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A Participatory Case Study of Primary Healthcare for Aboriginal Peoples in an Urban Setting

by

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ABSTRACT

This study examined the strengths and gaps of the current primary healthcare system within a large southern Alberta urban setting, system structures and processes, patient-centred teams, and cultural safety. The study used critical social theory, institutional ethnography, complex adaptive systems, and participatory action research as frameworks. An Advisory Committee was established to direct the study. Case study methods were used. Data were collected via Advisory Committee meeting notes (n=5), individual and group interviews with stakeholders (n=39 interviews; 47 individuals), documents (n=101), and observation (n=5). Using an iterative, inductive process, data were coded, categorized, and common themes identified. The published literature was consulted throughout the study.

Various strengths were identified: provider commitment and early development of services to build upon. Key gaps included: access; system coordination; and service gaps (e.g., prevention, promotion, mental health, children and youth). The current system functioned in a complex environment impacted by colonization, racism, jurisdictional issues, competitive funding, urbanization trends, and a diverse population. Due to the primary healthcare system's complexity and gaps, participants recommended structures and processes (e.g., community participation, reviewing governance, inclusion of culturally relevant and traditional care, incorporation of patient-centred teams) to improve the system for this population. Cultural safety was not well understood by participants. It was narrowly defined and implementation focused on the individual, although a systems approach was necessary.

Results will be of interest for the local urban Aboriginal population and healthcare system, as well as policy and decision-makers, providers, Aboriginal leaders, and community members provincially and nationally. Overall, there was a lack of systems approach as evidenced by an individual focus (providers and Aboriginal individuals), short-term funding, and lack of collaboration amongst organizations. Hegemonic structures and processes significantly influenced the system. Decolonization will be necessary for a culturally safe system to meet needs of this urban Aboriginal population; to effectively

address its health disparities. This study must be viewed as an ongoing project, the beginning of change in primary healthcare services for urban Aboriginal populations in a specific context.

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I wish to acknowledge the work and dedication of the Advisory Committee members, who contributed their time for meetings and reviewing documentation for this study. As well, I would like to recognize the participants, who were interviewed and observed, contributing their many perspectives to the research. I would also like to acknowledge the work of the research assistants Amrita Roy, Kate Appleton, and Jenny Willison for their assistance in completing the research and Pauline Fisk from the Interdisciplinary Graduate Program for answering my many questions and facilitating the graduate process. Above all I would like to recognize my supervisor for her endless hours of consultation and advice for the study and assistance with this dissertation. Finally, to my doctoral committee members thank you for your support and valuable advice over the last five years.

DEDICATION

This dissertation is dedicated to my family, Garry, Megan, Kirsten and Jeff, who supported me greatly through this process with understanding and patience. Last, but not least, I would like to dedicate this work to the Aboriginal individuals (leaders, providers, and community members), who contributed to the research process in numerous ways. You have been an inspiration to me and taught me much about yourselves, your community, and primary healthcare services for Aboriginal peoples.

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CHAPTER ONE—INTRODUCTION

This study examined two major components of healthcare. One is primary healthcare reform, including interprofessional collaborative practice for patient-centred care (AMA, 2003; Mazankowski, 2001; Romanow, 2002; Health Canada, 2004). The other concerns the well-documented disparities in the health status of Aboriginal peoples (e.g., morbidity, life expectancy) in Canada (British Columbia Provincial Health Officer, 2009; Labonte, Muhajarine, Winquist, & Quail, 2009; The Senate Subcommittee on Population Health, 2009). The study explored the structures and processes of the primary healthcare system and patient-centred care teams to address the needs of Aboriginal peoples residing within a large urban setting in southern Alberta.

The following sections of this preliminary chapter will introduce the reader to the researcher and the study. A brief outline of each of the chapters in this dissertation will be described.

About the Researcher

I am a doctoral student in the Interdisciplinary Doctoral Program at the University of Calgary. My professional background is nursing, and I have worked in a number of different areas from acute care to education, but the majority of my work was in community health. I worked as a public health nurse in the community and in cancer prevention and screening initiatives. I have worked with several populations that were marginalized, including Aboriginal people (urban and on-reserve) and immigrant populations. Most of my work was done in maternal child health and women’s health. My Masters’ thesis focused on cervical cancer screening with Sikh women. Currently, I am employed with Alberta Health Services, Calgary Zone in the Health Systems and Workforce Research Unit with key responsibilities in the areas of research and evaluation in primary care and primary healthcare initiatives. I am also involved in interprofessional education and health human resources research. More specifically, I have contributed significantly to the evaluation of the Calgary and area Primary Care Networks. Over the last year, I have been involved with the Aboriginal Friendship Centre of Calgary on an Aboriginal Homelessness Project through the University of Calgary. A proposal was submitted to the Canadian Institute of

Health Research in partnership with others from the Friendship Centre and the University of Calgary to complete an environmental scan, literature review, and a gathering to set a research agenda for Aboriginal homelessness in Calgary. We were successful in receiving funds and the work culminated in a community gathering of key stakeholders in the spring of 2010.

My interest in this research stemmed from my previous work with populations that have been marginalized, my expertise and interest in primary healthcare, and my commitment to equitable healthcare service delivery for all.

Situating the researcher in the research is an important component to ascertain any biases. Knowing the background of the researcher will assist the reader to better understand this dissertation and the interpretation of the results. At the outset, I want to disclose that I am not Aboriginal. I have worked hard in all phases of this research to work with Aboriginal peoples in a participatory manner. These participatory approaches will be discussed in detail in Chapter Four. It is important for me that this research be of value to Aboriginal peoples first and then also to the healthcare system providing services for this population.

Throughout this study, I have had ongoing conversations with my supervisor, Dr. W. E. Thurston. Her involvement in various initiatives informed this study. Dr. Thurston, with a background in social work, addictions, and prevention of violence against women, works as a professor in the Department of Community Health Sciences, Faculty of Medicine at the University of Calgary. Over the past number of years she worked in the areas of health services and domestic violence, Aboriginal women's health services, Strengthening the Spirit at the Alliance to End Violence, Aboriginal Primary Healthcare Research Network, Alberta Network Environments for Aboriginal Health Research, the Aboriginal Community Health Council and, most recently, the Aboriginal Homelessness Project.

Given the magnitude of the study and this dissertation, the following section will provide a short synopsis of each chapter. This will guide the reader through the processes of this research.

Organization of Dissertation

This research covered two major areas of healthcare: primary healthcare and healthcare for an urban Aboriginal population. Combined, these two components resulted in a large amount of data being collected to answer each of the research questions. The culmination of the report on this research provided a comprehensive description of Aboriginal health, primary healthcare, the current primary healthcare system for the urban Aboriginal community in Calgary, as well as structures and processes to improve this system.

Chapter One

The opening chapter provided an introduction to the study and the researcher. It will also include a description of each of the chapters describing the research for this dissertation.

Chapter Two

Important contextual information will situate this research in historical and contemporary settings. Chapter Two will provide a detailed description of the historical events and policies that continue to underpin Aboriginal health and healthcare services for this population. This chapter will assist the reader in appreciating the complexities of this topic.

Chapter Three

Chapter Three will report on the results of the literature review conducted for the study. The literature search included sources from both peer-reviewed and grey literature. The review focused on primary healthcare systems and services for urban Aboriginal populations in Canada. An exemplar of a primary healthcare system in Alaska for Native American Indians and Alaskan Natives will also be included due to the limited information available on primary healthcare systems for this population in Canada. Research questions will also be included in Chapter Three. Both the description of the context in Chapter Two and the literature review will provide the rationale for the study.

Chapter Four

Chapter Four will provide a comprehensive description of the conceptual frame and methods used for the study. Four separate, but interrelated theoretical concepts were employed to guide the research process. The following will be included: critical social theory; institutional ethnography; complex adaptive systems; and participatory approach.

This research used a case study methodology. The *case* studied was the current primary healthcare system for the urban Aboriginal population in Calgary. An Advisory Committee was established early on in the study. Data were collected via document review, interviews, participant observations, and Advisory Committee meeting minutes. Inductive analysis was conducted on the data to identify common themes. Analysis was completed in an iterative manner. Trustworthiness of the data was ensured through a variety of techniques including member checking and an audit. The subsequent three chapters will focus on the results of the study.

Chapter Five

Chapter Five was the first of three chapters describing research results. It will illustrate the current primary healthcare system for the Aboriginal population in an urban setting (Research Question 1). It will provide information on the services utilized when Aboriginal peoples were ill or had a need, services used for prevention, and services used for health promotion. The strengths and gaps of the system will also be addressed.

Chapter Six

Chapter Six will discuss the structures and processes for improvement (Research Question 2) including stakeholders to be involved in designing a primary healthcare system for this population (Research Question 3). The role of patient-centred teams (Research Question 4) including staff mix was also examined.

Chapter Seven

Chapter Seven focuses on cultural safety, a specific structure and process for improvement for this primary healthcare system. Definitions of cultural safety from the data will be presented along with information on racism in the current primary healthcare system. Finally, how cultural safety could be incorporated into a primary healthcare system for urban Aboriginal populations will be covered (Research Question 5).

Chapter Eight

Finally, Chapter Eight will provide a discussion of the various components of the results of this research. Reflections on methods and limitations of the study will also be included.

Summary

This chapter presented an introduction to this research and information about the researcher. An outline of each of the chapters was then included. The following chapter, Chapter Two, will provide a detailed description of contextual factors to better understand the topic area of study.

CHAPTER TWO—SETTING THE CONTEXT

This chapter will provide a comprehensive description of contextual factors for the study as well as building a rationale for the research. A detailed Glossary of Terms has been developed to define terms for readers (See Appendix A); defined terms used in this chapter are bolded. To assist readers to appreciate the complexities of this topic area, information on the historical context of Aboriginal peoples in Canada including **colonization**, signing of treaties, Canadian Aboriginal policies, residential schooling, and the impacts of colonization are discussed. A detailed description of the Aboriginal population in Canada, Alberta, and locally in Calgary is provided. Following the description of the Aboriginal population, the concepts of health and well-being for the Aboriginal population, the **social determinants of health and well-being**, and the health status of Aboriginal people in Canada are addressed. In addition, the topics of **primary healthcare** and its principles are discussed, and **collaborative patient-centred practice** and **cultural safety** are outlined as key components. Information on healthcare services for Aboriginal people in Canada, Alberta and Calgary are outlined. Ethical principles by which research with Aboriginal communities should be conducted are outlined. Finally, these various components are integrated to provide the background and rationale for the study.

Historical Context of Indigenous People in Canada

Pre-Contact

Prior to Europeans coming to North America, Aboriginal people lived throughout the continent in relative harmony with nature and one another. They existed in accord with the land; their food sources for the most part were acquired through hunting and fishing. Despite this harmonious existence, there were many challenges. Aboriginal peoples faced natural disasters such as drought, severe storms, and illness in addition to attacks from other tribes (Carter, 1999). Notwithstanding these adversities, the resilience of Aboriginal peoples ensured their survival.

Colonization

In the sixteenth and seventeenth centuries, Europeans, particularly the French and British, began to settle in North America. Contact with indigenous people was largely based on the fur trade between settlers and Aboriginal people of Canada, first in Eastern Canada and then moving west. The early contact period introduced various European illnesses (e.g., small pox, tuberculosis) that caused major epidemics in Aboriginal communities, killing many of their tribe members (Crane & McFarlane, 2006; Hackett, 2005; Waldram, Herring, & Young, 2006).

The influx of colonists to indigenous land brought about many changes for Aboriginal peoples living in Canada. By the end of the nineteenth century, most of Canada had been settled by Europeans. They brought with them their own values, beliefs, and religions, and instituted a capitalist economy. These Eurocentric thought processes and structures were considered to be *best* and formed the foundation of **colonization** that took place in Canada over several hundreds of years, with a continuing legacy today. Canadian Aboriginal people had been the victims of colonization through a variety of means. They were dispossessed of their traditional lands through treaty negotiations, placed on reserves, and forced to take on the way of life of the colonizers. On the reserve, they were held as prisoners on their own land, requiring a pass to leave. The reality of poverty on reserves, where they often had little food and inadequate housing, was apparent, and that reality continues today (Crane & McFarlane, 2006).

The period of colonization was characterized by many historical events that significantly impacted the Aboriginal population of Canada. Three events have been singled out for discussion because of their continued impact on Aboriginal peoples: the signing of treaties; legislation such as the Indian Act; and the creation of residential schools. Each of these will be discussed in the following sections of this chapter.

Signing of the Treaties

The Anglo-French War occurred in the mid 1700s, commonly referred to as the Seven Years' War (Fowler, 2006). First Nations were caught in the middle between the two European powers. Alliances were negotiated between the French and the English and various First Nations' groups. Hence First Nations were directly involved in the war with a parallel war existing between First Nations' groups dependent on their alliances. In 1763, the French were defeated. A Royal Proclamation was signed in 1763 (Borrow, 1997; Green

& Dickason, 1989) by Britain, France, and First Nations acknowledging the autonomy and independence of First Nations in Canada. The Proclamation included principles to manage “the allocation of land, resources, and jurisdiction” (Borrows, 1997, p. 156) between First Nations, Britain, and France.

The push-pull between First Nations and the colonial powers was concerned with the preservation of Aboriginal land and their sovereignty against Britain’s desire to expand its territories for trade and settlement purposes. The Treaty of Niagara, signed in 1764 with First Nations’ representatives from all areas of eastern Canada, was intended to ensure their involvement and make explicit their agreement with the Royal Proclamation. Peace, friendship, and recognition of the commitment of Britain to maintain the welfare of First Nations’ people in Canada was understood by Aboriginal people to be foundational to Treaties. The Royal Proclamation and subsequent Treaty of Niagara represented the first documents outlining the relationship between First Nations and the Crown. These documents set standards across Canada for later Treaties signed between individual Nations and the new colonial governments that represented the Crown (Borrows, 1997).

Prior to Confederation in 1867, several Treaties had already been signed between First Nations and the Crown in eastern Canada. Prior to the Royal Proclamation a series of Peace and Friendship Treaties were negotiated with First Nations in Nova Scotia and New Brunswick. Following the Royal Proclamation and before Confederation several more Treaties were signed (Upper Canada Treaties and the Vancouver Island Treaties). Following Confederation further Treaties were signed by First Nations and the Government of Canada in the 1870s. These included Treaties 1 through 11 covering the majority of the land in the Prairie Provinces as well as northern Ontario, and areas in the Yukon, Northwest Territories, and British Columbia (Department of Indian Affairs and Northern Development, 2000). Of interest, for the purposes of this research was Treaty 6, signed in 1876 with the Plains Cree in Alberta and Saskatchewan. Buffalo supplies were rapidly declining on the prairies and First Nations’ people were particularly concerned with the health and welfare of their people. They negotiated the inclusion of a *medicine chest*, the only treaty to include the same (Indian and Northern Affairs Canada, n.d.a; Morris, 1880) and interpreted by Aboriginal leaders as universal healthcare for all Aboriginal peoples (Venne, 1997). In the late 19th century and the early 20th century, a further five Treaties were signed across Canada (Indian and Northern Affairs Canada, n.d.a).

Three major Treaties (Treaties 6, 7, and 8) along with two Treaties from the bordering provinces of British Columbia and Saskatchewan encompass the agreements of First Nations in Alberta. Treaty 6 covers central Alberta, Treaty 7 southern Alberta, and Treaty 8 northern Alberta. The City of Calgary is included in the Treaty 7 geographic area. Treaty 7 was negotiated with the Blackfoot Nations of southern Alberta including the Blood, Piegan, Sarcee, Stoney, and others in the area (Morris, 1880). Currently, there are six reserves in close proximity to Calgary: Stoney (consisting of three separate reserves) to the west; Tsuu T'ina, west and south of Calgary; Eden Valley to the southwest; and Siksika to the east. Tsuu T'ina First Nation borders the city of Calgary and is often referred to as an urban reserve, one of the few in Canada.

The Indian Act

The British North American Act of 1867 provided the Canadian government with control of Aboriginal peoples and First Nations' reserves (Carter, 1999; Voyageur & Calliou, 2000/2001). The Indian Act was implemented in 1876. The Act was intended to amend and consolidate all laws and policies related to Aboriginal peoples in Canada and outlined those who would have status and those who would not. The goals of the Indian Act were assimilation and civilization of Aboriginal peoples in Canada via paternalistic policies (Canadiana, 2001-2005; Crane & McFarlane, 2006; Voyageur & Calliou, 2000/2001) serving the interests of the colonizers politically, economically, and socially (Kirmayer, Brass & Tait, 2000). A non-First Nations' woman who married a First Nations' man, for instance, could obtain Indian status for herself and their children, whereas First Nations' women who married non-First Nations' men lost their Indian status. **Métis** were not included in the Indian Act and were unable to obtain any of the benefits of status Indians covered by the Act (Canadiana, 2001-2005).

In addition to determining the status of Indian people, the Indian Act provided directives for the sale of reserve land and the ability of the government to take resources from these lands (e.g., timber) (Canadiana, 2001-2005). In fact, complete control of First Nations' land rested with the government (Voyageur & Calliou, 2000/2001). In effect, First Nations' people were made wards of the government and could be charged under the criminal code for such violations as leaving the reserve or selling alcohol on the reserve (Canadiana, 2001-2005). In addition, the Act imposed Britain's social organization and culture upon the First Nations' people and became to be considered the "formidable dossier of repression" for First Nations' people (Carter, 1999, p. 119).

Following the 1885 Métis rebellion regarding Métis land issues, led by Louis Riel, the government amended the Indian Act to ensure such unrest did not occur with First Nations' people. Prohibiting the sale of ammunition to First Nations' people and banning various traditional celebrations (e.g., Potlatch) were meant to curb collective action. Many Aboriginal peoples considered the year 1885 to be the turning point when activities of First Nations' people were excessively restricted (Carter, 1999).

In 1966, the Hawthorne Committee, a government committee studying First Nations' people in Canada, released its report. Recommendations included creation of the Department of Indian Affairs Branch and greater focus on increasing income and life expectancy for Canadian First Nations' peoples rather than solely on integration and assimilation. The Committee suggested Canada's indigenous people be viewed as citizens plus, having the full rights and duties of Canadian citizenship in addition to their unique rights as charter inhabitants of Canada. Substantially increased funding for First Nations' populations in Canada was also recommended, but the political will was not aligned with the Committee and none of its recommendations were adopted (Cairns, 2000).

The "Statement of the Government of Canada on Indian policy (The White Paper, 1969)" (Chretien, 1969) was introduced in 1969 by the Federal Government. This paper declared all First Nations' people would be assimilated within a short period of time and any agreements between the government and First Nations would be abolished (e.g., Indian Act, Treaties). These policy proposals were countered by "Citizens Plus," commonly known as the Red Paper, developed by the Indian Association of Alberta in 1970, and the government's proposal was withdrawn (Cairns, 2000). Since 1970, First Nations' leaders and communities, along with other Aboriginal leaders, had been more vocal in their fight for Aboriginal rights, and were successful in areas such as land claims in certain geographical locations and greater participation and self-governance in other areas (e.g., transfer of healthcare services).

Residential Schools

Assimilation of Aboriginal children through education in residential schools began in the 1870s. In 1920, attendance at a residential school for Aboriginal children aged 7-15 years of age was mandatory (Assembly of First Nations, n.d.). The goals of residential schools aligned with the Indian Act and other policies for the civilization and assimilation of Aboriginal peoples. This included basic literacy training and skills in agriculture and trades for the boys, and agriculture and housekeeping for the girls (British Columbia Provincial Health Officer, 2009; Kelm, 1998). Residential schools also taught children about health and hygiene, which was perceived not to be taught at home (Kelm, 1998).

Residential schools were built and operated across Canada by churches (e.g., Catholic, Methodist, Presbyterian, United) supported by government funding, which purportedly set up a partnership intended to bring about the beneficence of the policy. Métis children, although they did not formally fall within federal government responsibility, also attended residential schools (until the 1930s when government policy officially excluded them from schools for Aboriginal children). The government proposed Métis children, who lived in the Aboriginal culture, could benefit from the education in order to assimilate appropriately into Canadian society. The experiences of Métis children in residential schools were similar to First Nations' children (Chartrand, Logan, & Daniels, 2006).

Residential schooling resulted in children being removed from their parents and communities. They were taken away from traditional language, values, and practices and educated to be *civilized* from a Eurocentric standpoint. Children in these schools suffered multiple losses (e.g., families, identity, and social connection) as well as separation and isolation from those they loved and those who loved them. Rather than being cared for, as was intended, they were underfed and overworked. They often became sick and many died at school, or at a sanatorium or later at home when nothing more could be done for them. Estimates suggested death rates as high as 69%. In short, due to overcrowding, diseases such as tuberculosis spread very quickly in these environments, contributing to morbidity and mortality rates (Kelm, 1998).

Some authors have suggested cultural genocide resulted because of residential schools. Children were punished for speaking their own language and traditional customs were banned (Chartrand et al., 2006; Wesley-Esquimaux & Smolewski, 2004). Children were also often subjected to various forms of abuse (physical, emotional, sexual, and spiritual) (Chartrand et al., 2006; Kelm, 1998; Wesley-Esquimaux & Smolewski, 2004). Métis children were sometimes treated as second class pupils when attending residential school with other Aboriginal children as the school did not receive funding from the government for these children (Chartrand et al., 2006).

The legacy of the residential school experience left a lasting and devastating impact on Aboriginal peoples of Canada (Wesley-Esquimaux & Smolewski, 2004; Kirmayer et al., 2000; Royal Commission on Aboriginal Peoples, 1996). These events impacted individuals directly and had a collective effect on Aboriginal peoples leaving them to deal with continuing implications and after-effects. Intergenerational impacts (Smith, Varcoe, & Edwards, 2005) were evident, for instance, where Aboriginal people were perceived to be unable to appropriately care for their children (Crane & McFarlane, 2006). For some Aboriginal peoples, residential school experiences were the social origins for mental health issues experienced today (Kirmayer et al., 2000; Smith et al., 2005). The potential for trusting relationships between Aboriginal and non-Aboriginal institutions was severely damaged.

In June 2008, the Prime Minister of Canada, Stephen Harper, issued a "Statement of Apology—to former students of Residential Schools" (Harper, 2008). There was recognition by the Government that the assimilation policy through residential schools was wrong and had significant negative impacts for Aboriginal peoples in Canada and continued to play a negative role in social issues for Aboriginal people and their families. In an effort to move forward on the journey of healing and reconciliation, an Indian

Residential Schools Settlement Agreement was implemented in September 2007. One component of the agreement was the creation of the Truth and Reconciliation Commission (Truth and Reconciliation Commission, n.d.).

The Commission was given a five-year mandate with the following goals: recognition of experiences and impacts of residential schools; provision of a culturally safe environment for former students and their families to connect with the Commission; commemoration of former students; support for local and national truth and reconciliation events; provision of education to all Canadians about residential schools to develop a new relationship between Aboriginal and non-Aboriginal Canadians; creation of a database and library of historical documents available for future research; and the development of a final report on its initiatives and activities (Truth and Reconciliation Commission, n.d.).

Impact of Colonization

The impacts of government policy on Aboriginal peoples in Canada have been catastrophic. Such policies and actions were adopted by institutions such as religious organizations (e.g., Catholic, Anglican, Presbyterian, Methodist, United churches), private enterprise (The Hudson's Bay Company), and the justice sector (Northwest Mounted Police), working alongside government to *civilize and assimilate* Aboriginal peoples. White supremacist standards for all people were assumed by colonizers. The social values of the upper and governing classes, including economic materialism, were assumed to be the standard of comparison for society and conflated with moral values. For Aboriginal peoples, the result was poverty through the loss of land and resources, oppression by state policies and actions of other institutions, and the loss of culture and language to the point of losing their identities as indigenous peoples (Adams, 1999; LaRocque, n.d.). The foundation of colonialism was a power structure in which the colonizers at the top had control over the colonized at the bottom (Yazzie, 2000). The impact of colonization continued; colonized practices persisted by government and other institutions making decisions for Aboriginal peoples with little or no input from them.

The Aboriginal population faced **racism** on a daily basis when interacting with individuals, institutions, government policies, funding decisions, historical teaching in schools, social services treatment, and the media, to name but a few sources. Racism played a major role in colonization and sustained domination. The colonizers were deemed to be a superior race compared to more *primitive* Aboriginal peoples. Racism had a great impact on the Aboriginal population through policies and social disruption creating intense intergenerational trauma resulting in self-harm, self-rejection (LaRocque, n.d.), and lateral abuse and violence (Goodleaf & Gabriel, 2009).

The previous sections of this chapter have outlined key historical events, processes, and policies impacting Aboriginal peoples of Canada. The process of colonization occurred over hundreds of years. Two of the more significant policies that promoted civilization and assimilation of the Aboriginal community into Canadian society include the Indian Act and the education policy of residential schooling. Both have ongoing, negative impacts on Aboriginal peoples in Canada. The following sections of this chapter will describe the Aboriginal population nationally, provincially, and locally.

The Aboriginal Population

Aboriginal peoples in Canada are made up of three groups: **First Nations, Métis** and **Inuit**. This section will first provide a short description of the First Nations and Métis groups in Canada as well as some statistics specifically for these groups. The Inuit group was not included due to its relatively small population size in southern Canadian urban areas (Statistics Canada, 2008b). This section will then provide descriptions of the inclusive Aboriginal population, because statistics for the three groups have most often been reported collectively by Statistics Canada, by national, provincial, and local (i.e., Calgary and area) perspectives.

First Nations

As currently understood, **First Nations** refers to individuals both with **status** and **non-status** as defined by the Indian Act. In 2006, the First Nations' population in Canada accounted for approximately 2.2% of the country's total population (Gionet, 2009a), and were widely spread across Canada's geography, living on-reserve or off-reserve in rural and/or urban communities. Forty percent of the First Nations' population were recorded as living on-reserve, with the other 60% living off-reserve (Gionet, 2009a). Often, however, the First Nations' people in an urban setting traveled to and stayed on-reserve for periods of time.

Métis

Métis were formally recognized as one of three groups of Aboriginal peoples in Canada in the 1982 Constitution (National Aboriginal Health Organization, n.d.). In the late 1700s, two separate groups of Métis people were identified: the Red River Métis in Canada (Alberta, Saskatchewan, and Manitoba) and the Great Plains Métis in the northern United States (Chartrand et al., 2006). The term Métis also referred more generally to individuals with mixed backgrounds (First Nations and European).

Currently, Canadian Métis organizations have varying criteria to define the Métis population (National Aboriginal Health Organization, n.d.). According to the Métis Nation of Alberta (2003), Métis people in Alberta are defined by the following: "Métis means a person who self-identifies as a Métis, is distinct from other aboriginal peoples, is of historic Métis Nation ancestry, and is accepted by the Métis Nation" (Métis Nation of Alberta, 2003).

The Métis population in Canada increased rapidly in recent history; in fact the number of Métis people increased by 91% from 1996-2006, the fastest growth rate of all Aboriginal groups and 11 times faster than the non-Aboriginal population (Statistics Canada, 2008b). This significant growth was related to higher birth rates, but also to an increase in the number of individuals identifying as Métis. The largest concentration of Canada's Métis population lived in Alberta (22% of Canada's Métis population), with 69% living in urban areas. Calgary had the fourth largest concentration of Métis (14,770) among all Canadian urban centres after Winnipeg, Edmonton, and Vancouver (Gionet, 2009b).

Notably, Métis settlements were unique to Alberta. In 1938, eight settlements, located in the northern and central areas of the province, were set aside by the Alberta government for the Métis population (National Aboriginal Health Organization, n.d.).

The Aboriginal Population of Canada

According to the 2006 Census, Aboriginal peoples accounted for about 3.8% of Canada's population, representing a growth rate of 20% over the previous five years

(Statistics Canada, 2008b). Statistics Canada (2005) projected an Aboriginal population growth rate of 1.8% annually through the year 2017. The median age of the Aboriginal population was 27 years, much younger than the total Canadian population. Seniors (65 years and over) in the Canadian Aboriginal population accounted for only 5% of the total Aboriginal population, although the number was growing. This increase was due largely to increased life expectancy (Statistics Canada, 2008b).

More Aboriginal people were moving to urban areas. According to Statistics Canada, approximately 54% of all Canadian Aboriginal people lived in urban centres. Fifty percent of the urban population of Aboriginal peoples was First Nations, and 43% was Métis. Calgary, with 26,575 Aboriginal people, had the fourth largest Aboriginal population in Canada, tied with Toronto (26,575), and behind Winnipeg (68,380), Edmonton (52,100), and Vancouver (40,310) (Statistics Canada, 2008b). This trend in urbanization likely occurred in response to the need for better living conditions, work, and education. However, urbanization often led to the separation of individuals from families and their traditional cultural practices. In Calgary, where reserves border or sit in close proximity to the city, some people were able to maintain family and community ties.

The Aboriginal Population of Alberta

In Alberta, approximately 5.8% of the population identified themselves as Aboriginal in 2006 (Statistics Canada, 2008b). From 1996 to 2001, Alberta’s Aboriginal population grew at a rate of 27%, compared to a 10% rate of growth for Alberta’s population as a whole (Statistics Canada, n.d.a). Predictions showed Alberta would have the second largest Aboriginal population in Canada by 2017, remaining behind Ontario but moving ahead of British Columbia (Statistics Canada, 2005). In the Aboriginal population of Alberta, the median age was 23.5 years for males and 26.0 years for females (Statistics Canada, n.d.b). Seventy-six percent of Alberta Aboriginal people live off-reserve (Statistics Canada, n.d.a).

The Aboriginal Population of Calgary and Area

For the purposes of this research, Calgary and Area is defined by The Alberta Health Services, Calgary Zone geographic area (formerly the Calgary Health Region).

Three First Nations (Tsuu T'ina, Siksika, and Stoney) are located within the Zone's geographic area on six different reserves (Tsuu T'ina, Siksika, Stoney [Chiniki, Bearspaw, and Wesley], Eden Valley). The City of Calgary itself is home to a large number of Aboriginal people encompassing various groups from across the country (Calgary Health Region, 2006).

In 2001, approximately 3% of the population of Calgary and area was Aboriginal. Detailed population numbers have been provided in Table 1. Although still significantly less than that of Edmonton (the other major city in the province of Alberta), the City of Calgary's Aboriginal population increased by over 200% from 1981 through 2001 (Statistics Canada, n.d.a).

Table 1

Aboriginal Population in the Alberta Health Services, Calgary Zone Geographic Area of Residence (2001 Census Aboriginal Population Profile)

Geographic Area of Residence	Number of Individuals
Eden Valley	505
Stoney	2,165
Siksika	2,700
Tsuu T'ina	880
Rural (Off-reserve)	5,815
Urban (City of Calgary)	19,795
Total	**31,860**

Source: Calgary Health Region, 2006

The median age of Aboriginal people living in the City of Calgary was 27.3 years; median ages were 26 years for males and 29 years for females. Twenty-six percent of the population was below the age of 15 (Statistics Canada, n.d.c). The median age for Aboriginal populations surrounding the City of Calgary ranges from 19.8 to 21.9 years (Calgary Health Region, 2006).

In summary, the Aboriginal population in Canada accounted for approximately 4% of the overall population. In Alberta, the Aboriginal population was a higher percentage of the total provincial population, nearly 6%. In Calgary and area it was a smaller 3%, but the Aboriginal population had increased significantly since 1981. Calgary's Aboriginal population was generally younger with one quarter under the age of 15. The rapidly increasing population and the number of children and youth will be important to consider in the planning and implementation of primary healthcare services for the Aboriginal population in Calgary. Equally important to consider, the perspectives of Aboriginal peoples on health and well-being will be the focus of the following section.

Aboriginal Perspectives on Health and Well-being

Health was largely a western concept (First Nations Centre, 2005), and Aboriginal views on health and wellness differed considerably in comparison to western biomedical views. The biomedical model (Centre for Cancer Education, 2000), espoused by western Europeans, focused on illness, disease, or disorders caused by biological factors and, therefore, deficits and needs (Arnold & Bruce, 2005; Van Uchelen, Davidson, Quressette, Brasfield, & Demerais, 1997). The biomedical model tended not to include the impact of psychological, social, and spiritual factors on health. Disease was the central focal point, and health was conceptualized as the absence of disease (Long & Fox, 1996). Within the biomedical model the professional practitioner was expert (Long & Fox, 1996). With advancement in professionalization, specific diseases became compartmentalized within silos of care, further removing health from a more holistic approach focusing on the whole person (Culhane Speck, 1987; Peters & Demarais, 1997; Van Uchelen et al., 1997).

According to the literature, the concept of health did not adequately describe the various perspectives of well-being for the Aboriginal population. Most Aboriginal peoples suggested health be defined more broadly to encompass the "person's whole being" (Smye & Mussell, 2001, p.7). Health generally referred to the physical, while well-being was seen to encompass a more holistic reference (Bartlett, 2005). The concept of "wellness was a very complex and multi-layered philosophy" (First Nations Centre, 2005, p. 2). Individuals were integrally connected to nature and Creation through various different levels (e.g., Mother Earth, mankind, Aboriginal people, individuals, families, and communities) with each level interconnected one to another (First Nations Centre, 2005, p.3). Others described wellness in terms of harmony and sense of balance. They outlined four components of well-being: physical, mental, emotional, and spiritual, all functioning together to maintain balance and well-being in the individual, family, and community (Bartlett, 2005; Hunter, Logan, Barton, & Goulet, 2006; Long & Fox, 1996; Peters & Demarais, 1997; Royal Commission on Aboriginal Peoples, 1996; Smye & Mussel, 2001). The familiar Medicine Wheel used in some Aboriginal communities was based on these four components (Bartlett, 2005; Hunter et al., 2006; Peters & Demarais, 1997). Context was also incorporated into Aboriginal perspectives of well-being. Contextual factors included physical environment, social environment, culture, economics, historical factors, and other environmental factors (Smye & Mussel, 2001; Waldram et al., 2006). Thus, an important component of well-being was the integration of both individual and collective well-being; the well-being of individuals within families, within communities (Long & Fox, 1996), within symbolic and social institutions, and with a sense of global health.

Healthcare providers had to understand the tension between western models of health and healthcare and Aboriginal understandings of health and well-being (Smith & Davies, 2006; Van Uchelen et al., 1997). The biomedical model was known for its shortcomings for healthcare for all populations. For instance, it had long been criticized by feminists as perpetrating patriarchy (e.g., Chesler, 1972; Daly, 1978) and for failing populations that were marginalized, such as Aboriginal people. Healthcare based on biomedical models, or hegemonic medical models of the body in society did not incorporate Aboriginal worldviews, nor did it focus on the whole person (physical, emotional, mental, and spiritual). In order to work in partnership with Aboriginal people, managers, decision-makers and providers clearly needed to change their epistemological and ontological stances on health and well-being, and reflect on how western ideas of health and wellness differ from those of Aboriginal populations. This would require healthcare systems to re-examine the values and beliefs that drive health policy and the delivery of healthcare services. Reconciliation between western medicine, particularly the biomedical model and Aboriginal worldviews on health and well-being, was required and essential in providing services to and with Aboriginal peoples.

In summary, western concepts of health were narrowly defined and focused on the physical, while Aboriginal perspectives on health and well-being were more holistic and included the physical, emotional, mental, and spiritual components of well-being. The western biomedical model was not well aligned with Aboriginal worldviews. Current policies and practices utilize these western approaches and require re-examination in the delivery of primary healthcare services for and with Aboriginal peoples. The following section will discuss the social determinants of health and well-being, which go beyond the physical of the biomedical model and are more aligned with Aboriginal worldviews.

Social Determinants of Health and Well-being

The **social determinants of health** are a key component of primary healthcare. Social determinants of health frameworks focus on strengths versus problems, incorporating various aspects that impact the health of individuals, families, and communities. Some believe the determinants of health framework aligns more closely with Aboriginal views on well-being (Thomas, 2003; Waldram et al., 2006). In this dissertation, I will refer to the determinants of health as determinants of health and well-being because the latter is more closely aligned with Aboriginal terminology. The Commission on Social Determinants of Health (2007) consistently used this term in their international work with indigenous populations.

Social determinants of health and well-being were seen to be intricately connected and together they impacted the well-being of a population. Health experts traditionally focused on lifestyle factors (e.g., smoking, physical activity, diet) and genetics and their effect on health and illness. Today, experts take a more upstream approach and focus on the importance of social determinants (e.g., socio-economic conditions) influencing the well-being of individuals, communities, and populations. Personal, social, physical capacity, and resources determined whether one attained his or her aspirations for well-being, satisfied their needs, and managed contextual factors (Raphael, 2004b). Three determinants of health and well-being frameworks (Hamilton & Bhatti, 1996; Public Health Agency of Canada, n.d.; Raphael, 2004b) were key to understanding social determinants of health and well-being in Canada (see Table 2).

Over time there was significant change in conceptualizing the determinants of health and well-being. From the first framework, culture and gender were added to the second framework, but then did not appear in the third, and most recent, framework, The Toronto Charter for a Healthy Canada (Raphael, 2004b) developed in 2002. In it, the category of social exclusion did cover some of these issues in its definition as "the process by which Canadians are denied opportunities to participate in many aspects of cultural, economic, social and political life" (Raphael, 2004b, p. 363). Furthermore, populations that were marginalized were added, with a specific emphasis on Aboriginal peoples (Raphael, 2004b). These populations were particularly at risk for poorer health and well-being due to their exposure to various socio-economic components of well-being such as income and income distribution, employment working conditions, affordable housing, and the reality of safety nets. Raphael (2004a) placed a major focus on the socio-economic predictors of wellness including employment, unemployment, income security, income equality, social safety net, and food security as data supported the biggest gain in health status was attained by addressing these issues.

Although coping skills were not included, Raphael (2004a) did allude to the capacity for coping with the environment when describing the social determinants of well-being. Missing from the Toronto Charter list were biology, genetics, and personal health practices. Raphael explicitly stated, as noted earlier in this section, these were traditional determinants of health and simply not as influential as the socio-economic determinants for health and well-being.

Adding Aboriginal status to the latest Canadian Social Determinants of Health Framework (Raphael, 2004b; Shah, 2004) acknowledged the disparities in health status between Aboriginal peoples and Canadians overall, but the disparities were linked to many of the more traditional lifestyle factors such as smoking, substance abuse, nutrition, physical activity, body mass index, sexual practices, and immunization along with mortality and morbidity. Although some discussion was included on the socio-economic factors impacting health (e.g., education, employment, income, family violence, and housing)

Table 2

Determinants of Health and Well-being

Determinants of Health and Well-being	**Integrated Model of Population Health and Health Promotion (Hamilton & Bhatti, 1996)**	**Public Health Agency of Canada (Public Health Agency of Canada, n. d.)**	**Strengthening the social determinants of health: The Toronto Charter for a Healthy Canada (Raphael, 2004b)**
	Health services	Health services	Healthcare services
	Healthy child development	Healthy child development	Early life
	Personal health, practices & coping skills	Personal health practices & coping skills	
	Biology & genetics	Biology & genetic endowment	
	Physical environments	Physical environments	
		Social environments	Social exclusion
			Housing
	Working conditions	Employment & working conditions	Employment & working conditions
	Education	Education & literacy	Education
	Social support networks	Social support networks	
	Income & social status	Income & social status	Income & its distribution
		Gender	
		Culture	
			Social safety net
			Unemployment & employment security
			Food security

	Canadian women, Aboriginal people, Canadians of colour, & new Canadians[1]

(Shah, 2004), the significant focus was on the former, perpetuating a problem-based, downstream approach.

A brief discussion on healthcare organizations (e.g., jurisdictional programming, geographic isolation) and their potential impact on the well-being of the Aboriginal population was also included (Shah, 2004). No mention was made of culturally safe care and the responsibilities of health and social organizations to address institutional racism. Cultural awareness and sensitivity were considered more downstream challenges. However, these factors will have a significant impact on whether Aboriginal people access healthcare services, influencing earlier diagnosis of chronic conditions as well as overall well-being both physically and mentally.

In 2008, a think tank was held by the Métis Centre, National Aboriginal Health Organization to discuss Métis Determinants of Health. A literature search and discussions resulted in the development of a report on the topic (Dyck, n.d.). The report stressed the diversity of the Métis population and how the proposed framework did not address all perspectives but did provide some overarching themes. A set of underlying principles were identified in the development of the framework: it needed to be interconnected, flexible, and culturally relevant, consider context, focus on well-being, and incorporate holistic approaches. Central components of the framework included self-determination, colonization, spirituality, land and culture, and tradition. The developed framework was based on a continuum from past historical influences to the future. Past historical impacts on the health of the Métis population included colonialism, racism, marginalization, lack of Métis peoples' rights, and lack of land. In moving to the present, there was a concern by

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[1] Although all groups were mentioned in the Toronto Charter, there is a specific focus on Aboriginal status as a social determinant of health and well-being

participants that Métis knowledge and traditions (language, spirituality) were lost. The future phase provided the components of self-determination, resiliency, resurgence, healing, and education to counteract the past determinants of health.

The Métis Nation of Canada, a national Canadian organization, also developed a "Métis Nation Holistic Health/Well-being Framework" (Métis Nation of Canada, n.d.). Seven determinants of health and well-being were included: social environment; physical environment; economic opportunity; healthcare services; lifelong education; lifestyle habits and coping; and spirituality. These determinants were similar to other Canadian frameworks, except for the addition of spirituality. Spirituality referred to the involvement of Métis peoples in traditional ceremonies and other religious organizations. Generally, however, this list of determinants was limited.

Further work (Commission on Social Determinants of Health, 2007) was completed on the determinants of health and well-being and their relationship to the health of indigenous populations internationally. In addition to the already mentioned social determinants of health and well-being, six themes specifically linked to the health of indigenous people were identified. First, colonization was described as the most important determinant, fundamental to Aboriginal health and well-being. Historical influences such as European contact, displacement, assimilation, cultural genocide, and residential schooling were recognized to have significantly impacted the health and healthcare experiences of many individuals and communities. Second, was the connection for indigenous people to the land, the severing of which led to reduced cultural practices and participation in traditional economic activities which in turn impacted health and well-being. Third, was the deep seated poverty and economic inequities that led to poor health status for many indigenous people. Fourth was land degradation and climate change, which was seen as impacting indigenous peoples' ability to earn a living off the land as well as impacting their cultural traditions. Fifth, there was the profound "lack of understanding of Indigenous culture and worldviews" (p. 3) impacting society's understanding of health and well-being for this population and a lack of respect for their beliefs and values. Last, but not least, racism was identified as a significant determinant of health and well-being for indigenous populations (Commission on Social Determinants of Health (2007).

Krieger (2003) also suggested racism needed to be recognized, acknowledged, and assessed as a distinct determinant of well-being.

> Racism impacts the well-being of individuals and groups in the following ways: social and economic deprivation; toxic substances and hazardous conditions; socially inflicted trauma (mental, physical and sexual, directly experienced or witnessed, from verbal threats to violent acts; targeted marketing of commodities that can harm health such as junk food and psychoactive substances (alcohol, tobacco, and other licit or illicit drugs); and inadequate or degrading medical care (Krieger, 2002 as cited in Krieger, 2003, p. 196).

Racism was believed to be the underlying origin of much of the deficit thinking (Menchaca, 1997) where blame for circumstances and problems was placed on innocent individuals or groups by those from a dominant culture (Ryan, 1971). Racism was evidenced in both overt and covert acts of discrimination. Racism could be practiced in a number of different ways. Most often racism was identified as happening at the individual level; discriminating, degrading remarks were made to an individual or services were withheld from an individual (Adams, 1999; Jones, 2001; LaRocque, n.d.). Racism exhibited through discrimination also occurred at the organizational level where organizational policies provided inequitable treatment for different individuals or groups of people (Jones, 2001) (e.g., translation services were provided to one group of people but not to another). The most concerning was the systemic racism in society. Stereotypes and assumptions were deeply embedded in the ideology of colonized civilization and its establishments (e.g., schools, churches, media). These beliefs, stereotypes, and assumptions were assumed to be the norm and hence most people were unaware of the racism. Systemic racism was so profoundly entrenched in Canadian society. (Adams, 1999; LaRocque, n.d.). Sub-categories of racism were also described. *Othering* implied a deficit position where the dominant culture was superior (Ramsden, 2002). Romanticizing of Aboriginal people and their culture was discriminatory where experiences were sensationalized and real impact was not acknowledged. Democratic racism occurred when one said something, but did the opposite (Browne & Varcoe, 2006). Tolerance, another form of racism, was described as "fundamental ambivalence toward the other" (Browne & Varcoe, 2006, p. 160). All forms of racism, manifested in various acts of discrimination or non action, perpetuated the victimization and oppression experienced by Aboriginal peoples today.

The determinants of health and well-being discussed in this section were all important in understanding the well-being of Aboriginal individuals, families, and the Aboriginal population in urban settings. Determinants are interdependent, one with another, and ought to be addressed as a whole, promoting a holistic approach to facilitating Aboriginal peoples' well-being. To address the real needs of this population, social determinant frameworks should be used as a foundation in the assessment, planning, and implementation of primary healthcare services for the urban Aboriginal population. Delivering services built on determinants of health and well-being frameworks will assist managers and providers to move from the western biomedical model to incorporate Aboriginal worldviews of wellness. These frameworks will also assist healthcare providers in moving to a focus on strengths as discussed in the following section of this chapter.

Changing the Focus to Wellness and Strength

Many of the challenges Aboriginal people faced were in large part directly connected to historical events and policies (Royal Commission on Aboriginal Peoples, 1996). To reconcile western biomedical models of health and healthcare with Aboriginal models, a change in focus to a paradigm of wellness and strength was required. Well-being, as previously described, was a more familiar concept for Aboriginal peoples and better described their understanding of health.

Strength too was a familiar Aboriginal concept. Underscoring "individual and collective resources…strengths exist in activities, places, people, values, beliefs, and traditions that are working well in the life of the individual and/or community" (Van Uchelen et al., 1997, p. 40). Even when things were not going well, these sources of strength existed to be called upon. Support and nurturing of these strengths facilitated individual, family, and community wellness. A strength-based approach focused on the positive aspects of well-being rather than deficits behind health problems and issues. For Aboriginal peoples, the move from dependency on the state to self-determination was a strength to be supported (Royal Commission for Aboriginal Peoples, 1996), and would be obtained with direct involvement in and/or control of healthcare services by Aboriginal peoples for Aboriginal peoples.

A continued focus on problems and deficits could be framed as a continuation of the colonist ideals of setting their values above others and their practices as the best. This perpetuation of power over Aboriginal peoples often resulted in blaming the individual or group for their problems. A focus on individual, family, and community strength created a more positive approach, an approach required to impact the well-being of the Aboriginal population.

In summary, a focus on strengths, wellness, and the resilience of Aboriginal peoples was more aligned with Aboriginal ways of thinking and being. It also moved away from the more conventional deficit approach of colonizing institutions. The following section will report on the health status of Aboriginal peoples, using the determinants of health and well-being as a focus.

Health Status of Aboriginal Peoples in Canada

Given the predominance of the biomedical model, health status for Aboriginal and non-Aboriginal people in Canada was usually described in terms of mortality and morbidity. Attention to the determinants of health was growing in Canada and internationally, particularly in the public and population healthcare spheres (Marmot, 2005) as compared to the dominant healthcare system focusing on biomedical model. The Senate Committee on Population Health (2009) stated: “Although ill-health is distributed throughout the whole population, it is borne disproportionately by specific groups, notably Aboriginal peoples and individuals and families whose incomes are low” (Senate Subcommittee on Population Health, 2009, p. 9). Some believe the health status of Aboriginal peoples living in Canada was comparable to the health status of individuals living in developing nations (Cooke, Beavon, & McHardy, 2004 as cited in Reading, 2009). Although life expectancy for Aboriginal men and women improved, gaps in life expectancy were still apparent between non-Aboriginal and Aboriginal peoples (Senate Subcommittee on Population Health, 2009; British Columbia Provincial Health Officer, 2009), showing disparities between Aboriginal and non-Aboriginal Canadians continued to exist.

In the 2001 Aboriginal Peoples Survey conducted with non-reserve Aboriginal Canadians, 56% rated their overall health as very good or excellent, although still lower than Canadians overall. The difference was insignificant in the 15-24 year old age group (69% off-reserve Aboriginal peoples versus 71% in the non-Aboriginal population) (O'Donnell & Tait, 2004). Results from the 2000/01 Canadian Community Health Survey found 23% of Aboriginal peoples living off-reserve stated their health was either fair or poor. The rate of fair and poor health decreased as income increased, but a significant gap remianed between Aboriginal and non-Aboriginals in all three income levels (Tjepkema, 2002).

Sixty percent of off-reserve Aboriginal peoples versus 50% non-Aboriginal peoples reported at least one chronic condition. Not unexpectedly, the greatest disparity existed for diabetes where rates were double for Aboriginal peoples (Tjepkema, 2002). Obesity rates were also higher for Aboriginal peoples (Garriguet, 2008). Depression rates were reported to be 1.8 times higher for off-reserve Aboriginal peoplea (13% reported a major depression event in the last year) as compared to non-Aboriginal peoples (Tjepkema, 2002). Injuries were reported at a rate of 1.4 times higher by Aboriginal peoples than their non-Aboriginal counterparts in provinces across Canada, and activity limitations were 1.7 times higher (Tjepkema, 2005).

Studies repeatedly showed that income and education, significant determinants of health, were considerably different between Aboriginal and non-Aboriginal peoples living in Canada. Thirty-one percent of Aboriginal peoples lived in low income families as compared to 12% for non-Aboriginal peoples. The average income for Aboriginal households was $33,000 versus $43,000 for non-Aboriginal households. Unemployment rates were 19% and 7% for Aboriginal and non-Aboriginal peoples respectively. Lower income individuals had lower self-reported levels of health both for Aboriginal and non-Aboriginal peoples, although there was a major gap between Aboriginal and non-

Aboriginal peoples at each income level (low, medium and high). Although education levels for Aboriginal peoples improved over several years, there was still a gap between them and non-Aboriginal peoples. In those aged 15 and over (2001 Census), 48% had less than a high school education compared to 30% of non-Aboriginal peoples, and 3.4% had a Bachelor's degree compared to 10.8% of non-Aboriginal peoples (Loppie Reading & Wiens, 2009). Attendance at school by urban Aboriginal youth (15-24 years of age) increased from 1981 to 2001. There also was an increase in the number of young adults completing post-secondary education (Siggner & Rosalinda Costa, 2005).

Housing was another important determinant of health. According to research, 15% of all Aboriginal people lived in overcrowded homes as compared to 3% of non-Aboriginal people. Many of those homes required major repairs; in fact 14% and 28% of Métis and First Nations' people respectively lived in houses requiring major repairs in contrast to only 7% of non-Aboriginal people. In 1998-99, off-reserve Aboriginal people were almost three times as likely as non-Aboriginal people to live in households that lacked food security (Loppie Reading & Wiens, 2009). Results from the Aboriginal Children's Survey (First Nations, Métis, and Inuit living off-reserve) (O'Donnell, 2008) showed parents and guardians reporting higher levels of dissatisfaction with their finances and housing as compared to non-Aboriginal people (Statistics Canada, 2008a).

Furthermore, access to safe and affordable housing options were difficult for those on a low income. Hence they ended up living in situations where repairs were required, crime and vandalism were frequent, or they did not find housing at all. Homelessness increased in all Canadian cities, but a major increase was seen in the past 10 years in Calgary - in fact a shocking 650 % increase (Calgary Committee to End Homelessness, 2008). Overrepresentation of Aboriginal people in the homeless population persisted in Canada (Laird, 2007). In Calgary, 31% of those registered with the Homelessness Registry (those with a high vulnerability index) were Aboriginal (Calgary Homeless Foundation, 2009a). Representation of Aboriginal women living in secondary shelters due to domestic violence was also far higher than one would expect, with approximately one third of women living in shelters being Aboriginal (Thurston, 2006). Homelessness was a significant issue for urban Aboriginal individuals with complex underlying problems (Browne, McDonald, & Elliott, 2009). The extent of homelessness for this population was difficult to determine.

The Aboriginal Children's Survey (O'Donnell, 2008) reported off-reserve parents and guardians being very satisfied or satisfied with their social support networks. Yet the number of Aboriginal children and youth in care was estimated to be between 30 and 40% (Gough, Trocme, Brown, Knoke, & Blackstock, 2005). Specific numbers for urban Aboriginal children and youth were not available, although work done in Vancouver proposed that a disturbing 70% of children and youth in care were of Aboriginal background (Culhane, 2003). Children in care were at a much higher risk for negative outcomes (e.g., being involved with the justice system, isolation from their culture) (Browne et al., 2009; Gough et al., 2005), although other issues, beyond being in care, may also have contributed to negative outcomes for these children.

In a recently published British Columbia report (British Columbia Provincial Health Officer, 2009), various health indicators showed significant deficits for the Aboriginal population (Status Aboriginals only) compared to the general population. Although some of these indicators improved for the Aboriginal population over the last five years, the gap continued to exist. Deaths due to external causes (e.g., MVAs, accidental poisoning, substance abuse) were two to four times higher than those of British Columbia's overall population. Incidence of chronic disease and hospitalizations for various conditions was higher. The largest gap between Aboriginal and non-Aboriginal populations in British Columbia was with patients with HIV; they were hospitalized more frequently and death rates were higher. Of significant interest was the gap in socio-economic indicators, known to have considerable impact on health. Housing, food security, unemployment, and income levels were genuine challenges for Aboriginal peoples. Community well-being, another indicator of well-being for a population or community, was assessed in British Columbia. Only two First Nations' communities were in the top or best fifty communities, while First Nations' communities occupied all of the bottom fifty communities (British Columbia Provincial Health Officer, 2009).

In summary, although there was significant improvement in the health status of Canadian Aboriginal peoples over the last number of years, disparities in health status remained significant. Reframing health and healthcare services will need to be a priority for elimination of the gaps to be undertaken seriously. Consideration of Aboriginal concepts of health and well-being, historical influences, and the social determinants of health and well-being will facilitate addressing the gaps in health status. An increased focus on strengths, capacity, and Aboriginal community solutions, through increased self-determination and self-governance, will be another paradigm shift needed to develop effective and sustainable supports for Aboriginal well-being (Potvin, Cargo, McComber, Delormier, & Macauly, 2003; Wallerstein, 1993). For the urban Aboriginal population in Calgary, an effective primary healthcare system will be needed to address the health disparities and inequities. The following section will describe primary healthcare concepts and components required for an effective primary healthcare system.

Primary Healthcare

Currently, **Primary healthcare** is thought to be foundational to “a comprehensive national health system,” (World Health Organization, 1978, p. 3) and provides the underpinning of our Canadian health system (Health Council of Canada, 2005a). A focus on primary healthcare has the potential to improve health outcomes by addressing the needs of the population effectively and efficiently (Calnan & Lemire Rodger, 2002; World Health Organization, 2008). Reframing of healthcare to primary healthcare was introduced at the Alma-Ata Conference in 1978. The Alma-Ata Declaration outlined four basic principles of primary healthcare: universal access; equity; intersectoral collaboration; and participation of individuals and communities in the planning and implementation of healthcare services (World Health Organization, 1978). More recently, a number of key components have been added to the discussion around primary healthcare by other organizations and forums (Table 3). The following were the key components identified: the incorporation of the social determinants of health; the move to focus on upstream disease and injury prevention and health promotion; the effective utilization of interprofessional teams; the importance of information technology and electronic health records; and the need to focus on continuity

Table 3

Additional Components of Primary Healthcare

Organizational Document	Additional Components
Canadian Public Health Association (1990)	• Accessible services close to home • Health promotion, illness and injury prevention focus • Utilization of technology/information systems
Health Transition Fund Synthesis Series primary healthcare (Mable & Mariott, 2002)	• Incorporation of determinants of health and well-being • Health promotion, illness and injury prevention focus • Physicians working in groups • Comprehensive core services • Coordination and integration • Utilization of interprofessional teams with role optimization of all healthcare providers • Utilization of information systems
The Health of Canadians - The Federal Role Volume Six: Recommendations for Reform Final Report on the state of the healthcare system in Canada (Kirby, 2002)	• Utilization of interprofessional teams with an emphasis on the right provider • Comprehensive range of services with appropriate 24-7 access • Population needs-based services • Health promotion, illness and injury prevention focus • Utilization of Electronic Health Record • Utilization of alternate funding models
Building on values: the future of healthcare in Canada final report (Romanow, 2002)	• Incorporation of determinants of health and well-being • Health promotion, illness and injury prevention focus • Continuity and coordination • Population needs-based services • Utilization of interprofessional teams with role optimization of all healthcare providers • Integration of community-based leadership • Utilization of Electronic Health Record

Building on values: the future of healthcare in Canada final report (Romanow, 2002) (cont'd)	• Outcomes focus
World Health Report (2003)	• Accessible services close to home • Incorporation of determinants of health and well-being • Effective provision of healthcare services to the poor and groups who were marginalized • Health promotion, illness and injury prevention focus • Incorporation of broader population health issues • Seamless integration of care • Evaluation and performance measurement
Health Council of Canada (2005a)	• Community-based service delivery • Incorporation of the determinants of health and well-being • Focus on the population they serve • Health promotion, illness and injury prevention focus • Continuity and integration across the healthcare system • Incorporation of interprofessional teams • "Appropriate access to specialized health resources" (p.5)
World Health Report (2008)	• Increase of health inequalities between and within countries • Attention to population changes (urbanization, aging) • Political and economic instability • Fragmentation increased by focusing on episodic care • Reinforcement of social justice values, universality of healthcare • Integration of primary healthcare reform initiatives • Universal coverage for improvement of health equity

World Health Report (2008) (cont'd)	• Service delivery changes to ensure people-centeredness in health systems • Leadership reforms for reliability and accountability • Public policy changes "to promote and protect the health of communities" (p. xvi)

and integration of care. Unfortunately, only four of seven organizations recognized the necessity of looking at the needs of the population as a basis for service delivery and only three out of seven documents discussed the importance of accountability and outcomes. Although equity was the underlying principle for all discussions about primary healthcare, only the World Health Organization (2003; 2008) strongly reiterated the need for universality in healthcare. Equitable healthcare for all populations was stressed, including those with health disparities. The World Health Organization (2003) specifically mentioned populations who were marginalized.

Primary care was often used interchangeably with primary healthcare. In actuality, primary care was a subset of primary healthcare where frontline services were provided by a group of healthcare providers to a defined population, as opposed to a broader primary healthcare system directed by a larger set of principles discussed in previous paragraphs. However, some of those principles also applied to primary care. Primary care was characterized by first contact with the healthcare system for a perceived need. Care was accessible from a perspective of time and place (Starfield, 1993). Primary care was based on a longitudinal relationship with a healthcare provider or team of providers (Starfield, 1993; Tarimo & Webster, 1997 as cited in World Health Organization, 2008); it was comprehensive (Starfield, 1993) and had the opportunity to include prevention and promotion services (Tarimo & Webster, 1997 as cited in World Health Organization, 2008). Care coordination with other providers and services (e.g., referrals to specialty care, diagnostic services and procedures, etc.) was a key responsibility of primary care providers (Starfield, 1993; Tarimo & Webster, 1997 as cited in World Health Organization, 2008). Follow-up evaluation and monitoring of patient concerns was a key component of primary care (Starfield, 1993). Descriptions of primary care conceptualized care as being people-centered; a central component of a primary healthcare system.

Other authors (Health Council of Canada, 2005a; Starfield, 1992) made a distinction between primary care and **primary medical care**. Primary medical care was seen as a component of primary care focusing on clinical interactions for patients to address their needs. For the purposes of this study I distinguished between the three terms and did not use them interchangeably. Primary healthcare, the broadest term, referred to a healthcare system incorporating a set of primary healthcare principles; primary care was defined as the first point of contact with the healthcare system, whether with a primary care physician or other provider; and, primary medical care indicated care provided by primary care physicians for their patients.

Primary Healthcare Reform

Throughout the process of healthcare renewal provincially, nationally, and internationally, primary healthcare received much attention. Primary healthcare was a major focus of health systems reform (Crabtree, 1994; Lamarche, Beaulieu, Pineault, Contandriopoulos, Denis, & Haggerty, 2003; Moores, Donoff, Cave, Wilson, & Woodhead Lyons, 2002) and was highlighted in several key reports provincially (Mazankowski, 2001) and nationally (Kirby, 2002; Romanow, 2002). Quality of care, access to care (primary care, emergency services, specialists, and diagnostic testing), and lack of integration of services, particularly for those with complex health concerns, were identified as critical issues for physicians, other healthcare professionals, and the public (Health Council of Canada, 2005b; Quinn, 2003; Suter et al., 2007). Changes in healthcare trends were apparent, such as the changing demographics of the population (Aboriginal populations becoming younger and non-Aboriginal populations becoming older), increasing costs of service delivery, and shortages of healthcare providers (Bohmer & Edmonson, 2001; Statistics Canada, 2008b; World Health Organization, 2003), all of which made changes in healthcare service delivery necessary.

The Trilateral Agreement between Alberta Health and Wellness, the Alberta Medical Association, and Alberta Health Services, formerly Regional Health Authorities, provided an opportunity to facilitate the development of new ways to deliver primary healthcare services in Alberta (AMA, 2003; Primary Care Initiative, n.d.). **Primary Care Networks** were a formal relationship between physicians and Alberta Health Services to plan and deliver healthcare services for a specific population, geographic or otherwise. Primary Care Networks in Alberta (Primary Care Initiative, n.d.), **Family Health Teams** in Ontario (Ontario Ministry of Health and Long-term Care, 2009), and similar arrangements in other jurisdictions (Walker & Adam, 1998) had the potential to address the primary healthcare needs of populations and providers. Primary healthcare reform had the ability to provide timely access to healthcare services and teams to facilitate better access to information and care to prevent disease and promote health and to create a supportive environment for providers working in primary healthcare (Health Evidence Network, 2004; Starfield, Shi, & Macinko, 2005).

Indicators of Successful Primary Healthcare Systems

Many authors suggested there was no one model of primary healthcare to neither meet the needs of all populations, nor fit policy demands (Calnan & Lemire Rodger, 2002; Health Council of Canada, 2005a; Mable & Mariott, 2002; World Health Organization, 2008). The renewed focus on primary healthcare in Canada led to the creation of performance measurement frameworks to provide direction for development, implementation, and subsequent evaluation of primary healthcare models. Several key frameworks highlighted and provided information for important indicators, useful to measure an effective primary healthcare system. The Canadian Institute for Health Information (2006) undertook an extensive process of developing indicators for primary healthcare, resulting in 105 indicators that crossed eight key areas: access; comprehensive care including prevention and promotion and the management of chronic complex patients; continuity and coordination of care; accessibility to primary healthcare services 24/7; patient-centred care; focus on population health; quality and safety of primary healthcare; and components that support primary healthcare (e.g., providers, interprofessional teams, technology).

The Centre for Health Services and Policy Research at the University of British Columbia (Broemeling, Watson, Black, & Reid, 2006) developed a logic model for primary healthcare evaluation. They suggested primary healthcare effectiveness was based on a series of outcomes such as improved quality of life for providers, use of the appropriate provider, increased knowledge for populations about health and healthcare, reduced risk of acute and chronic health conditions, acceptability of services for patients and populations, and equity. These outcomes in turn will influence the longer term outcomes of a sustainable health system, improved health and well-being of the population, and a decrease in health disparities.

Both frameworks to measure the success of primary healthcare systems were very comprehensive, particularly the indicators recommended by the Canadian Institute for Health Information. They were developed for primary healthcare systems for the population as a whole, therefore indicators specific to the Aboriginal population were not included.

To summarize, primary healthcare was described as the foundation for a healthcare system in Canada. Primary healthcare was comprised of nine key components abstracted from the documents reviewed on primary healthcare: universal access; equity and addressing the needs of populations who were marginalized; intersectoral collaboration; community participation; population health approach; effective utilization of interprofessional teams; information technology and electronic health records; continuity and integration; and focus on evaluation and outcomes. Healthcare reform focused on primary healthcare with the development and implementation of such initiatives as primary care networks and family health teams. With an emphasis on primary healthcare in reform initiatives there also was a focus on outcomes measurement. One of the key components of primary healthcare was interprofessional collaborative team practice. This will be the focus of the following section.

Collaborative Patient-Centred Practice

Interprofessional collaborative patient-centred practice was a key component of primary healthcare that received increasing attention during the past decade. Healthcare delivered by an interprofessional team had the potential to better address the needs of patients (Bohmer & Edmonson, 2001), especially those with complex health issues (Schmitt, 2001); respond to needs in a more timely manner; improve quality of health services (Bohmer & Edmonson, 2001); impact positively patient safety; and increase provider satisfaction (Health Council of Canada, 2005b). As primary healthcare focused on the social determinants of health, in turn the healthcare team required intersectoral collaboration to address both the health and social needs of individuals and communities.

Notwithstanding the potential benefits of interprofessional teams for patients, providers, and the healthcare system, there was little evidence of the outcomes of interprofessional collaborative practice teams. Some evidence did exist for patient, provider, and system level outcomes in the areas of chronic disease management, mental health, and specialized populations (Barrett, Curran, Glynn, & Goodwin, 2007). "Outcomes include enhanced patient/client self-care, knowledge and outcomes; enhanced provider satisfaction, knowledge, skills and practice behaviors; and system enhancements such as the provision of a broader range of services, better access, shorter wait times and more effective resource utilization" (Barrett et al., 2007, p. i). Patients reported more knowledge of their condition when involved in team-based care (Canadian Institute for Health Information, 2009). There was also evidence that interprofessional collaborative practice decreased visits to the physician and hospitals (Sommers, Marton, Barbaccia, & Randolph, 2000). However, teams alone were not successful in achieving outcomes (Health Council of Canada, 2009). The appropriate staff mix with required skills training (e.g., communication, teamwork, content expertise) was necessary for success (Borrill, West, Shapiro, & Rees, 2000; Jones, 1992; Poulton & West, 1999).

Patient-centred teams were an important component of primary healthcare service delivery, particularly for the more complex patient. Though only early results were available, patient-centred teams had the potential for positive outcomes for patients, providers, and the primary healthcare system. Collaboration beyond the health sector will be required to address the multiple health and social needs often found in Aboriginal communities. Cultural competency of team members will be an important component of their service delivery. Cultural safety will be the focus of the following section.

Cultural Safety

Because of the different paradigms of health, the social determinants of health, and racism inherent in systems, **cultural safety** and primary healthcare were inextricably linked. Although cultural safety was not a primary healthcare principle, it was imperative that cultural safety be incorporated into primary healthcare systems, particularly those delivering healthcare services to Aboriginal peoples. Healthcare services provided for Aboriginal peoples both on- and off-reserve were often not perceived to be culturally safe. Aboriginal worldviews (values and beliefs) were not well understood and healthcare was not provided using a holistic approach focusing on physical, emotional, mental, and spiritual aspects of well-being (Smye & Mussell, 2001; Waldram et al., 2006). As a result, Aboriginal peoples were often treated with a lack of respect and with patronizing and harsh tones. They were misunderstood, judged, and not well accepted (Browne & Fiske, 2001; Crane & McFarlane, 2006; Culhane Speck, 1987; Masotti, Szala-Meneok, Selby, Ranford & Van Koughnett, 2003; Sinclair, Smith & Stevenson, 2006). Maintenance of privacy and lack of adequate explanations for diagnostics and treatments were also described as sources of disrespect and lack of safety. Overall, Aboriginal peoples were often treated as inferior (Browne, 1995). Furthermore, recognition of the historical impacts of colonization was not taken into account when providing care to Aboriginal peoples. The need for culturally safe healthcare was evident.

The concept of cultural safety, Kawa Whakaruruhau, originated in New Zealand and was defined as:

> The effective practice for a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and, disability…Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual (Nursing Council of New Zealand, 2005, p. 4).

Cultural safety was based on five key principles (Nursing Council of New Zealand, 2005; Ramsden, 2002): personal analysis of one's own culture, professional culture, and health system culture and their impact on the patient or community; diversity, a recognition and legitimacy of difference; consideration of historical, social, economic, and political influences on health and healthcare experiences of individuals and communities; recognition of power differentials between the patient and the healthcare professional; and the involvement of the patient in their healthcare. Cultural safety also incorporated the principles of the Treaty of Waitangi including: partnership, participation, and protection (Manchester, 2002; Nursing Council of New Zealand, 2005; Ramsden, 2002; Tupara, 2001).

The concept of cultural safety was alluded to in the primary healthcare principles via delivery of people-centred care (World Health Organization, 2008) and participation in primary healthcare service delivery (World Health Organization, 1978). Cultural safety fit well with a collaborative, equitable patient-centred practice through the inclusion of the patient, family, and community as equal members of the team, based on the principles of partnership and participation (Tupara, 2001; World Health Organization, 1978).

