

ABORIGINAL WOMEN'S EXPERIENCES
SEEKING HELP IN AN URBAN EMERGENCY DEPARTMENT

by

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ABSTRACT

Many Aboriginal women living in inner city areas are affected by structural inequities, racialization and other marginalizing practices, which in turn affect their health and access to health services. It is against this backdrop that some Aboriginal women seek help at emergency departments for health issues that, ostensibly, could be addressed in community-based primary care settings. The purpose of this study was to explore the social and political contexts of access to primary care from the perspective of Aboriginal women who attended an emergency department for health issues triaged as stable and non-urgent. It is anticipated that the findings of this study will be used to inform strategies for improving primary care services, in particular for Aboriginal women living in urban areas.

This study involved a secondary analysis of interviews gathered during a larger ethnographic study. It was decided a subset consisting of all 13 Aboriginal women's interviews from the primary study would be analyzed. In keeping with a critical cultural perspective, cultural safety was used as an analytical lens to examine the social contexts and influences that led Aboriginal women in this study to seek care at an emergency department for health concerns that were triaged as stable and non-urgent. The tensions Aboriginal women experienced in this study while seeking care were also explored. Using the methodology of interpretive description as a guide for analysis, four central themes were discussed. The four themes consisted of: 1) needing a safe place to live, 2) negotiating pain management, 3) seeking help against a backdrop of violence and trauma, and 4) the perception of discrimination and the awareness of how one will be *read* during

health care encounters. These findings have implications for understanding the influences that shape health care experiences, the role of the emergency department in relation to primary health care, minimizing the potential for emotional trauma and structural violence in the emergency department, and fostering greater equity in health services.

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This journey has been long but not without personal highlights. During my program, I met and married my husband, had two beautiful daughters, and all while continuing to work as both an emergency nurse and a nurse educator. I wrote this thesis in between sleepless nights, breastfeeding, changing dirty diapers and defusing temper tantrums. I would like to thank both my parents and my in-laws for your love and support, especially with the girls. I would have never been able to accomplish this without you.

To my mother: thank you for being tough and never allowing me to quit.

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CHAPTER ONE: INTRODUCTION

As a novice researcher, I take great interest in the area of Aboriginal women's health for a number of reasons. First, my mother, who is Métis, has imbued me with concern for Aboriginal health issues. Second, after spending many years working in the acute care setting as a registered nurse (RN), my interest in Aboriginal health was further sparked from the point of view of a clinician. I developed awareness about the discrepancies in health and access to health care faced by a large percentage of the Aboriginal population. Part of my time as a RN in the acute care setting has been spent in a busy emergency department (ED). It was in this setting that I became intensely aware of the problems faced by some people who identify as Aboriginal in relation to health care access. I found that the ED consistently served as a health care safety net for certain groups, for example, a large portion of the Aboriginal population living in the inner city areas. I questioned the social, economic, and personal circumstances that led some people to access primary care through the ED instead of in the community setting. At that same time, I began the Master of Science in Nursing program at UBC and participated in a directed readings course that analyzed the historical and political contexts surrounding Aboriginal peoples' health. The course tied into my experiences and understanding of Aboriginal health and encouraged me to explore its complexities, leading me to my thesis topic regarding Aboriginal women's access to health care services in the urban setting.

The way I work with and discuss aspects of Aboriginal people's health in this thesis is of critical importance. Dr. Judith Bartlett (2005), a Métis physician and

researcher, explains that even though it is important to acknowledge the health discrepancies experienced within some sectors of the Aboriginal population in Canada, we must be careful not to “personify Aboriginal peoples as victims with limited capacity to address problems” (p. 25). Though the health discrepancies experienced by both Aboriginal women and men are often bleak, the strength, endurance, and power that can be found in Aboriginal populations must also be acknowledged.

Central Problem

Even though growing numbers of Aboriginal women in Canada are leading healthy and successful lives, a disproportionate number of Aboriginal women continue to experience a poorer standard of health compared to non-Aboriginal women (Dion Stout, Kipling, & Stout, 2001; Royal Commission on Aboriginal Peoples, 1996). Canada takes pride in claiming to provide its people with one of the highest quality of life standards in the world, yet some Aboriginal women have health profiles comparable to developing countries (Dion Stout et al.). These health disparities stem from a variety of structural and historical inequities, some of which relate to access to effective health care. As Benoit, Carroll, & Chaudhry (2003) write, “research on general health service delivery in urban areas of Canada shows that Aboriginal people face formidable barriers in accessing culturally appropriate and timely care” (p. 821).

Many Aboriginal people in Canada are moving to urban centers, particularly women, who often move into low income inner city areas (Benoit et al., 2003; Newhouse & Peters, 2003). Due to the intersecting effects of colonization, sexism, racism, and classism, Aboriginal women in this setting face particular challenges including: poverty, violence, substance abuse, and the apprehension of children by the child welfare system

(Abbott, 2003; Benoit et al.). Given these social and historical contexts, many Aboriginal women face multiple burdens, including social and economic marginalization (Browne, 2005). This leads to challenges accessing health care and therefore some women seek services at the ED for primary care issues -- settings that are not able or equipped to provide quality primary care (Richardson & Hwang, 2001; Richardson, Irvin, & Tamayo-Sarver, 2003).¹ The health disparities experienced by some Aboriginal women are then compounded by inadequate and inappropriate access to primary care services, as part of the continuum of primary health care (PHC)². For these reasons, it is important to gain a deeper understanding of the social and historical contexts that influence some Aboriginal women living in inner city areas to access primary care in the ED.³

Purpose and Research Questions

This thesis involved a secondary analysis of interviews gathered during a larger primary study entitled, “Access Issues for Aboriginal People Seeking Primary Care Services in an Urban Center.”⁴ The purpose of the primary study was to further understand the factors influencing Aboriginal patients’ use of the ED for non-urgent health issues that could potentially be addressed in community-based primary care settings. (See Table 1, Primary Study Research Questions – Appendix A)

¹ Primary care refers generally to the first level of contact that people have with the health system, and the first element of a continuing healthcare process that may include the provision of secondary and tertiary levels of care (Hogg *et al.*, 2008).

² The World Health Organization (WHO) (1987), describes PHC as universally accessible health care based on sound methods and technology for the population by means acceptable, at an affordable cost with the goal of self-reliance and self-determination.

³ In this paper, the term “Aboriginal peoples” refers generally to the indigenous inhabitants of Canada, including First Nations, Métis, and Inuit peoples. Specifically, the term First Nation replaces the term Indian, Inuit replaces the term Eskimo, and Métis refers to people of mixed European and Aboriginal ancestry. (Royal Commission on Aboriginal Peoples, 1996, p. xii)

⁴ The primary data source for this study was from: Browne, A.J., Rodney, P., Smye, V., Mussell, B., Caplette, N., Calam, B., O’Neil, J., McCormick, R., Demarais, L. Canadian Institutes of Health Research funded study (2009).

The overall purpose of this thesis was to explore the social and political contexts of access to primary care from the perspective of Aboriginal women who attended an ED for health issues triaged as stable and non-urgent. The following research questions guided the analysis in this thesis:

1. What are the social contexts and influences that lead Aboriginal women in this study to seek care at an ED for health concerns that are triaged as stable and non-urgent?
2. What are the tensions that Aboriginal women in this study experience when they come to the ED?
3. What are the implications for improving health care services for Aboriginal women?

In this study, I conducted a secondary data analysis following the methodology of interpretive description (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004; Thorne, 2008). The tensions experienced while accessing care were also examined. Importantly, as discussed in Chapter Three, the primary study from which this secondary analysis data set derives from, was conducted by both Aboriginal and non-Aboriginal researchers experienced in this area of research.

Organization of Thesis

The following provides an overview of the organization of this thesis. In this chapter, I have discussed my position as a researcher, the central problem of this study and the purpose and research questions. In Chapter Two, I provide an in-depth literature review along with an analysis of the current gaps in the research. Then in Chapter Three, I explore the design, sampling plan, and methods of data analysis including theoretical underpinnings, methodology, ethical considerations and scientific quality. Next in Chapter Four I examine the findings based on the analysis from the data of the

participants. In Chapter Five, I discuss the implications and recommendations in relation to clinical practice, education, organizational policy, and research and end with a conclusion to the study.

CHAPTER TWO: LITERATURE REVIEW

A review of the literature is critical to get a sense of previous published work and establish the context of the present study for both the researcher and the reader of this study, highlighting the relevant research and revealing gaps in the literature. In keeping with the analytic framework of interpretive description, this study was located within existing knowledge, as suggested by Thorne, Reimer Kirkham, and Macdonald-Emes (1997). In order to gain a better understanding of how health care encounters of some Aboriginal women living in inner city areas are shaped by the social context of their lives, a relatively new and growing collection of studies was reviewed (Adelson, 2005; Browne, 2005; Bourassa, McKay-McNabb & Hampton, 2004; Lane, Bopp & Bopp, 2003).

This literature review will begin by providing an overview of the socio-historical context of a large number of Aboriginal women's lives, followed by an examination of Aboriginal women's current state of health, specifically women residing in inner city areas. Next, the growing trend of urbanization for some Aboriginal women and the challenges of access to health care in the urban setting for Aboriginal people will be examined. Finally, the gaps and weaknesses in the literature regarding Aboriginal women's health and access to health care in the urban setting will be addressed.

Socio-Historical Context of Many Aboriginal Women's Lives

The Impact of Colonial and Neocolonial Processes on Aboriginal Women's Lives

Colonization continues to have devastating effects on the lives of a large number of Aboriginal women. Kelm (1998) describes colonialism as a process that includes

geographical incursion, socio-cultural dislocation, the establishment of external political control and economic disposition, the provision of low level social services and the creation of ideological formulations around race and skin colour that position the colonizers at a higher evolutionary level than the colonized (p. xviii).

Neo-colonialism is a “term widely used to refer to current forms of control of prior colonies or populations such as indigenous peoples who continue to live under conditions of internal-colonialism” (Browne, Smye & Varcoe, 2007, p. 14). It must be emphasized that neo-colonialism is a current and less overt but dangerous form of colonialism that continues to hold power over the lives of specific populations, including that of indigenous peoples.

The Indian Act of 1867 is one example of how colonialism regulated the lives of Aboriginal women and erased the power and prestige that many once held in their traditional communities (Moffitt, 2004). Through the Act, the female lineage system that many Aboriginal families followed was dismantled by the Canadian government and as result, entire Aboriginal family systems were torn apart, leaving women in disempowered positions (Armstrong, 1996). Today, even with numerous revisions to the Act, gender-based discrimination experienced by Aboriginal women continues by way of status entitlement provisions, access to band membership, participation in self government, access to programs and resources controlled by band council and the methods of division of matrimonial property on reserves (Bennett & Aboriginal Women’s Health and Healing Research Group, 2005).

The residential school system also lowered the status of Aboriginal women by encouraging paternalistic values and promoting the dominant Canadian view at that time

that Aboriginal women were incapable mothers. It was believed that by removing Aboriginal children from their families and placing them in residential schools, they could be “saved” from their non-Christian lifestyles and neglectful mothers (Kelm, 1998). At school, girls were only educated to perform domestic duties inside the home, while boys were taught labour skills for outside the home to eventually access a source of income. Children were taught to reject their culture, dress in foreign clothes, and were banned from speaking their native languages, being subject to harsh punishment if they did. Both boys and girls raised in these schools grew up with few or no models of healthy parenting (Bennett & Aboriginal Women’s Health and Healing Research Group, 2005). The residential school system was responsible for the loss of many native languages and cultural identities that has continued in subsequent generations of Aboriginal people (Simpson, 2004).

The Social Positioning of Aboriginal Women in this Study

I would like to make mention that as I began to write this literature review, I worried about furthering the stereotypes that currently surround some Aboriginal women, especially those situated in the inner city. As Culhane (2009) writes,

Researchers and advocates working in the field of Aboriginal health point out that endless repetition of statistics about illness, disease, violence, and dysfunctional communities and of “horror stories” about painful personal experiences of trauma misrepresents the diversity and complexity of Aboriginal experience by excluding those who survive through extraordinary strength and resilience (p. 166).

I have tried throughout this paper, to also acknowledge the strength and resiliency found not only in the women in the study, but in all Aboriginal women.

