoing medical care. Researchers must insure confidentiality and ensure that the project is continually evaluated. The communities hosting the research project need their own checklist to determine whether they truly understand the nature of the questions, the expected benefits, any risk, confidentiality, and ownership of the data.

MACAULAY, A.C. 1988. The History of Successful Community-Operated Health Services in Kahnawake, Quebec. Canadian Family Physician, 34: 2167-2169.

This article describes the history of the development of health services in Kahnawake, discusses why the Kateri Memorial Hospital Centre (KMHC) has been so successful, and acknowledges some of the problems. The KMHC provides well-integrated and high-quality acute care and preventive health services for the Mohawk Community with its population of 5409 persons (1985). Since 1955, the hospital centre has been administered and largely staffed by the community. The author hopes that the KMHC experience will benefit other Aboriginal communities that are interested in gaining control of their own health services as well as non-Indian staff who provide professional care.

MANSON, S.M and Buchwald, D.S. 2007. Enhancing American Indian and Alaska Native health research: A multi-faceted challenge. Journal of Interprofessional Care, 21(S2): 31-39.

The quality, relevance, timeliness, and impact of public health research among American Indians and Alaska Natives (AI/AN) has improved markedly over the last several decades. These advances are attributable to the more careful fit between investigative methods and field exigencies, to the increased presence of Native scientists among research teams, to greater emphasis on meaningful collaboration between researchers and participating communities, and to new federal investments in the infrastructure that supports health research within this special population. This paper describes the lessons learned from this recent progress, and highlights opportunities to promote further gains as well as continuing needs in developing the capacity to conduct policy relevant AIAN health research.



MARBELLA, A.M., Mickey C. H., and Diehr, S. 1998. Use of Native American Healers Among Native American Patients in an Urban Native American Health Center. Archives of Family Medicine,7(2): 182-185.

In this study, Marbella uses a homemade tool developed by the advisory group, including both structured and open-ended questions, to calculate the use of Native American Healers in a specific health center. Open-ended questions provided the patients opportunities throughout the interview to share their personal experiences about encounters with their healers. Demographic info included age, sex and tribal affiliation. The information relating to the use of traditional Native American healers and conventional medical physicians included the following: the use or desired use (or both) of traditional healers, the types of healers used, rites and ceremonies the patient participated in, the reasons for seeing healers, ratings of the advice of healers and physicians, and whether their physician was told about the concurrent use of healers. A sample of 150 patients was interviewed using a convenience sampling method; patients who happened to be scheduled for a physician's appointment on the days that the research assistants were in the clinic were the ones recruited for the study.

MARKS, E., Cargo, M.D. and Daniel, M. 2006. Constructing a health and social indicator framework for Indigenous community health research. Social Indicators Research, 82: 93-110.

This document describes a product that was developed to create a universally applicable framework for health research with Aboriginal peoples. The authors argues that his Indigenous indicator framework permits Indigenous communities, public health researchers, and funding agencies to compare and select the most appropriate indicators for application in specific contexts from the scores of existing indicators. This tool is a combination of 33 frameworks from various organizations and agencies, using the "German System of Social Indicators" (German Social Science Infrastructure Services Social Indicators Department, 2004) as the foundation from which to develop the indicator framework. A total of 10 indicators administered in Indigenous communities were used (including indicators used by Indian and Northern Affairs Canada (INAC), 2000; Health Canada First Nations and Inuit Health Branch, 2003; etc.). There are over 142 items covering subject grouping (7 items), domain (22 items), goal dimension (101 items), indicator group (112), and indicator (unlimited). This framework may be a useful tool in finding specific indicators that are said to be important for government agencies, such as INAC and Public Health Agency of Canada (PHAC).

McCORMICK, R. M. 2000. Traditions in the Treatment of Substance Abuse. Canadian Journal of Counselling and Psychotherapy / Revue canadienne de counseling et de psychothérapie, 34(1): 25-32.

This paper describes the traditions and philosophy behind successful substance abuse treatment strategies used by Aboriginal people in Canada. It portrays how the discovery of meaning and the resultant healing for Aboriginal clients is being enabled through substance abuse treatment strategies that facilitate reconnection to cultural values and traditions. For traditional Aboriginal people, it can be very shameful and embarrassing to admit to having problems of drug and alcohol abuse and this fact represents an obstacle when accessing regular health services. The author also notes that it can take Aboriginal people considerable time and experience in talking with a therapist before they can begin to establish an effective working relationship because trust and intimacy is not something that is freely shared with strangers. These examples illustrate some of the reasons that alcohol treatment programs,



based on the medical model favored by many mainstream service providers often fail in their efforts with Aboriginal people. The author suggests how Aboriginal people have been reconnecting with their spirit through culturally appropriate and effective treatment of drug and alcohol abuse.

