

ARE NATIVE MEN AND WOMEN ACCESSING THE HEALTH CARE FACILITIES? FINDINGS FROM A SMALL NATIVE RESERVE

Mitch Verde

Nisga'a Valley Health Board
256 Tait Avenue
New Aiyansh, British Columbia
Canada, V0J 1A0

Han Z. Li

University of Northern British Columbia
3333 University Way
Prince George, British Columbia
Canada, V2N 4Z9

Abstract / Résumé

This study is concerned with males and females accessing health care on a Reserve. Clearly in the future gender specific strategies must be adopted. Three problems are identified in the delivery of health care. In addition it is clear that Native people must improve their economic status to better access health care.

L'étude porte sur les hommes et les femmes qui obtiennent des services de santé dans une réserve. Il est clair qu'il faudra adopter à l'avenir des stratégies propres à chaque sexe. L'étude cerne trois problèmes liés à la prestation des soins de santé. De plus, il est clair que les peuples autochtones doivent améliorer leur situation économique afin de rehausser leur accès aux soins de santé.

Founded upon the Health Belief Model, the main goal of this study was to examine the frequency of local health centre visits and their correlates among Natives in a small and isolated Native reserve in Canada. Four variables were found to influence the frequency of local clinic usage for females: 1) perceived susceptibility, 2) perceived financial barriers, 3) having a family physician, and 4) age. For males the variables were: 1) health knowledge, and 2) health importance. This study contributes to the field in three ways. First, by analysing females and males separately, we have gained much insight into the unique positions in which Native females and males are situated. In order for future health promotion efforts to work effectively, there is a need to implement gender specific strategies. The second contribution of this study is the illuminating findings from the open-ended questions. The three problems identified, lack of confidentiality, lack of qualified health professionals, and an inefficient appointment scheduling system, may well be the root issues which prevented Natives from accessing mainstream health care. Policy makers and band leaders may find it enlightening to take these three issues into consideration when designing health promotion programs in Native reserves. The final contribution of this study is the clear picture the results have presented us: for Natives to increase access to health care facilities, they need to improve their economic status. Health and health care is not an isolated issue, it is nested in the social, political, cultural and economic environment. Unless these issues are addressed, unless Natives' social and economic status is improved, unless there is more understanding between mainstream health professionals and Native patients, Natives will remain outsiders of the mainstream health care facilities.

First Nations people in Canada have been shown to have a higher prevalence of suicide, child mortality, and certain types of cancer, as well as a greater exposure to physical injuries and infectious diseases such as tuberculosis (Report on the Royal Commission of Aboriginal Peoples, 1996) in comparison with their non-Native counterparts. In recent years, rates of diabetes and heart disease are also on the rise among First Nations populations (Young, 1994). Overall, First Nations people in Canada have a lifespan of seven to eight years shorter than the general population (Report on the Royal Commission of Aboriginal Peoples, 1996). To improve this situation, it is important that Natives have their diseases treated at an early stage by visiting local health centres. The purpose of this study was to examine the frequency of local health centre visits and their correlates among Natives in a small and isolated Native reserve in Canada. Specifically, this study compared the factors influencing whether and/or how frequently Native men and women utilized the local health

centre when they needed to.

Theoretical Framework

This study was founded upon the Health Belief Model (HBM), developed in the 1950's and 1960's by Hochbaum, Leventhal and Rosenstock (Weinstein, 1993). HBM has since been widely tested and found to be a robust measurement of health behaviours in various cultural groups (Weinstein, 1993). The dependent variable in HBM is a health behaviour such as the frequency of visiting a health centre when the person needs medical attention. The most important independent variables are perceived susceptibility, perceived severity, perceived barriers, and perceived benefits and costs.

Perceived susceptibility refers to an individual's perception of the likelihood that they would become afflicted with a certain illness, disease or injury. Perceived severity refers to an individual's perception of how severely an illness, disease or injury would impact their life or lifestyle once inflicted. Perceived barriers are any type of real or imagined obstacles when an individual accesses the health care facilities (Janz & Becker, 1984). Perceived benefits and costs refer to the perceived "good things" and "bad things" associated with using the health care facilities or engaging in a health behaviour.

In addition to the four independent variables, HBM also identifies two groups of intermediate variables which may influence people's health behaviours. The first group consists of demographic, social psychological variables (Mirotznik, Feldman & Stein, 1995) and the second group is made up of "cues to action." Cues to action are usually categorized as internal cues such as the occurrence of symptoms, and external cues such as the media (Janz & Becker, 1984). HBM postulates that an individual's health behaviour is influenced by these four independent and the two groups of intermediate variables.