This said, the reality in Canada is that a large number of Aboriginal women live in extreme poverty, are single parents and experience violence in their lives (Dion Stout et al., 2001). The multiple intersecting contexts listed above, as well as lower levels of education compounded by gender and race issues, create differing levels of discrimination and disadvantage for the women (Browne & Fiske, 2001). The concept of intersectionality in relation to the current social positioning of some Aboriginal women is important and requires closer analysis. Intersectionality refers to the relationships of different historically and socially constructed categories that interact on multiple levels and manifest as inequality in society (Collins, 2000). Many women who identify as Aboriginal face inequities due to the intersecting effects of issues such as poverty, racism, and gender inequality and these inequities reinforce their position as other in society (Browne & Fiske). Othering, a process based on negative stereotypes, “refers to the projection of assumed cultural characteristics, differences or identities onto members of particular groups” (Browne, Smye & Varcoe, 2005, p. 21). Canales (2000) describes some of the consequences of othering as being: alienation, marginalization, decreased opportunities, exclusion, and internalized oppression. An example of othering can be found in stereotypes that associate dependency and substance abuse with the Aboriginal population (Furniss, 1999). The combination of destructive historical and current social, political, and economic factors, as described above, has severely impacted large numbers of Aboriginal women’s lives, leading to current health disparities.

Current Health Disparities

A discrepancy in health continues to exist between a large number of Aboriginal women and non-Aboriginal women in Canada. (Adelson, 2005; Bourassa et al., 2004;

Browne, 2005; Dion Stout et al., 2001). For example, the life expectancy of some Aboriginal women in BC continues to be lower than that of non-Aboriginal women in BC. In Vancouver, for the time period between 1991 and 1995, life expectancy was 12.2 years less for some Aboriginal women when compared to that of non-Aboriginal women (BC Provincial Health Officer, 2002). Not only do a large number of Aboriginal women have a lower life expectancy, but they also experience higher morbidity and suicide rates in comparison to non-Aboriginal women (Leeman, Harrell, & Funk, 2002, Thomlinson, McDonagh, Crooks, & Lees, 2004). It is important to understand that the discrepancies in health status for some Aboriginal women does not stem from personal lifestyle and cultural factors, a common misconception held by some of the general population (Smye & Browne, 2002). The poor health status experienced by some is a reflection of the intersection of colonization, classism, racism and sexism (Browne). Adelson (2005) describes how “health disparities are directly and indirectly associated with social, economic, cultural, and political inequities” and are not an “Aboriginal trait” (p. 45). With that said, though the health status of some Aboriginal women appears bleak, there are growing numbers of success stories regarding Aboriginal women scholars, artists, professionals and successful leaders in land claims that are sure signs of achievement (Adelson).

The health inequities faced by a large number of Aboriginal women are reflected in the incidence of specific diseases, particularly the HIV/AIDS epidemic (Culhane, 2009). Sexism, classism, racism, and colonialism all intersect to put many Aboriginal women at significantly greater risk for contracting the disease than non-Aboriginal women (Dion Stout et al., 2001). Aboriginal women are also three times more likely to

die of HIV/AIDS than non-Aboriginal women (Benoit et al., 2003; Culhane, 2003). Between 1998 and 2005, Aboriginal women comprised 47.3 percent of the total positive HIV reports among Aboriginal people. Within this same time frame, non-Aboriginal women comprised only 20.5 percent of the total positive HIV reports among the non-Aboriginal population in Canada (Health Canada, 2006). The high rates of HIV occur for a number of reasons and reflect the historical and social positioning of some Aboriginal women. One example of this can be seen in the number of Aboriginal women who are forced to work in the sex trade industry. Women who work in the sex trade are at an extremely high risk of contracting and developing chronic conditions such as HIV (Shannon, Bright, Duddy, & Tyndall, 2005). It has been estimated that up to 70 percent of the women who work in the sex trade in the inner city are Aboriginal (Benoit et al.). In addition, women generally have less power in sexual relationships, and therefore are less likely to be able to ensure condoms are used, putting them at greater risk of contracting HIV (Amaro & Raj, 2000). Also, due to the physiological characteristics of female genitalia, women are more susceptible, as compared to males, of contracting sexually transmitted diseases (Darroch & Frost, 1999). Another reason for the high rates of HIV are directly related to injection drug use and some Aboriginal women's social positioning in society (Spittal et al., 2002). Due to power inequities, Aboriginal women are more likely to share needles or be *second on the needle* than non-Aboriginal women when using injection drugs (Benoit et al.). Importantly though, the majority of Aboriginal women living in the inner city are neither current sex trade workers nor are they injection drug users. Many inner city residents, "Aboriginal and non-Aboriginal –

are poor and/or elderly and cannot afford to live anywhere else in Canada's highest-rent city" (Culhane, 2009, p 161).

Chronic diseases such as diabetes are also increasing at an alarming rate within Aboriginal populations (Adelson, 2005; Bourassa et al., 2004). As Adelson (2005) explains, non-insulin dependent diabetes is three to five times higher in the Aboriginal population. Within the Aboriginal population, diabetes is more prevalent among Aboriginal women than men (Bourassa et al.; Statistics Canada, 2001). This discrepancy may be due to both genetic and gender-related factors. As a large number of Aboriginal women face one of the highest economic poverty rates in Canada, (Bourassa et al.), the costs associated with food and childcare may make nutritious and healthy food unaffordable.

Women who identify as Aboriginal also have an increased chance of experiencing violence (Bourassa et al., 2004; Lane et al., 2003; Larocque, 1993; Royal Commission on Aboriginal Peoples, 1996). Although gender-based violence is experienced worldwide, Aboriginal women have a greater chance of experiencing violence and trauma than non-Aboriginal women (Statistics Canada, 2006). In Canada, it is estimated that Aboriginal women are up to eight times more likely than non-Aboriginal women to be killed by their partner (Trainor & Mihorean, 2001). Sadly, the statistics that do exist are likely an underestimation of the actual occurrence of violence (Statistics Canada). It is believed that the historical and social positioning of some Aboriginal women, as well as the destruction of families as a result of the residential school systems and its subsequent related traumas, have all contributed to the high rates of violence against Aboriginal women (Brownridge, 2003; Royal Commission on Aboriginal Peoples, 1996).

What is also interesting to note are the discrepancies among and between Aboriginal women themselves (Saskatchewan Women's Secretariat, 1999; Bourassa et al., 2004). For example, Métis women are more likely to be employed than status Indian women; however, Métis women are less likely to be employed than non-Aboriginal women (Saskatchewan Women's Secretariat). This area of study regarding the differences among and between Aboriginal women is new and developing, yet it is thought that the racist underpinnings of colonialism are contributing factors (Bourassa et al.). The intersecting oppressive forces of racism, sexism, classism, and neo-colonialism affect specific groups of Aboriginal women differently and ultimately lead to discrepancies in overall health status (Bourassa et al.). These discrepancies in health can be linked directly to the social determinants of, and access to, health services.

Urbanization of Some Women to the Inner City

Before I begin to describe the growing trend of urbanization of Aboriginal peoples, it should be pointed out that the area known as Vancouver, "has been owned and occupied by indigenous peoples of Coast Salish Nations for many thousands of years" (Culhane, 2009, p. 160). Some current Aboriginal residents of the inner city have had ancestors who have lived there for thousands of years.

Today, there is a large, diverse, and growing Aboriginal presence in urban Canadian cities. Aboriginal sub-populations vary significantly in their rate of urbanization. Newhouse & Peters (2003) explain that non-status First Nations and Métis have the highest rates of urbanization, 73 percent and 66 percent respectively. Status First Nations and Inuit people are the least urbanized; 37 percent and 30 percent respectively. Both Newhouse and Peters and Dion Stout et al. (2001) describe the

substantial growth in the urban Aboriginal population since the mid 1900s: “In 1996, 171,000 Aboriginal people, comprising approximately 20 percent of the total Canadian Aboriginal population, lived in Winnipeg, Edmonton, Vancouver, Regina, Saskatoon, Calgary or Toronto” (Dion Stout et al., 2001, p. 10). From 1996 to 2001, Aboriginal populations grew by 26 percent in the urban areas (Newhouse & Peters). Within these urban areas, Aboriginal women outnumbered Aboriginal men (Benoit et al., 2001; Royal Commission on Aboriginal Peoples, 1996).

A variety of factors have contributed to an increasing number of Aboriginal women migrating to urban settings as reported by Browne, McDonald, and Elliot (2008). As Newhouse and Peters (2003) claim, some of the women have moved to the urban centers by choice. These settings may offer increased opportunities for education or hold promise for better job opportunities. Other women may choose to move to cities because of the poor social conditions on their reserves. Many of the women have experienced impoverished economic environments and a lack of housing and health facilities on the reserves from which they come (Newhouse & Peters). Some of the younger women may also leave their reserves or small, isolated communities as a response to the lure of the bright lights of the big cities, only to find these bright lights come with a high price once they arrive (Newhouse & Peters). At the same time, some Aboriginal women flee to the urban centres, leaving their reserves out of the fear of violence, which has grown to endemic proportions (LaRocque, 1993; Royal Commission on Aboriginal Peoples, 1996). Finally, a growing proportion of Aboriginal women living in the urban setting are those living with HIV/AIDS (Benoit et al., 2001). After contracting HIV/AIDS, many women are shunned on their reserves or in their small communities due to the stigma associated

with the disease (Benoit et al.; Newhouse & Peters). The majority of the women then remain in urban centres, quite often isolated from their reserves and home communities (Benoit et al.). This growing population of Aboriginal women living in urban settings represents a significant shift in the distribution of Aboriginal peoples and also presents a new variety of challenges and opportunities for the women.

Challenges Accessing Health Care Services

Health Care Access and the Aboriginal Population

A number of researchers have examined Aboriginal populations' access to health care. O'Neil's (1989) landmark study examined Inuit dissatisfaction with the Canadian medical system. His study provided evidence of the continued colonial relations of the dominant, Euro-Canadian population and Inuit populations of northern Canada. Repeatedly, he found colonial ideology entangled within all medical encounters of community members from the Keewatin region (where the study took place) and the non-Inuit health care professionals providing service there. He presented clear examples of different Keewatin communities that had lost confidence in the non-Inuit staff running the health clinics. O'Neil concluded that racist and colonialist ideologies embedded within the medical system strongly influenced Inuit health, resulting in a complete distrust of the medical system by the Keewatin people, with many choosing not to use the health care system unless absolutely necessary. Though O'Neil's study was conducted in the rural northern Keewatin region, many Aboriginal peoples' distrust of the medical system continues today in both rural and urban settings, leading to inadequate access to health care.

Browne and Fiske (2001) studied First Nations women's health care encounters in Northern British Columbia. The majority of the women's encounters with the health care system were negative. Many of the women in the study thought their medical concerns had been dismissed by health care professionals. At other times, they found they had to "transform themselves" to be credible patients. For instance, the women believed they would have to dress in their best clothes or "act educated" in order to be taken seriously by their doctors (Browne & Fiske). The women provided specific instances in which they believed they had been unfairly judged according to racial stereotypes upon admission to hospital. One woman described her experience of being presumed a neglectful mother when she brought her child to a health care center for a diaper rash. The study found the layered social positioning First Nations women experienced within their daily lives carried over to, and was embedded within, the attitudes and assumptions of the health care professionals and the health care delivery system (Browne & Fiske).

Benoit et al. (2003) conducted a study on the health care needs of Aboriginal women living in an inner city area. The harsh realities of the women's lives were depicted in explicit detail and their unique health care needs were described. A description of the few Urban Aboriginal Health Centres in the inner city was provided. Sheway, one such program, was found to be an excellent source of help for pregnant and post-partum Aboriginal mothers. It was successful in making health and social services more available and accessible to the women (Benoit et al.). However, as the only program that provided care for pregnant and post-partum women, Sheway could only support a small percentage of the mothers who needed help, due to a lack of funding. Though Sheway provided hope in terms of access for this small group of women, much

more change was needed to improve overall access to health care for Aboriginal women living in urban areas (Benoit et al.).

Primary Health Care Reform and its Influences on the Emergency Department

Canada's current health care system is supported by the foundations of primary health care (PHC). Defined earlier in the study, PHC is universally accessible health care based on sound methods and technology, conducted by means acceptable to the population at an affordable cost, with the goal of self reliance and self determination (World Health Organization, 1987). Primary care, as defined in Chapter One, is the first level of contact that people have with the health system, and is part of the continuum of PHC services. PHC and primary care continues to be a priority for the Canadian government. In 2002, the Romanow report recommended renewed support for PHC and the removal of obstacles in PHC delivery (Health Canada, 2002). Despite continued support, PHC has never been fully implemented in British Columbia or most other parts of Canada (Health Council of Canada, 2008), nor does it appear to be working for a high proportion of the Aboriginal population, who experience health disparities and inequities in access to health care.

An example of this can be seen in the number of people who access EDs for primary care. Although the ED is not typically considered to be a primary care setting, evidence suggests that primary care services are in fact delivered to certain populations of people in this setting, for example, Aboriginal people living in inner city areas (Ospina et al., 2006). This reality causes increased strain on EDs while at the same time, does not allow for adequate primary care delivery to this patient population (Richardson & Hwang, 2001; Richardson, Irvin, & Tamayo-Sarver, 2003).

