



PERGAMON

Social Science & Medicine 56 (2003) 821–833

SOCIAL
SCIENCE
&
MEDICINE

www.elsevier.com/locate/socscimed

In search of a Healing Place: Aboriginal women in Vancouver's Downtown Eastside

Cecilia Benoit^{a,*}, Dena Carroll^b, Munaza Chaudhry^c

^aDepartment of Sociology, University of Victoria, P.O. Box 3050, Victoria, BC, Canada V8W 3P5

^bAboriginal Health Consultant, 3627 Revelstoke Place, Victoria, BC, Canada V8P 3X5

^cHealth Research Consultant, 1616 Prairie Street, Victoria, BC, Canada V8N 5X9

Abstract

Research on general health service delivery in urban areas of Canada shows that Aboriginal people face formidable barriers in accessing culturally appropriate and timely care. Over the past decade, Urban Aboriginal Health Centres (UAHCs) have emerged to address the unmet health concerns of Aboriginal people living in metropolitan areas of the country. The purpose of this research was to address the gap in social science literature on how the health care concerns of Aboriginal women are being met by UAHCs. The research aimed to give *voice* to Aboriginal women by asking them whether the appropriate professional services and educational programs they need to address their health care needs were being provided in the inner city. A case-study approach was used whereby three separate focus groups were conducted with Aboriginal women who were clients of the Vancouver Native Health Society (VNHS), its sister organization, Sheway, or residents of Vancouver's Downtown Eastside (DTES). In addition, twenty-five semi-structured interviews were conducted with VNHS staff, health providers, government representatives, and community leaders in health care (total $n = 61$). The findings indicate that despite efforts from various quarters to articulate the health and social concerns of the country's marginalized populations, such has not been the case for Aboriginal women living in one of Canada's most prosperous cities. Many Aboriginal women expressed a strong desire for a Healing Place, based on a model of care where their health concerns are addressed in an integrated manner, where they are respected and given the opportunity to shape and influence decision-making about services that impact their own healing. © 2002 Elsevier Science Ltd. All rights reserved.

Keywords: Aboriginal women; Urban Aboriginal Health Centres; Healing Place; Canada

Introduction

About 1.1 million persons claimed some Aboriginal ancestry in the 1996 census, up from 1 million in 1991.¹

Out of the general Aboriginal population in Canada, there are approximately 408,100 Aboriginal women (Statistics Canada, 2000; Dion Stout et al., 2001). Aboriginal Canadians are more likely to live in

*Corresponding author. Tel.: +1-250-721-7578; fax: +1-250-721-6217.

E-mail address: cbenoit@uvic.ca (C. Benoit).

URL: <http://web.uvic.ca/~cbenoit/>.

¹At the beginning of the 18th century there were about 10 Aboriginal people for every European settler in Canada; by 1881 there were about 40 Europeans for every Aboriginal person (Jaffe, 1992). This was not primarily because of a natural increase of European immigrants, however. Traders and later settlers to New France and British North America (later renamed Upper and Lower Canada) brought with them not only trade items, but also racist attitudes toward the non-Christian "savages" who resided in the New World. The Europeans were even prepared to use their superior military power to subdue any Aboriginal people unwilling to be colonized. Europeans also brought with them deadly diseases. Smallpox and other epidemic diseases (including measles, influenza, tuberculosis) had killed many Europeans in the previous centuries. However, for the Aboriginal people, these contagions were "virgin soil epidemics," ravaging hitherto unexposed populations without any built-up immunity to soften the impact. These "diseases of

single-parent families and have higher rates of unemployment and lower rates of high school completion than the non-Aboriginal population (Hanselmann, 2001). Their health status is likewise comparatively poor. Research shows that the average life expectancy for Aboriginal people is five or more years less than for other Canadians (Canadian Institute for Health Information, 2000; Statistics Canada, 2000; Dion Stout et al., 2001).

More than half of Canada's Aboriginal population live in urban centres, and the two-thirds of Canada's urban Aboriginal population lives in Western Canada (Hanselmann, 2001). Canada's urban Aboriginal people² today comprise a diverse, youthful and growing population (Dion Stout et al., 2001). Despite their growing numbers, urban Aboriginal people in Canada continue to earn far below the median average income for non-urban counterparts. Urban Aboriginal people also tend to have comparatively higher rates of homelessness, greater housing needs and higher rates of suicide and are particularly at risk of substance abuse, contracting tuberculosis, HIV/AIDS or developing diabetes (Health Canada, 1999). These data indicate that many Aboriginal

(footnote continued)

civilization," along with the ill effects of adulterated whisky, reduced the Aboriginal population of British Columbia, for example, by nearly two-thirds before the end of the 1800s. So marginalized were Canada's Aboriginal people that they were not entitled to vote alongside non-Aboriginal Canadian citizens until 1960. The situation was arguably worst for Aboriginal women. Prior to 1985, under the sexist provisions of the 1874 Indian Act, an Aboriginal woman who married a non-Aboriginal man automatically lost her official designation as Status Indian, including band membership, as did her children. However, an Aboriginal man who married a non-Aboriginal woman not only retained his Indian status, but also was able to claim it for his wife. Under Canada's federal Bill C-31, the original Act was finally revised to grant official Indian status to all Aboriginal women, irrespective of their marital status (Benoit, 2000).

²According to Canada's 1982 *Constitution Act*, Aboriginal people include Status and Non-Status Indians, Métis and Inuit people. Each of these groups of people has a distinct history and culture. Even within the groups, the cultures and histories are not homogenous. The term *Status Indian* was first defined in the Federal Government Indian Act of 1850 at which time an 'Indian' was defined as any person deemed to be: (1) Aboriginal by birth; (2) any person belonging to a particular band or body of Indians; or (3) any person who married an Indian or who was adopted by Indians. Status Indians who voluntarily gave up their status through enfranchisement or because they wanted to work in particular occupations became *non-Status Indians*. *First Nations* later replaced the term 'Indian' as the terminology preferred by an Aboriginal person who identifies as being a descendant of the first inhabitants of Canada, except in the Arctic. The *Métis* are a distinct group of Aboriginal people of mixed First Nations or Inuit and European ancestry. The *Inuit* are also a unique population of Aboriginal people who mainly reside in Northern Canada.

people, especially those residing in urban areas, are in danger of falling through the cracks of the Canadian health care system and social security safety net.