Major Literature on Native Gender Differences in Health Care Facility Usage

Native Women

A review of literature on the utilization of health care facilities by Native men and women presents an inconsistent picture. Some researchers found that Native men and women had similar utilization rates regarding community clinics (Joe & Lonewolf-Miller, 1989), while others reported that Native women used community clinics slightly more than Native men (Garro, 1995). Others have identified several differences between men and women in terms of their perceived barriers in accessing

public health care facilities (Waldram, Herring, & Young, 1994). For example, Native women identified barriers as the primary reason for not receiving pap tests (Deschamps et al. 1992). It was observed that Native women were more financially disadvantaged than Native men. Several studies have reported that more Native women than Native men lived below the poverty line (Report on the Royal Commission on Aboriginal Peoples, 1996). This situation was partly due to the high percentage of single mothers in Native populations (Health & Welfare Canada, 1991; Joe & Lonewolf-Miller, 1989; Mayfield & Davis, 1984). Several researchers identified poverty as the main reason for Native women to have reduced access to public health care facilities (Price & Everett, 1994; Rundall & Wheeler, 1979). The Report by the Royal Commission on Aboriginal Peoples (1996) indicated that lower income Native women were exposed to inadequate housing, sewage and unsafe drinking water, which may have contributed to greater occurrences of health problems. It was also found that lower income women, once diseased, were less likely to seek health care services than higher income women (Adler, Boyce, Chesney, Folkman, & Syme., 1993) and the former also had less healthy lifestyles than the latter (Price & Everett, 1994). Unhealthy lifestyles in turn brought a higher risk for diseases such as breast cancer (Earp, Altpeter, Mayne, Viadro, & O'Malley, 1995).

Waldram and Layman (1989) reported that lack of affordable child care on Native reserves is a major barrier for Native women to seek medical care when needed. Transportation was a top barrier identified by Native women (Rhoades, 1977), although this barrier was also reported by Native men but to a lesser extent (Waldram & Layman, 1989).

Another barrier was the lack of female physicians on Native reserves. Native women usually prefer female physicians to male physicians (Frideres, 1994) especially when intimate parts of the body needed to be examined (Miles, 1991). Native women feel uncomfortable with physical examinations made by male physicians. It is reasoned that Native cultures are conservative and physical examinations may be perceived as invasive. As Native cultures emphasize female modesty, Native women may feel embarrassed when exposing intimate parts of their body to a male physician (Browne, 1995; Deschamps et al., 1992). Besides cultural reasons, Native women may prefer female physicians in the belief that female physicians relate to female patients better than males physicians (Hall, Irish, Roter, Ehrlich, & Miller, 1994).

Although Native women face formidable barriers to health care, they may have some advantages over Native men with regard to several other contributors to health behaviours as specified by HBM.

In comparison with Native men, Native women may have more health

knowledge due to their involvement in health related activities such as extended family care, pregnancy, childbirth and child-rearing. As a result of these activities, Native women may have more cues to action, possibly obtained by more contact with public health information and health professionals. This increased contact may give them greater exposure to health issues than Native men. This additional exposure has been shown to decrease health risk behaviours, and increase pro-health behaviour (Aho, 1979; Lu, 1995).

In summary, Native women's health care seeking behaviour would be predicted primarily by perceived barriers and health knowledge.

Native Men

Culture shapes the way humans construe their health and illness. In Native cultures, sickness in men is perceived as a sign of weakness. To be strong, a Native man often ignores or plays down his illness and/or disease (Abbey, Hood, Young, & Malcolmson, 1993). In comparison with Native women, Native men showed less concern with their health (Norman, 1995), and made fewer visits to local health centres (Garro, 1995). They were less likely to have a family physician (Herring, & Young, 1994), displayed a higher prevalence of suicide (Ward, 1984), and had a shorter lifespan (Anderson, 1993).

The internalized cultural norms on male strength may have led to low perceived susceptibility to illness and/or diseases, as well as low perceived severity when Native men experienced physical symptoms. Both perceived susceptibility and severity have been found to be correlated with health seeking behaviour (Brunswick & Banaszak-Holl, 1996; Mirotznik, Feldman, & Stein, 1995; Alogna, 1980; Harris, Skyler, & Linn, 1982).

In comparison to Native women, Native men might have less exposure to health knowledge such as advice from family and friends, as Native men have a general unwillingness to discuss health issues. Since the notion of relying on others for health advice is not consistent with the Native male image of being strong and independent, Native men usually delay seeking medical care until their illness reaches a critical stage. Therefore it is not surprising to find that twice as many Native men relative to Native women used hospital emergency services (Walsh, 1995).

Native men were also less likely than Native women to have a family doctor (Waldram, Herring, & Young, 1994). Consequently, Native men had less exposure to health information and check-up reminders from physicians. Health information exposure has been found to be highly correlated with health seeking behaviours (Cameron, 1996; Larson,

Bergman, & Heidrich, 1982; Norman, 1995).

To summarize, Native men's health seeking behaviour would be mainly predicted by perceived susceptibility, perceived severity, and health knowledge.

