

**HOW DO COMMUNITY HEALTH CENTRES EVALUATE  
THEIR EFFECTIVENESS IN MEETING THE NEEDS OF  
THEIR ABORIGINAL CLIENTS?**

by

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## **ABSTRACT**

Aboriginal peoples in British Columbia experience serious health disparities, including higher rates of disease, lower life expectancy and higher hospital utilization rates, compared to the non-Aboriginal population. Community-based clinics are a promising model of primary care for vulnerable populations for the following reasons: focus on prevention and cost-effectiveness, and responsiveness to community needs. Community-based clinics are in place in many regions of British Columbia, and several of these serve a largely Aboriginal client population. This research project asked whether and how these clinics evaluate effectiveness in meeting the needs of Aboriginal clients. Although formal evaluations had not been conducted by all clinics, interviewees believed that the system of integrated healthcare offered by the community clinic model was successful at meeting the needs of their Aboriginal clients because the multi-disciplinary approach met complex client needs, and because they gained the trust of their communities and remained responsive to community needs.

**Keywords: Aboriginal health, community-based clinic, community health centre, evaluation**

## **EXECUTIVE SUMMARY**

Aboriginal peoples in British Columbia experience serious health disparities when compared to the non-Aboriginal population, including a life expectancy that is seven years less, an infant mortality rate two to four times higher, triple the rate of diabetes and double the HIV/AIDS deaths. Healthcare utilization rates among Aboriginal peoples in BC are higher than rates among non-Aboriginal members of the population, including 39% higher hospitalization rates.

Community Health Centres (CHCs) and community-based clinics are promising models of primary care for vulnerable populations. These clinics offer a community-based, multi-disciplinary approach to primary care, with a focus on prevention of disease. Research has demonstrated that the CHC model of healthcare is cost-effective and has the additional benefit of reducing hospitalizations in its client population.

Community-based clinics are in place in many regions of British Columbia, and several of them serve a largely Aboriginal client population. Little research has been done on how these community-based clinics evaluate their effectiveness in meeting the needs of their Aboriginal clients. This research project represents a pilot study that examined how the needs of Aboriginal clients are being evaluated and met at community-based clinics.

Qualitative research methods were used in this project, including purposive sampling to identify seven key informants at six community-based clinics whose clinic population included at least 33% Aboriginal clients. These clinics were located in urban and rural areas in three different health regions in British Columbia. The interviewees included clinic administrators, staff and clinicians.

The results of the interviews showed that while formal evaluations were conducted by some clinics, not all clinics conducted evaluations. Interviewees believed that the system of integrated healthcare offered by the community clinic model was most appropriate and successful at meeting the needs of their Aboriginal clients. Interviewees noted that their clinics' multi-disciplinary approach met the complex needs of clients, and their clinics were also successful because of the trust they have built in their communities and their responsiveness to community needs.

The results of this project show that community-based clinics and CHCs offer models of primary healthcare that have great potential to meet the pressing needs of British Columbia's Aboriginal population. While there is no single model of primary healthcare delivery that fits the needs of all Aboriginal Canadians, the community clinic model can bring locally based, multi-disciplinary healthcare services to Aboriginal peoples in or near their home communities, with the potential to become trustworthy and responsive institutions in the community.

Evaluation of clinic services, and the dissemination of evaluation methods and results, can assist community-based clinics in learning from each other, and

can assist health authorities and other funders in choosing primary care models. Consideration should be given to expanding community-based clinics in parts of BC where primary healthcare needs of Aboriginal populations are unmet. As these clinics are established, evaluation should be built into the structure of the clinic so that this element will receive the emphasis it deserves. Clinic staff and healthcare providers should be involved in regular evaluations of clinic services, in addition to evaluations done by clients. Evaluation of clinic services, and the dissemination of evaluation methods and results, can assist community-based clinics in learning from each other. These evaluations can also assist healthcare funding agencies to expand their understanding of the advantages offered by this model of primary healthcare in serving Aboriginal populations.

## **DEDICATION**

To Tim, Annie and Ben, whose love and encouragement supported me through the ups and downs of graduate school, and to my parents, Hector and Susie Black, who instilled in me the belief that working to make the world a more just and loving place is the most important work we can do. Thanks also to Timothy and Marilyn Takaro, who believed in me and encouraged me along this journey.



## **ACKNOWLEDGEMENTS**

I owe a huge debt to Marina Morrow, who mentored me these past two years and taught me both new ways to look at the world and new methods to work for change. I am also indebted to all my professors and classmates at SFU, who taught me, encouraged me, and learned with me. Finally, I am grateful to those who allowed me to enter their lives as a researcher, and I hope that my work will offer something of value to them.

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## **GLOSSARY**

**Aboriginal** This term is used to include First Nations, Metis and Inuit peoples.

# INTRODUCTION

## Background

British Columbia is home to 196,000 First Nations and other Aboriginal peoples, about 4.8% of the province's total population (Statistics Canada, 2006). The health challenges facing this population are numerous. Compared to the general population of BC, Aboriginal peoples have a life expectancy that is seven years less, an infant mortality rate two to four times higher, triple the rate of diabetes and double the HIV/AIDS deaths (Vancouver Coastal Health, 2008). There have been some improvements in Aboriginal health over the past decades, including improvements in infant mortality rates and overall life expectancy (British Columbia Provincial Health Officer's Annual Report, 2002).