On a more positive note, Canada's Aboriginal people have recently reasserted control over their health and social services and have assumed greater responsibility over the design and delivery of programs. During the last decade Urban Aboriginal Health Centres (UAHCs) have also emerged across the country to address the unmet health concerns of Aboriginal people living in large metropolitan areas (Royal Commission on Aboriginal People, 1996; Waldram, Herring, & Young, 1997). The best known of the UAHCs is *Anishnawbe Health Toronto* (AHT), which was established in 1989 (Lowry, 1993). Some of the strategies of AHT and the other UAHCs have included control and administration by a qualified team of Aboriginal people, recruitment of Aboriginal health professionals (including nurses, physicians, and social workers), and implementation of a holistic philosophy of care that blends traditional Aboriginal healing and Western medicine. The long-range vision of the UAHCs has been to improve both service delivery and health outcomes for urban Aboriginal people in Canada by increasing access to culturally suitable and appropriate health care and social services. In addition, the expectation has been that these UAHCs would operate quite differently from mainstream medical services in Canada, which are based primarily on a fee-for-service physician model, in order to meet previously unmet needs.³

The purpose of this research was to address the gap in social science literature on how effectively Aboriginal women's specific health concerns are being met by the innovative UAHCs in particular. The few available reports indicate that Aboriginal women have inadequate access to reproductive care services, including access to pap smears, mammogram screening and abortion services (Hislop et al., 1996; BC Provincial Health Officer, 1996; Clark, 1999; BC Women's Health Bureau, 1998; Baxter, 1999; Poole, 2000; Dion Stout et al., 2001). Our research focused on asking Aboriginal women living in Vancouver's Downtown Eastside (DTES) whether the service delivery model employed at the Vancouver Native Health Society (VNHS) provided them with the appropriate professional services and educational programs needed to take control of their health and healing.

³Community health centres and, more recently, Integrated Delivery Systems, have also been introduced in non-Aboriginal communities in Canada and countries abroad. Features have included alternative modes of physician payment, integrated service teams and emphasis on health promotion and preventive health (Vohlonen, Pekurinen, & Saltman, 1989; Derber & Thompson, 1992; Abelson & Hutchison, 1994; Leatt, Pink, & Taylor, 1996).

After describing the study methods, we present background information about the social-environmental conditions of the DTES. This is followed by a general profile of Aboriginal women living in the DTES. The main body of the paper focuses on the care Aboriginal women receive from three different types of services provided at the VNHS: the *Walk-In Medical Clinic*, the *Positive Outlook Program (POP)* and *Sheway*.

Research design and methods

An Ad Hoc Community Advisory Council comprising Aboriginal and non-Aboriginal professionals was formed to provide advice, direction and guidance regarding our research goals, respondent recruitment strategies, interviewing, and data analysis. Participant observation, semi-structured interviews and focus groups were our primary methods of determining Aboriginal women's perceptions of health care services at VNHS. Three focus groups were conducted with Aboriginal women who were clients of VNHS, clients of its sister organization, *Sheway*, or non-affiliated Aboriginal women living in the DTES. Twelve different women participated in each focus group and an honorarium was made available to participants at the end of their session. Despite some initial suspicions, most participants were eager to share their experiences, feelings and ideas. For many, this was the first time they had ever been consulted about access to services in the DTES.

In addition to the focus groups, twenty-five semi-structured interviews were conducted with VNHS and *Sheway* staff, health professionals connected to the facility, provincial government health authorities and community health workers knowledgeable about Aboriginal issues in the DTES (total $n = 61$). Our aim was to get a wider view of the challenges to providing adequate health care for urban Aboriginal women and to identify approaches needed to address these needs.

Thematic analysis, which is widely used in social science and health research, was chosen as the most appropriate method for analyzing the data. According to Luborsky (1994, p. 190), thematic analysis provides "direct representation of an individual's own point of view and descriptions of experiences, beliefs, and perception." By placing participants' own perspectives front and centre, thematic analysis gives *voice* to those who are usually silenced. This analytical approach involves a central goal of all qualitative research, which is to present the lived experiences and meanings of those who are the main focus of study. Themes were identified by searching for the main points or central topics most often repeated in and across the focus groups. Transcriptions of the focus group data and the content of the group discussion were summarized into several topics.

The constant comparative method (Glaser & Strauss, 1967) was used to compare the thematic findings from the focus group transcriptions with the central themes emerging from the transcribed personal interview data.

All qualitative studies are limited in terms of making generalizations about the entire population from a non-random sample of respondents (Creswell, 1994; Denzin & Lincoln, 1998). The self-selected sampling procedures used to attract focus group participants and to find interview respondents likely excluded the voices of many, including other Aboriginal women in the DTES, such as the elderly and women not in crisis, or those living in other residential neighbourhoods of Vancouver. In addition, only a small sample of service providers, government spokespersons and community health workers were interviewed, and may not represent the views of their peers. Yet there are important benefits to case studies that attempt to give *agency* to participants whose needs are great and yet whose voices are seldom heard (Rubin & Rubin, 1995; Maxwell, 1996; Berg, 1996; Perry, 2000; Dion Stout et al., 2001).

The urban ghetto: DTES

Are we doing enough? I don't think so. I just don't believe that I should have a family that comes in to me here on a Friday afternoon saying, 'we've had no food in the house for the last four days', or that 'I haven't been able to feed my baby for the last couple of days'.

-VNHS staff member

An estimated 28,000 Aboriginal people reside in the city of Vancouver, representing 7 percent of the city's population (Joseph, 1999). Seventy percent of Vancouver's total Aboriginal population lives in the city's poorest neighbourhood, the Downtown Eastside, and Aboriginal people make up nearly half (40 percent) of the urban ghetto's residents. A century ago this old Vancouver community was an upper class enclave; today it is infamous as Canada's poorest neighborhood (McCull, 1999; Joseph, 1999; TACCIT, 1999; Kazempour & Halli, 2000). Three-quarters of its residents live at the edge of poverty, with an annual income only one-third that of other Vancouver residents (City of Vancouver, 1998). Most DTES Aboriginal residents have been displaced from other areas of the province or have migrated from other parts of Canada (Currie, 1995). Housing for many DTES residents is a 12 × 9 ft slum hotel room, which can cost up to 65 percent of a person's monthly social assistance money. Slum hotels tend to lack even the basic amenities, such as a refrigerator, stove or private bathroom; security, privacy and safety are also rare. Such hotels often serve as shooting galleries for drug users, while 'crack' cocaine, heroin, and prescription drugs are routinely sold and used openly on the streets below the slum hotels.

The DTES' overcrowded hotels and poor living conditions, in combination with a substantial part of its population being dependent on addictive drugs and practicing unprotected sex, have led to the highest rate of HIV/AIDS transmission in the Western world (TACCIT, 1999). A Canadian record of 365 drug overdoses occurred in Vancouver in 1999, most of which were in the DTES (Clark, 1999). In addition, the urban ghetto is home to 'superinfections' of Hepatitis A and C, and epidemic outbreaks of tuberculosis and syphilis are commonplace (Kent, 1998). In 1997, the Vancouver Richmond Health Board formally recognized the severity of conditions in the DTES by declaring a public health crisis (Vancouver Richmond Health Board, 1997).