Method

Background

At the time of the study, the population of the community was about 400 people. The community had a health centre staffed by two full time registered nurses, and a physician who visited the community once a week. The visiting physician varied from month to month, and sometimes from week to week. The closest referral hospital was a two-hour drive, and a fully equipped health centre was one-hour away.

Approximately two years prior to the data collection of this study, the researchers consulted the community's Band Council. The Band Council discussed the proposal and a written authority to conduct the study was forwarded to the University of Northern British Columbia. The University's Ethics Committee then approved the application to conduct the study. At the time of data collection, the local Band Council gave the final permission for the study and participants also gave their permission for their data to be included in the study.

Sampling

During the five-month data gathering stage, the first author made six trips to this First Nations community. A list of all band members who were eighteen years of age and older was computer-generated. There were 378 potential participants and they were each assigned a number from 1-378. These numbers were placed in a large envelope and 101 numbers were randomly chosen: 50 males and 51 females. However, a number of the original people chosen were not living in the community any longer, and a few people (less than 10) did not want to participate in the study. To assure a sample size of 51 females and 50 males, a second list was generated from the pool to replace the missing members on the first list.

Two participants did not complete their questionnaires and were excluded from data analysis. Preliminary analysis of the data revealed two outliers. Two females who suffered from chronic illnesses utilized the clinic so frequently over the previous six months that their data affected the mean frequency dramatically. They were therefore excluded from data analysis. The final data analysis included 97 participants, 48 females and 49 males.

The Questionnaire

The questionnaire was made up of 40 items based on the Health Belief Model. The following variables were represented in the questionnaire: perceived barriers, perceived benefits, perceived severity, perceived susceptibility, cues to action, health importance, health knowledge, macho attitudes, delay, and age.

The questionnaire items were adapted from previous HBM-related studies (Norris & Ford, 1995) and had a five-point Likert scale: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree.

Perceived benefits and health priority items were patterned after items reported in Berkanovic, Telesky and Reeder (1981), who investigated structural and social factors in seeking medical care. One perceived benefits item was borrowed from Norman (1995), who investigated health attitudes as predictors of clinic attendance.

Perceived susceptibility and severity items were borrowed from Mirotznik et al. (1995) and Norman (1995), who assessed HBM variables as predictors of health regime maintenance and clinic attendance respectively. The internal reliability of items from Mirotznik et al. (1995) ranged from .95 to .96, and items from Norman (1995) ranged from .44 to .73. Perceived susceptibility was also assessed by examining the participant's perceived health, which had been previously used as an HBM-related variable by Rundall and Wheeler (1979). Rundall and Wheeler's (1979) susceptibility item was judged to be valid after two comparative health measures, an illness index and restricted activity index due to health problems.

The health importance statement "I think it is important that people take special care of their health" was borrowed from Carmel, Shani and Rosenberg (1994), who assessed whether HBM variables predicted change in skin cancer risk behaviour.

Health knowledge was measured by asking participants to mark "strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree" on this statement "I know plenty about health-related issues."

The variable "cultural barriers" was measured by asking participants to mark "strongly agree, somewhat agree, neither agree nor disagree, somewhat disagree, or strongly disagree" on this statement "health care professionals do not know enough about Native cultures to address Native people's health problems."

The macho attitude items were derived from a study by Berkanovic et al. (1981). Although the original items assessed the general concept of threat, the items were judged by the present authors as a useful indicator of macho attitudes.

Additional items which assessed health care usage and health care delays were measured with a four-point response scale "rarely, sometimes, often and always" (Li & Browne, 2000). An item assessing preference for physician gender had three possible choices which included male doctors, female doctors, and no preference. Participants were also asked to rate their current level of health on a scale of excellent, good, ok, or poor.

The frequency of self-reported non-emergency visits to the local health clinic during the past six months was the dependent variable. Measuring health care usage as the number of clinic visits in a given period has also been used in other HBM-related studies (Berkanovic et al., 1981; Norman, 1995).

Conducting the Interviews

In collecting the data, the first author maintained a consistent manner in administering the questionnaire to the participants. He first approached the individual at their residence, although several interviews were done where it was convenient for the individual, for example, at their place of employment. He stated to the prospective participant that he was conducting a health survey in conjunction with the local Band Council and politely asked if he could have five to ten minutes of the person's time to fill out a questionnaire.

The questionnaire items were read aloud, while the participant followed on their own or the researcher's copy. Queries about the items on the questionnaire were answered in a similar manner for all participants. During the interviews, the researcher encouraged participants to interpret the items and articulate their understanding in order that the questions were understood as intended.

When participants completed the questionnaire, they were asked if there were any reasons why they did not use the local health care facilities beyond what was in the questionnaire. This information was recorded as open-ended response data. Data were analysed using SPSS at the University of Northern British Columbia.

