Health Service Needs for Urban Indigenous Women with Co-Occurring Health Concerns

Creating a Safe Place for Empowerment and Service Integration

By Hasu Ghosh, Cecilia Benoit, Ivy Bourgeault

ABSTRACT

Addressing inequities in health service access and utilization among Indigenous Peoples is complex, especially for urban Indigenous women with co-occurring health conditions and addiction issues. Services for co-occurring health conditions are compartmentalized and disjointed. Urban Indigenous women are particularly at risk of falling through the cracks of the service system. With this in mind, we designed a study that would provide information about how best to provide services to urban Indigenous women with multiple health challenges. The paper reports from the first phase of the study which involved interviews with service providers and decision makers. Data were collected through in-depth interviews. All the key stakeholders expressed the view that services for co-occurring health needs should be based on Indigenous women's understandings of culturally safe and responsive care. The results suggest that services for co-occurring health concerns must begin with ensuring Indigenous women's safety. Women who experience safe health services are more likely to feel empowered throughout the process of their healing journey. The lack of safety in health services can be considered as a key factor in Indigenous Canadians' inequitable access to health services.

Key Words: Indigenous women, diabetes, mental health, health service access, intersectionality

Across Canada, Indigenous Peoples[1] experience inequities in health service access and utilization, co-occurring physical and mental health conditions, and challenging systemic and financial constraints--all of which require health services offered through more innovative and integrative approaches grounded in Indigenous knowledge (NCCAH, 2012; Reading, 2009). Inadequate involvement of Indigenous Peoples and integration of their insights in the planning, implantation, delivery and monitoring of current health services often result in lack of cultural-competency and responsiveness. This discourages Indigenous clients of different ages and genders while attempting to access health services (NCCAH, 2012). Together these limitations can result in negative effects on the overall health and wellbeing of Indigenous Peoples, their families and communities (Smye, 2008).

A particularly compelling health issue is that of co-morbid[2] physical and mental health conditions with addiction, which many in this population face. The term co-morbidity in health services research, policy and practice, is conceptualized as co-occurrence of two or more chronic physical and mental health conditions in primary care, and health services contexts. A higher

---

[1] Throughout this paper, we use the term Indigenous Peoples to refer to Aboriginal Peoples and other first peoples of Canada.

[2] In this paper the terms co-morbid or co-occurring health conditions were used to denote simultaneous experience of two or more health conditions in order to reflect the terms used in literature and in the scientific and lay communities.

existence of co-occurring mental health with chronic physical health conditions involving addiction is documented among Indigenous Peoples (CMHA, 2008a & 2008b; North East LHIN, 2011), and women are more likely than men to have more co-occurring health conditions (Broemeling et al., 2008). Co-morbidity is a serious public health concern for Indigenous Peoples, partly because both diabetes and mental health issues are significantly elevated among Indigenous Peoples compared to other Canadians (CCSA, 2013; PHAC, 2011). Additionally, mental illness such as depression can have direct physiological effects on the development of type 2 diabetes due to the impact on the body's resistance to insulin (CIHI, 2008; Reading, 2009; Bombay et al., 2009). Although the biological mechanism between alcohol intake and diabetes occurrence is inconclusive, it is evident in the literature (North East LHIN, 2011; CMHA, 2008; Ghosh, 2013) that untreated addiction, substance use and mental health issues can impact social and cognitive function and decrease energy levels, resulting in difficulty for people to take care of their health, which ultimately leads to worse outcomes for chronic diseases (e.g. diabetes). For some individuals, substances are consumed as an attempt to cope with their pain caused by physical and sexual abuse, low self-esteem, loss of culture and identity, and family history of substance use (Reading, 2009).

The burden of these conditions in the population is immense, especially among vulnerable population groups, such as Indigenous Peoples, women, and people of low socioeconomic status. Individuals with co-morbid health conditions experience a more complex and severe health profile than those with single health condition including greater symptoms, severity, multiple drug use, along with poorer social and interpersonal functioning, and poorer quality of life (Davis et al. 2006). Issues surrounding lack of affordable and accessible housing and homelessness are more pronounced among Indigenous Peoples with co-morbid health conditions (Crane and Joly, 2014; Belanger et al., 2012).

Studies that examine the relationships between co-occurring conditions such as diabetes, mental health and addiction among Indigenous Peoples generally, and among Indigenous women in particular, are extremely limited (Halseth, 2013; Lavallee and Howard, 2011). Indigenous women's limited access to services and resources might also result in the internalization of negative messages about oneself. The circumstances of Indigenous women are intimately interwoven from birth with historical and contemporary government policies and resulting consequences of addiction, mental illness and chronic health issues (Tait, 2013). They are at a particularly high risk of dying prematurely. Undoubtedly, growing initiatives for culturally specific health prevention programs offered in urban Indigenous organizations have empowered urban Indigenous women for improving both their own health, and health of their families (Williams and Guilmette, 2001).

An ever more vulnerable group among Indigenous women are those who live in urban areas. According to 2006 census over 49% of Indigenous Peoples lived in urban Canada, and this was particularly the case for Indigenous women (Statistics Canada, 2008). According to 2011 census data, off-reserve Indigenous Peoples constitute the fastest growing segment of Canadian population. In 2011, 56% of Indigenous Peoples lived in urban areas, which is 7% increase from 2006 in 14 years (INAC, 2016). Although this urbanization process in Canada follows the general pattern of migration, the processes of Indigenous migration are unique and have a distinct history of their own (UAKN, 2012). Indigenous reserve communities characterize particular living environments where the overall way of life is uniquely characteristic to those living in these geographically defined spaces. Consequently, cultural, spatial, legal and socio-economic identities of Indigenous Peoples result in a different migrant experiences in urban centres. Urban Indigenous lives represent the missing opportunities for land rights, connection to home communities, and loss of cultural heritage and traditional ways of life as consequences of federal policy decisions (Newhouse and Peters, 2003). Added to these are structural and institutional discrimination, poverty, lack of economic opportunities and struggle for urban living including limited access to urban services and resources, such as health and social services (Environic Institute, 2010).