In summary, cultural safety, although not a key component of primary healthcare, was well-aligned with this framework. The importance of a culturally safe healthcare system for Aboriginal people was evident given the racism and other impacts of colonizing structures that currently exist. The concept of cultural safety originated in New Zealand and was focused on care that recognized the power differentials between individuals and the system and the historical impacts of oppression for Aboriginal peoples. The following section will focus on primary healthcare service delivery for Aboriginal people in Canada and locally.

Healthcare Services for Aboriginal Peoples in Canada

Healthcare benefits were negotiated for First Nations' people in Canada through numbered Treaties signed by the British and Canadian governments in Canada from 1871 through 1930 (Waldram et al., 2006). Although contentious within some groups, the Treaties were understood to mean that First Nations' populations had the "right to free, comprehensive medical services" (Waldram et al., 2006, p. 173) including Non-Insured Health Benefits. It was important to note that Treaty benefits only covered First Nations' Aboriginal peoples with Indian status. Non-status First Nations' peoples, Métis, and Inuit were not covered in these agreements.

Various changes occurred over the years in health policy and the delivery of healthcare services for Aboriginal populations (Indian and Northern Affairs Canada, n.d.b). The Department of Indian and Northern Affairs was largely responsible for Aboriginal affairs including health and well-being until 1945 when official responsibility for health was moved to the First Nations and Inuit Health Branch of Health Canada (First Nations and Inuit Health Branch, n.d.a). Today, Indian and Northern Affairs Canada, as it is now called, works together with other federal departments, provincial and territorial governments, and other organizations to facilitate improved overall welfare for Aboriginal people and people living in Northern Canada. Indian and Northern Affairs Canada is one of 34 departments of the Federal Government that works with Canadian Aboriginal peoples. Through the Office of the Federal Interlocutor, Indian and Northern Affairs Canada also works with non-status Aboriginal individuals, Aboriginal people living in urban centres, and Métis (Indian and Northern Affairs Canada, n.d.b).

The First Nations and Inuit Health Branch's mandate was to improve the health of Aboriginal peoples in Canada. Initially, First Nations and Inuit Health Branch provided direct services to Aboriginal peoples on-reserve and to Inuit in northern Canada, but since the 1980s, efforts were initiated to enable First Nations and Inuit people to take control of their health services (First Nations and Inuit Health Branch, n.d.a). By 2005, transfer payments accounted for 45% of First Nations and Inuit Health Branch's budget expenditures (Waldram et al., 2006). First Nations and Inuit Health Branch worked closely with Aboriginal and Inuit communities to deliver healthcare services to their people directly or via self-governance arrangements. Most of the healthcare services included hiring of staff to work directly with communities, primary healthcare services such as community health nursing, and prevention and promotion services (First Nations and Inuit Health Branch, n.d.a). First Nations and Inuit Health Branch did not provide physician or hospital services, but administered the Non-Insured Health Benefits Program. This program provided such benefits as drug coverage, dental services, and vision care for those First Nations' peoples with status and Inuit people (First Nations and Inuit Health Branch, n.d.b). As the Federal Government funded health services for on-reserve Aboriginal populations, they had significant control over policy and the level of participation of Aboriginal peoples in the health system. The Assembly of First Nations provided input to Health Canada in an advisory capacity (Lavoie, 2004).

With the increase in urbanization, more and more services for Aboriginal peoples were provided by provincial healthcare plans (Waldram et al., 2006). Thus, those Aboriginal peoples not living on-reserve accessed and received the same healthcare services as the general population. The delivery of healthcare services for the urban Aboriginal population was largely left to the discretion of provincial and territorial governments, or in the case of many provinces, to local health authorities.

In Alberta, the face of provincial healthcare service delivery changed over the last couple of years. In the 1990s, healthcare services were regionalized, with a total of nine regions in its last iteration and the Calgary Health Region representing the largest health region in the province. In 2008, all health regions in Alberta were disbanded and a single provincial health authority, Alberta Health Services, was formed. This was the cause for frequent re-organization and sometimes minimal direction in service delivery over the last two years. As of 2010, a provincial Aboriginal Health Program within Alberta Health Services was implemented, reporting directly to the Vice President of Public Health. Programming differed across Alberta Health Services Zones, dependent on previous programming available past regional health authorities and the population demographics of the zone.

A variety of health and other services were provided for urban Aboriginal peoples in Calgary and in the surrounding areas. Individuals sought services from Aboriginal serving agencies (e.g., Elbow River Healing Lodge, Aboriginal Friendship Centre of Calgary, Calgary Métis Family Services, Awo Taan Healing Lodge) or mainstream organizations (e.g., Sheldon Chumir Urgent Care Centre, primary care physician's offices, community health centres). Primary healthcare services were also utilized at First Nations Health Centres on the reserves surrounding Calgary (e.g., Siksika, Tsuu T'ina, and the Stoney First Nations), as many individuals traveled back and forth between Calgary and their reserve.

The Aboriginal Health Program, Alberta Health Services, Calgary Zone, had been in operation for approximately 10 years. Initial work with the Program was completed in partnership with the Aboriginal Community Health Council, disbanded (as were all Community Health Councils) by the provincial government when regional health authorities were amalgamated into the current Alberta Health Services. Much of the initial work of the Aboriginal Health Program and Health Council included the development and implementation of the Elbow River Healing Lodge, which opened in Spring 2006. The Elbow River Healing Lodge offered primary care services, including services with family physicians. Social, economic, and cultural concerns as well as access, quality of care, and integration were addressed by the Elbow River Healing Lodge (Calgary Health Region, 2005).

The Elbow River Healing Lodge consisted of the following four components (Calgary Health Region, 2005):

- Enhanced clinical care pathways;
- A primary healthcare multidisciplinary team;
- A shared Aboriginal healthcare team; and
- Traditional medicine.

Another key primary healthcare program offered by Alberta Health Services, Calgary Zone was the Aboriginal Mental Health Program. A comprehensive listing of all programs currently a part of the primary healthcare system for Calgary urban Aboriginal people will be presented with the research findings in Chapter Five.

In summary, healthcare services for Aboriginal people had a long history of varied points of delivery dependent on the group of Aboriginal people and the timeframe. Services for First Nations were provided by the Federal Government or they transferred healthcare services to the Band Council, while services for Métis and non-status individuals were provided via provincial health services much the same way in which non-Aboriginal Canadians received services. A description of the current state of provincial healthcare services in Alberta reflected changes and impact of changes for Aboriginal health programming. Finally, primary healthcare services for Aboriginal peoples in Calgary were outlined. This specific area of healthcare, the primary healthcare system for the Calgary urban Aboriginal population will be the focus of this study.

Given the past history of research with Aboriginal peoples in Canada, research involving Aboriginal people now requires adherence to ethical codes of conduct. These will be discussed in the final section to set the ethical stage for this research.

Ethical Considerations in Research with Aboriginal Peoples

Historically, research with Aboriginal peoples in Canada and other jurisdictions was fraught with deficit thinking and disrespect. Aboriginal people were not involved - most research was *done to Aboriginal peoples* as opposed to *with Aboriginal peoples.* In essence, it was yet another way that colonization operated, through western views of research, oppression, and exploitation of the people being studied (First Nations Centre, 2007). There was a desire by Aboriginal peoples to be in control of their information and research conducted about Aboriginal peoples in Canada. Hence, two key policy documents were developed to oversee research with Aboriginal peoples in Canada. The first was broadly known as the OCAP principles (First Nations Centre, 2007; Schnarch, 2004) representing the desire and need for self-determination in the areas of information management and research. The OCAP principles were outlined as: ownership, referring to ownership of First Nations' communities of their cultural knowledge and other information; control, speaks to "their rights in seeking to control all aspects of research and information management processes which impact them (p. 2); access to data and research results; and possession, referring to the possession of data (Schnarch, 2004).

A second document was prepared by the Canadian Institutes for Health Research (2007), working in partnership with its Institute of Aboriginal Peoples' Health to produce ethical guidelines for health research with Aboriginal peoples. Consultations were conducted with Aboriginal researchers, community members, and other stakeholders. The document included a comprehensive set of guidelines with 15 articles. Articles covered such topics as: the valuing of Aboriginal worldviews; using a participatory approach; obtaining informed consent of community leaders and individuals; the recommendation of a research agreement outlining intellectual property issues, acknowledgement of contributions, control of research, involvement in interpretation, and review of results; protection of cultural and sacred knowledge; importance of ongoing communication; and ensuring the benefit of the research for the Aboriginal community.

Both the principles and guidelines outlined in these two documents were foundational to this research. In Chapter Four, specific ways in which these guidelines have been incorporated will be addressed. There were challenges in implementing these guiding principles. A research agreement was a particularly difficult. As this was a study with urban Aboriginal peopless, there was no single organization representing all Aboriginal peoples with which an agreement could be signed, and consequently one was not signed for this study.

In summary, research with Aboriginal peoples required the adherence to ethical principles as described in OCAP principles and Canadian Institutes of Health Research ethical guidelines. These principles were used to guide the protocols for this study.

The preceding sections described the context in which the research was situated. This context provided an important foundation for the researcher conducting the research; it will provide the essential background required for the reader when reviewing the results of the study. The following section, rationale for the study, concludes this chapter.

Summary and Rationale for the Study

Disparities in the health status between Aboriginal and non-Aboriginal Canadians were clearly evident and unacceptable. I have proposed that health systems should focus on reducing inequities through the development of programs and policies to support the rhetoric that these disparities are unacceptable. The primary healthcare system has the opportunity to attend to the inequities in well-being for Aboriginal people in Canada. An effective and efficient primary healthcare system based on the principles of primary healthcare could assist in addressing the healthcare needs for Aboriginal populations on- or off-reserve in rural or urban settings. Principles of access, equity, the development of services to address population health needs, and intersectoral partnerships will facilitate better health outcomes for Aboriginal peoples. Aboriginal leaders, healthcare professionals, and community members ought to be equal partners and participate in the process of planning and decision making for health services to address the needs of Aboriginal peoples (Labonte et al., 2009; Poxton, 1999). The social determinants of health and well-being should be taken into account, particularly historical impacts from colonization and racism. Interprofessional teams for collaborative practice are needed to address the often complex issues experienced by Aboriginal people. Healthcare services should reconcile western philosophical underpinnings with Aboriginal ways of thinking and being. A focus on the strength and resiliency of Aboriginal peoples will also be important. Culturally safe care (Ramsden, 2002) will be required. Racism and discrimination, it almost goes without saying, should be addressed in healthcare systems (Bucharski, Reutter, & Ogilvie, 2006; Sinclair et al., 2006). By focusing on the reduction and elimination of disparities and creating a primary healthcare system *with* Aboriginal peoples, the potential for a positive impact on the health status of Aboriginal peoples in Canada will be realized (Labonte et al., 2009).

Little was known about primary healthcare systems for urban Aboriginal peoples, as will be presented in the literature review in Chapter Three. The topic of this study was our current primary healthcare system for the Aboriginal population in the urban centre of Calgary, Alberta. An explication of what services currently exist, the strengths and gaps of the system, as well as an enhanced understanding of its processes and structures will assist in making improvements to better meet the needs of this population in an appropriate and acceptable manner and will extend knowledge of primary healthcare systems for urban Aboriginal peoples.

CHAPTER THREE—LITERATURE REVIEW

An extensive review of literature, both peer-reviewed and grey literature,[2] was conducted for this study. Various databases were searched along with a variety of websites, and a general search was done of the internet using the Google™ search engine. Databases and websites searched have been listed in Table 4. The following search terms were used: primary health care, primary care, community health, Aboriginal, indigenous, First Nations, Métis, and urban. The literature search was limited to information on primary healthcare services for urban Aboriginal people in Canada and by date (2000 – 2010). Overall, few peer-reviewed articles yielded information on primary healthcare services for urban Aboriginal people; reports on this topic were more available. Literature on other components of primary healthcare (e.g., education, social services) was initially collected, along with services for First Nations' and Métis' communities. It quickly became apparent this dissertation could not report this large body of literature. It was also apparent that much of the literature referred to reserves and other rural settings and would have little bearing on primary healthcare services in an urban context. Hence, the decision was made to focus the literature reported in this chapter on primary healthcare services for urban Aboriginal peoples in Canada, with the one exception of a better practices example of a primary healthcare system in Anchorage, Alaska, for Native American Indians and Alaskan Natives that was included. Literature on collaborative team practice in Aboriginal peoples' health and Aboriginal health human resources was also summarized as these two components were key to primary healthcare and impacted primary healthcare services for Aboriginal peoples. Information will be presented in the following order: national primary healthcare program information; provincial primary healthcare programs and specific urban centres in those provinces; specific service areas of primary healthcare; collaborative practice for patient-centred care; and Aboriginal health human resources. Then the literature review will be summarized in two key topic areas: key components of primary healthcare for urban

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[2] "Grey literature is the term used for documents and ephemeral material issued in limited amounts outside the formal channels of publication and distribution…Examples of grey literature include: scientific and technical reports, government documents, theses, patent documents etc." (University of Ottawa, n.d.).

Aboriginal populations and gaps in the literature. The chapter will end with the research questions for the study.

Table 4

Databases and Websites

Databases	**Websites cont'd**
Bibliography of Native North Americans	Indigenous Physicians Association of Canada
ERIC	Métis Nation of Alberta
Medline	Métis Nation of Canada
Social Work Abstracts	Métis National Council
Psychology and Behavioural Health Sciences	Native Aboriginal Health Organization
Websites	National Association of Friendship Centres
Aboriginal Canada Portal	National Collaborating Centre for Aboriginal Health
Aboriginal Healing Foundation	Native Women's Association of Canada
Aboriginal Nurses Association of Canada	NECHI
Aboriginal Human Resource Council	Prairie Women's Health Centre of Excellence
Aboriginal Health Human Resources Initiative	Public Health Agency of Canada
Aboriginal Act Now	Regina Qu'Appelle Health Region
Alberta Health Services Capital Health Region	Saskatoon Health Region
Anishnawbee Health Toronto	Truth and Reconciliation Committee
Assembly of First Nations	Vancouver Coastal Health
Government of Ontario	Vancouver Native Health Society
Health Canada	Winnipeg Health Region

National Primary Healthcare Services for Urban Aboriginal Populations

A national primary healthcare initiative implemented by Health Canada was the Aboriginal Diabetes Initiative focused on diabetes prevention and health promotion for Métis (those living in Métis settlements, rural, and urban areas), off-reserve First Nations' people (rural or urban), and Inuit (in urban areas). The initiative began in 2000 with funding extended to 2010. Funding was available for projects focused on primary prevention, health promotion, and awareness of diabetes risks (Health Canada, 2000).

Aboriginal Friendship Centres in urban centres across Canada provided an important gathering place for urban Aboriginal peoples and a range of primary healthcare services. A national organization, the National Association of Friendship Centres, represented the concerns of 121 Friendship Centres across Canada (National Association of Friendship Centres, 2006). Programming differed across Centres. Services provided included but were not limited to the following: language classes, traditional and spiritual activities, training and employment services, summer camps for children, activities for youth, programming for women suffering from abuse, and healing circles. Friendship Centres were an important resource for adults and families, particularly those new to an urban centre. For urban Aboriginal peoples they provided "a key connection to Aboriginal culture, spirituality and communal nature, and a key foundation to improving their health and well-being." (Canadian UNICEF Committee, p.42).

Although not a national initiative, a number of urban centres across Canada had Aboriginal Health Centres that provided a myriad of primary healthcare services to address the needs of the urban Aboriginal population (Browne et al., 2009; National Aboriginal Health Organization, 2002). Urban Aboriginal Health Centres were funded by provincial funding, private donations, and special project funding. Mixed funding generally led to fragmented care, not necessarily addressing the needs of the population served (Lavoie, 2005). Jurisdictional issues were a challenge for urban Aboriginal Health Centres (National Aboriginal Health Organization, 2002). "They are in fact 'patches' in the system tasked with addressing persistent inequities in access, particularly for those who 'fall through the cracks.' These clinics, therefore, are important features of the urban First Nations landscape in cities." (Browne et al., 2009, p.29).

A primary healthcare conference held in Winnipeg, Manitoba, discussed urban Aboriginal Health Centres as an exemplar of primary healthcare practice for Aboriginal people in Canada. The conference attendees agreed that these Aboriginal Health Centres incorporated traditional and western healthcare services, collaborative practice, interprofessional teams (e.g., physicians, nurses, social workers, community health workers, and Elders), and a positive health approach that focused on the strengths of clients (Intergovernmental Committee on First Nation Health, 2005). Examples of Urban Aboriginal Health Centres included: Anishnawbee Health Toronto, Access Health Centres in Ontario, Vancouver Native Health Society, and the Elbow River Healing Lodge in Calgary. Some of the urban Aboriginal Health Centres served the general Aboriginal population in the urban centre in which they were located while others provided services to a specific sub-population, such as was the case in Vancouver where a centre served the Downtown Eastside population.

Urban Aboriginal Health Centres faced issues that did not exist for health centres located in First Nations' communities. These included transportation issues, wherein individuals for the most part were responsible for their own transportation to and from the Health Centre. The significant diversity of Aboriginal peoples in urban centres made it more difficult to provide services that met the unique needs of community members. National meeting participants on urban Aboriginal Health Centres recommended the integration of western medicine with traditional medicine and worldviews as opposed to Aboriginal peoples integrating their views with a western, biomedical approach. They stressed the importance of interprofessional teams and coordination of care within health centres and with external services (National Aboriginal Health Organization, 2002).

In summary, information was provided on national urban primary healthcare initiatives for Aboriginal peoples in Canada. Two key components of primary healthcare described were Aboriginal Friendship Centres and Aboriginal Health Centres. The following sections of this chapter will focus on services for urban Aboriginal peoples in provinces and urban centres in Canada. Information will be organized by urban centres in their respective province.

Primary Healthcare Services for Urban Aboriginal Populations by Province

British Columbia

The British Columbia government has a relationship with Aboriginal peoples and the Federal Government for healthcare delivery for Aboriginal peoples living in the province. Through a Tripartite Agreement, the British Columbia government was given direct responsibility to provide all healthcare services to all Aboriginal peoples on- or off-reserve (British Columbia Provincial Health Officer, 2009). This Tripartite Agreement was signed in 2006 by the three parties (First Nations Leadership Council, Government of British Columbia, and First Nations and Inuit Health Branch, Health Canada) to commit to the development of a Tripartite First Nations Health Plan (British Columbia First Nations Leadership Council, Governments of Canada and British Columbia, 2007). This legislation was the first of its kind in Canada. All regional health authorities were required to develop an Aboriginal Health Plan addressing access to healthcare services, self-determination and self-governance of healthcare services, and data collection and outcomes measurement (British Columbia Provincial Health Officer, 2009). Each health authority was also mandated to have an Aboriginal Health Lead at the senior management level. This person acted as a primary contact for First Nations in a given region, oversaw planning and implementation of healthcare services to address the needs of the population, and oversaw the distribution of Aboriginal Health Initiative Program funding (Government of British Columbia, n.d.). Previously, there was lack of coordination and integration of healthcare services, particularly between levels of government. The goal of the Tripartite Agreement, senior management leadership, and an increased focus on healthcare service delivery for Aboriginal people was the increased coordination of services and improved health status for Aboriginal people in British Columbia (British Columbia Provincial Health Officer, 2009).

Fraser Health

Fraser Health, provided services to the urban areas of Surrey, Langley, Abbotsford, Chilliwack, and Mission, including several key programs for the urban Aboriginal population. There were two health centres located in the city of Surrey. One focused on women's health and was open to all women in the area, not specifically Aboriginal women. There was also a Healing Place Primary Health Clinic that provided the following services: community services; career counselling; employment services; programs for women, children, youth, families, men, and Elders; and health and wellness programs (e.g., primary care clinics, HIV/AIDs outreach, healing circles, support circles, and mental health).

> Several clients with complex health issues have experienced stabilization and improvement in current health status and improvement in outlook because of the holistic approach of clinic staff, extra time and effort spent with clients to build rapport during client interactions, and attention to the social determinants impacting health. (Fraser Health, 2010, p.17)

A major initiative of Fraser Health was the Aboriginal Patient Navigators, who provided support, advocacy, education, and navigation of services to individuals and families in hospitals and the community. Another focus was maternal and child health where cultural safety of perinatal programs was being assessed and a committee had been formed to look at the high infant mortality rate among First Nations' women. Health promotion programs (e.g., tobacco cessation, walking programs, nutrition, living well) were being conducted in partnership with Friendship Centres and surrounding First Nations' communities. Fraser Health was a key partner in Integrated Health Teams working in partnership with First Nations, government, and non-government agencies to identify needs and to collaborate to address those needs. The Aboriginal Operations Committee provided significant support and advocacy for Aboriginal healthcare services to ensure Aboriginal peoples' needs were met. Finally, Fraser Health offered opportunities for capacity building for Aboriginal employees within the organization and provided training to staff on working with Aboriginal peoples (e.g., all public health nurses received training as part of their orientation) (Fraser Health, 2010).

Vancouver Coastal Health

Vancouver Coastal Health (covering North and West Vancouver, Richmond, and coastal communities north of Vancouver) developed an Aboriginal Community Health Advisory Committee with urban and rural communities. Primary healthcare priority services encompassed maternity care, chronic disease management, and care of complex, frail patients. There was also an emphasis on coordination and integration of care. Programs and activities consisted of: Aboriginal Patient Navigator Program; cultural competency forum to act as a foundation for the development of a cultural competency framework; Human Resources Initiative to increase the number of Aboriginal staff; Aboriginal Advisory Circle to support Aboriginal employees; Aboriginal Healthy Family Strategy including food security, nutrition, physical activity, and tobacco reduction; Elder care; development of a mental health framework for Aboriginal peoples; and a number of health promotion initiatives (e.g., community kitchens) offered in partnership with other community organizations such as Friendship Centres. The goal of Aboriginal health initiatives in Vancouver and area was to increase access to healthcare services, to provide better coordination, and to educate healthcare providers about the effects of historical events for Aboriginal peoples (Vancouver Coastal Health, 2009b). Vancouver Coastal Health was working on an additional initiative focusing on self-determination to develop and implement data collection and health indicators for Aboriginal health. This initiative included partnering with provincial health outcomes initiatives (Vancouver Coastal Health, 2009a; Vancouver Coast Health, 2009b). In perusing the Vancouver Coastal Health website, numerous programs (mental health, youth, women and families) for Aboriginal people were apparent. Of note, these programs were distributed widely in Vancouver’s geographical area and appeared not to be connected to each other. One exception was a number of programs offered in the Downtown Eastside in partnership with the Vancouver Native Health Society and Sheway. These will be outlined in the following section of this chapter.

Vancouver Native Health Society and Sheway

In Vancouver approximately 70% of the Aboriginal population lived in the Downtown Eastside area, with many of these individuals women (Vancouver/Richmond Health Board, 1999). This population was extremely vulnerable given the substance abuse and violence occurring in this geographic area. In response to the needs of this population, an urban Aboriginal Health Centre, the Vancouver Native Health Society, was established in the Downtown Eastside in the 1990s; the Sheway Project was also established in the area at the same time. This Centre and its respective programs and the Project could be considered primary healthcare sub-systems addressing the needs of a specific, target population within the Aboriginal community in Vancouver.

The Vancouver Native Health Society opened its doors in 1992 with the intention of being administered by Aboriginal peoples to provide culturally relevant primary healthcare services. Unfortunately, Vancouver Native Health Society was not funded as an Aboriginal Healing Centre (Benoit, Carroll, & Chaudry, 2003). Therefore, services were provided to all clients in the Downtown Eastside; still, approximately 50% of their clients were Aboriginal. Services at the Centre will be listed in Table 5. A number of the services were offered in conjunction with partners such as the Vancouver Aboriginal Friendship Centre and Vancouver Coastal Health (Vancouver Native Health Society, 2009).

A case study of the model of care delivery at Vancouver Native Health Society was conducted (Benoit et al., 2003; Benoit, Carroll, Lawr, & Chaudry, 2001). Data were collected through focus groups with clients (only women participated as the focus of the case was women's health) and interviews with providers and staff. Strengths of the services included the co-location of services, support from staff, non-judgemental attitudes, minimizing barriers to access, and assistance with food, clothes, and baby supplies. Women appreciated the cultural components of the Centre, but felt an increased emphasis on traditional teachings and spiritual components would be beneficial. They also wanted more Aboriginal staff. Both women and staff stated the needs of Aboriginal women were not being met. They desired women's only programming and a safe place for women to meet with their children. Participants felt a need for a *healing place* with a holistic, integrated

Table 5

Services and Programs Provided by Vancouver Native Health Society

Service/Program	Service/Program Details
Walk-in primary care medical services	
Positive Outlook Program (POP)	• HIV/AIDS clients
Towards Aboriginal Health and Healing	• Intensive support, advocacy for POP Aboriginal clients for primary healthcare services access • Based on the Medicine Wheel • Funded by Public Health Agency of Canada Aboriginal HIV/AIDS Project
Positive Women, Positive Spaces	• HIV care, support, education and treatment • Held weekly • Physician and nurse access, counsellors, reflexologist, art therapist, and connection to peers
Alcohol and Drug Counselling and Support Services	• Individual counselling and group sessions
Walk-in Dental Clinic	• Preventative and restorative dentistry
Urban Aboriginal Food Enhancement Program	• Independent food security through Community Kitchens, Good Food Box Program, and Community Gardening • Indigenous food choices
Aboriginal Child and Family Support Services	• Early Childhood Development • Family Support Services (parenting, outreach, self help, family violence) • Aboriginal Building Blocks (families with children 5 and under) • Aboriginal Fetal Alcohol Spectrum Disorder outreach support worker • Aboriginal Infant Development Support Worker • Home support and education for families with preschoolers

Aboriginal Supported Child Development Services	• Working with children with developmental and language delays, other special needs • Circle of Elders • Child Development Centre
Aboriginal Diabetes Awareness Prevention and Teaching Program	• Funding finished March 2009 • Workshops and presentations on nutrition, prevention of diabetes at Aboriginal Head Start, Community Kitchens • Cookbook • Elders Healing Circle
Red Fox Active Outreach	• Recreation and training program • Provide outreach to Aboriginal people, those with disabilities, and inner city residents • Encourages physical activity, decrease in social isolation, and encouraging healthy choices • Free regular activities (e.g., walking, running) and special events • Worked with POP HIV clients to engage in recreational opportunities • Recruitment and training of Aboriginal youth/adults from Downtown Eastside to lead recreational activities • Traditional activities to increase cultural pride
Urban Aboriginal Community Kitchen Garden	• Located at University of British Columbia Farm • Intergenerational healing garden • Food, herbs, etc. grown and harvested collectively • Weekly trips for gardening run from Downtown Eastside • All participants have a say in planting, harvesting, etc. • Strong cultural component with traditional teachings from the land • Basis for future programs involving the land • Two to three Community Kitchens held on a weekly basis

approach to meet their needs. Focus group participants also wanted a voice in the planning and implementation of new service delivery models.

From data provided in the Vancouver Native Health Society's Annual Report (2009), it appeared they had implemented some of the feedback on the service delivery model utilized by the Society. A women's only program and space was implemented and an increased emphasis on cultural programming was apparent. What was not apparent was the number of Aboriginal staff working at the Centre or whether clients were now involved in planning services delivery.

Sheway was a prenatal and postnatal program for pregnant women in the Vancouver Downtown Eastside. It was separate from the Vancouver Native Health Society, but was located in the same building and staff from both worked together very closely. The program was woman-centred with a philosophy of harm reduction. Improvements in living conditions for women and children, nutrition, and decreased exposure to substance abuse during pregnancy were the focus of services provided. Cultural teachings and Aboriginal worldviews on health and healing were integrated into programming (Niccols, Dell, & Clarke, 2010).

The Sheway program with its more informal, flexible service delivery model and patient-centred team appeared to align more closely with Aboriginal worldviews than the Vancouver Native Health Society (Benoit et al., 2003). Sheway provided prenatal care, postnatal care up to 18 months of age, counselling, advocacy for women living with addictions, child development, and overall support (e.g., clothing, food, assistance with housing) (Hare, 2004; Niccols et al., 2010). Primary healthcare services were offered by an interprofessional team including a social worker, counsellor, nurses, physicians, midwife, outreach worker, peer support worker, and child development worker (Niccols et al., 2010). Sheway partnered with a number of organizations to deliver services. Some of the staff and services were provided by Vancouver Coastal Health, Ministry of Children and Family Development, YWCA, and Vancouver Native Health Society. Services were open to all women from the Downtown Eastside; in 2008 – 2009, 61% of clients self-identified as Aboriginal (Vancouver Native Health Society, 2009). Benoit et al. (2003) found that

Sheway clients appreciated the staff and found the environment safe and non-judgemental. This was not the case with Sheway patients' experience at the primary care clinic at Vancouver Native Health Society. Despite this positive feedback, women suggested there was a lack of space and reported that the environment was not always safe, particularly for children, as individuals high on drugs or otherwise intoxicated were allowed into the space. They also commented on the lack of services for children and families beyond 18 months. They described a lack of continuity in physician care particularly in the delivery of babies, while continuity of care was better with midwives. They also desired a greater focus on traditional and spiritual healing (Benoit et al., 2003). An evaluation of the Sheway program found increased access to prenatal and postnatal services for Downtown Eastside women. At intake only 30% of women had access to medical care while 90% were connected to a physician or midwife through the Sheway program. Again, at intake 65% and 79% had concerns about housing and nutrition respectively; at six months postpartum only 4-6% had concerns about the same issues (Poole, 2000). The Sheway program had a significant positive impact for women and their children in Vancouver's Downtown Eastside.

Summary of Primary Healthcare Services for Urban Aboriginal Populations in British Columbia

In summary, primary healthcare services in urban centres in British Columbia were characterized by extensive programming for urban Aboriginal peoples and partnerships between regional health authorities and First Nations' communities. Provincial legislation had a positive impact on the number of services available and on collaboration between stakeholders. Intensive programming was available in the Vancouver's Downtown Eastside where many Aboriginal peoples resided. A long standing sub-system existed for community members in this area. The following section will report on primary healthcare services in Alberta for urban Aboriginal peoples.

Alberta

Information provided will be limited to Edmonton as the focus of this study is Calgary's urban Aboriginal population and information on programs in Calgary will be related in the results, Chapters Five, Six, and Seven. Alberta Health Services, Edmonton

Zone (formerly Capital Health) currently encompasses Edmonton and surrounding communities. In 2005, Aboriginal specific primary healthcare programming was limited to an Aboriginal Diabetes Wellness Program (Capital Health, 2005). In partnership with the former Region's Aboriginal Wisdom Committee, a training program was developed for healthcare workers who specialized in diabetes care with the Aboriginal population. The goal of the program was to improve the health of their Aboriginal patients. Two four-day sessions were held twice yearly for staff. The focus of the sessions was the management and prevention of diabetes within a cultural context. The training program was delivered by Elders, dietitians, nurses, physicians, and other staff. Evaluation of the program suggested participants had a better understanding of Aboriginal patients and their communities, increased awareness of appropriate referrals and networks for available Aboriginal-specific services, and improved cultural and traditional knowledge. Participants stated the care they provided Aboriginal patients had improved and the program would be of beneficial to other healthcare providers (McKennitt, 2006).

Two articles were found on additional primary healthcare services in the Edmonton area, one on HIV testing and counselling services (Bucharski et al., 2006) and the other on an evaluation of an Inner City Public Health Project Clinic that serviced both Aboriginal and non-Aboriginal clients (Owens, McKim, Doering, & Hanrahan, 2003). In the case of the Public Health Project, a central office was located in one inner city clinic and housed a manager, a Community Health Representative, and three (0.4 FTE) Sexually Transmitted Disease Nurse Specialists. The Community Health Representative assisted in the development of relationships with potential clients and other community organizations. She also facilitated a weekly women's health group and Hepatitis C support group. Mobile outreach clinics were established in the inner city (e.g., Drop-in Centre, Shelters) to decrease barriers to access for the population. Mobile clinics provided: testing for HIV, hepatitis, and pregnancy; education to individual clients; referrals; and treatment of conditions such as lice and scabies. The pilot was considered to be successful as 305 new clients were seen for a total of 754 visits. Just over 50% of clients were Aboriginal. Only 13% of clients did not have appropriate testing done. Extensive follow-up was conducted with those clients with positive results by working through partnering organizations. Treatment and follow-up was carried out for 82% of clients requiring the same. This Public Health Project facilitated the opportunity to provide more proactive healthcare and better access to services for the inner city population including Aboriginal peoples (Owens et al., 2003).

Bucharski et al. (2006) studied the cultural appropriateness of HIV counselling and testing services for Aboriginal women in Edmonton. Seven women completed individual interviews and another six women participated in a focus group. Women identified themselves as First Nation or Métis and ranged in age from 27-42 years. All but one of the women had previously been tested for HIV. Women stated they were often asked *why* they wanted to be tested for HIV and were told they should be preventing the disease. They feared being judged when asked about high risk behaviours, feeling staff lacked an understanding of their life circumstances. Women, or their peers, had often encountered insensitive, judgemental, and discriminatory healthcare providers. They also feared child welfare involvement. They were asked to describe an ideal testing situation. They desired involvement in the planning and implementation of such services. They favoured a harm reduction approach, orientation to the present as opposed to past events, and a choice of options for testing and care. They stated that staff should be trained in working with Aboriginal people; some preferred Aboriginal staff and most preferred a female provider. Women suggested providers should first develop a relationship with a client, then provide information about HIV and testing, complete the paperwork, and ask about high risk behaviours. Staff should be sensitive to Aboriginal women's circumstances and the setting for testing should be non-threatening and safe. They suggested having food and a smoking area close by. They also recommended Aboriginal traditional and spiritual approaches be included in service delivery.

To summarize, primary healthcare services for Aboriginal peoples in Edmonton focused on the inner city population and providing services for HIV testing, hepatitis screening, education, and support. Cultural training was also provided to staff working with Aboriginal diabetes patients.

The following section will focus on primary healthcare services for Aboriginal populations in urban centres in Saskatchewan.

Saskatchewan

In 2008, Saskatchewan signed a tripartite agreement similar to British Columbia's. A Memorandum of Understanding was signed between First Nations' representatives and federal and provincial governments to address health services for Aboriginal people living within the province (Fontaine, 2008).

Regina Qu'Appelle Health Region

One of the Regina Qu'Appelle Health Region's key directions was to "enhance Aboriginal health" (Regina Qu'Appelle Health Region, 2009, p. 7). The Region's Eagle Moon Health Office was funded for a three year term and functioned as the central coordinating office for Aboriginal peoples' health. The office worked with other departments in the Region as well as community organizations to address the needs of the Aboriginal population. Together, they provided access to traditional healthcare services (e.g., Elders, healers, cultural ceremony) to promote health and well-being through healing. The Eagle Moon Office worked specifically with Home Care to adapt services to be more culturally relevant. A Métis Diabetes Education and Awareness Project was implemented along with Aboriginal Awareness training in the orientation of new staff and students. The Region also operated the Four Directions Health Centre providing public health services (e.g., immunization, well child, food security) for Aboriginal peoples. Care was based on the Medicine Wheel, using a holistic approach to healing. Students in the healthcare professions were highly involved in the clinic through practicum opportunities (Regina Qu'Appelle Health Region, 2009).

Saskatoon Health Region

The Saskatoon Health Region worked with First Nations' and Métis communities, including the Central Urban Métis Foundation. An Aboriginal Health Strategy was developed to address health challenges of Aboriginal peoples in the Region. There were plans to develop an Aboriginal Health Council to assist with adaptation of mainstream services. Upon the invitation of the Métis Foundation, public health services and other complimentary services were offered at their office (Saskatoon Health Region, 2009). An Aboriginal LiveWell Program was initiated by the Region. Seven Aboriginal peer leaders educated community members on living with chronic disease. Successful stories have been captured digitally and on posters for the program (Saskatoon Health Region, 2008).

In summary, information found on primary healthcare services for the urban Aboriginal population in Saskatchewan was limited, despite the high number of Aboriginal peoples that live in the province. This was similar for Manitoba, even though it too has large numbers of Aboriginal peoples residing in the province. The following section will focus on primary healthcare services for the urban Aboriginal population in Manitoba.

Manitoba

The Aboriginal Health Program, Winnipeg Regional Health Authority only provided programming to hospital-based patients. Other services were available to Aboriginal peoples in Winnipeg through other community organizations. Programs in these organizations included: healing circles for women, men, and children; parenting classes; shelters; addictions services; and programs for individuals transitioning to the city. An Aboriginal Health and Wellness Centre also existed and provided traditional and western healthcare services to children, women, men, families, and Elders. These included: healing programs; Head Start (preschool programs for Aboriginal children); traditional and spiritual healing; programs for Fetal Alcohol Spectrum Disorder; and support programs for Indian Residential School survivors (Winnipeg Regional Health Authority, 2009). Connections between the Health and Wellness Centre and the Health Authority were not clear.

The following section will focus on primary healthcare services for the urban Aboriginal population in Ontario.

Ontario

Ontario had a long history of working together with Aboriginal peoples to address the needs (including health needs) of on- and off-reserve First Nations, Métis, and Inuit people living in their province. A Joint Management Committee, made up of representatives from First Nations’ communities and other Aboriginal groups along with provincial and federal governments, worked closely in the delivery of healthcare services.

In 1994, the Ontario provincial government, in collaboration with its partners, developed the Aboriginal Healing and Wellness Strategy. This strategy covered a number of areas such as education, social services, and health. In healthcare, the strategy focused on governance, improved health status, and new service delivery models (Joint Management Committee, 2009).

A Phase 3 evaluation was completed on the Aboriginal Healing and Wellness Strategy in 2009 (Joint Management Committee, 2009). Data were collected via interviews with Elders and key stakeholders and questionnaires with clients representing urban, rural, and on-reserve sites. Forty percent of the clients surveyed had used Aboriginal Healing and Wellness Strategy services for over five years. Over 90% of clients felt the program was meeting their needs and had a positive impact on individuals, families, and communities. Self-reported health status had improved following utilization of the Strategy's services. Services and programs were culturally relevant, holistic in their approach (e.g., Aboriginal Circle of Care), provided access to traditional healers and services supporting Aboriginal identity, and supported healthy lifestyle choices with information and support for behavioural change. Participants interviewed discussed the positive impacts on health for Aboriginal peoples largely through the strength of cultural components and increased access to services. Two key themes were identified in the overall findings: the importance of cultural revitalization through the reclamation of culture and identity and recovery from historical trauma.

Unfortunately, many of the programs offered through Aboriginal Health Access Centres in Ontario had reached capacity and wait lists were in place. Evaluation participants suggested increasing services available in these centres as well as adding programming in the areas of family violence, cancer, diabetes, seniors, and youth. Increasing the number of Aboriginal healthcare providers working in Aboriginal programs was also important. Apprenticeship programs with Elders were recommended to ensure transfer of knowledge and the continuing availability of Elders. Lastly, participants suggested that governance structures be reviewed and improved linkages with partnering organizations to deliver care (Joint Management Committee, 2009). In 2009, the Ontario government desired further improvement in their relationships with Aboriginal people and communities. Several additional strategies were announced along with funding. Those impacting the urban Aboriginal population included additional funding to enhance social services delivery in Toronto and further capital funding for Friendship Centres across the province (Ministry of Aboriginal Affairs, 2009).

As part of the Aboriginal Healing and Wellness Strategy, 10 Aboriginal Health Access Centres were funded. Many of these Health Centres were located in large urban centres (e.g., Ottawa, Thunder Bay, Hamilton). There were two Aboriginal Health Centres previously implemented and not part of the funding provided by the Strategy. One of these health centres was Anishnawbee Health Toronto (Aboriginal Healing and Wellness Strategy, n.d.).

Anishnawbee Health Toronto

Anishnawbee Health Toronto had its early roots in 1984 and became a community health centre funded by the Ontario government in 1989. Anishnawbee Health Toronto's healthcare delivery model was entrenched in Aboriginal worldviews and traditional practices (Anishnawbee Health Toronto, n.d.a). It offered a wide range of services via a team of healthcare providers including Elders, traditional healers, medicine people, physicians, physician assistants, nurses, a dietitian, a diabetic nurse educator, Circle of Care workers, mental health workers, traditional counsellors, chiropractors, a naturopath, dentists, a chiropodist, massage therapists, psychiatrists, and women's helpers. Programming (e.g., mental health, addictions services, Fetal Alcohol Spectrum Disorder programs, primary care, traditional services, diabetic services) was varied to meet the needs of the population served (Anishnawbee Health Toronto, n.d.b). Anishnawbee Health Toronto could be considered to be a primary healthcare sub-system similar to Vancouver Native Health Society, targeting services for a specific Aboriginal population in Toronto.

A Multidisciplinary Mental Health Committee at Anishnawbee Health Toronto was formed to develop a mental health framework for the Centre. Rationale for the framework was based on the experiences of healthcare providers and a previous needs assessment conducted by Anishnawbee Health Toronto. Mental health services at Anishnawbee Health

Toronto had been provided in an ad hoc fashion. Overall mental health services were delivered by a variety of organizations and providers not coordinated one with another. Information sharing processes were not formalized; therefore information was often not shared between organizations and providers. Accountability for mental health services for Aboriginal peoples was an issue with no single core service available provincially or federally. Mainstream services were not accountable for Aboriginal peoples and hence did not utilize Aboriginal worldviews when providing care. There also was a lack of services, particularly for substance abuse, children, and youth. Most available services utilized a western, biomedical approach, were not culturally relevant, and lacked appropriate processes for data collection and performance measurement. Training and support for staff working with people with mental health issues were minimal. Despite these issues, Anishnawbee Health Toronto had positive relationships with their clients and others living on the streets that were beneficial in providing mental health services. They utilized a case management approach (Circle of Care) acceptable to Aboriginal clients and offered cultural and traditional services in their Centre (Anishnawbee Health Toronto, n.d.c).

The Multidisciplinary Mental Health Committee made the following recommendations for a new model of mental health: a holistic approach to mental health and well-being; capacity building for staff; engagement of community members to address population needs; partnership delivery of services with other organizations (Aboriginal and non-Aboriginal); utilization of a population needs focused approach including the social determinants of health; and, above all, the incorporation of genuine system change. Furthermore, the Committee recommended mental health services be built on the existing strengths of Anishnawbee Health Toronto, including interprofessional collaborative practice, provision of services across the continuum of mental health (promotion of well-being through to crisis), as well as services for men, women, families, children, and youth. Community outreach and working with other organizations (e.g., community organizations, other healthcare services, educational institutions) was also considered to be a key to success. Infrastructure (e.g., space, electronic health records), including resources (e.g., funding, providers and other staff), as well as appropriate processes (e.g., referral systems, information sharing agreements, evaluation) for the delivery of care were seen as necessary for the new model. Another key requirement expressed was support for mental health workers to avoid burnout. Aboriginal worldviews, traditional care, and cultural approaches were considered foundational to services, with Elders and traditional healers incorporated. All services should be culturally relevant and culturally safe. Lastly, committee members recommended a strong primary healthcare foundation for mental health services with support from specialty services (Anishnawbee Health Toronto, n.d.c).

To better understand the impact on clients of traditional healthcare at Anishnawbee Health Toronto, a qualitative study was conducted through interviews with clients and healthcare providers. Four key themes were found (Skye, 2006). First, the importance of identity for Aboriginal peoples positively impacted health and well-being for the urban Aboriginal population. Identifying one's self as an Aboriginal person to obtain services at the Centre initiated their journey to reclaim their identity. Second, the significance of receiving a spirit name for each individual provided a spiritual foundation for their identity. Third, there was a strong connection between identity and Aboriginal knowledge. Finally, the value of Anishnawbee Health Toronto for Aboriginal peoples in its current geographic location in Toronto was underscored.

Naturopathic services were also offered at Anishnawbee Health Toronto. Western biomedical models were not holistic in their approach and lacked emphasis on prevention and promotion. Naturopathic medicine had the potential to bridge the gap between western and traditional medicine. Patients interviewed commented on the positive impact on their health and well-being after receiving naturopathic care. Naturopathic practitioners were able to address needs not well managed by western medicine. Researchers concluded naturopathic medicine was better aligned with Aboriginal worldviews and focused on the physical, mental, emotional, and spiritual components of health (Department of Research and Clinical Epidemiology, Canadian College of Naturopathic Medicine, 2008).

Other Aboriginal Primary Healthcare Services in Toronto

The Native Canadian Centre in Toronto offered an Aboriginal martial arts program for male and female adults. The program was taught by a Cree instructor who incorporated

Aboriginal knowledge and traditions. A study (Lavallee, 2007) was completed to understand the impact of this program on the well-being of participants. Seventeen people, 26-49 years of age, participated in the program; 11 were Aboriginal. Data were collected via sharing circles and Anishnawbee symbol-based reflection. The martial arts program had an impact on all areas of well-being: physical; mental; emotional; and spiritual. Physically it impacted fitness level, weight loss, prevention of diabetes, stress relief, and the ability to protect one's self. Mentally, participants stated they felt better about themselves. Emotionally, it facilitated their identity as an Aboriginal person, provided them a sense of belonging (counteracted feelings of dislocation, isolation), and provided a positive social outlet. Spiritually, participants discussed the importance of the traditional content and how classes being taught by an Aboriginal person facilitated their connection to culture and identity. Overall, this program had a positive impact in all areas of well-being for participants.

Aboriginal Cancer Care Unit

A needs assessment of cancer services was conducted by the Aboriginal Cancer Care Unit (2002). Aboriginal community members were asked about the availability of different types of providers. Urban Aboriginal peoples suggested all types of providers were available (family physician, nurse practitioner, community health nurse, Registered Nurse, cancer specialist, traditional healer, traditional cancer healer, community health representative, nursing attendant, personal support worker, family support worker, home care coordinator, discharge planner, and dietitian), although traditional cancer healers and family support workers were available less often. While physicians were most available to community members, cancer specialists, traditional healers, and discharge planners were less frequently available. Participants stated there were few Aboriginal-specific services available for prevention, screening, and treatment. Most often they accessed information and services through community health workers. Urban health centres and Aboriginal Friendship Centres provided limited cancer services. Information provided to Aboriginal peoples was often via traditional means of brochures and presentations; few Aboriginal-specific materials were available. Planning of services for cancer prevention, screening, and treatment generally did not include Aboriginal leaders and individuals in direct planning. Forty percent of participants (urban and rural) wanted more accessible information on cancer prevention, screening, and the early signs of cancer. Other gaps included engagement with the community, translations, access to traditional healers and ceremony space, linkages to Aboriginal agencies, lack of Aboriginal providers and navigators for the healthcare system, lack of accessible screening services, culturally relevant services, and cultural competency training for staff. Most of the participants desired support and counselling services most of all. Jurisdictional issues, particularly coverage for health services, were also an issue. Participants recommended initiatives target the family and the whole population as opposed to individuals only (Aboriginal Cancer Care Unit, 2002).

Several case studies (Aboriginal Cancer Care Unit, 2008) were conducted to evaluate Aboriginal Tobacco Cessation Initiatives; two reported on programs delivered in urban settings. Both programs occurred in Aboriginal Health Centres, one in Ottawa and the other in Thunder Bay. The Wabano Centre for Aboriginal Health in Ottawa ran an eight week group program based on an existing Ottawa program modified with the assistance of Elders in the community. The program was called “Sacred Smoke.” The program provided Nicotine Replacement Therapy, support, and counselling. Six to eight individuals participated at one time. The quit rate was only 10%, although others had cut back. Strengths of the program included: culturally relevant approaches and materials; involvement of Elders, families, peers, and other community members; integration into existing programs; and removal of barriers such as transportation and childcare. Challenges also arose. The program was too long and future sessions were condensed into a six week program. Attrition of participants due to vacation, weather issues, and no shows was an issue. There was a lack of resources and dedicated staff for program coordination along with high staff turnover. A lack of training for staff in Aboriginal tobacco cessation was also apparent. The importance of traditional teachings, particularly for urban individuals with less exposure to the same, was emphasized. A champion was also cited as critical. Recommendations from the evaluation suggested a positive, holistic approach to tobacco cessation, working in partnership with other programs and organizations, using more multimedia approaches in group sessions, using evidence-based interventions to promote effectiveness, having dedicated trained staff working in the program, and working around school and vacation schedules.

A second tobacco cessation case study (Aboriginal Cancer Care Unit, 2008) was completed at the Thunder Bay Aboriginal Health Centre. A needs assessment was conducted prior to the development and implementation of the initiative. Leaders used an existing 12 week Aboriginal Misuse Program and adapted it to the local context. Six individuals participated in the program with a 100% quit rate. Strengths of the program included the facilitator, support from the facilitator, cultural components, and addressing the sacred use of tobacco. Not unlike the previous case study, challenges also arose. Due to funding constraints, healthcare providers were unable to provide childcare or transportation; hence, the second session was cancelled as participants were unable to attend. They were also unable to supply Nicotine Replacement Therapy. Participants suggested a shorter course (subsequent sessions were to be shortened to 8 weeks) and expressed a desire for more information on other health topics. Providers recommended securing funding for all components of the program and assessing sustainability from the start.

Summary of Primary Healthcare Services in Ontario

In summary, strong partnerships between governments and Aboriginal organizations were evident in Aboriginal healthcare services in Ontario. Anishnawbee Health Toronto was an excellent example of an Aboriginal health centre in an urban setting offering a variety of services to a sub-population of Aboriginal peoples in Toronto with a commitment to traditional care, fostering of identity, and a team-based approach to primary healthcare. The Aboriginal Cancer Care Unit also conducted several primary healthcare initiatives over the last decade.

The previous sections of this chapter provided primary healthcare information for Aboriginal peoples by province and their respective urban centres. Although both the peer-reviewed and grey literature, along with pertinent websites, were searched for Quebec and the Atlantic provinces, no information was found specific to urban primary healthcare services in these areas. The following sections will provide further findings organized around specific service areas: children and youth; mental health services; and chronic disease management.

Primary Healthcare Services for Children and Youth

Two studies (Carpenter, Rothney, Mousseau, Halas, & Forsyth, 2008; Klinck et al., 2005) reported on mentoring programs for children and youth. Klinck et al. (2005) explored the success factors associated with mentoring programs for Aboriginal youth in several western Canadian urban centres. Individual interviews (10) and one focus group were completed with program managers and other key stakeholders involved in program planning and implementation. Formal mentoring programs were limited, but many more informal ways of mentoring children and youth were identified.

For Aboriginal communities, mentoring was seen as an everyday event; opportunities for mentoring existed all the time and could be provided by anyone. Mentoring was most important in facilitating traditional teachings and values and healthy lifestyles. Family, extended family, and the community were important connections in mentoring programs. Recommendations for successful mentoring programs included: involving the community from the start of planning (e.g., protocols, ownership); building on existing strengths of the community; involving family members; incorporating traditional values and culture as a foundation for the program; addressing sustainability; and developing a community advisory committee for program oversight. Attention to the diversity of the urban community and work with the youth around ownership and development were required. Recreational activities in groups appeared to be an effective tool in youth mentorship programs. The value of positive peer groups for children and youth were discussed. Screening and training of mentors was described as important and resources to cover the costs of programs, activities, and transportation to events were necessary.

A second mentoring program worked with Aboriginal high school students acting as mentors for elementary students in Winnipeg. High school youth provided recreational activities including Aboriginal cultural activities, nutrition, physical activity, and education in a weekly after school program. Goals of the program were comprised of understanding how students could be supported in leadership, building a desire to participate in social change, building self-esteem in mentors, and considering education as a career. Interviews were conducted with mentors and school staff; mentoring team meetings were recorded and researchers kept field notes throughout the study. Four key themes emerged from the data: belonging; mastery; independence; and generosity. Providing space to conduct the program, being collaborative partners in the school, interacting with teachers and other staff, and being respected in the community all contributed to mentoring team's sense of belonging. Over time, mentors mastered a number of important skills (e.g., program planning, organizational skills, working with others) to deliver the program. Student mentors gained independence in making decisions impacting both themselves and their mentees. Lastly, students learned about generosity, building on small acts of generosity as a potential long term impact in other situations (Carpenter et al., 2008).

In summary, information in the literature on primary healthcare services for children and youth both focused on mentoring initiatives. Mentoring had the potential to make positive changes for youth, including teaching of traditional culture and values and learning of important skills such as program planning and decision-making. The following section of this chapter will discuss mental health services for urban Aboriginal populations in Canada.

Mental Health Services

The Canadian Mental Health Strategy (Mental Health Commission of Canada, 2009) supported "the development of initiatives that are targeted at people and communities at risk for mental health problems and illnesses" (p. 16). A strategy for mental health, it stated, must recognize and respond to the unique needs of the Aboriginal population in Canada. Mental well-being was said to be based on the interconnections between physical, mental, emotional, and spiritual health, coupled with the land, family, and communities. Identity and self-determination were also important components. The overwhelming effects of history, colonization, residential schools, and cultural genocide have had a lasting impact on the health and well-being of Aboriginal peoples, particularly on their mental health. Response to the diverse needs of the Aboriginal population was a necessity in the transformation of mental health services (Mental Health Commission of Canada).

In 2006, the then Aboriginal Mental Health Board of Alberta also developed a framework for Aboriginal mental health. The framework was intended to direct Aboriginal mental health services as well as encourage collaborative planning and delivery of services for this population (Alberta Mental Health Board, 2006). Aboriginal peoples in Alberta generally sought mental health services through primary care physicians and emergency departments as opposed to community-based clinics. A significant challenge in meeting the mental health needs of the Aboriginal population in Alberta was its huge diversity (Alberta Health and Wellness, 2004). Overall, there was a lack of knowledge about Aboriginal mental health including research into effective and appropriate service delivery models. There also were limited numbers of Aboriginal mental health workers. Jurisdictional issues and funding impacted access and coordination of care. Accessibility and availability of services were particular issues for children and youth. Recommendations for program development included: new culturally relevant, community-based models with unique and novel approaches; integration and coordination of existing services; provision of education and training, including cultural competency training, to ensure an effective workforce; and equitable and sustainable resources (Alberta Mental Health Board). In April 2009, the Alberta Mental Health Board was amalgamated into the provincial health authority, Alberta Health Services. No information was found discussing moving forward with the Aboriginal Mental Health Framework in Alberta.

A British Columbia report (Smye & Mussell, 2001) on Aboriginal mental health identified a number of related issues. Mental health services, particularly for Aboriginal people, were provided by a number of different organizations and programs, poorly connected with no core program offered by provinces or the Federal Government. Case coordination was not well-articulated and service coordination was inadequate or non-existent. A multitude of jurisdictional issues continued to exist in the delivery of healthcare services, particularly in mental health. Aboriginal mental health services were poorly resourced, and few services were available for children and youth. Mental health workers often had little or no training to address the needs of the Aboriginal population, and there was a lack of support for providers. Data management and outcomes measurement was inconsistent and often non-existent. Authors recommended the following: culturally safe services to meet diverse needs; a focus on strengths of individuals and communities; integrated care, support for community-based prevention and promotion (e.g., prevention of fetal alcohol issues, suicide prevention, promotion of mental well-being) and research (e.g., effective service delivery models, evaluation) (Smye & Mussell, 2001).

Several peer-reviewed studies were available on Aboriginal mental health services in urban settings. Jacobs (2000) studied mental health issues of urban Aboriginal peoples in Montreal with a focus on substance abuse. Participants discussed the importance of culture and spirituality as a central component to treatment; this was missing in mainstream services. Reconnecting to their Aboriginal identity was critical in prevention and treatment of substance abuse. A lack of services and long wait lists were identified issues, as well as transportation, childcare, and narrow service criteria (e.g., not accepting pregnant women). There also was a lack of pre-treatment and follow-up services. Aboriginal workers stated there was a need for outreach workers, Aboriginal social services, a boarding house for Aboriginal youth, and services for pregnant women with substance abuse issues.

A second study (Salmon, 2007) reported on a prevention program for Fetal Alcohol Syndrome and Fetal Alcohol Exposure in a British Columbia urban centre. In 1997, a manual for community-based initiatives was developed by Health Canada. A discourse analysis on the materials was conducted in the study, but it was the important information about prevention programs for this area provided by women that was of relevance. Through group interactions, perspectives were gathered from Aboriginal mothers attending prevention programs. All Aboriginal mothers had used various substances during pregnancy, all of their children had been impacted, and approximately half of the mothers reported undiagnosed fetal alcohol effects from their own mothers' substance abuse. Participants stated healthcare providers ought to understand Fetal Alcohol Syndrome and Exposure not as an isolated incident, but impacting their whole life. Many women were disconnected from their traditional cultural practices. Researchers recommended decolonization and revitalization (e.g., promotion of Aboriginal identity) versus cultural adaptation of materials and approaches to prevention programming for fetal alcohol disorders (Salmon, 2007).

In summary, frameworks for mental health services were developed both nationally and in Alberta. Other literature on mental health services for Aboriginal peoples spoke mostly of the gaps in services, despite the need for such services. The following section will discuss services in chronic disease management.

Chronic Disease Management

Chronic disease has become a significant issue in the Aboriginal population over the last number of years. More specifically, diabetes is on the rise and has affected many Aboriginal peoples. In fact, it has been considered an epidemic, involving Aboriginal peoples 2-5 times more often than non-Aboriginal Canadians (Young, Reading, Elias, & O'Neil, 2000). Minimal information was found on primary healthcare services for urban Aboriginal peoples with chronic disease.

Two exploratory studies, one looking at stress and diabetes (Iwasiki, Bartlett, & O'Neil, 2005) and the other, lifestyle changes with coronary artery disease (King, Sanquins, McGregor, & LeBlanc, 2007), provided some input on appropriate content of services for Aboriginal peoples with chronic disease. Iwasaki et al. (2005) suggested services be built on the strengths of Aboriginal peoples diagnosed with diabetes. Primary healthcare services for diabetes ought to use a holistic approach incorporating healing for the stress and trauma experienced by many Aboriginal peoples. Positive impacts from healing (interconnectedness, self-determination and control, incorporation of spirituality, use of culture and traditions to facilitate identity, and incorporation of leisure as a means to deal with stress) had the potential to influence lifestyle change and better management among Aboriginal diabetic patients. King et al. (2007) recommended healthcare providers consider historical, social, and cultural factors when working with Aboriginal people on lifestyle change.

To summarize, minimal information was found on services for urban Aboriginal peoples with chronic disease, despite the increase in chronic conditions in the population, particularly diabetes. Literature discussed key components to be included in programming for chronic disease such as the utilization of a holistic approach and the consideration of historical and social factors.

This first major section of the literature review was on primary healthcare services for the urban Aboriginal population in Canada. The absence of research spoke volumes about the federal lassitude or disinterest. This first section focused on actual primary healthcare services and delivery nationally, provincially, and in specific urban centres. Information was also included on specific service areas which arose in the literature review. The following section will focus on patient-centred team practice with Aboriginal populations in Canada.

Collaborative Patient-Centred Team Practice

Chapter Two provided an overview on interprofessional collaborative team practice for patient-centred care. In this section, the focus will be review of collaborative team practice specifically related to Aboriginal populations. Overall, little has been written on interprofessional education or collaborative team practice in Aboriginal peoples' health in Canada or beyond.

Based on a systematic literature review, Barr (2007) outlines four foci for interprofessional education. The first three were well documented in the literature, but the fourth less so. They consisted of: "preparing individuals for collaborative practice; learning to work in teams; and developing services to improve care; [and]…to improve the quality of life in communities." (p. 40; 42). The latter could be considered to be of specific benefit to Aboriginal communities. The author went on to describe different ways students can learn about collaborative practice through community placements. Some such examples are outlined in the following two paragraphs.

The University of British Columbia developed an interprofessional course elective on Aboriginal peoples' health, including a practicum. The course was developed in partnership with two Aboriginal communities. By living and working in an Aboriginal community, students gained firsthand experience in working with Aboriginal community members, as well as becoming more reflective of their practice and gaining knowledge and skills to work with Aboriginal peoples. Course content included information on interprofessional practice, social determinants of health, and the impact of historical events on Aboriginal peoples. There was no specific mention of cultural competencies training for students. In the practicum, they spent time with a variety of team members in the clinic, as well as Elders and community health workers. They also worked on a team project. A total of seven students participated in the pilot in the two communities. A key strength of the project was the community-university partnership established, although not without its challenges of continuity in representation, role definitions, etc. The elective (which has now become an ongoing course) had the potential to increase recruitment of healthcare professionals to work in Aboriginal communities as well as recruiting students from Aboriginal communities themselves to embark on a career in healthcare (Jarvis-Selinger et al., 2008).

Anishnawbee Health Toronto also participated in a student practicum, for chiropractic students. Although not specifically an interprofessional practicum, chiropractic students had the opportunity to work as part of the extensive interprofessional team at the health centre. Collaborative practice was further advanced at Anishnawbee Health Toronto by utilizing a common health record among all providers. Benefits of the practicum included better access to chiropractic services for Aboriginal peoples, while students experienced working with Aboriginal peoples and the broad team of healthcare providers (Kopansky-Giles et al., 2007).

Aboriginal health teams were inherently quite different from other health teams, even more so in small, northern communities. The range of team members included nurses, physicians, Aboriginal outreach workers, and community health workers. The use of Aboriginal paraprofessionals on the healthcare teams for communities of different cultures was a common practice as healthcare professionals from Aboriginal backgrounds were difficult to find (Burhansstipanov, Dignan, Wound, Tenney, & Vigil, 2000; Purden, 2005). Paraprofessionals supplied a bridge for those providers from the dominant culture serving patients/clients from other cultural backgrounds. Roles of paraprofessionals were not clearly understood (Jackson, Brady, & Stein, 1999; Purden, 2005) by other healthcare professionals working on the team; they were often used for translation of language and culture, rather than providing the care for which they were trained. Paraprofessionals were frequently not included as part of the team, particularly in Aboriginal communities (Purden, 2005); they were regularly left out, implying they had little to contribute or there was a lack of confidence and respect for their abilities (Boone et al., 1997; Jackson et al., 1999; Minore & Boone, 2002). Power differentials were common where healthcare professionals (e.g., nurses) were in charge of paraprofessionals and salaries and benefits differed significantly (Jackson et al., 1999) despite the fact that paraprofessionals often held more contextual and cultural knowledge than did healthcare professionals impacting the health of patients, families, and the community.

Although literature specific to Aboriginal collaborative team practice was limited, reports and articles reporting on urban primary healthcare services certainly spoke to the importance of the collaborative team in caring for Aboriginal populations (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2003; Benoit et al., 2001; Intergovernmental Committee on First Nations Health, 2005; National Aboriginal Health Organization, 2002). Collaborative patient-centred teams provided a collective approach to healthcare more closely aligned with Aboriginal models of care. They also supported a holistic approach to care to address the often complex needs of Aboriginal populations. Including patients and families as active team members in decision-making enhanced self-determination in their health.

In summary, patient-centred teams in Aboriginal peoples' health appeared to be an important component of primary healthcare although little research was available on the same. The following section of this chapter will report on human resources challenges in the delivery of Aboriginal healthcare services.

Human Resource Challenges in Aboriginal Peoples' Health

The shortage of healthcare providers was well-known and impacted all provinces and territories in Canada. Although shortages did not seem to be as much of an issue in

2010 due to the economic climate, shortages in specific professions, specialty areas, and geographic areas continued to exist. Shortages were apparent in Aboriginal health services both on- and off-reserve, in rural and urban settings (Coll, Mohatt, & LeMaster, 2004; McBride & Gregory, 2005; Romanow, 2002). All categories of providers were needed in Aboriginal communities, including psychiatrists (Chaimowitz, 2000), nurses (Arnault-Pelletier, Brown, Desjarlais, & McBeth, 2006; McBride & Gregory, 2005), and physicians (Spencer, Young, Williams, Yan, & Horsfall, 2005).

Furthermore, there was a substantial shortage of Aboriginal health professionals. In consultations conducted by a National Task Force on Recruitment and Retention Strategies (2002), many reasons for not entering the nursing profession were identified by Aboriginal peoples. These included factors such as negative perceptions of nurses and nursing, personal barriers, family commitments, barriers to entrance to post-secondary institutions, language barriers, different ways of learning and communication, relocation shock, lack of support from educational institutions, and financial barriers.

Another significant human resources issue was the high turnover of healthcare staff both on- and off-reserve (including urban centres). Lack of support for providers, burnout, and isolation were identified as concerns leading to problems with retention (Coll et al., 2004; Mignone, O'Neil & Wilkie, 2003).

In 2004, First Ministers of Canada developed a strategy for health human resources with a sub-strategy to address the needs of the Aboriginal population. The goals of the initiative included recruitment and retention of Aboriginal healthcare providers, retention of non-Aboriginal healthcare providers currently working in Aboriginal communities, as well as the adaptation of curriculum to include information on Aboriginal culture, history, and traditional practices for all healthcare students. Participation in planning and implementing health human resources strategies ought to ensure active participation of Aboriginal organizations and community members (McBride & Gregory, 2005). To facilitate increased numbers of Aboriginal individuals entering health careers, various approaches were recommended. These included: improvement in basic education; transition assistance from high school to post-secondary institutions; assistance and support with entrance requirements and procedures; as well as ongoing mentoring in the educational institutions and the workplace (National Task Force on Recruitment and Retention Strategies, 2002). Spencer et al. (2005) recommended dedicated seats for medical students along with assistance for admission and ongoing support throughout the program. A Saskatchewan program for nursing recruitment (Arnault-Pelletier et al., 2006) provided support for childcare and housing, academic support through tutoring, mentorship, advocacy by faculty for students, communication through regular meetings to assist with progress, and assistance with summer employment. Community partnerships were also established to provide students with opportunities to participate in community activities and cultural events. Evaluation results showed a significant increase in recruitment of Aboriginal students with all equity seats filled (12% of all seats available). Retention of students was high, with students commenting on the positive, supportive environment (Arnault-Pelletier et al., 2006). Other universities and colleges also had programs, such as Nunavut Arctic College offered in partnership with Dalhousie University (educated Inuit and other nurses in Nunavut) (Dalhousie University, 2005), the Faculties of Medicine and Dentistry, University of Alberta (pro-active recruitment and reserved seats), Faculty of Medicine, University of British Columbia (13 dedicated seats, Aboriginal Residency Program, and a Division of Aboriginal People's Health), and the Faculty of Medicine, University of Calgary (had employed an Aboriginal Recruitment Coordinator and Aboriginal students bypassed screening with all given interviews) (Indigenous Physicians Association of Canada & The Association of Faculties of Medicine of Canada, 2008).

Aboriginal self-governance of healthcare services had the potential for positive impacts on health human resources in Aboriginal communities. Evaluation in one community demonstrated an increase in retention and recruitment of staff in a rural First Nations' reserve with self-governance of healthcare services (Hiebert, Anges, Young & O'Neil, 2001).

Finally, there was a need to ensure the inclusion of Aboriginal culture, history, and determinants of well-being in the training for all healthcare providers. Not all individuals accessed services at Aboriginal primary healthcare organizations, particularly in urban centres. Services were often accessed in mainstream systems, with all specialty and acute care services provided via mainstream healthcare organizations. Although not ideal, it was not possible at this time to staff all Aboriginal healthcare programs with Aboriginal health workers. In the meantime, curriculum adaptation and cultural competency training will assist in providing accessible and acceptable care for Aboriginal people.

To summarize, challenges were clearly evident in the area of human resources in Aboriginal health. There were limited numbers of healthcare providers wanting to work in Aboriginal healthcare settings, and even fewer Aboriginal healthcare providers. Education initiatives were evident in numerous universities and colleges in Canada to increase recruitment of Aboriginal students and providing support for their education.

There was a notable lack of literature available on primary healthcare *systems* for the urban Aboriginal population in Canada. In reviewing the literature about other countries (not reported here) an example of a primary healthcare system in Alaska was found. The following section of this chapter will describe this primary healthcare system.

An Example of a Primary Healthcare System for Aboriginal Populations

As noted above, no literature was found on primary healthcare *systems* for the urban Aboriginal population in Canada, although several comprehensive primary healthcare sub-systems (Anishnawbee Health Toronto, Vancouver Native Health Society) targeting specific sub-populations were documented and reviewed in earlier sections of this chapter. In my search of the literature about other countries (Australia, New Zealand, and the United States), an excellent example of a primary healthcare system for Alaskan Native people and North American Indians was located.