Results

On average, the female participants used the local clinic 4.9 times over the previous six months while males used 3.5 times. There was no statistically significant difference between clinic use of the male and female participants, $t(95) = 1.62, p > .05$. However, a greater number of male participants (27%) did not visit the clinic at all compared with 16% of the females.

Clinic Usage and its Correlates for Females

Results of a Multiple Regression indicated that two variables accounted for the most variability: having a regular family physician and perceived susceptibility, $R^2 = .30$, $F(2, 45) = 7.3$, $p < .00$, $\eta^2 = .43$. According to Cohen (1992), this is a large effect size.

Pearson correlations were used to assess the relationship between the frequency of clinic usage and HBM variables. Four variables had a statistically significant correlation with the frequency of clinic usage: perceived susceptibility ($r(48) = .49$, $p < .001$), having a family physician ($r(48) = .27$, $p < .05$), financial barriers ($r(48) = -.26$, $p < .05$), and age ($r(48) = .27$, $p < .05$). Table 1 presents significant inter-correlations among independent variables and clinic use for Native women.

Clinic Usage and its Correlates for Males

Results of a Multiple Regression indicated that two variables accounted for the most variability: health knowledge and cultural differences, $R^2 = .16$, $F(2, 46) = 4.12$, $p < .01$, $\eta^2 = .19$. According to Cohen (1992), this effect size is between medium and large.

Pearson correlations were used to assess the relationship between the frequency of clinic usage and HBM variables. Four variables had a statistically significant correlation with the frequency of clinic usage for males: cultural differences ($r(49) = -.31$, $p < .05$), health knowledge ($r(49) = -.29$, $p < .05$), health importance ($r(49) = -.26$, $p < .05$), and having a regular physician ($r(49) = -.26$, $p < .05$). Table 2 presents significant inter-correlations among independent variables and clinic use for Native men.

Male-Female Differences

Gender Preference of Physicians

A t-test showed that the preference for the gender of a physician was significantly different for males and females ($t(95) = 2.09$, $p < .05$, $\eta^2 = .22$). Among female participants, 48% preferred female physicians, and 52% had no preference. In comparison, 8% of the male participants preferred male physicians, 8% preferred female physicians and 84% had no preference for either male or female physicians.

Perceived Barriers

Females perceived more barriers to visit the clinic than males although the difference was not statistically significant ($t(95) = 1.92$, $p = .058$). Twice as many females as males indicated experiencing a great

Table 1

Significant Intercorrelations among Independent Variables and Clinic Use for Native Females (n=48)

V1. General barriers	V2 (.29*)	V3 (.26*)	V4 (.34**)	V19 (-.35**)			
V2. Perceived benefits	V4 (.35**)	V5 (.29*)	V12 (-.28*)	V13 (-40**)			
V3. Health knowledge	V4 (.73**)	V5 (.37**)	V8 (.25*)	V14 (.27*)	V16 (.50**)	V18 (.34**)	V19 (.31*)
V4. Health importance	V5 (.41**)	V8 (.35**)	V16 (.31*)				
V5. Macho attitudes	V11 (.33*)	V14 (.35**)	V16 (.27*)	V18 (.39**)			
V6. Having a family Dr.	V7 (.23*)	V10 (.27*)	V14 (-.35**)	V15 (-.27*)	V18 (-.37**)	V20 (.27*)	
V7. Physical symptoms	V8 (.30*)	V19 (.41**)					
V8. Perceived severity	V3 (.25*)	V4 (.35**)	V7 (.30*)				
V9. Perceived susceptibility	V15 (-.25*)	V20 (.49**)					
V10. Age	V6 (.27*)	V12 (-.44**)	V14 (-.43**)	V15 (-.41**)	V20 (.27*)		
V11. Perceived health status	V17 (-.25*)	V5 (.33*)					
V12. Financial barriers	V2 (-.28*)	V10 (-.44**)	V20 (-.26*)				
V13. Lack of childcare	V2 (-.40**)						
V14. Cultural barriers	V3 (.27*)	V5 (.35**)	V6 (-.35**)	V10 (-.43**)			
V15. Trust modern medicine	V6 (-.27*)	V9 (-.25*)	V10 (-.41**)				
V16. Trust medical personnel	V3 (.50**)	V4 (.31*)	V5 (.27*)				
V17. Lack of transportation	V11 (-.25*)						
V18. Perceived racism	V3 (.34**)	V5 (.39**)	V6 (-.37**)				
V19. Physician preference	V1 (-.35**)	V3 (.31*)	V7 (.41**)				
V20. Clinical usage	V6 (.27*)	V9 (.49**)	V10 (.27*)	V12 (-.26*)			

* Correlation is significant at the 0.05 level (1-tailed).

