

MARGINALIZED VOICES FROM THE
DOWNTOWN EASTSIDE:
ABORIGINAL WOMEN SPEAK ABOUT
THEIR HEALTH EXPERIENCES

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**Marginalized Voices from the Downtown Eastside:
Aboriginal Women Speak About Their Health Experiences**

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EXECUTIVE SUMMARY

Research on general health service delivery in urban areas of British Columbia and other Canadian cities shows that Aboriginal women face formidable barriers in accessing provincial health services. Over the past decade, Urban Aboriginal Health Centres (UAHCs), controlled by Aboriginal people, have emerged to address the unmet health concerns of members of their population living in metropolitan areas. The purpose of this research is to address the gap in social science literature on how health care concerns of Aboriginal women living in marginalized areas of metropolitan cities are being met by UAHCs. Specifically, the research aims to give voice to Aboriginal women by asking them to identify whether the service delivery model employed at the Vancouver Native Health Society (VNHS), an urban Aboriginal health centre located in Vancouver's Downtown Eastside (DTES), provides them with the appropriate professional services and educational programs they need to take control of their health. A case-study approach was used in which we conducted focus groups with Aboriginal women who were clients of either VNHS, its sister organization, Sheway, or who were residents of the DTES. Interviews were also conducted with VNHS staff, health professionals, and community leaders on health care issues in the Vancouver area.

Two themes emerged from the focus groups with Aboriginal women: *access issues* and *support service issues*. In terms of access issues, Aboriginal women highlighted the importance of a non-judgmental, encouraging, non-task-oriented environment, greater gender sensitivity, and more woman-centered care. In addition, they expressed a need to focus on Aboriginal women's specific health concerns; the need for greater cultural-based programming (including traditional healing methods and therapies); and more

personal security and assurance of anonymity. Some women identified the need for Aboriginal-only exclusive services and programs; however, there was no consensus among the women participants on whether this was a critical issue in the DTES. The following support service issues were also identified: enhanced services for children, access to parenting support and education programs, access to food, basic supplies and other assistance during emergencies, access to professional dental care, and access to integrated community health support networks.

The health service providers and administrators who were interviewed brought up many of the concerns articulated by the Aboriginal women participants. In addition, the former raised concern about the way in which *regionalization* was affecting the delivery and control of Aboriginal health services and programs in the DTES. Although there was overwhelming support from administrators and service providers for the development of a new Aboriginal Healing Centre in the Vancouver area, they nevertheless felt a number of outstanding issues needed to be resolved before moving forward. Viewed as critical for immediate examination were: the location of the proposed Centre and how equal access to the city's Aboriginal people would be provided, the types of services and programs that would be offered and who would control them, and how the Centre would build on the VNHS's current strengths? The health service providers and administrators who were interviewed also wondered how consultations were going to be conducted to ensure that Aboriginal people themselves, as well as administrators, caregivers and families, would have an opportunity to become involved in addressing these pivotal questions concerning the proposed Aboriginal Healing Centre.

Despite efforts from various quarters to “give voice” to the country’s marginalized populations, this report shows that such has not been the case for Aboriginal women living in one of Canada’s most prosperous cities. Only by integrating what we have learned from Aboriginal women themselves into planning health service delivery can we hope to improve their health status. At the end of the report, we present recommendations from our findings as a starting point in what we hope will be an ongoing process of integrating the voices of Aboriginal women, who are the experts on their own health care needs, into future planning, policy development and program delivery models.

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There is an urgent need to hear the voices of Aboriginal women if improvements are to be made in their health status.

Aboriginal women face formidable barriers in accessing provincial health services that are sensitive to their health beliefs and responsive to their health concerns.

1. INTRODUCTION

Canada is not unique among high-income countries in its current attempt to restructure its existing health and social welfare systems to control costs and yet provide its citizens with opportunities for greater control over their health care. But despite efforts from various quarters to “give voice” to the country’s marginalized populations, this report shows that such has not been the case for Aboriginal women living in one of Canada’s most prosperous cities, Vancouver, British Columbia (B.C.). We argue that there is an urgent need to hear the voices of Aboriginal women if improvements are to be made in their health status.

The limited research that exists on general health service delivery for Aboriginal women in Vancouver shows that they face formidable barriers in accessing provincial health services that are sensitive to their health beliefs and responsive to their health concerns. The few available reports indicate that Aboriginal women have for some time faced serious health problems due to inadequate access to reproductive care services, including access to pap smears, mammogram screening and abortion services (B.C. Provincial Health Officer, 1996; B.C. Women’s Health Bureau, 1999.) However, the general lack of research has led to limited information that can influence health policy and planning for Aboriginal women.

Urban Aboriginal Health Centres have emerged to address the health concerns of Aboriginal people living in large metropolitan areas.

A critical component of this research was to examine the unique ways in which the DTES's social, cultural and physical environment, shapes the health care needs and experiences of Aboriginal women.

Over the past few decades Urban Aboriginal Health Centres (UAHCs), controlled by Aboriginal administrators, have emerged to address the unmet health concerns of Aboriginal people living in large metropolitan areas. To date, little evidence exists as to whether health care programs and services at UAHCs have been successful in fulfilling their mandate to offer more responsive, effective and culturally appropriate health programs and counseling services based on a holistic approach.

2. GOALS AND OBJECTIVES

The purpose of this research was to address the gap in social science literature on how health care concerns of Aboriginal women living in marginalized areas of metropolitan cities are being met by UAHCs. A critical component of this research was to examine the ways in which Vancouver's DTES environment, with its unique social, cultural and environmental problems, shapes the health care needs and experiences of Aboriginal women residents. Our research aimed to give voice to Aboriginal women by asking them to identify whether the service delivery model employed at the VNHS provides Aboriginal women residents with the appropriate professional services and educational programs they need to take control of their health.

Participant observation, personal interviews and focus groups were our primary methods of determining Aboriginal women's perceptions of health care services at VNHS.

For many of the women, this was the first time they had ever been consulted about the health services they access.

3. METHODS

Participant observation, personal interviews and focus groups were our primary methods of determining Aboriginal women's perceptions of health care services at VNHS. Our research was conducted in two phases. During Phase I (*July-August 1999*), we conducted a literature review of the DTES, an inventory of its relevant outreach services and an overview of the VNHS. This information served as background for the rest of the study. During Phase II (*October 1999-February 2000*) an Ad Hoc Community Advisory Council comprising Aboriginal and non-Aboriginal professionals was formed to provide us with advice, direction and guidance regarding our research goals, respondent recruitment strategies and interviewing. We eventually conducted three focus groups with Aboriginal women who were 1) clients of VNHS; 2) clients of its sister organization, Sheway; or 3) non-affiliated residents of the DTES. The focus groups were well attended. An honorarium was made available to the participants at the end of the session. Despite some initial suspicions, most participants proved to be very eager to share their experiences and opinions. For many of the women, this was the first time they had ever been consulted about the health services they access in the DTES. One participant articulated the importance for the women to be consulted about their health care needs:

There's a lot of women around that have their ideas, they know how to approach work and living down here, they have the experience of what's needed.