Healthcare utilization rates among Aboriginal peoples in BC are higher than rates among non-Aboriginal members of the population, particularly for tertiary care (Vancouver Coastal Health, 2008). Psychiatric hospitalization rates are 50-100 percent higher for Aboriginal people, and hospitalization rates for diabetes are 12% higher for Aboriginal men and 150% higher for Aboriginal women (Vancouver Coastal Health, 2008). Overall hospitalization rates are 39% higher among Aboriginal men and 77% higher among Aboriginal women, compared to the non-Aboriginal population (Vancouver Coastal Health, 2008).

Community Health Centres (CHCs) offer a community-based, multi-disciplinary approach to primary care, with a focus on prevention of disease.

Research has demonstrated that the CHC model of healthcare is cost-effective and has the additional benefit of reducing hospitalizations in its client population (Association of Ontario Health Centres, 2008).

This research project set out to interview staff at six of the community-based clinics in British Columbia that include a large proportion of Aboriginal clients. During the interviews it became clear that some of these six clinics do not define themselves as CHCs, nor do they fit the traditional definition of a CHC. For example, two of the key features of CHCs are the use of multi-disciplinary teams to deliver services and community participation in governance (Rachlis & Kushner, 1995). While most of the clinics included in this project offer multi-disciplinary medical and social services in one building, the clinic service providers do not always work in a coordinated team. Most of the clinics participating in this project do not have governing boards made up of community members; however, each clinic participating in this project described their mandate of being responsive to the needs of the community they served, and clinic staff emphasized the importance of gaining the trust of the community.

The CHC model and community-based health clinic model have been widely used in other Canadian provinces to serve predominantly Aboriginal populations, but little research has been done on how these community-based clinics evaluate their effectiveness in meeting the needs of their Aboriginal clients. This research project represents a pilot study examining how community-based clinics in BC evaluate their effectiveness in meeting the needs of their Aboriginal clients. The information presented below may be useful to those

working at CHCs or community-based clinics serving Aboriginal clients and seeking to include evaluation of their services to this population.

## **PURPOSE**

The goal of this research is to better understand the role of community-based clinics in meeting the needs of their Aboriginal clients. The research project involved a preliminary effort to review whether community-based clinics are currently evaluating their services to Aboriginal clients, and if so, what questions or methods are currently utilized by these clinics to evaluate their success in meeting the needs of these clients. This paper will propose methods for qualitative evaluation of the community-based clinic model, thus potentially improving the ability of community clinic administrators to perform evaluations of their programs to determine which features of the community clinic model are best suited to the Aboriginal population.

## **Research Objectives**

The objective of this research was to use qualitative interviews with key informants working in community-based clinics with Aboriginal clients to: 1) investigate whether community-based clinics currently evaluate their programs; 2) investigate what method community-based clinics use for evaluation of programs and services; 3) determine whether the evaluative methods of community-based clinics include measures to assess their effectiveness for Aboriginal clients; and 4) investigate the ways in which the needs of Aboriginal clients are currently being met in the community-based clinic model.



This objective was accomplished by the completion of seven key informant interviews at six community-based health clinics in five different regions of BC whose client population includes at least 33% Aboriginal clients.

## LITERATURE REVIEW

Community health centres (CHCs) are defined by Rachlis and Kushner (1995) as primary care health clinics that include some or all of these features: service to a defined population, a focus on prevention, integration of services, the use of multi-disciplinary teams to deliver services, salaried reimbursement for staff, and community participation in governance. CHCs often belong to regional associations, such as the Association of Ontario Health Centres, allowing for enhanced communication among centres.

In this research project, community-based clinics are defined as those clinics that provide services to a defined population, have a focus on prevention, and reimburse staff with salaries rather than fees-for-service. These clinics offer integrated services with multi-disciplinary providers to varying degrees, though not all of them have the staff or capacity to fulfil this key feature of CHCs. While the community-based clinics may have community participation in clinic program planning and administration, they do not include the defining mandate of CHCs for formation of governing boards.

Two features of CHCs that seemed absent in my interviews with community-based clinics were communication between clinics, and the formation of clinic associations to enhance and support the work of individual clinics. The community-based clinics appeared to operate in isolation, without support from

each other, whereas CHCs in some provinces have formed associations and published reports demonstrating close working relationships between CHCs.

While the community-based clinics surveyed for this project did not meet the full definition of CHCs, much of the literature demonstrating the value, advantages and effectiveness of CHCs is applicable to community-based clinics as well.

The CHC model of healthcare was widely used in the United States in the 1960s, when civil rights workers sought to extend the principles of individual rights to include the rights of African-Americans to adequate healthcare (Lefkowitz, 2007). Support for the CHC model has grown throughout North America, and today there are an estimated 900 CHCs in the United States (Lefkowitz, 2007), and 300 across Canada (Association of Ontario Health Centres, 2008).

Research on the CHC model in Canada demonstrates that CHC clients cost less to care for than clients treated in traditional fee-for-service practices (Rachlis & Kushner, 1995). In a comparison study of options for restructuring primary healthcare services in Canada, the “integrated community model” was determined to be the most effective in terms of health and service, provided the highest quality services, and offered the best cost control measures (Lamarche, Beaulieu, Pineault, Contandriopoulos, Denis & Haggerty, 2003). CHCs are included by Lamarche, et al. as one type of integrated community model. Their report concludes, “The integrated community model appears to meet the goals of primary healthcare to the greatest degree” (Lamarche, et al., 2003, p. 3).