The Southcentral Foundation, owned and operated by the local tribal authority, originated in 1982 as a not-for-profit healthcare organization delivering primary healthcare services to the indigenous population in Anchorage, Alaska and surrounding areas. In 1999, it obtained full ownership and accountability of operations for all primary healthcare services in the area previously owned by the Indian Health Services of the United States government. The goals of the Southcentral Foundation included the improvement of “the health and social conditions of Alaskan Native people, enhance culture, empower individuals and families to take charge of their lives" (p. 49). Services provided included primary care, behavioural health, dental, various community-based services, and residential treatment. Funding for the Foundation's healthcare services was provided by Indian Health Services, Medicare, Medicaid, and private insurance. The Southcentral Foundation employed approximately 1300 people (Gottlieb, 2007), many of them from the Alaskan Native community.

System change was based on extensive consultation (e.g., surveys, hot lines, advisory boards, listening conferences) with the community to determine needs of the Alaskan Native population. The needs identified were not unique. People wanted a system that was respectful, family friendly, and culturally relevant and suggested foundational principles should include indigenous values, community participation, relationships with physicians and other healthcare providers, and quality care. More specifically they desired residential treatment centres for substance abuse and a Head Start program for young children to learn about the Alaskan Native culture. The healthcare model developed and implemented utilized evidence-based models found in the literature and an environmental scan. Leaders established a vision, mission, and operating principles. Operating principles included the following: positive relationships between patients/families and providers; patients/families as active team members; a holistic approach to wellness for individuals, families, and the community; accessible services (e.g., location, decreased wait times); integrated services; continuity of care; attention to service and role duplication; patient and family navigation of services; a central focus on patients' needs and interests; a population-based approach; and culturally relevant services with integrated traditional cultural components (Gottlieb, 2007). Many changes were made in the system and will be highlighted in the following sections.

Primary Care

The primary care clinic originally utilized a traditional primary care approach. Intentional changes were made to ensure a long-term relationship between patients and providers. Attention to the social determinants of health as well as focusing on patient, family, and community strengths were other key components of their approach. In addition, staff focused on “family dynamics, nutrition, exercise, smoking, substance abuse, pride, honor, and dignity” (p. 7). Barriers to access were minimized (e.g., time, location, language). Patients and families connected with primary care providers via individual or group visits, phone, and e-mail. The primary care team was made up of primary care physicians, pharmacists, social workers, Elders, behavioural health providers, nurses, traditional healers, and community health workers. Community health workers provided care in the community as well as care coordination. Access to specialty and tertiary services was available when required for consultation and treatment, but patients were returned to their primary care medical home as soon as possible. Positive outcomes have been realized. Emergency and urgent care visits decreased by as much as 50%; specialty services visits by 65%, and primary care visits by 20%. Indicators were also collected for prevention (e.g., breast and cervical cancer screening). Additional indicators were being developed for such concepts as dignity, self-worth, and family wellness. Another key component was the integrated team. Extensive work ensured the right provider was caring for the patient and doing the right things. Perhaps the most important change was the control of individual health as well as the healthcare system (owned and operated by the Alaskan Native community) being managed directly by patients, families, and the community (Eby, 2007).

Depression Collaborative

The Depression Collaborative was a partnership between the primary care team and Behavioural Health Clinic to ensure coordinated and effective care for Alaskan Native patients with depression. Most patients were screened and treated effectively by the primary care team, while others were treated in partnership with the Behavioural Health Clinic. Protocols were developed. All depression screening of primary care patients was completed by the medical office assistant or a licensed practical nurse along with other intake assessments (e.g., vital signs, weight). Rescreening was done once every year. Patients with severe depression were referred to the Behavioural Health Clinic immediately. Mild to moderate depression was treated by the primary care provider at the current visit. All patients with depression were provided with educational information and self-care suggestions (e.g., physical activity). Social support was also assessed. If medication was prescribed, patients were followed by phone in one to two weeks. All patients with depression were scheduled for a follow-up visit in four to six weeks with the primary care team. Ongoing communication occurred between the primary care team and the Behavioural Health Clinic staff for protocol clarification. The biggest challenge faced by the primary care team was follow-up phone calls. Calls required a significant amount of time (e.g., several calls for each person), especially for transient patients. Sixty-three percent of patients in the clinic were screened. For those patients diagnosed with depression and receiving treatment (e.g., counselling, antidepressants), 78% had a normal screening score when re-screened in one year's time (Dillard & Christopher, 2007).

Tobacco Cessation

The Southcentral Foundation had a significant focus on prevention and promotion services. One such program was the Tobacco Cessation Initiative. Components of the Initiative included screening of all patients for tobacco use at all appointments, assessment of readiness for behaviour change, development of a data system, educational information, consistent counselling, follow-up, and access to Nicotine Replacement Therapy. As with depression screening, screening for tobacco use was completed by the medical office assistant. Counselling and follow-up were conducted by a health educator, paired specifically with a primary care provider to provide continuity for patients and providers. An intake questionnaire was completed. Based on their responses, if they were ready to quit they were provided with a counselling session approximately one hour in length. If not, the educator provided educational information and recommended the patient call back when they were ready. Follow-up was conducted by phone on or a few days before the quit date set, and then weekly for three weeks, at six, twelve, twenty-six, and fifty-two weeks. Pharmacy provided assessment for Nicotine Replacement Therapy. At the six month follow-up 21% of patients enrolled had quit (Fenn, Beiergrohslein & Ambrosio, 2007).

Traditional Care

Both complementary medicine (e.g., chiropractic, massage, acupuncture) and traditional medicine were introduced. Traditional healers worked alongside primary care providers as full members of the patient-centred team (Gottlieb, 2007). The Southcentral Foundation also had a traditional herb garden for educational purposes (Eby, 2009a).

Workforce Initiatives

Significant work took place in the area of workforce. Orientation on organizational vision and structures along with cultural competency training was provided to all existing employees and was part of the orientation for new employees. Mentoring programs were introduced for Alaskan Native youth and adults. Leadership training and mentoring for Alaskan Native people was increasing. Currently 57% of employees were Alaskan Native. With the workforce initiatives, a 50% reduction in staff turnover was realized (Gottlieb, 2007).

Support Services and Facility

Communication was a focus for the Southcentral Foundation. Formal agreements between departments were implemented to facilitate communication and coordination of care. Information management, data, and outcomes measurement were also key components of the healthcare system. Outcomes were communicated to physicians, staff, and patients on a regular basis. Research was also an essential aspect of work conducted at the Southcentral Foundation (Gottlieb, 2007).

Facilities were renovated to be more patient and family friendly. They incorporated Native art and cultural artefacts and reflected an environment where community members were secure. The goal was to facilitate a gathering place; cultural events often occurred in these healthcare facilities (Gottlieb, 2007).

In summary, the Southcentral Foundation provided a good example of a primary healthcare system for Aboriginal peoples in an urban setting. Several key components were evident in its success: extensive consultations with the community; system owned and operated by the community; significant changes in service delivery based on consultations and evidence; and a systematic approach to outcomes measurement. The following section of this chapter will outline essential aspects of primary healthcare systems for urban Aboriginal communities identified in the review of the literature.

Key Themes Identified in the Literature for a Primary Healthcare System for Urban Aboriginal Populations

A number of key themes were identified in the literature on primary healthcare services providing information about what a primary healthcare system for urban Aboriginal populations should include. Some of these factors were evident in the primary healthcare service examples, while others were recommended by service providers, community members, and researchers in their studies and reports. These factors have been mapped to the nine key components of a primary healthcare system outlined in Chapter Two and will be presented in Table 6.

Overall, key factors identified in the literature were well aligned with the key components of a primary healthcare system outlined in Chapter Two. There were several factors that did not fit as well and were specifically related to a primary healthcare system for the Aboriginal population. These included resolution of jurisdictional issues and self-governance. Sustainable, long-term funding was not specifically outlined in the key components of a primary healthcare system but was highlighted in the literature on primary healthcare services for the urban Aboriginal population. These key components and associated factors provided a comprehensive list for an ideal primary healthcare system for urban Aboriginal peoples and had the potential to address the inequities in primary healthcare service delivery along with the ability to impact the health disparities that continued to exist for Aboriginal peoples.

Gaps in the Literature

Despite the amount of information found on primary healthcare services for the urban Aboriginal population in Canada, there were significant gaps in the literature. First, there was little information in the peer-reviewed literature. Most information existed in reports and annual reports, completed by health authorities and government departments. Secondly, and most importantly, there was no information on primary healthcare systems in Canada for the urban Aboriginal population. The focus of the literature was on specific data were available on the effectiveness of primary healthcare service delivery models for

Table 6

Factors from the Literature Mapped to the Key Components of Primary Healthcare

Key component of Primary Healthcare	**Associated Factors from the Literature on Aboriginal Primary Healthcare Services**
Universal access	• Minimization of barriers to access • Co-location of services • Development of primary healthcare services for children and youth • Inclusion of mental health services • Inclusion and support of urban Aboriginal Health Centres as a centre of primary healthcare service delivery in urban centres
Equity and addressing disparities for populations that were marginalized	• A strong focus on identity for health and well-being through cultural revitalization, cultural and spiritual healing and connection to community • Integration of traditional healthcare services and traditional teachings around health • Integration of the needs of a diverse urban Aboriginal population when considering traditional teachings, cultural and spiritual components • A physically and psychologically comfortable environment (e.g., non-judgemental, supportive, safe)
Intersectoral collaboration	• Functional partnerships with other healthcare services, community organizations, and other sectors
Community participation in primary healthcare planning and implementation	• Community engagement (e.g., consultation, Advisory Councils) and involvement of Elders in all components of healthcare (e.g., planning, delivery of services)

Population health approach	• Inclusion of the social determinants of health when assessing needs of the population • Inclusion and support of Aboriginal Friendship Centres as a key gathering place for urban Aboriginal community members • Utilization of a harm reduction model
Effective utilization of interprofessional teams	• Utilization of a patient-centred approach with involvement of patients as team members in decision-making about their healthcare • Utilization and support of collaborative practice teams to deliver care for the population • High proportions of Aboriginal staff • Cultural competency training for staff, including impacts of history, to facilitate cultural safety in healthcare service delivery • Support of staff working in Aboriginal health, particularly those in mental health • Participation in interprofessional education on the health of Aboriginal populations • Work with organizations and communities to offer practicum opportunities for students in primary healthcare services for urban Aboriginal populations
Information technology and electronic health records	• Use of appropriate data information systems
Continuity and integration	• Coordination of services within and across sectors for the benefit of the client or patient
Focus on evaluation and outcomes measurement	• Evaluation of outcomes of services

services and programs, which were poorly connected to one another and therefore significantly impacted the continuity and integration of care. There was also little understanding of whether services were meeting the needs of the diverse urban Aboriginal population. Some information existed on recommendations for services, but little, if any urban Aboriginal people. Coupled with the above, there was a lack of data systems, standardized information management, and focus on outcomes.

In the preceding literature review, it was apparent many gaps existed in the research on primary healthcare systems for Aboriginal people in urban centres in Canada, yet many challenges in the delivery of primary healthcare were evident. Given the lack of data, research focusing on a specific case of an urban primary healthcare system for the Aboriginal population will provide much needed information on primary healthcare systems for this population. The following section will outline the research purpose and questions for such a study.

Research Purpose and Questions

The purpose of the research described in this dissertation was to understand the processes and structures required to support primary healthcare services for the Aboriginal population of Calgary and surrounding areas. In addition, given the primacy in provincial and local health policy of the model of interprofessional teams in a primary healthcare, the study explored the use of this model to address the needs of the Aboriginal population. The results of the research will be particularly helpful to Aboriginal people in Calgary, Aboriginal community leaders, decision-makers for Alberta Health Services, Calgary Zone and other organizations responsible for Aboriginal primary healthcare services, and primary care providers working with the Aboriginal population. Specific research questions addressed were:

1) What were the strengths and gaps in existing primary healthcare services for the Aboriginal population?
2) What were the structures and processes needed to improve primary healthcare for the Aboriginal population?
3) Who were the key stakeholders that needed to be involved in designing a primary healthcare system for the Aboriginal population?
4) What was the role of patient-centred teams and what was the ideal staff mix for this new system serving the Aboriginal population?
5) How could cultural safety be integrated into this primary healthcare system for the Aboriginal population?

This study answered these research questions in a variety of ways. A conceptual frame for the study and research methods will be described in Chapter Four.

CHAPTER FOUR—METHODOLOGY

This chapter will focus on research methods utilized in this study. I will begin with a discussion of the conceptual frame used for this study. Secondly, information on research design, methods utilized in data collection and analysis will be provided. Finally, issues of trustworthiness and ethics will be addressed.

Conceptual Frame

This research drew from a number of different theoretical foundations including critical social theory, institutional ethnography, complex adaptive systems, and participatory action research. These theoretical components have provided direction for the research questions, study design, and data collection as well as analysis and interpretation of data.

Critical Social Theory

Critical social theory was referred to in the literature as a group of theories collectively identified by either of two terms, critical social theory and social theory. For the purposes of this document the terms were used interchangeably. Critical social theory dated back to the 1920s originating in the Frankfurt School in Germany, based upon Marxist philosophical views. Berberoglu (2005) outlined major tenants of the philosophies of Karl Marx and Friedrich Engels: social class and struggles amongst classes were fundamental to societal functioning as well as how human beings related to one another. Power relations that resulted in oppression were central to society. Marx advocated for social transformation for social justice and consciousness raising (Hanks, 2002).

In the 1930s, Jurgen Habermas began to redefine critical theory looking at self-liberation and critical consciousness. Habermas stated that critical social theory ought to be further characterized by the concept of communicative interaction. Context and historical influences contributed to a genuine understanding of what was said by others (Grumley, 2006; Hanks, 2002).

Contemporary society continued to be fraught with inequities, power, and oppression despite the work of social theorists in uncovering the causes (Berberoglu, 2002; Hanks, 2002). Currently, critical social theory is focused on the analysis of structures of domination and the resources required to change our social systems (Sinnerbrink, Deranty & Smith, 2006). Careful self-reflection was foundational to contemporary social theory (Grumley, 2006); recognizing and analyzing the often more subtle relationships of power, privilege, oppression, and underlying motivations of these relations at the interpersonal level as well as at the system level (Sinnerbrink et al., 2006). Political, economic, and cultural factors influencing our society were not innate or fixed, but created and altered over time (Friere, 1972; Thomas, 1993). Knowledge and understanding of these factors and the relationships among factors, although important, was not enough in itself for change to occur. Human emancipation was the intent of contemporary social theory when we challenged our conventional or traditional assumptions (Crossley, 2005; O'Neill, 2006; Thomas, 1993):

> …it means liberating people from whatever causes them to suffer unnecessarily. The main causes of unnecessary suffering are the ways in which social, political and economic structures create, reproduce or exacerbate inequalities between groups of people, whereby some enjoy greater and more effective liberties than others in seeking to realise their full human potential. (O'Neill, 2006, p. 119-120)

The goal of social theorists was an *ideal* society with liberation for the disenfranchised, equity, and justice for all (Appelbaum, Hebert & LeRoux, 1999; Hanks, 2002).

Critical social theory provided a valuable framework for researching healthcare services for Aboriginal populations. Reflection on relationships of power, privilege, oppression, underlying rationales, and the linkages to racism assisted in understanding social injustices and health disparities, particularly for those most vulnerable groups such as the Aboriginal population.

Institutional Ethnography

Institutional ethnography was also used as a component of the conceptual frame for this study. Institutional ethnography originated out of the work of Dorothy Smith, initiated approximately 25 years ago. Although described as a method of inquiry and most often depicted as a qualitative research method, Smith (2005) stated institutional ethnography "is a sociology…research as discovery" (p. 2) through peoples' experiences. Hence institutional ethnography was as much a way of thinking as it was a specific qualitative research method. Institutional ethnography began in the actualities of peoples' everyday work (Smith, 2006); "finding out how people are putting our world together daily in the local places of our everyday lives and yet somehow constructing a dynamic complex of relations that coordinates our doings translocally" (Smith, 2005, p. 2).

Exploration began with the local and then moved to social relations beyond the individual and local example (Smith, 2006). Institutional ethnography "draws on local experiences in confronting and analyzing how people's lives come to be dominated and shaped by forces outside of them and their purposes" (Campbell & Gregor, 2002, p. 12). It was used to create greater understanding of the everyday world of people (Campbell & Gregor, 2002). Social organization (coordination of peoples' actions replicated time and again, not motivated or intended to occur from their own volition but something outside) and social relations (peoples' local actions and how those were hooked into the actions of others in a different place and time) were the focus of institutional ethnographical thinking (Smith, 2005). Institutional ethnography began with standpoint, defined as:

> …a position in people's everyday lives, from within people's actual experience, aiming to explore what lies beyond the scope of an ordinary knowledge of the everyday into the social relations that extend beyond us and catch us up in organization and determinations that we cannot see from where we are. (Smith, 2005, p. 206)

Another important component of institutional ethnography was the exploration of ruling relations. Ruling relations was defined by Smith (2005):

> Directs attention to the distinctive translocal forms of social organization and social relations mediated by texts [e.g., forms, policies] of all kinds…that have emerged and become dominant in the last two hundred years. They are objectified forms of consciousness and organization, constituted externally to particular people and places, creating and relying on textually based realities. (p. 227)

Institutional ethnography endeavoured to make visible the everyday acts of people and how they were bound to the social relations of ruling and the economy and interconnections between the two. For the most part, we are not controlled by individuals, but by large organizations managing people through individuals (e.g., health systems, educational institutions, governments) (Campbell & Gregor, 2002; Smith, 2005).

Institutional ethnography could be used as a tool for social justice, empowering the oppressed and disadvantaged (Campbell & Gregor, 2002). It utilized local experiences to explicate "how people's lives come to be dominated and shaped by forces outside of them and their purposes," (Campbell & Gregor, 2002, p. 12).

Institutional ethnography was an appropriate foundational component for this study and was used as a lens for data analysis and interpretation. It was particularly helpful in explicating the everyday experiences of people and how they were connected to one another. This study has taken the standpoint of Aboriginal peoples and the primary healthcare services they sought when they were ill or had a need that required attention, in the prevention of illness and injury and the promotion of health and wellbeing. Frontline healthcare professionals, managers, and other stakeholders were interviewed in addition to members of the Aboriginal population. As DeVault and McCoy (2006) have suggested, they were the intermediary actors between Aboriginal peoples and the health systems they accessed. Results facilitated the explication of connections or the lack thereof between services and the ruling relations and discourses that Aboriginal peoples encountered in their journey to seek primary healthcare services. They assisted in bringing to the forefront the social organization of the primary healthcare delivery system (McCoy, 2006). Findings could thus assist in a social justice and advocacy capacity for the Aboriginal population in this large urban centre.

Complex Adaptive Systems

Complexity science originated in the basic sciences (e.g., biology. astrology) where complex adaptive systems existed in nature such as a complex ecosystem adapting to its environment (Zimmerman, 1999). There was growing support for complexity science being applied to human systems or organizations in business, education, and healthcare (Holden, 2005; Zimmerman, 1999). Plsek and Greenhalgh (2001) define a complex adaptive system as: "…a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions change the context for other agents" (p. 625).

Another definition expanded the understanding of a complex adaptive system. It "involves multiple component parts that interact in a nonlinear fashion, and the results of their interaction are often greater than the sum of their parts" (Resnicow & Page, 2008, p. 1382). Interactions occurred at multiple levels (Holden, 2005; Forbes-Thompson, Leiker & Bleich, 2007). Agents or components of the system took action based on local information and circumstances (Zimmerman, 1999). The historical context of the complex adaptive system added to its complexity (Cilliers, 1998). Adaptation was one of the outcomes of a complex adaptive system often referred to as "emergence" (Holden, 2005, p. 654). Outcomes were also enhanced by diversity within systems and increased interaction among the various system components (Holden, 2005).

There was no doubt, "healthcare organizations are complex adaptive system" (McDaniel, Lanham, & Anderson, 2009, p.192), required to adapt to a large number of internal and external events (Forbes-Thompson et al., 2007; Rowe & Hogarth, 2005). Healthcare systems were often fragmented; by employing a complex adaptive systems theory approach, consideration of the unique characteristics of the system was possible (Lindstrom, 2003). Uncertainty, a key characteristic of a complex adaptive system (Rowe & Hogarth, 2005), was inevitable in our healthcare system.

A primary healthcare system was a complex system within the larger healthcare system. It was made up of many healthcare professionals providing a myriad of services to the overall population. While healthcare professionals were largely publicly funded in Canada, there were also significant proportions of fee-for-service professionals (e.g., physicians, physiotherapists). Complexity was added by focusing on the primary healthcare system for the urban Aboriginal population. Aboriginal populations were diverse, social determinants of health significantly impacted the health of the populations, many organizations were involved in providing services, and accountability and funding was increasingly complex with numerous jurisdictional issues. Indeed, using complex adaptive systems theory will assist in understanding the multiple players, the structures and interactions within such a system and its unpredictability.

Researching a complex adaptive system, such as a primary healthcare system for an urban Aboriginal population, meant one must be flexible and responsive to an ever changing environment, one that was not predictable and was likely unique to the setting (McDaniel et al., 2009). By framing the research to examine the various elements, the entire system as a whole and the complex relationship networks (Lindstrom, 2003; Forbes-Thompson et al., 2007) we were better able to understand the overall system and its functioning. McDaniel et al. (2009) suggested case study methodology was ideal for the study of complex adaptive systems. Lindstrom (2003) stated “the complex cannot be made simple, nor understood in simple terms, nor solved in simple ways” (p. 30). Reductionist approaches were no longer sufficient to understand the complexity of our organizations (Forbes-Thompson et al., 2007). In short, the context, multiple parts, and the relationships must be examined to understand the whole system. This made complex adaptive system theory ideal in studying the primary healthcare system for the urban Aboriginal population in Calgary.

Understanding a complex adaptive system was also predicated on “participatory planning and decision-making” with multiple stakeholders (Lindstrom, 2003, p.33). Community participation was a key principle of primary healthcare systems. This research, utilized a participatory approach, facilitating the involvement of key stakeholders in the research process. This approach will be explained in the following section of this chapter.

Participatory Approach

Participatory action research or participatory inquiry focused on research *with* people as opposed to *on* people (Thesen & Kuzel, 1999). Participatory action research emphasized active collaboration between participants and researchers from the development of research questions, collection of data, analysis and interpretation of findings, and dissemination of results (Marshall & Rossman, 2006; Morse & Richards, 2002). This approach was based on a number of key aims: development of knowledge and action directly benefiting the particular group of people and empowering groups or communities to facilitate social change (Reason, 1994). It also maintained a close relationship to the local context (Marshall & Rossman, 2006). Special attention must be undertaken to ensure reciprocity between researchers and participants and community control (Thesen & Kuzel, 1999). Participatory action research was based upon a number of key principles, one of which was to ensure the involvement of the community in interpretation of research findings (Herbert, 1996).

A participatory approach was used throughout all stages of the research project. The involvement of key stakeholders in all components of the study, from the refinement of questions to data collection and analysis, ensured the needs of the community were met and the results had the potential to influence a primary healthcare system to provide culturally safe services for the urban Aboriginal community in Calgary. A partnership with stakeholders from the population, the health system, and the research team assisted with the integration of the research ensuring the development of opportunities to learn from one another (Potvin et al., 2003).

Summary of the Conceptual Frame

In this study four frameworks were utilized as a conceptual frame informing all areas of the research. These frameworks were not unrelated, but overlapped significantly in a number of key areas as shown in Table 7. Other than complex adaptive systems theory, all other frameworks focused on *people*, particularly non-professional or working class groups of individuals. The interconnections among people and among people and organizations were emphasized by three out of four of the frameworks. The importance of context, particularly the local context, was a component central to all frameworks. Historical influences were significant to three of four frameworks. Emancipation of marginalized peoples was the focus of all frameworks other than complex adaptive systems. Lastly, participatory collaboration was a key component of complex adaptive systems and participatory action research.

The following sections of this chapter will focus on research methodology for the study. The previously outlined conceptual frame was considered in the planning and implementation of all study components.

	Critical Social Theory	**Institutional Ethnography**	**Complex Adaptive Systems**	**Participatory Approach**
Focus on the *people*	Social class struggles (focus on the working class)	Ordinary people		Focuses on research 'with' people versus 'on' people
		Everyday activities of peoples' lives		Knowledge & action directly beneficial to the community
Connections & interrelationships	Interrelationships among classes	Complex relationships between people & people & organizations (social relations & organization)	Multiple components interacting	
	Communicative interaction	Relations of ruling, economy	Interactions are non-linear	
			System is complex (e.g., web of relationships)	
Importance of context	Context was central	Began with the local, moving to the translocal & external	Context was central	Local context was central
Historical influences over time	Historical influences must be understood	Historical influence on social relations & organization	Historical influences on system	People come to understand the role of history
			Adaptation & change over time	

Emancipation	Emancipation & liberation of disenfranchised	Empowering oppressed		Empowering communities and emancipation of people who were marginalized
	Self liberation	Advocacy		
	Equity	Social justice		
	Justice for all			
Collaboration			Participatory planning & decision-making	Active collaboration throughout research process
			Outcomes enhanced by diversity & increased interaction	Reciprocity between participants & researchers
			Outcomes not easily determined	Community control
Other	Critical consciousness and self-reflection		Originated in basic sciences	Originated in low and middle income countries and international research
	Analysis of structures of domination, power, inequities, privilege			

Table 7

Key Components of Theories Foundational to This Research

Research Methods

Case Study Design

A case study design was used to examine the primary healthcare system for Aboriginal peoples in Calgary, a large urban centre in southern Alberta. Case studies were most helpful in answering *how* or *why* types of research questions and understanding the context in which cases develop (Yin, 1994). "The case study offers a means of investigating complex social units consisting of multiple variables of potential importance in understanding the phenomenon" (Merriam, 1998, p. 41). Yin (1994) stressed the importance of flexibility in the design of case study research; allowing for modification of methods as research progressed. A primary healthcare system was a complex model for health services delivery. This coupled, with the population being addressed, with its myriad of health and social challenges, made case study design an ideal choice for this study.

The Case

To determine a sampling frame for the study, it was important to ensure that the boundaries of the case were well defined (Marshall & Rossman, 2006; Merriam, 1998; Yin, 2003). This research conducted a case study of the current primary healthcare system servicing urban Aboriginal populations within the Calgary area. The time frame for the case was from September 2007 through September 2009. Data collection focused on those individuals or programs currently involved in the delivery of primary healthcare services for urban Aboriginal peoples, receipt of services, or those who would potentially be involved in an Aboriginal primary healthcare system. Linkages to key organizations identified by participants (e.g., First Nations organizations in close proximity to Calgary (e.g., Siksika First Nation) but outside of the Alberta Health Services, Calgary Zone geographic service area were also included. There were three key groups of stakeholders: decision-makers (both within the Aboriginal population and the health system); primary healthcare providers (those who currently provided services to Aboriginal peoples or those who would potentially be involved); and various community members themselves. In some cases these categories overlapped, for instance, when providing information in interviews a provider also shared personal information on accessing primary healthcare services as an Aboriginal person. The historical context of the case focused on the previous two years (back to September 2005). Ethics approval for the study was received in November 2007 with the collection of data beginning shortly thereafter. Data were collected through to the end of September 2009.

Sampling

Data should be collected from multiple sources in case study design (Merriam, 1998; Yin, 1994). Adequate depth and breadth of information was required to fully understand the case. Data collection was iterative where one data source informed the other, and vice versa (Merriam, 1998). Data for this research was collected through Advisory Committee meetings, individual and group interviews, observation, and document review. A matrix of research questions outlining the methods and data sources for the study was included in Appendix B.

The researcher sought to obtain a sample of maximum variation to represent diversity in the perspectives of the primary healthcare system (Lincoln & Guba, 1985; Polit & Hungler, 1999). Interview participants, observation of events, and documents were initially identified through snowball sampling techniques (Marshall & Rossman, 1999) through the researcher's existing networks with Aboriginal peoples and the healthcare system. Purposive sampling (Polit & Hungler, 1999) was then used to ensure the researcher selected interview participants, observation opportunities, and documents that would provide the best insight and understanding of the case. Data collection continued until data saturation occurred (Glaser & Strauss, 1967; Strauss & Corbin, 1990), where variation in information was minimal and little new information was being obtained.

Advisory Committee Meetings

An Advisory Committee was formed with representation from the urban Aboriginal population, providers, Aboriginal Health Program of Alberta Health Services, Calgary Zone, research team members and other stakeholders. Participants were approached to garner their interest in participating, provided with a summary of the study plan, and also asked about others who should be involved. The Aboriginal Community Health Council for the former Calgary Health Region was consulted early in the study to assist with the identification of key stakeholders for the Advisory Committee as well as reviewing interview questions. A total of nine individuals participated in Advisory Committee meetings, along with the researcher and her supervisor. Some only attended one meeting due to extenuating circumstances, and others participated in more meetings. A core group of approximately four participants attended most of the meetings. The Advisory Committee assisted in the process of refining and clarifying the research questions, provided advice on data collection, and assisted in facilitating access to data collection opportunities. They also provided feedback on preliminary research findings. This commentary was incorporated as additional data for the study. Advisory Committee members also provided input for dissemination of results. It is our intent to have a celebration with the Advisory Committee and the PhD Supervisory Committee upon completion of the dissertation to review results and discuss next steps.

Five Advisory Committee meetings were held at various points throughout the study. Informed consent was obtained at the time of the first Advisory Committee or the first meeting attended by a new member. All committee members were offered the opportunity to provide written or oral consent (Appendix C). Oral consent was preferred by this community (Meadows, Lagendyk, Thurston, & Eisener, 2003). Meetings were audio-taped and field notes captured by the researcher. Materials, particularly when it came to reviewing preliminary results, were circulated to Committee members electronically if they were unable to attend the meeting and their input was sought via e-mail or through phone discussions. Advisory committee members contributed significantly to the discussion of various components and did indeed influence the overall study.

The participatory approach used through our Advisory Committee helped to facilitate ethical principles in working with the Aboriginal population in this research. Ethical principles were addressed in the following ways:

- Ownership and control (Canadian Institute of Health Research, 2007; First Nations Centre, 2007; Schnarch, 2004) was aided by involving the Advisory Committee in decisions at all levels and points in time in the study. Input collected was incorporated into research protocols;
- Access and ongoing communication (First Nations Centre, 2007; Schnarch, 2004) was provided through regular meetings with the Advisory Committee with updates on the study along with study results. E-mail communication and phone discussions were used between meetings as well as for those who were unable to attend. All research results were channelled through the Advisory Committee meeting prior to their release elsewhere;
- Respect for Aboriginal worldviews (Canadian Institute of Health Research, 2007) was facilitated through the participation of Advisory Committee members, self-reflection, and supervisory committee discussion;
- Participatory approach (Canadian Institute of Health Research, 2007) was used through the incorporation of an Advisory Committee for the study and dissemination plans;
- Consents (Canadian Institute of Health Research, 2007) were utilized with Advisory Committee members to ensure confidentiality of information shared. Participants were offered both oral and written consent options;
- Value of research to Aboriginal peoples (Canadian Institute of Health Research, 2007) was important to the researcher from the beginning. Advisory Committee members participation helped to ensure that it would be beneficial to policy and decision-makers and ultimately to contribute to the health outcomes for this urban Aboriginal population;
- Interpretation and conclusions (Canadian Institute of Health Research, 2007). The Advisory Committee was involved in providing input in interpreting the results. Their feedback was collected and then utilized as new data to incorporate into research findings. The supervisory committee and published literature offered additional critical lenses; and
- Credit to Advisory Committee members (Canadian Institute of Health Research, 2007). Advisory Committee members have been acknowledged in this dissertation and will be acknowledged in other publications pertaining to the study. Their input has been invaluable to the success of the study and to the ultimate outcome.

Elder Involvement in the Study

Elder involvement with the study was discussed early in the study at the Advisory Committee level as well as at the Aboriginal Community Health Council. Discussions ensued as to whether Elders should be involved at the Committee level, engagement of Elders, and who to engage as Elders representative of the urban Aboriginal population. After further discussion at the Advisory Committee level there was agreement that Elder involvement would be valuable but we needed to be very clear in how they would be involved and what they would be asked to do. After further discussion and efforts on the part of the researcher, formal Elder involvement did not occur. Some Elders were interviewed to garner their perspectives and a seniors' group participated in a group interview.

Data Collection

Document Review

A document review was conducted of 101 key documents pertinent to the case. A list of public documents was included in Appendix D. Four additional confidential documents were reviewed. Documents selected for review were predominately dated within the case study timeframe of September 2005 through September 2009, but 14 documents dated prior to September 2005 were included as context for the case. Fifteen documents had no date; the majority of these were websites and brochures. The documents were grouped into national documents (n=31), provincial documents (n=14), and local documents (n=56). Pertinent documents were selected for review by the researcher, her supervisor, and the Advisory Committee. Other documents were identified in reference lists of documents being reviewed. Documents were included when they provided some or all of the following information on primary healthcare systems for Aboriginal populations in Canada:

- Consultations on primary healthcare service delivery;
- Information from Advisory groups;
- Primary healthcare strategies and frameworks;
- Current primary healthcare services (e.g., visionary documents, evaluations);
- Policy documents and reports appeared key by virtue of the number of times mentioned; and

- Other documents specifically related to the development and operation of the primary healthcare system for the urban Aboriginal community in Calgary.

The focus was on the urban Aboriginal population but provincial and national documents were not necessarily focused on urban populations only. Local documents did focus on urban services and populations.

An initial review of documents occurred early in the study, prior to other data collection. This assisted in further refining and clarifying research questions as recommended by Yin (1994). Documents were also used to inform and refine interview guides. A more in-depth analysis of documents was completed throughout the study and supplemented with other documents when discovered or when new documents became available. These were reviewed over the remainder of the study period and included as additional data.

Individual and Group Interviews

A total of 37 interviews were conducted with 38 individuals. One person was interviewed twice due to time running out in the first, and two other interviews included two individuals each. Twenty-five of the 38 individuals interviewed identified themselves as Aboriginal. Two additional group interviews were held with members of the urban Aboriginal population. A total of nine members of the urban Aboriginal population participated in the two group interviews. Participants for group interviews were recruited through several organizations via their existing memberships. All participants identified themselves as Aboriginal, including both First Nations and Métis from various locations in Canada, currently all living in Calgary.

Quotes from interviews were not identified by category of participant. There was a concern about the identification of participants due to the closely connected environment of Aboriginal health services where quotes might identify individuals.

Following the initial round of document review, individual and group interviews were conducted with key stakeholders including decision-makers, current and potential providers, Aboriginal leaders, Advisory Committee members, and members of the urban Aboriginal population currently involved in delivering or receiving primary healthcare services to ascertain their varied perspectives. All participants were recruited to the study via phone, fax, or e-mail. Informed consent (oral or signed consent) was obtained at the time of interviews (Appendix E).

Interviews were semi-structured in nature (Kvale, 1996) using an interview guide with open-ended questions and appropriate probes (Appendix F). Participants were asked to provide their perspectives on what types of services Aboriginal peoples in Calgary and surrounding areas accessed when they did not feel well or when they had a need, for illness, prevention, and to promote health and wellbeing. They were also asked to comment on the strengths and gaps of those services, how services could be delivered, including team members involved, and who should be involved in decisions around the planning of service delivery. Lastly, participants were asked to provide their definition of cultural safety and how cultural safety could be incorporated into a primary healthcare system for the urban Aboriginal population. If the participant represented a specific organization or program, the researcher often asked them to share information about the organization or program.

As the interview guide was rather lengthy, and time for the interviewees was frequently a concern, the researcher often used a summary type of question; "If they could build an ideal primary healthcare system for the urban Aboriginal population, what would that look like?" This covered how services ought to be delivered and who should be involved in delivery. The interview guide was used as a guide and interviews were frequently more conversational and semi-structured, hence not all questions were asked of all participants.

The interview guide was adapted for the group interviews with community members (Appendix G). Group interview participants were asked to share their perspectives on the following: where do you access services when you are sick, to prevent illness or injury, and to promote health and wellbeing; the characteristics of an ideal primary healthcare service; and who should be part of the team to address the needs of the urban Aboriginal population.

Individual and group interviews were approximately 30 – 90 minutes in length. Most of the interviews were audio-taped (n=32), unless the participant requested they not be recorded or the location of the interview did not lend itself to recording the interview (n=7). When interviews were not recorded, detailed notes were taken. Field notes were also made by the researcher after interviews to document context, and other components of the interview not captured in the recording. The opportunity to do a follow-up interview was requested by the researcher, but most of the stakeholders participated in only one interview. No need for follow-up interviews was identified.

Direct Observation

Direct observation was also used to collect data in this study allowing the researcher to observe real time events and context (Yin, 1994). A total of five different observations were completed as part of the study. Observations were conducted of meetings and discussions on primary healthcare services for the community, presentations, and less formal observations such as field visits. Information collected as part of direct observation included the physical setting, roles and interactions between participants, activities occurring or not occurring, conversations, and nonverbal communication. Consent for observations was obtained from the manager or leader responsible for the particular activity. Notes were taken during and following the observation sessions.

Analysis

Inductive analysis, making sense of the data through an iterative process (Lincoln & Guba, 1985), was used to analyze all data collected for the study. The goal was to transform data from individual sources to common, interactive themes. This process entailed coding, categorizing, and conceptualizing (Morse & Richards, 2002). Themes were explored and recurring patterns identified. Constant comparative methods (Glasser & Strauss, 1967) were also used to allow continuous comparison of the data. Data collection and analysis followed an iterative process with one data collection activity and preliminary analysis informing future data collection (Morse & Richards, 2002) and returning to analyze various data to confirm results or identify discrepancies. Detailed analysis activities (Crabtree & Miller, 1999; Morse & Richards, 2002) and involvement of the research team and/or Advisory Committee will be outlined in Table 8. Steps outlined occurred in a spiral process rather than in a linear fashion.

All audio recorded interviews, Advisory Committee meetings, and field notes from interviews and observations were transcribed verbatim. Electronic sources of all relevant documents were sought. Data management and analysis was facilitated by the NVivo7^{TM} software program to ensure that all elements could be fully explored and linked. Where electronic sources of documents were not available, a hard copy of the document was used. For hard copy documents, review was based on the coding tree and themes incorporated into memos that were coded in the NVivo7^{TM} project and used in the final data analysis.

A community assessment and analysis was included to better understand the dynamics of the Aboriginal population in Calgary and surrounding areas. This included a description of current primary healthcare services and related services available to community members as well as contextual information. Key informant interviews, documents, an environmental scan of services available (abstracted from interviews, documents and organizational websites), and participation in other projects related to Aboriginal peoples' health contributed to the community assessment.

Triangulation of Data

Through a process of constant comparison (Glasser & Strauss, 1967), data from the various sources were integrated. Themes were compared and refined throughout the analysis from different data sources. Collecting data from multiple sources (Advisory Committee, individual and group interviews, direct observation, document reviews, community assessment and analysis) ensured a rich description (Merriam, 1998; Morse & Richards, 2002) of the case. The use of the research team (Supervisor and PhD Committee members) also assisted in integrating data and providing multiple perspectives during analysis. Data and results were informed by the published literature (peer reviewed and grey literature reports) on both Aboriginal peoples' health and primary healthcare. The theoretical literature and results from other studies enabled

Steps	Activities Required	Category of Analysis	Who is Involved
1. Transcription of data	• Have interviews, field notes and Advisory Committee meetings transcribed • Import data sources (Advisory Committee and interview transcripts, field notes, documents) into • NVivo7^{TM} software program	• Data management	PhD student and transcriptionist
2. Describing what is seen in the data	• Reflection on activities thus far • Reflexivity on above in conjunction with beginning of analysis (e.g., assumptions, research paradigm) • Critical thinking regarding next steps	• Describing	PhD student, supervisor, committee members, and other qualitative researchers
3. Examination of entire file	• Develop broad categories related to themes and patterns • Define themes and patterns • Begin identifying relationships within data • Interview guides act as a guide	• Organizing (identifying initial codes or categories to interact with the text) • Categorizing or grouping related codes	PhD student
4. Analysis of file	• Discover meaningful units • Code under broad themes and patterns	• Connecting	PhD student

5. Assessment of themes and categories	• Refine definitions • Examine interrelationships among concepts and themes • Systematic comparison and differentiation • Combine similar themes • Develop sub-themes or patterns • Catalogue the sub-categories	• Organizing • Categorizing • Conceptualizing • Connecting	PhD student
6. Re-analysis of data	• Identify any gaps or duplication in data		PhD student
7. Validation & audit	• Review transcripts, themes & patterns with a number of interview participants • Obtain participants feedback and reaction to reconstructed data • Review with qualitative research colleagues • Re-viewing the texts for consistency • Ensuring multiple perspectives represented • Internal consistency • Member checking using multiple stakeholders (e.g., research team, other researchers, healthcare providers, decision-makers, and participants involved in the study)	• Corroborating & Legitimating	PhD student, supervisor, Advisory Committee, research participants and other qualitative researchers

8. Modification and revision	• Modify and revise questions for next data collection activity		PhD student, supervisor, and Advisory Committee
9. Comparison of data files	• Compare & contrast themes and categories from the various data sources • Analytic memos	• Connecting • Conceptualizing	PhD student
10. Writing up interpreted data	• Sharing new understandings and interpretations • Share analytic process • Type of account determined by audience targeted	• Representing the account	PhD student

Table 8

Steps in Data Analysis

the researcher to compare and critique assumptions and conclusions in this analysis and of those of the published literature. Finally, and most importantly, the perspectives provided by the Advisory Committee on the analysis of the results were included in further analysis.

Trustworthiness

Attention to rigor is an important component of qualitative research. Various strategies (Lincoln & Guba, 1985; Merriam 1998; Morse & Richards, 2002; Yin, 1994) were used to enhance the internal and external validity of the study.

The potential for researcher bias was addressed in a number of ways. The researcher completed some journaling to promote self-reflection during data collection, analysis, and interpretation. Reflective notes were also made in memos in the NVivo7^{TM} project for the study. Discussions were frequently held with the researcher's supervisor and the researcher was encouraged to look at alternative interpretations. Broad discussions related to the study were also conducted with other qualitative researchers and Aboriginal researchers to further consider and reflect on alternative understandings.

A skilled transcriptionist was used to transcribe all interview recordings. This transcriptionist has been used by the researcher in a number of studies and was found to be very accurate in her transcription. Even so, three transcripts were reviewed by the researcher to ensure accuracy of the transcription. If a concern arose while coding in any of the transcripts as to meaning of a particular statement, the researcher always went back to the original recording. Field notes were transcribed by the researcher herself and reviewed for accuracy throughout the transcription process.

A research assistant completed the coding for the document review. This research assistant was degree prepared (Health Sciences Degree) and trained in qualitative research. Further training specific to this project was provided and meetings were held to assess progress and answer any questions she had. Unfortunately, the first research assistant was unable to continue with the study. A second research assistant was then hired. She was Masters prepared and was working on her PhD. She had a background in health sciences and had a keen interest in Aboriginal health. She had received some qualitative training which was supplemented by the researcher. She reviewed all documents, reviewed coding of the previous research assistant, coded additional documents, and created memos for all documents. Discussions were held on a regular basis to determine appropriateness of coding, themes found during analysis of documents, and whether additional documents referenced should be included or not in the document review.

Member checking (Morse & Richards, 2002) was completed by two participants who reviewed their own interview transcripts to ensure accuracy of their transcript and provide clarification if necessary. A third interview participant was approached but, due to extenuating circumstances, was unable to complete the review of the transcript. These participants were also provided with themes from the study to determine whether themes were aligned to the perspectives they provided during their interview. A few minor editorial corrections were made by the two interview participants and both agreed that the themes reflected their interview as well as what they knew about the primary healthcare system for the urban Aboriginal population in Calgary. One participant also provided a short commentary on services since being interviewed. Clarifications, retractions or changes were noted by the researcher and considered in the analysis as new data (Borken, 1999).

Most valuable in determining internal validity of the study, was the member checking (Morse & Richards, 2002) conducted through Advisory Committee members. Preliminary and final results were presented to committee members with the opportunity to seek clarification, provide additional information, and ensure that the perspectives were accurate. As with member checking with individual participants, all feedback and changes were considered as new data in the analysis of the study.

An audit of five transcripts was completed by a skilled, PhD prepared, qualitative researcher. This researcher completed her doctoral studies in sociology focusing on Aboriginal tourism in Alberta, hence was aware of the complexity of Aboriginal issues. She was asked to code five transcripts representing 11% of the total transcripts available in the study (39 interview transcripts and five observation field note transcripts). Codes and themes identified by the auditor were then compared to codes and themes identified by the researcher. Although different words were chosen to delineate codes, coding was similar in nature to the coding completed by the researcher. Overarching themes were also very similar to those identified by the researcher (e.g., issues of racism, the need for culturally safe care and the importance of training for healthcare providers, lack of coordination of primary healthcare services for the urban Aboriginal population, lack of traditional services available for Aboriginal community members, need for improved data collection, and focus on outcomes).

Bi-weekly meetings were also held with my supervisor to discuss research progress as well as results as they arose. These discussions assisted in exploring themes more fully, obtaining more data on early themes and clarifying themes as they arose.

Member checking (Morse & Richards, 2002) through the Advisory Committee also contributed to the external validity of the study results. Integration of the existing academic literature on primary healthcare increased external validity. Finally, triangulation of data, researchers, and theories improved the likelihood the project would achieve its goals (Crabtree & Miller, 1999; Morse & Richards, 2002).

Ethics

Information on the study was presented to the Aboriginal Community Health Council, of the former Calgary Health Region. They were a key group concerned with the health needs of urban Aboriginal peoples in Calgary and surrounding areas. They gave consideration to ethical issues in research and were respectful of Aboriginal worldviews. Input on the study was sought from the members of the Aboriginal Community Health Council on potential Advisory Committee members, potential participants in the research, interview questions, and the involvement of Elders in the study. The study was supported by Council members in attendance.

Ethics approval was sought from the Conjoint Health Research Ethics Board at the University of Calgary. Ethics approval was obtained in November 2007. Research and ethical protocols as described in our proposal were adhered to.

The project worked within the “ethical space” (Ermine, 2007) referred to by the Canadian Institute of Health Research Guidelines for Health Research Involving Aboriginal Peoples (Canadian Institutes of Health Research, 2007) and the OCAP principles of ownership, control, access and possession (First Nations Centre, 2007). By including a participatory process there was opportunity to create a dialogue around ethical issues, values, research, and other assumptions that could have created inequity for Aboriginal people. Ownership and possession of the data were held by the university as there was not one organization to represent urban Aboriginal peoples with whom an agreement for joint ownership could be signed. The urban Aboriginal population in Calgary and their representative organizations will have access to the results of the study.

Summary

This chapter has provided information on the conceptual frame for the study, methods, including data collection and analysis, as well as protocols utilized to determine trustworthiness of the data. This research utilized four key approaches as a conceptual frame: critical social theory; institutional ethnography; complex adaptive systems; and a participatory approach. Case study methods were used to conduct the study. Data were collected via a variety of means including document review, interviews, participant observation, and Advisory Committee meetings. Inductive analysis was conducted to determine themes arising from the data. Trustworthiness of the data was ensured through a variety of processes. All research procedures adhered to appropriate ethical protocols for Aboriginal communities. The following three chapters of this dissertation will provide a comprehensive description of research results. Chapter Five will describe the current primary healthcare system for the urban Aboriginal population in Calgary, as well as identifying strengths and gaps.

CHAPTER FIVE—CURRENT PRIMARY HEALTHCARE SYSTEM, STRENGTHS, AND GAPS

This first chapter of research results will focus on answering the first research question, “What are the strengths and gaps in existing primary healthcare services for the Aboriginal population?” The following sections will be included: 1) information on what services the urban Aboriginal population utilizes for illness or need, disease and injury prevention and promotion of health and well-being; 2) a description of the current primary healthcare system; and 3) information on the strengths and gaps in primary healthcare services. Due to the nature of the research question, the majority of this chapter will be descriptive of the current primary healthcare system and its gaps and strengths. A table (see Table 9 of key results presented in this chapter will provide the reader with an introduction to these results.

Services Utilized for Illness and Need

“I think the urban Aboriginal individual within Calgary has access to the services that are available to everybody…starting with medical service, primary care” (Int. 036, Lines 28-30). This certainly was the expressed ideal, but unfortunately many interviews revealed that barriers existed for urban Aboriginal peoples seeking and receiving primary healthcare services in Calgary. Barriers will be discussed in more detail in the section on gaps in this chapter. Participants also felt that Aboriginal providers were desired for service delivery; “the ideal situation is we Aboriginal people should have an Aboriginal doctor” (GI 001, Lines 76-77). Secondly, participants suggested Aboriginal-specific organizations and services would be the first choice of community members to better ensure their comfort level. “I think through the local community organizations, the Aboriginal organizations. People firstly, I guess, want to see themselves reflected in who they ask for help” (Int. 019, Lines 94-96). Participants referred to Aboriginal-specific as those services for Aboriginal people only, where Aboriginal leaders and community members had been involved in the planning of services, and whenever possible and appropriate Aboriginal staff were hired. Interestingly, many participants did not necessarily seek out Aboriginal-specific services as they may not have known about them, or had not been referred to such services.

Table 9

Key Themes for Chapter Five

	Key themes
Services used for illness and need	• Ability to access services available to everyone • Aboriginal-specific services were desired • Utilization of emergency departments, urgent care centres, and walk-in clinics • Many did not have a primary care physician • Attendance at clinics in the city centre (e.g., Elbow River Healing Lodge, Calgary Urban Project Society) • Utilization of other services (e.g., Aboriginal service organizations, Calgary Women's Centre, internet sources, friends and family)
Services used for disease and injury prevention	• Prevention not a priority for community members • More pressing needs (e.g., food, housing, etc.) existed • Spiritual beliefs impacted whether prevention services were sought • Most prevention services had to be accessed through mainstream services
Services used to promote health and well-being	• Acknowledgement of importance, not readily discussed • Importance of connection to family and the community • Importance of identity • Value of healing and sharing circles • Importance of spirituality and traditional care • Spiritual and traditional care in home communities
Current primary healthcare system for Calgary's Aboriginal population	• Composition of many organizations, departments, and programs • Number of services increased due to boutique services responding to gaps, needs, and short-term funding • Relationships among organizations varied • Most Aboriginal-specific organizations were non-governmental organizations

Strengths of the current primary healthcare system for this urban Aboriginal population	• Commitment and expertise of frontline providers • Progress made in healthcare services for this population over the last decade • Commitment of former Calgary Health Region's leadership • Community participation in health services planning

Gaps in the current primary healthcare system for Calgary's Aboriginal population
• Access
	• Lack of services overall, specifically community-based services
	• Access if primary care physicians poorly understood
	• Structural barriers to access
	  • Complexity of the system
	  • Inclusion/exclusion criteria for services
	  • Wait times and limited hours of service delivery
	  • Jurisdictional barriers
	  • Access dependent on personal network
	  • Environment (e.g., décor, gatekeepers, etc.)
	• Transportation
	• Differing beliefs
	  • Aboriginal worldviews versus western biomedical medicine
	  • Accessing services in later stages of disease
	  • Varying beliefs due to the diversity of the population
	• Services not meeting the needs of Aboriginal community members
	  • Importance of assessing and meeting the needs of Aboriginal community members
	  • Strong proponents of Aboriginal-specific services
	• Racism
	  • Racism and discrimination abundant in healthcare system impacting access to services
	• Lack of trust in the healthcare system
	  • Deeply rooted in colonization practices, history

• Lack of Coordination	• Lack of coordination within healthcare and across sectors • Large number of organizations/programs involved in services • Many organizations did not have the resources to address coordination of care (e.g., Aboriginal organizations being non-governmental) • Coordination was dependent on who you knew • Attention to coordination was evident at the patient level, but a lack of at the systems level
• Gaps in specific service areas	• Prevention services • Health promotion services • Lack of a community gathering place • Services for children and youth • Chronic disease management, particularly diabetes • Mental health services • Dental health • Housing and homelessness • Traditional and spiritual services

> I'm usually not referred to Aboriginal-specific services or they're not made known to me. And I don't know if that's because the physicians do or don't know about them. But I've often found as a patient in Calgary, I have to do my own research to find out Aboriginal-specific services. And unless I'm willing to do that, then I just sort of will go to whatever is closest to me when I'm [not] feeling well or my kids are not feeling well. (Int. 015, Lines 41-49)

The above quote spoke to the work required by Aboriginal peoples to find and attend Aboriginal-specific services. For some, search efforts were possible, but for many, navigation of healthcare services was simply too difficult or required too much time to have made this a reality, hence they went to whatever service they knew about and was readily available.

Utilization of Hospital Emergency, Urgent Care, and Walk-in Clinics

Interview participants stated many community members used hospital emergency departments, urgent care centres, and walk-in clinics when they were ill or had a specific health concern. These were easily accessible, particularly after hours. Attending a walk-in clinic, however, impacted the continuity of care received, which was of particular concern for those patients with multiple, complex issues.

> In the urban centres amongst the Aboriginal population, walk-in clinics are used quite a bit I've noticed. People don't seem to be connected with a primary physician. And they seem to think that their doctor is at the walk-in clinic, their family doctor, but it's really not the case. And as a result, people don't get really consistent healthcare. (Int. 009, Lines 60-65)

The transient nature of the population and the ability to have a need addressed immediately were also reasons for using emergency, urgent care, and walk-in clinics. "…that's partially due because of the transiency and there isn't enough time to establish that relationship or the need is immediate at the time, so I'll just go into a walk-in clinic" (Int. 021, Lines 367-370). Utilization of these types of services may not be unique to Aboriginal people, as the population overall has increased their utilization of such services as they are readily accessible, 24/7, as well as the public's philosophy of urgency where they perceived care to be required immediately.

Aboriginal peoples may have attended the emergency department, urgent care, and walk-in for other reasons as well. Most primary care physician offices operated within narrow policies and procedures for service access (e.g., appointment times may be restricted for the convenience of providers, there were often penalties for no show appointments or being late, only one or two issues could be discussed at an appointment); making utilization of services more difficult for Aboriginal people. As noted by Fiske and Browne (2006), Aboriginal people were required to abide by the policies of the medical clinic and social etiquette without consideration of context further marginalizing community members. Emergency departments were also seen as a safety net for vulnerable groups and populations that were marginalized (Su, 2009).

Still others attended emergency or urgent care because they had waited so long that their symptoms were severe and hospital care was required. “People present when they’re so ill that they have no choice but to go to the hospital or to the doctor” (Int. 009, Lines 57-60). This was the case, particularly with individuals with mental health issues. They would wait to seek help, and attended urgent mental health services when they simply could not handle their situation any longer. Many participants also discussed the fact that community members often did not seek services at all, including such primary healthcare services as walk-in clinics or homeless shelters. Waiting to obtain care was found to be the case with other groups that were marginalized (e.g., street people) as they feared the way they would be treated by healthcare providers (Pauly, 2005 as cited in Pauly, MacKinnon, & Varcoe, 2009).

Primary Care Physicians

Participants suggested many community members did not have a family physician. A shortage of family physicians in Calgary was well known. The Health Quality Council of Alberta (2009) reported 81% of Albertans surveyed had a family doctor while 38% of those who did not have a family physician were due to physicians not taking new patients or being retired. This shortage, no doubt, also impacted the ability of Aboriginal peoples to obtain a regular family physician. This could be further complicated by such practices as *cherry picking* where physicians were reluctant to take new patients with multiple, complex conditions into their practice and preferred to fill open slots with healthier people. This practice with respect to Aboriginal people was supported by research conducted in British Columbia (Su, 2009). The fee-for-service model will be discussed in more detail in Chapter Six and its impact on working with patients with multiple, complex concerns. Also, the location of physicians taking on new patients may not be convenient (e.g., close to public transit, close to where prospective patients lived) making it difficult to attend.

Interview participants discussed the length of time it took to see a physician, where patients may have waited for a couple of weeks to get an appointment, when they had an immediate need at the time. Still others felt that Aboriginal peoples did not always feel comfortable in a physician’s office where they often experienced racism from providers, the front desk, or other patients in the waiting area. Bucharski et al. (2006) hypothesized that discrimination was a major factor in Aboriginal women not attending family physician offices for care.

Some participants (healthcare providers) felt the concept of seeing a regular physician was not a high priority amongst Aboriginal peoples. “The notion of family medicine with continuous care, as you see it in the larger population, simply does not exist. Or does not exist to the extent we would expect it to be” (Int. 013, Lines 47-50). Continuous care by a family physician was a western concept of medicine, hence the question must be asked if this type of care fits with an Aboriginal worldview. Connection was very much a part of Aboriginal worldviews (Wilson & Pence, 2006) and practice based on relationship was the foundation of family medicine (The College of Family Physicians of Canada, 2006). Other reasons for not having a regular family physician such as racism, lack of trust in physicians, and lack of accessibility of primary care physicians impacted Aboriginal peoples having a regular primary care physician. The relationship between Aboriginal peoples and primary care physicians was poorly understood and will require further study to determine why many members of the urban Aboriginal population did not visit family physicians regularly.

While some participants believed Aboriginal peoples did not seek a regular physician, others talked about the importance of having a family physician, particularly for continuity of care. “But I think I should get a doctor. Like in my hometown, I would have my own doctor” (GI 001, Lines 74-75). Seniors discussed seeking services from their family physician more often.

Clinics and Other Sources for Care

Other participants stated some members of the urban Aboriginal population would attend health centres and services located in the city centre. These included the Elbow River Healing Lodge, Calgary Urban Project Society (e.g., Health Clinic, Women’s Clinic, outreach nursing services at Alpha House, Drop-In Centre, Awo Taan Healing Lodge), and The Alex Community Health Centre located just north of downtown.

A variety of other organizations and services where Aboriginal peoples would access primary healthcare services or obtain information for their health and well-being were mentioned by interview participants. Not listed in any particular order of priority, were internet resources, books, asking friends or relatives, The Calgary Women's Centre (e.g., food, other referrals), Alex Health Bus, post-secondary school health clinics (e.g., Mount Royal University), Aboriginal service organizations, Health Link, Aboriginal Pride Coordinators, Métis Calgary Family Services, and pharmacists. Individuals may also receive referrals from healthcare professionals to attend another service.

Several other participants discussed using traditional healthcare services and remedies to deal with their illness. This was particularly true of the seniors who participated in interviews.

Summary of Services Utilized for Illness and Need

In summary, participants perceived Aboriginal peoples most often sought primary healthcare services from emergency, urgent care, or walk-in clinics. There was a belief that having a regular physician was not a priority for community members, although reasons for this were unknown. A variety of factors may have impacted where community members sought services when they were ill and in need including a shortage of family physicians, lack of accessibility of primary care physician clinics (e.g., hours of operation, office policies on no shows, being late for an appointment), and concerns of how they would we treated. Participants also discussed accessing a number of other organizations and sources.

Services Utilized for Disease and Injury Prevention

Participants were asked to provide their perspectives on those services that the urban Aboriginal population would use for disease and injury prevention. Overall participants felt that prevention services were important, but most thought these were not a priority for the urban Aboriginal population. "I don't know that Aboriginal people are using prevention services…I'm not going to worry about that or people are living more so in a survival kind of environment, as opposed to here's my priority" (Int. 021, Lines 196-197; 202-206). Others described prevention as challenging.

> I think that's challenging. I think because when I look at some of my friends and family members, they more or less live for today. And they don't plan for the future, they just you know live for today and worry about today. And the Higher Power, the Creator will take care of them for tomorrow. So I don't think that prevention is really, I think that's an area that we can certainly improve on. (Int. 025, Lines 185-191)

Others suggested that if acute issues were not being addressed by the population how could prevention even come to the forefront. "Preventative; I mean it's not even that acute things are being treated" (Int. 024, Lines 717-718). Street people were considered to be a special group, where prevention certainly was not a priority, where basic needs and survival were. Given the issues facing many Aboriginal peoples resulting from historical and current colonization practices of institutions, life's work was about taking care of today's problems mixed with spiritual beliefs for some that issues of the future would be taken care of by a Higher Power.

Many of the participants interviewed had difficulty even thinking about prevention services available for urban Aboriginal peoples. "I don't know of any. Like I don't find ourselves in that situation a lot" (Int.034, Lines 601-602). One participant spoke specifically of mental health services and was not aware of one preventive type of service available for urban Aboriginal peoples. Other participants did offer information on prevention services. Participants' responses have been separated into two broad categories of community members and other stakeholders including healthcare providers and managers.

Members of the urban Aboriginal population interviewed were aware of the limited availability of options for preventive services in Calgary. They compared services available here to those on-reserve and in other urban centres. "But here in Calgary, I feel like you're on your own" (GI 001 Line 629). Other places had services such as diabetes awareness, addictions workshops, healthy baby care, and Elder care but participants had not seen such services in Calgary. Members of the urban Aboriginal population interviewed suggested they used books, the internet, and television to obtain information on prevention. Others discussed the use of traditional medicine and remedies such as herbs.

Other stakeholders interviewed suggested that the urban Aboriginal population could access mainstream services for prevention (e.g., immunization, public health nursing, dental care), in fact, many thought this was where most prevention services were available. In addition to these, there were some Aboriginal-specific services at Alberta Health Services, Calgary Zone: the Aboriginal Tobacco Initiative and the Elbow River Healing Lodge, where pamphlets, information, outreach and advocacy services were provided. There were also a number of downtown services suggested where the urban Aboriginal population received preventive care such as: the SafeWorks van providing HIV/AIDs screening and harm reduction initiatives; Calgary Urban Project Society, particularly their family and women's programs; The Alex Bus; and The Alex Community Health Centre. Participants also suggested that community members would ask Aboriginal service organizations to obtain information on preventive services available. Some of these organizations advertised different events (e.g., workshops, presentations) both Aboriginal-specific and mainstream, but they were not sure how often these events were actually attended by the population. The importance of family members and friends was also reinforced by interview participants. Many Aboriginal peoples would utilize this latter group for information on healthcare practices including prevention. Lastly, the use of traditional medicine and remedies for prevention of disease was discussed by interview participants and will be discussed further later in this chapter.

In summary, prevention was important from the perspective of participants, but was not a priority in the urban Aboriginal population in Calgary. Other more pressing needs and varying spiritual beliefs impacted the emphasis on prevention of injury and disease. Most preventive services were accessed through the mainstream healthcare system, with few Aboriginal-specific services available in this area.

Services Utilized to Promote Health and Well-being

Overall, most of the participants had some difficulty answering the question about services available to promote health and well-being, until prompted by the researcher to think about those services utilized to maintain or increase wellness, one example being spiritual services. While some participants continued to provide minimal information in this area, others provided much more. Members of the urban Aboriginal population in particular, contributed little information when asked about health promotion services, including spiritual services. There was some recognition this was an important component of health and well-being. Other stakeholders such as providers and managers spoke both from the perspective of being a provider as well as shared some of their own personal perspectives. Just as with prevention, they discussed the priority of wellness for community members.

> I think everyone has the value to live well, unless they're preoccupied with work or someone with addictions, maybe not so much. That just means they have other underlying issues that need to be worked out and stuff. (Int. 034, Lines 662-665)

They discussed the value of a holistic approach ensuring all needs of individuals and communities were being addressed. Services for health and well-being also needed to be offered in the context of where an individual person was at and where they wished to go (e.g., treatment for addictions). "It has to be in that context that they begin that journey of reclamation of their identity and their culture and their spirituality. And then they begin their healing journey" (Int. 022, Lines 457-459).

Some participants were concerned as to where Aboriginal individuals would be able to find out about services and activities offered. It was suggested that Aboriginal service agencies, as well as healthcare providers, did help to connect people to services they were aware of or would direct them to a specific organization to obtain more information.

Importance of Social Connection

The importance of connection within the Aboriginal population was discussed by a number of participants as an essential component of well-being; "It's just even being able to get together as a group and visiting and celebrating, and that is so much a part of the well-being component" (Int.008, Lines 331-333).

> They try to seek it out in groups and connecting. Like even downtown, when you go downtown and you see the youth together or you see the adult seniors together.

> Wherever they are, they're collecting together. That is, they're doing that for their comfort, their safety, their spirituality. That is what keeps them going and keeps them connected. Is it offered by a service in general? I would say no. (Int. 020, Lines 434-440)

Many connections were made through community initiatives (e.g., celebrations, Pow-Wows) and were seen to be very important to one's health and well-being. Connection was reported as a key value for Aboriginal individual, families, and communities. Family, extended family, ancestors, the community, and the interconnectedness of their lives were important components of Aboriginal life and well-being (Niccols et al., 2010; Wilson & Pence, 2006). These vital connections were limited for Aboriginal peoples living in urban centres creating social isolation, loss of a sense of belonging, and loss of identity through dislocation from their home communities (Lavallee, 2007).

The value of healing and sharing circles was discussed in relation to connecting with one another, often around a common issue. Participants stated these had contributed significantly to the healing process for many community members:

> So just…being together. It doesn't necessarily have to be around very specifically spirituality or ceremony. It could be a place where you go to talk about residential schools. That is a big one I find where people connect in the spirit. And nurture that spirit…just by being together. And there's more of that happening now in town. (Int. 019, Lines 369-375)

The importance of family and friends was described as a component of connection and well-being for urban Aboriginal peoples: "In the Aboriginal community, the family is hugely important and the value of family well-being" (Int. 034, Lines 667-668).

Importance of Identity

Participants interviewed also discussed the significance of Aboriginal identity in the health and well-being of Aboriginal individuals, families, and communities. This was thought to be of particular importance for youth:

> I think a lot of it is related to identity issues. That's where it starts and I've always said I believe in the celebration of our identity as Aboriginal people. That is an

> integral part of our healing…for myself, that's where my healing journey began. When I was growing up as a child, I was ashamed to be an Indian. It was kind of a cultural shame. We were taught to be ashamed. There's nothing good about your ancestry; there's nothing good about your culture, your language. So you grew up thinking well, you know, I'm no good. I have nothing to offer, so that affects your self-esteem and your self-worth. But yet we have a lot to offer. (Int.022, Lines 406-416)

Others referred to cultural identity and the importance of teaching their children about their cultural identity.

The value of identity for the health and wellbeing of Aboriginal peoples was underscored by participants and documents reviewed. Specific primary healthcare strategies and programs to promote identity were crucial including historical traditional practices, understanding of historical trauma experienced by the community, and discussion of the continued oppression and racism due to social policies of various institutions in our healthcare system and overall society. The importance of identity for health and wellbeing of Aboriginal peoples was well supported in the literature including such components as language and integration of traditional teachings, indigenous knowledge, and ceremonial activities (Benoit et al., 2001; Canadian UNICEF Committee, 2009; Jacobs, 2000; Joint Management Committee, 2009; Lavallee, 2007; Skye, 2006; Van Uchelan et al., 1997).

Spiritual Well-being

Spiritual well-being was judged to be an important component of health and wellness for Aboriginal community members: "Like they look to their Elders, they look to religion as their guidance, their kinship, their community. It's huge in their spiritual and holistic well-being" (Int.020, Lines 417-419). Participants felt that non-Aboriginal providers in particular did not understand very well the spiritual components of well-being. Recognition of the spiritual component in Aboriginal peoples' health was important and provided the opportunity for building relationships when healthcare providers acknowledged and discussed spirituality with their patients. Spirituality was an important component of comprehensive assessment in interactions with all patients (Besner et al., 2009; Kozier et al., 2010) but few providers addressed spirituality due to time, personal comfort levels, and our Canadian philosophy of being *neutral*, as spirituality was often conflated with religion. With the urban Aboriginal population, where spirituality was so intertwined with health and well-being (spiritual well-being was one of the four components often illustrated in the Medicine Wheel); comprehensive and culturally safe care should include the recognition of and addressing spiritual care.

Participants specifically highlighted the spiritual services held at Calgary Urban Project Society and the Mustard Seed as places where urban Aboriginal peoples may attend. A number of the participants interviewed, stated many urban Aboriginal peoples will return home to their reserve or home community for spiritual and ceremonial services. "Sometimes we have to go back home…With your own people and your own language. And there's a need to do that continuously" (Int. 021, Lines 524-529). Members of the urban Aboriginal population would travel home because they knew the individuals back home, the medicines and wisdom they would provide, hence there was a trust relationship that existed for people. Others traveled to maintain connections with family and Elders in the community for themselves as well as their families:

> …but we also participate in those things back home as well. We go home quite often. Maybe every three months or so. And a large part of that is for my daughter to be connected to the people that she's a part of and to know what it's like there to live there, as opposed to where we live here. You know it's important for her to know that we have family that live a different way and somewhat of the same…But also to know where to go, to not only pick medicine that we need to help us in our prayers and our health, but also to know where to go to access those people back home. And who they are and how they do things, in terms of like the teaching lodges and the ceremonies. (Int.019, Lines 288-298)

As noted in the quote above the interconnection of family, community, spirituality, and traditional care was emphasized.