~ DTES Woman

In addition, we conducted twenty-five personal interviews with VNHS staff, health professionals, government representatives, and community leaders in health care. Our aim in doing so was to get a wider view of challenges in providing adequate health care for Aboriginal women in the DTES.

4. RESEARCH LIMITATIONS

As a case study, this research is focused on the broad health access issues of Aboriginal women in Vancouver's DTES, and identifies their perceptions of programs and services at the Vancouver Native Health Society. Due to the diversity of Aboriginal women's experiences and health needs and the unique issues associated with the DTES, the information we gathered cannot speak to the experiences of all Aboriginal women. As researchers, we recognize that the self-selected sampling procedures used to attract focus group participants and individual interview respondents likely resulted in exclusion of the voices of other Aboriginal women in the DTES, such as the elderly, women not in crisis, those from rural areas or even those living in neighbouring districts of the DTES.

As a case study, this research is focused on the health access issues of Aboriginal women in Vancouver's DTES and identifies their perceptions of programs and services at the Vancouver Native Health Society.

5. VANCOUVER'S DOWNTOWN EASTSIDE

Seventy percent of Vancouver's total Aboriginal population lives in the DTES.

A disproportionate number (40%) of DTES residents are Aboriginal (McColl, 1998). In fact, seventy percent of Vancouver's total Aboriginal population lives in the DTES (Joseph, 1999). The district is infamous as Canada's poorest neighborhood (TACCI T, 1999). Seventy-five percent of residents in the area live at the edge of poverty, with an annual income only one-third that of other Vancouver residents (City of Vancouver, Spring 1998). Most DTES Aboriginal residents have been displaced from other parts of Canada or the province (VI DUS, 1998).

Vancouver's Downtown Eastside is infamous as Canada's poorest neighborhood and for its prolific drug trade.

Housing for many DTES residents is a 12' x 9' 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, including a refrigerator, stove or private bathroom (Kinesis, 1997). Security, privacy and safety also tend to be absent (Kinesis, 1997). Some slum hotels serve as 'shooting galleries' for drug users. 'Crack' cocaine, heroin, and prescription drugs are routinely sold and used openly on the streets below the hotels. One Aboriginal woman participant described the housing situation this way:

My problem is cockroaches. The housing part, it's not adequate. There's a lot of slumlords out there, running these hotels and they don't put money into them and they just rent them as they are, and we have to try to fix them up when we move into them.

[B]ut we can't live that way. We've been there for months and the cockroaches have been there. There's a lot of germs. ~DTES Aboriginal Woman

There is broad acknowledgment that the social problems are the result of socioeconomic factors.

The DTES' overcrowded hotels and poor living conditions, in combination with a substantial part of its population who are dependent on addictive drugs and who practice unsafe 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 plagued with 'super-infections' of Hepatitis A and C (Kent, 1998), and frequently experiences epidemic outbreaks of tuberculosis and syphilis. 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 Resolution, Sept.1997). There is broad acknowledgment that the DTES's social problems are the result of socioeconomic factors such as poverty, lack of safe, affordable housing, social isolation, marginalization of injection drug users, little by way of supported training/employment for its marginalized population, and lack of access to sensitive and culturally appropriate health and social support services (Taccit, 1999).

Seventy percent of DTES sex trade workers are Aboriginal women.

5.1 Aboriginal Women in the DTES

Roughly 50 percent of the Aboriginal population living in the DTES is female (Joseph, 1999). Seventy percent of DTES sex trade

80% of Aboriginal children in the DTES live in poverty.

workers are Aboriginal women. Indeed, the average Aboriginal sex trade worker is 26 years of age, has three or more children, and is without a high school education (Currie, 1995). Teenage births are 13 times higher in the DTES than in the general Vancouver region (Joseph, 1999). In addition, 50 percent of Aboriginal families are headed by a lone female parent (Joseph, 1999) and 80 percent of Aboriginal children in the DTES live in poverty.

Aboriginal women are the fastest growing group of HIV+ people in the DTES (Parry, 1997) and are three times more likely to die of HIV/AIDS than other women (Joseph, 1999.) In general, unprotected sexual activity and reliance on the on-street sex trade industry to garner a living, places Aboriginal women at higher risk of having health problems than their non-Aboriginal counterparts (Parry, 1997.) Due to gender inequalities in male-female relationships, Aboriginal women are often more likely than men 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).

Aboriginal women in the DTES often find themselves isolated and lacking any sense of community and social support.

Many Aboriginal women with HIV/AIDS living in the DTES have been displaced from their reserve communities due to lack of understanding and acceptance of HIV/AIDS within their home community (Bouw, 1996). Like other residents of the DTES,

Aboriginal women also tend to find themselves isolated and lacking a sense of community and social support. Social agencies often become surrogate homes and families to the more traditional clan or community back home (Garm, 1997).

The statistics on Aboriginal women above are presented to provide a social context. However, these statistics are limited in that they do not provide the true picture of the negative effects of poverty, unemployment, and social welfare on overall health and social well-being of Aboriginal women residents. One woman who said expressed the complexity of these women's lives:

Of the over 180 social services in the DTES, only five are specifically aimed at serving women.

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.

Approximately 50% of VNHS clients are Caucasian and 40% are Aboriginal.

Of the over 180 social services in the DTES, only five are specifically aimed at serving women. These include: the Sheway Project for substance using pregnant women, which is affiliated with the Vancouver Native Health Society and discussed in more detail below; the YWCA Crabtree Corner, a daycare/women's drop-in; the DTES Women's Centre; WISH, a drop-in/support group for sex workers; and DAMS, which sponsors drug/alcohol support meetings.

Like other Aboriginal service providers in urban health centres in B.C. and Canada, the VNHS does not turn away non-Aboriginal clients.

6. THE VANCOUVER NATIVE HEALTH SOCIETY

The Vancouver Native Health Society (VNHS) operates from a cramped, street-level storefront two blocks from the main intersection in the DTES. Approximately 50 percent of VNHS clients are Caucasian and 40 percent are Aboriginal. Despite its visibility among Aboriginal people generally, it is telling that some of the focus group participants had never utilized services offered at the VNHS. Not all of the women participants were aware of the VNHS's Native Health Clinic. Most of the staff at the VNHS is of non-Aboriginal origin. This is due, in part, to the lack of qualified Aboriginal health professionals, human rights hiring policies and high risk factors associated with employment. VNHS is a provincially funded, non-profit society. Core administrative funding comes from the Ministry of Health's Aboriginal Health Division and other Ministry departments.