As an experienced ED nurse, I have seen firsthand how the current ED system is not the most appropriate setting for PHC. The ED is a busy, crowded, and noisy environment. Also, patient care in the ED is prioritized by acuity. For example, a person entering the ED with multiple gunshot wounds is prioritized and seen first, while someone entering the ED with complaints of chronic back pain or anxiety can be expected to wait for many hours. Finally, when patients seek PHC in the ED, there is a lack of continuity of care with no follow-up appointments; patients are treated and then discharged.

Richardson and Hwang (2001) conducted a review of the literature regarding ED usage and access to care. They found the ED to be a unique health care setting which was open 24 hours a day, seven days a week and provided care to all those who came. It was also found that the usage of the ED was a function of: “1) The nature, severity, and acuity of the presenting complaint and 2) The patient’s experience and access to other health care settings prior to the ED visit” (Richardson & Hwang, p. 1030). Factors found to effect experience and access to health care settings other than the ED included educational, cultural, linguistic, psychosocial, environmental, or institutional factors. Based on the review, Richardson and Hwang found the ED functioned as a safety net for individuals who were socially disadvantaged and vulnerable to social inequities, while at the same time provided for primary care that was less than adequate.

Other studies have shown certain factors associated with an increased rate of primary care sought in the ED. These included: lack of a regular primary care professional, poverty, homelessness and transience (Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000). Koziol-McLain et al. explained “marginalized, socially stigmatized

persons may prefer the anonymity offered by the ED setting and others may find a one or two day delay in accessing primary care too burdensome once they made the decision to seek care” (p. 555). As past studies have shown, people who tend to be marginalized due to social inequities continued to come to the ED for primary care regardless of overcrowding or length of waiting time.

Gaps in the Literature

To date, little has been written on Aboriginal women’s health and access to health care in an urban setting (Browne, McDonald, & Elliott, 2008). As noted earlier, Browne and Fiske’s (2001) study examined First Nations women’s health care encounters in Northern British Columbia. This was an excellent study that provided rich and detailed descriptions of First Nations women’s experiences in accessing health care. However, the participants of the study were from a small town in Northern British Columbia and the results that were gathered are therefore not directly applicable to the urban setting. Although the study by Benoit et al. (2003) examined the health care needs of Aboriginal women living in an inner city area, it did not address health care access through the ED. Some studies have been conducted regarding populations of people that tend to be marginalized by structural inequities in society who access the ED for their primary care needs, however none of these studies specifically addressed the aboriginal population. Notably, little has been published in this field of study specifically from the perspective of Aboriginal women in urban areas. This thesis addresses these gaps by looking specifically at urban Aboriginal women’s experiences of accessing primary care through the ED.

Summary

I began the literature review for this study by providing a background to the socio-historical context of many Aboriginal women's lives, followed by their current state of health and a discussion of the trend to urbanization to the core areas. Next I addressed the challenges of accessing health care services and finally the gaps noted in the literature.

In the following section I will provide a brief outline of the primary study from which this study was generated. I will begin by presenting the primary study's purpose, objective, design, and sampling plan, followed by the secondary analysis.

CHAPTER THREE: DESIGN AND METHODS

In this Chapter, I begin with an overview of the design and sample plan of the primary study from which this study originated. Next I then provide a detailed description of the approach to secondary analysis. Following this, an explanation of the theoretical perspectives used in this study is provided and the methodology of this study described, including the data analysis, the rigour of the study and ethical considerations. The Chapter concludes with the limitations of the study.

Primary Study Overview

Design and Sample

The primary study was informed by critical and postcolonial theoretical perspectives and used a qualitative, ethnographic design. Ethnographic research methods are borrowed from the field of anthropology and study the processes of cultural behavior (Thorne, 2000). Nurses and others in the health care field often use ethnographic methods to reveal how “different cultural and social groups understand and enact health and illness” (Thorne, p.69). The setting for the study was a downtown hospital ED in an urban setting. Purposeful and theoretical samplings were used to obtain participants for the study. Inclusion criteria for patients to be interviewed were (a) self-identification as Aboriginal, (b) age 18 or over, (c) ED triage classification as stable and non-urgent, and (d) no known cognitive impairment. Patients who entered the ED with serious health concerns who were rated on the triage scale as a 4 or lower were excluded from the study (5 being least urgent and 1-0 being extremely urgent or near death). All interviews took place within the ED. The data collection process used participant observation and in-depth semi-structured interviews to obtain a total of 44 interviews. Some of the questions

asked of the participants were as follows: Is this your first time in the ED?, We are interested to know where people choose to go for health care. Can you tell me about what led you to come here for care?, Some people have difficulty getting the health care they need. How has it been for you to get the care you feel you need?

After the study began, it was decided that data would also be gathered from non-Aboriginal patients in order to provide a comparison with the Aboriginal patient's experiences. Twenty-four males and 20 females were interviewed. Of the 44 interviews, 10 were with non-Aboriginal patients. The age range of the participants was 20 to 59 years. Approximately 70 percent of the participants were living on either social assistance or disability assistance or had no income at all and lived on the streets. Data analysis for the project occurred concurrently with data collection. Interpretive thematic analysis guided the analysis and a computer software program called NVivo was used to code the data.

Secondary Analysis

To answer my research questions, I used the technique of secondary analysis. Qualitative secondary analysis has been growing in popularity in recent years. It involves additional analysis of existing data for the purpose of readdressing the original research questions with different techniques, or for answering new research questions (Heaton, 1998). In this thesis, I asked more specific questions of the data set than was done in the primary study. I also worked in conjunction with the primary study researchers as well as members of the primary study research team. This collaboration allowed for consultation and a crosschecking of my results, which Heaton describes as being an essential component to secondary analysis.

Secondary analysis offers a variety of advantages. It helps to maximize the usage of primary data, cut the high costs of qualitative research collection, and saves time (Szabo & Strang, 1997). In addition, secondary analysis can lend support to existing theories and provide a wider usage of data from difficult-to-access respondents (Heaton, 1998). It also may decrease the burden upon participants to talk repeatedly about sensitive and emotional issues (Szabo & Strang), which it likely did in this case of this study.

Theoretical Underpinnings

As I began this research, I was initially drawn to the use of a gender-based analysis to help focus my gaze of the women's experiences seeking health care in the ED. Implementing such an analytic tool, I initially believed, would help to analyze the social context of the women lives and examine the impact it played on their health and access to health care. What I soon realized, however, was that a gender-based analysis does not look specifically at the factors among and between women's lives, such as history, class and race. The limitation, therefore, of a sex and gender-based analysis is that it overlooks neocolonial policies and practices (Wolski, 2007), which was needed when addressing the experiences of the women in the study.

Postcolonial-feminist theories.

Postcolonial-feminist theories provided a more relevant perspective for analyzing the women's transcripts. The use of postcolonial-feminist theories, which have been increasing among nursing researchers, arise from postcolonialism, a family of theories that share a concern for the effects of colonialism (Browne, Smye, & Varcoe, 2007). These theories address power relations and colonialism, making them relevant in

understanding the health and access to health care of Aboriginal peoples (Browne, Smye & Varcoe, 2005). Browne et al., (2005) explain, postcolonial theories “provide a powerful analytical framework and vocabulary for understanding how health, healing, and human suffering are woven into the fabric of the socio-historical-political context” of people’s lives (p. 19). Postcolonial theories are not just applicable to specific populations, which may be vulnerable to structural inequities in society. Anderson (2004) argues that “postcolonial theories are relevant to all; there are no spaces that are not colonized; the racializing gaze is fixed upon all of us” (p. 239).

One critique of postcolonialism, however, is that it does not provide a gendered lens (Anderson, 2004; Browne et al., 2007), which is essential when addressing the health needs of Aboriginal women. Therefore, some scholars have added feminist theories to postcolonialism to ensure gender is taken into account as an intersecting factor (Anderson; Browne et al., 2007). “Postcolonial-feminist theories bring to the forefront the issues of ‘race’, and how this socially constructed category intersects with gender, culture, and class to structure human relationships” (Browne et al., 2007). Postcolonial-feminist theories therefore provided an appropriate perspective from which to approach the study. This perspective helped to take into account the socio-historical positioning and colonization situating the women’s lives in the study, acknowledging the multilayered sociopolitical context affecting health and access to health care. In keeping with a postcolonial feminist perspective the notion of culture was applied from a critical perspective.

A critical cultural perspective.

Frequently in health care, the concept of culture is applied narrowly and the significance of power relations are diminished (Browne & Varcoe, 2006). When this occurs, culture is trivialized and attention is focused only on traditions that differ from the dominant norm. Attention is turned away from the webs of social and political influences that also compromise culture (Doane & Varcoe, 2005). In addition, Doane and Varcoe explain “ with a narrow understanding of culture, broader contextual issues are overlooked, and at the same time, problems that arise from those broader contexts are associated with the culture of the individuals” (p. 305). Ultimately, this can lead to the misguided implementation of nursing care, which borders on exclusionary practice and discrimination. A critical approach needs to be taken when addressing the concept of culture while engaging with patients in order to prevent care based on stereotypes and assumptions (Browne & Varcoe).

In this study, as well as in the primary study, culture was conceptualized as extending well beyond notions of cultural beliefs and practices. Smye and Browne (2002) explain,

although descriptions of cultural characteristics and practices can be useful to health care practitioners and researchers, they can also reinforce stereotypes and simplistic views of particular ethnocultural groups as outsiders, as different, and as ‘other’. (p. 45)

The way culture was defined in this study took into consideration of how race, class, and gender intersect, and was conceptualized as being embedded in a historical and socio-

political context. In keeping with a critical cultural perspective, cultural safety was used as an analytic lens.

Cultural safety.

Cultural safety, with its origins in New Zealand, was developed by Maori nurse leaders and educators to address the colonial effects the indigenous Maori suffered in terms of decreased levels of health and inequities in health care access (Ramsden, 1993; 2000; Anderson et al., 2003). Cultural safety provided an alternative to cultural sensitivity, the culturalist discourse in health care at that time. Cultural sensitivity was limited in that it dealt exclusively with cultural differences—thereby promoting stereotypes and reinforcing notions of *other* (Browne, Smye, & Varcoe, 2005; Papps & Ramsden, 1996; Smye & Browne, 2002). Cultural safety provided a new way of working with patients who were culturally different from the dominant population in the health care setting; an emphasis was placed on power imbalances and institutionalized racism in the health care system, while incorporating postcolonial perspectives into nursing practice and education (Browne, Smye & Varcoe). Implementing notions of cultural safety helps the practitioner reflect on his/her own social, economic, and political positioning in relation to the person or group with which he/she is working. The researcher must acknowledge that he/she is a bearer of culture (Ramsden, 2000) and how his/her assumptions affect relationships with research subjects. Though cultural safety was developed in New Zealand, this framework remains appropriate for Canada's health care setting, as neo-colonial policies and practices remain embedded within both health care systems (Smye, Rameka, & Willis, 2006).

To summarize, this research implemented postcolonial-feminist theories, a critical culture perspective and cultural safety to critically explore the social contexts and influences that led Aboriginal women in this study to come to the ED for stable and non-urgent issues and also examine their experiences once at the ED.

Methodology

Interpretive Description, a Methodological Approach

I used the methodology of interpretive description (Thorne et al., 2004; Thorne, 2008), as a guide for organizing the analysis of the study. The purpose of using interpretive description is to capture themes and patterns from subjective data with the goal of providing a clinical understanding of the ideas and concepts being studied (Thorne et al.). This methodology is usually used with a small sample size and with data, such as participant observation in-depth interviews, that are obtained from a variety of collection methods. The process of interpretive description involves,

carefully navigating within and beyond the original and theoretical scaffolding (or the analytic framework with which one entered the investigation) in order to fully engage the processes of inductive reasoning, including testing and challenging preliminary interpretations, and conceptualizing an ordered and coherent final product. (Thorne et al., p.9).

Interpretive description borrows from a wide range of analytic process “recipes” (Thorne, 2000; Thorne et al., 2004). The general format involves “comprehending the data, synthesizing meanings, theorizing relationships, and re-contextualizing data into findings” (Thorne et al., p. 11). Ultimately, it is the researcher and not the recipe that is fundamental to the findings (Thorne et al., Thorne, 2008). Normally, the stages of

analysis do not proceed in a linear fashion but move back and forth between data analysis and collection (Thorne et al.). Fortunately, as this was a secondary analysis and the data had already been collected, I was able to communicate with researchers involved with the data collection while I conducted my data analysis in order to confirm my findings.

Data analysis.