McKEE, G., Clarke, F. and Kmetc, A. 2009. Health Practitioners' Perspectives on the Barriers to Diagnosis and Treatment of Diabetes in Aboriginal People on Vancouver Island. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 7(1): 49-64.

This study discusses the barriers to care of Aboriginal people with diabetes from the perspective of health care providers on Vancouver Island. Non-standardized surveys containing multiple-choice and open-ended questions were distributed to 33 healthcare providers on Vancouver Island who reported working with Aboriginal people with diabetes; 18 completed surveys were returned. The population sample was limited to individual healthcare practitioners (physicians, nurses, community workers and volunteers) actively practicing on Vancouver Island. The survey was homemade: multiple choice questions with open ended questions (26 items), and open-ended questions (2 items). These items were divided in 4 sections: Setting, Practitioner, Barriers and Possible Solutions to Removal of Barriers. This last section was divided into 5 subsections: Geographical, Cultural, Financial, Educational and Systemic. Ethical approval for this study was obtained from the Joint UVic/VIHA Research Ethics subcommittee. While some specific barriers were emphasized by participants, the general trends were similar to those perceived by Aboriginal patients and researchers as reported in the reviewed literature. The solutions to the barriers in care centered on regional disparity in healthcare resources and the need to respect Aboriginal worldviews in western medical practice.

McLEAN, A.M. 1997. Eskimo native healing and the treatment of mental illness. M.Sc. Thesis, University of Alaska – Anchorage, 62 p.

This study by McLean gives an overview of the history of Eskimo traditional healing and the implications of the Eskimo perspective in the treatment of mental health. This could serve as interesting reading in understanding modes of healing used by the Inuit who come settle in Montreal.

MELLOR, D. 2004. Responses to racism: a taxonomy of coping styles used by Aboriginal Australians. Am J Orthopsychiatry, 74 (1):56-71

The author of this study takes up the challenge from social psychologists to explore the coping responses of those who experience racism. Mellor reviews previous attempts to provide taxonomies of responses to racism-discrimination-oppression and analyses data derived from semi structured interviews conducted with 34 Indigenous Australians. The questionnaire explored experiences of racism and emotional and behavioral responses and a taxonomy of coping made up of 3 broad categories: to defend the self, to control or contain the reaction or to confront the racism. He argues that this may be a more useful way to understand responses to racism than taxonomies previously proposed.



MURILLO, L. 2004. American Indian and Alaskan Native traditional health practices: Providing a socio-cultural context for health care and implications for health disparity. Dr.P.H. Dissertation, University of California, Berkeley, 128 p.

Here, Murillo examines the specific traditional health practices (THP) used in American Indian/Alaska Native (AI/AN) health programs. THP is the practice of medicine people and the AI/AN community through the use of cultural values, practices and knowledge. The purpose of this research is to legitimize the use of culture-based intervention and how these methods are being used to reduce the health disparity of AI/AN communities. To do so, Murillo used qualitative data from three AI/AN centers, the Native American Health Center in Oakland California, the United Indian Health Services in Arcata, California and the NatsooGah-Nee Clinic and Tribal Health Program in Fort Hall, Idaho. The data was collected from 12 interviews and two weeks of participation observation. Among some of the interesting findings, they realized that sharing information is a sensitive issue and can create role confusion about who is responsible for teaching culture: the health agency, staff or the local community. The research also concluded that the medical clinic is limited in using THP because medical providers do not have enough information about AI/AN THP, who practices it, and how to refer patients. These realities may become relevant on our proposed health center as the centers in this study also cater to urban-Aboriginal populations.

National Aboriginal Health Organization. 2007. National Environmental Scan: Comprehensive Survey of the Aboriginal Health Human Resource Landscape. Ottawa: National Health Organization.

This study was conducted by the National Aboriginal Health Organization (NAHO) in order to collect baseline information for the Aboriginal Health Human Resource Initiative (AHHRI) national scan to identify what organizations and institutions are collecting and managing information about Aboriginal human health resources and to identify the nature of the information being collected. Announced in 2004 by Health Canada, the AHHRI is a five year, \$100 million strategy with the intent to meet the unique health service needs of Canada's Aboriginal people. Its goal is to meet the need to increase the number of Aboriginal people taking up careers in the health care field, to improve the recruitment and retention of health care workers in Canadian Aboriginal communities, and to adapt health care educational programs to be more culturally responsive to the needs of Canada's Aboriginal communities. The surveys created by NAHO included 31 questions which sought to establish the number of Aboriginal Health professionals and paraprofessionals, the number of non-Aboriginal health care providers serving First Nation, Inuit, and Métis peoples, the number of universities and community colleges that train health care professionals and paraprofessionals, the number of institutions that offer formal and informal education for Aboriginal students and the number of Aboriginal students in various programs and their anticipated graduation dates.