The original intent of the VNHS was to establish an Aboriginal controlled, culturally appropriate health centre for Vancouver's *Aboriginal* people living in the DTES. Yet, philosophically, as well as in practice, the Centre's services and programs are not restricted to Aboriginal people. The current 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. Hence, like other Aboriginal service providers in urban health centres in B.C. and Canada at large, the VNHS does not turn away non-Aboriginal clients. Instead, they adhere to the belief that their clinical services and educational programs should be responsive to the needs and concerns of other client groups as well. Health care professionals, recognizing the crisis situation in the DTES, also embrace this philosophy, believing that services should mirror the ethnic mosaic of the community.

Programs and services at the VNHS include 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 Chinese medicine and acupuncture are also offered through the Positive Outlook program.

The walk-in Medical Clinic is the most public face of the VNHS and the first point of entry for most clients; however, Sheway, a partnering program located within the same building, appears to be the most successful in serving the needs of Aboriginal women.

The walk-in Medical Clinic is the most public face of the VNHS and the first point of entry for most clients. However, Sheway, a partnering program located within the same building, appears to be the most successful in serving the needs of Aboriginal women. The subsequent section of this report provides a brief overview of these two programs. Further information on other VNHS

programs and services can be obtained from the VNHS Annual Report.¹

6.1 The VNHS Walk-In Medical Clinic

The walk-in Medical Clinic offers extended evening and weekend services. Five male and four female doctors provide routine medical treatment, HIV/AIDS care, methadone maintenance and STD counseling and follow-up. The Clinic's mission is to provide free, non-judgmental primary care and health promotion to all residents of the DTES community (VNHS, 1999). Plain clothed security guards, indistinguishable from the medical office assistants, provide security in the small waiting area. A small children's playroom is available from the adjoining Sheway Project. Currently, almost half of clinic visits are by Aboriginal clients and roughly half again are by Aboriginal women, but the majority of services are provided to non-Aboriginal males who account for 36 percent of the total caseload. Women accessing services at VNHS (separate from Sheway) felt that, overall, services at VHNS were "good." As stated by one woman:

Women accessing services at VNHS felt that, overall, services at VHNS were good.

With the [VNHS's] Native Health clinic, they have a really good service there, but it's really quite small. They have really good doctors in there, and they do, I know where she's coming from when she says that they do sit and listen to you. [But] I just wish they had a bigger clinic.

-DTES Woman

¹ Vancouver Native Health Society 1998 Annual Report.

A review of clinic records indicates that Aboriginal women are overrepresented in the HIV/AIDS clinic files.

A review of clinic records indicates that Aboriginal women are overrepresented in the HIV/AIDS clinic files. In 1998, 70 percent of Sheway's clients were Aboriginal women. Aboriginal women accounted for 65 percent of the female HIV/AIDS caseload (VNHS, 1998). Despite these statistics, Aboriginal women comprise only 38 percent of female clients at the Positive Outlook HIV/AIDS drop-in program located next door. These data suggest that Aboriginal women are not frequenting the Positive Outlook program to the extent that we might expect. The mode of service delivery may help us to understand why. Sheway stands as an alternative example in this regard.

6.2 The Sheway Project

Sheway has earned a reputation as a model program focused on improving infant, child and maternal health.

Although a next-door-neighbour and partner of VNHS, Sheway is a distinct program that promotes holistic health care and a "homey" atmosphere for its women clients. Sheway's mandate is to assist substance-using pregnant women with the necessary services to have the healthiest babies possible. Because Sheway is currently the only program at the VNHS that specifically addresses Aboriginal women's health needs, it was chosen as a focus for this study.

Sheway has earned a reputation as a model program focused on improving infant, child and maternal health for marginalized DTES

In 1999, due to a severe shortage of physical space, the program was forced to turn away any new clients.

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 were apprehended by child protection authorities (Loock *et al.*, 1993). By contrast, 86 percent of the pregnant women who contacted Sheway in 1998 had infants with birth weights of over 2500 grams. Further, for over half of the new mothers (58 percent), child custody was not a major concern (Poole, 2000: 22). Nevertheless, the Sheway program has neither the staff nor the resources to provide support for FAS infants of the women clients, nor does it have the resources for prevention health programs.

In 1999, Sheway surpassed 100 open client files, of which 70 percent were Aboriginal women. Due to a severe shortage of physical space, the program was forced to turn away any new clients. Approximately 30 to 70 women and children drop in daily at Sheway. Further, many women continue to access Sheway services after they have been officially discharged, indicating the need for services after 18 months (access to services is officially limited to 18 months.)

Sheway staff use a team-approach to provide continuous, seamless and integrated services.

On-site professionals at Sheway include 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 available. Sheway staff use a team-approach to provide continuous, seamless and integrated services. One client expressed her satisfaction with the approach:

I like it because they have everything under one roof here, like they have the nutritionist, they have the doctors, they have the child development workers... I like it because they have everything under one roof and you can see everybody. ~ Sheway Client

Services provided include a daily nutritious hot lunch, food hampers, vitamin supplements, bus tickets, infant formula, baby supplies and other emergency services. The physical space at Sheway is limited to a small living and dining room area and miniature play area for children that spans the hallway between it and the medical clinic. Although maintaining the program's underlying principle of confidentiality is difficult in such a small space, the limited space has some advantages in that it promotes cohesion and community among the drop-in clients.

Aboriginal women identified many significant issues, with two themes emerging: access needs and support service needs.

7. KEY FINDINGS AND OUTCOMES

7.1 Perspectives of Urban Aboriginal Women

Aboriginal women who participated in the focus groups identified many significant issues, with two themes emerging: access

needs and support service needs. The predominant topics arising from the focus groups were:

Access Issues:

- importance of a non-judgmental, encouraging, supportive environment;
- need for focus on Aboriginal women's health concerns (social/emotional, spiritual as well as physical needs);
- security and anonymity;
- need for greater cultural-based programming (including traditional healing methods and therapies);
- greater gender sensitivity and woman-centered care;
- exclusively Aboriginal vs. inclusive services and programs.

Support Service Needs:

- enhanced services for children;
- access to parenting support and education programs;
- access to food, supplies and other assistance during emergencies.