Research conducted on the effectiveness of the CHC model in the US includes many studies showing that it meets or exceeds quality measures of other healthcare providers, sometimes at a lower cost (Lefkowitz, 2007; Proser, 2005; Starfield et al., 1994). One quality measure investigated by Regan, et al. (1999) was the use of cancer screening tests among CHC clientele. This study demonstrated that a higher proportion of women in CHCs were up to date on Pap tests and mammograms than women in comparison groups of similar populations. This finding is even more important considering that the target population of most CHCs includes groups of minority women with historically high morbidity and mortality from breast and cervical cancer (Regan, Lefkowitz & Gaston, 1999).

Part of the CHC mandate is elimination of health disparities, through provision of health care to populations with cultural, linguistic, financial, and geographical barriers (Regan, Lefkowitz, & Gaston, 1999). An Institute of Medicine study showed that CHCs demonstrate a sensitivity and responsiveness to minorities that increases the effectiveness of this model in addressing health disparities (Institute of Medicine, 2002). Lefkowitz states that, "it is an essential part of the health center mission to assure that care is provided with respect and sensitivity to cultural and linguistic differences" (2007, p. 27).

Community-based clinics and CHCs offer benefits beyond healthcare to their communities. In some communities CHCs may serve as a base from which to increase awareness of other social issues, and to promote a sense of community (Lefkowitz, 2007). Additionally, CHCs often provide employment and

employment training for the communities in which they are located (Lefkowitz, 2007).

In their book on Canadian health reform, Rachlis and Kushner (1989) argue that reformers should reduce spending on hospitals and expand community services, noting that while hospitals focus on individuals and illness, CHCs focus on communities and prevention. They argue that health reform should “begin at the bottom, with community programs developed by and for the community” (1989, p. 308). In a Rand Corporation study, data on patients from the Saskatoon Community Clinic in Saskatchewan and the Group Health Cooperative in Seattle were compared to patients attended by fee-for-service physicians in the same geographical areas. The study found that hospital costs for clinic patients were 30% to 40% lower than for patients attended by fee-for-service physicians (Rachlis & Kushner, 1995).

The community-based clinic model encourages active client participation in healthcare, and the concept of “cultural safety” can be key in these clinical encounters. Cultural safety is a concept that originated in New Zealand as a response to the effects of colonization on both Aboriginal peoples and on healthcare professionals’ treatment of Aboriginal clients. Cultural safety has been defined in many ways. Maori nurse, Irihapeti Ramsden, is considered the originator of the concept, and she writes, “Cultural safety addresses quality in healthcare though issues of communication and access to the health service” (Papps & Ramsden, 1996). Employed as both a theoretical lens through which to consider and evaluate interactions between the healthcare system and Aboriginal

peoples, and a competency towards which healthcare professionals can work, cultural safety has also been described as not simply cultural sensitivity, but also “an analysis of power imbalances, institutional discrimination, and the nature of relationships between the colonized and the colonizers as they apply to health care interactions...” (Browne, Fiske, & Thomas, 2000, p. 8-9). The work of Browne et al. (2000) found that Aboriginal women often describe feeling dismissed and ignored by medical professionals, and Browne’s research suggests that clinical encounters in settings where clients experience cultural safety can be more effective.

Healthcare settings are social institutions that often reflect the existing social order (Mackintosh, 2001). As such, Mackintosh argues, traditional medical settings do not empower clients, but rather “contribute profoundly to people’s experience what it is to be poor” (2001, p184). CHCs seek to build partnerships with clients in gaining health improvements, and therefore have the capacity to reflect a more equitable distribution of power, offering a representation of our society’s capacity for care, and “a public space for reworking those capacities” (Mackintosh, 2001, p. 176).

Ontario has utilized both CHCs and Aboriginal Health Access Centres (AHACs) to provide primary healthcare to Aboriginal peoples (Association of Ontario Health Centres, 2005). AHACs differ from CHCs or Aboriginal CHCs only in their funding streams. AHACs receive most of their funding through an Ontario government discretionary budget for the Aboriginal Healing and Wellness Strategy (Association of Ontario Health Centres, 2007). In a recent report

prepared for the Association of Ontario Health Centres, the authors note the wide success of these community health centres: “Since their introduction to the health system landscape in Ontario, AHACs and Aboriginal CHCs have not only helped slow the pace of alarming negative health trends within the communities they serve, but have shone light upon the true potential for community development based upon the principle of Aboriginal ‘ownership’...these centres have become a testament to the power of community-centred primary healthcare, as applied in the context of diverse Aboriginal settings” (Association of Ontario Health Centres, 2007, p. 36). When evaluations of the important work of these CHCs and AHACs are performed, the results can encourage provincial governments and health authorities to support the continued development of this healthcare model.

Evaluation has been defined as “not an ‘event’ that occurs at the end of a project, but...an ongoing process that helps decision-makers better understand the project...” (Kellogg Foundation, 2004, p.3). Viewed in this way, evaluation of clinic services is critically important as a way to inform clinic managers, clinicians, staff and clients regarding achievement of goals established for the clinic. Evaluation should be conducted not merely to “*prove* that a project worked, but to *improve* the way it works” (Kellogg Foundation, 2004, p.3).

The literature reviewed for this project clearly demonstrates the cost-effectiveness of CHCs in delivering primary healthcare. Further, it demonstrates the success of the CHC model and the community-based clinic model in serving Aboriginal populations. Evaluation of clinic services, and the dissemination of evaluation methods and results, can assist community-based clinics in learning

from each other. These evaluations can also assist healthcare funding agencies to expand their understanding of the advantages offered by this model of primary healthcare in serving Aboriginal populations.