Organizational Development Services. 2008. Needs Assessment of the Aboriginal People in the Urban Setting of Montreal. Montreal: Regroupement des Centres d'amitié autochtones du Québec.

This is a recent study that covers the diversity of needs of Aboriginal peoples living in Montreal. The data was collected through quantitative and qualitative questionnaires used in one on one interviews, phone interviews, and focus groups with services users and providers. A total of 113 Aboriginal peoples participated; the results from these interviews were compiled and divided into sections related to the specific needs they represented. A literature review accompanied the collected data in order to offer a comparative analysis of the results. The Homeless Needs report conducted by the NFCM in 2001, one of the many sources cited by the this study, reported gaps in health and medical services including access to services and continuum of care, an urgent need for support, accompaniment and translation services. They suggested more prevention and parenting programs and culturally appropriate pre/postnatal services, as well as a healing and wellness strategy that responds to the needs of the community. The results of the research highlight that Aboriginal people in Montreal are mostly in need of a community sense; this concept is explained by the desire to have a place to gather and establish network with other Aboriginals, a place to develop a support system. One interesting point is the inclusion by the Needs Assessment 2008 among their respondents Aboriginal peoples from the United States but also from Latin America, this research present itself to represent the urban issues Montreal experienced by Aboriginal peoples from various horizons.

Through interviews, the researchers of this study were able to identify health service needs that were deemed important. The participants of this study mentioned a need for a health and wellness center, medical escorts, better access to health professionals, a CLSC branch just for Aboriginal peoples and a willingness to work with people who have non-insured health benefits and other health agreements. There is also a need for health promotion and education related to nutrition, diabetes and HIV/AIDS, as well as healing, holistic health and wellness and detox services. Some respondents mentioned a need for traveling/outreach doctors, programs for the prevention of diseases such as Hepatitis, Tuberculosis and STDs. There was also a push for an Aboriginal health authority in Montreal. When asked what the greatest concerns are for the Aboriginal community of Montreal, one of the concerns was the level of physical and mental health. When addressing gaps in services for Aboriginal peoples, the needs included health services for Aboriginal peoples with special needs such as learning disabilities, attention-deficit disorder, psychiatric services, speech pathology, and hearing. These services are generally only offered in French. The respondents mentioned a need for medical services where an Aboriginal person is employed, such as a CLSC or an Aboriginal health center. It was stated that spiritual needs were not being met as non-Aboriginal organizations were not aware of Aboriginal cultural beliefs and spirituality.

This study didn't only focus on the limitations in available services; it also acknowledged the difficulties in accessing existing services. In conducting their survey, the researchers had difficulty in finding a comprehensive and current listing of services that encompassed the service/organizations that exist. It was not easy to find information on Aboriginal or Aboriginal-affiliated organizations on the Internet without being familiar with the names of key organizations. When searching for services in other cities,



such as Toronto, Ottawa and Winnipeg, the results were much more extensive and accessible. This reality reflects a need for a comprehensive database online which will enable service providers and users to become readily aware of the available health resources. In conducting their research, the authors of this study sent an inventory tool to every organization in order to get a better idea of the services offered. Only eight completed questionnaires were returned. Regardless of the limitation in these results, the existing inventory lists could be useful in compiling a repertoire of existing services.

In 2004 an Aboriginal Head Start (AHS) Program was carried out involving 25 Aboriginal families living in the Montreal area. In the issuing report from this study, respondents reported living in areas that enable ease in accessing services; 94.4% of respondents used the Native Friendship Center of Montreal (NFCM), 76% used CLSCs, 52% used the Native Women's Shelter of Montreal (NWSM). When asked what role the NFCM should have in the community, it was stated that the center should provide information on all the services available in the city. With an easily accessible online database, service providers should be able to answer this need with relative ease.

In summarizing the health needs of Montreal's urban-Aboriginal community, this Needs Assessment concluded that there is a need for integrated health services in holistic sense (physical, mental, emotional, and spiritual). The study mentioned the Wabano Center for Aboriginal Health in Ottawa as an existing model. The McGill Aboriginal Healing Clinic was a resource that used to answer some of these needs, including counseling to Aboriginal individuals who are primary and secondary victims of the residential school system, including those who are victims of multigenerational abuse. It also offered consultation and supervision to workers who are providing services to sexual abuse survivors and their family members. This center and the services it offered regrettably no longer existed. This study recommends the use of the Aboriginal Health Transitional Fund offered by health Canada to create new initiatives in health services provision. Unfortunately, this source of funding has since been discontinued. This study has made it apparent that there is an interest in creating an Aboriginal focused holistic health center; the challenge now is in finding the support and the resources to do so.