Traditional Care

Closely related to spiritual health was the value of traditional care. Several participants discussed three distinct components of traditional care: traditional wellness counsellors; ceremonialists; and traditional healers. Traditional wellness counsellors held knowledge and wisdom but not at the same level as a ceremonialist. "[They] framework traditional world views and ideas of wellness, which would help our service provider[s] to maintain that viewpoint" (Int.036, Lines 602-603). These individuals could be beneficial in seeing community members individually or in groups. Ceremonialists provided ceremony to promote health and well-being for community members. They bridged the gap between traditional foundations and western medicine: "These are people that specifically are traditionalist and have transferred right to do things regarding ceremony within communities" (Int. 036, Lines 606-608). Traditional healers were the herbalists and often referred to as the medicine person or traditional healer. Roles of traditional care providers overlapped and could be taken on by a single individual. Equality amongst traditional providers did not exist. Different providers were required for different roles, issues, and Aboriginal peoples' preferences. Including all different roles as part of the primary healthcare team was important, but difficult in an urban setting where traditional providers were limited.

One participant discussed the importance of grandmothers for their wisdom, knowledge of traditional medicines, and their role in well-being of individuals and communities. "I grew up with the grandmothers…I speak the language and understand the language, etc.. So that's where that whole wellness piece begins. My grandmother was one of those medicine women" (Int. 021, Lines 510-514).

Participants discussed the importance of traditional medicine for health and well-being. They suggested some individuals would consider traditional medicine over western medicine, while others utilized both traditional healing and western medicine, although they were not always comfortable sharing this with western healthcare providers (e.g., physicians). "For me it's very, very healing…and when I come out of that sweat lodge…you come out and you feel so refreshed, you're rejuvenated, you feel very connected and you feel like okay, what was I worried about again" (Int. 021, Lines 703-707).

A few of the participants interviewed discussed the Elbow River Healing Lodge as a place where Elder support, traditional services, and cultural services could be obtained. Clinics located in the downtown area would refer their patients to the Elbow River Healing Lodge for such services.

> …because of the Elder and sort of the spiritual leadership that's at Elbow River Healing Lodge, if I had an Aboriginal person wanting to talk about or be involved in some mental health or well-being in that area, [I] would probably send them to Elbow River Healing Lodge. (Int.010, Lines 136-140)

Summary of Services Utilized for Health and Well-being

In summary, primary healthcare services to promote health and well-being were not readily discussed by participants and not at all by members of the urban Aboriginal population. Recognition of its importance to Aboriginal well-being was acknowledged. By those who did discuss services in this area, important components of health and well-being promotion included: connection to family and other Aboriginal peoples; healing and sharing circles; importance of identity; spirituality; and traditional care. Traditional and spiritual care was most often accessed in their home communities while some utilized the limited services available in Calgary.

Current Primary Healthcare System for the Urban Aboriginal Community

Through data collected via interviews, documents and organizational websites, a picture of the current primary healthcare system for urban Aboriginal peoples in Calgary was developed (See Figure 1). It is important to note the figure was a snapshot in time developed by the researcher with input from the Advisory Committee throughout the research process. Relationships represented by solid lines (direct reporting relationships) and dashed lines (collaborative relationships between organizations and programs) also represent a point in time taken from the interview data and may not necessarily accurately reflect all relationships between organizations and programs, nor do they specify the strength of the relationships. Organizations and programs may collaborate once or twice or

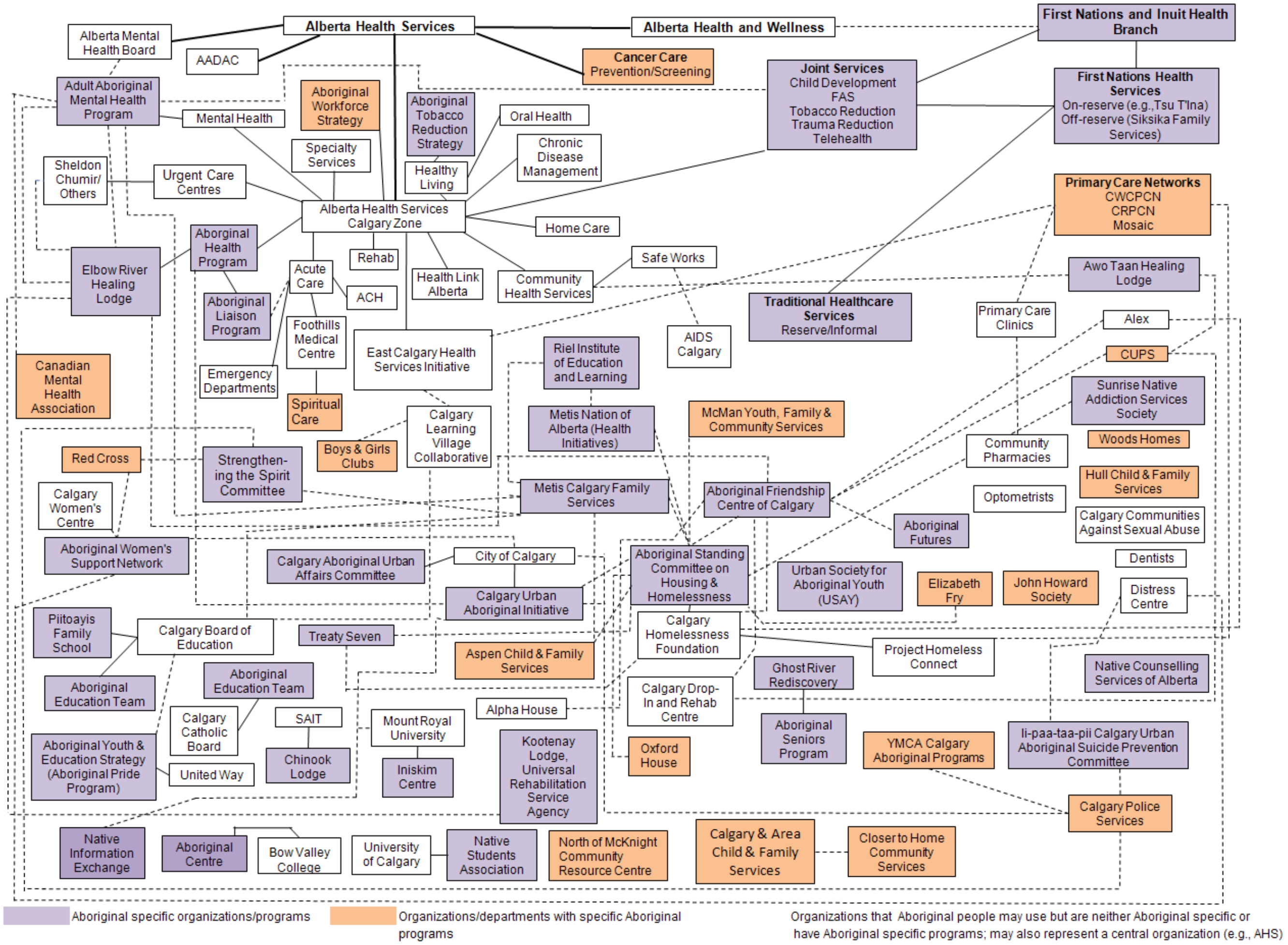

Figure 1 Primary Healthcare System for Calgary's Urban Aboriginal Population

may work together regularly. A full network analysis was not the intent of this study.

A brief description of organizations and programs currently involved in the primary healthcare system will be included in Appendix G. Descriptions of organizations and their services were obtained from interviews, documents, and organizational websites and represent information assembled by the researcher and research assistant.

Figure 1 outlines Aboriginal-specific organizations and programs, organizations and departments with Aboriginal programs, and non-Aboriginal organizations. The majority of the organizations were non-Aboriginal organizations, although if Aboriginal-specific organizations and Aboriginal-specific programs in other organizations were combined there were more of these than non-Aboriginal organizations. Not surprisingly, Alberta Health Services, particularly its Calgary Zone operations, provided most of the primary healthcare services for this urban Aboriginal population through both Aboriginal-specific departments and programming and mainstream services. Given this monopoly, this organization will need to lead the way in primary healthcare service delivery for the Calgary urban Aboriginal population. Even so, there were a large number of organizations and programs involved in the delivery of primary healthcare services for urban Aboriginal peoples in Calgary contributing to the complexity of this primary healthcare system. The large number of organizations and programs, all focusing on different components of health and well-being, made it difficult for one to know what organizations do, what services and programs they offer, as well as the criteria for attending the service. The importance of meeting the needs of Aboriginal peoples, as discussed later in this chapter, no doubt contributed to the number of organizations and programs involved. Over the years, gaps were identified and services created to meet those specific needs. This led to the boutique programs and services reflected in Figure 1. The number of programs and services was also related to project-based funding where new programs were developed because money was available. Funding will be discussed in further detail in Chapter Six.

The focus of some programs and services appeared to be the same or similar making it difficult for healthcare providers and members of the urban Aboriginal population to decide which program or service would be appropriate and meet the needs of the person. This confusion was no doubt most significant for Aboriginal individuals themselves. Given the large number of organizations and programs and the breadth of programs, connections between organizations and programs also impacted the complexity of the system. Some organizations appeared to be better connected than others, and some appeared to have little or no connection at all. Métis organizations appeared to be connected to one another to some degree, but had less connection to other organizations. Métis Nation of Alberta and Métis Calgary Family Services were connected to housing initiatives for the homeless through the Aboriginal Standing Committee on Housing and Homelessness. Métis Calgary Family Services was also connected to the Aboriginal Mental Health Program, Strengthening the Spirit Committee, and the Calgary Board of Education for a partnership in early childhood education. Métis organizations and individuals did not necessarily see services as meeting the needs of their communities.

Figure 2 shows primary healthcare services by type of organization (governmental, non-governmental, private and joint venture). Aboriginal peoples accessed services from a variety of organizations including government organizations and programs, non-governmental organizations, and private healthcare services (e.g., primary care physician clinics although physician fees were paid by the provincial government, dentists, optometrists, and community pharmacies). These different types of organizations varied in their agendas, priorities, policies, resources, target populations served, and reach making it more difficult for organizations to collaborate for an effective and efficient primary healthcare system for this urban Aboriginal population. Of greatest interest in this figure was the fact that most Aboriginal-specific organizations were non-governmental organizations making them perhaps less stable from a funding perspective (which will be reflected in more detail in Figure 3) and more limited in their delivery of services. Non-governmental organizations tend to be smaller organizations, with less infrastructure and staff impacting their ability to be major players in the primary healthcare system. Resources for leadership, coordination of care, and the services they deliver were limited given their funding. The number and types of organizations no

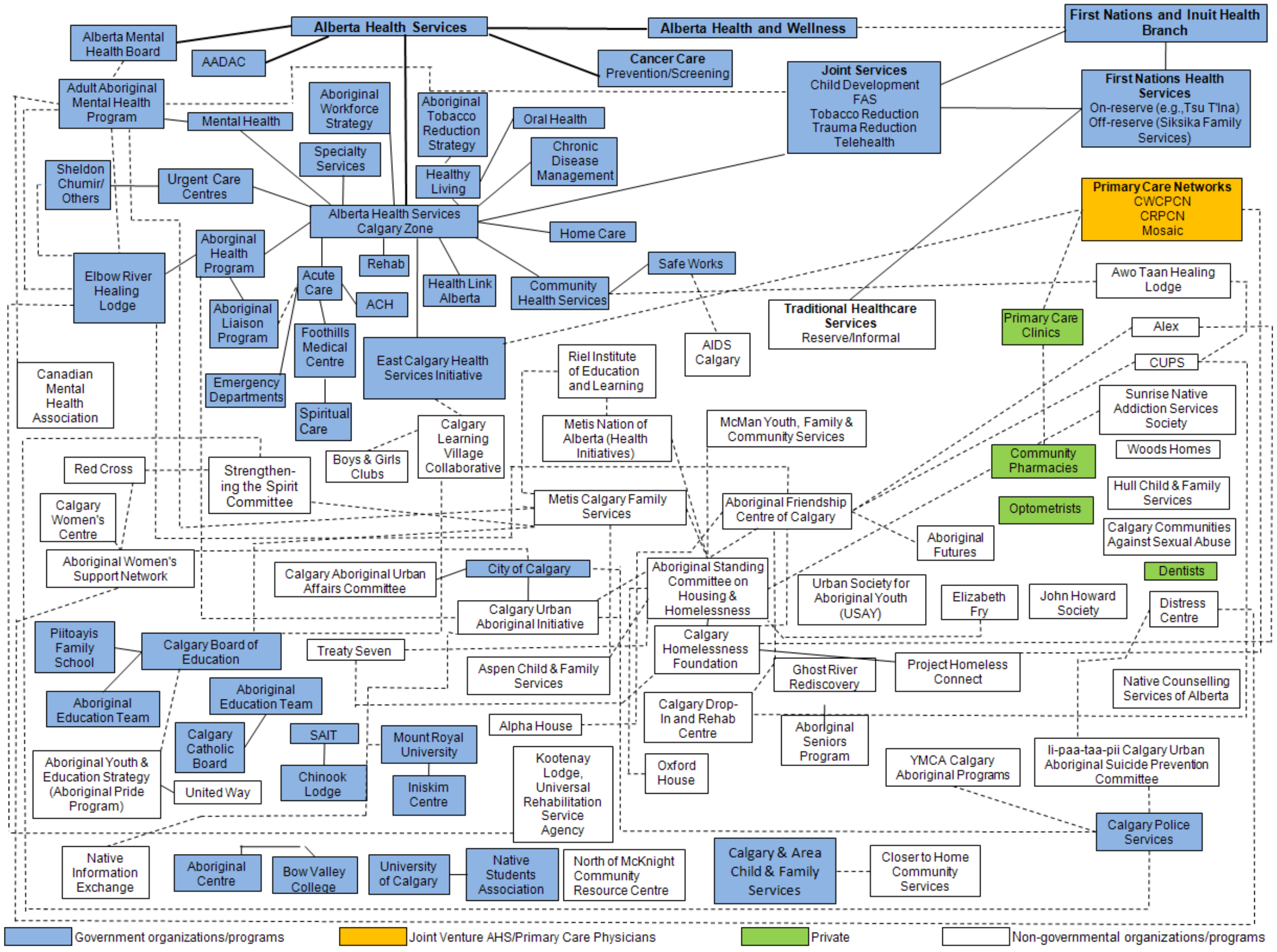

Figure 2 Governmental, Non-governmental and Private Organizations/Programs

doubt affected the level of coordination between services impacting healthcare delivery and continuity of care for patients (e.g., primary care physician charts were not shared with health authority services).

In Figure 3, organizations and programs were categorized by type of funding; where the majority of their funding was received. *Core funding* was applied to organizations where most of the funding was reasonably stable, ongoing, government funding. Those *non-core funded* organizations were dependent on donations, project-based funding, and funding from other sources. Funding for many organizations came from multiple sources. This categorization of organizational and program funding was completed based on the knowledge gained through data from the research.

Clearly apparent in Figure 3, was the lack of organizations and programs in the diagram once *non-core funded* organizations were removed. Figures 2 and 3 mirrored each other quite closely when it came to Aboriginal-specific organizations; most were non-governmental organizations and *non-core funded* but depended on soft funding (donations, grant funding, project-based funding, etc.). This created a number of potential issues both for the primary healthcare system and Aboriginal peoples themselves. Not having stable funding increased the difficulty in service planning and coordination of services as things changed from one year to the next, based on funding availability. The current economic climate has certainly decreased the amount of funding available for both government and non-government organizations. Private contributions have decreased in Calgary limiting funding available for those who function to a large degree on private donations.

Coordination of services was difficult when the landscape of organizations, programs, and services changed constantly based on short-term, project-based funding. Funding impacted Aboriginal community members in Calgary through a lack of continuity of organizations, programs, and services. Funding also affected the type of services delivered, not necessarily meeting the needs of urban Aboriginal community members but rather the priorities of governments and other funding bodies. Funding issues will be addressed in more detail in Chapter Six.

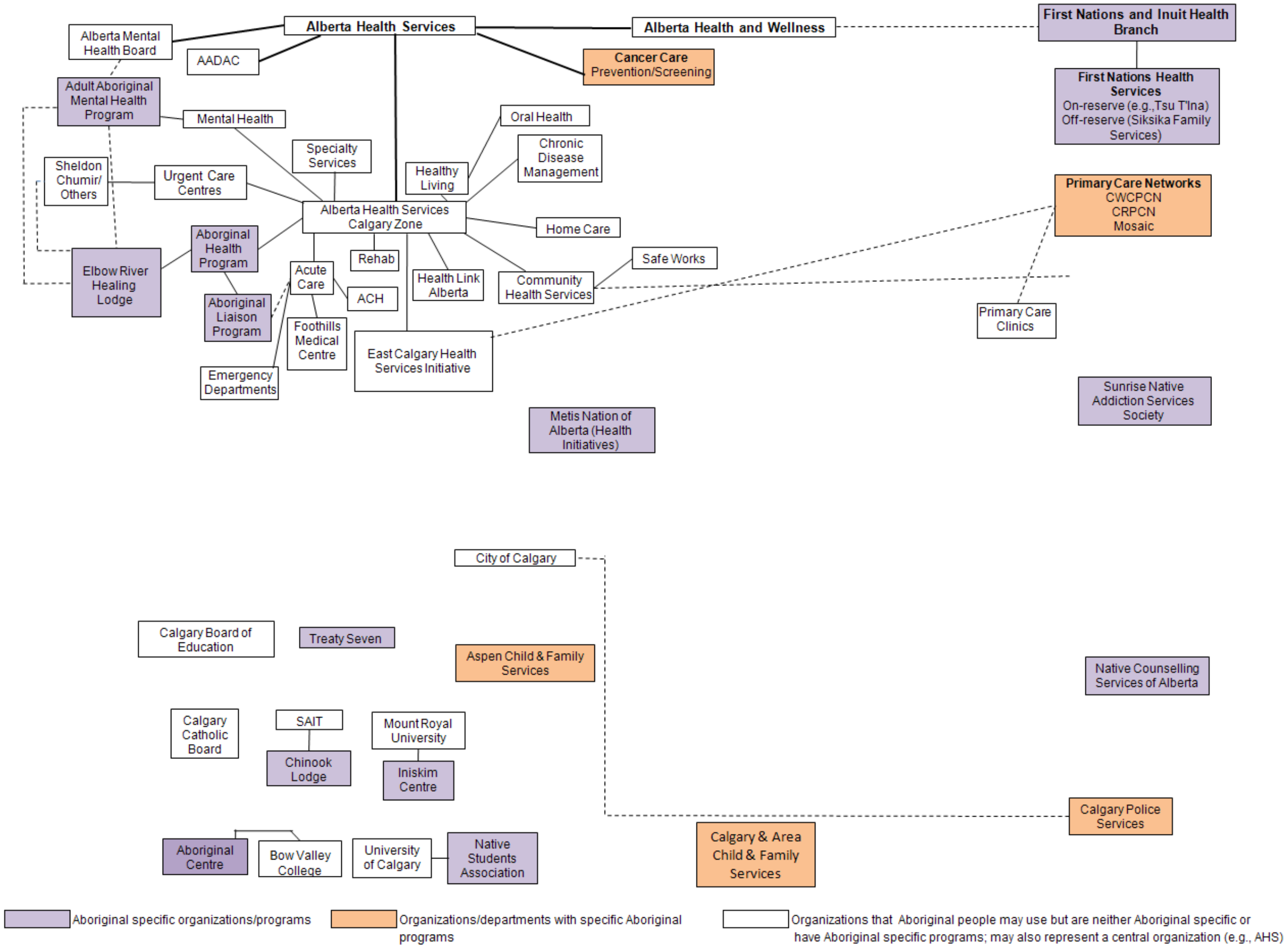

Figure 3 Core Funded Organizations

In summary, the current primary healthcare system for the urban Aboriginal population in Calgary was comprised of many organizations, departments, and programs involved in delivering care to this population. One reason for the large number of organizations stemmed from the development of boutique services in response to the needs and gaps in primary healthcare services for this population. Short term, project-based funding also increased the likelihood of a larger number of organizations and programs in health services delivery. Connections between organizations and programs varied. Métis services, in particular, appeared to be less connected to other services. Most Aboriginal-specific organizations were non-governmental and commonly had fewer resources, minimal infrastructure, and limited, often project-based funding. All of these components impacted the planning, delivery, and coordination of primary healthcare services for this population. This contextual environment certainly did not promote a systems level approach.

Strengths of Current Primary Healthcare System and Services

Not unexpectedly, when asked about the strengths and gaps in primary healthcare, participants spoke more readily of the gaps in the primary healthcare system as opposed to its strengths. Even so, there were four key themes identified from the data shared on the strengths of the current primary healthcare system for the urban Aboriginal community. First, the commitment and expertise of frontline providers (e.g., physicians, nurses, other providers) were seen to be a major strength of the system: "…the strengths of the services are their frontline workers. And their ability to understand the vulnerability of the Aboriginal population" (Int. 015, Lines 124-126). Second, in the last number of years there has been an increase in the number of Aboriginal staff working in primary healthcare in Calgary. This was seen to be of great value to the Aboriginal community: "…there's a comfort level, because Aboriginal people are serving Aboriginal people. Just right off the bat. And so, I think that's definitely a strength" (Int. 025, Lines 165-167).

Building a primary healthcare services had not occurred quickly, however there was a genuine sense of pride as to what had occurred over the last five to ten years in Calgary. When compared to primary healthcare services of 10 - 20 years ago, there was no doubt services for Aboriginal peoples had come a long way. Services were more accessible than they had been, the environment was less threatening, and services aligned more closely with Aboriginal peoples' expectations. Several participants commented specifically about the Elbow River Healing Lodge, as a good start in building primary healthcare services for the urban Aboriginal population in Calgary: "…there's huge benefits there [Elbow River Healing Lodge], because most of the staff is Aboriginal, so it creates an environment that is welcoming and comfortable again. It almost mirrors a clinic you would access if you were back home on the reserve" (Int. 016, Lines 67-70). It is important to note, although current services were a good start, participants felt there was still a long way to go to implement an effective primary healthcare system for this urban Aboriginal population.

Participants also spoke about the commitment of the former Calgary Health Region. There was a sense of excitement around forward thinking in Aboriginal health service delivery. There was strong support from senior leadership for Aboriginal programming, hiring of Aboriginal healthcare providers when possible, as well as hiring and mentoring Aboriginal managers. The Elbow River Healing Lodge and the Aboriginal Mental Health Program were cited as critical services to address the needs of the urban Aboriginal population in Calgary.

Interviews with participants occurred over a two-year time frame. During that time, the Health Region was disbanded and a single provincial health authority created. Services continued as they had been in the previous Calgary Health Region, but future planning and expansion did not occur. Unfortunately, the Aboriginal Health Program was in limbo for a period of about two years through reorganization and restructuring. Restructuring had the potential to have a significant impact on programs, staff, and Aboriginal individuals creating uncertainty in services and jobs for all concerned. An environment of frustration was evident with constant change in the organizational structure but no movement forward in service delivery for Aboriginal peoples' health. It also had the potential to devalue the program and Aboriginal peoples given other more pressing priorities of the organization (e.g., fiscal restraint, wait times) despite the many, complex issues in Aboriginal peoples' health. It will remain to be seen how the recently announced provincial Alberta Health

Services Aboriginal Health Program will be implemented in the province of Alberta and in the Calgary Zone.

Finally, interview participants discussed community participation as a strength of the current primary healthcare system. Community participation will be discussed in detail in Chapter Six and will only be described briefly here. Over the past number of years, an increased focus on community involvement (both leaders and population members) was evident in health service planning and delivery in Calgary and Alberta. Community participation was supported by documents (e.g., direction setting, wisdom committees, etc.) and participants comments. The planning of healthcare services had involved Elders from both the surrounding reserves and those living in Calgary. Partnerships have been forged with surrounding First Nations communities for joint planning and services (e.g., Telehealth) to meet the needs of Aboriginal people in Calgary and surrounding First Nations communities. "…some early attempts to collaborate in planning and also extend services to the reserve are limited, but some regional programs do go out to the reserves" (Int.004, Lines 393-395).

To summarize, participants depicted several strengths in the current primary healthcare system for this population. Participants praised the work carried out over the last number of years, suggesting significant positive change in primary healthcare services for urban Aboriginal peoples. The commitment of past leadership in a major health organization helped to assist in such change. Community involvement was also suggested as a strength facilitating input for service planning and delivery. But the key strength of the system was described as being the frontline staff with their commitment and expertise in working with Aboriginal peoples in Calgary. The following sections will outline gaps in the current primary healthcare system for this population.

Gaps in Current Primary Healthcare System and Services

A variety of gaps were described by participants. These were grouped into the following themes: access issues; lack of coordination; lack of prevention and health promotion services; gaps in services for children and youth; gaps in chronic disease management; lack of mental health services; issues with dental care; homelessness and lack of housing; and lack of traditional care and spiritual services.

Access

Access was not one single issue. Various factors impacted access to primary healthcare services for Aboriginal peoples. The consideration of the social determinants of health was essential when reflecting on access. There were “tons of barriers” (Int. 035, Field Notes, Line 6) for Aboriginal people in accessing services for their health and well-being. “We need to do something that is going to make it seem normal and all right to seek out medical help…And not have so many barriers for them when they do go to seek it out” (Int. 031, Lines 999-1005). There was a sense from some participants that the former Calgary Health Region and other mainstream organizations providing services for urban Aboriginal peoples were trying to better understand access issues for this population. Some participants also suggested there were many assumptions by healthcare providers and managers as to why the urban Aboriginal population were not accessing healthcare services.

Access to Primary Care

Interview participants suggested populations that were marginalized such as the Aboriginal population generally did not access services in primary care physician offices. Physicians in higher concentration areas of Aboriginal peoples in Calgary were aware this group generally did not present in their offices for care, although reasons for the same were not well understood.

Structural Barriers to Access

The complexity of our healthcare system as well as the complexity of the primary healthcare system for the urban Aboriginal population in Calgary significantly impacted the ability for community members to readily access services. “In Calgary there are at least 2,000 programs and services, three governments, eight Provincial departments and more than 140 non-profits that people experiencing homelessness can turn to” (CL049, Lines 1140-1141). “People [do] not understand who does what” (Adv. Comm. 004, Line 224). The number of services available for even one issue was astonishing, contributing to a very complex system for providers but especially for community members. Services for the homeless crossed government jurisdictional boundaries complicating accountability for the homeless population. The sheer number of services and not knowing who offered what, contributed to a lack of collaboration and duplication. The necessity of making numerous phone calls or visits to different offices to see different service providers or to know who would cover a specific service was seen to be time-consuming and frustrating. In short, participants stated that navigation of the healthcare system was difficult.

Inclusion and exclusion criteria for services (e.g., can treat for addiction but not mental health problems) also impacted access.

> However, there is a concern that the eligibility criteria of these programs are not aligned in ways that allow them to work together. Too often an Albertan who is in need of assistance faces a maze of qualifying thresholds and requirements which can be incompatible, result in claw-backs, or create gaps into which the person falls. In some cases a person becomes 'double-binded' in the system, where accepting assistance from one program disqualifies them from getting much-needed help from another. (Document PR012, Lines 685-689)

On top of having to navigate a complex maze of organizations and services, policies created barriers for Aboriginal peoples when accessing services required. They had to choose between programs and services, because if they received services from one organization or program they may not be eligible for another, further marginalizing some Aboriginal individuals. Having to make choices may be difficult given the large amount of information required to make informed decisions. Furthermore, decisions may be made by providers themselves as to fit, decreasing a person's independence and furthering the oppression experienced by many Aboriginal peoples.

The healthcare system also operated in silos of specialty services causing duplication and fragmentation. Labelling and categorizing individuals (Wilson & Pence, 2006) with a diagnosis or diagnoses and providing care based on those categories, often through specialized services, contributed to the fragmentation of care for Aboriginal peoples. The volume of services and narrowly defined criteria for inclusion made it difficult to know where to send individuals as well as increasing the risk of individuals falling through the cracks.

Despite there being a number of Aboriginal-specific services, participants discussed a lack of services at the community level in all areas of the city. No doubt this made accessing services more difficult for the urban Aboriginal population already experiencing numerous barriers, such as transportation, as will be discussed later in this chapter. This also contradicted ideal primary healthcare service delivery where experts recommended services be offered close to home (Canadian Public Health Association, 1990).

Wait times, not necessarily unique to the Aboriginal population in Calgary, were described as a barrier to accessing services. Participants discussed wait times in emergency as well as waiting time to see a family physician, specialists, and for addictions treatment. For the Aboriginal population significant wait times decreased the window of opportunity for care and treatment. In fact, several participants discussed the importance of providing same day services to facilitate individuals' seeking of services. Time of service delivery was also discussed. Most services were only offered during daytime hours from Monday to Friday, impacting the ability to obtain services for the urban Aboriginal population who worked or attended school.

The impact of jurisdictional issues on access to healthcare services was discussed by many participants. Status and non-status individuals (including Métis) were covered for different services, coverage was difficult to determine, First Nations and Inuit Health Branch forms were often difficult to complete, and approval processes were long. Jurisdictional issues will be discussed in detail in Chapter Six of this dissertation.

Some participants interviewed stated that access to services was dependent on their social network such as previous connections with Aboriginal service organizations, other organizations where they had established a relationship, and referrals from their family, friends, and peers:

> But I think by word of mouth, people learn in the community where they can go and where maybe they shouldn't go. Like it would be a waste of their time. So I think the word travels; call it the *moccasin telegraph* (Int. 022, Lines 194-197).

The above quote also spoke to services not meeting needs and potential racism.

Lastly, environmental factors were described as structural barriers to accessing services. Such factors as the décor, ambience of the setting (e.g., crowded and uncomfortable, institutional type of setting), and gatekeepers to clinics (e.g., security, receptionist, central admitting process) were cited as barriers. One participant described the ambience as a barrier: "And I know some clients find this very intimidating, you know? The shiny laminate and all that, that's not them and I can appreciate that" (Int.024, Lines 884-886). Another example was provided: "I speak to my receptionist through a glass when I go to my doctor and it just, it doesn't feel good" (Int.021, Lines 609-610). Both of these examples described environmental barriers to service access.

Transportation

Transportation was considered by a number of participants and documents to be a barrier to accessing primary healthcare services for Aboriginal peoples in Calgary, potentially impacting their health: "…transportation is a huge one…if you don't have transportation to get to your services, then you're not going" (Int.032, Lines 193-195). According to the National Aboriginal Health Organization (2002), transportation barriers were particularly evident in urban centres where no funding was available for transportation to healthcare services as it often was for First Nations community members living on-reserve. Fewer and fewer services were being offered in the downtown core (e.g., The Alex Community Health Centre, Elbow River Healing Lodge had moved in the last few years while Calgary Urban Project Society was also moving from their current downtown location) making access by public transportation more difficult. Parking costs were also considered to be a barrier adding additional costs for Aboriginal individuals. Some organizations and services did offer to drive their patients or provided bus tickets. This was an issue for some patients though, when the organization provided a limited number of tickets per week, restricting the number of appointments they could attend in any given week. Frustration was also mentioned when services and providers were not all located in one place requiring patients to travel to different locations.

Differing Beliefs

Participants discussed differing beliefs in limiting access to primary healthcare services. Beliefs differed in regards to Aboriginal perspectives and western medicine as well as varying across the continuum of Aboriginal peoples residing in Calgary. Healthcare providers found themselves in a double-bind having to reconcile western and Aboriginal perspectives on health and medicine, as well as managing the variation in beliefs given the diversity of the Calgary Aboriginal community.

Indigenous perspective versus western science.

> I think there is a gap between a western approach to healthcare and an Aboriginal approach to healthcare. And I think that it affects Aboriginal people who are seeking healing. Because when they present, what they're looking for is someone who cares and who is compassionate and is going to help them with their emotional pain or their physical pain…the biomedical approach doesn't really address that part of it. So I think Aboriginal people feel like they've been rejected or put off by that. (Int.012, Lines 109-118)

Fundamentally, definitions around health, well-being and illness varied from western language and philosophical thinking. Health and well-being were described by one participant to be analogous to breathing: "health is a living state of well-being *continuous flow;* living the life of *connections*" (Int.026, Field Notes, Lines 146-147). Another participant defined illness as: "a belief that the mind and the spirit are involved in an illness. So an illness can be seen as an outside force that can come into your body, so it can also be expelled with assistance from a ceremonialist" (Int.009, Lines 156-160). These definitions, in themselves, impacted the delivery of healthcare services. In the latter case, diagnosis and treatment could be counter intuitive to beliefs on illness. Others feared allowing the system and its biomedical treatments to overpower other treatments; western medicine has over medicalized natural processes (e.g., childbirth). "So medicine, drugs for treatment are seen as invasive and disempowering the mind and the spirit. So they feel you are disconnected from yourself and so you can't use your own mind and spirit to heal yourself, which is a belief" (Int.009, Lines 134-138). Western thinking was also equated with selfishness, looking after one's self and not valuing seniors and Elders as they were valued in their own communities.

Differences between Aboriginal perspectives and western thinking, particularly in medicine were strongly supported by the literature (Sherwood & Edwards, 2006; Waldram et al., 2006; Wilson & Pence, 2006) impacting the what and the way in which primary healthcare services were delivered. Without attention to these varying beliefs, access may be limited differentially for Aboriginal peoples.

Seeking services in later stages of disease.

Participants often mentioned that Aboriginal peoples did not seek services until they were in crisis or at a terminal stage: "…often it comes down to that crisis situation, where then the client will go either to the Urgent Care…or they go to the hospital" (Int. 024, Lines 225-226). This practice was mentioned earlier in this chapter in describing what types of services the urban Aboriginal population used when they were ill. Delay in seeking care was perceived by participants to be related to a number of different factors, one of which was a belief they were meant to have the condition and to deal with its consequences. Secondly, there could be fear and anxiety in seeking healthcare services because of an uncertain diagnosis and fear of cancer. "And it creates so much anxiety and fear that they avoid it and don't seek out medical services or mental health services" (Int.009, Lines 112-114). Other participants felt the delay in seeking services may have been related to issues of racism where Aboriginal peoples were treated disrespectfully, making it difficult to seek care. Lastly, participants also discussed the delay in seeking care being related to other priorities of basic needs or family issues. The healthcare system will need to respond to each of these various reasons for delaying care.

Varying beliefs due to diversity of population.

Participants discussed the need to be aware of the diversity of the urban Aboriginal population. "Participants also consistently emphasized the diversity and fluidity of Aboriginal populations accessing services within the Calgary Health Region. These populations include Métis, Status and non-Status Indians with individuals from diverse geographical and cultural origins" (Document CL046, Lines 493-496). First Nations represent various Nations from across Canada and "…each reserve, like they have their own way of what is accepted and what's the norm" (Int.031, Lines 802-803).

Many Aboriginal individuals were more westernized while others were more traditional, particularly in the area of traditional care and spiritual services. For some "old ways take precedence over the western medicine" (Int.013, Lines 538-539). There is a risk in trying to be *pan-Aboriginal* in the services provided; trying to be open to all cultural traditions and incorporating protocols serving the majority of the Aboriginal population in Calgary.

> And so, in some ways, that works very well in that people think it's open and accessible, but in some things, if you are an Aboriginal person who doesn't believe in those things for instance, or that is not your tradition, then that can actually exclude you from accessing those services potentially. (Int.002, Lines 211-216)

Services needed to be culturally relevant, in order for Aboriginal people to feel comfortable in accessing those services.

Métis people often felt they were not well-represented in services for Aboriginal people. "And I'm Métis. I know we're different, but we still have; I have my own belief system" (GI 001, Lines 1344-1345). Another participant spoke of doing consultations with Métis people in north central Alberta. "And one of the things that they said was, 'we don't subscribe to Aboriginal spirituality because that's not how we were raised. We're Métis and we have our own traditions'" (Int.002, Lines 250-252).

Services Not Meeting the Needs of the Urban Aboriginal Population

Primary healthcare services for urban Aboriginal people ought to consider the context of the individuals, families, and communities to ensure actual needs were being met, rather than just *Band-Aid* solutions. Some service providers were described as: "they don't have the background and knowledge to deal with our needs" (Int. 015, Lines 169-171). Patients often had multiple, complex health and social issues not necessarily acknowledged within the system. There was also a lack of recognition of the diverse needs of the community.

Needs were often based on the perceptions of healthcare providers, rather than from community members themselves. Healthcare decision-makers did not necessarily listen to the needs of Aboriginal peoples and many were focused on individual and community deficits versus strengths.

Overall, participants were strong proponents of Aboriginal-specific services, while others recommended supporting Aboriginal peoples' attendance at mainstream primary healthcare services. Providing Aboriginal-specific services in all service areas for all Aboriginal peoples in Calgary was considered not to be feasible. Issues did arise when no Aboriginal-specific services were available (e.g., prevention); where mainstream services were not addressing needs, causing some Aboriginal individuals to simply choose not to attend. Mainstream services were meant to address the needs of the population as a whole. With a population such as the urban Aboriginal population, funding and services were linked to *white problems*, as described by one participant:

> So basically, the prevention services that are available for First Nations are what's ever in the hype for the white crowd. So if it's a white problem, a white prevention problem, those are what's available. (Int.015, Lines 292-295)

The above quote speaks to problematization of issues in the Aboriginal population; if it was an issue for the mainstream population therefore it should also be an issue in the Aboriginal population with no prior assessment of needs. Funding was automatically dropped when it was no longer a priority in the mainstream population even though issues continued in the Aboriginal population. So priorities and funding simply followed issues for mainstream populations rather than being specifically targeted to the needs of a specific population.

Offering services in the same way they had always been delivered would continue to increase the gap in the health and well-being between Aboriginal populations and non-Aboriginal Canadians.

> Or with the mainstream strategies we're implementing in terms of public health and even in acute care for like mainstream populations. The way First Nations' people don't access services the way we currently provide them, we're actually widening the gap in disparities without targeting the programming. (Int.037, Lines 57-61)

Participants also spoke about services not meeting needs at the individual level. Being respected and listened to was not always the case. “Sometimes they don’t listen to what you have to say” (Int.031, Lines 244-245). People in the community would learn via the *moccasin telegraph* specific services more likely to meet their needs and where they would be treated with respect. Interview participants desired a more inclusive and holistic approach to address the often complex issues the urban Aboriginal population faced. This meant having longer appointments so issues could be addressed.

Racism

Many references to experiences of racism were made by participants; experiences they themselves or other community members had experienced when seeking primary healthcare services. Racism had a definite impact on Aboriginal peoples’ ability to obtain services and whether they accessed services in the future. Racism will be addressed briefly here as it affects access to primary healthcare services, but will be discussed in detail in Chapter Seven as a component of cultural safety.

“The encounters within the healthcare system are tainted with racism” (Int.009, Lines 126-127) and kept many from accessing services.

> But to me, the thing that stands out is racism…I mean you have two poor people who have challenges with transportation and access, right? But if one of them happens to be Aboriginal, they’re also facing racism and the other one isn’t. They’re also potentially facing racism and poverty and all the other issues. (Adv. Comm. 004, Lines 183-191)

Despite the statement above, racism was seen to impact all Aboriginal people: those who were well-dressed; well-educated; and the homeless. All reported often feeling unwelcome and waited for acts of racism to occur.

Lack of Trust

Lack of trust in the healthcare system and providers was shared by many of the participants interviewed. Lack of trust was deeply rooted in historical issues of colonization and racism in the paternalistic and oppressive practices directed towards Aboriginal peoples by the institutions in our society (e.g., healthcare system). Because of such practices, Aboriginal peoples have become guarded in their relationships with healthcare providers, particularly non-Aboriginal healthcare providers. Speaking about the healthcare system, members of the urban Aboriginal population suggested that they needed: "One that we trust. Because we're not trusting, see. Yeah, it's really hard to trust. Trust that we're going to be taken care of and respected" (GI 001, Lines 276-280). Aboriginal population members interviewed also talked about not trusting the government and discussed the many assumptions (e.g., substance abuse) that were made about Aboriginal people by healthcare providers.

The healthcare system was seen to be representative of institutions such as government, churches, and justice organizations that were highly oppressive of Aboriginal people historically and in many cases continued today: "…I think it has a lot to do with our background, the way we were brought up in the Indian residential school syndrome. You know how we've been affected. Some of them don't trust and there's fear there" (GI 002, Lines 900-903). Speaking specifically about healthcare, another participant stated, "Historically, the healthcare system hasn't been especially helpful for the Aboriginal people. That's sort of putting it mildly" (Int.009, Lines 124-126).

Lack of trust in healthcare providers was also discussed. Most participants talked about physicians, but the same could be applied to all healthcare providers: "There's a lot of mistrust of doctors, because Aboriginal people and First Nations' people just feel that they're not getting the same care as everyone else. That their life is not as valuable to society" (Int.009, Lines 256-260). Unfortunately, if a provider or clinic was not suitable or they were not comfortable there, they were not likely to go and seek out another provider or clinic.

In summary, lack of access was described as a significant gap in the current primary healthcare system for the urban Aboriginal population in Calgary. Access for the Aboriginal population referred to the lack of availability of primary healthcare services, particularly Aboriginal-specific services, difficulties in accessing current primary healthcare services for this population, as well as the acceptability of services. Key barriers in access were identified and included the following: complexity of the primary healthcare system for the population making it difficult to navigate the system to access services and to determine criteria for receiving services in different programs; transportation limited their ability to attend for care; the environment and ambience impacted their comfort level in accessing services; jurisdictional issues determined who was accountable for what service; differing beliefs, particularly Aboriginal worldviews versus western medicine; gaps in meeting the needs of the population with the development of more services increasing complexity; and the direct impact of racism on access; and the affect of racism and oppression on the lack of trust in the healthcare system and its providers. Barriers to access will be important to address to improve the primary healthcare system for urban Aboriginal peoples. Access barriers for urban Aboriginal populations in Canada were supported by the literature and approaches to tackle barriers minimizing their impact on health and well-being of Aboriginal peoples was required (Benoit et al., 2001; Benoit et al., 2003; Browne et al., 2009; Bucharski et al., 2006; Aboriginal Cancer Care Unit, 2008; Owens et al., 2003). Addressing these barriers will facilitate attention to the inequities in healthcare services.

Lack of Coordination of Primary Healthcare Services for the Urban Aboriginal Population in Calgary

"One of the other biggest issues with the healthcare system, across sectors is the lack of coordination; services for urban Aboriginal populations are hugely fragmented" (Int.028 Field Notes, Lines 105-106). Overall participants (managers, providers, policy-makers, Advisory Committee members, and community members) interviewed were in agreement that primary healthcare services for the urban Aboriginal community in Calgary were not well-coordinated within the healthcare system and across sectors. Lack of coordination of primary healthcare services was also supported by documents reviewed. "Service providers felt that if systems, agencies, service providers, and community members could collaborate, they could better coordinate and enhance resources and services to create a holistic and integrated system" (Document CL054, Lines 1123-1125). Aboriginal individuals in one of the group interviews discussed the lack of coordination and working together to address all aspects of Aboriginal peoples' health. Given most

Aboriginal-specific organizations were non-governmental organizations, coordination was difficult when few resources were available to accomplish this goal. “If they were cooperating and coordinating, it would be so much better for the people it affects. They’d be healthier” (GI 001, Lines 976-977). One participant talked about the Métis population and the fact they normally accessed services from mainstream organizations. Coordination of care for this group was similar to other Canadians but with underlying issues of racism.

Coordination appeared to be happening for the most part at the individual patient level. There were specific healthcare workers (e.g., Aboriginal Liaisons, Advocacy Workers) and organizations that brokered access to the system, but unfortunately there were not enough of them to ensure coordination and integration of care and most of these workers serviced patients in acute care only. In the community, coordination and connection were dependent on how connected the individual was him- or herself. If they were linked to well-connected Aboriginal serving organizations or other networks, connection and coordination of care were facilitated:

> I think it’s so relational; it’s highly relational. Your degree of coordination in the healthcare system, any system in the city of Calgary, if you’re Aboriginal, depends on who you know. The more Aboriginal people you know in organizations or systems, the more connected you’re going to be. (Int.019, Lines 816-821)

Coordination was about relationship and connection to individuals and services. Those who were well connected were likely to access and receive services more readily than those who were not, further marginalizing those who were already isolated, and likely in greater need of services.

Participants stated that significant opportunity existed to improve coordination for patients, particularly those with multiple and more complex issues.

> …there’s always the fact that the complex problems and the multiple agencies involved don’t communicate and it’s hard to deal with, whether its detox and addictions treatment over here or homeless and social agencies trying to deal with problems over here. (Int. 004, Lines 495-499)

Complex patients were seen to be best cared for by a patient-centred team but coordination in team care was impacted by repeated assessments, lack of interprofessional trust and inadequate communication. The role of patient-centred teams will be discussed further in Chapter Six.

Calgary was seen to be a very large urban centre with many services and initiatives both in Aboriginal and non-Aboriginal peoples' health. Hence there was a disconnect between one group and another in knowing about the services they provided. "I think lack of knowledge of the services that are out there and what's available is a huge barrier" (Int.016, Lines 349-350). Awareness of services between organizations did not always exist or if it existed it was not always accurate. Within organizations, different programs were not always aware of services provided or criteria for care. Lack of coordination was exacerbated by the development of new and different organizations and programs through specific, pilot, and project funding along with organizations wishing to address explicit, identified gaps. The result was an increase in the number of organizations and programs servicing the urban Aboriginal community in Calgary with specialized boutique services, differing agendas, competition in funding, reinventing the wheel, and staff and project turnover. These factors all impacted the ability to collaborate and coordinate primary healthcare services delivery.

> Even with Aboriginal-to-Aboriginal services. We tend to ask for funding for the same things, so three of us will be working on the same issues and we don't even know it because we're not coordinating or communicating well. We tend to repeat work that has already been done because of that. We don't disseminate what we find. Certainly not between each other and not back to the community at all. (Int.015, Lines 182-188)

Coordination of services at the system level was not something that currently happened formally but there was some sense of development of such initiatives.

> But I think that the opportunity exists to try to get everyone on the same page around that and work towards that again. So Primary Care Networks or other community-based health services, working in conjunction with the Calgary Health

> Region as a partner. You know not again, thinking that we're the only kind of provider in town. That there's others and how can we leverage each other's strengths and resources to meet the needs of the community members. (Int.001, Lines 411-412; 415-425)

Coordination among organizations in the primary healthcare system was done by frontline staff. This certainly was important and definitely facilitated coordination at the patient level. The ability to go beyond the patient level of continuity of care to system level coordination and integration was dependent on the expertise, capacity, and availability of frontline staff. Coordination of the primary healthcare system for Aboriginal peoples in Calgary was downloaded to the individual provider rather than taking a systems level approach to coordination.

Lack of coordination of care and the need for improvement was supported by the literature (Fraser Health, 2010; Regina Qu'Appelle Health Region, 2009; Vancouver Coastal Health, 2009). Gaps in coordination of care were particularly evident in mental health services (Anishnawbee Health Toronto, n.d.c; Mignone et al., 2003; Peters & Demerais, 1997; Smye & Mussell, 2001).

In summary, considerable lack of coordination of services and care for Aboriginal peoples in Calgary was noted by participants both within healthcare and across sectors. There was room for improvement, particularly for those patients with multiple and complex concerns. Aboriginal-specific organizations did not work well together and services were not well coordinated. Coordination was likely impacted by the fact that these organizations were mostly non-governmental organizations with less infrastructure and resources for coordination of care. The lack of collaboration between Aboriginal organizations will be further addressed in Chapter Six. According to participants, coordination was also dependent on who you knew. Pilot projects, boutique services to fill gaps, all contributed to an increased number of services and a decrease in coordination between services and organizations. Lastly, coordination of care was not well addressed at the systems level; rather it was left to individual providers to organize coordination of care.

Gaps in Specific Service Areas

Prevention Services

The lack of disease and injury prevention services was seen as a gap by participants interviewed; Aboriginal primary healthcare services needed to move beyond diagnosis and treatment. Local and regional documents discussed the lack of prevention specifically in the area of injury. Healthcare services focused on the treatment of injuries, while few Aboriginal injury prevention resources and initiatives were available on-reserve or in rural and urban settings. Lack of prevention services was also supported by the literature (Aboriginal Cancer Care Unit, 2002; Department of Research and Clinical Epidemiology, Canadian College of Naturopathic Medicine, 2008).

Some participants suggested the lack of prevention services was related to the evolution of Aboriginal peoples' health services to date, where most focused on providing treatment and addressing other needs. Others suggested it was a resource issue with few staff actually focused on prevention. Immunization and injury prevention were seen to be significant issues for the urban Aboriginal population.

Some mainstream prevention services were available, but few or none were Aboriginal-specific. Access to mainstream prevention services was impacted by contextual barriers such as transportation, cost, accessibility, racism and stigma.

> And if you're a lone Aboriginal person and you're walking into a room where you're feeling isolated and that your voice is drowned out, you're not going to stay. And so, there needs to be more targeted groups, I believe, in terms of education and awareness and early intervention. (Int.021, Lines 384-388)

As evidenced by the above quote, Aboriginal individuals did not feel secure in an environment where they were the only Aboriginal person amongst other non-Aboriginal people. When this was the only option available for prevention services, they simply would not attend.

Health Promotion Services

When interview participants were asked to comment about gaps in primary healthcare services for the urban Aboriginal population in Calgary, they discussed the limited number of services in health promotion. “Thinking about the continuum you asked about, the health promotion side, you know at a broad population level, there’s I would say very little going on” (Int.001, Lines 144-147). Another participant suggested the priority was not there for providers or patients. “I suspect, I guess, that there is a gap there because the need is so high for urgent issues and people coming when they’re sick” (Int.004, Lines 265-267). As with prevention services, community members were unlikely to participate in mainstream health promotion initiatives due to similar barriers as outlined in the previous section.

Several participants discussed the difficulty in setting up health promotion initiatives. This was related to lack of priority for the same amongst the urban Aboriginal population, care and treatment being the focus, and relinquishing control in true health promotion philosophy. “Well, it’s hard to do health promotion, so it’s easier to open a clinic. It’s hard to embrace like community development approaches and really share the leadership and share decision-making” (Int.004, Lines 409-412).

Specific gaps in health promotion services mentioned by interview participants included the following: nutrition education, dental and oral health, physical activity, and assisting Aboriginal community agencies to be better role models in health promotion (e.g., staff, Texas donut [extra large size donuts] sales for fundraising, etc.). Participants were unsure about current health promotion materials (e.g., brochures, videos, etc.) as to whether messaging was appropriate or whether they were utilized by community members.

The lack of cultural aspects in health promotion was also seen as a gap.

> And the services right now are inadequate because they don’t involve teaching. And First Nations need; we don’t just need to see a doctor and then to keep ourselves healthy, but we require verbal teachings and visual teachings to assist us in that. And that’s not there; that time is not made available when we seek out a service provider. It’s often very short, to the point visits. (Int.015, Lines 401-407)

One document, (data collected in 1999-2000 through a Listening Circle) discussed two key facilitators of health and well-being of Aboriginal people in the city of Calgary to address barriers.

> Two other common themes were creating an Aboriginal ombudsman and developing a cultural or spiritual centre in Calgary. The centre would be a place where "young people could come, feel welcome, talk and learn about their culture and history." It would be a place where seniors and traditional healers could practice their spirituality and ceremonies (Document CL054, Lines 1676-1679.

To date these initiatives had not occurred in Calgary.

One of the more significant issues identified by community members and other stakeholders was the lack of a central meeting place to connect with one another. Given the importance of connectedness in the Aboriginal population (Wilson & Pence, 2006), the lack of such a space was perceived to have a negative impact on community members, particularly those who were new to the city. "The other thing that I think is really affected the Aboriginal community; I think it's fragmented the community, although it's strengthened some of the Aboriginal organizations, is that we really don't have a place where we can go" (Int.022, Lines 490-494).

> I've met a lot of Aboriginal families and they want to meet other people, Aboriginal families. And they were asking me and I don't know...There is nothing...Whereas normally in the Aboriginal Friendship Centres in all cities across Canada usually, that's where they have those things. (GI 001, Lines 386-390; 422-423)

The Aboriginal Friendship Centre of Calgary, a number of years ago had undergone some difficult times and currently was housed in an old house where it was impossible to have a group or gathering of any type. Aboriginal Friendship Centres were seen to be an important place for Aboriginal people in urban centres to connect. They provided a variety of services and a connection to one another (Canadian UNICEF Committee, 2009). There were significant opportunities lost (e.g., gatherings, services that could be offered, services for children and youth) given the lack of a gathering place for the urban Aboriginal population in Calgary further fragmenting the community itself and service delivery. This was a significant gap in Calgary for the development of cultural identity and well-being for Aboriginal peoples.

Children and Youth

Overall participants interviewed agreed that there was a gap in primary healthcare services for children and youth. One participant asked the following question, "…what kind of programming are we providing for children and youth? And you look at the Medicine Wheel and you start in the east with infancy, childhood, and you move to the south, you know youth, young adulthood. To the west and so on" (Int. 022, Lines 517-520). Gaps in services described by participants have been categorized by age group while others cut across all age groups (Table 10).

Documents reviewed also supported significant gaps in primary healthcare services for children and youth. It was noted that the Canadian Aboriginal population was a young population, hence resources for this group were necessary. Two key issues identified were the number of children in care and the gap between Elders and youth. Gaps in services for children and youth were also corroborated by the literature (Benoit et al., 2003; Aboriginal Cancer Care Unit, 2008; Klinck et al., 2005). Aboriginal-specific mental health services for children and youth were particularly limited (Alberta Mental Health Board, 2006; Anishnawbee Health Toronto, n.d.c; Benoit et al., 2003; Smye & Mussell, 2001; Vancouver/Richmond Board of Health, 1999).

Chronic Disease Management

> I don't think that we've quite caught up to the types of chronic conditions that we're seeing in our population and addressing those culturally…for instance, diabetes is a prime example of that. Certainly, increases in things like heart conditions. We see a lot of that in our community. We see more and more incidence of cancers, so while we're seeing these in the general population, we're seeing them amplified in ours. So I think those are gaps that we need to do some planning about. (Int. 002, Lines 268-277)

Chronic disease had increased in the Aboriginal population over the last number of years. Overall, participants interviewed stated there were no targeted services in chronic disease for Aboriginal peoples in Calgary and mainstream services did not meet their needs.

Gaps in Services				
All age groups	**Maternal child**	**Preschool and School Age**	**School Age**	**Youth**
• Addressing foster care issues • Prevention of obesity • Dental health • Services for FASD	• Healthy babies • Healthy child development • Social development	• Healthy child development • Social development • Behavioural issues	• Behavioural issues • School health (prevention) • School attendance	• School health (prevention) • School attendance • General youth services • Recreational activities • Services for female Aboriginal youth • Mental health services (addiction, suicide, suicide prevention) • Connections to seniors and Elders

Table 10

Gaps in Primary Healthcare Services for Children and Youth

Diabetes and diabetes programming was of particular concern to individuals and providers. "…a diabetes program…There isn't something that's specifically targeted to Aboriginal people. There's a huge overrepresentation again" (Int.001, Lines 399-401). In a recently held diabetes consultation with Aboriginal individuals, several participants stated there was a lack of knowledge among individuals of where to obtain resources and information on diabetes. "People just answered, they don't know where to access" (Int.016, Line 101-102). There were gaps in diabetes services at all levels from diagnosis to treatment, awareness, screening and prevention. As noted in several local documents there was a desire by the previous Calgary Health Region to develop "a chronic disease management program to reduce the burden of diabetes, hypertension and high cholesterol levels and gender-specific programs that will support women and men in their health journeys" (Document CL042, Lines 1045-1049). Planning was still underway for such a program.

Mental Health

"Our present mental health system struggles with how to meet the mental health needs of Aboriginal people" (Document PR003, Line 64). "Mental health needs to be the core of primary healthcare for Aboriginal people" (Int.005, Field Notes, Line 121). Gaps in mental health services were categorized around five themes: issues of access; lack of culturally appropriate mental health services; lack of focus on mental well-being; issues with and lack of substance abuse services, and a lack of services for suicide prevention.

Overall, participants interviewed agreed there was a lack of mental health services for the urban Aboriginal population in Calgary. This was corroborated by documents reviewed and the literature (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2003; Smye & Mussell, 2001). More specifically mental health services were lacking for the homeless population; and more community outreach services overall would be beneficial. There also was a stigma attached to mental health services impacting the access of those services by the population. Services addressed very specific niche areas so many Aboriginal individuals did not qualify given their criteria and fell through the cracks. Because of the gaps in services, individuals were often sent to an emergency department where their needs were not always addressed.

"But it's especially hard to find culturally appropriate mental health services for Aboriginal people;" (Int.003, Lines 74-76) hence, many Aboriginal peoples were sent to non-Aboriginal mainstream services where their needs were often not being met.

> And then out of all those mental health services out there, there are none that can help an Aboriginal person living with mental illness. You know they might try and they might be open to it, but they never quite fit in. They never quite feel comfortable, because of those cultural elements. Social and cultural elements are not there or an understanding of the impact of colonization. (Int. 012, Lines 73-80)

Mental health services must meet the needs of Aboriginal people to be effective and make a difference. Documents also discussed the gap in culturally appropriate mental health services, including not being aware of or understanding the context and experiences of Aboriginal peoples. Lack of appropriate assessment tools was also raised as an issue. The importance of culturally relevant mental health services was supported by the literature (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2003; Browne et al., 2009; Kirmayer, Tait, & Simpson, 2009; Salmon, 2007; Smye & Mussell, 2001).

Although participants interviewed suggested more programs were being developed that focused on mental well-being, overall services focused on crisis as opposed to well-being. But things were changing with an increased number of initiatives dealing with the causes of mental well-being such as individual and community trauma, residential schools, and other impacts of colonization. Participants spoke of the importance of healing circles and the focus on healthy relationships, integration, and connection.

Participants also described a lack of services for patients with substance abuse. More specifically there was a lack of detox and treatment facilities, Aboriginal-specific substance abuse services, services that work with families where abuse was an issue, and as mentioned previously, services for youth. Few programs had follow-up to facilitate long-term success. There was also a lack of screening for substance abuse, particularly in primary care, where mental health programs ought to work collaboratively with the family physician. Many participants discussed the issue of separating substance abuse and mental health as was often the case with services. These two components were so intertwined that the need for services to work together was seen as essential. Unfortunately, current criteria for services often did not recognize these as concurrent issues. "We have such a high percentage of people with mental illness that will have an addiction at the same time. So to be exclusive, just poses a huge barrier to our clients" (Int. 024, Lines 812-815).

Suicide was a significant issue in Aboriginal communities both in urban and rural settings. Suicide was recognized as one of the potential impacts of intergenerational trauma experienced by many Aboriginal people. Participants discussed the mental well-being of Aboriginal people at length, but did not expound upon suicide in particular. Participants suggested there was some suicide prevention programming, but more initiatives, particularly Aboriginal-specific initiatives, were required to address this issue.

Dental Health

Oral health was described as a concern by many of the participants interviewed, especially for young children with a high incidence of dental caries and other oral health issues. Options for dental care were limited in the city of Calgary. Seeing a private dentist was one of the only options available to families and adults requiring dental care. Dentists accepting First Nations and Inuit Health Branch patients were hard to find.

> I've received calls from Aboriginal folks, who are concerned that they can't find a private dentist. I'm sure you've heard as well and so that's very troubling to me. Because this is the way our system is setup our expectation is that of the 1500 dentists in Alberta, that many of them will see Aboriginal folks. And my sense is that it's only a minority that are…So the private practice part of it and I assume the Alberta Dental Association and College is a key part of this, needs to be encouraging their members to be caring for these folks, because they do need care. (Int. 014, Lines 313-319; 324-327)

Jurisdictional issues were apparent when it came to dental care coverage for Aboriginal peoples with treaty status making it more difficult to access services as well. This issue will be addressed in more detail in Chapter Six. For those without coverage and in a low income bracket few options were available. Some dental services were provided for low income families through Alberta Health Services, Calgary Zone and SAIT's dental hygiene program. Calgary Urban Project Society performed extractions for those patients with no coverage elsewhere and were working to enable First Nations and Inuit Health Branch patients to access this service through Calgary Urban Project Society. Overall there were gaps in dental services for those who had coverage as well as those who did not.

Housing and Homelessness

The homeless population was ever increasing in Calgary and many homeless individuals were Aboriginal as noted in several documents reviewed. Many participants suggested that housing was one of the most pressing social health concerns currently facing the urban Aboriginal community. Homeless individuals were known to be in poorer health than those individuals having a home. Youth were also at high risk for homelessness since they often fell through the cracks due to service criteria. Youth homelessness was also mentioned in documents reviewed. Participants stated there were many issues for homeless Aboriginal people; it was a complex problem with no clear solutions. As noted in documents reviewed, current housing initiatives for homeless people in Calgary and Alberta, did not have specific strategies to address the homelessness issue for Aboriginal peoples, despite representing as much as 30% of the homeless population in Calgary (Calgary Homeless Foundation, 2009a). Few options existed for housing for Aboriginal homeless people, particularly women.

> We need to address housing and then other issues for the urban Aboriginal population, particularly those who are homeless, they are vulnerable and at risk and could benefit most from a coordinated primary healthcare system to address their needs. (Int.028, Field Notes, Lines 129-132)

Financial resources were also required by the homeless for other necessities such as transportation and medications not covered by social services. Another big concern for participants was the lack of housing assistance for individuals following detox and treatment for substance abuse, negatively impacting success for these individuals.

The lack of services for the Aboriginal homeless population as well as the limited access to culturally appropriate housing options was documented in several key reports (Browne et al., 2009; Laird, 2007; Turner et al., 2010; Webster, 2007). Aboriginal homelessness was also significantly impacted by jurisdiction (Calgary Homeless Foundation, 2009b; Turner et al., 2010; Webster, 2007). Urban Aboriginal homelessness had not been addressed in large part due to conflict between governments around the accountability for urban Aboriginal people. Historical and contemporary policies continued to underlie many of the pathways into homelessness for Aboriginal people. Current housing models for the homeless population were not culturally relevant (Turner et al., 2010). Social policies, oppression, and racism continued to impact the everyday work required for the Aboriginal homeless population to obtain services. Aboriginal homeless individuals in Calgary were an extremely vulnerable group that would benefit significantly from an organized, comprehensive primary healthcare system to address their needs.

Traditional Care and Spiritual Services

All participants agreed there were gaps in traditional care available for Aboriginal peoples in the current primary healthcare system. Often traditional practices were not recognized and there was a lack of desire to recognize such practices. This impacted the ability to integrate traditional care and western medicine. Many patients were seen to be disconnected both spiritually and from their communities. Participants also discussed the diversity of the population where individual needs around traditional care and spirituality should be ensured.

Offering traditional care was always the intent at the Elbow River Healing Lodge, but prior to moving the clinic to its current location, this was not realized. In its new location, they now had a ceremonial room used from time to time, but traditional services continued to be minimal. Currently, most members of the urban Aboriginal population used outside services for ceremony, making connections with surrounding reserves or accessing traditional care back at their home community. Although some space was now available for traditional care, feasts, sweats and other ceremonies could not necessarily be accommodated as resources (e.g., financial, providers) were required to offer these types of services. Lastly, medical-legal issues associated with traditional healers and traditional medicine also needed to be addressed. One participant suggested that decisions regarding the integration of traditional care were still being made.

> And then we have to sort out the ideas around traditional healing, which are herbalists and spiritual surgeons and all that stuff. And how they are located with us or do they still stay on the peripheral where ceremonialists and traditional people are the connectors. (Int.036, Lines 615-619)

Another participant suggested there was little emphasis or opportunity to address healing in non-Aboriginal primary healthcare services. As discussed earlier in this chapter, linkages between healing, connection, traditional approaches, and spirituality were significant. Hence these types of services were seen as absolutely essential in addressing the primary healthcare needs of the urban Aboriginal population in Calgary.

The lack of traditional and spiritual services was supported by the literature (Benoit et al., 2003; Benoit et al., 2001; Bucharski et al., 2006; Aboriginal Cancer Care Unit, 2002) where Aboriginal peoples desired more of these types of services. Lack of services was impacted by the unavailability of traditionalists because of issues of organizational policy, liability, remuneration, safety, and concern regarding the protection of their knowledge (Benoit et al., 2003; Waldram et al., 2006). The importance of including traditional and spiritual services was well documented (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2001; Aboriginal Cancer Care Unit, 2008; Joint Management Committee, 2009; Lavallee, 2007; Mignone et al., 2003; Niccols et al., 2010; Sinclair et al., 2006; Skye, 2006; Vancouver/Richmond Health Board, 1999; Waldram et al., 2006) given their impact on health, wellbeing, and identity. Health and wellbeing for Aboriginal peoples incorporated all aspects of health: physical, emotional, mental and spiritual. When balance was not maintained health issues occurred. "…traditional health practices are utilized to restore balance to either maintain or enhance overall health and wellbeing" (Skye, 2006, p. iii).

Summary of Gaps in Specific Service Areas

In summary, a number of gaps in primary healthcare services were found in the study. Not surprisingly, gaps in prevention and promotion services were discussed given the information provided earlier in this chapter on services utilized by community members for prevention and promotion. There was a lack of focus on prevention by community members and few or no Aboriginal-specific prevention services were available. The situation was similar for health promotion services. One of the biggest gaps in the promotion of health and well-being was the lack of a gathering place for Aboriginal community members. Few services were available for children and youth, chronic disease management, oral health, and mental health. Mental health services, in particular, were seen to be important given the intergenerational trauma experienced by community members. Housing and services for the homeless were also considered to be a gap, especially with the over representation of Aboriginal people in the homeless population in Calgary. Traditional and spiritual care services were also lacking in the current primary healthcare system for the urban Aboriginal community in Calgary; hence many individuals utilized such services in their home communities or did not have access to traditional and spiritual care.

Chapter Summary

This chapter outlined results related to research question one, namely what are the strengths and gaps in services in the current primary healthcare system? Primary healthcare services utilized by Aboriginal community members in Calgary were also summarized. Aboriginal community members most often used emergency departments, urgent care, and walk-in clinics when they were ill or had a need. Few were thought to have a regular family physician. Prevention was not a priority for the community considering other, more pressing needs. Very few Aboriginal-specific prevention services were available in Calgary. The case was similar for services promoting health and well-being. Connection, identity, traditional care and spiritual care were discussed as being important for well-being of individuals and the community.

The current primary healthcare system was comprised of many organizations, departments, and programs delivering services to this population. The large number of services was likely impacted by short term, project-based funding and gaps in services with new services implemented to address those gaps. Non-governmental organizations made up a large component of the Aboriginal-specific organizations and programs affecting resources and continuity of services in this primary healthcare system.

Several strengths of the current system were described by participants. These included the positive evolution of the system over the last decade, commitment of past leadership, and community involvement. The biggest strength was the frontline staff caring for Aboriginal peoples.

Numerous gaps were outlined by participants and supported by the document review. Barriers to access of primary healthcare services were evident (e.g., transportation, racism, jurisdictional issues, varying beliefs). There was considerable lack of coordination of this large, unwieldy system. Various gaps in specific service areas were also described by participants. These included such services as prevention, promotion, mental health, chronic disease management, traditional and spiritual care, and services for children and youth.

Information on primary healthcare services currently utilized by Aboriginal community members was outlined in this chapter. A comprehensive pictorial representation of the current primary healthcare system was also presented. Finally, information on strengths and gaps were provided. These results will provide a foundation for the improvement of the primary healthcare system for the urban Aboriginal community in Calgary, building on current strengths while addressing the gaps identified.

Chapter Six will outline the structures and processes required to improve this primary healthcare system. Such topics as jurisdictional issues, funding and patient-centred teams will be discussed.

CHAPTER SIX—STRUCTURES AND PROCESSES TO IMPROVE THE PRIMARY HEALTHCARE SYSTEM

This chapter will answer research questions two through four: what are the structures and processes needed to improve primary healthcare for the Aboriginal population; who are the key stakeholders that need to be involved in designing a primary healthcare system for the Aboriginal population; and what is the role of patient-centred teams and what would be the ideal staff mix for this new system serving the Aboriginal population? Data were collected in the same manner as for Chapter Five, through interviews with stakeholders including members of the Aboriginal population in Calgary, documents, observations, and Advisory Committee meetings. Research results in Chapter Six will focus on the complexity of the primary healthcare environment for the urban Aboriginal population in Calgary, including historical and current impacts of colonization, jurisdictional issues, funding challenges, trends in urbanization, diversity of the population, gender issues, and the impacts of globalization. Results will also address the structures and processes recommended by participants to improve the primary healthcare system including: the involvement of stakeholders in planning and implementation; primary healthcare models recommended; the role of patient-centred teams; ideal staff mix for patient-centred teams; and evaluation and outcomes. A table (See Table 11) will be included to provide the reader a guide to key themes identified in research results for this chapter.