## **METHODOLOGY**

The methodology underlying this research project involves a belief that qualitative research methods are well suited for projects that seek to tap into the personal and professional experiences of research participants (Denzin & Lincoln, 2003). This philosophy of research relies on encouraging participants to speak freely in interviews, expressing their opinions and telling their stories. The rich descriptive data elicited in qualitative interviews allows for a depth of understanding that can “make the world visible in a different way” (Denzin & Lincoln, 2003, p. 5). This depth of understanding may be missed by surveys or questionnaires. For the topic of evaluation of community-based clinics, this methodology allowed participants to provide context for their responses, thereby strengthening the researcher’s understanding of the topic.

The nurse-researcher leading this project has participated in and led other qualitative research studies, including a project on Aboriginal women’s health. These experiences strengthened the researcher’s belief that qualitative research is especially well-suited to a project such as this, where open-ended questions allow participants to tell their own stories and emphasize areas they feel are key.

## **METHODS**

### **Study Design**

This project involved exploratory research, approached through qualitative research methods that emphasize developing insights and generalizations from the data collected (Neuman, 2006). Interviews conducted with health clinic staff in different areas of the province allowed for the use of triangulation, with the benefit of studying evaluation of CHCs from multiple points of view (Neuman, 2006). The primary methodological tool employed in this project was key informant interviews, and a total of seven people were interviewed.

### **Interviewees**

The people interviewed for this project included clinic managers, a community health nurse, and other clinic staff working at community clinics in BC that serve a largely Aboriginal clientele.

### **Study Site and Population**

A purposive sample of five geographical areas in BC was chosen to include both urban and rural regions. The clinics included in this project, and the cities in which they are located, are not named here to protect the confidentiality of the participants.

## **Sampling Plan**

Health clinics serving Aboriginal populations in different parts of the province were identified through a Simon Fraser University professor, Dr. Laurie Goldsmith, who is currently involved in research identifying CHCs in BC. One additional interviewee was identified through a conference speaker at the November 2008 “Re-imagining Health Services” conference in Vancouver, BC.

Dr. Goldsmith’s team started with a list of clinics compiled by the (defunct since 2006) BC Network of Community Health Centres. The team expanded their list using ideas from their advisory board and suggestions from CHCs, then updated the list by phone calls to clinics, and information available through the internet. From this longer list, Dr. Goldsmith’s team provided a list of nine CHCs with a focus on Aboriginal clients. Contacts were made by this researcher at eight clinics, yielding a purposive sample of seven people, representing six different clinics and three different health regions in BC.

## **Data Collection Instruments**

Interviews consisted primarily of open-ended questions to encourage participants to offer opinions and propose solutions (see Appendix A). Hand-written notes were taken during interviews, and were typed up with critical reflections immediately following interviews. Direct quotes used in this report were confirmed with speakers during interviews.

## **Procedures**

Informed consent was received from each participant prior to beginning interviews (see Appendix B). No interviewee names or clinic names were attached to interview notes.

The researcher for this project placed phone calls to eight of the clinics on Dr. Goldsmith's list, and requests were made to speak to clinic managers. From these eight initial contacts, interviews were scheduled at six different clinics. One clinic did not respond to multiple phone calls, and one clinic declined to participate. In some cases the clinic manager suggested other staff for the interview, in some cases the clinic manager declined to be interviewed, and in one case the clinic manager was interviewed together with a community health nurse from her clinic.

## **Analysis Plan**

This exploratory research project consisted of six interviews with seven individuals (two people at one clinic were interviewed together). Notes taken during the interviews were categorized based on responses to specific questions, but were also reviewed carefully for emerging themes and ideas brought forward by interviewees.

The coding process was initiated by developing a description of the clinic populations, followed by coding interview notes into themes (Creswell, 2003). Interviews were thematically coded to identify clinic population demographics, evaluation techniques, and suggestions for improvements. Open coding was

performed, followed by axial coding to further organize ideas and themes emerging from the interview transcriptions (Neuman, 2006). Results are described in this report.

## **Limitations of the Study**

This study is restricted to five geographical areas in British Columbia, including clinics in three of the six health regions, Northern Health Authority, Interior Health Authority and Vancouver Coastal Health Authority. I attempted to secure interviews with clinic staff at a clinic in the Fraser Health Authority, and at one additional clinic in Vancouver Coastal Health Authority, but was unsuccessful. Due to time limitations, I was not able to interview staff at each health clinic serving Aboriginal clients in the province. The purposive sampling procedure, which did not include interviewees from all parts of BC, limits the degree to which the results and recommendations can be generalized.

The perspectives of clinic staff interviewed for this project do not represent the full range of opinions on evaluation of services held by all staff and providers at CHCs and community-based clinics serving Aboriginal clients in BC.

Interviews were requested with clinic managers, and with one exception, no interviews were performed with clinical staff. This bias towards administration staff limits the breadth gathered in interviews.

## **Ethical Considerations**

Ethics approval was obtained from the Simon Fraser University Research Ethics Board prior to beginning interviews for this study. Confidentiality was

provided by using quotations in a way that did not identify the location or position of the interviewee.

Interviewees were given a consent form to read and sign prior to participation in interviews. The consent form assured participants of confidentiality. The consent form clearly indicated that interviewees could decline to respond to any questions, or withdraw from the interview at any time.

As a non-Aboriginal person, I recognized the inherent challenges in developing trust with the interviewees at the clinics I contacted, many of whom were Aboriginal and all of whom work with a largely Aboriginal population. I relied on my own experience from previous research conducted in Aboriginal communities in BC (Black, 2008), and on the mentorship of others who have worked with Aboriginal clinics and communities. I encouraged the people I interviewed to describe their population's health challenges, priorities and successes, so that my priorities as a researcher would not dominate the interview. I remain committed to full distribution of the results of this research in order to benefit the Aboriginal peoples whom the project was designed to serve.