Canadian government's discriminatory colonial policies resulted in the enfranchisement and "deterritorialization" of Indigenous Peoples (De Leeuw and Greenwood, 2011). The enfranchisement was a practice of colonial efforts to impose categorization and varying identities on Indigenous Peoples by the implementation of Indian Act. Being not recognized as Indian in Canada continues to mean receiving services that differ vastly from those who are non-enfranchised or status Indians. The "deterritorialization" of Indigenous Peoples outside of their traditional territories or displacement of Indigenous children to residential schools along with enfranchisement speak to many of the negative consequences, including intergenerational trauma, violence and abuse, that today's Indigenous women experience. In discussing connection between past government policies and contemporary state of mental health among Canadian Peoples, Kirmayer et. al. (2000) state, "Some of these policies were well intentioned, but most were motivated by a condescending, paternalistic attitude that failed to recognize either the autonomy of Indigenous peoples or the richness and resources of their cultures. The cumulative effect of these policies has, in many cases, amounted to near cultural genocide. The collective trauma, loss, and grief caused by these short-sighted policies are reflected in the endemic mental health problems of many Indigenous communities and populations across Canada" (p. 609). The services for a number of "invisible" women who have co-morbid health conditions deserve policy attention for services integration. To further exacerbate the disadvantaged situation of urban Indigenous women, formal services are seriously inadequate and offered in silos in Canadian cities, while informal social and community support are inaccessible or limited for women who migrate from reserves or remote locations.

Colonialism is increasingly being recognized, particularly by Indigenous scholars as a significant social determinant of health that intersects with many other social identities of Indigenous Peoples (Loppie and Wien, 2008). The cumulative impact of these intersecting issues creates significant challenges in the urban realm, particularly for women. Indigenous women, specifically those are leading single parent households, comprise the most disadvantaged segment of the urban Indigenous population (AANDC, 2006). In urban sectors, Indigenous women become the subject of responsibility of various levels of governments, which is again inconsistent from province to province and territory to territory. Unfortunately, many of the contemporary shortcomings in Indigenous health and social services were identified in the Royal Commission on Indigenous Peoples' Report (RCAP, 1996) 20 years ago, and many of the issues identified back then remained inadequately addressed.

Nevertheless, there have been some notable promising practices in the urban Indigenous health services and policy landscape in the last

Figure 1.
Minwaashin Lodge:
Life Cycle Service Model

Reproduced with permission from the Minswaashin Lodge

decades (NCCAH, 2013). For example, Ma Mawi Wi Chi Itata Centre in Winnipeg, Manitoba, offers programs for urban Indigenous families; those are constantly guided by values grounded in Indigenous culture and allows meaningful community engagement (CCPA, 2009). Another notable example is Hiiye'yu Lelum (The House of Friendship) Society: Healthy Children Healthy Futures (HCHF) Program for urban Indigenous families in Duncan, British Columbia. The program is supported through the funding from PHAC (Public Health Agency of Canada) that aims to improve parents' skills and knowledge for positive parenting and provides opportunities to create social connections with other parents and community resources (Hiiye'yu Lelum, 2016; NCCAH, 2013). The services at the Minwaashin Lodge in Ottawa, Ontario are running for Inuit, Métis and First Nations, and derived from their traditional teachings about balanced, holistic health throughout the lifecycle. The Minwaashin Lodge: Life Cycle Service Model interweaves services (Fig 1) with seasonal ceremonies along the continuum of life from infancy to old age. This model fosters healthy relational attachment to the staff to family members, kin, community and land/culture; as well provides opportunity to reconnect with and maintain culture in an urban centre (Chansonneuve, 2009).

Presented below, qualitative findings from the first phase of an exploratory Ontario-based study clearly adds more nuances with service providers and decision makers' perspectives into urban Indigenous women's healing journey for co-occurring health conditions. Our findings point to the importance of ensuring safety in the first place for Indigenous clients, while offering holistic services for their co-occurring health conditions stemming from structural, institutional, and interpersonal racism, discrimination, and violence (Benoit et al., 2003). Indigenous organizations in particular operate as a safe place for Indigenous women's overall health and well-being.

Methods

The methodological approach undertaken in this study follows the fundamental principles of community based research. Following the basics of OCAP (ownership, control, access, and possession) principles of working with First Nations people (NAHO, 2005), and tri-council policy statement for health research involving Indigenous Peoples (TCPR, 2010), this study's governance structure includes a community advisory committee (CAC) consisting of members from supporting local Indigenous and non-Indigenous organizations. This study undertook extensive community consultations in order to understand the implications, suitability and timeliness of the study for the local Indigenous women. The research received ethics approval from the University of Ottawa's Research Ethics Board (Health Science and Science REB, File Number H11-13-11). The narratives of research participants illustrate how the Indigenous organizations operate as a safe healing place for urban Indigenous women for their co-morbid health needs.

Participants and Data Collection

The data were collected through one-on-one semi-structured interviews with ten participants in two groups of key stakeholders: health and social service providers and decision makers. The rationale for choosing these two groups involves the following decisions: first, each group deals with needs for services for co-morbid health conditions from their respective professional locations and relative positions; and each group plays a key role in applying and implementing this knowledge in decision making and service planning that affects service delivery for urban Indigenous women. Participants working in the field of chronic disease prevention, mental health and addiction services for Indigenous Peoples, and held decision making roles were selected purposefully and contacted directly by the first author by telephone or email. Follow up emails or phone calls were made to set up the interview time and location. All but one of the interviews were completed at a mutually convenient setting, generally at the participants' work places. The interview locations included Indigenous health centre, women's shelter, Native Friendship Centre, federal government department, and community health centres. One interview with a provincial government employee was completed via a long distance call. Each interview was scheduled for sixty minutes, which often went over time in order to accommodate research participants' desire to share their experiences. The interviews were audio-recorded with participants' consent to maximize true interpretation of interviewees' perspectives. Justification for the number of participants relates to the issues of data saturation, data manageability, and accessibility to experienced, knowledgeable participants and their willingness to participate in the interviews. Interviews were conducted by the first author over the month of March to July 2014.

The purpose of qualitative interview-based research is to describe and clarify peoples' social realities "as it is lived, felt, undergone, made sense of, and accomplished by human

Table 1. Research Participant's Demographic Details

Key Stakeholders	Professional Role	Years in Present Role	Years in Indigenous Health or Social Care	Years in Health/ Social Care Decision-Making	Indigenous Origin	Age	Gender	Education
Health Service Providers	Physician, diabetes educator, Advance practice nurse	5 yrs to over 10 years	Over 10 years	Over 10 yrs to never (but see Indigenous patients in their main stream care settings)	One First Nations (FN), two non-Indigenous persons	40 years to 60 years	Three females	Under-graduate to graduate degrees
Social Service providers	Program coordinator/ Liaison worker, Community support service coordinator, system planner	Over 10 years	Over 10 years	Over 10 years	One FN, One Métis and two non-Indigenous	41 years to 70 years	Three females	Post-secondary and college diploma to graduate degrees
Decision makers	ED, Manager, Director*, director/ project lead	4 years to over 10 years	10 years to over 40 years	5 yeasrs to over 40 years	Three FN, and one non-Indigenous	51 years to 70 years	Three females and one male	Post-secondary college diploma to undergrad degree

** Indicates one participant being both director and physician*

beings" (Schwandt, 2001: 84). Qualitative research places more emphasis on the richness and thickness of perspectives gathered rather than the number of participants recruited for data collection. Here, as with all aspects of qualitative research, the depth of the data is more important than the number of interviews completed (Burmeister and Aitken, 2012). In other words, rich data are deeply implicated in bringing to life the human beings that are centre of the qualitative research. The interviews were semi-structured and followed an interview guide with guiding questions to explore participants' extent of involvement in the Indigenous health and social services and decision making field; their understandings about co-morbid diabetes, mental health and addiction issues; and their perspectives on responsive services for co-morbid health concerns, and factors (both barriers and facilitators) that influence access to responsive preventive services. In order to maintain the natural flow of conversation, the interview guide was loosely followed to ensure that all questions were covered during each interview. In the beginning of each interview session, participants read and signed the consent form and completed a demographic questionnaire. Each participant gave consent to record their interview conversations. At the end of each interview, participants received a thank you note from the interviewer. The table above (Table 1) provides demographic information about the participated in this study.