Complexity of the Environment

The complexity of the primary healthcare system for the Aboriginal population in Calgary was highlighted in Chapter Five. The number of organizations, departments, and programs involved in delivering primary healthcare services and the relationships between them contributed to the complex system described. In addition to the information presented in Chapter Five, I will provide results describing the complex and evolving environment in which this primary healthcare system is situated.

Table 11

Key Themes for Chapter Six

	Key themes
Complex Environment	
Historical and current influences of colonization	Persistence of colonized practices in our institutions Importance of recognizing history as a determinant of health for Aboriginal people
Jurisdictional issues	Various stakeholders involved in jurisdictional issues including all levels of government, Aboriginal organizations, health authorities, etc. Issues have been ongoing for hundreds of years Jurisdictional issues focused on First Nations, while other Aboriginal groups were also impacted Lack of accountability for urban Aboriginal peoples Jurisdiction impacted access to services and coverage Self-governance seen as the solution to jurisdictional issues
Competitive funding	Coverage for health services differed dependent on Aboriginal group Short-term, project-based funding Funding models did not support the needs of Aboriginal people Capped government funding Impact of economic downturn Competition in funding between organizations
Urbanization	Increased numbers of Aboriginal people in urban centres

- Diversity of the population	- Calgary's Aboriginal people represented First Nations, Métis, Inuit, and non-status Aboriginal individuals from across Canada - Varying needs and beliefs - Métis group often felt excluded
- Gender/globalization	- Services for women seldom mentioned - Global issues/events impacted primary healthcare
Structures and processes to improve current primary healthcare system	
- Community participation	- Genuine participation of all types of community members (e.g., Elders, leaders, community members) - Participation at all levels of healthcare service delivery (planning, implementation, and evaluation) - Facilitate ownership of primary healthcare services - Communication with the community
- Exploration of new governance models	- Exploration of urban self-governance in healthcare - Concerns regarding leadership
- Population needs-based focus	- Holistic approach encompassing Aboriginal worldviews to assessment and understanding needs - Importance of social determinants of health - Understanding of intergenerational trauma to understand Aboriginal community members' needs - Upstream prevention and health promotion approaches
- Partnerships	- Development of partnerships within healthcare and across sectors to address multiple, complex needs
- Coordination and continuity of care	- Importance of coordination due to large, complex system - Relationship-based care between providers and community members for continuity of care

• Centralized, co-located services	• Multiple service windows desired for better access • Outreach community services
• Holistic, comprehensive, culturally relevant services	• Holistic approach • Inclusion of traditional care and spiritual services • Importance of a healing place
• Patient-centred teams	• Importance of patient–centred teams • A variety of providers recommended • Patients as equitable team members • Teams could address varied needs of community members
• Evaluation and outcomes	• Lack of data, evaluation, and outcomes measurement in current primary healthcare system • Importance for accountability and effectiveness of primary healthcare model and services

Historical and Current Impacts of Colonization

Many of the participants interviewed and documents reviewed commented on the historical and continuing impacts of colonization. Colonization had impacted the health status of Aboriginal peoples and determined to a large degree how healthcare services were delivered today. History was discussed in detail in Chapter Two to provide context for the study. Historical events for Aboriginal peoples in Canada no doubt contributed to the complex environment in which primary healthcare was situated. Government and other institutional policies of assimilation negatively impacted Aboriginal peoples through culture and language loss, racism and oppression affecting their health and well-being. The consequences of historical events continued to evolve changing the understanding of the political and social environments for both Aboriginal and non-Aboriginal peoples (e.g., The Federal Government's Residential Schools Apology and the Royal Commission for Aboriginal Peoples). The persistence of these institutional policies and practices had a significant impact on the health and well-being of Aboriginal peoples in Calgary. Recognition of history as a determinant of health (Commission on Social Determinants of

Health, 2007; Dyck, n.d.) will be necessary to ensure appropriate primary healthcare services will be delivered to Aboriginal peoples. Historical and current events and policy, as well as the inaction on past recommendations all had a significant impact on the complexity and the evolution of the environment in which primary healthcare was situated.

Governance: The "Jurisdictional Quagmire"

Jurisdictional issues were mentioned by all participants, in many of the documents reviewed, as well as being evident during observation. Jurisdiction involved a complex, multifaceted set of issues all individuals and communities were aware of but few took action to address. Jurisdiction had a significant impact on access to primary healthcare services, funding, and the development of collaborative partnerships across organizations and sectors to address the needs of urban Aboriginal peoples. "I think the urban Aboriginal [individual] is…where the lack of clear, coherent policy puts them at a disadvantage," (Int.037, Lines 165-167).

Various parties were involved in the primary healthcare system "jurisdictional quagmire" including all three levels of government (federal, provincial, municipal), Aboriginal leadership (e.g., First Nations, Métis), health authorities, other sectors, Aboriginal service organizations and other service organizations, and Aboriginal peoples themselves. Within the Federal Government alone, there were over 30 departments and 360 programs providing services for Aboriginal people (Senate Subcommittee on Population Health, 2009). The following discussion focuses for the most part on the First Nations[3] Aboriginal group as jurisdictional issues were most prominent given their Treaty relationships with the Federal Government. The literature too, highlighted jurisdictional issues for First Nations communities (Carr-Stewart, 2006; MacKinnon, 2005; Rae, 2009; Wilson, 2007). Other Aboriginal groups were as much a part of the jurisdictional quagmire, but in much of the conversation they were left out which was the problem or; they were simply forgotten.

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[3] Discussion in this chapter will refer to the specific group of Aboriginal people (e.g., First Nations, Métis and when discussion was more general Aboriginal will be used)

The Federal Government

Jurisdictional issues began at the time of the signing of historical Treaties in the 1700s and 1800s. Treaties were signed years ago with little thought to defining terminology and clarification of meaning. First Nations' chiefs and officials of the Crown interpreted Treaties differently when they were developed and contradictory interpretations continued. Ongoing negotiation, discussions, and legal conflicts persisted around Treaty obligations, including health services delivery. Treaties were a text directing the societal relations between First Nations' people and the Government of Canada. The Federal Government as a representative of the Crown was and will continue to be obliged to uphold the Treaties as recognized in the Canadian Constitution. Activation of Treaty texts resulted in continued conflict and negotiation. The implementation of Treaties by government officials through policy development such as the Indian Act, from the beginning, sought to control the Aboriginal population in Canada. The Federal Government continued the perpetuation of colonization where unilateral decisions were made by non-Aboriginal government or court officials (accountable to the government) for First Nations' communities in Canada. Not all Aboriginal peoples in Canada were incorporated in Treaty agreements. Treaties applied to First Nations' communities, while Métis, Inuit, and non-status individuals were not included.

In the past, the First Nations and Inuit and Health Branch of Health Canada was responsible for primary healthcare services on-reserve; many bands now have responsibility for their own healthcare services through various forms of transfer arrangements from the Federal Government. The Federal Government as the funder, continued to have some level of control over these healthcare services. First Nations and Inuit Health Branch also administered non-insured health benefits for First Nations' individuals with status under the Indian Act and similar benefits for Inuit people. Some mental health services on- and off-reserve (e.g., Native counselling services, addictions services) were also funded by First Nations and Inuit Health Branch.

Federal/Provincial Relations

Alberta had a unique, co-management agreement between First Nations and Inuit Health Branch and First Nations communities facilitating shared decision-making for health funding on-reserve.

> So it's intended that the First Nations' communities from…the three Treaty areas in Alberta, and the Federal Government sit at a table together and decide how the funding is to be used (Int.001, Lines 78-84).

Several participants suggested co-management existed only in principle, as the amount of funding remained the same based on a population formula calculated by the First Nations and Inuit Health Branch. Hence there was limited ability for leaders at the co-management table to make decisions; only on certain funding components. The co-management agreement was an organizational text, perhaps created in such a way to limit the ability for leaders to make genuine decisions on healthcare delivery; to "control and disempower people," (Campbell & Gregor, 2002, p. 22). Inadequate funding enabled government control over services and the people served. Insufficient funding for Aboriginal peoples' health was considered unethical practice (Tait, 2008).

Several First Nations' communities in Alberta participated in the transfer of healthcare services from First Nations and Inuit Health Branch, although uptake had not been significant in this province. A number of participants desired a situation similar to British Columbia (British Columbia First Nations Leadership Council, Governments of Canada and BC, 2007) and Ontario (Joint Management Committee, 2009) where a tripartite agreement and legislation directed the establishment of a collaborative relationship between provincial and federal governments and Aboriginal peoples. Such organizational texts in other provinces facilitated collaboration between governments and Aboriginal peoples creating positive changes in health service delivery.

> And I think that's what I would want here is from a legislative approach. Because in Canada, there's no legislation…at the federal level, regarding responsibilities for healthcare to First Nations' people. All it is, is just a stack of cards that can fall apart at whatever the government thinks or the party in power thinks should be

> done. It's just based on Treaty Number Six and pieced together by multiple court cases and legal actions of judiciary responsibility. There is no legislation…I think the resolution resides, sort of lies in that same framework. That we have to come at a national and provincial legislation level to redress the issues (Int.036, Lines 826-833; 843-845).

The previous quote spoke to the fragile nature of accountability for healthcare for First Nations' peoples. Decisions were being made by the Federal Government and through the courts based on the "medicine chest" clause (Indian and Northern Affairs Canada, n.d.a; Morris, 1880) which was open to interpretation by both parties. Colonial institutions continued to make decisions for First Nations, disempowering their peoples. Continual change, further controlling the population, was apparent dependent on the government in power, political cycles, and funding availability.

While the "Federal Government is responsible on-reserve, [nobody] is responsible in the city," (Int.025, Lines 470-472). The question of the government's role in providing services to off-reserve First Nations' peoples was raised by a number of participants.

> Their responsibilities for First Nations' folks end at the reserve boundary primarily. That is what they would say. My question then is when the last First Nations' person moves off-reserve, does the federal responsibility end, apart from the non-insured health benefit program? If you follow their logic, that is what it means. (Int.037, Lines 506-511).

Reserve boundaries created by the Federal Government via policies such as the Indian Act, caused numerous problems for Aboriginal peoples (e.g., service boundaries). Some participants suggested the Federal Government fund at least a portion of the cost of healthcare services for off-reserve individuals. By not doing so, they relinquished responsibilities for healthcare services for First Nations in urban centres in Canada further increasing the vulnerability of the urban First Nations' population. The Federal Government was required to uphold Treaty agreements for healthcare; they were accountable for First Nations' people. Oppression was also accomplished by *not doing* versus doing something to oppress a particular group of people. The Federal Government was seen to be discriminating against urban First Nations' peoples by no longer providing coverage for healthcare services.

The Provincial Government

Provincial governments also had responsibility for Aboriginal healthcare. First Nations' people residing off-reserve, Métis, and non-status individuals all pay federal, provincial, and municipal taxes; hence there was a responsibility for the Provincial Government to provide culturally safe healthcare for this Aboriginal population. The Federal Government also provided transfer funds for those healthcare services provided by provincial governments. All physician services, specialty services, hospital services, social services, and education off-reserve were paid for by the province of Alberta and were dependent on provincial policy and funding. The lack of healthcare services available on-reserve was seen to impact individuals' health where their well-being deteriorated requiring more chronic care, acute care, and specialty services through the province and Alberta Health Services. Downloading of care to the provincial healthcare system was perceived by many participants.

Participants suggested a lack of support by the Alberta Provincial Government for Aboriginal initiatives.

> …I think you need like leaders that support Aboriginal initiatives. And I don't think we have that in Alberta. And I think that Alberta is definitely lagging behind all the other western provinces for Aboriginal initiatives period or Aboriginal voices. I don't think we're recognized (Int.025, Lines 457-462).

There also was a lack of understanding as to the province's responsibility in Aboriginal health by the Provincial Government and health authority leaders.

> …these are Albertans as well. And that the provincial system has certain obligations to these folks. And if you take a look at the fundamental logic of it, that we need to be providing targeted programming so these people aren't falling through the cracks and the gaps in services. And that even if they are transitioning to and from reserve communities or Métis settlements, that we have in place the programs and services

> to make that possible. That we're linking back to those home communities (Int.037, Lines 175-182).

The Provincial Government appeared to abdicate responsibility with the assumption that accountability for all healthcare services for First Nations' people remained the responsibility of the Federal Government through the Treaty text. On the other hand, Federal Government control over the Provincial Government was evident in healthcare delivery through unilateral decisions made in Ottawa. Provincial and Federal government relations were not always ideal, particularly in Alberta. Bureaucratic relations impacted healthcare decisions at the expense of Aboriginal peoples.

First Nations' leaders also had difficulty seeing the relationship to the province for healthcare service delivery as they believed Aboriginal services were a federal government responsibility. Treaties were signed with the Crown and the Federal Government; hence First Nations' leaders believed they needed to negotiate federally. First Nations peoples (being a Nation) preferred to negotiate nation to nation. Coupled with their lack of trust in all outside government, this impacted negotiations and resolution of healthcare delivery between First Nations peoples and all levels of government.

Provincial policy development for Aboriginal health frequently occurred *ad hoc.* Then, a new strategic plan was developed in Alberta for Aboriginal health.

> A provincial steering committee of relevant sector and Aboriginal stakeholders was established in February 2007 to discuss and develop some collaborative solutions to this longstanding problem. The committee included participation from regional health areas, Federal Government departments such as Indian and Northern Affairs Canada, Services Canada, and Human Resources and Social Development Canada; and Provincial government departments such as Children and Youth Services, Education, and Employment & Immigration (Document PR011, Lines 108-114).

The plan had not yet been released but focused on principles, objectives, and collaboration with regional health authorities, now Alberta Health Services, to deliver services for Aboriginal peoples. Yet another text was developed to manage primary healthcare delivery for Aboriginal peoples. After two years, this text was not yet activated to manage service delivery for Aboriginal peoples residing in Alberta. Whether the non-activation of this text was beneficial or not, it represented yet another activity in an attempt to collaborate around healthcare delivery for Aboriginal peoples with significant resources (e.g., people's time, salaries, honorariums, general funding) expended with little result. Approval was stalled due to provincial health reorganization and ongoing issues between government levels and departments and Aboriginal leaders, and among Aboriginal leaders themselves.

In the meantime, participants recommended supporting local initiatives such as those in the Aboriginal Health Program, Alberta Health Services, Calgary Zone through policy and resources while promoting a more collaborative approach for the future.

> …we need to do what we think makes sense from a provincial perspective…to put supportive policies in place, so that people in [Calgary and Edmonton], they're encouraged to engage their local Aboriginal communities and discuss how they need to deliver services differently. And I mean targeted programs and services and not just in a cultural way, but targeted to specific health issues that are prominent in the Aboriginal communities…But that we advocate for a more visionary approach, where we are sitting down at a broader policy table (Int.037, Lines 853-860; 879-880).

Arguably, getting started somewhere was prudent but this piece-meal delivery did not support a comprehensive systems approach but rewarded one-off project-based initiatives.

Provincial Health Services

Reorganization of healthcare services in the province of Alberta over the last two years has also raised challenges. On the one hand, there was now a single entity to work with at the provincial health authority level to address Aboriginal peoples' health, but reorganization resulted in a hold on existing services with no expansion. Transition or "between stories is a disruptive, confusing, chaotic time, characterized by constant change and a patchwork of *ad hoc* arrangements," (Rae, 2009, p.44). Participants raised concerns about the lack of priority for Aboriginal peoples' health in the face of other issues (e.g., bed shortages, and budget shortfalls). Restructuring of large organizations responsible for public services often resulted in putting services on hold, lack of focus on prevention and promotion, and general overall confusion for staff and patients. Such processes could have a detrimental impact on patients and communities, particularly those already experiencing marginalization. Recently, a Director for a provincial Aboriginal Health Program was announced (Field Notes, Adv. Comm. 005), which bode well for Aboriginal peoples' health programming within Alberta Health Services. How that will translate into services in Calgary will remain to be seen.

Alberta Health Services, Calgary Zone did currently have several initiatives with First Nations' communities surrounding Calgary (e.g., Telehealth, mental health outreach services). These were not without their challenges, but participants felt it was a good start in delivering collaborative care for Aboriginal populations on- and off-reserve.

Primary Care Networks

Primary Care Networks in Alberta and Calgary have also become involved in the jurisdictional mix. Family physicians and other healthcare providers saw the needs of Aboriginal peoples and began working with First Nations' communities on-reserve. For instance, at Tsuu T'ina First Nation, primary care services were provided by Primary Care Network family physicians five half days per week. Organizations such as Primary Care Networks have noticed disparities in the health of First Nations' community members, particularly when they sought services for health needs off-reserve. There was a desire within Primary Care Networks to offer better primary healthcare services on-reserve, to provide better access for community members, and to address prevention and promotion issues, or at least attend to conditions at an earlier stage. With additional organizations providing services to Aboriginal peoples, it further complicated the already complex system. Such collaborations required Memoranda of Understanding and/or other protocols to direct relationships between parties. These institutional texts were developed to govern interaction between parties and outline responsibilities, particularly those of the Federal Government ultimately responsible for healthcare in First Nations' communities. It was unclear with which party the actual control existed (Primary Care Networks or First Nations) but First Nations' leadership were pleased and relieved in having additional resources available, particularly family physicians. There was significant concern with relinquishing of responsibility by the Federal Government.

> I know there's fear. Like people bring that up. Okay, what does this mean for us? What does this mean for the Treaty right issue? What does this mean, you know? But if you look at more, looking at Memorandum of Understanding and how you work together and that defines it; writing and respecting the Treaty right issues and what First Nations and Inuit Health Branch, you know what their mandate is…They're probably challenging it in some way, but it forces First Nations and Inuit Health Branch to look at things differently too. And for everyone to be at the table and find common ground. You know there are services First Nations and Inuit Health Branch can't service, and if primary care networks can, why not? Because if you want to be client centred, that's what you've got to be; not policy centred. (Int.008, Lines 699-705; 718-724)

The importance of community needs and patient-centred care was highlighted and should be the focus rather than having jurisdictional issues control healthcare delivery.

Aboriginal Community Leadership and Self-governance

Aboriginal leadership in relation to jurisdictional issues, healthcare disparities, and self-governance was also discussed by participants. Potential roles (e.g., leadership, consultation, mediation) for Native Friendship Centres were discussed as they serve all urban Aboriginal groups. Aboriginal leadership via the Aboriginal Friendship Centre of Calgary was considered by participants interviewed to be inadequate, lacking the ability to effectively represent and advocate for the Calgary Aboriginal community at this time. Approximately five years ago, the Aboriginal Friendship Centre of Calgary experienced some unfortunate leadership and consequent financial issues (Small, 2007). Currently, there is a move to strengthen the leadership at the Aboriginal Friendship Centre of Calgary.

In particular, members of the Aboriginal population in Calgary discussed the lack of leaders for urban Aboriginal people. "…no one represents the urban Aboriginal people," (GI001, Line 591). Lack of leaders may be related to Aboriginal organizations being small, non-government organizations with limited resources. Urban Aboriginal peoples were perceived to be caught in the middle of jurisdictional issues between government and Aboriginal organizations and other parties. They were often represented by First Nations' leaders, which was seen to be inadequate as First Nations' peoples could not speak for all urban Aboriginal peoples (e.g., non-status, Métis) nor could they effectively represent their issues not knowing the context.

Self-governance in urban Aboriginal populations had not been explored to any great extent, particularly in Alberta and Calgary. The researcher asked participants about Aboriginal-owned and -operated services as evident in other primary healthcare systems or subsystems in Canada and elsewhere (Anishnawbee Health Toronto, n.d.a.; Benoit et al., 2003; Eby, 2007; Gottlieb, 2007). Some thought the idea an interesting concept, but issues of leadership, accountability, and funding were bound to continue. "Native owned and operated in an urban setting; great idea with appropriate leadership," (Int.020, Field Notes, Lines 15-16). They acknowledged it would be difficult to move in that direction with no urban Aboriginal governance system in Calgary. Appropriate and adequate funding were also major concerns and supported by the literature (Lavoie, 2005; Rae, 2009).

> Because in a model of Aboriginal owned, we'd still be fighting all of those various parties that fund…First Nations and Inuit Health Branch, Health Canada…they'll just have a small entity that's outside of Health Canada [and] has no power within it to make change. It's always fighting for a few dollars and always stays the same (Int.036, Lines 836-839; 846-849).

Another participant felt healthcare services and Aboriginal peoples in Calgary had not yet evolved to that point. "I don't feel we are evolved enough to do that…I don't think we're well enough into our own healing and recovery to be looking at doing it in that kind of way" (Int.002, Lines 750-754).

If self-governance was explored in urban centres, collaboration with a variety of organizations would be necessary where competitiveness and differing agendas would be addressed. It would need to go beyond having First Nations' authorities represent all Aboriginal people as was perceived by other Aboriginal groups (e.g., Métis). Non-Aboriginal organizations would need to work with Aboriginal leaders (First Nations, Métis and others) to navigate political processes and build the capacity of leaders to address the disparities in the urban Aboriginal population. "…we need to resource them to be able to lead it. But help build some capacity, but they need to be part of the dynamic dialogue about how we deal with their people as they're moving off-reserve," (Int.037, Lines 626-629).

Some form of self-governance may be the ultimate goal for a primary healthcare system for the Calgary Aboriginal population and was also suggested by the literature (Rae, 2009; Wilson, 2007). Of note, were the quotes throughout this study that talk about the proverbial *we* referring most often to government and other institutions when discussing Aboriginal peoples' control over healthcare services (e.g., "*we* need to resource them; how *we* deal with their people"). This type of language could indicate ultimate control continued to reside within the institutions of non-Aboriginal society. *We* could also be interpreted in a more positive sense where genuine partnership was desired. Also important, was the fact that *we* in Canada no longer solely represented western Europeans but included a myriad of people from various ethnic backgrounds. Self-governance for primary healthcare services for this urban Aboriginal population will need to be explored further and no doubt will require further study.

Summary of Governance and Jurisdiction

In summary, governance of Aboriginal peoples' health was fraught with jurisdictional issues impacting many components of Aboriginal health services. Colonized policies and practices (historical and current) of government and other institutions continued to drive healthcare policy, planning, and implementation for urban Aboriginal peoples. Most notable was the lack of collaboration amongst levels of government, Aboriginal leaders, and Aboriginal and non-Aboriginal healthcare organizations given the multitude of jurisdictional issues. All parties were acutely aware of existing jurisdictional issues, but few addressed them. Downloading and relinquishing responsibilities led to a lack of accountability for Aboriginal health in Canada, particularly for urban Aboriginal people. The potential for self-governance was also impacted by jurisdictional issues and the lack of leadership in the urban Aboriginal community. Jurisdictional issues could not be ignored, or accountability for the urban Aboriginal population would continue to hang in the balance with no effective or efficient primary healthcare system to serve the population's needs.

Competitive Funding Environment

Consultation with Calgary Aboriginal community members and other stakeholders in 2001 identified numerous funding issues. These included: "inappropriate allocation of funds; lack of accountability…inefficiency and unfairness of funding application criteria and procedures (e.g., favouritism); lack of relationship between community and funders; lack of funding;…need to expand funding mandates to include holistic services; and sustainability of funding," (Document CL054, Lines 265-269). Overall, all interview participants suggested a lack of funding for a comprehensive primary healthcare approach for the urban Aboriginal population in Calgary. Participants described a number of funding issues summarized in five key areas: differential coverage; fee-for-service funding; short-term, project funding; capped government funding; and competition in funding between Aboriginal organizations. These will be described in the following sections of this chapter.

Differential Coverage for Primary Healthcare Services

One of the key issues with funding for Aboriginal peoples was the differential coverage available for different groups. "…it's just those government induced labels and definitions that are, really have become the cumbersome part of being able to deliver proper care," (Int.008, Lines 402-404). The Indian Act, a government text, had long been the source of many conflicts between Aboriginal people and the Federal Government and among Aboriginal peoples themselves. Several amendments were implemented over the last number of years (e.g., Bill C31; additional status amendment in 2010) addressing status issues. The Indian Act was written by government officials to rule every aspect of Aboriginal peoples' lives, to promote assimilation, and eliminate the *Indian problem*. It delineated who qualified for certain benefits according to Treaty agreements (status versus non-status) and to control how Aboriginal peoples would behave and interact with non-Aboriginal Canadians (e.g., ceremonies were outlawed, passes were required to leave the reserve). The activities and actions sanctioned by the Indian Act caused persistent and pervasive discrimination and oppression of Aboriginal peoples in Canada. Unfortunately, the Act left a legacy of issues; a key one being the labelling that occurred for various Aboriginal groups in Canada. This labelling was particularly evident in urban centres.

> I mean we got our non-status clients, we've got Métis' clients; we've got our First Nations' clients, so the First Nations' clients will have access to different things than the non-status or Métis' persons. So you've got to deal with those in different ways…The nursing staff, the physicians have to be up to speed with everything, all the way down to the pharmacist, down to the social workers. Everyone has to be aware of changes that are happening constantly (Int.008, Lines 408-419).

Differential funding had a significant impact on access to healthcare for Aboriginal peoples. Those individuals with status according to the Indian Act received non-insured health benefits. To obtain such services one participant reported they were always asked, "show me your Treaty Card first," (Int.022, Line 138). The Treaty Card enacted the invisible, social relation of access and coverage for a First Nations' individual seeking healthcare. Access for those First Nations' peoples with Treaty status was also determined by whether the organization had the ability to collect payment from First Nations and Inuit Health Branch. "…depends if a clinic is accessing [and] has permission to work with First Nations' people and to receive payment through First Nations and Inuit Health Branch," (Int.006, Lines 40-44); permission must be obtained from the Federal Government to be able to provide care for First Nations' people. Hence, the Federal Government controls what services were covered and where services could be accessed.

Some services were not easily accessed due to the difficulty in completing forms for direct billing by providers to First Nations and Inuit Health Branch. Sometimes prior approval of service from First Nations and Inuit Health Branch was required, while others had to pay out of pocket prior to being reimbursed. Forms required to be completed by patients or staff in clinics was yet another text necessary to receive services and/or payment; it was a component of the everyday work required of First Nations' people and those working with them. Due to the complexity of the forms, both patients and providers simply gave up and did not receive care required. The available coverage was more limited in the last number of years due to delisting of certain services and drugs. Individuals with status also had provincial health coverage for services such as primary and hospital care through federal government transfer payments. Status individuals, if employed off-reserve, may be covered by third party insurance benefits such as Blue Cross. First Nations and Inuit Health Branch remained the primary insurer and third party insurance would be used if services were not covered by non-insured health benefits.

Urban Aboriginal peoples with status could also be treated differently than if they were living on-reserve. Additional challenges in obtaining coverage were apparent as some bands would only cover services for those actually living on-reserve.

> …you know you're positioned between two lands. You're not really a part of a band, or if you're living off the reserve…you know receiving dollars is tricky. It's somewhat political. That is you're not living on the band, then you don't receive dollars from your band for, I guess, miscellaneous. And that if you're living on the band, you need to solely depend on the band (Int.006, Lines 118-124).

This was reinforced in an observation at a community pharmacy where an Aboriginal individual was attempting to fill a prescription. The pharmacy could not bill First Nations and Inuit Health Branch, but required the individual to return to their reserve to obtain coverage for the medication. Unfortunately, the band would not cover the cost either and hence he was back at the pharmacy to obtain the medication. The band would cover some miscellaneous expenses for band members (e.g., if a medication was delisted). The individual eventually walked away without having the prescription filled. Now healthcare for a First Nations' individual living off-reserve was controlled by the Band, First Nations and Inuit Health Branch through non-insured health benefits, provincial healthcare benefits, health authorities, and third party funding. No wonder there was an overall lack of understanding of differential coverage by the various parties involved, including Aboriginal individuals themselves.

Non-status Aboriginal and Métis people were funded for healthcare services in the same way all other Canadians were. Healthcare was funded via provincial healthcare funding. Some individuals also had third party insurance through an employer to cover other additional benefits. Not having benefits through First Nations and Inuit Health Branch impacted their ability to access services as they simply were not able to afford them.

> Because I mean I have a lot of friends who don't have status and so, they won't access medical services, because they can't afford it…Or if they do, they can't afford the prescriptions…or if there's other specialized treatment that has to happen (Adv. Comm. 004, Lines 440-447).

Métis people do not have benefits through Aboriginal government programs either. They were unable to access primary healthcare services infrastructure provided by the Federal Government and often did not feel included in provincial and regional healthcare services designed for Aboriginal people. Métis individuals' healthcare benefits, however, were covered just as for all other Canadians.

In summary, having multiple insurers and benefits for different groups, and for some no benefits at all, made it particularly difficult for healthcare providers, organizations, and Aboriginal individuals to sort out payment for services provided, thereby impacting access to services for Aboriginal peoples in Calgary. Much effort was required by healthcare providers to access other benefits for non-status and Métis individuals. Staff advocated continually for these groups with no access to the benefits First Nations' people had.

Fee-For-Service Funding for Primary Medical Care

The current primary medical care funding model also impacted the accessibility of services required by Aboriginal peoples to meet their complex needs. The fee-for-service model did not support caring for patients with complex health and social needs rather it supported a volume-driven system where one issue was addressed per appointment. This model, utilized by most physicians in Calgary, made working with Aboriginal individuals with complex needs particularly difficult to assess their needs adequately and provide effective care.

Short-term, Project Funding

Aboriginal healthcare services were often subject to short-term, project-based funding for pilot projects as was noted in Figure 3 shown in Chapter Five. Services provided were limited by soft funding and funding cycles as opposed to core funded programs and services.

> But the funding has a cycle. Maybe it's a one-year project or two-year or three-year and when the money is gone…if it's not sustainable…many of them are not designed to be sustainable, they cease to exist. And then it's another cycle of writing proposals and maybe establishing an organization with a Board of Directors, a non-profit (Int.022, Lines 231-237).

Funding criteria also limited flexibility to address the real needs of Aboriginal peoples.

> So if it's a white problem, a white prevention problem, those are what's available. And that's what will be available for Aboriginal specific, because that's what will be funded as well. So in the matter of say tobacco or even SIDS, when that was a white issue, we got the funding too. When the smoking rates went down and they were able more to start drawing conclusions around SIDS, then it wasn't a brown problem, then the funding was cut for us (Int.015, Lines 292-301).

Funding not meeting the needs of Aboriginal peoples was also supported by several documents reviewed. One document described findings from consultation sessions on women's health issues where participants:

> …expressed frustration that policy makers do not sufficiently understand First Nations, Inuit, and Métis issues and needs. As a result, they confront a range of barriers in applying for funding while also feeling forced into deficit models to access financial support. One participant remarked that Aboriginal programs have to "fit" and "adapt" to mainstream programs while communities tend to lose sight of their needs (Document ND001, Lines 377-382).

In summary, funding criteria were determined by funding agencies (e.g., governments, health authorities, other private funding agencies) to guide and ultimately control where and how funding was spent. Predetermined criteria lacked the flexibility needed to address the complex issues of Aboriginal peoples and to facilitate Aboriginal specific approaches. Short-term, project-based funding did not support coordinated planning and a systems approach required to address the healthcare needs of Aboriginal people, instead disparities continued to be perpetuated.

Capped Government Funding

In recent years, government funding had been limited and in some cases capped due to burgeoning healthcare spending and the economic recession. Although limiting government funding made fiscal sense, it was not always the best approach. For those populations negatively impacted by numerous social determinants of health and well-being, such as the urban Aboriginal population, capped funding contributed to increased inequities. As discussed earlier, limiting funding also significantly controlled people and the services they received.

Competition in Funding Between Aboriginal Organizations

Competition between organizations for funding was noted as an issue by participants, both members of the urban Aboriginal population and other stakeholders (e.g., managers, providers, policy-makers). “They compete against each other. That’s why, because of funding,” (GI001, Lines 968-972). Similar information was also found in the document review where “The competitive nature of funding applications was also at issue because it creates mistrust and infighting” (Document CL054, Lines 1306-1307).

As noted in Chapter Five, most Aboriginal service agencies were non-government agencies further impacting competitiveness as they all vied for the same funding. Several participants suggested this competitiveness was not culturally-based, but seemed to be the only way forward for Aboriginal service organizations.

> But at one time it wasn’t like that. There was collaboration and we worked together, but I think that again that’s a systemic barrier. We’re all fighting for the same pot of money (Int.025, Lines 496-498).

Other participants were concerned about the current economic environment and its impact on Aboriginal organizations. They predicted some of the organizations could be forced to dissolve due to lack of funds.

This competitive funding environment caused rivalry between organizations, particularly Aboriginal organizations, creating an environment of antagonism not natural for Aboriginal peoples. Funding competitions were a social structure that had existed for years in our healthcare system, one which fueled rivalry and often discouraged collaboration. The ultimate losers in this case were Aboriginal peoples themselves.

In summary, competition in funding was evident in the case, contributing to the complexity of the environment in which the primary healthcare system for the Calgary Aboriginal population was situated. The institutional categorization (Wilson & Pence, 2006) of Aboriginal peoples (e.g., status, non-status, Métis) based on the Indian Act determined coverage for health services as well as determining what services were accessed dependent on affordability. Determining coverage was extremely difficult for providers and Aboriginal individuals themselves. Inadequate government funding and recently restricted funding were issues for the effective delivery of primary healthcare services for urban Aboriginal peoples. Project-based funding was common for initiatives and created an environment of competition between organizations. Short-term, specific projects also contributed to a non-systems approach, causing disorganization, turnover, and frustration for staff and members of the Aboriginal population at large in Calgary (Tait, 2008).

Increased Urbanization of Aboriginal Peoples

Trends in urbanization of Aboriginal peoples were well known. “There is some transition to and from the home communities. But they’re largely moving into urban centres,” (Int.037, 131-133). Many reasons for moving to urban centres such as employment, education, and healthcare services were described. The circumstances on First Nations’ reserves (e.g., housing, lack of clean water, violence, lack of employment) for some were reasons they left their communities. This was related to the lack of funding for infrastructure by the Federal Government. One might question if this was an intentional relinquishing of responsibility by the Federal Government or not.

Whatever the reasons for urbanization over the last 50 or more years, the issues facing urban the Aboriginal population were different than those faced by other Aboriginal peoples in Canada. These added to the complexity of the environment in which primary healthcare services were delivered to this population.

Diversity of the Urban Aboriginal Population

Diversity within the Aboriginal population in Calgary was already discussed in the access of primary healthcare services and differing beliefs (See Chapter Five). In this section, I will discuss how diversity contributed to the complexity of the environment in which primary healthcare services were delivered for this urban Aboriginal population.

Many participants spoke of the diversity of Aboriginal peoples in Calgary.

> …certainly our population in the city, within Calgary is one of the most diverse Aboriginal populations in all of Canada, as far as the different types of Aboriginal people in our community. There's a huge diversity, compared to say a population in Saskatoon or Regina. You know even Edmonton has a larger percentage of Cree speaking people than say, for instance, in Calgary. We don't have such a huge concentration of Blackfoot people that would be comparable. Even though this is Treaty 7 area (Int.002, Lines 221-230)

An Aboriginal individual stated, "You've got to consider too, other Aboriginal people. We're not all the same," (GI002, Lines 882-883). Diversity within Calgary's Aboriginal population was also reported by documents reviewed, for instance, where the "heterogeneity [of the population] had a direct impact on service design and delivery," (Document CL046, Lines 496-497).

Métis' individuals were a significant group in Calgary's Aboriginal population, although they often felt excluded. "…the general population sometimes, they assume Aboriginal means First Nations and not enough focus have been placed on the Métis population," (Int.033, Lines 28-30). Métis peoples represented a large proportion of Calgary's Aboriginal population; 14,770 self-identified as Métis (Gionet, 2009b). Métis individuals and communities sat outside of the Federal Government's responsibility and funding commitments to Aboriginal peoples, where First Nations' peoples received non-insured health benefits and most special project funding targeted First Nations' groups. Métis peoples felt First Nations' peoples had been the centre of attention, although not necessarily purposeful, in the planning and delivery of healthcare services in Calgary. First Nations' populations were more organized whilst Métis' peoples existed all over the province and were limited in their collective voice, despite being granted official Aboriginal status in the early 1980s and the formation of Métis Nation national and provincial organizations across Canada. Historical relationships between First Nations' and Métis' peoples were often difficult, where Métis' peoples were looked down upon by First Nations' peoples. In this case, the Indian Act text through status and non-status definitions created power over the Métis' peoples.

Participants suggested the diversity in the Aboriginal population in Calgary was a strength but also presented challenges. The needs of the urban Aboriginal population varied; one could not assume the needs were the same for all individuals even if they came from the same or similar community. The diversity of the urban Aboriginal population in Calgary was not well understood, but clearly diversity needed to be respected. "That we're not just sort of taking a generic Aboriginal approach in how we deliver programs," (Int.037, Lines 340-342).

At the individual level, some of the participants discussed the political nature of identity. Some Aboriginal staff were accepted more readily than others dependent on their status and where they were from. Those Aboriginal individuals that received status through Bill C31 were often looked down upon by Aboriginal peoples. Individuals were concerned about organizations saying they provided services to all Aboriginal peoples, but in actuality only served certain groups. Others were concerned when a specific organization (e.g., Métis) provided services to all Aboriginal peoples preventing the Métis peoples from accessing the services when they were filled to capacity. Events occurring hundreds of years ago prevented some individuals and organizations from being able to work together.

At the organizational level, many participants, including members of the urban Aboriginal population, described the difficulty Aboriginal organizations had in working together. They spoke of the lack of oneness among Aboriginal peoples in Calgary.

> P2: Why do they work together so good and Native people just can't do that, you know? P1: They can do it. P: They can, but it's almost like… P1: They have barriers. P: I feel like it's always a money issue (GI001 Lines 481-491).

Other participants suggested competiveness amongst Aboriginal peoples was not in alignment with traditional thinking. There was no doubt that individual and organizational identity impacted collaborative processes within the urban Aboriginal population in Calgary as summarized in the following quote:

> And I think that's where things break down and that's where the gaps emerge. Is with the competitiveness and we're just going to do our thing and you do your thing. I've been in meetings like that. I've been in meetings where all of a sudden, one Aboriginal authority, they wanted things done a certain way and another Aboriginal authority, they wanted things done a certain way. And then the urban Aboriginal community in the middle that is very diverse, it's not represented by either Aboriginal authority, wanted things done a certain way. And they all walked away from the table and nothing was done. And they just, well, we're going to go on our own because we have, I guess they had a vested interest they had to protect. Besides Native affairs. But I think that's the future. I don't know what it's going to take for the Aboriginal community to get back to [a] more traditional way, more cultural way of doing things. What I always say is the white man has taught us well (Int.022, Lines 264-279).

The potential for lateral violence was discussed at the Advisory Committee level where participants wondered if the competitive environment described above was in some way indicative of the oppressive environment in which they existed. Lateral violence was described as internal violence or racism (e.g., gossip, verbal abuse, physical violence, sexual abuse) directed toward one's own people (e.g., other members of the urban Aboriginal population) by those who were oppressed by the dominant group or society (Goodleaf & Gabriel, 2009; Mussell, Cardiff, & White, 2004; Victor, 2004). Given the continued oppression experienced by Aboriginal peoples and the statements by participants that competitiveness amongst themselves was not in alignment with traditional cultural values, lateral violence was certainly a possibility.

In summary, there was no doubt that Calgary's urban Aboriginal population represented a diverse group of individuals from all over Canada and beyond. Diversity needed to be respected in the delivery of healthcare services, with particular attention to less obvious groups of Aboriginal peoples (e.g., Métis). The diversity of the population also contributed to competition amongst individuals and organizations.

Gender

Gender issues would add complexity to any environment. Interestingly, gender issues were not discussed by participants interviewed, even though the majority of participants interviewed were women; 25 women participated in individual interviews, while 13 men were involved in interviews. Group interviews with Aboriginal individuals included only two men. The higher number of women in individual interviews mirrored the high number of women working in primary healthcare services delivery. Higher numbers of women in group interviews was reflective of the role women play in health and well-being for their families. Gaps in women's health did not rise to the top as a theme during analysis. In fact, only four participants discussed women's health in terms of domestic violence, maternity care, and overall women's wellness despite the significance of these issues in the urban Aboriginal population. One could suggest being Aboriginal took precedence over gender when discussing vulnerability in primary healthcare for the urban Aboriginal population. Nevertheless, gender was an important component of vulnerability, along with a myriad of other factors (e.g., being homeless, those living in poverty).

Globalization

The globalization of our environment cannot be denied. Several participants interviewed as well as several documents discussed briefly the experiences of indigenous people in other countries (e.g., United States, New Zealand), particularly in relation to cultural safety, traditional knowledge, and healers. International organizations such as the World Health Organization had published position papers on Aboriginal health and well-being, particularly on historical traditional knowledge and practices. The recent economic downturn reiterated the global impacts of financial institutions and policies in countries beyond Canada. Our economy was no longer a local or even national economy but a global economy. Decisions regarding funding and policy for Aboriginal peoples' health were not controlled locally, provincially, or nationally but impacted by global decisions, events, and policy.

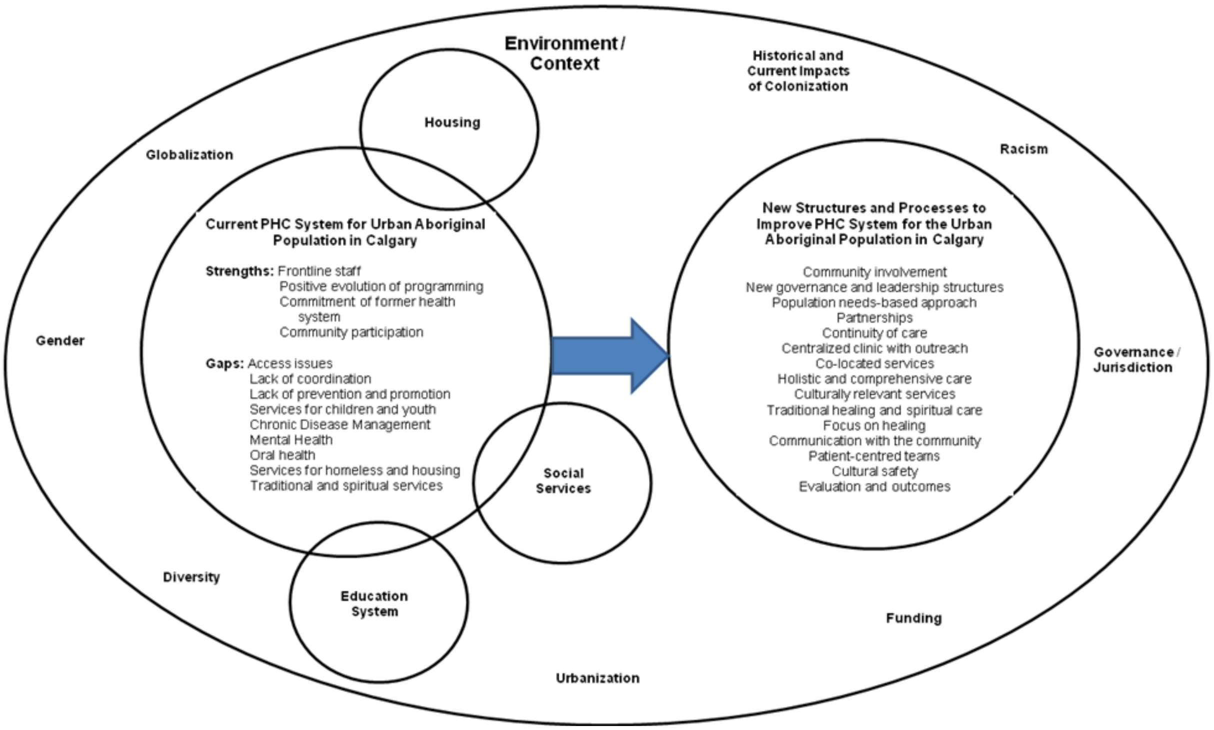
Summary of the Complex Environment

Seven key areas of the complex environment (See Figure 4) in which the primary healthcare system for urban Aboriginal peoples in Calgary was situated have been discussed in the first half of this chapter. These included historical and current impacts of colonization, governance and jurisdictional issues, competitive funding environments, increased urbanization of the Aboriginal population; the diversity of the population, gender, and globalization. An eighth area, racism, included in the figure will be discussed in Chapter Seven. Additional complexity was added as the primary healthcare system overlapped with other systems given the impact of the social determinants of health and well-being (e.g., education system, social services). The primary healthcare system was also situated within the larger healthcare system with linkages between adding to its complexity.

The result was a *mishmash* of information that was difficult to make sense of. This complex environment and hence the system was significantly influenced by the structures and processes of social institutions (e.g., governments, healthcare authorities, and other organizations), and organizational texts with the intention of controlling people causing oppression, disempowerment, and discrimination. They have contributed to furthering the disparities in the health status of Aboriginal peoples, particularly those in urban settings. The institutional landscape for Aboriginal peoples was totally different than other groups such as immigrants (Browne & Varcoe, 2006; Harding, 1995; Reimer Kirkham et al., 2002). Aboriginal peoples were indigenous to Canada; they were the caretakers of this land. Colonization policies and practices were directed towards Aboriginal peoples with the intent of assimilation and elimination contributing to vastly different circumstances than for immigrants coming to Canada. Given this complex, evolving environment, the feasibility of a primary healthcare system for Calgary's urban Aboriginal population was in question. The continued lack of collaboration perpetuated structures and processes that blocked the development of a primary healthcare system for this population.

Figure 4

Complex Environment and the Primary Healthcare System



Despite the complexity and barriers, there was a call to action by participants and within documents for change in the primary healthcare system for the Calgary urban Aboriginal population.

> There is growing acknowledgement that health systems and governments (i.e., provincial, federal, and territorial as well as Aboriginal – i.e. First Nations, Métis, and Inuit – governance structures) must work together in new ways to address persistent health disparities that exist within Aboriginal populations in Canada (Document PR014, page II).

Participants interviewed strongly recommended solutions be found to address primary healthcare service delivery for Aboriginal peoples in Calgary. Collaboration of all stakeholders for resolution will be required. “The success of instituting collaborative relationships will depend on the attitudes and open-mindedness of all parties who have put aside jurisdictional differences to work on common solutions to health issues,” (Document

N007, Lines 199-201). A spirit of trust between stakeholders will facilitate addressing the health and well-being of Aboriginal people in urban centres. Given the complex environment discussed in the preceding sections of this chapter, new and/or enhanced structures and processes will be required to improve the primary healthcare system for the urban Aboriginal population in Calgary. The following sections of this chapter will focus on those structures and processes.

Structures and Processes to Improve the Primary Healthcare System for the Calgary Urban Aboriginal Population

Involvement of Stakeholders in Designing a Primary Healthcare System for Calgary's Urban Aboriginal Population

Participants were asked about who should be involved in the planning and implementation of a primary healthcare system for the urban Aboriginal population in Calgary. They discussed the involvement of community leaders and members, Elders, current providers and other potential providers representing a broad range of services (e.g., across sectors), decision-makers, and policy-makers from all three levels of government. Documents provided several examples of the inclusion of Elders (e.g., Elder Advisory Committee, Wisdom Committee) in the development of fundamental frameworks for healthcare delivery for Aboriginal populations in Calgary and Alberta. Elders though should be included in all components of primary healthcare planning and delivery. There was strong support for such Elder involvement in the literature (Aboriginal Cancer Care Unit, 2008; Anishnawbee Health Toronto, n.d.c; Aboriginal Cancer Care Unit, 2008; Eby, 2007; Fraser Health, 2010; Jarvis-Selinger et al., 2008; Joint Management Committee, 2009).

Community participation was discussed in more detail by participants and also was a key component of many documents reviewed. Interview participants suggested primary healthcare services be developed in partnership with Aboriginal peoples.

> We've got to get out there; we've got to consult with the community. Not just the council, not just the leadership, but the broader community and identify our target

> issues. Go out there and work with them to develop strategies that they can have ownership and participation (Int.013, Lines 460-465).

Participants stressed the importance of engaging and Aboriginal peoples about their needs, and what type of primary healthcare services they required to address those needs. Unfortunately, administration and leadership both in and outside of the Aboriginal population were not necessarily well connected to the needs of Aboriginal peoples. "…organizations that host programs [do] not completely understand the issues and challenges; overall policies and procedures [are] not aligned with Aboriginal need," (Int.026, Lines 37-39). Two issues were evident: leaders were sometimes too far removed from practice and therefore not aware of needs in the community and institutional policies likely did not allow them to address the real needs of Aboriginal peoples. In addition, services did not always address the differential needs apparent in the diversity of the population. All of these issues could be mitigated with improved engagement of Aboriginal peoples.

> But at the same time, [they] have their own diverse beliefs and I think that if we connect with the community and engage with them in a meaningful way and ask them how best to work with them and serve their needs, then I don't think we'll have the problems we're facing today (Int.003, Lines 236-241)

Partnership with Aboriginal peoples was essential to address issues described earlier but did partnership equate to community ownership? The quote above also uses the term *we*. The question needs to be asked who was *we* or was this referring to the proverbial *we* discussed earlier in this chapter? Terminology and potential underlying meaning led me to think this was still about control rather than relinquishing full control and ownership to the urban Aboriginal population.

The importance of Aboriginal peoples' involvement was highlighted over and over again in local documents reviewed. Many documents described the results of community consultations and focus groups reaching the same general conclusions. They reported repeatedly on the needs, gaps, and problems in Aboriginal peoples' health in Calgary reinforcing what often happened; too much consultation and no action. On the surface, many opportunities for Calgary Aboriginal peoples' involvement appeared to be evident, but data did not specify who participated or how they were recruited.

Themes in documents focused on community consultation, community control of healthcare planning and implementation, and empowerment of individuals and communities in addressing their healthcare issues. Empowerment can be interpreted in many different ways dependent on the individual, group, or context. I would suggest it was considered a *buzz word* in healthcare circles and was largely perceived as being positive, but due to ambiguity did not often translate into action. Another question to be asked, was how does one actually empower an individual or community when their circumstances (e.g., education, poverty) were such that empowerment would not change anything unless their circumstances changed? Other discourses also mention empowerment as a way of off-loading, making individuals or communities responsible for their own healthcare when they were in no position to accomplish this.

> "Individuals thrive when they feel that they have some control over their own health and are consulted in the development and delivery of health services…Aboriginal communities must continue to be consulted and involved in the development and delivery of health services," (Document CL040, Lines 587-588; 788-789).

Although I agreed with the above quote in principle, I was not sure that individuals *thrive* simply through consultation with the potential for *some* measure of control over their own health. This was a pretty optimistic point of view.

The need for advocacy for voices to be heard of groups that were marginalized was critical for community engagement. "Strengthening community voice in providing Aboriginal people with the space to be heard are essential activities promoting community engagement and inclusive practices," (Document CL052, Lines 129-131). One participant pointed out, given the consistent undervaluing of Aboriginal peoples' needs, facilitation of their voices was essential.

In summary, interview participants suggested community participation had increased over the last few years, but there was room for continued improvement in engaging Aboriginal leaders as well as Aboriginal peoples themselves. Community engagement and participation were key components of primary healthcare (Health Council of Canada, 2005a; Romanow, 2002; World Health Organization, 2008). Community involvement was essential (Anishnawbee Health Toronto, n.d.c; Aboriginal Cancer Care Unit, 2008; Klinck et al., 2005; Vancouver Coastal Health, 2009) in the planning and delivery of primary healthcare services for the urban Aboriginal population but was often lacking (Benoit et al., 2003; Benoit et al., 2001; Aboriginal Cancer Care Unit, 2002; Niccols et al., 2010). Community consultation was somewhat of a catchall phrase and activity in primary healthcare service delivery. One wonders if it was about being politically correct or whether healthcare decision-makers truly wanted to hear from the community and whether their input could actually be incorporated into service planning. Many consultations in the form of focus groups were completed making further community participation (consultation) of this type redundant. Now was the time for action integrating the goals of genuine Aboriginal partnership and ownership in primary healthcare service planning and delivery. Effective engagement of both leaders and Aboriginal peoples will lead to a more trusting environment, as well as a change in practices to address the needs of the urban Aboriginal population in Calgary.

Primary Healthcare Models and Model Components Recommended by Participants

"There is no real simple solution," (Int.029, Field Notes, Line 72) to designing a primary healthcare system for the urban Aboriginal population in Calgary. Even so, participants made a number of key recommendations for primary healthcare models to serve this Aboriginal population in Calgary.

Governance and Leadership

Participants discussed the need for community ownership and the healthcare system relinquishing control of Aboriginal health services. Aboriginal peoples themselves needed to lead change in primary healthcare service delivery. One of the documents stated, "Health care service delivery should be inherently tied to First Nations governance," (Document CL040, Line 792). There was a desire by those members of Calgary's Aboriginal population interviewed to explore opportunities to develop a group or governance system to represent urban Aboriginal peoples in Calgary. Although Aboriginal owned and operated would not necessarily be the best option, self-governance within the current health system was desired (See earlier discussion in Chapter Six on governance, jurisdictional issues, and self-governance). An Aboriginal Health Board in Alberta Health Services at the provincial level, along with a local Aboriginal Advisory Committee for primary healthcare services to work in the Calgary Zone was suggested. A distinct entity within the health system was desired rather than being a component of a larger portfolio. The proposed Health Board would ideally be governed by provincial legislation on Aboriginal peoples' health in Alberta.

> And this board or it would be a sub-board to the current board and would have their credibility and their responsibilities and their resources and their jurisdiction defined by legislation. So there would be legislation inherent within the provincial level that integrates the disparities and the jurisdictional barrier that First Nations' people have and that Métis people and non-status people have as well, because they don't get those resources from the Federal Government. So there would be a provincial legislation regarding Aboriginal people that outlines the nature of resources and programming. That they would be a board within Alberta Health Services that is responsible for ensuring that the government is living up to this legislation and that Alberta Health Services as a programmer and decision-maker is doing those things (Int.036, Lines 473-489).

Such a health board provincially and locally was essential considering the earlier disbandment of the Aboriginal Community Health Council in Calgary in 2008 with reorganization of health services in Alberta.

Accountability was referred to at various levels: Aboriginal leadership; federal and provincial governments; and health authorities. Creating a mandate for collaboration through the institutional text of legislation was seen to be one of the only ways to be successful to ensure all parties worked together to address Aboriginal peoples' health. Ironically, legislation reinforced institutional interference hampering Aboriginal peoples for so long. But it appeared action would require a mandated decree for collaboration in this very messy, contemporary context. Legislation and tri-lateral agreements were definitely the way other provinces in Canada were addressing this issue. It was also interesting that provincial leadership in legislation or tri-lateral agreements was desired and enacted in other provinces as opposed to the historical federal government leadership to manage Aboriginal services.

Leadership of the proposed Board should reflect the diversity of the Aboriginal population residing in Alberta and local committees and local management of Aboriginal programs should reflect Calgary's Aboriginal population. Strong leadership was seen to be important along with a shared vision and mandate, and the development of administrative principles, goals and objectives.

Population Needs-based Focus

The importance of a population needs-based focus was emphasized by many of the participants. Four key themes of a needs-based approach were outlined and will be discussed in the following paragraphs. They included: a holistic approach to individual and community assessment; awareness of the needs of sub-groups; understanding intergenerational trauma to understand needs; and moving from treatment to prevention and promotion.

First, participants discussed the value of a holistic approach in assessment of individuals and the population. Overall, little was known about the demographics of the urban Aboriginal population. A comprehensive community assessment was recommended. Attention to the social determinants of health and well-being (e.g., education, income security, food security, social isolation) was required both in assessment and in the development of solutions. "…including the determinants of health was critical especially when discussing a primary healthcare system for Aboriginal populations," (Int.005, Field Notes, Lines 8-9). Not unexpectedly, some participants stated there was a continued lack of understanding of the determinants of health and well-being. Documents also supported focusing on the social determinants of health and well-being in healthcare for Aboriginal populations. Utilizing a determinants of health and well-being approach for Aboriginal primary healthcare changed the focus from a deficit approach to a more strength-based one. Few references on the strengths of Aboriginal populations as a means of addressing health needs were found in documents reviewed. Strength-based approaches tended to be mentioned more in passing rather than as a substantive point. Most of the documents appeared to be written to obtain funding for various projects or initiatives so emphasized deficits to provide rationale for action.

Deficit approaches (Arnold & Bruce, 2005; Van Uchelen et al., 1997) had long been used by governments and other institutions in describing the health status of Aboriginal peoples as well as informing and administering healthcare services for this population. Deficit approaches were rooted in racism and oppression perpetuating power over the target population (Menchaca, 1997). The text of the social determinants of health and well-being framework moved people away from the biomedical model to one more encompassing of all components of health (Raphael, 2004a). On the downside, it allowed the health system to abandon those components of social determinants (e.g., education, employment, income security) over which they claimed to have no control. Hence they continued to focus as usual on the biomedical components of health creating a vicious circle with little or no change in outcomes.

Secondly, closely related to community assessment, was awareness of the different needs of various sub-groups. Needs and strategies for the homeless, those experiencing domestic violence, youth and teen girls, could all be quite different. These sub-populations were particularly marginalized within the already vulnerable larger Aboriginal population.

Third, an understanding of historical and current issues causing intergenerational trauma due to colonization, racism, residential schools, and child welfare was required to be able to comprehend the needs and issues facing Aboriginal people. Without this type of understanding, it was highly likely that discrimination and domination would be maintained through the delivery of primary healthcare services.

Fourth, many participants recommended a move from treatment to the prevention of illness and injury and the promotion of health and well-being to better address the needs of urban Aboriginal peoples. Such an upstream approach appeared to be better aligned with Aboriginal philosophy on well-being but would require a paradigm shift from the biomedical model of treatment to prevention and promotion (Van Uchelen et al., 1997;

Waldram et al., 2006). The biomedical paradigm was not easily dismantled due to institutional policies, educational focus for healthcare providers and public expectations around treatment and cure.

Partnerships

The importance of partnership in a primary healthcare system for Aboriginal populations was discussed by interview participants and supported by several documents. "Respectful, equitable, and operational partnerships are required to address Aboriginal Albertans' health in an effective manner," (Document PR013, Lines 332-333).

Partnership at three levels was discussed by interview participants: between Aboriginal organizations; linkages within the healthcare system; and partnership across sectors. As discussed earlier in this chapter, participants described the lack of collaboration between Aboriginal organizations. Participants felt a new primary healthcare system should have Aboriginal organizations working together and sharing resources to deliver care to Aboriginal peoples.

> We need to work together to improve the quality of life of our community and families and that should be the focus. Not perpetuating our organization; let's work together…Let's have a vision to reach our community and serve our community with all of these services that we're trying to provide separately (Int.022, Lines 283-286; 557-559).

Work with organizational staff to create capacity for collaboration and coordination of services was also recommended.

As documented in Chapter Five, coordination was a significant gap in the primary healthcare system for the urban Aboriginal population in Calgary. Improved linkages with other healthcare departments, programs and organizations and with providers in primary healthcare was highly recommended.

> …it's very much of a model that links…linking and knowing where the service provision is that will truly meet the needs of the client base. And then linking out from there. And it's going to take time to build that as well, that infrastructure. But I

> do believe it can be done quite, you know within and throughout communities (Int.020, Lines 269-275).

Connections (Wilson & Pence, 2006) and therefore connected services made sense from an Aboriginal perspective enabling more comprehensive care for patients. Better linkages between services had the potential to decrease duplication and provide better outcomes for the Aboriginal population. Participants stated it was time there was a *genuine* working together to be able to address the primary healthcare needs of urban Aboriginal peoples in Calgary.

To address the broad needs of Aboriginal peoples, formal partnerships across sectors were also necessary.

> …if we're going to look, like from a medicine wheel, mind/body/spirit perspective, population perspective or whatever we want to frame it as, you need to have representation from all sectors there. And that means the groups and the organizations, the key organizations at a systems level, so Justice, Education, Social Services, all of that at the table…but we also need the [Aboriginal] agencies and the groups and the individuals represented around that table and no one voice plays a greater role than the other (Int.020, Lines 498-506).

This was reinforced in the discussion on population needs and determinants of health and well-being, where the healthcare system in of itself could not take full responsibility for all determinants. Hence, intersectoral collaboration was absolutely necessary and corroborated by the literature (Ramsden, Osborne, Turner & White, 2006; Scott & Thurston, 1997; World Health Organization, 1986). Unfortunately, organizations were socialized in education and work settings to focus on a specific area of primary healthcare as evidenced by siloed care, territorialism, turf protection and maintaining funding security. The above quote would also suggest organizations currently may be partnering, but did not really collaborate. Partnerships may have existed in name only, but were ineffective in working together. Attention to equity was also required as vulnerable populations often have little power in partnerships with large organizations where the institutional social relations were strongly entrenched and often retained the power over smaller, more vulnerable groups.

Participants suggested partnership development was often difficult as the health system itself created barriers to advancing partnerships. Rules, regulations, and socialized practices of organizations did not facilitate partnership. Such factors as inflexible work schedules to allow participation in evening meetings hampered participation. Organizational leaders and department and program managers unwilling to relinquish control were often a significant barrier to partnership development and/or success. Such issues with partnership development were also found in the literature (Scott & Thurston, 1997). A partnership with education was strongly recommended by a number of participants to be able to work with children, parents, and families towards positive change.

Coordination and Continuity of Care

Inadequate coordination of care (as discussed in Chapter Five) highlighted the need for coordination and continuity of care in a primary healthcare system for the urban Aboriginal population in Calgary. Continuity of care should be a central component for this system, as described by many participants.

> So it’s really the linkages, and creating a place that people can go and be navigated through the system. So it’s triaging and navigating, so it’s very supportive and it doesn’t have to house everything, but it needs to understand where the supports are that truly meet the needs (Int.020, Lines 478-472).

Participants discussed the complexity of the system and the difficulty community members had in navigating the system, particularly those with chronic conditions. Due to the transiency of some Aboriginal community members (e.g., moving back and forth from reserve, homeless), continuity of care became difficult both for patients as well as providers. Much work was required of frontline providers for follow-up for all patients but particularly those who were more transient. Access and navigation of healthcare services for patients and families described the everyday work required to meet their healthcare needs or those of a family member. For most, this work was intensive and difficult requiring a significant amount of time and knowledge of the primary healthcare system to be able to access and navigate healthcare services successfully. As will be discussed later in this chapter on patient-centred teams, liaisons and/or cultural workers were recommended to assist patients and families in the navigation of the system. Some organizations outside of Calgary had introduced Aboriginal Patient Navigators to facilitate patient and family navigation of the complex healthcare system (Fraser Health, 2010; Vancouver Coastal Health, 2009b).

Participants discussed the importance of relationship between patients and providers to promote continuity of care. The foundation of healthcare reform in Anchorage, Alaska's primary healthcare system was the relationship between the patient/family, and providers (Eby, 2007). Relationship was especially important considering the lack of trust Aboriginal community members had for the healthcare system and its providers. Communication between organizations and providers and a single health record were emphasized to ensure patients were not having to tell their story over and over again. Single health records and sharing of information raised potential issues of confidentiality and privacy. Aboriginal people worried about these issues given their historical experiences with inappropriate data collection and use by institutions to maintain power over Aboriginal peoples. Assurance of the privacy of patient data was required to facilitate Aboriginal peoples' trust and to ensure continuity of care for patients.

Centralized Clinic with Outreach Services

Interestingly, participants often conflated a clinic or health centre with a primary healthcare system. Participants recommended a centralized clinic, likely best located downtown. Some suggested the Elbow River Healing Lodge could be the foundation for such a clinic. The clinic would act as a central hub with a strong outreach system to other areas of the city. Outreach could be in the form of a mobile unit and/or satellite clinics. "What we have noticed is you bring the services where the clients are if you want to be effective in your service delivery," (Int.024, Lines 67-69). The importance of outreach and community-based services was emphasized to make services more accessible for the urban Aboriginal population. An important question to ask was how many services could realistically be provided through outreach, given barriers of space, availability of providers, and financial resources? A balance of centrally located and community-based services will be required to meet community needs.

Co-location of Services

Participants, both members of Calgary's Aboriginal population and providers, desired *one-stop shopping*, where cross-sectoral services were located in one central location for easy access. Co-location would facilitate coordination of care, collaboration, and team-based care (Suter et al., 2007) given organizations and providers would be working in the same location and passing one another in the hallway.

> They talked about multi-service windows and I think Winnipeg was a good example of that. Where they provided all the services at one location, whether it's health, education, employment, housing. All of those services, all of those issues that are affecting Aboriginal people there was one place they could go. Instead of going to one organization or picking up the telephone and going there and saying sorry, we can't help you and sending them across town. And then they go across town and sorry, we don't really help people in that area. And they send them somewhere else and it's just a vicious cycle and they get frustrated and they give up and say we're not getting help. They get discouraged (Int.022, Lines 536-547).

Furthermore, the "need for *one-stop shopping* for services" (Document CL054, Line 268) was identified in consultations with Aboriginal peoples in Calgary in 2001. Currently, in Calgary, Aboriginal organizations were located throughout the city each offering bits and pieces of services often targeting specific groups. One participant also suggested co-located Aboriginal services should be located close to mainstream services to facilitate easy access if required.

Co-location of services will be trumped by such factors as organizational policy, funding, and space availability. In a large healthcare organization, although services may wish to be co-located and co-location would made sense, but it simply would not be possible due to decisions made at higher levels. Even with smaller organizations, they may wish to be located with or near another organization they collaborated with or where the same patients were using the same services but this was not necessarily realistic or feasible given the factors mentioned above.

While many participants recommended the co-location of services, others suggested services be connected through strong linkages. Co-location was not as critical as connection and not necessarily feasible. A virtual primary healthcare system was recommended by these participants.

Holistic and Comprehensive Services

In line with Aboriginal philosophies, services should be holistic, attending to the whole person in assessment and treatment, focusing on all four areas of health and well-being (physical, mental, emotional, and spiritual) (Bartlett, 2005; Hunter et al., 2006; Long & Fox, 1996; Peters & Demarais, 1997; Royal Commission on Aboriginal Peoples, 1996; Smye & Mussel, 2001). Service delivery should also be comprehensive addressing all needs of individuals and the community. One participant aptly described such a primary healthcare service for Aboriginal peoples.

> It would be open access, same day appointment, accommodate walk-ins all the time. It would have resources on hand that are Aboriginal specific for teaching. We would have a complete case management team in place that deals with their medical, social, emotional needs, as well as their cultural needs. Which would mean we would have physicians available, someone there to do their social work that needs to get done. Of course, their mental and emotional well-being, so you‘d need to have a team for that. You’d need to have a community wellness team, someone who can do all their community resource and liaison work available. You need to have an Elder on hand too for them, and you’d need to have a number of different Elders…Teacher, community and cultural in order to fully have that full spectrum of services. Then you could have the doctors just dealing with their biomedical instead of acting like their social worker at the same time, right? And so, that would be the key thing. I would see an open ceremony room for the public being used…I see this place as a place where we’re not just medical, but we’re providing food and socks even, and you know basic, every day needs that the person getting off the bus from the reserve or another province needs. That we’d have all the resources in place to set them up. Because most of the time what we’re dealing with in this clinic

> is not medical needs. We're dealing with social needs…And able to heal them culturally, because they are so acculturated or assimilated to the point that their soul is hurting. And a lot of times that's what they need fixed. Biomedical is easy. That's the real easy part. It's these other parts that we need (Int.015, Lines 476-509).

The term holistic was often used by participants and in documents to describe the approach recommended for Aboriginal healthcare services. The difficulty was the terminology meant different things to different people. Overall it was used fairly loosely to mean care beyond the physical. Holistic care in this case would not necessarily be aligned completely with Aboriginal worldviews. Most participants spoke about primary healthcare from an individual perspective as opposed to the system. They talked about being holistic, but their approach was from an individual therapy perspective.

Other participants described a very different model for a primary healthcare clinic; one of a gathering place.

> …a place where people could just gather…For me that would be ideal, because I would go there to socialize. I would go there to read, go there to meet people and I would go there for healthcare (Int.016, Lines 484-485; 533-535).

A gathering place certainly fit well with Aboriginal worldviews on connection (Wilson & Pence, 2006) but current healthcare systems could have difficulty implementing such a clinic. This vision conflicted with professional ethics such as privacy, confidentiality, and anonymity. Balance between connectedness and privacy will need to be addressed to ensure the needs of all Aboriginal peoples would be met.

Culturally Relevant

Primary healthcare services should be culturally relevant to the diverse population being served. Most participants described culturally relevant as the inclusion of historical traditional practices such as ceremony, as well as the décor reflecting Aboriginal culture (e.g., Aboriginal art, artefacts). "…we try to do all this programming with traditional Aboriginal values. So there's a strong cultural component," (Int.031, Lines 64-66). The integration of historical, traditional practices was described in the literature as being fundamental to the health and well-being of Aboriginal individuals and their communities

(Canadian UNICEF Committee, 2009; Joint Management Committee, 2009; Lavallee, 2007).