I began the data analysis process by briefly reviewing all 44 transcripts from the primary study, including all Aboriginal and non-Aboriginal women and men. With consultation from the research team, I decided to analyze a subset of the transcripts, which consisted of all 13 Aboriginal women who participated in the study. I chose to focus on these transcripts alone because my research interest was that of Aboriginal women's access to health care. Though it would have been interesting, analyzing more transcripts other than those from Aboriginal women may have become too complex of a task.

Once it was decided I would focus solely on the 13 women, I reread the women's transcripts more thoroughly and listened to the taped transcripts— giving me a better feel for the interviews as I had not participated in the data collection process. As I read and listened to the transcripts repeatedly, I did not do any coding. From this, I was able to form my first impressions of the transcripts and understand the interviews as a whole (Thorne, 2008). Thorne et al., (1997) recommend immersion with the data prior to coding when following the interpretive descriptive method, which I employed to best supplement the theorizing process. In addition, listening to the taped interviews enabled me to get a sense of the intonation and to hear particular pauses that may have been indicative of emotion, thinking processes, emphasis on ideas, etc. It also allowed me to

check for any errors or omissions that were made during the transcription process, and provided a depth and meaning to the interviews that transcribed verbatim could not supply, which Weber also provides as reasons for listening to taped interviews (1986). I tried to examine the transcripts with a naive approach and constantly questioned what I was reading. However, as Thorne (2008) writes, “as open-minded as we believe ourselves to be, we are already hardwired for highly selective organizing and sorting into what counts as meaningful” (p.142). My committee assisted me to reflect on my assumptions, as I found it hard at times, being an ED nurse and coming into this study with my own preconceived notions. For example I initially found it hard to ask the question of why some of the women in the study were coming to the ED repeatedly without forming my own opinions as to why they came. There was a large amount of data that I needed to sift through and one way I did this was by asking specific questions such as: What were the circumstances that led the participants in the study to obtain care in the ED?; What was it about being women that made them obtain care in the ED?; What were their experiences with health care once they got to the ED?; Were the participants aware of other health care resources?; What other health care resources were available to the women?

After immersing myself in the data and getting a feel for the interviews as a whole, I began a general coding method for grouping my first impressions. Coding involves breaking down the data and comparing similarities and differences. Thorne et al. (2004) recommend avoiding “line by line coding” and believe it is better to move “in and out of the detail” in order to “focus on and engage in intellectual processes that are the cornerstone of qualitative data analysis” (p. 14). Concepts and ideas are grouped together

into similar categories where they can be linked and contrasted (Strauss & Corbin, 1998). While looking for specific reoccurring statements, thoughts and ideas, I wrote my initial, broad based codes (Thorne, 2008) directly on the margins of each transcript. Some of the codes I found consisted of: a history of violence, experiencing current violence, racializing experiences in the health care setting, and disconnection from children and family. At this point I did not worry about comparing the codes of the transcripts but coded each transcript independently from one another. I also wrote an in depth summary of the social circumstances of each woman's life which would provide important context to their health care experiences.

At the next stage I met with my thesis committee to review my initial codes and plan for a way to organize them. My committee suggested I make a large chart with three columns entitled: observational notes, corresponding analytical notes, and theoretical notes. Under the heading of observational notes, I formed a box for each woman, and in it I placed the summary of her social circumstances and the codes found within her transcript with the corresponding transcript page numbers. This allowed me to see if some of the codes were reoccurring throughout the transcripts. Codes that I found repeatedly for example, were those pertaining to disconnection to children and family. Under the heading of corresponding analytical notes I described initial and analytic impressions, reflexive comments, and insights in relation to the codes found for each woman. For example, under observational notes for one woman I listed the code disconnection from children and family. Under the heading of corresponding analytical notes for the same woman I wrote, "this woman had a number of children, with two in the care of a family members but does not mention where the others are. Must be very

painful and difficult for her to talk about. Maybe they are in foster care?” Under the heading of theoretical notes pertaining to the same woman, I then linked and tracked ideas from the literature that related to my observations of the data and analytical hunches. For example, I listed the reference of Jacobs and Williams (2008) and drew attention to their description of how the numbers of Aboriginal children currently in care has risen dramatically from the past. This chart was a constant work-in-progress. Since it was on my computer I could add things as I went—dating each of the changes made. I found this charting process was a great way to bring clarity to my analysis, especially as I started by feeling overwhelmed as a first time researcher.

Upon completion of the coding chart, I made a colour-coded graph depicting the frequency of the codes, allowing for easy visualization of how frequently each code appeared in the transcripts. Some of the most frequently appearing codes were: history of violence, current violence, experiences with pain, disconnection to children and family, and racializing experiences in the health care setting. After I had completed my colour-coded chart, I met with my two faculty supervisors to review both the chart and the colour-coded graph. I was given feedback and reminded to keep analyzing the transcripts informed by postcolonial-feminist perspectives, while using cultural safety as an analytic lens to help shift my gaze towards the historical and power dynamics that affect the women’s health care experiences.

Next, I formulated larger categories or themes as groupings for the codes and placed multiple codes in each theme. For example I did this by grouping the codes consisting of, history of violence and current violence together to form an experiences with violence theme. Themes are defined as units derived from patterns such as

"conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs" (Taylor & Bogdan, 1989, p.131). Themes are sometimes identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). I developed a number of preliminary themes to group the coding into and met with my thesis committee for further discussion. From here I was instructed on how to structure themes and collapse some of the sub-themes into findings. For example, experiences with violence was changed to seeking help against a backdrop of violence and trauma and became one of my central themes.

The final phase of my data analysis consisted of recontextualizing the data into findings (Morse, 1994). It is during this process that published literature was consulted to compare and contrast the newly formulated theory from the research. This is the point at which advances in knowledge and theory developments are made. I met with my committee on numerous occasions to critically reflect on developing my findings section. The process included writing, reflection, and rewriting repeatedly. The final result was the identification of four central themes which included: needing a safe place to live, negotiating pain management, seeking help against a backdrop of violence and trauma, and the awareness of how one will be *read* during health care encounters.

Ensuring Rigour

Rigour in qualitative research is an essential component in the development of the trustworthiness of the research findings. There are a number of variations on how to assess the trustworthiness of research, however the framework developed by Lincoln and Guba (1985) was used in this study. Accordingly, there are four general criteria necessary

to ensure trustworthiness in qualitative evaluation: credibility, applicability, consistency, and confirmability. Each area is evaluated using specific criteria tests to enable trust in the study (Szabo & Strang, 1997).

Credibility refers to research that was subject-oriented, not researcher defined (Sandelowski, 1986). In this study, credibility was obtained through journaling my thoughts and feelings after each transcript in order to attempt to prevent my personal opinions from affecting the research process. Applicability is the criteria concerned with transferring findings to other contexts or settings. Applicability of the current findings were confirmed and validated by members of the primary research team. Since I was not able to directly confirm or refute the themes and ideas that emerged from the data with the study's participants, I did so with the primary research team who were experienced in the area of Aboriginal women's health. Consistency refers to the study's ability to generate similar findings. Consistency in this study was maintained by using the same guiding questions and approach – from the primary data collection interview and using an audit trail that included an in-depth recording of the research process – for this study. Confirmability refers to research procedures and results that are free from bias. Lincoln and Guba (1985) suggest the researcher identify personal biases by memo writing and reflection with other researchers to increase confirmability in their research study. Confirmability in this study was maintained by keeping an audit trail, which included an in-depth recording of the research process by way of personal journal and maintaining notes regarding my methodological choices (Szabo & Strang, 1997). This practice allowed myself to reflect more critically on the research process and enable the research findings to come out of the data and not from personal bias (Szabo & Strang).

Ethical considerations

There were several factors to consider when addressing the ethical concerns of the thesis: informed participant consent, the primary study's researchers' approval, and approval from the UBC ethics review board. First, the primary study's researchers obtained informed consent from the participants. Second, I obtained approval for a secondary analysis from the primary researcher as well as the entire working team, including all Aboriginal and non-Aboriginal researchers as well as the Aboriginal leaders involved with the project. Third, approval was obtained from the University of British Columbia Behavioral Research Ethics Board with specific attention to research with Aboriginal populations. There are a number of important ethical considerations in relation to the history of research with Aboriginal people. I followed several documents that outlined the principles and protocols used in such research. The Four Rs model (Respect, Relevance, Reciprocity, and Responsibility) of Kirkness and Barnhardt (1991), adapted by BC ACADRE (see Archibald, Jovel, Vedan, & McCormick, 2006) was followed in this study, along with the National Aboriginal Health Organization (NAHO) principles of ownership, control, access and possession (Schnarch, 2002). My study enacted the protocols, using the Four Rs model guidelines:

- 1) Respect (towards health science knowledge that contributes to Aboriginal community health and knowledge): This study has the potential to contribute to the health and well-being of Aboriginal women living in the urban setting by suggesting ways to ensure appropriate, safe and effective care and thereby reduce the inequities in access to health care.

2) Relevance (to culture and community): The documented literature revealed that the study of access to health care for urban Aboriginal women was relevant due to the current health and access to health care inequities some Aboriginal women in the urban setting face.

3) Reciprocity (accomplished through a two-way process of research and learning exchange): I hope to present my findings to a variety of audiences including Aboriginal organizations, health care organizations, policy makers, and health authorities. I also hope to produce a number of journal publications resulting from the findings of the study. Importantly, Aboriginal co-researchers from the primary study will help with the dissemination process.

4) Responsibility (empowerment fostered through active and rigorous engagement and participation): The primary study, from which this study drew on, involved dialogue between Aboriginal and non-Aboriginal team members, as well as Aboriginal community stakeholders.

Another ethical concern is the importance of the increased indigenization of the research process. This study drew on a primary study that consisted of both Aboriginal and non-Aboriginal researchers. Dion Stout et al. (2001) encourage an increase in the number of Aboriginal women engaging in the research process in general, specifically related to Aboriginal women's health issues. Increased participation will allow for more Aboriginal control over the research process and will help address the many weaknesses and gaps that currently exist in the area of Aboriginal women's health and access to health care. In addition, as a woman of Aboriginal ancestry, I take great interest in the

research process. It is my privilege and pleasure to have the opportunity to conduct research on a topic that I find important and which is close to my heart.

Limitations of the Study

To begin, the first limitation to the study was my inexperience as a researcher. As I began, I found the research process overwhelming as I read through most of the 44 transcripts from the primary study. The most challenging aspect for me, though, was the data analysis process. It was difficult trying to ensure I was analyzing the data through a postcolonial feminist perspective while using cultural safety as an analytic lens. However, my thesis committee continually provided support and reassurance to keep my data analysis moving forward.

Second, the act of conducting a secondary analysis was a limitation in itself (Szabo & Strang, 1997). As the data collection had long been completed, I was unable to ask the participants questions that came to mind while listening to or reading through the transcripts. I was fortunate, however, to have continued contact with the research team throughout the analysis process to answer questions or provide clarification to the transcripts. Next in Chapter Four I discuss the major findings of the study organized under four central themes: needing a safe place to live, negotiating pain management, seeking help against a backdrop of violence and trauma and the perception of discrimination and the awareness of how one will be *read* during health care encounters.

CHAPTER FOUR: FINDINGS

In this chapter, I describe the major findings, providing insight into the complex issues surrounding the participant's experiences seeking health care in an urban setting. Given the first research question guiding the study, what are the social contexts and influences that lead some Aboriginal women to seek care in an ED for health concerns that are triaged as stable and non-urgent? the analysis revealed three central themes common to most of the participants in the study. These themes were: 1) needing a safe place to live, 2) negotiating pain management, and 3) seeking help against a backdrop of violence and trauma. Under the second research question, what are the tensions that some Aboriginal women experience when they come to the ED? an analysis highlighted one central theme: the perception of discrimination and the awareness of how one will be *read* during health care encounters.

Before I begin this chapter, I would like to emphasize that I feel honored and privileged to have read and listened to the women's stories. As this study is a secondary analysis, I unfortunately did not have an opportunity to meet the women first hand. Yet by reading the women's stories repeatedly and then listening to their taped interviews, I felt as if I knew the women and consistently found strength and courage in all of their accounts.

The following is an analysis of in-depth interviews conducted with 13 women who self identified as Aboriginal that came to the ED seeking care. These excerpts provide a window into the social context of the women's lives, and how those contexts influence access to and use of the ED.

It is important to recognize that the women in this study were not directly asked to discuss the social contexts of their lives during the interview process. The women told these stories without any prompting. This was important for two reasons:

- 1) The issues surrounding the social context of their lives likely had a great impact and that is why they felt the need to tell the researcher.
- 2) The social issues could not be separated from the women's health care experiences.

Therefore, organized under the heading of question one, I begin with a brief description of the socio-demographics of the women's lives and then move onto the first central theme of the study, needing a safe place to live.