Analysis

Following Riessman (2008), the data were analyzed thematically to create a holistic narrative from the different perspectives of service users and providers. Narratives are bounded segments or excerpts from stories, and the emphasis was to find out what was said and why it was said. For example, it was deemed important to analyse the meanings that participants attach across contexts to deal with diabetes, mental health, and addiction. In so doing, participants revealed a great deal about how they developed and offered services for Indigenous women, barriers participants faced in their scope of practices, and their suggestions to improve these services to meet their Indigenous client's needs. After being transcribed verbatim, interviews were coded using inductive and deductive coding methods and entered into the NVivo qualitative analysis software. In order to find the commonalities as well as variations amongst the narratives between and within key informant participants, a within-case and an across-case narrative thematic analysis was undertaken. Analysis proceeded, drawing on conceptual framework of intersectionality and narrative analysis. To keep confidentiality and anonymity, all identifying details about partici pants have been removed.

Findings

Determinants of Co-occurring Health Conditions – Intersecting and Overlapping

Findings of this study indicate that there are intersecting spatial, social and historical determinants of health specific to urban centres that have great bearing on Indigenous women's health outcomes (Benoit et al., 2001). Review of literature demonstrate that diabetes co-occurring with mental health and addiction issues is not uncommon, but is underaddressed and understudied in Indigenous communities. In the Indigenous population in Canada, these health conditions present challenges that are unique to this group, and to those who are otherwise marginalized and living in socio-economic deprivation (Goodwin, 2011).

It is apparent from participants' narratives that root causes of co-occurring health conditions among Indigenous women can trace its way back to Canada's colonial policies, or legacy of them. The key stakeholders pointed out that in the present context, the federal government's fiduciary responsibility regarding service provision further implicates health service access for women living in urban, rural or reserve settings (although there were differing views among key stakeholders about intersecting roles that diverse Indigenous identities, status, and place of residence play in shaping women's access to services for co-occurring health conditions). Service providers more or less agreed on the fact that multiple layers of marginalization can significantly determine Indigenous women's access to health services and their overall health and well-being. Participants identified how the barriers of urban living including racism, discrimination, lack of safe housing can intersect with limited economic opportunities and legal Indigenous status and gender, making Indigenous women more vulnerable in their capacity to maintain health and well-being. As one service provider stated:

> *Certainly, I think poverty is the first piece. [an individual] living in poverty isn't getting best possible medical attention, it is the reality. And depending on where people live, certainly... people living in urban centres?... Again you have*

> *discrimination, people often don't feel safe... so I think that definitely impacts on the number of times they should go [to the doctor]... they go less than they should go....*

The research participants further emphasized the fact that in contemporary urban contexts, Indigenous women face formidable challenges of urban living. One example is when discrimination, stigmatization, and lack of affordable housing intersects with their challenges of navigating and accessing the education, health, housing and legal systems, and social services and dealing with poverty and food insecurity. Participants recognized the contextual determinants that give rise to the risk factors of diabetes, mental health and addiction issues among Indigenous women. Likewise, participants noted Indigenous women may be at increased risk of developing co-occurring health conditions as a result of intersecting determinants of mental and physical health problems and addiction, indicating the need for holistic and integrated care models to address these complex situations. As noted by one service provider:

Women that we served are abused, they have been physically abused, sometimes spiritually and emotionally... [S]o there is a layer upon layer of trauma coming in and then they are living in poverty, and they are often disconnected from family and home... [B]ut now in the city they have more problems; if they are coming from remote reserve, the culture shock of coming to Ottawa is overwhelming for many, because they don't know how to take a bus, they don't know the social rules... [T]here is so much happening to the women when they come, and if they have diabetes, and mental health and addiction, and other health issues, you could see how that would be? A huge amount to manage which is why it has to be managed holistically in one place… they have to receive the assistance for everything, because otherwise this is just overwhelming.

The stakeholder interviews provided important insights about the roles Indigenous organizations play as healing places and their vision for the ideal services for those with co-occurring mental health, diabetes and addiction issues. The healing qualities that characterize Indigenous organizations include dealing with Indigenous clients with respect and dignity, addressing their issues from a non-judgemental point of view, ensuring safety for them at several levels, and most importantly addressing their health challenges in a holistic way. The providers explained that for Indigenous women physical space, settings, and situations that encompass both the physical and cultural environments for healing and health care are considered as safe places for health. These safe places are considered to have an enduring reputation for achieving physical, mental, emotional and spiritual safety. Service providers and decision makers illustrate the important place that health promotion and disease prevention programming provide specific to urban Indigenous women's health.

Participants expressed the need for specific targeted approaches to culturally competent care in order to engage Indigenous women more effectively. As one participant noted,

> *We do not have role models who are healthy who are doing parenting in a way they want to do it now. The women that we serve want to be good, healthy parents, but they need support in the community, in the [name of an Indigenous organization] which can assist them, can demonstrate them... how it is like holding a child, how feeding a child, nursing a child... all of these they may not have experienced in a healthy way. Because of-*

> *ten times the women, that we are serving have addiction issues... living with addiction and trauma, it is difficult to find a role model in the community sometimes. Experiences of women that are coming to us are many, and attachment disorder is one of the issues.*

For the participants, it is obvious that the key to meaningfully addressing the simultaneous needs of women is to make both health and social services more available and accessible in a safe and culturally appropriate setting.

A Safe Place – A Healing Place

Local Indigenous organizations that offer culturally-defined programs for Indigenous women have been recognized as safe places by key stakeholders of both Indigenous and non-Indigenous origins. A number of factors work together to make these organizations a healing place: the structure and content of the programs, characteristics of the staffs who offer the services, access to the providers, and providers' commitment toward clients. The healing qualities that characterize Indigenous centres and the programs they provide include a restorative landscape, where clients' health conditions are understood in the context of past and present while attempting to address the root causes of health anomalies in the contemporary contexts (Cardinal, 2008; Kirmayer et al., 2003). For some Indigenous women, a safe healing place in urban areas can function as a place of reunification to their people, cultures, and ceremonies, while for others it provides a space to be able to maintain their cultural continuity (Benoit et al., 2003). This place of reunification can have significant therapeutic values not only in curing physical or mental ailments of Indigenous women, but also in empowering them with lessons from Elders and community leaders, and formal education to enhance their life skills.