One point of criticism is that the proportion of respondents are quite different than the official Aboriginal representation in Montreal made by both Statistics Canada and the UAPS survey, and the final results do not appear to have been weighted at first sight. The first point is the fact that the research has been answered at 77% by female, being less representative than the UAPS where both sexes were equally represented. Also, of the 113 respondents, almost a quarter turned out to be non-Aboriginal (25 persons = 23%). The percentage of respondents with a good education was also overrepresented, as the Regroupement reports that none of their informants has less than a grade 11 education, and 76% had completed post-secondary studies and hold a diploma or degree (versus the official statistic of 57% of Aboriginal people holding a postsecondary degree for the Montreal region, and being also superior to the median of non-Aboriginal having degrees, which is, 65%). The Regroupement also claims that of their respondents, 83% were employed, the majority being full-time, when according to Statistics Canada, the median percentage for the full-time employment among the



Aboriginal people from the Montreal region was only 33% (and 27% for Aboriginal women). This would make these results more representative of the opinion of an educated portion of the Montreal Aboriginal population but nevertheless apply to point out that they do consider the most telling and important needs for this community.

ORTIZ, L. 2003. Toward Authentic Participatory Research in Health: A Critical Review. Pimatziwin: A Journal of Aboriginal and Indigenous Community Health, 1(2): 1-26.

In this study, Ortiz examines the practice of participatory research in primary care, health promotion and public health. She focuses on strategies and interventions employed by practitioners that demonstrate the core elements and principles of participatory research. Elements are taken from Deshler and Ewert to capture the different traditions of participatory research. First, the democratizing, the development and use of knowledge; in healthcare practice, this diminishes the monopoly of health knowledge of professional health providers. It also demystifies expert knowledge by grounding it in the experiences of the people and community members. Second, the ownership and control of the research process, which in health services translates to the emergence of patients' rights in advocating a shared responsibility for decision-making between patient and health provider. Third, the multiple construction and interpretations of reality; the health experience of people can best be understood within the contextual reality of their values and beliefs, historical experience and socio-political circumstances. Fourth, a commitment to action: which means the pragmatic, whether the research had answered the research question; the historical materialist, whether the research contributed to advancing the status of the oppressed class in society; and the critical approach, which addresses the issue of whether the research has revealed underlying social structures that result in unequal relations and opportunities for change. The final element is the belief in people's capacities, in potential of peoples and communities in their quest for learning and change.

PANDHI, N., Guadagnolo, A., Kanekar, S. 2011. Intention to receive cancer screening in Native Americans from the Northern Plains. Cancer Causes Control, 22:199-206

The survey for this study was designed using community-based participatory methodology. The research team started by identifying known barriers to cancer screening in underserved populations and then developed questions about these barriers. Focus groups in the community examined these questions for cultural appropriateness and clarity of concept. After revision, the questions were sent to the tribal leadership and the Indian Health Service for comment and approval. The final survey contained 65 questions. Questions covered demographics, logistical difficulties with accessing care, personal medical history, knowledge of cancer and clinical trials, perceptions and beliefs about cancer and future intentions regarding cancer screening and treatment.



PINKEY, D. E. 1995. Patterns of decision making in health care among the Siberian Yupik villagers from the St. Lawrence Island near Nome, Alaska. M.S. Thesis, D'Youville College, 270 p.

The goal of this research project was to get a better understanding of the Native Alaskan's perceived health care needs. In a time of health reform, health providers have shown an interest in expanding therapeutic health services into rural Alaska. Through qualitative ethnographical analysis, Dorothy Pinkney recorded culturally related therapeutic vignettes through interviews with 18 villagers on the St. Lawrence Island. The results showed that the needs vary with the age and the working style of the individual. The ethnographic interview approach proved to be a useful tool, allowing some clarity in the development of future rehabilitation programs.

POUDRIER, J and Mac-Lean, R.T. 2009. 'We've fallen into the cracks': Aboriginal women's experiences with breast cancer through photovoice. Nurs Inq, 16(4): 306-317.