** Correlation is significant at the 0.01 level (1-tailed).

Table 2

Significant Intercorrelations among Independent Variables and Clinic Use for Native Males (n=49)

V1. General barriers	V2 (.71**)	V3 (.33**)	V4 (.60**)	V8 (.44**)	V11 (.26*)	V19(.23*)	
V2. Perceived benefits	V3 (.33**)	V4 (.65**)	V8 (.62**)	V16 (-.24*)			
V3. Health knowledge	V4 (.53**)	V9 (.33**)	V20 (-.29*)				
V4. Health importance	V1 (.60**)	V2 (.65**)	V3 (.53**)	V8 (.42**)	V10 (-.35**)	V19 (.25*)	V20 (-.26*)
V5. Macho attitudes	V12 (.35*)	V13 (.27*)	V16 (.23*)				
V6. Having a family Dr.	V10 (.45**)	V19 (-.29*)	V20 (-.26*)				
V7. Physical symptoms	V9 (.24*)	V10 (.35**)	V11 (-.27*)				
V8. Perceived severity	V1 (.44**)	V2 (.62**)	V4 (.42**)	V17 (-.32*)			
V9. Perceived susceptibility	V3 (.33**)	V7 (.24*)	V11 (-.30*)				
V10. Age	V4 (-.35**)	V6 (.45**)	V7 (.35**)	V12 (-.29*)	V16 (-.27*)		
V11. Perceived health status	V1 (.26*)	V7 (-.27*)	V9 (-.30*)				
V12. Financial barriers	V5 (.35**)	V10 (-.29*)					
V13. Lack of childcare	V5 (.27*)						
V14. Cultural barriers	V20 (-.31**)						
V15. Trust modern medicine							
V16. Trust medical personnel	V2 (-.24*)	V5 (.23*)	V10 (-.27*)				
V17. Lack of transportation	V8 (-.32*)						
V18. Perceived racism							
V19. Physician preference	V1 (.23*)	V4 (.25*)	V6 (-.29*)				
V20. Clinical usage	V3 (-.29*)	V4 (-.26*)	V14 (-.31*)				

* Correlation is significant at the 0.05 level (1-tailed).

** Correlation is significant at the 0.01 level (1-tailed).

deal of barriers when accessing the health care facilities.

Eighty-three percent of the females reported having a family physician compared with only 67% of the males though the difference was not statistically significant.

Sixteen percent of the females reported their current health level was excellent, 44% reported "good," 31% reported "OK," and 8% reported "poor." In contrast, 18% percent of the males reported their current health level as excellent, 59% reported "good," 22% characterized their health as "OK," and none perceived their health as "poor."

Additional Findings

Besides the questionnaire, participants were also asked to add information of their own. Three issues were reported. First, there was a lack of confidentiality in the clinic. For example, a patient was diagnosed with breast cancer. One staff member of the clinic whispered the news to her sister; her sister to her best friend and so on. In about three days, the news was spread in the whole community. Participants said that lack of confidentiality in the clinic prevented them from using the clinic.

The second issue identified was the clinic's appointment scheduling policy. Participants said that when they needed to see a physician, they could not obtain an appointment in the same day. For example, one participant said he had to wait for eight days to see a physician for a broken leg. In other instances, patients didn't have the need to see a doctor any more after waiting for a whole week for their scheduled appointment.

The third issue was a lack of qualified physicians and nurses in the clinic. One physician visited the clinic twice a week and was not the same one from month to month. The nurses were perceived as inexperienced. Both physicians and nurses were perceived as knowing too little about Native culture to provide culturally sensitive care.

Discussion

The present study examined, guided by the Health Belief Model, differences in the frequency of local clinic usage between Native men and women. Four variables were found to influence the frequency of local clinic usage for females: 1) perceived susceptibility, 2) perceived financial barriers, 3) having a family physician, and 4) age. For males the variables were: 1) health knowledge, 2) health importance, 3) cultural barriers, and 4) having a family physician. Females and males differed with regard to physician preference. In addition, lack of confidentiality,

lack of qualified health professionals, and the inefficient appointment scheduling system prevented participants from accessing the local clinic. These findings will be discussed below.

Female Usage of Local Clinic and its Correlates

Consistent with previous research (Mirotznick, Feldman & Stein, 1995), perceived susceptibility and external cues to action were associated with an increase in health care usage. Female participants who perceived themselves to be more susceptible to health problems were more likely to use the local health clinic. Likewise, those who experienced more external cues such as exposure to educational materials were more likely to access the local clinic than those who didn't. The implication of these findings is to distribute, in doctors' offices and community centres, more pamphlets with information on illness, well-being, treatment and prevention.

Female participants who had a regular family physician were more likely to have used the local clinic. It is reasoned that to have a family doctor exposes one to more contact with health professionals in a more personal way, thus increasing the possibility for a patient to seek medical care when needed. The implication of this finding is that efforts need to be made by health professionals, band leaders, and opinion leaders in the community to urge Native people to have a regular family doctor.