Importance of a Non-Judgmental, Encouraging and Supportive Environment

A welcoming, group-oriented approach to service delivery, such as that offered at Sheway, was highlighted by many women 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, as a first step in preventative health. For instance, many women initially approach Sheway for non-medical reasons, such

A welcoming, group-oriented approach to service delivery, such as that offered at Sheway, was highlighted by many women as an important factor in determining their comfort with accessing services.

In addition to social and emotional factors, the overall organizational structure, environment and location, influence whether Aboriginal women perceive an organization to be supportive.

Aboriginal women also identified the value of peer support and appreciated the opportunity to socialize with other new mothers who share similar life situations.

as to access wholesome food and to socialize with other new mothers. In time, once trust with staff has been developed, they begin to address their health issues. Were they faced with numerous personal and medical questions upon first arriving, as is the norm in medical offices, most would not enter the site at all or would not stay long enough to begin a treatment program. As expressed by one VNHS client:

You need to go in there for support or someone to talk to. They need to listen, and not just say 'Well, what is it you really want from us?' It's like we have to have something to get from them and we just want to talk.
~VNHS Client

In addition to social and emotional factors, the overall organizational structure, environment and location influence whether Aboriginal women perceive an organization to be supportive. At Sheway, services are organized in a non-hierarchical manner and it is not uncommon for staff to have lunch or tea with clients. The women we spoke with praise Sheway staff for being easy to talk to and for meeting the women's diverse emotional and psychological needs:

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. And I just find it easy to talk to some of the people there.
~ Sheway Client

Aboriginal women also identified the value of peer support and appreciated the opportunity to socialize with other women and mothers who share similar life situations. The women valued the

For many, Sheway provides a safe place of refuge, away from their hotel rooms that offer little or no security from abusive partners and street-life.

Some focus group participants voiced the need for more structure or rules with respect to program accessibility and acceptable behaviour on site.

opportunity that Sheway provides for their children to socialize with other children and to just 'hang out' in a non-judgmental environment. 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 modeling and learning from other women. As one woman put it:

What I really like is just sitting there watching the other mothers; sometimes you learn from [the] experience [of other mothers]. ~Sheway Client

For many, Sheway provides a safe *place of refuge*, away from their hotel rooms that offer little or no security from abusive partners and street-life. As stated by one participant and reiterated by others:

I t'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. They have supported me a long, long time. ~Sheway Client

Yet, despite a fondness for the openness and informal atmosphere, some focus group participants voiced the need for more structure or rules with respect to program accessibility and acceptable behaviour on site. Some of the women mentioned that Sheway programs were too lenient in providing access to people who didn't 'qualify', such as people who were looking for meals or a 'place to crash'. Due to limited amounts of food available, the women were particularly concerned

about non-pregnant women, as well as male acquaintances, receiving meals before pregnant women themselves had eaten. Others did not like the fact that clients who were 'high' or 'passed out on the couch' were nevertheless permitted on site. Still others felt staff did not intervene enough when clients parented inappropriately, although others recognized that this was a parent's choice.

The women also appreciated the hot lunches, food, vitamins, formula and diapers, among other things.

Access to Services in Emergencies

In addition to the importance of Sheway's unique atmosphere, the women also appreciated the hot lunches, food, vitamins, baby formula and diapers, among other things. As expressed by one woman, the food provided nutrition that would not otherwise be available:

I think that a big help is the milk and the food, because a lot of times you don't have money. Because welfare... it's not enough money. They think it is, but it's really not. ~DTES Woman

Many women praised Sheway staff for helping out in a crisis and looking out for their welfare.

In addition, many women praised Sheway staff for helping out in a crisis and looking out for their welfare. An example provided by one participant illustrates that the support provided extends beyond the walls of Sheway:

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. ~DTES Woman

The ability to control security and anonymity were additionally identified by the women as important factors in determining whether they felt comfortable accessing services.

Aboriginal women do not access health services due to the presence of social workers/ child welfare workers being there and their association with child apprehensions.

Security and Anonymity

The ability to control security and anonymity were additionally identified by the women as important factors in determining whether they felt comfortable accessing services. For example, some women felt uncomfortable and unsafe entering the crowded waiting area at the VNHS's adjacent Walk-In Medical Clinic, which is mainly frequented by male clients. Some of our women participants were concerned about encountering men in the Clinic who they knew and feared. Furthermore, the DTES community is comparatively small in population and geographical area and some of the Aboriginal women said that they did not feel comfortable seeking medical attention for mental and physical injuries caused by family violence. Others did not want significant others knowing that they were seeking professional care. As expressed by one woman:

If you're going to get a flu shot or you're going because you got an infected splinter or something, that's different than if you're going for a breast lump or something to do with your body as a woman. Or if it has to do with sexually transmitted diseases or something related with childbearing, you may not want any men to know. ~DTES woman

Overall, the women seemed to be more comfortable accessing services at the DTES Women's Centre than at the VNHS's Medical Clinic. Concerning the former:

It's always a safe place to be. There's always a woman there and you know for a fact that men are not allowed to come in. ~Aboriginal Client

Another issue of security and accessibility was raised by a DTES health professional who stated that many Aboriginal women do not access health services at the VNHS due to the presence of social workers/ child welfare workers being there and their association with child apprehensions.

On food bank days at the VNHS, clients also commented that they were afforded little privacy, but instead were forced to line up down the street. Despite attempts to ensure confidentiality and safety by VNHS staff, Aboriginal women expressed serious concerns about how the lineup might foster racism and stereotyping.

Exclusive Aboriginal Only Services and Programs vs. Inclusive Services and Programs

Aboriginal women in the DTES do not unanimously agree that exclusive Aboriginal-only services and programs in the DTES would improve their access to appropriate and sensitive health care services.

Aboriginal women in the DTES do not unanimously agree that exclusive Aboriginal-only services and programs in the DTES would improve their access to appropriate and sensitive health care services. Some women felt that Aboriginal-only programs and services were racist; other women, however, mentioned that the particular needs of Aboriginal women (and men) in the DTES could only be met through exclusive programs and services.

As noted above, the official mandate of VNHS is to enhance the health status of urban Aboriginal people by improving their access to appropriate health care services. However, philosophically

and practically, the VNHS operates on a non-exclusive basis. As stated by one participant:

What started out as Aboriginal didn't stay... [W]hen I first came to Native Health and Outreach, there were Native health workers, and all of a sudden they're gone. What should have been a Native outreach is now multicultural; now we've got everybody down there.
~VNHS Client

Most of the Aboriginal women participants expressed a desire to access traditional healing such as healing circles, talking circles, sweat lodges, traditional healers and teachings.

Regardless of their particular views on exclusivity along race-ethnic lines, there was consensus among the women participants about their desire for culturally appropriate care.