Aboriginal women in the DTES

Even though I'm a strong woman on the outside, deep down I'm hurting and many of us women are like that. But we don't show it because we don't want people to look at us like we're less than we are. It's just our way; we walk with our head high and proud.
-Aboriginal woman participant

The ratio of males to females in the DTES is estimated at 3:1. Yet the urban ghettos' Aboriginal population is roughly balanced along gender lines (Joseph, 1999). Estimates are that as many as 70 percent of DTES sex workers are Aboriginal women, and that the average Aboriginal sex worker is 26 years of age, has three or more children, and is without a high school education (Currie, 1995; Hanselmann, 2001). Inadequate access to birth control, the rising incidence of drug use and the growing problem of AIDS are all problems for Aboriginal women in the DTES (Todd-Dennis, 1995). Equally disturbing are that teen births, a large portion to Aboriginal adolescents, are 13 times higher in the DTES than in other regions of Vancouver; half of Aboriginal families are headed by lone mothers; and as many as 80 percent of Aboriginal children in the urban ghetto live in poverty (Joseph, 1999; Hanselmann, 2001).

Aboriginal women are also the fastest growing group of HIV+ people in the DTES, and are three times more likely to die of HIV/AIDS than other Vancouver women (Joseph, 1999.) In general, unprotected sexual activity and reliance on the street sex trade industry to garner a living place Aboriginal women at a much higher risk of having health problems than their non-Aboriginal counterparts (Parry, 1997). Furthermore, Aboriginal women are more likely than male counterparts to share needles, to be 'second on the needle' and to associate condom use or non-use with the important distinctions between work and relational sex (Whynot, 1998; Garm, 1997). It is important to note as well that many Aboriginal women with HIV/AIDS living in the DTES have been displaced from their reserve communities and

extended families. Like most other residents of the DTES, Aboriginal women migrants to the city tend to find themselves isolated and without a strong social support system or cultural base to access when in crisis. Many keep to themselves and try to cope on their own while others seek out frontline agencies for help and support (Garm, 1997).

These statistics on Aboriginal women in the DTES are presented to give a social environmental/health determinant context to the daily challenges they face. Yet, as other researchers have argued about marginalized women elsewhere, homelessness is symptomatic of larger problems, including substance abuse, mental health issues, family breakdown, underemployment, low income, and racism (Mohanty, Russo, & Torres, 1991; Wojcicki & Malala, 2001; Hanselmann, 2001). However, it would be shortsighted to see Aboriginal women in the DTES merely as victims of larger structural forces, without a sense of agency about how to change their situation, improve their health and ensure a better life for their children.

Vancouver Native Health Society

The VNHS, a provincially funded, non-profit society, operates from a cramped, street-level storefront two blocks from the main intersection in the DTES. The Society's core administrative funding comes from the provincial government. Approximately 50 percent of VNHS clients are of European descent, 40 percent are Aboriginal, and the remaining clients are members of one of Canada's Visible Minority groups⁴. Few staff are of Aboriginal background. This has been the case since the VNHS's inception nearly a decade ago, due, in part, to the lack of qualified Aboriginal health professionals, human rights hiring policies that make it difficult to recruit Aboriginal people exclusively, and the high-risk factors and crisis management focus associated with employment in the DTES.

The original intent of the VNHS when it was established in 1992 was to establish an Aboriginal-administered, culturally focussed health centre exclusively for Vancouver's Aboriginal people in the DTES. According to the VNHS administrative staff interviewed for this study, however, the proposed on-site Aboriginal Healing Centre (AHC) did not receive the economic support it needed from government officials and local health organizations. In addition, few traditional healers were willing to work in a clinical setting, not only because it was located in an urban ghetto, but also because of problems regarding adequate remuneration, government regulation of traditional practices, and

⁴Canada's Employment Equity Act defines *Visible Minorities* as persons, other than Aboriginal people, who are non-Caucasian in race or non-white in colour.

threat to traditional knowledge contents. Ultimately, for these and other reasons, the proposed Healing Centre notion was eventually abandoned and the commitment to revitalizing and implementing traditional Aboriginal healing and health practices as an integral part of the VNHS was lost.

Whether the DTES Aboriginal population agrees or not, the VNHS, like other UAHCs in BC and across Canada, today practices an ‘open door’ policy, and the majority of its staff adhere to the belief that the clinical services and educational programs are open to non-Aboriginals and Aboriginals alike. Indeed, the Director and many of the staff maintain that it is important to work with the entire DTES community and that health care services must not “ghettoize” Aboriginal people or “encourage a system of apartheid”, especially since the overall needs in the area are so great.

Yet, as made clear by the focus group participants and echoed below by a DTES community health worker, some believe that the VNHS is not adequately meeting its mandate to serve Aboriginal people,

If you’re going to do something for Native people, I think you need to be like traditional and spiritual ‘cause that’s what Native people are about, you know? Do they have elders in the VNHS? Do they have Native healers? No, they have doctors! Gee, that’s not my system, that’s not where I come from. You know, for a First Nations organization, how come there’s like, not a lot of Natives working? It’s like the same White system with just a different name on it.

Programs and services at the VNHS focus on main-stream risk management models and include services such as a Walk-In Medical Clinic, Positive Outlook (an HIV/AIDS Home Health Care Program), The Sheway Project, Pre-Recovery Empowerment Program, TBSA Outreach Program (Tuberculosis Services to Aboriginals), DTES Health Outreach Van Program, Youth Safe House Project, and Inner City Foster Parents Project. Traditional healing approaches, including Chinese medicine and acupuncture, have recently been made available through the POP. The Walk-In Medical Clinic is the most public aspect of VNHS and the first point of entry for most clients. The POP is popular among the local population afflicted with HIV/AIDS and Sheway is the only program specifically focussed on meeting some of Aboriginal women’s health needs in the DTES.

Walk-In Medical Clinic

I use the Native Health Clinic. It’s a bit of a slow process ‘cause you got to sit and wait. But that’s part of the doctor thing. The doctors sit here and listen to you, so I find that’s more helpful down here.

-Focus group participant

I see some doctors are great with women, but they don’t have women-only services. [And] they need like a women-only space. If you’re going to have a clinic for everything, you don’t want to be sitting in the waiting room with some guy, you know?

- Community health worker

The mission of the Walk-In Medical Clinic is to provide free, non-judgmental primary care and health promotion to all residents of the DTES community (VNHS, 1998). According to one of the attending physicians, “there is no discrimination in this Clinic. It is remarkable that we will take anybody—whether they are disheveled, whether they are inebriated, whatever! Our function [is] to assist people in this area and we are doing it.”