Male Usage of Local Clinic and its Correlates

Among Native males, health knowledge and perceived health importance increased their usage of the local clinic. These findings are consistent with previous research showing that individuals who are more knowledgeable about health-related issues and who perceived the importance of health were more likely to use the health care facilities (Frideres, 1994). The implication of these findings are to work out ways to increase health-related knowledge, thus increasing local clinic usage.

Two findings among the male participants are contrary to other research (Mirotznick et al., 1995): males who had a family physician were less likely to use the local clinic, and males who perceived more cultural barriers were more likely to access the local clinic. These "odd" findings provide ground for further in-depth research among Native men in this and other reserves.

Male-Female Differences

Besides the above differences in the variables associated with the frequency of clinic use among Native males and females, we also found

two more differences. First, females had a strong preference for female health care professionals whereas males didn't have. This finding is consistent with reports by previous researchers (Frideres, 1988, 1991; Miles, 1991). Browne (1995) and Deschamps et al. (1992) explained that Native women generally didn't feel comfortable to be touched by male physicians because they are products of a traditional culture in which female modesty is emphasized. Hall et al. (1994) offered further explanation for this phenomenon: in comparison with male physicians, female physicians understand and relate to female patients better.

Second, we found that females perceived more barriers to health care than males, which hindered females from accessing the local clinic. This finding is consistent with previous researchers who noted that Native women were more financially disadvantaged than Native men (Report on the Royal Commission on Aboriginal Peoples, 1996) and poverty was the main reason for Native women to have reduced access to health care facilities (Price & Everett, 1994; Rundall & Wheeler, 1979; Wotherspoon, 1994).

To improve this situation, it is recommended (Sinclair, 1993; Scott, 1993) that affordable child care on Native reserve be established and transportation be provided for those who cannot afford but need them to access medical care.

Additional Findings

The three findings from the open-ended questions are: (1) lack of confidentiality, (2) lack of qualified health professionals, and (3) an inefficient appointment scheduling system.

The first finding, lack of confidentiality, is consistent with Browne (1995) and Bohn (1993) who reported that lack of confidentiality for Native clients was a major obstacle for Natives to access health care facilities.

The second finding, lack of qualified health professionals, prevented Natives from using the health clinic. This may be a general problem in small and isolated communities where there is no choice in terms of health professionals. However, this problem may become intense in Native reserves if the physicians and nurses were from a different cultural background (Ross & Ross, 1992), which was the case in this reserve. The only possible solution is to recruit health professionals of Native cultural background (Runion, 1984), who may be able to communicate with Native patients better and be perceived as more competent. In several studies, Li has demonstrated that cultural barriers resulted in inefficient communication in inter-cultural settings (1999a, 1999b, 2001), and reduced access for Asian Canadians to access main stream health facilities (Li & Browne, 2000).

The third finding indicated that the inefficient appointment scheduling system frustrated Natives, thus preventing them from using the local clinic. Respondents complained that it was not possible to see a physician on the same day even when they suffered from acute symptoms. What is more, culturally Natives are not familiar with strict schedules. It may be advisable to consider changing the scheduling system into a drop-in format.

Limitations

The research findings were limited by the unknown validity of the outcome measure. The Health Board would not permit cross checking the number of clinic visits for respondents and as a result, there was no accurate way of substantiating the actual number of clinic visits.

Several questionnaire items were not culturally sensitive to this particular First Nation. One example was that in order not to place bad luck on themselves, many of the respondents, particularly females, were hesitant to admit their susceptibility to injury and disease.

Due to seasonal employment and the need to leave the community for education opportunities, the sample was over-represented by people who work in the community or who are unemployed. Although this is a limitation in one sense, the advantage to canvassing this population is that they were more likely to have used local health services.

Conclusion

This study contributes to the field in three ways. First, by analysing females and males separately, we have gained much insight into the unique positions in which Native females and males are situated. In order for future health promotion efforts to work effectively, there is a need to implement gender specific strategies.

The second contribution of this study is the illuminating findings from the open-ended questions. The three problems identified, lack of confidentiality, lack of qualified health professionals, and an inefficient appointment scheduling system, may well be the root issues which prevented Natives from accessing mainstream health care. Policy makers and band leaders may find it enlightening to take these three issues into consideration when designing health promotion programs in Native reserves.

The final contribution of this study is the clear picture the results have presented us: for Natives to increase access to health care facilities, they need to improve their economic status. As pointed out by O'Neil and Postle (1994), health and health care is not an isolated issue, it is

nested in the social, political, cultural and economic environment. Unless these issues are addressed, unless Natives' social and economic status is improved, unless there is more understanding between mainstream health professionals and Native patients, Natives will remain outsiders of the mainstream health care facilities.