The main objective of this study was to explore and to begin to make visible Aboriginal women's experiences with breast cancer using the qualitative research technique "photovoice". The research was based in Saskatchewan, Canada and participants were Aboriginal women who had completed breast cancer treatment. Participants in the study emphasized two important issues. First, Aboriginal identity and traditional beliefs, although expressed in diverse ways, are an important dimension of breast cancer experiences and have relevance for health-care; and second, that there is a need for multidimensional support which addresses larger issues of racism, power and socioeconomic inequality. The authors draw upon a critical and feminist conception where Aboriginal women are either invisible or visible in disempowering ways. They believe Aboriginal women who have experienced breast cancer must be made visible within health-care in a way that recognizes their experiences situated within the structural context of marginalization through colonial oppression.

Public Health Agency of Canada. 2004. Needs Assessment For First Nations Populations in the Montreal Area with a View to Establishing an Aboriginal head Start (AHS) Program. Final Report. Aboriginal psychosocial interventions research group. Ottawa: PHAC.

A total of 25 families participated in this 88-question, closed-ended survey which aimed at measuring the needs of Aboriginal families living in Montreal in order to establish an Aboriginal Head Start program. Just over half of the respondents had an annual income under \$10000 and the household income of just over three quarters of the families was less than \$30000. Ear infections affected 40% of children surveyed, 32% had a contagious illnesses and 28% had asthma. Less than 5% of the participants did not use the services of the Native Friendship Center of Montreal, and less than a quarter did not use the services of CLSCs (local community service centers). Nearly one third of children had never been to a dentist, all the children had been vaccinated and four out of five had undergone at least one complete physical examination. The majority of the respondents considered the transmission of traditional Aboriginal languages and cultures as being of great or primary importance.



SANDERS, N.L. W. 2000. The relationship of spirituality and health among the Yup'ik of southwestern Alaska: An explanatory study. Ph.D. Dissertation, Wayne State University, 174 p.

This study focused on specific beliefs and values of the Yup'ik people in regards to spirituality and health, primarily on the relationship between the two. The data was collected through participatory observation and interviews with 6 key informants and 11 general informants, primarily in the regions of Bethel and Toksook Bay, Alaska. Four conclusions emerged from the interpretation of the findings. First, Yup'ik spirituality influences health. Second, actions dictated by spiritual beliefs may confound Western health care professionals including nurses. Yup'iks also believe that they are more prone to illness after contact with Westerners, partly because of a change in diet. Finally, spiritual distress may result from the failure to acknowledge the influence of spirituality on health among Yup'iks.

SHERWOOD, J; 2009; Who is not coping with colonization? Laying out the map for decolonization; Nura Gili Indigenous Programs; Australas Psychiatry; 17 Suppl. 1:S24-7

This paper explores reasons for using decolonization as a method for improving Indigenous health status. The authors see decolonization as a method required to shift the current paradigm of Western dominance and colonial amnesia that constructs and maintains Indigenous poor health status. They conclude that decolonization requires every Australian to examine the impact colonization has upon their past and present in order to formulate a future that does not reinstate the past.

SHIP, S.J. and Norton, L. 2001. "Breaking the Walls of Silence": Aboriginal People and HIV/AIDS in Montreal: HIV/AIDS Needs Assessment: Final Report. Sweet grass consulting. Prepared for Native Friendship Center of Montreal and La Direction de la Santé Publique.

This study was conducted to better understand the growing epidemic of HIV/AIDS with Aboriginal peoples, specifically within Montreal's urban-Aboriginal community. According to the majority of service providers who participated in this study, Inuit women on the streets are the most high-risk of Aboriginal peoples. However, Aboriginal people are virtually invisible in mainstream HIV/AIDS services. The majority of service providers interviewed knew little about the lived experiences, needs, perspectives, cultures and traditions of Aboriginal peoples. It was observed that the seven main barriers for Aboriginal people accessing care are: cultural barriers, linguistic barriers, structural barriers, the historical relationship of entrenched inequality, mistrust of doctors and nurses, divergent expectations and experiences around medical services delivery, financial barriers/non-insured health benefits or beneficiaries and lack of knowledge about existing services. It was also noted that Aboriginal people tend to refuse to take part in mixed support groups with non-Aboriginal people.

To improve services for Aboriginal people, service providers suggested including greater collaboration between services, to promote an exchange of information and expertise, to provide identifiable contact people within all relevant organizations, to constitute a resource for services and new projects, and to provide cross-cultural and anti-racist education for non-Aboriginal service providers. The number of AIDS cases has increased steadily since the 1990s with an increase from 1% to 10.8% of the Canadian population from 1990-1999. It was noted that vulnerability to HIV often had more to do with social and environmental factors such as stigma, poverty, discrimination, racism and sexism than individual behavior. For Aboriginal peoples, these realities are emphasized by the residential school system, multigenerational abuse and forced assimilation, which has also brought loss of traditional values and ways of life.