Greater Cultural Sensitivity

Many of the women expressed the importance of cultural awareness in relation to their overall healing, health and well-being.

Most of the Aboriginal women participants expressed a desire to access traditional health services, including healing circles, talking circles, sweat lodges, traditional healers and elder teachings. Our women respondents expressed concern that while elements of Aboriginal culture are integrated into programs in varying degrees, there is no overarching attempt to ensure that traditional models are integrated with bio-medical models across VNHS programs and services. Noteworthy in this regard is that the services provided at the Medical Clinic have no cultural or traditional component, although the Life skills programs include a historical-cultural component, as well as regular sweat lodge ceremonies. Other programs, such as Sheway, attempt to embody holistic aspects of Aboriginal culture. As the women see it, the Sheway model is more akin to Aboriginal

traditional 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 values and structures of the more communal, traditional Aboriginal societies. Many of the women participants stressed the importance of cultural awareness for their overall healing, health and well-being. As stated by one woman and reiterated by others:

I speak my language, but I don't know about my background. I know where I'm from and all that, but I remember my mom and dad used to do all this Native stuff. I'd like to know about that. It's just lost.
~DTES Woman

The desire for a shift to traditional ways was especially noted in the area of counseling and social services.

The women participating in this research hoped that a future Aboriginal Healing Centre would provide a much-desired holistic and integrated system of health services specifically for Aboriginal people.

The desire for a shift to traditional ways was especially noted in the area of counseling and social services. Some women were dissatisfied with the counseling they had received because they felt it was Western-based, 'by the book' counseling. They desired instead more traditional, spiritual healing such as talking circles:

Aboriginal women felt at ease speaking to someone with a broadly similar cultural background who had had similar life experiences as themselves, both in terms of Aboriginal culture as well as 'street life' and drug use.

Concern was also expressed about the amount of time some physicians spent listening to the women's concerns, forming relationships, explaining procedures and generally demonstrating a sense of care and compassion.

The reason I quit coming to counseling here [at the VNHS] is because the counseling is done very poorly... I go to healing circles and all kinds of stuff for my drug addiction now...[E]very time I used to come here the problems that I used to go through when I was pregnant, they would just get pushed under the table and I'd be leaving here worse than the way I walked in... 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.

~Sheway Client

Whether the focus was on Sheway or the other branches of the VNHS, the women participants in this study expressed greater comfort in talking to Aboriginal staff rather than non-Aboriginal staff. Aboriginal women felt at ease speaking to someone with a broadly similar cultural background who had had similar life experiences as themselves, both in terms of Aboriginal culture as well as 'street life' and perhaps drug use. The ease and comfort of talking with another Aboriginal person was described by one woman:

I prefer to be around First Nations, because they're the ones who understand where we come from. When you go in there, 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.

~VNHS Client

Greater Gender Sensitivity

On the one hand, concern was also expressed about the short amount of time some physicians (of both genders) spent listening to the women's concerns, forming relationships, explaining procedures and

**Aboriginal women
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health needs.**

generally demonstrating a sense of care and compassion. One woman shared her experience with us:

I think there are a couple of doctors here 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." ~VNHS Client

On the other hand, the Aboriginal women desired more female staff to meet their health needs. This desire for female physicians may be in part because Aboriginal women are likely to have experienced abusive or unhealthy relationships from men and, therefore, have a deeper discomfort in seeking health care from male practitioners.

[Aboriginal women] tend to go to those [all-women programs] as opposed to the 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.

~DTES Health Professional

The patient-doctor relationship was especially relevant to Sheway clients as they approach delivery time. Many Sheway clients commented that they never knew which doctor would be on duty at the hospital's maternity ward, or if an intern or student would show up instead. One woman stated:

Sheway clients spoke highly of the midwifery services that were offered at Sheway during 1996-97 as a pilot project

I've had five (children) and not one of the doctors I was seeing was ever there. Not once. I had interns. I had students. I had everything else, [other than] the doctor that I was supposed to [have help me] deliver. He was on call, or off, or whatever. ~Sheway Client

Many of the Aboriginal women participating in our study spoke highly of the midwifery services that were offered at Sheway during 1996-97 as a pilot project. The women said the midwives had more time for them, got to know them and were there for them during labour because they were always on call. One woman shared her experience:

When they had midwives, it was just phenomenal... 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... and it made it so much more comfortable. ~ Sheway Client

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 B.C. (Benoit, 2000). To the researchers' 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 or provided to Aboriginal women across B.C.

The lack of services for older children and children of parents with HIV/AIDS was identified by the women as an area requiring significant improvement.

Many women identified a need for education and support for children with HIV+ parents.

Dental services were also a concern for the Aboriginal women.

Enhanced Services for Children

The lack of services for older children and children of parents with HIV/AIDS was identified by the women as an area requiring significant improvement. The women felt that the needs of older children, particularly those without any 'identified problems' were not being met. It is important for these children, at the very least, to be able to interact with other children their age for support and comradery. 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 deals with kids up to age six and after that you can't go in there. 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.
-DTES Woman

In addition, many women identified a need for education and support for children with HIV+ parents. As one woman put it:

AIDS places in Vancouver have no support for our children. It's the year 2000 and I've been saying this for the last ten years and nothing's been done. So how can we look out for our future? I think that's what our AIDS organizations need to do, something for our future.
-DTES Woman

Dental services were also a concern for the Aboriginal women participating in this project, particularly in terms of services for their children. Many of them stated that they had difficulty finding a good dentist nearby. Many women also expressed difficulty in

having their dental services covered through the federal government due to current policy to transfer these services to Aboriginal peoples themselves.

Access to Parenting Programs

Many women expressed a desire for greater access to formal parenting skill training.

Although the women enjoyed learning parenting skills through observing and conversing with other parents at Sheway, many women expressed a desire for greater access to formal parenting skill training. Because many of the women did not have family from whom to learn parenting skills and others did not experience positive parenting themselves, they felt, as one woman put it, that 'it would be good to have someone come in and teach parents about their children, discipline and all this stuff.' One woman said she wanted to learn about 'ages and stages of the children, sibling rivalry, when they lost their teeth...'

A number of women also expressed concerns regarding a gap in services for mothers after their children were 18 months.

Finally, a number of women expressed concerns regarding a gap in services for mothers after their children were 18 months. The need to address this gap was articulated by one woman who said:

Sheway's mandate is that when you have a baby that's eighteen month, you're done your time here and it's time to move on. If you've got a baby with FAS or FAE the most difficult time is the terrible twos. Sheway says it's time to move on and that's when you need the most help, more support, more understanding and that's when you need the next step.