References

- Abbey, S. E., Hood, E., Young, T., & Malcolmson, S. A.
1993 Psychiatric Consultation in the Eastern Canadian Arctic: Mental Health Issues in Inuit Women in the Eastern Arctic. *Canadian Journal of Psychiatry*, 38, 32-35.
- Adler, N. E., Boyce, W. T., Chesney, M. A., Folkman, S., & Syme, L.
1993 Socioeconomic Inequalities in Health: No Easy Solution. *Journal of the American Medical Association*, 23, 3140-3144.
- Aho, W.R.
1979 Participation of Senior Citizens in the Swine Flu Inoculation Program: An Analysis of Health Belief Model Variables in Preventive Health Behaviour. *Journal of Gerontology*, 34, 201-208.
- Anderson, J. M.
1993 Health Care Across Cultures. *Nursing Outlook*, 38, 136-139.
- Berkanovic, E., Telesky, C., & Reeder, C.
1981 Structural and Social Psychological Factors in the Decision to Seek Medical Care for Symptoms. *Medical Care*, 19, 693-709.
- Browne, A. J.
1995 The Meaning of Respect: A First Nations Perspective. *Canadian Journal of Nursing Research*, 27, 95-109.
- Brunswick, F. B. & Banaszak-Holl
1996 HIV Risk Behaviour and the Health Belief Model: An Empirical Test in an African American Community Sample. *Journal of Community Psychology*, 24, 44-64.
- Cameron, C.
1996 Patient Compliance: Recognition of Factors Involved and Suggestions for Promoting Compliance With Therapeutic Regimens. *Journal of Advanced Nursing*, 24, 244-250.

- Carmel, S., Shani, E., & Rosenberg, L.
1994 The Role of Age and an Expanded Health Belief Model in Predicting Skin Cancer Protective Behaviour. *Health Education Research*, 9, 433-447.
- Cohen, J.
1992 Quantitative Methods in Psychology: A Power Primer. *Psychological Bulletin*, 112, 155-159.
- Deschamps, M., Band, P. R., Hislop, T. G., Clarke, H. F., Smith, J. M., To Yee Ng, V., & Math, M.
1992 Barriers to Cervical Cytology Screening in Native Women in British Columbia. *Cancer Detection and Prevention*, 16, 337-339.
- Earp, J. A., Altpeter, M., Mayne, L., Viadro, C. I., & O'Malley, M. S.
1995 The North Carolina Breast Cancer Screening Program: Foundation and Design of a Model for Reaching Older, Minority, Rural Women. *Breast Cancer Research and Treatment*, 35, 7-22.
- Frideres, J.S.
1988 Racism and Health: The Case of the Native People. In B. S. Bolario & H. D. Dickinson (Eds.). *Sociology of Health Care in Canada*. Harcourt, Brice and Jovanavich: Toronto.
- Frideres., J.S.
1991 From the Bottom Up: Institutional Structures and the Indian People. In B. S. Bolaria (Ed.) *Social Issues and Contradictions in Canadian Society*. Harcourt Brace Jovanovich, Toronto.
- Frideres, J. S.
1994 Racism and Health: The Case of the Native People. In B. S. Bolaria, & H. D. Dickinson (Eds.). *Health, Illness, and Health Care in Canada* (pp. 202-220). New York: Harcourt Brace Canada.
- Garro, L. C.
1995 Individual or Societal Responsibility? Explanations of Diabetes in an Anishinaabe (Ojibway) Community. *Social Science Medicine*, 40, 37-46.
- Hall, J.A., Irish, J.T., Roter, D.L., Ehrlich, C.M. & Miller, L.H.
1994 Gender in Medical Encounters: An Analysis of Physician and Patient Communication in a Primary Care Setting. *Health Psychology*, 13, 384-392.

- Harris, R., Skyler, J. S., & Linn, M. W.
1982 Relationship Between the Health Belief Model and Compliance as a Basis for Intervention in Diabetes Mellitus. *Psychological Aspects of Diabetes in Children and Adolescents. Pediatric Adolescent Endocrinology, 10*, 123-132.
- Health and Welfare Canada
1991 *Health Status of Canadian Indians and Inuit*. Ottawa: Minister of Supply and Services Canada.
- Janz, N.K., & Becker, M.H.
1984 The Health Belief Model: A Decade Later. *Health Education Quarterly, 11*, 201-225.
- Joe, J.R. and Lonewolf-Miller, D.
1989 Barriers and Survival: A Study of an Urban Indian Health Center. *American Indian Culture and Research Journal, 13*, 233-256.
- Li, H. Z.
2001 Co-operative and Intrusive Interruptions in Inter- and Intra-cultural Dyadic Discourse. *Journal of Language and Social Psychology, 20*, 259-284.
- Li, H. Z.
1999a Grounding and Communication in Intra- and Inter-cultural Dyadic Discourse. *Discourse Processes, 28*, (3), 195-205.
- Li, H. Z.
1999b Information Communication in Conversations: A Cross-cultural Comparison. *International Journal of Intercultural Relations, 23*, 387-409.
- Li, H. Z. & Browne, A.
2000 Defining Mental Health Illness and Accessing Mental Health Services: Perspectives of Asian Immigrants. *Canadian Journal of Community Mental Health, 19* (1), 143-159.
- Lu, Z.
1995 Variables Associated With Breast Self-examination Among Chinese Women. *Cancer Nursing, 18*, 29-34.
- Mayfield, M., & Davies, G.
1984 An Early Intervention Program for Native Indian Infants and Their Families. *Canadian Journal of Public Health, 75*, 450-453.