Several participants also discussed the importance of Aboriginal focused strategies in healthcare (e.g., the importance of aligning with Aboriginal worldviews versus the western biomedical model) to ensure care approaches were applicable for the population. "So I think if the new and the old could just meet together and incorporate them, I think it would be very beneficial. Along with the spiritual, the cultural," (Int.017, Lines 565-567). Culturally relevant was also closely associated with loss of culture and identity. Alignment of primary healthcare services with Aboriginal worldviews integrating Aboriginal and western medicine was also considered to be an important component of primary healthcare services (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2003; Salmon, 2007; Smith & Davies, 2006; Van Uchelen et al., 1997).

Overall, there was divergence in the discussion of culturally relevant care. Culturally relevant was defined differently by individuals. Consideration must be given to the meaning of the term and to who determined cultural relevance. The push-pull of traditional and contemporary practices will also need to be explored. These would be important components for decision-makers and providers to ensure the cultural relevance of the primary healthcare system for this urban Aboriginal population.

Traditional Healing and Spiritual Care

Traditional healing (e.g., herbs, other healing practices) and spiritual care overlapped with cultural relevance discussed in the previous section, but the concepts were different. Culturally relevant should refer to how care was delivered (although many participants simply describe the inclusion of historical traditional practices) while traditional healing and spiritual care were types of care. Traditional healing and spiritual care were seen as essential components of well-being for the Aboriginal population and part of the holistic approach often discussed. The importance of including traditional and spiritual services was well documented (Anishnawbee Health Toronto, n.d.c; Benoit et al., 2001; Aboriginal Cancer Care Unit, 2008; Joint Management Committee, 2009; Lavallee, 2007; Mignone et al., 2003; Niccols et al., 2010; Sinclair et al., 2006; Skye, 2006;

Vancouver/Richmond Health Board, 1999; Waldram et al., 2006) given their impact on health and well-being. These types of services should be easily accessible to community members within the primary healthcare system, and address the multiple, diverse needs of the urban population. The importance of traditional care was also supported by team members recommended for a primary healthcare system; the inclusion of Elders and traditional healers was important. Whether they should be staff or act as advisory consultants was open to debate (See page 210 for further discussion).

Focus on Healing

The foundation of the primary healthcare system and/or clinic for the Calgary Aboriginal population should be healing; an environment of nurturing and caring for the Aboriginal population. Focusing on the strengths of the Aboriginal population (e.g., resilience and connection), while addressing the intergenerational trauma impacting their lives was recommended. The terms nurturing and caring existed in juxtaposition to the institutional rulings (e.g., domination, oppression, racism) that occurred against Aboriginal peoples over the last several hundred years. Changes to the primary healthcare system to incorporate nurturing and caring, challenging the institutional domination, will need to be investigated. Cultural safety was closely linked to nurturing and caring and will be further discussed in Chapter Seven.

Communication with the Community

The importance of communication to members of the Aboriginal population in Calgary was emphasized by many participants. Related to community engagement, keeping community members in the loop on services delivery and health issues was seen to be critical in a primary healthcare system for this urban Aboriginal population. As noted by one participant, reporting back to the Aboriginal population occurred infrequently.

> …not back to the community at all. There's rarely community conferences, health forums for First Nations, like for the community to attend. It's always for professionals or people working in that and that's okay for information sharing on some level. But if it doesn't get to the community, it really doesn't matter (Int.015, Lines 188-193).

In communicating with members of the Aboriginal population in Calgary, the primary healthcare system should consider different target audiences and varying modes of communication.

Some participants wondered if lack of communication was purposeful in keeping Aboriginal peoples in the dark. Lack of communication with the community, whether real or perceived, was an issue which aided in the maintenance of institutional control over the urban Aboriginal population.

Role of Patient-Centred Teams

Care of health services delivered by patient-centred teams was promoted in mainstream healthcare (Bohmer & Edmonson, 2001; Health Council of Canada, 2005b; Schmitt, 2001), particularly in primary healthcare (Barrett et al., 2007; Health Council of Canada, 2009). Consideration ought to be given to whether this was an appropriate approach and how best could teams be incorporated into Aboriginal primary healthcare service delivery. All participants agreed that a patient-centred team approach was most appropriate to address the multiple issues of Aboriginal peoples in Calgary. Few documents discussed patient-centred teams in Aboriginal primary healthcare service delivery. One document, suggested primary healthcare reform supported the formation of teams to address the needs of Canadians overall. Aboriginal Health Centres were well aligned with this recommendation as they utilized a holistic team approach to address the needs of their populations (Anishnawbee Health Toronto, n.d.b; Intergovernmental Committee on First Nation Health, 2005; National Aboriginal Health Organization, 2002). Although teams were highly recommended by participants and supported by the literature, Aboriginal primary healthcare had not seen the uptake of teams or at least had not seen the focus on patient-centred team work in the literature.

A number of key competencies were recommended for team members by participants. Beyond professional content expertise, team members should have an in-depth understanding of Aboriginal worldviews, Aboriginal culture, and historical issues impacting the community.

> Individuals who are well knowledged with the cultural background, the traditional background, the socioeconomic background of First Nations' people. And those who are knowledgeable with the traditional medicines, the foods and the traditional practices of health and healing. And collaborating their knowledge and looking at what's going to be the best approach to heal a patient (Int.006, 476-482).

Many other skills and competencies were also required for effective team work beyond those mentioned by the participants, for instance, knowledge and skills of how to work together and address conflict (White, 2006), as well as cultural safety which will be discussed in Chapter Seven. This narrow view of team competencies will impact the success of teamwork and the ability to create a more coordinated primary healthcare system to effectively address the needs of Aboriginal peoples.

Having Aboriginal primary healthcare providers was considered the ideal. Community members in particular discussed the importance of having Aboriginal healthcare providers on the team. "Including like having Aboriginal people in there…So they can be more aware with our needs," (GI001, Lines 991; 1076-1077). Unfortunately, there were significant shortages of Aboriginal providers making it difficult to fill all positions working with Aboriginal individuals and often impacted service delivery. There were shortages in specific areas: mental health workers and counsellors; physicians; and nurses. Although there had been several initiatives to recruit and train Aboriginal healthcare providers (e.g., Arnault-Pelletier et al., 2006; Spencer et al., 2005), few existed in Calgary. Other issues also arose in hiring Aboriginal providers for urban health services where government policies and social institutions controlled where Aboriginal people worked.

> A lot of times, the nurses for the most part, if they're coming from on-reserve, there is, well, I mean if it's a First Nation nurse coming from on-reserve to off-reserve, you've got challenges of salary, taxation issues, coming into a city where the cost of living is pretty high. So recruitment is definitely an issue when it comes to some of these positions, including physicians (Int.008, Lines 520-527).

Participants also discussed the issue of the high turnover of staff, both Aboriginal and non-Aboriginal in healthcare service delivery for Aboriginal peoples in Calgary.

Competition between organizations for staff and staff moving from one organization to another for a better job with higher pay was certainly evident. Short, project-based initiatives, as previously discussed in this chapter, also contributed to turnover. Overall, staff turnover in Aboriginal healthcare was poorly understood. Staff expectations could differ from the expectations of the program or organization or represented differently than at the time of interview. Aboriginal providers existed in a liminal state where they were trained in mainstream education and healthcare systems and then expected to be something else when they worked in their community. The potential for staff burnout was high with a lack of support for staff working with Aboriginal peoples (Coll et al., 2004; Gottlieb, 2007; Mignone et al., 2003). Whatever the issue, staff turnover was highly disruptive, causing disorganization in primary healthcare systems planning and delivery of services. No doubt it was also frustrating for community members with a lack of continuity in providers and services.

Patient as team member.

Participants discussed the importance of involving patients in their care. "Because then we're not taking away their autonomy, but rather increasing it" (Int.003, Lines 673-674). To ensure patient involvement, a supportive environment and advocacy was required. Participants also discussed family involvement. Aboriginal individuals were all connected to their families, hence including family members as part of the team was critical. The inclusion of patients and families as team members was also supported by the literature (Abreu, Zhang, Seale, Primeau, & Jones, 2002; MacDonald, Herrman, Hinds, Crowe & McDonald, 2002; Walker & Dewar, 2001).

Although it was admirable and necessary to include patients and family members as team members, the above discourse resonated with the individual focus that continued to direct the Aboriginal primary healthcare system as opposed to a systems level approach.

Ideal staff mix for patient-centred teams.

Participants were asked in interviews to describe who should be part of the patient-centred team to provide care for the urban Aboriginal population. A variety of providers were included. In analyzing the data, I looked at providers mentioned most frequently and categorized those answers by type of participant (See Table 12). More often, participants recommended more conventional healthcare providers (e.g., physicians, nurses) as opposed to non-conventional providers (e.g., traditional healers, childcare workers, liaisons), but overall a large mix of team members was recommended. Considering healthcare was steeped in the western biomedical model, it may not have occurred to participants to suggest non-conventional types of providers. There was also no discussion of the importance of utilizing a population needs-based approach (Besner et al., 2009) to determine appropriate team mix, but rather recommendations were based on personal desire and anecdotal information. This was not an uncommon practice in healthcare limiting the success of service delivery in meeting outcomes for communities (Besner et al., 2009; White et al., 2009).

Elders and physicians were recommended by participants most often. Elders were seen as a necessary part of the provider team. “Elders are huge, you know, in my life. I go to them for guidance; I go to them for spiritual healing, you know just to talk and learn from.” (Int. 034. Lines 714-716). The diversity of the population should be considered in choosing Elders as well as respecting those that desire not to have an Elder involved in their care. Both male and female Elders were needed dependent on the health issue and the person requiring care. A variety of Elders were also necessary given the numerous roles: teacher, cultural leader, or community representative. An Elders Council was believed to be critical to oversee the primary healthcare system or Centre.

Physicians were also highly recommended as being part of the primary healthcare team. Participants desired physicians with the capacity to work with Aboriginal poeples considering the demographics of the population, multi-generational trauma, and addictions. Many also recommended additional expertise in the area of addictions for physicians.

Mental health workers, social workers, and traditional healers[4] were the next most frequently recommended team members by participants. Mental health workers desired included therapists, counsellors, and psychologists. In addition, some participants felt there

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[4] Traditional healers may have been included in the category of Elders by some as some Elders were traditional healers.

Provider type desired	Type of interview participant				
	Members of the urban Aboriginal population	Healthcare providers	Managers/decision-makers	Administrative support	Total
Childcare Providers		1	1	1	3
Cultural Broker/Liaisons[5]			1	2	3
Dietitian/Nutritionist	1	2			3
Elders	2	4	5	1	12
Mental Health Workers	1	3	5	2	11
Nurses		3	2	2	7
Pharmacists		2	1	1	4
Physicians	2	5	3	2	12
Social Workers	5	2	3	1	11
Traditional Healers		5	4	2	11

Table 12

Team Members Desired by Category of Participant

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[5] Cultural broker and liaisons were defined as providers that acted as a link between individuals of different cultures. These individuals provided mediation and advocacy (Jezewski, 1990). Aboriginal hospital liaisons in Calgary ensured patients and families felt secure in the hospital setting and needs were met, particularly spiritual and cultural needs. Also provided referral, advocacy, and linkages to community services (City of Calgary, Community & Neighbourhood Services, 2009).

was a need for mental health workers trained in addictions for individuals, families, children, youth, and seniors. Mental health workers should differ in their areas of expertise (e.g., homelessness, residential school trauma, addictions) and be available to offer support groups.

Social workers were recommended by all categories of interview participants although there were some concerns expressed about this type of provider. "…in the Aboriginal community, when they hear a social worker, you know, they get really tense and you know? Because they associate it with children. And maybe a different title would be better." (GI001, Lines 1393-1396). Unfortunately, social workers were associated with negative outcomes for patients and families in Aboriginal populations. In the past they often utilized fear tactics controlling individuals they worked with as well as having significant control over Aboriginal communities in general. These ways were difficult to unlearn, both for social workers and communities and therefore perpetuated colonial domination and deficit thinking. Hence, some participants recommended a change in title to support worker.

Despite these issues, a provider such as a social worker was strongly recommended. They were often dealing with social needs in the clinic and did not have the capacity to address these issues. As one participant said, "physicians are not social workers." (Int. 035, Field Notes, Line 25). Social issues encountered were employment, food and clothing, transportation assistance, and housing. Participants desired someone who knew community resources and would make appropriate referrals to facilitate meeting Aboriginal peoples' needs. Perhaps, healthcare providers did not see social issues as health problems and therefore a social worker was recommended to address the same. This also spoke to the lack of a holistic and comprehensive approach in addressing the health needs of the urban Aboriginal population.

Traditional healers were seen as an important member of the primary healthcare team but currently were seldom included. There were a number of concerns to address when including traditional healers as team members. Issues of accreditation and liability were the main concerns as well as meeting the needs of the diverse urban population. Many people sought traditional healers back on their own reserve, necessitating travel and expenditure of personal resources.

Traditional healers were successfully incorporated into other primary healthcare systems or subsystems for Aboriginal peoples (e.g., Anishnawbee Health Toronto, South Central Foundation in Alaska). In Alaska, traditional healers worked as part of the team alongside western medical providers (Gottlieb, 2007). Traditional teaching gardens with native plants were located on site at the primary healthcare facility providing the opportunity for traditional healers to discuss different plants and their uses with Aboriginal individuals and their families seeking care. Herbs were not actually prescribed or provided, but information was offered to patients via the teaching garden. This practice assisted in addressing liability issues (Eby, 2009a).

There was a strong desire by stakeholders to include traditional healers as part of the primary healthcare system for Calgary's Aboriginal population. A couple of participants discussed upcoming decisions regarding traditional healers being internal or external to the primary healthcare team. If traditional healers were not physically part of the team, then strong linkages should be developed with local healers for Aboriginal peoples access should they choose to do so.

Nurses were also recommended as team members for the primary healthcare system for the urban Aboriginal population. Participants suggested a variety of nurses (e.g., RNs, LPNs, NPs) with a diversity of expertise.

Pharmacists were also desired as team members. The lack of pharmacists in the current system was seen as a gap. If a pharmacist could not be directly involved as a team member, strong linkages were recommended for the same.

Lastly, childcare workers, cultural brokers or liaisons and dietitians were suggested as team members by participants. Child friendly environments were desired in primary healthcare settings including childcare services as mothers were frequently unable to attend without their children. Participants also desired Aboriginal cultural brokers or liaisons. These individuals would need to be familiar with cultural and contextual issues and would be able to assist Aboriginal patients to navigate the primary healthcare system. Dietitians or nutritionists were also desired to assist in a variety of ways. These providers would be helpful in working with diabetic patients, families, and in overall health promotion initiatives.

Not surprisingly, this latter category of providers, particularly cultural brokers and liaisons, was recommended least often. These roles were often occupied by paraprofessionals, while others had a social work background. Their role was not *glamorous* and commonly undervalued in healthcare systems. They assisted patients with the everyday work of access and navigation, not the biomedical, more prestigious work. They were most often female providers and poorly paid reinforcing stereotypical thinking about these roles.

Participants were asked by the researcher about the relationships between professional providers and paraprofessionals as the literature suggested conflict between the two was common (Boone et al., 1997; Jackson et al., 1999; Minore & Boone, 2002). When asked about the same, participants stated this was not an issue for them. Perhaps conflict was less apparent as there were a limited number of these types of workers in the current system. Professionals did state they valued the contribution of all providers. Aboriginal-specific organizations did suggest that the formal healthcare system often did not recognize their assessments of Aboriginal individuals as important and therefore did not always attend to the needs of Aboriginal individuals. Could this have originated from a conflict between professionals and paraprofessionals or was racism at work, or the fact that healthcare providers generally did not trust others to do their assessments and therefore they needed to be repeated? The relationship between professionals and paraprofessionals in this primary healthcare system will require further study.

As previously shown in Table 12, data were further analyzed to determine which participants desired which types of providers. Members of the urban Aboriginal population interviewed most frequently recommended social workers be part of the team, followed by Elders, physicians, dietitians/nutritionists, and mental health workers. Interestingly, nurses and traditional healers (although traditional healers may have been included in the Elders group) were not recommended at all by members of the urban Aboriginal population.

Despite the negative associations with the social work role, members of the urban Aboriginal population still recommended this type of provider most often.

Providers suggested physicians and traditional healers most often, followed by Elders, mental health workers, and nurses. Cultural brokers/liaisons were not mentioned at all by providers, although they may have been seen as most helpful by members of the urban Aboriginal population. Managers and decision-makers suggested Elders and mental health workers most frequently, followed by traditional healers, physicians and social workers. It is clear from the data a variety of team members were seen to be important for the primary healthcare team for members of the Aboriginal population in Calgary. Elders, physicians, mental health workers, social workers, and traditional healers were most commonly suggested. Interestingly, few documents discussed patient-centred teams in Aboriginal health, nor did they provide information on team members desired and required to address the needs of the Aboriginal population on or off-reserve, in rural or urban settings.

In summary, the role of patient-centred teams was well documented in mainstream primary healthcare systems. Documentation on teams in Aboriginal primary healthcare was limited and mirrored the literature, even though the utilization of patient-centred teams represented a more holistic approach to healthcare service delivery for this population and had the ability to address the often complex needs of Aboriginal peoples. A variety of team members were recommended including the patient and family being equitable members of the team. Staff mix should be based on the needs of the population. Exploration of more non-conventional team members will be required to align with Aboriginal philosophy on health and well-being. Elders and traditional healers were recommended by all groups but institutional policies and barriers will need to be addressed to include these types of providers as part of the team. Finally, Aboriginal providers were considered to be the ideal to care for this urban population. Shortages of knowledgeable and skilled providers, turnover, and burnout will need to be addressed to ensure an effective primary healthcare system for the urban Aboriginal population in Calgary.

Evaluation and Outcomes

Few participants discussed evaluation and outcomes as a component of a primary healthcare system unless prompted to do so by the researcher but when asked agreed these were important components. Data was considered to be a huge gap in Aboriginal peoples' health by participants and in the literature (Smylie & Anderson, 2006). Little data were collected or available specific to the Aboriginal population. There were also significant difficulties in collecting healthcare data on non-status and Métis individuals representing a large proportion of the Aboriginal population in Calgary. The lack of availability of data for specific groups was supported by the literature (Smylie & Anderson, 2006; Young, 2003) although a new report on the health status of Métis' groups was recently released (Martens et al., 2010). Attention to confidentiality, privacy, and ownership was required prior to data collection and analysis due to historical misuse of data perpetuating deficit thinking, domination, and control. This was one of the key issues for data information systems and surveillance in Aboriginal populations (First Nations Centre, 2009; Schnarch, 2004; Smylie & Anderson, 2006). Despite these issues, participants did agree this information was necessary to determine the outcomes for a primary healthcare system (e.g., program outcomes, health indicators and health status of Aboriginal people) and should be included with initial development of such a system.

> …the information technical stuff needs to be in place at all times for us to be able to address and deal with our data to make change, to show that we're doing a great job, to show us where we need to change and improve. So we need to have electronic medical records and an electronic health records and we need to be linked and have the resourcing around us to be able to utilize data that we don't have access to or that we don't currently collect (Int.036, Lines 509-515).

Some participants suggested there were opportunities to work together across the province as well as nationally and with First Nations' communities to discuss, develop, and implement a surveillance system. Surveillance was seen as an important component of Aboriginal peoples' health (Anderson, Smylie, Anderson, Sinclair & Crengle, 2006; First Nations Centre, 2009; Smylie & Anderson, 2006).

A Calgary survey conducted with Aboriginal peoples described in one of the documents reviewed, asked about the potential for collection of ethnicity data to monitor specific health indicators. Results showed both support for (filling gaps in knowledge for the Aboriginal population) and against (issues of confidentiality) such information being collected. Survey participants suggested such data collection be voluntary, making it more difficult to monitor outcomes due to incomplete data. A status blind recommendation to collect ethnicity data for the Aboriginal population meant all Aboriginal groups would be included in a single category. Although status blind seemed appropriate, it defeated the purpose of recognizing the diversity of the population making it difficult to have programming targeted at specific population groups (e.g., Métis peoples).

The term evaluation itself had many negative connotations for people (e.g., negative critique, not being relevant), particularly for Aboriginal peoples. Study data supported the collection of both quantitative and qualitative data, as well as the importance of stories as these were more aligned with Aboriginal worldviews. Evaluation criteria and indicators were based on mainstream systems and not necessarily well suited to Aboriginal programming. There also was a lack of capacity within the Aboriginal community for evaluation. Lastly they were concerned about evaluation results not being used to change service delivery.

The lack of emphasis on evaluation and outcomes was not surprising as this area was often treated as an add-on in healthcare planning and delivery. Unfortunately, it emphasized the lack of a systems level approach, where primary healthcare services were based on anecdotal evidence with ineffective strategies to meet needs.

In summary, evaluation and outcomes was considered to be an important component of the primary healthcare system for Calgary's Aboriginal population even though it was initially not mentioned. The development of data systems, attention to data privacy and ownership will need to be addressed along with the development of Aboriginal specific measurement indicators and culturally relevant evaluation methods.

Chapter Summary

This complex adaptive system, the current primary healthcare system for the urban Aboriginal population in Calgary, was situated in a complex environment where adaptation was required to deliver effective services. This complex environment was affected extensively by the historical and current impacts of colonization and was burdened with a multitude of interconnected jurisdictional issues. Collaboration by the different stakeholders involved, particularly governments and Aboriginal leaders, was not an option to ensure change and support for legislation as had occurred in other provinces and was desired by some. Differential coverage for healthcare services, competitive funding, short-term funding, and global economic factors only further contributed to this complex environment. In addition, Calgary's urban Aboriginal population had increased considerably over the last number of years representing an exceptionally diverse population comprised of all Aboriginal groups (First Nations, non-status Aboriginal individuals, Métis, and small numbers of Inuit) from many different areas of Canada and beyond. Addressing the needs of such a diverse group can be daunting.

Given the complexity of the interconnected environment, necessitated the need for continued improvement in its structures and processes to effectively address the needs of the urban Aboriginal population in Calgary. Many recommendations were assembled from the study data. Effective community participation and ownership were strong recommendations. Exploring new governance models including urban Aboriginal self-governance options was desired although issues in Aboriginal leadership in this urban centre could impact the speed at which these were fully implemented. The development of partnerships within healthcare and other sectors was essential to meet the varied needs of this urban Aboriginal population. Recommendations also included a centralized clinic, co-location of services, and outreach to facilitate access to primary healthcare services. Services should use a holistic, comprehensive, healing approach and be culturally relevant including traditional healing and spiritual care. The importance of patient-centred teams with a variety of team members was underscored to ensure the ability of the system to address healthcare needs. Finally, evaluation and outcomes was discussed including data management, evaluation approaches and the importance of outcomes measurement.

Chapter Six provided a comprehensive review of the results addressing research questions two through four. Chapter Seven will focus on cultural safety as a specific structure and process required for the primary healthcare system for the urban Aboriginal population in Calgary.

CHAPTER SEVEN—CULTURAL SAFETY IN A PRIMARY HEALTHCARE SYSTEM FOR THE URBAN ABORIGINAL POPULATION

Chapter Seven will focus on the results linked to the research question "How can cultural safety be integrated into this primary healthcare system for the Aboriginal population?" Although participants were specifically asked about cultural safety, they responded using a variety of terms that fall under the umbrella of cultural competencies. Cultural competencies will be used in this chapter to denote the group of competencies required by healthcare professionals to provide competent healthcare. The term encompasses other components such as cultural awareness, cultural sensitivity, cultural competence, and cultural safety (Carberry, 1998), each defined in the literature. This chapter will focus on three key components related to cultural safety: defining cultural safety; racism; and incorporating cultural safety into the primary healthcare system for the urban Aboriginal population in Calgary. Table 13 will summarize the key themes from the data.

Defining Cultural Safety

Interview participants were asked to define cultural safety and describe what the term meant to them. Cultural safety was defined in a variety of ways. Eight of the 38 individual interviewees acknowledged they had not heard of the term previously, while others struggled in providing a definition. "I don't know; it sounds really complex," (Int.034, Line 725). Still others provided a lengthy definition for the term, but only two participants moved beyond the conversation about culture, and discussed the concepts of history and power, foundational elements of cultural safety as defined in the literature (Nursing Council of New Zealand, 2005; Ramsden, 2002).

One participant discussed their journey of defining cultural safety in their workplace where there was a lack of consensus on terminology and what the journey was actually about.

> A lot of times, people don't know how to define it...cultural competency and cultural safety...we're perceiving it as a lot of lingo in the context of, they don't know exactly what it means. We're bringing out mainly it's just a knowledge, a

Table 13

Key Themes for Chapter Seven

	Key themes
Definition of cultural safety	• Confusion in terminology • Evolution of cultural competencies over time (e.g., cultural awareness, sensitivity, cultural safety) • Cultural safety conflated with cultural customs and traditions • Seldom included power differentials and history • Aboriginal peoples often included in multicultural initiatives
Racism	• Common occurrence in the healthcare system • Different types of racism (individual, organizational, systemic) • Need for a culturally safe system critical
Integration of cultural safety into the primary healthcare system	
• System level	• Cultural safety to start with system level leadership • Cultural safety needed at all levels of the system • A paradigm shift required
• Organizational level	• Focus on organizational policies, structures, and processes • Cultural safety core to organizations and outcomes
• Individual level	• Commitment to self-reflection • Development of a trust relationship with patients • Training for staff—most often focused on cultural traditional practices and customs • Education on history and impacts of colonization important • Importance of cultural competencies training for all staff (Aboriginal and non-Aboriginal) at all system levels

- Team level	- Patient-centred teams an excellent opportunity for cultural safety training - Cultural safety important for team functioning
- Environment	- Setting reflective of Aboriginal philosophies - Deinstitutionalized setting with décor reflecting Aboriginal culture - Incorporation of Aboriginal languages - Aboriginal staff desired to mirror community - Support for choice in healthcare - Advocacy

> knowledge base. But what is that knowledge base or how can you increase that knowledge base? (Int.008, Lines 570-576)

This participant conflated cultural competence and cultural safety and then was uncertain about the required knowledge for either.

Some participants spoke about the continuum of cultural competencies and how the terminology, understanding, and expectations for change had evolved over time. “We used to talk about cultural sensitivity and then, as we learn and grow that’s sort of become dated. And we can do so much more than just being aware” (Int.007, Lines 465-467). Cultural competencies as a continuum was also reflected in several of the documents reviewed.

Several participants also discussed the definition of culture and the potential impact on moving a cultural competencies framework forward. “I think the term culture narrows it for white people. I think what it is, is cultural, historical, and social competence” (Adv. Comm. 003, Lines 722-725). Another participant highlighted Aboriginal worldviews versus western, European thinking in defining cultural safety.

> But the Aboriginal people saw it in that framework, which tells us that an indigenous viewpoint regarding culture incompetence, goes beyond just issues of culture. Well, for the non-Aboriginal people, the issues of cultural competence only reside in the issues or differences or similarities of culture. They don’t see the social

> exclusion and power and privilege and all those things to be in the same category. (Int.036, Lines 408-414)

Similar concerns were described in the literature where non-Aboriginal individuals did not include in their definition of culture the dynamic nature of the term and how meaning was impacted by social, political, and historical structures. (Anderson et al., 2003; Browne & Varcoe, 2006; Reimer Kirkham et al., 2002).

Diversity was frequently discussed in documents reviewed and by some participants. The importance of recognizing Aboriginal peoples as being indigenous to Canada; having distinct issues from those of immigrants was emphasized by some participants and some of the documents as well as being reflected in the literature (Harding, 1995; Barsh, 2005). Even so, cultural competencies frameworks and approaches for Aboriginal people were often included in broader diversity initiatives for a variety of diverse groups (e.g., immigrant populations), while others underscored the need for separate initiatives for cultural safety with the Aboriginal population. Aboriginal peoples had:

> …distinctive concerns and perspectives on what constitutes competent care. Patient feedback suggests that health delivery systems and individual providers need to take into account a range of complex and interrelated factors that are unique to Aboriginal people's experience of healthcare in order to consider appropriate approaches to ensure culturally competent and safe care. Moreover, Aboriginal patients hold particular perspectives on health and views on what constitutes culturally competent care, indicating that a distinctive set of approaches reflecting Aboriginal principles and values needs to be developed and implemented to address Aboriginal people's health needs in a meaningful, respectful, and effective ways. (Document CL057, p. 34)

The language used by participants and in documents, even some Aboriginal participants (managers, providers, and community members), often reflected diversity and multiculturalism as frequently seen in healthcare. The debate between issues for Aboriginal people versus issues for other diverse populations was clearly evident in the data. These concerns were largely misunderstood by policy-makers, decision-makers, and primary healthcare providers further contributing to the lack of culturally safe healthcare. Multicultural policies and practice perpetuated *othering* and neglected to include reference to the social structures and processes that created power differentials and racism in our society (Barsh, 2005; Browne & Varcoe, 2006; Harding, 1995; Reimer Kirkham et al., 2002). Multiculturalism policy and practices could further marginalize Aboriginal peoples (Dion Stout & Downey, 2006).

Cultural safety was most often defined as building a relationship "between Aboriginal and non-Aboriginal" peoples. (Int.031, Field Notes, Line 25). Others suggested cultural safety was not specific to the Aboriginal population but referred to relationships between the dominant culture and other minority groups. Relationships in a culturally safe environment required building trust, honesty, and a focus on understanding each other.

> It's that environment where the trust in a relationship is there, so that people feel safe to say what needs to be said, regardless of position. Whether you're a care provider or a care receiver or a recipient or whatever. It's just that safety; non-judgmental environment. (Int.020, Lines 227-231)

Many participants described cultural safety as being respectful. "So respect would be huge in terms of safety. Respect and honouring the individual's way of life and way of being and spirituality" (Int.021, Lines 710-712). Reciprocity of respect was also highlighted. "So the respect has to go two ways and be reciprocal. So that the questions coming back can't be perceived as abrasive or evasive. It's what both sides need to share, to develop a common understanding and learning" (Int.020, Lines 238-241). Others emphasized specifically the need to be respectful of differences and similarities, "trying to be respectful of differences, respectful of our similarities, understanding and trying to make that understanding and seeing the person as a person" (Int.008, 579-580).

Still others described cultural safety as being a component of patient-centred care contributing to quality care for the Aboriginal population. If health systems, organizations, and providers focused on the patient being central to the care provided, cultural safety would also be addressed.

Cultural safety was described by others as the maintenance of cultural traditions, ensuring cultural knowledge and practices were kept safe. "Protecting what is sacred," (Int.021, Line 691). This reflected the same confusion where the maintenance of cultural practices was conflated with cultural competencies discussed earlier in this chapter in terms of non-Aboriginal people's responses about culture. Members of the urban Aboriginal population interviewed also described this type of cultural safety where they wanted to ensure cultural practices were passed on to their children.

In addition, cultural safety was portrayed as providing individuals a sense of belonging, identity, and room for self-expression. Cultural safety in this case was expressed as safety for individuals themselves within a system that was largely unsafe (e.g., filled with racism, lack of access to services).

Still other participants described cultural safety not as a single event or something a person did, but as an environment of comfort and safety.

> Cultural safety, to me is providing an environment and system that allows, develops a comfort and an openness in the clients. So it's client-focused and it's more than just cultural competency in the individual, [it] would be the whole environment, the context and all that you can do to understand and promote an appropriate environment for a cultural minority. (Int.004, Lines 575-581)

Members of the urban Aboriginal population interviewed also described cultural safety in the form of a comfortable environment (e.g., friendly and accepting staff, artwork/symbols, language). Cultural safety was not specific to healthcare service delivery, but could be applied in any and all contexts.

Several of the documents reviewed highlighted the difficulties Aboriginal peoples encountered in dealing with the healthcare system and its providers. The importance of relationships and the understanding required by healthcare providers was underscored. "…relationships between Aboriginal people and health service providers can be difficult and that all involved need to work to establish relationships and cultural understanding" (Document, CL040, Lines 643-646). A key local document defined cultural competencies as "a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations" (Document, CL052, Lines 31-33). Cultural competencies for Aboriginal healthcare was further defined as "a conceptual and methodological approach to determine the policies and practices that come together in a system, organization, or among professionals to remove the barriers that limit Aboriginal people's access to equitable health care" (Document, CL052, Lines 37-40). Non-judgement was also seen as a key component.

> Health providers need to approach patients in a non-judgmental manner so as to avoid making decisions based on assumptions, stereotypes, or biases. The principle of non-judgment reflects ethical values related to compassion, empathy, and acceptance. It is also articulated as a means to address the discrimination and marginalization that Aboriginal people face in dominant society or mainstream health services. (Document, CL052, Lines 173-178)

A total of seven documents specifically discussed cultural safety or cultural competencies as a concept. Definitions in the documents, unlike interviews, reflected the original definition of cultural safety developed in New Zealand by the Maori people. Power differentials, racism, and historical impacts of colonization were foundational to the definition of cultural safety. "…the recognition of the position of certain groups within a society and the need to attend to socio-political issues such as racism, discrimination, and differences in power among various ethnic groups in society" (Document C057, p. 23). Bicultural relations were emphasized and open communication was urged to ensure culturally safe care.

In summary, culture safety and related terms (e.g., culture) were defined in a variety of ways. Just as there was no coordinated and collaborative primary healthcare system, as discussed in Chapters Five and Six, there appeared to be insufficient opportunity for participants to develop consensus on the goals of cultural competencies and the language used. The fact that power, privilege, and the domination of colonizing institutions were not recognized by everyone as components of cultural safety was noteworthy. Others recognized these components but conceivably found them difficult to integrate into their experience of cultural safety working in the current primary healthcare setting. Without agreement in terminology and definitions, and a broader concept of culture, movement forward in the cultural competencies debate will not be realized. Consistent terminology, definitions, and opportunity to engage in discussion of culture and cultural safety (Browne & Varcoe, 2006) were necessary for a culturally safe primary healthcare system to be created.

Racism

Racism was a common thread running through the data collected from interviews. "Racism is the number one issue. When you come down to it, it is all about racism. When we talk about unfairness, inequity, inequality, it all stems from racism" (Int.015, Lines 780-782). Both documents reviewed and participants suggested racism was very common in Calgary and Canada and often occurred in healthcare settings. Documented consultations in the early 2000s in Calgary found "overarching themes in every domain were discrimination, systemic racism, and prejudice" (Document CL054, Lines 1364-1365). The pervasiveness of racism was also corroborated by the literature (Adams, 1999; Browne & Fiske, 2001; Browne et al., 2009; Browne & Varcoe, 2006; Crane & McFarlane, 2006; Furniss, 1999). This section will discuss racism directed towards Aboriginal people including individual, organizational, and systemic racism. Examples will be provided from participants' experiences of discrimination and racism.

Examples of Racism from Participants

Many interview participants discussed issues of racism and shared personal experiences or those of family, friends, or acquaintances when accessing services in Calgary and elsewhere. Aboriginal peoples experienced discrimination in their everyday interactions in accessing services of all kinds. Several participants spoke about their experiences while shopping.

> Well, there is such a lack of trust and with good reason, you know, from Aboriginal people. And the darker you are, the worse it is for you. And unfortunately, it happens here in Calgary all the time. We get women coming back and saying you

> know I was at this store and the managers followed me around the aisles as if I was going to steal something. (Int.021, Lines 266-271)

They felt they were treated differently and did not receive the same service as other customers at the grocery store or at the mall. One local document of consultations with Aboriginal peoples described *the look* Aboriginal individuals received in the community. "Both seniors and youth talked about *the look*, the expression that they see on people's faces in the community and in service industries that tells them they are not valued or welcome" (Document CL054, Lines 1367-1369). Yet another participant discussed the lack of comfort in certain establishments, as he laughed. "They feel like oh, I don't know, do they allow Indians here? That kind of mindset" (Int.022, Lines 615-617). Even though the participant laughed at his own comment (he appeared very comfortable with his Aboriginal identity) one can only wonder at the impact of such behaviour by members of mainstream society on the participant and other Aboriginal individuals.

Participants also talked about being able to practice their culture without being placed at risk for doing so. "…they should know that they can be who they are within their culture. And feel secure and not threatened in any way. That I [provider] need to be that sensitive" (Int010, 294-297). They feared losing a job and other opportunities or not receiving services when carrying out their cultural practices.

Housing was particularly difficult to obtain as an Aboriginal individual or family due to stigma and racism. Security in an institution also was described as intimidating for Aboriginal community members coinciding with issues they frequently experienced in the past with institutions such as the RCMP, where considerable control, power, and discrimination were all too often familiar and part of colonizing activities.

Incidents of racism were also described in educational settings; the education system being another institution greatly influenced by colonizing structures and processes. During interactions with parents and school personnel, parents were often ostracized and blamed for their children's behaviour and performance. "…it's a victimization and a blaming. And the parents always go away feeling like they're unfit parents" (Int.020, Lines 177-179). Education was described as being very important to Aboriginal peoples but the education system was fraught with issues of racism and impacted Aboriginal individual's ability to obtain an education.

> Racism and discrimination by teachers and students, and in the curricula were issues of concern to community participants. They felt that their traditions and history were dismissed, misrepresented, or inaccurately portrayed in the school system, causing Aboriginal children to be ashamed of their ancestry. These barriers were blamed for the alienation of Aboriginal youth and the high dropout rates in Calgary. (Document CL054, Lines 949-953)

According to participants interviewed, racism occurred often during encounters with the healthcare system. "…it's either perceived or real experiences of racism and stereotyping and things like that. And I hear about them every week, and it's unfortunate" (Int.001, Lines 810-813). Participants discussed that they personally, or their family and friends experienced a feeling of unfairness when they entered a healthcare facility or clinic. "So when they come in, there seem[ed] to be a real, almost a bias from the minute they walk in the doors. And so, I mean the Aboriginal people feel that" (Int.027, 589-591). Another participant suggested that hospitals and other healthcare facilities were unfamiliar to many Aboriginal peoples making them highly uncomfortable and coupled with racism it significantly impacted their experience in the healthcare system. "It's a foreign place and they're in the minority and there's a lot of stereotypes. Sometimes there's underlying racism; sometimes it's overt" (Int.022, Lines 632-634).

Underlying assumptions and attitudes of staff contributed to many of the experiences that participants described.

> One mother, grandmother, her grandchild ran into something at daycare and when she took him to the doctor, they apprehended that child right then and there. And she tried to tell them no, this happened at the daycare. And so, she didn't get the child back for a couple of weeks. All they had to do was make calls and stuff. She hasn't worked a day since. She is living on welfare, because she totally distrusts the system. (Int.025, Lines 574-580)

Another participant shared the following experience:

> She fell down some stairs and she sustained a black eye. And she went to the walk-in clinic in the northeast where she lives and just the looks that everybody gave her; the nurse and the doctor and the people in the waiting room. She could see right away; it was like oh yeah, she probably got beat up by her husband. Well, she doesn't even have a husband right now. And she felt very, she felt acutely humiliated. (Int.012, Lines 171-180)

Inappropriate care was often received due to staff assumptions and the lack of a comprehensive assessment. Aboriginal community members were "offered T-3's; drugs before assessed without even being asked why they were there—this occurred often and occurred to him [participant] as well, while he doesn't drink or use narcotics" (Int.029, Field Notes, Lines 90-92). Another participant described her experience:

> …I mean he [physician] kept asking me about narcotics and told me that no matter what, he would never give me narcotics. And when he did the physical on my daughter and I sat in the room, he was checking her for, he wasn't giving her a full physical. He was actually checking her for child abuse…And I knew what he was doing, so I stopped him and I said: 'You know, my daughter is not abused and we're here for a physical.' But he was doing that on his own. And then he made me sign a narcotics agreement and I know that's not practice, because you usually don't sign an agreement unless you've been caught abusing narcotics. And I've never even taken narcotics in my life, so I don't know what that would be about. And at the time, I felt really bad about it but I didn't say anything about it till about two weeks later. (Int.015, Lines 97-101; 103-111)

Participants also described several other issues Aboriginal peoples faced in seeking healthcare services. They often waited much longer than others in the clinic or emergency, they described being ignored by administrative staff and healthcare providers, and sometimes were even turned away from the hospital or clinic for care.

Another participant commented on the benefits of not having to identify herself as an Aboriginal person. She feared being treated differently.

> But I know when I went to the walk-in clinic, they just took my Alberta Health Card number. So it didn't identify me as being Aboriginal. Which I was pretty happy with. Because sometimes when I'm identified as Aboriginal…I'm concerned that I'll be discriminated against. And because that does happen. (GI001, Lines 1513-1517)

Most notably, racism had impacted Aboriginal peoples' access to health services. Racism and access to primary healthcare care was discussed in Chapter Five. Evident in the data was the increase in the everyday work of Aboriginal community members to access services due to issues of racism; work that was often overwhelming and painful causing them to simply give up. Racism also impacted the quality of care received by Aboriginal peoples. One document suggested that Aboriginal peoples were not aware of the poor services they had received until they attended an Aboriginal-specific healthcare service that provided them with a contrast.

Participants also discussed actions by some of the Aboriginal organizations and Aboriginal providers. "We've become a very sterile, very colonized model of treating and treating everyone with the same cookie cutter" (Int.021, Lines 613-615). The systemic nature of colonization structures and processes in our society resulted in Aboriginal peoples and organizations themselves adopting and incorporating colonialism in their practices.

During one observation they discussed providing information on the "cultural peculiarities of the people" (Observation004, Line 128). This statement was made by an Aboriginal person in an Aboriginal led forum. Participants were not challenged about the statement or their thinking by Aboriginal or non-Aboriginal participants. The statement underscored where people's thinking currently stood on cultural safety (Aboriginal and non-Aboriginal) and what they felt was required to make organizations culturally safe.

The constant bombardment of covert and overt acts of racism, as evidenced by the experiences shared by participants, had significantly impacted the health and wellbeing of Aboriginal individuals and their communities. Effects such as lack of self-esteem, lack of trust in institutions and government, and intergenerational pain and trauma were obvious. Such impacts of racism were also documented in the literature (Krieger, 2003).

Reasons for Racism Directed Towards the Aboriginal Population

Participants discussed a number of underlying reasons for discrimination towards Aboriginal peoples. Stereotyping of Aboriginal peoples resulted in a number of issues. First, glamorizing the Aboriginal culture was frequently carried out by non-Aboriginal individuals. Aboriginal peoples were associated with *beads and feathers*, a "stereotypical ideation of Aboriginal people" (Int.029, Field Notes, Line 23). This type of stereotyping resulted in the following described by one of the interview participants. "Native people are jammed into a box (e.g., what you think, your practices, etc.); white people are allowed to change what they think, wear, and their practices" (Int.031, Field Notes, Lines 20-23). Even these more positively perceived stereotypes sought to control the *what and how* Aboriginal peoples should act.

Secondly, Aboriginal peoples were impacted by large numbers of negative stereotypes as outlined in participants' stories described earlier in this chapter. Typical negative stereotypes included the abuse of narcotics, always being drunk, being homeless, high incidence of child abuse, sexual promiscuity, always being late, and not keeping appointments. These negative stereotypes supported deficit thinking about Aboriginal peoples as a whole.

Closely related to stereotyping were assumptions and biases. Aboriginal peoples were often prejudged. One participant described the labelling that occurred, "your people; your kind; where you come from" (Int.029, Field Notes, Lines 86-87) and Aboriginal youth were habitually categorized as being no good.

Negative stereotypes, assumptions, and biases were and will continue to be ways society dominated and exploited Aboriginal peoples impacting their health and healthcare experience, and limiting their opportunities for such things as education and employment. "It is no longer acceptable to view Indigenous people and communities through lenses coloured by assumptions, negative stereotypes, victim blaming, and deficit explanations. At best these are unhelpful and perpetuate marginalisation within the health sector," (Wilson, 2006, p. xii) and contribute to increasing the gap in disparities between Aboriginal and non-Aboriginal Canadians.

Types of Racism

Three types of racism were described by participants and discussed in documents reviewed.

Individual Racism

Racism that was directed at Aboriginal peoples by individuals was most commonly discussed by participants. These were represented in the many examples provided by participants outlined previously in this chapter.

Organizational Racism

A few of the participants interviewed discussed racism at the organizational level. Urban institutions were described as being highly oppressive (e.g., large, unfriendly, with security) by several participants and associated with assimilation. Organizational racism was often enacted through the institution's policies reflecting the goals of continuing colonization. Aboriginal peoples were required to *fit in*, to become *more white*, or to stop complaining.

Systemic Racism

For Aboriginal peoples, oppression was described as still being pervasive in our society today. Stemming from historical practices (e.g., residential schools, sixties scoop) and current government and other institutional policies, systemic racism had become so embedded in our society it was not recognized by organizations, decision-makers, and care providers as oppression but was characterized as best practices, evidence-based policy, or cost efficiency. The lumping of all racialized groups into one policy category was one example. Colonizing policies and practices controlled and dominated Aboriginal peoples and resulted in discrimination and racism towards this group. "Service providers [in addition to community members] also identified systemic discrimination and prejudice as barriers in every domain. The fact that so many participants could unequivocally cite these conditions speaks to the pervasiveness of discrimination in our society" (Document CL054, Lines 1392-1394). The situation was no different in healthcare as described by a participant. "The continued ignorance and avoidance of Aboriginal health problems is due to racism" (Int.015, Lines 786-787).

The Aboriginal Population: The Most Vulnerable of the Vulnerable

Aboriginal peoples were described as being extremely vulnerable; the belief was immigrants were more accepted than Aboriginal peoples even though they were also considered to be *outsiders or others* in comparison to the dominant white society. The greater degree of racism towards Aboriginal peoples categorized them as being a *bigger other* than those who immigrated to Canada.

Participants described the fear Aboriginal peoples often had in responding to the discrimination directed towards them.

> I'm going into any type of a service and I feel that there is some of that other stuff going on, that other negative stuff, I won't stay. But I would also probably voice my opinion and I may ask for something else. A lot of people can't do that…No. And even if they can, sometimes they might voice their opinion, but it might not change anything. (Int.021, Lines 778-784)

Aboriginal peoples were reluctant to say or do anything for fear of being reprimanded, being removed by security, not receiving services at all, or they feared child welfare. "People just don't [talk], because of what is in the media or the stereotypes or the racism that's been instilled" (Int.016, Lines 413-415). It was better to submit to the discrimination, however humiliating it was, rather than fighting the racism and suffering potential consequences. Advocacy, as discussed in Chapter Six, was urged by participants and documents reviewed. "…allies of those who experience the impacts of discrimination use their position and power to speak up and out — to challenge the status quo that maintains social structures that exclude some while bestowing privilege on others" (Document CL053, Lines 42-44).

In summary, racism in many shapes and sizes was present in our healthcare system as evidenced by the stories and experiences shared by participants. Racism was based on stereotypes, assumptions, and bias towards Aboriginal people. Systemic racism was of particular concern, considering how embedded it was in our society through years of past and current colonized practices. Since the majority of society was not even aware of their discrimination, systemic racism will take much time and effort to unlearn years of its practice. The need for culturally safe care in our healthcare system was all too evident given these issues. The ideal primary healthcare system would be a place where Aboriginal people "wouldn't be stereotyped" (Int.022, Line 582). As stated by one of the participants, "the Spirit has no gender and no color; white, yellow, red and black don't exist" (Int.029, Field Notes, Lines 113-114). A system with such a philosophy would address many of the issues described in this section on racism. The next section of this chapter will outline how cultural safety can be incorporated into a primary healthcare system for the urban Aboriginal population in Calgary.

Incorporating Cultural Safety into the Primary Healthcare System

Cultural safety was considered by authors to be the answer to issues of racism and ongoing domination of Aboriginal peoples in healthcare (Carberry, 1998; Dion Stout & Downey, 2006; Reimer Kirkham et al., 2002; Wilson, 2006), because of its attention to power differentials that existed in our healthcare systems as well as the historical and social structures and processes that contributed to the current relationships within the system (Anderson et al., 2003; Dion Stout & Downey, 2006; Polaschek, 1998; Ramsden, 2002; Nursing Council of New Zealand, 2005; Smye & Browne, 2002; Reimer Kirkham et al., 2002). Ideally, a culturally safe primary healthcare system had the potential to address racism and oppression. In of itself, it was not a panacea, rather effective integration of all components at all system levels was the key. It was considered to be a beginning in the decolonization of the healthcare system, towards a system of cultural safety (Wilson, 2006).

The following sections will outline how cultural safety can be incorporated into the primary healthcare system for the urban Aboriginal community in Calgary. Integration will be addressed at various levels of the system: overall system; organization; individual providers; patient-centred team; and the environment.

Integration at the System Level

Integration of cultural safety into the primary healthcare system for the urban Aboriginal population required the commitment of all components of the system to ensure the safety of Aboriginal peoples when interacting with the system as well as the safety of the care they received. According to participants and documents, a culturally safe primary healthcare system did not currently exist in Calgary. "…we need to do a lot more on the cultural competency, safety piece" (Int.037, Lines 759-760). While cultural competency was happening in various forms and in a piece-meal approach (even as noted in the language in the above quote), participants and documents reviewed recommended a comprehensive, multi-pronged approach to target all levels of the primary healthcare system. Cultural safety was not seen to be a single event but rather described as a journey; a process of continual learning.

Cultural safety called for a paradigm shift. Although this study discussed cultural safety from the primary healthcare perspective, it required "…society wide collaboration" (Int.004, Lines 614-615) and being open to change. "We need to be really open to it, to changing things" (Int.029, Field Notes, Lines 83). Some participants suggested education about the Aboriginal population, racism, and oppression beginning at the elementary school age level. A complete shift in attitudes towards Aboriginal peoples was required to facilitate this paradigm shift in our society overall.

Most of the documents and many of those interviewed did recommend a change in how cultural competencies were delivered in the primary healthcare system. As we know from earlier descriptions in this chapter on defining cultural safety, most participants were not aware of what would be implemented because they did not understand what the full continuum of cultural competencies, including cultural safety, would look like. Their lack of understanding was reflected in their recommendations of how to incorporate cultural safety into this primary healthcare system. "And whether it's providing a few posters in your waiting room, versus really changing the whole approach to patient care, which is a radical and difficult approach" (Int.004, Lines 599-602). Evident in the quote above, was the juxtaposition of change; should it occur as part of the environment, at the individual level, or as an innovative systems level approach.

Cultural safety was required across all levels of the primary healthcare system; the system as a whole, organizations across the system, teams, individuals and the environment.

> Researchers, educators, and health administrators have stressed that cultural competence must be integrated into multiple levels of the health care system. For cultural issues to be adequately addressed in health care, policies, programs and services need to be developed, implemented and evaluated to enhance the ability of organizations and individual practitioners to provide culturally competent health care. (Document CL057, p. 20)

The importance of a systems level approach for cultural safety was also supported by the literature (Polaschek, 1998; Sherwood & Edwards, 2006; Williams, 1999).

It was incumbent on the large and influential healthcare system to collaborate across sectors in promoting cultural safety. In fact, cultural training was recommended for other organizations outside of the health system such as mainstream social service organizations and those dealing with the homeless.

A primary healthcare system was suggested that would create a ‘win-win’ for both the urban Aboriginal population and the healthcare system. Despite the support for an ideal systems level approach on cultural safety, the reality, as described later in this chapter, was participants and documents most often focused on changing the individual as opposed to system wide change.

Cultural Safety in Primary Healthcare Organizations

Healthcare organizations were based on colonizing policy and practices, where they “just simply reflect[ed] the values and beliefs and principles of the broader society” (Int.001, Lines 949-950). The “health sector needs to open their minds [and] recognize and deal with their assumptions” (Int.029, Field Notes, Lines 48-50). Organizational policies were perceived to be very ethnocentric. One provincial document recommended learning sessions for both parties.

> Aboriginal people need an ethnography of the health care world/culture and so the health care world needs an ethnography of the Aboriginal people. Part of that would be found in recognizing traditions and cultural strengths, but as well, recognizing colonization, the impact of colonization, and the contemporary manifestations of that and how that affects [mental] health. (Document PR013, Lines 159-163)

Cultural competencies must be a core component of primary healthcare organizations serving the urban Aboriginal population; part of performance measurement both for organizations and their staff. Cultural safety should be second nature in organizational policy. “It also involves developing policies that are respectful and inclusive of Aboriginal health, healing and medicine” (Document CL042, Lines 410-411). But policies were required beyond a simple approach including cultural practices (e.g., policy for smudging). No doubt, these were inherently easier to incorporate, as opposed to a change in policies reflecting colonized thinking and institutional racism. The intent of policies, their background, how they would be implemented and monitored all required consideration in policy development. “…how we engage communities in a culturally safe way, in a respectful way and incorporate their needs, their feedback and their expertise into how we make policy and how we go about delivering it” (Int.003, Lines 849-852). Including the community in policy development was essential.

Cultural safety required starting with the leaders of healthcare organizations which was supported by the literature (Polaschek, 1998; Sherwood & Edwards, 2006). Leadership support was seen to be lacking at various levels within organizations as well as at the political level. “I don’t know; it’s challenging. I think you need…political support. I think you need…leaders that support Aboriginal initiatives” (Int.025, Lines 456-458). Without the support of upper management it was difficult to implement cultural safety initiatives at all levels of the organization. In particular, it impacted the ability for teams and individuals to spend time on cultural safety initiatives if they were interested and recognized the importance of the same.

Cultural safety was also recommended at the service level. Programs and services should be structured to reflect Aboriginal worldviews to enable community members to feel more comfortable in seeking and receiving primary healthcare services. “So I think that it needs to be recognized and incorporated as the pivotal part of service that it is” (Int.003, Lines 788-790).

Several participants discussed the large size of the health authority, particularly with the amalgamation of all regional health authorities in Alberta. They perceived the integration of cultural safety to be much more difficult due to the organization's size. They recommended beginning at the individual and team levels (e.g., Aboriginal Health Program) and then incorporating cultural safety into the larger organization. This could be difficult considering earlier recommendations for strong support from leadership to move cultural safety agendas forward.

Several documents over the last number of years have recommended the development of a cultural competency framework for Aboriginal health in Calgary as well as compulsory awareness training for *all* staff, administration, and management, including history and its impacts for Aboriginal peoples. Regrettably, the latter had not been realized even though ongoing training was an important component of cultural competencies, particularly when it goes beyond cultural awareness. A cultural competency framework for Aboriginal peoples' health was recently completed in 2009 and implementation had occurred in the Aboriginal Health Program, Alberta Health Services, Calgary Zone. The framework desired a standardized approach to cultural competency for Aboriginal peoples' health. Evaluation of cultural competency will occur at the individual level, where staff will develop their own portfolio of cultural competency learning and performance which will be reviewed at their annual performance review. The cultural competency framework represented a text to direct the attitudes and behaviours of staff in interchanges with Aboriginal peoples. Although system and organizational levels were mentioned in the framework document, the focus of the document was on individuals and teams. While this framework was only implemented in one program in a single geographic area, it may be the impetus necessary for a cultural competencies focus across this healthcare organization and the broader primary healthcare system.

With the exception of the recently developed cultural competency framework mentioned above, all other recommendations by participants and documents described in this section represent the ideal for cultural safety in primary healthcare organizations and ultimately the system rather than current practices in Calgary primary healthcare organizations. There was a sense from participants they had little control at organizational or system levels, and therefore focused more on individuals or teams where there was greater potential for change. The following sections will discuss further how cultural safety can be incorporated into the primary healthcare system at the individual and team levels.

Cultural Safety for Individual Primary Healthcare Providers

Cultural safety at the individual level required commitment on the part of providers. "…achieving cultural competence in professional practice requires the commitment from health service providers to engage in a process of ongoing professional learning and self-reflexive practice during the course of their careers" (Document CL057, p. 4). Participants discussed challenging one's beliefs and assumptions to better understand the Aboriginal population and deliver care in more appropriate ways: "…exploring even our own personal biases and experiences, and trying to understand them and be able to discuss them in a safe environment" (Int.008, Lines 594-596).

Mutual respect, acceptance, and the development of trust between providers and community members were seen to be foundational to cultural safety. The development of a trust relationship would be critical considering the lack of trust in the healthcare system and other similar institutions (as mentioned in earlier chapters) characteristic of Aboriginal peoples. Providers were encouraged to be respectful and accepting of the differences of Aboriginal peoples. "So acknowledging the differences and respect[ing] the differences and understand[ing] the people" (Int.033, Lines 784-785). Respect and acceptance were fostered by building relationships with Aboriginal individuals and the population as a whole. "But they have to be willing to engage in the relationship and that's where they're going to learn the most" (Int.012, Lines 206-208).

> …it's all about relationship building; it's all about not making assumptions. It's all about non-judgmental care, picking the client up where they're at. If they have tried twenty times to kick their crack cocaine habit, being really proud of them that they're trying for the twenty-first time. (Int.024, Lines 464-468)

Overall, there was strong support for workshops for staff about the Aboriginal population and their culture; regular, formal workshops only occurred in one organization represented by participants. Many described the training in terms of cultural awareness and cultural sensitivity including information on customs, cultural traditions, and ceremony.

"…to have someone from whatever culture come in and talk to staff and increase our awareness of what might be offensive, how to approach people, how not to approach people and that kind of thing" (Int.010, Lines 343-345). Not surprising, given the discussion on defining cultural safety, the focus of participants was on traditional cultural practices as opposed to information on history, power, and privilege. Cultural sensitivity was espoused by participants in the study and was enthusiastically adopted by healthcare systems. It was based on the recognition and celebration of cultural traditions and practices (e.g., food, dress) and promoted tolerance and equal opportunity regardless of ethnic background (Browne & Varcoe, 2006).

Some participants did comment on the evolution of cultural competencies and the importance of moving beyond cultural awareness to include additional information to facilitate an individual's cultural competency. Learning about cultural practices and traditions was historically the way to be culturally competent, "…so I just know about smudging and I'm good" (Adv. Comm. 003, Line 759), but was insufficient in creating cultural safety.

Some of the participants discussed the importance of education around history, impacts of colonization, assimilation, discrimination and racism, essential components of cultural safety. The latter was more strongly supported in documents reviewed suggesting even though the importance of such information was known; it had not been implemented to any great extent at the practice level. Education on "understanding racism, colonization, and discrimination; and their role in the creation and maintenance of mental health issues" (Document CL055, p. 31) was fundamental to cultural competencies training. "Mental health providers can only create an environment of cultural safety for Aboriginal people if they have been trained to understand and accept the cultural, linguistic, tribal, geographical, economic, political, and community context of the various Aboriginal communities" (Document PR003, Lines 1214-1217). Understanding terminology such as culture was highlighted by several participants and in a number of documents. Training was strongly recommended annually, as cultural safety was a process of ongoing learning.

> …I've done the training many times and every time I come out of it challenging myself on something maybe that I thought or maybe that I believed or a stereotype or a label. And every time I come out with something else. (Int.032, Lines 404-407)

Most often, more conventional, pedagogical learning approaches were discussed by participants. These included such activities as workshops, lectures, presentations, and resource binders. Several participants suggested more innovative approaches to training: experiential learning through cultural events and interactions with the community; reading Aboriginal literature; viewing Aboriginal films and video; Forum Theatre; monologues; mentorship; and interchange tours to garner more interest from staff and a better understanding of the issues. The latter, being more experiential, had a greater opportunity for impact. Other participants commented on materials currently available (e.g., frameworks for Aboriginal healthcare) and the lack of utilization of such resources for staff orientation and ongoing education. This was yet another example of texts being developed but not enacted or utilized.

While some providers saw the need for cultural competencies training workshops, others were not impressed by the same nor saw the need for these workshops. "We had cultural awareness workshops, doing whatever internally [healthcare facilities] to promote that awareness. And quite frankly there was a lot of resistance in some areas. First of all, what is the big deal? And why do we need to do this and so on and so forth" (PR014, p.42). This type of reaction was not surprising given the earlier discussions on culture and the pervasiveness of racism in our systems and society. Attendance and acceptance of cultural competencies workshops in the healthcare system were also impacted by staff time, workload, permission to attend, resources and funding. The current environment of cost cutting and staff shortages in healthcare had affected the ability to offer training workshops and for staff to attend. Priority was placed on the institution's priorities as opposed to facilitating cultural safety for Aboriginal peoples.

Cultural competencies training for Aboriginal staff was also mentioned by a number of participants. The consensus was that all staff, Aboriginal and non-Aboriginal, should participate in regular, ongoing cultural competencies training. Speaking as an Aboriginal provider, one participant stated, “I can’t make any assumptions and sometimes I think we do, but we need to have that self-awareness” (Int.022, Lines 721-722). As discussed earlier in this chapter, comments by participants about some Aboriginal organizations and Aboriginal providers adopting colonized practices made training for all staff appropriate.

Cultural Safety at the Patient-centred Team Level

Cultural safety at the team level was discussed only by a few participants and highlighted in only one document reviewed. Team members working with the Aboriginal population needed to be flexible, passionate and compassionate, committed to the population, with a willingness to learn from and about the population. As noted in the previous section, cultural competencies training was recommended for all staff and the opportunity to deliver training at the team level, for team members to learn together, was excellent and should be maximized. Participants suggested working with a champion on the team to encourage cultural safety among team members. The single document discussing cultural competencies at the team level, reported its importance in relation to teamwork. Being respectful, flexible, valuing and supporting one another were all principles of cultural competencies also essential for successful teamwork. So not only was cultural safety vital to interactions with Aboriginal individuals it contributed to more effective team functioning.

Participants also briefly talked about the importance of cultural safety training at the student level. The importance of teaching healthcare students about self-awareness, openness, and respect for differences was emphasized. Cultural safety training should be included in basic professional education. Not only was cultural safety training essential in basic health professional education it was equally important in continuing education in the primary healthcare system.

Lastly, participants discussed the importance of having Aboriginal staff as part of the system to further cultural safety in primary healthcare. As noted previously, there was no assurance of culturally safe care from Aboriginal staff but participants felt they were more likely to understand the issues faced by Aboriginal peoples dependent on their own experiences and teachings.

Cultural Safety of the Environment

Cultural safety also extended to the environment in which healthcare services were delivered and although not specified, cultural safety was likely missing to ensure the safety of the environment for Aboriginal peoples (See structural barriers to access in Chapter Five). Participants were looking for a comfortable environment that reflected their beliefs, values, and worldviews, which mirrored their community.

> The physical locations need to be organized or developed to look acceptable in terms of a structural sort of physical relationship to health outcomes and to preferences in comfort level. So ideally, our health services would be designed for Aboriginal people in the way they see the world or the way they want to interact with each other in the front room. Front rooms need to have good resourcing…these are places where people come together and meet, so it needs to be respectful and private at the same time. It's communal and it needs to have good graphics and places for them to sit; things for them to do. (Int.036, Lines 738-748)

The environment should be home-like (e.g., imagery, smells) incorporating Aboriginal language, and friendly staff. One participant suggested offering primary healthcare services in a house, deinstitutionalizing the environment, and promoting safety for Aboriginal individuals attending. Deinstitutionalization was a direct contrast to mainstream healthcare systems governed by rules controlling how providers were supposed to act and how Aboriginal individuals were cared for. In addition to the physical space and ambience, a safe environment was also associated with quality of the care provided and confidentiality and privacy practices.

Cultural safety was also accomplished by providing a supportive environment for patients. Patients relinquished some degree of control when they attended a healthcare service, hence there was a need to make them feel comfortable, allow them to express themselves, and for others (family members, providers) to advocate for effective care. "P2: Yeah, it's really hard to trust.P1: Trust that we're going to be taken care of and respected" (GI001, Lines 278-280). Members of the urban Aboriginal population interviewed, discussed the importance of a supportive environment at length including such components as non-judgemental attitudes, advocacy, nurturing and respectful care, being approachable, and trusting relationships. Being greeted by an Aboriginal person reflecting the urban Aboriginal population was desired. “But when they see myself, they see another Aboriginal person, another brown face…they feel more comfortable. And they smile; a big smile comes across their face and even though we may be complete strangers” (Int.022, Lines 636-639). Support was perceived to be important from Aboriginal staff. Positive Aboriginal staff role models would be beneficial to Aboriginal peoples assisting them to realize that with appropriate care and support, Aboriginal individuals were able to make positive changes in their lives.

A supportive environment also maintained an Aboriginal individual’s ability to make choices about the care received and their overall health. Supporting choice stood in direct contrast to the domination and oppression often characteristic of interactions with Aboriginal peoples within our primary healthcare system. Support for families was also required as well as accommodating families in care.

> …that power differential shouldn’t exist and not just respect, but also belonging. So that families feel that they belong and I think that is, I think that’s something that we really try and that the staff work really hard is that they do belong and they are welcome and this is their place to come. And everybody is safe here. It’s a safe place to be. (Int.032, Lines 323-325; 330-333)

This participant highlighted key components of cultural safety: power differentials, belonging, and ownership for individuals and their families which they endeavoured to create in their organization.

The importance of the environment was highlighted in the literature as well. An environment reflecting Aboriginal culture (Benoit et al., 2003; Bucharski et al., 2006; Eby, 2007; Gottlieb, 2007), as well as an environment that was safe when accessing services (Benoit et al., 2003; Bucharski et al., 2006) were recommended.

Chapter Summary

The confusion in terminology was highlighted by participants’ definitions of cultural safety and other related terms (e.g., culture). Part of the confusion existed because of the evolution of understanding of cultural competencies over time with different terms being used, such as, cultural awareness, cultural sensitivity, cultural competence, and cultural safety. Culture safety was also conflated with cultural customs and traditions as opposed to the inclusion of power and privilege limiting the ability to move beyond cultural awareness. Varying terms, different definitions, and the lack of understanding of cultural safety have contributed to the perplexity described by study participants about how to move forward in cultural competencies. To some degree there was a desire for continued confusion and lack of progress by policy and decision-makers thereby perpetuating colonized practices consciously or unconsciously. The goal for a culturally safe system was not likely to be a priority, where other higher priority issues trumped this agenda. Priorities at the system level were the reduction in the number of complaints (e.g., decreased wait times) from Albertans, fiscal restraint, physician payment plans, and rewarding individuals with stellar ideas to accomplish them. On the other hand, cultural safety, much more like patient-centred care, although important, did not align with priority areas. A commitment to social change was certainly not evident. Priorities and economics of healthcare should not be able to eliminate the movement towards social justice for Aboriginal peoples (Williams, 1999).

Without a doubt, the ethnicity debate continued to exist at all levels: policy, health system, organizations, teams, and individuals (providers and community members) despite persistent presentations by Aboriginal leaders and others of the distinct circumstances of Aboriginal people. There was and continued to be a lack of clear understanding of the difference in issues faced by Aboriginal peoples versus immigrant groups. This lack of understanding was undoubtedly related to the continued influence of colonized structures and processes that permeated our society through organizational, social, and political structures and processes. Language used in documents and by participants also reflected this lack of understanding. Some Aboriginal health documents included information on the distinct needs of Aboriginal community members and then referred to ethnicity more broadly to encompass Aboriginal issues. Historical events and the impacts of colonization (e.g., residential schools experience) were the differences experienced by Aboriginal people contributing to their health and wellbeing. Cultural safety (including attention to power differentials and incorporation of history) was essential to provide culturally safe care for Aboriginal peoples.

Fortunately, there was recognition by some that care should be delivered in a different way for Aboriginal peoples. "…we do need to do things differently…to provide culturally sensitive services to the Aboriginal community…And I have to say I learned a lot, because I just thought whatever we do for the non-Aboriginal clients would work for the Aboriginals [people]" (Int.024, Lines 32-36). The need for cultural competencies training was also identified. Sadly, both practice and training focused on awareness and sensitivity as opposed to cultural safety. The focus on individual change versus system change was also evident.

Racism directed towards Aboriginal peoples was alive and well in our systems as evidenced by the examples provided by participants. Racism was and continued to be a very unfortunate legacy of our colonized system and its oppression of the Aboriginal peoples. The need for cultural safety as a foundation for the primary healthcare system for the Calgary Aboriginal population to ensure their safety in accessing and receiving care will be critical to tackle the inequities in our healthcare system and to begin to address the health disparities of Aboriginal peoples in our community. As so aptly said by the following participant, if the Seven Teachings (well aligned with cultural safety) were implemented fully as intended, there would be limited discrimination and racism in our healthcare system. "It's all in the seven teachings. Respect, honour, love, honesty, wisdom[6]. All those things are there and if people would learn how to properly use them, cultural safety and cultural competency wouldn't even be an issue" (Int.015, Lines 672-676).