Stigma was a widespread issue that service providers reported. In line with previous research (Denison et al., 2014), findings of this study also reflect that stigma associated with addiction and mental health issues often lead Indigenous women to suppress their health service needs because of the fear of losing their children. This indicates the critical need for ensuring cultural safety in care provision to mitigate the ongoing impact of colonialism and its effects on health of contemporary Indigenous women. Hiding one's substance use or avoiding mental health professionals gets in the way of service users with multiple health issues. Programs offered at Indigenous organizations that do not stigmatize substance users is a much needed step for treatment of these Indigenous women. As one program manager put it,

> *We start off by ensuring safety... for women, physical safety. And from there... could be counselling, could be psycho-educational workshop, helping women understand their situation, helping them and their children to be able to lead healthier lives.*

Both service providers and decision makers spoke highly of Indigenous organizations and the incredible work that their staff members is doing while providing services to help build or rebuild their clients' lives. Additionally, a non-judgmental approach of these staff members do not make Indigenous women with co-occurring health issues feel stigmatized, where their health and social service needs receive far beyond basic outreach services and where they feel safe, welcomed and heard. The following comments resonate similar perspectives:

> *Some of the women we serve were taken out of their families during the 60's scoop, for instance, and so they didn't have cultural teachings, didn't have any roots; essentially they were rootless, and when they come to a place like [name of an Aboriginal organization], and begin to reconnect, and to perhaps for the first time practice ceremonies, connect with Elders, do all the things essential to a person's spiritual well-being, then things fall into place. We have tremendous success... so we have been able to be of assistance in reunification of families, and then through education and all the programming we have here and the cultural support, women have gone on to be extremely successful... who then turn around and use their skills to create role models to pull out other women along behind them...*

The commitment of staff members and the knowledge and understandings they share with them while offering services for Indigenous women are considered important factors of successful service provision. Their services extend beyond the core service options, connecting the Indigenous patients and families to associated health and social services and programs in the areas of public health, prevention, promotion, mental health, and chronic disease prevention and management. As one decision maker related,

> *Staff here are incredibly committed to the work they do, and the women and families that they help, that is their core reason [to do what they do], it's not to have a job to make money. And I believe that applies to lot of Aboriginal people working in the field. They want to help their own people.*

Many researchers have noted the problem of miscommunication or the gap in communication between Indigenous clients and non-Indigenous health service providers, particularly in urban health care settings, where a higher level of English proficiency and cultural understanding of biomedical concepts is assumed (Ware, 2013; Coulehan et al., 2005). In contrast, Indigenous Peoples have different cultural models of communication. Shahid et al (2013) noted that for effective patient provider communication, expression of empathy, attention to detail, listening to patients, culturally-sensitive usage of language, knowledge and use of medical terminology and cross-cultural differences in the concept of time are essential. These factors can affect the extent of comprehension of diagnoses and treatment regimes leading to a gap in service providers/ users communication. Here, the stakeholders of Indigenous origin identified cultural communication as a crucial determinant of health for Indigenous women living in urban areas. In their views, lack of cultural communication between health service providers and their Indigenous clients are yet to be fully recognized. As one physician noted,

> *There is a difference... a cultural difference in the way, cultural way the Aboriginal people interact and if the dominant culture [is] not aware, the medical people are not aware, they would not take that into consideration, and would misinterpret, so this is one of the determinants that is not recognized. They are starting to recognize...*

Similarly, another service provider from an Indigenous organization illustrated how their clients face barriers in communication while accessing services from main-stream organizations. The participant also illustrated their crucial role in mitigating these communication barriers and establishing their clients' connection with their treatment regime, noting:

> *Often time they [clients] would come back from an appointment and say 'I didn't understand what the doctor said' and they will have a piece of paper, may be a prescription. [For example], a women [client]came and said 'they talked and talked but I didn't know what they really said but they gave me this,' and it was [a prescription] for antibiotics, so she clearly had an infection. So I called the doctor's office and said 'she doesn't understand… what was it?' And it ended up being an ear infection, but she didn't understand because they did a lot of talking... not being sensitive to understand [that] this person is not understanding... I think that happens often... I think medical doctors are often accused of just not necessarily speaking plainly to patients, speaking clearly… I think that is across the board... because people talking really quickly in English and using very long medical phrases, most people don't know what they are saying... FN people coming down and feeling very 'fish out of water' already in the urban context and then having to access services [makes it even harder].*

The excerpts above also speak to the need for consultation and training of agencies in culturally appropriate communication-- not only in mainstream settings, but also in Indigenous organizations. This is also necessary for Indigenous staff members in order to respond to the Indigenous cultural and linguistic diversities between First Nations, Métis, and Inuit peoples.

Figure 2. Logo of Minwaashin Lodge

Reproduced with permission from Minswaashin Lodge

Integrated support offered at Indigenous centres has the great potential to address not only Indigenous women's health and social needs, but also to reduce communication gaps with their service providers to a great extent:

> *We are dealing with women when they are coming out of a very emotionally charged situation [such as separation from children by Children's Aid Society]. Typically people do better once they are settled and they are connected to other services. When they first arrive, our intention is to provide everything we can in the way of support to kind of stabilize people... We have two support workers who would accompany people like this, who would drive them, and sit with them. With the woman's permission…[we] would advocate with the doctors to perhaps have a look at the medication, to see if there is something that could be adjusted, which increases the likelihood of successfully taking her medication... and to reduce the communication gap.*

Overall, a safe place for healing particularly seems important when urban Indigenous women's simultaneous struggle with mental health, addiction, and chronic health conditions are dealt with dignity, privacy, and respect. The meaning of 'safe place' not only refers to ensuring physical safety for Indigenous women but spiritual, emotional and cultural safety for them as well. Additionally, cultural safety can be considered as a resource for Indigenous women to deal with the continued and multipronged challenges of their co-morbid health conditions, which is discussed in the following section.