## **Knowledge Exchange**

Copies of this report will be distributed to each of the six clinics whose staff participated in this project. As well, copies will be offered to other CHCs in BC serving Aboriginal populations. Submission to a peer-reviewed journal will also be considered.

## **RESULTS AND FINDINGS**

Listed below is a synthesis of the interview responses for this project.

### **Clinic Background and Client Population**

The age of the clinics involved in this project ranged from 5 years to 30 years, with a median age of 13 years. When asked to describe the population of people served by their clinic, respondents noted that they served the clients in their general neighbourhood, which included urban, rural, HIV-positive, those with chronic illnesses, the young, the elderly, drug-addicted, and low-income neighbourhood residents. One respondent stated that her clients include “urban Aboriginal people who have faced poverty, discrimination and homelessness.”

Of the six clinics whose staff participated in this project, five keep records on the percentage of Aboriginal people in their population. Aboriginal clients made up 33% to 100% of the total clinic population at these five clinics, with a median of 80%.

### **Primary Needs and Concerns of Aboriginal Clients**

When asked to describe the primary needs and concerns of their Aboriginal clients, interviewees responded with long lists of things that their clients need, including: “assistance with achieving a healthy lifestyle,” “advocacy in negotiating how and where to go to get the help they need,” assistance in understanding their medications and treatments, help in addressing “lifestyle

issues like violence, poverty, lack of good nutrition,” social and financial assistance, assistance with finding adequate housing, chronic disease management and pain management. Also listed were medical conditions such as addictions, mental health problems, diabetes, cancer, HIV and Hepatitis C.

## **Ways to Address Aboriginal Clients’ Needs**

When asked what things worked well to address these needs, several respondents noted that integrated services at the clinic level are key. “We have a dentist on site, and we also work in conjunction with alcohol and drug counsellors and a social worker,” noted one respondent. Others listed psychiatrists, nutritionists, an ophthalmologist, mental health counsellors, and HIV specialists among the service providers working or volunteering at least part-time at their clinics. One interviewee explained that having the community health nurse in the clinic with the primary care physician allowed for better communication between these two service providers, which benefited the clients. Other respondents agreed that communication between providers and clients was enhanced when different services were offered in one clinic.

One respondent stated, “We respect Aboriginal culture first and foremost. That makes all the difference.” She went on to describe how her clinic staff worked to make the clinic a place where clients feel secure, where “they can rest and have a cup of coffee.” Another interviewee suggested that clinic staff should seek to “understand their (Aboriginal clients’) perspective on healthcare and align our services more with traditional beliefs.” A respondent said, “The first time I



came in our waiting room and saw a client napping on a sofa, I realized we had become a safe place for our clients.”

Others responded that establishing trust in the community is a key concern, and emphasized the importance of being responsive to the needs expressed by the community. One respondent described how a women’s group at her clinic requested a physician to attend clients at the clinic, and the clinic responded by hiring a part-time physician: “When the doctor first started coming here, only two or three patients would show up and we would sit and drink tea with the doctor.” But after a few months of gaining the trust of the community, the doctor “is running off her feet she’s so busy at our clinic.”

### **Is the Community-Based Clinic Model a Good Way to Meet Aboriginal Clients’ Needs?**

When asked whether the integrated model of primary care delivery through community-based clinics was a good way to meet the needs of their Aboriginal clients, all interviewees said “yes.” One interviewee said, “Not only would I say that a community clinic is the best way, I would say it is the *only* way to meet the healthcare needs” of the Aboriginal population. She explained that many of her Aboriginal clients “do not do well in the mainstream healthcare system,” and that in the absence of a trusted community clinic, some clients postpone seeking medical care until their situation is urgent, because they have been mistreated by mainstream medical practices or hospitals.

Another respondent said, “First Nations families have complex needs, well... all families have complex needs! But many First Nations families have

complicated histories and are dealing with issues from residential schools, substance abuse, etc. And the multi-disciplinary approach is a much better way to meet these complex needs than the traditional 'silo' approach to medicine.”

Another person responded that the “one-stop shop” works well for Aboriginal people, and noted that her clients are comfortable at the community clinic: “They don’t like to go elsewhere. Here, we are familiar, close-by and trusted.”

Several respondents noted that low staff turnover at the community clinics has a positive impact on clients’ comfort level: “Our staff have been here a long time. They know the patients, and when they see them on the street, they drag them in to see the doctor if they’re sick.”

Community clinics traditionally have a focus on prevention, and that was exemplified by the work of the staff at the clinics interviewed for this project. “Our clinic allows people to find health, not just healthcare,” one respondent stated. She also related anecdotes of clients who previously delayed care until they were taken to the emergency room, but who are now established clients of the clinic and have learned to manage their healthcare and improve their health.

## **Evaluation of Clinic Programs**

Most of the clinic staff interviewed for this project conducted formal evaluations of their programs, sometimes because evaluations are a requirement of funding agencies. Some evaluations consisted of counting numbers of clients served by the program and documenting money spent on transferring clients

from remote areas to diagnostic and treatment centres in urban areas; however, other clinics performed evaluations that were more focused on patient and provider satisfaction. One respondent outlined how her clinic built in evaluation from the very beginning, and noted that the clinic has utilized staff evaluation forms and client focus groups. She explained, “We work to make the evaluation tools culturally familiar, so for example, we base some evaluation tools on the medicine wheel and the seasons...we ask clients to pin notes on a bulletin board telling us how they’re doing and what things about the clinic are working well for them.”