Five male and four female doctors provide routine medical treatment, HIV/AIDS care, methadone maintenance, STD counselling and follow-up professional services. Currently, almost half of the visits to the Clinic are by Aboriginal clients, and roughly half again are by Aboriginal women; the majority of services are provided to non-Aboriginal males who account for 36 percent of the total caseload (for more detail, see Benoit & Carroll, 2001).

Plain-clothed security guards, indistinguishable from the medical office assistants, provide security in the small waiting area. As one Clinic health provider points out, the clientele is not without its problems:

They’re difficult people, most of the people we see, could quite easily get rejected in a standard practice, you know, because of difficult behaviour. They’re impatient, can’t wait very long, they can be aggressive, they don’t dress normally, don’t necessarily take baths, they can’t make appointments and [often don’t] follow up. So you have to try to be more tolerant of this sort of behaviour.

Another health provider noted: “on some level, we are certainly functioning as a mini-emergency room. Below that, depending on how many people are in the waiting room, what the day is like, and what the time is like, I always try to delve underneath the [initial] level to make the connection and do more health, healing work.” However, due to the transient nature of the population, high-risk lifestyle behaviours and difficulty in measuring outcomes of services, it is not an easy task to know if the services and support have any meaningful impact. In addition, most of the people who received services had little choice in the selection of service provider. In fact, while waiting for the focus groups to begin, many participants lined up just to ensure they could get an appointment for a latter time.

Focus group participants had a number of positive things to say about the Walk-In Clinic. Among other things, they liked the fact that it is accessible in the

evenings and on weekends, embraces an open-door policy, and employs physicians who take time to listen to their patients and help out in an emergency. A focus group participant recalled,

I went to another downtown clinic and the doctor that I had was giving me constantly the same pills all the time when I was getting sick. I went over to the Native Health and the doctor there, as soon as she saw me, said, 'Get to the hospital.' And now she is my doctor. She is somebody who cares and takes the time to listen to me. Where, down at my other doctor, it was in and out and bye.

However, some Aboriginal women expressed concern that the practice style of a few Clinic physicians fell short of the mark. One woman identified "there are a couple of doctors who don't belong here because they're very rude and there's no compassion, there's no caring, there's no nothing. We don't need doctors like that here." Other research reports similar findings concerning Aboriginal women's reluctance to return for regular check-ups, even when in extreme physical pain, due to earlier disrespectful treatment by a physician (Todd-Dennis, 1995).

Some of our participants also expressed a desire for female physicians, due in part to the high rate of family violence, physical and sexual abuse issues, and high-risk behaviours in their earlier or present lives. One of the community health workers interviewed stated that Aboriginal women often have been or perhaps currently are "in abusive relationships and they need to have that trust foundation in place." Fear of authority figures—especially for residential school survivors—means that many Aboriginal women on the streets were not getting the basic medical and social treatment they need (Todd-Dennis, 1995). Our focus group participants additionally identified an urgent need for meaningful counselling and emotional support. As one participant noted: "The reason I quit coming to counselling here [at the VNHS] is because the counselling is done very poorly...I'm a First Nations person, and I believe that a healing circle would help because that is our spirituality, that's how we help each other." There also was an identified gap in the availability of mental health services for children and youth, as well as for homeless urban Aboriginal women who suffer from severe and often long-term mental illnesses.

Other features of the Clinic that some Aboriginal women participants wished were different concerned the waiting room space and lack of integration of traditional models of healing with bio-medical models across all programs and services. Many were uneasy about the lack of Aboriginal staff and felt the need to have more workers with similar cultural backgrounds and life experiences as themselves (Todd-Dennis, 1995). The desire to be cared for and supported by another

Aboriginal person in a more traditional way was very real for many displaced persons in the DTES. As one Aboriginal woman noted:

I prefer to be around First Nations people because they're the ones who understand where we come from. When you go in there [the Clinic], a non-Native person will look at you as a client. But a First Nation's person will look at you like a friend, but will maintain her professionalism.

While cultural sensitivity workshops have been made available to Clinic staff from time-to-time, there has only ever been one Aboriginal doctor working at the Clinic, along with one 6-month intern locum.

In their defense, VNHS staff noted that it is extremely difficult to find qualified Aboriginal doctors, nurses and other health professionals in BC and in Canada in general. Furthermore, they noted traditional healers are planned as part of future staff recruitment, though they were unable to give an indication as to when such appointments might take place, not least of all, as noted above, because of difficulties recruiting traditional healers/elders. In the meanwhile, VNHS staff have gone some distance in integrating Aboriginal volunteers into the Clinic's and other programs. One physician saw this development as a sign of success: "I think that the success of Native Health [VNHS] has been that one way or another, they've been able to recruit even volunteers that are Aboriginal, even if the health practitioners may not be. So when you walk in, you at least have the sense that it's an Aboriginal agency."

Our focus group participants additionally identified that access to meaningful counselling was needed. As one participant noted: "The reason I quit coming to counselling here [at the VNHS] is because the counselling is done very poorly...I'm a First Nations person, and I believe that a healing circle would help because that is our spirituality, that's how we help each other."

Positive Outlook Program

At VNHS, the POP also provides medical care, nursing services, methadone treatment outreach services, and a drop-in for DTES residents who have HIV/AIDS. The program was initially developed to reach clients who, because of the stigma attached to their medical condition and/or poor health record, tended not to reach out for help.

The key to the POP's success, according to its coordinator, is its non-judgmental philosophy focussed on treating the needs of the client and providing support whenever requested. On this basis, the program has developed a supervised treatment strategy whereby clients' medicines are stored at the drop-in and administered when they come in on a daily basis. Other incentives to drop-by include a food bank, meal program, free

access to a phone, showers, and a washer and dryer. If a client fails to show up on any given day, an outreach worker will actively search for him or her in the adjacent neighbourhood. The program operates seven days a week, with shorter operating hours on weekends.

Medical Clinic records indicate that Aboriginal women are over-represented in the HIV/AIDS files. Sixty-five percent of the Clinic's female caseload is HIV/AIDS related (Vancouver Native Health Society, 1998)⁵. However, Aboriginal women comprise only 38 percent of female clients at the POP HIV/AIDS drop-in program located next door. Further, while the Clinic's HIV/AIDS caseload for Aboriginal clients was almost equal across gender, Aboriginal women comprised only 29 percent of total Aboriginal visits to the POP in 1998 (Vancouver Native Health Society, 1998). These data suggest that Aboriginal women are not frequenting the program to the extent expected.

Some research participants identified the lack of integration between program areas as a barrier to restoring health and well-being to Aboriginal women. As one provincial government representative stated: "I don't see Native Health [VNHS] services as being fully integrated. They [are] more like a series of separate programs within a health centre." Yet service providers interviewed maintained that networking between the Medical Clinic and the POP was not a problem, as informal processes and referrals were generally coordinated and patients' records shared across the two units.