Cultural Safety Enables Empowerment

Cultural safety moves beyond cultural sensitivity and cultural competency. It focuses on analyzing and addressing power imbalances, importance of respecting differences, the legacy of colonial relationships, and institutional discrimination that can contribute to access deterrents (Smye et al., 2010; Deer, 2009; Varcoe, 2004). Cultural safety is grounded on understanding the power differences inherent in health service delivery and redressing these inequities through educational processes (Spence, 2001; Varcoe, 2004). It involves changing attitudes and the continued self-reflection of providers and institutions on their own culture that they bring into practice, whilebecoming cognizant of historical, political, and socio-economic determinants of health inequities of the population they serve. Thus, ensuring cultural safety in services for co-morbid health conditions offered through Indigenous organizations is a key option in addressing many access barriers that emerge out of structural inequities and disempowering attitudes within the mainstream health care system. It is well recognized in the literature that mental health and physical health are fundamentally linked. Many determinants of mental and physical health conditions are common in nature (CMHA, 2008a). These determinants can be addressed by improving health care access in coherent culturally safe ways at individual, group and societal levels (ANAC, 2009). Similarly, a community support worker said: "You can build on [health services]through cultural teaching and ceremonies to build their [women] confidence."

Additionally, the concept of cultural safety acknowledges the diversities that exist within and between Indigenous groups, and provides a notion of culture that is not static, but rather linked to historical, socio-economic and political forces and factors. Offering services in a culturally safe manner diminishes stakeholders' concerns around cultural relevance (which is lacking in mainstream services), and creates empowering experiences of care and services, thereby encouraging clients to access care in a safe Indigenous setting. Key stakeholder's narratives depict that operationalizing cultural safety in their practice includes openness, respect, relevance, acknowledgement, and acceptance of all Indigenous cultures and territories. As one program manager of non-Indigenous descent working in an Indigenous organization related:

> *Here? It depends who is doing ceremony... it is her ceremony, ok? It is coming from her territory, so, here [referring to Aboriginal organization] Grandmother is from the west…has specific cultural ceremonies that she does. If we have a visiting Elder from somewhere else, then she would introduce hers…[if] we have an Inuit Elder coming, and they have featured different practices of their community and what's important to them, that is very important to share... Indigenous people are welcome, they are meant to feel welcome*

> *here, and their practice and ceremonies are respected... so I think that it is very inclusive People are very welcomed here, very interested to learn about others...*

Another program manger and service provider of Indigenous descent added that with each ceremony or program they offer in their centre, at the start they always acknowledge which nation or culture to which they belong. A provider may perform a ceremony according to her/his cultural teachings but they call every participant/client to join and perform in the ceremony in their culturally-appropriate ways. This is how the providers attempt to create a common space for Indigenous peoples of all nations and cultures and respond to the diversities that exist within and between Indigenous cultures. The provider mentioned that a simple strategy of greeting their clients in different Indigenous languages can create a different level of attachment and sense of belonging among Indigenous women, as well as foster improved communication with their clients.

Service Integration – Responding Holistically

Overall, service providers were in agreement that more integrated services are needed to address co-morbid health conditions, especially given the multiple intersecting determinants that are associated with mental health, addiction and chronic health conditions that require simultaneous care and management. This was referred to as "holistic service option for getting help with diabetes, mental health and addiction issues." These co-morbid health conditions are compounded by the disjointed or siloed nature of service provisions, which place Indigenous women more at risk of developing further complications that traces its way back to colonization, forced relocation, enfranchisement of women's right, and contemporary racist issues against Indigenous women. In this regard, it is worthwhile to mention that the Report of the Royal Commission on Indigenous Peoples (RCAP, 1996) emphasized the effectiveness of integrated health services for Indigenous Peoples. It was noted that "The Peguis First Nation community in Manitoba found that a combination of traditional and western healing approaches was especially effective for those who suffer from emotional problems, including those related to alcohol and drug abuse, violence, and suicide" (RCAP, 1996, p. 213). Unfortunately, the system level service delivery for Indigenous Peoples still represents a specialty-dependent disjointed approach, which was identified as less effective by the Canadian government itself, when we hear from one service provider and program manager saying:

> *Colonization and the residential school system have created a situation where many women are experiencing multiple issues and getting help or treatment has been particularly problematic because women typically are not (for many good reasons) very trusting of the system... [With] the mainstream system, they have first hand experiences of brutalization at the hand of systems, or they are just alienated from the services they need, so often time women's issues have been divided very much into silos. If you have diabetes, you need to go there, if you have mental health issues you need to go there... and there has been no attempt, until now [to integrate the systems]... the mainstream is finally starting to catch up, [but] that holistic treatment of a person is in disorder. Unfortunately that was the experience of many of our women where they have to go to this for that, and*

> *another for another and nothing is connected. It just compounds the issues that women have and makes accessing the care much harder...*

Even though a wide range of health and social services exists in urban centres, they are not necessarily accessible for Indigenous women due to various reasons including a lack of cultural sensitivity, distance, hours of operation, transportation, childcare and so on. Accessible health services are critical for overall health and well-being of Indigenous women given that complex health needs they have due to their co-morbid health conditions. As one service provider of Indigenous descent said,

> *.... If a person does not have a place to live... enough to eat... has been separated because of apprehension order or whatever... all of these things contribute to the lack of health.*

Again, despite the diversities within and between Indigenous communities, they tend to have more holistic understandings of health, in which 'physical, mental, emotional and spiritual' components are all intrinsically intertwined and linked. Participants believe that access to holistic and the health care system that meets all the needs of a person is essential in order for them to be successful.

Discussion and Conclusion

A substantial body of research on Indigenous health indicates that Indigenous women face formidable challenges in gaining equitable access to systemic services (Browne et al., 2016; Denison et al., 2014; Benoit et al., 2001; Benoit et al., 2003). The study reported here constitutes the first phase of a two-year long community-based research project, which conceptually builds on previous publications of Indigenous women's health service needs in an urban Ontario setting. The key stakeholders interviewed here communicated the need for 1) better understanding of intersecting determinants of co-occurring health conditions among Indigenous women; and 2), provision of integrated services that address these determinants and provide safe healing places for Indigenous women with improved communication between patients and providers to help build or rebuild Indigenous womens' lives.

These findings provide further evidence for responsive and integrated services for co-occurring mental and physical health conditions and addiction among urban Indigenous women. Indigenous women share many of the similar challenges and concerns with services for co-occurring health conditions as other women in Canada. However, culturally, socio-economically, linguistically, geographically and legally, Indigenous women are a unique population in Canada. Since there are also significant diversities within and between Indigenous women of First Nations, Métis, and Inuit descent, they demonstrate diverse needs for health services. This refers specifically to the contextual and overlapping determinants of co-occurring diabetes, mental health and addiction, which includes navigating and accessing education, health, housing, employment, legal systems, social services and dealing with poverty and food insecurity in urban settings. As research participants indicated, the majority of these determinants intersect with each other and doubly marginalizes women because of their gender and ethnic minority status. Additionally, the legal status of Indigenous women creates a divide between status and non-status Indian women, which further exacerbates their challenges and acts as a barrier to equitable access to health services specific to Indigenous Peoples. Likewise, it limits their capacity to maintain health and well-being. In short, there is not only a scarcity of responsive services for co-occurring health conditions for Indigenous women in urban areas, but the available services lack cultural sensitivity and fails to connect with their clients when they are judgemental, discriminatory and stigmatizing.