One respondent noted that while her clinic does not yet perform formal evaluations, they are aware of clients’ opinions of certain programs: “Our clients speak with their feet. If they like a program we’re offering, they attend it and if not, well, we’ve had one program we gave up because no one was attending, and we have other programs that are really well attended and we know the community likes those programs.”

Another clinic manager noted that her funder requires a written evaluation be performed every five years, with a specified minimum percentage of clinic clients involved in the evaluation survey. The clinic manager hired an outside consultant to perform the evaluation, and the consultant offered incentives, made phone calls and walked door-to-door to get adequate participation in the survey. This clinic manager noted that while the evaluation itself is time-consuming, the community health plan developed as a result of the evaluation is very useful to the clinic.

Low literacy levels among clinic clientele limit the feasibility of written client satisfaction surveys at some clinics. According to one project interviewee, “We would have to sit with our clients, read them the questions, and fill out the (evaluation) forms with them. And we simply don’t have the time and staff to do that.” One clinic manager noted that researchers based at a nearby university are currently involved in an evaluation of her clinic’s services to Aboriginal clients, and she looks forward to utilizing the results of that research.

### **Advice for Others Considering Using the Community-Based Clinic Model for Aboriginal Populations**

I received enthusiastic responses from many participants in reply to questions about advice for other community-based clinics. Several interviewees emphasized the importance of including Aboriginal community members at the planning stages for developing a community clinic: “Get their buy-in from the start, and make sure their participation isn’t just tokenism. Develop an open dialogue.”

Another respondent shared this learning about community involvement: “Talk to them. Gain their trust. From there, they will open up and talk to you. It takes some time, and you have to build trust, then you’ll hear what you need to hear, they’ll give you ideas.” She described a recent program that was being developed at her clinic, and noted that the clinic held focus groups with clients to come up with a name for the new program and help design it so that the clients would feel a sense of ownership of the program.

The advice from another community clinic staff-person was this: “You have to prove to your community that you’re trustworthy, and you do that by being absolutely consistent. People have come to see that we’re reliable, we keep our word. You have to practice client-centred care. Be responsive to what your community is telling you it needs.”

One respondent advised that providers at community clinics be allocated more time with their clients in order to build relationships with clients: “If the provider can even take time to ask ‘how did you get here this morning’ they may discover that the client is homeless or has no transportation, and those are important things for providers to know about.” She explained that the ‘no-show’ rate at her clinic dropped significantly when the clinic began offering longer appointments with greater opportunity for clients and providers to build trusting relationships. The clients want to keep their appointments now, she noted.

Another interviewee offered suggestions for how to get client participation in evaluation: “You need to find ways for clients to have feedback in good ways. Provide lunch for a group of clients and ask them, ‘What’s working well for you and what’s not working so well?’”

The seven people interviewed for this project face the daily challenge of addressing the complex healthcare needs of the Aboriginal population in their area. While most participants were busy and found it difficult to fit in time for this project interview, all were eager to describe the successes they have had in meeting the needs of the Aboriginal clients served by their clinic. The interviews illustrate how each of these clinics represents a dynamic force in their

community, working to maintain the trust of their clientele and adapting when necessary to meet the changing needs of their populations.

## **DISCUSSION**

Community-based clinics and CHCs offer models of primary healthcare that have great potential to meet the pressing needs of BC's Aboriginal population. While there is no single model of primary healthcare delivery that fits the needs of all Aboriginal Canadians, the community clinic model can bring locally based, multi-disciplinary healthcare services to Aboriginal peoples in or near their home communities, with the potential to become trustworthy and responsive institutions in the community.

Concerns were raised by some participants about the barriers to providing a full range of health services to their clients. For example, while all interview participants noted the importance of offering multi-disciplinary services to their clients, some clinics had not yet incorporated this into their clinic model, partly due to lack of physical space and lack of funding. Availability of healthcare providers was an issue raised by some research participants who felt frustrated by the lack of referral options in their remote settings.

Among the clinics included in this research, the clinic model that seemed most successful at integrating services was the clinic that housed multiple service providers, including mental health, dentistry and social work, along with primary medical care in one building. This clinic had weekly staff meetings with the goal of improving their work as an integrated team, and continually engaged in provider evaluations of clinic function and clinic services. Client care and

provider satisfaction were both enhanced in this model, where there were close working relationships between clinic providers.

Community-based clinics have the potential to tailor their services to meet the needs of their population. One clinic that was successful in this area developed programs they felt the community needed, but later adapted these programs based on community input and community participation, enlarging those programs that were well attended and changing those that weren't well attended. Another clinic serving clients in remote parts of the province adapted its services to include home visits by community health nurses and access to mobile screening services.

Several research participants felt that building trust with clients in the community led to client engagement in the work of the clinic as well as client feelings of ownership of the clinic and its programs. This enhanced trust with clients offers opportunities for working towards cultural safety in the CHC and community-based clinic setting. Clients' engagement and the trusting relationships underlying it are perhaps the most promising development in community-based clinics. Clients, including Aboriginal clients, feel safe, empowered and involved in the health-building work of these clinics. These features are more difficult to build in the traditional medical model of individual physician offices where the power dynamics are set and clients are not usually asked to participate in the development of healthcare programs.

It is difficult to say whether or not BC's health authorities plan to support more community-based clinics in the province, as no interviews with health



authority staff were conducted for this project. This model of healthcare has certainly proved its usefulness and effectiveness in other provinces, and this research project supports the use of the CHC/community-based clinic model for meeting the needs of Aboriginal peoples. It is hoped that BC will include support for CHCs and community-based clinics in its plan to improve healthcare to vulnerable populations such as Aboriginal peoples.