- Miles, A.
1991 *Women, Health And Medicine*. Philadelphia: Open University Press.
- Mirotnik, J. Feldman, L., & Stein
1995 The Health Belief Model and Adherence With a Community Center-based, Supervised Coronary Heart Disease Exercise Program. *Journal of Community Health, 20*, 233-247.
- Norman, P.
1995 Applying the Health Belief Model to the Prediction of Attendance at Health Checks in General Practice. *British Journal of Clinical Psychology, 34*, 461-470.
- Norris, A. E., & Ford, K.
1995 Condom Use by Low-income African American and Hispanic Youth With a Well-known Partner: Integrating the Health Belief Model, Theory of Reasoned Action, and the Construct Accessibility Model. *Journal of Applied Social Psychology, 25*, 1801-1830.
- O'Neil, J. D., & Postle, B.
1994 Community Healing and Aboriginal Self-government: Is the Circle Closing? In H. Hylton (Eds.). *Aboriginal Self-government in Canada: Current Trends and Issues* (pp. 67-83). Saskatoon: Purich Publishing.
- Price, J. H., & Everett, S.
1994 Perceptions of Lung Cancer and Smoking in an Economically Disadvantage Population. *Journal of Community Health, 19*, 361-375.
1996 *Report On The Royal Commission On Aboriginal Peoples*, Volume 3. Ottawa: Canada Communications Group.
- Rhoades, E.
1977 Barriers to Health Care: The Unique Problems Facing American Indians. *Civil Rights Digest, 25-31*.
- Ross, J., & Ross, J.
1992 Keep the Circle Strong: Native Health Promotion. *JSLPA, 16*, 291-302.
- Rundall, T. F., & Wheeler, J. R. C.
1979 The Effect of Income on Use of Preventative Care: An Evaluation of Alternative Explanation. *Journal of Health and Social Behaviour, 20*, 397-406.
- Runion, K.
1984 Training Native American to Deliver Mental Health Services to Their Own People. *Counsellor Education and Supervision, 2-10*.

- Scott, K. A.
1993 Funding Policy for Indigenous Human Services. *The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues* (pp. 90-107). Ottawa, Canada: Canada Communications Group.
- Sinclair, B. F.
1993 Health and Social Issues of Aboriginal People With Disabilities: An Alberta Perspective. *The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues* (pp. 139-157). Ottawa, Canada: Canada Communications Group.
- Waldram, J.B., Herring, A.D. and Young, T.K.
1994 *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*. Toronto: University of Toronto Press.
- Waldram, J. B., Layman, M. M.
1989 *Health Care in Saskatoon's Inner City: A Comparative Study of Native and Non-Native Utilization Patterns*. Winnipeg: Institute of Urban Studies, University of Winnipeg.
- Walsh, M.
1995 The Health Belief Model and Use of Accident and Emergency Services by the General Public. *Journal of Advanced Nursing*, 22, 694-699.
- Ward, J.A.
1984 Preventive Implications of a Native Indian Mental Health Program: Focus on Suicide and Violent Death. *Journal of Preventive Psychiatry*, 2, 372-385.
- Weinstein, N.D.
1993 Testing Four Competing Theories of Health-protective Behaviour. *Health Psychology*, 12, 324-333.
- Wotherspoon, T.
1994 Colonization, Self-determination, and the Health of Canada's First Nations Peoples. In B.S. Bolaria & R. Bolaria (Eds). *Racial Minorities, Medicine and Health* (pp. 249-266). Halifax.
- Young, T.K.
1994 *The Health of Native Americans*. New York: Oxford University Press.

Authors Note

The authors would like to thank all the participants for their time and efforts in making this study possible. We would like to thank Editor Corrigan and the two anonymous reviewers for constructive comments on an earlier version of the manuscript.

Please direct correspondence to Mitch Verde, Director of Mental Health, Nisga'a Valley Health Board, 256 Tait Avenue, New Aiyansh, B.C. V0J 1A0, Canada Mitch Verde, email: mverde@nisgaahealth.bc.ca or Dr. Han Li, Psychology Program, University of Northern British Columbia, Canada V2N 4Z9. Email: lih@unbc.ca