Because of the nature, extent, and organization of culturally appropriate services that Indigenous organizations offer, they serve as safe healing places for urban Indigenous women dealing with co-occurring health conditions. Participants' narratives illustrate the outstanding healing environment the Indigenous organizations provide, where their Indigenous women clients feel safe and secure, develop a social network, re-establish connection with their roots, overcome stigma associated with their multiple health challenges, and more importantly, empower themselves to take care of their health and become role models for their own and other Indigenous women and families. The key stakeholders credited much of the success of these Indigenous organizations to the dedication and commitment of their staff members in creation, implementation, and making the services culturally sensitive and responsive to Indigenous womens' needs.

Indigenous women with simultaneous health needs exert power over their health status through participation in culturally-specific programs offered by the Indigenous organizations to help them feel safe and accepted, overcome their negative experiences of racism, discrimination and challenges of urban living, and a sense of belonging. These programs not only create social support network for all clients involved, but also make opportunities in nurturing their cultural identity and learn more about their roots. As a result, Indigenous clients become valued and respected members in their community. Indigenous organizations as safe healing places, perceived by the research participants, provide further opportunities for development of overall health and well-being.

The Canadian government has acknowledged the failure of disjointed services and success of integrated services among Indigenous Peoples in Royal Commission on Indigenous People's report two decades ago (RCAP, 1996). Unfortunately, the siloed approach in service provision still continues. Findings of the current study demonstrate that Indigenous organizations providing culturally-sensitive and integrative services to address co-occurring or co-morbid health conditions among Indigenous women fare better in responding to the women's needs. Despite some movements in recent years, much more work needs to be done in the area of health services and policy research for co-morbid health conditions. In this regard, much deeper multi-level collaboration involving conceptual collaboration between Western science and traditional ways of knowing is needed that extends beyond structural or organizational collaboration (Benning, 2016). This is especially true among high risk and vulnerable populations. The lack of appropriate services for those with co-morbid health problems has consequences that extend beyond the persistence of worsening of mental health issues or substance use (Drake et al, 2001). Further tailoring and integration of Indigenous knowledge and concepts, along with the use of different, flexible modalities, and a move toward addressing multiple intersecting determinants of health is essential to better research and assisting those in need. Consideration should be paid to strategies to best translate ground-up evidence-based research knowledge into practice, increase access, and create sustainable treatment programs in places where Indigenous women of all ages feel safe, connected, and respected. In this regard, the Urban Indigenous Strategy (UAS) in

Canada (INAC, 2016b) can take a significant lead to help support local urban Indigenous organizations to have a strong base with their renewed or new initiatives. With support from UAS, Indigenous organizations are likely able to coordinate programs and services through improved intersectoral collaboration and partnerships (e.g. the federal government, provincial and municipal governments, Indigenous groups, and private sectors). Potential solutions to effective Indigenous patient-provider communication may include recruiting more Indigenous staff, providing appropriate cultural training for health service providers, health education for Indigenous stakeholders (such as culturally-specific diabetes education, awareness and education for substance abuse and mental health issues), continuity of care, avoiding use of medical jargon, accommodation and acceptance of patients' psychosocial and logistical needs, and service coordination. ■

References

AANDC (Aboriginal and Northern Affairs Canada) (2008). Accessed on November 11, 2016 via http://www.aadnc-aandc.gc.ca/eng/1100100014298/1100100014302

ANAC (Aboriginal Nurses Association of Canada) (2009). Cultural Competence & Cultural Safety in First Nations, Inuit and Metis Nursing Education: AN INTEGRATED REVIEW OF THE LITERATURE. Accessed on November 8, 2016 via http://casn.ca/wp-content/uploads/2014/12/FINALReviewofLiterature.pdf

Andrews G, Slade T & Issakidis C 2002. Deconstructing current co-morbidity: data from the Australian National Survey of Mental Health and Well-Being. British Journal of Psychiatry 181:306–14.

Available from http://www.thestar.com/opinion/editorialopinion/2012/12/23/creating_cultural_safety_for_aboriginal_people_in_urban_health_care.html

Belanger, Y. D. Weasel Head, G. Awosoga, O. (2012). Housing and Aboriginal People in Urban Centres: A Quantitative Evaluation. Aboriginal Policy Studies, 2(1): 4-25. Accessed on Nov 7-2016.

Benning, T. (2016). Envisioning deep collaboration between psychiatry and traditional ways of knowing in a British Columbia first nations setting: A personal reflection. Fourth World Journal, 15(1): 55-64.

Benoit, C. & Carroll, D. Lawr, L., Chaudhry, M. (2001). Marginalized voices from the Downtown Eastside: Aboriginal women speak about their health experiences. Report prepared for Health Canada. York University: National Network on Environments and Women's Health.

Benoit, C., Carroll, D. & Chaudhry, M. (2003). In search of a healing place: Aboriginal women in Vancouver's Downtown Eastside. Social Science and Medicine, 56 (4): 821-833.

Bombay, A. Matheson, K. Anisman, H. (2009). Intergenerational Trauma: Convergence of Multiple Processes among First Nations peoples in Canada. Journal of Aboriginal Health, Accessed on November 7, 2016 via http://www.naho.ca/documents/journal/jah05_03/05_03_01_Intergenerational.pdf

Broemeling, A. M. Watson, D. E. Prebtani, F. (2008). Population Patterns of Chronic Health Conditions, Co-morbidity and Healthcare Use in Canada: Implications for Policy and Practice. Healthcare Quarterly, 11(3): 70- 76.

Browne, A. J. Varcoe, C. Lavoie, J. Smye, V. Wong, S. T. Krause, M. et al., (2016).

Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. BMC Health Services Research, 16:544. Accessed on November 2, 2016 via https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1707-9

Burmeister, E. and Aitken, L. M. (2012). Sample size: How many is enough?. Australian Critical Care, 25(4): 271-274.

Cardinal, C. (2008). Should Aboriginal healing practices be integrated into conventional medical care. CrossCurrents,11(3): 20.