Among the limitations of the project, researchers noted that it was hard to reach respondents; 19 out of the 20 were at the Native Friendship Center of Montreal. There was also a difficulty for services providers to identify Aboriginal peoples. The researchers were not able to administer focus groups because those who were to be involved expected to get paid to participate. The service providers were easier to reach. Here is a list of the organizations that participated: Native Women's Shelter, Native Friendship Center, ASTEQ, Cactus, Chez Doris, Waseskun House, Le Chaînon, Kateri Hospital, Maison du père, The Open Door, Stella, CLSC des Faubourgs, Old Brewery Mission/Women's Shelter, Old Brewery Mission/Men's shelter, L'Abri de l'Espoir, Dans la rue, and CLSC Metro. Some of the comments raised by the service providers included: Aboriginal people rarely come back for follow ups; Hepatitis C is a big problem but many refuse services; difficulty establishing trust relationships with Aboriginal clients; and Aboriginal clients seem to be deeply mistrusting of health and medical professionals. From the data collected from the interviews with services providers, an exploration of experiences, perspectives and needs of Aboriginal peoples in hard to reach communities such as Montreal was proposed, in order to develop a demographic, socio-epidemiologic and socio-epidemiologic profile. Also, to find the links between the residential schooling, cultural and family breakdown, multigenerational abuse, cycles of abuse, violence and other reoccurring challenges in Aboriginal communities.

From the results collected, Ship and Norton believe there should be culturally appropriate peer counseling for relevant HIV/ AIDS education to Aboriginal Peoples, culturally appropriate HIV/AIDS and Hepatitis C education/prevention, culturally appropriate pre and post HIV testing counseling and counseling for victims of sexual and other kinds of abuse. There should be a program and halfway house for Aboriginal women released from prison and a detoxification center for Aboriginal people with alcoholism problems and substance abuse. The authors also believe that the entire community needs to have better access to traditional healing.

SMALL, C.J. 1996. The healing of American Indian/Alaska Native men at mid-life. Ph.D. Dissertation, Gonzaga University, 121 p.

This study explored the challenges in wellness for American Indian/Alaska Native (AI/AN) men at mid-life. The research methodology used was heuristic inquiry, a qualitative approach that combines the personal experience and insight of a researcher with his or her interpretations of the phenomenon being studied. The findings from four in-depth interviews of AI/AN men at mid-life were connected with 80 surveys, a review of literature, and the researcher's own interpretations as an AI/AN man on a wellness path at mid-life. The questions asked were, what are the factors that cause AI/AN men at mid-life to seek a wellness path? And, what are the recommendations for AI/AN men, including the development of a healing model? From the answers of these questions, five themes emerged: alcohol and other addictions, multi-generational trauma and cultural oppression, father-son relationships, spirituality, and role modeling and service to the community.



SPILLANE, N. S., & Smith, G.T. 2010. Individual Differences in Problem Drinking Among Tribal Members From One First Nation Community. *Alcoholism: Clinical and Experimental Research*, 34(11): 1985–1992.

The authors of this study conducted a test of a model of First Nation drinking risk that incorporates personality and psychosocial learning to examine its cross-cultural applicability. That model identifies a risk process thought to explain aspects of individual differences in both Aboriginal problem drinking and non-Aboriginal problem drinking. The tools consisted of a 14-item demographics questionnaire that includes age, gender, education level achieved, and occupation, as well as a drinking style questionnaire with two sub-scales that measure drinking/drunkenness and problems related to drinking. The later scale used includes quantity of consumption, frequency of consumption, proportion of time drinking leads to drunkenness, maximum quantity consumed and physical effects of alcohol. The problem factor includes items measuring various negative consequences of consumption (e.g., legal difficulties, trouble with family, trouble with relationships, illness). A structural modeling analysis of 211 First Nations people and 236 Caucasian people found that personality, alcohol expectancy and problem drinking measures were invariant across the two cultures and that the results were consistent with the hypothesis that positive alcohol expectancies mediated the influence of negative urgency on problem drinking were also invariant across culture.

STEENBEEK, A.A. 2005. An epidemiological survey of chlamydial and gonococcal infections in a Canadian Arctic community: Determinants of sexually transmitted infections among remote Inuit populations. Ph.D. Dissertation, University of British Columbia, 245 p.