-DTES Woman

7.2 Perspectives of Service Providers and Administrators in the DTES

The service providers and administrators identified many of the same issues of concern to the Aboriginal women participating in the focus groups

The service providers and administrators identified many of the same issues of concern to the Aboriginal women participating in the focus groups; however, there were some differences in perceptions regarding integration of programs and exclusivity of services. The effect of regionalization and overall visions for an Aboriginal Healing Centre were also discussed with the service providers and administrators.

Integration of VNHS programs within the DTES Community

Services are often provided in crisis intervention mode, leaving little time for coordination of service delivery and development of preventive programs.

The service providers commented that there appeared to be fairly good communication among service providers at the VNHS. However, at the same time our respondents noted that improvements could be made to better integrate client care services. The main reason given for the current lack of tight service integration was that there are too few personnel to meet health care demands. The result is that services are often provided in crisis intervention mode, leaving little time for coordination of service delivery and development of preventive programs. A government official who was interviewed for this project also identified the lack of integration:

I don't see Native Health services as being fully integrated. They [are] more like a series of separate programs within a health centre.

-Provincial Government Representative

There was also general consensus among service providers that VNHS maintained a strong presence in the DTES community at large and with other service provider groups.

Most VNHS programs and services are based on the Western biomedical model.

The service providers, however, maintained that networking was not a problem, as informal processes and referrals were generally made between services. There was also general consensus among service providers that VNHS maintained a strong presence in the DTES community at large and with other service provider groups. A female doctor at VNHS had this to say regarding one means of how integration is facilitated:

I think our monthly meetings help, you know, each program within VNHS each gives an update on what's going on, so that way we hear about each other, we see people, we recognize who does what, and I mean I've always tried personally to get better at that. I'm thinking when I see patients which programs they could be sent to, or should I send this woman to the Life Skills program or to Sheway.

~ VNHS Doctor

According to a provincial government official, there is considerable flexibility in how the VNHS allocates its resources. The limits are "pretty much open to them as to how they want to do it - within limits." For example, funding provided for physicians may be reallocated to other programming better suited to the needs of the community, such as social workers. To some extent this helps prevent a medically-driven model from become dominant. Yet, in actuality, most VNHS programs and services are based on the Western biomedical model. In addition, most services are tailored to meet the overall needs of the DTES population, which means that few

Most service providers and administrators were of the opinion that addressing the needs of the DTES community in general was more important than offering exclusive Aboriginal services.

culturally appropriate and traditional models of healing are incorporated.

Exclusivity of Services

There was greater consensus among the service providers and administrators than Aboriginal women with respect to health services. Most service providers and administrators were of the opinion that addressing the needs of the DTES community in general was more important than offering exclusive Aboriginal exclusivity/inclusivity of primary services. A health board member reiterated this view, stating that services for women in the DTES should be targeted to all women in the DTES:

[There is a] debate [when] you're developing health services for women in the DTES: do you really want to get into developing two frames, one for Aboriginals, one for other women?... I think the way that we've gone about it so far is [to] develop services for all women in the DTES, making sure that they're accessible and sensitive and all those things, regardless of who you are. ~Health Board Member

Regionalization and Urban Aboriginal Health Centres

Advocates of regionalization suggest that greater efficiencies will be made as decision-making and accountability is provided at the local level.

The decentralization of health care planning from governments to local health boards and the devolution of decision-making powers have affected how services are delivered to specific population groups, including Aboriginal women in the DTES. Advocates of *regionalization* argue that greater efficiencies will be made as decision-making and accountability are provided at the local

Regional Health Boards, at the local level, now have a significant say in how services in their regions will be organized and greater accountability in ensuring that appropriate services are provided.

Many Aboriginal 'governors' have resigned and others complain of feeling unheard, invisible, and/or unsupported by the process

level. It is anticipated that greater voice will be provided to local residents to express their health concerns and needs (B.C. Policy Manual for Regional Health Boards, 1996). Whether or not greater voice for residents has been achieved is still an open question. What is clear is that the Aboriginal Health Division of the Ministry of Health monitors fewer and fewer contracts for targeted programs for Aboriginal people, and will oversee even less in the coming years. Regional Health Boards, at the local level, now have a significant say in how services in their regions will be organized and will be responsible for ensuring that appropriate services are provided.

The Vancouver/Richmond Health Board came into being in 1997, and at the point of writing this report had eight Population Health Advisory Committees (PHACs) representing groups traditionally under-served by the health system. One of these PHACs represents the city's urban Aboriginal population. In addition to its Aboriginal Population Advisory Committee, the Vancouver Health Board has also recently instituted an Aboriginal Advisor to the Board. Although the Minister of Health has appointed Aboriginal governors to most Boards and Councils to help facilitate this process, many Aboriginal 'governors' have resigned and others complain of feeling unheard, invisible, and/or unsupported by the process (Aboriginal Health Association of B.C., 1999). A DTES Aboriginal

community leader in health found this to be her experience with PHAC and other committees:

I bring in my experiences and my concern for the community and the people. Sometimes they overlook what I'm trying to say because 'I'm not in her shoes.' You've got to walk the path for people to know where you're coming from. I think people need to recognize we have parents out there, or people out there, who've got very much say in what goes on and they need to be heard and listened to.

~ DTES Community Leader

To date, there is little evidence to show that regionalization has improved health service planning or provided greater control and decision-making for Aboriginal people.

To date, there is little evidence to show that regionalization has improved health service planning or provided greater control and decision-making for Aboriginal people. Of immediate concern is whether improvements will occur for marginalized groups, such as Aboriginal women living in the DTES. A representative from B.C. Women's Hospital stated that Aboriginal women's issues were not of themselves a priority for DTES health care authorities. Rather, their priority is to improve primary health care services for the DTES population as a whole:

I think that people were so concerned to set up a proper clinic for Native people in general and to respond properly to the AIDS epidemic and drugs and things like that. But they weren't thinking about women's issues and they still aren't basically [doing much for Aboriginal women], except that they have some very wise people.... But basically [the concerns of Aboriginal women were not] on the plate, and it wasn't on the plate for any of the services down there...

~ Health Professional

Most Aboriginal specific-health care organizations are funded on a contract basis directly from various Provincial Ministries, the local health board, and by private donations. Health professionals interviewed expressed concerns about how such organizations will continue to access health dollars from the Vancouver Health Board. The competition with 'big players,' such as hospitals and other large health organizations with power and prestige was a factor that did not work in their favour, as expressed by one VNHS doctor:

Can you distribute your money equitably? As you know you're dealing with big enormous hospitals with which the region is involved and they have a lot of power and there are prestige factors involved, etc. etc. They walk away with the vast majority, with the greatest piece of the pie. -VNHS Doctor

There was general agreement between both the women who participated in the focus groups and the service providers that an Aboriginal healing centre would benefit Aboriginal people in Vancouver.