Chansonneuve, D. (2009). Presentation to the Select Committee on Mental Health and Addictions. Accessed on Jan 10, 2016 via http://minlodge.com/images/Presentation%20to%20the%20Select%20Committee%20on%20Mental%20Health%20and%20Addictions%20C%20(2)%20(2).pdf

Cook, Catherine (2012). Creating cultural safety for aboriginal people in urban health care Deeply entrenched stereotypes about aboriginal people exist throughout Canadian society. Accessed on February 26, 2014 via http://www.thestar.com/opinion/editorialopinion/2012/12/23/creating_cultural_safety_for_aboriginal_people_in_urban_health_care.html

CCPA (Canadian Centre for Policy Alternatives) FAST FACTS, We All Work Together To Help One Another: The Story of Ma Mawi. Accessed on Nov 7, 2016 via https://www.policyalternatives.ca/sites/default/files/uploads/publications/Manitoba_Pubs/2009/FF_mamawi_091009.pdf

CCSA (Canadian Centre on Substance Abuse) (20130. When Mental Health and Substance Abuse Problems Collide. Accessed on Nov7, 2016 via http://www.ccsa.ca/Resource%20Library/CCSA-Mental-Health-and-Substance-Abuse-2013-en.pdf

Crane, M. and Joly, L. (2014). Older homeless people: increasing numbers and changing needs. Reviews in Clinical Gerontology, 24(4): 255-268.

CIHI (Canadian Institute for Health Information), (2008). A Framework for Health Outcomes Analysis: Diabetes and Depression Case Studies (Ottawa: CIHI, 2008).

Coulehan, K. Brown, I. Christie, M. Gorham, G. Lowell, A. Marrnanyin, B. et al. (2005). Sharing the true stories: evaluating strategies to improve communication between health staff and Aboriginal patients: Stage 2 report. Darwin: Cooperative Research Centre for Aboriginal Health. Accessed on November 2, 2016 via http://www.lowitja.org.au/ lowitja-publishing/C019.

CMHA (Canadian Mental Health Association) (2008a). Backgrounder: The Relationship between Mental Health, Mental Illness and Chronic Physical Conditions. Available via http://ontario.cmha.ca/public_policy/the-relationship-between-mental-health-mental-illness-and-chronic-physical-conditions/#.Uai5XECTiT4

CMHA (Canadian Mental Health Association) (2008b). What Is the Fit Between Mental Health, Mental Illness and Ontario's Approach to Chronic Disease Prevention and Management? Discussion Paper. Available via www.ontario.cmha.ca

CMHA (Canadian Mental Health Association) (2008c). Position Paper: Recommendations for Preventing and Managing Co-Existing Chronic Physical Conditions and Mental Illnesses. Available via http://ontario.cmha.ca/public_policy/recommendations-for-preventing-and-managing-co-existing-chronic-physical-conditions-and-mental-illnesses/#.Uai6QkCTiT4

CMHA (Canadian Mental Health Association) (2009). Diabetes and Serious Mental Illness: Future Directions for Ontario. Think Tank on Diabetes and Serious Mental Illness. Available via www.ontario.cmha.ca

Coodin, S. (2001). "Body Mass Index in Persons with Schizophrenia," Canadian Journal of Psychiatry, 46(6): 549□ 555.

Davis LL, Frazier E, Husain M, Warden D, Trivedi M, Fava M, et al. (2006). Substance use disorder comorbidity in major depressive disorder: A confirmatory analysis of the STAR*D cohort. American Journal on Addictions,15(4):278-85

De Leeuw, S. and Greenwood, M. (2011). Beyond Borders and Boundaries: Addressing Indigenous Health Inequities in Canada through Theories of Social Determinants of Health and Intersectionality, in Olena Hankivsky, Sarah De Leeuw, Jo-Anne Lee, Bilkis Vissandjee and Nazilla Khanlou (edtd) Health Inequities in Canada: Intersectional Frameworks and Practices. UBC Press: Vancouver, Toronto.

Denison, J. Varcoe, C. Brown, A. J. (2014). Aboriginal women's experiences of accessing health care when state apprehension of children is being threatened. Journal of Advance Nursing, 70(5): 105–1116.

Deer, S. (2009). Decolonizing rape law: A Native feminist synthesis of safety and sovereignty. Wicazo Sa Review. Available via https://scholar.google.com/citations?view_op=view_citation&hl=en&user=5xCQInoAAAAJ&citation_for_view=5xCQInoAAAAJ:Y0pCki6q_DkC

Environic Institute. 2010. Urban Aboriginal Peoples Study: Main Report. Available via http://uaps.ca/wp-content/uploads/2010/03/UAPS-Main-Report_Dec.pdf

Feinstein AR: The pre-therapeutic classification of co-morbidity in chronic disease. J Chron Dis 1970, 23:455-469.

Ghosh, H. (2013). Diversity, Disparity and Diabetes: Voices of Urban First Nations and Métis People, Health Service Providers and Policy Makers. Unpublished PhD Dissertation, University of Ottawa, Canada.

Goodwin, I. (2011). Diabetes, Mental Health & Aboriginal People Literature Review. Accessed on November 9, 2016 via https://www.nwac.ca/wp-content/uploads/2015/05/2011-NWAC-Diabetes-Mental-Health-and-Aboriginal-People-Literature-Review.pdf

Halseth, R. (2013). Aboriginal Women in Canada: Gender, socio-economic determinants of health, and initiatives to close the wellness-gap. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Hiiye'yu Lelum House of Friendship (2016). Healthy Children Healthy Futures Program. Accessed on November 7, 2016 via http://hofduncan.org/?page_id=85

INAC (Indigenous and Northern Affairs Canada) (2016a). Urban Indigenous Peoples. Accessed on Nov 2, 2016 via https://www.aadnc-aandc.gc.ca/eng/1100100014265/1369225120949I

AC (Indigenous and Northern Affairs Candaa) (2016b). Urban Aboriginal Strategy. Accessed on November 10-2016 https://www.aadnc-aandc.gc.ca/eng/1432837046128/1432837073962

Kraemer HC: Statistical issues in assessing comorbidity. Stat Med 1995, 14:721-723.

Kirmayer, L. Brass, G. M. and Tait, C. L. (2000). The mental health of aboriginal peoples: transformations of identity and community. Canadian Journal of Psychiatry, 45:607–16.

Kirmayer, L. Simpson, C. and Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. Australasian Psychiatry, 11:18.

Lavallée, L.F. & Howard, H.A. (2011). Urban Aboriginal Diabetes Research Project Report. Anishnawbe Health Toronto. Toronto, ON.McEvoy et al., "Prevalence of the Metabolic Syndrome in Patients with Schizophrenia: Baseline Results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) Schizophrenia Trial and Comparison with National Estimates from NHANES III," Schizophrenia Research 80, no. 1 (2005): 19□ 32.

NAHO (National Aboriginal Health Organization). Ownership, Control, Access and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities. (2005). Available via http://www.naho.ca/documents/fnc/english/FNC_OCAPCriticalAnalysis.pdf.