Social Influences on Aboriginal Women's Use of the ED in this Study

Thirteen transcripts were analyzed for this study from women who self-identified as Aboriginal (see Table 2 - appendix B). This included nine status women, three non-status women and one Métis woman. The average age of the women was 41 years (range:19-58). One woman was HIV positive, another was Hepatitis C positive, and a third was both Hepatitis C and HIV positive. Five of the women were explicit about their current or past substance use. Out of the 13 women, all but one had her own family doctor.

The socio-demographic characteristics of the women's lives were similar. The education level of the women in this study ranged from grade seven to some post secondary school. However, the average grade attained among the women was grade ten. Four of the women in the study had some post-secondary education and were all employed full-time. On the other hand, the other nine women in the study, without a post

secondary education were unemployed. The same nine women also lived in profound poverty in low-income neighbourhoods in the downtown core.

Needing a Safe Place to Live

The majority of the women in the study who resided in the inner city lived in single room occupancy housing (SROH) which were commonly infested with rats, bedbugs, and lice. According to a study by Benoit et al., (2003), SROH in the downtown core consist of:

...12' x 9' rooms, which can cost up to 65 percent of a person's monthly social assistance money. Slum hotels tend to lack even the basic amenities, such as a refrigerator, stove or private bathroom, security, privacy and safety. Such hotels often serve as shooting galleries for drug users, while 'crack' cocaine, heroin, and prescription drugs are routinely sold and used openly on the streets below.(p. 823).

Three of the participants who were not living in SROH were staying in shelters at the time of the interview, including the youngest women in the study. Previously, this woman had lived in foster care but had had herself removed due to "all the moving around" (P11).⁵ While in care, she sometimes had to move homes every two weeks. The other two women were residing in women's safe houses at the time of the interview. Both were in the process of leaving abusive relationships and were in hiding. The realities of the women's lives were supported by recent literature that has shown Aboriginal women report higher rates of spousal violence and more violent acts including being beaten, choked, having a gun or knife used on them and being sexually assaulted as compared to non-Aboriginal women (Native Women's Association of Canada, 2007b).

⁵ All participants were assigned a number in the study. (P11) refers to the number assigned to the participant the excerpt was taken from.

Violence against Aboriginal women is a major social determinant of health (Amnesty International, 2004; Browne et al., 2008; Dion Stout et al., 2001, Native Women's Association of Canada, 2007b). Violence was a predominant theme in the lives of many of the women in the study; six out of the 13 women described experiencing violence and abuse as children. Four of the women described the continued violence they faced as adults. As discussed later in this chapter, the ongoing violence that many of the women experienced significantly impacted where and how they sought health care.

A number of the women in the study were removed from their birth families as children and placed either in residential school or foster care. Some had experienced a complete disconnection with their families: "I was raised in foster care, so up until this past year I did not know I had any living relatives...until my sister found me..." (P10). The women portrayed their experiences in care with a sense of loss of family, culture and traditional values, experiences that are supported by recent literature (Jacobs & Williams, 2008). Many of the same women also described the abuse they often experienced while in care, as one woman explained, "I was raped by a white man...while in foster care" (P5). Another woman described being beaten by a tennis racket for vomiting in her bed when she was ill as a child in a residential school. Government policy supported the extensive removal of Aboriginal children from their families and communities when it was made illegal for parents to keep their children out of residential schools beginning in 1920 (Armitage, 1995; Kelm, 1998). Research has shown that these past government actions caused a disrupted sense of self, also evident in the women's stories (Jacobs & Williams).

As a result of being raised in residential schools or bounced from foster home to foster home as children, many of the participants lacked life and parenting skills and had lost custody of their children; many of their own children were in foster care at the time of the study. According to Jacobs & Williams (2008), the number of Aboriginal children currently in care has risen dramatically from the past. Social factors, including lack of education, poverty, violence, and a disconnection from family and community intersect to negatively impact the health of the women in the study.

On a more positive note, almost all of the women spoke about the importance of elders in their lives. Many described how elders had, in some cases, served as their only source of companionship and support. In the following interview excerpt, a participant speaks about her support system:

Through the smudging of the elders in [name of the downtown core] and a few of the elder's homes...I attend as many Pow Wows as I'm able to get out to... (P10).
For other women, elders served as counselors when things got tough, as was the case for one participant after she described having been attacked by a man in her SROH, she said;

I go see a native elder once a month...but now that this happened to me, I'll probably go see her once every other day because she tells me to come anytime right ... (P5).

In this section, I described a number of intersecting factors that negatively impacted the participant's lives and their access to health care including poverty, violence, and a disconnection to family. Yet despite these constraints, the women's lives were also shaped by sources of strength and resiliency, for example as they found when they accessed support and the companionship of elders. Next, I describe the second

central theme in the study in relation to a number of the women's attempts at seeking pain relief in the ED.

Negotiating Pain Management

A number of the women in the study sought help to manage the effects of pain. Because of the complexity of this theme, stories will be used to illustrate how four different participants attempted to seek help at an ED.⁶ The analysis begins first with *Darlene's* story, an Aboriginal woman, who attended the ED for a rash and flank pain.

Darlene is a 38-year-old non-status First Nations woman who has four grown children, a grade 12 education, and is currently unemployed. She described being sexually abused as a child, which led later to a diagnosis of post-traumatic stress disorder (PTSD) and was receiving counseling at the time of the interview. Darlene is severely immunocompromised. She is HIV positive with a "very low CD4 count," Hepatitis C positive, and is without a spleen as a result of a previous accident. She is also "17 days clean" from injection drug use. Darlene described the progression of her pain that prompted her to come to the ED:

I have a bit of a rash that started coming up about a week ago and it gets itchy and I scratch and they break open and they were spreading and now they're getting sore and right beside my spine, on my back there, there's a sharp pain a couple of days ago and now its spreading all through the side flank and in the last twenty-four hours, especially well since this morning its been swelling up and its getting more painful it seems from the waist down (P9).

⁶ In the following examples, pseudonyms have been provided in order to protect the participants. These pseudonyms however, have been made by no means to objectify the women. In addition, biographical details have been changed to preserve confidentiality.

As an emergency room nurse, I know that someone with a drug-use history like Darlene is often seen as *drug seeking* in the context of emergency room interactions, especially when they present with pain, as shown in other studies (Brooke, 2005). In these situations, patients sometimes have their complaints of pain minimized or are not taken seriously by staff. However, Darlene's health history, pain, as well as open lesions would need to be investigated thoroughly as the outcome could be profoundly problematic or catastrophic in that she is profoundly immunocompromised and could subsequently die.

Darlene has been to this ED before, "I was in because my ex kicked me in the head." This example illustrates the complexity of Darlene's life that brings her to the ED frequently. She lives with extreme violence in her life and described "living in fear." She noted that her ex-boyfriend "stalked" her. She is currently fleeing the relationship and is living in a safe house. As an Aboriginal woman living in poverty and using drugs and alcohol, Darlene is extremely vulnerable to violence. This finding is in keeping with other literature that also describes Aboriginal women's increased risks for violence (Dion Stout, 1997; Dion Stout et al., 2001; Royal Commission on Aboriginal Peoples, 1996).

Upon reflection on the transcripts as a whole, it was apparent that for Darlene coming to the ED for pain relief was essential and legitimate. She was aware of how weak her immune system was and took the pain she experienced seriously because it could signal something more troubling. Darlene chooses to access this particular ED because of the health care professionals' knowledge regarding HIV. This is a place she trusts and values the staff's expertise, as described by Darlene: "if I have a choice I always come here... they have a lot of staff that deal with HIV and hepatitis all the time." Darlene's experiences seeking care at the ED will be revisited later in the analysis.

Next is the story of an Aboriginal woman who attended the ED for acute left leg pain. *Anne* is a 47-year-old Métis woman who is Hepatitis C positive and currently lives in the inner city. She had been in eighteen different foster homes by the time she was sixteen. Anne has faced many challenges in her life. For example, in the following excerpt she explained what happened once the government relinquished care of her:

I just travelled ... I was just a lost wandering girl for many, many years ... I got lost in the drugs and the sex trade and the alcohol and the marital abuse and relationship abuse and self abuse (P10).

Another challenge faced by Anne is that she lives with a disability. She was born as an only surviving twin, with internal and external “body deformities and malfunctions” leaving her with no use of her right leg. Anne has now come to the ED unable to weight bare on her only “good” leg. For Anne, not being able to move her left leg is a worry. For example, in the following Anne described a situation related to her concerns:

... My partner tried to help me out of bed because I was so distressed ... I got really frantic by one o’clock this afternoon ... I thought I had better go to see what was going on... (P10).

Anne lives in profound poverty in the inner city in single room occupancy housing (SROH), where most lack elevators and, if they do, they do not work, making it impossible to leave her residence if she could not get around by foot. She lives with real anxiety about the possibility that she may be stranded in her hotel room if she loses the use of her left leg. Anne did not choose to attend the ED for her leg pain; she had

initially gone to a walk-in clinic in the downtown core, but was referred to the ED after being assessed by a doctor in the clinic. She was sent to the ED by way of Saferide.⁷

Although Anne presents to the ED with pain, the social context of her life must also be taken into consideration. Anne's experiences of disability and poverty leave her with a decreased level of health and access to health care. However, not all of the women in the study who sought help at the ED were severely marginalized by social inequities in society. Next is a story of a woman who because of her social status as a middle class woman has somewhat different reasons for coming to the ED.

Lora

Lora is a 30-year-old status First Nations woman who grew up on a reserve in Western Canada but now resides in the city. She has a college education and is employed full-time. Lora's presenting issue to the ED was a sprained ankle that occurred at work. She was brought by ambulance and felt it unnecessary to be at the ED for this complaint. In the following, Lora described her concerns:

... I'm constantly thinking about the amount of money that's being spent just for me to be in the emergency for an ankle, you know, but there's nothing I can do I, you know, couldn't protest to my employer... (P8)

It is the first time Lora has been to this ED and most likely would not have come if her employer had not insisted. Lora has presented with a work-injury complaint; in keeping with expectations of some ED health care professionals, and as a middle-class woman,

⁷ The Saferide Program is "a free mobile response unit dedicated to providing safe transportation, within the healthcare system, for clients with alcohol and drug problems who are seeking relief from their addictions. The two types of calls Saferide responds to are: emergency and non-emergency transportation (shuttle) requests." (Vancouver Recovery Club, 2008) It has been my experience, however, that Saferide is used by the healthcare staff in the ED to expedite discharged and intoxicated patients back to their places of temporary residence, usually in SROH in the downtown core.

Lora may be *read* in ways that preclude her from being seen negatively as some of the other women in the study, when she enters the ED. Lora's case example, in relation to her experiences with social work, will be revisited later in this thesis.

For other women however, the pain they sought help for in the ED was more complex in nature. The fourth story is from *Sharon*, a woman who came to the ED for back pain that was exacerbated by her ongoing mental health issues.

Sharon is a 50-year-old status First Nations woman who has a grade 12 education and is currently unemployed. She denies any drug or alcohol use and has lived in the inner city for over 35 years. Sharon attends the ED on a frequent basis. In the following interview excerpt, she described how the triage nurse confronted her about this: "I had one nurse say this... 'You know how many times you've been here?'...I said no... 'She said 33 times'...and I said well today is the 34th" (P1). Sharon came to the ED on this occasion for the treatment of back pain. She had been mopping the floor and slipped, landing on her back. However, she has also come to the ED on other occasions for "frequent flare-ups" of her asthma.

After reviewing the transcripts, it became apparent that Sharon's back pain may have been made worse by chronic anxiety, possibly related to residential school experiences of physical and mental abuse. This finding is in keeping with other literature that describes the possibility that many Aboriginal people suffer from trauma related disorders due to:

long standing stress in the form of suppression of traditional lifeways, dislocation of whole communities, and childhood separation from families with virtual incarceration in residential schools (Kirmayer et al., 1993, p. 26).

Sharon was able to recount many traumatic events throughout the interview: “The principal noticed that I wasn’t paying attention so he told me to go to his office ... and he took his belt off and he strapped me” (P 1). Although Sharon lived in an era where children were punished, often severely in the general school system, abuses in residential school were exacerbated by the forced removal of children from their homes and from the support and love of their families and community.

Sharon explained in the interview that she was referred to counseling services at the hospital as a result of her numerous visits to the ED. In the following she described how this process occurred:

... I didn’t understand what was going on with myself ... They got one of the doctors or nurses to come and talk to me and asked me if I could see a psychologist to find out what was really bothering me and it had mostly to do with residential school ... I had very bad anxiety...(P1).