Aboriginal Healing Centre

There was general agreement between both the women who participated in the focus groups and the service providers that an Aboriginal healing centre would benefit Aboriginal people in Vancouver. Yet reservations were expressed by some research participants and other wanted more information regarding what exactly an 'Aboriginal Healing centre' would look like: would it look like a medical centre, social centre, or spiritual centre? Others had concerns around the location of the proposed Centre and who would be able to use it.

The lack of consultation with existing groups and failure to ensure programs complement and support one another is of great concern.

Service providers recognized that the larger issue of Aboriginal control of a healing and health centre might create problems between the Aboriginal community and the Regional Health Board.

Further, a VNHS administrator described recent concerns over the duplication of health services by the Regional Health Board. An experimental drug treatment program was recently set up one block from VNHS, based on the same treatment premise used at a VNHS program, yet the same program at VNHS continues to be under-funded. The lack of consultation with existing groups and failure to ensure that programs complement and support one another was of great concern to some respondents. One service provider put it this way:

I guess my first reaction is that it would be nice to [acknowledge] some of the services that are already doing a good job...We do have a lot of services in the DTES area for First Nations people that are really good. And so if the healing centre comes around to build another service that duplicates the services that are already existing, [it] would be a waste because the dollars are so scarce.

~VNHS Service Provider

Service providers recognized that the larger issue of Aboriginal control of such a Centre might create problems between the Aboriginal community and the Regional Health Board. Some service providers interviewed were concerned that the Health Board would overstep its role in facilitating the Centre:

They haven't really done the jobs in terms of any kind of coordination. Because again, I think they see that as something working counterproductive to meet their own needs because if you're strengthening groups within a community then you know how can you sort of stop them from being competitive with you, you know. And if you want to own and operate

everything, that's really not a way to go about you know, becoming all-powerful.

~DTES Administrator

8. CONCLUSION

Based on our interviews with Aboriginal women, a number of recommendations were put forth to improve accountability and to ensure systemic change to improve Aboriginal women's access to health services and to enhance participation and control over services targeted specifically to them:

1. Reserve seats (more than one) on the VNHS and the Vancouver Health Board for Aboriginal women from the DTES;
2. Host regular informal focus groups or feedback sessions at VNHS, specifically for Aboriginal women to help ensure Aboriginal women's decision-making and control over their health care needs;
3. On a trial basis, implement a one-day a week clinic for women seeking services at the VNHS;
4. On a monthly basis, plan information-sharing sessions for all staff at the VNHS and Sheway;
5. Implement policy changes to address human resource hiring strategies;
6. Seek funding for a 'Next Step' parenting program for middle and older aged children;
7. Ensure Aboriginal women's input into the development of an Aboriginal Healing Centre;
8. Invite Aboriginal women to become one of the partners in the development of a provincial Aboriginal Health Strategy or similar initiatives;

9. The population health committee at the Regional Health Board is advised to establish committees made up of Aboriginal women with expertise in their own health care concerns. Adequate housing should be among the top priorities.

Research conducted on the DTES over the past five years has identified the need for more detox treatment centres and shelter beds for women, especially for single mothers.

Women in the DTES want more street outreach workers, as well as more and/or better drug and alcohol services and service providers who have 'been there' themselves.

Our findings from the focus groups were echoed in previous research carried out in the DTES. Research conducted on the DTES over the past five years has identified the need for more detox treatment centres and shelter beds for women, especially for single mothers (Core Women Care, 1995; Parry, 1997; Baxter, 1999). Other studies have found 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). Reports have also indicated that women in the DTES want more street outreach workers, as well as more and/or better drug and alcohol services (Core Women Care, 1995; Poole, 2000). In addition, both Aboriginal and non-Aboriginal women have identified a need for service providers who have 'been there' themselves, to ensure a better mutual understanding and trust between provider and client (Core Women Care, 1995). Despite new and upcoming health initiatives in the DTES [i.e., Sobering Centre/Detox; Drug Resource Centre; Dental Centre], there is still no evidence of gendered service delivery in these initiatives. In addition, despite recommendations for a new health facility in the Greater

Aboriginal women in DTES spoke of the physical, cultural, socio-emotional and historical wounds that have affected their health, language, identities and self-respect.

Aboriginal women, one of the most marginalized of all inner city populations, hold the key to a healthier way of life for themselves and their children.

Vancouver/Richmond area, no consultation has been undertaken with VNHS or Aboriginal women in the DTES.

In our conversations with DTES Aboriginal women, we learned that they carry an incredible inner strength that has sustained them thus far. Many spoke of the physical, cultural, socio-emotional and historical wounds that have affected their health, language, identities and self-respect. One does not have to go far on any street corner in the DTES to see the intractable problems related to infant and child health and infectious and chronic diseases. 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; so many of them are lost in the perils of a place that is so far from their culture, that offers them little by way of tenderness, caring, or empowerment. As we create change in governance of health services, at federal, provincial, regional and organizational levels, there remains a difficult challenge ahead regarding how best to balance Aboriginal and Western ways of healing. We believe that the best place to start is with the women themselves, the traditional “keepers” of Aboriginal cultures. Aboriginal women, one of the most marginalized of all inner city populations, hold the key to a healthier way of life for themselves and their children.

In conclusion, we believe this study points to the necessity of asking marginalized urban Aboriginal women themselves about their health concerns and needs and how both might be better integrated into the organization and delivery of future services. Otherwise Aboriginal women, confronted with cultural and gender discrimination, racism and poverty will continue to fall through the cracks of programs and services of health organizations, even those specifically set up to serve Aboriginal people, such as the VNHS.

9. IMPLICATIONS FOR ABORIGINAL WOMEN AND HEALTH RESEARCH POLICY

The importance of this research lies in the fact that, while Aboriginal women in the DTES have particular health concerns associated with high-risk behaviour and the environment in which they live, their health and social needs are in no way being adequately met. Aboriginal women are the largest growing HIV+ population in the DTES, but from our research and medical clinic statistics it is apparent that they are not accessing services and that there are gaps in the services they require. Currently, there are no specific policies for addressing these issues, nor is there specific funding available to further investigate barriers to access for these women. Only by integrating what we have learned from Aboriginal women into planning, policy development, and new models of health service delivery can we hope to improve their health status. This research

Only by integrating what we have learned from Aboriginal women into planning, policy development, and new models of health service delivery can we hope to improve their health status.

highlights what is working in Aboriginal health organizations and provides support to make the needed changes to health policy programming and service delivery that is specific to the needs of Aboriginal women.