The style of service delivery in the POP was offered as an explanation for why participation by Aboriginal women might be low. In particular, the women said they wanted more traditional, spiritual healing such as healing circles, access to traditional healers and more support and compassion from staff. The lack of a separate, private waiting room space for women to wait for their appointments was a further concern. As one of the Clinic physicians explained, Aboriginal women "tend to go to [all-women programs] as opposed to mixed services. Well they, you know, they may see their drug dealer in there right? They see them and maybe they owe them something. Or maybe there's a cop in there and they've got warrants out for their arrest. Or there may be some guy that they turned a trick with." Safety also was a key issue as expressed by another health provider, "I don't think that women would assume when they come into the downtown waiting area that they are safe. There are only a few places in the DTES that women do come and congregate, at women's centres and a few others. Not much thought had been put into how you could really serve the needs of these

women whose health has been affected by violence." This issue concerning the need for support services and safety strategies for street-involved women has been identified in other research (Currie, 1995).

According to our focus group participants, there are very few places in the DTES where Aboriginal women feel comfortable to go and sit with their children in a safe environment. There are even fewer support systems available for children to learn how to cope with the fact that their mothers are seriously ill. There is also little information available on basic health care and how to manage chronic diseases. The Program is not alone in this regard, as one focus group participant, herself suffering from AIDS and with a child to care for, stated: "No AIDS places in Vancouver have support for our children. It's the year 2000 and I've been saying this for the last ten years and nothing has been done. So how can we look out for our future if we're not? I think that is what our AIDS organizations need to do, something for our future."

Sheway

I think the unique feature of Sheway [is that] it helps to make health and social services more available and more accessible and more relevant to women, as well as being a safe place.

-Sheway staff member

Sheway's mandate is that when you have a baby that's eighteen months, you're done your time here. Sheway says it's time to move on and that's when you need the most help, more support, more understanding. That's when you need the next step.

-Focus group participant

Although a nextdoor neighbour and partner of VNHS, Sheway, which is Aboriginal (Coast Salish) for *Growth*, is a distinct program for substance-using pregnant women in the DTES. Sheway appears to come closer to our focus group participants' vision of a safe refuge and community program for themselves and their children. It has earned a reputation in BC as a model program focussed on improving infant, child and maternal health in the urban ghetto. In 1999, Sheway surpassed 100 open client files, of which 70 percent were Aboriginal women. When the program opened in 1993, 40 percent of babies born in the DTES had FAS/NAS syndrome; of these, 33 percent had low birth weights and virtually all of these were apprehended by child protection authorities (Loock, Kinnis, Robinson, Segal, & Armstrong, 1993). By 1998, 86 percent of the pregnant women who used Sheway services had infants with birth weights of over 2500g. Furthermore, child custody was no longer a major concern for the majority (58 percent) of the new mothers (Poole, 2000, p. 22).

⁵ These statistics correlate with the Vancouver Injection Drug User Survey. The Survey found that, given their relative population size in the city, Aboriginal people were over-represented in the HIV/AIDS category (see Currie, 1996-1998).

Approximately 30–70 women, children and, less frequently, male partners or other relatives drop in daily at Sheway. On-site professionals include a multi-disciplinary team of two part-time physicians, three community health nurses, two social workers, one outreach worker, a dietician, an infant development program worker and an alcohol and drug counselor. Through partnerships with other agencies, the services of an occupational therapist, physiotherapist, pediatrician, nurse clinician, and financial aid worker are also made available. Other services include a daily nutritious hot lunch, food hampers, vitamin supplements, bus tickets, infant formula, baby supplies and other emergency services. For many of the women interviewed, poverty was a major issue and these services often meant the difference between feeding and clothing their child or not.

Sheway's philosophy of care is based on *harm reduction* in regard to use of alcohol and addictive drugs as well as potentially risky sexual practices. As one staff member pointed out:

We spend a lot of time talking about birth control with a lot of women. I know the nurses will counsel on safe sex; we all do. If we know that a woman is practicing unsafe sex we are able to discuss [condom use] as a form of prevention. We talk about prevention in regard to safeness for the women working in the sex trade. We talk about looking out for themselves, making sure they have a date list.

Our focus group participants had many positive things to say about Sheway's approach and the services provided. Above all, they liked the fact that so many things they needed were available on site, including doctors and child development workers. A welcoming, group-oriented approach to service delivery was also noted as an important factor in determining their comfort with accessing services. More than an 'open door', this program practices a non-task-oriented philosophy of care critical to getting women through the front door—a first step in preventive health. Many of the women taking part in this study said that they initially approached Sheway for non-medical reasons, including gaining access to wholesome food and availing of the opportunity to socialize with other new mothers. In time, once trust with staff had been developed, the new arrivals began to address their specific health issues. Were they required to reveal their personal histories and health concerns upon first arrival, as is the norm in medical offices, many of the women said that they would not have entered the site in the first instance. As expressed by one of our focus group participants, "many [women] go in there for support or someone to talk to. [The workers] need to listen, and not just say: 'Well, what is it you really want from us?'" The research

literature lends support to these findings (Tait, 1999; Dion Stout et al., 2001).

In addition to social and emotional factors, the overall staff–client structure at Sheway also influences whether Aboriginal women perceive a facility to be supportive. One research participant had this to say about an administrator she liked: "I love the way she handles all these clients, the way some of them are, you know (laughs)...She's got good coordination and good help behind her." Other Sheway staff were also praised for being easy to talk to and for meeting the women's diverse emotional and psychological needs. One focus group participant said: "I like talking to the workers up there and I find that it's a good place for me right now, where I'm at, to be around the people."

Our research participants identified the value of peer support and appreciated the opportunity to meet with other mothers who shared similar life situations. Sheway provides a space for their children to socialize with other children and to just 'hang out' in a non-judgmental environment, something not available to them in the adjacent Medical Clinic or the POP. For these women, the program provides a safe, encouraging and supportive environment where women can learn problem-solving skills, gain valuable experience in interpersonal relationships, and enjoy role modelling and learning from other women. Other women said that Sheway not only drew them out of their isolated hotel room hovels, but also offered them some sense of security from abusive partners and the dangers of the street. As one participant put it, "It's [Sheway] a safe place; instead of being out there...I'm lucky this place is here, otherwise I'd probably be six feet under long ago."

In addition to the positive features of Sheway noted above, the focus group participants also appreciated the hot lunches, nutritional snacks, vitamins, baby formula and diapers, among other things. As expressed by one woman, these provisions would not otherwise be available: "...a big help is the milk and the food, because a lot of times you don't have money. Because welfare [is] not enough money." Sheway staff were also praised for helping out in a crisis and for providing support to the women: "When I had my second daughter, I didn't have a car seat and they [Sheway staff] came to the hospital and gave me a car seat and clothes and they took me home."