Chapter Seven focused on cultural safety as a specific structure and process required to improve the primary healthcare system for the urban Aboriginal population in Calgary. This chapter concluded the presentation of results from this study. Results have provided a

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[6] Seven sacred teachings include love, respect, courage, honesty, wisdom, humility, and truth (Calgary Health Region, n.d.) Humility and truth were not included in the list provided by the interview participant.

comprehensive description and analysis of the data answering each of the research questions. Chapter Eight will focus on the discussion of results, reflections on methods, limitations, and conclusions.

CHAPTER EIGHT—DISCUSSION AND CONCLUSION

This case study research focused on the primary healthcare system for the urban Aboriginal population in Calgary. Previous chapters provided information on context, the literature on primary healthcare for urban Aboriginal populations, methods, and detailed results for research questions. This final chapter will focus on discussion and conclusions given the information presented in previous chapters. Discussion will attempt to bring all results together focusing on system level issues and solutions to create an ideal primary healthcare system for this urban Aboriginal population as well as other urban Aboriginal populations provincially, nationally, and internationally. Discussion and conclusions will also include reflections on methods and limitations of the study.

Many key topics are identified for discussion based on the results from this research. These include the lack of emphasis on primary healthcare overall in our healthcare systems, lack of priority on Aboriginal peoples' health, and the gaps in Aboriginal leadership in urban settings. In addition to the above topics, I will go back to the description of key components of primary healthcare in Chapters Two and Three. Mapping research results to these key components provides an indication of how the current primary healthcare system for the urban Aboriginal population in Calgary compares to the ideal as documented in the literature. Highlights of all of these topics will provide the basis of the discussion in the following sections of this chapter.

Lack of Emphasis on Primary Healthcare

Overall, healthcare systems do not place a priority on primary healthcare despite being touted as the foundation of the healthcare system (Barclay & Fletcher, 2010; Eby, 2009b; Health Council of Canada, 2005a; Lavis & Shearer, 2010; World Health Organization, 1978). Politicians, policy and decision-makers, providers, Aboriginal leaders, and consumers all focus more on healthcare services in secondary and tertiary areas as opposed to primary healthcare. Funding for primary healthcare services is limited in healthcare budgets (Alberta Health and Wellness, 2010); research funding for primary healthcare is less than funding available for biomedical research (Barclay & Fletcher, 2010; Lavis & Shearer, 2010). The current focus on acute care meets the expectations of the public (e.g., high tech treatment and cure, decreased wait times for surgical procedures) but creates an environment of unrealistic expectations for consumers.

Primary healthcare has always been the *poor cousin*, which certainly impacts primary healthcare services available for the urban Aboriginal population in Calgary as well as the quality of such services. The continued priority on secondary and tertiary care is well aligned with western biomedical models of healthcare and in direct opposition to Aboriginal worldviews. The fact that one type of care is privileged over others creates an environment of dominance not unlike the relationship between mainstream society and Aboriginal peoples.

In summary, there is a lack of focus on primary healthcare overall in our healthcare systems. This situation places Aboriginal peoples in a double-bind with a lack of focus on primary healthcare in addition to being the recipients of institutional policies and practices that marginalize Aboriginal peoples.

Lack of Priority on Aboriginal Peoples' Health

Not only is there a lack of priority on primary healthcare, there also is a lack of focus on Aboriginal health. Relatively speaking, the Aboriginal population in Calgary is small compared to the overall population (approximately 2%) (Calgary Health Region, 2006), leading many to suggest a priority on Aboriginal peoples' health is not required. Such thinking can be interpreted as discriminatory and is certainly influenced by colonizing views. The 200% increase in the Aboriginal population in Calgary from 1981 through 2001 makes our urban Aboriginal population one of the fastest growing in Canada (Statistics Canada, n.d.a). This, coupled with the continuing disparities in health and their indigenous status in Canada, makes a priority on Aboriginal peoples' health in Calgary important.

The reorganization of provincial healthcare services in Alberta has focused on key issues of concern for the system and the general public. High priority issues include elimination of wait times in emergency and for surgical procedures as well as fiscal restraint (e.g., closing beds, eliminating duplication in administrative staff, hiring freezes). Other, less high profile programs have waited much longer for reorganization. One such program is the Aboriginal Health Program which has only recently been addressed, following almost two years of reorganization of other departments and programs in the provincial health authority. The potential message for program staff and Aboriginal peoples is that a low value is placed on Aboriginal peoples' health. This type of institutional approach can have a number of impacts on staff and the community. Given the indeterminate state of Aboriginal healthcare services, staff frustration is inevitable. Turnover of staff can be an issue, where skilled staff may move on to more secure positions given the uncertainty in their home department. For the community, it suggests a lack of importance of Aboriginal peoples and Aboriginal health within the healthcare system. Given the fact that services for Aboriginal peoples are so new, this iss yet another demonstration of organizational racism. Restructuring, particularly in the light of fiscal restraint, often further marginalizes those populationsthat are already vulnerable to poor health outcomes (Lynam et al., 2003).

The lack of attention to Aboriginal peoples' health in Calgary was also evident in how primary healthcare services remain at status quo throughout reorganization with no new partnerships, no expansion of existing services, and no addition of new services. Given the uncertainty of the environment, current levels of funding are maintained along with project-based and limited-term funding for service delivery. Despite the rhetorical support for primary healthcare for Aboriginal peoples, therefore, the political will to take a systems level approach to designing urban Aboriginal peoples' primary healthcare is absent.

Gaps in a systems level approach are also apparent in the overall primary healthcare system, not just in primary healthcare for Aboriginal peoples. Currently, healthcare systems lack direction and agreement on vision, mission, and principles (Eby, 2009b; Forbes-Thompson et al., 2007). Organizations, programs, or departments work on their own to deliver care in the absence of system design (Eby, 2009b). This observation suggests it may be hopeless to think about creating an effective primary healthcare system for Aboriginal peoples; however, Aboriginal peoples have a history of resilience and collective action that health organizations could tap to create real change. Developing a primary healthcare system for Aboriginal peoples in Calgary could demonstrate steps needed for primary healthcare to flourish overall.

A systems level approach is necessary for effective change in the primary healthcare system for the Aboriginal population in this urban centre; “tinkering won’t do, fundamental transformational change is required” (Eby, 2009b, p.64). As Thurston and Potvin (2003) discuss, social change requires deliberate planning and evaluation to succeed. Without a systems level approach, programs and organizations currently operating (e.g., Elbow River Healing Lodge, Awo Taan Healing Lodge, etc.) will be tasked on their own to address the needs of *all* urban Aboriginal peoples. They are tasked to deliver service and asked to address gaps but not resourced to provide the leadership that is needed for real change. Systems thinking and approaches will have the potential to eliminate health disparities given the complex, interconnected issues that exist for Aboriginal populations (Leischow et al., 2008; Rashid et al., 2009).

To summarize, there is an absence of priority on Aboriginal health in our current healthcare system in Alberta. Without such a priority we will not have a systems level approach that is required for an effective primary healthcare system for this urban Aboriginal population.

Comparison to Key Components of Primary Healthcare Systems

The following sections of this dissertation will discuss the study results in light of the key components of primary healthcare identified in Chapter Two. Prior to that, a short discussion will be included comparing these key components to factors found in the literature in Chapter Three.

Comparison of Key Components of Primary Healthcare Systems to Factors Identified in the Literature on Aboriginal Primary Healthcare Services

There is strong alignment between the key components of primary healthcare systems extracted from key Canadian and World Health Organization documents and those factors identified in the literature on primary healthcare services for urban Aboriginal peoples. This alignment is not surprising considering research and practice in primary healthcare with Aboriginal populations exists within the dominant healthcare system. Those who work in Aboriginal peoples’ health continue to use the same language and discourse prevalent in our dominant healthcare system and in healthcare overall. Jurisdictional issues and self-governance, specific to Aboriginal primary healthcare are not mentioned in the documents in which key components of primary healthcare were found. The jurisdictional issues are linked to longstanding struggles for self-government and respect of Treaty rights. These have led to recent clashes characterized by violence, such as, Oka (Cassidy, 2005) and people are often reluctant to address issues that may raise strong feelings. Discussion of the jurisdictional issues in the health sector also means confronting a powerful government system of health care for peoples on-reserve and/or who are registered under the Indian Act. Discussion between governments, municipal, provincial, federal, and tribal, take place at other tables than where specific services are planned. With the increasing numbers of urban Aboriginal peoples, however, their needs and rights will have to become a part of the conversation, and new relations must be developed.

A lack of willingness from mainstream systems for Aboriginal self-determination in primary healthcare services is sustained by beliefs that biomedicine is a superior model. Furthermore there is a widespread belief perpetuated by social media that Aboriginal peoples do not know how to care for their people or how to manage a system. An Aboriginal primary healthcare system with non-Aboriginal leadership and control allows for the persistence of current oppression in our healthcare institutions. The literature suggests that some form of ownership by Calgary urban Aboriginal peoples would assist in integrating Aboriginal worldviews into the primary healthcare system (Joint Management Committee, 2009; Kirmayer, Brass, & Guthrie Valaskakis, 2009; Kral & Idlout, 2009).

The other factor from the literature review that is not explicitly mentioned in the key components of primary healthcare is that of sustainable funding. In fact, sustainability of programs has evolved into a condition for evaluation of success even though the ability of organizations to obtain sustainable or long-term funding is negligible. Within the health sector, programs often disappear with the rationale that fiscal restraints require that decision. It is not surprising, therefore, that people on the front lines do not mention this as a key factor.

Several of the factors mentioned in the literature on urban Aboriginal primary healthcare services are highlighted here as they were also mentioned by study participants.

First, the importance and inclusion of primary healthcare services for children and youth is emphasized. This focus is justified given the young demographics of the population of Aboriginal peoples as well as the importance of family among Aboriginal peoples. Second, the importance of mental health services is underscored given the ongoing impacts of colonization. A move from deficit approaches is needed with a focus on mental well-being and the incorporation of Aboriginal thinking and ways of being (Kirmayer, Brass, & Guthrie Valaskakis, 2009; Van Uchelan, et al., 1997). Third, a strong focus on identity for health and well-being (Benoit et al., 2001; Canadian UNICEF Committee, 2009; Jacobs, 2000; Joint Management Committee, 2009; Lavallee, 2007; Skye, 2006; Van Uchelan et al., 1997) through cultural revitalization, cultural and spiritual healing and the promotion of connection among Aboriginal peoples is recommended. Fourth, the integration of traditional services (Eby, 2007; Gottlieb, 2007) is key to a primary healthcare system for urban Aboriginal peoples; however, as discussed under Key Component Two below, this has to move well beyond arts, crafts, or dietary preferences. All other factors are included in the discussion of key components of primary healthcare systems and are discussed in the following sections of this dissertation.

Key Component One: Universal Access

Theoretically, Aboriginal community members in Calgary have the same access to primary healthcare services as non-Aboriginal community members. In reality, this is not the case. Access is limited by such barriers as transportation, wait times, jurisdictional issues specifying payment plans, complexity of the system, and services not meeting the needs of the population. While some of these access issues are shared with some non-Aboriginal populations, jurisdictional issues, population needs, and other contextual factors create complexity that is more strongly focused on the Aboriginal population.

Varying beliefs of Aboriginal peoples conflict with western biomedical models of healthcare and impact access to primary healthcare services. Connection to ancestors, family, community, and the land (Kirmayer, Tait, & Simpson, 2009; Niccols et al., 2010; Wilson & Pence, 2006) operate in direct contrast to western medicine models of individualism and competitiveness. Accountability to others and the community are key foundational components of Aboriginal value systems (Wilson & Pence, 2006). Aboriginal beliefs about well-being focus on the whole person, including the social, emotional, mental, and spiritual needs of the community (Benoit et al., 2003; Niccols et al., 2010; Wilson & Pence, 2006); therefore, treatment and cure for specific conditions and disease functions are contradictory to holistic care and viewed as not helpful by many Aboriginal peoples.

Despite some acknowledgement that Aboriginal peoples may hold different world views, western biomedical paradigms are sustained as the foundation of primary healthcare services for Aboriginal peoples. Primary healthcare services continue to be an *expert-based model* delivered by healthcare providers who are deemed by decision-makers to be superior. Some Aboriginal peoples also support the expert model, asking for professionals to provide services. This practice is based on the perpetuation of the colonizing institutional policies that believe non-Aboriginal is automatically superior. The superiority may be defended in terms such as evidence-based or scientific.

Furthermore, educational institutions where healthcare providers are trained privilege western biomedicine. A primary healthcare system based on the foundations of Aboriginal worldviews is desired by Aboriginal peoples (Joint Management Committee, 2009; Lavalee, 2007; Skye, 2006; Waldram et al., 2006) incorporating western medicine when appropriate (Anishnawbee Health Toronto, n.d.c.). Unfortunately, primary healthcare is still situated within and dominated by colonized institutions. As such, the ability to move towards a primary healthcare system that will meet the needs of the urban Aboriginal peoples is difficult. A post-colonial analysis of primary healthcare is required to overcome some of the inconsistencies between Aboriginal and non-Aboriginal world views.

Access to primary healthcare services is also significantly limited by racism and discrimination. Discrimination by individuals and organizational policies perpetuates the racism towards Aboriginal people. For example, policies that include Aboriginal people with other immigrant groups in diversity initiatives undermines the unique indigenous and historical context of Aboriginal peoples (Browne & Varcoe, 2006; Harding, 1995; Kirmayer, Brass, & Guthrie Valaskakis, 2009; Reimer Kirkham et al., 2002) and their Treaty rights. Systemic racism, where institutional and societal thinking, policies, structures, and practices contribute to racism, are so embedded in our system they are practiced by organizations and individuals unconsciously. Systemic racism, in particular, contributes to the persistence of racist policies and practices in our healthcare system. The lack of a culturally safe system creates a lack of trust in the current primary healthcare system and its providers, limiting the access to services for Aboriginal communities and their members. Aboriginal peoples are criticized in ways that imply they have created the lack of well-being in their communities, through laziness, corruption or some other negative trait. Cultural safety will be addressed in more detail in the following key component on equity. When people are not receiving the care they need from the healthcare system, and when large and persistent health inequities exist, trust in Aboriginal people to provide leadership for changing the system is also eroded.

Universal access to healthcare services also has its drawbacks. Although universal access is prudent and necessary, providing universal access to all current services for all people would be impossible to sustain. Decisions about what the system can afford will be necessary. The problem then becomes who makes the decisions, what information is provided, and how equity is achieved. Without political power, these decisions may further marginalize the urban Aboriginal population.

In summary, access is limited in the current primary healthcare system for the urban Aboriginal population in Calgary by a number of barriers (e.g., transportation, jurisdictional issues, wait times), western biomedical worldviews, and racism. The ideal primary healthcare system will support capacity for self-determination in the system to minimize such issues. Finally, a culturally safe system operating at all levels is needed to ensure universal access to primary healthcare services for Aboriginal community members in urban settings.

Key Component Two: Equity and Addressing Disparities for Populations that are Marginalized

Inequity for this urban Aboriginal population is apparent in many areas in the current primary healthcare system. Jurisdictional issues speak to the inequity of healthcare services available to different Aboriginal groups. Policies such as the Indian Act and funding mechanisms for Aboriginal health continue to impose an environment of competition among Aboriginal groups. Those Aboriginal individuals with status receive services different from those without status and Métis individuals. Accountability for healthcare services for urban Aboriginal peoples is not clear. An environment based on equity cannot exist where competitiveness among Aboriginal peoples and their organizations is institutionalized and where no one takes accountability for healthcare services for this population.

Most of all, a system based on equity is not possible considering the issues of racism and discrimination described in the study. Cultural safety does not exist, other than in a few pockets in the current primary healthcare system. A central issue in cultural safety is power differentials. Unfortunately, cultural safety has, for the most part, been reduced to *beads and feathers*, focusing on cultural traditions and practices of Aboriginal people. The primary healthcare system and society will not be able to address hundreds of years of racism by being simply culturally aware and sensitive. Being aware of and incorporating some traditional cultural customs and practices into some parts of the system and then expecting this type of cultural safety to resolve power differentials and issues of inequity is not realistic. A focus on cultural traditions undermines Aboriginal peoples in many ways even though some discourses and institutionalized practices imply such actions will be good for Aboriginal peoples. One outcome is often ignoring the diversity in the Aboriginal population and encouraging competition. Another is the racist response of staff and others when practices are viewed as giving special rights to Aboriginal people. There is a tendency among non-Aboriginals to forget there is more to the community and their people than cultural traditions, and that all culture is constantly adapting and growing. Implementing cultural practices in a culturally unsafe environment obscures the fact that Aboriginal peoples are human beings with experiences impacting their health and well-being; they are exposed to racism and discrimination in our healthcare systems and society overall on a regular basis.

A primary healthcare system without cultural safety at all levels of the system (policy, the environment, management, provider, and patient levels) cannot provide equitable care for Aboriginal peoples. We must address why we continue to operate a system with racism. If formal policies to rid the system of such practices at all levels (e.g., organizational, individual) do not exist, unwritten policies are allowed to continue (Bacchi, 1999). Without dedicated resources to implement such written policies, the same effect will prevail. I suggest that we (providers, decision-makers, and policy-makers) are so conditioned to the colonizing practices of oppression and racism we are often not conscious of the discrimination that exists. Cultural safety will take a commitment by leaders to implement. A comprehensive review of policies will be required; cultural safety training for all employees from Chief Executive Officers to frontline staff whether Aboriginal or non-Aboriginal will be essential. An audit of the environment will also be required. Institutional ethnography methods, through the analysis of interchanges between Aboriginal individuals and organizational processes, have the potential to explicate marginalization by institutional policies, processes and texts (Campbell & Gregor, 2002; Pence & McMahon, 2003; Smith, 2005; Wilson & Pence, 2006). Institutional ethnography is used as a frame of reference in this study, not as a method, so in-depth analysis of the impact of institutions on the interchanges and processes, of Aboriginal individuals seeking primary healthcare services is not included as part of this study. Research on experiences of racism and discrimination is in its infancy (Paradies, 2006) and the health sector could play a leadership role in developing this field of study.

A culturally safe primary healthcare system is an ideal that can be worked toward, but it will not be achieved easily. Considering the nature of racism, which is systemically entrenched in our institutions, including healthcare, are we naïve to think that it will somehow disappear. Cultural safety is about power differentials which occur in interactions with all people at all levels of the system. Power differentials must be addressed in personal as well as institutional relationships, and this is difficult in a system where power over people is rewarded. Ultimately, a culturally safe primary healthcare system would be beneficial to the overall population. In the meantime, Aboriginal peoples may need advocates for better care and remediation after bad experiences.

There is a need for reconciliation among Aboriginal and non-Aboriginal people. Feelings of guilt of some white people will not lead to cultural safety and neither will reverse racism from Aboriginal peoples. An environment that supports the value of genuine respect for other people will be required. This value and commitment is not historically part of colonized European practices. Through a commitment to cultural safety in the primary healthcare system for Aboriginal people, a new way of working together among Aboriginal and non-Aboriginal people can be created in Canada. The Truth and Reconciliation Commission of Canada, while focused on residential school issues, provides an opportunity to pursue reconciliation more broadly if the will to do so exists (Truth and Reconciliation Committee, n.d.).

Currently, competencies training for healthcare professionals both at the basic education level and continuing education focuses on cultural awareness and sensitivity. Significant opportunity exists for cultural safety education of healthcare providers. At the basic education level, cultural safety should be integrated to all courses, rather than a two-hour workshop that is intended to make individuals culturally safe. This is an inherent danger in cultural competencies training where individuals have a small amount of knowledge and feel they are culturally competent. Cultural safety should also be incorporated into interprofessional courses and training to have a positive impact on team functioning. Cultural safety training also needs to be supported in practice, encouraging continual self-reflection. It is not about one-time education to ensure cultural safety.

In summary, the current primary healthcare system for the urban Aboriginal population in Calgary is not based on equity. Jurisdiction and other issues perpetuate an environment of competitiveness with no accountability for the health of urban Aboriginal peoples. The primary healthcare system for the urban Aboriginal population should be culturally safe for Aboriginal peoples. The integration of cultural safety will need to be mandatory at all levels of the primary healthcare system and in educational institutions to ensure justice and equitable healthcare practices for all.

Key Component Three: Intersectoral Collaboration

Some evidence of collaboration is seen in the current primary healthcare system for this urban Aboriginal population. Even so, gaps are found in collaboration in all areas: within primary healthcare; within the healthcare system; and most notably, intersectoral collaboration. Intersectoral collaboration is necessary to effectively address the often complex needs of Aboriginal peoples. Health systems will need to work with such sectors as justice, education, and housing. Housing is a key component of well-being for individuals; other issues will not be a priority until they have somewhere to live other than the street or a homeless shelter. The interconnectivity of issues for Aboriginal peoples will need to be addressed. The health sector can ill afford to transfer accountability to individuals, the community, or other organizations for those social determinants of health and well-being the sector does not officially control (e.g., employment, education, housing). Partnership in addressing all issues for urban Aboriginal peoples will be required (Rashid et al., 2009).

Experience to date reveals that it is difficult to build partnerships with other programs and organizations within and outside of the primary healthcare system even though this is recognized as effective in planning and delivery of primary healthcare services. Current organizational policies and structures can make it difficult to work with others (e.g., difficulty in attending meetings outside of regular daytime work hours, meeting space for internal meetings trump meetings with external organizations and partners) while politics and differing agendas impede organizational partnerships. Turf protection is evidenced by competitive funding environments and organizations not wanting to share information or make referrals even if it is in the best interest of Aboriginal populations. Partnerships may not include the right people, those able to make decisions for organizations, preventing effective working.

Equity in partnerships will also need to be addressed. Mainstream and large organizations can easily dominate other, smaller not-for-profit organizations. Aboriginal-specific organizations and services often do not stand a chance of equitable partnership with mainstream, larger organizations. (Thurston et al., 2005; Thurston, Farrar, Casebeer, & Grossman, 2004).

Competitive relationships between Aboriginal organizations are clearly evident in study results, despite a traditional philosophy of connection and accountability for others in Aboriginal communities (Kirmayer, Tait, & Simpson, 2009; Wilson & Pence, 2006). With the exposure to hundreds of years of colonization practices and western ways of thinking and being, Aboriginal peoples have learned well the behaviours of competiveness and individualism. Institutional policies such as the Indian Act, funding competitions, and boutique services have resulted in the increase of competition among individuals and organizations.

Lateral violence occurs in all populations in our society. In Aboriginal communities, lateral violence arises, in part, from the multiple, intergenerational traumas (e.g., residential schools) experienced by Aboriginal peoples over the last several hundred years (Goodleaf & Gabriel, 2009; Mussell et al., 2004; Victor, 2004). Lateral violence has a significant impact on Aboriginal communities: power differentials within and between communities; internal strife within communities; and the inability to trust one another. This internalization of colonized violence has negatively affected the ability for Aboriginal peoples to work together (Goodleaf & Gabriel, 2009; Victor, 2004). Although not named as such by participants in this study, the potential for lateral violence was evident given the lack of collaboration and competitiveness between Aboriginal individuals and organizations.

Lateral violence between Aboriginal peoples is a direct impact of the institution of racism. Those individuals and groups that are discriminated against may have a tendency to discriminate against others in their own circles. If we cannot deal with the systemic nature of racism against Aboriginal peoples, then this type of lateral violence will be allowed to continue.

There is a need to better understand the lack of collaboration, competitiveness, and lateral violence in this urban Aboriginal population and how such learned behaviours and thought processes can be modified and mitigated through institutional policies and practices. A desire to go back to historical, traditional Aboriginal philosophies and governance is apparent. In some ways these traditional values and practices are but idealistic thinking from another era (Waldram, 2009). Going *back* to traditional Aboriginal practices is not entirely feasible as traditional practices are continually adapted to the contemporary context (Kirmayer, Tait, & Simpson, 2009).

> Aboriginal peoples are engaged in an ongoing process of re-articulating themselves in the modern world in ways that honour their ancestors, maintain links with crucial values, and creatively respond to the exigencies of a world simultaneously woven together by electronic media and driven apart by conflicts of culture and value. (p. 24)

Aboriginal peoples must reconcile their traditional practices and values with the current environment in which they live. This is not a simple task.

In summary, partnerships are limited within Aboriginal populations, within the healthcare system, and across sectors affecting the ability for the primary healthcare system to effectively address the broad, often complex needs of Aboriginal peoples. Collaboration within the current primary healthcare system for the urban Aboriginal population in Calgary is also impacted by an increasing focus in Aboriginal peoples on competitiveness and individualistic philosophies.

Key Component Four: Community Participation in Primary Healthcare Planning and Implementation

Some evidence of community participation in the primary healthcare system is confirmed by study results and in fact, some feel this is a strength of the current system. Inclusion of community leaders, Aboriginal providers, and Elders is evident in the development of foundational documents (e.g., Kim ma pii pi tsí – Caring for Health 2007 – 2014 [Calgary Health Region, n.d.], Aboriginal Mental Health: A Framework for Alberta [Alberta Mental Health Board, 2006]) with the intention to guide healthcare services for Aboriginal peoples in Calgary and Alberta. Absent is the direct involvement of a broader cross-section of community members. Role confusion and undervaluing of the contributions of lay people in health service planning and implementation are evident in all health consumer groups. Community members desire, as a minimum, three components for participation to be effective and worthwhile from their perspective: a fair and legitimate process of participation, knowing how the information gathered will be used in decision-making, and the difference it will make (Abelson & Eyles, 2004; Abelson et al., 2003; Church et al., 2002). Representation of perspectives can be difficult given the diversity of the population (e.g., First Nations, Métis, non-status Aboriginal individuals), gender, socio-demographics, and the process of recruiting participants (Quantz & Thurston, 2006). Selection bias and the ability for all strata of the community to be empowered to voice their perspectives also come into play. Citizen participation sometimes is a token exercise and, therefore, community members are cynical of the process and what, if any, changes will result (Abelson & Eyles, 2004). As policy and decision-makers in healthcare systems, we perpetuate undervaluing contributions of patients and community members in healthcare service delivery. In the case of the Aboriginal population, at times we simply do not want to hear what Aboriginal people have to say. Inequitable contribution of information for primary healthcare system design favours the voice of some over others; yet another example of domination of one group over another.

Despite some success with the inclusion of the community in participating in the overall direction of policies regarding service delivery, improving community participation at all levels for all components of primary healthcare planning, delivery, and evaluation is highly recommended. The previous Aboriginal Community Health Council (The Council was disbanded with the move to a single provincial health authority) provided an opportunity for participation in healthcare services planning and delivery in Calgary (Quantz & Thurston, 2006). Community participation in health services is generally understood to be an important component for health services delivery (Abelson & Eyles, 2004; Abelson et al., 2003; Eby, 2007; 2009). But we continue to use participation as an add-on, as evidence shows where discussion about community participation often occurs at the end of directional documents and frameworks. A commitment to genuine community participation is needed to avoid further pessimism of Aboriginal peoples in token participation.

Relinquishing control of primary healthcare service delivery is difficult for policy and decision-makers. The willingness to commit to legitimate Aboriginal ownership and control in the primary healthcare system is also inadequate. Our healthcare systems continue to be based on *expert models* (Abelson & Eyles, 2004), particularly in relation to Aboriginal health services (Kirmayer, Brass, & Guthrie Valaskakis, 2009). Healthcare providers and decision-makers are highly educated with experience in healthcare, therefore, they believe they know best when it comes to planning, implementation, and evaluation of primary healthcare for urban Aboriginal populations. For Aboriginal peoples, it reinforces the supremacy of Eurocentric beliefs of the colonized institution of healthcare. Turf protection is another reason why there is reluctance to give control to the community for healthcare service delivery. Again the superiority of our knowledge and skills is underscored, as well as the desire for policy and decision-makers to remain employed. Furthermore there is a lack of trust in Aboriginal leadership (e.g., accountability, fiscal management) given some recent issues with some First Nations' bands and Aboriginal organizations. This excuse is used to explain reluctance of giving control to the community as though a jointly acceptable model is impossible to find. Finally, the lack of available Aboriginal leaders and their capacity for healthcare services delivery in urban centres is evident. The latter has significantly impacted community participation and self-determination in primary healthcare systems for urban Aboriginal communities (Mussell et al., 2004).

In summary, community participation is evident in the current primary healthcare system, but can be strengthened to include participation of all levels of the population in all components of primary healthcare planning, delivery, and evaluation. A variety of issues have limited community participation: role confusion and undervaluing the contribution of community members, reluctance to give up ownership and control, expert-driven models, lack of trust by both Aboriginal and non-Aboriginal groups, and a lack of trained leaders for the planning and implementation of a primary healthcare system for this urban Aboriginal population. Given the importance of community participation as a key component of primary healthcare since inception of the concept (World Health

Organization, 1978), community participation should be front and centre; it should be the foundation and starting point for primary healthcare system redesign for this urban Aboriginal population and others.

Key Component Five: Population Health Approach

Population health is well-aligned with Aboriginal philosophies and ways of being. First, health and well-being are much more broadly defined in both population health and Aboriginal worldviews (Bartlett, 2005; First Nations Centre, 2005; Smye & Mussell, 2001; World Health Organization, 2006) than in biomedicine or positivist health research traditions. The focus of western worldviews and the biomedical model are the individual, and the treatment and cure of disease. Needs are associated with deficits (Arnold & Bruce, 2005; Van Uchelen et al., 1997). The population health and Aboriginal frameworks integrate a holistic approach to health and well-being including emotional, spiritual, and mental well-being components (Bartlett, 2005; Hunter et al., 2006; Long & Fox, 1996; Peters & Demarais, 1997; Royal Commission on Aboriginal Peoples, 1996; Smye & Mussel, 2001). Second, both thus incorporate the importance of the social determinants of health and well-being (Kindig & Stoddart, 2003; Public Health Agency of Canada, n.d.; Raphael, 2004b; Thomas, 2003; Waldram et al., 2006). Finally, there is concern for collective well-being (population health and the community) as opposed to a focus on individual health status (Friedman & Starfield, 2003; Kindig & Stoddart, 2003; Mussell et al., 2004; Wilson & Pence, 2006).

Despite the alignment in philosophies, decision-makers, healthcare providers, Aboriginal leaders, and members of Calgary's Aboriginal population most often discussed primary healthcare at the individual level as opposed to a population health focus. This can be explained by the domination of the individual perspective in the media. Thus lay people, Aboriginal leaders, and providers reflected this type of thinking. But at the policy and decision-maker levels, one would think that ideas could be characterized by bigger picture thinking, vision, and employing a systems level approach. Services are ultimately delivered at the patient level, but managers and providers need to look beyond the individual patient to the health of the population in order to focus on the social determinants of health and well-being, up-stream approaches of disease and injury prevention and promotion of health and well-being, and the use of a population needs-based approach. Assessment, planning, and the implementation of primary healthcare services needs to move from thinking about the individual and the current episode of care to a more comprehensive and proactive approach attending to the continuum of care for patients, families, and communities, inclusive of prevention and promotion.

Difficulty in making the shift in thinking from the individual to the population, from illness to health, from treatment and cure of disease to upstream approaches of prevention and promotion, are not new issues for population health leaders (Collins & Hayes, 2007; Labonte, 2005; Lin & Fawkes, 2005; Raphael & Bryant, 2006). The primary healthcare system for this urban Aboriginal population can ill afford to focus on individual outcomes alone, given the significant health disparities that exist. Leadership in Aboriginal primary healthcare may provide an example of how to make the shifts that are needed.

The individual focus in healthcare is also contrary to cultural safety. Implementing cultural safety at all levels of the system beginning with senior leadership support is not apparent; rather, the accountability for creating a culturally safe primary healthcare system is downloaded to individual providers. Cultural safety is a paradigm shift required at the system level to create social change across all components of the primary healthcare system for this urban Aboriginal population. Unfortunately, the dominant political ideology in Alberta and beyond is focused on individual responsibility and accountability (Scott, Horne, & Thurston, 2001), materialism, and capitalism (Kirmayer, Brass, & Guthrie Valaskakis, 2009). Universal healthcare and education are threatened by private systems driven by market economies and demand by those who can pay for services (Armstrong, 2001; Labonte, 2005). Caring for populations who are marginalized and have few resources is simply not a priority under such an ideology. Aboriginal peoples are often blamed for being poor, for not resolving the impacts of intergenerational trauma , and for the inequities they face in determinants of health; hence individuals and groups become responsible for problems. Aboriginal worldviews of connection and accountability stand in direct conflict with these political ideologies (Kirmayer, Brass, & Guthrie Valaskakis, 2009; Wilson & Pence, 2006). In addition, Aboriginal scholars are addressing the gaps in written history reflecting the contributions that Aboriginal peoples have made to Canadian society over the years (Newhouse,Voyageur, & Beavon, 2005).

In summary, individual level thinking (e.g., individual patients versus population, episodic care versus the continuum of care) is very evident in this study. There will be a need to look beyond the individual level to a population health focus which is well aligned with Aboriginal thinking. A population health approach should include components such as the social determinants of health and well-being, upstream approaches to address population needs, a focus on population needs to drive service delivery, system-wide cultural safety, and population outcomes.

Key Component Six: Effective Utilization of Interprofessional Teams

As noted in Chapter Two and Three, patient-centred teams have the potential to impact outcomes in primary healthcare for individuals and ultimately the primary healthcare system, particularly for those patients with chronic complex conditions (Barrett et al., 2007; Bohmer & Edmonson, 2001; Health Council of Canada, 2005b; Schmitt, 2001). Despite this early evidence, the literature does not contain many examples of patient-centred teams in Aboriginal health. Given the historical and current impacts of colonization, the needs of Aboriginal peoples tend to be more complex and highly interconnected with one another; hence patient-centred teams provide an ideal primary healthcare model to address the needs of Aboriginal people (Dillard & Christopher, 2007; Eby, 2007; Fenn et al., 2007). The gap in information on patient-centred teams in Aboriginal health in Canada is even more noticeable because of the fit of this model. Perhaps the barriers (e.g., lack of resources and funding, lack of leadership) to innovation were considerable enough to stall the integration of patient-centred teams in primary healthcare service delivery for this population. Tait (2008) would suggest such barriers may be intentional and are unethical in healthcare service delivery. Given the lack of emphasis on primary healthcare and Aboriginal peoples’ health overall, a lack of resources for patient-centred teams will definitely impact the ability for the Aboriginal primary healthcare system to move forward and provide the best care possible for community members.

The current primary healthcare system does include the operation of a few interprofessional teams although membership of teams is fairly conventional with physicians, nurses, and mental health workers, whereas a long list of different types of providers is desired by participants in this research. Team membership to date is based on anecdotal evidence without carefully examining the needs of the population. The utilization of a population needs-based approach (Besner et al., 2009) is suggested to ensure team composition reflects population needs as opposed to provider recommendations or the priorities of the system. Consideration of the skills, knowledge, and training of providers is necessary to ensure the optimization of roles on the team (Interprofessional Care Steering Committee, 2007; White et al., 2009). Such attention to team mix and role optimization will facilitate better health outcomes for Aboriginal populations.

The inclusion of patients as team members is highly supported by the research and literature (Abreu et al., 2002; MacDonald et al., 2002; Walker & Dewar, 2001) but is limited in reality. The evidence of power differentials between providers and Aboriginal individuals as well as institutional structures and processes overall does not support equitable partnership and cultural safety with Aboriginal individuals and their families. Due to power differentials that give providers more control in patient-provider relationships, the integration of patients and families as equitable team members will need to be initiated by the health system and its employees (Walker & Dewar, 2001). The inclusion of Aboriginal individuals and their families as part of the team requires relationship building to develop an environment of trust, valuing of their contribution as team members, and significant advocacy on the part of staff given their exposure to past and current paternalistic practices.

There is a move in the Aboriginal primary healthcare system in Calgary to hire Aboriginal staff when possible. Health services provided by Aboriginal healthcare personnel have shown improvement in outcomes for Aboriginal people (Aboriginal Nurses Association of Canada, 2002; Gregory & Hart-Wasekeesikaw, 2002). Availability of skilled Aboriginal healthcare providers is limited in all settings: on-reserve; rural; and urban (Coll et al., 2004; McBride & Gregory, 2005; Romanow, 2002). A health human resources strategy based on population needs incorporating policies for hiring Aboriginal providers and support staff does not exist in the Aboriginal primary healthcare system nor in the healthcare system overall. Diversity initiatives exist and incorporate, according to institutional policy, Aboriginal healthcare workers. An Aboriginal human resources professional is employed by one organization where some project initiatives are underway in developing partnerships with educational institutions to promote careers in Aboriginal health. Working with educational institutions to recruit Aboriginal individuals into health provider programs is critical. To facilitate the education of Aboriginal students (e.g., policies, openness to Aboriginal worldviews, safety of the environment), educational institutions need to address their structures and processes which are steeped in colonizing ideology. Including educational institutions in the development of a health human resources strategy will better ensure the availability of a skilled Aboriginal workforce in primary healthcare for the future.

It appeared from study results that there was minimal utilization of paraprofessionals in the current primary healthcare system for urban Aboriginal peoples. This was an urban phenomenon as paraprofessionals are often used in First Nations communities. The role of paraprofessionals in the current primary healthcare system for Aboriginal peoples along with potential contributions in an improved system requires further exploration.

There is little recognition in our primary healthcare system of the commitment required and stress encountered when working in Aboriginal primary healthcare service delivery. Higher rates of burnout and turnover are clearly evident in this provider group whether they are Aboriginal or non-Aboriginal. Support for these workers and acknowledging the value of their service is essential (Coll et al., 2004; Gottlieb, 2007; Mignone et al., 2003). Some Aboriginal providers are also undergoing their own healing journey parallel to that in those they serve. Acknowledgement of this fact, support, and treatment to maintain their well-being is therefore necessary from a human resource management perspective.

In summary, patient-centred teams provide an ideal model to address the multiple health needs of Aboriginal communities. Attention to staff mix, population needs, and role optimization will facilitate better health outcomes for Aboriginal peoples served by a team of primary healthcare providers. Patients also need to be included as equitable team members. A move to hiring more Aboriginal staff is apparent, but overall, Aboriginal healthcare providers are still limited in numbers. Partnerships with educational institutions will be required to facilitate an increase in the Aboriginal health workforce. If the health sector is serious about a primary healthcare system for Aboriginal people, it cannot afford to leave the changes needed in other sectors like education to chance.

Key Component Seven: Information Technology and Electronic Health Records

The primary healthcare system for the urban Aboriginal population in Calgary does not have information systems that accurately capture data for Aboriginal peoples. In fact, effective and efficient data systems and electronic health records do not exist in the healthcare system as a whole (Canada Health Infoway & Health Council of Canada, 2006; Romanow, 2002). Historically, institutional policies for collecting data on Aboriginal peoples were based on colonizing practices and data was often misused. Overall, confidentiality and privacy policies are being strengthened, but still, rightfully so, there is a great deal of mistrust by Aboriginal peoples given data is collected, stored, and owned by colonizing institutions (e.g., healthcare institutions, government departments). There is a push-pull around the needs for Aboriginal specific data to assess needs and outcomes versus the needs for confidentiality and privacy. Attention to OCAP principles of ownership, control, access, and possession (Schnarch, 2004) may be required in the collection of any information on and about Aboriginal peoples. OCAP is not without controversy, however, so attention to models of ethical research with Aboriginal peoples is still needed.

In the case of the urban Aboriginal population, negotiation will be necessary to determine ownership given the lack of a single entity of governance. As evident in this study, a written, signed agreement around ownership was not possible due to the lack of a single governance entity for Aboriginal peoples in this urban centre. An Advisory

Committee was used as a proxy for ownership, control, and access (see Chapter Four) for this urban Aboriginal population. Further exploration of such processes in urban populations will need to be explored. Self-governance, which will be discussed later in this chapter, could assist in addressing these issues.

In addition, a significant financial commitment will be required to develop and implement an effective information system in the primary healthcare system for the urban Aboriginal population. Historically, financial commitments such as these, where different systems need to be linked together, were fraught with jurisdictional issues, lack of resources, and lack of priority for this work. As discussed earlier in this chapter, there is a lack of priority on primary healthcare overall as well as a lack of priority on Aboriginal health and hence a lack of vision, action, and resources (e.g., qualified personnel to do the work, financial resources) are apparent in this area. Much work is still required in the area of information technology and electronic health records both in the Aboriginal primary healthcare system as well as the mainstream system.

To summarize, information systems are limited both in primary healthcare and Aboriginal health. Creating such systems in healthcare services delivery for Aboriginal peoples requires attention to the ownership, control, access, and possession of data. Financial commitment is also required to make an effective information system a reality in the primary healthcare system for this Aboriginal population.

Key Component Eight: Continuity and Integration

The primary healthcare system for urban Aboriginal peoples in Calgary is characterized by disorganization, fragmentation, duplication, and people falling through the cracks. Individuals are required to tell their stories over and over again and there is a lack of ability to share information across providers. As noted in Chapter Five, there are also significant gaps in services and programs further contributing to the fragmentation of the system, and the ability to meet people’s needs. Lack of coordination and integration of primary healthcare services is not a new phenomenon in healthcare service delivery (Health Council of Canada, 2005a; Shortell, Gilles, Anderson, Erickson & Mitchell, 2000; Suter et al., 2007; World Health Organization, 2008). There is no doubt that this primary healthcare system is a complex system with many components (as shown in Chapter Five) and a context compounded by various complex environmental issues as noted in Chapter Six. All of these further contribute to the lack of coordination and integration present in the primary healthcare system for this urban Aboriginal population. Institutional structures and processes in the Aboriginal primary healthcare system further complicate this system and hamper coordination and integration (e.g., project-based funding, non-insured health benefits, current governance policies that increase jurisdictional issues). It is altogether possible, disorganization of the primary healthcare system is desired by institutions to perpetuate oppression and dominance of urban Aboriginal peoples. This would be an interesting topic for future study.

In summary, coordination and integration are significant issues in healthcare systems including the primary healthcare system. As such, the lack of coordination and integration in the primary healthcare system for Aboriginal peoples in Calgary is not unexpected. Even so, institutional policies and complex environmental issues contribute to an even greater level of disorganization and fragmentation for this urban Aboriginal population. The current state of coordination and integration in the primary healthcare system for the urban Aboriginal population in Calgary will need to be addressed given the multi-faceted needs of Aboriginal people contributing to their ongoing health disparities.

Key Component Nine: Focus on Evaluation and Outcomes Measurement

There is a limited emphasis on evaluation and outcomes measurement in the primary healthcare system for the urban Aboriginal population in Calgary. The lack of importance placed on evaluation and outcomes is all too familiar in primary healthcare where evaluation often will occur as an afterthought (Bergman, 2007; Broemeling et al., 2006; Health Evidence Network, 2004). There is also a lack of resources for evaluation and outcomes measurement. Even so, there are new directives on outcomes measurement given the focus on accountability and fiscal restraint (Broemeling et al., 2006; Marshall et al., 2006; Mattke, Epstein, & Leatherman, 2006). Although these are important components, it is easy to lose sight of the priorities and needs of the community versus those of the much larger primary healthcare system. A new focus on evaluation and outcomes measurement in primary healthcare for Aboriginal peoples is necessary to ensure accountability and sustained funding, but is even more critical to understand if disparities so obvious in our urban Aboriginal populations are being addressed effectively. Since evaluation research is often highly politicized, trust and relationship building again become important to advance this key component of primary healthcare.

In summary, evaluation and the measurement of outcomes is an area for improvement in the primary healthcare system for urban Aboriginal peoples. Given the new emphasis on outcomes in healthcare, it will be important for this system to develop and implement appropriate measures rather than have institutional policies and processes drive the agenda primarily from accountability and fiscal restraint perspectives.

Summary of Comparison to Key Components of Primary Healthcare Systems

The primary healthcare system for the urban Aboriginal population in Calgary exhibits few of the key components of primary healthcare identified in the literature. Although in some areas there are some initial efforts to build upon, there is much work left to do to create an effective primary healthcare system to meet the needs of this urban Aboriginal population.

Aboriginal Leadership in Primary Healthcare and the Urban Aboriginal Community

Politics are pervasive at all levels of leadership in all organizations and communities. Differing leadership agendas impact the direction of the various organizations comprising the primary healthcare system for the urban Aboriginal population. There is acknowledgement that Calgary exists on Blackfoot land and that this be respected, while there is difference of opinion as to who should provide leadership for the urban Aboriginal population in Calgary. The population is represented by many Aboriginal groups, some larger than the Blackfoot group in Calgary. Policies, such as population-based funding for First Nations, create inequities in and around Calgary where larger communities have more power. Although this is most evident in Treaty organization operations, these policies carry over into urban communities and leadership. Leadership in an urban Aboriginal population will need to reflect its diversity and be able to represent its membership. Another policy causing some issues is the professional credentials required to hold a management position within the primary healthcare system, hence the person with credentials is hired, but does not necessarily have a relationship in the population or have their support.

Politics and leadership concerns impact directly Calgary Aboriginal peoples. The difficulties at the Aboriginal Friendship Centre of Calgary some years ago are one example limiting leadership in this urban Aboriginal community. The Friendship Centre model has been touted as an international example of leadership, advocacy, and service provision (resources, cultural and well-being activities) in Canadian urban centres (Canadian UNICEF Committee, 2009). For the most part, organizations (both Aboriginal and non-Aboriginal) have simply allowed Aboriginal leadership to unfold. They did not support the Friendship Centre or create new structures to provide similar services as are provided by other Friendship Centres in Canada, nor did they provide the leadership the urban Aboriginal population requires. It is important to note the Aboriginal Friendship Centre recently is making efforts to once again provide some services and leadership for this urban Aboriginal population.

Self-governance is desired and supported by the literature (Rae, 2009; Wilson, 2007) and is the mainstay of the primary healthcare system highlighted in Alaska (Eby, 2007). Even so, self-governance in healthcare for Calgary’s urban Aboriginal population has not been explored to any extent. Questions arising are numerous. What should self-governance look like in an urban setting? Is self-governance possible given the current void in Aboriginal leadership in Calgary? Is lack of leadership only an issue in healthcare or does it exist in other areas of government and private industry? Would current Aboriginal leadership have a broad enough representation to be inclusive of diverse groups in Calgary? Can governments and other institutions genuinely assess their structures and processes that continue to control Aboriginal peoples as well as services and transfer ownership? Will a model of urban self-governance facilitate better capacity to deal with this complex environment (e.g., will outcomes be improved)?

The downside to self-governance is the shirking of responsibilities of other organizations (e.g., federal and provincial governments, health authorities), particularly for the health challenges facing the urban Aboriginal population. Self-governance has the potential for off-loading to the Aboriginal population and its leadership without appropriate resources to meet the needs of their population. The contribution of the colonizers and colonized institutions to the disparities that exist now become the responsibility of the Aboriginal population.

The lack of trained leaders in Aboriginal communities to deliver primary healthcare services is evident. Work in leadership development will be necessary to create effective leaders to govern and support this primary healthcare system. Capacity building for Aboriginal leadership in the primary healthcare system will be essential to ensure self-determination in primary healthcare service delivery (Gottlieb, 2007). Such training cannot be accomplished in the current primary healthcare system that exists for the most part in the dominant, Eurocentric worldview. A new leadership needs to be created. Such leadership may indeed be a combination of Aboriginal thinking and western worldviews, but room must be made for Aboriginal people to determine how best to incorporate western and Aboriginal worldviews. A training program at the Banff Centre provides promise in this direction.

In summary, leadership in this urban Aboriginal community is at a crossroads. In the last couple of years, we see more Aboriginal managers and staff being hired in the health and other sectors benefiting primary healthcare service delivery for Calgary's Aboriginal population. Issues in leadership in primary healthcare and in the Aboriginal population as a whole continues to exist and is beginning to be discussed in the literature (Kirmayer, Tait, & Simpson, 2009). Differing agendas, the impact of policies, and the diverse nature of the Aboriginal population all affect the leadership of primary healthcare services for this urban Aboriginal population. There is no doubt that Aboriginal leadership will be required to develop and implement a well functioning primary healthcare system for the urban Aboriginal population.

Where Do We Go From Here?

Maintaining the status quo of the current primary healthcare system for Aboriginal peoples in Calgary will continue to uphold the ideologies of colonization (e.g., imperialism, oppression and dominance, racism). Why would such a system of primary healthcare services delivery be retained? Because of our trust in the biomedical model where the body is equated with the physical as opposed to including other components of health and well-being (e.g., emotional, spiritual, mental). The system also continues to reward individual thinking and competitiveness versus systems level vision and strategies. Power is held by a few, particularly those who continue to make money in the current system. Those who hold the power stand to lose significantly if the system is changed drastically (Eby, 2009b). Power is certainly not being held by Aboriginal peoples in the current primary healthcare system. Power exists within mainstream institutions of healthcare and government. Physicians also hold significant power in our healthcare system in Alberta.

Several overarching issues are apparent that are juxtaposed one to another: chaos versus organized complexity; Aboriginal worldviews versus western models; individual versus systems thinking; community participation, self-determination, and self-governance versus control; colonizing system versus post-colonial/decolonized system; and racism and discrimination versus a culturally safe system. A push-pull dynamic currently exists between many of these issues that need to be resolved to be able to move forward in primary healthcare for the urban Aboriginal population in Calgary. A joint resolution may in some cases be the most desirable option.

The current primary healthcare system for the urban Aboriginal population in Calgary is in a state of disorganization. As noted previously, project-based funding, piece-meal approach, and lack of ability to work together all contribute to the disorganization in the current primary healthcare system. There is a gap in the capacity for collaborative, systems organization, a lack of genuine desire for change, and perhaps a desire by institutions to continue the oppression that is served by disorganization in primary healthcare. Many people, both Aboriginal and non-Aboriginal, in healthcare and in the Aboriginal population itself, talk endlessly of the complexity of Aboriginal issues, health, and health services delivery. The complex environment discussed in Chapter Six has provided excellent examples of this complexity. Some have a philosophy of starting small, considering the complexity of the issues and the primary healthcare system, while others believe the magnitude of the complexity will never result in success. This may be interpreted to mean healthcare stakeholders are suggesting the Aboriginal problem is so big; simply put, nothing could be done about the issue. Yes, it is and will continue to be an immense undertaking, but one that will be required given the inequities in healthcare and the disparities in health for urban Aboriginal communities. All social issues (e.g., primary healthcare) are complex and working in networks is considered to be a valuable way of addressing "wicked problems" of complexity (Koppenjan & Klijn, 2004, p. 14). A collective approach is required to move primary healthcare forward for urban Aboriginal peoples.

The continuing clash between Aboriginal worldviews and western thinking is apparent in many areas of this primary healthcare system. The persistence of hegemonic western philosophies (e.g., west versus east, north versus south) as being superior must be addressed. Reaffirming traditional Aboriginal worldviews is possible while recognizing that using the label traditional creates political struggles. Kirmayer, Tait, & Simpson (2009) note that practices are adapted to the contemporary context in which they exist. The primary healthcare system for this urban Aboriginal population will need to value and incorporate Aboriginal worldviews and include western philosophy when appropriate.

Individual thinking is evidenced on many levels in the primary healthcare system for urban Aboriginal peoples in Calgary. Lack of collaboration and partnership, lack of coordination and integration, a high number of boutique services, and downloading accountability for Aboriginal peoples' health and healthcare to individual providers and individual patients all contribute to the lack of a systems level approach. This complex adaptive primary healthcare system will require innovative approaches to incorporate all stakeholders and address the issues of the system. It will necessitate an emphasis on the interactions between system components, collaboration across disciplines, and systems thinking (Leischow et al., 2008; Rashid et al., 2009) and most of all a relationship with Aboriginal peoples themselves (Eby, 2007) to be able to address the health disparities in this urban Aboriginal population.

Control continues to be perpetuated via institutional structures and processes in the primary healthcare system for the urban Aboriginal population in Calgary. A movement towards authentic community participation and self-determination will need to be undertaken. One key issue in community participation is Elder involvement which was also encountered in this study. Elder involvement is about respecting the role of Elders and community input. Hence having a token Elder involved in a process is not the same as consultation with Elders. It is more about the process of public participation; how Elders are involved, their representation particularly in urban settings, how their input is utilized, and what ownership they possess for the initiative.

Study results suggest planning for Aboriginal primary healthcare is completed with the inclusion of Elders and other community stakeholders to develop comprehensive frameworks reflecting Aboriginal worldviews to direct and guide future work in Aboriginal health. But action and implementation of such work is lacking. Inactivated institutional texts are as much of a concern as those institutional texts (see discussion in Chapter Six) that exist and act in the best interests of the institution and its providers as opposed to Aboriginal peoples. Ultimately, self-governance in some form is the ideal for the primary healthcare system for this population. Exploration of self-governance of Aboriginal peoples in the Calgary urban setting is needed.

Racism and discrimination abound in the primary healthcare system for the urban Aboriginal population in Calgary. Changes at all levels of the system are required to ensure the goal of a culturally safe system.

A colonizing system in primary healthcare continues to persist. A move away from such a system to a post-colonial system is necessary and will address many of the issues in the current primary healthcare system for the urban Aboriginal population in Calgary. Decolonization will be necessary. Creating the freedom for dialogue on decolonization will generate space for a new post-colonial system with the revitalization of Aboriginal worldviews, foundations, culture, and identity (Salmon, 2007).

There is also a role for the current primary healthcare system to be involved beyond its immediate borders. For example, the Federal Government’s Truth and Reconciliation agreement (Harper, 2008) has not yet been activated beyond an apology and some funding for healing services. But colonizing practices mirroring the residential school experience (e.g., racism, children being removed from homes by child welfare) continue today. The primary healthcare system should play a role in changing policies to create a culturally safe healthcare system free of racism and to advocate for policy change in other sectors (e.g., child welfare, employment) locally, provincially, and nationally.

Maintenance of the status quo is not an option. The primary healthcare system for the urban Aboriginal population serves governments, the system itself and its organizations, and providers; it does not serve the community requiring healthcare services. The primary healthcare system will need to take a genuine look and reflection at its current state, to attend to the key components of primary healthcare, to use systems thinking for social change, and to advocate for change for Aboriginal peoples. There is no room for naïve and idealistic attitudes. Advocates must understand the historical and power issues that continue to impact Aboriginal peoples. We cannot simply tinker with our existing primary healthcare system for this population for a new ethics is required; one based on post-colonial theory that includes post-colonial policy, structures, processes, and practices ideal for our Aboriginal population in this and other urban communities, First Nations communities, Métis settlements, and Inuit communities. A new post-colonial primary healthcare system will be required to meet the needs of all Aboriginal people, one that is culturally safe, includes self-governance, and effectively addresses health disparities. Creating such a primary healthcare system will be of immense benefit to our urban Aboriginal population. Ultimately, movement towards such an ideal system would also be welcomed by non-Aboriginal people and community health leaders who have been advocating for upstream approaches and comprehensive primary healthcare including family and patient-centred approaches.

Reflections on Method

This section will provide a brief reflection on the methods utilized for the study. Case study methodology (Merriam, 1998; Yin, 2005) is an ideal approach to better understand complex adaptive systems such as the primary healthcare system for the urban

Aboriginal community in Calgary. Processes to establish trustworthiness of the data were carried out as outlined in Chapter Four further strengthening the research results.

Conceptual frames (complex adaptive systems theory, critical social theory, and institutional ethnography) provided a suitable, critical lens with which to better understand the study results. The complexity of the system is obvious. Critical social theory and institutional ethnography assisted in exploring power differentials, oppression, colonizing policies and practices, and social justice for this urban Aboriginal community. It is hoped that the results of this study will facilitate social change in primary healthcare for this population and result in better outcomes over the longer term.

Limitations of the study

The research had several limitations. The study of the case represented a snapshot in time, so it is possible structures and processes of the primary healthcare system studied changed over the duration of the study. Indeed, there was significant evolution during the study (e.g., development of Alberta Health Services, people leaving and new people in new or existing positions). These have been captured to the best of my ability dependent on the time frame of data collection and the knowledge provided by documents, interviewees, and participants during observation.

Given the vastness and the complexity of the primary healthcare system studied, boundaries were set to clearly articulate and define the case (Marshall & Rossman, 2006; Merriam, 1998; Yin, 2003). Remaining within the bounds of the case and ensuring an in-depth coverage of the subject matter was challenging. I was unable to interview participants from all organizations or all individuals that could contribute to the topic. As analysis of the data was conducted using an iterative process, I was attentive to data saturation. Once data saturation of system level issues was achieved, interviews were stopped. Both the process of data saturation and having a broad representation in interviews, observations, and documents allowed me to go beyond a superficial, broad brush stroke of the case to meet the criteria of an in-depth case study.

Lack of Elder involvement at all levels of the research was a limitation of the study. As noted in Chapter Four, attempts were made by the researcher to engage Elders at the

Advisory Committee level. Issues arose in choosing Elders that represented urban Aboriginal peoples, as well as clearly articulating the role of Elders on the Advisory Committee. To mitigate the lack of involvement of Elders in the research process, the researcher has interviewed several Elders to garner their perspectives on primary healthcare for this urban community.

Being a non-Aboriginal researcher is likely considered by many to be a limitation of the study. This situation was mitigated through broad Aboriginal representation on the Advisory Committee. As noted in Chapter Four, throughout the research the Advisory Committee has been involved through finalizing research questions, data collection, and analysis and interpretation of the results. A fellow PhD student who is Aboriginal also participated by reading sections of the results.

Conclusion

This research should not be considered to be a positivist project or an authoritative text on Aboriginal peoples in this urban setting. Rather, it should be read, interpreted and interpretations negotiated to explore and better understand the results. This research project is not over; this document is not the end of the process of change in the primary healthcare system for this Aboriginal population. The research has provided an increased understanding of the case and highlights the issues apparent in the primary healthcare system for this population. There are many more research questions to answer in the area of primary healthcare for urban Aboriginal populations. There is a need for community-based research to look at issues such as human rights, equity, and the exploration of various different concepts as a start. For example institutional ethnography utilizes a unique approach to solving institutional problems. Basic science as a primary mode of research in this area is not feasible considering the questions to be answered and respecting Aboriginal worldviews and ways of knowing. Both research and mechanisms for change will need to build on the current strengths of the primary healthcare system and Aboriginal peoples themselves. Despite the effects of past and present colonization, Aboriginal peoples and its people are resilient. Both the non-Aboriginal and Aboriginal healthcare community need to change how we think and how we act in order to create a new primary healthcare system that will truly meet the needs of this population.

This study provides a comprehensive description of the current primary healthcare system for the urban Aboriginal community in Calgary. Detailed analysis is also presented on the complex environment in which it exists (e.g., jurisdiction, diversity of the population, funding environments, racism) and how the components interact with one another. Finally, structures and processes to improve this primary healthcare system are presented. All of these results together provide information for policy-makers, decision-makers, providers, and Aboriginal individuals and leaders in designing and implementing changes for a primary healthcare system that is culturally safe and meets the needs of urban Aboriginal peoples in Calgary.

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APPENDIX A—GLOSSARY OF TERMS

Aboriginal Peoples refers to the indigenous people of Canada including First Nations, Métis and Inuit (Royal Commission on Aboriginal Peoples, 1996).

Collaborative Patient-Centred Practice takes place when two or more healthcare providers from various professional backgrounds actively participate in care for patients, families, caregivers and communities to facilitate quality care. It is characterized by the enhancement of patient-centred goals, continuous communication among team members, active participation of all team members in clinical decisions, and promotes an environment of respect (Health Canada, 2010; World Health Organization, 2010).

Colonization refers to a “form of invasion, dispossession and subjugation” of a group of people. (LaRoque, n.d.)

Cultural Safety is “the effective practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and, disability” (Nursing Council of New Zealand, 2005, p. 4)

Family Health Team (FHT) is an Ontario-based initiative in primary healthcare. FHTs create a team of different healthcare providers to provide quality care for patients. FHTs provide support for family physicians from other complementary providers such as nurses, nurse practitioners, nutritionist, and social workers. Team members work collaboratively, each utilizing their skills to provide care for patients in the community (Ontario Ministry of Health and Long-term Care, 2009).

First Nations refers to the original people of Canada along with their descendents. This group is comprised of both Status and Non-Status Aboriginal peoples excluding Inuit and Métis individuals (National Aboriginal Health Organization, n.d.).

Interprofessional is defined as the interconnected education and/or practice among professionals from various diverse disciplines (D’Amour & Oandasan, 2005). The term “professional” implies inclusivity of all types of workers involved in patient care where the patient and family are considered a partner and member of the team.

Métis is a French word for "mixed blood," and is one of three groups of Aboriginal people in Canada. More specifically, Métis refers to the descendents of the French, English and Scottish fur traders who married Aboriginal women (e.g., Cree, Ojibwa, Sauteaux, Dene, and Inuit) in western and northern Canada and Newfoundland (Métis Nation of Alberta, 2003; National Aboriginal Health Organization, n.d.).

Non Status Aboriginal Peoples are those that are not recognized by the Government of Canada under the Indian Act for a variety of reasons (e.g., loss of status, inability to prove their Indian status) and therefore not eligible for the same benefits (National Aboriginal Health Organization, n.d.).

Primary Care is most often defined as the first point of contact with the healthcare system, most often provided by a primary care physician (College and Association of Registered Nurses of Alberta, 2008).

Primary Care Networks (PCNs) is an Alberta-based primary care initiative. PCNs are a formal relationship between physicians and Alberta Health Services to plan and deliver primary care services for a specific population, geographic or otherwise (Primary Care Initiative, n.d.)

Primary Healthcare is defined as "essential healthcare, based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (World Health Organization, 1978). "Furthermore PHC is typically the first point of entry to the Canadian health system. It is linked to and often provides a referring or coordinating function for other specialized health care sectors as well as community services…PHC recognizes the broader determinants of health and includes coordinating, integrating, and expanding systems and services to provide more population health, sickness prevention, and health promotion, not necessarily just by doctors. It encourages the best use of all health providers to maximize the potential of all health resources" (Mable & Mariott, 2002, p. i)

Primary Medical Care refers to that care provided by family physicians for their patients focusing particularly on clinical symptoms, diagnosis and treatment (Starfield, 1998).

Racism “is prejudice or discrimination based on the belief that one or one’s group is innately or genetically superior to another” (LaRoque, n.d.).

Social Determinants of Health incorporates a much broader definition of health. “Health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour” (Public Health Agency of Canada, n.d., paragraph 3). The determinants include factors (e.g., income, education, social support, gender) within and outside of our health system that influence the health of individuals, families or communities (Public Health Agency of Canada, n.d.).

Status Aboriginal Peoples refers to those who are registered under the Indian Act and eligible to a set of predetermined rights (National Aboriginal Health Organization, n.d.)

APPENDIX B—MATRIX OF RESEARCH QUESTIONS AND METHODS

Research Questions	**Methods**	**Data Source**
What are the strengths and gaps in existing PHC services for the Aboriginal population?	• Document review • Individual and group interviews	• Relevant documents • Interviews with providers, decision-makers, Aboriginal leaders, population members, other stakeholders (e.g., Native Friendship Centre, CALGARY URBAN PROJECT SOCIETY, Alex Health Centre, etc)
What are the structures and processes needed to improve PHC for the Aboriginal population?	• Individual and group interviews • Observation	• Interviews with providers, decision-makers, Aboriginal leaders, other stakeholders • Observation of relevant meetings, etc.
Who are the key stakeholders that need to be involved in designing a PHC system for the Aboriginal population?	• Document review • Individual and group interviews	• Relevant documents of meetings, proposals, etc. • Interviews with providers, decision-makers, Aboriginal leaders, population members, other stakeholders
What is the role of interprofessional teams and what would be the ideal staff mix for this new system serving the Aboriginal population?	• Individual and group interviews	• Interviews with providers, decision-makers, Aboriginal leaders, population members, other stakeholders
How can cultural safety be integrated into this PHC system for the Aboriginal population?	• Individual and group interviews	• Interviews with providers, Aboriginal leaders, population members, other stakeholders

APPENDIX C—ADVISORY COMMITTEE CONSENT FORMS

Oral Consent for Advisory Committee

TITLE:	A Case Study of Assessing Interprofessional Primary Health Care in an Urban Aboriginal Community
SPONSOR:	University of Calgary
INVESTIGATORS:	Dr. WE Thurston, Professor, Department of Community Health Sciences, Faculty of Medicine, University of Calgary Nelly D. Oelke, PhD Student, Interdisciplinary Graduate Program, University of Calgary

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Primary health care services (those services that are sought when not feeling well, to prevent one from getting sick, and to help one to be healthier) for the urban Aboriginal population in the Calgary area are not well understood. This project will study primary health care services for this population to understand what services are available, how services are coordinated, whether those services are meeting community members' needs and whether they are easy to get to for community members.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to understand the different components that support primary health care services for the Aboriginal population of Calgary and the surrounding areas. We will also look at how health team members help to meet the needs of this population. The results of the research will be helpful to the Aboriginal people of Calgary and surrounding areas, decision-makers from the Aboriginal community and the Calgary Health Region and health care workers working with the Aboriginal population.

WHAT WOULD I HAVE TO DO?

You have been asked to participate as a member of the Advisory Committee for this study. Information about primary health care services and your interpretations of initial data collected will be discussed during committee meetings. Meetings will be held 4-6 times per year and will be approximately 1-1½ hours in length. Materials will be provided prior to the meetings for your review and discussion at the Advisory Committee meetings. Permission will be requested to audio-tape the meetings to provide an accurate record of our discussions. You may request that the tape recorder be turned off at anytime during the meeting. Notes will also be taken. Audio recordings and notes will be used as additional data for the study.

WHAT ARE THE RISKS?

There are no known risks to participating in this study.

WILL I BENEFIT IF I TAKE PART?

There is no direct benefit to participating in this study although information collected may be used to change the way primary health care services are delivered for the Aboriginal population in Calgary.

DO I HAVE TO PARTICIPATE?

Your participation in the study is voluntary. You may decline to answer any of the questions and end your part in the study at anytime. Should you wish to withdraw from the study, please inform the research team member or contact the individual listed below. You also have the right to ask questions and ask for more information whenever you like.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

You will only be asked for the time required to participate in the Advisory Committee meetings as well as the time required to read and review materials prior to these meetings.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid to participate in an interview.

WILL MY RECORDS BE KEPT PRIVATE?

Anonymity and privacy will be assured as much as possible however, within groups anonymity cannot be guaranteed due to the nature of group participation. Confidentiality will be guaranteed as much as possible for group participants. Confidentiality of information shared within the group will be emphasized to participants at the beginning and end of each session. Code numbers will be used for audiofiles, transcripts and notes. Lists of participants along with the code number will be stored separately from the data. All other information from interviews will be used only in an aggregate form; your name or organization will not be identified. Only research team members and transcriptionists will review transcripts and notes. All data collected will be stored in a locked cupboard at the University of Calgary for a period of seven years.

Ideas and quotes from interviews will be used for interim and final reports, publications and presentations of research information, but at no time will you be known by your name, agency or in any other way. Anonymity and privacy will be assured as much as possible. You may have a copy of your transcript, as well as interim and final reports if you wish.

ORAL CONSENT:

Your verbal consent indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have further questions concerning matters related to this research, please contact:

Dr. WE. Thurston
Professor, Department of Community Health Sciences, Faculty of Medicine, University of Calgary
(403) 226-6940

Nelly D. Oelke
Doctoral Student, Interdisciplinary Graduate Program, University of Calgary
(403) 943-1177

If you have any questions concerning your rights as a possible participant in this research, please contact Research Services, University of Calgary, at 220-3782.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

Consent for Advisory Committee

UNIVERSITY OF CALGARY

TITLE:	A Case Study of Assessing Interprofessional Primary Health Care in an Urban Aboriginal Community
SPONSOR:	University of Calgary
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Anonymity and privacy will be assured as much as possible however, within groups anonymity cannot be guaranteed due to the nature of group participation. Confidentiality will be guaranteed as much as possible for group participants. Confidentiality of information shared within the group will be emphasized to participants at the beginning and end of each session. Code numbers will be used for audiofiles, transcripts and notes. Lists of participants along with the code number will be stored separately from the data. All other information from interviews will be used only in an aggregate form; your name or organization will not be identified. Only research team members and transcriptionists will review transcripts and notes. All data collected will be stored in a locked cupboard at the University of Calgary for a period of seven years.