The above excerpt points to the importance of linking the social context of people’s lives to their health and access to health care. The association between Sharon’s history and her presenting complaints were revealed in light of the extent to which she uses the ED.⁸ This can be shown in relation to why Sharon keeps coming back to the ED in that abuse, history, and colonization played a major role in leaving her with inequities to health and health care access.

Seeking Help Against a Backdrop of Violence and Trauma

As described throughout this study, and in keeping with recent literature, (Dion Stout et al., 2001, Native Women’s Association of Canada, 2007), violence affects a

⁸ At this time, there is only one clinic in the city that *explicitly* deals with the issue of PTSD/complex trauma, “The North Shore Anxiety Stress and Anxiety Clinic” (personal communication, Vicki Smye, November 10, 2008).

disproportionate number of Aboriginal women. After a repeated analysis, a third central theme in the data was related to the violence and trauma in a large number of the women's lives. To begin, I will present *Mary's* story.

Mary is a 39-year old status First Nations woman who was born to a heroin-addicted mother and raised in the foster care system in Eastern Canada. While in foster care in her pre-teens, she was raped by a "white man" and she described how the experience created "a whole lot of anger" in her towards "white people." After the rape, she ran away to live on the streets, became involved in criminal activity, and as a result spent much of her adulthood in prison. Mary has a grade 10 education and is currently unemployed. She has a total of nine children, seven living, including twin girls in the care of her sister. She did not elaborate on her other children's whereabouts. During the interview Mary also described the harsh life her siblings had endured. For example she explained that her youngest sister had given birth to nine children and also had been raped by her eldest brother.

At the time of the interview, Mary was actively using narcotics and smoking crack cocaine. Violence is the backdrop in Mary's life and the consequences of violence have brought her to this particular ED on many occasions, "... I've been here more than 20 times ... for street fights, mostly stabbings..." (P5).

Mary presented to the ED on this occasion as a result of being stabbed with a needle. Mary described being attacked by a man in her single room occupancy housing (SROH) and then stabbed by a hypodermic needle he had used. The participant was very concerned that she may have contracted HIV from this stab injury. During the interview

Mary told the researcher several times that she has been checked for HIV frequently and “was always very careful.”

Despite just being attacked in her SROH, she was thankful for where she lived, “it’s a nice hotel ...real home...which is not like living on the streets” (P5). Mary’s statement about her housing situation sheds light on the level of violence she must have experienced living on the street. Violence is often an everyday experience and/or a risk for many of the women living in conditions like Mary in the urban context (Dion Stout et al., 2001). Mary’s experience needs to be understood in the context of powerful intersecting and oppressive forces—she is a woman, she is impoverished, and she lives with substance use—all factors that increase her risks for experiencing violence.

As was the case with other women in the study, the ED was not Mary’s first choice; she would not have come to the ED if it was not needed. In the following, Mary shared her discomfort with accessing the ED:

... I don’t feel comfortable coming here ... I avoid coming here in a big way...like if I was dying I guess they would have to bring me here, I’d have no choice, no say in the matter...(P5).

Mary had initially gone to an Aboriginal women’s health and social service agency in the downtown core, hoping to obtain prophylaxis treatment for her needle stick injury. This is a place she accesses often, about two to three times per week. Mary likes the health care and support she receives there: “...I like it there in a big way, they help you out and they are very understanding and everything is confidential.” Mary’s GP (whom she likes) also works at the women’s agency one day per week, she shared: “...he’s a nice, good guy...he understands me and plus he listens to me and gives me good feedback.”

However, on this particular day, Mary could not get the proper treatment for her needle stick injury at the women's agency and was urged to seek care at the ED. She trusts the agency staff; it was this trust that eventually convinced her to go to the ED. After persuasion, Mary was driven by a woman from the agency to the ED for care. It is problematic that Mary would not have gone to the ED for care if she had not been encouraged and then driven by one of the women from the women's agency. This exemplar points to the importance of relational practice (Doanne & Varcoe, 2005) – where the professional works to build trusting relationships with clients and understands the client in the context of social and other factors that enable adequate health care access; this woman may not have gone to the ED without professional support given her situation.

Jane is another woman who came to the ED because of violence. Jane is a 39-year-old status First Nations woman who was in the midst of trying to leave an abusive relationship and was living in a safe house for women at the time of the interview. She has a grade seven education and is currently unemployed. She uses crack cocaine and has seven children with the five youngest in foster care and the eldest, who is 16, in jail. Jane came to the ED on the day of the interview to have pins removed from her wrist, pins which held her bones in place after they were shattered by her boyfriend.

Jane described how she lives in fear of her boyfriend: "... I don't even go out...and where I am he can't get in unless he sneaks in." Jane explained she has been in abusive relationships all her life. Many Aboriginal women interviewed in this study live in situations like Jane, situations of fear. The ongoing violence the women have suffered has had a powerful effect on their lives, sometimes making it difficult for them to venture

far from the places they feel safe. For Jane, right now, the safe house is the only place where she feels secure.

Similar to Mary, Jane also does not like coming to the ED and only comes if she has to because her experiences “have not been good...”. However, because Jane missed her scheduled appointment with her orthopedic surgeon regarding removal of the pins in her wrist, she was hoping she might have her pins removed in the ED. For women like Jane, hiding and living in fear, may make it next to impossible to keep scheduled doctor’s appointments. For Mary and Jane, the backdrop of violence shaped why they came to the ED.

The examples provided here point to the ways in which women’s access to the ED was mediated by the social context in which they live. Nurses and other health care professionals need to be critically aware of the complexities that exist in the lives of people who have been marginalized by structural inequities. At the same time, this is not to imply that all people who identify as Aboriginal are necessarily disadvantaged; many of the women’s lives in this study were also shaped by strength and resiliency. Next, I examine the fourth major theme of this study, the perception of discrimination and the awareness of being *read* during health care encounters, organized under the heading of question two.

Tensions Experienced in Health Care Settings

Although the study took place in a particular ED, the women did not talk exclusively about the ED. Without prompting, the women in the study also described other health care experiences they had with walk-in clinics, community health care centres and other EDs. The experiences the women described in the ED, reflected their

experiences in other health care settings as well, including discrimination, racism, and other marginalizing experiences. I begin this next section with the fourth major theme of the study.

The Perception of Discrimination and the Awareness of How One Will be *Read* During Health Care Encounters

A theme central within the majority of the participant's stories, as well within the stories from the larger primary study (Browne et al., 2009), was the perception of discrimination and the awareness of being *read* in particular ways by health care professionals in the health care setting. For example, some women questioned whether they had been treated differently on the basis of race. As one woman noted:

...I wound up in the hospital back in February and everyone talked about what great service they got there... and I got the crappiest service, and I was like...was it because of my colour? (P4).

For another woman, prejudice was very clear. She stated, "you can always tell when someone is prejudiced in the hospital...it's just by how they look at you and the way they talk to you like sharp..."(P1). In the same vein, another woman described her experiences seeking health care in a community based setting: "I went to (name of the place) and he said we welcome new patients so I made an appointment and as soon as I get there...we don't take you kind of people" (P6). Upon further reflection, the women in the study believed their negative health care experiences had been shaped by their Aboriginality and/or other intersecting social categories such as poverty, substance use, and the neighbourhoods in which they lived.

To further illustrate experiences of discrimination in the health care system, a number of stories will be presented. The purpose of discussing these are not to determine the *truth factor* in these claims, but rather to highlight the extent to which women felt they were perceived or treated differently. In the following interview excerpt, Darlene described how she believes Aboriginal people who use substances and are HIV positive receive differential care in the health care setting:

... Staff treat Aboriginal people a little bit differently especially if they're coming in and they're HIV because people assume you're still using drugs, they assume that's how you got it so its assumptions, its assumptions and personal treatment. I know like, because I got treated very well here, that's why I came back here and I'm not afraid to come here when I first start getting sick, I know that when I come here I'm going to get treated like a human being, not Native, not HIV, not this, not that, I'm not categorized, I'm just another person whose sick and needs help... (P9).

This excerpt is taken from a woman who is HIV positive, currently using substances, and according to the researcher's fields notes, *not visibly* Aboriginal. She acknowledges that differential treatment does occur to those that are visibly Aboriginal. For this participant, racializing experiences for those who are noticeably Aboriginal are made evident by the differential treatment they receive in comparison to herself.

Next follows another excerpt from the interview with Mary who described the care she experienced:

... They have attitude with me, like the last time I was here they had major attitudes, oh man, very rude...yeah I didn't like it at all and my feelings were hurt ... (P5).

Researcher: So why do you think they're "mean" to you?

...I don't know...because I am a drug addict...yeah, just that alone or I'm native... (P5).

Mary's personal experiences echo what Darlene said she had witnessed. Mary believed she had experienced discrimination and Darlene had witnessed it occur to others.

Ultimately, any perceived experience of discrimination in the health care setting must be acknowledged as it seriously affects the outcome of care.

Important to note as well, one woman believed she had experienced discrimination while the other did not. Yet, according to the field notes, neither woman appeared to be visibly identifiable as Aboriginal. What this helps to show is that people's perceptions and experiences in the health care setting vary tremendously. Women are being perceived across multiple factors differentially and women navigate those experiences differently based on personal resources, their past experiences, and social location.

Related to the above, a number of the women in the study described the awareness of being *read* in particular ways. Some women described how it was assumed by health care professionals they were intoxicated when they sought health care. The chances of being *read* as drunk or on drugs seemed more likely to occur if the women were also poor and from the inner city. In the following excerpt, one woman describes how she has come to expect assumptions when health care is sought: "As soon as you come in and they find out you are from the downtown core, the first thing that is thought about you is that you're a drug addict or a drunk" (P10). This finding is in keeping with what other researchers have found—Aboriginal people are often presumed intoxicated

when health care is sought (Browne, 2003; Kurtz, Nyberg, Tillaart, & Mills, 2008). To this day, one of the most colonizing stereotypes endured by Aboriginal people is that of the “drunken Indian,” (Furniss, 1999), one which still persists as demonstrated by this study.

Several of the women’s experiences further provided a window into the ways in which assumptions were perceived by the women in the study to be operating in the health care setting. In the following, Anne describes how her health care experiences changed once her social status changed.

...when I was here as Mrs. (her past married name) I got good treatment because I was on my husband’s health care...and he made a good living...(she was evidently living in another part of the city also) ...but as soon as I arrived here as Miss (separated name), on a social services disability pension, then there was a change of attitude...so being on assistance...gives you second class treatment because you get pigeon holed and stereotyped...you know I am honest enough to say that I have Hepatitis C...and the first thing they say is... when’s the last time you’ve used drugs?...well excuse me, its been proven that I’ve got Hepatitis C because of all the surgeries I’ve had in my lifetime (P10).

Anne believed she was *read* differently by virtue of how she was socially positioned. Research supports this that those who are Aboriginal, coupled with other social categories including class and history do experience inequitable access to health and health care access (Tang & Browne, 2008).

For Sharon, the health care encounters she disclosed in her interview were complex in that many factors intersected to affect the way she was *read*. Sharon too

believed she had been *read* as substance using: "...they assume you're drunk or on drugs and they better not come in here and say something like that to me, you know, cause I'm not on both..." (P1). She is angered by the assumption that she is intoxicated, as she does not have a history of nor is currently using any drugs or alcohol. As an Aboriginal woman living in poverty in the inner city, she may automatically be tagged with certain stereotypes as she enters the health care system.

Another factor affecting the way Sharon was *read* was her trouble with communication. As a patient, Sharon talks slowly and quietly and describes having difficulty talking with "authority figures." She relates her difficulties in communication to the years she spent in residential school:

...Being raised in residential school, you know you are always told to shut up and we didn't have an opinion about anything, you know so it was really hard for me to try to converse with doctors or anything... it affected the way I deal with authority figures... the reason we couldn't say anything was because they were the authority (referring to the staff at the residential school) so like now I have a very difficult time talking to my doctors (P1).

Sharon's experiences with communication are not uncommon among people who attended residential schools. In another study, First Nations women who attended residential school also experienced difficulties in navigating their way throughout the health care system (Browne & Fiske, 2001). The difficulties experienced were due to a lack of assertiveness that was encouraged by residential school staff to promote conformity.

Yet, there was still another factor that may have influenced the way Sharon was *read* when she accessed the ED. Sharon is someone who frequents the ED regularly. As an ED nurse, I know that Sharon would be labeled as a “frequent flyer,”⁹ as a woman who attended the ED over 33 times and may be *read* as a patient who possibly may not have a legitimate presenting issue.