Potential barriers to the development of additional CHCs and community-based clinics might be the opposition of groups like the Canadian Medical Association, whose members strongly support fee-for-service practice models. There is initial funding required for the building and staffing of CHCs; health authorities may be reluctant to make the initial investment in this model unless they are convinced of the cost-effectiveness of this model.

The results of this project must be viewed in the larger context of the lives of Aboriginal peoples. As Frideres and Gadacz note, "The effectiveness of the Native health system is related as much to the environmental conditions in which Aboriginal Canadians live as to the treatment and facilities provided" (2008, p. 80). Poverty, unemployment, poor nutrition, overcrowding, family and community violence all combine to counter the positive effects of quality healthcare. White, et al., explain, "Thus, an Aboriginal person, after receiving effective medical treatment, finds himself or herself returning to the social conditions that created the problem in the first place" (2007, p. 80). As long as the social contexts that foster poor mental and physical health are not addressed, even high quality,

community-based health centres will not be able to adequately address the health disparities facing Aboriginal Canadians.

In considering ways to reduce health disparities in Aboriginal populations, Adelson has written that reducing these disparities "...is ultimately linked to a larger political will and attendant policy framework that will effectively acknowledge the relationship between inequality and ill health" (2005, p. S59). The development of community-based clinics and CHCs can be an expression of political will to address health disparities.

In a recent special to the *Vancouver Sun*, Caron and Penikett describe the close links between feelings of powerlessness and poor health outcomes in the Aboriginal community: "The poor health of B.C.'s first nations population needs to be addressed actively, not just by policy papers delivered at conferences in expensive hotels but also by community-based initiatives..." (2009). Community-based clinics, and the projects that develop from them, represent examples of empowering initiatives. Evaluation of these initiatives allows other communities to benefit by example, as well as offering solid evidence to health authorities and other funding agencies upon which to base their primary healthcare funding decisions.

## **IMPLICATIONS AND RECOMMENDATIONS**

The results of this project demonstrate that community-based clinics work well in meeting the needs of the large population of Aboriginal peoples in BC. This study contains examples of the range of evaluation tools that are used by community-based clinics in BC to prove their effectiveness at meeting the needs of their Aboriginal clients. Dissemination of information about evaluation methods and tools used by community-based clinics can assist these clinics in learning from each other.

The recommendations arising from this research project include advice to community-based clinics that evaluation is critically important in demonstrating to funders, community members, other clinics and clients that the community-based clinic is not only a reliable and 'culturally safe' place in which to receive health care assistance, but that these clinics are working to be responsive to the changing needs of the Aboriginal clients they serve.

It would be beneficial to the further development of CHCs and community-based clinics to have evaluation performed in a systematic and regularly scheduled way. The evaluation of CHCs should focus on four questions: 1) Has the health status of clients improved; 2) Are clients satisfied; 3) Are the wider social determinants of health being addressed for clients of CHCs, and if so, in what ways are they being addressed; and 4) To what degree are clients protected from the financial risks of ill health (Roberts, Hsiao, Berman & Reich,

2008). These questions will allow for the collection of quantitative as well as qualitative data, ensuring that important contextual features will not be overlooked. As evaluation methods are considered for CHCs and community-based clinics, comparisons should be made between evaluation results at CHCs and evaluation results of the models to which CHCs are being compared, usually fee-for-service medicine.

I recommend that consideration be given to expanding community-based health clinics in parts of BC where the primary healthcare needs of the Aboriginal population are unmet. As these clinics are established, I recommend that evaluation be built into the structure of the clinic so that this element will receive the emphasis it deserves. I recommend that clinic staff and healthcare providers be involved in regular evaluations of clinic services, in addition to evaluations done by clients. In this way, clinics can demonstrate to funding agencies, other clinics, and to their communities the ways in which they are achieving success and the ways in which they plan to change and adapt in response to community, client or provider suggestions.

My suggestions for future research include an expanded review of evaluation methods at community-based clinics, in order to identify and interview participants at all community-based clinics in BC serving a large population of Aboriginal clients. Additionally, interviews with clients at these clinics could be performed, to develop a fuller picture of how services are evaluated and how well client needs are being met. This research should include knowledge translation that includes returning the study results and recommendations to the

communities where interviews originated. Finally, study results must be made available to decision-makers at health authorities and others who allocate funding to community healthcare, so that community-based clinics are given full consideration as a service model to meet the needs of BC's Aboriginal population.

## **CRITICAL REFLECTION**

As a public health practitioner with an interest in promoting Aboriginal health, my work has focused on progress being made by and in Aboriginal communities to address persistent health disparities arising from the poverty, unemployment and other social contexts existing in Canada's First Nations. I have found that the use of qualitative research methods, through site visits and key informant interviews, is the best way for me as a researcher to build relationships that encourage participants to describe their experiences and share their stories and their wisdom. My responsibility as a researcher is to share their stories more widely so that others can learn from them and ultimately, so that positive changes in health care delivery to Aboriginal peoples will occur.

It is important that Canadians become more aware of the challenges facing Aboriginal peoples, and there is work to be done in this regard. The results of a poll released in the mid-1990s, soon after the Royal Commission on Aboriginal Peoples Report, showed that close to 50 percent of Canadians thought that First Nations reserves had similar standards of living and well-being as non-Aboriginal communities (Insight Canada, 1996, as cited in White, et al, 2007). The Canadian public must understand the difficulties facing Aboriginal communities before they will take on the challenge of working to make real improvements, or agree to support individuals and institutions working on improvements.