This study examines the prevalence of sexually transmitted infections (STIs) in a remote Inuit community in order to better understand the determinants of this ever-growing problem. In total, 181 participants, with an average age of 29.6, were screened for chlamydia/gonorrhea and interviewed. The questionnaire, which followed the Theories of Reasoned Action and Planned Behavior, was used to collect information on demographics, use of health services, sexual histories, STI and contraceptive knowledge, high-risk behaviors, perceived risk and barriers of condom use. The findings showed a percentage of infected peoples that was consistent with the literature, over 10%, in this case, 35 out of 181. The reasons for not wearing condoms included being embarrassed to purchase condoms and discuss condom use, and fear of giving a bad impression. Judging from her findings, Steenbeek believes there should be universal screening, prompt treatment and comprehensive contact tracing for STI prevention in all Inuit communities.



TANDON, SD, Phillips, K., Bordeaux, B.C. 2010. A vision for progress in community health partnerships Progress. Community Health Partnerships: Research, Education, and Action, 4(4): 11-30.

This study used community-based participatory research in a large cohort study of chronic diseases among Alaska Native adults. The collaboration with regional THO staff, Tribal leadership, and local experts impacted multiple aspects of this study. Each of the three THOs contributed research questions to the study. After development of the protocol, the Alaska Area Institutional Research Board, the National Indian Health Service Institutional Research Board, the Tribal health research and ethics committees, and the governing boards of each of the participating regional THOs reviewed and approved the study design, instruments, and research questions. Regional coordinators then made presentations to local Tribal Councils. Out of the 27 Councils approached, 26 signed resolutions allowing the research study to enroll Tribal members in their communities. This study also used less standard methods of recruitment such as flyers, radio announcements, and presentations to boards, health providers, and community groups, and offered home visits by local recruiters. Research team members lived and worked in the community for blocks of time ranging from 1 to 8 weeks. During that time, they participated in community events such as bingo nights, traditional dance presentations, pow-wows and other tribal gatherings.

TARLER, D.S., Brown, A.J., Johnson, J. 2007. The influence of geographical and social distance on nursing practice and continuity of care in a remote First Nations community. Can J Nurs. Res., 39(3): 126-48.

The purpose of this article, which draws on the findings of a larger ethnographic study, is to explore the influences of geographical and social distance on nursing practice and continuity of care in a remote First Nations community in Canada. The authors employed an ethnographic design using multiple data sources to ground the analysis in the unique context of health services in the selected community. The findings suggest that remote geographical location, the inequitable social conditions that shape the health and well-being of First Nations people, and nurses' level of preparedness to practice in this complex environment fostered patterns of social distancing in nurse-patient relationships. These patterns constrained nurses' ability to engage in practice that promotes continuity of care. In some cases, social distancing took the form of "othering" and relational disengagement from patients. The authors believe that changing the social determinants of Aboriginal people's health in remote communities is an important first step in supporting the changes in nurses' practice that are key to improving continuity of care and to effecting long-term, sustainable health improvements.



TAYLOR, D.M. and Osborne, E. 2010. When I know who "we" are, I can be "me": the primary role of cultural identity clarity for psychological well-being. *Transcult Psychiatry*, 47(1):93-111.

This article presents a series of studies that illustrate the importance of cultural identity clarity for personal identity and for psychological well-being. The authors' theoretical model proposes that interventions aimed at clarifying cultural identity may play a constructive role in the promotion of the well-being of group members exposed to collective trauma whether it be through colonization (e.g., Aboriginal Peoples), slavery (e.g., African Americans) or war. This form of trauma has a dramatic impact on the psychological well-being of each and every individual member of the collective and interventions are often conceptualized and delivered at the individual level with a view to minimizing the psychological disequilibrium of each individual. To contrast this view, Taylor and Osborne propose a theory of self that emphasizes the primacy of cultural identity for psychological well-being.

TEDFORD GOLD, S. 2003. Inuit engagement in Nunavut and Canada: Struggles for health and citizenship. Ph.D.Dissertation, McMaster University, 254 p.

This thesis is a post-structural analysis of Inuit engagement in health governance in Nunavut. The creation of Nunavut brought decision-making power to a largely Inuit population through both a land claims agreement and the establishment of a public government. As such, it marks a new moment in the history of Aboriginal governance in Canada and in relations between north and south, Inuit and non-Inuit. This study is based on a qualitative methodology including fieldwork in three Nunavut communities, interviews, and document analysis. The researcher considers how relations between North and South, Inuit and non-Inuit have shaped health governance in the Central and Eastern Arctic. The study explores how various conceptions of health and self are implicated in how citizens participate in health governance in Nunavut. It explores notions of health and citizenship as contingent and variable and points to the need for new research on the implications of citizenship struggles in remote communities for health governance. Finally, this research points to the instability of power relations and joins in efforts to rethink the way we organize and govern health and our lives.