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SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have further questions concerning matters related to this research, please contact:

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Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

A Case Study of Assessing Interprofessional Primary Health Care in an Urban Aboriginal Community
PI: WE. Thurston; Ethics ID: 21250; Version 1.0; May 2007
Page 3 of 3

APPENDIX D—LIST OF DOCUMENTS

Title of Local Documents	**Type of Document**	**Publication Date**
Aboriginal Community Health Council Main Page	Website	No Date
ACHC Officers and Members	Website	2007
Aboriginal Community Health Council Meeting Minutes	Minutes	May 18, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	June 15, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	September 21, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	October 19, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	November 16, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	December 9, 2005
Aboriginal Community Health Council Meeting Minutes	Minutes	January 18, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	February 15, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	March 15, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	April 19, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	May 17, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	June 14, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	September 20, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	October 18, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	November 15, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	December 8, 2006
Aboriginal Community Health Council Meeting Minutes	Minutes	January 17, 2007

Aboriginal Community Health Council Meeting Minutes	Minutes	February 21, 2007
Aboriginal Community Health Council Meeting Minutes	Minutes	March 21, 2007
Aboriginal Community Health Council Meeting Minutes	Minutes	April 18, 2007
Aboriginal Community Health Council Meeting Minutes	Minutes	May 16, 2007
Aboriginal Community Health Council Meeting Minutes	Minutes	June 20, 2007
Aboriginal Community Health Council Meeting Minutes	Minutes	September 18, 2007
Aboriginal Framework for Healing and Wellness Manual	Strategies document	May 1, 2007
Aboriginal Health Program About Us	Website	No date
Aboriginal Health Program Home Page	Website	Updated January 2007
Aboriginal Health Program Service Components	Website	No Date
Aboriginal Hospital Liaison Services (Adult Care)	Brochure	No Date
Aboriginal Health Program	Brochure	No Date
Aboriginal Health Program Directional Document 2003 - 2005	Strategies document	No Date
Calgary's 10 Year Plan to End Homelessness	Strategies document	January 1, 2008
Calgary Urban Aboriginal Initiative Reporting Back to the Community	Report	January 1, 2006
The City of Calgary Community and Neighborhood Services	Bulletin	Summer 2005
Community Resiliency: Female Aboriginal Youth in Calgary Report	Report	October 1, 2008
Directional Document Bulletin 1	Bulletin	October 5, 2006
Directional Document Bulletin 2	Bulletin	December 20, 2006
Directional Document Bulletin 3	Bulletin	March 15, 2007
Directional Document Bulletin 4	Bulletin	May 1, 2007
Directional Document Bulletin 5	Bulletin	June 22, 2007
Elbow River Healing Lodge	Brochure	October 1, 2006
Healing Your Spirit Surviving After the Suicide of a Loved One	Booklet	2006
Healthy Diverse Populations Education and Resources	Website	No Date

The Homeless Among Us Calgary Homeless Foundation Report to the Community 2009	Report	2009
Kimmapiipitsi Caring for Life Aboriginal Health Program 2007-2014	Strategies document	2007
Making Research Matter Calgary's 3 Year Research Agenda to End Homelessness	Report	January 1, 2009
Region 4 Aboriginal Community Health Council Community Consultation #1	Report	January 2003
Removing the Barriers: A Listening Circle	Report	1999-2000
Report on Developing the Urban Aboriginal Health Research Network Research Project	Report	May 1, 2008
Report on the Health Status and Health Needs Aboriginal Children and Youth	Report	January 2005
Urban Aboriginal Injury and Injury Prevention Study	Report	July 31, 2002

Title of Provincial Documents	Type of Document	Publication Date
Aboriginal Injury Prevention Model	Report	March 2007
Aboriginal Mental Health	Fact Sheet	No date
Aboriginal Mental Health, Alberta Mental Health Board, Home page	Website	No Date
Aboriginal Mental Health, Alberta Mental Health Board, Wisdom Committee	Website	No date
Aboriginal Mental Health, Alberta Mental Health Board, Initiatives	Website	No date
Aboriginal Mental Health A Framework for Alberta	Report	2007
Aboriginal Mental Health A Framework for Alberta	One pager	No date
Aboriginal Research Protocols	Report	2006
Alberta Plan to End Homelessness	Strategies Document	2008
Best Practices in Aboriginal Health Programming Project Final Report September 2008	Report	2008
Environmental Scan of Research and Services for Aboriginal Women in Alberta	Master's Thesis	2005
Little Red River Cree Nation Safe Communities Demonstration Project Evaluation Report	Report	No date
Provincial Aboriginal Health Care Issues and Initiatives	Presentation	February 26, 2009
Searching for 'Best' Practices in Aboriginal Health Programming & Service Delivery in Alberta	Presentation	No Date

Title of National Documents	**Type of Document**	**Publication Date**
Aboriginal Health Systems in Canada: Nine Case Studies	Journal Article	June, 2004
Aboriginal Women and Girls' Health Roundtable April 25-27, 2005	Ottawa, Ontario Final Report	August, 2005
Aging Presentation	Presentation to the Senate Standing Committee on aging	November 27, 2006
Blueprint on Aboriginal Health A 10-Year Transformative Plan	Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations	November 24-25, 2005
BN044_senate	Briefing Note 044/02	November 18, 2002
Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators	Report	January, 2008
Fact Sheet Cultural Safety	Fact Sheet	January 31, 2006
First Nations and Inuit Health, Improving Access to Health	Website	August, 2005
First Nations and Inuit Health, Integrated Primary Health Care for Elsipogtog First Nation – Improving Access to Health Services	Website	August 4, 2005
First Nations and Inuit Health, Keeping Safe--Injury Prevention	Website	June 26, 2007
First Nations and Inuit Health, Many Jurisdictions, One System: A Diabetes Integration Partnership Project – Improving Access to Health Services	Website	August 4, 2005
First Nations and Inuit Health, Mental Health and Wellness	Website	July 19, 2007
First Nations and Inuit Health, National Youth Solvent Abuse Program	Website	April 8, 2005
First Nations and Inuit Health, Non-Insured Health Benefits	Website	2007
First Nations and Inuit Health, Program Compendium	Program information	March, 2007

First Nations and Inuit Health, Suicide Prevention	Website	March 6, 2006
First Nations and Inuit Health, Tobacco	Website	October 31, 2007
Indian Residential Schools Resolution Health Support Program	Brochure	June 12, 2007
Indian Residential Schools Resolution Health Support Program	Website	October 30, 2007
Making communities work - How to Decrease Tobacco Use	Website	April 12, 2005
Midwifery and Aboriginal Midwifery in Canada	Report	2004
National Aboriginal Health OrganizationWorking towards Social Change and Equity for First Nations, Inuit and Métis	The 19th IUHPE World Conference on Health Promotion and Health Education, Vancouver, BC	June 10, 2007
National Environmental Scan: Comprehensive Survey of the Aboriginal Health Human Resource Landscape	Report	July 12, 2007
National Native Alcohol and Drug Abuse Program	Website	March 6, 2006
New Direction: Aboriginal Health Policy for Ontario Executive Summary	Report	
Review of Métis Health Policy Forum Proceedings	Proceedings	2002
Sacred Ways of Life Traditional Knowledge	Report/Tool Kit	2005
Shelter Homelessness in a Growth Economy: Canada's 21st century paradox	Report	2007
Strategies to Address Child Welfare	Issue Paper	2007
Winnipeg Regional Health Authority Aboriginal Health	Website	No Date
Youth Health Knowledge Report	Report	2006

APPENDIX E—INTERVIEW CONSENT FORMS

Oral Consent for Individual Interview

TITLE:	A Case Study of Assessing Interprofessional Primary Health Care in an Urban Aboriginal Community
SPONSOR:	University of Calgary
INVESTIGATORS:	Dr. WE Thurston, Professor, Department of Community Health Sciences, Faculty of Medicine, University of Calgary Nelly D. Oelke, PhD Student, Interdisciplinary Graduate Program, University of Calgary

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BACKGROUND

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WHAT WOULD I HAVE TO DO?

You have been asked to participate in a face-to-face interview. The interview will take approximately 1 1/2 hours to complete. Interviews will be completed in a mutually agreed upon place. Interviews will be conducted by a research team member. Permission will be requested to audio-tape the interview to provide an accurate record of our conversation. You may request that the tape recorder be turned off at anytime during the interview. Notes will also be taken.

WHAT ARE THE RISKS?

There are no known risks to participating in this study.

WILL I BENEFIT IF I TAKE PART?

There is no direct benefit to participating in this study although information collected may be used to change the way primary health care services are delivered for the Aboriginal population in Calgary.

DO I HAVE TO PARTICIPATE?

Your participation in the study is voluntary. You may decline to answer any of the questions and end your part in the study at anytime. Should you wish to withdraw from the study, please inform the research team member or contact the individual listed below. You also have the right to ask questions and ask for more information whenever you like.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

You will only be asked for the time required to participate in an interview.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid to participate in an interview.

WILL MY RECORDS BE KEPT PRIVATE?

The information that you provide will be kept confidential. Code numbers will be used for audiofiles, transcripts and notes. Lists of participants along with the code number will be stored separately from the data. All other information from interviews will be used only in an aggregate form; your name or organization will not be identified. Only research team members and transcriptionists will review transcripts and notes. All data collected will be stored in a locked cupboard at the University of Calgary for a period of seven years.

Ideas and quotes from interviews will be used for interim and final reports, publications and presentations of research information, but at no time will you be known by your name, agency or in any other way. Anonymity and privacy will be assured as much as possible. You may have a copy of your transcript, as well as interim and final reports if you wish.

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UNIVERSITY OF CALGARY

Consent for Individual Interview

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SIGNATURES

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Dr. WE. Thurston
Professor, Department of Community Health Sciences, Faculty of Medicine, University of Calgary
(403) 226-6940

Nelly D. Oelke
Doctoral Student, Interdisciplinary Graduate Program, University of Calgary
(403) 943-1177

If you have any questions concerning your rights as a possible participant in this research, please contact Research Services, University of Calgary, at 220-3782.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Oral Consent for Group Interview

TITLE: A Case Study of Assessing Interprofessional Primary Health Care in an Urban Aboriginal Community

SPONSOR: University of Calgary

INVESTIGATORS: Dr. WE Thurston, Professor, Department of Community Health Sciences, Faculty of Medicine, University of Calgary
Nelly D. Oelke, PhD Student, Interdisciplinary Graduate Program, University of Calgary

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BACKGROUND

Primary health care services (those services that are sought when not feeling well, to prevent one from getting sick, and to help one to be healthier) for the urban Aboriginal population in the Calgary area are not well understood. This project will study primary health care services for this population to understand what services are available, how services are coordinated, whether those services are meeting community members' needs and whether they are easy to get to for community members.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to understand the different components that support primary health care services for the Aboriginal population of Calgary and the surrounding areas. We will also look at how health team members help to meet the needs of this population. The results of the research will be helpful to the Aboriginal people of Calgary and surrounding areas, decision-makers from the Aboriginal community and the Calgary Health Region and health care workers working with the Aboriginal population.

WHAT WOULD I HAVE TO DO?

You have been asked to participate in a group interview. The interview will take approximately 1 1/2 hours to complete. Interviews will be completed in a mutually agreed upon place. Interviews will be conducted by a research team member. Permission will be requested to audio-tape the interview to provide an accurate record of our conversations. You may request that the tape recorder be turned off at anytime during the interview. Notes will also be taken.

WHAT ARE THE RISKS?

There are no known risks to participating in this study.

WILL I BENEFIT IF I TAKE PART?

There is no direct benefit to participating in this study although information collected may be used to change the way primary health care services are delivered for the Aboriginal population in Calgary.

DO I HAVE TO PARTICIPATE?

Your participation in the study is voluntary. You may decline to answer any of the questions and end your part in the study at anytime. Should you wish to withdraw from the study, please inform the research team member or contact the individual listed below. You also have the right to ask questions and ask for more information whenever you like.

WHAT ELSE DOES MY PARTICIPATION INVOLVE?

You will only be asked for the time required to participate in an interview.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid to participate in an interview.

WILL MY RECORDS BE KEPT PRIVATE?

Anonymity and privacy will be assured as much as possible however, within groups anonymity cannot be guaranteed due to the nature of group participation. Confidentiality will be guaranteed as much as possible for group participants. Confidentiality of information shared within the group will be emphasized to participants at the beginning and end of each session. Code numbers will be used for audiofiles, transcripts and notes. Lists of participants along with the code number will be stored separately from the data. All other information from interviews will be used only in an aggregate form; your name or organization will not be identified. Only research team members and transcriptionists will review transcripts and notes. All data collected will be stored in a locked cupboard at the University of Calgary for a period of seven years.

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UNIVERSITY OF CALGARY

Consent for Group Interview

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APPENDIX F—INTERVIEW GUIDE FOR INDIVIDUAL INTERVIEWS

1a. Can you tell me about the services that are provided for Aboriginal people in the Calgary area when they do not feel well?

- In this setting?
- In other settings?

1b. What are some of the strengths of these services?

- How they are offered?
- By whom?
- Location?

1c. What are some of the gaps of these services?

- Coordination of services?
- Access issues?

1d. Are these services meeting the needs of the population?

- How or how not?
- What are the gaps?

2a. Can you tell me about the services that are provided for Aboriginal people in the Calgary area when they want to prevent illness?

- In this setting?
- In other settings?

2b. What are some of the strengths of these services?

- How they are offered?
- By whom?
- Location?

2c. What are some of the gaps of these services?

- Coordination of services?
- Access issues?

2d. Are these services meeting the needs of the population?

- How or how not?
- What are the gaps?

3a. Can you tell me about the services that are provided for Aboriginal people in the Calgary area when they want to be healthier?

- In this setting?
- In other settings?

3b. What are some of the strengths of these services?

- How they are offered?
- By whom?
- Location?

3c. What are some of the gaps of these services?

- Coordination of services?
- Access issues?

3d. Are these services meeting the needs of the population?

- How or how not?
- What are the gaps?

4. Of all the types of services we discussed, what types of services do you think should be offered for this population to meet their needs?

5. If the delivery of those services discussed above were changed how should this type of service be delivered?

6. Who should be involved in designing the delivery of these services?

7. Who should be involved in delivering these services?

- Team members?

8. How can cultural safety (defined as effective practice that is determined by individual/family—do they feel safe in the setting and by the care provided or is it uncomfortable, do they feel threatened as a member of another culture) be incorporated into these health care services?

- Policies
- Competency for staff

9. Are there any additional comments that you would like to add?

APPENDIX G—INTERVIEW GUIDE FOR GROUP INTERVIEWS

1. Where do you access services for primary healthcare (sick or a need, prevention, health promotion, wellbeing)?

2. What are the characteristics of an ideal primary healthcare service?

3. Who should be part of the team to care for your needs and the needs of the urban Aboriginal population?

4. What makes you feel really comfortable walking into a service that you have accessed?

5. Other comments?

APPENDIX H—PRIMARY HEALTHCARE ORGANIZATIONS FOR THE URBAN ABORIGINAL POPULATION IN CALGARY

Organization: Aboriginal Friendship Centre of Calgary

Website: http://www.afccalgary.org/

Mission: "The Aboriginal Friendship Centre of Calgary is committed to a holistic and traditional approach in the development and provision of services and resources for the Aboriginal peoples of Calgary. We will serve as an ethical, community minded organization, respectful of Aboriginal Cultures and Teachings for the benefit of all Aboriginal and non-Aboriginal peoples" (Aboriginal Friendship Centre of Calgary, n.d.)

Target Population: Aboriginal people in Calgary and area

Services provided: Aboriginal Friendship Centre of Calgary provides "social, cultural, educational, and employment services" (Aboriginal Friendship Centre of Calgary, n.d.). More specifically they provide access to computers, phone, and fax, recreational activities, activities for youth, and services for homeless.

Organization: Aboriginal Futures
Website: www.aboriginalfutures.com

Mission: "Aboriginal Futures Career & Training Centre assists urban Aboriginal people to create greater opportunities for self-sufficiency and independence through access to career or employment counseling programs and services. Aboriginal Futures Career & Training Centre works in partnership with other service delivery agencies, educational institutions and employers to create training and employment opportunities for its' clients" (Aboriginal Futures, n.d.).

Target Population: Urban Aboriginal people (Aboriginal Futures, n.d.).

Services provided: Provides training (e.g., resume writing), educational resources (including access to scholarships), and employment postings. Specific programs include Trade Winds to Success, Alberta Aboriginal Apprenticeship Program, Petroleum and Administration Program, and Wage Subsidy (First Nations only eligible) (Aboriginal Futures, n.d.).

Organization/Program: Aboriginal Women's Support Network
Website: No website

Target Population: Aboriginal women in Calgary

Services provided: Four agencies work together (City of Calgary, Calgary Women's Centre, Red Cross, and The Distress Centre to provide workshops and other presentations for Aboriginal women in Calgary. Childcare and food are provided. It is an opportunity for women "to socialize and interact with other native women and an opportunity to learn about a service that's provided within the city" (Int.025 [Aboriginal Provider], Lines 108-110). They have presented education programs at Riel Institute of Education and Learning, nutrition, traditional communication, and traditional parenting by Elders.

Organization: Aboriginal Standing Committee on Housing and Homelessness
Website: No website

Vision: "The Aboriginal Standing Committee on Housing and Homelessness is committed to reducing these numbers [Aboriginal Homelessness] by seeking solutions for urban Aboriginal peoples in Calgary through research, information sharing, outreach, capacity building, and supporting urban Aboriginal-based programs and projects" (Pov Net, 2010).

Committee Membership: "…open to all Aboriginal community members and organizations as well as non-Aboriginal organizations that are committed to enhancing, improving, and supporting health and wellness, and the rights of urban Aboriginal peoples" (Pov Net, 2010).

Additional Information: The Calgary Urban Aboriginal Initiative Housing Domain developed a partnership with the Calgary Homeless Foundation and the Aboriginal Standing Committee on Housing and Homelessness to housing issues for Calgary Aboriginal people (Calgary Urban Aboriginal Initiative, n.d.e).

Organization: AIDS Calgary Awareness Association
Website: www.aidscalgary.org

Vision: "Empowered lives in a compassionate society in the face of HIV/AIDS" (AIDS Calgary, 2009b).

Mission: "To reduce the harm associated with HIV and AIDS for all individuals and communities in the Calgary region" (AIDS Calgary, 2009a).

Services provided: Education and resources on HIV and AIDS, outreach and support services. Outreach services include prison project, youth initiative, and the African Communities Project. No specific support or outreach services were listed on the website for Aboriginal communities. Support services include the SHIFT program (services for those who work in the sex trade), nutritional programs, counselling, Calgary Cares Centre (AIDS Calgary, 2009c).

Organization: Alberta Health Services, Calgary Zone:
Website: www.albertahealthservices.ca
Mission: "To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans" (Alberta Health Services, n.d.f).
AADAC:

Services provided: AADAC is now situated under the umbrella of Alberta Health Services. A variety of counselling and prevention services are provided for alcohol, drug, tobacco, and gambling addictions (Alberta Health Services, n.d.e).

Aboriginal Health Program: Overarching program for Aboriginal health services accountable for program planning, strategic direction, etc. Responsible for "customized approaches to health care recognizing the diversity of Aboriginal peoples in the Calgary area. Development and implementation of strategies that will enhance the ability of Aboriginal communities to achieve optimal spiritual, mental, emotional and physical health" (City of Calgary, 2009, p. 11).

Aboriginal Hospital Liaison: Provides direct service, consultation, liaison, and linkages to other services for patients and families in hospital. Liaisons are located in each of the urban centre hospitals (Alberta Health Services, n.d.a).

Acute Care Hospital Services: Services provided in hospital from various different healthcare providers. Hospitals in Calgary include the Foothills Medical Centre, Rockyview General Hospital, Peter Lougheed Centre, and the Alberta Childrens Hospital (Alberta Health Services, n.d.g).

Adult Aboriginal Mental Health:

Vision: "*Iikaakiimaat* (try hard and find inner strength)" (City of Calgary, 2009, p. 13).

Mission: "Walking the path of cultural resilience towards mental wellness" (City of Calgary, 2009, p. 13).

Services provided: Assessment, treatment, and referral for Aboriginal people with mental health concerns. A phone referral is required for services. Also provide information and education on cultural awareness and mental well-being. Outreach services are provided in surrounding communities and on several First Nations reserves (Alberta Health Services, n.d.b).

Aboriginal Spiritual Care:

Goal/Objectives: "Compassionate, holistic spiritual care to Aboriginal patients and their families in a manner that is respectful of their unique cultural and spiritual needs," (City of Calgary, 2009, p. 15).

Services provided: Services are provided at the Foothills Medical Centre. Services include "emotional and spiritual support for patients and families" (p. 15), supplies for smudging, Elder support upon request, weekly smudging ceremony, and consultation to patient-centred teams (City of Calgary, 2009).

Aboriginal Tobacco Reduction Strategy:

Goals/Objectives: "promoting the appropriate use of tobacco as a sacred plant within the Aboriginal community and prevents the misuse of commercial tobacco" (City of Calgary, 2009, p. 14).

Services provided: Initiatives being completed with post-secondary institutions, several schools in partnership with the Aboriginal Pride Program, and after school program at Métis Calgary Family Services. The focus of a lot of the work in tobacco reduction was on-reserves around Calgary.

Aboriginal Workforce Strategy: An Aboriginal human resources representative was hired several years ago. Several initiatives have included work with educational institutions to increase training opportunities for Aboriginal community members in the healthcare field. The Initiative also seeks to create linkages to Aboriginal workforce, increase the number of Aboriginal people working for Alberta Health Services, Calgary Zone, retention, and cultural relations (City of Calgary, 2009).

Community Health Services: Community health services include: prenatal, post partum, health promotion, prevention, bereavement for children, communicable disease, and school health (Alberta Health Services, n.d.c).

Cancer Care (Prevention and Screening): Previous Alberta Cancer Board prevention and screening initiatives are now subsumed under the umbrella of Alberta Health Services. Some Aboriginal initiatives in prevention in place.

Elbow River Healing Lodge:

Vision/Mission: "Healthy Aboriginal communities through connectedness. Optimal integrated Aboriginal health care, supporting access to respectful resources for Aboriginal people," (City of Calgary, 2009, p. 13).

Services provided: Located at the Sheldon Chumir Centre. Patients are seen through booked appointments or walk-in. Services are offered by a variety of providers (e.g., physicians, nurses, outreach workers). Services include primary care services (e.g., prenatal care, wound care, diabetes), street outreach, advocacy, and health promotion (City of Calgary, 2009). Elder consultation is provided on request (Alberta Health Services, n.d.d)

East Calgary Health Services Initiative: “While the unique health needs of the population living in East Calgary have been recognized for some time, the Health of the Region 2005 Report identified specific health disparities between community groups in the Calgary Health Region. In response to this disparity, the Calgary Health Region initiated the East Calgary Health Services Initiative to determine and implement strategies that would focus on improving the health status of vulnerable communities living in the East Calgary catchment area “ (Alberta Health Services, Calgary and Area, 2009).

Services provided: Community development, oral health, recreation connectors (through the Boys and Girls Club of Calgary), prenatal education (with an Aboriginal prenatal educator), and connections to the Calgary Learning Village Collaborative.

HealthLink Alberta: “Health Link Alberta is a 24 hours a day, seven days a week telephone health advice and information service answered by registered nurses that anyone in Alberta can access” (Alberta Health Services, n.d.g).

Healthy Living: “This service provides system and community consultation on health promotion principles, issues, trends, and programs” (Alberta Health Services, n.d.f).

Home Care: “Provides a wide range of health services to persons within their homes, including palliative care, wound care, personal care, homemaking support, etc.” (Alberta Health Services, n.d.g).

Oral Health: “Qualified dentists provide reduced-fee dental treatment services to families in financial need and without access to dental insurance. Provides preventative services, including oral health education, screenings and fluoride applications for high risk children” (Alberta Health Services, n.d.g).

Safeworks:

Mission: “Safeworks is a prevention and education program, with a harm reduction philosophy. The first priority to our clients is to their risks related to substance use, but aims for their eventual achievement of a healthier lifestyle” (Alberta Health Services, Calgary and Area, 2007a).

Services provided: Safeworks provides services such as clean needles for drug users, condoms, education, vaccinations, counselling, and referral services (Alberta Health Services, Calgary and Area, 2007b)

Urgent Care Services: “Medical care for complex or urgent health concerns” (Alberta Health Services, n.d.g). Services are provided in various urgent care centres across the city such as the Sheldon Chumir Centre.

Organization: Alpha House
Website: www.alphahousecalgary.com

Mission: "Our mission is to provide a safe and caring environment for individuals whose lives are affected by alcohol and other drug dependencies. We provide hope and service through the promotion of well- being through our three programs: Shelter, Detox and Outreach" (Alpha House, 2009).

Goals/Objectives: To provide assistance in the stabilization of substance abuse conditions for their clients (Alpha House, n.d.).

Target Population: Services are provided to men and women as a safe haven during the reduction of their intoxication (Alpha House, n.d.).

Services provided: Shelter, Detox, and Outreach

Organization: Aspen Child and Family Services
Website: www.aspenfamily.org

Vision: "Helping people draw upon their inner strengths to address life's challenges and create a better life" (Aspen Child and Family Services, n.d.c)

Mission: "Aspen Family supports Calgary region children, youth, individuals, families and communities in vulnerable situations to define and build upon their resilience and capacity to successfully navigate their futures through:

- Individualized strength focused, quality services
- Offering research-based and measurable programs
- Collaboration with communities, partners and volunteers" (Aspen Child and Family Services, n.d.a.)

Programs: A variety of programs are provided to support adults, youth, and families in various situations—poverty, homeless or risk of being homeless, substance abuse issues, etc. (Aspen Child and Family Services, n.d.b.)

Organization: Awo Taan Healing Lodge Society
Website: www.awotaan.org

Vision: "Nurturing families living in peace" (Awo Taan Healing Lodge Society, 2007a).

Mission: "To provide shelter and community services, guided by Native traditional teachings, to anyone affected by family violence and abuse" (Awo Taan Healing Lodge Society, 2007a).

Target Population: The Lodge services all women and children who have experienced family violence and abuse (Awo Taan Healing Lodge Society, 2007a).
Services provided: "24 hour crisis line, emergency accommodations, counselling and support, Elder services, advocacy and referral, and education in family violence and safety" (Awo Taan Healing Lodge Society, 2007b). Also provide children's services, outreach, and family violence prevention education (Awo Taan Healing Lodge Society, 2007b).

Program: Parent Link is located in various communities in Calgary to provide support to families. Services provided through Parent Link include healthy childhood development, parenting classes, in-home and outreach support for families, weekly healing circles, Mother Goose, workshops on topics of interest to families, traditional Aboriginal teachings, educational information, and referrals (Awo Taan Healing Lodge Society, 2007b). Also have provided programs for children and parents facilitated by grandmothers.

Organization: Bow Valley College
Website: http://bowvalleycollege.ca/

Program/Department: Aboriginal Centre

Services provided: Support for Aboriginal students including academic and financial support, counselling by Elders, social and cultural gatherings, information sessions for other students, and addressing contemporary Aboriginal issues in their educational institution (Bow Valley College, 2010)

Organization: Boys and Girls Clubs of Calgary
Website: www.boysandgirlsclubcalgary.com

Vision: "All children, youth, and their families are empowered to believe in themselves and the support of others in creating a compelling and successful future" (Boys and Girls Clubs of Calgary, 2009b).

Mission: "To provide a safe, supportive place where children and youth can experience new opportunities, overcome barriers, build positive relationships and develop confidence and skills for life" (Boys and Girls Clubs of Calgary, 2009b).

Target Population: Vulnerable children, youth, and their families.

Services provided: Services are provided after school, evenings and weekends. They include educational support, recreational activities, youth leadership, emergency shelters and housing support for youth unable to live at home, family support, and nutrition programs in school (Boys and Girls Clubs of Calgary, 2009c).

Program: Aboriginal Programs – A number of different programs (social, education, cultural and recreation) are provided for Aboriginal children, youth and families living in Calgary. Programs include Aboriginal culture (fostering cultural awareness and identity), the inclusion of Elders, connections with other Aboriginal community members, education and information on health and well-being, and development of literacy and other academic skills. Families are strongly encouraged to be involved in programs with and for their children (Boys and Girls Clubs of Calgary, 2009a)

Organization: Calgary Aboriginal Urban Affairs Committee
Website:
http://content.calgary.ca/CCA/City+Hall/Boards+and+Committees/Aboriginal+Urban+Affairs+Commission/Calgary+Aboriginal+Urban+Affairs+Committee.htm

Mission: "…to investigate areas of concern to people of Aboriginal ancestry and to make recommendations on policies and resolutions which would give urban Aboriginal people a more meaningful role within the Calgary community. The Committee strives to improve the opportunities and the quality of life of Aboriginal people living in the city of Calgary" (City of Calgary, 2010)

Services provided: Accountable to City Council and responsible for the administration of the Chief David Crowchild Memorial and Youth Achievement Awards (City of Calgary, 2010).

Organization: Calgary and Area Child and Family Services
Website: www.calgaryandareacfsa.gov.ab.ca

Mandate: "Protect, serve, and enhance the well-being of vulnerable children, youth and families through engaging our communities and leading in the creation and delivery of services" (Inform Alberta, n.d.).

Responsibilities:
- "Assessing needs, setting priorities, planning, allocating resources, and managing the provision of services to children, families and other community members in the region
- Ensuring that children and families have reasonable access to quality services
- Ensuring that provincial policies and standards are followed in the region
- Monitoring and assessing the provision of child and family services
- Working with other CFSAs, public and private bodies, and government to coordinate services for children and families" (Calgary and Area Child and Family Services, 2007)

Programs: In addition to regular programs provided the following programs are provided for Aboriginal Children, Youth, and Families

- Métis and non-Status Bursary Program
- Delegated First Nations Agencies
- Aboriginal youth—scholarships, education initiatives, webcasts, etc. (Calgary and Area Child and Family Services, 2007)

Organization/Program: Calgary Board of Education
Websites: www.cbe.ab.ca
www.cbe.ab.ca/programs/prog-aboriginal.asp
www.cbe.ab.ca/b244

Vision: "We provide quality learning opportunities and options. Our learners take ownership by discovering and developing their potential, passions and gifts they take their places as lifelong learners and make a significant contribution within a complex changing world" (Calgary Board of Education, 2009).

Mission: Educating tomorrow's Citizens Today

Program: Aboriginal Education

Goals/Objectives: "Through the Aboriginal Education Team the CBE facilitates opportunities for Aboriginal students to feel pride and experience success by focusing on their academic, cultural, and individual growth" (Calgary Board of Education, 2010).

Target Population: Calgary Board of Education Aboriginal students

Services provided: Support for Aboriginal students in all areas of education, Medicine Wheel Kindergarten, and education of non-Aboriginal student on cultural understanding (Calgary Board of Education, 2010).

Program: Piitoayis Family School

Vision: "To create respectful learning environment based on the balance of traditional cultural values and academic excellence. The holistic and meaningful approach will enhance pride and self-esteem enabling our students to become successful, responsible lifelong learners" (Piitoayis Family School, Calgary Board of Education, n.d.)

Mission: "We will strive to honour the teachings of our ancestors: wisdom, love, respect, bravery, honesty, humility and truth" (Piitoayis Family School, Calgary Board of Education, n.d.)

Goals/Objectives:

- "Increase knowledge and practice of Aboriginal cultures;
- Promote and support the importance of education to families and students;
- Empower families through Aboriginal content and culture; and
- Balance education and culture through a whole-person/whole-family approach" (Piitoayis Family School, Calgary Board of Education, n.d.)

Target Population: K-6 diverse Aboriginal students

Services provided: Educational services based on the Alberta curriculum along with **l**anguage education (Blackfoot, Cree), music instruction (e.g., drumming, dancing), programs for families, and the involvement of the community and other agencies.

Organization: Calgary Catholic School District
Website: www.cssd.ab.ca

Goals/Objectives: "...balance maintaining a strong link to their culture and heritage with learning the skills necessary to live successfully in today's society" (Calgary Catholic School District, 2006).

Target Population: Aboriginal Students

Services provided: Academic and other support for Aboriginal students, education for other students/staff regarding Aboriginal history, culture, beliefs and current issues, and consultation on Aboriginal issues (Calgary Catholic School District, 2006).

Organization: Calgary Communities Against Sexual Abuse
Website: www.calgarycasa.com

Mission and Vision: "Provide leadership to impact attitudes and actions around sexual abuse and sexual assault," (Calgary Communities Against Sexual Abuse, 2010a).

Services Provided: Main focus includes crisis and education. Specific programs and services include crisis and information line, Calgary Sexual Assault Response Team, counselling, partnerships and connections with other community organizations, education programs, Police and Court Education and Support Program, and 'Who Do You Tell Program?' (Calgary Communities Against Sexual Abuse, 2010b).

Organization: Calgary Drop-in and Rehab Centre
Website: www.thedi.ca

Vision: "The needs of people who are homeless or at risk are met in a respectful, comprehensive and safe way" (Calgary Drop-in and Rehab Centre, 2009).

Mission: "To prevent homelessness where possible, offer care and shelter when needed, and provide opportunities for people to rehabilitate and rebuild their lives" (Calgary Drop-in and Rehab Centre, 2009).

Goals/Objectives:

- To effectively meet Calgary's changing needs for homeless shelter and care;
- To be a valued presence in the community;
- To be the employer of choice;
- To strengthen our impact through strong ties with civic and provincial governments, funders and community organizations (Calgary Drop-in and Rehab Centre, 2009).

Services provided: The main service provided is shelter for the homeless. Three levels of housing are provided for the homeless. A variety of other support services are also provided for their clients such as woodwork shop, job skills training, and a healthcare clinic (Calgary Drop-in and Rehab Centre, 2009).

Organization: Calgary Homeless Foundation
Website: www.calgaryhomeless.com

Vision: "By the year 2018, all people facing homelessness in Calgary will have access to affordable, safe and appropriate housing as well as the resources and supports necessary to sustain it" (Calgary Homeless Foundation, 2010c).

Mission: "To end homelessness in Calgary," (Calgary Homeless Foundation, 2010c).
Services: Led by a multi-stakeholder leadership group. Development and implementation of the 10 year plan to end homelessness in Calgary. Also involved in working with partners, evaluation, monitoring, and research (Calgary Homeless Foundation, 2010a).

Programs: Project Homeless Connect
Project Homeless Connect "is a one-day event where homeless or near-homeless individuals and families are provided with services and supplies in one location. Services provided include medical treatment, mental health services, income support, employment counselling, identification documents, access to housing, and more. Participants can also receive clothing, comfort kit items, haircuts and a nutritious lunch" (Calgary Homeless Foundation, 2010b). Events are held several times a year. Medical services are provided by Calgary West Central Primary Care Network.

Organization: Calgary John Howard Society
Website: www.calgaryjohnhoward.org

Vision: "An informed community active in preventing crime," (Calgary John Howard Society, 2009b).

Mission: "Promoting positive change through humane, just, and informed responses to crime and its effects" (Calgary John Howard Society, 2009b).

Target Population: Male adults and youth in Calgary involved with the criminal justice system or at-risk of being involved (Calgary John Howard Society, 2009c).

Services provided: Adult services include literacy programs, attendance centre with anger management and family violence prevention, reintegration services (emergency services, etc.), Learning Employment Enhancement Program, and Fetal Alcohol Syndrome Disorder Project. Youth services include Alternatives program, community conferencing, child and youth empowerment strategy (work with at-risk youth), Crime Impact Program, Criminal Justice Education, Victim/Offender Reconciliation, Youth Advocacy and Support, Youth Opportunity Route (transition to adult program for youth), Youth Drug Impact Project, and the Aboriginal Youth Outreach Program (Calgary John Howard Society, 2009c).

Program: Aboriginal Youth Outreach Program works with Aboriginal youth involved with the justice system or those at risk of being involved. Many of these clients are homeless, live in shelters, or in a difficult home situation. Aboriginal workers provide "one-to-one support, family mediation, crisis resolution, counselling, assistance with securing affordable and safe housing, assistance finding and maintaining employment," (Calgary John Howard Society, 2009a). The society also operates four residences for individuals reintegrating into society (Calgary John Howard Society, 2009d).

Organization: Calgary Learning Village Collaborative
Website: www.clvc.ca/

Vision: "Strong Families and supportive communities with schools at the centre.Where children thrive and achieve their full potential in life" (Calgary Learning Village Collaborative, n.d.d).

Mission: "Working together to enhance student, family and community learning in Greater Forest Lawn" (Calgary Learning Village Collaborative, n.d.c).

Goals/Objectives: “To increase the capacity of Forest Lawn schools to provide a safe, supervised and positive environment for expanded experiences that improve student achievement, attendance, behaviour and other skills for healthy development and academic success.

To increase family involvement in supporting the school and school-based activities that build individual and community assets.

To increase community and business involvement in supporting schools and school-based programs that combine academics, recreation and social/health services.

To improve the system of collaboration among schools, government, community-based agencies, families, citizens and businesses through established and written agreements in order to achieve a better, more comprehensive and coordinated delivery of services for all community residents.

To improve use of public facilities and services by locating community-based services in the schools” (Calgary Learning Village Collaborative, n.d.b).

Target Population: Families in the Greater Forest Lawn Area (Calgary Learning Village Collaborative, n.d.a).

Services provided: Work with professionals, providers, community organizations, schools, and community members to provide services to support families (Calgary Learning Village Collaborative, n.d.a).

Organization: Calgary Police Services
Website: www.calgarypolice.ca

Mission: “To maximize public safety in Calgary with vigilance, courage and pride” (Calgary Police Service, 2010).

Goals/Objectives: Working with other organizations and Calgarians, “the Calgary Police Service strives to preserve the quality of life in our community by maintaining Calgary as a safe place to live, work and visit,” (Calgary Police Service, 2010).

Program: Diversity Unit Aboriginal Portfolio "The Aboriginal liaison officer works to increase trust and confidence between the Aboriginal community and police" (Calgary Police Service, 2009). The officer works with community members, organizations, and sits on a variety of relevant committees (Aboriginal Justice Council, Aboriginal Opportunities Committee, Calgary Urban Aboriginal Affairs Committee, Calgary Exhibition & Stampede, Indian Events Committee, City of Calgary Corporate Aboriginal Team, YMCA Aboriginal Outreach Project, Native Information Exchange, Ii-paa-taa-pii Calgary Urban Aboriginal Suicide Prevention Committee) (Calgary Police Service, 2009).

Organization: Calgary Rural Primary Care Network
Website: www.crpcn.ca

Goals/Objectives: "The Calgary Rural Primary Care Network works to sustain and improve community health status and primary healthcare services. The Calgary Rural Primary Care Network will feature "local" multidisciplinary primary care teams that work together to coordinate existing services, lead new initiatives and monitor performance" (Calgary Rural Primary Care Network, n.d.a).

Programs: A nurse practitioner will assist Siksika First Nations staff and physicians to address healthcare gaps with their community members. A Women's and Children's Health Initiative was developed in partnership with the Eden Valley First Nation. Services are provided by a primary care physician and focus on pre and postnatal care along with immunization. Referrals are made by the Eden Valley Health Centre staff and services are provided on site (Calgary Rural Primary Care Network, n.d.b).

Organization: Calgary Urban Aboriginal Initiative
Website: www.cuai.ca

Vision: "Coming together to effect positive change for Calgary's Aboriginal Population" (Calgary Urban Aboriginal Initiative, n.d.a).

Mission: "To provide a home for an going discussion, coordination, and informed action in support of Calgary urban aboriginal issues and initiatives" (Calgary Urban Aboriginal Initiative, n.d.a).

Services provided: Calgary Urban Aboriginal Initiative is a collaborative of partnering organizations that work across eight domains to advocate and affect change for Aboriginal people (Calgary Urban Aboriginal Initiative, n.d.a). The eight domains include: services, justice, health, housing, human rights, employment, education, and funders (Calgary Urban Aboriginal Initiative, n.d.c).

Program: Health Domain

Vision: “Community coming together in the spirit of trust, respect and encourage to improve health by sharing knowledge and influence change in self, community and policy” (Calgary Urban Aboriginal Initiative, n.d.d).

Mission: “A socially healthy and vibrant Aboriginal community, emotionally, physically, mentally and spiritually” (Calgary Urban Aboriginal Initiative, n.d.d).

Services provided: Presentations and workshops on health and well-being, living with diabetes, and traditional healing. Build on opportunities that arise and work together with partner organizations to collaborate on Aboriginal health initiatives (Calgary Urban Aboriginal Initiative, n.d.d).

Program: Native Information Exchange

Services provided: Agency representatives come together monthly at Mount Royal University to share agency programs, upcoming events, and discuss related issues. Sponsored by the Calgary Urban Aboriginal Initiative (Calgary Urban Aboriginal Initiative, n.d.b)

Organization Name: Calgary Urban Project Society(Calgary Urban Project Society)
Website: www.Calgary Urban Project Societycalgary.com

Mission: “We seek through compassionate healthcare and social and educational services to nurture and promote healing to those that have been rejected or neglected by society” (CALGARY URBAN PROJECT SOCIETY, 2009a)

Services provided: Medical Clinic, Family Centre (e.g., advocacy, counselling, parenting, life skills training, children’s programs, assistance with other social issues), Women’s Health Clinic, Outreach (e.g., work with individuals living on the street to provide crisis services, housing support, etc.) , Health and Education Centre (provides a variety of topical workshops), One World Child Development Centre (early intervention for preschool and kindergarten aged children), RAPID Exit (housing and housing support for the homeless), and support for education through bursary (CALGARY URBAN PROJECT SOCIETY, 2009b). Calgary Urban Project Societyhas an Aboriginal worker in their Family Centre. Calgary Urban Project Societyalso works collaboratively with other organizations to provide health outreach services (e.g., nurse at Calgary Drop-In Centre and a nurse practitioner on a weekly basis at Awotaan Women’s Shelter.

Organization: Calgary West Central Primary Care Network
Website: www.makinghealthhappen.com

Vision: "Expanding capacity and improving patient access to Primary Care through physician support and multidisciplinary teams" (Calgary West Central Primary Care Network, 2010a).

Program: Tsuu T'ina Health Program
Primary Care Network physicians provide primary care services five half days per week to band members at their health centre at the Tsuu T'ina Nation. A primary care nurse works alongside physicians supporting obstetrical care, chronic disease management and mental health. Physicians participate in monthly meetings with Tsuu T'ina staff to plan care as well as discuss issues and program evaluation (Calgary West Central Primary Care Network, 2010b).

Organization: Calgary Women's Centre
Website: http://members.shaw.ca/womens-centre/index.html

Vision: "Every woman's place for support, connections and community. Woman supporting communities, communities supporting women" (Calgary Women's Centre, 2010).

Target Population: All women from any community, with any type of question or need (Calgary Women's Centre, 2010).

Services provided: "Provides a variety of information and services for women at no cost including peer support, legal advice, referrals, collective kitchens, groups, practice English, workshops, information, Girl Power Summer Camps, crisis assistance, drop-in access, volunteer training, social integration, computer and equipment use, community participation, Good Food Box Depot, safety planning, women's camp, networking, coalition and shared resources, and women and diversity issues" (Calgary Women's Centre, 2010). More specifically they provide staff and space for the Aboriginal Women's Support Network (Calgary Women's Centre).

Organization: Canadian Association of Elizabeth Fry Societies
Website: www.elizabethfry.ca

Mission: "CAEFS is an association of self-governing, community based Elizabeth Fry societies that work with and for women and girls in the justice system, particularly those who are, or maybe, criminalized" (Canadian Association of Elizabeth Fry Societies, n.d.a).

Goals/Objectives:

- "To increase public awareness and promotion of decarceration for women.
- To reduce the numbers of women who are criminalized and imprisoned in Canada.
- To increase the availability of community-based, publicly funded, social service, health and educational resources available for marginalized, victimized, criminalized and imprisoned women.
- To increase collaborative work among Elizabeth Fry Societies and other women's groups working to address poverty, racism, and other forms of oppression" (Canadian Association of Elizabeth Fry Societies, n.d.b).

Target Population: Women and youth.

Services provided: Calgary Elizabeth Fry office provides a variety of services including counselling, transition programming, prison outreach, support groups, and information about the legal system (Canadian Association of Elizabeth Fry Societies, n.d.c).

Programs: There are two Aboriginal specific programs, The Women's Healing Circle and Aboriginal Employment program (Canadian Association of Elizabeth Fry Societies, n.d.c).

Organization/Program: Canadian Mental Health Association
Website: www.cmha.calgary.ab.ca

Vision: "Mentally healthy people in healthy society" (Canadian Mental Health Association, Calgary Region, n.d.a)

Mission: "A leader in reducing the impact of mental disorders and in promoting mental health and wellness through community based services" (Canadian Mental Health Association, Calgary Region, n.d.a)

Program: Street Outreach and Stabilization (SOS)

Goals/Objectives: "…to address the basic needs of hard-to-reach homeless individuals who have a mental health concern" (Canadian Mental Health Association, Calgary Region, n.d.b)

Target Population: Adults 18 and over who are homeless with mental health concerns (Canadian Mental Health Association, Calgary Region, n.d.b)

Services provided: (Canadian Mental Health Association, Calgary Region, n.d.b):

- Referrals to psychiatric and medical care
- Teaching of daily living skills
- Linkages to financial resources
- Referrals to housing resources
- Help finding legal assistance
- Leisure and recreational opportunities
- Increased awareness and access to community resources
- Referrals to vocational counselling

Aboriginal case workers have also been hired. In addition to services listed above, these case workers assist individuals to "reconnect with their community; access elders…learn independent living skills" (Canadian Mental Health Association, Calgary Region, n.d.b).

Organization/Program: Canadian Red Cross (Southern Alberta)
Website: www.redcross.ca/article.asp?id=2799&tid=082

Vision: "The Canadian Red Cross Society is a non-profit, humanitarian organization dedicated to improving the situation of the most vulnerable in Canada and throughout the world" (Canadian Red Cross, 2010.)

Mission: "**…**to improve the lives of vulnerable people by mobilizing the power of humanity in Canada and around the world" (Canadian Red Cross, 2010.)

Target Population: The southern Alberta Canadian Red Cross serves the vulnerable populations of southern Alberta.

Services provided: The Canadian Red Cross of southern Alberta offers general programming such as violence and abuse prevention education, water and fire safety education, social justice training for youth, support for low income and homeless, and youth art programs. The Tipi of Courage is an Aboriginal focused community-based program for HIV/AIDS prevention as well as providing support for those diagnosed with HIV and AIDS. Combines HIV/AIDS education with Aboriginal teachings. The program also addresses stigma, misinformation, discrimination related to HIV/AIDS directed at Aboriginal people (Canadian Red Cross [Southern Alberta], n.d.).

Organization: Children's Cottage Society
Website: http://www.childrenscottage.ab.ca/

Our Mission: "Preventing harm and neglect to all children and strengthening families through a network of crisis, respite and support services" (Children's Cottage Society, 2009).

Our Vision: "Safe Children in Healthy Families" (Children's Cottage Society, 2009).

Programs: "Crisis nursery, respite care, and family support" (Children's Cottage Society, 2009).

Organization: Closer to Home Community Services
Website: www.calgaryclosertohome.com/

Mission: "Our mission is to unite families and give children a place to call home" (Closer to Home Community Services, 2009b).

Programs: Kiwetata Parenting Program is an effective parenting program for Aboriginal families living in Calgary with children up to three years of age. Sample topic areas include: nutrition, FASD, post partum depression, and oral health. Pekewe Family Reunification Services works with families in the child welfare system to build knowledge and skills to strengthen their parenting skills with the ultimate goal of reuniting families and children. Support is provided to families through Pekewe House along with a house parent in residence (Closer to Home Community Services, 2009a).

Organization: Distress Centre
Website: www.distresscentre.com/Default.aspx

Mission: "To improve the quality of life in our community by providing crisis support, information and referral services without discrimination" (Distress Centre, 2010a).

Services provided: Crisis line, face-to-face counselling, and information and referral (Distress Centre, 2010b).

Organization: First Nations and Inuit Health Branch

Overview: "Health Canada is working with First Nations' people and Inuit to improve their health. Together with First Nations and Inuit organizations and communities, we carry out many activities aimed at helping people stay healthy, and prevent chronic and contagious diseases" (Health Canada, 2010).

Services provided: Provide some healthcare services on-reserve. Prevention and promotion initiatives such Diabetes Initiative and e-health services. Administers the Non-Insured Health Benefits for First Nations and Inuit people (Health Canada, 2010).

Organization: Ghost River Rediscovery
Website: www.ghostriverrediscovery.com

Vision: "Drawing on the strength of Indigenous culture, the wisdom of the Elders, with a philosophy of love and respect for the Earth and all peoples Ghost River Rediscovery aims at empowering people of all ages and cultures to discover the natural world, the worlds between cultures and the worlds within themselves" (Ghost River Rediscovery, n.d.b).

Target Population: Children and youth, seniors (Ghost River Rediscovery, n.d.c).

Services provided: Cultural training, outdoor programs, camps, Rediscovery School, and an Aboriginal Seniors Program. All are focused on traditional Aboriginal values and teachings (Ghost River Rediscovery, n.d.c.).

Aboriginal Seniors Gathering Place: "…originally designed to reduce the barriers that elderly residents encounter in accessing supportive services and as a program to improve the social climate, to ease isolation, to oversee on-site supportive service that will be available to Aboriginal residents in housing complexes and in their own homes, establish a health liaison worker program, health promotion, nutrition, vaccines and health nurse visits, to arrange involvement of extended families, to bridge the gap between Aboriginal seniors and non-Aboriginal agencies, and allowing Aboriginal seniors to improve their knowledge of health services available to them" (Ghost River Rediscovery, n.d.a)

Organization: Hull Child and Family Services
Website: www.hullservices.ca

Vision: "Hull Child and Family Services is a leader in serving children, adults, and families who experience significant mental health, behaviour and developmental challenges. We will use our expertise to help move them to success, and actively confront the barriers to wellness in our whole community" (Hull Child and Family Services, n.d.c)

Mission: Helping kids, adults, and families achieve success in their lives" (Hull Child and Family Services, n.d.c)

Target Population: Children, youth and families.

Services provided: A variety of services are provided including early intervention, in-home support, school based programming, out of home services, group homes, residential programs, and transitional programs for children, youth, and families experiencing challenges with developmental, behavioural, social and emotional concerns (Hull Child and Family Services, n.d.b).

Program: The Aboriginal Resources Department provides cultural support and training to all clients and staff at Hull Child and Family Services. They work with Aboriginal children and youth along with their families, but also provide support to all who are interested in learning about Aboriginal history and traditions (Hull Child and Family Services, n.d.a).

Organization: Ii-paa-taa-pii Calgary Urban Aboriginal Suicide Prevention Committee
Website: No website

Overview: The committee has been in operation for a number of years through partnerships with a number of organizations such as the Calgary Police Service and the Distress Centre.

The Committee received federal funding through the Calgary Urban Aboriginal Initiative and "will build capacity for suicide prevention in the urban Aboriginal community of Calgary by: 1) developing strong and culturally appropriate organization able to provide services and training in suicide prevention; 2) increase its committee membership; 3) incorporate as a legal entity; and 4) develop or offer training to Aboriginal people in Applied Suicide Intervention Skills Training (ASIST), Aboriginal Awareness workshops and Aboriginal specific bereavement workshops" (Indian and Northern Affairs Canada, 2009).

Training sessions for Suicide Intervention Skills are provided several times a year. Work is supported by the City of Calgary, Community and Neighbourhood Services.

Organization: Kootenay Lodge, Universal Rehabilitation Service Agency
Website: http://www.ursa-rehab.com/specialized-aboriginal-services.html

Mission: To provide community-based housing where culture and traditions are honoured (Universal Rehabilitation Service Agency, n.d.).

Goals/Objectives: To "assist residents in stabilizing their health, providing emotional healing, offering personal skill development and assisting with meaningful connection to family, community and employment," (Universal Rehabilitation Service Agency, n.d.).

Target Population: Aboriginal people with severe addictions and disabilities, those who are long term users of shelters and those chronically homeless (Universal Rehabilitation Service Agency, n.d.).

Services provided: Provide housing services for Aboriginal individuals with severe disabilities (Universal Rehabilitation Service Agency, n.d.).

Organization: McMan Youth Family and Community Services
Website: www.mcman.ca/html/regions_calgary.htm

Mission: "To support and encourage individuals and families to achieve their full potential as members of their community" (McMan, 2010a).

Target Population: Children, youth and families in Alberta (McMan, 2010b).
Services provided: Support for children, youth and their families through a variety of programs such as family resource centres, foster care, crime prevention, supported independent living, etc. (McMan, 2010b).

Program: Hope Homes for Aboriginal Youth—provides housing for Aboriginal youth 16-24 years of age who are homeless or at risk of being homeless. Youth are required to attend day program, school or be employed (McMan, 2009).

Organization: Métis Calgary Family Services Society
Website: www.mcfs.ca

Vision: "The healthy development of Native children and families" (Métis Calgary Family Services Society, n.d.a).

Mission: "To provide a balanced holistic spectrum of services to Aboriginal children and families," (Métis Calgary Family Services Society, n.d.a).

Goals/Objectives: One of the key objectives of the society is the health and well-being of Aboriginal children, families, and communities in Calgary. Prevention and early intervention are key components of programming (Métis Calgary Family Services Society, n.d.a).

Target Population: Aboriginal children and families in Calgary (Métis Calgary Family Services Society, n.d.a).

Services provided: Services offered are broad in nature and are offered at a variety of locations in Calgary (Métis Calgary Family Services Society, n.d.b).

- Native Network Family Resource Centre, Parent Link Centres, and Rainbow Lodge Family Resource Centre;
    - Parenting programs, family resources, Little Turtle Preschool, employment services, collective kitchen, good food box, and assistance with basic needs (e.g., housing, food)
- Medicine Wheel Early Learning Centres
    - Work in partnership with the Calgary Board of Education to offer full day Kindergarten and half day preschool programming
    - Significant cultural components including traditional teachings, dance, and other special events
- Aboriginal Students Program
    - Stay in school initiative for Aboriginal youth in Grades 9-12
    - Provide tutoring, cultural teachings, and support from a youth worker
    - Also includes summer activities
- In-home Support Program
    - Services to support families going through a challenging time or crisis (short and long term)
    - Referrals from Calgary and Area Child and Family Services Authority
- High Fidelity Wrap Around
    - Support for families with complex issues
    - Family is central to the team and team members also includes those that the family chooses to be involved along with a trained facilitator
- Cultural Teachings
    - Provide workshops with traditional teachings, cultural awareness, and the inclusion of Elders for clients and other organizations
    - Workshop content developed by Elders
- Elder Youth Program
    - Elders work with youth in high schools and post secondary settings. Can be involved in such activities as mediation, etc.
- Rainbow Lodge
    - Transitional housing for at risk urban Aboriginal families
    - Work in partnership with other organizations in the community to provide services for the family
    - Closely linked to family initiatives of Métis Calgary Family Services Society including the Family Resource Centre located at the Lodge
    - Address a variety of concerns for families (e.g., living skills, child development, nutrition, health and well-being, etc.)
- Indian Residential Schools Survivors Program (Métis Calgary Family Services Society, n.d.b).

Organization: Métis Nation of Alberta
Website: www.albertametis.com

Vision: "A strong Métis Nation embracing Métis rights" (Métis Nation of Alberta, 2007a). **Mission:** "To pursue the advancement of the socioeconomic and cultural well being of the Métis people of Alberta" (Métis Nation of Alberta, 2007a).

Target Population: Services for Metis adults, children, and families **(**Métis Nation of Alberta, 2007b).

Services provided: Information and assistance on issues related to Alberta Métis population. Also work in the area of policy. Key areas of focus include: health – information and projects on public health surveillance, diabetes, Hepatitis C and healthy choices for children and youth; education (scholarships, bursaries, and awards, for students); services for families; Métis Urban, current events and issues in justice (e.g., Métis harvesting); and tripartite initiatives between Métis Nation of Alberta, and federal and provincial governments (e.g., Michif language initiatives) (Métis Nation of Alberta, 2007b).

Organization: Mosaic Primary Care Network
Website: www.mosaicpcn.ca

Target Population: Individuals and families living in the north and east areas of Calgary as well as those who are patients of primary care physicians who practice in these areas (Mosaic Primary Care Network, n.d.).

Services provided: After Hours Clinic, Women's Clinic, behavioural health consultants, and chronic disease management (Mosaic Primary Care Network, n.d.).

Organization: Mount Royal University
Website: www.mtroyal.ca

Program/Department: Iniskim Centre

Mission: "…to increase the enrolment and retention of Aboriginal students at Mount Royal University (Mount Royal University, 2009).

Goals/Objectives:
- To facilitate academic success
- To increase the awareness of Aboriginal history and culture (Mount Royal University, 2009).

Target Population: Aboriginal students at Mount Royal University

Services Provided: Aboriginal Education Program, Aboriginal Student Housing, Computer Lab and Resource Centre, (Mount Royal University, 2009).

Organization: Native Addictions Services Society
Website: www.nass.ca

Vision: "An addiction free lifestyle for Aboriginal peoples, families, and communities" (Sunrise Native Addictions Service Society, n.d.a).

Mission: "In a setting of hope and dignity, we provide a holistic, Aboriginal based addictions program through education, prevention and treatment" (Sunrise Native Addictions Service Society, n.d.a).

Target Population: Aboriginal and non-Aboriginal men, women, and families suffering from a variety of addictions (e.g., drugs, alcohol, and gambling) interested in an Aboriginal approach to healing (Sunrise Native Addictions Service Society, n.d.b).

Services provided: Six week and long term residential treatment, out-patient services, CROW group for men (caring, responsible, overcoming, willing), EAGLE Circle group for women, and counselling for youth and families (Sunrise Native Addictions Service Society, n.d.b).

Organization: Native Counselling Services of Alberta
Website: www.ncsa.ca

Mission: "Our mission is to contribute to the holistic development and wellness of the Aboriginal individual, family and community. By respecting differences, we aim to promote the fair and equitable treatment of Aboriginal people and advocate for the future development of our partners. By developing and maintaining strong partnerships and honouring our relationships, we are committed to evolving pro-actively with our changing environment. We will continue to strategically plan and deliver culturally sensitive programs and community education through accountable resource management" (Native Counselling Services of Alberta, 2010).

Vision: "…to operate in an environment that honours our Elders' visions and the dreams of our children. We will continually provide culturally sensitive programs that recognize and respond appropriately to the changing needs of the Aboriginal individual, family and community. We will provide a safe environment where people are treated with dignity, respect and have freedom of expression…Through our partnerships, our efforts aim to support community wellness and growth…Our vision is to honour all our relationships" (Native Counselling Services of Alberta, 2010).

Services provided: Various services are provided under a variety of categories: Court workers, Family and Wellness, Homelessness and Housing, Residential Schools and Healing, Corrections and Restorative Justice, Bearpaw Communications (publish the Pimatisiwin A Journal of Aboriginal and Indigenous Community Health) and a number of health promotion initiatives, (Native Counselling Services of Alberta, 2010).

Organization: North of McKnight Community Resource Center
Website: www.northofmcknightcrc.ca

Mission: "We, the NMCRC, support and connect our culturally diverse communities with resources, activities and services that will strengthen the well being of the individuals & families in our communities" (North of McKnight Community Resource Center, n.d.a).

Services provided: The Center provides a variety of services including basic needs, well baby clinic, good food boxes, parent support, support programs for youth and adults, and an Aboriginal Family Violence Prevention Worker (North of McKnight Community Resource Center, n.d.b). Awo Taan Healing Lodge also provides some community-based programming for children and parents.

Organization: Oxford House Calgary
Website: www.oxfordhousefoundation.ca

Mission: "To provide safe and affordable housing for individuals in recovery from addictions" (Oxford House, n.d.b).

Services provided: Oxford house provides a safe housing environment for individuals who have received treatment for substance abuse. They have 24 houses in Calgary, with three specifically designated for Aboriginal individuals. Residents must apply and when accepted by the organization and the other residents in the house they can continue to live in the house as long as they choose. They must be employed and attend outreach programs (Oxford House, n.d.a).

Organization: Riel Institute of Education and Learning
Website: www.rielinstitute.com

Vision: "To improve the economical viability of all Aboriginal people by the creation of the Riel Institute for Education and Learning" (Riel Institute for Education and Learning, n.d.c).

Mission: "…to create an environment where all Aboriginal Students have the opportunity of Education and Training to enhance their employment skills" (Riel Institute for Education and Learning, n.d.a).
Target Population: All Aboriginal people (Riel Institute for Education and Learning, n.d.a).

Services provided: Delivery of training programs to the Aboriginal community (Aboriginal Family and Youth Worker, Office Support Specialist). Services are provided to those on employment insurance, social service recipients, and youth (Riel Institute for Education and Learning, n.d.b).

Organization: SAIT
Website: www.SAIT.ca

Goals/Objectives: Provides polytechnic education for the trades and applied degrees (SAIT, 2006a).

Program: Chinook Lodge

Goals/Objectives: The Chinook Lodge Aboriginal Resource Centre is a space dedicated to serving the learning, training, and personal needs of Aboriginal students at SAIT (SAIT, 2006b).

Target Population: Aboriginal students at SAIT (SAIT, 2006b).

Services provided: Provides support for students, social and cultural activities, and to create a link between students and industry for employment opportunities. Also provide some educational programs for Aboriginal people on Employment Insurance,(SAIT, 2006b).

Organization/Program: Siksika Family Services Corporation
Website: http://www.siksikanation.com/familyservices.html

Services Provided: Office located in Calgary. Provide support to families from Siksika Nation living in Calgary.

Organization/Program: Strengthening the Spirit Committee
Website: No website

Vision: "The elimination of violence in Aboriginal families and communities" (Strengthening the Spirit, n.d., p. 1).

Mission: "Strengthening The Spirit exists to plant seeds of hope for urban Aboriginal peoples by developing culturally competent treatment programs and other resources that contribute to the reduction of family and sexual violence in Aboriginal families and communities. All programs developed must take into account, Aboriginal cultures, historical and contemporary factors unique to Aboriginal people, and emphasize the importance of a holistic approach" (Strengthening the Spirit, n.d., p. 1).

Goals/Objectives: Culturally competent information and services

Target Population: Aboriginal community members affected "by domestic, sexual, and intimate partner violence" (Strengthening the Spirit, n.d., p. 1).

Services provided: Strengthening the Spirit Aboriginal Treatment Program for care for those experiencing domestic violence. The program provides culturally specific treatment for men, women, and children (HomeFront, 2010, p. 11). Provide guidance on research, culturally relevant services, policy development, partnership development, and capacity building for providers in the area of domestic violence and Aboriginal peoples (Strengthening the Spirit, n.d.).

Other information: Committee reports to the Action Committee Against Violence and HomeFront (Strengthening the Spirit, n.d.). Member agencies include: Calgary Police Services, Native Counselling Services of Alberta, Tsuu T'Ina Stoney Correction Services, YWCA Sheriff King Home, and Mental Health Addiction, Alberta Health Services (Strengthening the Spirit, 2009).

Organization Name: Treaty 7 Management Corporation
Website: www.treaty7.org

Mission: "To provide effective advisory services in order to continue to build capacity for all Treaty 7 First nation in a fair and consistent manner" (Treaty 7 Management Corporation, n.d.b.).

Target Population: Provides services to all Treaty 7 Nations. All seven Nations are located in southern Alberta.

Services provided: Covers five core areas (education, health, housing, IT, economic development) as specified by the Federal government, (Treaty 7 Management Corporation, n.d.b.). "…T7MC does not provide program service delivery. Our mandate is to provide advisory services in areas of common interest to Treaty 7 First Nations. We try to facilitate, coordinate, and develop positions for lobbying in areas such as Treaties, Education, Health, Community Development, Social Development and Economic Development" (Treaty 7 Management Corporation, n.d.a.)

Organization/Program: United Way of Calgary
Website: www.calgaryunitedway.org

Goals/Objectives: "United Way gives individuals and families the opportunity to reach their potential and improve their quality of life" (United Way of Calgary, 2006c).

Services provided: Fund services in a variety of different areas in Calgary and surrounding communities (United Way of Calgary, 2006c). Also works on underlying social issues, advocacy, and policy (United Way of Calgary, 2006b).

Program: Aboriginal Youth and Education Strategy

Mission: Improve completion of high school rates in Calgary's Aboriginal youth (United Way of Calgary, 2006a).

Goals/Objectives: "Our goal is to remove the stigma of being "just an Aboriginal kid." We want to strip away the burden of history, inequality and cultural fragmentation that have affected Aboriginal families and their communities" (United Way of Calgary, 2006a).

We believe education is the key. By increasing students' self-esteem, cultural identity and confidence, urban Aboriginal youth will have greater opportunities to complete their education and get good jobs, participate in the community and provide for their families' basic needs" (United Way of Calgary, 2006a)

Target Population: Aboriginal youth under 25 years old.

Services provided: Work with Aboriginal community partners to organize community action activities and events, support for parents of Aboriginal students, Aboriginal Pride Program, Aboriginal Pride Mentoring Program, Galileo Educational Network, staff awareness training in partner schools (United Way of Calgary, 2006a). Programs serve over 600 Aboriginal students each year (United Way of Calgary, n.d.).

Organization: University of Calgary
Website: http://www.ucalgary.ca/

Program: Native Students Centre

Mandate: "The mandate of **The Native Centre** at the University of Calgary is to provide a culturally appropriate environment that encourages and supports the success of Aboriginal students in their pursuit of knowledge and higher education" (University of Calgary, n.d.).

Goals/Objectives: "…enriching the quality of the student experience for Aboriginal learners at the University of Calgary, and [to] promoting the beauty, vitality, and diversity of Aboriginal culture within the University community" (University of Calgary, n.d.).
Target Population: Aboriginal university students

Services provided: Programs and services provided include: academic and other support for students; access to funding for Aboriginal students, LYNX (Aboriginal Student Career and Employment Program), Community-based Academic Outreach Programs at the request of Aboriginal communities, ASAP (Aboriginal Student Access Program); and NAPI (Native Ambassador Post-secondary Initiative Program) (University of Calgary, n.d.).

Organization: Urban Society for Aboriginal Youth
Website: www.usay.ca

Vision: "USAY will be recognized as a fundamental organization in society, empowering urban Aboriginal Youth to envision and attain a healthy sustainable future while upholding traditional Aboriginal values" (Urban Society for Aboriginal Youth, 2006a).
Mission: "USAY will enrich the lives of all urban aboriginal youth by nurturing self-empowerment and fostering collaboration and communication to ensure healthy future generations" (Urban Society for Aboriginal Youth, 2006a).

Target Population: Aboriginal youth in Calgary (Urban Society for Aboriginal Youth, 2006a).

Services provided: USAY provides youth their own place to gather. Services include advocacy, opportunities for youth to volunteer, recreational activities, and a resource centre with computers. Several e-learning projects have also been developed with topics such as business skills, budgeting and finance and Aboriginal cultural teachings (Urban Society for Aboriginal Youth, 2006c). USAY also houses the New Tribe, a magazine that provides a voice for urban Aboriginal youth (Urban Society for Aboriginal Youth, 2006b). USAY and New Tribe work closely together to meet the needs of Aboriginal youth in Calgary.

Organization: Woods Homes
Website: www.woodshomes.com

Vision: "Locally and nationally known and respected as a centre of excellence for child and family treatment, research and training, a workplace of choice and a leader in the development of innovative service choices" (Woods Homes, n.d.b).

Mission: "Our mission is to promote and assist the development and well-being of children, youth and families within the community" (Woods Homes, n.d.b).

Target Population: Youth (11-18 years of age) (Woods Homes, n.d.b).

Services provided: Over 30 different programs are provided by the organization including residential treatment, crisis services, in-home support, community outreach, counselling services (no fee is charged), services for homeless youth, and learning centres for specific needs (Woods Homes, n.d.b)

Program: Eagle Moon Lodge – provides residential treatment for substance abuse to Aboriginal adolescents from age 12 – 17. Treatment includes screening and treatment of associated mental health conditions. Treatment includes traditional teachings based on the medicine wheel combined with western approaches. Support and counselling are also provided for families of youth in treatment. Professional development workshops for other organizations are also offered (Woods Homes, n.d.a).

Organization: YMCA Calgary
Website: www.ymcacalgary.org/web/home.aspx

Mission: "YMCA Calgary is a charitable organization driven by its mission to facilitate and promote the spiritual, mental, physical and social development of individuals and to foster a sense of responsibility within the community" (YMCA Calgary, n.d.b)

Program: YMCA 7th Generation – leadership program for Aboriginal youth. Activities include cultural teachings, workshops, and leadership training (YMCA Calgary, n.d.a).

Target Population: Aboriginal youth Grades 9-12 from Calgary (YMCA Calgary, n.d.a).

Program: Aboriginal Day Camps – two outdoor summer camps including outdoor recreational activities, traditional teaching, drumming and dance (YMCA Calgary, n.d.a).

Target Population: Aboriginal children in Calgary (YMCA Calgary, n.d.a).

Program: YMCA Aboriginal Active Life – recreational activities at various YMCA locations in Calgary provided on a drop-in basis (YMCA Calgary, n.d.a).
Target Population: Aboriginal youth ages 14-24 (YMCA Calgary, n.d.a).