NCCAH (National Collaborating Centre for Aboriginal Health). (2012). Challenging Hidden Assumptions: Colonial Norms as Determinants of Aboriginal Mental Health. Accessed on March 15, 2014 via http://www.nccah ccnsa.ca/Publications/Lists/Publications/Attachments/70/colonial_norms_EN_web.pdf

NCCAH (National Collaborating Centre for Aboriginal Health) (2013). Strengthening Urban Aboriginal Families: Exploring Promising Practices. Accessed on November 7, 2016 via http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/87/Urban_Families_EN_web.pdf

Newhouse, D. and Peters, E. (2003). Not Strangers in These Parts: Urban Aboriginal Peoples. Policy Research Initiative.

North East LHIN (2011). NE LHIN Aboriginal/ First Nations and Métis Mental Health and Addictions Framework. Available via http://www.nelhin.on.ca/WorkArea/showcontent.aspx?id=12188

Reading, J. (2009) A Life Course Approach to the Social Determinants of Health for Aboriginal Peoples'. Available via http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/appendixAjun09-e.pdf

RCAP (Royal Commission on Aboriginal Peoples) (1996). Report of the Royal Commission on Aboriginal Peoples. Ottawa: Minister of Supply and Services Canada. Shadid, S. Durey, A. Bessarab, D. Aoun, S. M. Thompson, S. C. (2013). Identifying barriers and improving communication between cancer service providers and Aboriginal patients and their families: the perspective of service providers. BMC Health Service Research, 13:460.

Schwandt, T. A. (2001). Qualitative inquiry: A dictionary of terms (2nd ed.). Thousand Oaks, CA: Sage.

Smye, V. Research Summary: Aboriginal Peoples' Experiences of Mental Health and Addictions Care. 2008. Accessed Jan 23, 2013. http://www.heretohelp.bc.ca/visions/aboriginal-people-vol5/research-summary

Spence, D. (2001). Hermeneutic notions illuminate cross cultural nursing experiences. Journal of Advanced Nursing, 35(4):624-630.

Starfield B. (2011) Challenges to primary care from co- and multi-morbidity. Prim Health Care Res Dev.;12(1):1–2.

Tait, C. (2013). Resituating the Ethical Gaze:

Government Morality and the Local Worlds of Impoverished Indigenous Women. International Journal of Circumpolar Health, Vol. 72. Accessed on November 2, 2016 via http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/21207?trendmd-shared=0

TCPS (Tri-Council Policy Statement) (2010) Ethical Conduct for Research Involving Humans. Available via http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf

UAKN (Urban Aboriginal Knowledge Network) (2012). The Urban Aboriginal Middle Income Groups in Canada: A Demographic Profile. Available via http://uakn.org/wp-content/uploads/2014/05/2012-UAKN-Research-Paper-Series_The-Urban-Aboriginal-Middle-Class-in-Canada_Dr.-Amanda-Parriag-and-Paul-Chaulk1.pdf

Varcoe, C. (2004). Context/Culture: Unpublished Collaborative Nursing Program in BC Curriculum Guide. Vancouver: Collaborative Nursing Program in British Columbia.

Ware, V-A. (2013). Improving the accessbility of health services in urban and regional settings for Indigenous people, Australian Institute of Health and Welfare, Canberra. Accessed on November 2, 2016 via http://dro.deakin.edu.au/eserv/DU:30069870/ware-improvingtheaccessibility-2013.pdf

Williams, a. and Guilmette, A. M. (2001). A Place For Healing: Achieving Health For Aboriginal Women in and Urban Context. The Canadian Journal of Native Studies XXI, 1: 1- 25.

Young, T. K. (2003). Review of research on Aboriginal populations in Canada: relevance to their health needs. BMJ, 327: 419- 422.

Acknowledgment:

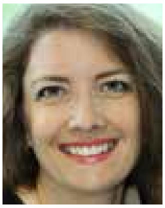
The authors gratefully acknowledge the research participants for sharing their thoughts during data collection. Sincere acknowledgement goes to the Odawa Native Friendship Centre, Minwaashin Lodge and Centre Town Community Health Centre for their continued support throughout this research process. Acknowledgement is due to the CIHR-IMPART (Intersections of Mental Health Perspectives in Addiction Research) for providing post-doctoral fellowship and offering mentorship support to the first author during the tenure of this fellowship and beyond. The authors would like to acknowledge the traditional custodians of land, in the respective communities in which they work.

Authors:

Hasu Ghosh completed her PhD in Population Health in 2013. Following her doctoral training, , Hasu completed CIHR-Strategic initiative funded IMPART (Intersections of Mental Health Perspectives in Addiction Research) Post-Doctoral Fellowship jointly offered by IMPART and the University of Ottawa. This paper stems out of Hasu's CIHR- IMPART funded post-doctoral research. She recently finished her CIHR Science Policy post-doctoral fellowship at the Public Health Agency of Canada, and teaches public health courses for vulnerable population as an adjunct professor of the Dept of Public Health, Concordia University of Edmonton. Hasu's research and teaching interests lie primarily within the fields of population and public health, and span the areas of Indigenous and minority health, social contexts of health-seeking behaviour and health care access, health inequities, qualitative and community-based research methodologies including narrative and intersectional analysis.

Address:
Adjunct Professor, Public Health,
Concordia University of Edmonton
17 Long Gate Court
Nepean, Ontario
K2J 4E9
Ph: 613-843-0971
e-mail: hasu.ghosh@gmail.com

Cecilia Benoit was born and raised in Newfoundland, with Mi'kmaw and French ancestry. She is a Professor in the Department of Sociology at the University of Victoria and Scientist at the Centre for Addictions Research of BC. Her research examines the multiple dimensions of health inequities embedded in laws, policies, programs and research agendas and searches for evidence-based solutions. In addition to research focused on the historically-suppressed occupation of midwifery and the organization of maternity care in Canada and internationally, she has been involved in a variety of projects that employ mixed methodologies to investigate the social determinants of health inequities of marginalized groups, including Aboriginal women in Vancouver's Downtown Eastside, young people confronting health stigmas linked to obesity and asthma, street-involved youth in transition to adulthood, pregnant women and their families dealing with poverty, substance use, and other challenges, and people involved in the sex industry.



Ivy Lynn Bourgeault, PhD, is a Professor in the Telfer School of Management at the University of Ottawa and the Canadian Institutes of Health Research Chair in Gender, Work and Health Human Resources. She also leads the pan Canadian Health Human Resources Network. She has been a consultant to various provincial Ministries of Health in Canada, to Health Canada, the Pan American Health Organization, the Organization for Economic Cooperation and Development and to the World Health Organization. Her recent research focuses on the migration of health professionals and their integration into the Canadian health care system.

This article may be cited as:

Ghosh, H., Benoit, C. & Bourgeault, I. (2017) Health Service Needs for Urban Indigenous Women with Co-Occurring Health Concerns. *Fourth World Journal*, 15(2) 5-25.