TIESSEN, M., Taylor, D.M. and Kirmayer, L.J. 2009. A Key Individual-to-Community Link: The Impact of Perceived Collective Control on Aboriginal Youth Well-Being. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 7(2): 241-268.

This study investigates the impact of perceived collective control on the wellbeing of Aboriginal youth. Students from grade 7 and up from two Cree communities in northern Manitoba collaborated in the research. They were asked to fill out two surveys on their well-being. Questionnaire response options were based on a Likert type scale and the level of wellbeing was measured by three qualifiers. The first, self-esteem, was measured using seven items in the first study and nine in the second study which were taken from the Rosenberg Self-Esteem Scale (Rosenberg, 1965). The second, positive and negative affect, was measured through sixteen items taken from the Positive and Negative Affect Scale for Children (Laurent et al., 1999). The third qualifier, general happiness, had a single-item rating of subjective well-being taken from Grootaert et al. (2003), wherein participants indicated their general level of happiness, on a 5-point scale ranging from very unhappy to very happy. In the second survey, the levels of substance use were measured from items taken from the substance use section of the Inuit Youth Survey (Malus, Kirmayer, and Boothroyd, 1994). Participants indicated the frequency with which they used each substance, ranging from never to every day. There were three items for those respondents who had used a substance in the past, but since quit. The levels of group and individual control were assessed using the “Personal Instrumentalism” and “American Instrumentalism” scales as a base which contained nine items (Mirowsky, Ross, and Van Willigen’s, 1996). Collective efficacy was valued by 10 items from Sampson, Raudenbush, and Earls (1997), and six items from Browning and Cagney (2002). The results of each study indicated that greater perceived individual internal control was associated with greater psychological well-being. However, multidimensional measures of control employed in Study 2 indicated an association between greater perceived individual control over drinking and decreased well-being.

WALJI, R., Weeks, L., Cooley, K., Seely, D. 2010. Naturopathic Medicine and Aboriginal Health: An Exploratory Study at Anishnawbe Health Toronto. Canadian Journal of Public Health, 101(6): 475-480.

The goal of this study was to explore the experiences and perceptions of providing and receiving naturopathic care within the Aboriginal community served by community health centre Anishnawbe Health Toronto (AHT). This exploratory study used a descriptive qualitative approach to enable better understanding of the care provided to Aboriginal patients by naturopathic interns and clinician supervisors at Anishnawbe Health Toronto. Semi-structured interviews were conducted with three naturopathic supervisors, seven naturopathic interns, and seven Aboriginal patients to gain an in-depth understanding of participants' experiences and perceptions of naturopathic medicine at AHT. There were also three interviews with naturopathic doctors practicing in other Aboriginal communities. It was found that naturopathic medicine is perceived to fit with health care philosophies in Aboriginal communities, as it emphasizes spiritual, mental and emotional aspects of health. Specifically, strengths of naturopathic medicine within the Aboriginal community relate to the philosophical suitability of naturopathic medicine, the ability to meet a wide range of health needs, the lack of power imbalance in the patient-practitioner relationship, and the cultural sensitivity of the practitioners. While AHT is highly regarded by patients and practitioners, certain limitations at the local setting regarding privacy and inter-professional communication were evident. In concluding, the researchers found that the



naturopathic clinic at AHT contributes to positive patient outcomes and satisfaction, and helps address unmet health needs in its clientele population. They found that naturopathic medicine may be well suited to address Aboriginal health care needs through its holistic and respectful approach to care and a foundation of traditional knowledge and research evidence for treatment of a person's mind, body and spirit.

WARRY, W. 1998. Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government. Toronto: University of Toronto.

This book offers an extensive interpretation of how the lack of Aboriginal self-government policies has contributed to poor health conditions in Aboriginal communities. It underlines the negative impacts of colonialism that have created and maintained divisions between community members. It explains the importance of understanding their history and the ways in which the governments have greatly contributed to the loss of culture and community, leading to a variety of public health and psychosocial problems. The author recommends better interaction between Elders and youth, and better communication between all members of the community. These can be accomplished through many forms of sharing circles, traditional ceremonies and community events.

WEXLER, L. M. 2006. Inupiat youth suicide and culture loss: Changing community conversations for prevention. Social Science and Medicine, 63(11): 2938-2948.

This research study used a Participatory action research (PAR) approach to engage the community in discussing issues surrounding youth suicide. Via this approach, etiological suicide information along with interview, focus group and survey data was shared with community members over the two-year study in order to develop village plans and foster community-based action focused on suicide prevention and wellness.