In my research I have attempted to shift focus from the shameful health disparities themselves, for as White, et al., have noted, "...shame is not what is needed. What is needed is better policies developed from solid research evidence created in partnership with the Aboriginal peoples themselves" (2007, p.5). I will seek projects that focus on empowerment and health improvements as I work to build partnerships with those in the Aboriginal community who are also seeking these changes.

My role as a public health practitioner is to educate the public about the current challenges facing Aboriginal communities, focus more attention on successful efforts to address health disparities and improve health in this population, and continue my involvement in research to support the Aboriginal community as it strives to promote health.

## **APPENDICES**



## **Appendix A**

### **Interview Questions**

#### **Introduction**

The interview you have agreed to participate in is part of a research project being conducted by Agnes Black as part of the degree requirements for her MPH degree at Simon Fraser University. The informed consent form has been explained to you and signed by you, and confidentiality of the information has been assured. This research project is being conducted with the goal of improving the ability of community health centres to evaluate their effectiveness in meeting the needs of their Aboriginal clients. Your participation is appreciated and will assist us in identifying appropriate evaluation methods to improve the delivery of primary care to Aboriginal peoples. You may receive a copy of the final report upon request.

1. How long has your clinic been in operation?
2. Can you describe the population served by your clinic?
3. Do you collect data on how many of your patients are Aboriginal? If yes, approximately what percent of your clinic population is Aboriginal?
4. Do you believe the Community Health Centre model is a good way to meet the health care needs of Aboriginal peoples?
5. If yes, elaborate on why it is a good model. If not, why not?
6. Do you currently have a systematic way to evaluate your programs? If yes, please describe your evaluation measures.
7. What are some of the primary needs and concerns brought to your clinic by your Aboriginal clients? What works well generally for meeting those needs?
8. How do you measure your success as a CHC providing care to Aboriginal peoples?
9. What advice would you offer others who are considering using the CHC model for a patient population that includes a significant percentage of patients who are Aboriginal?

## Appendix B

### SIMON FRASER UNIVERSITY



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#### Consent Form for Interviews

#### Research Title: How Do Community Health Centres Evaluate Their Success in Meeting the Needs of Their Aboriginal Clients?

Principal Investigator: Agnes Black  
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Co-investigator: Marina Morrow, PhD  
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Dean of Faculty of Health Sciences: John O'Neil, PhD  
Telephone Number: 778-782-5361

#### I. PURPOSE AND GOALS

The goal of this research is to better understand the role of CHCs in meeting the needs of their Aboriginal clients. The objective is to provide health authorities, health care researchers and the CHCs themselves with qualitative data that will inform future decisions about how to evaluate success in meeting Aboriginal patients' health care needs at CHCs. The goals include performing key informant interviews to examine the features of CHC models that are best suited to Aboriginal populations and to propose strategies for enhancing evaluation of this model to improve the model and thus the health of Aboriginal peoples. A report will be written detailing results from the interviews.

The primary purpose of this interview is to gather information on how health care delivery for Aboriginal clients is currently evaluated by staff and providers at community health centres in BC. The interview will take approximately 30 minutes and will be recorded by tape. Hand written notes may also be taken during the interview.

## **II. POSSIBLE RISKS**

This interview will have no more risk or harm than you would experience in everyday life. You may experience discomfort because interview questions are related to the evaluation of the quality of care provided by your community health centre. All information provided in this interview will be kept confidential. Because there are a small number of community health centres in BC who include among their client base a significant number of Aboriginal clients, it is not possible to guarantee anonymity of all interviewees. Names will be changed to pseudonyms in the transcriptions and no identifying city or location names will be used in the report produced by this project. All interview information will be kept in a secure location at SFU and will be shredded after five years.

## **III. POSSIBLE BENEFITS**

Information shared during the interview may be beneficial in improving understanding of how community health centres might better meet the needs of Aboriginal peoples and improve evaluation methods at these centres.

## **IV. STATEMENT OF CONFIDENTIALITY**

Confidentiality will be provided by changing interviewee names to pseudonyms following transcription. Interview information will be kept in a secure location at SFU, including a password-protected computer, for five years, and will then be destroyed.

## **V. INTERVIEW OF EMPLOYEES ABOUT THEIR COMPANY OR AGENCY**

Your participation in this interview is voluntary. The principal investigator has not sought or obtained permission from your employer or Band/Counsel. You may decide not to begin or to stop this interview at any time. All information provided in this interview will be kept confidential. Your participation in this study will not jeopardize your employment. Names will be changed to pseudonyms in the transcriptions.

## **VI. INCLUSION OF NAMES OF PARTICIPANTS IN REPORTS OF THE STUDY**

All information provided in this interview will be kept confidential. Names will be changed to pseudonyms in the transcriptions.

## **VII. QUESTIONS OR CONCERNS ABOUT PARTICIPATING**

Dr. Hal Weinberg, Director  
Office of Research Ethics  
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## **VIII. YOUR CONSENT**

By participating, you agree that you have read this informed consent form, you understand what is involved, and you agree to take part in this interview. You may stop at any time. You will receive a copy of this consent form.

**IX. RESEARCHER STATEMENT**

I certify that the research study has been explained to me, including the purpose, the procedures, the possible risks and the potential benefits associated with participation in this interview. Any questions raised have been answered to my satisfaction.

Signature of  
Participant\_\_\_\_\_

Date\_\_\_\_\_

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