The way Sharon is *read* often leads her to believe she is not “listened to” by health care professionals when health care is sought. In order to avoid these feelings, she described how sometimes she delayed or did not seek care at all: “Most doctors don’t listen...I’d rather suffer through all the pain that I’m going through than have to deal with doctors” (P1). Regardless of the number of times Sharon sought care at the ED, she does in fact have complex/chronic health conditions that should not be ignored. Avoiding care could have dire consequences for someone with a chronic condition such as asthma, as Sharon has. Other studies have found that those who tend to be marginalized by structural inequities or street-involved people do in fact often delay seeking care because they know how they will be read by health care professionals (Pauly, 2005). The exemplar above provides a poignant example of how access to health care can be paradoxically compromised.

Aboriginal women from all socioeconomic backgrounds experienced treatment based on assumptions when health care was sought. Lora, introduced earlier in the analysis, was also *read* in a certain way, despite being a middle-class woman in for treatment of a workplace injury. In the following story, Lora is discharged home after

⁹ “Frequent flyers”, “repeat offenders”, or “regulars” are just some of the terms given to those that attend the emergency department frequently and are perceived by many healthcare professionals as arriving for “inappropriate reasons”. These patients are more likely to be poor, mentally ill, dependent on drugs or alcohol, and/or socially isolated. Many times these patients fall victim to stereotyping and it is often assumed by health professionals they do not need or deserve care (Malone, 1996).

being assessed and treated by the ED physician. However, as she leaves, an RN offers her the services of a social worker. Lora relays her concerns to the researcher in the following excerpt:

...I was like a social worker?... Why the heck would I need a social worker? Is there something wrong with me? Because you would think a social worker would be for someone whose maybe distraught, just came out of a situation that they couldn't handle or violence, that's my immediate thought and I thought... Why a social worker...? (P8)

Researcher: They offered you a social worker?

...They said well maybe we will call you the social worker right... and that's when I was thinking about this in my mind like why would they get me a social worker? Have they got me confused with somebody else that just had a traumatic experience or something... (P8).

Lora is distressed by the thought that the RN may have believed she was experiencing violence. This example relates to the assumptions surrounding violence and Aboriginal women that permeate through Canadian society. At the same time it reinforces the understanding that though it is important to acknowledge the increased incidence of violence Aboriginal women experience, it is of equal importance not to assume all Aboriginal women experience violence. In the previous example, Lora is likely aware of how Aboriginal women are perceived by society and may have internalized these assumptions.

Lora relayed relief to the researcher however when the RN provided reason for the referral to social work. The RN had not offered the services of a social worker to

Lora for reasons of violence, she just assumed Lora would *need help* getting home. As both an ED RN and a researcher, however, I question why social work was offered to her at all as a middle-class woman in with a workplace injury.

Though we may never know the actual reason for Lora's referral to social work, Lora knows that health care is often provided based on assumptions and is affected by this. Though she came to the ED with a work-place injury, a complaint seen within keeping with expectations of some ED health care professionals, Lora experienced care based on assumptions. Despite the likely good intentions of the RN – Lora experienced inequitable access to health care because of this interaction. If the RN had implemented a culturally safe approach, assumptions may not have been made and Lora could have left the ED with a better health care experience.

Lora's experiences in the ED are not isolated. Her health care encounters echoed findings from another paper. In a study conducted by Browne (2007), an Aboriginal woman was delayed in being discharged for seven hours because she had to be seen by the social worker despite being a middle-class woman with extensive support at home. Both Lora and the woman in the Browne (2007) study became marked as needing a social worker simply by being Aboriginal women.

The way the women in the study were *read* in the health care setting was also reflective of the way they were *read* in their every day lives. Jane, a woman introduced earlier, describes how her awareness of how she might be *read* affected where she chose to go for health care. She explains why she chooses to go to one particular hospital (where the study was situated) over another:

...It's convenient because it's close to where I am, at least if I have to take a bus home I know how to get home. You know if I was to go to (name of other ED) I'd be lost and I've lived in the city for sixteen years...so I mean like that's how far I go and how far I don't go... (P 7).

The other hospital Jane is referring to is about a 15 minute bus ride from the ED. Though a short distance, Jane does not want to travel to an area less familiar and comfortable. Going over town would be crossing a neighbourhood boundary for Jane. Many people from the inner city area, due to their socio-economic status and how they are *read* by others, do not want to or feel they ought not to cross these boundaries. Jane accesses a hospital closest to the inner city area, often accessed by people living in similar circumstances, she knows this hospital and it feels safer for her. Jane's reason for accessing this site is practical – it simply feels safer.

Summary

The majority of the women in the study lived disrupted lives in that many had histories of abuse and were often living in challenging situations with violence, profound co-occurring illnesses and social inequities such as poverty, homelessness and unemployment. Their experiences of health care in the ED and elsewhere were mediated by a number of factors such as race, class, and substance use – meaning these experiences could not be separated from the social context of the women's lives.

CHAPTER FIVE: IMPLICATIONS AND RECOMMENDATIONS

The central line of argument in this thesis illustrates that some women's experiences of seeking help in the ED are mediated by a number of factors associated with the social and historical context of Aboriginal women's lives. Issues such as pain, violence, trauma and discrimination influence women's access to primary care services, including use of the ED and their health care experiences at the ED. This is significant for a number of reasons; although not the only factor, access to appropriate, culturally safe healthcare is important to achieving overall improvements in the health status of Aboriginal women.

In the previous chapter, I described the influences that led the participants in the study to seek care at the ED in relation to the social contexts of their lives and also explored the tensions they experienced while accessing care. A number of factors negatively impacted the women's lives, such as profound poverty, lack of education, violence and dislocation. Thus, the women's health and access to the ED was mediated within the social contexts in which they lived. This is not to imply that Aboriginal women are necessarily disadvantaged; the women in this study expressed how certain sources of strength, such as elders, sustain them. However, due to policies and practices, embedded within the health care system, such as inadvertent marginalizing practices, the women were at further risk of experiencing racialization and marginalization while seeking care.

In light of these findings, I will discuss the implications organized into three main headings: a) understanding the influences that shape Aboriginal women's health care

experiences in this study; b) revisiting the role of the ED in relation to PHC; and c) minimizing the potential for emotional trauma and structural violence in the ED.

Understanding the Influences that Shape Aboriginal Women's Health Care Experiences in this Study

As discussed in the Chapter Four, the participants' experiences seeking health care in the ED and elsewhere cannot be separated from their wider social interactions. One key theme in this study was related to the women's experiences of being *read* in particular ways by nurses and other health care professionals; women perceived being *read* based upon their social positioning-- for example, as women living in poverty, who are experiencing violence, using substances and are visibly Aboriginal. The women's experiences of being *read*, drew attention to how health care interactions occur in the context of historical social relations between Aboriginal people and wider society. It is likely that the dominant and deep-seated ideas embedded in Canadian society regarding Aboriginal women continue to shape the perspectives of nurses and other health care professionals working in the system, which also has been found in previous studies (Browne, 2005, Browne, et al., 2009). Assumptions and discrimination are present and woven into interactions that shape the relations between health care professionals and Aboriginal women living in the urban core who have been marginalized by structural inequities. Women's health care experiences and their interpretations of these experiences must be acknowledged and taken seriously, regardless of the intent of nurses and other health care professionals providing care. That is, experiences of marginalization and racialization in health care settings create barriers to health care access, with the potential of negatively impacting health.

The experiences of patients must be considered in light of the restructuring of hospitals, which has meant increased workloads for staff and a cutback in the in-service education needed for professionals to respond to an increasingly complex patient population (Anderson et al., 2005). Nurses and other health care professionals need to look critically at the positions of power they hold in relation to their patients. The findings of this study support the idea that health care professionals must develop a critical awareness both inwardly and more broadly to the social, political, and historical factors that shape some Aboriginal women's health; an idea supported by other Aboriginal health researchers (Browne & Varcoe, 2006; Smye, et al., 2006, Tang & Browne, 2008, Browne et al., 2009). This to ensure those persons most vulnerable to health inequities are not further marginalized through racializing and other discriminatory practices within the health care system. At the same time, changes need to take place at the policy level to address those institutional barriers that pose a threat to appropriate, safe access to health care.

Revisiting the Role of the ED in Relation to PHC

Today, as a result of massive health care restructuring, it has become normalized for patients to access the ED with issues considered stable and non-urgent. In Canadian EDs, non-urgent patients account for more than half of all ED visits (Canadian Institute for Health Information, 2005a; Canadian Institute for Health Information, 2005b). Some of the factors that contribute to patients accessing the ED for non-urgent issues are: a decreasing number of primary care physicians, decreased homecare services, and pressures to discharge patients home from hospitals early (Canadian Institute for Health Information, 2005a; Canadian Institute for Health Information, 2005b; Health Council of

Canada, 2008). As the findings of other research (Browne et al., 2009; Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000; Richardson & Hwang, 2001) also demonstrate in addition, the ED, serves as a safety net for patient populations who are vulnerable to the effects of marginalization and also suffer from complex health care problems.

Despite the fact that many EDs are over-crowded and staff are often stretched to the limits, the ED serves as an important entry point of access to health care for a growing percentage of the population (Stephens, 2000). The majority of the participants in this study experienced challenges in having their complex health care needs met when accessing community health settings. However, regardless of describing past negative health care experiences and believing they would be judged negatively by nurses and other health care professionals, the women in this study continued to come to the ED to supplement their care.

Aboriginal health is provided against a backdrop of policy and practice shifts that impact how care is provided in EDs. For example, recently the Provincial government initiated a pilot project to employ strategies to increase the efficiency of EDs in B.C. The incentive-based project, the Emergency Decongestion Pilot (EDP), was launched in late 2007 as a pay-for-performance experiment to see if funding incentives would encourage better patient flow and faster access to hospital care (Vancouver Coastal Health, 2009). Under this project, EDs were and continue to be offered dollar incentives by the BC Ministry of Health to treat and discharge patients as quickly as possible. This pay-for-performance initiative uses financial incentives to increase productivity. Although decreased wait times in some of the EDs have been noted, shorter wait times do not necessarily equal better care. Efficiency and equitable care do not go hand in hand, for

example for people who live with complex health problems related to mental illness, violence, poverty, and experiences with racialization, such as Sharon. As noted in Chapter Four, Sharon described being told by a nurse that she had visited the ED 33 times. It was apparent that Sharon's complex health care needs were not being met in the community health or the ED setting. Many of the women who accessed the ED in this study with complex health care needs, including Sharon, required comprehensive, timely, coordinated and compassionate care, such as access to social work, home care, psychiatry, pain specialists, and a Native liaison worker. As patients with complex health care issues continue to come to the ED, health care based upon efficiency alone will likely not be adequate in attending to these patients' needs.

Studies are needed to assess the ways in which primary health care could be best offered to populations who are vulnerable to the effects of marginalization due to social inequities in society, including some Aboriginal people living with complex health challenges in the inner city. This to ensure appropriate, safe and effective care – care that may be most appropriately delivered in an ED setting for some people. If so, increased resources, staff and space would be needed to provide primary care in this way. As a clinical nurse in this setting, one recommendation might be to expand the size of the fast track area and have the expanded area function as a primary care clinic open round the clock, and be supported by nurse practitioners and clinical nurse specialists. Studies such as Browne and Tarlier's (2008) have begun to examine the potential of nurse practitioners to provide care to people with complex health problems who face significant barriers in accessing services. This expanded fast track area would move at a slower pace and staff would have the resources to address patients' needs more thoroughly. Although

women's lack of access to primary care in the community setting is complex and a reflection of the current inadequacies in the health care system, the onus should not solely be placed on the ED to fill the void. It appears that the Canadian government is interested in continuing to support PHC and undertake the needed changes (Health Council of Canada, 2008). However we need to also look at the bigger picture and fix the actual areas in which PHC is failing, such as in the community setting. Solutions are required that not only address *efficiencies* in the ED but those aspects of the health care system that create barriers to access for populations that tend to be vulnerable to structural inequities in society.

Minimizing the Potential for Emotional Trauma and Structural Violence in the ED

Women who have been marginalized by structural inequities are frequently subjected to trauma and violence, as could be seen in the lives of many of the women in this study; violence for many women was a constant and daily threat. Some women described how their lives had been affected by being forcibly removed from their homes to attend residential schools and although some did not attend residential school themselves, they still described being profoundly affected by the residential school experiences of their parents and grandparents. The experience of trauma passed down from generation to generation, described by some of the women in the study, is known as historical trauma, a term developed by Brave Heart (2003). It is not surprising, then, that many of the women in the study (for example Jane, who came to the ED to have pins removed from her shattered wrist), described an ongoing lack of trust and safety in their lives due to extensive histories of violence and trauma. For the women, these feelings may then have been re-created unwittingly by practices and policies within the health

care system – a type of trauma Paul Farmer (2003) refers to as structural violence. Structural violence, originally coined by Galtung (1969) in relation to Liberation Theology in Latin America, is now commonly applied to medical and public health issues (Farmer). According to Farmer (2004), structural violence is a way of explaining social arrangements that put individuals and populations in harm's way. It is subtle, gradual, and embedded in social structures, institutions and experience, with most of the general population unaware of its existence (Farmer, Nizeye, Stulac, & Keshavjee, 2006).