Yet not everything about Sheway gave comfort to the women. Like the rest of the VNHS, the physical space at Sheway is extremely cramped, consisting of a walk-through street reception in front, a small living and dining room area, miniature play area for children that spans the hallway between Sheway and the Medical Clinic, and a few offices off to the other side. While some of the focus group participants expressed fondness for the cozy fit of these tight quarters, others expressed dismay at the overcrowded conditions of the

facility. One of the Sheway staff described the situation like this:

A lot of women come back for second and third pregnancies, so you don't just have infants here, and you have toddlers up to school age kids. If a woman comes in and she's having problems, you can't take her aside and talk about childcare, talk about parenting, talk about discipline. There's not even a place for a woman to put her baby down.

Some focus group participants argued that Sheway staff was partly to blame for the overcrowded conditions because they were too lenient in providing access to people who did not 'qualify', such as people who were looking for meals or a 'place to crash'. Because the amount of food available daily was limited, concern is expressed that non-pregnant women, as well as male acquaintances, received meals before pregnant women and their children. Others did not like their children seeing clients who were 'high' or 'passed out on the couch'. One woman expressed her frustration in this way, making note as well that she felt her privacy was invaded:

Sheway is like Grand Central Station. I noticed like fifteen people walking through here today that have nothing to do with Sheway and they're not pregnant and we weren't even notified. A few of us who got really offended because we go there with the confidence that it's our privacy.

Another concern raised was in regard to the patient–doctor relationship, especially for Sheway birthing clients as they approach delivery time. Many commented that they never knew which doctor would be on duty at the hospital's maternity ward, or if they would have an intern or student. Several participants spoke highly of the midwifery services that were offered at Sheway during 1996–1997 as a pilot project to VNHS. The women felt midwives had more time for them and were there for them during labour and delivery. However, Sheway's pilot midwifery project was terminated in 1997, at the same time that the midwifery profession was granted legal standing and public funding in the province (Benoit, 2000). To the authors' knowledge, none of the users of midwifery services at Sheway were consulted about the elimination of the program. Despite evidence of cost-effectiveness and lower risks of complications in midwifery-assisted childbirth (Clarke, 2000), the service has yet to be replaced for Aboriginal women living in Vancouver's DTES. One participant described what she missed with the elimination of the Sheway midwives:

When they had midwives, it was just phenomenal. Most of the women went through midwives and plus the nurses and the doctors, so you got to know the

people before you went into labour. You knew who was going to be there for you way before you got pregnant. You knew who was going to be in there for you and it made it so much more comfortable.

As the women see it, then, the Sheway model is more akin to traditional Aboriginal health structures; it includes a fluid and informal service delivery, a collective, non-hierarchical staff structure, and horizontal relationships between staff and clients, all of which reflect the holistic values and structures of the more communal, traditional Aboriginal societies. Yet others are concerned that more could be done at Sheway to promote traditional Aboriginal ways of healing and practice. As one participant commented: "There's lots of Native women that come to Sheway, and I believe that's something that should be brought into their lives too. Because that is our spirituality, that's how we help each other." Similar to observations about the Medical Clinic and POP, participants voiced complaints about the lack of Aboriginal staff at Sheway and applauded the promise of an Aboriginal nurse and outreach worker whose position had just been funded at the time of interview. Focus group participants also expressed dismay that Sheway was not able to meet the needs of older children, particularly those without any 'identified problems'. As expressed by one Aboriginal woman:

What we need to develop is a more structured core program for kids. Sheway deals with young children; Crabtree [a DTES childcare centre] deals with kids up to age six. But where do kids go after that? I just find that it's really stressful, especially for someone like myself, living with an illness and no support. There needs to be a support program or a place for my son to interact with other children and people who are going through something similar.

Finally, women expressed a desire for greater access to formal parenting skill training. Many admitted they did not have family from whom to learn parenting skills and many did not experience positive parenting themselves. As one focus group participant put it, "it would be good to have someone come in and teach parents about their children, discipline and all this stuff."

A Healing Place

When asked what they would like to see in a new vision for programs for Aboriginal women in the DTES, participants were unanimous about the urgent need for something akin to a Healing Place. Their desire was to build on the positive features of VNHS and especially Sheway and at the same time provide a more holistic and integrated system of health services specifically for Aboriginal families across the life span. One of the focus group participants stated that, "a Healing Place is

not only for your health, physical health, but also for your spiritual and mental health. It should be all combined, not separated.” An Aboriginal community health worker put it like this: “health is like mind, body, spiritual and emotional, right? So, you got to have all four in balance to be healthy. So my [vision] is a place that looks after all four and you walk in balance. A place that’s holistic and follows traditions as well.”

It is somewhat ironic that while this research was in process the Vancouver Regional Health Board had discussions underway about whether or not to establish an Aboriginal Healing Centre (AHC) in the city, something that was also recommended by a federal government royal commission on the nation’s Aboriginal people (Report on Aboriginal People, 1996). Most of the women participating in our focus groups had not heard about the proposed AHC, yet another indication that they have little opportunity to give input in the design of health services aimed at improving their health and that of their children. And it was equally interesting in this regard that all of those interviewed—VNHS staff, health providers, government representatives and community health workers—had heard about the proposed facility. While few opposed the concept, many wondered what components it would include—a Medical Centre, Social Centre, or Spiritual Centre or all combined? Others had concerns around its possible geographical location. Would it be in the DTES or in one of the more privileged neighbourhoods of the city? And who would be able to use the facility? Would it only be for Aboriginal people? Would it be safe and welcoming for Aboriginal women and their children?

Discussion

There is now a substantial body of research on Aboriginal health showing that Aboriginal women face formidable barriers in gaining access to the mainstream health care system as well as related social welfare services (Dion Stout et al., 2001). The study reported here builds on this literature by examining the situation of Aboriginal women in Vancouver’s urban ghetto, the so-called Downtown Eastside. Analysis of data gathered from focus groups with Aboriginal women residing in the area and interviews with a sample of Vancouver Native Health Centre staff, attending physicians, community health workers and government health officials, indicates that Aboriginal women in the DTES are not accessing services in the manner that would be predicted. Regardless of their individual experiences in seeking care, all of the Aboriginal women taking part in the study were in search of culturally appropriate services that (1) offered support and safe refuge from the inhospitable urban ghetto around them; (2) provided staff who understood Aboriginal women’s historical

wounds and were aware of the lingering racism and sexism that continue to negatively affect their health, language, identities and self-respect; (3) endorsed a philosophy that promoted preventive health and incorporated traditional Aboriginal medicine into modern health care practices; and (4) opened its doors to Aboriginal women’s families, especially their children.