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APPENDIX A

CLINIC TABLES HIGHLIGHTING SEX AND ETHNICITY

1992-1998 VISITS BY SEX

YEAR	TOTAL	MALE	%	FEMALE	%
1992	1 397	867	63	509	37
1993	5 343	n/a	n/a	n/a	n/a
1994	6 610	4 254	64.4	2 356	35.6
1995	7 382	4 866	65.9	2 516	34.1
1996	7 053	4 453	63.1	2 600	36.9
1997	10 971	6 985	63.7	3 986	36.3
1998	13 756	8 877	64.5	4 840	35.2

- Visits by men outnumber those by women almost 2 to 1. Men at the clinic considerably outnumber women.
- While tremendous growth has occurred in clinic visits, the percentage of both male and female visits has remained stable.

1992-1998 VISITS BY NATIVE STATUS AND SEX

YEAR	NATIVE	% of all clinic visits	NATIVE MALE	% of all clinic visits	NATIVE FEMALE	% of all clinic visits
1992	n/a	n/a	n/a	n/a	n/a	n/a
1993	n/a	n/a	n/a	n/a	n/a	n/a
1994	2 556	38.7	1 406	21.3	1 150	17.4
1995	3 110	42.1	1 766	24	1 344	18.2
1996	3 352	47.5	1 928	27.3	1 424	20.2
1997	5 441	49.6	3 215	29.3	2 226	20.3
1998	6 079	44.2	3 373	24.5	2 706	19.7

*Thanks to Clinic Coordinator Gordon Kliewer for sourcing the raw data compiled in the tables.

- Visits by Natives now represent almost half of all visits. As a percentage of total clinic visits they have increased slightly though steadily up to 1997 (10.9%).
- Visits by Native males represent almost one third of all visits. As a percentage of total visits they also increased steadily until 1997 (8%),
- Visits by Native females as a percentage have remained relatively stable, representing roughly one fifth of all visits.

1992-1998 FEMALE VISITS BY ETHNICITY

YEAR	WOMEN (% of Total Caseload)	NATIVE WOMEN (% of Total Women)	ALL NATIVE (% of Total Caseload)	NATIVE WOMEN (% of Total Caseload)	NATIVE WOMEN (% of Total Native)
1992	37	n/a	n/a	n/a	n/a
1993	n/a	n/a	n/a	n/a	n/a
1994	35.6	48.8	38.7	17.4	45
1995	34.1	53.4	42.2	18.2	43.2
1996	36.9	54.8	47.5	20.2	42.5
1997	36.3	55.8	49.6	20.3	40.9
1998	35.2	55.9	44.2	19.7	44.5

- Visits by Native women represent just over half of all visits by women. As a percentage of all female visits they have increased steadily (7.1%).

1992-1998 MALE VISITS BY NATIVE STATUS

YEAR	MEN (% of Total Cases)	NATIVE MEN (% of Total Men)	ALL NATIVE (% of Total Cases)	NATIVE MEN (% of Total Cases)	NATIVE MEN (% of Total Native)
1992	63	n/a	n/a	n/a	n/a
1993	n/a	n/a	n/a	n/a	n/a
1994	64.4	33.1	38.7	21.3	55
1995	65.9	36.3	42.2	24	56.8
1996	63.1	43.3	47.5	27.3	57.5
1997	63.7	46	49.6	29.3	59.1
1998	64.5	38	44.2	24.5	55.5

- Visits by Native men as a percentage of all men are increasing slightly (4.9%). They represent roughly 40% of all male visitors.
- Visits by Native men comprise slightly more than half of all Native visits, and have remained stable.

Summary of Clinic Visits:

- Of total clients, sex ratios have remained unchanged over the clinic's 6-year history.
- Of visits by Native clients the sex ratio is almost equal, whereas it is almost 2:1 for total clinic visits. (Caucasian males are by far the most frequent clinic visitors.) This apparent under representation of Caucasian females may simply reflect the gender demographics of the community. Informal discussions with other Community Health clinics in the area reveal similar male: female ratios.
- Native visits have been increasing slowly and steadily until 1998 (10.9%).
- Visits by Native males until 1998 were increasing as a percentage both of total clinic visits and of Native visits (8% and 4.1%).
- Visits by Native women are increasing steadily relative to those of Caucasian females (7%). As percentages of both total clinic visits and Native visits, visits by Native women remain unchanged.

- The largest percentage change overall has been of total Native visits (10.9% increase).
- In 1998, the trend towards increases reversed to slight decreases for several groups, all involving Natives: Total Natives as % of Total Visits (5.4%); Native Males as % of Total Visits (4.8%); Native Males as % of Total Men (8%); Native Males as % of Total Native (3.6%); Native Females as % of Total Visits (0.6%).
- The reverse trend occurred for Native women as a % of Total Natives in 1998: after steadily decreasing percentages, Native Women increased by 3.6%.
- The greatest trend reversal occurred for Native Males as % of Total Men (8%).

Total and HIV Caseloads by Ethnicity - 1998

	<i>Caucasian</i>	<i>Aboriginal</i>	<i>Other</i>
Total Caseload	50%	40%	10%
HIV Caseload	46%	50%	4%

- Aboriginals are disproportionately represented with HIV, compared to Caucasians.

Total and HIV/AIDS Female Caseloads - 1998

	<i>Caucasian</i>	<i>Aboriginal</i>	<i>Other</i>
Total Fem. Caseload	41%	53%	6%
HIV Caseload	34%	65%	1%

- Aboriginal women are over-represented in the female HIV+ caseload.

Total and HIV/AIDS Male Caseloads - 1998

	<i>Caucasian</i>	<i>Aboriginal</i>	<i>Other</i>
Total Male Caseload	54%	34%	12%
HIV Caseload	52%	42%	6%

- The clinic's HIV/AIDS statistics correlate well with the Vancouver Injection Drug User Survey's observation that First Nations people are over represented in the HIV/AIDS category. Although Aboriginals accounted for 40% of the clinic's total caseload, they were disproportionately represented with HIV/AIDS, making up 50% of the caseload. This pattern was most evident with Aboriginal women, who accounted for 65% of females with HIV/AIDS while making up only 53% of all female patients. Similarly, Aboriginal males were afflicted more frequently with HIV/AIDS than their Caucasian counterparts. Aboriginal males accounted for 34% of all male patients yet comprised 43% of males with HIV/AIDS.
- Alcohol/drug visits: 36% total visits (1997) HIV/AIDS related issues: 13% total visits (1997).