In this study, structural violence was evident and consistent with some of the features described by Smye (2008). The women in the present study described situations in which they experienced health care as being *culturally unsafe*, for example when they perceived they would potentially be *read* a certain way or have their health care concerns dismissed upon the basis of their social location, i.e., being visibly Aboriginal, living in poverty, and using substances. Many nurses and other health care professionals are unaware of the ways in which their everyday practices may unwittingly re-create trauma. Without understanding the personal and social context of peoples' lives, for example women's life histories, nurses often go about their work without recognizing that their demeanor may be *read* in ways that may or may not be intended as discriminatory. We know from research (Anderson et al., 2005) that people know when they are being negatively evaluated. For some people, there is an acute awareness of, and sensitivity to, a lack of respect, given their group history and personal and collective experiences of racialization (Smye et al., 2006). In this case, cultural safety could be used to prompt critical reflexivity on particular issues such as understanding how the social context of people's lives are linked to disparities in health and inequities in access to health care.

A more complete discussion of structural violence and its relationship to health care access is beyond the scope of this paper, however, I draw attention to it here because of its relevance to health care access for women in this study. People who are at risk for marginalization due to the structural inequities in society are at the continued risk of being further marginalized upon entering the health care system. Findings of this study underline the importance of ensuring that nurses and other health care professionals practice from the understanding that people marginalized by structural inequities often have experienced violence and trauma (Doane & Varcoe, 2005), and for many, over the course of their lifetime.

In the second half of this chapter I discuss recommendations to inform the development of appropriate policies, programs, and practice that support change in the areas of clinical practice, education, organization policy and research.

Recommendations

Based on the outcomes of this study, the following recommendations have been formulated. These are suggested to provide direction to nurses in clinical practice, education, policy and research as they work towards transformative change in the area of Aboriginal health. They have deliberately been outlined in point form so as to be clear, concise, and accessible.

Clinical Practice

It is clear that some of the women in this study experienced health care that was culturally unsafe, for instance when they perceived they would potentially be *read* a certain way or have their health care concerns dismissed based upon their social location.

It is important that changes be made to the area of clinical practice in order to improve health care access for Aboriginal women with suggestions listed in the following:

- 1) Provide adequate and appropriate resources, including health care professionals (e.g., 24-hour social work, Aboriginal liaison workers, women and trauma specialists, and pain and addiction specialists) in the clinical setting to address the needs of patients with complex health and social issues. These health care professionals would function in comprehensive multidisciplinary health care teams, which would include health care professionals representing community based services and resources.
- 2) Implement nurse practitioners and clinical nurse specialists in an expanded fast track area to work with the patients who are triaged as stable and non-urgent with complex health care challenges. Nurses working in advanced nursing practice roles have the expertise to “meet gaps in health services and provide cost-effective, accessible care to the citizens of the province, particularly to those whose access to healthcare is limited (McDonald et al., 2005, p.2).

Education

Educational initiatives need to be adopted to assist health care professionals to reflect critically on the impact of their practice on health care access and the health and well being of their patients. As access for the women in this study was influenced by issues such as pain, violence, dislocation, and discrimination, practice needs to be informed by an understanding of the historical, social, political, and economic contexts of peoples lives and the need for culturally safe and responsive health care. The following provides suggestions for change in the area of education:

- 1) Introduce cultural safety to foster the social and political consciousness of nurses and other health care professionals as a way of critically reflecting on the impact of professionals' health care practice and policy (Browne & Varcoe, 2006; Doane & Varcoe, 2005; Smye et al., 2006). One strategy suggested recently by nurse educators/researchers (Browne, Varcoe, Smye, et al. [in review]) is to take up a series of interactive social justice learning modules by researchers and leaders in clinical settings. This way a number of issues can be addressed, such as racialization and power issues in the health care system, as well as other critical issues pertinent to the practitioner's clinical area.
- 2) Provide education sessions that address structural violence, (for example through ethics workshops), that inform nurses and other health care professionals about how to provide care with an understanding that many people marginalized by structural inequities in society often have violence and trauma histories.
- 4) Role model culturally safe practice. For example, as a nurse educator, I recently witnessed culturally safe care in practice by one of my students, and encouraged her to further role model the care she provided to the rest of our clinical group during post conference. I had placed one of my students with a post-operative surgical patient who happened to be a young Aboriginal man living in poverty with a history of substance use. After his surgery, he refused to do any deep breathing and coughing and became increasingly agitated as the day progressed. The student however did not pass judgment and make assumptions – she stayed with him and inquired further as to what was actually going on. After only a few minutes she found while in hospital he had just obtained his child from foster care, as he was “clean” and not using substances anymore, he “had gotten his life back on track.” He was now worried that he could not effectively care for

his child at this time, as he was in the hospital. He had not relayed this very information to anyone prior to speaking with the student nurse, as he was worried about having his child apprehended again. After this, the student promptly contacted social work to see what could be done about the situation. During post conference, the student, with my encouragement, led the group discussion regarding the importance of providing culturally safe care. In addition to this, I wrote a “letter to the editor” in a provincial nursing journal regarding this situation as I felt it imperative to provide examples of how culturally safe practice can be implemented in the clinical setting successfully (Su, 2009).

Organizational Policy

The incidents of racialization and marginalization encountered by the women in the study were deeply embedded within the health care system and also linked to the women’s wider social interactions. Change needs to be implemented to address the effects of marginalizing practices in the health care system not only at the micro level but at the macro level as well.

1) Organizations need to adopt anti-racist policies (e.g. See Appendix C).

Policies regarding racism and discrimination should be made part of the hospital wide orientation for new staff and should be made visible in forms of posters in the workplace. These policies should be reviewed regularly to assess their effectiveness and proper functioning and should be made easily accessible to staff at all times.

2) Create a system of safety in departments so that health care professionals can send a message anonymously if they are feeling threatened, uncomfortable, or have witnessed racializing or discriminatory practices in their work setting. Regular debriefing sessions

for health care professionals should be provided to improve communication and positive organized change (Storch et al., 2009).

3) Create policies to attract and recruit more Aboriginal health care professionals into the health care system. Supports would need to be in place, however, early on in the educational system to encourage Aboriginal people to obtain a career in the health care field. For example, a poster campaign of Aboriginal health care professionals with statements depicting the kinds of jobs available could be placed within various different settings in the Vancouver School Board.

5) Encourage health care authorities to be more representative of the people they serve, for example recruiting Aboriginal elders for board positions.

Research

In terms of research, this study has only brushed the surface regarding issues surrounding Aboriginal women's health and access to health care. The findings of this study suggest Aboriginal women's access to and experiences with health care must be seen within the social contexts of their lives. The findings bring about more questions, suggesting areas for further research which are listed in the following:

1) Studying what currently is working in terms of safe and effective care. Some of the women felt *safe* accessing care and trusted the staff at the Aboriginal women's health and social service agency in the urban core. It would be important to assess which health care practices the participants deemed as safe.

2) To what capacity can the EDs take on providing primary care for groups of patients who are vulnerable to the effects of marginalization and are not currently having their health care needs met elsewhere?

3) Explore and develop other non-ED primary care sites. For example, setting up a clinic that has interdisciplinary health care professionals working in teams to address the needs of patients with complex health and social issues.

Conclusion

In this study, the social and political contexts of access to primary care from the perspective of Aboriginal women who attended the ED for health issues triaged as stable and non-urgent was explored. Consistent themes found within the women's stories were: needing a safe place to live, negotiating pain management, seeking help against a backdrop of violence and trauma, and the perception of discrimination and the awareness of how one will be *read* during health care encounters. The importance of understanding the social contexts of the women's lives in relation to health and access to health care cannot be emphasized enough.

Despite having supposed access to primary care services through their family physicians, the majority of the women in this study were unable to have their health care needs addressed adequately and therefore came to the ED to supplement their care. In addition, regardless of experiences of racialization and marginalization, the ED served as an important primary care entry point for many of the women in this study. However, experiences of racialization and marginalization continued to shape women's health care experiences, and women's access to the ED was influenced by the historical and social contexts of their lives. People's health care experiences cannot be neatly separated from their wider societal experiences. Experiences of racialization and marginalization remain present within the health care interactions of health care professionals and Aboriginal women marginalized by structural inequities. Taking into account an increasingly

complex and challenging work setting as restructuring and cutbacks occur in the health care system, a call to action continues to be needed in order to foster the social and political consciousness of health care professionals as well as to encourage critical self-reflection to address the power inequities that currently exist. Although provincial governments in Canada continue to push for greater efficiencies in ED settings, it will be important to see the same amount of energy, time and resources invested toward promoting health care equity. As the findings of this study show, working towards greater equity will be essential to improving health and access to health care for Aboriginal women in urban centers.

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Appendix A
Primary Study Research Question

Table 1.

Primary Study Research Questions

1. Explore why high proportions of Aboriginal people seek help at the ED for primary care concerns classified as ‘non-urgent.’
2. Explore the social context and mediating factors influencing Aboriginal peoples’ decision to seek health care at the ED.
3. Examine how health care interactions in the ED shape Aboriginal patients’ expectations of health care and patterns of seeking health care.
4. Examine how health care interactions in the ED are shaped by health care professionals’ knowledge of Aboriginal people, culture and the wider context of Aboriginal health.
5. Use the research findings in practice, health policy, and professional education to inform the provision of accessible, culturally safe primary care services to diverse groups of Aboriginal peoples (Browne et al., 2009).

Appendix B
Participants' Demographics

Table 2.

Patient	Age	Nation	Level of education	Employment	Presenting issue
1	58	Status Nuxalk	Grade 12	Unemployed	Back pain/chronic anxiety
2	62	Status Nuxalk	Grade 10	Employed	Back pain
3	20	Non-status Wet'suwet'en	Grade 10	Unemployed	Sprained ankle
4	34	Status Tsilhqot'in (Chilcoltin)	College	Unemployed	Pain during breast feeding
5	39	Status Cree	Grade 10	Unemployed	HIV post exposure prophylaxis
6	57	Status Squamish	College	Full-time Employed	Knee injury
7	39	Status Tsimshian	Grade 7	Unemployed	Pins d/c from fractured wrist
8	35	Status Carrier Sekani	College	Full-time Employed	Sprained ankle
9	40	Non-status Shoshone	GED	Unemployed	Abdominal pain and rash
10	48	Métis	Grade 10	Unemployed	Leg pain
11	20	Status Sto:lo	Grade 12	Unemployed	Hip pain
12	42	Status Cree	Grade 10	Unemployed	Post-surgery infection
13	41	Non-status Secwepemc (Shuswap)	College	Full-time Employed	Post-surgery pain

Appendix C

Multicultural and Anti-racism Policy



CANADIAN MENTAL
HEALTH ASSOCIATION

L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE

Canadian Mental Health Association, BC Division

Multicultural and Anti-racism Policy

The Canadian Mental Health Association, BC Division (CMHA) recognizes and values the diversity of the community we serve and the fundamental human rights of all people. CMHA is committed to ensuring that its mission and operations embrace the whole community. It actively encourages the entire community to participate and benefit fully from its services. CMHA acknowledges the barriers to employment, education, access to health and other social and economic opportunities experienced by racial, cultural and religious groups. We are committed to working towards the elimination of these barriers.

CMHA's Multicultural and Anti-Racism Policy applies wherever our services and programs are provided. It applies to all people who provide service to the CMHA; people to whom we provide service, staff, Board, volunteers and students.

In keeping with our mission we are committed to providing an environment that is free from racism, prejudice, discrimination and harassment. We strive to reflect the entire community in our structure (volunteer and staff) and to promote equal access to the services we provide.

The CMHA, BC Division will ensure that:

Its policies and programs eliminate systemic barriers to full participation and promote positive race relations and attitudinal change.

Discriminatory or racist incidents or behavior from staff and volunteers are not tolerated.

Communications reflect and are accessible to diverse ethnic communities.

There is ongoing cross-cultural and diversity training for staff, Board and volunteers.

There is fairness and equity in all of its operations for all people reflected in its open door policy and procedures.

Diverse ethnic communities are involved in designing new programs, policies, services and communication strategies.

There are on going reviews and evaluations of its existing programs, policies, all Committee's and Work Groups' Terms of Reference, constitution by-laws and services with a view to removing inequities and biases.

It cultivates understanding and acceptance of cultural diversity amongst its staff, volunteers and people it serves.

It pro-actively looks beyond the medical model to gain and promote a broader understanding of mental health.

It works towards staff, Board and volunteers reflecting the community they serve.

(Canadian Mental Health Association, 2007)