In brief, not only were there significant gaps identified in the available services for DTES Aboriginal women, but they also had to contend with discrimination and racism in many of their encounters with the mainstream system. Other research has shown this to be the case for Aboriginal women in BC as well as other parts of Canada (Aboriginal Nurses Association of Canada, 1996; Tait, 1999; Browne, Fiske, & Thomas, 2000). Previous research in the DTES has likewise shown that Aboriginal women are less likely to seek treatment for substance abuse for fear their children will be apprehended and placed in adoptive homes or formal arrangements of some kind (Parry, 1997; Poole & Isaac, 2001). Early work has indicated as well that women in the DTES want more street outreach workers, as well as more and/or better drug and alcohol services (Poole, 2000). In addition, as in this study, reports have shown that Aboriginal women wish to be cared for by service providers who have ‘been there’ to ensure a better mutual understanding and trust between provider and client (Core Women Care Report, 1995).

Currently, however, there are no specific policies or strategies for addressing these concerns (Native Women’s Association of Canada, 1997; Dion Stout et al., 2001; Browne, forthcoming). The need to integrate the experiential knowledge gained from urban Aboriginal women into our policies and programs is vital to improving their health status in the long-term. Aboriginal women in the DTES are well aware of the strengths and weaknesses of available health and social services and are also willing to give voice to more innovative ways of moving forward. In short, we agree with Dion Stout et al. (2001, p. 30) that health research, but also health and social policy, need to be ‘indigenized’ so that both are truly reflective of Aboriginal women’s lives and grounded in their personal experiences and life challenges.

Conclusion

This paper has attempted to give agency to Aboriginal women in one of Canada’s most disadvantaged urban neighbourhoods. In this respect, our study is not unlike recent research on the health and well-being of women in low-income countries who, despite the formidable barriers they face daily, are not mere victims of others’ doing (Mohanty et al., 1991; Wojcicki et al., 2001). Many of the Aboriginal women who took part in this

study were unable to direct major change in their lives. Nevertheless they displayed an incredible inner strength that has sustained them thus far. Many spoke of the historical, cultural, socio-emotional and physical wounds that have affected their health, language, identities, self-respect and very survival as women. Each woman is a warrior in her own right, fighting a losing battle against poverty, disease, racism, sexism and abandonment.

The DTES is not where Aboriginal women belong. Many of them feel lost in the perils of a place that is so far from their culture, offering them little by way of tenderness, caring, or empowerment. Yet they remain the main caretakers of their children, struggling to feed, educate and comfort them, typically by putting off their own health problems for another time in the future.

The VNHS was established over a decade ago with the mandate to offer effective and culturally appropriate health care based on a more holistic approach than had previously not been available to Aboriginal people in the DTES. Its initial vision of an AHC disappeared over the years as the agency, and the facility, evolved to become a frontline urban health service for the predominantly male multi-ethnic marginalized population that resides in the urban ghetto. While admirable in what it has achieved to better the health situation of this population living on the edge, the VNHS nevertheless is only partly able to serve the needs of the Aboriginal women interviewed for this study. Aboriginal women continue to search for services that are gender-sensitive, culturally appropriate and at the same time inclusive of their children. The challenge ahead for the Centre is how to better integrate and at the same time ensure balance between Aboriginal and Western ways of healing practice and holistic practices.⁶

As Canadian governments create change in governance of health services there is concern that local community governance structures may lose some of their community-based authority and not be flexible enough to meet emerging and current needs. In addition, there is considerable evidence that existing services are not getting at the root causes but instead remain focused on symptoms of the problems or adopt medical oriented strategies. If policy-makers are serious about affecting real change, Aboriginal women, one of the most marginalized groups of all inner city populations must not be overlooked. The challenge will be how to address the inequities and ghettoization that exists in the DTES and at the same time work with urban Aboriginal

women to help them effectively reclaim control over their health and social services. It is time we clearly acknowledge that these women have a *voice* as well as a *vision* about what kind of Healing Centre would best meet their needs and effect positive change for themselves and the next generation of Aboriginal children in the DTES.

Acknowledgements

Foremost, we would like to thank the Aboriginal women who participated in the focus groups and those individuals who voluntarily participated in the interviews. Without their voices, this project would not have been possible. In addition, our thanks go to the following organizations and people: the Vancouver Native Health Centre, especially Lou Demarais, Executive Director and Annette Garm, former Director of Sheway, the Ad Hoc Advisory Committee for their valuable expertise and advice, the National Network on Environment and Women's Health for their major financial contribution, the Women's Health Bureau in Victoria for the additional financial support, Lisa Lawr for her project co-ordination and research assistance and Christina Zacharuk for her timely transcriptions of the personal and focus group interviews. Finally, we would like to extend gratitude to the University of Victoria for its in-kind funding for this project, without which it would have been difficult to bring to a final conclusion.

References

- Abelson, J., & Hutchison, B. (1994). *Primary health care delivery models: A review of the international literature*. Hamilton, McMaster University: Centre for Health Economics and Policy Analysis.
- Baxter, B. (1999). *Health services for women living in the downtown eastside*. Vancouver, BC: Report submitted to the Vancouver/Richmond Health Board.
- BC Provincial Health Officer (1996). *A Report on the Health of British Columbians: Provincial Health Officer's Annual Report-1995 Feature Report: Women's Health*. Ministry of Health and Ministry Responsible for Seniors, Victoria, BC.
- BC Women's Health Bureau (1998). Minister's advisory council on women's health. *Women's health in the context of regionalization*. Victoria, BC: Ministry of Health and Ministry Responsible for Seniors.
- Benoit, C. (2000). *Women, work, and social rights*. Scarborough, Ont: Prentice Hall.
- Benoit, C., & Carroll, D. (2001). *Marginalized voices from the downtown eastside: Aboriginal women speak about their health experiences*. Report prepared for Health Canada. National Network on Environments and Women's Health, York University.

⁶ Between the writing of this article and its final acceptance, changes have been made at Sheway suggesting that perhaps Aboriginal women's voices are being heard by some authority figures. Among the new developments are a larger physical space for the facility and additional Aboriginal staff (personal communication, Nancy Poole, January 2002).

- Berg, B. L. (1996). *Qualitative research methods for the social sciences* (3rd ed). Toronto: Allyn and Bacon.
- Browne, A. (forthcoming). *Improving health care services for first nations women: A community case study*. Vancouver, BC: BC Centre of Excellence for Women's Health.
- Browne, A., Fiske, J., & Thomas, G. (2000). *First nations women's encounters with mainstream health care services and systems*. Vancouver, BC: BC Centre of Excellence for Women's Health.
- Canadian Institute for Health Information. (2000). *Health Care in Canada: A first Annual Report*. Ottawa: Statistics Canada.
- City of Vancouver (1998). *Downtown eastside community monitoring report*. City Hall, Vancouver, BC.
- Clark, G. (1999). 365 Overdose deaths last year set grim new record. *The Province*, January 21, p. A3.
- Clarke, J. (2000). *Health, illness, and medicine in Canada*. Don Mills, Ont: Oxford University Press.
- Core Women Care Report (1995). *The place to start: Women's health care priorities in Vancouver's DTES*. Vancouver, BC: Vancouver Women's Health Collective.
- Creswell, L. (1994). *Research design. Qualitative & quantitative approaches*. Beverley Hills, CA: Sage Publications.
- Currie, S. (1995). *Assessing the violence against street-involved women in the DTES/Strathcona communities*. Written for Downtown Eastside Youth Activities Society (DEYAS).
- Currie, S. (1996–98). *The Vancouver injection drug user study (VIDUS) project: Updates #1–4*. Vancouver, BC: BC Centre for Excellence in HIV/AIDS.
- Denzin, N. K., & Lincoln, Y. S. (Eds.) (1998). *Collecting and interpreting qualitative materials*. Thousand Oaks, CA: Sage.
- Dion Stout, M., Kipling, G., & Stout, R. (2001). *Aboriginal Women's Health Research Synthesis Paper: Final Report*. Centres of Excellence for Women's Health. Ottawa: Women's Health Bureau.
- Derber, R., & Thompson, G. (Eds.) (1992). *Models for integrating and coordinating community-based human service delivery: An analysis of organizational and economic factors*. Toronto: University of Toronto Press.
- Garm, A. (1997). *How risk factors combine to put inner city, substance using women and their infants at an increased risk for HIV infection*. Vancouver, BC: Vancouver Native Health Society.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory*. New York: Adline.
- Hanselmann, C. (2001). *Urban Aboriginal people in Western Canada: Realities and policies*. Calgary, Alberta: Canada West Foundation.
- Health Canada. (1999). *HIV and AIDS in Canada: Surveillance Report*. Ottawa: Health Canada, Laboratory Centre for Disease Control.
- Hislop, T. G., Clarke, H. F., Deschamps, M., Joseph, R., Band, P. R., Smith, J., Le, N., & Atleo, R. (1996). Cervical cytology screening: How can we improve rates among first nations women in urban British Columbia? *Canadian Family Physician*, 42, 1701–1708.
- Jaffe, A. J. (1992). *The first immigrants from Asia: A population history of the North American Indians*. New York, London: Plenum Press.
- Joseph, R. (1999). *Healing ways—Aboriginal health and service review*. Vancouver, BC: Vancouver/Richmond Health Board.
- Kazempiur, A., & Halli, D. (2000). Neighbourhood poverty in Canadian cities. *Canadian Journal of Sociology*, 25(3), 369–379.
- Kent, H. (1998). Hepatitis A and C 'superinfections' tackled in BC. *Canadian Medical Association Journal*, 159, 6.
- Leatt, P., Pink, G., & Taylor, C. (1996). Integrated delivery systems: Has their time come in Canada? *Canadian Medical Association Journal*, 154(6), 803–809.
- Loock, C. A., Kinnis, C., Robinson, G. C., Segal, S., Blatherwick, F. J., & Armstrong, R. W. (1993). *Targeting high-risk families: Prenatal alcohol/drug abuse and infant outcomes*. Vancouver, BC: Department of Pediatrics, Faculty of Medicine, University of British Columbia.
- Lowry, F. (1993). New native Healing Centre in Toronto opens eyes of non-native MDs who work there. *Canadian Medical Association Journal*, 148(2), 270–272.
- Luborsky, M. (1994). Identification and analysis of themes and patterns. In J. F. & Gubrium, & S. Sankas (Eds.), *Qualitative methods in aging research*. Thousand Oaks, CA: Sage Publications.
- Maxwell, J. (1996). *Qualitative research design. An interactive approach*. Beverley Hills, CA: Sage Publications.
- McCull, M. (1999). This is DTES, Vancouver's Downtown Eastside. *Kahtou News*, 8(1), 15.
- Mohanty, C., Russo, A., & Torres, L. (1991). *Third world women and the politics of feminism*. Bloomington, IN: Indiana University Press.
- Native Women's Association of Canada (1997). *'Hear their Stories': 40 Aboriginal Women Speak*. Ottawa: The Association.
- Parry, P. (1997). *Something to eat, a place to sleep, and someone to give a damn: HIV/AIDS and injection drug use in the DTES*. Vancouver, BC: The Vancouver/Richmond Health Board.
- Perry, B. G. (2000). Beginning anew: Doing qualitative research. *The Canadian Journal of Sociology*, 25(1), 97–107.
- Poole, N. (2000). *Evaluation report of the Sheway project for high-risk and parenting women*. Vancouver, BC: BC Centre of Excellence for Women's Health.
- Poole, N., & Isaac, B. (2001). *Apprehensions: Barriers to treatment for substance-using mothers*. Vancouver, BC: BC Centre of Excellence for Women's Health.
- Royal Commission on Aboriginal People (1996). *Report of the royal commission on aboriginal peoples. Gathering Strength, Vol. 3*. Minister of Supply and Services Canada, Ottawa.
- Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.
- Statistics Canada (2000). *Women in Canada 2000: A gender-based statistical report*. Ministry of Industry, Ottawa.
- Tait, C. (1999). *New beginnings project: Wellness needs assessment of Aboriginal women living in Montreal*. Montreal: Aboriginal Women of Montreal.
- Todd-Dennis, A. (1995). *Qwum Qwum Sleni: A Report on Aboriginal Women's Health Issues in the Lower Mainland*. Vancouver: BC Women's Hospital and Health Centre and the Association of First Nations' Women.
- The Trade and Convention Centre Community Impact Team (TACCIT) (1999). *Which legacy? Vancouver's downtown*

- communities and the expansion of the Vancouver convention and exhibition centre.* Vancouver, BC: TACCIT.
- Vancouver Native Health Society (1998). *Vancouver native health society: annual report.* Vancouver Native Health Society, Vancouver, BC.
- Vancouver Richmond Health Board (1997). *Vancouver Richmond health board resolution.* Vancouver, BC: Vancouver Richmond Health Board.
- Vohlonen, I., Pekurinen, M., & Saltman, R. B. (1989). Re-organizing medical care in Finland: The personal doctor program. *Health Policy*, 13, 65–79.
- Waldram, J., Herring, D. A., & Young, T. K. (1997). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives.* Toronto: University of Toronto Press.
- Whynot, E. (1998). Women who use injection drugs: The social context of risk. *The Canadian Medical Association Journal*, 159(4), 355.
- Wojcicki, J., & Malala, J. (2001). Condom use, power and HIV/AIDS risk: Sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. *Social Science & Medicine*, 53, 99–121.